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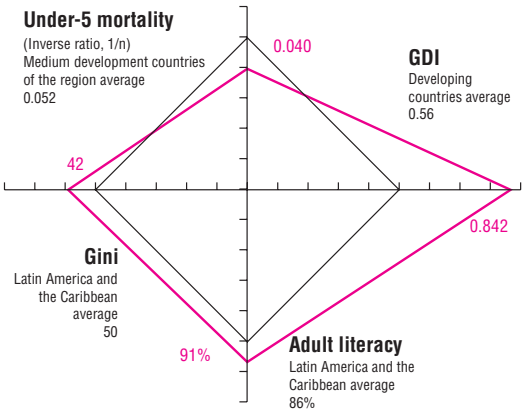

The Equity Diamond: National values in terracotta compared to regional ones in blue.

Social and gender inequity is high in Venezuela. Inequity has become more acute with structural adjustment, the shrinking of the middle class, and growing poverty.
Health policies derived from the structural adjustment programme (SAP) have been speedily implemented. By contrast, the slowness with which international agreements signed by Venezuela on the right to health are being implemented indicates an absence of political will in this field.
However, until actions, measures, laws and initiatives to correct gender disparities promoted by the National Council of Women (CONAMU) are implemented, these are mere formality.

Both governmental and non–governmental organisations (NGOs) have various programmes to fight gender disparities. These programmes are being incorporated into the National Plan for Women, which was designed with the participation of civil society. However, given the feminisation of poverty, there is cause for concern over the non–participation of NGOs in the design of economic and social adjustment policies.

TWO DIMENSIONS: HEALTH AND GENDER

STRUCTURAL ADJUSTMENT AND HEALTH POLICIES

The transition towards a market economy in Venezuela has been on the table since 1983. Venezuela signed a «Letter of Intent» with the International Monetary Fund (IMF) in 1989 that establishes guidelines for the Structural Adjustment Program (SAP). With SAP, privatisation and decentralisation became the axes of health policies. The State's responsibility was turned over to the population. People have a right to minimum assistance only in the event that they fail to satisfy their most pressing needs.

In 1989, the Office of the Attorney General of the Republic referred to the crisis in the health sector in the following terms: *«...there is in fact a crisis of assistance in the country, characterised by progressive deterioration, deficient provision of services in all areas, misappropriation of resources, inadequate management of facilities where hospital centers operate, appearance of diseases that had been eradicated previously, unsanitary conditions in these facilities, lack of management, lack of attention to staff problems, poor maintenance and scant conservation of costly medical and surgical equipment and material, a deplorable condition of the laboratories, lack of equipment and lack of preventive medicine in the country.»* (Office of the Attorney General of the Republic: En defensa del ciudadano, Caracas, 1989. Page 53).

Health indicators had fallen at the same pace as policies abandoning the preventive approach were implemented. Far from halting this fall, privatisation under SAP accelerated it. Terms such as *«socialisation», «administrative co–management», «semi– privatisation»* were used to identify a process which, from 1990, awarded hospital installations as free loans to doctors, bio–analysts, dentists, etc. who had been providing their services from the private sector.

In 1991, the President of the Republic appointed a Special Commissioner to carry out the pilot plan for *«Modern Hospital Management»* and the Hospital Restructuring Committee was established. As a first step in restructuring towards privatisation,

concessions were made to the private sector consisting of *«the transfer of administration and operation of hospitals and other public sector services to enterprises and institutions of a private nature» (Commission for restructuring hospital management: Documento Estrategia.* Caracas, 1991).

In 1989, at the start of SAP, 79.19% of the Venezuelan population lived in abject or relative poverty, a percentage that has remained almost unchanged. The figure for 1992 was 78.19%, but the numbers of people living in abject poverty had increased. Fourteen per cent of the population lived in the «fourth world», the situation qualified by UNESCO of people who are condemned never to break away from being underprivileged. Given the magnitude of poverty, the logic of SAP cannot be sustained.

The percentage of Gross Domestic Product (GDP) allocated to health in 1980 was 2.29%. Undergoing variations, it reached a ceiling of 2.63% in 1992 and fell to 1.87% in 1995. According to international parameters, 5% is considered an adequate portion of GDP to be spent on health.

1989: FROM SHARP CHANGE TO GREAT FALL

The year 1989 marks the beginning of a fall in most health indicators. With SAP, preventive and educational programmes were abandoned and basic sanitation services such as piped water and sewage collapsed.

