

2. OVERVIEW OF EXISTING RESEARCH

2.1. INTRODUCTION

According to LHR at least 65 percent of South African incarcerated offenders engage in same sex sexual activities. It is important to note that the concept of homosexuality will not be used in this study, since in most cases prison rape has no relationship with a person's sexual orientation. The prevalence of sexual assault and rape in correctional centres is especially high in the unsentenced population, where an estimated 80 percent of detainees will be subjected to abuse before being officially charged with a crime (Goyer, 2003:33). According to Helena du Toit, a social worker at PLCC, this high prevalence can be ascribed to the notion that no classification system exists for awaiting-trial detainees and a person that is charged with theft can for example be placed with a serial rapist (Inmates 'open to sex abuse', 2004:6). Placing a non-violent detainee with an aggressive inmate may increase the risk of physical as well as sexual assault.

Sexual abuse and rape in a correctional centre is often compared to rape in the broader community, where it is seen as an act of power and violence rather than a sexual act (Jones & Schmid 1989:53; Pantazis, 1999:371; Scacco, 1982:4). Researchers (Man & Cronan, 2001:129; Scarce, 1997:78) state that same-sex rape between heterosexual males in a correctional centre is an act of power, control, dominance, intimidation and terror. Men who are incarcerated are told by others when to eat, sleep and with whom to live with. Thus rape may become a tool for attaining power in a powerless situation. However, according to Pantazis (1999:371), sexual gratification is sometimes the primary goal during the sexual assault, especially if the victim is being "feminised" to validate the masculine identity of the rapist. The victim is often chosen on the grounds of him being less masculine in appearance and in his behaviour. Another explanation offered for rape in a correctional centre is that if a male offender engages in consensual sex with another man, his masculinity and manhood may be questioned. However, his heterosexual identity stays intact when he uses force (rape) while having sex with another man (Jones & Schmid, 1989:53; O'Donnell, 2004:243; Sivakumaran, 2005:1300). In this regard Davis (in O'Donnell, 2004:243) states the following:

The typical sexual aggressor does not consider himself to be a homosexual or even to have engaged in homosexual acts. This seems to be based upon his startlingly primitive view of sexual relationships, one that defines as male whichever partner is aggressive and as homosexual whichever partner is passive.

The sexual abuse of an offender often starts before he enters a correctional facility. In the court holding cells, first time non-violent offenders are often targeted by offenders who has already spent some time in a prison and who are accustomed to life in a correctional facility. In some cases, an unsuspecting first time offender may be forced to smuggle drugs into the correctional centre in his rectum (known as a koeël [bullet] in South African prison slang) (Aupiais 2002).

Below is a description of how an awaiting-trial detainee was first raped in the court holding cells by two prison gang members and thereafter had a koeël (drugs) forcefully inserted into his rectum to smuggle into Pollsmoor Correctional Centre.

...I didn't notice that the one standing behind me had pulled down his pants. Before I knew what was happening the one behind me forced himself into me. I was screaming out in pain, nobody took any notice. The other prisoners were told to look away or the same will happen to them. ...I was crying and pleading with them to stop. He raped for about two minutes. When he was finished I would feel wetness running down my legs. It was blood mixed with excrement and semen. The one standing in front passed him the koeël of dagga. He violently forced it inside me. The pain almost made me faint. I was told to put on my pants ... Nobody came to my aid while this ordeal was going on. I felt humiliated, dirty and sick (Parliamentary Monitoring Group, 1996).

Upon admission into the correctional centre the new inmate may be subjected to one of various forms of non-consensual sexual victimisation, such as sexual harassment, sexual extortion and/or sexual assault. Sexual harassment comprises of a new offender being treated as a sexual object and often subjected to verbal abuse. Sexual extortion occurs when an offender must repay his debt (money, cigarettes etc.) to another inmate by means of sex, due to a lack of resources. The ultimate form of sexual abuse is sexual assault when the victim is threatened with injury if he does not succumb to the sexual advances of another inmate (Cotton & Groth, 1982:49). It is during this phase that the victim is most vulnerable to being raped.

The sexual assault in a correctional centre depends on the opportunities available to the perpetrator, which include the presence of correctional officials and other inmates who act as “watchdogs”. When the opportunity arises, such as during poor supervision due to lack of manpower, anal sex will usually be the preferred sexual activity. In a letter to Human Rights Watch (2001), a prisoner revealed that forced sex usually involves “bodily forced rape” where one or more prisoners will sexually assault a victim either anally or orally or both. It is during this type of sexual assault that the victim suffers physical injuries. However, if correctional officials are constantly supervising a section, the victim will be forced to perform oral sex on the perpetrator, since this does not involve the removal of clothing, and therefore no suspicious behaviour is suspected by the correctional officials (Scacco, 1982:11).

According to Gear (2001), there is a need for better understanding of sexual victimisation inside correctional centres for the following reasons: The transmission of STI’s and HIV/Aids, the consequences of sexual victimisation on the male identity of the victim and the problems it holds for the rehabilitation and re-integration of offenders.

This chapter deals with the offender and the victim of rape, the causes of rape in a correctional centre, the consequences of male rape and strategies aimed at reducing sexual assault and rape.

2.2. THE OFFENDER AND THE VICTIM OF MALE-ON-MALE RAPE

In corrections there is a distinction between “men” (rapists) and victims. This is evident in the labels given to the “men”, namely stud, wolves or jockers, whereas victims are referred to as whores, turn-outs, kids, punks and in South Africa “wyfies”. The “men” take the masculine role in the sexual victimisation and are the violent aggressors in a rape. The “man” will always be the “inserter”, meaning that he will penetrate the victim anally or the victim will perform oral sex on him. Many researchers refer to this as situational homosexuality (Castle, Hensley & Tewksbury, 2002:17; Koscheski, Hensley, Wright & Tewksbury, 2002:112; Wooden & Parker, 1982:37). In contrast to this, the

victim is regarded as the passive partner or the insertee. In the majority of cases the victim is not a homosexual but has been “turned out” by another man (Castle *et al.*, 2002:17; Scacco, 1982:9).

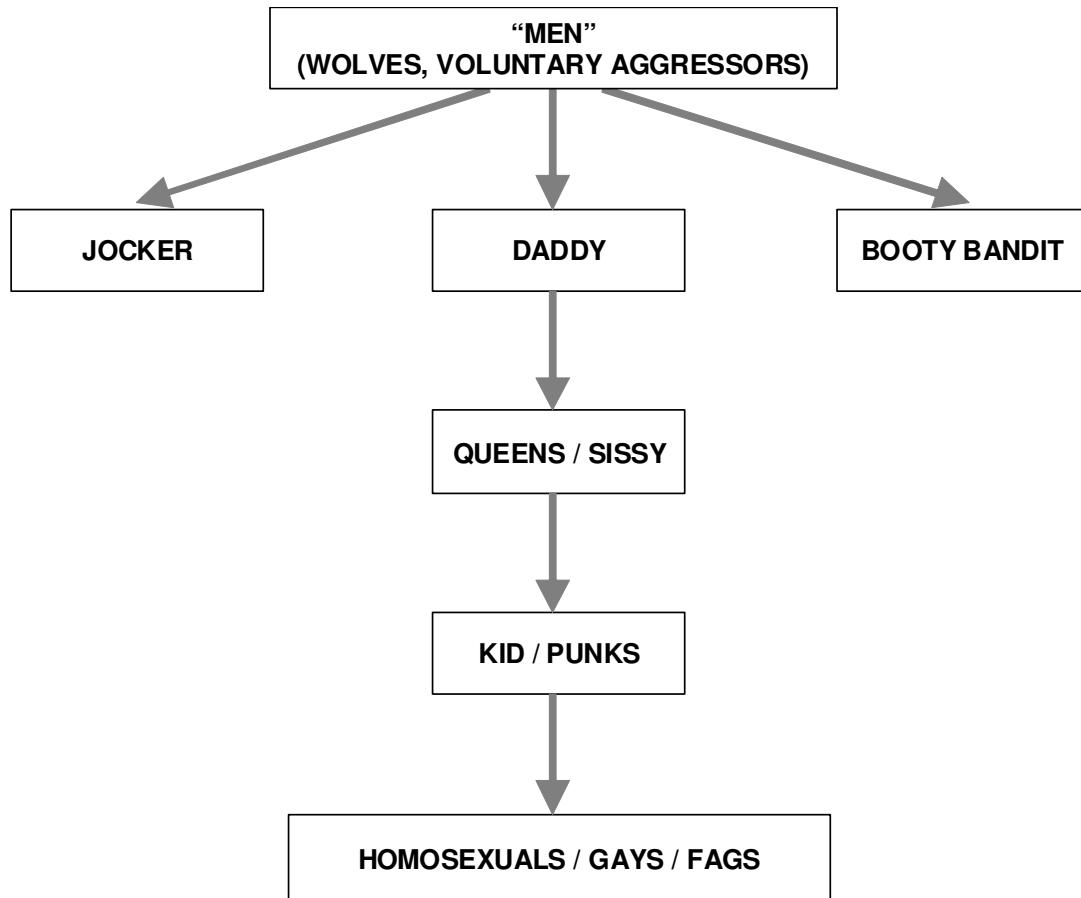
The offender may force the victim to participate in masturbation, oral sex and anal sex. Scacco (1975:36) postulates that the most conventional way to release sexual tension is through masturbation. There are two ways masturbation is practiced in USA correctional facilities, namely “hand shake” and “leggings”. A “hand shake” involves the men relieving each other simultaneously with their hands, while “leggings” involve a man putting his penis between the legs of another man, usually in the standing position (Scacco, 1975:37). In South African correctional centres “leggings” or inter-femoral sex is known as “thigh sex”, “the new road”, “eating the leg” and “dried fruits” (Gear & Ngubeni, 2002:61). Oral sex is also performed regularly within the confines of a correctional facility. Scacco (1975:40) found that the man who performs oral sex is usually also the victim of verbal abuse and even physical threats. This may be due to the aggressor aiming to maintain his male identity in the presence of others. The victims may also be anally penetrated. In South African correctional centres this is known as “do it in the eye”, “the old road” and doing a “boiler” or putting it “inside the boiler” (Gear & Ngubeni, 2002:66).

The majority of adult South African offenders hold the view that inter-femoral sex happens more frequently in prison, when compared to juveniles who state that anal sex is more popular in prison. The juveniles explained their viewpoint by stating that the rectum of a man in prison can be compared to the vagina of the female, orgasm is reached faster and that after inter-femoral sex many inmates progress to anal sex (Gear & Ngubeni, 2002:61). The type of sex also depends on the preference of a particular gang, and it is suggested that anal sex is preferred by the 28’s gang, while members of the Big 5 gang are only allowed to engage in inter-femoral sex (Gear & Ngubeni, 2002:62).

2.2.1. Argot roles in corrections pertaining to offenders and victims of male-on-male rape

Dumond (in Donaldson, 2001:118) postulates that “prison slang defines sexual habits and inmate status simultaneously”. Below is an illustration of the argot roles and classification system as it pertains to prisons in the USA. It can be generalised to correctional facilities worldwide, since the sexual assault and rape of inmates are universal problems. Each country will however have its own prison slang referring to offender, victims and the “turn out” process.

