

**WITHOUT SAFEGUARDS:
INTERSECTIONAL VIOLENCE, SEXUAL
AND REPRODUCTIVE RIGHTS OF VENEZUELAN
AMAZONIAN INDIGENOUS WOMEN**

**SIN GARANTÍAS:
VIOLENCIA INTERSECCIONAL Y DERECHOS SEXUALES
Y REPRODUCTIVOS DE LAS MUJERES INDÍGENAS
AMAZÓNICAS VENEZOLANAS**

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Abstract

The obstacles faced by Amazonian indigenous women to exercise their sexual and reproductive rights, as well as access to related healthcare, are generally associated with “problems” related to their ethnicity, without revealing the responsibility that the States have in the formulation of laws, actions, and differentiated protection policies. In this document, we propose how regulatory advances and specific public policies on sexual and reproductive rights are required for indigenous women in the context of a humanitarian crisis embedded with historical discrimination and intersectional violence in Venezuela.

Keywords: women’s rights, indigenous women, indigenous health, sexual and reproductive health, Venezuela.

Resumen

Los obstáculos que enfrentan las mujeres indígenas amazónicas para el ejercicio de sus derechos sexuales y derechos reproductivos, así como el acceso a la salud en esta materia, generalmente son asociados a “problemas” relacionados con su condición étnica, sin visibilizar

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la responsabilidad que tienen los Estados de en la formulación de leyes, acciones y políticas de protección diferenciadas. En este trabajo, nos proponemos indicar cómo en Venezuela se precisan de avances normativos y en políticas públicas específicas en derechos sexuales y reproductivos para las mujeres indígenas frente al contexto de crisis humanitaria imbricada con una histórica discriminación y violencia interseccional.

Palabras claves: derechos de las mujeres, mujeres indígenas, salud indígena, salud sexual y reproductiva, Venezuela.

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Introduction

In Venezuela, norms have given importance to indigenous people's specific and collective rights, with pluriculturality being a constitutional principle. Although there is a wide variety of laws that were adjusted –to a large extent– to the demands of the indigenous agenda and the commitments made in international instruments adopted in Venezuela, there is still a lack of institutional, political, and cultural conditions that would allow indigenous groups to realize their human rights effectively.

Likewise, since the enactment of the Bolivarian Republic of Venezuela's Constitution (henceforth, CRBV, by its acronym in Spanish, *Constitución de la República Bolivariana de Venezuela*) and its Eighth Chapter, referring to indigenous peoples and communities, institutional spaces were created for the dignification of the life in indigenous communities. While some of these spaces generated some positive actions, they did not last through time. Also, they failed to remedy the historical status of the individual and collective vulnerability of indigenous peoples and communities.

Those who endure with greater force the neglect and non-compliance of government bonds surrounding the rights of indigenous groups are women, children, and elders. In the case of indigenous women and girls, the vulnerability lies in multiple and simultaneous discrimination that is embedded, comes, and feeds from patriarchal colonist oppression.

Although this paper's objective is not to analyze the general status of Venezuelan Indigenous women's rights¹, it is essential to mention that the country has not created any public policies for the specific attention and protection of Indigenous women. The few notes that have been done about indigenous people have not gone beyond the declarative aspect –the most prominent example being the significant loopholes around the topic of the People's Power Ministry for the Woman (henceforth MINMUJER by its acronym in Spanish, *Ministerio del Poder Popular para la Mujer*)² and its implementing bodies plans and programs.

1 To delve into this topic, search for Moncada, Alicia (2019). *Estado de los Derechos de las Mujeres Indígenas en Venezuela* (Status of the Rights of Venezuelan Indigenous Women) in CEPAZ. *Memorias del I Encuentro de la Red Naranja. Miradas por los derechos humanos de las mujeres en Venezuela* (Memories of the 1st Red Naranja Encounter. Venezuelan Women's Human Rights Outlooks). Available at: <https://cepaz.org/wp-content/uploads/2019/11/Informe-Memorias-Encuentro-Naranja.pdf>

2 We refer to plans like the Plan for equality and gender equity *"Mamá Rosa"* (Pink Mom) (2013-2016). National Plan to Prevent, Assist, and Eradicate Violence Against Women, and First National Plan for the Protection of Sexual and Reproductive Rights.

