Tracking community perceptions in Venezuela during COVID-19

Raissa Azzalini and Oxfam team in Venezuela

A new tool to collect and track people's perceptions in the context of COVID-19 is providing valuable information to help support communities during the pandemic, while enabling greater community engagement.

In June 2020, Oxfam launched a project led by local partners to engage communities in preventing the spread of COVID-19. In a context where there was limited availability of official data, a Community Perception Tracker (CPT) was used to record communities' insights and concerns about the virus with the aim of giving voice to their views and supporting them to develop their own action plans to reduce disease transmission.[1]

During the first cholera epidemic in Haiti in 2010, and while responding to Ebola in West Africa in 2013–14, Oxfam learned valuable lessons about engaging with communities in disease outbreaks. The importance of collecting qualitative data was recognised to be key to putting crisis-affected people at the centre of the response,[2] and in 2018 Oxfam developed the CPT. This was piloted in the Democratic Republic of Congo during the 2018–19 Ebola outbreak. In 2020, Oxfam adapted the CPT for COVID-19 and implemented it in 13 countries, including in Venezuela where the pandemic had exacerbated an existing crisis in which an estimated seven million people were already in need of humanitarian assistance.

How does the CPT work?

A form loaded on a mobile device (whether phone, laptop or tablet) using Survey CTO software is used to record people's perceptions – their questions, concerns, beliefs and practices in connection with the spread of disease. Respondents are asked about their geographical location, age and gender, whether they are disabled, and if they (or a family member) have had COVID-19. They are also asked from where and whom they got the information which has influenced their perceptions. This is repeated regularly – daily or weekly – because of the dynamic nature of the disease outbreak and responses. Oxfam teams and partners enter data on the perceptions of individuals and groups they meet (in person and remotely) during the course of their daily activities. The information can be recorded directly in the form on the mobile device, or on paper and then transferred to computer later, depending on the sensitivity of the context.

Perceptions are grouped in relation to twelve pre-determined categories (including existence of the disease, treatment, vaccination and stigmatisation) to facilitate analysis and identify trends. Analysis of the qualitative data is then triangulated with epidemiological data. Weekly reports encapsulate the data analysis and recommendations for action, and rapid feedback can then be provided to communities and authorities. As people's priorities and perceptions change, staff are able to monitor and adapt responses. When more in-depth, supplementary information is needed, other data collection methods such as focus group discussions and semi-structured interviews are used. CPT is particularly useful in that it brings the voices of communities – through the evidence-based information gathered – into coordination and advocacy platforms.

Findings from Venezuela

From June to December 2020, Oxfam analysed people's perceptions in 16 communities across three states, providing valuable information about the situation of people on the move. Local communities shared their concerns about contagion risks in temporary shelters hosting migrant returnees. In addition, people spoke of their fear of infection from

returnees and expressed discriminatory beliefs and attitudes towards them. The lack of COVID-19 prevention measures at the unofficial border crossing points increased local communities' concerns and in some cases led them to restrict access to their communities for returning migrants.

"In the border area this affects us directly because returnees use the illegal roads on a daily basis and this means that the virus can be more widespread as many people pass through." (Male resident, Pedro María Ureña municipality)

As a result of better understanding people's perceptions, Oxfam's local partners promoted dialogue around inclusion in order to reduce discrimination; in addition, information on staying safe and preventing the spread of the virus while welcoming migrant returnees was included in community action plans. Community members disseminated social media and offline messages promoting inclusion.

One of the important features of the CPT in Venezuela has been its ability to provide systematic information where there has been a long-standing lack of official epidemiological data. Its ability to highlight trends has been vital in shaping and adapting Oxfam's humanitarian response. Between June and December 2020, the most commonly cited concerns relating to COVID-19 were about the perceived risk of contagion from migrant returnees, questions about prevention, doubts about the efficacy of using masks, poor acceptance of the importance of physical distancing, concerns about income-generating activities and access to food, concerns about children's education, and the psychological consequences of the pandemic. During the first months of data gathering, people even denied the existence of COVID-19. Six months later, people believed it existed. In December, the key concern expressed was about how to prevent COVID-19.