FIGURE 1: SEXUAL CLASSIFICATION SYSTEM IN A CORRECTIONAL ENVIRONMENT (OWN ILLUSTRATION)



At the top of any prison hierarchy are the so-called “men” because they have successfully avoided being sexually assaulted. Whenever a man is anally penetrated or

is forced to perform any sexual act against his will, he has “lost his manhood”. A “man” who is sexually active is known as a “jocker”. These offenders engage in sexual acts with heterosexual and homosexual men, but do not regard themselves as homosexual as they assume the masculine role during the sexual act. If a “jocker” pairs off with only one partner he is known as a “Daddy”, and if a man uses coercion he is known as a “booty bandit” (Donaldson, 2001:118; Knowles 1999:271). Following the “men” category is the category known as “queens” or “sissy’s”. This category usually consists of homosexual or transsexual males who take on the feminine role and will always be the submissive partner. Feminine terminology is used when describing these men, for example they have “pussies” not “assholes” and they wear “blouses” not shirts (Donaldson, 2001:119; Knowles, 1999:271). The general prison population is aware that these men will readily provide sexual favours in exchange for some type of payment (e.g. cigarettes, money, food). Although this category of men constitutes the smallest group their willingness to have sex causes problems in the prison as they are in demand by many “men” (Stojkovic & Lovell, 1997:346). Because of this, some correctional institutions segregate “queens” from the general prison population and they are placed in special units often referred to as “queens’ tanks” (Donaldson, 2001:119). The “kids” or “punks” are the next category in the classification system. These are the men who “have been forced into a sexually submissive role” (Donaldson, 2001:119). “Punks” do not display feminine characteristics, but are chosen because they are young, inexperienced, first time offenders and are physically smaller than their attackers. These men often engage in prison sex either for protection or for receiving goods and services – known as “canteen punks” (Castle *et al.*, 2002:16). This category of victims is nothing less than slaves, who can be sold, traded, rented or loaned to other prisoners (Donaldson, 2001:119). Lastly there are the offenders who are known as “homosexuals” or “gays”. They will take on both the passive and active sexual roles and display very little or no effeminate behaviour (Knowles, 1999:271).

Castle *et al.* (2002:17-18) compiled a similar classification system. According to them there are four dominant argot roles, namely “fags”, “fuck-boys”, “straights” and “turnouts”. The former two types are known homosexuals in prison, but the “fags” are the effeminate homosexuals who can be identified by their dress, hair, speech and walk. On the other hand “fuck-boys” are not identified by these characteristics. The latter two regard themselves as heterosexual and are viewed by other prisoners as

heterosexual. Some “straights” develop consensual sexual relationships with other men, while “turnouts” may seduce men in return for commodities.

2.2.2. The offender in male-on-male rape

As already indicated, when a man takes on the dominant sexual role in a correctional centre, he is still viewed as heterosexual, although he is engaging in homosexual behaviour. By raping fellow inmates these men show that they have power (physical and sexual) over women and men alike. To support this, a prisoner stated that “a man who fuck a male is a double male” (Bowker, 1980:11; Scacco, 1975:86). Once released from a correctional centre, these men will continue with normal heterosexual relationships. They can therefore be seen as situational homosexuals within the prison environment. According to Eigenberg (2000:437), situational homosexuality refers to heterosexual men having sex with other men because of the situational nature of the sexual deprivation.

Offenders of male-on-male rape share the following characteristics:

- They tend to be older than their victims, but younger than the general prison population. They are usually younger than thirty-five years.
- Men who rape other inmates tend to work in the kitchen since they use food (or the lack thereof) in exchange for sex.
- They are usually larger and stronger than their victims and seem to be well adjusted to the prison environment.
- Offenders tend to be gang members, are convicted of violent offences and have a criminal record. They serve a longer than average sentence (5 to 10 years) and has served at least six months of the current sentence.

- These offenders consider themselves to be heterosexual and have engaged in heterosexual relationships prior to and after their release (Chonco 1989:74; Gear 2001; Goyer 2003:19; Kunselman, Tewksbury, Dumond & Dumond, 2002:42; Human Rights Watch, 2001).

According to Chonco (1989:74) offenders may exhibit the following behaviour:

- They tend to be too nice and over-friendly towards potential victims.
- They give goods such as cigarettes, money and sweets to potential victims.
- They do favours for other inmates, such as protecting them and lending them television sets and radios.
- They tend to touch other inmates' private parts, put an arm around their shoulders or make sexual remarks.

2.2.3. The victim of male-on-male rape

A myth exists among offenders that there are two ways of dealing with inmates' sexual or physical aggression. One can either retreat from the potentially violent situation and go into protective custody (flight response), or attack the aggressor (fight response). Vulnerable men are advised by fellow inmates and correctional officials to counter aggression with aggression. However, for some men this response is outside of their usual way of solving problems (i.e. by means of communication). Furthermore, since violence is not permitted in a correctional facility, the victim may cause more problems for himself and is likely to be punished for attempting to protect himself (Toch, 1992:207-211).

The characteristics of a potential victim of male-on-male rape include the following (Chonco, 1989:73; Gear & Ngubeni, 2002:28; Human Rights Watch, 2001; Man & Cronan, 2001:166):

- Young and youthful-looking men are at particular risk for rape, and are usually younger than the perpetrator. As one prisoner explained to Human Rights Watch (2001):

Mostly young youthful Boy's are raped because of their youth and tenderness, and smooth skin that in the mind of the one doing the raping he think of the smooth skin and picture a woman ... prisoners even fight each other over a youth without the young man knowing anything about it to see whom will have the Boy first as his property.

This is one of the reasons why the Correctional Services Act (Act 111 of 1998) stipulates that juveniles are to be separated from older offenders. In addition the South African Constitution (Act 108 of 1996) stipulates that those under the age of 18 years must be detained separately from adults. It is also stated in the White Paper on Corrections in South Africa (2005:81) that the vulnerability of children and youth to pressure, force and abuse from older offenders must be addressed in the training of all correctional officials.

- Vulnerable inmates are also those who are first time offenders or repeat offenders who are imprisoned for the first time. These inmates are unaccustomed to the prison subculture and therefore vulnerable to intimidation and domination by more experienced long term inmates.
- Mentally ill or retarded offenders are also at particular risk to become victims of rape.
- Homosexual inmates with stereotypical feminine characteristics.

- Those who have been convicted of a sexual offence, especially against a minor, are likely to become victims of rape. The following explanation is given for this: “You need to be raped too ‘cos you raped our sisters outside”. A prisoner convicted of sexually abusing a minor describes his violent attack by fellow prisoners to Human Rights Watch (2001) as follows: “They beat me with mop handles and broom sticks. They shoved a mop handle up my ass and left me like that.” These prisoners therefore attempt to hide the crime they have committed from their fellow inmates.

- Those that seem “very needy” are also likely to become victims.

They are usually recently detained, either juveniles or young adults, who have no blankets, soap, plates or food. They have no relatives from the outside to help them and care for them, they are in physical need and confused by their recent detention and they turn to somebody to care for them. The ones they usually turn to are those who have outside supplies. The relationship between them was described as similar to that between a poor prostitute and a rich client (Goyer, 2003:19).

- Criminal status can also determine whether a man will become a victim of rape. According to Gear and Ngubeni (2002:28), offenders indicated that those inmates whose crimes involved violence and weapons are perceived to be brave. However if a man was convicted of theft, a crime where no weapon was used, or indecent assault and/or rape, he is perceived to be a “women” and is a likely target for rape.
- Victims of rape tend to be weaker and smaller than the perpetrators. Not only physical size and strength, but also attitude can contribute. Inmates who are perceived to be timid, fearful, “passive” and non-aggressive are also likely to be targeted.

Some men manage to escape sexual assault and rape by exhibiting the following behaviour (Chonco, 1989:75; Kunselman *et al.*, 2002:39-40):

- Minding their own business and not involving themselves in the functioning of the prison.
- Not associating with many inmates.
- Not accepting any “gifts” from other inmates.
- Being a fighter and gaining the respect of other inmates through tough talk, physical aggression and displaying violence.
- Attempts to sexually victimise another prisoner.

Van Huyssteen (in Gear 2001) is of the opinion that male victims of rape in a correctional centre are subjected to secondary victimisation in the following ways:

- Some correctional officials insist that what happens to awaiting-trial detainees during their term of imprisonment is not their responsibility, since the detainees are under the control of the SAPS.
- The lack of SAPS members to follow up on reported cases of indecent assault.
- The view by DCS that rape in correctional centres does not take place, since acknowledging this will be an embarrassment to the Department.
- The viewpoint that a real man cannot be raped.
- Correctional officials become “desensitised” to the sexual violence and in effect turn a blind eye.

- Lack of acknowledgment by the broader society regarding the victimisation that takes place in correctional facilities.

2.2.4. The victimisation process

Fisher (in Toch, 1992:188) defines victimisation in a correctional environment as a predatory practice whereby inmates of superior strength and knowledge lure prey on weaker and less knowledgeable inmates". According to Chonco (1989:75), the sexual victimisation process in corrections consists of various phases and in each phase there is a key role player. The phases are: Observation, selection, testing, approaching and actual victimisation. Key role players are known as observers, contacts, turners and pointmen.

In the **observation phase**, observers are paid by other prisoners to observe a new inmate and to collect information on the potential victim. The information usually includes the victim's criminal history, the name of a previous correctional institution in cases where the potential victim has a previous conviction, names of friends he may have inside the prison and the type of crime he is currently imprisoned for. Observers tend to single out first time offenders as well as repeat offenders who are imprisoned for the first time (Chonco, 1989:75).

During the **selection phase**, a potential victim is selected on account of his weakness (naive, friendly, shows fear). The contacts and turners play an important role during this phase. They tend to listen in on conversations between the potential victim and other inmates to provide information to the offender regarding the victim's likes, dislikes and habits, as well as the type of work he does in the correctional facility. Usually these men are not aware that they are being observed and in effect being "turned into victims". The turner is the inmate who attempts to establish a bond between himself and the potential victim, and often does favours for the target. This will ensure that the potential victim will have to do something back for him and usually includes a sexual favour (Chonco 1989:75-76). For example, in Pollsmoor Correctional Centre, a severely overcrowded centre, there are sometimes not enough blankets for all the inmates during the winter. The turner might suggest to the new inmate that they could

share a blanket. If the sharing of the blanket is accepted it is considered to be an agreement to sex. Usually new inmates are unaware of this “unwritten” agreement (Harvey, 2002:47).

In the **testing phase**, the information gathered during the first phase is used to evaluate and assess the potential victim. A method that is frequently used during testing is to leave cigarettes, money, toothpaste or any other commodity on the potential victim’s bed and observe whether he will take or use any of the goods. If the target refrains from taking or using the goods, a more direct approach of giving him the goods is used. During this phase he is also tested to see how far he can be pushed before breaking down. This phase is decisive in determining whether the potential victim will use the “fight” or “flight” response. If he refuses to be manipulated and puts up a physical fight he may be accepted as a “man”, if he does not fight he becomes a victim (Chonco, 1989:76).

The **approach** is the fourth phase. The potential victim is expected by the perpetrator to contravene certain rules of the correctional facility, such as distributing drugs. In the fifth phase the potential victim becomes the **actual victim** of sexual assault. During this phase the pointmen will stand guard while the initial perpetrator is sexually assaulting the victim. The pointmen will warn the perpetrator if a correctional official is approaching. In some instances pointmen may also engage in sex with the victim once the perpetrator has finished. Pointmen will also determine whether the victim is sexually assaulted by other inmates. As one prisoner puts it: “An inmate who has a record of being fucked by other guys is in trouble in prison because the word goes around and before the guy knows what is happening his manhood is taken without consent” (Chonco, 1989:77). The sexual victimisation takes place in what is called “trouble spots” such as the bathroom, shower or cell. It is believed that the sexual victimisation takes place within 16 weeks after the target has entered the prison (Chonco, 1989:76-77; Scacco, 1975:26; Stojkovic & Lovell, 1997:353). It is suggested by Chonco (1989:77) that once the target has been selected, tested, approached and victimised it will be difficult to avoid future sexual assaults.

