

The Right to Health in Venezuela

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I. GENERAL CONSIDERATIONS

1. Currently, the Venezuelan State **offers no assurance of minimum guarantee of health care in medical centers**. Public hospitals, which represent approximately 90% of all care centers, sum up 70% of the beds, and constitute the only accessible service to more than 60% of the population. **There is a broad and marked deterioration of the services, which impedes their proper functioning according to minimum standards of adequate and timely care.**
2. **Private hospitals**, which represent less than 10% of all care centers, sum up 6% of the beds. Not having found minimum guarantee of health in the public service, most of the population has turned to the private sector, even state employees and officials, who are covered under health services paid for by public funds. Neither public nor private care centers guarantee a quality service since they are both being severely affected by a shortage of supplies and medicines; having devastating consequences in public health.
3. The deteriorating state of public health is the result of stringent conditions, both multiple and combined, to which health centers have been subjected for a long number of years, associated with a permanent and systematic failure of national authorities regarding their obligations to conduct and ensure the right to health, in compliance with Articles 83, 84, 85 and 86 of the Venezuelan Constitution. The deterioration of public health has exacerbated health inequities, shifting costs of this deterioration to people with fewer resources.
4. At the same time, the State has contributed to the undermining of the governance, management and funding of national and regional public institutions, whose responsibilities are concurrent with the right to health, by taking measures of broad discretionary power over the direction of policies and resources that have distracted enormous efforts to parallel structures, many of which are now isolated and under extensive restrictions. This, in turn, has reduced the capacity of these formal institutions to conduct health policies and manage services, solve their deficiencies and effectively cope with health problems that are urging for the population.
5. To further worsen the situation, economic and internal order policies are generating a crisis of widespread shortages of imported supplies and medicines, which has been extended in time and has caused an alarming and growing suspension or closure of services in health centers, mainly in public ones. Consequently, people with health needs are presently having serious difficulties in getting care and essential medicines, and human lives are being lost. This compromises the responsibility of the State with its obligations to protect the physical integrity and life of everyone in Venezuela, to prevent and stop any imminent risk to people's health. Today, many people are dying at home, not due to diseases, but because health services are unable to assist them.

II. OMISSION OF MEASURES

Organic Healthcare Law

6. The Constitution of the Bolivarian Republic of Venezuela (CBRV), in article 83, recognizes health as a fundamental social right and establishes the state's **obligation to its guarantee to everyone, without distinction, as part of the right to life**. This is a remarkable change from its previous formulation in the 1961 Constitution (art. 76) when the State was only required to provide the means for prevention and assistance to those who lacked them.

7. After 15 years, an Organic Healthcare Law that complies with the norms set forth in the constitution has not yet been enacted. In absence of such legal instrument, according to a ruling from the Supreme Court from 2012 in response to an appeal on legislative omission¹, the Organic Healthcare Law from 1998, framed within the 1961 Constitution, is in effect. This violates principles established in the 1999 Constitution, and would allow, for instance, to charge for services rendered in the public health sector by "scales of cost recovery".

National Public Health System

8. The CBRV establishes in articles 84 and 85, the State's obligation to create a National Public Health System (NPHS) decentralized, participatory, and duly integrated into the social security system (including funding sources) and governed by principles of gratuity, universality, integrity and equity, among others, prohibiting its privatization.

9. **Public Health** is under the responsibility of the Ministry of Health, covering 230 hospitals, 245 ambulatory health centers II and III, 4,597 ambulatory health centers I and rural. The Social **Security System** has centers of Social Welfare Institutions, which sum up to 17 hospitals and 77 ambulatory health centers, and those belonging to the Venezuelan Institute of Social Security (IVSS in Spanish), under the Ministry of Labor, consisting of 35 hospitals, 57 ambulatory health centers, and pharmacies, which distribute expensive drugs. The number and geographical extension covered by these services is much higher than that of the private sector.

10. **Decentralization of health services** started in the 90's, sometime after political decentralization had initiated with the direct and popular election of mayors and governors. Almost 80% of hospitals and ambulatory health centers that were under the administration of the Ministry of Health were decentralized and transferred to 17 out of 24 regional governments through the creation of new laws and conventions. However, this decentralization was only administrative rather than financial; consequently, it is the Ministry of Health the entity responsible for annually transferring required funds.

¹ Appeal presented before the Supreme Court in 2010, declared inadmissible in 2012, brought by the NGO's Provea, AcSol, Accsi and Fundación Reflejos de Venezuela.

11. The constitution provides for the creation of the National Public Health System in order to solve the fragmentation of services within the public sector and to consolidate the decentralized administration under the supervision of the Ministry of Health, with the sole purpose of overcoming inequity in availability, access, coverage and quality of health care. However, **the State has failed at creating a NPHS. Services still miss a common political framework and legislation, and are still fragmented in terms of funding, regulations, functioning and territory.**

III. EXECUTIVES ACTIONS

Funding of Public Health

12. The CBRV establishes in article 85 the State's obligation to ensure a budget that meets the objectives of health care. Nonetheless, having received the highest amounts of income from oil revenues in the last decade, **Venezuela keeps one of the lowest public expenditures on health**, in comparison to the efforts made by other states in Latin America. In Venezuela the investment on health represented 4.5% of the GNP in 2011, while in Bolivia was 5%, Argentina 7, 9%, Uruguay 8, 6%, Brazil 8, 9%, Cuba 10% and Costa Rica 10, 2%².

