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State Regulation of Rape Insurance in India and South Africa

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Abstract

Are states that permit or provide rape insurance, which ameliorates the impact of violence rather than addressing the cause, actually legitimating sexual inequality? Are governments that permit or provide rape insurance discriminating against the half of their citizenry who are female by treating rape as if it were a natural disaster rather than systematic political violence against a disadvantaged social group (women) by a more privileged one (men)? If so, do such moral abstractions really matter when grappling with prevention of life-threatening diseases such as HIV? This paper explores these questions in the context of first, India and next, South Africa in the late 1990s and the first years of the new millennium, when the rape insurance schemes first appeared. The conclusion is that rape insurance would collectively do women more harm than good. Having women pay premiums to compensate their medical providers or themselves if they are assaulted is akin to placing the financial burden of rape squarely upon the victim.

Introduction

Should governments permit women to buy rape insurance? Feminists have argued that heterosexual rape is not just a criminal act but a political one -- the penultimate expression of the imbalance of power between men and women (Brownmiller, 1975; Reardon, 1985, 38-36).[1] Are states that permit or provide rape insurance, which ameliorates the impact of violence rather than addressing the cause, actually legitimating sexual inequality? Are governments that permit or provide rape insurance discriminating against the half of their citizenry who are female by treating rape as if it were a natural disaster rather than systematic political violence against a disadvantaged social group (women) by a more privileged one (men)? If so, do such moral abstractions really matter

when grappling with prevention of life-threatening diseases such as HIV? Might such gender discrimination be considered positive, a protection of women's rights, or at least a lesser evil, in light of the terrible psycho-social and bodily trauma of rape?

The conclusion is that rape insurance would collectively do women more harm than good. Having women pay premiums to compensate their medical providers or themselves if they are assaulted is akin to placing the financial burden of rape squarely upon the victim. The underlying premise of the rape insurance schemes is that rape is an accident against which women must guard, not that rape is a violation of the social contract upon which the state's very existence is predicated.

This paper explores first, India and second, South Africa in the late 1990s and the first years of the new millennium, when the rape insurance schemes first appeared. India and South Africa have many shared characteristics. Both are multilingual, multi-ethnic societies; both are former British colonies; both are technologically-advanced, free-market developing countries, both are federations; both are democracies with high levels of popular participation and civil liberties; and both have world-class medical facilities available at a price that most of their citizens cannot afford. Although South Africa now has the world's highest number of HIV-positive residents (Jewkes, Sikweyiya, Morrell, & Dunkle, 2009), it used to compete with India for this dubious distinction. In 1999, India was reported to have four million citizens with HIV/AIDS – more than any other country (Kumar 1999, 48).[2]

The rape insurance policies in India and South Africa were not identical. In India, the insurance to be was offered by a public, or government-run, company for under 40 cents a year per subscriber; in South Africa, private insurers offered it at a much higher monthly fee. In India, the rape insurance was to be sold to women as one part of a general insurance policy; in South Africa, a man or woman could purchase only "The

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[1] The crime of rape is no less heinous when men or boys are the victims. The focus here is upon male rape of women because that was the type of assault primarily envisioned by the architects of rape insurance.

[2] In 2006, UNAIDS officials stated that India's HIV+ population was 5.7 million, the world's largest (surpassing South Africa). India's leaders believed that the U.N.'s estimate was almost double the true number ("India in the Spotlight" 2006).

Rape Survivor" coverage if desired. The Indian policy would provide monetary compensation according to the degree of disability resulting from having been raped; the South African policies promised the insurance subscriber free psychological therapy (usually lasting a year) and "post-exposure prophylactics," or month-long emergency treatment to prevent HIV known as "PEP," should she suffer rape. This medical care can be prohibitively costly for individuals in the world's rich countries, much less the poorer ones.

The question of whether rape insurance is a good idea in developing countries across the world cannot be answered definitively by a comparison of only two case studies. However, there are so many consistent independent variables (democracy, plurality, levels of development, and so on) between the two cases of India and South Africa that the findings drawn from studying these two countries' very different experiences with the proposed rape insurance policy may be meaningful. Is there key difference that citizens (particularly women's lobbying groups) objected to *government involvement* in such rape insurance schemes? If so, why? Should other developing countries want to experiment with offering rape insurance to women, is it better to do so through public or private providers?

