

ORIGINAL RESEARCH

Occupational Safety and Health in Venezuela

Yohama Caraballo-Arias, MD

Caracas, Venezuela

Abstract

INTRODUCTION Venezuela has pioneered a preventive-focused and comprehensive movement for Occupational Safety and Health (OSH) in Latin America. However, despite being an oil-rich country, it has some of the lowest salaries for their workers and highest levels of hyperinflation, devaluation, crime, and violence of the world.

OBJECTIVES Review the current status and challenges on relevant aspects of OSH in Venezuela.

METHODS Review of literature and documents from national governments, UN agencies, NGOs, and the Venezuelan government concerning OSH and related topics since 1986.

RESULTS Reformed in 2005, the Organic Law on Prevention, Conditions and Environment (LOPCY-MAT) was a fundamental moment of change for OSH. Factors which have impacted OSH the strongest are (i) the creation of the National Institute of Occupational Safety and Health (INPSASEL) and (ii) the socioeconomic crisis Venezuela is going through.

Venezuela's laws are innovative and yet non-compliance is enormous. Almost half of the population works in the informal sector. Following the International Labor Office projections, 5 people die per day in Venezuela due to occupational accidents or diseases, making health and safety at work a luxury rather than a right. The quality of life for the average worker has deteriorated, affecting not only health but the overall well-being of all Venezuelans. The political and socio-economic situation has led to a mass exodus of more than 1.6 million highly qualified and talented professionals. Many statistics concerning OSH are not updated and are unreliable regarding occupational accidents and diseases.

CONCLUSIONS There is a substantial difference between what is written to protect individual Venezuelans in the workplace and the reality of workplace conditions. Substantial governmental actions are needed in the immediate future to improve occupational safety and health of Venezuelan workers.

KEY WORDS occupational medicine, occupational health, social security, Venezuela

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INTRODUCTION

Workers represent half of the world's population and are the major contributors to the economic and social development of a contemporary global society.^{1,2} Usually "oil countries" are considered wealthy because oil is one of the most profitable

businesses in the world. Venezuela has the world's largest oil reserves and has been one of the world's leading exporters of oil and activities related with oil and other minerals; however, fewer than 2% of the workers are employed by these industries.³ Venezuela may be considered a privileged country in terms of oil, minerals, water, diamonds, gold,

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From the Central University of Venezuela (UCV) and the Associate Venezuelan Group for the Iberoamerican Cochrane Network Foundation Learning and Development on Occupational Health (LDOH), Caracas, Venezuela. Address correspondence to Y.C-A. (yohama.caraballo@ucv.ve).

aluminum, and other natural resources, but the paradox is that at least 48% of its population live in extreme poor conditions.⁴ Unfortunately, with the dropping price of oil and increased social, economic, and political instability in 2014, Venezuela entered an economic recession.⁵ In addition, the country's internal turmoil is evident in the extraordinarily high body count statistics for the decade preceding this economic decline, with the 2014 alone surpassing 24,980 deaths and a rate of 82 murders per 100,000 people.⁶ These numbers mimic that of the Iraq War and at some points surpass them, even though the population is in peacetime.⁷ These numbers make Venezuela the second highest in the world for homicides.⁸ The declining economy and increasingly dangerous environments have significantly decreased the quality of life for Venezuelan workers and their families to the point where not even the workplace is exempt from becoming a crime scene. Based on a university study, the troubled population and overall negative situation in Venezuela has led to a migration of an estimated 1.6 million Venezuelans since 1999; however, official statistics have not been published.⁹

As is well known, the health of the workers is determined by a number of factors, including hazards in the working environment, social factors, individual behaviors, and access to health services.¹⁰ All these factors and risks are easier to control in the formal economy. Unfortunately, large portions of the working population are part of the informal workforce and therefore excluded from a number of social security rights. Many work in extremely hazardous conditions that are physically demanding and adversely affect their health.¹¹

This article is a snapshot of what occupational safety and health (OSH) in Venezuela looks like today. Many of the socioeconomic factors, legislation, regulations, health system, education system, training, and research that affect OSH in Venezuela are discussed for their impact on the field at present and prospectively in the future. Ultimately we shed light on the difference between Venezuela's attempts to improve the occupational health (OH) standards for the country's workers and the current reality of unsafe working conditions.