The *Ministerio del People's Power* Ministry for Indigenous Groups (henceforth, MINPPI, by its acronym in Spanish, *Poder Popular para los Pueblos Indígenas*), implementing entity of public policies in Venezuela does not have any dedicated offices nor has published data on the situation of Venezuelan indigenous human rights. Likewise, the *Defensoría del Pueblo* (Ombudsman Office) –which sporadically carries out some human rights promotion and dissemination activities with indigenous organizations close to the government's party– has not generated any internal or public reports on the matter.

In this investigation –which arises from the deep concern about the terrible outlook exposed– we will focus on highlighting the gaps related to the ethnical variable in the normativity and State policies in sexual and reproductive rights (henceforth, SRRs) in Venezuela, as well as we will offer an outlook on intersectional discrimination and violence that Indigenous women living in the state of Amazonas against to the ones found in total lack of protection.

Sexual and Reproductive Rights of Women in Venezuela

SRRs refer to “a series of rights related to the free practice of sexuality without risks, to physical and emotional pleasure, to free sexual orientation, free choice of the number of children, to the protection of motherhood, among other aspects”** (Gómez, 2012, p. 38).

Although SRRs are not explicitly contemplated in the *CRBV*, Venezuela's regulatory framework and public policies recognize their importance in preserving other human rights established in national laws and international instruments.

Likewise, the Venezuelan State has signed declarations and action plans like the ones that come from the *IV International Conference on Population and Development* (El Cairo, 1994), the *World Conference on Social Development* (Copenhagen, 1995), and the *IV World Conference on Women* (Beijing, 1995).

The *Action Plan* from the *International Conference on Population and Development* –also informally known as the Cairo Conference– urges the member states to be part of the reduction of neonatal, child, and maternal mortality and the universal access to reproductive health services, particularly those of family planning and sexual health. Also, the *Beijing Declaration*, which comes from the *IV World Conference on Women*, refers to health and the SRRs, indicating that the reaffirmation of women's rights to control their bodies and sexualities is an essential requisite for empowerment and reaching effective equality.

From these and other international compromises acquired by the Venezuelan State, the Official Standard for Comprehensive Care in Sexual and Reproductive Health (2003/2013) (henceforth NOAISSR by its acronym in Spanish, *Norma oficial para la atención integral en salud sexual y reproductiva*) was set as an initiative of the People's Power Ministry of Health (henceforth MPPS by its acronym in Spanish, *Ministerio del Poder Popular para la Salud*) and was combined with a series of plans and programs related to sexual and reproductive health.

** All quotation translations from languages other than English are made by the translators.

The NOAISSR was a leading instrument for public policies in sexual and reproductive rights that established “the competencies and functions of the management levels and the procedures for comprehensive care in this field” (NOAISSR, 2013:7). This was framed within the guidelines of the *Primer plan socialista de la nación* (First Socialist Plan of the Nation) (Simón Bolívar, 2008-2012) and the *Plan de la Patria* (Homeland Plan) (2013-2019), relating to the creation and development of the *Programa nacional de salud sexual y reproductiva del MPPS* (MPPS’ National Program for Sexual and Reproductive Health).

Both the NOAISSR, and the documents of the program “included its conceptual and pragmatic bases, the technical, administrative regulation and the procedures for its development” (Idem), such as “the strategic guidelines for the promotion and development of sexual and reproductive health.” (Ibídem: 11) This instrument proved to be a significant improvement from the former *Normas de atención materna y planificación familiar* (Standards for Maternal Care and Family Planning) (1992), pushing gender equality and sexual and reproductive health autonomy as essential pillars of policies in national health policies.