13. The public **financing in health has not improved affordability to goods and services. Public transfers** in goods and services do not exceed 40% of health expenditures of Venezuelan households³, and budgets allocated to public health are below 50% of total health expenditure. Additionally, they are highly deficient; they arrive late to health centers and depend on 50% of extra credits, subjected to the availability of foreign currency.

5

Centralization and public funding of private medicine

14. Regressively and contrary to the CBRV, the executive branch implemented a **policy of re-centralization of health services**. In 2008 several executive orders were issued via Enabling Act, to revert the transfer of services previously given to the Metropolitan District of Caracas and Miranda state, thus preventing their authorities from managing public hospitals and ambulatory health centers in their jurisdiction. Subsequently, through administrative measures, most hospitals became run by the Ministry of Health.

15. Furthermore, the Executive intervened private insurance companies which provided medical insurance to public entities, as part of existing collective benefits for public employees prior to the CBRV. With these resources self-administered funds were created, as well as an **Interinstitutional Health Alliance (IHA)**, which currently gathers 45 public bodies. This IHA established an agreement with private clinics for a health insurance plan for 8 million public employees and their families, which is charged to these funds that represent 20% of public health expenditures. This decision makes it

² WHO. World Health Statistics, 2014.

³ Figures from Central Bank of Venezuela (CBV). The percentage of public expenditure in health of total expenditure was 36,6% in 2011, according to data reported by WHO published in World Health Statistics 2014. It is also the lowest in comparison with some of its peers in Latin America such as Brazil (45, 7%), Chile (48, 4%), Peru (56, 0%), Argentina (66, 5%), Uruguay (69, 5%), Costa Rica (75, 2%), Colombia (75, 2%) and Cuba (94, 7%).

impossible to move towards a National Public Health System and it is detrimental to the financing of public health and social security.

Parallel System Misión Barrio Adentro

16. Since 2005, the Executive branch has **set aside and discretionally managed extra revenues** from oil exports. In the health sector, these incomes are used to **finance a parallel structure that includes Misión Barrio Adentro (MBA)**, as part of the cooperation agreement with The Republic of Cuba. Between 2003 and 2012, the state-owned company **Petróleos de Venezuela (PDVSA) invested in different plans of MBA a total of 18,531 million dollars**, equivalent to **10 years of public health budget**.

17. **MBA began in 2003, outside the Ministry of Health.** To staff the program, 14,345 community doctors from Cuba were taken to settlements in popular urban areas of the country. In 2004, the Executive branch decided to classify **MBA as a system, parallel to the public health system and social security**. The Ministry of Health should have carried out a first census of Cuban doctors a year after their arrival and should have coordinated a construction plan of medical offices with financial support from PDVSA. These commitments have been partially completed, but with significant deficiencies in infrastructure. MBA has always worked under **the direction and coordination** of the Cuban Medical Mission (**CMM**), with total **secrecy, and it was never integrated into the health system**. In 2009, President Hugo Chávez declared a **national emergency** after finding out that of **4,298 medical units that had been built, 2,149 (50%) were abandoned and 1,199 had reduced their activities to half time**.

18. With the **CMM**, in 2005, the Executive branch opened a National Training Program in Integral Community Medicine (ICM) with Cuban professors and a curriculum from the Latin American School of Medicine (ELAM). None of the medical schools in autonomous and experimental universities in Venezuela was consulted. In 2011, 8,000 Integral Community Doctors graduated and were enrolled in rotating internships during which their performance was evaluated. Evaluations showed wide competence deficiencies that were duly documented⁴. In spite of these results, the Ministry of Health authorized the entry of Integral Community Doctors to postgraduate studies in Medicine; many of them have abandoned their studies since they lack a complete basic medical training.

19. The second program was **Misión Barrio Adentro II**. It began in 2005, in order to build and equip **600 Integral Diagnostics Centers (CDI in Spanish), 600 Integral Rehabilitation Rooms (SRI in Spanish) and 30 High Technology Centers (CAT in Spanish)**. In 2012, the General Comptroller Office (CGR in Spanish) determined the paralysis of 1.235 works at the CDI between 2005 and 2009, due to a late delivery of resources and internal control failures in allocations and supervision. Until 2013, 561 CDI, 583 SRI y 35 CAT had been finished. In 2014, workers from CDI in Táchira, Zulia and Vargas states alleged abandonment of centers, an advanced estate of deterioration of the infrastructure, shortage of

⁴ Among these deficiencies are: difficulties in writing and performing medical records, manage medical terminology, perform a physical exam, interpret lab test results, electrocardiograms, chest radiographs, and prescribe treatments. A second evaluation with information provided by 10 specialists from 5 hospitals in the Capital District and Miranda state revealed that, in terms of performance, IMD lacked essential competencies to perform unsupervised medical records, to diagnose, to make a work plan and give out indications in the outpatient consult independently, or to indicate acceptable treatments in case of hospitalization.

personnel, medical supplies, sheets and toilet paper, air conditioning, as well as low wages and harassment for demanding and defending their labor rights.

20. The third program was **Misión Barrio Adentro III**, created to allocate resources for remodeling and re-furbishing **public hospitals**. In 2007, several works were initiated in 62 hospitals which forced the closure of rooms, postgraduate programs, emergency rooms and operating rooms for up to six years. Until 2010, 77% of the work had not been completed. In 2008, members of the ruling party presented before the National Assembly a report of irregularities in 10 hospitals. In 2013, in 32 contracts for 8 hospitals, the CGR found an absence of planning tools, unsupervised, uninspected and non-evaluated works; others were initiated without having a signed contract; some unfinished works were given certification as terminated and delivered; expenses with insufficient guarantees, there was no budget availability or ensuring of fair and reasonable prices.