The subsequent case studies of India and South Africa follow an identical format. A background to the HIV/AIDS and rape policies in each precedes a description of the rape insurance policy or policies created. An analysis of popular response in each country concludes each case study.

INDIA

Public Health & HIV/AIDS

In 1998, when the short-lived rape insurance program was born, HIV was spreading rapidly especially in Southern India. The HIV infection rate among the general population was thought to be over 1% in three cities (Vicziany 2001, 97). At the time, the government-did not provide ARVs (anti-retroviral drugs which tremendously

improve the survival rates of people with advanced HIV).[3]

Since the structural adjustment program of 1991, India has developed a highly privatized health care system. Fine medical care is available – for those who can pay for it. Even though a recent national five-year plan aimed to improve the primary health care of the most disadvantaged, "(t)he evidence from India shows that the lower an individual's socioeconomic position, the worse their health" (Subramanian *et. al.* 2008, 132).

Until the 2004 government decision to provide ARVs to 100,000 people, international agencies and other external donors funded approximately 90% of the country's National AIDS Control Project (Sridhar and Gomez 2010, 7). Poverty and misinformation about HIV/AIDS cause many of those whom medical practitioners have diagnosed as HIV-positive to go to traditional healers instead of doctors and nurses for treatment (Chomat *et. al.* 2009).

Public Policy & Rape

The Indian Penal Code (Section 375) defines rape as heterosexual intercourse (penetration alone is sufficient) against the woman's will.[4] Rape includes sexual intercourse when the woman's consent has been gained by threat of injury; when she has been tricked into believing the rapist is her husband; when she is intoxicated or of unsound mind and thus unable to provide consent; and in all cases in which the victim is under age sixteen, even if she freely consented (Indian Penal Code, Sec. 375). Rape victims are entitled to free legal representation in the police station and in court, as established in the 1995 Supreme Court case, *Delhi Domestic Working Women's Forum v. Union of India and Others*. However, they seldom get this free representation. The state is also supposed to provide the victim counseling and compensation (Bhat 2003, 3-5; 9-16).

[3] Because the price of Indian-produced ARVs had dropped significantly, in April 2004, the government introduced ARV therapy for free in state hospitals in six of India's high-prevalence states. Pregnant HIV-positive women, children under 15, and those who already have full-blown AIDS get priority. Demand still far surpasses the availability of medication; less than a fifth of those eligible for the treatment are actually getting it (Chomat *et. al*. 2009, 477).

[4] Section 377 of the Indian Penal Code criminalizes "carnal intercourse against the order of nature with any man, woman or animal" with a potential life sentence.

Three-quarters of Indian police interviewed agreed that the rape of a woman brought shame upon her family, although the same percentage believed that there should not be a social stigmatization of rape victims (Khan *et. al.* 2008, 14). Most women in India do not report having been raped because of stigma, because the court proceedings are cumbersome, and because the likelihood the court will find a rapist guilty is slim (Dayal, 1999, 16).[5] Police may disbelieve the victim and simply refuse to proceed with filing the charges (Mathur 2008, 61). Similarly, family, neighbors, and the members of one's caste and *panchayat* (local governing council) usually keep mum about rape in an effort to protect the reputation of the victim and her family (Roy 1999, 467-469).

Reported rape rates in India increased in the 1990s, and especially of girls aged 10 to 15 (Dayal, 1999, 15). In 1994, women reported 11,000 rapes across India (Dayal, 1999, 8). By 1998, the official number of reported rapes was 15,330 (Prajnya 2009, 12).[6] As the statistics grew higher, discussion of new solutions to the rape problem intensified. Favor of the reinstatement of the death penalty for rape became popular among some women's groups and government circles (Muralidhar 1998). India's National Commission for Women (established upon the recommendation of the U.N. CEDAW Committee) proposed in a draft bill in 1997 that, in the light of rising rape rates, the state should create a National Compensation Fund for rape victims at both the federal and provincial levels (Dayal, 1999, 7-8).

