SI-PANDA
Behavioural Insights Survey on COVID-19: Slovenia

NIJZ National Institute of Public Health

COVID-19 PANDEMIC IN SLOVENIA

Results of a panel online survey on the impact of the pandemic on life (SI-PANDA), 19th wave

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KAZALO

INTRODUCTION

Pandemic fatigue is the expected and natural human response to long-lasting public health crisis that significantly affects the daily life of an individual. It appears gradually and is influenced by emotions, experience, and attitudes. It is a response to long-lasting and unsolved distress in people's lives. The severity and the scope of COVID-19 pandemic and the introduction of strict measures to prevent and limit the transmission of the infection have a huge impact on the daily lives of all people, including those not directly affected by the virus. Over time, people's compensatory mechanisms for crisis management become fatigued and so these people lack motivation to follow recommended self-protective behaviours, and consequently jeopardize the effectiveness of measures to prevent the spread of SARS-CoV-2 virus infection among the population.

Understanding COVID-19-related human behaviour enables the identification of at-risk target groups and contributes to finding solutions that encourage better adherence to protective behaviour recommendations. Adherence to measures most effectively reduces the transmission and spread of SARS-CoV-2 in the long run, reduces fatigue and distress of all kinds, and increases the quality of life. In addition, it maintains a functioning healthcare system, enables the normalization of health promotional, preventive, and curative treatments, normalizes the functioning of all segments of society, from education to economy, and enables reducing inequalities through remote determinants of health. Above all, it can most effectively reduce the COVID-19 burden at the individual and social level in Slovenia.

The aim of the research is to investigate and understand human behaviour in relation to COVID-19 and to assess pandemic fatigue during and after the COVID-19 pandemic in Slovenia. With the help of this research, we hope to identify and address the impact of the pandemic, the measures introduced, and the recommendations and decisions made by the government on people's lives. Here are some key results. The data collected in the survey provide key information on pandemic fatigue of the general population for professionals and decision makers. This also enforces the recommendation of the World Health Organization[1], that countries regularly conduct qualitative and quantitative population surveys, which should serve as the basis for further action.

[1] https://apps.who.int/iris/bitstream/handle/10665/335820/WHO-EURO-2020-1160-40906-55390-eng.pdf.

METHODOLOGY

The survey in the form of an online questionnaire takes place in nineteen replicates starting on 4 December 2020. The first part of the survey (up to and including the 12th wave) was conducted by the Mediana Institute for Market and Media Research on behalf of the National Institute of Public Health (NIJZ); and the second part is conducted by Valicon. The first twelve repetitions were performed once every two weeks and the second part once a month. Data are analysed at the NIJZ.

Selected panel members are invited to the online survey, which takes place through the online panel. Each wave of online survey involves a sample of about 1,000 adults aged 18 to 74.

In the survey, we use the World Health Organization (WHO)[2], questionnaire, which was translated, and adjusted to the situation in our country in accordance with the WHO instructions, and we also included some additional questions.

The data presented in the report are weighted by gender, age groups and statistical region.

The report mostly presents data from the **19th wave** of the panel web survey, that took place **from 7 December 2021 to 10 December 2021** on a sample of 1,029 adults aged 18 to 74 years. Some comparisons with previous waves of survey are also shown.

So far, the following waves of survey have been conducted:

1st wave:	from 4 Dec 2020 to 6 Dec 2020	10th wave:	from 9 Apr 2021 to 12 Apr 2021
2nd wave:	from 18 Dec 2020 to 21 Dec 2020	11th wave:	from 23 Apr 2021 to 26 Apr 2021
3rd wave:	from 4 Jan 2021 to 5 Jan 2021	12th wave:	from 7 May 2021 to 9 May 2021
4th wave:	from 15 Jan 2021 to 17 Jan 2021	13th wave:	from 8 Jun 2021 to 10 Jun 2021
5th wave:	from 29 Jan 2021 to 30 Jan 2021	14th wave:	from 6 Jul 2021 to 9 Jul 2021
6th wave:	from 12 Feb 2021 to 15 Feb 2021	15th wave:	from 25 Aug 2021 to 28 Aug 2021
7th wave:	from 26 Feb 2021 to 1 Mar 2021	16th wave:	from 21 Sept 2021 to 23 Sept 2021
8th wave:	from 12 Mar 2021 to 15 Mar 2021	17th wave:	from 12 Oct 2021 to 15 Oct 2021
9th wave:	from 26 Mar 2021 to 29 Mar 2021	18th wave:	from 9 Nov 2021 to 12 Nov 2021
		19th wave:	from 7 Dec 2021 to 10 Dec 2021

[2] https://www.euro.who.int/en/health-topics/health-determinants/behavioural-and-cultural-insights-for-health/tools-and-resources/who-tool-for-behavioural-insights-on-covid-19/survey-tool-and-guidance-behavioural-insights-on-covid-19-produced-by-the-who-european-region.

SUMMARY OF THE SURVEY

SI-PANDA
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Indicator	1st wave (4 Dec to 6 Dec 2020) %	13th wave (8 Jun to 10 Jun 2021) %	19th wave (7 Dec to 10 Dec 2021) %
Testing in case of close contact with a COVID-19 positive person *(the share of respondents who would definitively get tested in case they were in contact with COVID-19 positive person and would not develop any symptoms themselves)*	64.4	67.9	85.4
Vaccination rate *(the share of respondents who were vaccinated with at least one dose of COVID-19 vaccine)*	/	49.0	68.4
Hesitation regarding vaccination *(the share of respondents who do not intend to be vaccinated)*	/	32.1	26.7
Long COVID *(the share of respondents who reported at least one medical problem one month after the recovery from the infection)*	/	73.5	77.9
Avoiding visiting the doctor due to a non-COVID-19 problem *(the share of respondents who avoided visiting the doctor in the last 2 weeks due to a non-COVID-19 problem)*	35.8	27.6	26.8
Physical activity *(the share of respondents who reported they were less physically active in the last 2 weeks than before the pandemic)*	44.8	32.6	35.2
Stress *(the share of respondents who have often, or every day, felt tense, stressed or under a lot of pressure in the last 14 days)*	/	23.3	23.4
Mental health problems *(the share of respondents with depressive disorder or mental health problems)*	37.5	37.7	39.3
Deterioration of the personal financial situation *(the share of respondents who estimated that their financial situation in the last 3 months was worse than before)*	31.4	24.1	25.3

MAIN RESULTS

Supporting the measures currently in force

Soon, two years will pass since the first case of infection with the SARS-CoV-2 virus was confirmed in Slovenia (March 4, 2020) and the coronavirus epidemic was declared (March 12, 2020). Since then, we have been faced with more or less restrictive measures to prevent and limit the spread of the SARS-CoV-2 virus. They changed considerably between the individual waves of the survey and received very different support. In the report, we show the opinion of the respondents regarding the measures that were in force at the time of the survey, i.e. from 7 to 10 December 2021. During this time, the measure receiving the greatest support was that the RVT[3] condition certificate is only valid upon presentation of a valid identity document (60.5%), more than half of respondents also supported the use of a digital green certificate and self-testing every 48 hours for employees who do not meet the RV[4] condition (Figure 1). The measure of lowering the age limit to 12 years to meet the RVT condition received the least support (40%).

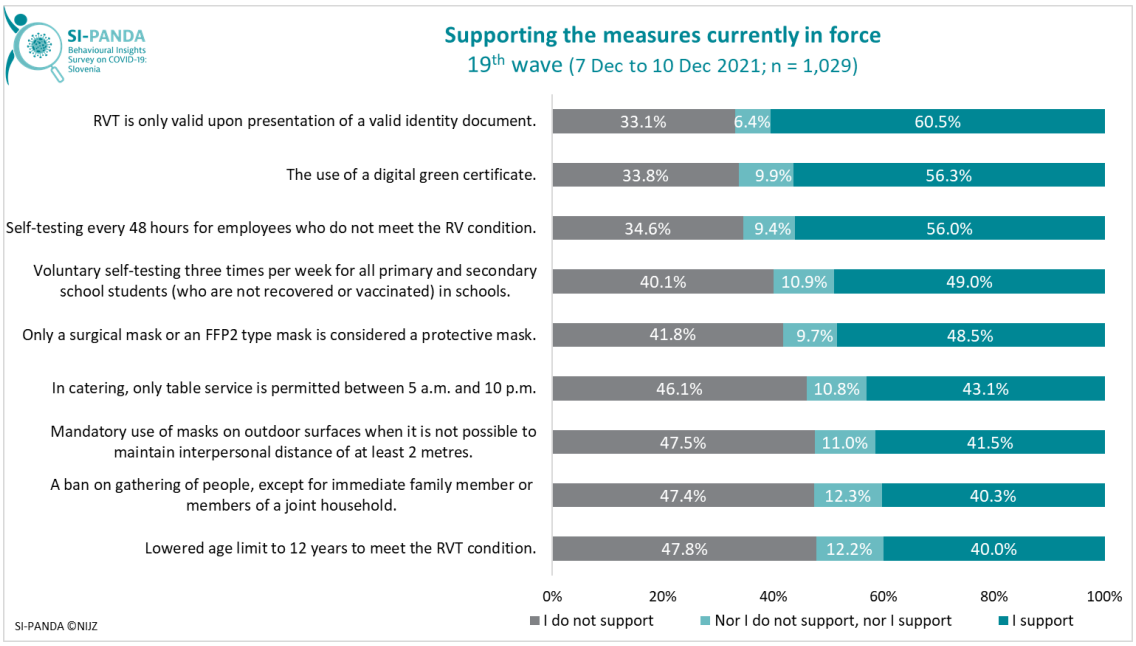

Figure 1: Supporting the measures currently in force, total.

[3] RVT condition: recovered, vaccinated, tested.
[4] RV condition: recovered, vaccinated.

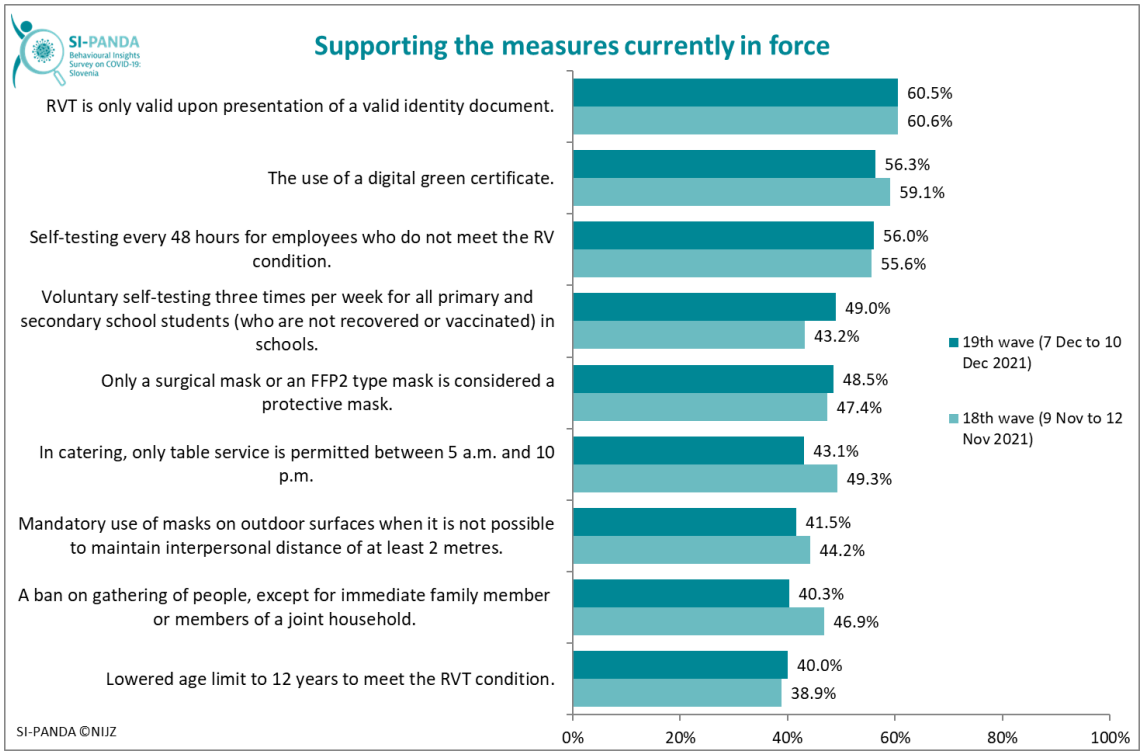

Figure 2: Supporting the measures currently in force, total, 18th and 19th survey waves.

If we compare the 18th and 19th waves of the survey, there were no significant differences in support for individual current measures. Support for mandatory self-testing three times per week for primary and secondary school students (who are not recovered or vaccinated) in schools increased by almost 6 percentage points, while support for the measure that only table service is permitted between 5 a.m. and 10 p.m. (by 6.2 percentage points) and a ban on gathering of people, except for immediate family members or members of a joint household (by 6.6 percentage points) (Figure 2).