21. The fourth program began in 2010 as **Misión Barrio Adentro IV**, aimed at the construction of **6 specialized hospitals in 5 states**. In 2012, engineers and architects consigned before the CGR allegations of double financing, breach of tender rules, and modification of projects after advanced works -two had been moved from their location. In 2011, the Permanent Commission of Finance and Economic Development of the National Assembly informed that none of the projects had advanced more than 15% in their physical implementation. In 2013, President Nicolás Maduro ordered an inspection in all construction sites, which confirmed that **all of them were paralyzed**.

International conventions on imports

22. Extraordinary funds managed by the Executive branch also went to **deepening a policy of imports** of supplies and medicine. Since 2005, there was an increase from **23 to 77 in the number of contracts** for the purchase of medicines, vaccines, reagents, and equipment from the Republic of Cuba; and medical-surgical supplies and diagnostic equipment from the Republic of China.

23. In 2013, the **CGR found irregularities committed by Cuban and Venezuelan officials from 2005 to 2013**, in contracts and activities of import, storage and distribution of medicine and medical-surgical supplies from Cuba destined to the CDI. Some of these irregularities included: unnecessary requirements, lack of compliance with delivery schedules and set amounts, double acquisition, delays in deliveries and nationalization at custom offices and weaknesses in storage and distribution, which resulted in the expiration of products and their inability for use.

Regulation of prices and private sector imports

24. Since 2010, the Executive branch implemented a **rigid policy of price regulation to private sector companies**, which also included the health sector. In 2013, Administrative Providence N° 294 was issued; it established a pricing scheme to 20 medical services and 28 diagnostic procedures on all private services⁵.

⁵ Clinics, scientific societies, academics, bioanalysts, laboratories and chambers said the measure was not enforceable and asked for it to be postponed until adjustments to actual prices were done. The Venezuelan Association of Hospitals and Clinics (VAHC) warned that the measure would lower the quality of service in hemodynamic, catheterization, intensive care, lab tests and pathology.

25. Furthermore, within the context of **control policies to access currency exchange**, the State decreased allocations and effective settlements to import medicines, equipment, and medical-surgical and lab supplies, leading to accumulation of debts with foreign suppliers which, in the case of those affiliated to the Venezuelan Association of Medical and Dental Equipment Distributors (AVEDEM in Spanish), now total 265 million dollars⁶, and to the closure credit lines. There are also applications pending for approval of settlements in foreign exchange for 152 million⁷.

IV. HEALTH SERVICES

Infrastructure

26. One of the flaws that affect public health centers is the **deterioration of infrastructure** (leaks in walls and roofs, flooding, broken sewage, water shortages and power outages). These flaws reduce space, produce overcrowding and contamination. In 2013, the President described the situation of public hospitals as deplorable and being *“an embarrassment to the revolution”*, after finding about their deterioration.

27. Besides all the infrastructure problems, it must be added that most hospitals do not have any policies or protocols for handling potential infectious waste and there is little investment in facilities equipment and materials for proper disposal of solid waste. Incinerators are not working, are damaged or working in irregular conditions; there are no controllers for atmospheric pollutants.

28. Between 2009 and 2013, **the number of operating beds in public hospitals was drastically reduced** from 30.964 to 21.770. Most hospitals had a 50% decreased in operating beds⁸. According to the Pan-American Health Organization (PAHO), **the rate of beds in Venezuela dropped from 1.3 x 1,000 between 2005 and 2008, to 0.9 x 1,000 in 2009-2011; being the recommended standard 3 beds x 1,000**. In 2012, the Ministry of Health reported that having reduced the number of emergency beds between 2011 and 2012 had meant neglecting service for 1,125,610 people.

Health Personnel

29. In addition to inadequate infrastructure, **insufficient health personnel** is one of the main problems of public health, and it is the most common reason for closing outpatient consults and elective surgery in healthcare centers. Because of the multiple constraints to adequately perform medical practice, the permanent violation of labor rights, hostility and insecurity in the workplace, **hospitals and public ambulatory health centers have lost 6,700 doctors and physicians**, according to statistics from the Venezuelan Doctors Association (Federación Médica Venezolana-FMV), equivalent to **24% of available professional personnel**. To this, it must be added a **30% less of training of resident**

⁶US \$ 180 Million correspond to debts of imports before 09.30.2013, US \$ 16 million debt correspond to imports from the last quarter of 2013, US \$ 8 million correspond to imports related to arrivals without closing and US \$ 61 million related to imports from 2014.

⁷ Among the procedures established are: Authorization for Settlement of Currency (ALD in Spanish) and Certificates of No National Production, of which there were 209 pending applications until the last quarter of 2014 and others that could not be processed because the site was closed.

⁸ Report of the Venezuelan Medical Scientific Society Network. 2013.

physicians, reaching as high as 90% in specialties such as anesthesiology⁹. In addition, there is a **shortage of nurses that has been calculated by unions at 60%** and, in recent years, laboratory personnel has also been reduced.

Medical-Surgical Supplies

30. The lack of **medical-surgical supplies, spare parts for equipment and reagents for laboratories**, is another frequent constraint for the provision of services in public healthcare centers that has worsened since 2010, with rising inflation, control policies and lack of allocation of foreign currency. Since 2013, there is a **severe shortage crisis** of these materials –since 84% are imported-, thus producing an alarming **suspension of elective and emergency surgeries, and services in other areas such as radiology, laboratories and blood banks**.