CHARACTERISTICS OF THE BOLIVARIAN REPUBLIC OF VENEZUELA

The current Venezuelan population makes up approximately 30 million people of whom 49.8% are males and 50.2% females.¹² The economically active population in January 2015 was 14.2 million

people and the working population was 13.1 million people (including informal economy), 61% males and 39% females. The unemployed population was 1,100,000, equivalent to 5.5% of the economically active population.¹³ According to PAHO, the life expectancy in Venezuela is estimated at 72 years for men and 80 years for women.¹⁴ Between 2001 and 2011 the rate of aging in the Venezuelan population has increased from 21.3% to 32.4%, representing the percentage of persons older than 59 years per 100 persons under 15 years.¹⁵ It has been confirmed that there is an overall decline in the crude birth rate over the last 15 years: in 2010 the rate per 1000 inhabitants was 24.6, and in 2015 the rate was dropped to 18.6.¹⁶ Between 1990 and 2000, the percentage of adults and elderly individuals in Venezuela increased by almost 17%.¹² All data indicate an aging working population and a potential problem in future.

By the end of 2008, the working population by economic sector was distributed as follows: commerce 37.9%; manufacturing 18.2%; hotels and restaurants 9.3%; transportation 8.1%; community services 7.5%; real estate 5.9%; construction 5.6%; health and social services 4.0%; education 2.8%; electricity, gas and water 0.8% (Fig. 1).¹⁷

In Venezuela there are 427,173 enterprises; 99.49% are medium and small enterprises (<100 workers), 75.5% have between 1–4 workers, and only 0.5% are large enterprises (>101 workers).¹⁷ At least 40.8% of the working population works in the informal sector.¹³ As previously stated, there is a total working population of 13.1 million people, and out of the formal sector 21% work in the public sector and 79% in the private sector.¹³ On the other hand, it is important to mention an example of the low salaries¹⁸ in Venezuela: a full-time university professor gets paid 7.854 bolívares per month, equivalent to \$37.70 (according

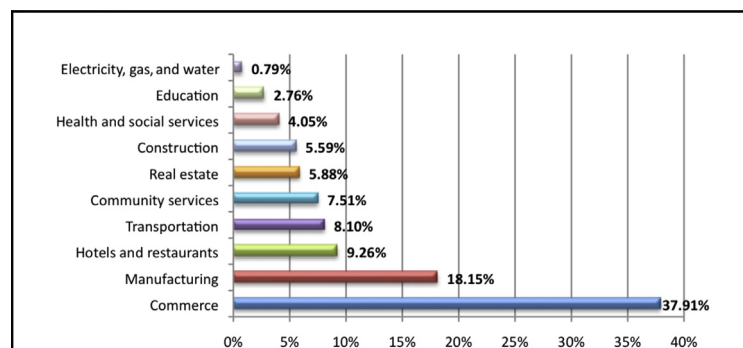


Figure 1. Worker population by economic sector. (Source: Chart translated by the author with numbers from the *Instituto Nacional de Estadísticas. IV Censo Económico 2007–2008*.¹⁷)

to official dollar rate in Venezuela by the *Sistema Marginal de Divisas* [SIMADI], which is currently in 198.5 bolívars per dollar¹⁹; however, there are other exchange rates and the existence of a black market).

GOVERNMENTAL ORGANIZATIONS

The National Institute of Prevention, Health and Safety (*Instituto Nacional de Salud y Seguridad Laborales*). In Venezuela the attention on health and safety at work has expanded significantly since the creation of the *Instituto Nacional de Salud y Seguridad Laborales* (INPSASEL) under the Ministry of Popular Power for the Social Process of Work (*Ministerio del Poder Popular para el Proceso Social de Trabajo*).²⁰ In May 2002, INPSASEL was created with the intention of reviving OSH in Venezuela. It was thought that institutional development and action would enable the design and implementation of a national policy on OSH prevention. A public system of inspection and supervision of working conditions and worker's health was constructed. This comprehensive approach was designed to exist within the Venezuelan social security system and to act according to the demands of the current workplace with the well-defined goal of control and prevention of occupational accidents and diseases.²⁰ However, after more than a decade since its creation, INPSASEL has become more a reactive than a preventive institute, generally making inspections to private companies after an accident has occurred or an occupational disease has been reported. Furthermore, although inspections may be made to public businesses or institutions and recommendations are given, little or no sanctions are ever implemented for inappropriate procedures, in contrast to the approach for private companies. Statistics on deaths, diseases, accidents, and improper following of OSH procedures in these facilities are rarely shared with the public.

