

# WOMEN

2019

ON THE EDGE

WOMEN'S RIGHTS IN THE FACE  
OF THE WORSENING COMPLEX  
HUMANITARIAN EMERGENCY  
IN VENEZUELA



AMNESTY  
INTERNATIONAL





## WOMEN ON THE EDGE 2019: WOMEN'S RIGHTS IN THE FACE OF THE WORSENING COMPLEX HUMANITARIAN EMERGENCY IN VENEZUELA

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Caracas, Venezuela. May 2019



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## ACRONYMS

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<b>AIDS-</b>	Acquired Immunodeficiency Syndrome
<b>AVESA-</b>	Asociación Venezolana para una Educación Sexual Alternativa
<b>CHE-</b>	Complex Humanitarian Emergency
<b>CHET-</b>	Ciudad Hospitalaria Enrique Tejera Hospital
<b>CLAP-</b>	Local Committees for Supply and Production
<b>ECLAC-</b>	Economic Commission for Latin America and the Caribbean
<b>ENCOVI-</b>	Survey on Living Standards
<b>FEFARVEN-</b>	Pharmaceutical Federation of Venezuela
<b>HIV-</b>	Human immunodeficiency Virus
<b>IACHR-</b>	Inter-American Commission for Human Rights
<b>IACOURTHR-</b>	Inter-American Court of Human Rights
<b>IEMA-</b>	Contraceptive Scarcity Index
<b>IMF-</b>	International Monetary Fund
<b>INAMUJER-</b>	National Institute for Women
<b>IOM-</b>	International Organization for Migrations
<b>IUD-</b>	Intra-Uterine Device
<b>LODMVLV-</b>	Organic Law on the Right of Women to a Life Free from Violence
<b>MINMUJER-</b>	Ministry of Popular Power for Women and Gender Equality
<b>MM-</b>	Maternal Mortality
<b>MPPS-</b>	Ministry of Popular Power for Health
<b>OAS-</b>	Organization of American States
<b>PAHO-</b>	Pan-American Health Organization
<b>RLB-</b>	Registered live births
<b>RSH-</b>	Reproductive and sexual health
<b>STD-</b>	Sexually transmitted disease
<b>UCAB-</b>	Andrés Bello Catholic University
<b>UCV-</b>	Central University of Venezuela
<b>UN-</b>	United Nations
<b>UNFPA-</b>	United Nations Fund for Population Activities
<b>UNHCHR-</b>	United Nations High Commissioner for Human Rights
<b>UNHCR-</b>	United Nations High Commissioner for Refugees
<b>USB-</b>	Simón Bolívar University
<b>WB-</b>	World Bank
<b>WHO-</b>	World Health Organization

## INTRODUCTION

**A**s early as 2014, numerous civil society organizations, academics, guilds and qualified voices in various spheres were alerting of what has today materialized in Venezuela: a complex humanitarian emergency (CHE). Unlike humanitarian crises determined by disasters or armed conflict, CHE tend to be political in origin and long-lasting, infusing them with a destructive impact upon all aspects of life and generating high mortality rates.

According to the Dictionary of Humanitarian Action and Cooperation for Development (2006) CHEs are characterized by:

- a.** The weakening, breakage or fragmentation of the State in countries with high levels of poverty and which are peripheral to the global economy. Depending on the degree of decomposition, they are referred to as weak, fragile or failed;
- b.** The collapse of the formal economy and the rise of an informal economy articulated through clandestine networks;
- c.** Civil or internal conflict, though frequently with international implications, exacerbated by identity-based tensions (ethnic, national, religious) but stimulated by the political economy of war;
- d.** Famine, as a process of the increase in malnutrition, poverty and epidemics, which are occasionally deliberately provoked as a weapon of war or as a mechanism of despoliation against vulnerable sectors;
- e.** Exodus or forced migrations caused by the need to search for assistance and, above all, by practices of persecution or destruction such as ethnic cleansing or scorched- earth policies, often generating waves of refugees.

The Venezuelan CHE is political in origin and involves a web of diverse factors such as restrictive economic policies which in turn include currency-exchange and price controls; high levels of corruption; diminished income; nationalization of agricultural and industrial activities; low investment in infrastructure and basic services such as water, electricity and transportation; institutional weakening and de-professionalization of the State apparatus. It occurs, furthermore, within a context of serious threats and restrictions for the exercise of civil and political rights, such as the right to protest and freedom of expression and grave setbacks in economic, social and cultural rights. The worrying collapse of the State's capacity to deliver services, including the crumbling of the public health system, has had a devastating effect on the promotion, protection and guarantee of fundamental rights and, consequently, on the quality of life of Venezuela's population.

It would be disingenuous to deny that the CHE in Venezuela is the responsibility of Nicolás Maduro's de facto regime and its indolence in the face of the generalized suffering of the population. Its repressive policies have only deepened the crisis and increased the pressure upon a citizenry abandoned to their own fate.

No humanitarian crisis, whether originating from disasters, health emergencies, armed conflict or complex humanitarian emergencies is gender-neutral, as they affect women and men, boys and girls in a differentiated manner (UN Women 2017). For example, data from the United Nations Fund for Population Activities (UNFPA) confirms that, by 2015, the estimated number of maternal deaths in 35 countries affected by humanitarian crisis or fragile contexts was 185.000, or 61% of the global figure of maternal deaths (303.000). Thus the average of 417 maternal deaths per 100.000 live births in contexts of humanitarian crises or fragile States is 1.9 times greater than the world average of 216 (UNFPA, 2015).

In Venezuela's case, the CHE has widened the gender gaps and placed women, girls and adolescents in a situation of greater vulnerability. In its June 2018 report, the Office of the United Nations High Com-

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missioner for Human Rights (UNHCHR) observed that women had been especially affected by the health crisis and disproportionately impacted by the scarcity of food (2018). Even before the publication of that report, in October 2017, the Rapporteurs on the rights of women, children and on economic, social, cultural and environmental rights of the IACHR had already requested the Venezuelan State to allow a visit to gather information on the “grave situation of women and girls in the country” (IACHR, 2017). As we write this report, this visit has yet to be permitted.

Since 2016, the Venezuela-based organizations Asociación Civil Mujeres en Línea, Asociación Venezolana para una Educación Sexual Alternativa (AVESA), Centro de Justicia y Paz (CEPAZ) y el Centro Hispanoamericano de la Mujer FREYA, gathered in the “Equivalencias en Acción” coalition, have called attention to how the CHE in Venezuela has a differentiated and often disproportionate effect upon the lives of women, girls and adolescents. By documenting and public denouncing, our organizations have provided evidence of such effect, which frequently translates into grave violations of rights such as the right to a life free from violence; the right to health, including the right not to die from causes related to pregnancy and labor; the right to reproductive autonomy and the right to food, amongst others.

With this report, we aim to continue the work undertaken in 2017 in “Women on the Edge. The Weight of The Humanitarian Emergency: The Infringement of Women's Rights in Venezuela” wherein, on the basis of official information available at the time, we carried out an analysis of existing gaps in the exercise and

enjoyment of rights in the areas of health, especially sexual and reproductive health, food and violence against women. On this occasion, and as a response to the State's policy of hiding statistics and official information, we incorporate data resulting from research by our own organizations, which serve to illustrate and comprehend the real situation in the fields of sexual and reproductive health and human mobility. We have also included information regarding the differentiated effects upon women in the area of food, gender-based violence against women in the context of the CHE and the violation of the rights of indigenous women in the context of the activities in the Orinoco Mining Arch in the south of the country.

In the context of Venezuela's current reality, this work has two clear purposes. On the one hand, to provide diagnostics that serve as a base for the design of responses aligned with the realities and needs of Venezuelan women, girls and adolescents in the midst of the CHE. On the other, to build a repository for the historical memory of a period wherein the rights of women have experienced an unprecedented setback, placing them in situations comparable only to the 19th Century, all under the guise of an official, though false, feminist narrative.

Caracas, May 2019.

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## I. SOCIO-ECONOMIC AND DEMOGRAPHIC CONTEXT OF VENEZUELAN WOMEN

Although the deterioration caused by the CHE is evident in all areas, there is no official data to grasp the real dimensions of the undeniable crisis. It is a known fact that there is an official policy to prevent the dissemination of figures and information – from those related to gender violence or employment, to health indicators whose notification is mandatory. As pointed out by the Inter American Commission on Human Rights (IACHR), in Venezuela there is a persistent lack of access to official sources and to information that should be public (2017). For example, the Epidemiological Bulletins of the Ministry of Health, an essential public health tool, were last published in May 2017. Furthermore, neither that Ministry nor the Ministry of Popular Power for Women and Gender Equality or any other ministry, publish annual reports of their activities or expenditures since 2015. In this context, the work of civil society organizations and academic institutions

has become fundamental to comprehending the CHE. According to the Survey on Living Standards (ENCOVI), carried out by three universities (UCAB, UCV, and USB, 2018), 94% of homes do not have sufficient income to survive. The International Monetary Fund (IMF)<sup>1</sup> has estimated an annual inflation rate for 2019 of 10.000.000%. The purchasing power of the Venezuelan currency has thus been pulverized in a state of affairs wherein economic and social indicators show no sign of improving and, much to the contrary, are rapidly worsening. Official social programs, such as direct transfers and subsidized food through the Local Committees for Supply and Production (CLAP), which reach around 63% of homes (ENCOVI, 2018), apart from being irregular and managed with political criteria, have proven insufficient in the face of the great needs of most of Venezuela's population. And all this, with a differentiated effect on the lives of women.

In December 2018, the basic foods basket experienced a month-to-month increase of 133.7%. This variation triples the increase registered the month before and was the highest throughout the year. But the local minimum wage had a purchasing power of only 4.3% of the basic foods basket (Cáritas Venezuela, 2018).

In these conditions, it is well known that poverty, crisis and the implementation of macro-economic adjustment measures do not have a homogenous effect across the whole of a population. They impact women more negatively, given their difficulty in finding stable, well-remunerated employment, the growth in rates and duration of unemployment, as well as the structural disadvantages they face during a crisis. Reductions in investment in health and education frequently translate into women spending more time in house-keeping activities, caring for the ill or socializing boys and girls, while at the same time devoting most of their days in queues for access to social services. Given traditional gender roles, women have historically been responsible for seeing to the basic needs of the family, and thus the way in which policies aimed at supplying said needs are formulated and managed affects women considerably.<sup>2</sup> The economic, political and social crisis is joined by an enormous institutional precariousness that deepens the violation of fundamental rights such as access to food, education and decent work.

The economic, political and social crisis, turned into

a CHE, has produced an additional “invisible adjustment” that affects women in particular, given that the disinvestment resulting from public spending reductions is compensated by the social fund provided by them through their remunerated and non-remunerated work (Bethencourt, 1998). This fund is sustained, fundamentally, by their domestic and community work. While it is true that existing community policies in Venezuela were already resting almost exclusively on women, the crisis has made them directly responsible for the management of the poverty alleviation programs launched in their communities by the governments of Hugo Chávez and later of Nicolás Maduro. It is important to point out the voluntary, and thus not formally remunerated nature of this “extra” work for poor women, which has turned into a kind of precarious outsourcing by the State of the conditions under which women inhabiting popular sectors may accede to a given income or “benefit” from the State, without regard for their living standards or their specific needs in the midst of the most severe crisis experienced by the nation throughout its recent history.

To the everyday problems associated with survival (food, clothing, transportation) we must add the specific needs of women regarding sexual and reproductive health, as well as regarding access to and opportunities for education and moderately stable work that guarantee them minimal income of their own in a context of hyperinflation, scarcity and acute shortages.

# 1. DEMOGRAPHIC CONTEXT

By 2018, the National Institute of Statistics (INE) projected the total estimated population of Venezuela at 32.828.110 people, with women representing 48.88%. Of the latter, 63.2% are of reproductive age, one third are girls or adolescents (25.3%) and the rest are elderly (11.5%).

**TABLE 1: POPULATION PROJECTION ACCORDING TO AGE AND SEX, 2018 CALENDAR YEAR.**

SEX		
GROUPS BY AGE	WOMEN	MEN
0 - 14	4.011.956	4.265.265
15 - 59	10.037.618	10.131.125
60 - 95 AND OVER	1.825.372	1.556.774
TOTAL	15.874.946	15.953.164

This population data is a projection from the last Population and Housing Census in 2011. Massive migration, the rise in maternal and infant mortality and mortality associated with the crisis in public services as well as the general scarcity of medical supplies and medicines are some indicators that suggest that the CHE could have a significant impact upon the population structure in Venezuela.

Life-expectancy has also been affected by the CHE, having decreased by 3.5 years by 2018:

“It seems like just another statistic but it is devastating: every child born in Venezuela has the expectancy to live 3.5 years less than those born in a previous generation (...). The setback in life expectancy is a phenomenon indicative of the very grave state of economic destruction, epidemics, wars or famines. Other than the regression registered after World War II in several European countries, modern history has registered a drop in life expectancy in Cambodia, with the genocide carried out by the Khmer Rouge; in Africa, with the advent of the HIV epidemic (in the first decade of the Millennium countries like Sudan, Botswana and Swaziland registered a drop of up to 20 years) and following the dissolution of the Soviet Union” (Lares, 2019).

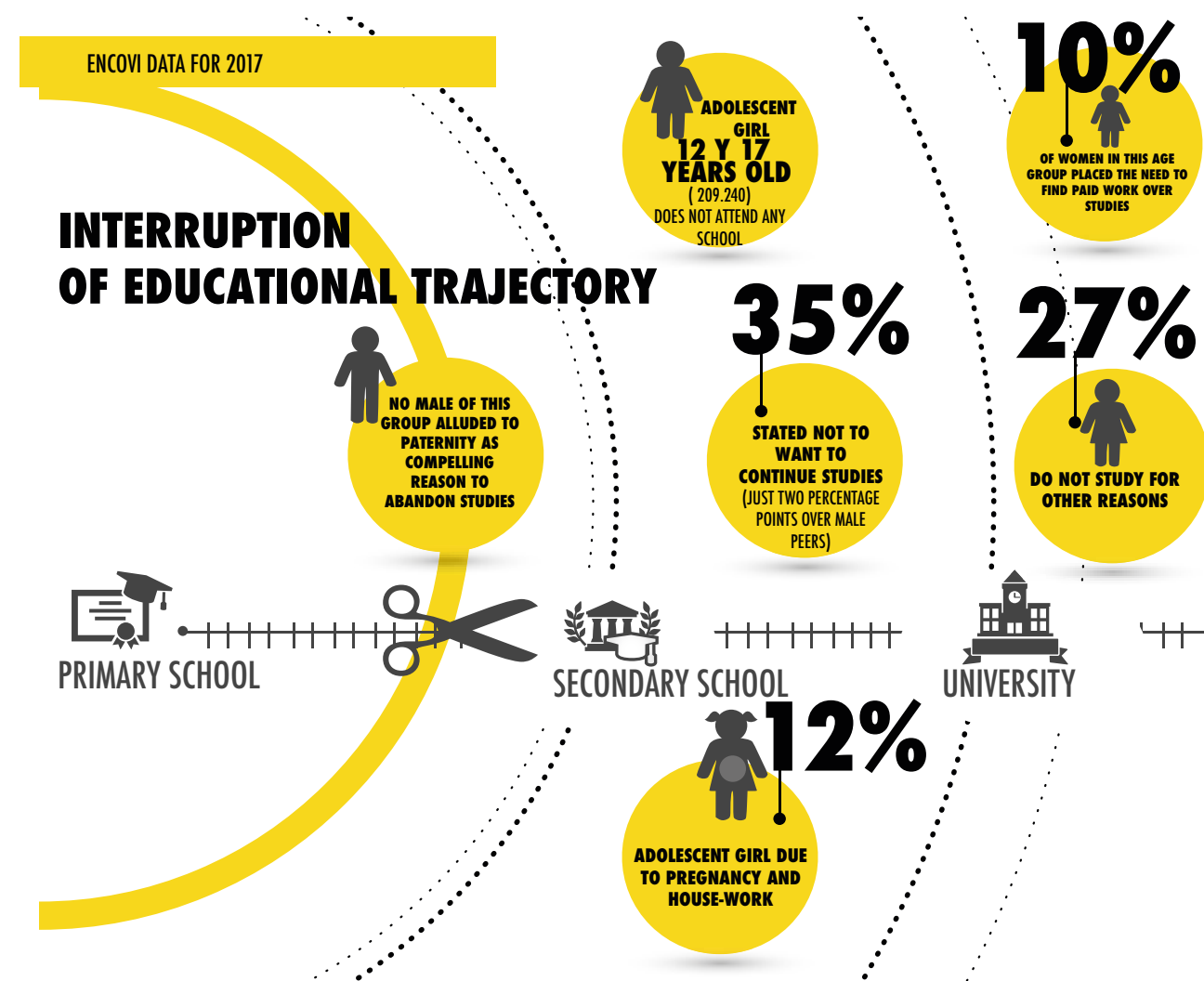
A setback in life expectancy is evidence of structural damage to the standards of living of the population. The Venezuelan case is exceptional in that it is not the result of a disaster or of sustained armed conflict.

## 2. EDUCATION

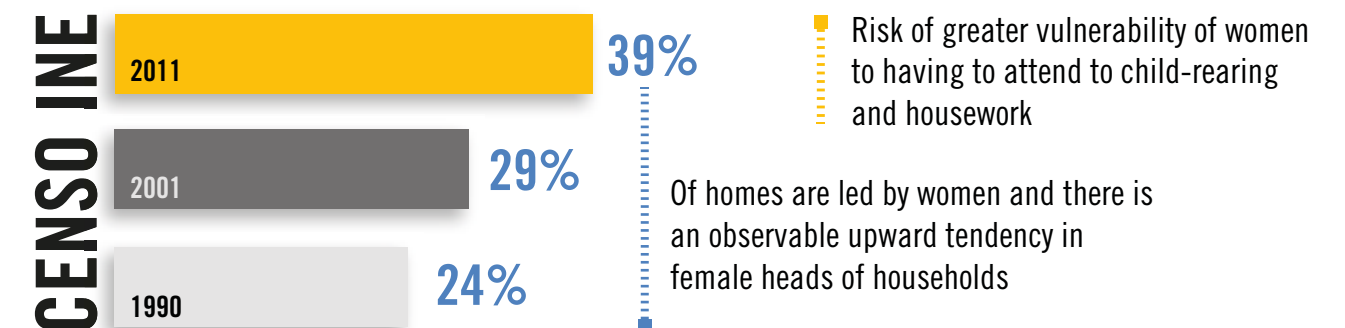
Access to quality education is, by definition, an indicator of social mobility and a nation's level of development. In the context of a profound and prolonged economic, political and social crisis this, along with health and employment, are the most violated rights. According to ENCOVI (2018), between 2015

and 2017 access to education by those between 3 and 24 years-old dropped on average 7%, going from 78% schooling to 70%, representing a little over one million children and adolescents (3 to 17 years old) out of school in the past 3 years.

### INTERRUPTION OF EDUCATIONAL TRAJECTORY



### Female Heads of households



SOURCE: INE. 2011 CENSUS

There is enrollment parity in the educational system, and girls (3-5 years) and women (18-24) register slightly higher enrollment than their male peers. ENCOVI data furthermore bears out that of the 475.000 adolescents in school with severe grade lag, girls between 12 and 17 represent 13%. However, in contrast to previous years, this percentage is slightly lower. This could be due to the general drop in school enrollment.

Among the main limitations reported by those surveyed for attending an educational center regularly, 28% pointed to lack of water, which impacts women, adolescents and girls in particular for reasons related to menstrual hygiene and pregnancy. While it is true that the lack of water has general and severe effects upon the functioning of schools, for girls, adolescents and women in general the absence of potable running water increases the risk of exposure to infectious diseases.

ENCOVI data on the interruption of educational trajectories for 2017 reveals that the group of women between 12 and 17 (about 209.2040) do not attend any school. As for the reasons given for abandoning their studies: 35% stated they no longer wished to study (barely two percentage points above their male coun-

terparts); 12% due to reasons related to pregnancy and housework; and 27% for other reasons. No male in the study alluded to paternity or childcare as a significant reason for abandoning his studies, a reflection of unaltered traditional gender roles which deposit on women all domestic and child-rearing work. 61% of women between 17 and 24 were not studying. The women themselves alluded to the need to find remunerated employment and to childcare. Of this group, 22% expressed no wish to continue their studies, followed by 21% who stated having left their studies due to pregnancy and/or directly attending to the home and children. 10% of the young women in this age group declared the need to find remunerated work as a priority, above studies.

This data points to a marked precariousness in the educational and social security systems in the context of the CHE which merits greater analysis, particularly as it pertains to the differentiated effect upon boys and girls. At any rate, it would seem that full-time school attendance is becoming a privilege, even at ages when it should not be so. This is particularly worrisome at the middle-school level, but also at the technical level and in higher education.



### 3. LABOR FORCE

According to Census data (INE, 2011) 39% of homes were headed by a woman. 10 years ago that figure was 29% and 20 years ago it was 24%, whereby a growing tendency toward female-headed households may be observed, suggesting greater vulnerability of women to having to attend to child-rearing and housework.

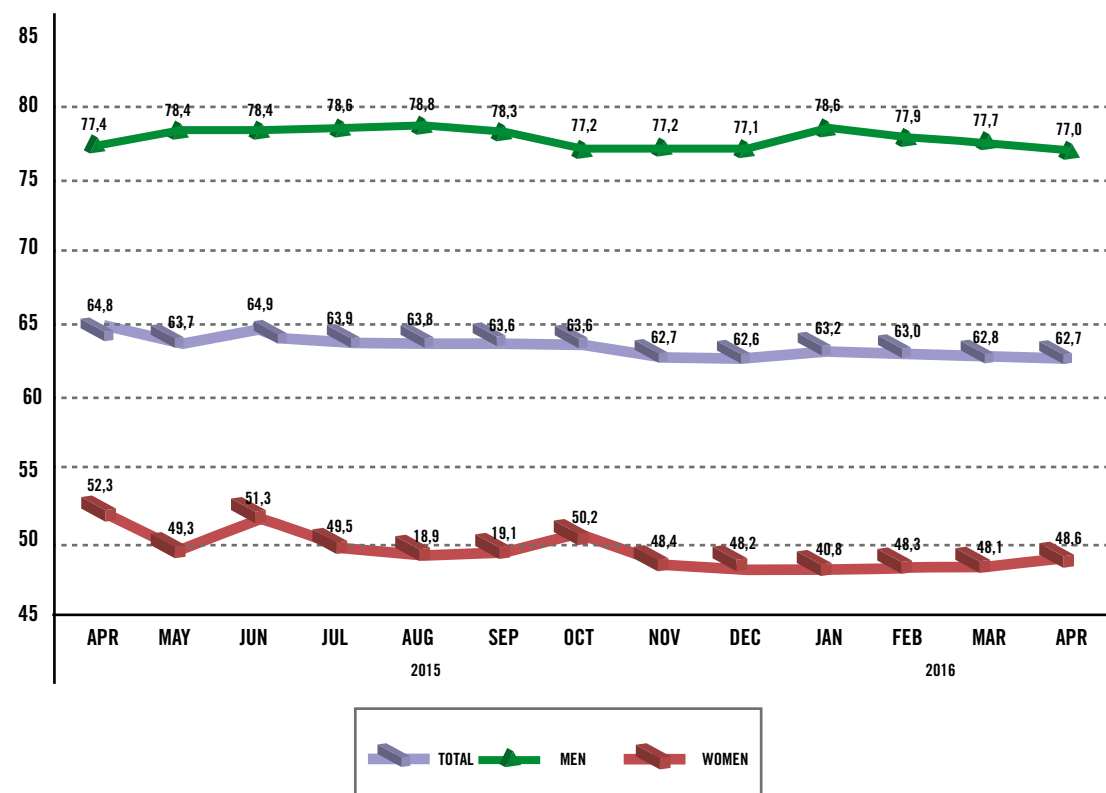
According to one relatively recent official surveys, (INE, 2016) the economically active population at the time was of 14.124.319 (67.7%) which, in comparison to April 2015, when it was 14.322.536 (64,8%) points to a reduction in absolute terms of 198.217 or 2,1 percentage points. An analysis of these num-

bers when disaggregated by gender indicates a significant increase of men of 110.290 in absolute terms (0,4 percentage points) and a decrease of women of 308.507 (3,7 percentage points).

According to the INE itself:

“(…) this decrease in women within the economically active population has been very marked since 2015 and continues to manifest itself in 2016, having brought about a reduction in the total active population at the national level” (2016).

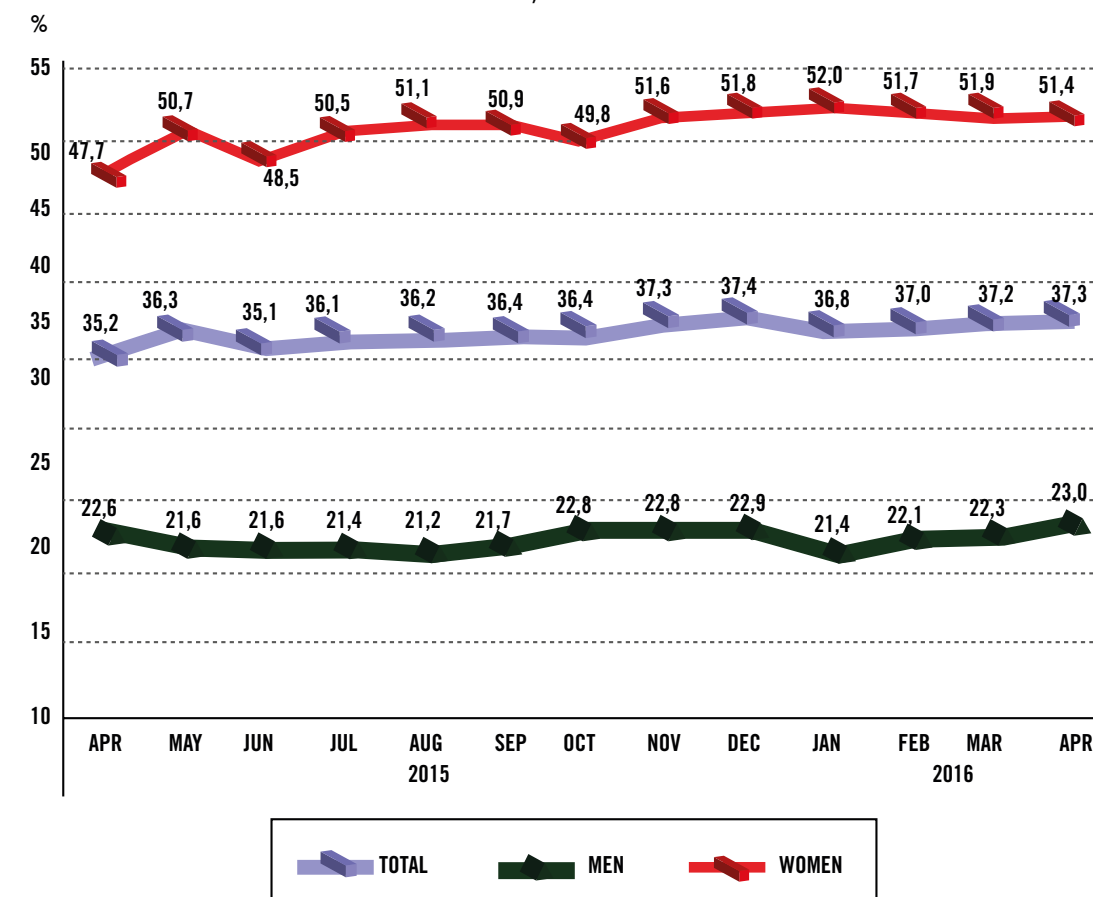
RATE OF ACTIVITY, APRIL 2015-APRIL 2016



The economically inactive population in April 2016 was 8.396.288 (37,3%) which, when compared with the same month in 2015 when it was 7.783.374 (35,2%), reflects a significant increase in absolute terms of 612.914 and 2.1 percentage points. The data disaggregated by gender reveals significant increases in women of 518.716 (3.7 percentage points) and 94.198 (0.4%) in men. The increase of inactivity in the 15-24 age group may be explained by the incorporation into the educational system (an increase of 204.055). However, as the INE itself points out:

“(…) it is noteworthy that the inactive female population has increased significantly in the inter-annual comparison and increases notably in the category: “housework” (428.330). This is an ongoing situation since the beginning of 2015, but it is important to call the attention to this figure, given that the abandonment of the labor market by an important percentage of female population has an impact on household incomes” (2016).

RATE OF ACTIVITY, APRIL 2015-APRIL 2016



The same survey finds gender differences regarding full-time dedication to home keeping: a group of 3.071.881 of women against 64.000 men. This demonstrates how the official narrative of recognizing domestic work as productive, value-adding labor, has had no effect upon the general socio-economic and cultural dynamic. On the contrary, a clear gender division of labor continues to be observed which limits, excludes and expels women from the public/formal labor market and sustains the gap between men and women when it comes to care. This “responsibility” to care has diminished women’s opportunities of joining the labor market and therefore, to achieving economic autonomy.

It is to be expected that in the current economic and social crisis, most recently intensified by the crisis in public water and electric utilities, the figures thus far analyzed would show a poorer performance. Apart

from ENCOVI, official figures date back to 2016 and there are no up-to-date information to allow a more accurate insight into the socio-economic conditions of the population, and of women in particular. However, the data discussed here provides a fairly clear sketch of existing gender inequalities and their exacerbation due to the CHE. All this has, furthermore, resulted in an unprecedented regression in the enjoyment of fundamental rights and guarantees.

Any process of re-institutionalization of the country must take into account the specific ways in which the crisis has affected women in order to guarantee their full re-enfranchisement into the labor market, as well as provide specific policies that guarantee opportunities for access to and permanence in quality education at all levels, unfettered by the dimensions of care and child-rearing labor.



## 4. FOOD AND NUTRITION

In December 2018 the basic food basket had a month-on-month increase of 133.7%. This variation triples that of the previous month and is the highest on record for the year. But the minimum wage had a purchasing power of only 4.3% of that basic food basket (Caritas Venezuela, 2018). According to the Center for Documentation and Analysis for Workers (CENDA), for that very same month of December 2018, a family required 23 minimum wages to cover basic food expenses. CENDA also estimated that a home with two working persons, that is two minimum wages and two food vouchers, could only cover food for three days a month.<sup>3</sup> And all this bearing in mind that, by April 2019, the minimum wage in Venezuela is 18.000 Sovereign Bolivars, equivalent to US\$ 3.46 (at the official rate of 04/25/2019) or US\$0.16 per day.

This economic outlook has a direct impact on the food purchasing and consumption power of the population in general and has a differentiated effect in the case of women, girls and adolescents. According to the United Nations Food and Agriculture Organization (FAO), Venezuela is the Latin-American country with the greatest increase in hunger and malnutrition in the biennium 2016-2018. The same source states that hunger tripled, going from 3.6% between 2010-2012

to 11.7% between 2015-2017. FAO points out, however, that this data only shows a tendency, as access to official information is limited (2018).

The survival strategies that the Venezuelan population has had to turn to are many, from scavenging for food in non-conventional places to begging in the streets; reducing the quality of meals; selling off belongings; going into debt to eat; disincorporation of a member of the household and emigrating in search for a better standard of living (Observatory of Food Security, 2018).

According to data from a study of women about to embark on a migratory process (AVESA, CEPAZ, FREYA and Mujeres en Línea), 96.5% of those consulted expressed concern over the lack of food in their homes. Said concern is associated with a socio-economic context that restricts the access to food and the deterioration of women's income in their homes, as commented in previous paragraphs. Asked how often in a four-week period they felt that they would have no food, 43.63% stated that they "often" (more than 10 times) were worried about not having food available at home; 28.60% stated that they worried "sometimes" (3 to 10 times) and 24.5% said "rarely" (1 to 2 times).