31. A survey carried out by Doctors for Health (a network of resident physicians in public health centers) in 130 hospitals from 19 states found that **61% of hospitals had serious or absolute failures in medical-surgical supplies; 65% serious or absolute failures of catheters and probes; 86% had damaged X Ray equipment; 94% had damaged or not operating scanners; 94% have laboratories with reagents failures and 44% of operating rooms are either closed or inoperative**.

32. The member companies of the Venezuelan Association of Distributors of Medical and Dental Equipment (AVEDEM in Spanish) report faults ranging from **sutures, gauzes, antiseptics solutions and saline, sterile gloves and gowns**, systems for administering medicine and drains; **contrast agents for diagnostic imaging, laboratory reagents**¹⁰, pipes and manifolds for sampling, **buckets and paraffin biopsy**; to catheters and probes, medical-surgical instruments, anesthesia machines and anesthetic gases, surgical staplers and staples, stents of all kinds, resuscitators, micro-nebulizers and oxygen masks, parts of fans for respiratory therapy in intensive care, implants and prostheses, endoscopy and electrosurgical equipment, and radio isotopes and radiopharmaceuticals for nuclear medicine, among others.

Medicine

33. The shortage crisis also affects access to medicines, since 70% are imported. In public hospitals, Doctors for Health reported that **67% of 130 hospitals had serious or absolute lack of medicines**. Many hospitals have even reported lack of antibiotics, syringe and basic materials such as plaster, wadding, alcohol and sterile dressing. In 2012, pharmaceutical companies and drug stores reported failures in a range of 20-25% in medicine; which increased between 2013 and 2014 to 37-50% and, presently, it has reached 50-60%.

34. The chamber of pharmaceutical companies (FEFARVEN in Spanish) reported that between 2011 and 2015, the fault level increased from **15% to 60% in Caracas and 70% in the rest of the country**.

⁹ The specialties in the most critical situation are: anesthesiology, pediatrics and neonatology, internal medicine, intensive care, surgery, cardiology, gynecology and obstetrics, oncology, infectious diseases, urology, gastroenterology, dermatology, toxicology, psychiatry y geriatrics.

¹⁰ Lack of materials and reagents to test for HIV, syphilis, dengue, chagas, tuberculosis, hepatitis, toxoplasmosis, rubella, and special tests of thyroid hormones, adrenal, tumor markers, prostate disease, cholesterol and clotting problems.

There are 98 drugs in failure in their inventories that severely affect people with central nervous system conditions, hypo and hyperthyroidism, diabetes, hypertension, convulsion, asthma, psychosis and neuromuscular diseases. FEFARVEN has also noted intermittent failures in analgesics, anti-inflammatories, antacids and antiparasitic, contraceptive, vitamin for pregnant women and creams for burns.

V. CASES OF HEALTH CENTERS

35. Reports collected by NGO Provea indicate that between 2004 and 2013 **the number of hospitals and public ambulatory health centers with complaints of serious or severe restriction in different working areas increased from 89 to 178**. As complaints grew, so did the multiplicity and combination of restrictions, causing a partial or total closure of services. The situation has forced people to pay large sums of money in supplies, materials and medicines; or, those who can afford it, have shifted to private clinics, generating a chaotic situation in some of these health centers. The following are some of the most critical cases in public health centers.

Hospital de Niños J.M. de los Ríos (HJMR)

36. HJMR is a health center specialized in pediatrics service located in Caracas but well-known in the country. It receives children from low income families (65%) from other states in Venezuela. It is in extreme state of impairment, with infrastructure problems, unsanitary, overcrowded, staff shortage and lack of medical-surgical supplies.

37. With a **capacity of 420 beds, only 160 are available for use**. The **areas of infectious disease, neurosurgery and emergency have been closed due to flood of sewage**, thus

services have been moved to a makeshift space where there are only six beds available. In 2015, patients' relatives reported the deaths of three children with leukemia by opportunistic diseases. All children, when entering to hospital, are prescribed antibiotics to prevent possible contamination from bacterial infections.

38. Lack of **medical-surgical supplies is 50-60 %**, tomography and resonance **equipment do not work**. There is a waiting list of **4,428 children since 2012, for cancelation of elective surgeries**. In 2013, the Ministry of Health refurbished 7 operating rooms that were out of use for five years for remodeling works, but **there are only 6 anesthesiologists today, when 36 worked there before**; there are only **four spots available in intensive care and air conditioning units are out of order**. In 2015, doctors warned of a technical shut down in elective surgeries and emergency service.



Maternidad Concepción Palacios (MCP)

39. MCP is a health center specialized in gynecology and obstetrics services located in Caracas but well-known in the country. It receives women and pregnant women from low income families from other states in Venezuela. It has severe problems in its service due to infrastructure problems, water shortage, shortage of specialists, and shortcomings of medical-surgical supplies.



40. It has a capacity of **490 beds, but only 100 are operating**. It went from dealing with **850 deliveries a month to less than 100**. Only **3 out of 11 operating rooms are in use** for not having anesthesiologists and pediatricians specialized in neonatology. **Neonatal and adult intensive care units were closed from 2009 until 2014, when only five new neonatologists were incorporated, but a minimum of 80 are needed for an institution of such characteristics**. Nor does it have sufficient residents in gynecology and obstetrics and it has a deficit of nurses. Additionally, it lacks medications and basic medical-surgical supplies for comprehensive care of women.