The Insurance Policy

On March 8, 1999, Prime Minister Atal Behari Vajpayee announced the advent of rape insurance through India's state-run General Insurance Corporation (GIC) for India's females aged 10-75. Coverage for rape was listed (along with drowning, snakebite and other "'incidents that happen in day-to-day life'") as one provision of an accident insurance policy intended for housewives (Kazmin 1999). Premiums were to cost Rs.15 annually (less than forty cents USD at that time). Within hours, women activists from the All-India Democratic Women's Association (AIDWA) expressed their outrage at the

[5] The conviction rate at present is slightly over 26% (Prajnya 2009, 13).
[6] By 2007, this figure had increased to 20,737 (Prajnya 2009, 12).

proposal to leaders of the GIC. The government issued a statement declaring that it would reconsider the rape insurance proposal (George 1999). India's national rape insurance policy died the same day it was born.

The rape insurance offered through GIC would have rewarded a rape victim monetarily according to the severity of physical injuries due to the rape (as to be ascertained by the GIC). A (critical) newspaper editorialist explains:

> What madness could have made actuarial experts classify rape outcomes into those involving loss of a limb or an eye and those inflicting "permanent damage". Victims who are fortunate, by GIC's calculations, to have not been permanently damaged can claim Rs 12,500, while the other category may get double the amount ("An Idiotic Scheme for a Heinous Crime," 1999).

AIDWA members voiced three major objections. First, the proposal trivialized rape by equating it with ordinary accidents; second, instead of taking responsibility for preventing rape the government was asking women to pay in advance for the inevitability of being raped; third, incestuous sex crimes against girls might increase in order for the parents to receive insurance money from the GIC (George 1999).

South Africa

Public Health & HIV/AIDS

Division of the public health system into fourteen ethnically-based departments, unequal geographic distribution of medical professionals, and tremendous disparities in provision of medical care on the basis of race were official policies of *apartheid*. *Apartheid*'s legacy and the HIV/AIDS epidemic have left South Africa with an overstretched public health system and a life expectancy of 50 (SAHRC 2009, 12-14). When insurers created the rape insurance schemes, over 90% of citizens relied on the understaffed public health system for their medical care ("South African Insurance Company. . .").[7]

In 1999, the estimate was that one in eight adults in South Africa carried HIV (Maykuth). Men who rape may be even more likely to be HIV positive than the average

[7] Ironically, the private health sector has over 70% of the country's health care professionals (excluding nurses) (McIntyre 2010, 20).

South African man. A 1990s study in Cape Town found that men who perpetrate sexual violence are more likely to be at high risk for HIV than are other men because they are more likely to engage in other sexual and substance-abusing behavior that puts them at high risk of HIV infection. Men who had raped were more likely to have had a high number of sexual partners and to have multiple sex partners at the time of the study with whom they had unsafe sex; had more unprotected intercourse; and were more likely to have used alcohol or drugs in a sexual setting than did men who did not rape (Kalichman *et al*, 1997).[8] Adding to the danger is the fact that very seldom does a man wear a condom during rape. Gang rape is especially perilous. The chance of HIV exposure increases with the number of rapists, and gang-rape usually leaves more wounds on and in the victim's body through which the virus might get into her bloodstream (Bhana *et. al.* 2004).

Women's rights and Democratic Party (DP) leaders demanded that the government provide free prophylactic drugs to all South African rape victims who wanted them to diminish the likelihood of contracting HIV. The DP women's affairs spokeswoman argued that the government should provide free AZT (a predecessor of ARVs) to rape victims because the rape was a demonstration that the state had failed to uphold its obligation to protect the bodily integrity of its citizens (Mathiane 1999a).