In health and reproductive rights, the concept of motherhood—from which the Venezuelan Government started to elaborate its initial policies on the subject—is exposed in the NOAISSR where it refers to motherhood as a “differential expression of biological nature” (NOAISSR, 2003/2013:28) coupled with gender. The notion of motherhood is determined by socio-cultural, geographical, and time-related factors that assign it a series of meanings, roles, and functions. Thus, in a culture where inequality between men and women is naturalized, the function of women will be only coupled with reproduction, splitting them from the autonomy to choose reproduction and its ideal time. The NOAISSR considered that sexuality and reproduction are independent processes that may intersect if motherhood is chosen, as the international standards for SRRs establish.

Regardless, NOAISSR provisions faded over time and were replaced by a series of inadequate and insufficient plans and actions created by MINMUJER.

In the *Plan Mamá Rosa* (2013-2019), MINMUJER set out to establish several alliances with the MPPS to “stimulate the inclusion of the gender perspective in the National Public Health System (SPNS by its acronym in Spanish, *Sistema Público Nacional de Salud*) (MINMUJER, 2013:24), becoming the first objective in the social dimension of the *Plan Mamá Rosa*. Another of the objectives related to SRRs is to “educate women and men about rights to happy and responsible sexuality in their different phases of life, and educate women and men about reproductive rights” (Idem) to comply with article 76 of CRBV.

Within the framework of this planning, the National Women Institute (henceforth, INAMUJER, by its acronym in Spanish, *Instituto Nacional de la Mujer*), as the executing body of MINMUJER, shaped the *Plan nacional de protección de los Derechos sexuales y reproductivos de las mujeres* (National Plan for Women’s Sexual and Reproductive Rights Protection) (2014-2019) as a form of creating:

“specific actions for those women who, for various reasons, are still vulnerable and socially excluded from public policies governing such matters. Encouraging the access to attention and prevention services in health, education, and justice –considering their specifications and needs–and developing the necessary actions to reach the full exercise of their Sexual and Reproductive Rights” (INAMUJER, 2014:9)

Despite that, in the National Plan for Women’s Sexual and Reproductive Rights Protection, the creation of a series of policies for the exercise of women’s SRRs was proposed, and a patriarchal vision of women’s sexuality, and especially motherhood, prevailed. Proof of this is the current *Plan Parto Humanizado y Lactancia Materna* (Humanized Childbirth and Breastfeeding Plan) created in 2017 for the promotion of “natural childbirth and with no pain³, and that includes money transfers for nursing and recent births mothers that prove to be registered in the *Patria Platform*⁴. The Plan mentioned above aims to promote motherhood to “make the homeland grow”⁵, as stated by President Nicolás Maduro in an event related to the policy, and where he also assured that the “woman was made to give birth”⁶.

None of the programs and social missions indicated in their objectives ensure SRRs have positive, factual, and verifiable results. From the National Program of Sexual and Reproductive Health from the MPPS⁷, the *Niño Jesús* Mission⁸ to the current Humanizes Birth Plan has not left any results that have contributed to creating conditions for the effective exercise of SRRs of Venezuelan women.

3 Deutsche Welle. (March 4, 2020). Maduro invita a todas las venezolanas a parir por la patria [Maduro Asks All Venezuelan Women to Give Birth for the Homeland]. Deutsche Welle. <https://www.dw.com/es/maduro-invita-a-todas-las-venezolanas-a-parir-por-la-patria/a-526424033>

4 TeleSur. (November 16, 2018) Plan Parto Humanizado protege a las embarazadas en Venezuela [Humanized Birth Plan protects pregnant women in Venezuela]. TeleSur. <https://www.telesurtv.net/news/venezuela-plan-parto-humanizado-politica-social-201811160031.html>

5 Deutsche Welle. (March 4, 2020). Maduro invita a todas las venezolanas a parir por la patria [Maduro Asks All Venezuelan Women to Give Birth for the Homeland]. Deutsche Welle. <https://www.dw.com/es/maduro-invita-a-todas-las-venezolanas-a-parir-por-la-patria/a-526424033>