41. In 2010, there were several floodings that reached operating rooms, stairs and consulting rooms. Until 2012, **2 floors with 120 beds had been closed for remodeling works**. In 2013, mothers and newborns were evacuated due to the **collapse of sewage pipes and lack of air conditioning units**. In 2014, the hospital had no running water service during a month, forcing mothers to buy bottles of mineral water to clean their babies and to collect water in barrels. Because of these conditions, mothers and children are at risk of being infected so the hospital has suspended several times emergency and caesarean surgeries.

Hospital Universitario Manuel Núñez Tovar (HUMNT)



42. HUMNT is a teaching medical center located in Maturín, the main hospital in Monagas state. Since 2009, this hospital goes through a collapsing situation due to overcrowding, sewage overflow, flooding, disruption of water service, insecurity, lack of stretches and medical-surgical supplies.

43. In this hospital only **2 out of 9 operating rooms are available. 60 births are daily attended; pregnant women complain that they have to wait up to 24 hours for treatment**. In 2013, patients' relatives reported having spent 20.000 bolivars in medications (around \$1,000 at the time), medical supplies, and cleaning products to avoid possible contamination by sewage overflow in bathrooms.

44. Also in 2013, the Government of Monagas declared health emergency in the state because of the precariousness of the hospitals. It allocated 900 million bolivars for supplies, provision and maintenance of medical equipment, improvement in infrastructure, and the payment for 6,200 workers. However, in 2014, the delivery room collapsed due to a lack of specialists. In 2015, the kitchen **was flooded with sewage for 12 days, consultations were suspended because of water leakage and water overflow.** Currently, some services are closed for insufficiencies of surgical supplies.

Hospital Universitario de Caracas (HUC)

45. HUC is a teaching medical center located in Caracas but well known in the country. It offers the majority of postgraduate programs in Venezuela. It currently presents a serious situation of deficit of medical-surgical supplies and equipment. **300 out of 1,200 beds are out of use.** This hospital has a waiting list of **5,000 people for different types of surgery** (cardiovascular, oncological and umbilical hernia, among others). **600 children are waiting for a turn to have pediatric surgery and others for urologic emergencies.**



There is no scanner in the radiology and imaging service; a resonator and a mammography scanner are being repaired. In 2014, **more than 50 people from the waiting list died on hold for a cardiovascular surgery, 13 of whom were hospitalized at the HUC.** In 2015, **all surgeries have been suspended due to a scarcity of sutures, compresses, blood, anesthesia, prosthesis, instruments, equipment, laboratory and medications while hospitalized.** Some people have been discharged to prevent more deaths at the hospital.

Banco Municipal de Sangre (BMS)

46. The BMS is a national referent blood lab in Venezuela, specialized in assisting people with hemophilia, lymphoma and drepanositosis. There are 7 laboratories for abnormal hematology, HLA, flow cytometry, molecular biology, coagulation and serology.

47. The **budget deficit of this institution has reached 95%** and it translates into broad problems of infrastructure, lack of reagents and supplies due to red tape and foreign exchange difficulties for several years.



Refrigerators are broken or unable for use, there are failures in equipment and there is absence of hemo-therapists, bioanalysts, physicians, hematologists and nurses. Some tests are no longer being made leaving thousands of people unprotected and receiving treatment without a diagnosis.

VI. PERSONS AT RISK

Persons in need of urgent attention and surgery

48. **Every year, 250 persons with cerebral-vascular accident (CVA) and 500 with blocked coronary artery, are at a high risk as a result of lack of instruments, equipment and spare parts for surgeries; around 750 persons with heart deficiencies need pacemakers every year, which are currently unavailable; 500 persons, who need to save their lower limbs, are at risk of being amputated because of the lack of instruments.**

49. People with gunshot wounds, severe burns or trauma, are likely to face serious obstacles to receive immediate and adequate medical care, because of the high deficit of ambulances, beds and medicines and shortage of medical-surgical equipment, oxygen, blood banks, X-ray equipment and emergency health personnel in public hospitals. Since 2012, the number of reports of dead people while being moved from one center to another in order to get attention has increased. Also, 300 people on average are on waiting lists for elective surgery in different hospitals.

Pregnant women and newborns

50. Pregnant women and newborns do not receive an adequate and timely care in maternity and pediatrics units. **Spaces are overcrowded, there are not enough incubators, water and power shortages are common, medical equipment are damaged, there are no surgical supplies and blood banks are not functioning.** Additionally, there are few neonatologists, obstetricians, and anesthesiologists.

51. **58% of pregnant women do not receive prenatal care; Venezuela is currently the third country in Latin America with the highest rate of teenage pregnancy,** which is calculated by the United Nation Population Fund (UNFPA). It estimates there are 101 births for every 1,000 women aged 15 to 19, and 3 out of every 10 pregnant women had their children before 19 years old¹¹.

52. 380 pregnant women died in 2014 of causes related with the care received during birth. Likewise, 7,000 children under a year of age have died, 60% of which are newborns. Maternal mortality has not varied in the last decade; since 2006, infant mortality rate in children under 1 year of age is 14 deaths per 1,000 births.

53. From 2012 to 2013, **maternal mortality went up from 92 to 110 dead women per 100,000 births, which places Venezuela among the highest rates in Latin America**¹². In 2013, the WHO and the UNFPA pointed out that Venezuela would not reach objective N°5 of the Millennium Goals, based on

¹¹ Demographic Survey of Venezuela (Encuesta Demográfica de Venezuela (ENDEVE)).

