
◆ VENEZUELA (REPUBLIC OF)

MAP PAGE (859)

Klaus Jaffe and Marino J. González

Location: Venezuela is located on the southern Caribbean coast of South America north of Brazil and east of Colombia. The climate is tropical but is influenced by changes in altitude from the coastline, to the plains and high plateaus, to the Andes Mountains. It is divided into 23 states. The total land area is 912,050 km² (352,144 square miles). The capital city is Caracas. Agriculture covers only about 5% of the country. The Orinoco River (2150 km) divides the country into the more densely inhabited north and the mostly uninhabited rain forests and savannas to the south that extend into the Amazon Basin north of Brazil.

Major Languages	Ethnic Groups	Major Religions
Spanish	Mestizo 67%	Roman Catholic 96%
Indigenous	White 21%	Protestant 2%
	Black 10%	Other, none 2%
	Amerindian 2%	

Spanish is the official language. Various indigenous languages are spoken in the remote interior. The population is estimated to be 23 million, and more men than women are younger than age 40; more women than men are older than 40. The 1999 literacy rate for individuals 15 years of age and older was 93.8%. In 2000 the per capita income (in purchasing power parity) was \$6200, and 87.11% of the inhabitants lived in urban areas. Venezuela has African, Amerindian, Arab, and European (primarily Spanish, Portuguese, and Italian) influences. A heterogeneous and developing country, Venezuela has three distinct classes (rich, middle class, and poor). According to 1997 estimates, the distribution of classes was 1.5% rich; 31.3% middle class, and 67.2% poor.

Health Care Beliefs: Western and traditional; active and passive roles. The health services provided by the Ministry of Health and Social

Development (MSDS) place more emphasis on primary and secondary health care, whereas the social security system, which also attends nonsecured citizens, covers more specialized treatments, such as renal dialysis, transplantation, and antiretroviral drugs, among others. Health agents and public health monitors provide some community intervention. Those in the middle class are actively involved in health care, whereas those who are poor are more passive. Numbers of private health care providers are growing and providing service to most of the middle class and some of the lower economic classes. A large majority of Venezuelans (including Amerindians) believe in Western, or science-based, medicine. Only when science-based medicine does not work or official or private medical health care is too difficult or costly to obtain do people seek out alternative medicine. Alternative medicine is, for the most part, practiced by witches (*brujos*). In addition to prayers, chants, and ceremonies, witches use herbs to cure their clients. Amulets and religious articles are used as protection against bad luck or bad influences from other people. Belief in astrology is widespread among all social classes.

Predominant Sick Care Practices: Biomedical and magical-religious. The Venezuelan health system can be divided according to its two major sources of financing and methods of delivery: public and private. The public system is financed through fiscal revenues and payroll taxes, and the private system is primarily financed through community and personal insurance plans. The public sector comprises national hospitals, social security institutions, and decentralized services (hospital and out-patient care services) at the state level. The major public institution is the MSDS, which accounted for 63% of the total public health expenditure in 2000. The public health expenditure per capita was \$128 in 2000.

Ethnic/Race Specific or Endemic Diseases: Endemic diseases are dengue fever, hemorrhagic dengue fever, malaria (including chloroquine-resistant varieties), AIDS, cholera, tuberculosis, schistosomiasis, and measles. The population is at risk for transit accidents, malnutrition and dysentery, work-related problems, iatrogenic diseases, maternal and neonatal morbidity, and asthma and respiratory complaints. The World Health Organization's (WHO) estimated prevalence rate for HIV/AIDS in adults ages 15 to 49 is 0.49%. The estimated number of children from birth to 15 years living with HIV/AIDS is 580. The number of people infected with HIV is 62,000; and the total number of HIV deaths reported through December 1999 was 8047. The UNAIDS estimated morbidity rate was 2.4 cases per 1000 inhabitants. Life expectancy at birth in 2001 was estimated to be 70.29 years for men and 76.56 years for women.

Health Team Relationships: The term *doctor* is used indiscriminately as an expression of respect and affection. Nurses are addressed by the title *enfermera* or their first name. *Brujos* and *comadronas* are male or female healers who often serve rural populations and sections of suburban populations.

Families' Role in Hospital Care: The family is responsible for direct care, and family members may bring food or take turns staying with the patient 24 hours a day. It is common for the family to take part in decisions about procedures such as surgeries and referrals.

Dominance Patterns: The extended family can include godparents (*compadres*), who are occasionally chosen according to their social status in the community and as a form of recognition. Godparents are expected to help provide medical care for their godchildren if needed, although it is common for godparents and godchildren never to see each other after the baptism. The tradition of asking for the parents' blessing for marriage is weak in the younger generation but remains popular in many parts of Venezuela. When more than one last name is used, the mother's name follows the father's. Having the same last name gives families a sense of belonging.