6 Deutsche Welle. (March 4, 2020). Maduro invita a todas las venezolanas a parir por la patria [Maduro Asks All Venezuelan Women to Give Birth for the Homeland]. Deutsche Welle. <https://www.dw.com/es/maduro-invita-a-todas-las-venezolanas-a-parir-por-la-patria/a-526424033>

7 It was an MPPS initiative that seeks to generate actions and comprehensive services for sexual and reproductive health. As indicated by the MPPS, alliances were used between the public and private authorities, for the development of public policies on “promotion, prevention, restoration, and rehabilitation in sexual and reproductive rights, with an integrated approach on gender equality; according to needs, risks, and specific rights –of women and men–, during their whole life cycle.” (MPPS. Digital version)

8 Arising in 2009, it was a national mission that had an objective to generate and execute protective measures for maternal and child populations. It intended to create conditions for efficient health services delivery for pregnant women, during pre and post-partum periods. In the same way, this Mission was to watch over and generate optimal attention conditions for children during their first years of life.

The Ethnical Variable in Normativity and Venezuelan Public Policies Related to Sexual and Reproductive Rights

Among the rights of indigenous people that are recognized and protected by the Venezuelan legislation, the right to health is erected as a priority for the reproduction of individual and collective life.

Individually, indigenous people enjoy these constitutional provisions as the rest of the national population, being “a fundamental social right, an obligation of the State, which shall guarantee it as part of the right to life.” (Art. 83, CRBV, 1999). Correspondingly, it is declared that indigenous groups possess the collective right to a “comprehensive healthcare that considers their practices and cultures. The State will recognize their traditional medicine and complementary therapies, in conformity with bioethical principles.” (Art. 112, CRBC, 1999).

The concept of health to which these constitutional provisions refer is of a holistic nature; it transcends the Western biomedical paradigm and is related to overall physiological, psychological, and spiritual well-being. This idea is very similar to the principles of most indigenous groups about health, conceiving it as inherent well-being to the harmonious relationship between people, tangible beings, nature, and the transcending or spiritual world. Under these principles, diseases represent the result of a rupture of the symbiotic relationship between the material and spiritual world.

Just as the State in its rules promotes the articulation between traditional Indigenous medicine and Western medicine, it also expresses that

“This recognition does not limit the right of indigenous groups and communities access to other services and programs from the National Health and Social Security System (*Sistema Nacional de Salud y Seguridad Social*), which must be provided based on equal opportunity, equity, and quality of service concerning the rest of the national population” (Art. 111, LOPCI^{***}, 200).

It should be noted that when indigenous healthcare is addressed in Venezuelan regulations, these communities are assumed to be a homogenous block without gender distinctions; so, there is no mention of SRRs of the sexual and reproductive health of indigenous women. The policies, regulations, and normativity that SRRs considered in Venezuela included the ethnic variable as a politically correct addition without clarifying the implementation processes and their technical, community, budgetary, and regulatory requirements. All because the wrong idea of women as a homogenous group has persisted in Venezuelan institutionalism, unaware of the complexity of intersectional discrimination and practical and strategic gender needs according to belonging to groups who have historically been in situations of social vulnerability.

^{***} LOPCI: *Ley Orgánica de Pueblos y Comunidades Indígenas* (Basic law on Indigenous Peoples and Communities)

The NOAISSR, for example, recognized as a significant limitation the lack of mainstreaming from the ethnic perspective or variable in institutional responses related to the deficit of sexual and reproductive healthcare attention (NOAISSR, 2003/2013: 52). They also admitted the “low coverage, quality/friendliness, and accessibility to sexual and reproductive health care services –from a comprehensive, promotional, and cross-sectional perspective– for the attention of the own needs of each group according to age, gender, territory, and social class, with an emphasis in primary health care.” (Idem)

In the Project of Sexual and Reproductive Health Autonomy Development (*Proyecto de desarrollo de autonomía en salud sexual y reproductiva*) from the MPPS, the importance of an intercultural focus was mentioned (Ibidem: 55-58), and the focus on ethnic groups, but it does not state the strategies and course of action, the development of regulation or criteria for sexual and reproductive healthcare of indigenous groups, and –even less– of intercultural protection or adaptation in maternal care services.