PHOTO: SHUTTERSTOCK

## II. SEXUAL AND REPRODUCTIVE HEALTH

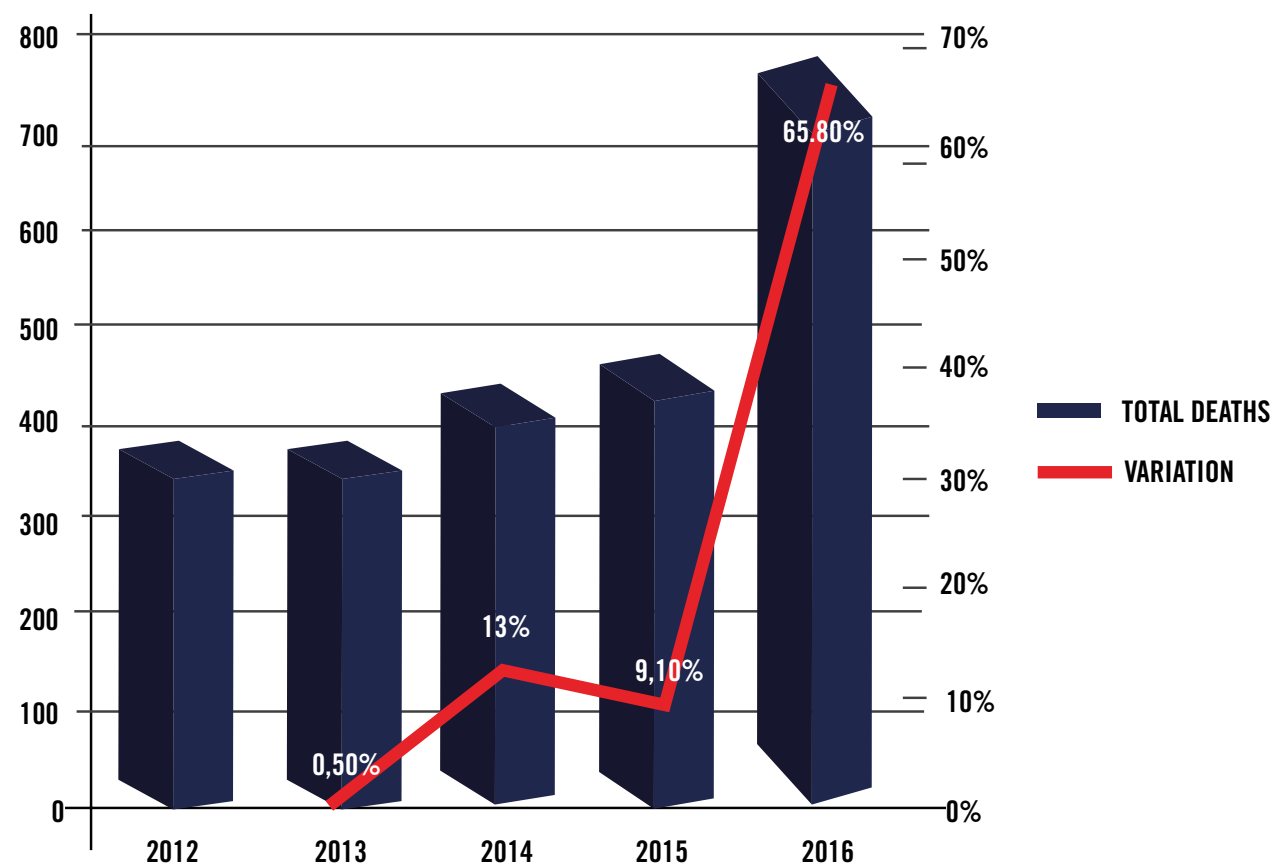


The situation of rights and sexual health in Venezuela is of considerable severity and unprecedented setbacks, given the absence of coherent, effective, and efficient public policies to guarantee the sexual and reproductive rights of the population. There is a national framework for the acknowledgement of sexual and reproductive rights, enshrined in diverse legal instruments providing the required platform for the development of these public policies, including resource allocation (AVESA, ACCSI, Aliadas en Cadena, 2015); however, there has been no political will for this. This serious situation is also the result of a crumbling public health system, including centers for maternal care and sexual and reproductive health services, as well as of restrictive policies that have prevented the local production and/or import of essential supplies such as family-planning methods whose scarcity has been denounced since at least 2014, when the crisis affecting Venezuela today was already in sight.

The absence of effective public policies for sexual and reproductive health, combined with the collapse of the public health system and the scarcity of contraceptives, has generated serious implications for the enjoyment of rights and of sexual and reproductive health on the part of Venezuelan women and has undeniably impacted the rise in maternal mortality, teenage pregnancy, sexually transmitted diseases (STDs), including HIV/AIDS, and unsafe abortions as a result of unwanted pregnancies. As pointed out in our previous report (Equivalencias en Acción, 2017), by 2016 the Venezuelan Pharmaceutical Federation (FEFARVEN) calculated that the scarcity of family planning methods was at about 90%.<sup>4</sup>

According to official figures, between 2012 and 2016 there was a sustained increase in maternal deaths in the country (see Graph 1). In just one year (2015-2016) maternal mortality increased by 66%.

GRAPH 1: MATERNAL MORTALITY IN VENEZUELA 2012-2016



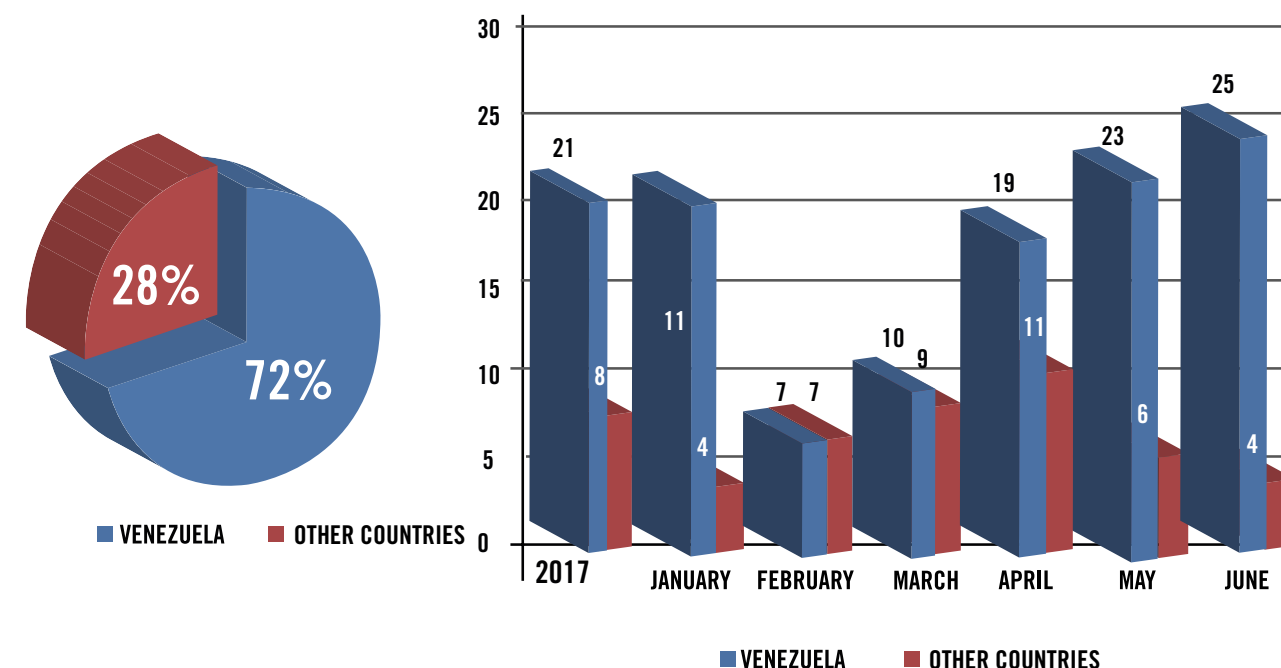
SOURCE: PREPARED BY THE AUTHORS

The precarious socio-economic conditions in which most of the population finds itself and which conditions the access to food, including for pregnant women, have brought about negative consequences both for them and for their unborn children. For example, according to data gathered by Caritas for July-September 2018, 21% of pregnant women in parishes in 7 states presented with acute malnutrition, out of which 24% of them were adolescents under 19 (Caritas Venezuela, 2018).

Given the non-responsiveness on the part of official entities, the remaining option for many Venezuelan women has been to cross the border to Colombia and Brazil. Research by Colombian NGO PROFAMILIA

found that the trend of births in Colombia from women residing in Venezuela rose significantly between 2015 and 2018, compared to the average for the period 2012-2014. The Departments of Norte de Santander (40.1%) La Guajira (19.7%) and Bogotá (15.8%) had the highest incidence of births from mothers residing in Venezuela between January and July 2018 (PROFAMILIA COLOMBIA and IPPF, 2019). During 2017, three out of four abortions at PROFAMILIA carried out on foreign women were performed on Venezuelans (a total of 21 procedures), while by June 2018, 165 abortions had been performed on women of various nationalities: 116 on Venezuelans (71%) and 49 on women of other nationalities (29%) (see Graph 2).<sup>5</sup>

GRAPH 2: ABORTIONS ON WOMEN FROM VENEZUELA AND OTHER COUNTRIES AT PROFAMILIA



According to figures from Colombia's migration authority, 8.209 pregnant Venezuelan women were registered entering the country, 6.304 (76.7%) without pre-natal control and 8.045 (98%) without social security. 7.496 lactating Venezuelan women were also registered, corresponding to 3.4% of the total 219.799 who entered during the same period. And according to a report of the Secretariat of the Presidency of Brazil, 10% of births in the bordering state of Roraima between January 2017 and March 2018 were to Venezuelan women.<sup>6</sup>

The PROFAMILIA study (2019) reveals another worrisome datum: men and women coming from Venezuela, of various age groups, were not familiar with the concept of sexual and reproductive health nor with the attending services and rights. Similarly, they did not exhibit sufficient knowledge about contraceptives, abortion, STDs, HIV and the health services necessary

for the clinical management of rape. The group of youths between 14 and 25 claimed not to have received comprehensive sexual education.

All this data reveals the situation surrounding the right to sexual and reproductive health in Venezuela. However, there are no official figures regarding abortion, teen pregnancy, maternal mortality or the availability of family planning methods, among other factors that affect women, girls and adolescents, constituting a violation of the right to information and having a direct impact on the right to health, both enshrined in the Constitution of the Bolivarian Republic of Venezuela. In view of this vacuum of information and given the precariousness of the right to sexual and reproductive health described above, the Equivalencias en Acción coalition carried out two studies between August and December 2018 in order to measure:

- Supply of contraceptive methods at the private pharmacy level in five cities in Venezuela (Equivalencias en Acción, 2019a) and
- Teenage pregnancy, maternal deaths, unsafe abortions and service conditions in four health institutions: Dr. José María Vargas Maternity and Child Hospital, known as the Maternidad del Sur or Southern Maternity (Carabobo State); Supreme Commander Hugo Chávez High-Risk Maternity, part of the Enrique Tejera Hospital Complex or CHET (Carabobo State); Victorino Santaella Hospital (Miranda State); Concepción Palacios Maternity (Caracas) (Equivalencias en Acción, 2019b).



# 1. AVAILABILITY OF FAMILY-PLANNING METHODS

20

The Cairo World Conference, held in 1994, acknowledged the right to reproductive health defined as:

“[...] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant [...] (UN, 1994)

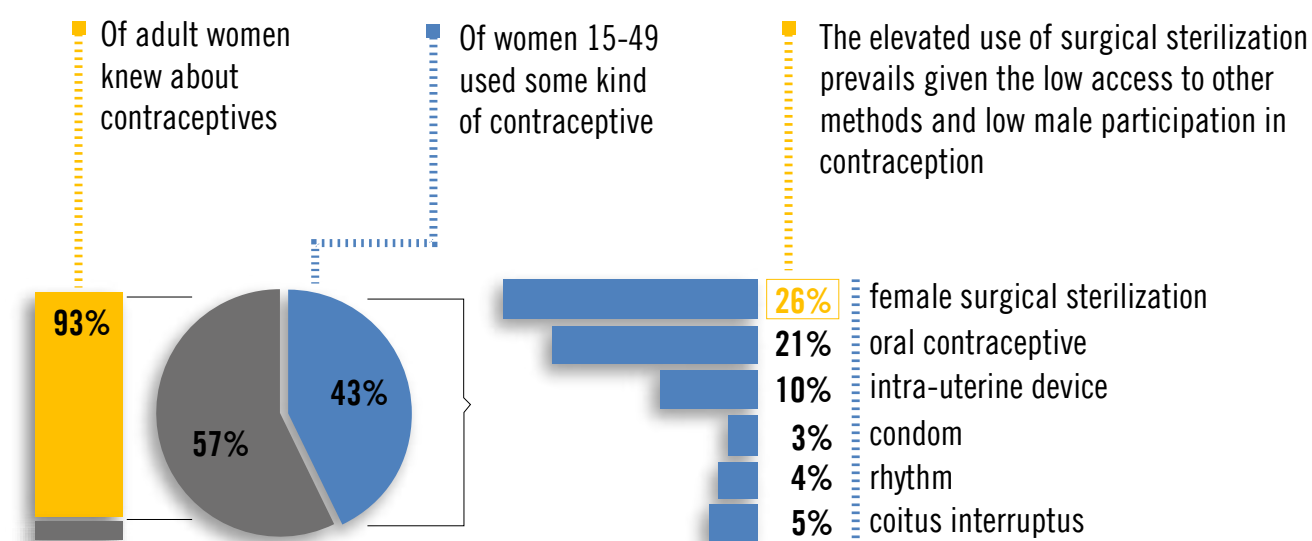
Within this definition and according to the analysis regarding reproductive rights carried out by the Inter-American Institute for Human Rights (2003), it is understood that reproductive health rights include access to fertility regulation methods which are not forbidden. Access to safe, effective, affordable and acceptable methods is a part of this right, hence the State's obligation to guarantee it.

Contraception has clear benefits for the health of women, as the prevention of unwanted pregnancies gi-

ves rise to a subsequent reduction in maternal and child mortality and morbidity. They further contribute by allowing people to take control of their sexuality, health and reproduction, which in turn promotes the achievement of a satisfactory sexual life (WHO, 2014) and facilitates the exercise of other rights by women such as the right to work and education. Access to contraceptives therefore, must be assumed from a rights perspective. As pointed out by WHO (2014, pg. 5):

“Human rights are guaranteed in international and regional treaties, as well as in national constitutions and laws. They include the right to non-discrimination, the right to life, survival and development, the right to the highest attainable standard of health, and the rights to education and to information. These rights have been applied by international, regional and national authoritative human rights bodies – such as UN treaty-monitoring bodies, international and regional courts, constitutional and supreme courts – to a wide range of sexual and reproductive health issues, including the accessibility of contraceptive information and services. All rights are interdependent and indivisible. The right to the highest attainable standard of health, for example, which includes access to health services and health-related information, cannot be fulfilled without promotion and protection of the rights to education and information, because people must know about health commodities and services to be able to use them.”

## STATUS OF FAMILY-PLANNING METHODS IN VENEZUELA BEFORE THE CHE



Source: 2010 figures (Ministry of Popular Power for Health, 2013)

It may be said that contraceptive availability is guaranteed or assured when people may choose, obtain and use high-quality methods at the moment they need them, both for family-planning and for HIV/AIDS prevention. This implies both access to free or subsidized products and to access at the commercial level (pharmacies) in a continuous and permanent manner (USAID, no date).

According to figures for 2010 (Ministry of Popular Power for Health, 2013) 93% of adult women knew about contraceptives but only 47% of women 15-49 used any kind with the following distribution: 26% surgical female sterilization; 21% oral contraceptives; 10% intra-uterine devices; 3% condoms; 4% rhythm; 5% withdrawal or coitus interruptus (the latter, though included here, should not be considered as a contraceptive method). These figures reveal a high prevalen-

ce of surgical sterilization which prevails as a result of the scant access to other methods and low masculine participation in contraception.

Historically, adult and adolescent Venezuelan women had access to contraceptive methods through private pharmacies without major restrictions. That is, contraceptive methods were accessible both in price and availability in pharmacies, and no prescription was needed for their purchase, even in the case of the day-after pill. According to the Official Norm for Sexual and Reproductive Health (Ministry of Popular Power for Health, 2013) by 1998 most adult and adolescent women had access to contraceptives through pharmacies (67%) and 17% through public institutions. This, without including surgical sterilization which at the time had increase significantly.

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## SICM FOR FIVE CITIES IN THE COUNTRY

The Scarcity Index for Contraceptive Methods in pharmacies (SICM) is the percentage of pharmacies where a given contraceptive method is not found. Value between 0 and 100.



**151 pharmacies consulted.**  
**(August-December 2018) in:**

Barquisimeto, Mérida, Maracaibo, Porlamar and Caracas Metropolitan Area

Método anticonceptivo	IEMA		
	Lesser value	Greater value	Average
Oral (pills)	74,7%	82,9%	78,8%
Injectable	95%	100%	97,5%
Intra-uterine devices (IUD)	83%	97,3%	90,15%
Implantable devices (Implants)	91%	100%	95,5%
Contraceptive patches	100%	100%	100%
Condoms	41,6%	62,5%	52%
Vaginal rings	91%	100%	95,5%
Emergency contraception	71%	88%	79,5%

- **SICM** for all methods: between **83,3%** and **91,7%**.
- **SICM** for condoms average: **52%**. The most widely available in market.



*Availability and distribution of contraceptive methods not guaranteed.*



*Constitutes a violation of sexual and reproductive rights of Venezuelan women and adolescents*

Currently, there is an acute scarcity of contraceptives. There are reports that the last major purchase of contraceptives by the State through the Ministry of Popular Power for Health (MPPS) was in 2015 (Agencia EFE, 2018). FEFARVEN, for its part, has pointed out that the shortage of contraceptive methods has increa-

sed from 45% in 2015 to 80% in 2016 and 90% in 2017 (Grupo de Mujeres sin Tregua, 2017). However, there is no recent information, whether official or otherwise, on the levels of supply of contraceptives nor on their use or the percentage of women who acquire contraceptives in pharmacies.

## 1.1 INDEX OF SCARCITY OF CONTRACEPTIVE METHODS IN PHARMACIES IN FIVE CITIES IN THE COUNTRY.

Contraceptive methods are those supplies or medicines that provide necessary protection from unwanted pregnancy and/or sexually transmitted infections. For the purpose of this study, those included in the WHO list of essential medicines were considered:

❖ Oral Contraceptives: two active principles in 3 types of combinations or presentations (Ethinilestradiol/Levonorgestrel, ethinyl estradiol/Noretisterone, Levonorgestrel)

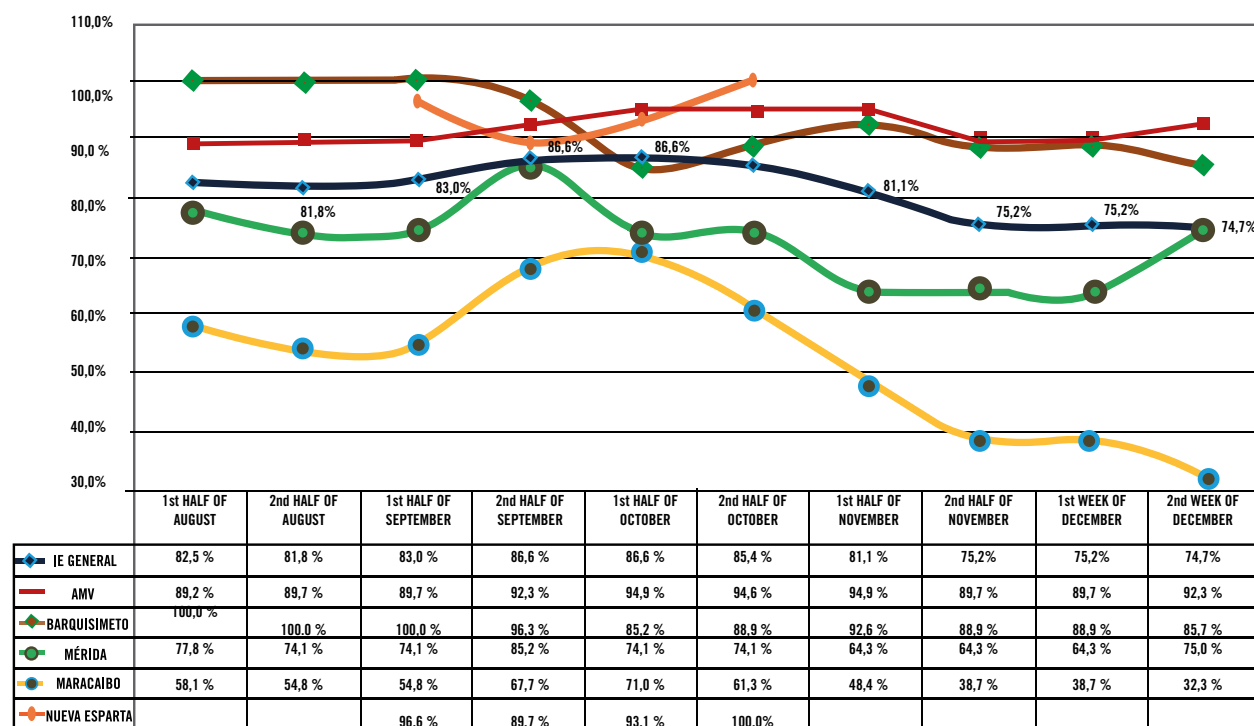
❖ Injectable Contraceptives: three active principles in three types of combinations or presentations (medroxyprogesterone acetate, medroxyprogesterone acetate/ estradiol cypionate, norethisterone oenanthate)

❖ Other Methods: intra-uterine devices (IUD); implanted devices (Levonorgestrel-releasing implants); patches, condoms, vaginal rings and emergency contraceptive. The scarcity index for contraceptive methods in pharmacies (SICM) is understood as the percentage of pharmacies in the sample where a given contraceptive method was not found, and it is a value that ranges between 0 to 100 expressing the percentage of establishments consulted where the requested contraceptive was not found.

The geographical area for the study comprised 5 capitals in Venezuela: Caracas Metropolitan area, Barquisimeto, Maracaibo, Mérida and Porlamar.<sup>7</sup> The sample in each city was determined through random stratified sampling, proportionate to the number of establishments in the municipalities, parishes and sectors corresponding to a confidence level of 95% and an admissible error level of 10%, depending on the city. The selection of establishments was done systematically in order to ensure inclusion in the sample of every socio-economic sector in each municipality, parish and sector. 151 pharmacies made up the sample. Two measurements per month were made during the duration of the study (August-December 2018). The results point to the following:

a. Oral contraceptives: returned a stable SICM during the five months of measurement, with values oscillating between 74.7% and 82.9% in the consulted cities. This allows us to conclude that the availability and access to this type of contraceptive method is definitely not guaranteed through the pharmacies in these cities. These results are worrying, as oral contraception was the preferred method by Venezuelan women and adolescents (Fernández, López, & Martínez, 2009; Ministry of Popular Power for Health, 2013).

GRAPH 3: BEHAVIOR AND EVOLUTION OF THE SCARCITY INDEX OF ORAL CONTRACEPTIVES AUGUST-DECEMBER 2018

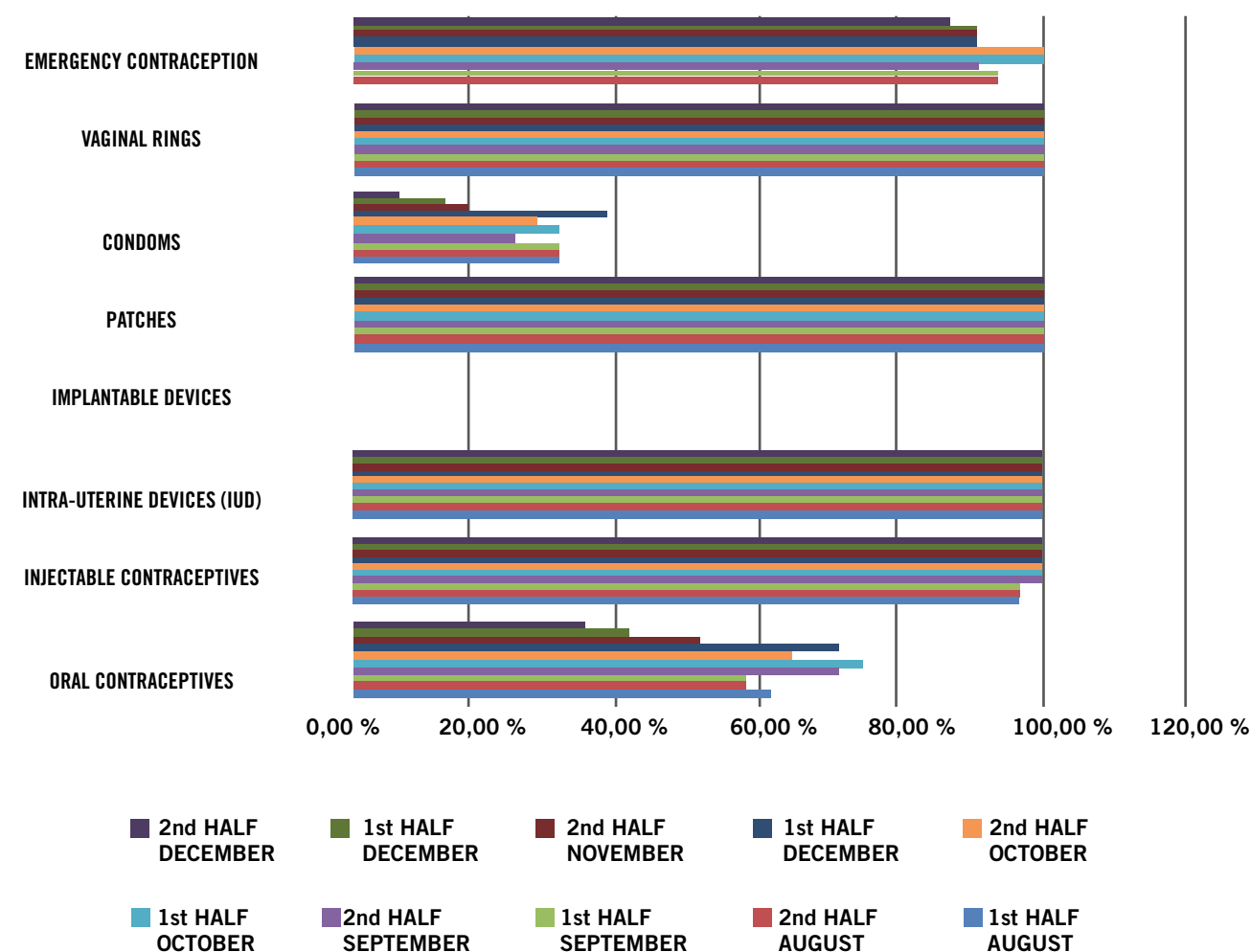


SOURCE: EQUIVALENCIES IN ACTION 2019a

At 48.4%, Maracaibo was the city with the lowest scarcity of oral contraceptives in relation to other cities as in the case of condoms at 16.1%. (see Graph 4). While researchers did not inquire about the possible causes of this difference, allied persons and organizations posit that the greater availability of these methods may be due to two reasons: 1. The circulation of an undetermined though significant number of medicines (not just oral contraceptives) that enter

Venezuelan territory from Colombia as contraband and are sold in many establishments, and 2. The direct purchase of medicines abroad with foreign currency obtained through the so-called black market and imported directly by some pharmacies in that city. This hypothesis is reinforced by observing that the scarcity index is lower in independent pharmacies and local chains where State scrutiny on their activities is lower than in the case of national chains of pharmacies.

GRAPH 4: SCARCITY INDEX OF CONTRACEPTIVES AT PHARMACIES IN MARACAIBO, ZULIA STATE. AUGUST-DECEMBER 2018



b. Injectable contraceptives: maintained an elevated SICM, always above 95%. During the second measurement of October 2018 it reached 100%, that is absolute scarcity of this method in these pharmacies.

c. Intra-uterine devices: returned a SICM between 83% and 97.3%. It should be noted that this method was the third most used by Venezuelan women and adolescents after surgical sterilization. (Fernández, López, & Martínez, 2009; Ministry of Popular Power for Health, 2013)

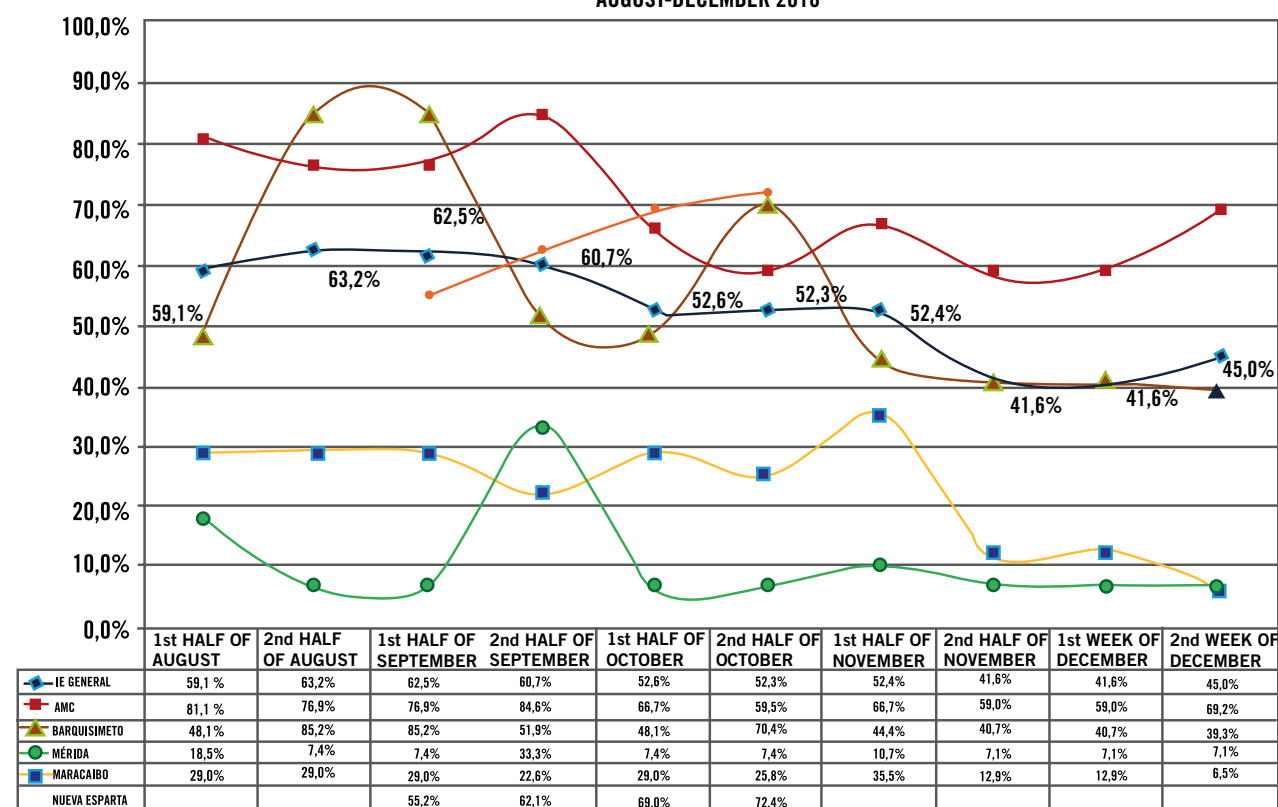
d. Implantable devices: in cities such as Barquisimeto and Maracaibo (two of the most important in the country) this contraceptive method returned 100% throughout the study as did the Caracas Metropolitan area as of the second measurement in August 2018. Only in Mérida was there certain, though minimal, availability (SICM between 91.8% and 96.3%) during

the first months of the study, though by November scarcity reached 100%. It is notable that during the second measurement for December 2018, the scarcity index decreased slightly in the Caracas Metropolitan Area (94.9%) and Barquisimeto (96.4%).

e. Contraceptive patches: scarcity was 100% in almost all measurements in the cities and only in a few of them was there some availability. In November the scarcity index was at 100% in all cities. It should be noted that this contraceptive method has been rarely employed by women and adolescents in Venezuela (0.37%) (Fernández, López, & Martínez, 2009).

f. Condoms: are the most widely available in all consulted cities, having scarcity indexes oscillating between 41.6% and 62.5%. However, when available, their price makes them unaffordable to the great majority of people in a context of hyperinflation and the loss of the currency's purchasing power.