The Regional Institute for Management of Workers' Safety and Health (*Gerencias Estadales de Seguridad y Salud de los Trabajadores*). As part of the INPSASEL, the Regional Institute for Management of Workers' Safety and Health (*Gerencias Estadales de Seguridad y Salud de los Trabajadores* [GERESAT]) "State Authority Managers Safety and Health Workers" institutes were developed as regional branches. A GERESAT could provide direct customer service to the workers and employers and be more attuned to the needs in their geographical area than 1 centralized national office could do. The emphasis in these regional centers was on creating a culture for prevention and health promotion

in the workplace and also on providing technical consultants specializing in the areas of occupational medicine, health, hygiene, ergonomics, safety, and labor law. Likewise, these offices would provide evaluations of working environments and working conditions, do accident investigation work, complete procedures for the certification of OSH, and stimulate the establishment of Health and Safety Committees.²⁰ Such committees, with 50% representing the employees and 50% representing the employer, have the mission to gain better rights and benefits to the workers in public and private companies.

Legislation

The Constitution of the Bolivarian Republic of Venezuela. The Constitution of the Bolivarian Republic of Venezuela from 1999 is among the world's longest, most complicated, and most comprehensive constitutions.²¹ Currently Venezuela is 1 of 3 Latin American countries to have their own constitution with an OSH component, specifically Article 89, which declares the Right for Health at Work, which makes Venezuela in principle a leading country in the protection of its workers.²² Article 308 of the Venezuelan Constitution showed a change from how the government previously viewed businesses, introducing support for alternative management of businesses: "The State shall protect and promote small and medium-sized manufacturers, cooperatives, savings funds, family-owned businesses..."²³ In practice, however, problems were created as the operationalization in cumbersome and increasingly bureaucratic procedures were not helpful to the development and perpetuation of small and medium enterprises. These regulations included higher taxes and the need for legal permissions to operate all businesses and did not include sufficient institutional support. In addition, the detailed new rules were ever changing, adding to the volatility of the country and the near impossibility of opening new businesses in Venezuela.

In theory, the government supported these business alternatives as a way to democratize capital and challenge the oligopolistic control of the economy. Government support of cooperatives is in the Constitution, and these cooperatives in Venezuela became a more prevalent business option after the introduction of this government support. Behind the written theory that "the state shall promote and protect these associations destined to improve the popular economic alternative,"²³ the fact is that these associations have promoted less and less the protection of workers' rights; with the absence of a formal employer, it became a conflict for

workers to complain or declare the issue through the INPSASEL system if an accident or occupational disease happened. This is especially true because the relationship between employer and employee is completely horizontal. At the same time, it is clear that these associations face the same difficulties of developing a business as other companies within the formal economic structure. Therefore, many form businesses within the informal structure, with the added benefit of not having to pay any taxes—which are substantial—if they develop this way. In the formal sector, Venezuelan factories as well as public and private companies have been facing budget cuts and have fewer raw materials. This has affected the workplace environment and the employers' investment in OSH, ultimately leading to less healthy workers and less production.

The Republic of Bolivarian Venezuela Constitution (1999) enshrines the right of everyone to social security and protection in the workplace during working hours. To ensure compliance, it was necessary to create institutions with the power to enforce OSH measures and compel employers to guarantee workers an optimally safe and healthy work environment. This constitutional mandate implies the need to develop a policy to protect the health of workers and to prevent accidents and occupational diseases.²³

REFORM OF THE ORGANIC LAW ON PREVENTION, CONDITIONS, AND LABOR ENVIRONMENT—"LEY ORGÁNICA DE PREVENCIÓN, CONDICIONES Y MEDIO AMBIENTE DE TRABAJO"

Before the creation of the 1986 version of the Organic Law on Prevention, Conditions and Labor Environment ("*Ley Orgánica de Prevención, Condiciones y Medio Ambiente de Trabajo*" [LOPCYMAT])²⁴ occupational risks were not considered a priority in Venezuela or Latin America as a whole.^{25,26} The reform of the LOPCYMAT in 2005 was an improvement developed with the intention of constructing a new social security system. The aim was to adapt current Venezuelan law to the necessities of a working population. The dire state of employed Venezuelans demanded regulations that would promote safe and healthy workplaces as well as put in place preventative measures to avoid accidents and occupational diseases.²⁷ The reform also aimed to promote a new, integrated culture of work and leisure as equally important components in the life of every worker. In this

sense, the definition of the working conditions is substantially wider with the added component of leisure and recreation. This breaks with the traditional view that fragmented workers' lives in 2 separate domains (areas)—the factory or workplace and the home or public space.