In the First National Plan for Women’s Sexual and Reproductive Protection (2014/2019) from INAMUJER, cultural relevance in sexual and maternal attention services was not added to its course of action. Nor in the Basic Law on Indigenous Peoples and Communities do women count with safeguards that promote their SRRs.

Among the general provisions from the National Program of Sexual and Reproductive Health, emphasis was placed on the pressing need to create institutional responses that require justified adaptations in the diagnostic of needs, inequalities gap identification, and attention deficit, mentioning indigenous peoples and communities as one of the prioritized groups. Nevertheless, such responses and adaptations do not exist.

In this vein, in Venezuela, regulations, plans, and actions around SRRs make scarce and almost forced mentions of differentiated care, cultural relevance, or intercultural adaptations of sexual and reproductive healthcare services.

Without Safeguards: Intersectional Violence, Sexual and Reproductive Rights of Venezuelan Amazonian Indigenous Women

From the feminist theory, intersectional discrimination has been defined as the interaction between sexism and racism (Williams, 1989; Colling, 2000; Anzaldúa, 2001). In the Latin American context, Esther Pineda, on her behalf, has indicated that “while all women share the oppression of being women, they experience sexism and find themselves in situations of vulnerability and risk because of their sex, sexist oppression deepens in racialized women” (Pineda, 2020, p. 271). Assuming that gender, class, and race are structures of oppression –that, embedded, affect racialized women in a specific and differentiated manner –it could be said that intersectional gender-based violence is those acts of violence based on intersectional discrimination that aim to generate suffering and different types of harm (physical, sexual, psychological, symbolic, etc.) towards racialized women and girls, affecting their individual development and community life.

As already mentioned, indigenous women, teenagers, and girls are part of a historically vulnerable group, which is subject to intersectional discrimination that –in Venezuela– does not enjoy specific protection policies that assist them or take into account their particular issues. Among the long list of forms of discrimination, risk factors, and vulnerability they experience, it is essential to mention the high maternal mortality rates that –among Amazonas state’s indigenous groups⁹– used to be 120.5 for every 100,000 RLV (registered live births) (data from 2012 and the last public data issued by the Venezuelan government¹⁰) compared with a national average of 73.34 for every 100,000 RLB in the same year. In 2011, Amazonas was the second state with the highest maternal mortality rate (123.3 by every 100,000 RLB) after Delta Amacuro (179.8 by every 100,000 RLB), with pregnancy ending in abortion being a large part of maternal deaths, which accounted for 60% of all deaths. The ethnic variable has an immense weight in this situation because it tells us that 100% of the deaths corresponded to indigenous women –80% of women in the *jivi* group, and 20% of the *kurripaco* group, both Amazonian groups. The terrible differences in Venezuela regarding epidemiological surveillance are added, worsening the scene, with sub-recording as a common problem.

Facing this complex situation, the lack of spaces for sexual and reproductive healthcare –and conditions for the exercise of their SRRs– is a factor that contributes to the state of vulnerability of indigenous women in general. Especially the Amazonian women, since they can be found in territories falling behind in Venezuelan public policies, or as the national government calls them, silent zones.