Then -President Mbeki, notorious for disputing the effectiveness of AZT and ARVs and for disbelieving any correlation between HIV and AIDS, stated that the government could not pay for such an expense (Schuettler 1999).[9] A 28-day course of AZT at the time cost approximately $700 in South Africa ("South African Insurance. . ." 1999). Starting in 2002, South Africa's government announced it would give PEP for free to rape victims, but this program received little publicity or follow-up (Bhana *et. al.*, 2004).

[8] A more recent study found that the HIV infection rate in men who admitted to raping women was approximately 19 percent, just slightly higher than rates in men who said they had not raped (Jewkes *et. al.* 2009).

[9] The South African Government in August of 2003 agreed to make ARVs available for free in government hospitals (Bhana *et. al.*, 2004). Access to this free treatment is not yet universal (*HIV & AIDS Strategic*, 2007).

Public Policy & Rape

Until the 2007 amendment to the penal code, the definition of rape in South Africa was quite similar to that in India. [10] Legal scholars noted:

> Under the common law, it currently needs to be proven that a man unlawfully and intentionally had sexual intercourse with a woman without her consent. By definition, therefore, only a man can rape a woman, and then only by inserting his penis into her vagina (Artz and Smythe 2007, 10).

Women's groups in the 1990s estimated that one in three women in South Africa would suffer rape in her lifetime (HRW 1995, 2). In 2000, female victims reported 53,000 rapes to police (Kalichman, Simbayi, Cain, Cherry, Henda and Cloete, 2007). That same year, boys and men reported almost three thousand rapes to the police (Bhana, Gerntholtz, Hurt, Meeson and Vetten 2004). Approximately ninety-seven percent of rapes in South Africa were unreported (HRW, 1995, 52-53). Less than a third of the reported rapes went to court, and less than half of those prosecuted resulted in conviction (Dept. of Justice, 1997 "Safety and Security", 1).[11]

Although the vast majority (95%) of reported rapes in the 1990s involved black African women, women of this ethnic category were, even after the multiracial elections of 1994, those *least* likely to report having been raped (HRW 1995, 52-53; UNHCHR 1997, 8). During apartheid, black South Africans usually did not perceive the police as beneficent. Lingering mistrust of the law enforcement institutions prevented reporting of much crime even under the new government (UNHCHR 1997, 8).

If the victim filed a rape charge, she had to visit a medical examiner who would look for evidence of rape. A study of eleven rape survivors' experiences of the medico-legal system near Cape Town found that not one received information on HIV, nor was asked if she wanted HIV testing. One woman raised the issue with the doctor herself.

[10] The definition also encompassed heterosexual sex involving a woman or girl unable to give consent because she was retarded, insane, drugged or drunk, or under age 12 (Rape Crisis, 1989: 7).

[11] Although all agree that rape is underreported, statistics on reporting rates in South Africa still vary from approximately 11% to 50% (SAHRC 2009,48).

The medical examiners gave seven of the survivors pills without telling them what the medication was or what it did (Stanton et. al. 1997, 97).

The government at the time of the launch of the rape insurance schemes deemed it unconstitutional for the state to test convicted rapists for HIV/AIDS (*Convention for* . . .n.d., 17-19). South African law grants citizens the right to confidentiality concerning HIV status. Nobody, not even a health care worker or a police officer, could disclose the HIV status of another person fourteen years of age or older without written consent from that person. Neither could anyone be forced to take an HIV test against his or her will. This included rapists and rape survivors (unless the latter was unconscious and needed medical care immediately, in which case the doctor or medical superintendent might test for HIV after first attempting to contact the patient's next-of-kin) (Bhana *et. al.*, 2004). If the accused rapist chose to test for HIV, the state had no obligation to make the results known to the victim (McGreal 1999).[12]

The Insurance Policies

In October of 1999, the British-owned Commercial and General Union (CGU) unveiled what it believed to be the world's first rape insurance policy.[13] It cost approximately $4 USD per month and was available to both sexes and all ages. If raped, subscribers could access a multilingual 24-hour help line and receive free PEP, HIV tests for a year, and counseling. Although a for-profit venture, a portion of the company's earnings were earmarked for grassroots anti-rape groups (Bamford 1999).