In the 18th wave of the survey, half of respondents (50.1%) believed that measures related to SARS-CoV-2 virus unfairly limit the lives of some population groups more than of others. After the last six waves of the survey, when it had been steadily declining, the percentage of people who hold this opinion has slightly increased again. On the other hand, 46.9% of the respondents think that, given the current state of the pandemic, the measures infringe on our rights to an appropriate extent – this percentage also increased compared to the previous five waves of the survey. Compared to the 18th wave of the survey, the share of respondents who estimate that the inhabitants of Slovenia follow the measures related to the control of the SARS-CoV-2 virus has increased by almost 10 percentage points, but still only 32.3% of the respondents believe that the measures are followed (Figure 3).

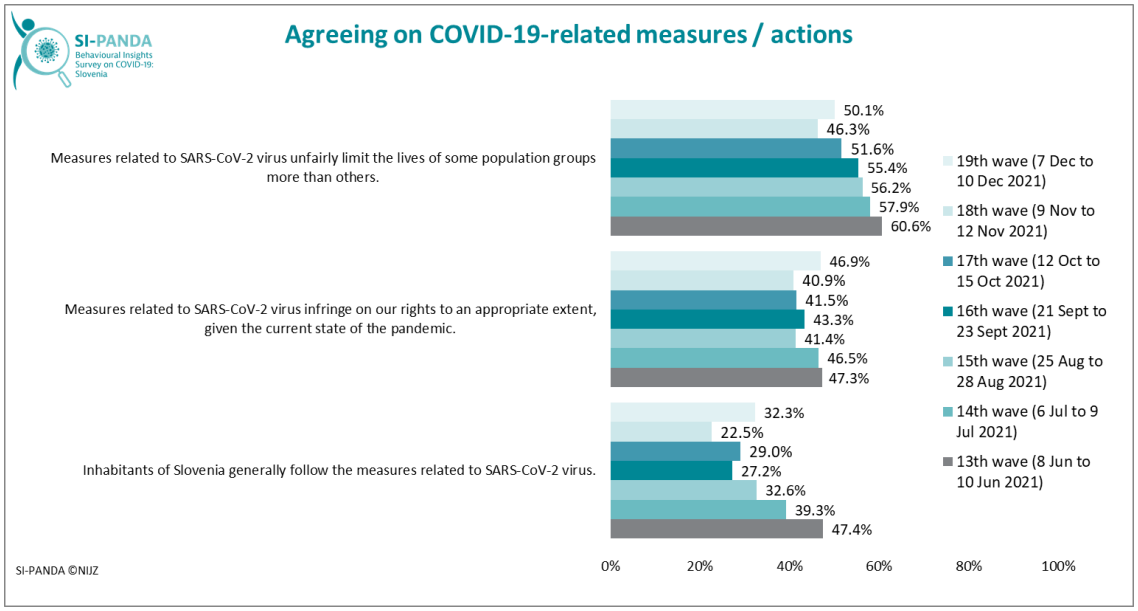

Figure 3: Opinions on COVID-19-related measures / actions, total and by survey waves.

According to vaccination status, almost a quarter more of those who will not be vaccinated than those who already are agree with the statement that measures related to the SARS-CoV-2 virus are unfairly limiting the lives of some groups of the population more than others (Figure 4).

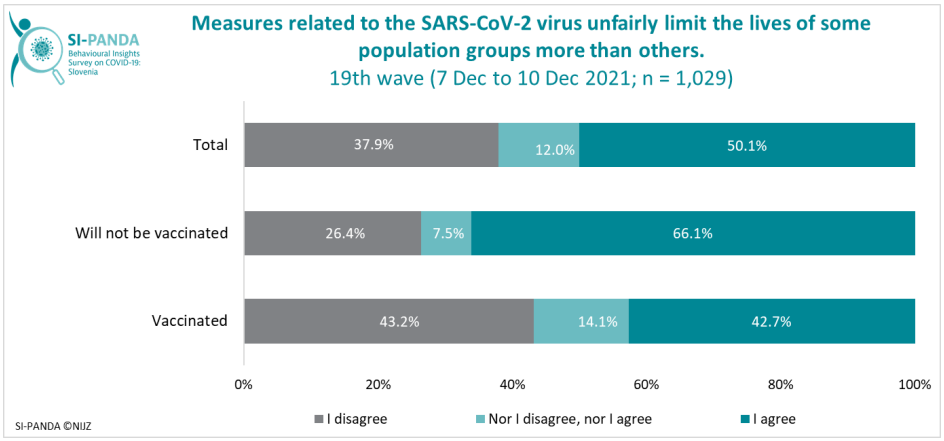

Figure 4: Opinion on whether measures related to SARS-CoV-2 virus unfairly limit the lives of some population groups more than others, total and by vaccination status.

"Recovered, vaccinated, tested" (RVT) rule

Respondents in the 19th wave of the survey were asked to what extent they support the fulfilment of the RVT condition as users of individual services or activities. To the greatest extent, the respondents support meeting the RVT condition when visiting theatres or cinemas, when watching live sports events and when visiting the tourist accommodations; these are supported by half of the respondents (Figure 5). Respondents least agree with the need to meet the RVT condition when visiting a doctor and dentist (41.6%) and when visiting gas stations (36.6%).

For all listed services or activities, respondents from the oldest age group (65–74 years) agree in the largest share with the need to meet the RVT condition, while respondents from age group 30–49 years of age agree with it in the smallest share (Figure 5). Support for meeting the RVT condition for individual services varies between age groups and of course depends on various factors, including how important these services are to people of a certain age.

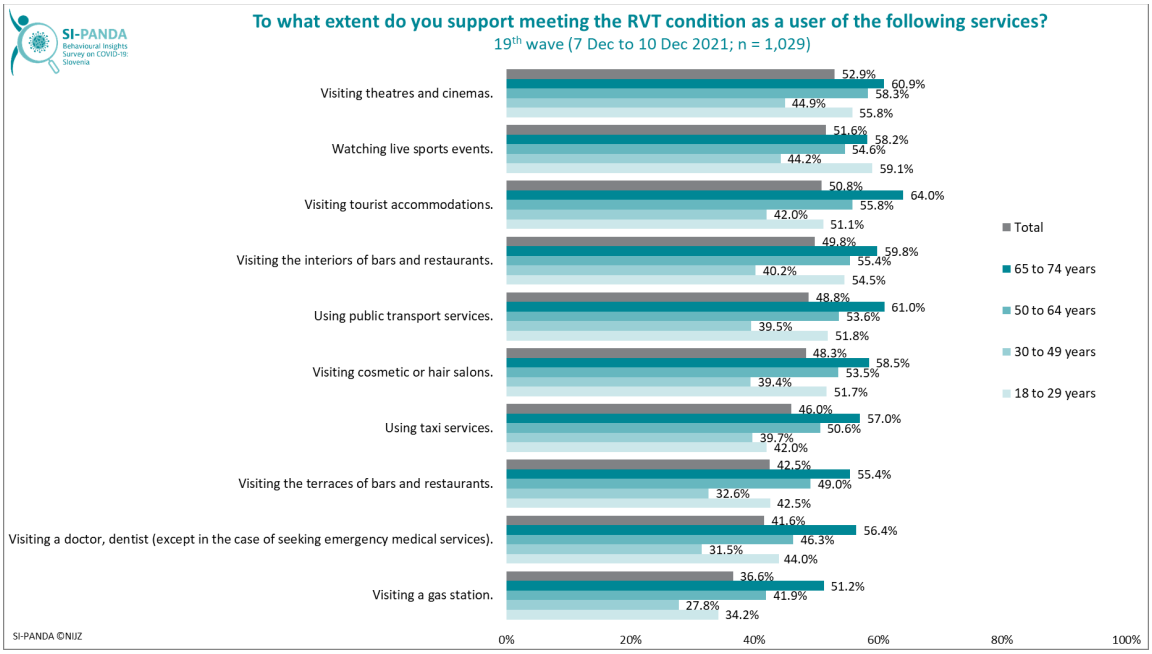

Figure 5: Supporting meeting the RVT condition as a user of various services, total and by age groups.

Support for meeting the RVT condition has increased for all activities in the 18th wave of the survey compared to the previous two waves of the survey. In the 19th wave it stayed approximately the same compared to the 18th wave of the survey. This confirms the fact that the majority of residents of all age groups are aware of the importance of the RVT condition in limiting the spread of the SARS-CoV-2 virus, especially during the bad epidemiological situation in Slovenia (Figure 6).

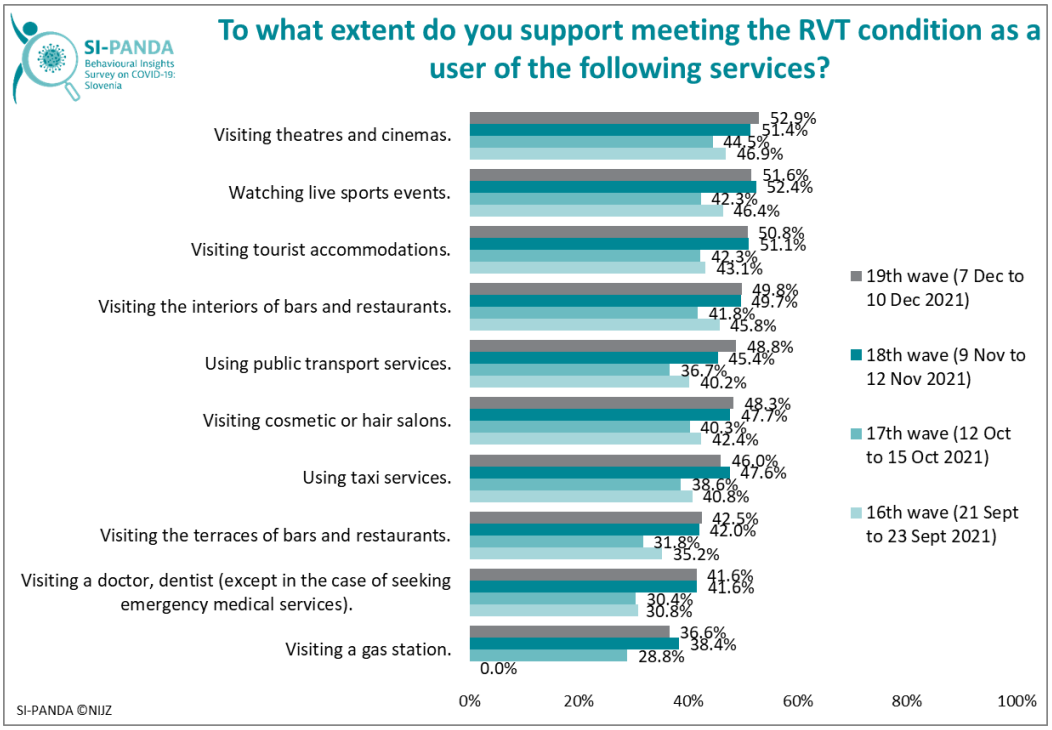

Figure 6: Supporting meeting the RVT condition as a user of various services, total and by survey waves.

More than half of the respondents support the meeting (62.8%) and checking (58.6%) of the RVT condition at the workplace. Support for meeting and checking the RVT condition at the workplace varies greatly among respondents according to their vaccination status. Almost three times more respondents who are vaccinated compared to those who are not vaccinated support meeting and checking the RVT condition at the workplace. Overall, respondents express slightly greater support for meeting than checking the RVT condition in the workplace (Figure 7).

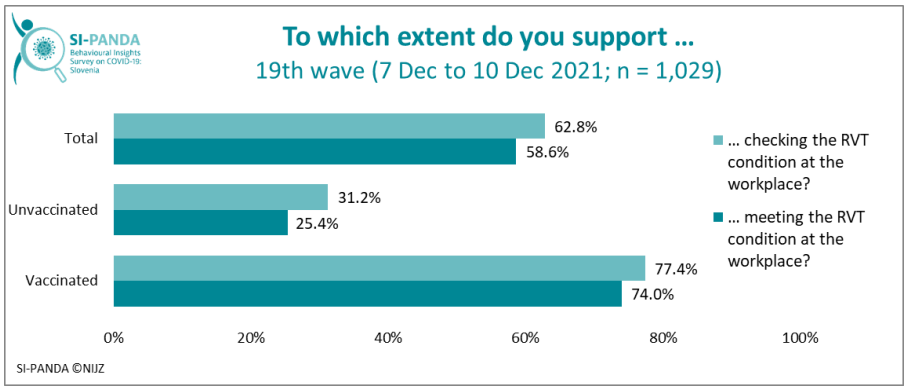

Figure 7: Support meeting and checking the RVT condition in the workplace, total and by vaccination status.

Support for checking the RVT condition at the workplace stays approximately the same as in the previous wave of the survey. Compared to the 17th wave of the survey, when it was the smallest, it increased both among the vaccinated, by 20.2 percentage points, and among those who do not intend to be vaccinated – by 17.2 percentage points (Figure 8). Also in this case it is evident that

the change in opinion is probably the consequence of deterioration of the epidemiological situation in Slovenia.