Until 2015 and 2016, some medical services that provided sexual and reproductive medical attention existed. These limited spaces were concentrated in Puerto Ayacucho, the only urban settlement in the entire state. Here is a short description of the state of these services during the mentioned period:

1. By 2016, the José Gregorio Hernández Hospital –the only one in the region– had a gynecology and obstetrics service with a few specialists. Only four (4) doctors specialized in gynecology and obstetrics were working and had to attend to 71,414 women who –according to the last national census– live in the state¹¹. The medical personnel divided their time between private and public practice. In the latter service, indigenous women had to deal with long waiting times to access their turn for a

9 According to the 2011 census, indigenous groups represent 2.8% (724,592) of the total Venezuelan population (26,071,352). Constituting the most extensive ethnic diversity in the state of Amazonas, representing 53.7% of the total population. Indigenous women are 49.5% (359,016) of the country’s total indigenous population, and in Amazonas, they represent 26.4% of the state’s population.

10 It is important to mention that the Venezuelan government stopped publishing the Weekly Epidemiological Report (*Boletín Epidemiológico Semanal*) from October 2014 until the 26th week of 2015 (June 28th to July 4th). In the first few months of 2016, the Venezuelan Society for Public Health (*Sociedad Venezolana de Salud Pública*) reported that the reports corresponding to the 15 months of an epidemiological information gap about more than 72 diseased of mandatory notification and other valuable data for the public were silently added to the Ministry of Health’s web portal. Likewise, epidemiological data with ethnic variables have not been published since 2012.

11 See: National Statistics Institute (*Instituto Nacional de Estadística*) (2014). *Resultados por Entidad Federal y Municipio del Estado Amazonas* [Results by Federal Entity and Municipality of the State of Amazonas]. Online Version. Available at: <http://www.ine.gov.ve/documentos/Demografia/CensodePoblacionyVivienda/pdf/amazonas.pdf>

consultation, and many times, they were returned to their homes due to medical personnel's absence. Also, indigenous women had to bypass the lack of medical supplies and the ineffectiveness of imaging equipment.

2. Integral Diagnostics Center “Gilberto Rodríguez Ochoa” in Puerto Ayacucho has not offered gynecology service since 2015. However, in previous years, several health activities that included the delivery of condoms and contraceptives were arranged.
3. Among the few spaces that provided sexual and reproductive health attention was Puerto Ayacucho's Comprehensive Care and Training Center for Women (henceforth, CAFIM by its acronym in Spanish, *Centro de Atención y Formación Integral de las Mujeres*), affiliated with INAMUJER. Inaugurated in 2015, CAFIM offered fluctuating care, and the center's functioning was deeply affected by INAMUJER's central administration's hesitant support. Who, on multiple occasions, argued the lack of funding for equipping a gynecology consulting room and pap-smears funding – analyzed by a private medical laboratory– due to the lack of a similar service in the public system.
4. While the Regional Health Directorate (*Dirección Regional de Salud*) organized activities between 2014 and 2015 that included sexual and reproductive healthcare, these activities decreased (doing only 3) and operating range (covering only the urban area) by 2016. Additionally, the Amazonian Center's Autonomous Investigation and Tropical Diseases Control Service (*Servicio Autónomo Centro Amazónico de Investigación y Control de Enfermedades Tropicales, SA-CAICET*) –does not have any offices with direct competencies in the area of sexual and reproductive health– planned and implemented an HPV early detection activity in 2015, but it was an action inherent to an investigation being carried out by female researchers close to the center, so it did not have a medical-care nature¹².

If the situation was dramatic in the city of Puerto Ayacucho, the neglect in other of the state's municipalities was, and still is, distressing. None of the other municipalities far away from Puerto Ayacucho has services like the ones found in Puerto Ayacucho, which –despite its significant limitations– is the only place in the state where it is possible to find gynecology and obstetrics specialists. Integral Diagnostics Centers of the other municipalities never offered specialized medical attention. Therefore, when indigenous women attend those centers seeking to solve specific sexual and reproductive health problems, which cannot be treated with traditional indigenous medicine, are referred to health centers in the city. This place is currently almost unreachable –because of its remoteness and transport cost– for most of the indigenous population¹³.

The complex humanitarian crisis that Venezuela has faced destroyed healthcare spaces nationwide, being that Amazonia is one of the territories with a more significant impact in terms of access to the right to health. The COVID-19 pandemic has recently intensified the already-

12 This activity, done during May 2015 and June, was coordinated along with CAFIM (Comprehensive Care and Training Center for Women) and INAMUJER (National Women Institute).