A) Food and health indicators

Contagious diseases that were considered eradicated or under control years ago increased at an alarming rate. From 4,200 cases of malaria in 1982, there were over 21,283 cases in 38 weeks in 1997. Dengue reappeared in 1989 and in 1997, there were over 17 thousand cases by November. Two hundred seventy–five thousand cases of diarrhea were reported in 1988; in 1991, this figure had almost doubled to 494 thousand cases. In 1984 there were 2,438 cases of tuberculosis; in 1995 this doubled to 5,232 cases with 764 deaths. There have already been two outbreaks of cholera in the 1990s. The last one at the end of 1996 is still active, **with over 2,000 cases up to October 1997.**

According to 1992 records, there has been an increase in eight diseases. Some of these, such as measles – which reached epidemic proportions in 1994, could be prevented. Others, such as scabiosis (94,941 cases) or amebiasis (62,500 cases), are associated with poverty and unhygienic living conditions.

According to records kept by the National Institute of Nutrition (INN) for the period 1982–1991, most nutrition indicators fell abruptly from 1989 onwards and remained below average for the decade over subsequent years. Although definite data are not available, INN confirms that malnutrition increased in 1996 over 1995 despite efforts of social programmes in this area.

Life expectancy at birth is 71.7 years (1990–95), while the SPT/2000 aims at 70 years of age. However, in 1990, when the value was 70.1 years, there was dramatic variation among social strata, with differences of up to 12 years. Life expectancy for the richest was 70.1 years; for the poorest, it was 58 years.

B) Mother and Child Health

In August 1997, the heads of the Puericulture and Pediatrics Society noted two main problems in child health: the reappearance of severe cases of malnutrition in school children; and the increase of pathologies of the gastro–intestinal and respiratory tracts in nursing infants (Periódico Ultimas Noticias, 24.08.97, page 6). Diarrhea continued to affect mainly children and reached epidemic levels in the Federal District at the end of 1996.

The infant mortality rate rose from 22.6 per 1,000 live births (LB) in 1988 to 24.9 per 1,000 LB in 1989. According to WHO/PAHO figures, it stabilised over the 1990–95 period when it descended from 31.3 to 28.1 per 1000 LB (Pulido de Briceño, Mercedes: *Algunos indicadores generales de salud.* Revista SIC. Op.cit. page 292). According to UNICEF, the figure is as high as 33.3 (MSAS/PAHO: *Salud en Venezuela, Situación e indicadores basicos*, Caracas, 1997, Page 29). However, there are alarming variations within the average, rising to between 31.5 and 50 per 1,000 LB in the states of Amazonas, Delta Amacuro, Nueva Esparta, Zulia and Bolivar (MSAS/PAHO: *Aplicación de la Estrategia*... Op. cit. page 23.). The SPT/2000 strategy goal for the year 2000 is 30 per 1,000 LB (PAHO*: Salud para todos en el año 2000, Plan de acción para la instrumentalización de estrategias regionales*, official document No.179, Washington, 1982, page vii).

A similar situation holds for the post–neonatal mortality rate. In 1988 it fell to 8.8 but in 1989 it started rising (10.3) and reached 12 in 1992. In parishes with 90% and 100% Unsatisfied Basic Needs (UBN), the rate of infant mortality is 2.5 times higher than in groups with 10% to 0% UBN. Similarly, death due to contagious diseases is three times more frequent, and death from perinatal causes is six times higher in the most underprivileged groups. Almost all cases of neonatal tetanus are recorded in municipalities with 70% of the population having UBN. (Malaga, Hernan*: Proyecto Municipios Hacia la Salud. La experiencia venezolana*, in WHO: *Proyecto Municipios Hacia la Salud: la experiencia venezolana*. Caracas, 1996, page 15.)

The main causes of problems in the area of reproductive health, as identified by the Ministry of Health, are the increase in poverty, the high percentage of pregnancies in women under 20 years of age, and lack of assistance from the public sector.

C) Environmental conditions

Adequate environmental conditions are essential to physical and mental health. These include access to drinking water, sewerage and waste disposal. In 1988, an estimated 25% of the population lacked drinking water, over 50% did not have sewerage and over 60% were without garbage collection (Marcano, Esther: *El Problema de los servicios*, in Revista Sic, N: 498, Caracas, Sep-

tember–October 1987). After 1989 the problem became more acute as most of the public services collapsed. This deterioration is reflected in the figures provided by the Central Office for Statistics and Computer Science (OCEI): **by 1991, 43% of the population lacked drinking water and 50% of families were without sewerage**.