¹² Maternity mortality ratio in some Latin American countries are: Uruguay (14), Chile (22), Costa Rica (38), Argentina (69), Brasil (69), Colombia (83), Cuba (80), Ecuador (87), Perú (89), Bolivia (200).

the commitment to reduce maternal mortality rate by 75% and achieve universal access to reproductive health by 2015. Worst of all is that, according to UNFPA, those death rates remain the same as when these goals were adopted in 2000.

Children of age for vaccination

54. Vaccination in Venezuela presents setbacks. Between 2005 and 2010, the amount of doses were reduced by 32% and the coverage rate is under 95%, the standard recommended by the WHO, with deficiency in Triple Virus (Measles, Mumps and Rubella), Influenza Type B, yellow fever vaccine, Triple Bacterial (Diphtheria, Tetanus and whooping cough), yellow fever, BCG (Tuberculosis and Meningitis), Anti Rotavirus, Anti Hepatitis B, Anti pneumococcal and pentavalent. Between 2007 and 2009, the Ministry of Health did **not provide Antipolio vaccines, pentavalent and Trivalent Viral to the population under 5 years of age**; in 2010, almost 70% of the population was not vaccinated; 20% of the infant population in municipalities around the country is still awaiting vaccination. The number of vaccines produced in Venezuela fell by 96% in the last decade, although the State financed a plant that until 2012 had not been opened.

Persons in need of dialysis and transplants

55. **15,000 people with kidney problems that require dialysis do not receive the minimum conditions in care, comfort, sanitation, medical supplies and routine blood tests under the regulations stipulated by the Ministry of Health**, noting an absence of monitoring and evaluation by the governing body to such units. The number of dialysis units has been decreasing. New cases fail to fit into existing units, risking people's lives, since this type of replacement therapy is their only option.

56. **5,000 people on the waiting list for transplants are at serious risk because, in 2013, the Ministry of Health decided, arbitrarily and without any planning, to manage alone the delicate and complex task of organ procurement.** This was a function performed by the National Transplant Organization of Venezuela (ONTV in Spanish), a not-for-profit organization, for 15 years. The Ministry established a transition program whose goals have not been met and the rate of donors per million inhabitants dropped dramatically from 4.5 to 1.7 between 2012 and 2014¹³. Fundavene, an agency of the Ministry, now in charge of this task, no longer provides information to people on waiting lists, which has caused great concern among them and their families.

57. Venezuela has only two units for bone marrow transplant, one in Caracas and the other in Valencia, Carabobo state, although standards establish there must be 1 per every 4 million inhabitants. These units had been carrying out a complete and successful significant number of transplants per year. However, the unit of Valencia, located in the Transplant Foundation in Carabobo state, ceased its activities in 2013 because it did not receive the resources the Ministry of Health had committed to transfer annually. The staff has been transferred to other centers and the Foundation is to be closed, which will affect 720 people waiting transplants.

¹³ Until 2011 there was a waiting list of 1.500 persons waiting for kidney transplants and 1.500 waiting for corneal transplants.

Persons with hypertension and diabetes

58. More than 50% of the population over 50 years is affected by, or presents risks of suffering from, hypertension or diabetes. Currently, these people cannot acquire daily medications such as anti-hypertensive, insulin, oral hypoglycemic agents neither in regular health providers programs nor in private pharmacies. These deficits also affect laboratories, having as a consequence the near impossibility of carrying out laboratory tests for adequate control of chronic diseases.

Persons with cancer

59. **1,500 people with cancer are affected by lack of reagents, bone scans and nuclear medicine drugs such as radioactive iodine.** Also, not all chemotherapy drugs supplied by the IVSS are available. Between 2011 and 2012, 19 radiotherapy units and 27 nuclear medicine equipment, purchased from Argentina in 2004, were paralyzed by lack of maintenance because contracts with the supplier were not renewed. In 2013, units were in use again; however, they are regularly damaged by power outages and it takes time for them to be repaired due to the shortage of spare parts¹⁴. **Venezuela has not yet approved the introduction of the vaccine that protects people with HPV (Human Papilloma Virus), which causes cervical cancer in women.**

Persons with lymphoma and myeloma

60. **560 people with lymphoma face lack of medicine, prescribed in chemotherapy protocols, in at least eight states**¹⁵. People receive copies of drugs that experts warn do not have the same positive effect of the original, forcing people to make changes in their schemes or to interrupt treatments due to relapse.

61. All states in Venezuela experience a shortage of reagents for the diagnosis and monitoring of hematology and blood chemistry, such as immunohistochemistry. There are few operating scanners and equipment; there is lack of contrast for carrying out some tests. In addition, health centers do not have sufficient hematologists specialized in lymphoma, nurses or trained personnel, in general.

62. **The Institute of Hematology and Oncology at the Central University of Venezuela (UCV in Spanish), an institution with a history of 38 years, pioneer in the study and treatment of lymphomas, has been technically closed for 9 months due to scarcity of supplies,** resources and the precarious state of infrastructure. Also, the unit of lymphomas in Caracas, a diagnostic center and treatment protocols nationwide have been closed.

63. People with multiple myeloma or bone marrow cancer cannot find the medications for their treatment in pharmacies from state institution –IVSS, where high cost medications are sold at lower prices. In addition, some medications are being supplied without the proper evaluation by the

¹⁴ Professionals, academics and health activists, parliamentarians, patients and their families consigned a letter to the General Prosecutor of the Republic, in which it was alleged that the Venezuelan government had violated its obligation to ensure the right to health and the life of people with cancer, by not taking positive actions to overcome in due time the interruption of radiotherapy treatment measures. In December 2013, authorities of MPPS proceeded to renew at least for one year a maintenance agreement.