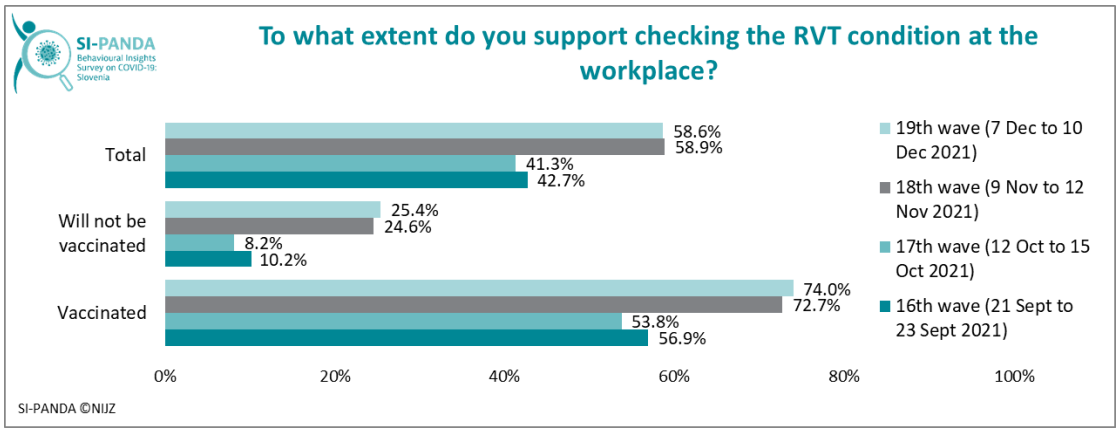

Figure 8: Support meeting and checking the RVT condition in the workplace, total and by vaccination status 16th to 19th wave of the survey.

At a time when it was not yet necessary to show a personal document with the certificate of meeting the RVT condition, there was a lot of talk in the media about the misuse of certificates. Therefore, in the 18th and 19th waves of the survey, respondents were also asked whether they had ever used another person's RVT certificate in order to meet the RVT condition. Among those respondents who do not meet the RV condition, in the 19th wave, 30.4% of them reported that they had already used such a certificate at least once.

6.1% of all respondents in the 19th wave of the survey reported that they had given their RVT certificate at least once to another person so that they would meet the RVT condition. The largest share of people who have ever given their RVT certificate to another person is among the respondents in the youngest age group (Figure 9).

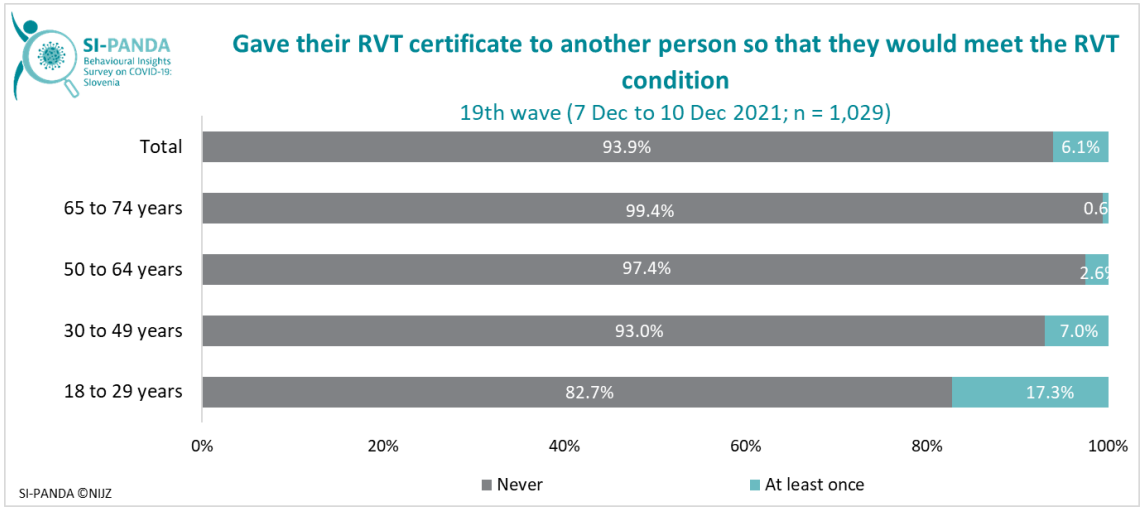

Figure 9: Giving one's RVT certificate to another person, total and by age groups.

Also in the 19th wave of the survey, we asked about the opinion regarding the introduction of the recovery or vaccination (RV) rule for employees in certain fields of work, or for all adult residents.

The largest share of respondents still supports the introduction of the RV rule for employees in the health sector (62.8%); in the age group 65–74 years, as many as 82.1% of respondents would support this introduction (Figure 10). More than half of the respondents also support the RV rule for employees in the state administration (56.9%) and in education sector (57.2%), while slightly less than half of the respondents (49.5%) support the introduction of the RV rule for all adult residents of Slovenia. Support for the introduction of the RV rule for all mentioned groups is the highest in the oldest age group of respondents and the lowest in the age group 30–49 years.

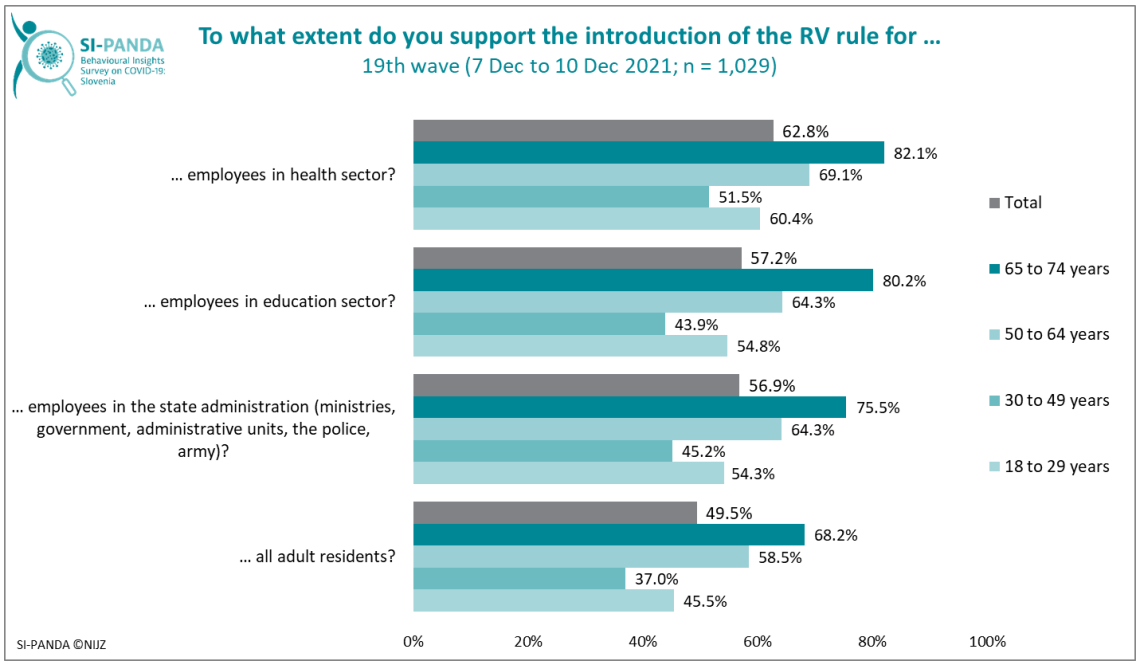

Figure 10: Supporting the introduction of the RV rule for employees in the listed fields of work or for all adult residents, total and by age groups.

We also asked the respondents whether they think that vaccination against COVID-19 should be mandatory for employees in certain fields of work or for all adults. Here, too, the largest share of respondents supports the introduction of mandatory vaccination for employees in the health sector (60.8%), followed by employees in education sector (54.1%). More than half of the respondents (54%) believe that vaccination should be mandatory for residents over the age of 50, who are most at risk in case of infection with the SARS-CoV-2 virus.

Less than half of the respondents (44.1%) believe that vaccination against COVID-19 should be mandatory for all adult residents of Slovenia. In general, the obligation to vaccinate is most supported by respondents in the oldest age group, and least supported by respondents aged 30 to 49 (Figure 11).

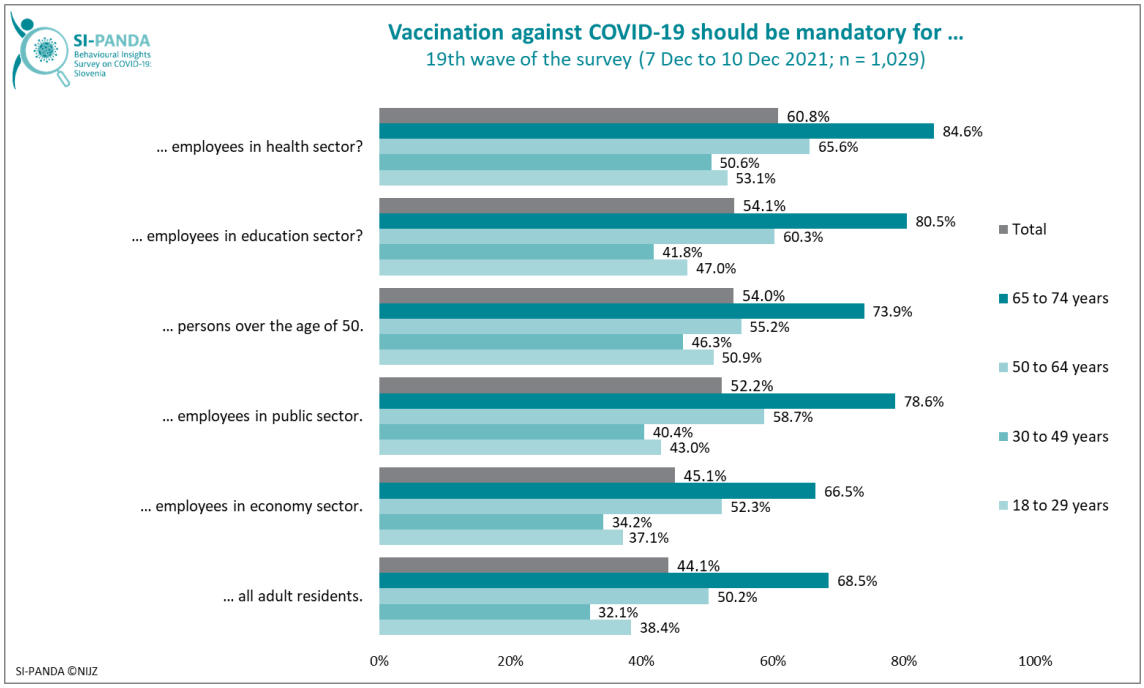

Figure 11: Supporting the mandatory vaccination against COVID-19 for employees in the listed fields of work or for all adult residents, total and by age groups.

Respondents who are vaccinated support the introduction of mandatory vaccination to a much greater extent for all categories listed in (Figure 12), compared to those who are not vaccinated. For example, 63% of vaccinated respondents support mandatory vaccination for all adult residents of Slovenia (Figure 12).

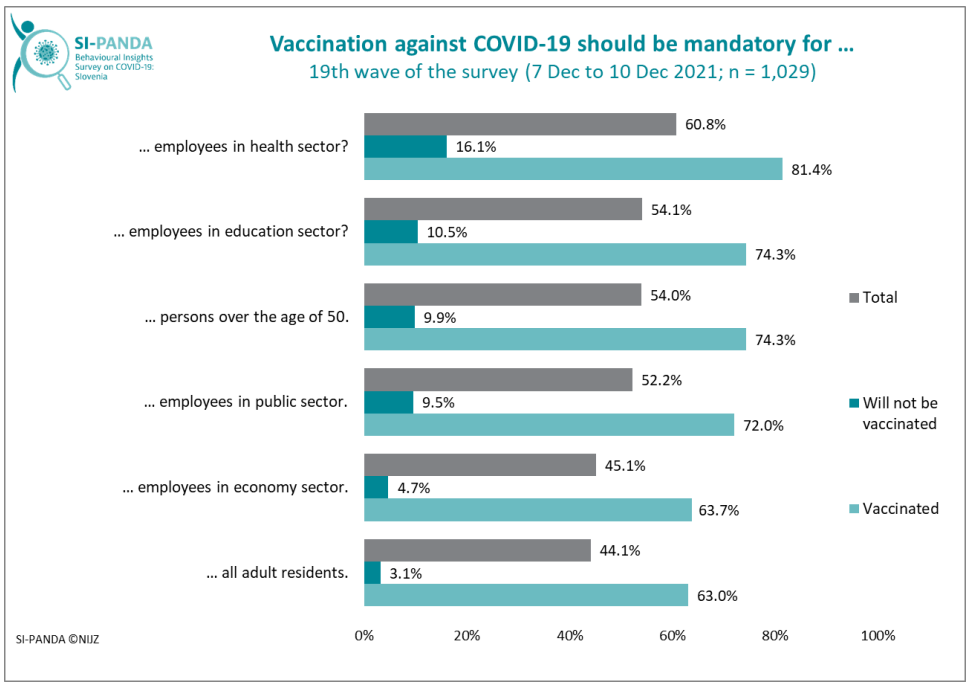

Figure 12: Supporting the mandatory vaccination against COVID-19, total and by vaccination status.