The reform of the LOPCYMAT had 5 basic objectives:

1. The first objective aims to encourage an authentic culture of promoting safe and healthy work.²⁷
2. Second, the reform actively combats workplace accidents and occupational illnesses through active worker participation and involvement of social stakeholders, in addition to the implementation of policies and mechanisms for monitoring and control.
3. The third objective focuses on reinforcing the need to integrate the control of hazardous working conditions in the management systems of companies, promoting effective mechanisms for monitoring, recording, evaluation, and updating.²⁷
4. The fourth objective is aimed at encouraging an authentic culture of leisure, which contributes to an increased quality of life for workers and has value added to work, also incorporating in everyday life recreation practice, the use of free time, rest, and social tourism.²⁷
5. The fifth objective seeks to improve the enforcement of the rules of health promotion and the quality of life at work by creating substantive rules and by strengthening the regulatory oversight function and control of both the labor inspection system and social security as a mechanism of social participation control.²⁷

In addition to the LOPCYMAT, there is a partial regulation of this law (*Reglamento parcial de la Ley Orgánica de prevención, condiciones y medio ambiente de trabajo*), which was published in 2007.²⁸ One important achievement is the creation of the Health and Safety Committees (*Comite de Seguridad y Salud Laboral* [CSSL]), resulting in more than 17,000 of them across the country. Some consider these committees as the first stage of resolution for health and safety problems.²⁷

With regard to public policies, Venezuela has spearheaded OH in Latin America since the 1980s. The Technical Standards Committee from the *Fondo para la Normalización y Certificación de la Calidad* (FONDONORMA) managed to produce a completely modern regulatory framework and even served as a model for standards in other Latin American countries. However, after the change to make INPSASEL the regulatory body, Venezuela has had very low productivity in the

publication of new standards and in updating the old ones. Since the creation of INPSASEL in 2008, 2 technical norms and 1 guideline have been published: 1 norm about the “Occupational Safety and Health Program,” in which it was established—among other requirements—that all companies should provide 16 hours of training related to OSH per trimester,²⁹ and the norm about the Occupational Diseases declaration including a list of 64 occupational diseases³⁰; 1 technical guideline of prevention regarding prevention delegates.³¹ In contrast, the Regulations for Occupational Health and Safety at Work (*Reglamento de Condiciones de Higiene y Seguridad y Salud en el Trabajo*) has not been updated since 1973.³² From a positive perspective, the Law for Persons with Disabilities (*Ley para las Personas con Discapacidad*) was published in 2007.³³

The country is still expecting more than 10 guidelines to be published, but many are convinced that changes do not happen magically just with the creation of more regulations, and the gap between the already existent written guidelines and the reality of life for the average Venezuelan worker is a definite problem that needs to be remedied for life to improve for the people.

ORGANIC LABOR LAW FOR MALE AND FEMALE WORKERS (*LEY ORGÁNICA DEL TRABAJO DE LOS TRABAJADORES Y LAS TRABAJADORAS*)

In addition to LOPCYMAT, the Organic Labor Law for Male and Female Workers (*Ley Orgánica del Trabajo de los Trabajadores y las Trabajadoras*

[LOTTT]) was reformed in April 2012.³⁴ It incorporated many important milestones for OSH like the reduction of the weekly work hours standards to a maximum 40 hours a week, increased maternity benefits, declaration of formal rights for domestic workers, and creation of several other relevant articles protecting workers in specific jobs.

Occupational Accidents and Diseases. The ILO estimates that approximately 2.3 million workers per year are dying worldwide as a result of occupational injuries and illnesses.²⁹ In Venezuela, according to Article 70 of the LOPCYMAT, an occupational disease is defined as a disease that was “incurred or aggravated during work or exposure “to the disease states in which the worker is required to work”, such as those attributable to the action of physical and mechanical agents, ergonomic conditions, meteorological, chemical, biological, psychosocial, and emotional factors, which are manifested by an organic lesion, enzyme or biochemical disorders, functional or mental disorders, temporary or permanent imbalance.”²⁴ Today OSH is a public health problem because it affects a high percentage of people around the world.³⁰ And taking the ILO projections into account, in Venezuela it is estimated that 5 deaths occur daily because of occupational accidents. This is alarming considering that 100% of them could be prevented.