13 With gas price dollarization in Venezuela, most indigenous and rural communities are entirely devoid of constant access to nearby cities.

mentioned conditions. Similarly, geographical challenges in access to territories, historical discrimination in access to health, armed group presence, and widespread crime that controls indigenous territories amplify the obstacles to the exercise of the right to health of indigenous peoples in all its dimensions. Effective healthcare intervention in indigenous territories depends on structured, urgent, and differentiated government actions in alliance with indigenous peoples and communities, which has not been carried out in Venezuela.

In addition to the previously described health emergency, a series of expressions of intersectional discrimination and violence are produced in inpatient and outpatient medical care spaces that –superimposed the lack of public policies and protection regulations for indigenous women and their SRRs– rendering impossible the effective exercise of their human rights.

One of the main manifestations of intersectional violence can be seen in the constant and supported aggression from medical and nursing personnel against indigenous women and girls of their ethnic condition and difficulties that arise from their poverty and social exclusion situation. For most indigenous women, especially those who come from indigenous communities, the sole fact of entering the hospital represents a first death. This idea was repeated by Marlenys Blanco¹⁴, an indigenous leader interviewee when she claimed: “As my daughter died, I did not want to see how she suffered at the hospital because that is what happens there to all indigenous people.” (M. Blanco, personal conversation, November 21st, 2016).

The medical healthcare space as a place of suffering and death, and not healing, comes from racist systematic institutional violence that expresses the way of addressing and understanding the needs of indigenous women in ob-gyn services provision.

There are numerous possibilities of institutional and obstetric violence toward Indigenous women due to the challenges that some may have to communicate in

Spanish and understand diagnoses and indications. This obstacle is one of the most common reasons why gynecological, prenatal, and postnatal medical controls are not done and continued. These violent acts frequently go unreported since some indigenous groups use silence as a rejection manifestation against the discrimination they experience.

The lack of complaint –that from the Westernized perspective is a symptom of passivity or simply indifference– is one of the most common outrage demonstrations among some Amazonian indigenous groups like the *huottüja*¹⁵, even considering the confrontation towards the offending medical personnel as a sign of vileness and poor emotional containment.

Incidentally, one of the *huottüja* contributors who offered her testimony for this work stated: “When one is in the hospital, there is one person who gives you the food but does not treat you well. Some doctors mistreat them, and some treat them nicely. To the ones who mistreat, I don’t say anything to them because if I do, I am like them.” (R. García, personal conversation, January 10th, 2016).

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15 Commonly called *piaroas*, the correct definition to name them is the term *Huottüja*.

Thus, the most significant manifestation of rejection towards aggression is leaving and not returning to the healthcare center.

Indigenous women's challenges to approaching scientific and institutionalized medicine are not only related to language-related challenges; they are intrinsic to the healthcare personnel's exercise of power, who also offer information filled with technicalities and devoid of the necessary sensibility to make it accessible to indigenous women.

The lack of timely support and guidance (which should be paired with diagnoses) negatively affects patients, who do not find the empathy and company necessary to face the results and find solutions. Hence, it is common for them to return to their original communities without treatment or medical guidance, where they will pass away without any record. Although the MPPS had assigned the company task to the indigenous health directorate and its personnel, this policy has not had the necessary support to ensure efficient work since its creation.

The image of the indigenous woman as a subhuman being, as a being incapable of understanding medical indications, is inserted in the mentality of most attention personnel, but what is also embedded is the idea of the indigenous woman as an experiment subject, for whom no one will worry about. Precisely, the gaps in indigenous women's SRRs guarantee contribute to this phenomenon and enable the reproduction of obstetric violence.