Lifesense began offering rape insurance in South Africa shortly after CGU did. The insurance provided a rape victim with four weeks of ARV treatment, testing for sexually transmitted diseases, psychological counseling for the entire family, and help with legal fees up to R19,000 (approximately $2,375 in U.S. dollars at that time). Security upgrades to one's residence and "alternative therapies" such as reflexology or

[12] The South African Law Commission in 1999 urged the government to test those arrested for rape or indecent assault for HIV upon the request of the victim or the victim's guardian (Streek 1999). Today, after much pressure from women's rights groups, a rape survivor or police officer investigating rape can demand within 3 months of the rape that the alleged rapist undergo an HIV test and that the victim learn the result (Roehrs 2007).

[13] Alexander Forbes, another South African insurer, included rape as part of its comprehensive accident policy. It did not sell rape insurance as a single policy (Pile, 2000).

massage (as fear of human touch is often part of rape trauma syndrome) were also included. It cost the subscriber R15 a month, which was less than $2 USD (Pile 2000, Swindells 2001). AIG (American International Group) launched a similar rape insurance policy, although less information about it is available. The companies claimed that they did not expect to make a profit by charging such low premiums (Pile 2000). By January of 2001, 50,000 people had subscribed to Lifesense's RapeCare, but only a handful to the more expensive CGU (Pile 2001).

A widespread criticism of the rape insurance policies was that the price of premiums put the coverage out of reach for most working-class South African women, thus widening the already vast gap between rich and poor's access to medical care. Racism may have played a role in the marketing of these policies. Strict racial segregation in South Africa had ended only a few years prior. A white woman might feel frightened or degraded by the prospect of going to a police station or the office of a district surgeon (a government doctor) in an unfamiliar neighborhood, where the personnel could be of any ethnicity. A Lifesense subscriber could access her choice of any doctor in the private health care sector to assess whether she had been raped. She would not have to go to the police or to the district surgeon, as one must do if filing charges (Pile 2000).

POWA (People Opposing Women Abuse), the leading anti-gender based violence group in the eastern half of South Africa, condemned rape insurance as "immoral" (Mathiane 1999b). Rape Crisis, the most prominent anti-rape group in the western half, initially stated that they were not sure the insurance was necessary. A representative pointed out that in the Western Cape rape victims already were entitled to 4 weeks of ARV therapy, that Rape Crisis and several other groups provided free rape counseling, and that no woman has to pay for her defense in a rape case in South Africa because rape is considered a crime against the state (Swindells 2001).

The dramatic HIV/AIDS policy developments in South Africa that followed should have made private rape insurance unnecessary. A Cabinet decision in 2002 permitted public health facilities to provide free PEP (post-exposure prophylaxis) to rape survivors (Vetten 2007). They had to file formal charges of rape within three days of the

event to be eligible (Combrink, 2006). Similarly, a 2007 update of the national rape laws assures access to post-exposure prophylaxis for HIV/AIDS -- but again, only if the survivor files a formal report with the police (Parliament of the Republic of South Africa, 2007; Artz and Smythe, 2007). As noted previously, however, most victims of rape do not file charges and therefore cannot receive free treatment. Many do not get the prophylaxis to which they are legally entitled even if they do report rape. PEP has been unavailable at many state-run facilities, and some health care workers are not aware of the laws guaranteeing its provision to rape survivors (Singleton, 2008).

Conclusions

Women's and human rights groups "demand accountability" from the state for addressing violence against women, such as rape (Bunch and Reilly 1994). Is offering rape insurance at odds with or in keeping with the state's exercise of due diligence in protecting one's citizenry? Does it matter whether the state simply permits a private institution to offer this insurance, rather than the state administering the policy itself?

In India, where HIV infection rates per capita are much lower than in South Africa, women activists strongly opposed rape insurance. The policy that the government initiated was not intended to prevent HIV; the goal was to award compensation to a rape victim for any physical disability resulting from rape. In South Africa, however, where HIV infection rates were and are much higher, speedy and free access to PEP was the primary benefit of insurance for rape survivors. Another perceived benefit was that the rape survivors could receive PEP and any other treatment at a private medical facility rather than a public one.