In 2006, INPSASEL published a report stating that musculoskeletal disorders were the most common occupational diseases diagnosed (76.5%), followed by conditions related to psychosocial factors (6.3%), respiratory diseases (3.9%), voice pathologies (1.5%), and noise-induced hearing loss³³ (1.3%) (Fig. 2).³¹ The latest news from INPSASEL states that 90% of the occupational diseases are musculoskeletal disorders,³² showing these are relatively on the rise. Again, 100% of these diseases and accidents could be prevented with adequate OSH policies enforced by the government, social organizations, unions, schools, and universities and the active participation of the workers.

It has been found that 90% of workplaces in Venezuela do not have access to occupational health services. Therefore when an accident occurs, or symptoms of an occupational disease are noticed, these workers visit their primary care physician, who usually does not suspect the connection between the injury or health complaints and the workplace.³⁵ In practice, the diagnosis of occupational diseases is one of the most important challenges for occupational physicians and members of the Health and Safety Committees in Venezuela.

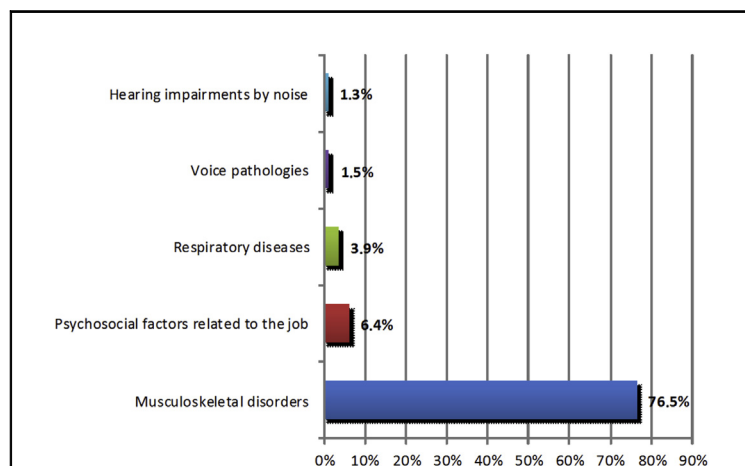


Figure 2. Top 5 occupational diseases in Venezuela. (Source: Based on data published by Instituto Nacional de Prevención, Salud, y Seguridad Laborales, 2006.³³)

It requires the intervention of professionals from different disciplines and an analysis of various aspects that may be involved in the genesis of work-related complaints and diseases. This process of genuine inquiry is made even more complex because it warrants biopsychosocial assessment of intra- and extra-workplace issues, which further hinders the process. It is important to emphasize that in Venezuela the concept of occupational disease also includes nonoccupational pathological conditions that could be aggravated during work. In other words, all common pathological conditions such as a hypertension could be qualified as “aggravated by the occupation” if sufficient elements to consider it are collected. Such a claim requires a genuine, critical analysis and highly qualified professionals to determine the contribution of causal factors at work in addition to the whole context and the personal history, identifying and considering each of the possible causes. For many years it has been recognized that there are no accurate statistics reflecting the problem, but it can be inferred that it is generally high because high rates of disability are common among the Venezuelan working public.³⁶ With the significant issue of under-reporting, occupational disease figures are often not reliable.³⁵