2.2.5. The relationship between the offender and the victim

Once a man has been sexually victimised, one of various relationships may develop between him and the perpetrator. These relationships can manifest in one of the following ways:

The first type of relationship is described by Gear and Ngubeni (2002:11-12) as a “marriage”. Within such a “marriage” one is either a “husband” or a “wife”. Other terms used by South African offenders to refer to a “husband” are “big man” or “boss”. A “wife” (“wyfie”/“wyfietjie”) is also known as a “small boy”, “young man”, “madam”, “girlfriend” or “concubine”. The “husbands” are the men and they are superior to their “wives”. Central to this “marriage” is that the man must provide financially for his “wife”, and he can have many “wives” as long as he is able to support all of them. The “husband” must therefore provide luxuries such as cigarettes, food, dagga and other goods. Because he is “paying” for services he is allowed to move around while the “wives” activities are usually restricted, and they tend to stay in the cell. The “wives” must do the domestic chores such as cleaning the cell and washing the clothes of their “husbands”. The main function of a “wife” is however to fulfil the man’s sexual needs. The “husband” **always** penetrates the “wife” or requests that oral sex be performed on him.

“Uchincha ipondo” is another type of sexual relationship that may develop in a correctional centre and simply means to “change or exchange a pound” (Gear & Ngubeni, 2002:52). In this type of relationship sex is exchanged for sex and not for goods or protection, since the exchanging of goods or protection constitutes a “marriage”. There are no clear roles in this relationship and neither partner is considered superior (male) or inferior (female). Partners will take turns to penetrate and be penetrated. This practice tend to be associated with juvenile offenders since it is often they who are other inmate’s “wives” and would also like to fulfill their sexual needs by sometimes penetrating. Many inmates are also experimenting with sex for the first time. These sexual relationships are usually not accepted by the gangs and can be punished by them. Individuals who engage in “uchincha ipondo” tend to keep their activities secret. A common form of punishment when caught doing “uchincha ipondo” is physical assault. Gear and Ngubeni (2002:53) postulate that the guilty parties may

even be forced to have sex with the person that caught them. In the Big 5 gang, guilty parties may be subjected to “funky mama”. This implies that the victims are gang raped as punishment. According to one offender a “wife” may ask his “husband” whether he can engage in “uchincha ipondo” with another offender. The “husband” who agrees to this will require that it takes place in his absence or that both parties provide sex on demand to him (Gear & Ngubeni, 2002:53). The practice of “uchincha ipondo” is regarded as a homosexual relationship whereas a “marriage” is a heterosexual relationship because there are clear gender roles as the “women” are “created” and are convinced or forced to act accordingly (Gear & Ngubeni, 2002:55).

Some men enter a relationship for protection in order to avoid continual sexual victimisation. In order to escape being abused by many men, the victim chooses to “pair off” with one partner who can protect him against abuse from others. Since these prisoners are “voluntarily” exchanging sex for protection, many correctional officials fail to see the hidden coercion that lies within this relationship (Harvey, 2002:47).

According to Gear (2001), men also engage in a short-term sexual relationship similar to the relationship between a prostitute and a client. The inmate who works as a prostitute is stigmatised less than a man who is raped because he sells his body in exchange for commodities instead of being forced into sexual acts with another man. This willingness may be questioned in that some prostitutes are actually rape victims, but after the forced victimisation negotiate commodities in exchange for their bodies. This is commonly known as “survival sex” (Eigenberg, 2000:437).

Some offenders who are unable to escape rape may become the property of other men. These men are the slaves of the perpetrators, and may be “rented out” for sex, sold or auctioned off to other inmates, representing the financial benefits of traditional slavery. The prisoner(s) who “own” these men tell them what to wear, how to dress and whom to talk to (Human Rights Watch, 2001).

Regardless of the nature of a sexual relationship one man will always be sexually exploited in exchange for protection, money, cigarettes and even friendship. Some sexual relationships in correctional centres even seem to be consensual in nature. The

question that arises from this is: How consensual is a relationship when one has sex in order to survive in a correctional facility?

2.3. THE CAUSES OF MALE-ON-MALE RAPE

Koschescki *et al.* (2002:113-114) offer six reasons why heterosexual men will engage in situational homosexuality:

- Male correctional facilities are mainly unisex communities, with male correctional officials, male psychologists, male educators and male administrators. Therefore due to a lack of contact with females, men strive towards sexual gratification with other male inmates. Although this statement may have been true some years ago, there are currently many females working as correctional officials, psychologists, social workers and educators in correctional settings.
- Correctional officials tend to tolerate and turn a blind eye towards sexual behaviour between men since it contributes towards a non-violent and riot-free correctional centre. When inmates with power get what they want (“wyfies”), they will not cause problems.
- Limited work opportunities inside a correctional centre may lead to sexual behaviour between men. If inmates are kept busy there will be less time to engage in sex. It is estimated that about 90 percent of the prison population are idle during their term of imprisonment.
- Overcrowding may also cause prison homosexuality, as offenders are forced to share a shower, toilet and sometimes even a bed. It is also impossible for correctional officials to control inmate behaviour in these conditions effectively.
- Lack of a classification system forces young, first time non-violent offenders to be locked up with hardened violent criminals.

- The last factor is the complete detachment from the outside world.

In this section the following causes of male-on-male rape will be discussed: Prison gangs, overcrowding and sexual orientation.

2.3.1. Prison gangs

Gangs have been an integral part of South African corrections for over a hundred years (Dissel, 2002:10). According to Lotter and Schurink (in Minnie *et al.*, 2002:53), there are two main categories of gangs operating in South African correctional centres. The first category is the Number gangs namely the 26 gang, 27 gang and 28 gang. The second category is known as the Fourth Camp and includes the Big 5 gang, Airforce gang, Fast Elevens and the Desperadoes. Each gang has its own vision, mission and aims and members are identified by distinct tattoos. Gangs have their own set of rules and a member will often be violently punished for contravening these rules.

It is postulated (Dissel, 2002:10; Draft White Paper on Corrections in South Africa, 2003:77; Minnie *et al.*, 2002:52) that gangs are in charge of prison life, and are responsible for smuggling, assaults, murder, distribution of food, escapes, intimidation, encouraging corruption amongst officials and forced sexual activity. In support of this a prisoner insisted that “people who are not gangsters are not allowed to practice homosexuality in prison” (Gear & Ngubeni, 2002:39). It has also been documented that gang members are often responsible for transmitting the HIV/Aids virus. An ex-offender who served a sentence for car theft claimed that he was given a “HIV puncture”, meaning that he had been raped by gang members who know they are HIV positive, because he did not want to join a prison gang during his incarceration (Peete, 2004:3). Gangs do however also fulfil a positive function in corrections as they satisfy the physical, psychological and social needs of offenders, such as comradeship, status and protection (Minnie *et al.*, 2002:52). A discussion of the four major gangs operating in South African correctional centres follows.

2.3.1.1. The 28 gang

The 28 gang is the most powerful prison gang and their main aim is to recruit “wyfies” and to encourage sodomy amongst its members (Gear, 2001; Gear & Ngubeni, 2002:13; Minnie *et al.*, 2002:54).

In order to understand the practice of sexual activities amongst gang members, an exposition of the rank strategy is given and the role each member plays within this gang. According to Hlongwane (1994:171) the rank strategy of the 28 gang has two divisions, namely the private division and the blood division. The private division consists of the following gang members (Hlongwane, 1994:171-172):

- The boy-wives (“wyfies”) of the 28’s members.
- Magistrate: Presides over minor offences committed by gang members.
- Secretary: Whenever meetings are held the secretary must take the minutes.
- Inspector (investigator): Investigates all matters that relate to the gang and investigates the new inmates who want to join the gang.
- Landdros: Is responsible for the medical care of all members.
- Doctor: The function of this member is twofold: Firstly he is responsible for all the patients who have sustained injuries during gang related fights, and secondly he must examine all inmates who want to join the 28 gang. Furthermore, the doctor examines all weapons to be used by its members and the length of the knife blade determines the seriousness of the offence to be carried out.

- Government: Takes care of the statute book and gives the commands to the members.
- *Nonzala* (instructor): Exercises discipline over soldiers and “wyfies”.

Included in the “blood division” are the following members (Haysom, 1981; Hlongwane, 1994:173-174):

- Soldiers: They are at the bottom of this division and have to protect the gang members by means of assaults on other inmates.
- Sergeant two: If a prisoner wants to join this gang he must approach Sergeant two who will take him to the Inspector.
- Sergeant one: He is in charge of the new soldiers and has to make sure that they do not leave once they have joined the gang.
- Captain two: Chairs the meetings whenever they take place.
- Captain one: Handles minor cases and is the commander of the soldiers, Sergeants one and two as well as Captain two.
- Jim Crow (Germiston-Lieutenant): He is the middle-man and is an expert on the gang codes. This gang member is also responsible for assigning “wives” to gang members.
- Captain who works with a radio: Collects all information from other inmates about the 28 gang, sees to it that members are punished and when there is a complaint about food he will convey the message to the correctional official.

- Colonel: Writes the statutes of the 28 gang and defends members of the gang who are accused of an offence.
- General (Blacksmith): Makes the weapons for the members, is aggressive and called upon an “up” (fight) with other gangs.
- Judge: If a gang member is guilty of an offence that requires the death sentence, he will make sure that it is carried out. A death sentence usually entails being stabbed to death by fellow members.
- Lord: The most senior member of the 28 gang.

The objectives of the 28 gang are as follows (Hlongwane, 1994:176):

- Acquiring “wives”;
- Lodging complaints about the quality of the food; and
- Correcting the wrongs perpetrated by the correctional officials.

Internal conflict arises when the “wives” of senior gang member have sex with junior gang members. It is believed that sex between these two men is “dirty and must be washed”. This entails that the junior member provides the “wife” with soap and a cloth and he must wash himself for eight days before he may have sex with the senior member again (Hlongwane, 1994:178).

According to the code of the 28 gang no sexual relations are allowed with junior members of the Big 5 gang and the Airforce gang. Sexual relations were previously allowed between 28 gang members and Big 5 gang members, but it was soon realised that the Big 5 gang members revealed the secrets of the 28 gang to correctional

officials and fellow gang members. A 28 gang member is allowed to have sex with a junior member of the 26 gang, in exchange for 26 packets of B.B. tobacco. However no attempt may be made by the 28 gang member during or after the sexual intercourse to recruit the junior 26 gang member. The junior 26 gang member can be bought back for eight packets of B.B. tobacco. Members of the 28 gang are allowed to have sex with an inmate that does not belong to any gang (Hlongwane, 1994:181).

A “wife” of a 28 gang member who no longer wants to engage in sex must make this desire known to the members. If his reasons are not valid he will be forced to continue being a “wife”, but if he has valid reasons he will be promoted to a soldier (Hlongwane, 1994:182).

An offender incarcerated at Pollsmoor Correctional Centre described the night he was raped by members of the 28 gang as follows (Oersen, 2001:28):

... the second time I drove through the gates of Pollsmoor was in August 1999. I was 19, and had been sentenced for assault ... I was initiated as an *indoda* (gangster) - I became a member of the 28's ... they took me into a room and asked me to sit down so the officials wouldn't see me. I was taught all the rules and regulations, and was given a new name. I thought I'd be protected, I was wrong. Two days later I was summoned by Tony who asked me to become his 'son'. He explained to me that it was quite a privilege, because he could protect me. I knew what he meant, I would have to sleep with him for that privilege ... First he pulled my pants down and had sex with me through my thighs. Then he wanted to have anal sex ... Tony made me lie on my stomach and used Vaseline to lubricate me ... When he entered me, I screamed ... sore, torn an bleeding, I went to the shower and cleaned myself with cold water ... He raped me regularly for the next eight months.