GRAPH 5: BEHAVIOR AND EVOLUTION OF THE SCARCITY INDEX OF CONDOMS  
AUGUST-DECEMBER 2018



SOURCE: EQUIVALENCIES IN ACTION 2019a

TABLE 2: ACCUMULATED CONTRACEPTIVE SCARCITY INDEX BY TYPE AUGUST-DECEMBER 2018

CONTRACEPTIVE	1st AUGUST	2nd AUGUST	1st SEPTEMBER	12nd SEPTEMBER	1st OCTOBER	2nd OCTOBER	1st NOVEMBER	2nd NOVEMBER	1st DECEMBER	2nd DECEMBER
ORAL	82,5 %	81,8 %	83,0 %	86,6 %	86,6 %	85,4 %	82,9 %	81,1 %	75,2 %	74,7 %
INJECTABLE	97,5 %	100,0 %	99,0 %	96,1 %	98,5 %	100,0 %	100,0 %	100,0 %	98,0 %	96,7 %
IUD	97,0 %	96,6 %	97,3 %	98,5 %	92,5 %	93,4 %	89,8 %	91,4 %	92,5 %	88,6 %
IMPLANTABLE	98,4 %	100,0 %	99,9 %	99,9 %	99,9 %	99,9 %	100,0 %	100,0 %	100,0 %	96,7 %
PATCHES	97,7 %	100,0 %	100,0 %	100,0 %	100,0 %	100,0 %	99,3 %	100,0 %	100,0 %	94,7 %
CONDOMS	59,1 %	55,2 %	62,5 %	60,7 %	52,6 %	52,3 %	52,4 %	44,5 %	41,6 %	45,0 %
VAGINAL RINGS	98,6 %	100,0 %	100,0 %	100,0 %	99,9 %	99,9 %	99,9 %	100,0 %	100,0 %	96,7 %
EMERGENCY	83,6 %	100,0 %	88,7 %	88,8 %	86,4 %	86,9 %	81,6 %	71,4 %	69,0 %	73,0 %
GENERAL	89,3 %	91,7 %	91,3 %	91,3 %	89,6 %	89,7 %	88,2 %	86,1 %	84,5 %	83,3 %

SOURCE: EQUIVALENCIES IN ACTION

Generally, the scarcity index of contraceptives in pharmacies oscillated between 83.3% as the minimum and 91.7% as a maximum value in the five cities consulted. However, the city which exhibited the greatest scarcity level by percentage was Caracas (90.1%). Injectable contraceptives, implantable devices, patches and vaginal rings are the methods with the highest

scarcity indexes throughout all measurements. The scarcity index of oral contraceptives (the most widely used among Venezuelan women) and emergency contraception remain in the order of 85% (except in December when scarcity was slightly lower), while condoms maintained an average of 50%. The latter are, definitely, the most widely available in the market.



## 1.2. PROVISION OF CONTRACEPTIVE METHODS AT FOUR HOSPITALS

28

All four hospitals part of the observation made between August and December 2018<sup>8</sup> remained without availability of oral or injectable contraceptives, patches and vaginal rings (with the exception of CHET, where there was an irregular provision of vaginal rings in December). Provision (normal and irregular) of male condoms was found at the Victorino Santaella Hospital (Miranda State) and Concepción Palacios Maternity (Caracas),

while at the Southern Maternity and CHET (both in Carabobo) there was provision (irregular and normal) of intrauterine devices. The only occasion and institution where availability of implantable devices with normal provision was found was the Southern Maternity in December. Emergency contraception was only available, with both normal and irregular provision, at the Concepción Palacios Maternity.

PROVISION OF CONTRACEPTIVE METHODS. AUGUST-DECEMBER

	SOUTHERN MATERNITY				VICTORINO SANTAELLA					CONCEPCIÓN PALACIOS MATERNITY					CHET				
	SEP	OCT	NOV	DEC	AUG	SEP	OCT	NOV	DEC	AUG	SEP	OCT	NOV	DEC	AUG	SEP	OCT	NOV	DEC
ORAL																			
INJECTABLE																			
IUD																			
IMPLANTABLE																			
PATCHES																			
VAGINAL RINGS																			
MALE CONDOMS																			
EMERGENCY CONTR.																			

These results demonstrate that availability of family planning at hospitals where measurements took place is not guaranteed and they corroborate reports that there has not been procurement of contraceptives for the public health system by the State, through the MPPS, since 2015.

## 1.3. CONSEQUENCES OF THE VIOLATION OF THE RIGHT TO ACCESS TO CONTRACEPTIVE METHODS

29

While this data is partial and not statistically generalizable to the national reality, it does point to a clear situation of lack of availability of family planning methods both at the commercial level at pharmacies in the explored cities and the four hospitals observed. Furthermore, the results obtained coincide with the scarcity percentages denounced by FEFARVEN and suggest that there is a persistent tendency toward scarcity of contraceptive methods both at the level of commercial establishments (pharmacies) and at public health centers.

It may be thus stated that in at least the five cities included in the measurements (three of which are the principal cities in the country) there is no guarantee of availability or sufficient and adequate distribution of varied contraceptive methods, including emergency contraception, constituting a clear and general violation of sexual and reproductive rights of Venezuelan women and adolescents. This affects their reproductive autonomy in particular, enshrined in Art. 76 of the Constitution of the Bolivarian Republic of Venezuela, as they cannot make fundamental decisions regarding their sexuality and reproduction due to lack of means.

Comprehensive education for sexuality, access to contraceptive methods and family planning services constitute the basis of the guarantee of sexual and repro-

ductive rights and their absence generates a series of consequences such as:

- ▲ Increase in unplanned pregnancies (including those of teenage mothers)
- ▲ Increase in forced maternity
- ▲ Increase in unsafe abortions
- ▲ Increase in maternal deaths associated with unsafe abortions
- ▲ Increase in sexually transmitted infections, including HIV-AIDS.

In Venezuela's current context of CHE, the violation of sexual and reproductive rights deepens gender gaps by trapping women in their reproductive dimension and unpaid care work, making them more likely to remain in poverty, diminishing their possibilities for access to productive work and exposing them to diverse forms of violence, including sexual violence, trafficking and exploitation. It also has an impact on the increase of unwanted pregnancies, many of which end in abortions practiced in unsafe conditions, implying high risks to the health and lives of women.



It is important to point out that, faced with the absence of family planning methods, the Venezuelan State has promoted the surgical sterilization of women in the framework of the “National Surgical Plan” which has been ongoing since at least 2014. Similar plans have been offered from Municipalities and State governments. The drives within this Surgical Plan do not include vasectomies, representing a biased and discriminatory measure that confirms that, in Venezuela, reproductive matters are considered the purview of women and not men. While surgical sterilization is a valid elective contraceptive method and enjoys acceptance among Venezuelan women<sup>9</sup> it is worrisome that the decision to submit to such an irreversible intervention is made out of fear of unwanted pregnancies and from despair stemming from the absence of other methods. It seems clear that it is not a free decision (and it is unknown how well-informed) made by women in accordance with international standards of sexual and reproductive health or even in accordance with Article 76 of the Constitution of the Bolivarian Republic of Venezuela, but rather a decision based on coercion due to the current crisis.

It is calculated that, according to information from official organs, at least 4,500 women have been sterilized since 2014 in the following states in the country Bolívar<sup>10</sup>, Carabobo<sup>11</sup>, Zulia<sup>12</sup>, Guárico<sup>13</sup>, Táchira<sup>14</sup>, Yaracuy<sup>15</sup>, Trujillo<sup>16</sup>, Miranda<sup>17</sup>, Barinas<sup>18</sup> and Lara<sup>19</sup>.

Some media outlets have documented the stories of women who have undergone sterilization. For example, a mother of two girls, sterilized in 2016, stated that:

“It’s very difficult to find contraceptive methods and a baby’s most basic needs are also very hard to satisfy” (The Intercept, 2018)

In an interview, a 28 year old woman bluntly stated:

“I am a bit afraid of getting sterilized, but I would ra-

ther do that than having more children. Having a child nowadays means making him suffer” (Sandy Aveledo. com, 2016)

Another 27 year old woman, mother of two girls, told one publication that, though frightened, she balanced many other things such as the fact that she would like to have another child in the future but, given the current situation in the country, it was preferable to give her existing daughters comfort and security rather than thinking of bringing “more children into the world to suffer” (The Intercept, 2018).

Various cases of malpractice and at least one death of women who have undergone sterilization have been registered in the context of the Surgical Plan. On 4th October 2017, a 35 year old patient was admitted without vital signs at the Simón Bolívar Complex of the José Ignacio Baldó Hospital (known as Algodonal), after doctors of the Surgical Plan performed a sterilization procedure on Sunday 24th September at the same hospital. According to press reports, the patient had not been operated by Algodonal hospital doctors but by doctors from the Surgical Plan (El Pitazo, 2017). Another patient, 31 years old, also after undergoing sterilization during a National Surgical Plan drive also at Algodonal, ended up with complications days later when her small intestine started exiting through the incision in her stomach.<sup>20</sup>

It is worrying that information on these procedures is not public. Generally, the objectives, goals, budgetary allocations or administrative entity to which the Surgical Plan is ascribed are unknown. The only available information is that the sterilizations, along with other interventions considered “low complexity”, are performed during one or two-day drives by health personnel from outside the hospitals, and that no registries of medical histories of the patients remain. According to a note from the Vice-presidency, the “Plan” is implemented in co-ordination with data from the “Carnet de la Patria”.<sup>21</sup>







PHOTO: SHUTTERSTOCK

## 2. TEENAGE PREGNANCY

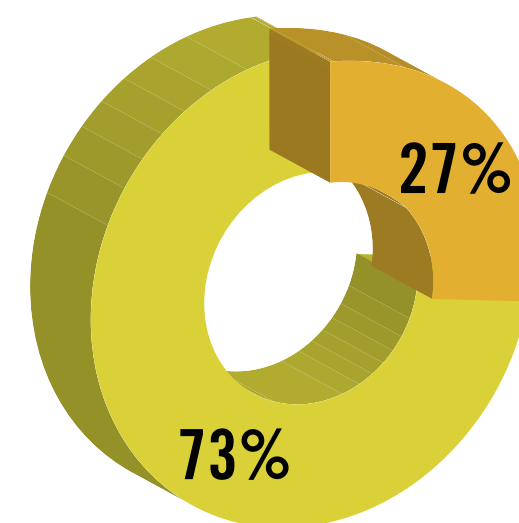
By 2011, according to INE data, 24% of live births registered were to women under 19 years old (Ministry of Popular Power for Health, 2013). The current state of affairs is unknown, as there is no data to bring us closer to the real indicators for sexual and reproductive health. The figures for abortions, teenage pregnancy and maternal mortality, among others affecting women, are not published.

According to UNFPA's State of World Population report (2019) the rate of teenage pregnancy in Venezuela is at 95 births per 1.000 adolescents between 15 and 19 years old. It should be noted that the figures in this report come from official sources and, in Venezuela's case, have at least a 4 years lag. But even with outdated data, Venezuela is still among countries where teenage pregnancy is high: for 2019 it is the third country in the region with the highest teenage fertility rate, only behind Ecuador (111) and Honduras (103), and well above the regional average (62). (UNFPA, 2019).

Given the current vacuum of information, the Equivalencias en Acción coalition undertook a descriptive qualitative/quantitative crosscutting research with a human rights and gender focus, which took the form of: interviews with health providers; service-user focal groups and surveys of health providers. The aim was to gauge the state of the services, as well as to acquire a daily register of maternal deaths, teenage pregnancies and abortions at four hospitals during the August/December period of 2018 (Equivalencias in Action, 2019b).

Of the 8.518 women giving birth accounted for at the four hospitals (Southern Maternity, Concepción Palacios Maternity, Victorino Santaella Hospital and CHET), 2.339 were adolescents under 19 (27% of all births). These results suggest that the figures for teenage pregnancies, as compared to previous years (when they were available) have not diminished.

GRAPH 6: TOTAL PERCENTAGE OF BIRTHS AMONG ADOLESCENTS. AUGUST-DECEMBER 2018



WOMEN IN LABOR UNDER 19

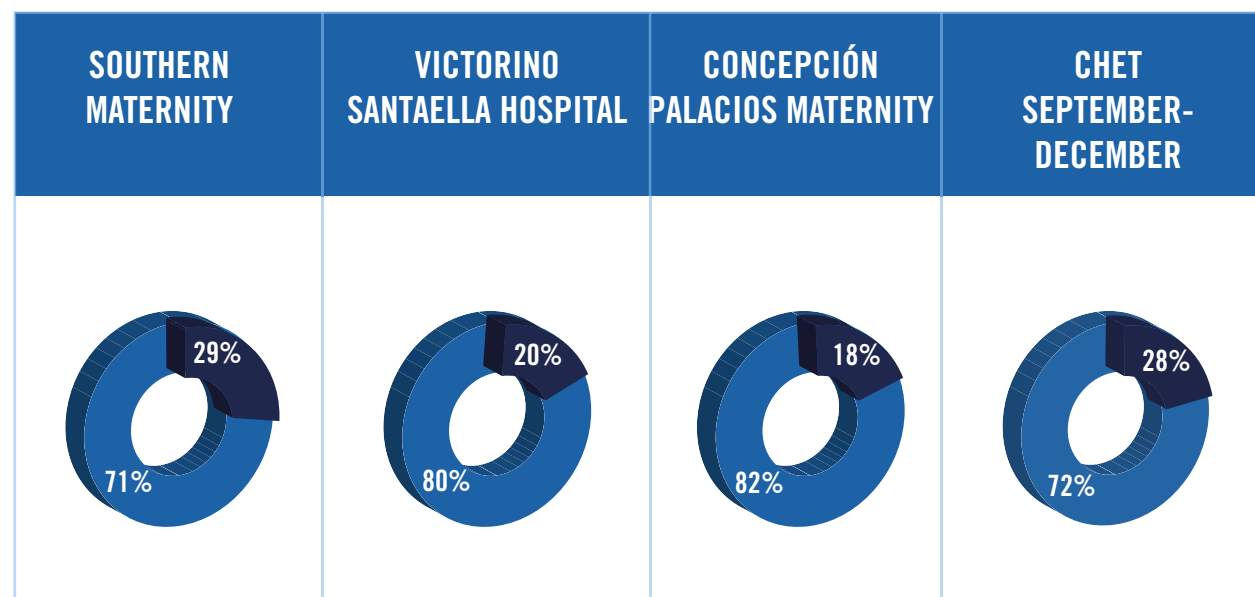
WOMEN IN LABOR 20 AND ABOVE

SOURCE: EQUIVALENCIES IN ACTION, 2019B

Looking at the data disaggregated by hospital we found that Southern Maternity in Valencia (Carabobo State) exhibits the highest percentage of teenage pregnancies (see Graph 7). This data could be interpreted as confirmation that in socio-economically deprived sectors with a high poverty index, such as the one surrounding Southern Maternity, teenage pregnancy returns higher figures, being three to four times higher among those without access to formal education. Low-income adolescents and in less urbanized areas become pregnant and form their own families after abandoning their studies, while those in urban contexts with more education delay their sexual initiation and first union (Ministry of Popular Power for Health, 2013).



GRAPH 7: PROPORTION OF BIRTHS TO WOMEN UNDER 19.  
DATA PER ESTABLISHMENT AUGUST-DECEMBER 2018 <sup>22</sup>



■ WOMEN IN LABOR UNDER 19

■ WOMEN IN LABOR 20 AND ABOVE

In the opinion of health providers at these hospitals, the high proportion of teenage pregnancies and births is associated with deficiencies in comprehensive sexual education, scarcity in contraceptive methods and the high costs of contraceptives that may be found in the market. With respect to sexual education, one health provider points out:

**“We have not yet managed to confront sexual education as we should. We should educate from the families, we should educate from the schools with a sexual education curriculum, we must remove myth from sexuality. Sexuality is not a bad thing. Sexuality is good given certain conditions of safety and maturity, both biological and psychological. Though we are in the age of the Internet, the lack of knowledge in Venezuela regarding the matter of sexual education is surprising.”**

As to access to contraceptive methods, another health provider explains:

**“(…) it is difficult to find contraceptive methods in Venezuela and this has created a black market. We see how the few contraceptives that may be found are sold in [US] dollars, raising their cost and making them inaccessible to many patients.”**

The information from these providers is consistent with data obtained by the scarcity of contraceptive methods index in five cities presented in the previous section, as well as with the results obtained by the regional initiative “Mira que te Miro” (2017) which carries out social monitoring of the commitments made in the Montevideo Consensus of the Regional Conference on Population and Development in Latin America and the Caribbean (Montevideo, 2013). Said initiative has recommended that the Venezuelan State assigns, in a progressive though constant manner, an appropriate budget to cover a greater percentage of contraceptives, as well as to the operational channels for their distribution, in order to reach the goal established in the National Plan for Sexual and Reproductive Health.

The right to education in sexual and reproductive health in Venezuela is established in the Organic Law for the Protection of Boys, Girls and Adolescents (LOPN-NA) and in the Law of Popular Power for Youth. Also acknowledged is the right of young, working or student mothers to protection of pregnancy and to childcare during their studies or work. However, this legal norm has not effectively materialized, as there is no specific program dealing with sexual education and related curricula contents are dispersed throughout various educational programs for each school grade. There are also no known programs for teacher training, nor have any campaigns arising from the Ministry of Popular Power for Health been identified or even specific budget items for comprehensive education in sexuality. Mira que te Miro rates as deficient the content of the curriculum for comprehensive sexual education in Venezuela, as they do the training of professionals and the budgetary resources assigned (Mira que te Miro, 2017).

PHOTO: ARCHIVO AMNISTIA INTERNACIONAL

3

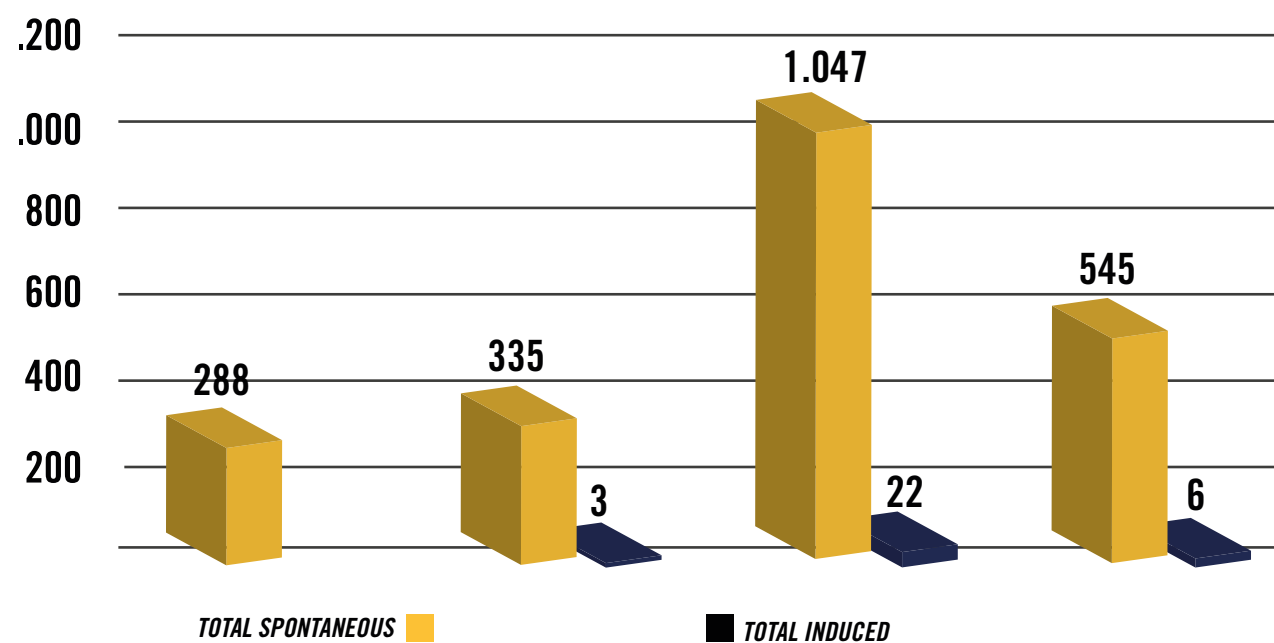
CLINICA GINECOLÓGICA

## 3. UNSAFE ABORTIONS

Contraceptives shortages, both in private pharmacies and public hospitals, together with the precariousness of the health system and the dramatic deterioration of quality of life when basic subsistence needs cannot be covered, places women and adolescents of reproductive age in a situation of vulnerability vis a vis unwanted pregnancy, within a legal context that restricts the possibilities of women to obtain safe abortions.

During the examination of four hospitals during August-December 2018 (Equivalencies in Action, 2019b), a total of 2,246 abortions were registered (15 daily abortions on average). The institution reporting the greatest number of abortions was the Southern Maternity (1069), followed by CHET (551<sup>23</sup>), Victorino Santaella Hospital (338) and, finally, Concepción Palacios Maternity (228) (see Graph 8). This data indicates that one abortion was registered for each four births.

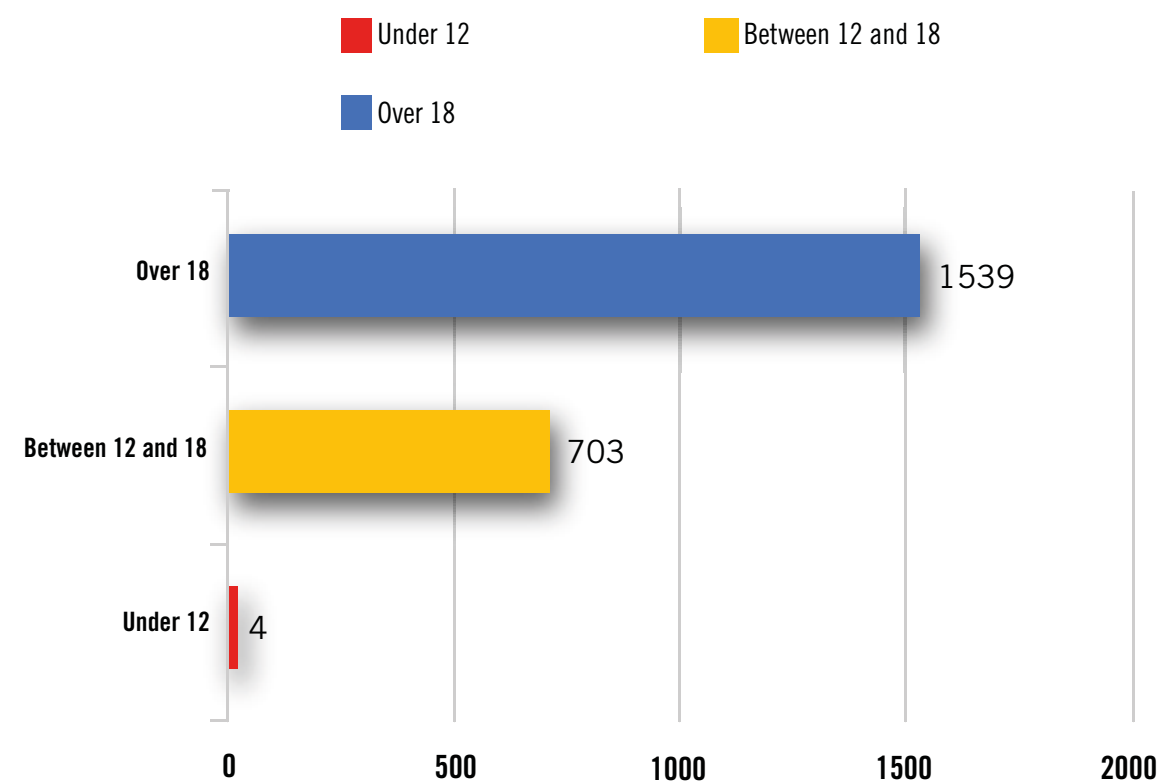
GRAPH 8: TOTAL ABORTIONS BY HOSPITAL. AUGUST-DECEMBER 2018



SOURCE: EQUIVALENCIES IN ACTION

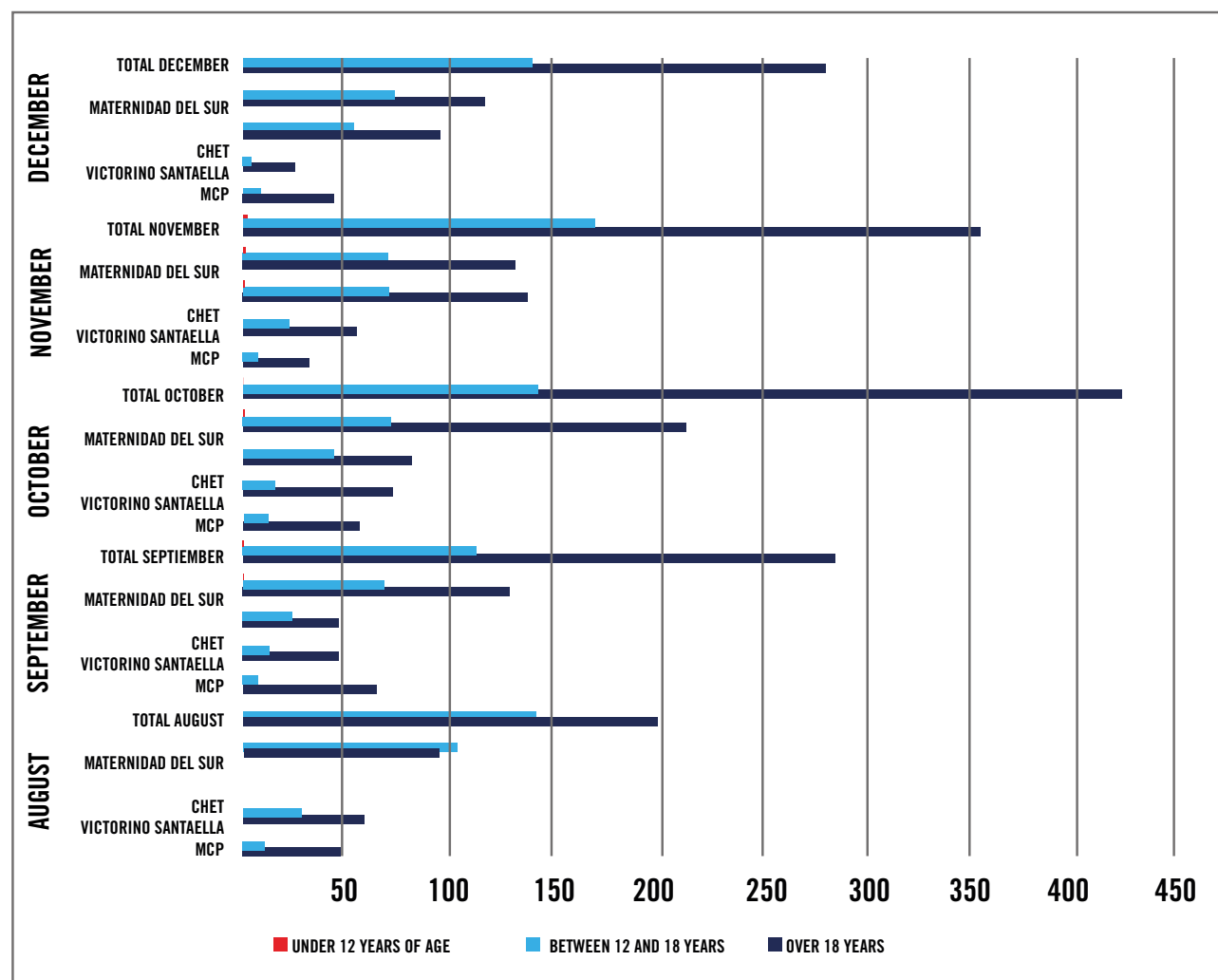
69% of abortions were performed on patients over 18 years of age, while 31% were carried out on patients under 18, reaffirming the situation regarding high rates of pregnancies among adolescents (see Graph 9). A total of four abortions on girls under 12 were also registered, all in Carabobo State (three in the Southern Maternity and 1 at CHET), behind which there may be cases of sexual violence (Graph 10).

GRAPH 9: TOTAL ABORTIONS BY AGE





GRAPH 10: ABORTIONS DISAGGREGATED BY AGE AND INSTITUTION<sup>24</sup>



SOURCE: EQUIVALENCIES IN ACTION 2019B

The Southern Maternity (Carabobo) reports to have maximum to receive eight women daily with abortions (having no more beds for curettage). Additional patients are sent to other hospitals.

Of all registered abortions, only 31 were reported as induced (Graph 8). It should be noted that distinguishing between spontaneous and induced abortions is

no easy task for health providers, who may suspect that abortions were induced but register them as spontaneous based on the women's statements. It should also be underscored that in cases where the abortion was identified as induced, patients were not reported to the justice system, demonstrating the flexibility of health providers when addressing abortion as a crime.



In October, it was reported one maternal due to an induced abortion: a 23 year old woman who presented with multiple perforations in her uterus and colon. Later, in December, a maternal death from an induced abortion was reported, in this case a 33 year old woman, who died after five days in intensive care. The abortion was performed with a soapy solution which brought about necrosis in the uterus.

While there is no data to compare these results, health providers refer to an increase in abortions in their institutions. They also link the rise in spontaneous abortions to nutritional deficiencies and the lack of prenatal care, while induced abortions are associated in failures in family planning and difficulties in access to contraceptives.

As for spontaneous abortions, one health provider stated:

"(...) People no longer eat as before. It is common that pregnant patients cannot acquire medicines for their prenatal care. All that weighs in."

Regarding induced abortions they pointed out:

"The fundamental cause is a lack of family planning. The economic crisis is so serious that there is scarcity of contraceptives in pharmacies. When they can be found, they are exorbitantly priced. Most women would rather buy food than contraceptives. An unwanted pregnancy, in this context, means that some overwhelmed families will seek inadequate solutions, such as abortions, which implies the use of non-salubrious substances or tools."

It must be said that the Penal Code in force (written in 1915 and most recently reformed in 2005), in its Chapter Four, prohibits abortion in its various forms, except when meant to save the life of the woman (therapeutic abortion, Art. 435) and diminishes the penalty in cases when it is carried out to safeguard honor (honoris causa abortion, Art. 436). This means that we have one of the most restrictive legislations regarding the interruption of pregnancy in Latin America. Induced termination of pregnancy is not decriminalized, nor is it legalized in the case of pregnancies caused by rape, incest or malformation of the fetus. Abortion is a crime that is punished with a prison sentence from six months to two years for the woman and from one to three years for the practitioner.

At least two United Nations Committees<sup>25</sup> have recommended the State on various occasions the flexibilization of the norm penalizing abortion. The Montevideo Consensus on Population and Development (ECLAC, 2013), signed by Venezuela, urges States to "consider the possibility of modifying laws, norms, strategies and public policies on the voluntary interruption of pregnancy to safeguard the lives and health of women and adolescents, improving their quality of life and decreasing the number of abortions" (par. 42, 2013).

Mira que te Miro, for its part (2017), recommended that the State include Mifepristone in the list of essential medicines, in order to guarantee its entrance into common use in obstetric emergencies linked to incomplete abortions in public and private health facilities as well as to eliminate such articles that prevent guaranteeing women access to safe abortion, along with the passing of a law that includes the interruption of pregnancy in a variety of situations, among them, voluntary interruption.

The Venezuelan State has not complied in any of these cases.