Supporting the potential measures

In the 19th wave of the survey, respondents were asked about their support for specific potential measures that could come into force in the event of a deterioration in the epidemiological situation. The largest share (57.4%) would support the introduction of home quarantine controls, while almost a third would support the temporary tightening of measures to stop public life (Figure **13**). This is followed by support for a ban on organized exercise for all but elite athletes (23.5%) and support for restricting outdoor movement between 10 pm and 5 am, which would be supported by a good fifth of respondents. Again, as in all previous waves of the survey, restricting movement to municipalities would have the least support (11.2%). Respondents were asked about the same potential measures in 10th wave of the survey (early April 2021), when complete lockdown was in force in Slovenia; at that time, respondents were more supportive of these potential measures.

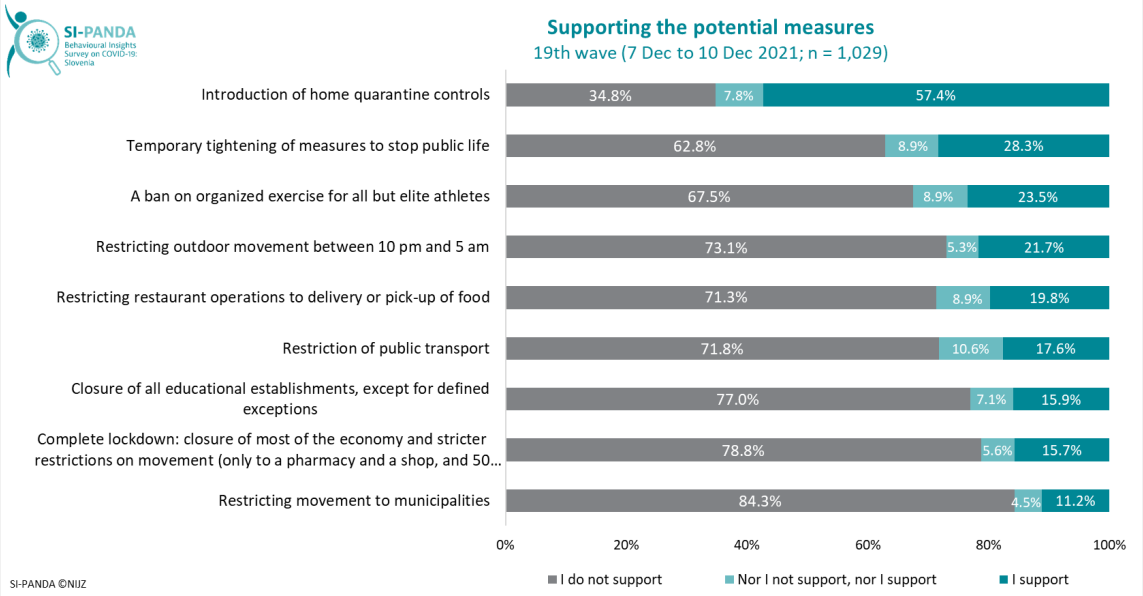

Figure 13: Supporting the potential measures, total.

Support for the potential measures to contain the spread of SARS-CoV-2 listed in Figure 14 has decreased slightly for most measures compared to the previous wave of the survey. The same share of respondents in 19th wave of the survey as in 18th wave of the survey would support the introduction of home quarantine controls, while 3.1 percentage points fewer respondents in 19th wave than in 18th wave would support the temporary tightening of measures to stop public life (Figure **14**).

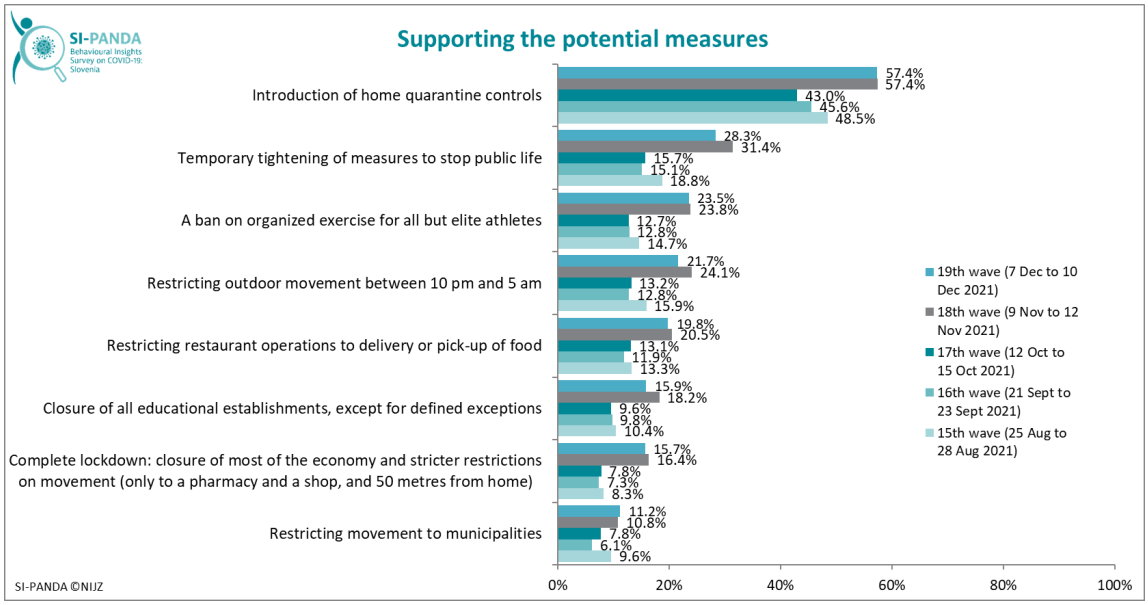

Figure 14: Supporting the potential measures, total and by survey waves.

Trust in persons and institutions to adequately manage the pandemic

Throughout the survey, respondents trust their personal physicians the most to manage the pandemic adequately, with an average trust score of 5.3 on a 7-point scale in 19th wave of the survey. This is followed by trust in hospitals with an average of 5.2 (Figure 15). Trust in health profession and institutions in general is known to be associated with the decision to vaccinate, as shown by our data. There are significant differences in trust between vaccinated and unvaccinated respondents. Interestingly, unvaccinated persons trust their employer more than the hospital.

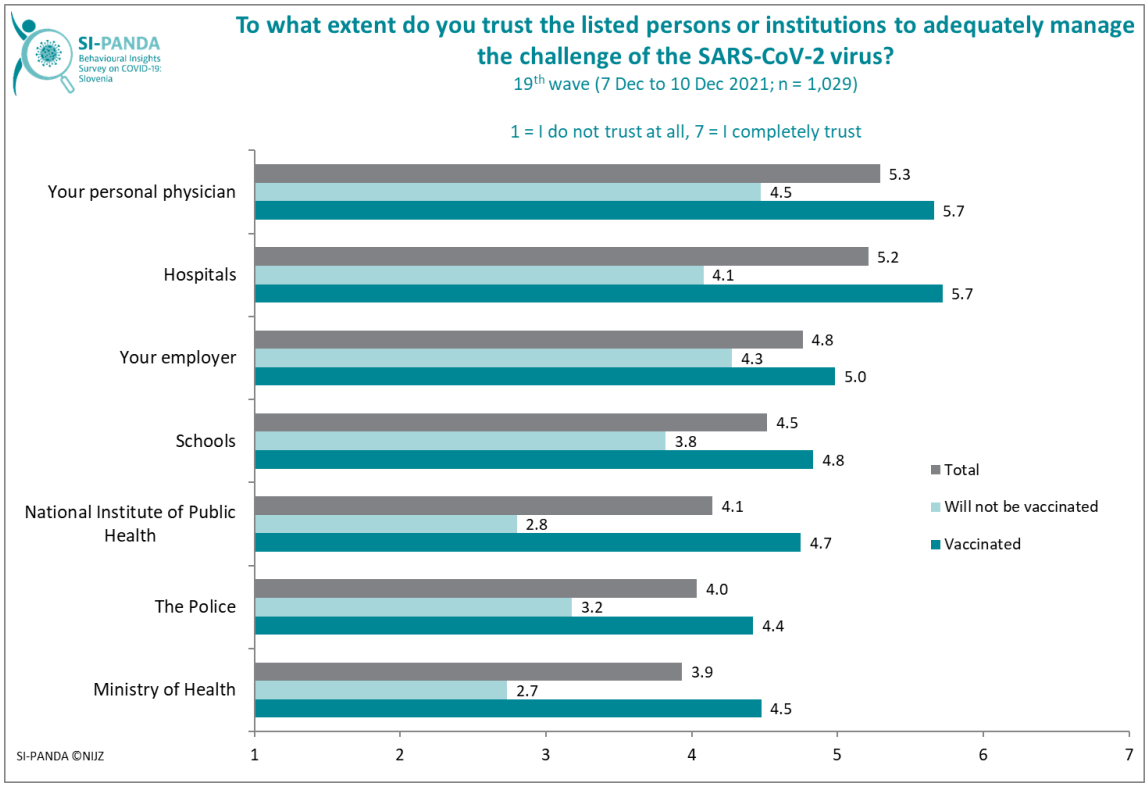

Figure 15: Trust in persons and institutions to adequately manage the pandemic, total and by vaccination status.

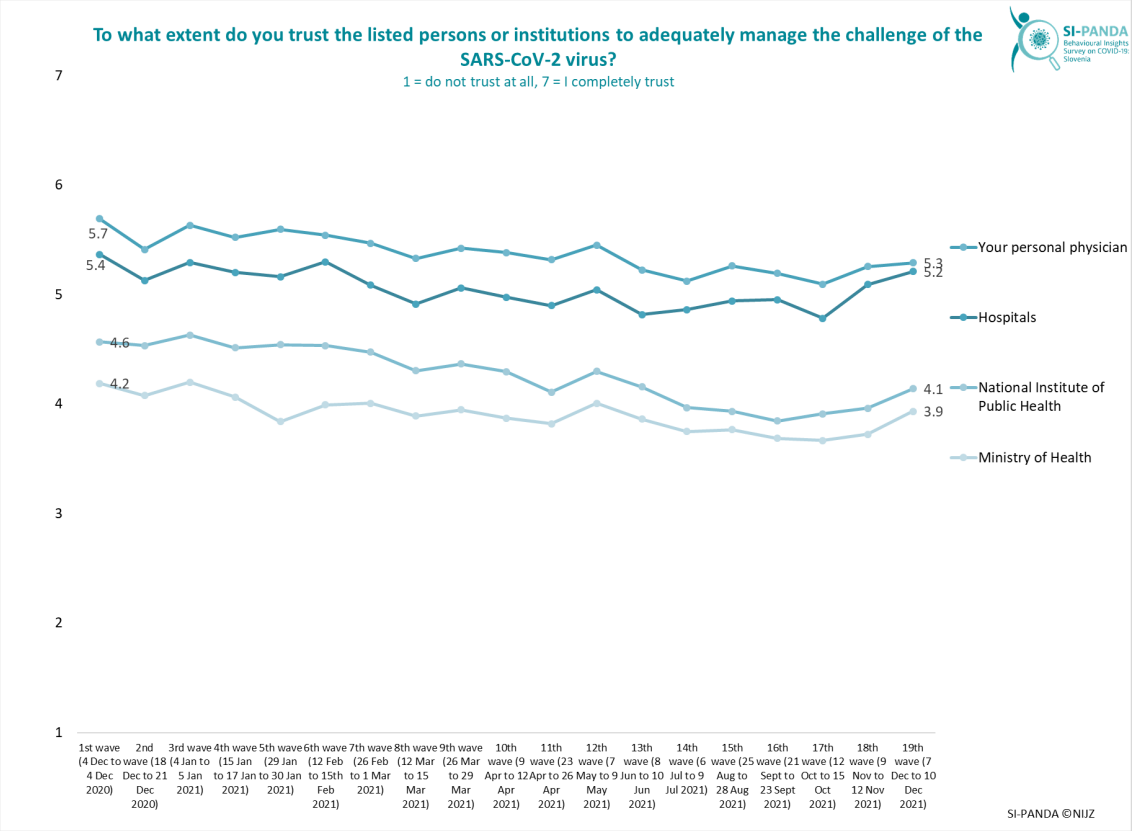

Figure 16: Trust in persons and institutions to adequately manage the pandemic, total and by survey waves.

Trust in all listed persons and institutions gradually decreased over the course of the survey, least of all in personal physicians and hospitals. While trust in all listed categories has been rising again in the last two waves of the survey, the biggest increase since 17th wave has been in trust in hospitals (Figure **16**)

Vaccination

Data from the 19th wave of the survey show that more than 68% of the respondents (aged 18–74 years) have been vaccinated, 37.8% have received two doses of vaccine and 7.9% have received one dose of the COVID-19 vaccine (Figure 17). 22.7% of respondents have received a third (booster) dose of the vaccine. More men (73.2%) than women (63.3%) are vaccinated. 26.7% of respondents in 19th wave of the survey indicate that they do not intend to be vaccinated. 4.8% of respondents were not vaccinated due to medical reasons. Throughout the survey, women (30.9%) were more likely than men (22.9%) to be hesitant to be vaccinated (Figure 17).