2.3.1.2. The 26 gang

The second most powerful Numbers gang is the 26 gang. Members of this gang are also known as boys from the east because they operate early in the morning. The main objective of this gang is assault (“taking blood”) by stabbing a rival gang member and non-gang members with knives or other sharpened instruments. They may not “take blood” after the sunset, except in self-defence (Haysom, 1981; Hlongwane, 1994:149,

152). Although the code of the 26 gang forbids members to have sex with “wyfies” or to recruit “wyfies” into the gang, some members do have sex with younger gang members, known as “school boys” or with inmates who are non-gang members, known as “mphatha”. When a 26 gang member is caught having sexual relations he will be punished for contravening the gang code (Hlongwane, 1994:163).

2.3.1.3. The Big 5 gang

One of the Fourth Camp gangs is the Big 5 gang, who collaborates with correctional officials in order to maximise privileges (Haysom, 1981; Hlongwane, 1994:192).

The Big 5 gang has the following prohibitions regarding same-sex practices (Hlongwane, 1994:191):

- The “wife” of a Big 5 gang member should not associate with rival gang members.
- A Big 5 gang member is not allowed to force another inmate to become his “wife”.
- A “wife” of a Big 5 gang member may, with the permission of the gang, engage in sexual relations with a non-gang member.
- Only Big 5 members high up in the hierarchy are allowed to have “wives”.

The members who are allowed to have “wives” may only sleep with them on a Saturday, which is called “canteen day”. From Sunday to Friday the “wives” sleep in a communal cell. Whenever it comes to the attention of the gang that a “wife” has had sexual relations with a member from a rival gang he must be punished. The punishment usually entails the “wife” being hit 25 times or given five liters of water to drink. A “wife” who wishes to no longer have sexual relations with a Big 5 member can

be promoted to the defence category and can become a soldier (Hlongwane, 1994:198-199).

2.3.1.4. The Airforce gang

The Airforce gang specialises in escapes from a correctional centre. The reasons for the escape may be due to internal factors such as frustration with their current situation and dissatisfaction with conditions inside the correctional centre, but also external factors including marital problems and concerns about the family (Hlongwane, 1994:125).

Sexual relationships with “wyfies” are prohibited by Airforce gang members (Hlongwane, 1994:143). However, an offender indicated that this is only a means of encouraging new inmates to join this gang. Once a member of the gang, he is made into a “wife” for sexual exploitation by other gang members (Gear & Ngubeni, 2002:34-35).

From the above discussion it is clear that prison gangs still form an integral part of prison life and play a major part in the coerced sexual activities that take place inside South African correctional centres. This is however not the only contributing factor. Another concern is the overcrowding of correctional centres and how this can cause men to engage in coerced sexual activities with each other.

2.3.2. Overcrowding

It is stated in the Draft White Paper on Corrections in South Africa (2003:42) that South Africa has the world’s highest prison population in relation to the actual population of this country. Four out of every 1 000 South Africans are incarcerated in a correctional facility. This causes overcrowding, and often 50 to 70 inmates are being incarcerated in a communal cell intended to accommodate 18 inmates (Goyer & Gow, 2000:16). In Pollsmoor Correctional Centre there is only one toilet and one shower per communal cell that houses fifty inmates, while 50 percent of the inmates are forced to share a bed

or sleep on the floor. A similar situation exists in PLCC (in the awaiting-trial section), where up to 65 detainees are housed in a communal cell intended to accommodate 30 detainees (Eybers, 2004:8; Pollsmoor not fit for humans, 2002).

On 31 October 2007 South Africa's correctional population consisted of 163 049 inmates, of whom 114 349 were sentenced offenders and 48 700 were awaiting-trial detainees. Currently South African correctional centres have a capacity to cater for 114 559 inmates. This implies that the level of overcrowding in South African correctional centres was 142.35% during 2007 (Department of Correctional Services, 2007). In addressing the relationship between rape and overcrowding of correctional centres, the previous Minister of Correctional Services, Ben Skosana, insisted that sodomy can be attributed to the overcrowding of correctional centres (Ministry of Correctional Services, 2001). Thomas (in Goyer & Gow, 2000:16) also stated that "... the more crowded the prison is, the greater the likelihood is of acts of rape and homosexuality". Other consequences of overcrowding include violence, aggression, influence on stress tolerance and illness (Goyer & Gow, 2000:16; Minnie *et al.*, 2002:55).

The main reasons for prison overcrowding are the following (Dissel, 2002:9; Draft White Paper on Corrections in South Africa, 2003:26-27; Judicial Inspectorate of Prisons 2002/2003:26-27):

- High levels of awaiting-trial detainees due to delays in processing court cases.
- Introduction of minimum sentences for serious offences in 1997. The effect of the long sentences is an increase in the sentenced prison population. There was also an increase in the number of prisoners serving a life sentence from 1 885 in 1995 to 7 885 in 2002.
- Legislative changes in bail application, where the responsibility rests on the accused to prove why he or she should be released on bail. Relating to this is the fact that many accused cannot afford to pay even a small bail amount of R50,00 and are forced to spend a long period (on average 143 days) awaiting trial in a

correctional centre. On 24 March 2003 there were 19 592 accused persons with this dilemma.

- There was also the amendment to the Parole law during 1997, making it compulsory for an offender to serve half of his or her sentence before being eligible for parole.

Because of the overcrowding of correctional centres due to the factors listed above, the following reduction strategies have been identified:

2.3.2.1. Reducing overcrowding of correctional centres

Possible solutions to reduce overcrowding in South African correctional centres pertaining to awaiting-trial detainees and sentenced offenders are as follows (Fagan 2002:17-19; Judicial Inspectorate of Prisons 2002/2003:23; Minnie *et al.*, 2002:55; Draft White Paper on Corrections in South Africa, 2003:27):

(a) Awaiting-trial detainees

The awaiting-trial prison population can be reduced through provisions set out in legislation, but also through strategies specifically aimed at juveniles awaiting-trial in a correctional centre. Firstly with regard to legislation, there are two provisions which stipulate that awaiting-trial detainees may be released under certain circumstances:

- Section 63A of the Criminal Procedure Act (Act 51 of 1977) provides for a Head of Prison, who feels that overcrowding in that particular prison has an influence on the human dignity, physical health or safety of awaiting-trial detainees who are unable to pay bail, to apply to court for release under certain conditions. It may not be used in cases where a person is accused of committing a serious offence. Under this section 176 prisoners were released from Pollsmoor Correctional Centre in 2002.

- Section 81 of the Correctional Services Act (Act 111 of 1998) provides that an awaiting-trial detainee who has been allowed bail but cannot afford it, be released under specific conditions.

The release of detainees under the above provisions should not be regarded as amnesty since they must still appear in court on the specific hearing date.

A second reduction strategy is the use of pre-trial diversion especially for juveniles. In this regard the following may be applied:

- Extensive use of plea bargaining in all types of cases.
- Since 14 February 2003 higher maximum amounts for admission of guilt fines can be set by police officials (R2 500, 00) and by prosecutors and clerks of the court (R5 000, 00) without a court appearance.
- Greater use of alternatives to imprisonment such as correctional supervision.
- Cases of awaiting-trial detainees in correctional centres should be given preference over those awaiting-trial outside a correctional centre.

Regarding the reduction of sentenced offenders two options have been identified, namely diversion and the use of non-custodial sentences.

(b) Sentenced offenders

- The use of diversion for both juvenile sentenced offenders as well as adult sentenced offenders.
- Greater use of non-custodial sentences such as:

- (i) Postponed sentences in cases where compensation is paid to the victim, or community service;
- (ii) Suspended sentences;
- (iii) Discharge with a reprimand;
- (iv) Affordable fines;
- (v) Community-based sentences;
- (vi) Periodical imprisonment; and
- (vii) Increased use of parole.

Although there is no guarantee that reducing the number of inmates will have an impact on male rape inside a correctional centre, it is certainly an initiative worth pursuing.

Another cause of sexual assault and rape of male offenders and awaiting-trial detainees may be an inmate's sexual orientation. This possible link will now be discussed.

2.3.3. The role of sexual orientation

Sexual orientation is described by Lemmer (2005:128) as a person's sexual attraction towards another person. Four types of sexual orientation can be distinguished, namely heterosexual, homosexual (gay or lesbian), ambisexual (bisexual) and asexual. The most common form of sexual orientation is heterosexual, meaning being sexually attracted to a person of the opposite gender. Homosexual means that one feels sexually attracted towards people of the same gender. An ambisexual person is someone who is neither exclusively heterosexual nor exclusively homosexual. Thus ambisexual entails being sexually attracted to both genders. Asexual means that a

person has no sexual feelings towards either gender (Lemmer, 2005:129-130; Nietzel, Speltz, McCauley & Bernstein, 1998:489).

A dearth of research exists regarding the sexual orientation of the victim of prison rape, but the Jali Commission of Inquiry into corruption has shed some light on this issue. Evidence was heard by this Commission that homosexual and transgendered people are particularly vulnerable in a correctional system where corrupt officials allow sexual exploitation between inmates, gangs and hardened criminals. During his awaiting-trial period of 18 months, Louis Karp was sold as a sex slave by correctional officials, raped repeatedly by inmates and verbally assaulted by correctional officials. He believes that this was due to his sexual orientation (Eybers, 2004:8). A prisoner that was interviewed by Human Rights Watch (2001) holds the following viewpoint:

The theory is that you are not gay or bisexual as long as you yourself do not allow another man to stick his penis into your mouth or anal passage. If you do the sticking, you can still consider yourself to be a macho man/heterosexual

In February 2004, the Jali Commission heard evidence of gross human rights violations suffered by lesbian, gay, bisexual, transgender and intersexual offenders. The hearing, led by the Jali Commission and The Lesbian and Gay Equality Project, delved into the following issues (The Lesbian and Gay Equality Project, 2004):

- Prisoners being raped repeatedly by other inmates while correctional officials had full knowledge of the abuses and did nothing to prevent it.
- Transgendered offenders being kept in solitary confinement because DCS does not know whether to incarcerate them in the general prison population of male or female correctional centres.
- Homosexual males being sold by corrupt correctional officials to “men”.

- The DCS has not yet developed or implemented any policy to address the violation of rights of offenders based on their sexual orientation.

Voluntary consensual sexual relationships are rare in correctional centres and are often kept a secret. This is done to avoid sexual assault and rape from other inmates, but also because it is prohibited by the DCS. According to Evert Knoesen, director of The Lesbian and Gay Equality Project, the DCS is a human rights violator and can be subjected to civil claims under the Promotion of Equality and Prevention of Unfair Discrimination Act (Act 2 of 2000) (Hlahla, 2004:4).

All of the above factors can be considered contributory to some extent to the sexual assault and rape of male offenders and detainees. After a sexual assault or rape the male victim may experience a range of consequences which will be discussed in the next section.