# 4

## 4. MATERNAL MORTALITY

PHOTO: ARCHIVO AMNISTIA INTERNACIONAL

Most maternal deaths are preventable. It is estimated that since 1990 maternal mortality has decreased by 44% worldwide (UNFPA, 2016). Today there are highly effective interventions and resources to treat eclampsia, serious hemorrhages, sepsis or the consequences derived from abortions practiced in unsafe conditions; all of which are causes of maternal mortality.

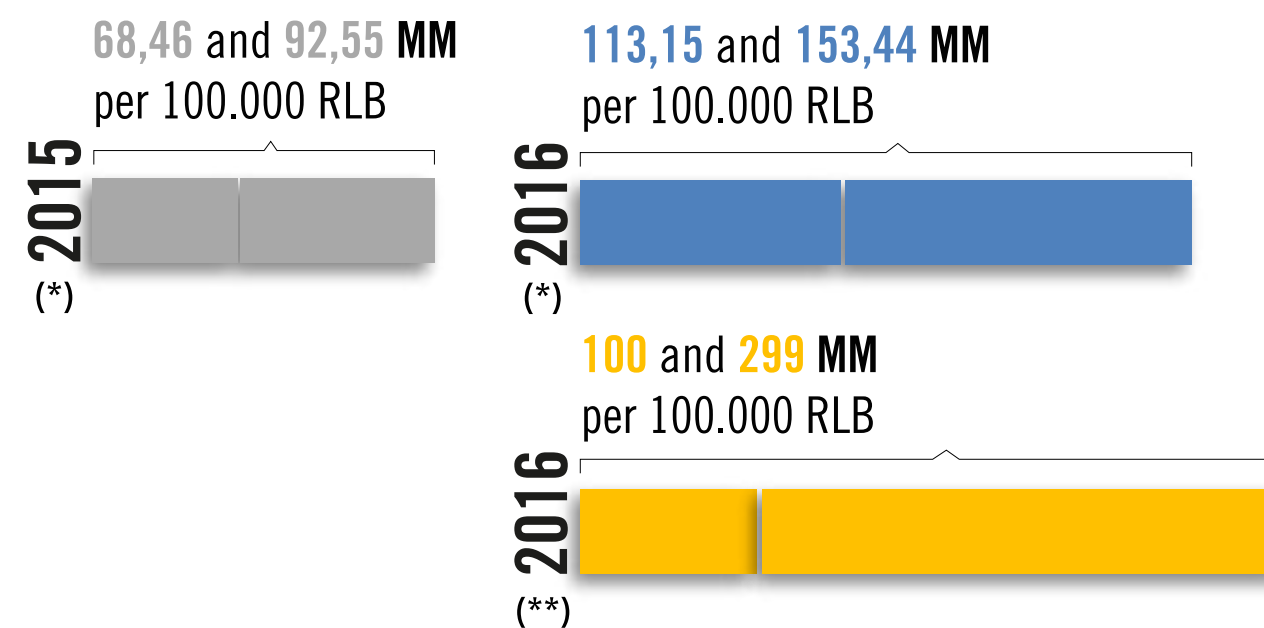
When mothers die, their families are much more vulnerable and their children are more likely to die before the age of two (2016). But maternal mortality is also an indicator of the state of public health systems given that, along with other important indicators, they represent “(...) summary measurements that capture relevant information on the various attributes and dimensions of the state of health and of the performance of the health system (...) which, seen as a whole, try to reflect the health situation of a given population and serve to monitor it” (González Blanco, 2017).

Maternal mortality (MM) in Venezuela has spiked alarmingly in the past few years and in the absence of official figures, it can only be presumed that said trend has been aggravated by the CHE (see Graph 1). As has been pointed out, MM rose by 66% in only one year (2015-2016), that being the last figure available on this indicator published in 2017. At the time, the figures were presented in absolute terms: 756 maternal deaths in 2016. This use of absolute figures prevents

undertaking definitive analyses and comparisons that would allow to grasp the magnitude of the problem. That is why indicators specifically designed to measure MM must be used, such as MM ratio which represents the risk associated with pregnancy and obstetric risk and is calculated with the number of women who die in a given year due to complications related to pregnancy, labor or postpartum for each 100.000 live registered births. Thus, for example, six maternal deaths in Delta Amacuro are not the same as an equal number of deaths in Nueva Esparta. In order to underscore the importance of using adequate indicators and not absolute numbers, González Blanco (2017) undertook the exercise of calculating the MM ratio for both states from available data from 2016 (six maternal deaths each), taking into account the number of registered live births from 2012. The result was that MM in Delta Amacuro would be 128.7 per 100.000 registered live births (one of the highest in the country) and that of Nueva Esparta would be 60.95 per 100.000 registered live births. Considering that both states have a similar situation regarding maternal mortality by virtue of having the same number of deaths would be a mistake. While these figures are not valid, given that they use a denominator from a different time period (2012), they evidence the need to identify specific health indicators in order for analyses and comparisons to adjust to reality so that they may be the basis for effective interventions.

PHOTO: SHUTTERSTOCK

## MATERNAL MORTALITY



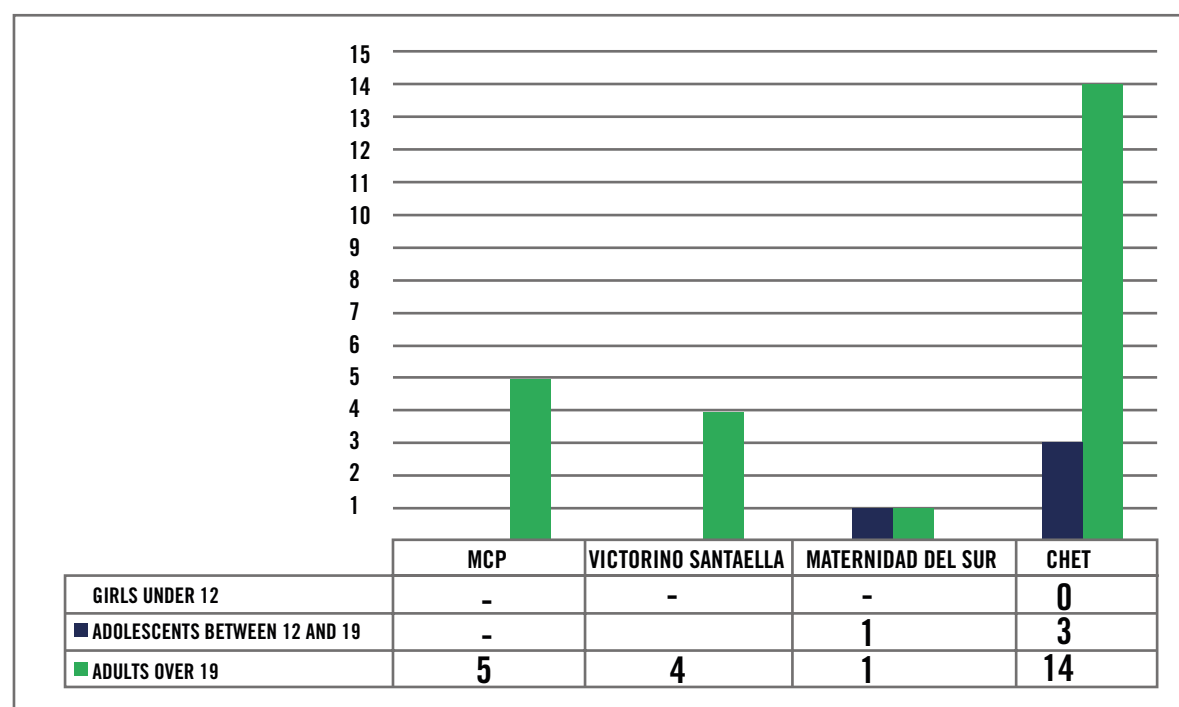
Source: (\*) González Blanco, 2017 / (\*\*) UNFPA, 2016

Some estimates place the MM ratio for 2015 between 68,46 and 92.55 per 100.000 live births (González Blanco, 2017). UNFPA places Venezuela in the group of countries with a MM ratio between 100 and 299 per 100.000 (UNFPA, 2016).

As pointed out earlier, given the absence of official figures, a study was carried out of cases where maternal mortality, teenage pregnancy and abortion were observed, as well as on hospital conditions between August and December 2018.

During the measurement period at four hospitals (Concepción Palacios Maternity, Victorino Santaella Hospital, Southern Maternity and CHET) the total accumulated maternal mortalities were 28. Most of them were women over 19 (see Graph 11). Observing the total, disaggregated by cause of death (see Graph 12), hypertension and hemorrhaging prevail as the main causes of maternal mortality.

GRAPH 11: MM PER HOSPITAL. AUGUST-DECEMBER 2018<sup>26</sup>

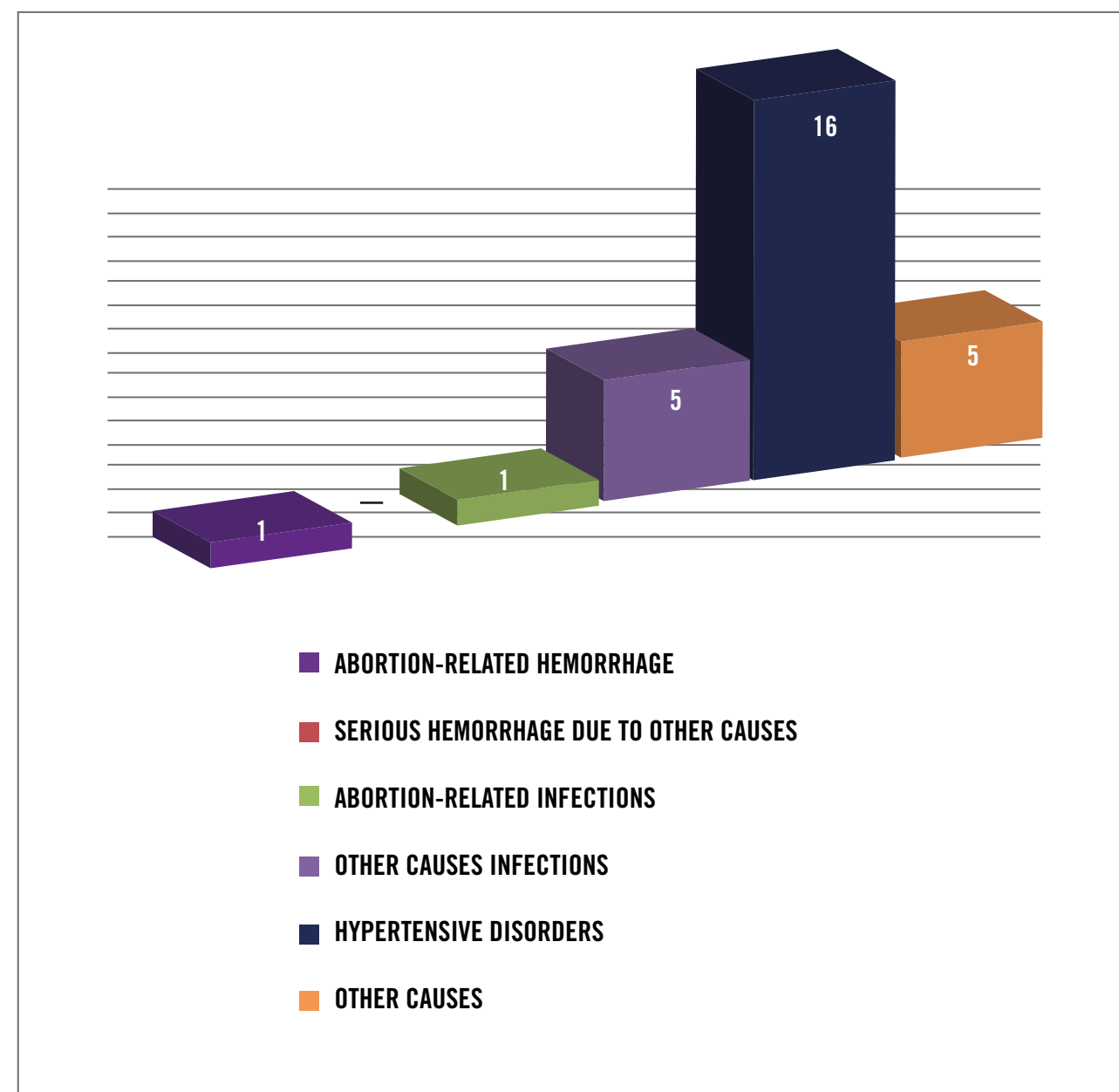


SOURCE: EQUIVALENCIES IN ACTION 2019B

As indicated in another section of this report, maternal mortalities associated with unsafe abortions were registered. It should be noted that informants at the hospitals reported the observance of abortive practices that had not been seen in quite some time, such as the insertion of sharp, puncturing objects; the use of herbs and homemade beverages as well as the introduction of substances of various natures, including

soapy substances. This, they point out, could be due to the unavailability of surgical abortions in safe conditions (which, though clandestine, are available albeit at prices beyond the means of most women) and the absence of supplies such as Misoprostol for pharmaceutical abortions. This medication is available through networks of informal commerce (commonly known as “bachaqueros”)<sup>27</sup> but at elevated costs.<sup>28</sup>

GRAPH 12: TOTAL NUMBER OF MATERNAL MORTALITIES FOR ALL HOSPITALS BY CAUSE AUGUST-DECEMBER 2018<sup>29</sup>



SOURCE: EQUIVALENCIES IN ACTION 2019B

Most maternal mortalities were registered at CHET (17), followed by Concepción Palacios Maternity (5), Victorino Santaella Hospital (4) and Southern Maternity (2). Figures for CHET (Carabobo) stand out and suggest that conditions persist in that state which impinge upon the number of maternal deaths. It should be noted that Carabobo placed second in the number of maternal deaths in 2016 (76 MM), which translates into a 484% increase in relation to the number of maternal deaths registered in 2015 (13 MM) (Ministry of Popular Power for Health, 2016).

While 2 maternal deaths were registered at the Southern Maternity, health professionals at that hospital

report that “(...) as that institution has no anesthesiologists nor equipment and supplies to care for patients with complications, at-risk patients are referred to CHET, where they are cared for and where the maternal mortalities are registered”. (Equivalencies in Action, 2019b)

Consulted as to the reasons linked to these maternal deaths, medical staff refer to the 4-delay model, as summarized as follows (UNFPA Guatemala, 2010):





PHOTO: SHUTTERSTOCK



PHOTO: SHUTTERSTOCK

- First delay: linked to the lack of knowledge by women, families and communities regarding the signs of danger that threaten the lives of women during pregnancy, labor, postpartum and of the newborn;

- Second delay: though the woman recognizes the signs of danger, gender inequality prevents them from assuming their rights by making decisions for themselves, but rather it is decided by their partner or close family member (parents, in-laws, midwife, among others);

- Third delay: related to existing limitations due to lack of access to roads and means of transport in order to reach health services;

- Fourth delay: associated to deficient and untimely institutional care due to many causes, chief among which is a lack of competency (knowledge, skills, abilities and attitudes) on the part of health providers, as well as the lack of supplies, medicines and proper equipment.

They emphasize that the fourth delay (deficient institutional care) serves as a precipitating factor in

maternal death. In this regard, one doctor points out:

“(...) the current lack of supplies at the national level limits the prevention of maternal deaths. While some institutions have supplies (sort of), but other have nothing. Among the first causes of maternal death you have hypertensive disorders but, truth be told, you don't have antihypertensive drugs (...) We lack many things at the hospital level in order to resolve these situations and prevent a maternal death”.

Another professional explains:

**“It has been happening that patients are showing complications before labor, that is during pregnancy they present complications due to infections, hypertension or hemorrhages, and these are the main three causes of maternal deaths. Infectious, because there are no antibiotics. Their administration in hospitals is not guaranteed either due to their absence or because the patient cannot afford them. So, the patients end up with complications due to infections and they die on us. In the case of hypertension, we**

**find that there are no medications for arterial tension and they are very costly, so the patient doesn't take them, ends up with complications and dies. As for hemorrhages, there are patients who, due to their malnutrition or anemia, any bleeding (which another patient in stable condition could endure) turns into complications to a degree that it ends in death, in moments, seconds.”**

This information is consistent with collected data regarding the provisioning and supplies at hospitals which are dealt with in another section.

The collected figures suggest that the trend of MM increase in the country persists. In the case of Concepción Palacios Maternity, when comparing the information obtained with some available data from previous years, we observe a progressive rise in the number of cases in absolute figures (Cabrera, Martínez & Zambrano, 2014).<sup>30</sup> The registry of 5 maternal mortalities from August to December 2018 at this hospital suggests that the tendency holds (see Table 4). According to unofficial reports, thorough 2018, the Concepción Palacios Maternity registered a total of 15 MM.

TABLE 4: MATERNAL MORTALITIES, CONCEPCIÓN PALACIOS MATERNITY. 2009-2013	
YEARS	MATERNAL DEATHS
2009	2
2010	2
2011	6
2012	8
2013	9

SOURCE: CABRERA, MARTÍNEZ & ZAMBRANO, 2014

The information obtained indicates that the plans and programs being implemented by the State to reduce maternal mortality have not been successful. These plans touch upon sociocultural aspects and matters of knowledge and practices, which favors decision-making and the search for help by women when faced with possible obstetric risk (first and second delay) as well as formative aspects for health staff (fourth delay) but leave out aspects related to access to services (third delay) and the deficiencies in institutional care regarding the condition of services and their pro-

visioning (fourth delay), which are in a state of grave precariousness. In this regard, it is of utmost urgency that official policies deal with structural and systemic aspects that prevent staff and hospitals from caring for and preventing maternal deaths. In the current conditions, the risk of dying due to complications associated with pregnancy and labor in Venezuela is high, given dire living conditions and a crumbling health system. All of which constitutes a violation of the rights of Venezuelan women and adolescents.



PHOTO: ALICIA MONCADA

5

5.1

## 5. CONDITIONS AND ACCESS TO SERVICES AT HOSPITALS

The conditions and capacities to facilitate access to sexual and reproductive health services is a factor in problems such as maternal mortality, teenage pregnancy and unsafe abortions. In the context of the CHE in Venezuela, there is no doubt that the collapse of the public health system, particularly the acute deficiencies in hospitals, have a direct impact on these situations which affect women girls and adolescents in a specific manner.

This is why we set out to find out more details about the conditions for the provision of services at four hospitals, with a special emphasis on food, water, electrical supply, clinical laboratory services, medicines and supplies, human resources and equipment, as well as costs, schedules and transportation to reach services. Also included were levels of access to family-planning services (especially differentiated services for adolescents).

This exploration was undertaken through an online survey between August and December 2018 at Southern Maternity (Valencia, Carabobo State), Concepción Palacios Maternity (Caracas), and Victorino Santaella Hospital (Los Teques, Miranda State). The Hugo Chávez High-Risk Maternity at CHET (Valencia, Carabobo State) was also included in the online survey for September and December 2018. For this last hospital, the number of patients examined in triage or admitted for hospitalization are not available.

Interviews with health providers and focal groups of users of these hospitals in Valencia, Caracas and Los Teques were also included with the aim of exploring the conditions and access to services. The results obtained allow to better understand the mechanisms that generate discrimination and/or exclusion in the access to services (barriers) or of which factors are facilitating admission and care in the health system (facilitators).

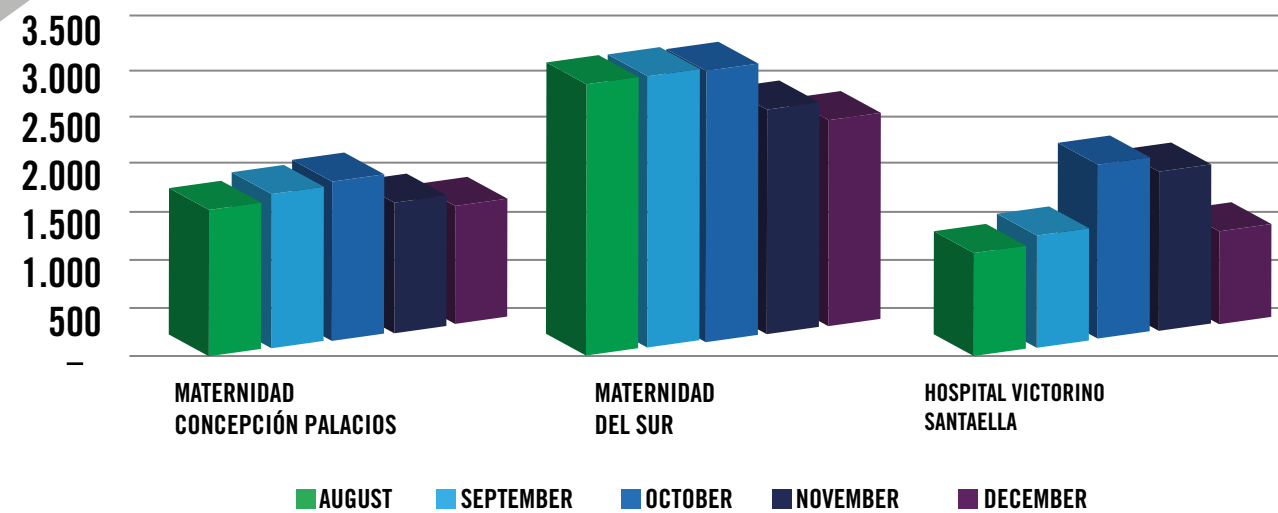
CONSULTAS  
MEDICINA INTERNA  
ONCOLOGICA

### 5.1. CARE CAPACITY

Between August and December 2018 the number of patients cared for in outpatient triage and the number of patients admitted for hospitalization at three hospitals were measured (Concepción Palacios Maternity, Southern Maternity and Victorino Santaella Hospital)

as an indicative of the care capacity at these health facilities. A total of 28.328 women received attention in outpatient triage, (see Graph 13), while those admitted for hospitalization were 8.722 (see Graph 14).

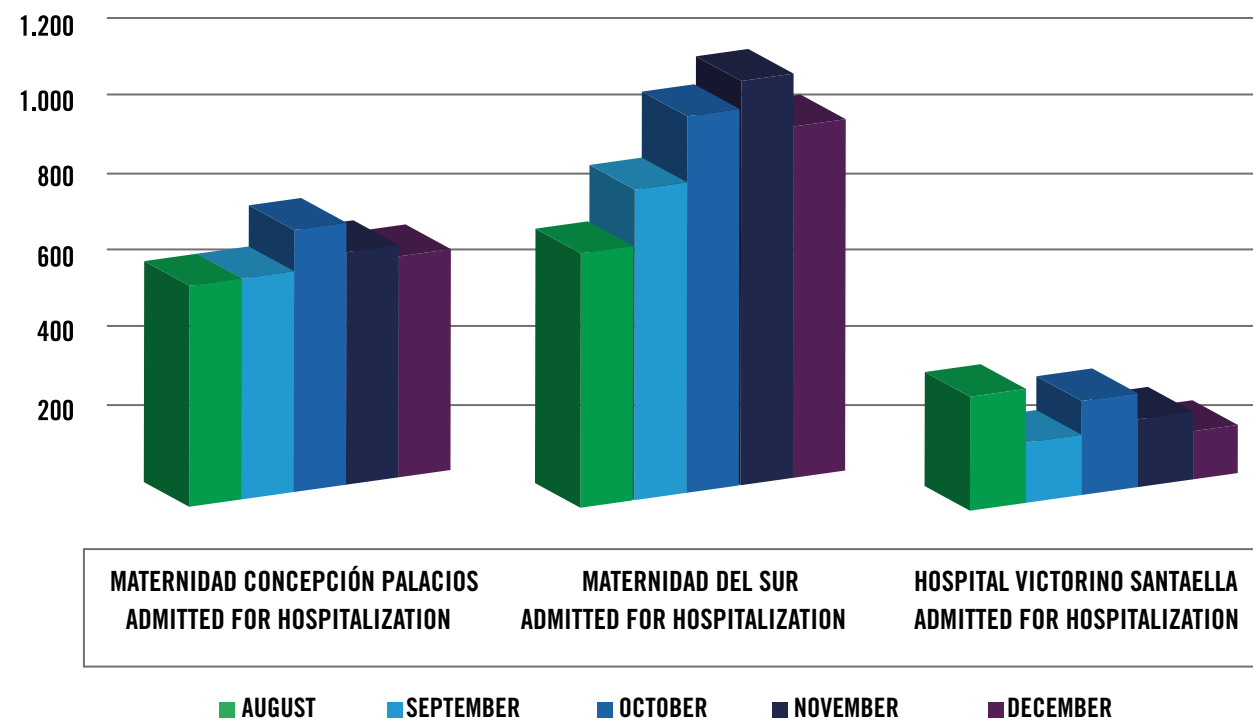
GRAPH 13: NUMBER OF WOMEN CARED FOR IN OUTPATIENT TRIAGE AUGUST-DECEMBER 2018



Throughout the period, the Southern Maternity showed the highest care capacity, with an average of 700 patients per month (greater than the other two hospitals). The difference in numbers of cases dealt with in triage and hospitalization at Concepción Palacios Maternity and Southern Maternity stands out, as they are theoretically comparable facilities, both being specialized type IV hospitals for maternal and child care. These differences might be attributable to deficiencies in provision

ing of supplies and medications; in staffing and in infrastructure as they relate to admissions and proper care. From this data (triage, hospitalization and number of births) we may state that the Concepción Palacios Maternity is operating at half-capacity or less. In the case of Victorino Santaella Hospital, even though it is a type IV establishment, the lesser level of pregnant patients or in labor is to be expected, as it is not a specialized institution in maternal and child care.

GRAPH 14: HOSPITAL ADMITTANCE. AUGUST-DECEMBER 2018



Also, of the four establishments (including CHET) it is evident that the Southern Maternity is the center with the greatest number of women in labor, in some cases at double the number of those cared for at the other

hospitals (see Graph 15). Of the total 10,059 women in labor cared for, 40% were in the Southern Maternity, followed by CHET, at 32%, both in Carabobo State (see Graph 16).

GRAPH 15: TOTAL WOMEN IN LABOR BY MONTH AND HOSPITAL<sup>31</sup>

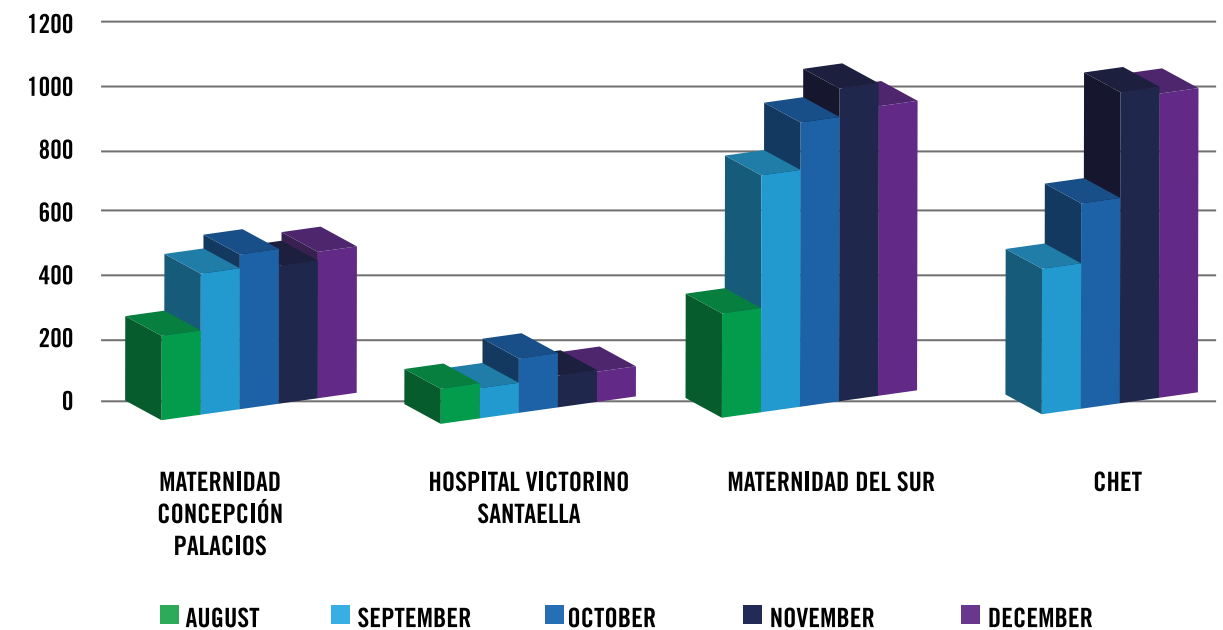
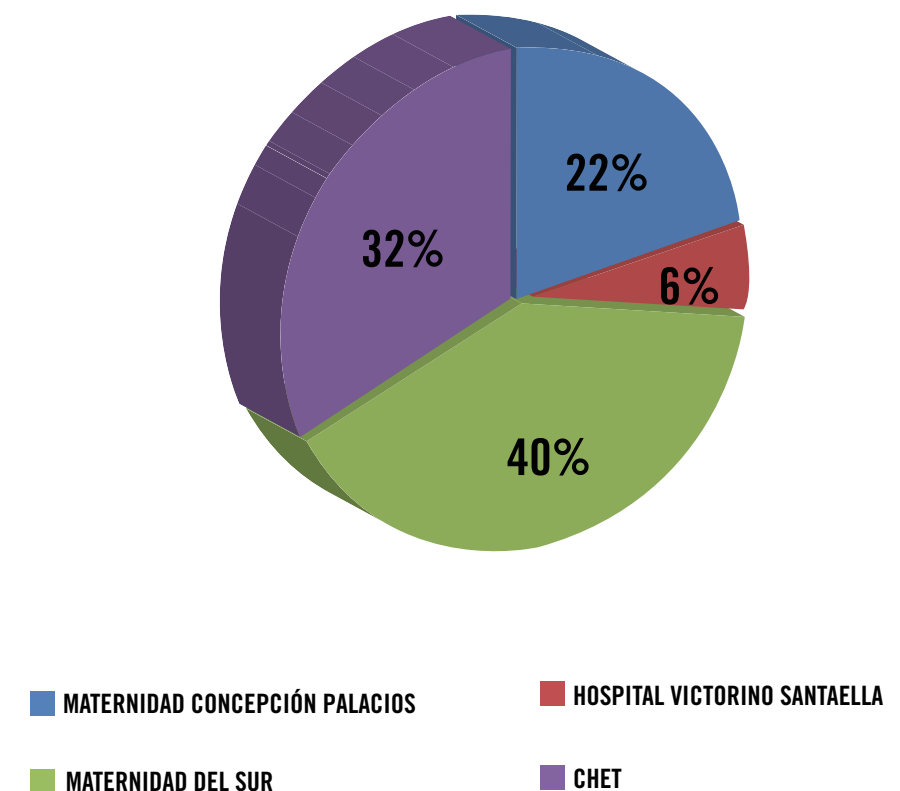


GRÁFICO 16: WOMEN IN LABOR CARED FOR PER HOSPITAL AUGUST-DECEMBER 2018





## 5.2. GENERAL CONDITIONS OF HOSPITALS

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The general conditions of the four hospitals vis a vis provisioning, infrastructure, services and human resources showed little substantial variations throughout the period; exhibiting serious deficiencies in the delivery of food services, interruptions in water and electric utilities, partial or total closure of laboratories, irregular provision of medicines and supplies and equipment failure, among others.

### Water, electricity and food

Throughout the period, neither the Victorino Santaella Hospital nor CHET had food service (see Table 5). With the exception of December, the Southern Maternity had no food service either. At Concepción Palacios Maternity, service was intermittent.

TABLA 5: FOOD SERVICE, WATER AND ELECTRICITY. AUGUST-DECEMBER 2018

	MATERNIDAD DEL SUR					HOSPITAL VICTORINO SANTAELLA					MATERNIDAD CONCEPCIÓN PALACIOS					CHET				
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
FOOD																				
WATER																				
ELECTRICITY																				

	ABSOLUTE FAILURE (NO SERVICE DURING WHOLE MONTH)
	INTERMITTENT (NO SERVICE FOR MORE THAN FIVE CONTINUOUS OR DISCONTINUOUS HOURS)
	NORMAL ( SERVICE 34/7 ALL MONTH)
	NO DATA AVAILABLE

51

The total or partial lack of food services shifts the responsibility and costs of guaranteeing food in the case of hospitalization to patients and their families which, in the current socioeconomic conditions, makes it hard for most of those who turn to these hospitals. The cost of food in or outside public health facilities are usually beyond what patients and their families can afford, so their meals must come directly from their homes. This involves two important problematic elements: first, the family is not always able to provide a balanced diet in keeping with the nutritional needs of the patient, and secondly involves aspects of food preparation and transport to patients in hospital.