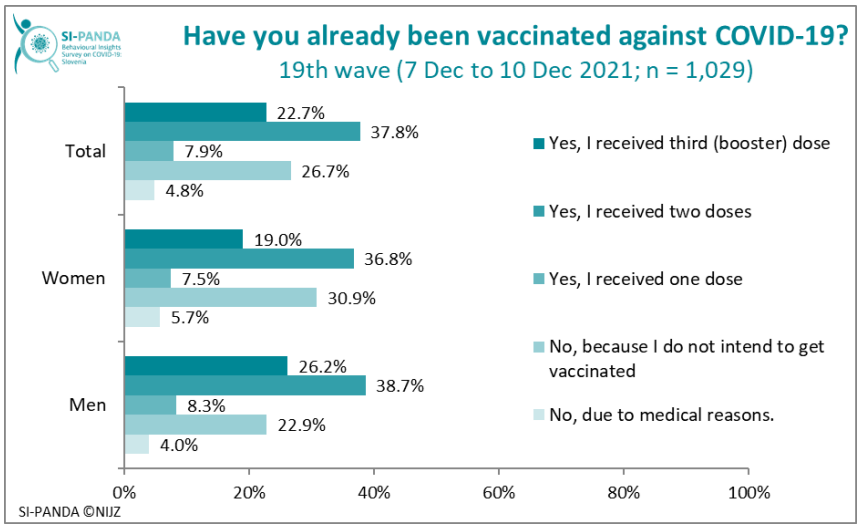

Figure 17: Vaccination against COVID-19, total and by gender.

The share of vaccinated persons (with one, two or three doses of COVID-19 vaccine) among the oldest age group (65–74 years) is 82.2%, while the share of vaccinated persons in the 50–64 age group is 76.6% (Figure 18). The share of those who do not intend to be vaccinated is highest in the 30–49 age group, where 36.3% of people share this opinion. This share has increased by 7.3 percentage points in this age group compared to the previous wave of the survey. This is followed by the youngest age group (18–29 years), where 28.8% of people do not intend to be vaccinated.

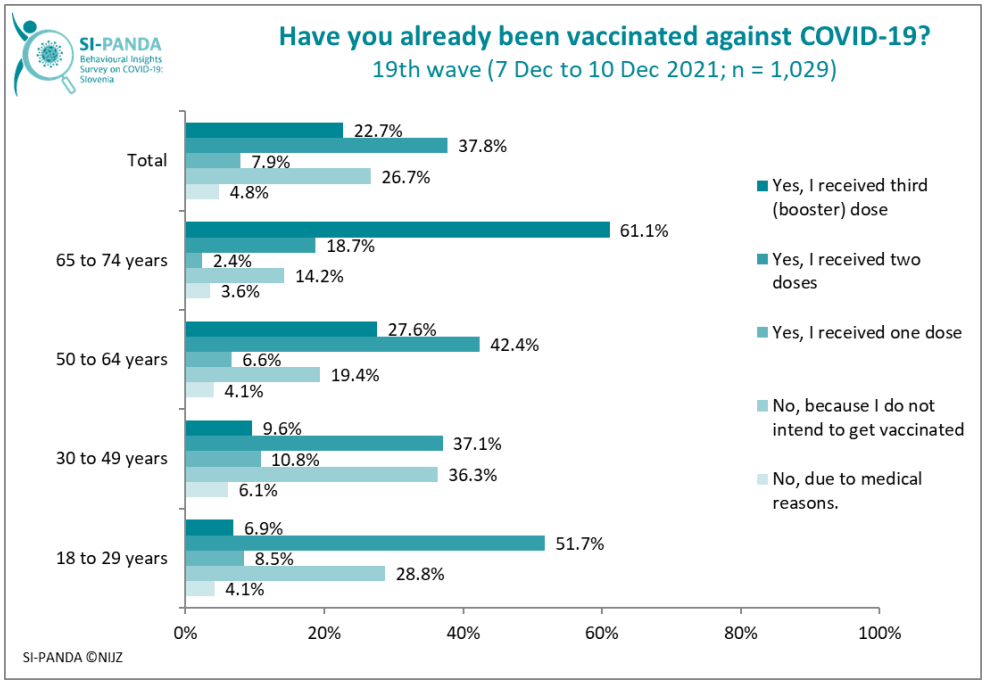

Figure 18: Vaccination against COVID-19, total and by age groups.

In the 19th wave of the survey, compared to the 18th wave, there is a lower share of respondents who have already received both doses of the vaccine (37.8% in 19th wave, 54.2% in 18th wave) and a higher share of respondents who have already received the third dose of the vaccine (22.7% in 19th wave and 7.4% in 18th wave). The share of people who do not intend to be vaccinated has shown a gradual downward trend since 14th wave of the survey (when it peaked at 35.2%), but is has slowed down again in the recent period.

Looking at the waves of the survey from 13th wave onwards, we can see that there is a significant decrease in the share of people who have not recovered from COVID-19 and have not been vaccinated against SARS-CoV-2. There are only 18.6% of such persons among the survey participants, and their share in the 19th wave compared to the 13th wave decreased by 18.3 percentage points. However, the share of those vaccinated is increasing both among those who had already recovered from COVID-19 (by 8.1 percentage points compared to 13th wave) and among those who have not (by 11.4 percentage points compared to 13th wave of the survey) (Figure **19**).

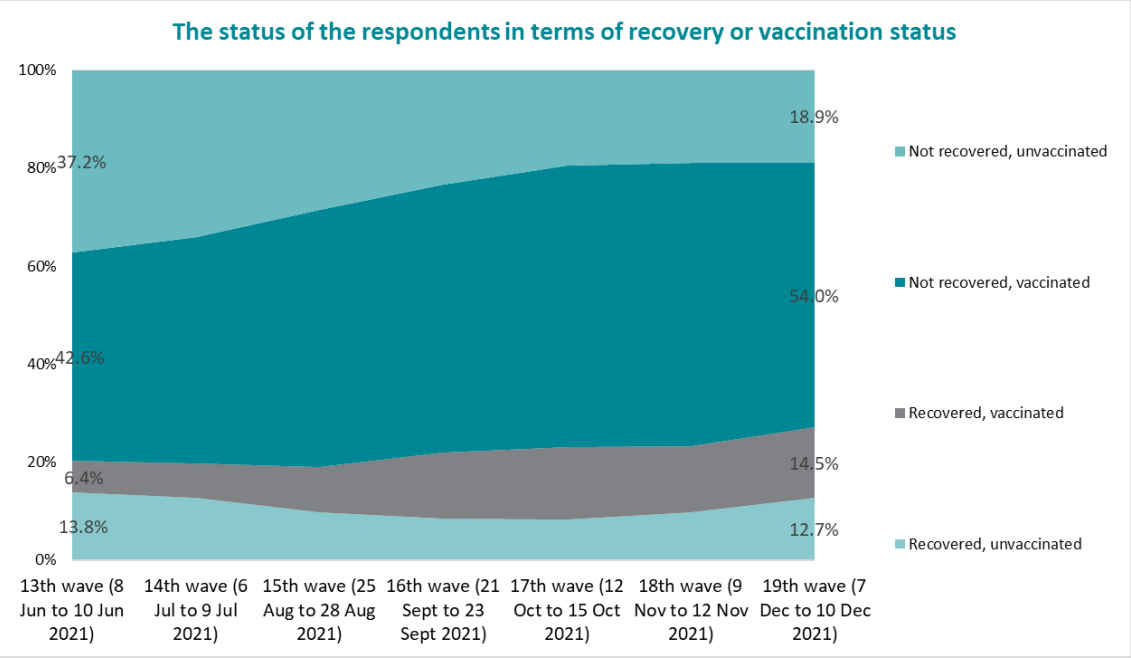

Figure 19: The status of the respondents in terms of vaccination status or recovering from COVID-19, total and by survey waves.

The largest share of respondents (71.6%) in 19th wave of the survey reported having been vaccinated with mRNA vaccines, while just under a fifth had been vaccinated with vector vaccines (17.5%) and 10.9% with a combination of vector and mRNA vaccines (Figure 20). Among the respondents who received mRNA vaccines, the vast majority (79.0%) have not recovered from COVID-19, 17.3% recovered from COVID-19 and then got vaccinated, and 3.7% were first vaccinated and then recovered from the disease.

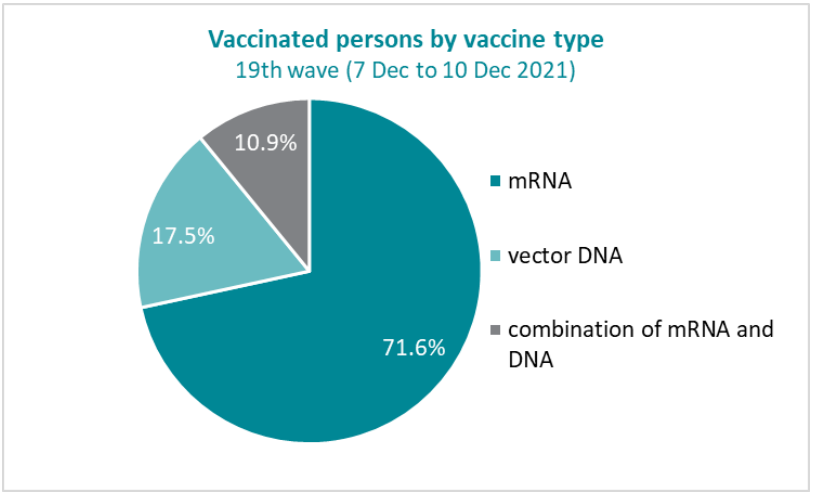

Figure 20: Vaccinated persons by COVID-19 vaccine type.

In this wave of the survey, we asked respondents a few questions to determine their level of preparedness to be vaccinated against COVID-19, or their level of rejection, on a 7-point scale. Men in the oldest age group are most likely to be vaccinated (average 5.4 on a 7-point scale), while women in the 30–49 age group are the least likely to be vaccinated (average 3.6 on a 7-point scale) (Figure 21).

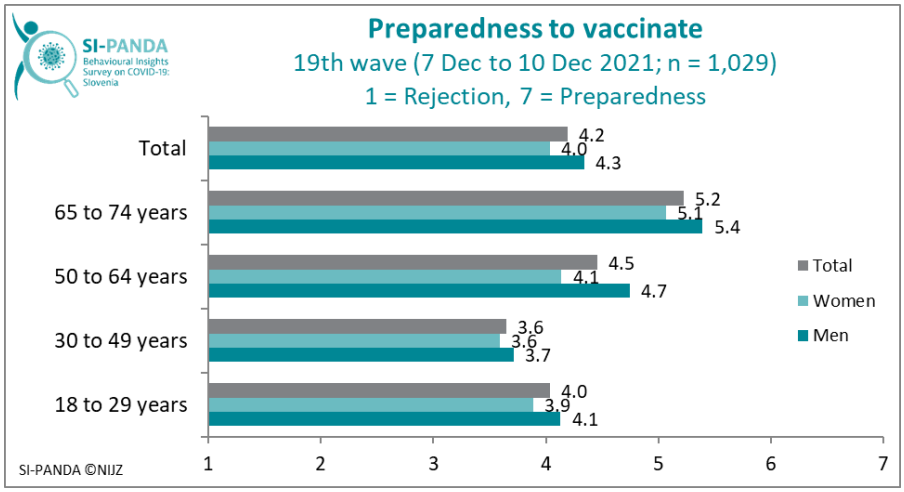

Figure 21: Preparedness to vaccinate against COVID-19, total, by gender and by age groups.

Looking at the last 6 waves of the survey, the level of preparedness to vaccinate is currently at an all-time high in the oldest and youngest age groups, while it has declined in the other two age groups (Figure **22**).

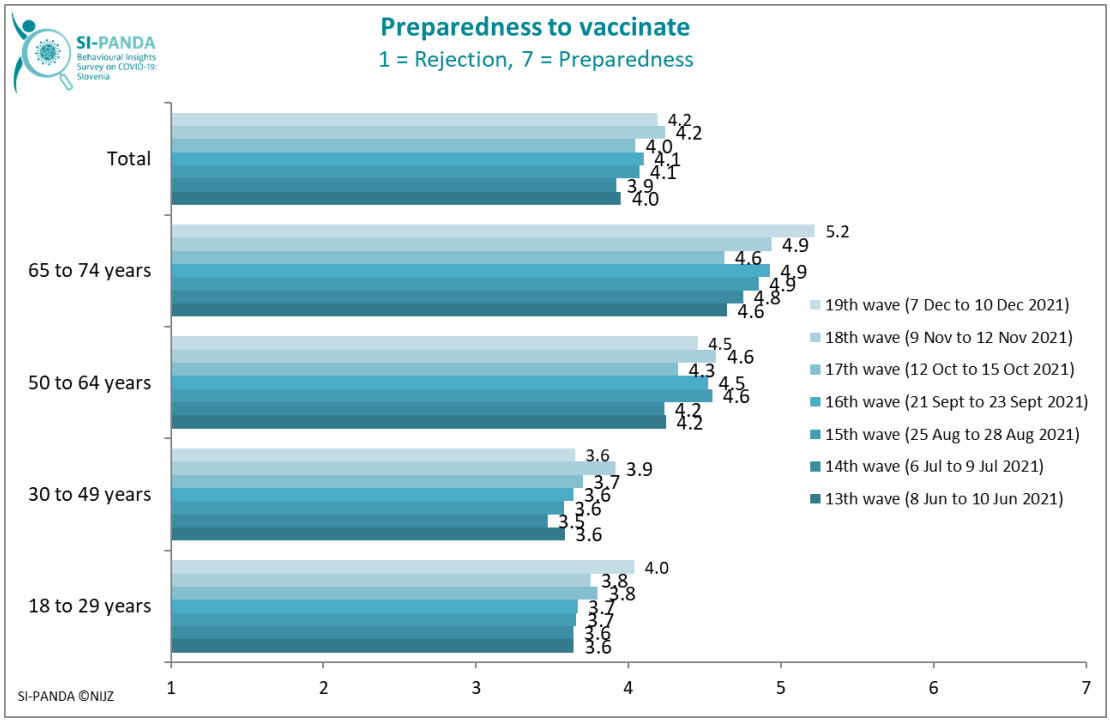

Figure 22: Preparedness to vaccinate against COVID-19, total, by age groups and by survey waves.