¹⁵ Zulia, Táchira, Carabobo, Lara, Nueva Esparta, Guárico, Aragua y Sucre.

international drug-monitoring authorities, so no one knows their real effects or effectiveness. Given the serious situation in which diagnostic centers are, people with myeloma do not have access to diagnosis, treatment, follow up of disease, or blood donations; also in public health schools there are not enough hematologists-oncologists up to date with studies and advances in this condition.

Persons with breast cancer

64. **3,285 women diagnosed with breast cancer do not get all essential drugs on a regular basis.**

Breast cancer continues to rise and ranks first in mortality of women for oncological reasons. Early diagnosis is limited by the insufficient number of mammography and ultrasound in public health centers, and the ones being used cast images of very poor quality. Once diagnosed, women with breast cancer must wait for up to two years to get the corresponding surgeries.

Additionally, there is lack of film and contrast for tomography and resonance magnetics, cutting and vaccum needles for puncture, blue patent, radiopharmaceutical for sentinel node, paraffin to hold the specimens, reagents for bone scans and chemotherapy drugs and filters. Besides the lack of mastology physicians, radiologists and oncology surgeons, there is not a national program for prevention, diagnosis and treatment of breast cancer; diagnostic units are insufficient and there are no pathologic-anatomy units.

Persons with HIV/AIDS

65. **More than 45,000 people with HIV face, since November 2009, recurrent episodes of shortages of antiretroviral drugs and drugs for opportunistic infections associated with AIDS,** leading to frequent and prolonged interruptions, with the risk that the treatments lose their effectiveness¹⁶. Between 2013 and August 2014, there was the most serious disruption in the provision of antiretrovirals, 15 to 19 drugs each month, since the start of the access-to-treatment program in 1999. In the "Antiretroviral Treatment under Scrutiny Report" 2012, the Pan American Health Organization (PAHO) reported that Venezuela was the Latin American country with the largest number of episodes of shortages of antiretrovirals reported in a year.

66. People with HIV also face the **ongoing shortage of reagents for testing HIV for antibodies, CD4 counts, viral load and genotype. Reagents for quantitative VDRL test are not available.**

67. There are not enough specialized services in HIV and treating physicians in all states. **Pregnant women with HIV are victims of obstetric violence and there are no breast milk substitutes for children of mothers with HIV.**

¹⁶ Provision of Antiretroviral Treatments of High Efficiency (TAR in Spanish) is the responsibility of the National AIDS/STD Program of the Ministry of Health and it is an obligation of the Venezuelan state according to various judgments from the Supreme Court issued between 1999 and 2002, at the request of HIV organizations in the country. In 2012, more than 50 NGOs requested the Ministry the intervention of the HIV program due to recurring failures from inventory and wide gaps in the process of purchasing, distribution and delivery of the TAR.

68. **The epidemic is expanding due to the absence of a program of epidemiological surveillance and a comprehensive public policy on prevention, including official campaigns for the prevention of HIV and STD's as well as access to male and female condoms** for sexually active population. According to official reports, more than 11,000 people contract HIV every year, mostly young people of 15-24 years old. Similarly, the Global Report on the Situation of HIV/AIDS, 2013, prepared by UNAIDS, informed that **Venezuela fell in its capacity to respond to HIV, due to 85% increase in new cases of young people with HIV and 50% of deaths by AIDS.**

69. Stigma and discrimination in health centers against people with HIV are causing an increase in illnesses not associated with HIV, and it has influenced the annual deaths of AIDS. In June 2014, the National Assembly adopted a Law on Equality for people with HIV, through a joint effort between the Ombudsman and civil society organizations working in this field. The Act was enacted on December 30, 2014. However, the general health system restrictive conditions prevent its full implementation.

Persons with hematologic afflictions

70. **4,242 people with hemophilia and other blood problems do not have a regular supply of clotting factors in the blood**, to be applied once or twice a week, depending on the diagnosis, to avoid spontaneous or traumatic bleeding. The supply disruption is due to resolution that prevents from running out of stocks, which exposes people with hemophilia to bleeding episodes because their lives are at risk as it occurred in 2013. **3,660 people with hematologic conditions (leukemia, hemophilia and sickle cell disease) attended monthly nationally by the Municipal Blood Bank, are deprived of attention due to technical closure of this institution.**

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Persons with sickle cell anemia and thalassemia

71. **25,017 children-including people with sickle cell disease and thalassemia and 100 people with major thalassemia have difficulty receiving immunization against pneumococcal, hepatitis B and influenza viruses.** Children with sickle cell disease SS and S β 0 thalassemia are being treated with second option antibiotics since Oral Penicillin is not available, causing them physical damage by receiving a monthly intramuscular injection that is extremely painful.

72. The treatment of acute pain -first cause of hospitalization- is inadequate and untimely. There is lack of leuko-reduction filter sets and reagents for transfusion; there is no service for detection of hepatic iron and that for serum iron is extremely small; there is also lack of equipment and trained personnel to perform transcranial doppler echo.

73. The diagnosis of ophthalmic, lung, heart and kidney complications is bureaucratic and inefficient; neonatal screening is insufficient, postpartum follow up is not being done and only 4 public hospitals nationwide are performing post-natal hemoglobin studies.

Persons with mental health problems

74. **10,000 people with mental health problems are not treated by psychiatric care centers¹⁷.** In 2012, **5,000 people staying in socio-care residences of the IVSS reported poor state of infrastructure, shortages of drugs and lack of budget for food and medical staff.** Having shortage of medicines, families are required to remove people with psychiatric conditions who are difficult to control. Additionally, there is a deficit of resident physicians in psychiatry. In the 2012-2013 period, only 3 candidates were enrolled for 20 seats available.