Gaps in the supply of food affects the quality of care afforded to patients and interferes with their permanence in hospital. For example, it is known that in order for patients to be admitted at some hospitals, the family must commit to guarantee their food, as the hospital is not supplying it.

Of the four hospitals, only the Victorino Santaella Hospital had regular water-supply during three out of the five months of the survey. All the others had irregular supply. However, it should be noted that the women participating in the focal group from the Victorino Santaella Hospital reported that the stairwell smelled of urine and were in a dismal state of hygiene. The Valencia focal group women reported the intermittence of the water supply as a barrier to access health services, linked to their hygiene conditions.

As in the case of water supply, both hospitals in Valencia (Southern Maternity and CHET) presented irregularities in their electrical supply. The Victorino Santaella Hospital registered irregularities during two of the five months of the survey and the Concepción Palacios Maternity had regular electrical service, except during September when there were serious interruptions. Health providers in Valencia stated that continuity of service in the absence of electrical service was carried out by using daylight or light from their cellphones.



Laboratories at the four hospitals operated intermittently most of the time, and there were months when they remained closed (see Table 6). This implies that patients must have their lab tests done at other public institutions or privately, with the latter being the most frequent given the failures in laboratory services at various public institutions.

TABLA 6: FUNCIONAMIENTO DE LABORATORIO CLÍNICO. AGOSTO - DICIEMBRE 2018

HOSPITAL	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
MATERNIDAD DEL SUR					
HOSPITAL VICTORINO SANTAELLA					
MATERNIDAD CONCEPCIÓN PALACIOS					
CHET					

NON-OPERATIONAL  
 OPERATIONAL WITH INTERMITTENT FAILURES  
 100% OPERATIONAL  
 NO DATA

The Valencia focal group pointed out:

“They told me to have tests and to take all samples elsewhere and to bring the tests back for the doctor to check.”

“There was nothing, none of the instruments and they sent me to get the tests done somewhere else. At the public facility I went to there was absolutely nothing. There was at the private one.”

“When you have a cytology, they give you the sample to take to the Red Cross for evaluation”

“The doctor would tell you to take the sample somewhere else for testing and to then bring the results for her evaluation.”

One health provider at the Victorino Santaella Hospital said about the situation:

“We do not even have a [clinical] laboratory. At this time the blood bank is not functioning nor is the area of X-rays. All patients must process their tests at private centers.”

All this postpones medical attention, which can become an undue delay that puts the health of women at risk. Patients must go to other institutions for their tests. Those that can afford the tests go to private facilities, while those that attend public ones must undergo waiting periods for appointments for the laboratory.

Some do not manage to continue treatment because they do not have the necessary economic resources to have the requested tests carried out. This becomes a barrier to the access to sexual and reproductive health services for women. One service provider reports:

“(…) the economic situation spares no one and they are patients that generally come for the first consultation...one requests a series of para-clinical tests established in the protocols for the care of pregnant women and I imagine that the limitations is that there are no public facilities to process that type of para-clinical tests, whether it be a complete hematology or special tests, and I imagine that, mostly for economic reasons, they cannot afford to do it at private institutions and it is a limiting factor for them to return to the service (…)”

PROVISIONING OF  
MEDICINES AND SUPPLIES

The provisioning of basic medicines and supplies for care in sexual and reproductive health, including obstetric emergencies, showed important gaps at the four hospitals included in the survey (see Table 7). Few are the items whose supply is normal. Most hospitals have irregular or non- existent provisioning. The facility be-

ter provisioned was the Concepción Palacios Maternity, unlike the other three which showed considerable gaps in fundamental items such as antibiotics. Shortages are reported by both health providers and users of the services.

TABLA 7: MEDICINES IN STOCK. AUGUST-DECEMBER 2018

	MATERNIDAD DEL SUR					VICTORINO SANTAELLA					MCP					CHET				
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Oxytocin 10 UI/ml																				
Methergine 0.2 Mg/ml																				
Misoprostol 200 mcg																				
Parenteral ampicillin																				
Parenteral Ceftriaxone																				
Clindamycin																				
Parenteral furosemide																				
Parenteral Gentamicin																				
Parenteral Metronidazole																				
Paracetamol, dipyrone,																				
Metamizole																				
Parenteral calcium gluconate																				
Parenteral Hydralazine																				
Oral Nifedipine																				
Parenteral magnesium sulphate																				

No supply  
 Irregular supply  
 Normal supply  
 No data

A service provider points out:

“(...) there are no supplies, there are no medicines, none of what is needed in the hospital. I lived that too, that is the patients live it and I live it I see it every day and I live it as a family member, and after you manage to miraculously survive that emergency in desperation, (...) the doctors perform magic with whatever they find, you solve the urgency, only to face the karma and calamity of staying in that same hospital convalescing. And then, look here: we have to give you antibiotics to cover you after we operate but we have none here, you find them. And then you get out and find that you need more than thirty ampoules. Just an example, and each ampoule costs millions of Bolivars, I mean I say: who has the means today to cover that need? (...) I see the woman cry when she cannot buy it and how I cried with what I had to go through as a family member to cover that need. Because that kills. That kills you more than the disease itself.”

The cost and responsibility for finding medicines and supplies, as in the case of food and lab services is transferred from the hospital to the patient and his or her family members. A member of the Valencia focal group retells:

“The attending physician tells me that he will supply the gloves and the materials for the cytology, I had to come up with the rest”.

Basic supplies for care, such as sutures, test tubes, gauze and gloves are irregularly stocked or not at all. According to information from health service providers, some of these supplies are sold by informal tradespeople in the vicinity of hospitals. For example, test tubes (irregularly supplied or non-existent at every hospital during the period) are sold at 12.000 sovereign bolivars (about US\$2.00 in May 2019). For most patients who turn to these institutions, these costs are impossible to bear.

TABLE 8: SUPPLIES IN STOCK AUGUST – DECEMBER 2018

	MATERNIDAD DEL SUR					VICTORINO SANTAELLA					MCP					CHET				
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
SALINE SOLUTION 0.9 500CC																				
LACTATED RINGERS SOLUTION																				
FOLEY CATHETER																				
URINE COLLECTION BAG																				
JELCO CATHETER																				
CHROMIC CATGUT SUTURE																				
NYLON OR SILK SUTURE, NO NEEDLE (SUTUPAK)																				
ENDOVENOUS INFUSIÓN SYSTEM- MACRODRIP																				
OXYGEN MASK WITH RESERVOIR																				
MAYO CANNULA # 4 OR 5																				
SYRINGE 10CC																				
STERILE GLOVES SIZE 7 AND 8																				
LARGE STERILE GAUZE																				
TEST TUBE WITH ANTICOAGULANT																				
TEST TUBE WITHOUT ANTICOAGULANT																				



PHOTO: SHUTTERSTOCK

One health provider states:

“We have every intention of helping you. Here is the OR, here are the doctors, but we don’t have such and such, and the patient, regardless of the willingness of hospital staff, from the highest ranking to the lowest, involving directors and doctors, who have the will and intention to help, if the materials and supplies do not exist, how do we manage to help? Because I may have these two hands but if a sick patient with an emergency is assigned to me and I don’t have (...) the proper sutures to open and close the uterus, well no! If I don’t have what I need to sew the patient up after I open her to remove the baby, how can I assist her?”

A big NO!. There is no proper infrastructure. No supplies for care. None. As simple as that. Enough said. Deficit, that’s the word. There is nothing.”

Women in all focal groups mentioned having had to purchase supplies given their absence at these services and the possibility of going without care or having to turn to the private sector to receive complete care, something that most cannot afford:

“My sister-in-law received care but had to buy everything as there was nothing.”

Women with fewer income and adolescents are potentially the most affected, as they do not have the money necessary to undergo laboratory tests and other studies at private centers and/or purchase medication and surgical supplies. This constitutes a definite barrier to the timely access to sexual and reproductive health services.

Though hospitals are meant to provide services free-of-charge, this is not the case in reality. As discussed, women must undergo and pay for laboratory tests and other studies at private centers out of their own poc-

kets, as well as provide for their own food, medication and supplies in order to have access to medical attention.

Bearing in mind that, according to ENCOVI (UCAB, UCV, USB, 2018), 94% of homes lack sufficient resources to cover their needs, it is clear that most of the women who turn to these public hospitals are in no capacity to assume the totality of the aforementioned costs, which imposes a limitation on their access to services, especially in the case of adolescents. With health being made contingent on the patients’ economic conditions, we are before a sort of privatization of services that is incompatible with the Constitution of the Bolivarian Republic of Venezuela, which establishes that health is a protected right that must be guaranteed by the Venezuelan State.





## ACCESS TO HEALTH ESTABLISHMENTS AND SERVICES

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The schedules and procedures to request appointments for sexual and reproductive health services at health establishments present obstacles that hinder timely access to care. One service provider posits:

“(...) if I become pregnant today and have four weeks (...) and I responsibly want to go and get checked out because I am one month pregnant and I want to start right away, they will probably give me an appointment in a month and a half, two months. So, the purpose or intention of the patient to get checked out adequately is lost when the appointment is postponed for so long. This is the case with check-ups, with everything. Sometimes prenatal controls, which are monthly during the first weeks, turn into every month and a half to two months because the appointment schedules are collapsed and the consultation rooms are so full of patients that they end up being much longer. So, what is the real or regular control of the patients? Very few achieve the goal of good pregnancy control.”

According to this, the absence of prenatal control is also linked to barriers in access to services. This lack of care during pregnancy supposes a risk to life and health of women and their children.

In the words of another service provider:

“(...) there really aren't enough hospitals to provide adequate care to the number of patients who should be seen at each of them and the levels of healthcare we have are precarious. Whereas before the patient

went to an outpatient clinic where there was a trained doctor who said (...) ‘these are the first little pains’ or ‘let’s wait a bit, see? I’m touching the baby and it’s fine. You have to wait a bit so they don’t prod you so much at the hospital.’ That is no longer the case. The healthcare system is so deteriorated, it is so precarious, that the primary health-care system which previously existed, which helped us to compensate hospital work (that is real admittance, real emergency) has now collapsed because those centers don’t exist or don’t have the supplies, don’t have the doctors, don’t have the staff or are closed due to insecurity or for any reason. That is, they exist in name, in structure (...) but have no capacity to care for patients. So, what happens? The upstream systems collapse. The hospitals that should receive the real emergency are receiving outpatients and primary care patients, they are handling everything. It is now both emergency-room and doctor’s office, everything. That obviously means that the levels of care no longer exist. Those centers that should receive patients are not functioning as they should.”

Medical staff reports that, given the reduction in capacity of the primary health-care services, patients turn to type IV hospitals such as the Southern Maternity, the Victorino Santaella Hospital or the Concepción Palacios Maternity, which are also presenting with great deficiencies. This translates into delays in the assignment of appointments and important postponements in the care of emergencies and the capacity to resolve cases, all within a context wherein public health



PHOTO: SHUTTERSTOCK

network hospitals are crumbling. In other words, there are fewer services and those that do exist have collapsed.

In interviews with users of the hospitals covered by the survey, it was found that in order to reach them patients run into several barriers: few assigned places for appointments in services; insecurity; transportation and cash. Some of them stated that:

(...) one must arrive at 3:00 a.m. to get a number because they give out very few and there are many people. And insecurity is high because how do I leave my house at that hour? There are criminals about and the situation is not so good.”

“(...) there is no transportation, not many buses, and no matter if you get up at 4:00 a.m. there will be

no transport, you will have to walk to be on time.”

“(...) transportation, security and money. To arrive on time because they only give out ten numbers. And money, because it’s very expensive.”

“Insecurity, money and transportation. Because I have to leave very early in order to get there and sometimes I have to wait about three hours at the stop waiting for a car. I don’t arrive on time.”

Health providers, for their part point out:

“(...) we have patients that overnight at the hospital, who remain drifting and walking around the

hospital. Because they arrive because they got a ride, because they hitched a ride during the day or they found some awful transportation that they get on. What are they called? Kennel trucks?”<sup>32</sup>

“(...) you find that you see the patient when they come into the emergency room (...) and you continue seeing patients all day (...) you get up at six in the afternoon and take a walk around the hospital and you may run into the same face you evaluated at two p.m. You find her out there and when (...) you go to ask what happened, why is she still there and, what does she say?: that she has no means to getting back (...) because there is no transportation. She has no way to leave (...) she has no way to leave because the family has no vehicle (...)”



# HUMAN RESOURCES AND EQUIPMENT

All four hospitals presented considerable gaps regarding human resources to provide services, particularly in the area of anesthesiology and pediatric/neonatal care. According to health providers at Concepción Palacios, care was severely restricted by the intermittence of all staff but, particularly, by the absence of anesthesiology professionals. In August, for example, there was not one such professional. The Victorino Santaella Hospital also had absences, with the exception of the

OBGYN service, which was fully staffed during the survey. The Southern Maternity also presented staff deficits, going from having full teams in November to partially incomplete teams in December (between six and twenty absentees). CHET also had worrying deficiencies. Only in September did they have a full team (pediatrics-neonatology). As for the rest of the period, teams were more or less incomplete (see Table 9).

TABLE 9: HUMAN RESOURCES AUGUST-DECEMBER 2018

	MATERNIDAD DEL SUR					HOSPITAL VICTORINO SANTAELLA					MATERNIDAD CONCEPCIÓN PALACIOS					CHET				
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
OBGYN																				
PEDIATRICS-NEONATOLOGY																				
ANESTHESIOLOGY																				
NURSING																				
CLEANING (CHAMBERMAIDS)																				

	INCOMPLETE (MORE THAN 20 DAYS OF ABSENCE)
	PARTIALLY COMPLETE (BETWEEN 1 AND 5 DAYS OF ABSENCE)
	PARTIALLY INCOMPLETE ( BETWEEN 6 AND 20 DAYS OF ABSENCE)
	COMPLETE (NO ABSENCES)
	NO DATA

TABLE 10: AVAILABILITY OF BIOSAFETY KIT. AUGUST-DECEMBER 2018

	MATERNIDAD DEL SUR					HOSPITAL VICTORINO SANTAELLA					MATERNIDAD CONCEPCIÓN PALACIOS					CHET				
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
BIOSAFETY KITS (OVERALL, GOGGLES, GLOVES)																				

NO

YES

NO DATA

We see then that these hospitals lack the required human resources, which diminishes their response capacity and of service delivery to patients. This may be a determining factor in timely care, particularly in the case of complications or obstetric emergencies that might lead to maternal deaths.

Biosecurity kits were lacking during most of the survey (see Table 10). That absence has become a barrier for the care of pregnant women with HIV, as it leads to the denial of C sections clinically indicated to prevent vertical transmission from mother to child during labor (Kislinger, 2018).

As for the conditions of infrastructure and equipment, such as ambulance service, data showed disparate situations at the four hospitals. The Southern Maternity and CHET had one operating (albeit intermittently) ambulance throughout the period. The Victorino Santaella Hospital has none and at the Concepción Palacios Maternity it is not operational. In general, beds, both in emergency and in the delivery room were operative, though with noticeable variations. At Victorino Santaella Hospital, health providers report that the pediatric ICU has not functioned for some time.

What has been described above speaks of a substantial reduction in the capacity for care at health centers and of a very serious lack of resources and minimum necessary conditions for providing adequate service to women and for guaranteeing their rights with regards to health, including sexual and reproductive health. As one service provider points out:

“We don’t have the equipment as such. Absent are the ultrasound machines, absent the fetal monitors, absent the FHR monitors, ah...absent, absent, absent. The gynecological gurneys, though deteriorated, are used and many of them even smell bad. What’s more,

one gurney was even diagnosed with screwworm, and it was only removed after we complained a thousand times: ‘That has worms’ we complained, ‘it smells bad, it is rotten.’ Two thousand times repeating the same thing until finally someone said: ‘yes it does’ and they removed it. You do the math.”

One cannot sidestep the fact that these conditions of generalized precariousness and scarcity at these health centers undoubtedly not only have a direct impact on the access to sexual and reproductive health services, but represent a risk for the health of women and newborns. Such was the view of the Inter-American Commission for Human Rights (IACHR) when it decided to grant precautionary measures on behalf of the Concepción Palacios Maternity (IACHR, 2019).

The impoverishment of health centers and the lack of response on the part of State institutions have prompted protests by hospital’s workers, administrators and medical staff. In this context, there has been an increase in cases of harassment towards these health workers, along with a greater presence of security forces or groups sympathetic to the ruling party. At the Concepción Palacios Maternity, for example, the presence of military personnel, paramilitary “collectives” and, most recently, of members of the “militia” has been reported.

Cases of harassment and threats toward all hospital staff have become the hallmark of a State policy to discourage attempts to denounce conditions at these health facilities. But there have also been cases of harassment and threats by patients or their family members, desperate for care. The Southern Maternity in Valencia was the center to report the most cases of harassment and threats coming from patients themselves, while at the Concepción Palacios Maternity said harassment and threats came not only from patients, but also from the “collectives” and from hospital management. A case of aggression of a hospital manager against a female resident-doctor was reported there.<sup>33</sup>

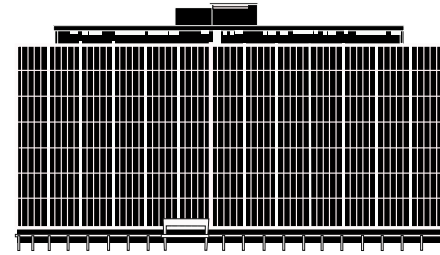
# MIGRATE OR DIE

## Precautionary Measures Granted Concepción Palacios Maternity

### What measures did it grant?

Adopted precautionary measures in favor of patients and newborns at Concepción Palacios Maternity.

(Resolution 13/2019 el 18-03-2019)



### Who requested them?

Asociación Civil de Mujeres en Línea, AVESA, FREYA, CEPAZ and Women's Link Worldwide.

### Why?

They find that patients are at grave risk and urgency of risk of irreparable damage to their rights.

### What does the IACHR request of the Venezuelan State?

- To adopt the necessary measures to guarantee the life, personal integrity and health of the beneficiaries;
- To guarantee the provision of supplies, medicines, and adequate medical services to offer effective care in emergencies
- To ensure that a gender perspective is incorporated into the protection and access to maternal health and services directed at the beneficiaries own medical needs;
- To guarantee the provision of nutrition programs and of adequate medical controls before and during pregnancy as well as pot-partum for both women patients and the newborn;
- To ensure minimum infrastructure conditions, electricity and water, as well as of sufficient medical personnel;
- To involve the beneficiaries and the staff of the Maternity in the measures to be adopted and that their human rights are respected, especially their right to participate freely and adequately, without being targets of reprisals.





### III. WOMEN IN THE CONTEXT OF VENEZUELAN HUMAN MOBILITY

Human mobility processes are not a new phenomena in humanity's development, as they have been associated to the historical processes of nations. However, over the past few years there has been an increase in migratory movement which, while facilitated by globalization and the rise of new technologies that allow for greater movement and connectivity over borders, from our gender and rights-focused approach is intimately linked to an important deficit in the States' capacity or willingness to fulfill their responsibility to protect. In other words: worldwide and especially in the Venezuelan case, migration has been fostered and driven by serious violations of fundamental rights, violations that have a differentiated effect on women.

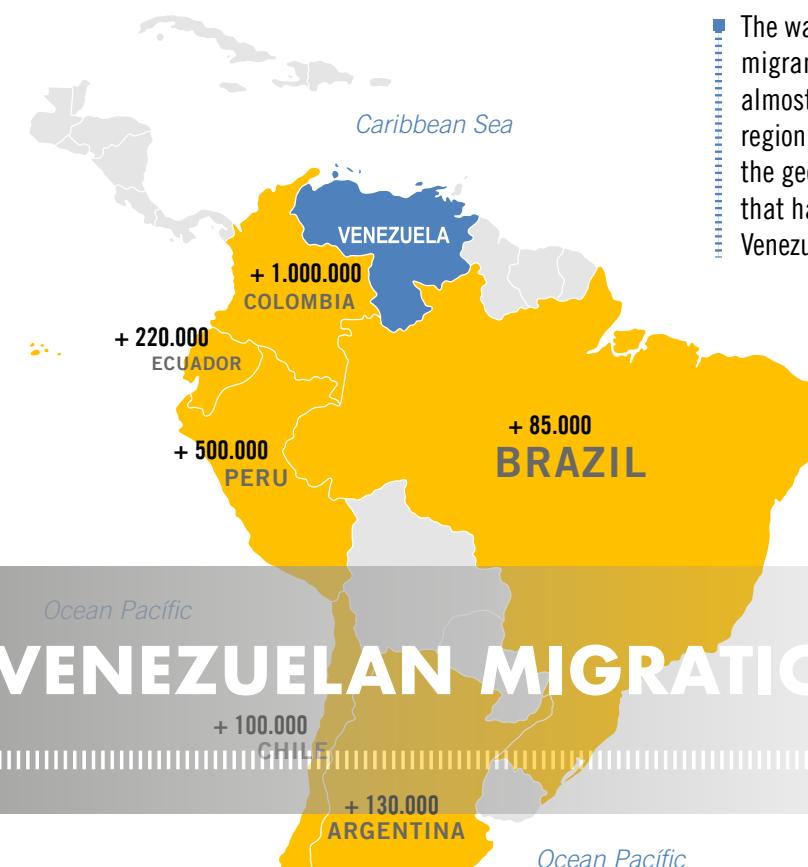
To understand this phenomenon of human mobility it is necessary to apply a human-rights approach, as the factors that apply to these migratory flows are in themselves multicausal, expressing as they do; both the violation of fundamental rights, generated by the internal human condition and the politico-institutional situation. This includes a variety of reasons that go from insecurity and violence; to the lack of food and medicines or of access to essential social services, all the way to loss of income. The preceding fully justifies

the Venezuelan situation as one of complex humanitarian emergency. An emergency that has generated a human mobility crisis without precedent in South America.

Although attention to the issue of women and migration has garnered attention since the eighties, analysis from a gender perspective in studies on human mobility has not been attributed the weight and relevance it requires. This involves comprehending the changes that have taken place in power relations or in traditional roles and the rise in numbers and characteristics of female migratory movements, as well as the protagonism of women in the process of mobility.

This chapter builds upon the results obtained in the study: "The Situation of the Human Mobility of Venezuelan Women and Girls with a Differentiated and Gender Perspective" carried out in order to identify the risk factors and vulnerabilities experienced by migrant Venezuelan women (Asociación Mujeres en Línea, AVESA, CEPAZ and FREYA, 2019). Data in this study is the result of 605 surveys of women embarking upon their migratory process by land from Caracas and San Antonio de Ureña in Táchira State.

## VENEZUELAN MIGRATION In Latin America and the Caribbean



The wave of Venezuelan migrants has reached almost all countries in the region, in large part due to the geographical corridor that has been created from Venezuela.

Source: OIM, 2018.

## 1. VENEZUELAN MIGRATION

The Latin-American and Caribbean region has not escaped the upward trend in migratory movements. The most tangible sample of this Latin-American flux has been the exodus of people from Venezuela who, over the past three years, have fled a grave economic, social and political crisis that has produced a marked deterioration in living standards.

The first peak in migrant mobility of Venezuelans came between 2002-2003, within a context marked by political, economic and social instability that characterized the mandate of then President Hugo Chávez Frías. In 2014 the number of persons fleeing the country started to rise: according to the IOM, while Venezuelans have been abandoning the country for years, global migration of Venezuelans rose between 2014 and 2017 by 132% and during that same period the number of those migrating to other South American countries rose by 895%. These movements, however, beca-

me acute in 2018, reaching their most critical point. The IOM estimates that there are more than three million Venezuelan migrants and refugees in different countries worldwide, which would point to an average of 5.500 persons abandoning the country daily in 2018 (IOM, 2018). The IOM has alerted that this crisis of human mobility is so serious that it may equal the Mediterranean diaspora, which in 2015 turned into a critical humanitarian situation exacerbated by the uncontrolled flow of refugees, asylum-seekers and other migrants in a state of vulnerability.

The migratory wave of Venezuelans, product of the CHE, has been felt practically by all countries in the region, due in great part to the geographical corridor established between Venezuela, Colombia, Ecuador and Peru and to the ease of mobility between them associated with the accessibility of transport and the relatively affordable costs. Countries in Latin America and

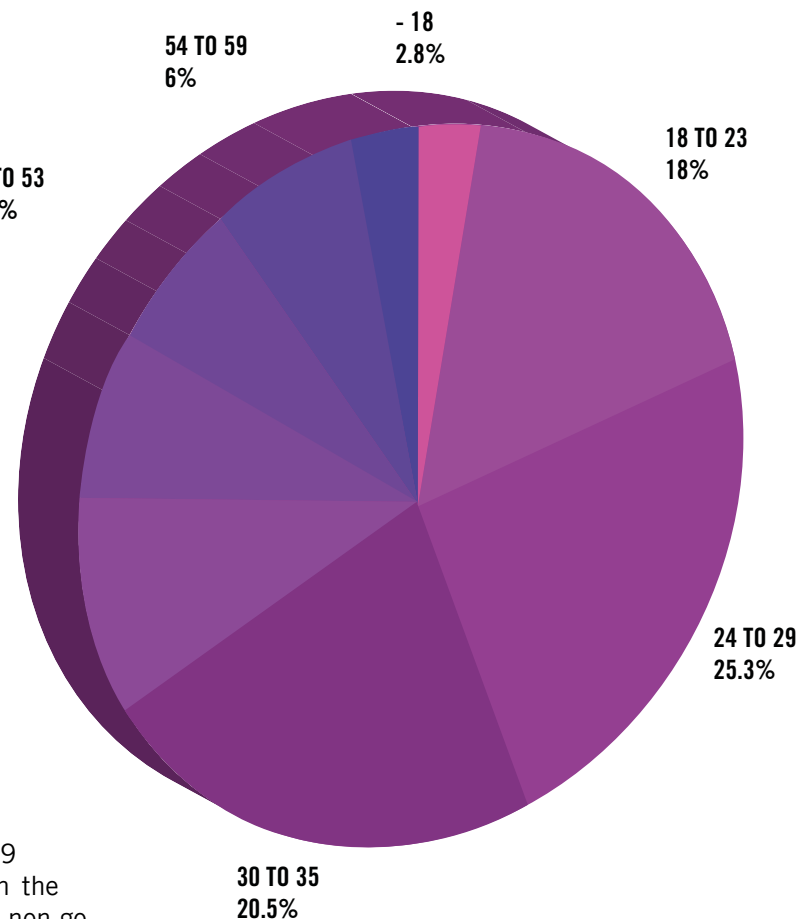
the Caribbean harbor approximately 2.4 million Venezuelan refugees and migrants. Colombia hosts the highest number with more than one million. It is followed by Peru, with more than half a million and Ecuador, with more than 220,000. Argentina, for its part, harbors 130,000, Chile more than 100,000 and Brazil 85,000 (IOM, 2018).

The inflow of migrants from Venezuela has started to generate pressure upon the governments of the receptor countries due to the internal impact produced. The required social investment to care for the population rises and the economic and social needs under which Venezuelans are arriving and remaining are complex, forcing receiving States to generate institutional responses to care for Venezuelans. The growing influx of Venezuelans is also generating situations of rejection and acts of xenophobia on the part of native populations.



## 2. VENEZUELAN MIGRANT WOMEN

GRAPH 17: INTERVIEWED WOMEN, BY AGE



The state of the human rights of women in Venezuela cannot be viewed in isolation from the CHE and its direct incidence upon the rise in Venezuelan migrant flows toward the region or worldwide.

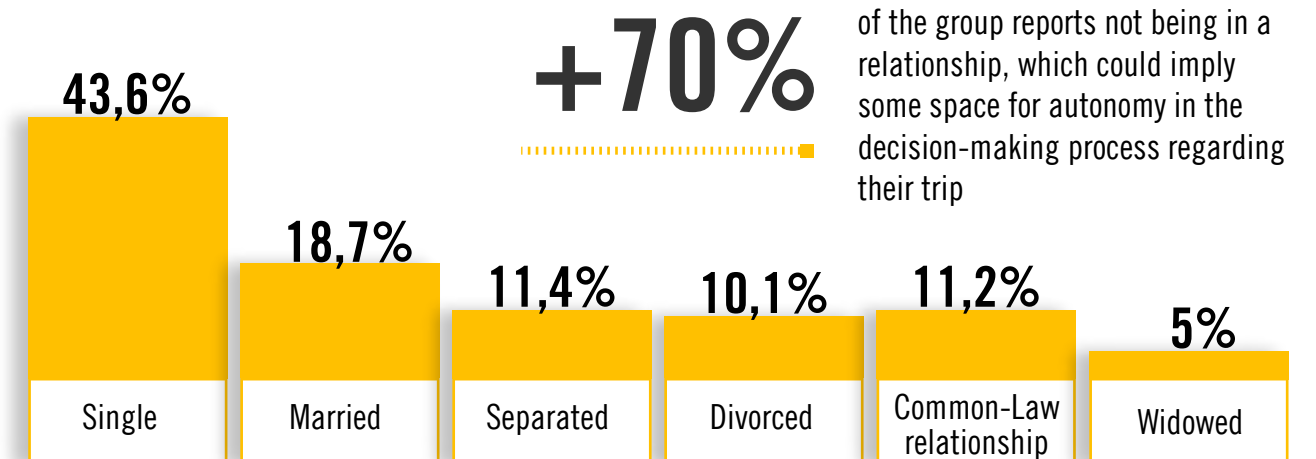
In this regard, the shared vision that inspired this chapter starts from the idea that the enjoyment of rights by women and the guarantees of their protection in human mobility contexts will only be possible through the understanding of the interrelatedness between human mobility contexts and situations of grave violations of human rights or humanitarian crises.

A profile of women who mobilize from Venezuela toward countries in the region may be drawn from the data obtained. The age group with the highest representation were young people between 18 and 29 (46.09%). This tendency may be observed in the various reports prepared by the IOM and other non-governmental organizations (Venezuelan Jesuit Service, 2018) on their follow-up studies of mobility during 2018, wherein the largest percentage of mobilized Venezuelans were under 30 years old. The second representative bracket were those between 30 and 47 (38.33%).

Age, along with gender, are factors that can drive triple discrimination in the context of reception, that is: for being female, young and a migrant. This phenomenon may have an effect at various levels, from the micro, such as the integration in the communities, in the workplace or in the economic, where they may be excluded or subordinated to conditions established by the locals.