Beyond national averages, in some social groups these services are practically non–existent. As is well–known, cholera is associated with poor environmental conditions. The outbreak of cholera in 1991 had 30.4 times more impact on indigenous groups than on the rest of the population. Thirty–five per cent of all cases were recorded among the indigenous population, which represents 1.55% of the total population of the country. The Wayuz and Warao ethnic groups were the most affected.

ABANDONMENT OF THE PREVENTIVE APPROACH

Between the launching of SAP and 1993, the cost of medicine rose by an average of 1,923.22%. Presently the Medicine Bill is under discussion in the senate. It has been the subject of argument for some time now, mainly due to disagreements from the private sector. The discussion is centered on aspects related to price regulation, guarantees concerning medicine accessibility and the production of generic products.

Most outpatient centers lack essential medicines, making access by the population even more difficult. Furthermore, the basic (type I) outpatient network in the country is inadequate, although it is the first link in the health chain and constitutes the main nucleus for primary health care. According to national planners, there should be a type I outpatient center for every 20 thousand inhabitants. Thus, for example, in the state of Amazonas, in zones where access to these centers is by river, the only hospital may be six hours away by river. The cost of an air ticket to hospital (45 minutes flight) is the equivalent of 30% of minimum wage. This example illustrates the inequity of the distribution of outpatient centers that, according to official figures (3,797 in 1992), should be sufficient.

General coverage for medical care in the event of illness has also been reduced since the application of SAP. In 1963, there were 3.03 hospital beds per one thousand inhabitants. This figure had fallen to 2.5 in 1991 when, according to WHO, countries such as Venezuela required 5 beds per one thousand inhabitants.

PRINCIPLES GOVERNING THE RIGHT TO HEALTH

The SAP has widened existing social gaps, particularly affecting the more vulnerable sectors. The Ministry of Health itself considers that, in spite of existing facilities, 30% of the population does not have access to health care for geographical, cultural or economic reasons (MSAS/WHO: Salud en Venezuela. *Situación e Indicadores Básicos.* Caracas, 1997, page 24).

Data and indicators show that the right to health has not undergone progressive development. Furthermore, the principle of free health services, guaranteed by national law, is violated by privatisation, which requires users to pay fees.

The principles of universality and non–discrimination have also been violated by SAP. Structural discrimination based on the failure to provide adequate health coverage for vulnerable groups (indigenous and peasant populations, persons in a situation of poverty, old people, etc.) has widened. Part of this structural discrimination is the lack of regulation of private centres and the failure to sanction those that deny emergency services to persons requiring them.

Adjustment policies, far from alleviating the impact of economic development on low income people, have accelerated the deterioration of living conditions in general and the enjoyment of health rights in particular. The basic principles of health rights have been seriously violated, including those of equity.

Venezuela has not honoured its commitments to ensure health rights. These rights are increasingly inaccessible to the majority of people. This reflects the contradiction between health needs and the profit–driven approach of SAP that marks health policies.

GENDER EQUITY

According to the Constitution, gender discrimination is forbidden in Venezuela. However, the actual situation –determined by the dominant culture– is different. This culture assigns to women of every social class a subordinate identity, manifest in various ways and in particular in their access to power and decision–making.

We do not have up–to–date information on the participation of women in the world of business. However, a study carried out in 1988 showed that in 599 private Venezuelan firms, women occupied 18.2% of the managerial posts.

The trade union sector is also difficult for women, and their participation in decision–making is extremely limited. For example, there are only two women on the Executive Committee of the Venezuelan Workers Union (CTV) and only one women managing one of the regional federations.

In the educational sector, where women predominate, most of the leaders are men. Venezuelan women participate widely in civil society organisations, especially in grassroots organisations. However, as in other fora, their participation in decision–making is not in keeping with their overall presence.

There exist a considerable number of women's organisations, feminist or not, that work steadily for women's rights. Most work with very little or no funding (state and/or external). In addition to their contribution of voluntary or insufficiently remunerated labour, women who belong to these organisation make monetary and in–kind contributions towards their operation.

The Non–Governmental Women's Organisations' Coordination (CONG) was created in 1985 to articulate and enhance the efforts of grassroots organisations. The CONG was created by grassroots non–governmental organisations to clearly express their autonomy of action and reaction to government policies.

The participation of women in political parties is important, but it is mainly at the base of the pyramid. The further up the

structure and the closer to decision–making, the fewer women there are.

TABLE 1.

Representation of Women in the Chamber of Deputies		
Year	Men	Women
1983	94.0%	6.0%
1988	90.5%	9.5%
1993	93.4%	6.6%

Source: Supreme Electoral Court, 1994.

TABLE 2.