Women activists in South Africa voiced mixed feelings about rape insurance, but did not wage war against it as activists in India had done. In South Africa, the market for rape insurance diminished somewhat when the government promised to deliver free PEP to rape victims in 2002. Moreover, South African insurers revised their comprehensive plans to include a rape provision so that they might compete with the new rape insurance policies (Wilson 2005). Finally, even at the moment when rape insurance was launched, several NGOs in the country funded by foreign donors provided free legal, medical and psychological services to rape victims (Dynes 2000).

As demonstrated in these two case studies, even in some of the most technologically advanced countries of the developing world, the public health care system may be inadequate. In such countries, rape insurance that guarantees proper medical and psychological treatment to survivors could be a boon for those women who can afford it. It could even save their lives if it prevents them from developing HIV/AIDS. This reassurance was the relative appeal of the concept of rape insurance in South Africa, although at the same time the policies received criticism for being unethical and elitist.

The fatal flaws of the Indian rape insurance plan were three. First, that the policy was state-run, and that it is the state that is supposed to prevent and prosecute crimes such as rape, raised suspicions of a conflict of interest. Had state actuaries decided that rape insurance would be more cost-effective than crime-preventing measures such as better policing and prosecution? Second, that the plan was introduced by someone of such high political stature as the Prime Minister placed it firmly in the battlefield of Indian partisan politics. Third, instead of guaranteeing treatment, which is not assured to a rape victim in the Indian medico-legal system, it awarded money for having been raped. A money-for-sex arrangement seems little different from prostitution, and this taint is even more important in the various subcultures in India in which family honor has been traditionally enmeshed with female chastity. The authors of the compensatory rape insurance plan overlooked the fact that much of the trauma surrounding rape concerns the victim's sense of shame, which is not usually present in other sorts of injuries (such as snakebite) and which offers of cash would probably make worse instead of better. Finally, equating rape with accidents in which one might suffer disability, such as a steep fall, makes it seem that rape is an uncontrollable force rather than a human rights issue for which men and the government should take responsibility.

Do women still have such an inferior political status that they are exempt from the privileges of citizenship, such as state protection from the threat of injury? According to the social contract theorists, it is because of the threat of crimes such as murder and rape that we submit to state authority in the first place. Thomas Hobbes posited that under anarchy, "naturally every man has a right to every thing" ([1651] 1962, 103). Because

this existence is so perilous, however, we sacrifice this right to every thing so as to permit harmonious coexistence with others ([1651] 1962, 104). We surrender our liberty to the sovereign and, in so doing, become members of civil society, or the "body politic" in exchange for the sovereign's protection ([1651] 1962, 132–3). From this perspective, the very reason for the state's existence is to prohibit violence, such as rape, amongst its people.

Imagine a national insurance scheme in which an ethnic minority – for example, Arab citizens of Israel -- might purchase policies to guarantee medical treatment and/or compensation should they become the victims of hate crimes. When the variable of sex is replaced by ethnicity, and when sexual violence is replaced by another type of violence, the unfairness of such an insurance policy seems obvious. Why should an ethnic minority be expected to pay the bill for any injury inflicted upon them by their fellow citizens? Why are their countrymen and countrywomen not being held accountable by the state for their crimes against the ethnic minority in the first place?

Should countries with skyrocketing rape rates impose a "rapist tax" upon men, the proceeds of which would physically and psychologically treat rape survivors, social responsibility for paying for rape would return to that social group which is most responsible for it. Admittedly, it is not likely we will see such legislation anytime soon.

Women are the ones who bear the overwhelming burden of rape. In rape insurance plans such as India's and South Africa's, women (despite typically earning less than men) are the ones who must additionally pay the monetary costs of rape by men. Feminists have long decried the common defense tactic of "blaming the victim" in rape cases ("she should not have been out by herself at night," "the way she was dressed she was asking for it," etc.). The insurance schemes are a variation on this blame-the-victim-for-rape theme in that they bill the victim for her victimization – even before she is victimized. Such policies can hardly be viewed as liberation for women.

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