In Zulia state, data reflected information overload within communities, leading to misunderstanding of COVID-19 transmission and treatment. As a result, at the beginning of all their activities Oxfam and its partners organised question-and-answer sessions led by medical staff. For example, one boy said: "I would be afraid to go to the hospital if I felt any symptoms." Given that this fear was widely shared, more information was subsequently provided on self-isolation and shielding so that people could still help themselves even if they did not go to health facilities.

The analysis of data collected through the CPT process was fed back to communities who were encouraged to use the findings to develop community action plans to increase their capacity to prevent transmission of COVID-19. Examples of community action plans include plans for the dissemination of information, face-to-face and virtual workshops, training of community promoters, delivery of brochures with information on preventive measures to mitigate the risks of contagion, distribution of hygiene kits, and street art with prevention messages.

Challenges and successes

Given mobility restrictions, all CPT training, analysis and monitoring meetings were conducted remotely. This was challenging due to constant power cuts and poor internet connectivity and mobile networks, but with motivation, creativity and adaptability the local partners succeeded in engaging with communities.

Since 2015, Venezuela's health ministry has not published its epidemiological bulletin. The lack of regular dissemination of official data has led local organisations to question the reliability of the data which is actually available. Although the CPT cannot substitute for official epidemiological data, it does provide regular, relevant, useful and trusted data generated by community perspectives.

The CPT is not able to fully encapsulate the concerns of people on the move because it requires repeated contact with the same community members. Migrants and people moving frequently do not stay long enough to share perceptions regularly via the CPT or to build trust with the staff who want to record their perceptions. It is also more challenging to share CPT findings with migrants. Nonetheless, the communities

that participated in the CPT are greatly affected by migration and mobility. Many of their members have been displaced before or they have close relatives living in other locations, and their opinions are influenced by mobility trends in their communities.

Another limitation, which was also found in other countries where the CPT has been used, is that the CPT for COVID-19 does not necessarily allow capture of other concerns such as natural disasters or other diseases. Oxfam is exploring how a CPT for a broader range of issues could be developed and implemented.

In the evaluation conducted in Zulia among communities with Community Action Plans, people reported that they felt ownership of the action plans and described changes in their beliefs and attitudes about COVID-19 prevention. By 'taking the pulse' of communities and facilitating active community engagement, the CPT had contributed to creating an enabling environment for people to protect themselves despite the challenges they face. Over the course of several months, local organisations have developed their skills in listening and analysis, and the CPT has become part of their way of working. In Venezuela the CPT has also contributed to the Oxfam team's goal to provide valuable data and analysis to enable communities to design and implement their own action plans to prevent the spread of the virus.

Using a combination of participatory methods and tools to understand affected communities in humanitarian responses is not new, but it is more often done in relation to a specific sector of intervention (such as health promotion, protection or livelihoods) and not always well documented. What is new about the CPT is that it provides a single tool for all teams and partners, a more holistic approach when listening to communities, and a fast, systematic means of collecting and reporting. During the process, all sectors – plus managers and the monitoring, evaluation, accountability and learning teams – work together to get to the heart of community concerns in disease outbreaks. The CPT has shown great potential for adding value to improving community engagement in disease outbreak responses although its full potential has yet to be realised.

Raissa Azzalini *raissa.azzalini@oxfam.org*
Public Health Adviser/CPT coordinator, Global Humanitarian Team, OXFAM with the Oxfam team in Venezuela[3]

1. www.oxfamwash.org/communities/community-perception-tracker

2. See UNICEF (2020) *Minimum Quality Standards and Indicators for Community Engagement*, pp18-19 bit.ly/UNICEF-MinStds-comm-engagement-2020

3. For security reasons individuals are not named.