## VENEZUELAN MIGRANT WOMEN

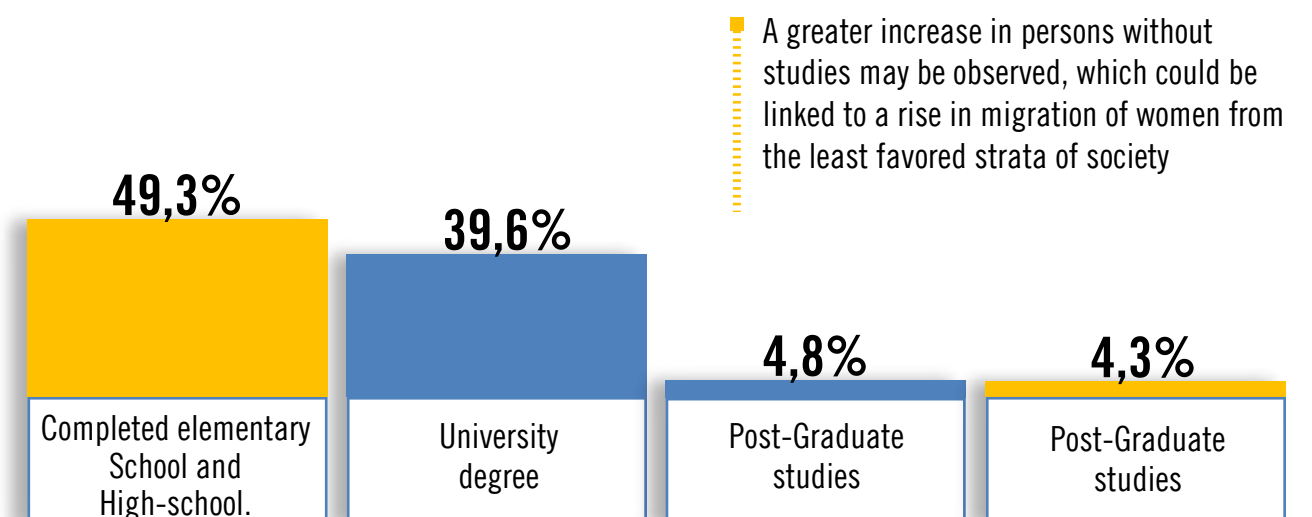
### Marital Status



As for legal and affective bonds (marital status) of the women, it was found that 43.6% were single; 18.7 were married; 11.4% were separated; 10.10% were divorced; 11.2% are in common-law unions and the remaining 5% are widowed. Changes in the gender-roles can be observed in the homes of these women, turning them into family providers. This role does not imply a transformation in power relations of the women vis a vis their families, but it does represent a redefinition of their responsibilities of care for others.

## VENEZUELAN MIGRANT WOMEN

### Last level of completed studies



Asked about their level of studies, 49.3% stated that they had elementary and completed high school education. 39.6 had university education, 4.8% had finalized pot-graduate degrees and the remaining 4.3% reported no studies at all.

Comparing the data obtained with other reports on Venezuelan migrants during 2018, there is a variation in their educational profiles. We see a reduction of the

percentage with higher education and an increase in persons without studies, which might be linked to the increment of women from the least favored strata of society. This situation generates greater conditions of vulnerability in terms of women's entry into the labor market and of their income once in the host communities, as it leads them toward occupations in the care of others, jobs that locals don't want to take and which are generally poorly remunerated.

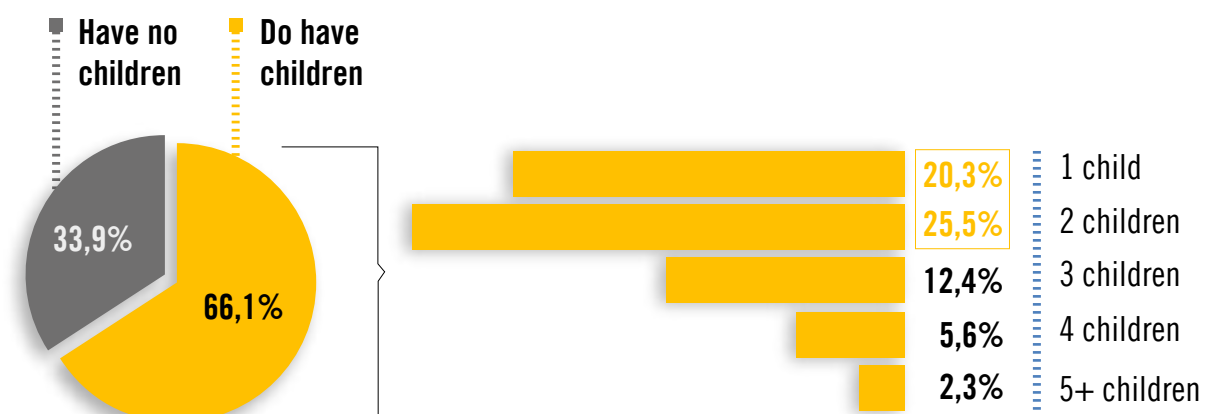


Group composition shows that, in the Táchira subgroup, female health professionals make up the highest percentage at 14.32% while in the Capital District the highest percentage work in the education sector.

As for occupation, women travelling from the Capital District reported that most of them work in administrative support (20.5%) and stylists (16.5%). In Táchira it was observed a wider distribution of occupations and activities generating lower incomes. In this group, 8.40% report having no skills. In total, 1.32% of the women reported working in the sex trade.

This data points to a higher level of vulnerability in women in their insertion into the labor market and a higher risk factor for becoming victims of violence in all its forms. The Colombian city of Cúcuta, on the border with Venezuela, has become focal point for the recruitment of groups for the sex trade, a situation that according to press reports is on the rise (ABC Internacional, 2019) as well as for networks of traffickers in persons (La Nación, 2019). According to this information, brothels in this city have been taken over by Venezuelan women, while the participation of Colombian women diminished.

## FERTILITY RATE OF VENEZUELAN WOMEN



33% stated that they had no children, while 66.1% said that they did. 20% has only one child, 25% two, 12.4% three, 5.6% four and the remaining 2.3% more than five. According to the 2011 Census, the fecun-

dity rate of Venezuelan women was at two children, a tendency which persists in the sample, where 45.8% have from one to two children.

## 2. VENEZUELAN MIGRANT WOMEN

All migrants are vulnerable to abuse and exploitation, but women migrants are especially at risk. For example, women and girls represent 71% of all victims of human trafficking (UNFPA, 2018). When women are displaced due to armed conflict, disasters or, as in Venezuela's case, a complex humanitarian emergency, they face additional vulnerabilities.

"Chaos and the rupture of systems of protection mean that perpetrators may abuse with impunity. Lack of shelter, overpopulation in camps and scarcely illuminated public bathrooms increase the risk of gender violence, including sexual violence" (UNFPA, 2018).

Humanitarian emergencies, such as the one in Venezuela, have a disproportionate impact upon women and girls which pushes them to migrate from their places of origin in search of improved standards of living. What follows, is review of some risk and vulnerability factors faced by Venezuelan women embarking in a migration process.



FOTO: SHUTTERSTOCK



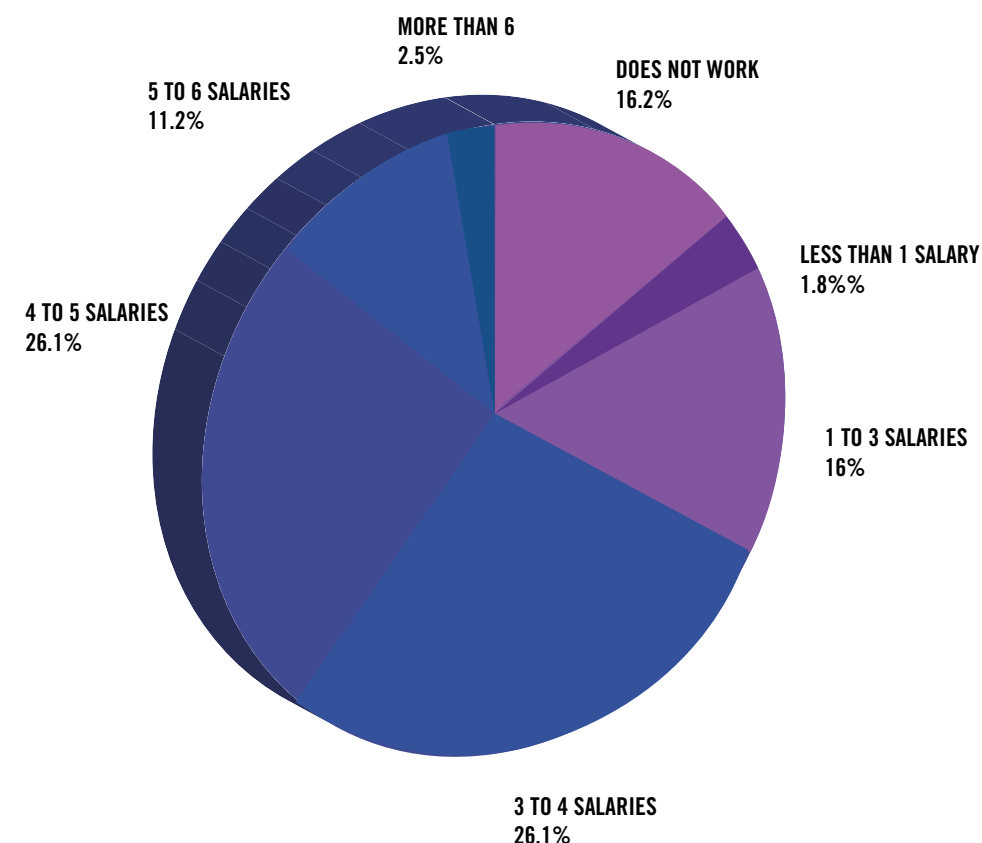
## 3.1. EMPLOYMENT

66% of women interviewed were working before departure, while 14.2% were unemployed and 15.2% were seeking employment. The remaining 4%, though employed, were seeking a better option. It should be noted that, in Venezuela, being employed is not sufficient guarantee of earning sufficient income to cover all household needs, due to the high levels of inflation that have suppressed the local currency's purchasing power.

47% of the women were in formal employment, meaning their inclusion in the social security system. This system involves a framework of labor and health protection such as: social benefits, food vouchers, social security or hospitalization insurance, among others. 34% of the sample performed casual jobs, which do not offer job continuity, income stability or access to social security.

## 3.2. INCOME

GRAPH 18: INCOME



Women's salaries were measured using the minimum wage indicator, a standard established by the executive branch on the basis of the so-called basic basket variable, a set of staple goods and services required by an average family to survive over one month. It was found that 16.06% reported earning between one and two minimum wages, 26.12% between three and four minimum wages and 26.12% between four and five minimum wages. Only 2.48% earned over six minimum wages (see Graph 18).

As for total home income (the sum of all salaries of persons in the household), 66.61% of women's households earned between four and six minimum wages and 33.39% received less than three minimum wages to cover the expenses in the basic basket. While observing the indicator in an isolated manner might give the impression that the income of women and households

is adequate given the number of minimum wages, due to the context of hyperinflation and shortages, said amounts are not enough to cover all of the basic basket. According to the Center for Documentation and analysis of Workers (CENDA), by January 2019, 23 minimum wages were required just to cover the basic food basket, though not the complete basket, which encompasses other needs beyond food.

Regarding food security, access to food figures indicate that a total of 91.24% of the women have had to go without food due to lack of resources. This data, furthermore, speaks to the inability of women to earn money for their trip, that is, sufficient funds for their relocation and arrival in the destination country. This becomes a risk factor in their mobility, as the lack of money might push them toward organized crime networks.



### 3.3. HOUSING

70

FOTO: SHUTTERSTOCK

Regarding ownership of the dwelling that they inhabited before leaving the country, 31.6% of the women consulted reported ownership, while 64.4% did not. Of the group of women not possessing a home, 21.8% lived in a house owned by a relative, 24.6% rented an unit, 9.1% had been taken in by a family member, 5.9% resided in Housing Mission units<sup>29</sup>, 5.3% rented a room and the remaining 0.2% lived in a shelter.

As a group, women are more vulnerable to the violation of the right to adequate housing. This restricted access may stem from conditions of structural discrimination based on gender roles and social, economic, cultural and discriminatory legal aspects, as well as social practices that perpetuate inequality between men and women, all of which limit their ability to purchase homes.

Gender gaps keep women in the role of caregivers and guarantors of the home's well-being and functioning

but without economic independence, which generates barriers to the purchase of homes. This keeps women in a state of dependence and subordination before others who take them in. This "support" subordinates them and leaves them exposed to the possibility of being victims of violence or other forms of violations of their rights, such as forced expulsion from their places of residence.

In the case of women who live in State-allocated complexes, political control has become a mechanism for subordination and generation of dependence, as their permanence in the units is contingent upon their participation in proselytizing or upon keeping quiet any opinion contrary to the de facto government and its party. There have been public denunciations regarding the expulsion of people from these housing complexes in retaliation for expressing opinions contrary to the State's official discourse<sup>35</sup>. Said measures violate the right of women to housing.

### 3.4. HEALTH

71

Health as a fundamental right implies the guarantees for achieving well-being in all its biopsychosocial dimensions. As has been detailed in other parts of this report, the health sector is one of the most affected by the CHE in Venezuela. This has severely affected the exercise and enjoyment of the right to health, including sexual and reproductive health.

During the survey, it was found that 84.63% of women do not have private health insurance and only 15.37% some kind of private health care plan. Having private health insurance has become a basic necessity in Venezuela, due to the precarious state of the public health

system. Access by women to services is limited if they only have the possibility to access those offered by hospitals, which are very limited and overwhelmed.

As for the perception regarding health, 63.31% state that they are healthy, 22.31% perceive themselves as not so healthy, 2.64% suffer from a chronic disease and 11.74% do not know. Some of the women stated that their departure from the country was due to a chronic health condition for which they require medications and controls that are unavailable in Venezuela.

Finally, information was requested regarding their most recent medical

check-up. 32.23% stated that their last check-up was over a year ago, 21.49% had it one year ago, 25.45% eight months ago and 20.33 less than three months ago. One of the reasons that keeps women from the health services required for their well-being are economic limitations. The state of Venezuela's health system also limits access to essential services to guarantee their well-being and to avoid belated diagnostics or the deterioration of pre-existing conditions.





FOTO: AMNISTÍA INTERNACIONAL

## 3.4.1. SEXUAL AND REPRODUCTIVE HEALTH

In the field of health, sexual and reproductive health is considered a fundamental axis as an essential part of the exercise of the right to health. Thus two dimensions were taken into account: access to services and the availability of family-planning methods as indicators of the exercise of reproductive autonomy.

### Access to sexual and reproductive health services

More than half of the women consulted (56.04%) indicated that their last gynecological check-up was a year or more ago; 21.82% less than eight months ago and the remaining 20.33% less than three months ago. 56.36% of the sample went to public hospitals or CDIs<sup>36</sup>,

while 43.64% went to private services.

### Access to family-planning methods

The second dimension considered was access to contraceptive methods, which permit women to enjoy their sexuality and to decide when to have children and how many. In this regard, 30.75% of women consulted reported not using any kind of contraceptive before departing the country and 69.25% used some kind of planning. Of the women making use of some method, reported to be 24.63% sterilized, 21% used condoms, and only 15.21% used the pill. The remaining percentage used other methods.

When asked about their knowledge of sexually transmitted infections and protection against them, 23.47% expressed no knowledge, while 16.53% had knowledge though used no protection. 59.67% have information and protect themselves while 0.33% neither have information nor protect themselves.

The two dimensions of unsatisfied needs identified are access to family-planning services and the prevention of sexually transmitted diseases. Barriers to the exercise of reproductive autonomy by women must be an area of priority attention in host countries, as underlined by UNHCR in its guidance notes about Venezuelan migrant flows (2018).

FOTO: DESIGNED BY BEDNEYIMAGES / FREEPIK



## ACCESS TO FAMILY-PLANNING METHODS

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expressed no knowledge, while 16.53% had knowledge though used no protection. 59.67% have information and protect themselves while 0.33% neither have information nor protect themselves.

The two dimensions of unsatisfied needs identified are access to family-planning services and the prevention of sexually transmitted diseases. Barriers to the exercise of reproductive autonomy by women must be an area of priority attention in host countries, as underlined by UNHCR in its guidance notes about Venezuelan migrant flows (2018).



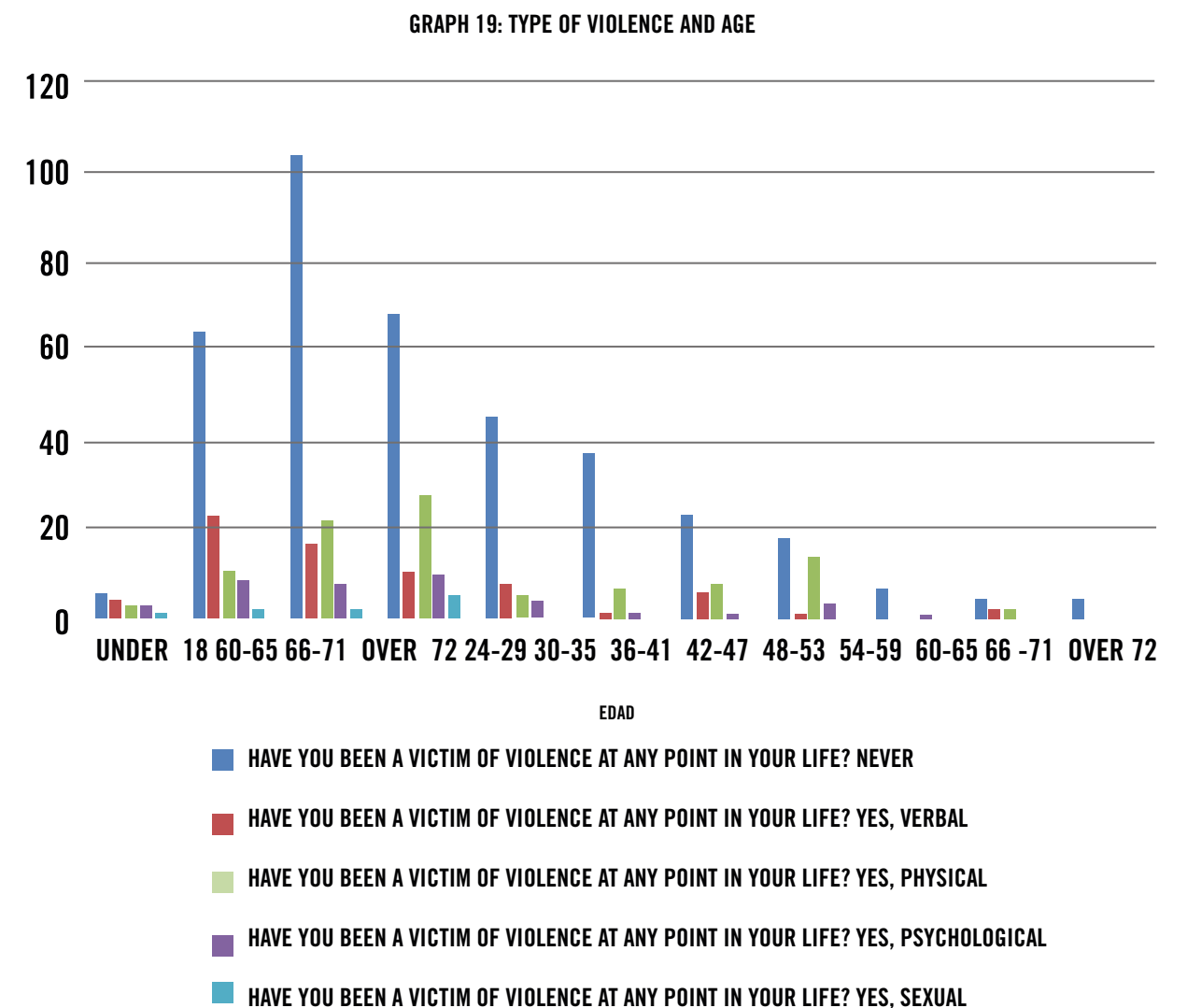
## 4. VIOLENCE AGAINST WOMEN

The real magnitude of violence against women in Venezuela is unknown, as there are no available official figures about this problem. The Organic Law on the Right of Women to a Life Free from Violence (LODM-VLV in Spanish) identifies 21 modalities of violence which, in theory, should generate a wide spectrum of protection. Reality, however, is otherwise.

Consulted about having experienced gender-based violence, 37.02% of the women consulted reported having suffered some type of violence, while 63.97%

reported they had not. Disaggregated by type of violence 18.67 reported verbal and psychological violence, 16.56% physical violence and 1.82% reported having been victims of sexual violence.

As for the age-groups in which violence was more frequent, the study found the greater number of victims in the younger age range (see Graph 19), which could lead to the conclusion that there is double discrimination at play: by gender and by age.



Violence experienced by women might play a part both in their migratory project and in the types of violence that they encounter in the host country.

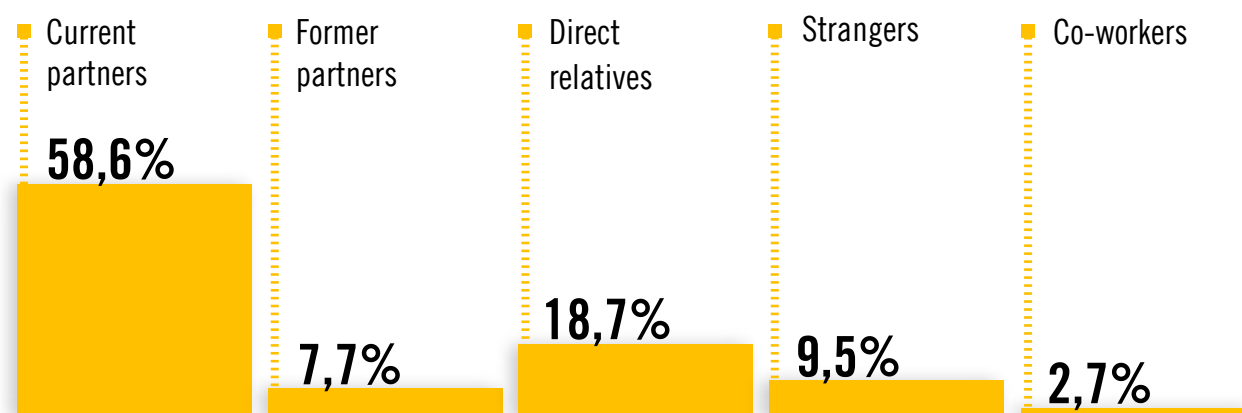
“Violence against women can be a detonator for emigration from the countries of origin, preparation and departure, but it becomes a threat during the rest of the migratory route transit and destination and during the return; particularly when taking into account the indicators for public safety and violence against wo-

men in the countries in the region where the women return” (Gimenez, 2016).

In 15.8% of cases the situation of violence had occurred less than three months ago, in 20.6% eight months ago, in 18.4% one year ago in 17.1% more than one year ago and in the remaining 28.1% more than two years ago. 63.6% of victims reported that the situation of violence was on-going for more than a year.



## VIOLENCE AGAINST WOMEN



In 58.6% of cases, perpetrators were their current partners, in 7.7% their previous partners, in 18.7% direct relatives (fathers, uncles, grandfathers, cousins) and 9.5% involved strangers while in the remaining 2.7% perpetrators were co-workers.

Only 32.14% of the women turned to authorities to file charges of violence.

FOTO: DESIGNED BY senivpetro / Freepik

## 5. ROLES AND RESPONSIBILITIES

### 5.1. MATERNITY AND CARE FOR OTHERS

One of the roles associated with the construction of the feminine is linked to maternity and the care for others as these are expressions of gender roles. Responsibility for care and decision-making within households fall on the shoulders of women. Care for the family and decision-making have been changing to new forms of expression and practices, such as distance or transnational maternity.

These constructs generate transformations in the bonds between family members, which implies a shift in the sexual division of labor.

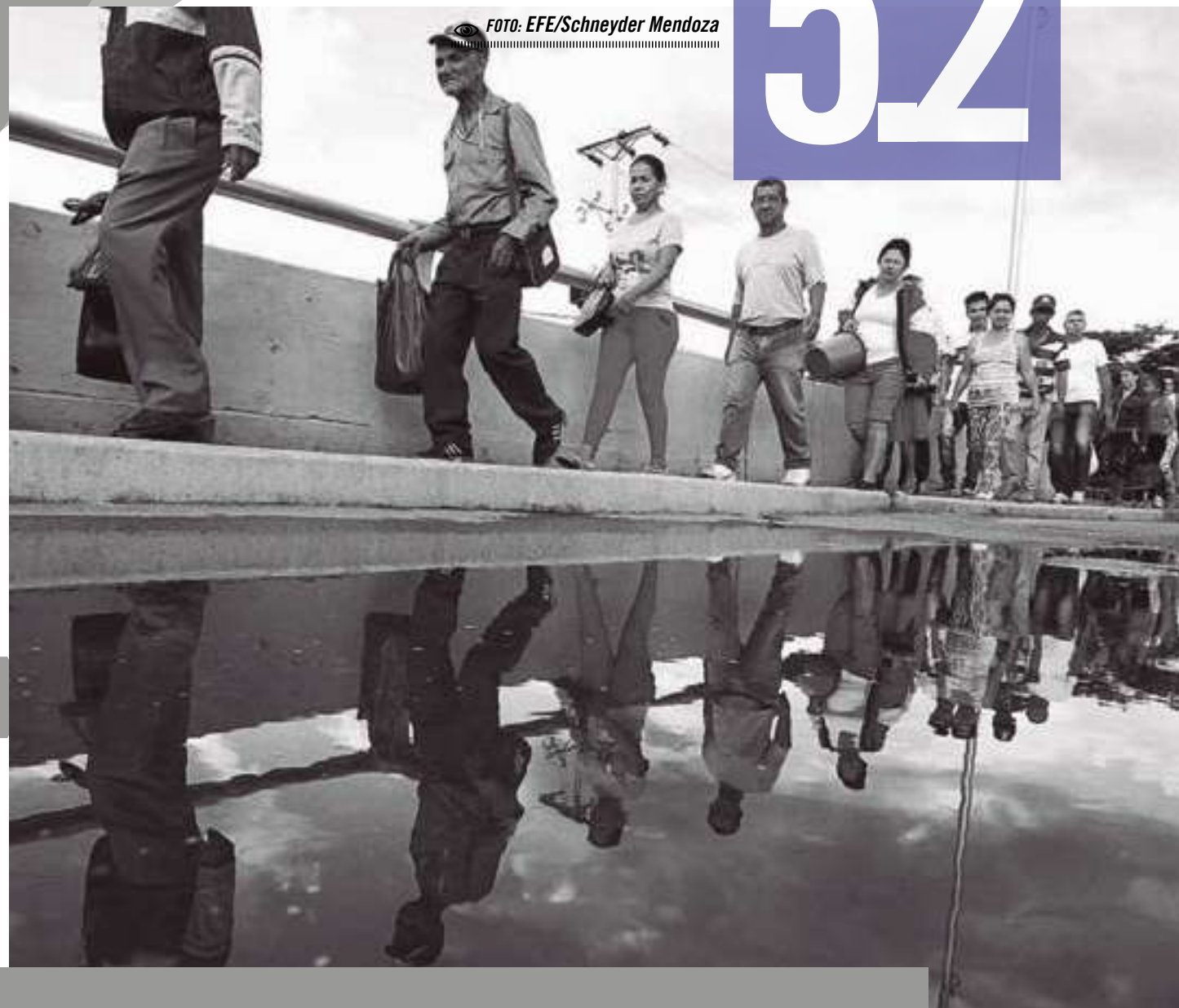
Faced with these alternate constructs, the first decision to be made by women considering migration is on whether to bring along their children or not. In the case of women consulted, 39.9% of those with children said that they would travel with them while 48.3% would leave them in Venezuela. 3.7% reported that the father had travelled ahead with the children, 3.4% said that the children had gone with a relative and 4.7% reported that the children had gone on their own.

There are various reasons for women to leave their children in the care of the father or third parties. The main reason, however, is associated with economic factors (44.2%), followed by those who reported that fathers had denied permission for children to leave the country or that fathers had no contact with them (21.5%).

Within this last percentage are also cases in which the father has denounced the mother before protection bodies which, in turn, deny permission. This situation can generate feelings of guilt, sadness and confusion in the mother, given the social construct surrounding what it means to be a mother, as well as the expectations and responsibilities attached to it.

The dynamics of transfer of care for others occurs with more frequency in the case of female figures, especially maternal grandmothers or other women in the maternal family (46%). There are also cases of maternal grandparents (21.6%). In the remaining cases, care is assumed by fathers (14.8%) the paternal grandfather (5.7%) and other relatives (aunts, godmothers, cousins) (9.7%).

FOTO: EFE/Schneyder Mendoza



## 5.2. REMITTANCES

Another change in gender roles in the context of human mobility has been the shift from care-giver to provider, without this variation necessarily meaning a change in power relations between men and women. The transfer of money becomes a survival strategy for the family in the country of origin, with the money going mainly toward the living expenses and feeding of children, as well as toward covering the needs of the home where the children remain.

70.58% of the women reported being responsible for sending remittances to their families and/or children, while 29.42% have no responsibilities toward third parties in Venezuela, 22.48% of the women reported that remittances were for supporting both their parents, 15.20% for their mother, 9.25% for children and both grandparents, 8.1% for children and grandmother and 7.6% only for children.

## 6. CONDITIONS OF TRAVEL



The process of departure from the country of origin implies actions and decision-making on the part of women, as does transit and arrival in the destination country.



FOTO: SHUTTERSTOCK



## 6.1. DEPARTURE AND TRANSIT

Regarding departure, aspects related to trip organization, the information the women have and the resources available for travel were considered. Regarding the planning process women were asked about the time invested in preparing the trip: 2.31% organized the trip in less than one month, 18.68% in one month, 26.96% took between one and three months and 27.27% planned it over a period between three and six months. 14.05% took between six months to one year planning their trip and 10.74% took over a year.

Another aspect taken into account was the investigative process undertaken by the women regarding the destination countries. 22.64% did no research while 60.83% did. As for the information that they have, 41.65% inquired about economic aspects in the

host country, 33.55% about migration requirements, 4.63% about the health system, 4.31% regarding rent, 1.98% about opportunities for study and 1% about culture and customs.

92.56% of the women stated that they had money for the trip while 7.44% said that they had no resources, though they were in the process of leaving the country. 65.12% reported in-hand resources to cover transportation costs to the destination country, 19.83% could cover meals during the trip and 9.75% could cover an emergency. This data suggests that the level of vulnerability of these women is quite high, as they are left exposed to persons or organized-crime groups and to unforeseen situations that might prevent arrival at their destination.



## 6.2. ARRIVAL

Regarding the arrival, the women were asked about the funds they had to cover entrance expenses at the destination country. 79.70% of them had resources while 20.33% reported not having resources for arrival.

13.55% reported that they could support themselves for three days with the money they carried, 33.06% could cover their stay for a week, 21.65% would have enough for a month and 15.20% could cover more than one month. This data is also indicative of the high level of vulnerability in which these women find themselves in the host countries. Women arrive in conditions of subsistence and without a support system, which makes them vulnerable to exploitation and prostitution, as well as organized networks of trafficking and smuggling in persons.

The regulatory frameworks in some of the destination countries mean that regularization of documents to enter the labor market can take up to one month, posing important barriers to labor insertion, renting of housing or payment for documents. This situation might make women enter into a spiral of exclusion and discrimination.

Regarding the support-networks that they rely on after arrival, 38.84% of the women have friends in the host country, 33.72% have a relative there, 15.04% were referred to someone and 12.40% had no one upon

arrival. Having someone on the other side is an important protection factor, as it facilitates integration and affords a guide for the understanding of the cultural frameworks.

Another risk factor is the place of shelter upon arrival. Data reveals that 7.60% of the women don't have a place to stay when they arrive and 3.80% have a space assigned as part of a job offer. Though shelters have been established in the main four receptor countries, these are at maximum capacity with homeless Venezuelans. These conditions, furthermore, exposes them to the possibility of having to sleep in the streets. Of the women who have shelter upon arrival, 15.54% will be able to rent, 27.60% will be temporarily with a relative, 32.90% will be temporarily staying with a friend and, finally, 12.56% will be taken in by someone they were referred to.

As for knowledge about the institutional support networks in case of emergencies in the host country, 87.60% have no information at all, while 12.40% know of some emergency-support organizations.

Findings thus far allow us to sketch some conclusions. First, the group of younger women and of those without higher education is the largest one. Their socioeconomic status places them at significant levels of risk and vulnerability due to their lack of means of subsistence





### III. OTHER SITUATIONS THAT AFFECT THE LIVES OF WOMEN, GIRLS AND ADOLESCENTS IN THE FRAMEWORK OF THE CHE.

and for the generation of adequate conditions for the trip. The social and educational status of these women expose them to limited labor markets, with low-skilled jobs or poor pay in the host countries.