When asked what the decision to vaccinate depends / will depend on, respondents most agree on average that their decision to vaccinate depends / will depend on whether enough data is / will be available that the vaccine is safe (in the 19th wave, the average value on a 7-point scale is 4.7), whether sufficient data is / will be available on whether the vaccine is effective (4.6), and whether they can choose the type of vaccine themsleves (4.3) (Figure **23**).

However, if we look at what the decision to vaccinate will depend on among those who have already been vaccinated, the main reason for the decision to vaccinate was whether higher vaccination rate will lead to the release of restriction on movement and socializing in groups while among those who are hesitant about vaccination, the decision on vaccination depends the most on whether there is sufficient data that the vaccine is safe (4.2 among the unvaccinated) (Figure 23). According to the results, releasing restrictions on movement and socializing in groups is less important for those who are hesitant about vaccination than for those who have already been vaccinated.

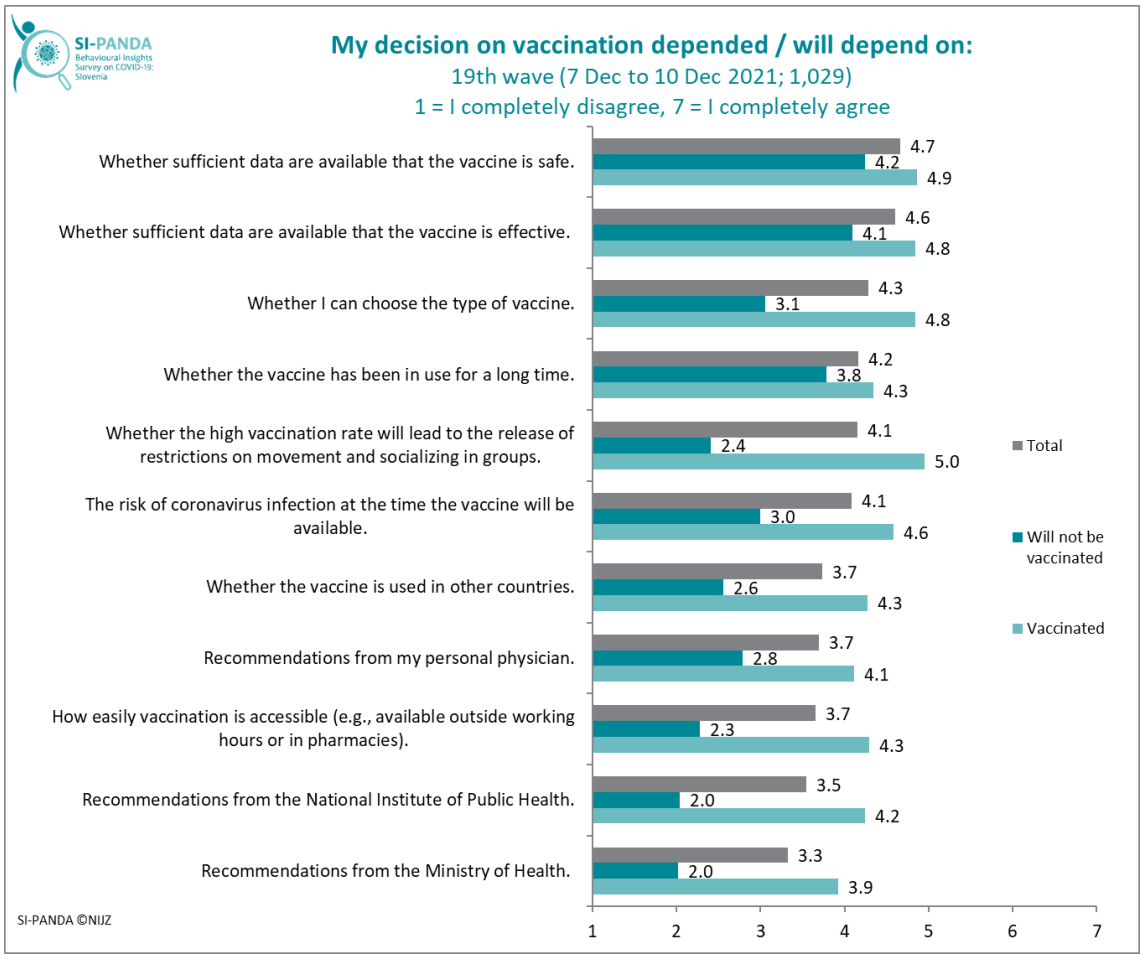

Figure 23: Reasons for the decisions to vaccinate, total and by vaccination rate.

In the 19th wave of the survey, we again asked the unvaccinated respondents for more detailed reasons why they do not intend to be vaccinated. The main reasons included concerns about the side effects after vaccination, concern about long-term health effects, and opinion that vaccine is not safe. More than half of those respondents still believe that too much pressure is being put on vaccination, which indicates that a potential introduction of mandatory vaccination would encounter even greater resistance in this group (Figure 24).

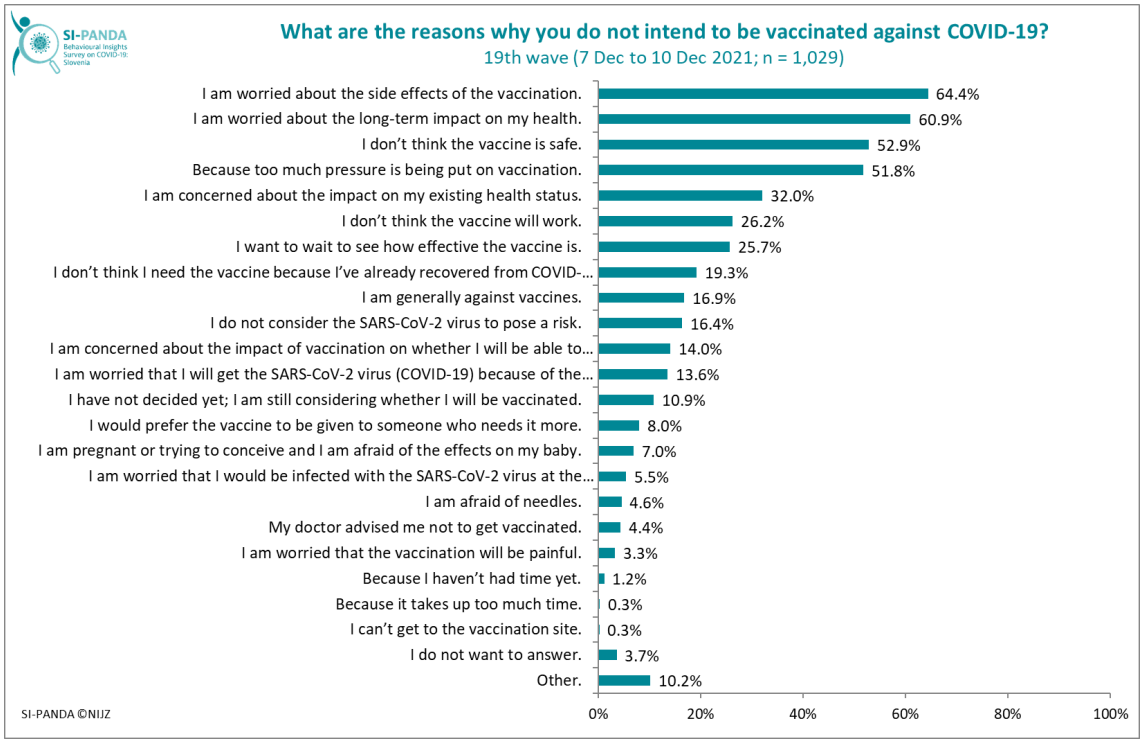

Figure 24: The reasons why respondents do not intend to vaccinate against COVID-19, total.

Note: multiple answers were possible.

Respondents who had already been vaccinated reported that they had decided to be vaccinated mainly to prevent a more severe course of the diseases or its consequences (62.6%), to protect their health (62.0%), and to contribute to curbing the epidemic as soon as possible and returning to normal lives (59.7%) (Figure **25**).

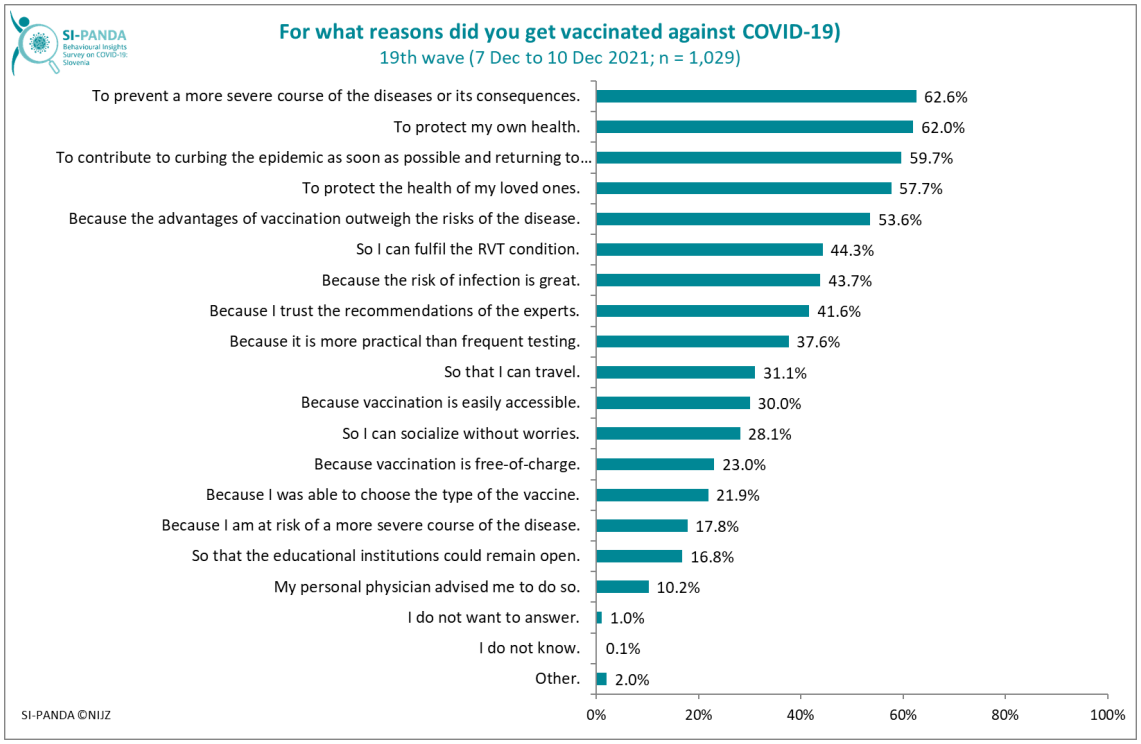

Figure 25: Reasons why the respondents decided to vaccinate, total.

Note: multiple answers were possible.

The impact of the pandemic on lifestyles and other areas of life

In 19th wave of the survey, 42.9% of respondents reported spending more time in front of the television, computer or other electronic devices in the last 2 weeks than they did before the pandemic, with a particularly high share of youngest respondents (18–29 years old), where 61.2% of respondents said they did so; this shows an increase of 18 percentage points compared to the previous wave of the survey. The youngest age group, as has been the case throughout the survey, was also the most likely to report most other unhealthy lifestyle habits in the last 2 weeks. Thus, compared to other age groups, they were more likely to consume more unhealthy food (28.2% of 18–29 year olds), smoke more (14.2%) and drink more alcohol (12%) than before the pandemic (Figure 26).