2.4. THE CONSEQUENCES OF MALE-ON-MALE RAPE

The victim of male-on-male rape may suffer psychological, physical, emotional, social and sexual consequences. In this section two broad categories, namely psychological consequences and physical consequences will be addressed. Psychological consequences encompass Post-Traumatic Stress Disorder (PTSD) and Rape Trauma Syndrome (RTS) as a form of PTSD. The physical consequences include immediate medical treatment of the rape victim for cuts, bruises and tearing of the skin around the anus as well as the transmission of STI's and/or HIV/Aids.

2.4.1. Psychological consequences

According to Cotton and Groth (1982:51), the traumatic event of rape can have a more severe psychological effect on a male victim than on a female rape victim. A traumatic event can be described as a critical incident that influences a person's coping skills. Three post-trauma responses can usually be identified, namely re-experiencing, avoidance and increased arousal. Re-experiencing an event may include nightmares,

flashbacks and fear or anxiety about the possibility that the event may re-occur. Avoidance includes withdrawal from others, lack of interest in one's life and not thinking about the traumatic event. Increased arousal consists of mood swings, poor memory, an inability to concentrate and hyper-vigilance (Nietzel *et al.*, 1998:240; Van Houten, 2002:53). In the context of a correctional facility these responses could be acute as rape is in many cases not a single incident. It may also be impossible for the victim to escape from the traumatic event, thus re-enforcing the responses. It should however be noted that two people may react differently to the same traumatic event, and that some victims of male-on-male prison rape are able to cope without intervention.

2.4.1.1. Post-Traumatic Stress Disorder

Exposure to trauma can cause acute or prolonged stress related disorders respectively known as Acute Stress Disorder (ASD) and PTSD (Nevid, Rathus & Greene, 2000:180). For the purpose of this discussion the focus will only be on PTSD.

Traumatic stress was first described in 1919 by Mott (in Dumond & Dumond, 2002a:70) as shell shock and battle fatigue experienced by war veterans during World War I. In 1952 the American Psychiatric Association (APA) adapted Mott's work to describe human reactions to extreme stress as General Stress Reaction Syndrome in the Diagnostic and Statistical Manual of Mental Disorders (DSM-I). However the syndrome was not included in the DSM-II since the symptoms were described as "fleeting and reversible". In 1980 it was re-introduced in the DSM-III as PTSD and is currently used to describe "reactions of individuals to a wide range of traumatic events, including war, combat and victimisation" (Dumond & Dumond, 2002a:70). Although the definition of PTSD includes victimisation as a traumatic event, Kupers (2001:194) postulates that it is under-diagnosed in corrections and thus not being treated in correctional centers.

The symptoms of PTSD include the following (Kupers, 2001:194; Rogers, 1997:6; Scarce, 1997:19-27):

- Shock and embarrassment: Male victims may feel embarrassed that they did not do anything to prevent the sexual attack and are in some way responsible for the rape.
- Depression: Rape may leave some male victims unable to cope with a perceived loss of manhood, sexual dysfunction and isolation, all contributing to feelings of depression. In an attempt to cope with the depression some may turn to alcohol and drugs.
- Conflicting sexual orientation: Forcefully engaging in a “homosexual act” may lead some men to question their sexual orientation. Furthermore, if a man confides in a person who is homophobic this person’s view of homosexuality may be imposed on the victim, thus enforcing the “gay” label.
- Suicide: According to Dumond and Dumond (2002:81) suicide “is the most serious concern following an inmate sexual assault”, due to increased fear, stress and anxiety following the incident. It is for this reason that male victims of prison rape should be considered at risk of committing suicide until a psychologist or social worker can intervene. However due to the underreporting of prison rape the suicidal inclination of these victims is unknown.
- Denial: Male victims of rape are more likely than female victims to use denial of the event as a coping mechanism. Society’s neglect to address the issue of male rape further strengthens the man’s belief that the rape did not occur.

Because of a lack of psychologists and social workers in South African correctional centres, the researcher proposes that the symptoms associated with PTSD mainly remain undetected in male victims of rape. If a correctional official or fellow inmate does notice a man appearing irritable or suffering from panic attacks, it could be wrongly identified as normal adjustment problems to life inside a correctional centre.

2.4.1.2. Rape Trauma Syndrome

The RTS is a form of PTSD, and the phrase was coined in 1974 by Burgess and Holmstrom, to describe a condition affecting female victims of rape. Currently RTS is applied to both female and male rape victims (Harvey, 2002:47; Scarce, 1997:20). The RTS is defined as “an acute stress reaction to a life threatening situation” and includes behavioural, physical and psychological reactions (Roos & Katz, 2003:58). The greatest behavioural and psychological difference between male and female rape victims is the silence surrounding rape. With the woman’s movement the plight of women as victims of rape and other forms of sexual victimisation was brought to light. However, the rape of men still remains a taboo subject. This may be understood in the context that only since 2007 does South African legislation make provision for male victims of rape. Thus, even if a man wants to report this incident he is often not believed or the charge is not taken seriously. Regarding the physical reaction, the risk of contracting STI’s and/or HIV/Aids is higher for male victims of rape than for female victims of rape, since anal penetration more often leads to the tearing of the skin making it easier for the virus to enter the bloodstream of the victim (Harvey, 2002:47-48).

RTS is divided into two phases, namely the acute phase and the long-term phase. The **acute phase** commences with impact reactions such as physical trauma, muscle tension and gastro-intestinal irritability. During this phase, victims experience one of two emotional reaction styles: The expressive style which includes crying, sobbing and restlessness, or the controlled style where the victim appears calm, controlled or subdued (Dumond & Dumond, 2002a:72; McMullen, 1990:58; Scarce, 1997:20). The victimisation of the prisoner who expresses the controlled reaction style may be questioned by correctional officials, since this is not a “normal” reaction to a traumatic event. During the **long-term phase** victims attempt to reorganise their lifestyles. This phase is characterised by increased motor activity, nightmares and what Scarce (1997:21) labels as “traumatophobia” – avoiding situations associated with the rape, for example avoiding the outdoors if the victim was raped outside the home. However, for the male victim of prison rape it may be difficult to avoid the associated situation since, in many instances, he is locked up in the same cell as the perpetrator, thus exposing him to repeated victimisation.

McMullen (1990:85) postulates that some men may experience psycho-sexual problems after the rape, which to many are worse than the rape itself. Psycho-sexual problems can take on one of two forms, namely erectile impotence, which means the inability to have or maintain an erection until orgasm and secondly becoming sexually aroused when recalling the rape. These psycho-sexual problems could be ascribed to the notion that for many victims male rape is the first same sex encounter. If the victim has an erection or an orgasm he may question whether he, in some way, consented to the act or enjoyed the sexual encounter. However, having an erection or orgasm is a natural biological response. According to McMullen (1990:87)

... erection is a vascular phenomenon that is triggered by a nervous reflex. Clinical evidence indicates that the rapid engorgement and disengorgement of the penis facilitated by the penile blood vessels is controlled by the autonomic nervous system centred in the spinal cord. These reflexes are involuntary in the sense that their response is automatic and does not require a 'decision' by the brain to effect the condition.

Thus an erection occurs involuntary in perceived or real dangerous and stressful situations. It may also be influenced by the behaviour of the rapist who may be kissing, touching, orally or anally stimulating or penetrating the victim (McMullen, 1990:87; Sivakumaran, 2005:1291). Moreover ejaculating and orgasm is not always the same thing. Men who have had a prostatectomy (partial or complete removal of the prostate gland) are unable to ejaculate, but can still experience an orgasm. Thus "ejaculation may signal full orgasm but it may also be no more than a physiological consequence" (McMullen, 1990:87). This implies that abnormal physiological response takes place if the prostate gland is touched or manipulated in some way. Many victims of prison rape are unaware of these normal sexual responses, mainly because they do not speak about the rape and subsequently do not receive any counselling.

2.4.2. Physical consequences

The physical consequences of male rape include a range of physical injuries and sexual injuries as well as the transmission of STI's and/or HIV/Aids.

2.4.2.1. Physical and sexual injuries

Physical injuries may occur around the mouth, when force was used to coerce the victim into oral sex, around the nipples and around the penis and testicles. Also if the victim was constrained during the rape (by means of ropes or held down by other inmates), injuries of such a nature may be visible on various parts of the body. Minor physical injuries may include cuts, bruises and scratches (McMullen, 1990:102).

Male rape victims are at high risk of sexual injuries and often these injuries are not visible since they are located in the anus or rectum (McMullen, 1990:101; Roos & Katz, 2003:58). The risk of sexual injury during male rape lies therein that the anus differs from the vagina in two ways. Firstly the vagina has muscle tissue in its entire length that protects it, whereas the muscle in the ano-rectal area is only capable of expanding and contracting to allow for the passing of solids, liquids and gasses. Secondly the vagina is capable of creating lubrication, making penetration easier, whereas the anus is not naturally lubricated. The rapist may make use of an artificial lubricant, such as a homemade oil-based lubricant or saliva, both of which may cause infection due to germs being transferred from the rapist's finger or his saliva to the victim. If no lubricant is used, forced penetration can tear the anus, causing the formation of abscesses.

The rapist may also insert objects into the rectum of the victim. This can be dangerous since the rectum "can 'grasp' or 'draw in' to the point where the object is literally pulled in beyond a point of easy extraction" (McMullen, 1990:101-102). Furthermore, the object being inserted can damage the rectal wall, or if dirty can lead to the transmission of STI's and other diseases (McMullen, 1990:102).

After a sexual assault the victim needs to consult a medical professional as soon as possible, not only to prevent the contraction of STI's, but also for the collection of physical evidence that may be used during the criminal investigation. However it is postulated that most male prison rape victims do not receive medical attention even if they request it (Scarce, 1997:164,173). It is the viewpoint of the researcher that this may be due the notion that in a correctional centre a "real man" cannot be raped and subsequently does not need medical care if the sex is "consensual". Also it may simply

be too much effort for some correctional officials to investigate such allegations and to escort the victim to the prison hospital.

2.4.2.2. The transmission of STI's

An STI is transmitted through direct contact with blood, semen or vaginal secretions or through intimate skin-to-skin contact of an infected person (Love for Life, 2001-2003; Your sexual self, [sa]). It is postulated that in South Africa the prevalence of STI's in the general population is high when compared with other countries. For example, the prevalence of syphilis in the USA or United Kingdom (UK) is about fifteen cases per 100,000 of the population, compared to South Africa where there are between 5 000 and 15 000 such cases per 100,000 of the population. This is important when one considers that ulcerative STI's such as syphilis increase the risk of HIV transmission (Goyer, 2003:29).

Some of the types of STI's which can be transmitted through anal penetration include the following:

- Syphilis is caused by the bacteria *Treponema pallidum* and is often referred to as “the great imitator” because many of the signs and symptoms are indistinguishable from those of other diseases. There are two stages to this disease. The primary stage is marked by a single sore, called a chancre, but there can also be multiple sores. The chancre is usually firm, round, small and painless. It appears on the external genitals or in the rectum. The time between infection and the start of the first symptom range from 10 to 90 days. Skin rash and moist lumps around the genitals and anus characterise the second stage. The rash appears as rough, red or reddish brown spots on the palms of the hands and the soles of the feet. Other symptoms of the secondary stage include headaches, sore throat, hair loss, weight loss, muscle aches and fatigue. Antibiotics are used to treat a person diagnosed with syphilis (Centre for Disease Control and Prevention, 2004; Student health service, [sa]).