The violations of the rights to health and employment and to decent living standards that characterize the CHE in Venezuela, push these women to start their journeys without suitable conditions for transit and settlement, making them vulnerable to factors of exclusion and discrimination. Thus, women are exposed to being victims of smuggling and trafficking in persons due to the lack of conditions to protect them during transit or once in the host country. Vulnerabilities increase exponentially when the woman is a migrant due to other factors such as their migratory status, being a foreigner, the possibility of suffering acts of xenophobia and analogous forms of modern slavery are thrown into the mix.

Comprehension of the interrelation between human mobility and its differentiated impact on migrant women unveils the manner in which gender influences the experience of people in the context of crisis and allows us to address the protection and specific needs of assistance according to gender, while preventing and acting against new forms of violence against women.

The enormous absence of data, research and analysis related to women migrants in general, particularly in Venezuela, calls out to reflect upon the extent to which they have been ignored. In the specific case of the Venezuelan migratory crisis as a product of the CHE, it becomes necessary to procure realistic diagnoses in order to improve national and regional responses, while ensuring that these duly incorporate a gender perspective that sees to the particular needs of girl, adolescent and women migrants.

#### 1. Gender violence against women

The most recent data published by State sources on gender violence against women date from 2016. That data was included and commented upon in our previous report (2017). But if data was then scarce, it is now nonexistent. This is due to a persistent official policy to conceal (or not generate) official figures that would allow for an understanding of the magnitude of the problem. The only official information available comes in the Venezuelan State's response to the questions posed by the CEDAW Committee as a follow-up to the presentation of its periodic reports on compliance with the Convention. The State's response presents information that is incomplete or does not reply adequately to the questions posed by the CEDAW Com-

mittee (CEDAW, 2018). This, in spite of the fact that the CEDAW Committee itself urged Venezuela to act to establish a system for statistic-data gathering on violence against women, disaggregated according to type of violence and relationship between perpetrators and victims; as well as on the number of complaints, prosecutions, convictions and sentences against perpetrators and on reparations awarded victims. (CEDAW, 2014). However, no initiatives have been undertaken to this effect.

Thus, given the absence of official information, in this section we will present some of our own contributions toward the comprehension of the current state regarding gender violence against women in Venezuela.



FOTO: SHUTTERSTOCK

## 1.1. GAPS IN THE NORMATIVE FRAMEWORK AND PUBLIC POLICIES, AS WELL AS IN THE PRODUCTION OF FIGURES ON GENDER VIOLENCE AGAINST WOMEN

Since 2018, there has been a tendency on the part of the Office of the Prosecutor-General and other competent bodies to inform on some figures verbally. For example, in October 2018, during a press conference, the Prosecutor-General (designate) reported that “since his arrival at the institution, 93 cases were received; 63 of them consummated femicides and 30 frustrated femicides,”<sup>37</sup> that “83 alleged perpetrators were jailed and that 75 indictments and 70 accusations had been made.”<sup>38</sup> That is, according to official figures, 93 femicides were registered by the Prosecutor-General’s Office between August 2017 and October 2018. This modality for data delivery is problematic. On the one hand, the information is not verifiable, as there

are neither official reports detailing these acts nor explanations on the methodology used for data-collection. On the other, it is not periodic, which makes it difficult to establish a general overview of the levels of violence and femicide. Furthermore, this information is inconsistent with that gathered from civil society and the media. For example, according to the Cotejo.info website, there were 448 femicides in Venezuela during the whole of 2018, meaning a rate of increase of femicide of 10.89% over 2017 (2018). According to the same site, 35 out of every 100 femicides in the country involved women between 25 and 45; while approximately 27 out of every 100 were women under 25.

### Since 2018

High-level officials of the Prosecutor-General’s Office provide some figures verbally

#### ■ Octubre 2018, rueda de prensa

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- Modality of reporting is problematic
- Information is unverifiable and there are no official reports
- Methodology is not periodical
- Information is inconsistent with that gathered by civil society and media

**Official figures**  
Between August 2017 and October 2018  
The Office of the Prosecutor-General registered 93 femicides.

According to  
**Cotejo.info** Website

**10,89 %** increase in rate of femicide in respect to 2017 (2018)  
**448** femicides in Venezuela. 2018



In **35** of **100** femicides age oscillated between **25** to **45**  
Approximately **27** of **100** women were under **25**

As has been pointed out, the absence of official figures regarding violence against women persists. The number of cases annually received by institutions mandated to do so is unknown, as is the number of processed and prosecuted cases.

The Venezuelan State has yet to approve a national plan of action to prevent, punish and eradicate violence against women. According to the Organic Law on the Right of Women to a Life Free from Violence (Art. 18) it is the responsibility of the Ministry of Popular Power for Women and Gender Equality (MINMUJER),



## 1.2. INACTION OF PUBLIC ENTITIES

One of the features of the crisis-turned-CHE in Venezuela is the weakening of the capacities of State bodies to fulfill their obligations, which includes the lack of budgetary appropriations for official institutions and the subsequent suspension of programs and activities due to lack of personnel or supplies (or both). The situation is intertwined with the lack of political will observed from official instances in responding to and fulfilling the terms of the Organic Law on the Right of Women to a Life Free from Violence.

One example is the situation surrounding the shelters for women victims of violence, defined by MINMUJER as:

“Discreet and confidential facilities for the temporary hosting of women in this situation, whose lives and physical integrity are in imminent danger, to protect and care for both them and their children under 12 (...) These spaces offer psychological, legal, social, medical, care and mentoring in socio-productive projects for hosted women (...) To enter the program, the surviving woman must make the complaint and the Prosecutor General’s Office must dictate the corresponding protection and safety measures(...)”<sup>39</sup>

There is no official information on the number of existing shelters, their capacity or the number of women beneficiaries. According to non-official information, there were four in Aragua, Cojedes, Sucre and Trujillo states, of which the last two functioned until the first semester of 2018 while the first two continued to functioned but with significant difficulties.<sup>40</sup> Other non-official information indicates that all the shelters have ceased to operate, but there is no official information in this regard. Shelters run by civil-society organizations have had to suspend or curtail their programs of care for women victims of violence due to lack of resources. Prosecutors, when confronted with

requests for shelter, indicate that there are no possibilities of taking these protective measures.

The Office of the Ombudsman, as a body of Citizen Power, has the responsibility to promote, defend and monitor the rights and guarantees enshrined in the Constitution of the Bolivarian Republic of Venezuela and in international human rights instruments. Though acting on threats or violations of the human rights of women, girls and adolescents (National Assembly of Venezuela, 2014) is within its competencies, there is no evidence of it having acted in this regard. Only a few specific awareness-raising and training activities have been known.

The Subcommittee on Gender Statistics that operated within the National Institute for Statistics has, among its competencies, the identification of information needs regarding gender statistics; promoting gender statistics in the National Statistics Plan and facilitating the structuring and coordination of public and private statistics offices to update, integrate, harmonize and follow up gender statistics. It is unknown if this Subcommittee continues to operate. The last known gender bulletin published by this Subcommittee dates of 2014.<sup>41</sup>

Therefore, though there is a normative and institutional framework regarding violence against women, there are significant gaps in access to justice as well as to attention and prevention of violence against women. There are structural deficiencies that prevent cases from being duly addressed, channeled and resolved; protection measures are not effective and victims often feel abandoned in the midst of what ends up being a judicial ordeal. Furthermore, justice system has no programs, services or specialized personnel to properly address violence against women cases, making re-victimization commonplace.

as the governing body, to develop policies to prevent and address violence against women. But this institution does not fulfil its obligations as a national mechanism for coordination and monitoring, mainly due to the great political and ideological bias that characterizes its activities, to the detriment of fundamental issues surrounding the attention to and prevention of violence against women.

Another obstacle to addressing and preventing violence against women and to due implementation of the Organic Law on the Right of Women to a Life Free from Violence is the lack of the regulation of such law. 11 years after its approval and five years after its reform (during which femicide was included and typified as a crime) the executive branch continues to evade its responsibility of drafting and enacting the law’s regulation. Even when MINMUJER itself acknowledges the need to draft and approve the norms and some efforts have been made, there have been no results (MINMUJER, 2017). Thus, at the time of this writing, Venezuela lacks a regulation to this law that would permit

defining procedures for the prevention, attention and reparation for women victims of violence, facilitating the structuring of national actors at the national level in the current context. It should be remembered that the CEDAW Committee requested that the Venezuelan State put the Organic Law on the Right of Women to a Life Free from Violence into full effect by adopting the rules and protocols necessary to ensure that the law adjusts to international standards. It further requested that the State approve a national plan of action on violence against women that includes specific measures to combat all forms of violence and a national plan for coordination and monitoring regarding violence. (CEDAW, 2014).

The above is complicated by the fact that there is no information regarding budgetary appropriations and execution nor regarding activities undertaken by MINMUJER or its different directorates and programs for 2016, 2017 and 2018, as the yearly ministerial reports for said years have not been made public.



## DIFFICULTIES IN ACCESSING JUSTICE FOR WOMEN VICTIMS OF GENDER VIOLENCE

Routes, circuits and procedures that impact \*on the rights of victims of violence



- The practice of bouncing victims around when they turn to the police
- Delay in dealing with victims at the Prosecutor's offices
- Measures of protection for victims are inoperative, particularly restraining orders, as it is difficult to receive immediate support from police when they are violated. There is no presumption of good faith from victims.
- Physical difficulties for entrance to the Tribunal which violate the dignity of victims and family members.
- The spaces are not designed to prevent victims and perpetrators from coinciding.
- Dossiers are misplaced and relocating them is emotionally exhausting. Furthermore, documents submitted by the parties generally take between 15 and 20 days to be included in a file.
- Interested parties must provide all types of supplies so court workers can work on dossiers.
- Notices summoning victims and their legal representatives are not issued due to lack of paper or ink.
- Schedules of hearings are not observed.
- Trials are interrupted three or four times.
- The Comprehensive System for Management, Decision and Documentation (JURIS 2000) used to handle cases regularly fails, making it difficult to consult the setting of actions, the status of processes and the physical location of files. It also cannot be used to obtain statistical information.



Because the Judiciary tends to ignore its deep structural problems, the inauguration of new offices (such as the appeals courts with competency in violence against women in the Santa Barbara del Zulia and Valencia, Carabobo State circuits<sup>42</sup>) offers no guarantees of access to justice for victims. As long as there continue to be structural deficiencies in the judicial system and while fundamental aspects such as the training of personnel (among many others) are sidestepped, the Venezuelan State will continue to be in arrears in its obligation to prevent, investigate and punish violence against women.

Gaps, deficiencies and State's inaction regarding violence against women are evinced in the unprecedented decision of the Inter-American Commission of Human Rights condemning the Venezuelan State in the case of Linda Loaiza, who was a victim of sexual violence, torture, physical violence, psychological violence and attempted murder over a four-month period, during which her aggressor kept her abducted. This is an emblematic case, not only because of the aggressions suffered by Linda Loaiza, from which she still suffers physical and psychological consequences, but because of the re-victimization that she and her family endured throughout two trials during which her rights were violated (Inter-American Commission for Human Rights, 2018).

The guilty verdict finds the Venezuelan State res-

ponsible for the various violations of human rights catalogued not only as violations of personal integrity, dignity, autonomy, and private life of Linda Loaiza, but also as acts of torture and sexual slavery in the terms established in the Inter-American Convention on Human Rights and the Convention of Belem do Pará.

The Venezuelan State, for its part, acknowledged its responsibility stemming from the violation of the rights to judicial guarantees, legal protection and the duty to investigate acts of violence against women as Linda Loaiza was not afforded adequate attention and treatment in her condition as victim of violence against women from the moment of her rescue and afterward, making it patent that the grievous acts of violence that she suffered were investigated and judged within a discriminatory normative framework.

The sentence is unprecedented in that it is the first time that the Inter-American system declares the responsibility of a State for heinous acts committed by an individual given the gross omission by the Venezuelan State in protecting and preventing violence against Linda Loaiza, in spite of having full knowledge of the risk she was in. And it is also the first time that it condemns the Venezuelan State for acts of violence against women, acknowledging that the Linda Loaiza case also occurred in a context of serious institutional failures, many of which currently persist.







## 1.3. SEXUAL VIOLENCE IN THE CONTEXT OF THE CHE

FOTO: SHUTTERSTOCK

### Obligations of the Venezuelan State in relation to violence against women derived from the sentence in the case of Linda Loaiza (September 2018)

1. The State must publish the sentence: a) in an official journal in a legible and adequate font; b) the official summary of the sentence prepared by the Court, one time only, in a high-circulation national newspaper in a font size legible and adequate, and c) the full sentence in its entirety, available for a period of one year, on an official State website, in a manner accessible to the public from the homepage;
2. The State must hold a public act acknowledging Venezuela's international responsibility regarding the facts of this case. During this act, reference must be made to violations of human rights declared in the sentence;
3. The State must dictate the corresponding regulation for the Organic Law on the Right of Women to a Life Free from Violence;
4. The State must make courts for violence against women adequately functional in every state capital;
5. The State must adopt, implement and oversee protocols that establish clear and uniform criteria both for the investigation and for the comprehensive attention for acts of violence that have women as victims. These instruments must adjust to the guidelines in the Istanbul Protocol, the United Nations Manual for the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions and the guidelines of the World Health Organization, as well as the Court's own jurisprudence. These protocols must be directed at personnel in the justice system and in the sphere of health, whether public or private, who intervene in any way in the investigation, handling or attention of cases of women victims of any of the types of violence indicated in the Organic Law on the Right of Women to a Life Free from Violence;
6. The Venezuelan State must incorporate in the national curriculum of the educational system, at all levels and modalities, a permanent educational program under the name "Linda Loaiza";
7. The State must immediately implement, through the competent State body, a system for the gathering of data and figures linked to cases of violence against women throughout its territory;
8. The State must determine, within a reasonable period of time and through competent public institutions, the possible criminal responsibilities of officials who, from the outset, did not investigate what occurred to Linda Loaiza, as well as of those responsible for the unjustified irregularities and delays during the investigation and substantiation of legal proceedings carried out internally, and to the extent possible, the State will apply corresponding penalties as provided by law.

As in contexts of armed conflict and disasters, the CHE exacerbates the population's vulnerabilities. It is a situation characterized by precarious living conditions and scarce means to cover basic necessities, turning a good part of the population into "exploitable persons" (León, 2018).

These vulnerabilities, combined with institutional frailty and a patriarchal culture of commodification of bodies centered on masculine sexual pleasure that sees women and girls as sexual objects, devolve into a scenario that facilitates the increase of sexual violence associated with commercialization and/or sex as a means of exchange. But said violence is also exercised by power groups as part of a policy of repressing civil and political rights.

In the case of Venezuela's CHE, two major dynamics

may be identified with regards to sexual violence: the first is linked to economic interests that take advantage of the population's poverty and vulnerability, especially in the case of women, adolescents, girls and boys characterized as "commercial sexual exploitation"; and the second, linked to population control, used to intimidate and demoralize victims, especially protestors and detained individuals and is characterized as "sexual violence for political reasons" (León, 2018).

### A.COMMERCIAL SEXUAL EXPLOITATION:

It encompasses diverse forms of sexual violence which involve the exchange of money or of goods or services for sex with a woman, a girl or a boy (Aya and Borges as cited by León, 2018, pg. 13). This includes i) commercial sexual exploitation of children and





FOTO: SHUTTERSTOCK

adolescents, understood as a violation of fundamental rights of the child involving abuse by an adult and remuneration in money or goods for the child or a third party and ii) the trafficking and smuggling of persons for sexual purposes, especially of women, which involves the transport within and outside the country to sexually exploit them through forced prostitution, sexual tourism or pornography.

It is necessary to underscore that in the Venezuelan socio-cultural milieu, particularly in the precarious conditions brought about by the CHE, there is a culture that encourages sexual exploitation of women and girls whereby prostitution is considered a valid option to face the crisis. On the other hand, exploitation networks are not evident. There is no visible face of those who attract victims but rather “word of mouth” as part of an informal structure for recruitment. There is information that, in some cases, women and adolescents must single out others for recruitment into networks of exploitation as partial payment of their own debts (León, 2018).

The above notwithstanding, there is no detailed in-

formation in Venezuela (official or otherwise) on commercial sexual exploitation discriminated by type of crime, affected groups or high-risk areas. But information reported by national and international media outlets have shown evidence that these situations are occurring. Among the cases (cited by León, 2018) are: girls and adolescents, including some of Wayúu ethnicity, in the Los Plataneros Market (Maracaibo, Zulia State); sexually exploited girls and adolescents in La Guaira, Vargas State; the identification of a network for trafficking and smuggling of women, adolescents and girls operating in Táchira State, on the border region with the Norte de Santander Department in Colombia. Victims were trafficked towards Brazil and Colombia.

In places such as Barcelona (Anzoátegui State) and points in Caracas such as Sabana Grande, Plaza Caracas, La Hoyada; Catia, San Martín, Coche, Avenida Libertador; La Florida and Avenida Andrés Bello, boys, girls and adolescents who live in the streets are sexually exploited. Similarly, there is information regarding diverse forms of sexual exploitation of indigenous women, girls and adolescents in the Orinoco Mining Arch region.

## B. SEXUAL VIOLENCE FOR POLITICAL REASONS

Consists of “any form of sexual violence carried out by State security forces against protesters and/or persons detained in the framework of political and social protests” (León, 2018). Some of its manifestations may be: fondling of the body or genitals; verbal mistreatment and sexual taunting; threats of rape; forced nudity (of the whole or part of the body); exposure to the genitals or masturbation of third parties; demands for sex acts; slaps on the buttocks; pinching and biting of the breasts and rape.

According to Foro Penal and Human Rights Watch, of 88 documented cases of victims of serious violations of human rights in the context of public protests between September and April 2017, 53 were subjected to physical or psychological abuses which included sexual abuse and rape. The report of the Office of the United Nations High Commissioner for Human Rights on violations of Human Rights in Venezuela (2018) also pointed out that persons detained during protests that year were subjected to mistreatment and sexual insults, forced nudity, threats of rape and other forms of sexual violence.

The State’s response regarding sexual violence has been historically deficient. More than 95 Venezuelan civil-society organizations issued a communique alerting of a series of failures on the matter of prevention and obstacles to access by women and adolescents to justice and to the reestablishment of their dignity, particularly those who have been subjected to sexual violence. Among the obstacles identified, are the lack of rapid, transparent and effective response to which

State institutions are obliged by virtue of the Organic Law on the Right of Women to a Life Free from Violence; the persistence of myths and false beliefs regarding the dynamics and forms of sexual violence by persons charged with offering support to victims and with channeling cases and a system of justice that re-victimizes women. This includes professionals who insist on legitimizing a positivist interpretations of the law that place the preservation of the “legal order” above the rights of victims of sexual violence and favor perpetrators of these crimes through ploys and technicalities. This has a grave impact upon the victims’ recovery process and in their access to justice (AVESA, 2017).

If the State’s response was already deficient, it has worsened in the context of the CHE. León (2018) points out that complaints are not being received by the responsible authorities, which drives victims and families to search for individual protection mechanisms as they consider that State’s institutions are failing to provide adequate responses to their claims. A greater number of complaints related to child and adolescent victims are being received, which could be associated to improved functioning of the National Governing System for the Comprehensive Protection of Boys, Girls and Adolescents. But these are received four or five months after the sexual aggression takes place and there is no protocol in place for medical care in these cases. The most visible cases are those involving LGBTI persons, which go unanswered, mostly because sexual violence against these group is not acknowledged as a crime, but rather as “just punishment” given their sexual orientation or gender identity (2018, pg. 11).

# 2



FOTO: ALICIA MONCADA

## 2. INDIGENOUS WOMEN

The general absence of official data limits the enjoyment of constitutional rights and the full exercise of citizenship in Venezuela. This is even more serious when the situation of precariousness and structural discrimination of indigenous people contributes to limit the generation of data to facilitate the formulation of fact-based diagnostics to respond to the context of complex humanitarian emergency. Epidemiological data, when available, does not include an ethnic variable, which leads to the assumption that there is significant under-reporting of epidemiological information, especially in difficult-to-reach territories with little coverage by the public health system (Moncada, 2018).

In spite of the above, however, it is evident that indi-

genous people, especially women, continue to be the most marginalized sector and subjected to State apathy, which contributes to the aggravation of their precarious standard of living, characterized by the worst socioeconomic and health indicators in the country.

There are 51 indigenous peoples in Venezuela. According to the Population and Housing Census of 2000 and 2011, the largest group for 2011 were the Wayuú/Guajiro (57.1%) followed by the Warao 6.7%), Kariña (4.7%), Pemón (4.1%), Jivi/Guajibo (3.3%) Kumanagoto (2.9%) and Añú/Paraujano (2.9%). The remaining indigenous people are 16.2% while 2.1% declare themselves as indigenous without specifying a particular people.

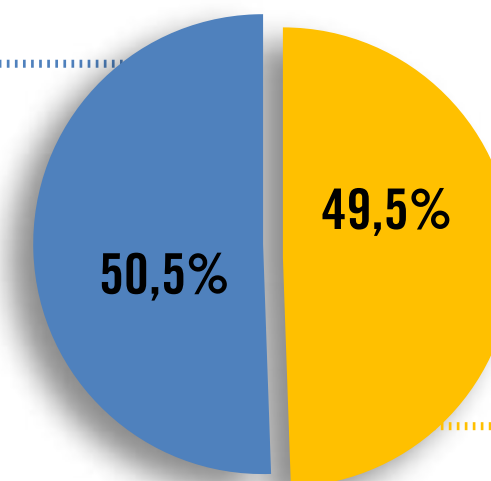
## ABORIGINAL WOMEN

Distribution of indigenous population by state

STATE	INDIGENOUS MEN	INDIGENOUS WOMEN	TOTAL POPULATION
Amazonas	38.542	37.772	76.314
Anzoátegui	17.638	16.210	33.848
Apure	5.952	5.607	11.559
Bolívar	27.755	26.931	54.686
Delta Amacuro	21.312	20.231	19.636
Monagas	9.219	8.679	17.898
Sucre	11.504	10.709	22.230
Zulia	222.067	221.477	443.544
Resto de entidades	11.587	11.401	22.988

SEX: Male

Total 359.016

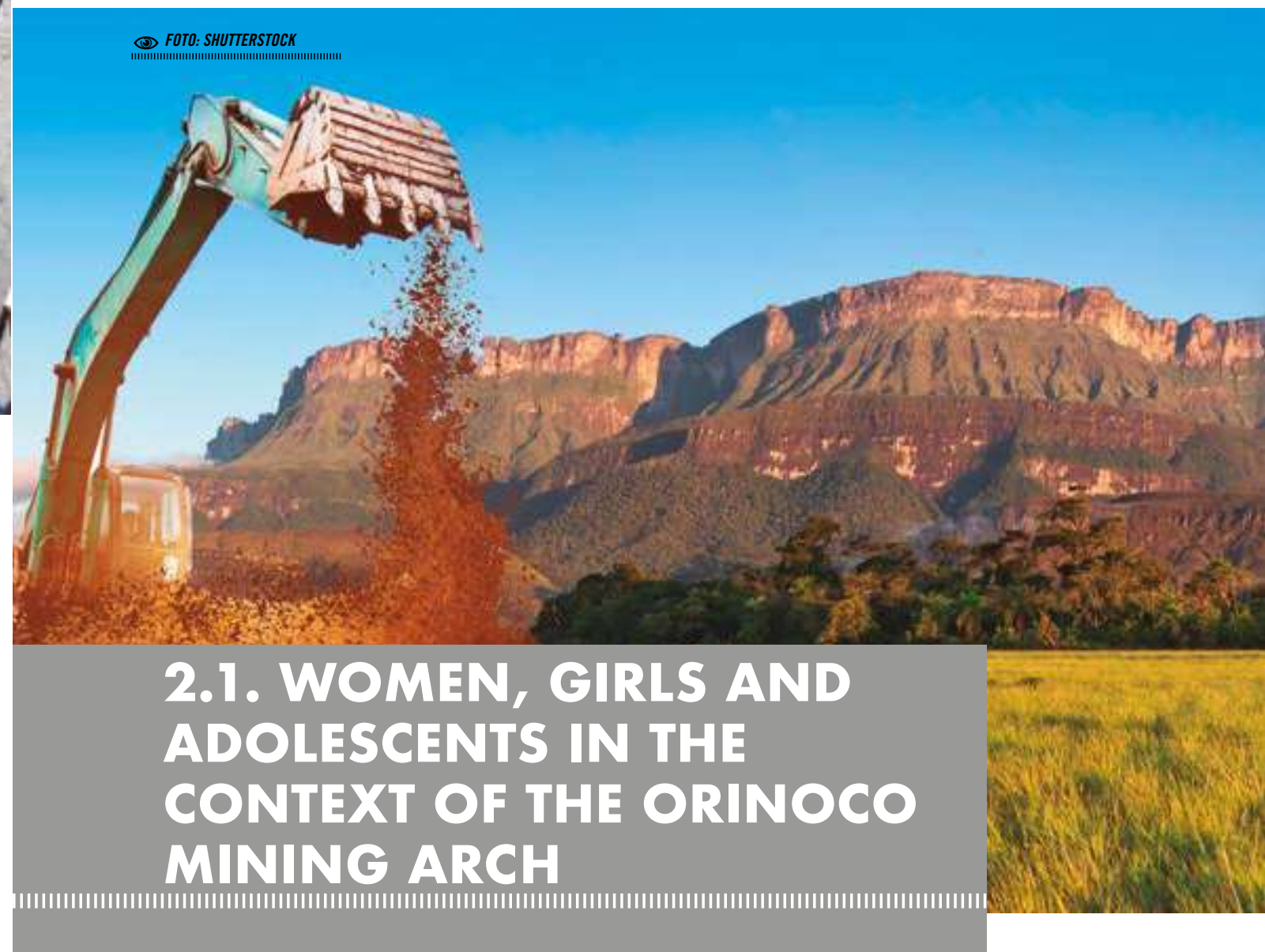


SEX: Female

Total 359.017

Source: INE, 2011





## 2.1. WOMEN, GIRLS AND ADOLESCENTS IN THE CONTEXT OF THE ORINOCO MINING ARCH

In Venezuela, indigenous women of reproductive age (15-49) are 73.4% of said population's total.

The preeminence of indigenous populations in these states paints a geographical distribution directly related to mining exploitation processes, such as the Orinoco Mining Arch and another, lesser known but equally pernicious one: the Zulia Carboniferous Arch. Conflict in these zones has been exacerbated not only by the CHE, but also by the State's macroeconomic plan which has reconfigured the exploitation of the national territory by sectioning it into the so-called Special Economic Zones (Pacheco, 2017). This, along with the implementation of the plan dubbed the "15 Economic Engines", which was formalized in 2014, has entrenched the extractivist logic in detriment of natural goods and their uncontrolled exploitation (Finance Ministry, 2016).

Globally, living standards of indigenous populations, particularly those of women, fall within certain patterns that accentuate inequalities and negatively affect indicators for mortality, formal education, and life expectancy, among others. In Venezuela, a feature of the context that covers up this reality is the accompaniment of variables associated with ethnic identity. Data in these cases is limited to reflecting the distribution of the indigenous population by geographic area, ethnicity and age groups, without providing detailed information on the status of indigenous women.

The need to include specificity on the female indigenous populations in these contexts, evidences the scope of an intersectionality perspective<sup>43</sup>, including the indigenous worldview of racialized women faced by a stereotype of universal woman in her creole/urban character. This creates a context wherein the dynamics between sex, gender, class, race and sexual orientation act as baggage upon the shoulders of indigenous girls, youths and women.

Advances in terms of legal frameworks and acknowledgement of indigenous rights, as well as the inclusion of the principles of multiculturalism, multi-ethnicity and multi-linguicism in the Constitution of the Bolivarian Republic of Venezuela have not been sufficient to effectively vindicate indigenous peoples, which has aggravated their conditions of poverty and discrimination. Even more complex is the situation of vulnerability of indigenous women, girls and adolescents who are subjected to multiple types of discrimination and violence in a global system of patriarchal relations and structures as well as the extractivist dynamics of their milieu. These girls and women have the challenge of defeating their invisibilization and the risk of the fusion of their ethnic, gender and class demands in an institutional context intended and destined toward fomenting a stereotype of "universal woman" at odds with their characteristics while, at the same time, facing the internal inequalities of the organizational structures of their own peoples.

The growing process of environmental degradation due to the launch and entrenchment of extractive projects countrywide, of which the Orinoco Mining Arch is an alarming example, are increasingly impacting, with varying degrees of intensity, upon the standards of living of the whole population, but especially in the case of indigenous communities, directly and indirectly affecting their health and conditions of their existence.

Venezuelan indigenous communities, which represent 2.7% of the population, (INE, 2011) participate intensively in the defense of their territories and in the preservation of their environment, as it is constantly besieged by multiple and complex interests. Many of the principal causes of environmental degradation are determined by deep social and economic inequities, exacerbated by gender inequalities in a context of complex humanitarian emergency.



## FACT SHEET: ORINOCO MINING ARCH PROJECT (DECREE NRO. 2248)

<b>Date of enactment</b>	The “Strategic National Development Zone Orinoco Mining Arch” was officially created on 24th February 2016. Decree 2248.	Official Gazette Nro. 40855.	In the framework of the “Law for Comprehensive Regionalization for the Socio-Productive Development of the Fatherland”.
<b>Territories encompassed</b>	11.843,70 km <sup>2</sup> .	12% of Venezuelan territory.	Equivalent in territory to countries such as Cuba or Bulgaria.
<b>Firms</b>	150 international firms.	Firms from at least 35 countries.	Includes US, Canada, Russia, China, Turkey, Italy.
<b>Minerals to exploit</b>	Bauxite, copper, coltan, iron, and of course gold.	Highly polluting substances like cyanide and mercury are used in the exploitation of these minerals.	Regardless of the scale (small, medium, or mega) the effects make “ecological mining” impossible.
<b>Government strategy</b>	Transform the national territory into a scheme of Special Economic Zone and Strategic Military Zone.	Implement the “15 economic engines” hand in hand with investors from Russia, China and other world powers through extractivist projects. The Orinoco Mining Arch belongs to the 8th Engine, the Mining Engine.	Military firms such as CAMIMPEG. A corporatist State.
<b>Territorial control</b>	Direct control through the mining “pranato” or so-called “guilds”.	Social control through assistance. A criminal logic from the State.	Intertwining of the role of the State and its security forces with the mining “pranato.”
<b>Environmental impact</b>	Orinoco, Caroní, Caura, Aro, Paraguaza, Cuyuní rivers.	Special Administration Regime Areas: Jaua-Sari-sariñama National Park; El caura Forestry Reserve; Natural Monuments: Ichún-Guanacoco, Cerro Guinima and the Sur de Bolívar Protected Zone.	The affected territory is characterized by extensive forests, mesas and cliffs and are home to thousands of species of animals and hundreds of thousands of people.
<b>Indigenous peoples involved</b>	Most affected: Warao, Pemón, Pumé, Jivi, Guajibó, Kariña, Piaroa.	Also affected Mapoyo, Eñepá, Kariña, Arawak, Akawako, Yekwana, Sanema.	Bolívar, Amazonas, Delta Amacuro, and part of Monagas are home to the largest number of aboriginal peoples in Venezuela.

Source: prepared by the authors



FOTO: SHUTTERSTOCK

At first glance the Mining Arch project stands out not only because of the extension of the territories it encompasses, but also due to the magnitude of investments and financial activities which have been increasingly featured in newscasts and other information sources over the past year. According to official information, the Orinoco Mining Arch delivered 10.5 tons of gold to the Central Bank of Venezuela (BCV) in 2018, resulting from “extraction activities of artisanal

miners partnered with the State” (El Universal, 2019). Behind these activities there is a generalized state of precariousness and indifference regarding mining populations, besieged by diseases, institutional apathy, unconscionable State repression and by a system of criminal gangs self-styled as “unions”, who impose their will by blood and fire in a sort of new para-State order, where women and girls play a crucial role.