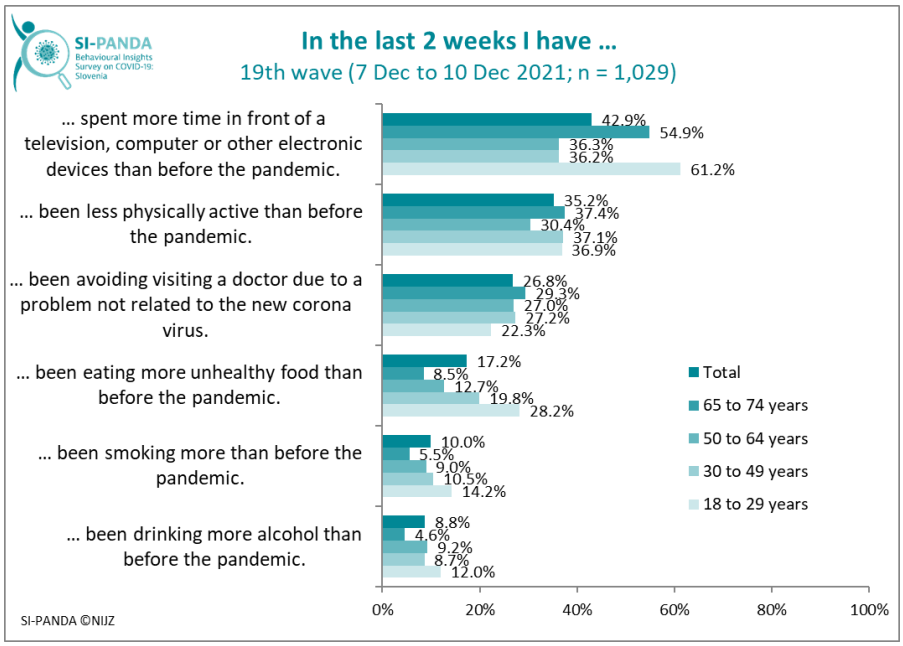

Figure 26: The impact of the pandemic on lifestyle in the past 2 weeks, total and by age groups.

In 19th wave, respondents were also asked about the impact of the pandemic on specific areas of life. As expected, the largest share (59.6%) of people reported that the pandemic had a negative impact on their social contacts with extended family and friends, followed by a negative impact on financial security (33.7%) and on physical activity (deterioration was reported by 34.6% of respondents) (Figure 27). These shares are approximately the same as in the previous wave of the survey.

On the other hand, those who reported the positive impact of the pandemic, for the most part observed this impact in the area of physical activity and also in the area of healthy nutrition and family relationships, which can be explained by the fact that they may have had more time for these activities and for their loved ones, because other activities, in which they would otherwise engage, were severely curtailed during the pandemic.

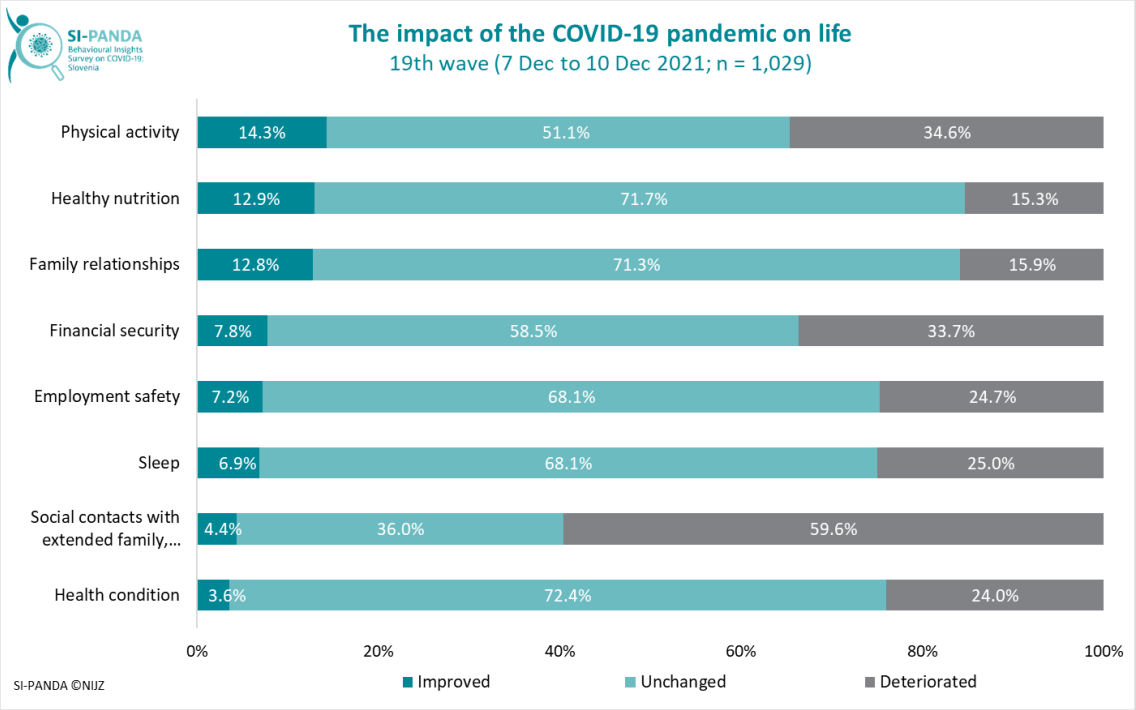

Figure 27: The impact of the COVID-19 pandemic on areas of life, total.

Experiencing stress

In prolonged emergencies and uncertainties, such as an epidemic, the experience of stress usually increases, but there may also be an immediate adjustment, especially if the stressors remain at a similar, albeit higher, level or increase gradually[5].

In the 19th wave of the survey, respondents were asked about how often they felt tense, stressed or under a lot of pressure in the last 14 days. A quarter of respondents (23.4%) experienced stress daily or often, most often in the age groups 18 to 29, and 30 to 49 where the share was 30 percent (Figure 28). The frequency of experiencing stress decreases with age and is the lowest in the oldest age group (65 to 74 years), namely 8.7%. However, the distribution of frequencies by age groups remains approximately the same in all survey waves.

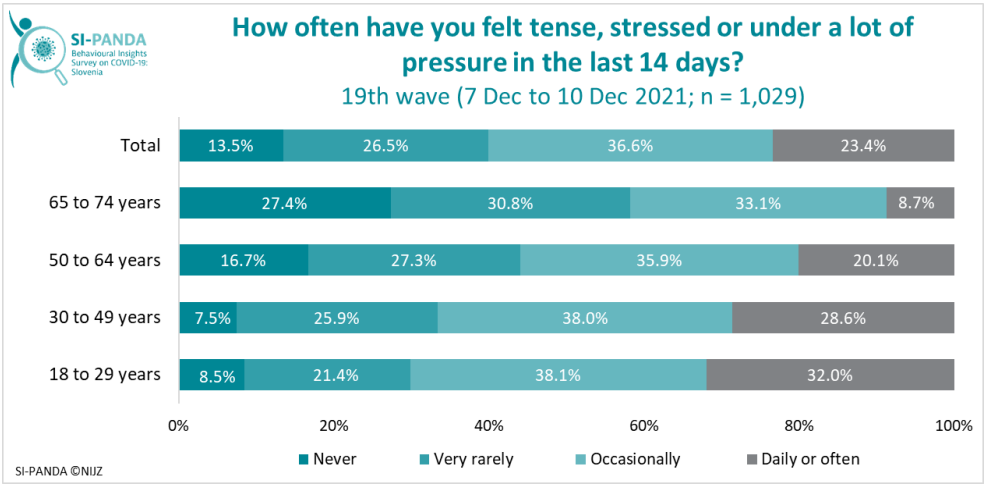

Figure 28: Frequency of experiencing stress in the last 14 days, total and by age groups.

If we look at experiencing stress through individual survey waves, we see that the share of people who experience stress daily or often is relatively stable and ranges from 20 to 24.8%. Similar temporal consistency is seen in the shares of persons, which experience stress very rarely or never (Figure 29).

[5] Fu S, Greco LM, Lennard AC in Dimotakis N. Anxiety responses to the unfolding COVID-19 crisis: Patterns of change in the experience of prolonged exposure to stressors. Journal of Applied Psychology 2021; 106(1): 48.

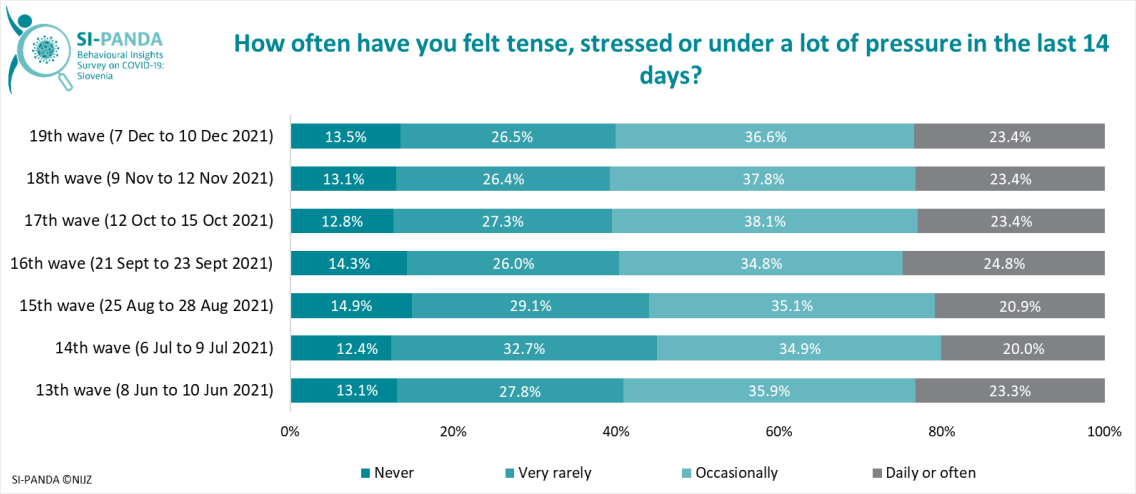

Figure 29: Frequency of experiencing stress in the last 14 days, total, by survey waves.

Respondents cited workload as the most common reason for stress in the last four waves of the survey (37.7% in the 19th wave). This is followed by concerns about untrue information about SARS-CoV-2 virus (34.8%) and concerns about the uncertain financial future (31.7%) (Figure 30).

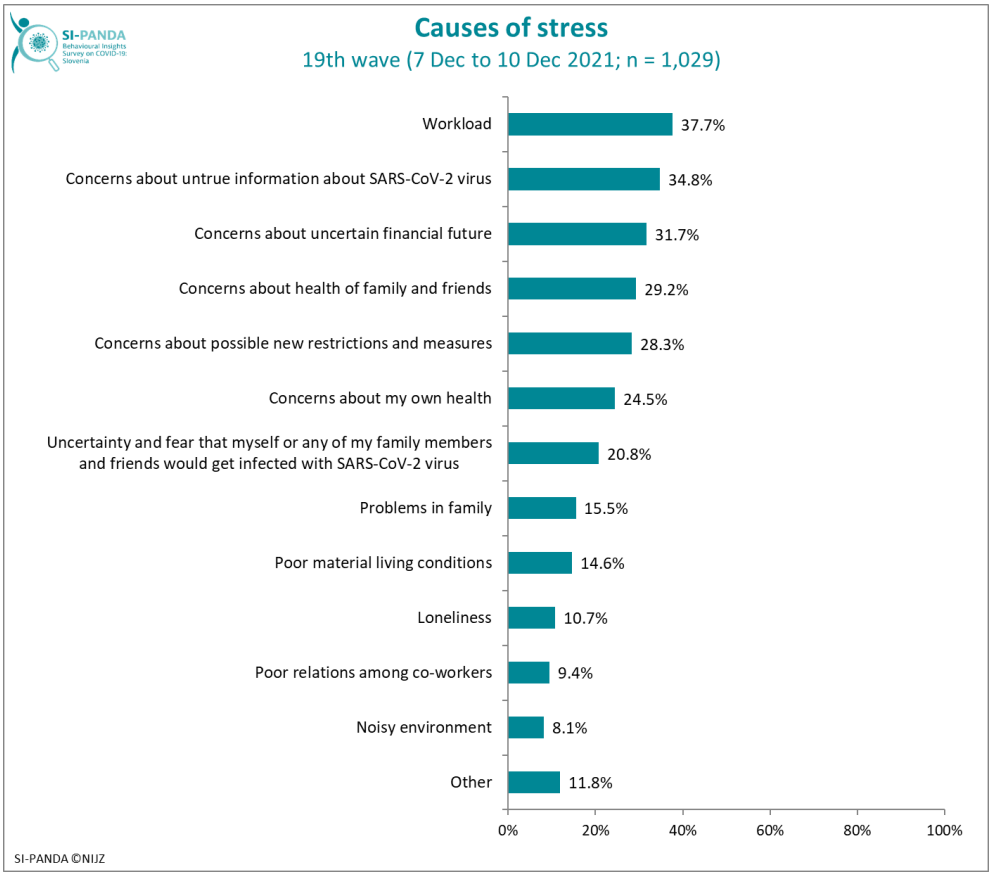

Figure 30: Causes of stress, total.

Note: multiple answers were possible.

The biggest differences between the more and less educated in the causes of stress are in experiencing workloads and poor material living conditions. Respondents with higher educational attainment were more likely to experience stress due to workload and poor relationships with co-workers; respondents with secondary and lower education were more likely to experience stress due to poor material conditions.