- Gonorrhoea is caused by the bacteria *Neisseria gonorrhoeae* that grows and multiplies in warm, moist areas such as the urethra (urine canal) and the anus in men. Gonorrhoea is transmitted through contact with the penis, vagina, mouth or anus of another person. Ejaculation does not have to occur for this STI to be transmitted. Men with gonorrhoea will show symptoms two to five days after infection and the symptoms include a burning sensation when urinating, or a white, yellow or green discharge from the penis. Sometimes men can also get painful or swollen testicles. The symptoms of rectal infection are discharge, anal itching, soreness, bleeding or painful bowel movements. Since gonorrhoea is a bacterial infection it can be successfully treated with antibiotics (Centre for Disease Control and Prevention, 2004).
- Genital herpes is a skin condition and the symptoms are small blisters that appear around the genital area and anus. The symptoms can appear within thirty days after contact with an infected person. This is a viral infection and as such there is no cure. There are however drug treatments available to manage and reduce the re-occurrence thereof (Student health service, [sa]).
- Genital warts are caused by the *Human Papilloma Virus (HPV)*, and in men may appear as soft fleshy growths on the penis or around or inside the anus. Symptoms may appear one to eight months after contact with an infected person. The warts can be removed by cryotherapy, laser or chemical treatment (Student health service, [sa]).

It is postulated that in a correctional facility the transmission of STI's can be reduced by means of six strategies (Moran & Peterman, 1989:4):

- Screening new inmates and treating those who show an infection.
- Tracing and treating persons known to be diagnosed with an STI while incarcerated.

- Educating inmates regarding the transmission of STI's.
- Prohibiting all forms of sexual contact. Although this strategy is the ideal, it is not realistic due to the prevalence of gangs, overcrowding, corrupt officials and deprivation of heterosexual relationships.
- Distributing condoms to reduce the transmission of STI's. South Africa's policy regarding the provision of condoms to offenders will be discussed later in this chapter.
- Segregating infected inmates from uninfected persons. Although this approach has been adopted by some USA correctional facilities, it does present ethical concerns in South Africa. The segregation of infected inmates in South African correctional centres will be discussed later in this chapter.

2.4.2.3. The transmission of HIV/Aids

HIV is the virus found only in humans and damages a person's immune system, making it easier to obtain infections and other diseases, known as an Aids-defining condition or illness. It is suggested that Aids spreads fast in poverty stricken environments and it is therefore not surprising that 70 percent of people who have Aids are living in Sub-Saharan Africa. South Africa was the country worst infected in the world during 2001, with an estimated ten percent of the global total, which relates to 4,7 million people living with the Aids virus in South Africa. The projections for 2008 are that about half a million South Africans will die every year as a result of Aids related causes (Barrett-Grant, Fine, Heywood & Strode, 2001:10-11; Hamilton, 2002:155).

Body fluids that contain sufficient quantities of the virus include semen, blood, vaginal fluid and breast milk. Taking this into consideration the main types of HIV transmission in South Africa are as follows (Barrett-Grant *et al.*, 2001:13):

- Unprotected sexual intercourse;
- Mother-to-child transmission during childbirth (blood) or breast-feeding (milk);
- Sharing of contaminated needles by drug users; and
- By means of a blood transfusion.

In prison HIV is most commonly transmitted by unprotected penetrative anal intercourse. Furthermore, the likelihood of HIV transmission is higher for the receptive partner (victim) than for the insertive partner. The reason for this is that the semen is exposed to prolonged contact with mucous membranes in the rectum (Goyer, Saloojee, Richter & Hardy, 2004:13). The probability of transmission is also influenced by the viral load (amount of HIV present in the body fluids). Therefore the more advanced the stages of HIV in an inmate, the more likely the person is to transmit the virus (Goyer, 2002). According to Scarce (1997:137-139) the risk of HIV transmission should be assessed according to the following guidelines:

- Is the sexual assault oral, anal or both? As already stated, anal penetration creates more risk for transmission than oral penetration. This is especially true if the anus is torn, making it easier for the virus to enter the bloodstream of the victim.
- Is the anus penetrated by a finger, penis or another object? If penetrated with a penis, the possibility of contact with blood or semen increases the risk of transmission. Even if a finger or another object was used, there may be some risk if the perpetrator's blood or semen is on his finger or the object.
- Did the perpetrator ejaculate during the sexual assault? If the perpetrator did ejaculate infected semen may enter the bloodstream of the victim.

- What is the severity of the sexual and/or physical injury? Forced penetration can cause tears in the anus or mouth, allowing the perpetrator's blood or semen to enter the victim's bloodstream.
- How many perpetrators raped the victim, and with what frequency did the assault(s) occur? If the victim was gang raped he will be exposed to more individuals blood and semen, thus increasing the risk of HIV transmission.

Once a person has been raped there are various blood tests to show whether a person is HIV positive. These tests include the following (Barrett-Grant *et al.*, 2001:25; Hamilton, 2002:157; Scarce, 1997:139):

- The Enzyme-linked Immunosorbent Assay (ELISA) survey for antibodies against HIV. Antibodies are protein complexes that the immune system produces to attack and neutralise disease causing organisms.
- A Western Blot HIV antibody test if the ELISA test shows a positive result.
- Rapid antibody tests are easy to use and can accurately pick up if there are HIV antibodies in the blood or saliva of the victim. This test gives a result within fifteen minutes and is performed outside a laboratory.
- P24 Antigen test measures the proteins of the virus.
- Polymerase Chain Reaction (PCR) tests for HIV rather than the HIV antibodies. This test is very useful in that a small sample of semen or blood can be tested, and HIV can be detected in the victim's blood much quicker than a test searching only for HIV antibodies such as the ELISA survey.

- A recent development is the saliva test that can detect HIV antibodies in the saliva of a person.

Although rape victims should be tested for HIV infection as soon as possible after the assault, the window period may influence the outcome of the test results. The window period is the time between HIV infection and the development of antibodies to the virus. In the case of the most sensitive antibody test, the window period is three to four weeks, and can be longer if less sensitive tests are used. In some instance the window period can be up to twelve weeks and in rare cases between six to twelve months (Barrett-Grant *et al.*, 2001:20; Hamilton, 2002:157). This means that a person may test HIV negative during the window period, although already infected with the virus.

2.4.2.4. The Department of Correctional Services policy on HIV/Aids

The first policy referring to HIV/Aids in South African prisons was formulated in 1992. With this policy the DCS aimed to segregate HIV positive inmates from the general prison population. During this period the procedure was to interview new inmates to determine whether they engaged in high risk behaviour, test those who were considered high risk and if tested HIV positive to segregate them. Inmates were considered high risk if they were illegal immigrants, convicted of a sexual crime, intravenous drug users or had had sexual relations in a country where “HIV infection is present in ten percent or more of the population” (Goyer *et al.*, 2004:29).

This policy which promoted the segregation of HIV positive inmates was criticised by the World Health Organisation (WHO), and as a result was amended in 1996. The outcome was the end of segregating HIV positive inmates and that inmates were only to be tested if they requested it or on demand by the district surgeon. Inmates had to consent to this in writing before the test could be administered. This amended policy also made provision for the introduction of various projects. These projects included STI clinics at all prison hospitals where offenders can be tested, treated, counselled and given information about STI's. The condition of offenders with HIV/Aids was also to be monitored and special supplements issued to them (Goyer *et al.*, 2004:29-30). In a separate policy document the issue of condom distribution to inmates was set out “to

be provided to the prison population on the same basis as condoms provided in the community” (Goyer *et al.*, 2004:31). However inmates were not to be issued with condoms before they received education and/or counselling regarding Aids, the use of condoms and the consequences of high risk sexual behaviour. Furthermore, condoms would only be issued on request by the inmate and then only issued by a nurse trained as an Aids counsellor (Goyer *et al.*, 2004:31).

In the case of *W and Others v Minister of Correctional Services* (Cape Town Supreme Court, Case no:2434/96) the judge ordered the Minister of Correctional Services, the Commissioner of Correctional Services, the Commander of Pollsmoor Correctional Centre and the Provincial Minister of Health that management must abide by the following (Barrett-Grant *et al.*, 2001:358; Goyer *et al.*, 2004:32):

- Keep the status of HIV/Aids offenders confidential;
- Protect offenders from stigmatisation based on their sexual orientation or HIV status;
- Ensure that condoms are made available to all offenders;
- Provide treatment for offenders with HIV/Aids;
- Test offenders for HIV only once they have given informed consent;
- Not to deny offenders the opportunity to work, based on their HIV status;
- Not to discriminate against a HIV positive offender regarding accommodation and ablution facilities; and
- Provide HIV/Aids education to all offenders and correctional officials.

In October 2002 the DCS again amended the HIV/Aids policy in prisons and a Management Strategy on HIV/Aids in Prisons was developed. This policy is currently the working document for the DCS in dealing with HIV positive offenders and is based on the following (Barrett-Grant *et al.*, 2001:351; Goyer *et al.*, 2004:32):

- Human rights principles;
- Fundamental rights as set out in the Bill of Rights; and
- WHO guidelines on the treatment of prisoners.

General principles on HIV infection and Aids in corrections were formulated in March 1993 by the WHO and have been adapted by local authorities to meet their specific needs. The principles are as follows (WHO guidelines on HIV infection and Aids in prisons, 1993):

- “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.
- The national Aids programmes should apply equally to prisoners and to the community.
- In each country, specific policies for the prevention of HIV/Aids in prisons and for the care of HIV-infected prisoners should be defined. These policies and the strategies applied in prisons should be developed through close collaboration among national health authorities, prison administrations and relevant community representatives, including nongovernmental organisations. These strategies should be incorporated into, a wider programme of promoting health among prisoners.

- Preventive measures for HIV/Aids in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.
- The needs of prisoners and others in the prison environment should be taken into account in the planning of national Aids programmes and community health and primary health care services, and in the distribution of resources, especially in developing countries.
- The active involvement of nongovernmental organisations, the involvement of prisoners, and the non-discriminatory and humane care of HIV-infected prisoners and of prisoners with Aids are prerequisites for achieving a credible strategy for preventing HIV transmission.
- It is important to recognise that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information, and in avoiding discrimination.
- Prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.
- Independent research in the field of HIV/Aids among prison populations should be encouraged to shed light on – among other things – successful interventions in prisons ...”

Considering the above principles, the current DCS policy on HIV/Aids includes the following:

- **Non-discrimination**

The Supreme Court ordered that prisoners with HIV/Aids have the right not to be discriminated against (Refer to *W and Others v Minister of Correctional Services*) (Barrett-Grant *et al.*, 2001:358).

- **Confidentiality**

Offenders have the right to confidentiality regarding their HIV/Aids status (Barrett-Grant *et al.*, 2001:355). The WHO guidelines on HIV infection and Aids in prisons (1993) regarding the confidentiality of HIV positive prisoners are as follows:

- “Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.
- Information regarding the HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff.
- Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoner’s files, cells or papers to indicate their HIV status.”

- **HIV testing**

Voluntary testing for HIV should be available in prisons, in conjunction with pre- and post-test counselling. Testing should only be carried out with the informed consent of the offender. Informed consent in this regard means that the offender understands the purpose of the test and how the results may impact on his life (Barrett-Grant *et al.*, 2001:355; WHO guidelines on HIV infection and Aids in prisons, 1993). In *C v Minister of Correctional Services* (1995) a prisoner accused the DCS for testing his HIV status without him giving informed consent. The judge ruled in favour of the prisoner stipulating that: “Generally speaking, it is axiomatic that there can only be consent if the person appreciates and understands what the purpose of the test is, what an HIV positive result entails and what the probability of Aids occurring thereafter is” (Barrett-Grant *et al.*, 2001:355).