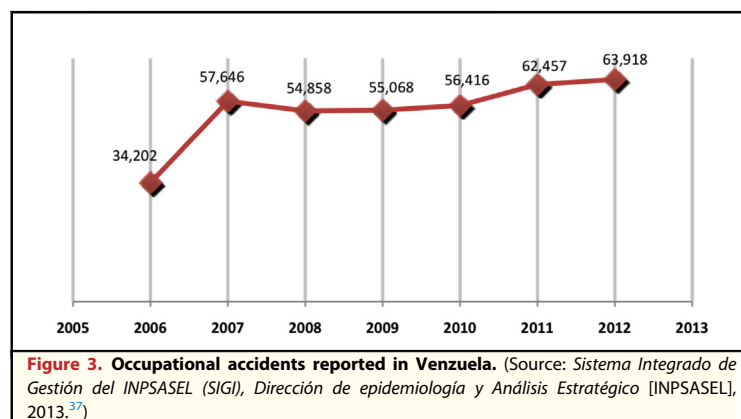
Work-related Accidents. Before the creation of INPSASEL, the best statistics were reported by the Directorate of Occupational Medicine at the Venezuelan Institute of Social Security (*Instituto Venezolano de Los Seguros Sociales*). However, in 2008, this institute was only able to cover 23% of the working population.²⁷ Based on this information it was estimated that there would be at least 144,000 accidents at work, and 10% of those workers would be permanently disabled from these accidents every year.³¹ However, in 2008, only 54,858 workplace accidents were reported—that means less than 50% of the accidents in the workplace. The failures in the Venezuelan system of labor statistics, as well as the issue of under-reporting, have made it impossible to quantify the real impact of accidents³⁷ and occupational diseases on the working population (Fig. 3).

The 2006 statistics showed that the occupational fatality rate for accidents was 15.6 per 100,000 people in Venezuela, very high compared with the United Kingdom at 0.8 per 100,000 inhabitants; Sweden, 1.4 per 100,000 inhabitants; and Switzerland, 2.0 per 100,000 inhabitants.³⁸

Crisis and Informal Economy. In recent years, Latin America has begun experiencing a socioeconomic crisis, and Venezuela could not avoid these problems.

The economic crisis is reflected in a decline in purchasing power, high levels of poverty, and a great rise in unemployment. A large consequence of this situation is the growth of an informal economy, which has significant potential to create jobs and income but has minimal requirements in education, qualification, technology, and capital.³⁰ If a person chooses to leave the formal economic sector and enter the informal sector to gain an income, they also have the added benefit of not having to pay taxes, a substantial benefit to the Venezuelan working class.

The Venezuelan National Institute of Statistics conducted a comparative analysis of the population employed in the informal sector that showed that in June 2011 there were 5,177,000 informal sector workers, whereas in June 2012 there were 5,401,000, an increase of 223,600 people.³⁰ Because of the precarious situation, low incentives, and very low salaries in the formal economy, the informal economy is growing, and new desperate ways to make money are starting to appear. With lines for basic products at the grocery stores that last for hours, the black market for goods is growing quickly and employing more Venezuelans who could have been part of the formal economy if the economy was more stable. In the meantime, while the workers and their families spend a lot of time trying to get basic products, their leisure time is reduced, giving them less time to relax and perform rewarding activities. In turn, the loss of these activities has a negative impact on other areas of life including their work productivity. As a conclusion, if well-being is the sum of economic, social, cultural, and labor conditions as well as favorable health, leisure time, and sports, we can conclude there has been a significant deterioration to the overall well-being of the working population in Venezuela.



Occupational Medical Training and Research Resources.

It is a paradox that medical schools in Venezuelan universities promote healthy environments and yet these students will end up in unhealthy work environments by no fault of their own.³⁹ With little care from the government for the working environment of our medical professionals and scientists, there are few incentives to stay in Venezuela. Approximately 1.6 million professionals have left the country for a better life elsewhere. One element that measures the importance that countries attach to scientific research is the allocations of funds to institutions and technology development programs.⁴⁰ Japan allocates 2.8% of its GDP, United States 2.6%, France 2.3%, whereas Argentina allocates 0.38%, Chile 0.4%, Mexico 0.31%, and Venezuela 0.34%.⁴⁰ This means Venezuela provides a very small budget to research compared with many other Latin American countries, in principle rich nations. This is why research centers, universities, and public and private health are losing highly qualified staff, specialists, and researchers for lack of incentives.

UNESCO has estimated that developing countries should have at least 1 researcher per 1,000 inhabitants to advance science and technology. According to that argument, Venezuela should have 24,000–30,000 researchers in all areas of knowledge. However, the Observatory of Science and Technology and the Research Promotion Program (*Observatorio Nacional de Ciencia tecnología e Innovación*, created by the Chavez government and operated until 2009) estimates that Venezuela had 6822 registered researchers,⁴⁰ but there are no statistics about how many of them are OSH researchers. Without question this number has dropped in the last 5 years as economic turmoil and social unrest has increased. As a courtesy, the Venezuelan Society of Occupational Health (*Sociedad Venezolana de Salud Ocupacional*) provided registration numbers from the year 2014 that said there were 815 occupational physicians, 31 hygienists, 18 ergonomists, and 45 occupational physiologists.⁴¹ Venezuelan scientists started facing budget cuts and increasing pressure from government institutions. Most basic science programs in Venezuela are currently destined to disappear.⁴² This dire situation within Venezuelan science has worsened considerably as a product of a combination of factors, which include political decisions and an unprecedented economic crisis. Venezuela is the only South American nation whose scientific output is declining, and it ranks among the lowest