Representation of Women in the Senate		
Year	Men	Women
1983	100.0%	0.0%
1988	91.8%	8.2%
1993	93.8%	6.2%

Source: Supreme Electoral Court, 1994.

CUADRO 3.

Representation of Women in the Legisletive Assemblies		
Year	Men	Women
1983	92.2%	7.8%
1988	88.8%	11.2%
1993	87.4%	12.6%

Source: Supreme Electoral Court, 1994.

Formally, decisions have been taken on some mechanisms of positive discrimination to increase the role of women in political parties and the State. Three political parties have taken such decisions: the Movement towards Socialism (MAS), Democratic Action (AD), and more recently the Christian Social Party (Copei). However, women leaders in political parties are becoming aware of the need for action to make the participation quotas a reality, and to elect women candidates to office.

With regard to the State, CONAMU, with the support of the Congress of the Republic's Bicameral Commission on Women's Rights, the Center for Women's Studies at the Central University of Venezuela and non–governmental women's organisations, introduced a bill in congress supporting equal participation by men and women in political power. The bill, which is backed by over 20,000 signatures, should be considered during the debate on voting law reform.

In July 1997, there was a debate on the matter in the Chamber of Deputies, but the proposal introduced by women was not considered. In a first debate, agreement on a quota of only 30% women was achieved, without considering their position on the lists of candidates. Since the Venezuelan system entails a single–nomination election by lists, affirmative action would only reach those who were nominated on the lists, further reducing women's real possibilities. The bill still has to be discussed by the Senate and the Chamber in full.

INEQUITY IN THE LABOUR MARKET

Of the total employed in 1990, 19.8% were in the public sector and 80.3% in the private sector. In 1996, 17.1% of workers were in the public sector and 82.9% were in the private sector (see table attached).

For the period 1990–96, people aged 15 and over in the labour–force were occupied in activities referred to as «communal, social and personal services», «commerce», «manufacturing industry» and «agriculture, hunting and fishing» (in that order). However, on examination, the latter activity actually ranks third.

Labour–force indicators offered by OCEI show that unemployment has increased in absolute terms. From 751,052 people in 1990, it reached 1,122,119 people in 1996. The same source shows that the rate of redundancy rose from 9.3% in 1990 to 9.8% in 1996.

On the basis of the general labour–force indicators by sex provided by the OCEI Household Survey for the Second Semester/89–Second Semester/96, the following should be noted: the labour–force grew by 30.7% (23.4% men and 47.5% women); employment rose by 27.8% (23.9% men and 36.4% women); redundancy rose by 38.3% (10.1% men and 126.0% women); the rate of persons aged 15 or more seeking work for the first time increased by 199.1% (men 128.9% and women 262.4%).

The same household survey showed other points of relevance:

First, 57% of employed people have basic education (nine grades of study) with men predominating; 19.8% have completed secondary education and here, too, men predominate. However, among those with higher education (12.5% in 1989 and 16.5% in 1996), there was a slight predomination of women at the end of the period (see table attached).

Secondly, in the public sector, women predominated in the Second Half of 1996, in contrast with the situation in 1989. This may be because women tend to seek employment in the service sector, because of the low wages paid in the public sector (not always attractive to men), and/or because of the process of streamlining the State.

Thirdly, concerning occupational groups, it should be noted that more women are to be found than men in the professional and technical group. This does not occur in the managerial and administrative group, however. In the Second Half of 1989, there were 40,563 manager–administrators, in the Second Half of 1996 there were 75,100.

A brief comment should be made concerning the farm–workers group. The presence of women in this group is insignificant (see tables attached). However, there is an important discussion going on among those in charge of preparing national statistics concerning the invisibility of women's work in this sector.

There are salary differences between men and women in Venezuela. Thus, according to data provided by OCEI and the

Central Bank of Venezuela, it is estimated that women earn 25% less than men for the same job. This difference is higher in some regions of the country, such as the Zulian region (42.7%), the Central region (38.6%) and the Capital region (26.9%).

INFORMAL WORK INCREASES

An analysis of the Venezuelan labour market based on data provided by OCEI, shows that, out of the total of employed workers, 41.8% were in the informal sector in 1990. By the second half of 1996, this figure had risen to 48.6% (see table attached).

During the entire period under consideration, workers in the informal sector were likely to be found in the sub–sector of «non–professional self–employed and workers in enterprises having four or less workers.» Thus, in an increasing trend, by 1996, 30.5% of the employed population appears to be self–employed and 16.1% worked in enterprises with four or less workers (See table attached).