Persons living in remote places

75. Indigenous people **face extremely restrictive conditions of availability, accessibility, acceptability and quality of health care.** The communities of Bolivar State have requested community health workers for Kariña people, food, medical supplies, and airlift and river ambulances. The communities of Monagas state have requested a medical health module, land and river ambulances. In Amazonas state, the Pemón people have reported malpractice, lack of medical-surgical equipment and medicines in Hospital Rosario Vera Zurita, the only health center in the Gran Sabana. In that state, 12 communities of Pemón people of Canaima National Park, have demanded food and health by air. There exists only an outpatient consultation with 2 rural doctors. In the Delta Amacuro state, the Koberuna community of the Warao people does not have any physician or a boat for transporting people in case of emergency.

76. Cases of **malaria** have risen considerably in recent years. Between 2012 and 2014, cases increased from 44,150 to 71,802. Bolívar is the state with the majority of cases (87.7%). In the region of the Caura River, second most important basin in extent of water and production in Bolívar state, and where a large indigenous population lives, the pattern of increase of malaria cases is similar to that recorded for the state, as the number of malaria cases by place of origin of infection by parish of Sucre Municipality, reported in the Epidemiological bulletins for the same dates.

Comparative Chart of Malaria Cases
between 2012 and 2014, in parishes of
Municipality of Sucre in Bolívar state.

Parrish	2012	2014
Aripao	620	1.586
Guaratao	463	349
Las Majadas	160	73
Maripa	378	760
Moitaco	295	600
Total	1.916	3.368

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77. This situation shows that in Venezuela malaria is an **epidemic**, with increasing trend and there is **no evidence that it can be controlled and reversed.**

78. In 2014, malaria in the age groups from pre-school, school age and high school age (range 0-19) matched the casuistry to working age groups (range 30-49), a situation that highlights the active transmission of malaria at home and schools, increasing the vulnerability of children and adolescents in the country.

¹⁷ Information reported in 2012 by the Committee of Relatives and psychiatric and geriatric patients, care takers, drugs users and VIH patients.

RECOMMENDATIONS

Current situation of the right to health in Venezuela is of extraordinary and critical features. Therefore, it is the duty of the Venezuelan State to address it urgently and immediately and take all necessary measures, **in strict compliance with the parameters set by the Constitution of the Bolivarian Republic of Venezuela, and in accordance with the norms and standards established by international covenants on human rights**, in order to solve the problems that cause it and protect people at risk with due diligence to prevent them from having consequences for their life and health.

Given the seriousness and magnitude of the problems, we believe that the need to find solutions and implement them in the shortest possible time should be a task that has the support of everyone. International organizations for the protection of human rights and international and regional cooperation agencies can collaborate and provide technical, scientific and logistical expertise in the delicate work of the pursuit of goods and health services, and that the current situation in Venezuela involves topics such as infrastructure, drugs and medical equipment.

Measures to be taken should also be **timely, relevant and consistent with the urgency of needs**, taking as criteria the level of risk to people according to their conditions, places where they are and barriers for mobilization or their families. In this report, we want to offer an approach that highlights the most affected groups and relate their needs with their corresponding restrictions, a task in which many of the people directly affected collaborated, as well as medical organizations, human rights organizations, academic organizations and suppliers.

More specifically:

- a) **An agile, simple and flexible system to ensure the permanent flow of foreign currency into the health sectors** should be implemented as soon as possible; as well as follow up plans and monitoring of inventory of medicines and supplies, setting security levels to be respected, considering the time required for solutions to take effect.
- b) **The impact of policies as a result of the economic situation and the significant reduction of state resources should be assessed and measured**, establishing mechanisms that safeguard the health sector from the negative consequences that these policies may have, since, in the current conditions of health services, a decrease of resources can have catastrophic impacts and result in the loss of more human lives or cause severe and irreparable damage to people's health.

- c) **A thorough review of the obstacles that prevent every health center from solving the constraints,** improving and restoring their full operation should be performed as soon as possible, with broad and direct participation of staff, workers, managers, people affected and those organizations that want to collaborate in overcoming the problems.
- d) **Public health centers should have priority,** both in relation to urgent measures such as those related to funding policies and management, **without neglecting the people who receive attention in the private sector because they too are being affected by the crisis of shortages.**
- e) **A thorough assessment of the needs and requirements of programs and units of the Ministry of Health should be undertaken** to restore their planning, management and control of the epidemiological situation and enable decisions to give effective responses to needs and gaps in services.
- f) A draft of an **Organic Healthcare Law** should be developed that complies fully with the rules and safeguards laid down in Articles 83, 84, 85 and 86 of the Constitution of the Bolivarian Republic of Venezuela, with the participation of all interested parties involved in the health sector, in order to **restore the powers of governors in the administration and management of public health systems in their respective jurisdictions.**

Finally, we request immediately **a halt to the harassment of those reporting, documenting and denouncing the situation in Venezuela in the health area and, in general, on human rights.** We also request the **protection**, in the first place, of the **affected people** themselves in their legitimate right to protest freely and peacefully for the conditions to which they are subjected; secondly, **health personnel**, who nowadays face the situation and need to take difficult decisions as a result of these conditions; and, in third place, **journalists and advocates and human rights organizations** whose duty is to inform, gather evidence and support victims of the situations previously described.