current citation impact weighted by research field in the region.⁴²

A study in lower- and lower-middle-income countries (2 Venezuelan medical schools participated) explored the attitudes of medical students toward OSH and its perceived importance in overall health. This attitude could be changed by modifications in OSH courses that reflect the importance of OSH.⁴³ However, individuals spend much time and efforts to be aligned with evidence-based medicine and to promote occupational health-based evidence with a Cochrane Associate Group in the Universidad Central de Venezuela. It is led by an occupational medicine specialist professor⁴⁴ with the goal of using the best scientific evidence possible to increase awareness in professional practice and to improve practice and care for the workers.⁴⁵

CONCLUSIONS

The written regulations for OSH in Venezuela are innovative and detailed; however, the gap between what is written and reality is significant. Although there are multiple governmental groups all attempting to use their limited resources—Venezuelan Institute of Social Security, Ministry of Popular Power for Health and Protection Social, Ministry of Popular Power for Work and Social Security, INPSASEL, Ministry of Popular Power for Environment, Ministry of Popular Power for Energy and Petroleum²⁷ they are not completely articulated with each other. Greater coordination among these government organizations would contribute to a substantial development of OSH policies and enforcement of policies in industries, in the public sector, and in the informal sector of Venezuela.

It seems that despite having increased the OSH structure in the country over the past decade (legislation, inspector body, more OSH services, OSH delegates, labor, health and safety committees, more professionals) the overall performance has not improve in the same proportion. Unfortunately, it seems that Venezuela will not have good updated basic information from statistics in the near future, avoiding consequences on public policy, so there is no way to know what the situation really is. Not knowing the size of the problem and having unreliable or old data limit the possibility of developing a successful solution.

The low diversification of the Venezuelan economy is one of the main reasons for the country's limited economic growth, with a current situation

that puts Venezuela well within the category of unpredictable and turbulent markets, with high levels of volatility.⁴⁶ Venezuela is facing a recession, extreme scarcity of basic goods and medication, poverty, hyperinflation, and criminal violence. Some of the country's biggest overarching problems are issues of social inequality and political instability. If these areas are at best in flux and at worst diminishing, they are undoubtedly affecting the practice of OSH in the country. Venezuela is a country that has made some attempts to decrease social inequities and to improve OHS by creating additional social welfare benefits—called “missions”⁴⁷—for its working population, but most have fallen short. And now with its primary source of income—oil—dropping in price, the sustainability of these benefits are in doubt with the presumption that these programs will tend to disappear. Nevertheless, closing the gaps in health and achieving better results demand that Venezuela strengthen their technical capabilities. It is important to spread the message to the entire community and educate the public on the cost of not taking preventative measures.²² Ultimately, investing in OSH now will bring far more benefit than cost.

Despite more than a decade of significant endeavors on the part of the Venezuelan government, the needs of the majority of workers are not met. In addition, the working conditions for the majority of those employed in this country do not meet the basic standards and guidelines set by the ILO regarding

decent jobs. Ultimately, the Venezuelan authorities still have huge challenges to overcome in order to reach internationally standardized levels of workplace safety and well-being.

Venezuela is a young country with relatively recent occupational safety and health regulations; important steps have already been taken to address the challenging task of creating a preventive culture in a hardship location with parallel priorities in the society. The expectation is that in the next decade the OSH management system can mature and get the necessary consolidation with the synergy, integration, and commitment of all layers of the society; with the active participation of the principal social actors from the public and private sectors, universities, and intellectual, scientific, and technical professionals; with the support of good infrastructure, enough inspections, an appropriate number of OSH professionals, informative lessons, and websites; and even the inclusion of new ways to communicate and spread the preventive message to improve the working conditions and reach the authentic transformational change to reach the development of the potentialities of the workers, including spiritual growth that goes beyond the borders of the workplace.

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