The Domestic Workers sub–sector showed a declining trend, falling from 3.4% in 1990 to 2.0% in 1996. Since domestic workers were not considered as self–employed, we suppose that an important portion of workers in this sub–sector work on a daily basis (see table attached).

The panel on «Women, Economy and Labour», which met during the Second Consultation Workshop for the Formulation of a National Plan for Venezuelan Women, made several clarifications on equity:

- **the lack of legal protection and sexual harassment makes many women leave their jobs;**
- **statistics are insufficient to know the magnitude of professional and job–related diseases suffered by women workers at all levels;**
- **labour laws and existing instruments for women's protection are scantly respected in Venezuela.**

The Ministry of Labour recently shut down the office responsible for women workers, despite the many violations regarding maternity, requisites for pregnancy tests, certificates of sterilisation, etc., that should be penalised under Title VI of the Organic Labour Law.

EDUCATING FOR EQUITY

During the current decade, the Venezuelan public education system has undergone gradual deterioration. Such deterioration affects the poorest in particular (men and women). The World Bank (1994) noted that *«…[i]n 1991, both men and women in the 10% poorest households had a little over half the education received by their peers in households that are not poor. There is also a gap between the levels of education of rural and urban households: in rural zones, both men and women had received an average of nearly half the education received by urban men and women. Although less than 20% of the Venezuelan population live in rural zones, apparently the country has had scant success in increasing the level of education in rural zones, especially those of low income groups.»* (Castillo, 1996, page 75).

However, equitable access of men and women to education at all levels is one of the major achievements of Venezuelan women. This fact is recorded with great precision by María Auxiliadora Banchs. Recent studies of Venezuelan women in the educational system agree that a major achievement of the second half of this century has been the massive incorporation of women into all the levels of formal education.

Freites, Castillo and Jiménez synthesise this achievement very clearly: *«one of the most important revolutions that has taken place in the field of education, is the incorporation of women in all areas of education. Until 1950, women (in general) did not continue studying after primary school. The percentage of female illiteracy continues to be higher than that of men (8.87% for women and 8.3% for men). Women have overcome obstacles and are in forefront positions regarding higher education. According to OCEI data, in 1990, over 53% of the graduates from the higher education system were female.»* (Banchs: 199, p.19).

However, given the deep crisis of public education in the country and its loss of quality, there has been a high rate of school dropout in the past few years. We do not have reliable figures on this subject and do not know the comparative percentages between boys and girls. Obtaining a university degree does not ensure obtaining a decent job. Furthermore, *«…in practice we find that graduates from private secondary schools enter university more easily»* (Olivo: 1997).

The National Women's Council and the Ministry of Education, with the support of UNICEF, have been working on a proposal to remove sexism from textbooks, and on a project concerning «educating for equality.» Revision of school textbooks has progressed, not so the project. At a recent consultation for the preparation of a National Plan for Women, one of the agreements concerned the promotion of such a programme. Pregnant adolescents are allowed to continue their schooling under Decree No. 1762 passed 9 October 1996 by the national executive and published in Official Gazette No. 296526 of 11 October 1996.

FEMALE HOUSEHOLD HEADS

As a consequence of the economic crisis the country has undergone since the early eighties and the economic adjustment programme, the living conditions of most Venezuelan families have deteriorated. Added to this is the increase in regressive distribution of income and the concomitant increase in poverty.

National and international organisations studying poverty point out that this is the most important and acute problem existing in Venezuela today. Following the «poverty line» method, over two–thirds of households (65.8%) were poor in 1991, and this figure reached 66.2% in the first half of 1993, with abject poverty at 30.3% (Women, Economy and Labor Commission/CONAMU: 1997).

According to official figures, in 1995, 36.5% of the population lived in abject poverty; 32.1% of the urban population and 57.3% of the rural population were poor (OCEI: 1995).

Regarding households headed by women in the work force, we find that *«...according to official figures, for the second half of 1994, there was a total record of 1,179,025 single–parent households, of which 30.1% were headed by men, while the remaining (69.9%) were headed by women. During the first semester of 1995, the total number of single–parent households fell slightly, to 1,174,486. This decrease corresponded to households headed by men (28.2%), while households headed by women rose to 71.8%»* (Women, Economy Commission: 1997).

By the second half of 1995, the total number of households was 4,037,000 and of this total, 1,211,426 were recorded as being incomplete, that is to say households having only the mother or the father. Of this total, 71.0% were headed by women, which in relation to the total number of households in the country, means nearly 22%. (OCEI: 1995).

- PROVEA is a Human Rights NGO who prepares an annual report on the national situation.
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