Eye Contact Practices: Direct eye contact is common between sexes and social classes.

Touch Practices: Use of the body and touch during social contacts is the "tropical" way of relating. Two women greet each other by kissing on one cheek, as do men and women and men and men. The *abrazo* (embrace) is a common greeting among males. Handshaking occurs primarily with foreigners and on formal occasions. Touching while talking is common.

Perceptions of Time: Venezuelans are casual about punctuality and live in the present. The future is a very ambiguous and heterogeneous concept, and definitions of "early" and "late" are flexible. Arriving late can be a sign of a higher social standing. Immediate rewards for activity are preferred to delayed gratification.

Pain Reactions: Pain is expressed vocally through moans and groans, although men tend to be stoical. It is much more common for women to somaticize their problems.

Birth Rites: Fathers are not usually present during labor and delivery, although the presence of a family member is common. Male circumcisions are not routine. Girls may have their ears pierced soon after birth, frequently while they are still in the hospital. A rest period of 45 days after birth is typical for the mother, and fathers usually take some days off from work. Working parents continue to collect their salaries, and working mothers usually have flexible hours, including time off to breast-feed. The extended family may assume the role of primary caregiver when parents return to work. Tubal ligations in women after they have had two children (one boy and one girl) are common among those in the middle and upper class. This procedure is more difficult for those in the lower class to obtain. Childbirth is often by cesarean section. In 2000 the estimated birth rate was 22.52 births per 1000 people. The 1999 infant mortality rate was 19.1 deaths per 1000 live births.

Death Rites: Death rites are class dependent. The poor carry their dead to a cemetery, often in a cardboard casket. In small towns the funeral may involve the entire community, and many people join the family procession. Small businesses may be closed and activities suspended as a sign of sympathy and respect. Children often lead the procession by carrying a crown or cross of natural flowers. Male relatives such as brothers, sons, or grandsons are the pallbearers and are followed by close relatives and friends. Family and friends pray. Middle- and upper-class individuals are buried in wooden caskets. Family graves, in which several people may be buried, are becoming less and less common. Cremation is slowly becoming more popular but is not widely practiced. During a funeral service the body is surrounded by flowers, and only the head shows. Burial is usually the day after death. In the middle and upper classes the procession is done in cars. Cremation is becoming available in larger cities.

Food Practices and Intolerances: *Arepas* (corn bread) or bread with eggs, meat, cheese, and black beans are common for breakfast, although cereals and fruit are becoming popular as well. The main meal is eaten at noon and consists of rice, black beans, mashed bananas, pasta, and meat or fish. The consumption of vegetables and salads is increasing. The trend in middle-class families in which mothers and fathers work is to eat the noon meal at a self-service restaurant or in a luncheonette, although going back home is a popular choice because of the 2-hour lunch break allowed by most employers. Away from home, *arepa*, *empanada* (cornbread sandwich), or a sandwich is common. Supper is a light meal (of soup or leftovers from lunch) and is eaten in the evening, although it is not uncommon to eat a two- or three-course dinner.

Infant Feeding Practices: Breast-feeding is generally short term, and the attitude of the father can be the most significant factor in its duration. Filling formula made of a thickening agent (e.g., flour of manioc, corn, or rice) and water is often used, especially by poor families, to fill the stomach of a hungry infant or toddler. Slight obesity in infants or children is considered a sign of health.

Child Rearing Practices: Children are treated affectionately. Warm embraces by all family members are common. Grandmothers and friends play an active role in caregiving, especially in families in which the mother works outside the home. Middle- and upper-class children are enrolled in private or parochial schools. Lower class students receive a public school education. Young children are enrolled in a *crèche* (day care) or kindergarten. The normal school day is half a day (in the morning or afternoon). Children in the lowest socioeconomic class often work instead of going to school. Homeless children are a concern in large cities.

National Childhood Immunizations: BCG at birth; DTP at 2, 4, 6, and 18 months; OPV at 2, 4, and 6 months; hep B at birth and at 1 and

6 months; Hib at 2, 4, and 6 months; MMR at 1 year; and YFV younger than 6 months; anti-Sarampo.

BIBLIOGRAPHY

- Biblioteca Nacional, Venezuela: <http://www.bnv.bib.ve>
Central Intelligence Agency: *The world factbook 2001* <http://www.cia.gov/cia/publications/factbook/>
González R, Marino J: Reformas del sistema de salud en Venezuela 1987–1999: balance y perspectivas. Santiago de Chile, *Serie Financiamiento del desarrollo*, No 111, 2001, CEPAL.
Oficina Central de Estadística e Informática: <http://www.ocei.gov.ve>
Pan American Health Organization: <http://www.ops.org>
Riutort M: El costo de erradicar la pobreza. In *UCAB-asociación civil para la promoción de estudios sociales*, vol 1, pp 15–26, Caracas, 1991, UCAB.