In South Africa the process of voluntary HIV testing of inmates is as follows: The offender is referred to a member of the nursing staff to receive pre-test counselling. If, after this, the offender agrees to have the test, he must sign an informed consent form. Hereafter a blood sample is taken and the results are usually available after two weeks. The nurse will submit a list to the correctional officials of all the inmates whose results are back from the laboratory, regardless whether positive or negative, for post-test counselling. Offering post-test counselling to all inmates will ensure the confidentiality of those who are HIV positive. Only the nurse and the offender know the HIV status and this information is recorded in his medical file (Goyer, 2003:55).

- **Education and information**

According to the WHO guidelines on HIV infection and Aids in prisons (1993), all prisoners and correctional staff should be informed about HIV/Aids and the prevention thereof. Information made available to the general community should also be available to offenders, but appropriate to the educational level of the offenders. Furthermore, it is proposed that offenders receive HIV/Aids education on entry, during their prison term and during the pre-release stage.



- **Condoms**

The current DCS policy is that condoms are freely available from dispensers in common areas. Condoms can also be acquired on request from a medical officer or social worker (Barrett-Grant *et al.*, 2001:357). Although this policy principle is indicative of making condoms available to inmates “on the same basis as condoms are provided in the community”, there are certain implications. The condoms distributed in correctional centres are not made for anal penetration and may break during intercourse. Also the dispensing of condoms in common areas means that the offender will be observed by correctional officials as well as by fellow inmates, thus diminishing the objective of anonymity (Goyer *et al.*, 2004:32). In PLCC the researcher did not see a condom dispenser in any section of the centre. The only condom dispenser is at the main entrance of the centre. However over the period that the research was conducted the dispenser was empty and inmates were not allowed to enter this area of the centre anyway.

- **Segregation**

Offenders with HIV/Aids may not be segregated from other inmates on the basis of their health status. An offender may only be segregated if he has a contagious disease such as tuberculosis (TB) or hepatitis, or acts aggressively towards other prisoners (Barrett-Grant *et al.*, 2001:256; WHO guidelines on HIV infection and Aids in prisons, 1993).

- **Medical treatment**

The WHO guidelines on HIV infection and Aids in prisons (1993) prescribe the following regarding the treatment of prisoners with HIV/Aids:

- Medical follow-up and counselling should be available for asymptomatic HIV prisoners;

- Treatment for HIV infection and the prophylaxis and treatment of related illnesses should be provided by prison medical services; and
- Prisoners should have the same access as community members to clinical trials of treatments for HIV/Aids related diseases.

The medical treatment of South African inmates is set out in the Correctional Services Act (Act 111 of 1998). This Act entails that:

- The DCS must provide adequate health care services to all prisoners;
- All prisoners have the right to medical treatment;
- Prisoners may request to be treated by their own doctor at their own expense; and
- Prisoners cannot be forced to undergo a medical examination, test or treatment unless this condition is threatening the health of fellow prisoners.

The DCS policy is not to provide anti-retroviral treatment (ARV) to offenders who report sexual assault or other potential exposure to HIV (Barrett-Grant *et al.*, 2001:354; De Vos, 2003:33; Goyer *et al.*, 2004:33). Post Exposure Prophylaxis (PEP) like Zidovudine (AZT) and Lamivudine (3TC) is **only** available to correctional officials who are exposed during the course of their duties and to prisoners who are working in the prison clinic or hospital (Goyer *et al.*, 2004:33). Only correctional centres that have been accredited by the Department of Health to provide ARV treatment are allowed to dispense such medications. Correctional centres that are not accredited have to make it possible for the offenders to access ARV treatment through accredited public health facilities (Prisoners denied access to treatment, [sa]).

During 1997 in the case of *Van Biljon and Others v Minister of Correctional Services*, offenders challenged the DCS policy regarding the treatment of HIV positive prisoners. The result of the case was the High Court order that the DCS provide ARV treatment to HIV positive prisoners, and the ruling is set out below:

Even if it is accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve their immune systems than that which the State provides for HIV patients outside (Barrett-Grant *et al.*, 2001:354).

The court decided the following in connection with the above:

- A prisoner's right to medical treatment depends on an examination of circumstances such as prison conditions, to decide what is adequate.
- As the two prisoners were prescribed ARV treatment by a doctor, this was considered adequate medical treatment.
- This decision does not mean that all HIV positive prisoners should receive expensive medical treatment (Barrett-Grant *et al.*, 2001:354).

Although this case appears to be a major victory for HIV positive inmates in South African correctional centres, De Vos (2003:32-33) is of the opinion that it can be at best described as a pyrrhic victory. While some of the applicants in this case did receive ARV treatment, they did not receive all the drugs prescribed to them.

In 2005 the availability of ARV treatment to offenders again came to the legal forefront when fifteen inmates from the Westville Correctional Centre in KwaZulu-Natal complained to the Aids Law Project that they are denied access to ARV's. According to

the DCS there were two reasons why these inmates at Westville Correctional Centre could not get access to ARV treatment: Firstly the Department of Health requires that all applicants for ARV's have to be in possession of a valid South African Identity Document (ID), including all offenders and detainees who want to apply for treatment. However, the majority of South African offenders and detainees are not in possession of an ID book and are too poor to afford to pay for it. The second reason was that Westville Correctional Centre had difficulty accessing public health facilities to dispense the medicine, as the centre is not accredited to provide ARV treatment. However on 22 June 2006 Judge Pillay ruled that **all** prisoners at Westville Correctional Centre who need ARV's are to be assessed for treatment. The government applied for leave to appeal against this judgement and the execution of Judge Pillay's order was suspended until the final determination of the appeal. On 28 August 2006 Judge Nicolson ordered the government to immediately start with ARV treatment to sick prisoners at Westville Correctional Centre and stated that the government was in contempt of court for ignoring the previous order by Judge Pillay (Access to treatment for prisoners, [sa]; Prisoners denied access to treatment, [sa]; Victory in Westville Prison case, [sa]).

Again this judgement seemed to be a victory for prisoners rights, but the judgement is not directly binding on other offenders in the same correctional centre or to offenders in other provinces. Therefore it seems the only way for inmates to get the necessary HIV/Aids treatment is to apply for legal intervention.

- **Early release of prisoners living with HIV/Aids**

In the WHO guidelines on HIV infection and Aids in prisons (1993), it is stipulated that "...prisoners with advanced Aids should be granted compassionate early release, as far as possible, in order to facilitate contact with their families and friends and to allow them to face death with dignity and in freedom". It is postulated by Barrett-Grant *et al.*, 2001:360) that currently early release is not often recommended by the DCS. If it is recommended by the DCS, the process of being released early on medical grounds is complicated and difficult. An awaiting-trial detainee has to get permission from a judge or magistrate and a sentenced offender can get early parole on medical grounds if the Commissioner of Correctional Services consents to it. If the health status of a person

on medical release improves he or she must return to a correctional centre and complete the remaining sentence of imprisonment (Luyt, 2005:74).

In the DCS policy document, Management Strategy on HIV/Aids in Prisons, the following is stipulated regarding the early release of prisoners with HIV/Aids (Meerkotter & Gerntholtz, [sa]):

- “Terminally ill prisoners should be considered for placement on medical grounds (compassionate release).
- Monthly medical reports must be submitted for all offenders under consideration for early release or placement on medical grounds to assist the parole board’s decisions.
- Thorough medical examinations should be conducted to assist decisions by parole boards.
- Two independent medical doctors should examine the prisoner who is to be considered for early release.
- Social work reports should also be submitted to indicate the availability of after care and care providers.
- In all cases of referrals to other care providers, the offender should give informed consent.
- Early identification of the relatives and other service providers for HIV/Aids infected prisoners is important to facilitate placement after release. This can be achieved by partnership with other service providers, including the families.

- Each person must identify community structures to assist with placement after release. Such services should include hospice care, social workers and others to assist in training relatives.”

In practice this policy is flawed in that offenders often die before their application for early release is approved. For example, at Westville Medium B Correctional Centre an offender submitted an application for early release in February 2000, the offender died in March of that year and his early release was only approved on 16 April 2000. According to a social worker at the same correctional centre, five applications for early release are received per week: On average only one prisoner lives long enough to be released and die at home (Goyer *et al.*, 2004:62; Meerkotter & Gerntholtz, [sa]). There are many factors contributing to the delay in approving early release (Meerkotter & Gerntholtz, [sa]). These include the following:

- There is an increase in the number of HIV positive offenders and offenders diagnosed with TB.
- There may be reluctance by family members to accept a terminally ill person into the household.
- Before an offender can be released early he must be checked by the district surgeon and a specialist. He must also be interviewed by a social worker and the Correctional Supervision and Parole Board. This process can take several weeks, even months in certain cases.

Under the Correctional Services Act (Act 111 of 1998) the Commissioner of Correctional Services has the power to change an offender’s sentence to correctional supervision, if diagnosed by a medical officer as being in the final stages of a terminal disease (including Aids). In *State v Cloete* (1995) the Supreme Court released an offender who was serving a five year sentence for fraud early and placed him under correctional supervision. This decision was based on his HIV status and the judge indicated that “... his condition is such and has changed so that to continue to serve

imprisonment would be far harsher a sentence for him than for any other person serving a similar sentence” (Barrett-Grant *et al.*, 2001:359).

Since the male victim of rape may suffer from any of the above psychological and/or physical consequences it is important that correctional centres are geared towards offering the necessary support. A description of two types of unofficial support services available to rape victims in South African correctional centres follows.

2.4.3. Support services available to victims of prison rape

The support, or lack of it, that a male victim receives after a sexual assault may have a profound effect on his recovery. Formally organised support services to rape victims in correctional centres are scarce and on the African continent there was only one, namely Friends Against Abuse (FAA), situated in the Pollsmoor Correctional Centre. At PLCC awaiting-trial child detainees organised an informal Sodomy Committee, addressing rape in their particular section of the correctional centre.

A description of the two types of support services offered to male victims of prisoner rape follows:

2.4.3.1. Friends Against Abuse

The FAA offered support to victims as well as offenders of prison rape and was established in 2001 by concerned staff and inmates at Pollsmoor Correctional Centre (Malgas, 2003; Aupiais, 2002). Initially FAA started as an intervention process in the Admission Centre of the correctional centre, separating new potentially vulnerable inmates from gang members and placing them in a “safe cell”.

The goals of FAA were as follows:

- Preventing male rape in prison through the provision of effective programmes and support services.
- Counselling and offering support to rape victims and perpetrators.
- Training DCS staff to become facilitators and counsellors when dealing with a rape victim.
- Raising awareness around prison rape and HIV/Aids by means of plays and posters.
- Selecting and placing victims as well as vulnerable inmates in a “safe cell”. This is a cell in which only the inmates identified by FAA may be accommodated in. Although the researcher is in agreement that there should be such a cell in all correctional centres, the overcrowding of South African correctional centres makes the establishment of such a cell difficult.
- Offering orientation programs to new inmates (Harvey, 2002:44, 49; Malgas, 2003).

However the FAA was closed down by the DCS in 2004 because, according to the DCS, the members wanted to run this as an NGO and make money out of it. But Lizelle Alberts, a former correctional official at Pollsmoor Correctional Centre and founder of FAA, who is currently working as an Inspector of Prisons for the Judicial Inspectorate of Prisons stated that the members paid for the project with their own money. A more sinister reason given by the DCS to Magadien Wentzel, an ex-offender and former 28 gang member, is that the DCS does not want the world to know what happens inside their prisons (For the Boys, 2006).

2.4.3.2. Sodomy Committee

The Sodomy Committee was established in 2004 by concerned awaiting-trial child detainees at PLCC. This is an informal group consisting of eight members, offering advice, guidance and support to victims of attempted rape and/or rape.