# 2.2

## 2.2. HEALTH SITUATION

100

According to WHO, in 2017 the number of malaria-infected persons in Venezuela exceeded 400.00, representing 53% of reported cases continent-wide (PAHO, 2017). The Sifontes Municipality (Bolívar State), which concentrates part of the mining activity, is the geographical area with the greatest incidence of malaria, reporting almost half of all cases nationwide. The progressive spread of malaria has turned this disease into the major causes of mortality in indigenous communities in Bolívar State.

In 2018, the Master Plan for strengthening the response to HIV, tuberculosis and Malaria (UNAIDS, PAHO, Ministry of Popular Power for Health, 2018) registered a state of epidemic in nine states (Bolívar, Amazonas, Sucre, Monagas, Delta Amacuro, Anzoátegui, Nueva Esparta, Miranda and Zulia), with an increase in the dispersion of malaria into new municipalities and parishes as well as within already affected municipalities.

Between 1990 and 2009, maternal mortality remained relatively stable in Venezuela, at 60 deaths per 100.000 live births. There was a later increase to 70 deaths per 100.000 live births in 2015. The principal causes were hemorrhage and hypertensive disease. Of these cases, 3.17% involved indigenous mothers and 1.8% involved afro-American mothers (Amnesty International, 2018).

The Ministry of Popular Power for Health has not published figures that would allow to grasp the state of health of indigenous women, particularly sexual and reproductive health, since 2016. At that time, the

State with the greatest number of maternal deaths (107 in total, 42.67% more than the previous year) was Zulia State, home to the greatest concentration of indigenous populations in the country (61%). In Bolívar State, where the Pemón people are preeminent, maternal mortality rose by more than 60% in relation to 2015. The rise in Amazonas and Delta Amacuro states was 50%, with the principal causes being hemorrhages, pregnancy-induced hypertension and infections.

These numbers are associated with the precariousness of the public health system, which prevents access to sexual and reproductive health services by indigenous women and represents a violation of their rights.

By the same token, chemicals used in illegal mining, such as mercury and cyanide, as well as the dust from explosions have grave consequences for young women and especially for pregnant women. Organic mercury (methylmercury), which concentrates in fish in contaminated rivers, also affects pregnancies, as it passes into the fetus damaging the nervous system and brain. Chemicals in women's bodies give rise to the birth of children with serious motor, neuronal and cerebral deficiencies (Wanaaleru, 2016). Concentrations of these chemicals in women's bodies are harmful to their health and may even cause cancer. Uterine and breast cancer has been linked to high concentrations of chemicals (used and disposed of during mining operations) in the blood of women affected by extractivist megaprojects and areas where illegal mining takes place.

# 2.3

## 2.3. MILITARY AND PARA-MILITARY VIOLENCE AGAINST INDIGENOUS WOMEN

FOTO: SHUTTERSTOCK

Over the past few years, the military (that is, the components of the National Bolivarian Armed Force) has consolidated around its direct and indirect intervention in the processes of extraction, processing and commercialization of gold and other minerals exploited at all scales in the region (Pacheco, 2018). The Mining Arch Decree grants the military special powers to guarantee the full development of all mining and commercial activities in the zone, and the Law for the Exploration and Exploitation of

Gold (Official Gazette # 6.210, Extraordinary, 2015) designates mines as security zones, administered directly by the Ministry of Defense. Thus, the full militarization of the Mining Arch is evident and security forces act freely to prevent and repress any kind of protest or complaint against the project, as these are considered "(...) acts intended to hinder operations (...)" (Official Gazette # 40.855, 2016).

The militarization of the Mining Arch zone, which has also been

designated by decree as a Military Zone<sup>44</sup>, has not diminished the levels of violence and criminality in the states encompassed. Rather, the State acts through a series of interwoven relationships between the "pranato"<sup>45</sup> and security forces, constituting what some researchers have called a "mining pranato" (Romero, 2017). In Bolívar State, according to data from the Observatorio Venezolano de Violencia, a non-governmental organization, in 2017 the three municipalities with the highest rates





## 2.4. DEGRADATION OF THE LIVES OF WOMEN AND GIRLS IN THE MINING ZONES

of violent death belong to: El Callao mining zone, with 816 victims per 100,000 inhabitants; Roscio (capital Guasipati) with 306 per 100,000 inhabitants and Sifontes (capital Tumeremo) with 274 per 100,000 inhabitants. Between 2012 and 2018 alone, the nation has known of at least thirty massacres perpetrated in mining zones.<sup>46</sup>

All this happens at the time it is not known the degree of participation of new actors who have joined the narrative of violence, such as the Colombian National Liberation Army (ELN), with whom there have been clashes.

It is a widely-known fact that in contexts of general violence, gender violence against women increases considerably, bringing with it the rise in femicide, sexual violence, trafficking in persons, exploitation and other manifestations.

The Observatory of Gender Violence of Guayana reported that 28 femicides took place during the first semester of 2017, with 40% of the victims being between 13 and 21 years old. (Equivalencias en Acción, 2017).

According to Transparency Venezuela, during the first semester of 2018, 12 women were murdered in Bolívar State in the municipalities of Caroní, Heres, El Callao, and Sifontes. The most violent month was May, when five homicides of women took place, equivalent to 41% of crimes registered that month.

In 2018, violence against women increased throughout Bolívar State. According to data from the local human rights organization Comisión para los Derechos Humanos y Ciudadanía (Codehciu), between January and June a total of 14 femicides and five victims of sexual

violence were registered in Bolívar State,<sup>47</sup> as well as cases of abuse of power by State officials and even cases of frustrated femicides (Transparencia Venezuela, 2018).

Though there is no data disaggregated by ethnicity regarding gender violence and femicide, in a general context of absence of data and information, we may infer that these crimes must be occurring, given that illegal-mining milieus are highly aggressive toward creole and indigenous women. In the case of indigenous women the situation of violence is even more complex, given the little access to justice and to the tools for filing complaints. Another contributing factor is that for indigenous people, the reality of gender violence holds particular conceptions and interpretations, and there is little tradition (or possibility) of filing complaints.

Mining activity carried out in the territory have produced constant clashes between armed gangs and between these and security forces stemming from attempts to control territory. Many of these confrontations have taken place in the vicinity of indigenous communities, displacing and terrorizing the population. Recent cases of murder of indigenous in the Pemón community of San Luis de Morichal (Sifontes Municipality, Bolívar State) and in the Jivi communities (Sucre Municipality, Bolívar State), speak to State and para-State violence to which these populations are subjected. It should be noted that reports usually refer to the deaths of men only, while little reference is made to cases of intimidation and sexual abuse that, as in the case of San Luis de Morichal, have been perpetrated against women (Entrompe de Falopio, 2018).

According to the Wanaaleru Amazonian Women Organization, mining-related violence against women centers around the construction of villages wherein bars, houses of prostitution and food-vending, controlled and managed by miners themselves, are established.

These miners end up running businesses related to sexual exploitation which, in turn, lead to high rates of femicide and territorial violence (Diario de Caracas, 2016).

“In the mining zones, women are bought as objects. In the so-called “currutelas”<sup>42</sup>, sexual exploitation is an element of the extractive dynamic itself. As the miners

cannot leave the mines, they take women to them and, aside from prostituting them, they also exploit their labor, mainly in the kitchen” (Wanaaleru, 2016).

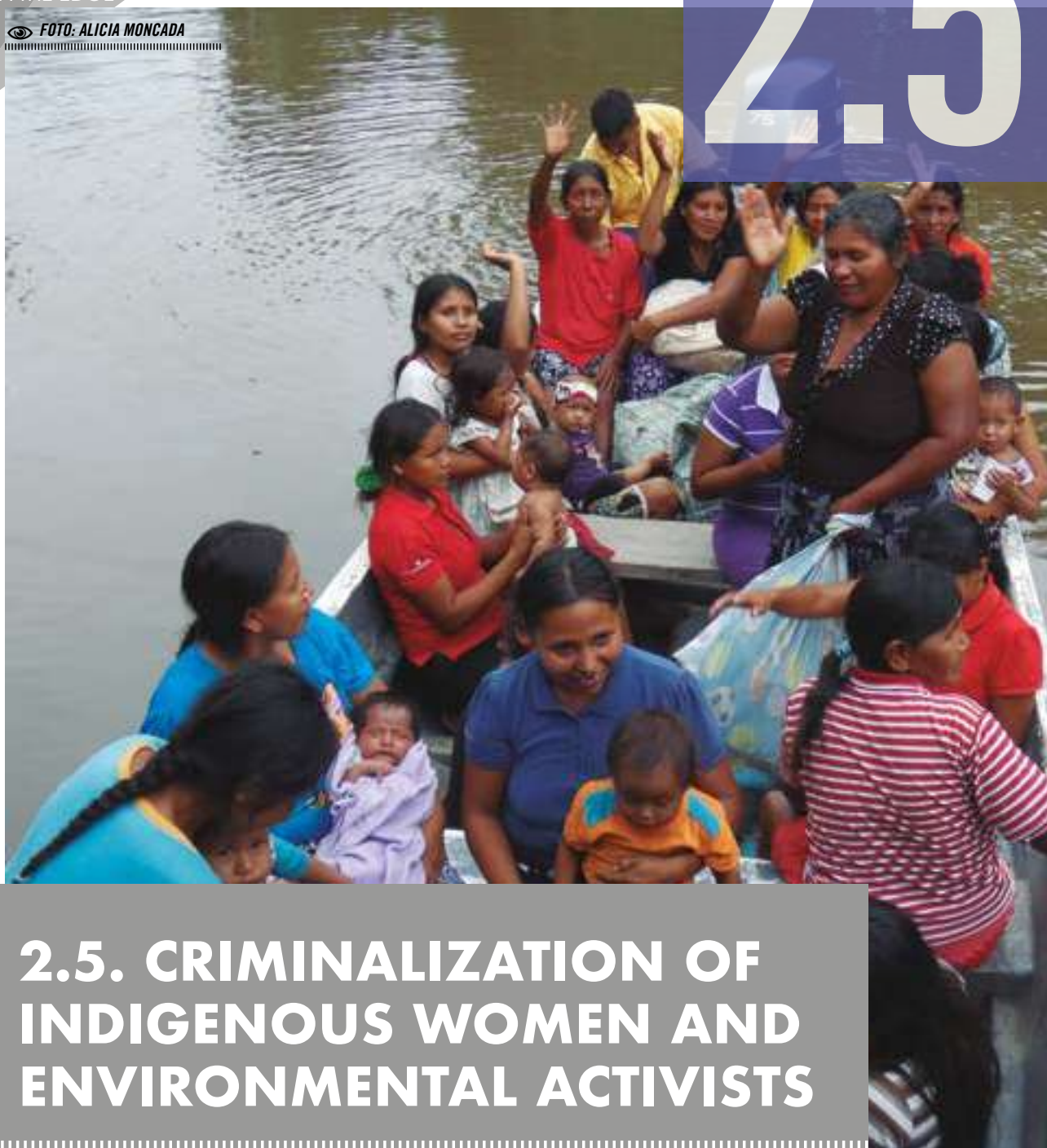
These spaces for prostitution or “currutelas” dominated by operatives in charge of bringing mining jobs, buy women like everyday items in order to generate income for the businesses. Most of the purchased women are girls and adolescents who are raped, mistreated and forced to become involved in criminal activities by soldiers, miners or armed groups. There are reports that indicate that girls and adolescents exhibited for selection, are exchanged for grams of gold (between 5 and 10), with the youngest being the most costly as, the older the woman, the less sought-after and therefore, cheaper (Licón n/d).

According to research by the Network for Activism and Research for Coexistence (REACIN), in several Bolívar State municipalities, male and female miners live in conditions of slavery, owned by criminal gangs that dominate the gold sector (Moreno Lozada, 2018). In this context, women bear the burden of the “triple shift” whereby, apart from mining, they are responsible for the care of others and domestic work, as well as community work through social participation aimed at the organization and functioning of the mine and the community formed around it. In Central America, for example, it is estimated that these women work at least three hours more than men (Heinrich Böll Foundation, 2018).



FOTO: ALICIA MONCADA

# 2.5



## 2.5. CRIMINALIZATION OF INDIGENOUS WOMEN AND ENVIRONMENTAL ACTIVISTS

According to Amnesty International, Latin America is the most dangerous region in the world for environmental activists (Malkin, 2017). At least 207 activists have lost their lives in 22 countries (almost four per week), with 2018 being the worst year on record. 60% of registered murders of activists took place in Latin American countries.<sup>43</sup>

Numerous cases were registered in Venezuela over 2018 of intimidation, harassment, and institutional omission against indigenous women leaders of their

communities, as well as aggressions that go from defamation and unfounded accusations to abduction and cruel treatment (Alba TV; Wainjirawa/Aporrea.org, 2018). Cases of indigenous women who led environmental and/or territorial conflicts were notable over 2018, yet remain invisible to the media and State institutions.

One of these cases was in the context of the resistance of the Pemón people in the territories of the Orinoco Mining Arch, which had as its leaders Luisa Henrito.

### FEMALE INDIGENOUS LEADERS ASSAULTED OR HARASSED IN 2018

Case	Date and characteristics of the assault	
Luisa Henrito 22 July 2018	Accused of "treason and secession" by a high-ranking military spokesman on state television.	Though the aggression was soundly rejected by the Pemón people, the harassment has continued and the government has not retracted the accusation.
Mary Fernández 24 November 2018	Yukpa teacher, daughter of Chief Carmen "Anita" Fernández. Kidnapped and tortured by persons linked to the cattle industry in the state.	Released on 29th November and though the denunciation has been made, there is n progress in identifying those responsible.
Chief Carmen "Anita" Fernández 23 November 2018	A Kuse Chief, her house was looted and burnt and her cattle was stolen.	The case remains unpunished and her losses have not been compensated.
Lucia Romero Throughout 2018	Her struggle for justice in the case of the murder of her husband Chief Sabino Romero and her steely denunciation has brought more death and repression to her family. During 2018 she denounced aggressions against her family and threats	The masterminds singled out by the Yukpa community have still not been processed. There are no precautionary measures for Lucia or her family.

*Source: prepared by the authors*

Mining and oil activities, which are predominant in the territories that concentrate indigenous populations, are highly masculinized activities. It is men who make decisions in most cases and there is a rigid power dynamic, institutionalized through the State's military forces, as well as through para-military for-

ces that cohabit and interact with them. Related to these activities and the CHE, is the phenomenon of forced internal migration of indigenous populations, especially women, which has been rendered invisible and insufficiently documented.

## CONCLUSIONS AND RECOMENDATIONS

When we drafted our first Women on the Edge report in 2017, the social, political and economic situation in the country was quite dire. Enough so to affirm that we were before a humanitarian emergency that affected the lives of women, girls and adolescents in a differentiated and often disproportionate manner. Today we witness the worsening of that emergency and its most evident effects: avoidable deaths of pregnant women faced with a health system incapable of responding to minimum requirements of supplies and medicines; women without contraceptive methods, for whom the only available option to control their fertility is surgical sterilization; women with increasing unwanted pregnancies without options beyond putting their lives at risk in unsafe abortions or abandoning their babies when faced with no resources to sustain them; an increase in teenage pregnancies

and poverty among women; indigenous women being subjected to exploitation and violence amidst the ruthless depredation of the Mining Arch; violence against women exacerbated by State's weakness and apathy which promotes an environment of impunity; trans women made invisible and ignored; women exchanging sex for food for themselves and their families; migrant women who leave their children behind in search of income or who cross into Colombia or Brazil to obtain adequate medical attention during delivery. These are but few of the women who the complex humanitarian emergency has pushed to the edge of their capacity to resist, in a descending spiral that damages their dignity and violates their rights.

The Venezuelan State has the responsibility of guaranteeing the human rights of the population, in-

cluding those of women, girls and adolescents. It is so enshrined in the Constitution and so it is established in various international conventions on human rights. But the State is in arrears.

Only the government, currently occupied by the de facto regime of Nicolás Maduro, is solely responsible for the current situation in Venezuela. To him we demand fulfilling the State's responsibilities. His is the responsibility for the violations of women's rights of which there are numerous examples in this report.

But we also ask other actors to subscribe and pay attention to our call to promote and respect the rights of women. Thus, we demand that any response to the humanitarian crisis in Venezuela take into account the needs and differentiated risks faced by women, girls and

adolescents. We further demand that UN agencies and other humanitarian actors deployed or to be deployed in the field, as well as national and international political actors, take into account said differentiated needs and risks by duly incorporating a gender perspective into their plans and programs aimed at attending Venezuela's complex humanitarian emergency, whether inside or outside its territory. In this context, it is paramount to prioritize relevant issues such as the specific needs in sexual and reproductive health, including those of adolescents; the provision of family-planning methods; the access to menstrual hygiene supplies; the provision of food supplements to pregnant women and their children in risk of malnutrition and due attention to

cases of sexual violence, as well as institutional responses to cases of violence against women, particularly femicide, sexual exploitation and trafficking and smuggling in persons.

The structural situation aggravated by the CHE must also be addressed. Humanitarian assistance will not solve that women have nowhere to turn when they are physically, sexually or psychologically assaulted, or when they turn to illegal abortions in unsafe conditions because of unwanted pregnancies due to the lack of contraceptive methods. Neither will it change the systemic problems that prevent Concepción Palacios Maternity from delivering the care that women and their babies need, without risk of death. It is indispensable that both plans for

a democratic transition and for the economic and social recovery of the country acknowledge women in their experiences and their rights and incorporate their demands and aspirations into decision-making processes.

The yearning to see Venezuela transit the path of development and democracy necessarily involves the full incorporation of women at all levels, while promoting and respecting their rights. Our country must reinsert itself into the world stage guided by the objectives outlined in 2030 Agenda, wherein gender equality, sustainable development and the observance of human rights are fundamental axes.

That is the Venezuela that we are committed to.



## END NOTES

<sup>1</sup><https://www.imf.org/external/datamapper/PCPIPCH@WEO/WEOWORLD/CHL/VEN>

<sup>2</sup>For a broader discussion on the effects of economic crises in the lives of women see: Women and Crisis. Responses in the Face of Recession. Editorial Nueva Sociedad, Caracas. 1990.

<sup>3</sup><https://www.cesla.com/detalle-noticias-de-venezuela.php?Id=5883>

<sup>4</sup>El Nacional. Aseguran que escasez de anticonceptivos alcanza 90% este año. 9 de diciembre 2016. Available at: [http://www.el-nacional.com/noticias/sociedad/aseguran-que-escasez-anticonceptivos-alcanza-este-ano\\_35606](http://www.el-nacional.com/noticias/sociedad/aseguran-que-escasez-anticonceptivos-alcanza-este-ano_35606)

<sup>5</sup>Abortion is decriminalized in Colombia when continuation of pregnancy represents a danger to the life or physical or mental health of the woman, when there is grave malformation of the fetus which makes extra-uterine life unviable and when the pregnancy is the result of sexual violence

<sup>6</sup>Diario Tal Cual. Cifras revelan que más de 800 venezolanas han dado a luz en Brasil desde enero de 2017. May 8th 2018. Available: <http://talcualdigital.com/index.php/2018/05/08/cifras-revelan-que-mas-de-800-venezolanas-han-dado-a-luz-en-brasil-desde-enero-de-2017/>

<sup>7</sup>Data collection in Porlamar was possible during September and October 2018 only.

<sup>8</sup>Unlike the other three hospitals, measurements at CHET was done between September and December 2018.

<sup>9</sup>According to ENDEVE figures (2010), 26% of Venezuelan women opted for surgical sterilization as a contraceptive method (data includes women with hysterectomies) Official Norm SRH (2013)

<sup>10</sup>Governorship of Bolívar, <http://www.e-bolivar.gob.ve/noticias/detalle/gestion-rangel-ha-esterilizado-mas-de-2-mil-165-damas-para-mejorar-su-calidad-de-vida>; Bolivarian Municipality of Heres, 28th June 2018, <http://www.alcaldiadeheres.gob.ve/noticias/equipo-de-salud-municipal-participa-en-el-plan-quirurgico-nacional>; Bolivarian Municipality of Caroní, 21st February 2018, [http://www.alsobocaroni.gob.ve/portal/index.php?option=com\\_content&view=article&id=2226:alcalde-tito-oviedo-inicio-segunda-fase-del-plan-quirurgico-nacional-en-caroni&catid=31&Itemid=101](http://www.alsobocaroni.gob.ve/portal/index.php?option=com_content&view=article&id=2226:alcalde-tito-oviedo-inicio-segunda-fase-del-plan-quirurgico-nacional-en-caroni&catid=31&Itemid=101); Ministry of Popular Power for Electrical Power, 11th December 2017, <http://www.corpoelec.gob.ve/noticias/jornada-de-esterilización-quirúrgica-atendió-más-de-70-mujeres>; Bolivarian Municipality of Caroní, 11th June 2016, [http://www.alsobocaroni.gob.ve/portal/index.php?option=com\\_content&view=article&id=1237:fundacion-social-caroni-beneficio-a-20-mujeres-en-jornada-quirurgica-de-esterilizacion&catid=25&Itemid=101](http://www.alsobocaroni.gob.ve/portal/index.php?option=com_content&view=article&id=1237:fundacion-social-caroni-beneficio-a-20-mujeres-en-jornada-quirurgica-de-esterilizacion&catid=25&Itemid=101).

<sup>11</sup>Carabobo Governorship, 8th April de 2018, <http://www.carabobo.gob.ve/plan-quirurgico-nacional-ha-atendido-a-mas-de-200-mujeres-en-guacara/>; Carabobo Governorship, 9th March 2018, <http://www.carabobo.gob.ve/gobernacion-activo-jornada-de-esterilizacion-en-guacara/>; Governorship of Carabobo, 22nd March 2018, <http://www.carabobo.gob.ve/mas-de-130-mujeres-han-sido-esterilizadas-en-hospital-miguel-malpica/>; Guacara Municipality, 24th February 2018, <https://www.alcaldiadeguacara.gob.ve/plan-quirurgico-nacional-llego-a-guacara/599/>; Governorship of Carabobo, 17th November 2017, <http://www.carabobo.gob.ve/este-sabado-inicia-plan-quirurgico-nacional-en-el-hospital-prince-lara/>.



<sup>12</sup>Bolivarian Governorship of Zulia, 11th October 2017, <http://saludzulia.gob.ve/noticias/gobernador-arias-da-respuestas-quirurgicas-a-mujeres-del-municipio-colon/>.

<sup>13</sup>Governorship of Guárico, 9th October 2017, [http://www.guarico.gob.ve/pagina\\_oficial/wp-content/uploads/ciudad\\_guarico/09-10-2017/09-10-2017.pdf](http://www.guarico.gob.ve/pagina_oficial/wp-content/uploads/ciudad_guarico/09-10-2017/09-10-2017.pdf); Governorship of Guárico, 29th June 2017, [http://guarico.gob.ve/pagina\\_oficial/plan-quirurgico-nacional-ha-atendido-a-mas-de-400-pacientes/](http://guarico.gob.ve/pagina_oficial/plan-quirurgico-nacional-ha-atendido-a-mas-de-400-pacientes/); Governorship of Zulia, 25th October 2016, <http://www.zulia.gob.ve/gobierno-regional-continua-desarrollando-jornadas-de-esterilizacion-femenina-en-el-hospital-central-de-maracaibo/>; Governorship of Guárico, 5th December 2016, [http://guarico.gob.ve/pagina\\_oficial/exitosa-jornada-medico-asistencial-se-llevo-a-cabo-en-el-socorro/](http://guarico.gob.ve/pagina_oficial/exitosa-jornada-medico-asistencial-se-llevo-a-cabo-en-el-socorro/); Social Security Information System, 5th September 2016, <http://www.siss.gob.ve/jornada-de-esterilizacion-masiva-en-hospital-de-cala-bozo/>; Ministry of Popular Power for Health, 9th September 2016, <http://www.sahum.gob.ve/19308-gobernacion-del-zulia-realiza-jornadas-de-esterilizacion-totalmente-gratis-en-el-sahum/>.

<sup>14</sup>San Cristóbal Central Hospital, 3 April 2017, <http://hospitalcentralsc.gob.ve:8080/index.php/author-login/jornadas>; Governorship of Táchira, 4th April 2017, <http://www.tachira.gob.ve/web/2017/04/con-exito-se-realizaron-40-esterilizaciones-en-el-hospital-central-de-san-cristobal/>.

<sup>15</sup>Governorship of Yaracuy, 9th September 2017, <https://yaracuy.gob.ve/web/noticias/more/16082-Jornada-de-Esterilizacin-benefici-a-mujeres-de-Pea>; Governorship of Yaracuy, 4th June 2017, <https://yaracuy.gob.ve/web/noticias/more/15064-Pueblo-Sano-realiz-jornada-especial-de-esterilizaciones-en-Nirgua>.

<sup>16</sup>Governorship of Trujillo, 9th April 2018, <http://www.trujillo.gob.ve/index.php/component/content/article/8-noticias/5477-gobierno-regional-retoma-plan-de-esterilizacion-quirurgica>

<sup>17</sup>Correo del Orinoco, 17th April 2018, <http://www.correodelorinoco.gob.ve/atendidas-84-mujeres-con-el-plan-quirurgico-nacional-en-la-maternidad-de-carrizal/>; Correo del Orinoco, 20th March 2018, <http://www.correodelorinoco.gob.ve/plan-quirurgico-electivo-arranca-en-la-maternidad-de-carrizal/>; Ministry of Popular Power for Health, 18th July 2017, <http://espromedbio.gob.ve/min-salud-realizo-jornada-de-esterilizacion-quirurgica-y-colocacion-de-implantes-subdermicos/>; Chacao Municipality, 15th May 2015, <http://chacao.gob.ve/?p=10970>; Autonomous Service of the Maracaibo University Hospital, 20th March 2017, <http://www.sahum.gob.ve/21474-mas-de-80-mujeres-fueron-ligadas-en-jornada-de-esterilizacion-en-la-maternidad-concepcion-palacios/>.

<sup>18</sup>Ministry of Popular Power for Health, 5th September 2017, <https://www.dirsaludbarinas.gob.ve/index.php/site/contenido/690/plan-quir%C3%BArgico-nacional-un-gesto-de-amor-en-revoluci%C3%B3n>

<sup>19</sup>El Impulso. 35 women surgically sterilized in Duaca. 26th May 2015. <http://www.elimpulso.com/noticias/regionales/en-duaca-35-mujeres-fueron-esterilizadas-quirurgicamente>.

<sup>20</sup>El Pitazo. 1st May 2018. Woman admitted at El Algodonal with intestine on the outside after bad operation in Surgical Plan. <https://www.youtube.com/watch?v=tQaBjwBacMU>; El Mundo, 2nd May 2018, <http://epmundo.com/2018/terrible-lo-que-le-hicieron-a-esta-mujer-en-el-plan-quirurgico-nacional/>.

<sup>21</sup>Bolivarian Government of Venezuela, 11th June 2017, <http://www.vicepresidencia.gob.ve/index.php/2017/06/11/mas-de-21-mil-pacientes-atendidos-por-el-plan-quirurgico-nacional/>. Regarding the use of the “Carnet de la Patria” the IACHR has expressed concern over the use of “citizen-control mechanisms to benefit from health and food services, as they are discriminatory on the basis of political opinion” (CIDH, 2017. Par. 444).

<sup>22</sup>No available data for CHET during August 2018.

<sup>23</sup>Observation at this hospital was done between September- December, 2018

<sup>24</sup>No available data for CHET during August 2018.

<sup>25</sup>Recommendations of the CEDAW Committee (2014) and the Committee on Economic and Social Rights (2015)

<sup>26</sup>No available data for CHET during August 2018.

<sup>27</sup>Translator’s Note: In reference to red leafcutter ants

<sup>28</sup>See: BuzzFeed. 28th February 2019. “This Woman Performed Her Own Abortion — And Was Lucky To Survive.” <https://www.buzzfeednews.com/article/karlazabludovsky/venezuelas-crisis-is-pushing-women-to-have-illegal-abortions>

<sup>29</sup>No available data for CHET during August 2018.

<sup>30</sup>There is no access to the figures on registered live births in order to calculate causes of maternal mortality.

<sup>31</sup>Data from the Maternidad Concepción Palacios, Maternidad del Sur and Victorino Santaella Hospital go from the 1st to the 15th of August 2018. No data available for the month of August at the CHET.

<sup>32</sup>Translator’s note: kennel trucks or “perreras” in Spanish, a type of transportation for animals. Its use for transporting persons has become popular in Venezuela over the last months due to a severe deficit in public transportation units.

<sup>33</sup>See: <http://efectococuyo.com/salud/medicos-denunciaron-agresion-a-residente-por-parte-del-director-la-maternidad-concepcion-palacios/>

<sup>34</sup>Translator’s note: “Misión Vivienda” refers to housing complexes managed by the State.

<sup>35</sup>See: <https://infovzla.net/noticias/que-abuso-mujer-denuncio-que-fue-despedida-y-desalojada-de-su-vivienda-en-fuerte-tiuna-por-reirse-de-maduro/>

<sup>36</sup>State-run Comprehensive Diagnostic Clinic.

<sup>37</sup>Tarek William Saab was designated Prosecutor-General by the National Constituent Assembly in August 2017.

<sup>38</sup>Statement by the Prosecutor-General. 10/05/2018. Portal: Con el mazo dando. <https://www.conelmazodando.com.ve/saab-ministerio-publico-no-tolerara-impunidad-en-relacion-con-los-femicidios>

<sup>39</sup>See: <http://minmujer.gob.ve/?q=minmujer/programas/casa-de-abrigo>

<sup>40</sup>Annual Report 2018: Desde nosotras. Situación de los derechos humanos de las mujeres venezolanas. En-trompe de Falopio.

<sup>41</sup>Boletín de Indicadores de Género. II Semestre 2013. N° 3. July 2014. Available in: [http://www.ine.gov.ve/documentos/Boletines\\_Electronicos/Estadisticas\\_Sociales\\_y\\_Ambientales/Indicadores\\_de\\_Genero/pdf/201407.pdf](http://www.ine.gov.ve/documentos/Boletines_Electronicos/Estadisticas_Sociales_y_Ambientales/Indicadores_de_Genero/pdf/201407.pdf)

<sup>42</sup>The TSJ inaugurated an appeal court with competence in violence against women in Carabobo State (<http://www.tsj.gob.ve/-/tsj-inauguro-corte-de-apelaciones-con-competencia-en-materia-de-delitos-de-violencia-contra-la-mujer-en-el-estado-carabobo>)

<sup>43</sup>Intersectionality is a tool for analysis, advocacy and policy-making, which addresses multiple discriminations and helps us to understand the manner in which different sets of identities influence the access to rights and opportunities (AWID, 2004).

<sup>44</sup>Telesur (2016), Maduro crea zona militar para protección de mineros en el país

<sup>45</sup>“Pranato” refers to the power wielded by “pranes”, in colloquial Venezuelan, the negative leaders who control penal institutions such as jails or prisons, and who have criminal networks whose influence extends beyond these places of reclusion.

<sup>46</sup>Correo del Caroní (2018), El Callao y Roscio fueron los municipios más violentos de Venezuela durante 2018

<sup>47</sup>Observatorio de Violencia Armada con Enfoque de Género <http://www.correodelcaroni.com/index.php/nacional/1715-en-monagas-y-bolivar-hubo-13-femicidios-entre-diciembre-y-febrero>

<sup>48</sup>Translator’s Note: from the Portuguese: Brothel/bar for garimpeiros or illegal miners.

<sup>49</sup>EFE (2018), América Latina: La región más peligrosa para ambientalistas, según expertos.



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Venezuelan women, girls and adolescents are affected differently by the complex humanitarian emergency in the country, which widens discrimination and gender gaps. In order to document and make visible what is happening with women, girls and adolescents in Venezuela, we have prepared this second release of the report “Women to the Limit: women’s rights for the worsening of the complex humanitarian emergency.”

The increase in poverty and unemployment among women, the acute shortage of contraceptives, forced migration for better opportunities abroad or the sexual exploitation to which indigenous women and girls are subjected in the Orinoco Mining Arc are just a few examples of differentiated affectation that also violates the dignity and rights of Venezuelans.

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