One of the testimonies collected reveals how, during the first birth of an indigenous woman, the obstetric violence of which she was a victim also involves a form of intersectional violence:

“I went through many things; I was being pushed so the baby would come out forcefully because they did not want to put me in the operating room. They said there was no anesthesia [the doctors]. They screamed at me: Give birth normally because you give birth like the bitches in the wild! I almost died; it was there that I no longer wanted to go to the hospital ever again.” (L. Pérez, personal conversation, May 22nd, 2015)

Indigenous women's vulnerability towards the patriarchal medical power is related to the colonist vision that affiliates health with the dominance of Western medical science, which –we must emphasize– pushes aside and discredits the forms of traditional birth care of indigenous peoples.

Traditional Western maternal, gynecological, and obstetrical care miserably fails among indigenous women (especially girls and elders) because of its overly invasive clinical tests and analysis procedures. Due to cultural reasons, indigenous women need special conditions for gynecological and obstetrical care, which are essentially characterized by respect for the ancestral conception of sexuality, maternity, and traditional indigenous medicine.

This implies sensitizing staff on indigenous issues, but in a more significant measure, on how indigenous people conceive the body and the symbolic meanings encompassing genitalia and sexuality.

Conclusions

Even though SRRs are not constitutionally embodied in Venezuela, the government has acquired international compromises in the matter. Nevertheless, there are no public policies that ensure conditions for the exercise of these rights, aggravating this scenario for groups that are victims of social vulnerability, like Indigenous women.

The institutional gap around Indigenous women's rights –specifically SRRs– is so noticeable that it exposes how little relevance this topic has for the Venezuelan government. However, reality shows that the highest rates of mother-child mortality and patriarchal violence, which comes from non-governmental armed groups involved in illegal mining, put at risk the life and integrity of Indigenous women, teens, and girls¹⁶.

Actions and policies that have been implemented nationwide, in addition to being client activities with no measurable impact, have not had a positive impact on the indigenous populations because they have been set from a perspective that considers women as a homogenous group, ignoring indigenous women's differentiated needs. Similarly, they do not take into account systemic racism and sexism, seen in intersectional violence and discrimination, from the medical power that complicates and hinders indigenous women in the exercise of their SRRs.

Finally, it is essential to remember that the Venezuelan government has tried to hide the severity and impact of the humanitarian crisis in Venezuela, as well as it has contributed to the dismantling of healthcare institutions. Thus creating and favoring a scenario where the lack of guarantees of indigenous women's SRRs has endangered –and continues to do so– the right to life and continuity of indigenous groups, which infringes the State's obligation to respect, protect, and ensure the right to life.

16 Also see: Conde, Amelia & Moncada, Alicia (2014). *Segunda asamblea de mujeres indígenas de Autana* [Autana's Indigenous Women Second Assembly]. Available at: https://www.academia.edu/24220098/Segunda_Asamblea_de_Mujeres_Indígenas_de_Autana; Moncada, Alicia (2016) "Aportes para el análisis de la violencia contra las mujeres indígenas en los contextos mineros" [Input for the violence analysis towards indigenous women in mining contexts]. In: *Mujeres, Derechos y Políticas Públicas en América y el Caribe* [Women, Rights and Public Policies in the Americas and the Caribbean]. Mexico City. MobyDick Editorial [publishing]. Moncada, Alicia (2017) "Oro, sexo y poder: violencia contra las mujeres indígenas en los contextos mineros de la frontera amazónica colombo-venezolana" [Gold, sex, and power: violence against indigenous women in mining contexts in the Colombian-Venezuelan Amazonian border]. In: *Textos e Debates* [Texts and Debates], Universidad Federal de Roraima, 31, January-June, 43-53, and Moncada, Alicia (2020) "Trata de mujeres indígenas en Venezuela: la continuidad de la conquista sexual de América" [Indigenous Women Trafficking in Venezuela: The Continuity of America's Sexual Conquest]. In: *Revista Venezolana de Estudios de la Mujer* [Women 's Studies Venezuelan Magazine], Universidad Central de Venezuela, Vol. 25, No 54, January-July 2020.