According to the detainees that participated in the current study, the goals of this committee are as follows:

- “Teaching *stimela* (new detainees) about sodomy”.
- “Teaching long time prisoners not to do sodomy”.
- “Teaching one about life-skills”.

After a sexual assault has occurred in the section where the children are detained, the perpetrator, if identified by the victim, is approached by members of the committee and asked about the circumstances surrounding the event. If there is enough evidence a case will be opened by the committee on behalf of the victim.

During the period in which the research was conducted, four cases of indecent assault had been opened by the sodomy committee against one of the child detainees. A Departmental charge has been laid against the perpetrator, for which he must appear in Court 62 (an internal court situated in the correctional centre dealing with, amongst others, crimes that occur in the correctional centre) as well as a SAPS charge. Pending the outcome of the case the alleged perpetrator has been transferred to the awaiting-trial juvenile section.

Although these children should be commended for their contribution in combating sexual assault, the researcher has the following comment against the DCS. It is opined

that the sexual assault perpetrated by this detainee could have been prevented from the outset, since it emerged that he was older than eighteen years, but was awaiting his trial with the children (those under the age of eighteen years). Thus the DCS placed a potential high risk inmate with a vulnerable group of inmates. Also by transferring him to another section of the centre, his motivations for sexually assaulting other inmates are not being addressed since he is not likely to receive any form of counselling or attempts at rehabilitation. Therefore it seems as if the DCS is just “displacing” the problem from one section of the centre to another.

Currently no correctional official is actively involved in assisting the children in achieving their goals, and there is a possibility of this committee disintegrating. If official participation can be established, similar committees can be formed in all the sections of PLCC and the success thereof monitored.

A discussion of the reduction strategies that could be implemented to address the sexual victimisation and rape that occurs in correctional centres follows:

2.5. REDUCTION STRATEGIES

The researcher is of the opinion that male-on-male sexual assault and rape in correctional centres will be difficult to prevent due to factors such as gang activities, perceptions of offenders that a real man cannot be raped and corrupt officials. It can, however, be reduced by implementing mechanisms such as classification and screening procedures, separating vulnerable offenders, and the training of correctional officials in terms of the detection of sexual victimisation and also the official response to such a case (Knowles, 1999:276). Another reduction strategy includes inmate education where inmates are made aware of how to report incidents of sexual assault and rape and to recognise unacceptable behaviours displayed by inmates and staff (Zweig, Naser, Blackmore & Schaffer, 2006:21).

It is the opinion of the researcher that the sexual assault and rape of male offenders and detainees can be reduced cost effectively by having a protocol in place, which

includes some of the reduction strategies discussed below. This protocol will be applicable from the moment an inmate enters the correctional facility, to the forensic investigation after a sexual assault, and should continue to the pre-release period of the inmate. Thus correctional officials will be in the position to follow official procedures when an inmate reports sexual assault and rape. An Offender Sexual Assault Protocol designed specifically for PLCC will be described in Chapter 6.

For the purpose of this study the following reduction mechanisms will be discussed: Conjugal visitation, identification and separation of vulnerable prisoners, training of correctional officials, legislation, mapping and punishment of perpetrators.

2.5.1. Conjugal visitation

Conjugal visitation entails an inmate having personal time with his wife or common-law partner during which they may engage in sexual intercourse. For example, during 1967 the Mississippi state penitentiary system in the USA allowed inmates to bring their wives or girlfriends into the general prison population's sleeping quarters. The inmates were allowed to hang blankets around their beds for privacy (Scacco, 1975:106). Later in this study the researcher will discuss a similar practice in South African correctional centres where inmates also drape sheets around their beds to give them privacy while engaging in sexual activities with another inmate. However the "get tough" policy in the USA of "lock' em up and throw away the key" has led to several correctional facilities doing away with conjugal visits, but it is still practiced in five states, namely Mississippi, New York, California, Washington and New Mexico. In European and Latin American countries conjugal visits are also widely accepted (Hensley, Rutland & Gray-Ray, 2002:143). Currently the policy in South Africa holds that conjugal visits may not take place. Even if it were to be allowed, overcrowding, insufficient manpower and lack of facilities will hinder the implementation of such a policy (Lazarus, 2002:83).

Advocates of conjugal visitation insist that it decreases violent behaviour and sexual assault in that it is used as a behaviour controlling mechanism, increases family stability and reduces homosexual related activities. Opponents maintain that conjugal visits increase negative feelings amongst inmates who are not allowed to participate.

What benefits will those who are not married or do not have common-law wives therefore receive? It is also argued that very few inmates are married, and that the smuggling of drugs and contraband may increase. Lastly is the significant notion that rape in prison is not about sex but rather about power and dominance (Hensley *et al.*, 2002:153; Knowles, 1999:268). According to the researcher a man, especially a gang member, may engage in conjugal visits with his wife, but continue to rape in order to validate his manhood among his peers. Only two research participants in the current study were of the opinion that conjugal visits will reduce prison rape.

2.5.2. Identification and segregation of vulnerable inmates

According to researchers such as Cotton and Groth (1982:53) as well as Zweig *et al.*, (2006:24) potentially vulnerable inmates should be identified and segregated from the general population upon admission. In the current study two transsexual participants were interviewed and they indicated that they were placed in the hospital section of the correctional centre immediately after their arrest. Both display feminine characteristics such as long hair and the use of cosmetics. Although this is the ideal, it is not always possible in the South African context due to the overcrowding of correctional centres. Another research participant in this study indicated that he requested to await his sentence in the hospital section after being raped in PLCC. This request was denied and the participant was placed back in the general correctional population after completing his ARV treatment. He has, however, been transferred from the section where the rape occurred to another section of the correctional centre.

Regarding the segregation of offenders, the Correctional Services Amendment Act (Act 32 of 2001) sets out that segregation of an offender for a period of time is only permissible under the following conditions:

- Upon the written request of an inmate;

- To give effect to the penalty of the restriction of amenities;

- If prescribed by a medical officer on medical grounds;

- When an offender displays violent behaviour or is threatened with violence;

- If an offender has been recaptured after an escape and there is a possibility that he will attempt to escape again; and

- If at the request of the SAPS.

According to the stipulations set out in this legislation, potential as well as actual victims of rape may be segregated if they request it, for example based on their sexual orientation or if they have been threatened with violence, including rape. However, a drawback to this legislation is that the offender or detainee who's application is successful may only be segregated "for a period of time". This leaves the potential or actual victim with two options, namely taking his chances in the general correctional population to avoid sexual victimisation or to re-apply for segregation.

2.5.3. Training of correctional officials

Booyens, Hesselink-Louw and Mashabela (2004:10) are of the opinion that in South Africa correctional officials are not adequately trained to reduce rape in correctional centres or to treat victims after a sexual assault. This is probably due to the fact that most correctional officials received their training during the military era (pre 1994) and are as such not geared towards a human rights perspective.

According to Dumond and Dumond (2002b:93), knowledge of the incidence of rape, information about prison sexuality, victim response to rape and the dynamics of rape, as well as addressing official's perceptions and attitudes toward homosexuality and sex in prison should be included in the training that correctional officials receive. The importance of this type of reduction strategy will be detailed in the Offender Sexual Assault Protocol.

2.5.4. Legislation

In the USA the Prison Rape Elimination Act (PREA) was signed into law in 2003. This Act was the result of increased public and government concern about sexual violence in USA correctional facilities (Zweig *et al.*, 2006:1). The aims of PREA are as follows (Zweig *et al.*, 2006:1):

- To describe the nature and extent of sexual assault and rape in USA correctional facilities;
- To investigate how sexual violence is addressed by correctional facilities across the USA;
- To enhance correctional official's accountability when they fail to protect inmates from sexual violence;
- To develop national standards for addressing prison rape;
- To establish the National Prison Rape Reduction Commission with the objective to understanding "the penological, physical, mental, medical, social and economic impact" of prison sexual assault and rape;
- To establish a zero tolerance approach towards prison sexual violence; and
- To making the prevention of prison assault and rape a priority in USA correctional facilities.

From the above legislation it is evident that the USA regards male rape in its correctional facilities as an existing problem. It is the only legislation in the world that

addresses the issue of the rape of male offenders and detainees and how correctional officials can be held accountable for the abuse.

2.5.5. Mapping

The Texas Department of Corrections in the USA has a paper mapping system, known as the Visual Tracking Grid, designed to track cases of sexual assault. This grid was initially used to track gang activities in the prison, but later expanded to track fights, assaults, suspicious activity and sexual assaults. For each incident a tack is placed on a map, indicating the location of the incident. Information about both the victim and the perpetrator is added. Thus, officers have a visual picture of where incidents are occurring, which aids them in identifying potential problem areas. However, the major contribution of the mapping system is the documentation of “blind spots” (places where the correctional official cannot easily see) in the prison where most of the sexual assault takes place (Zweig *et al.*, 2006:24).

In South African mapping can be applied to track not only gang activities, which are still an integral part of corrections, but also sexual assault and rape. However, because male sexual assault and rape is such a secret crime this system will only work if inmates report cases to the authorities.

2.5.6. Punishment of offenders

According to Cotton and Groth (1982:56), inmates should upon admission be warned about the consequences of engaging in sexual assaults. The consequences can entail institutional disciplinary actions and/or prosecution. However Booyens *et al.* (2004:10) maintain that the prosecution of a perpetrator of male-on-male prison rape is rare. The reasons for this are threefold: Firstly the underreporting of sexual violence causes many perpetrators to get away with this crime; Secondly the failure of officials to adequately respond to and investigate complaints of rape results in forensic evidence being lost; Thirdly prison abuse, including rape has a low priority to most prosecutors.

Although all the above mentioned reduction strategies do have certain drawbacks they are worth exploring with an aim to reduce the sexual assault and rape of male offenders and detainees.

2.6. CONCLUSION

From the information contained in this chapter it is evident that male rape remains a reality in South African correctional facilities and will continue because of the unique relationship between the offender and the victim. In correctional facilities worldwide there is a distinct line between the “men” and the victims. If you are younger than a certain age, work in the kitchen, are a gang member and appear stronger than another inmate you are likely to be labelled a “man”. However if you are a young first time non-violent offender your chances of becoming a victim of male rape seem to increase solely based on your personal characteristics (over which you have no control) and criminal record.

Within South African corrections there are however three main factors identified as contributory to male sexual assault and rape. The first factor is the role of prison gangs, especially the 28 gang. Since the main objective of this gang is the recruitment of “wyfies” it will be very difficult, if not impossible, to prevent the sexual abuse of young inexperienced inmates. The only alternative is to advise new inmates not to join prison gangs, but many will still join because of the protection and camaraderie prison gangs provide their members with. The second contributory factor to male-on-male prisoner rape is the overcrowding of correctional centres. It has been postulated that the sharing of beds, due to overcrowding, may lead to forced sexual activities between inmates. The last contributory factor is the sexual orientation of an inmate. Although not much research has been done on the relationship between a person’s sexual orientation and the likelihood of rape, the Jali Commission of Inquiry found that homosexual and transsexual inmates are particularly vulnerable to sexual exploitation.

This chapter also explored the consequences of the sexual assault or rape on the victim. Existing evidence shows that the victim may experience psychological as well



as physical consequences, of which the transmission of STI's and HIV/Aids is of great concern. Regarding the psychological consequences, the symptoms of PTSD and RTS following a rape are not uncommon in male rape victims. These symptoms are often misdiagnosed and associated with an inmate's maladjustment to life inside a correctional centre. Subsequently various reduction strategies have been discussed by the researcher.