Most respondents (81.1%) managed tensions, stress and pressure easily or with some effort, 15.1% had major problems, and 3.8% had severe problems or did not manage stress.

In the 19th wave of the survey, a good half of the respondents (50.7%) reported that they could always or often find a way to relax when they needed to, and 12.3% reported that this happened very rarely or never. In terms of mental health problems, those with signs of depressive disorder very rarely or never found a way to relax (33.2%), followed by those with mental health problems (14.3%) and those without mental health problems (6.2%) (Figure 31).

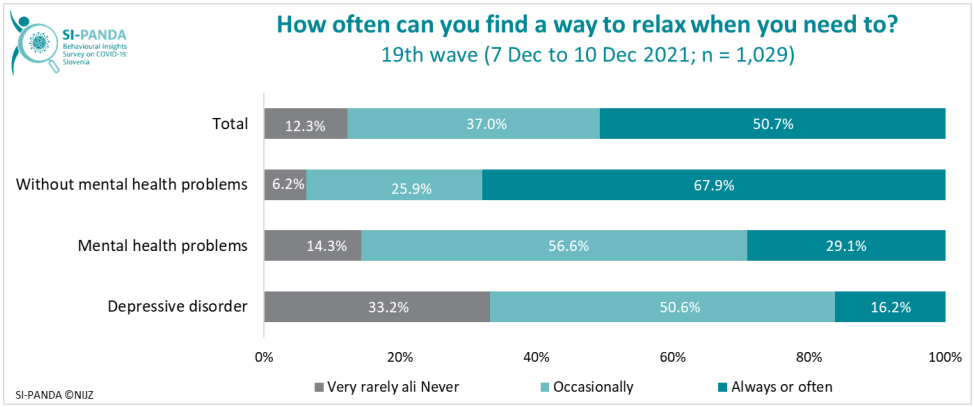

Figure 31: Frequency of relaxation, total and by mental health problems.

Problems after SARS-CoV-2 virus infection recovery – post-COVID syndrome or long COVID

Most people who get COVID-19 recover in a few weeks. But, researchers, as well as healthcare professionals, are increasingly finding that in some people, individual symptoms persist for months after the diagnosis, or they disappear and reappear weeks or months after initial recovery. Abroad, these problems have been termed post-acute COVID-19 or long COVID. It is more common among hospitalized and elderly patients, but it also occurs in those who have overcome a milder form of the disease and also among young adults who did not have health problems before the infection[6]. The symptoms of long COVID are varied, e.g., fatigue, shortness of breath, insomnia, memory and concentration problems (i.e., foggy brain), heart palpitations, pain in various parts of body, diarrhoea, nausea, etc.[7].

In the 19th wave of the survey, 26% of respondents report that they are or have been infected with the SARS-CoV-2 virus so far, of which 6% stated that their infection was asymptomatic, 66.8% report that the course of the disease was mild. In 24.5% of the infected respondents, the course of the disease was more severe, but did not require hospital treatment, and 2.9% had been treated in the hospital. Respondents who are or have been infected with SARS-CoV-2 virus so far were asked from the 11th wave onwards about possible problems after recovering from SARS-CoV-2 virus infection.

According to the WHO, a quarter of people who become infected with the SARS-CoV-2 virus have some health problems for at least one month after infection, and one in ten patients is thought to have some symptoms after 12 weeks[8]. Therefore, we were interested in whether the respondents who recovered from COVID-19 had or still have any of the symptoms shown below one month after recovering from SARS-CoV-2 virus infection (Figure **32**).

We can find that in 19th wave most people (77.9%) still had some problems[9] one month after recovering from the infection. The most common problems were malaise, fatigue and lack of energy, reported by more than one third of recovered patients; just under a third of respondents reported problems with the perception of taste and smell; good fifth reported muscle and joint pains as well as problems with concentration and memory; and almost a fifth reported cough and / or headaches (Figure **32**). In all nine waves of the survey, the average number of problems is the same (2 problems). The data therefore show that the share of people who have health problems one month after COVID-19 is significant, so it is important that the health status of patients is monitored for a longer period of time

[6] Brackel, CLH, Lap, CR, Buddingh, EP, et al. Pediatric long-COVID: An overlooked phenomenon? Pediatric Pulmonology. 2021; 56: 2495– 502. https://doi.org/10.1002/ppul.25521.
[7] Nalbandian, A., Sehgal, K., Gupta, A. et al. Post-acute COVID-19 syndrome. Nat Med 27, 601–15 (2021). https://doi.org/10.1038/s41591-021-01283-z.
[8] WHO Policy brief 39 In the wake of the pandemic, Preparing for Long COVID, https://apps.who.int/iris/bitstream/handle/10665/339629/Policy-brief-39-1997-8073-eng.pdf.
[9] V 17th wave of the survey, headache and cough were added to the possible answers.

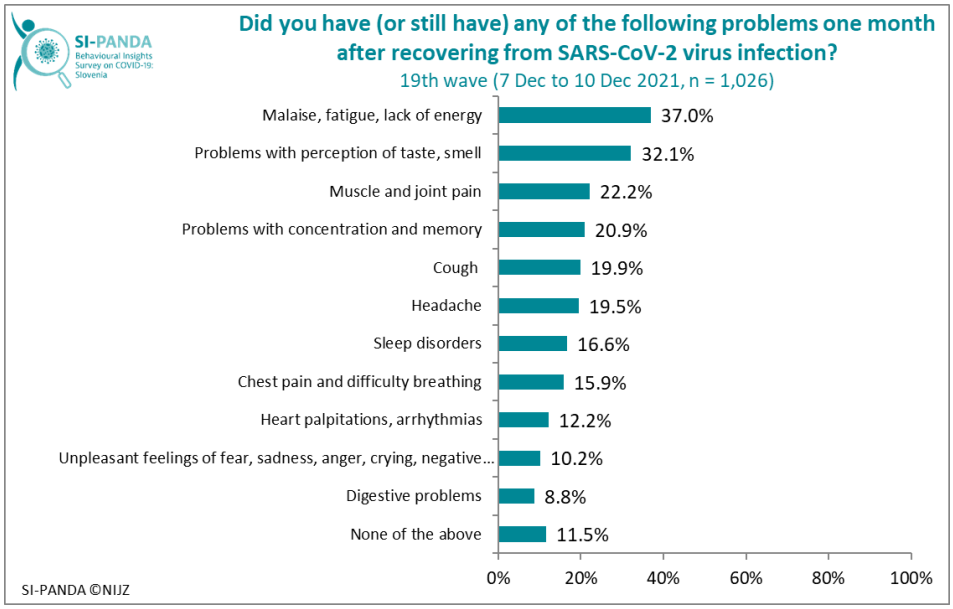

Figure 32: Health problems one month after the respondents had already recovered from SARS-CoV-2 virus infection, total.

Note: multiple answers were possible.

Comparisons of the most recent waves of the survey show that the share of people with one problem fell to an all-time low in 16th wave (47.6%), rose again in 17th and 18th waves of the survey, and fell by around 10 percentage points in 19th wave, currently standing at 50% (Figure 33).

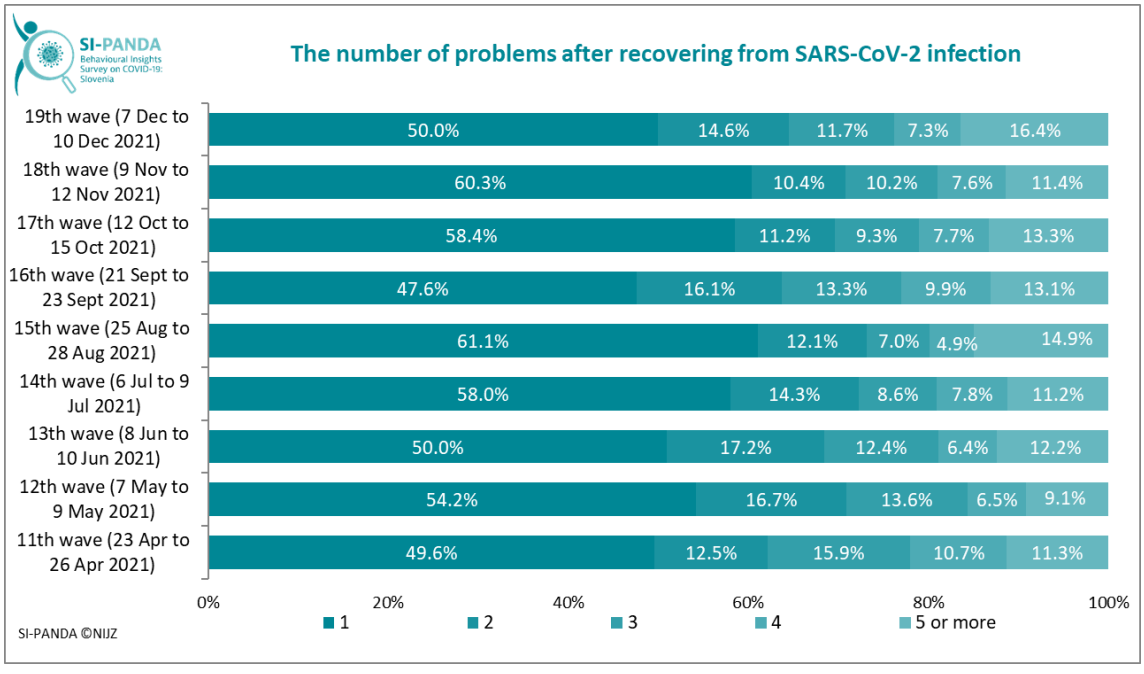

Figure 33: The number of problems after recovery from SARS-CoV-2 infection, total, by survey waves.

Surprisingly a large share of persons does not consult a doctor about problems after recovery from COVID-19. In the 19th wave, there were 60.7% of such respondents.

When asked how long the problems lasted after the recovery from infection, most of respondents (44.2%) answered that 3 months and more, 29% answered that the problems lasted from 1 to 2

months and 26.7% answered that they lasted up to 1 month. If we look at the shares of responses by individual categories from the 14th wave of the survey onwards, we can see that they are constant (Figure 34). Most respondents (75.7%) answered that the problems affected their work, caring for things at home and relationships with people; 22.4% reported that the problems had a great or an extreme impact on work, care for the home and relationships with people. A quarter of recovered respondents (24.3%) reported that the problems did not affect their daily functioning.

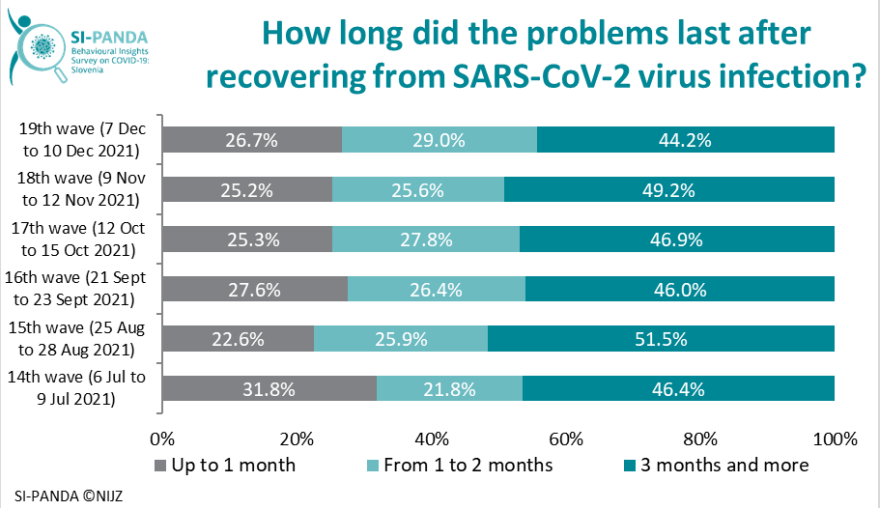

Figure 34: Duration of problems after recovering from SARS-CoV-2 virus infection, total, by survey waves.

Given this, it can be assumed that these are, on the one hand, mild and non-specific health problems, but on the other hand, it is often a rather complex picture, to which the profession is currently not paying enough attention, namely from research and from clinical point of view.

Much is still unknown about the causes and long-term effects of SARS-CoV-2 infection on humans, but research is underway. It is already clear that long COVID is relatively common and has a significant impact on an individual's ability to work and their daily life. All this can have economic consequences for the individual, their family and society. In Slovenia, there are already specialized clinics for people with long-term problems after recovering from COVID-19.

Most people with COVID-19 recover quickly. Given that research shows that the risk of long-term health problems after infection with the SARS-CoV-2 virus is not so small, vaccination against COVID-19 is also important in this regard and probably not mentioned enough in the communication about the benefits of vaccination.

Highlighted topics of the 19th wave of the survey:

Compliance with isolation and quarantine and dealing with cold

Data from the 19th wave of the survey show that 10% of the respondents would not comply with the 10-day quarantine[10] order, which means that they could potentially spread SARS-CoV-2 infection. Among the youngest group of respondents, 18.3% would not comply with a quarantine order, while among the 30–49 age group there are 11% of such persons. Therefore, the persons who are most likely to disregard the ordered quarantine are those who are expected to have the most contact with other people (Figure 35).

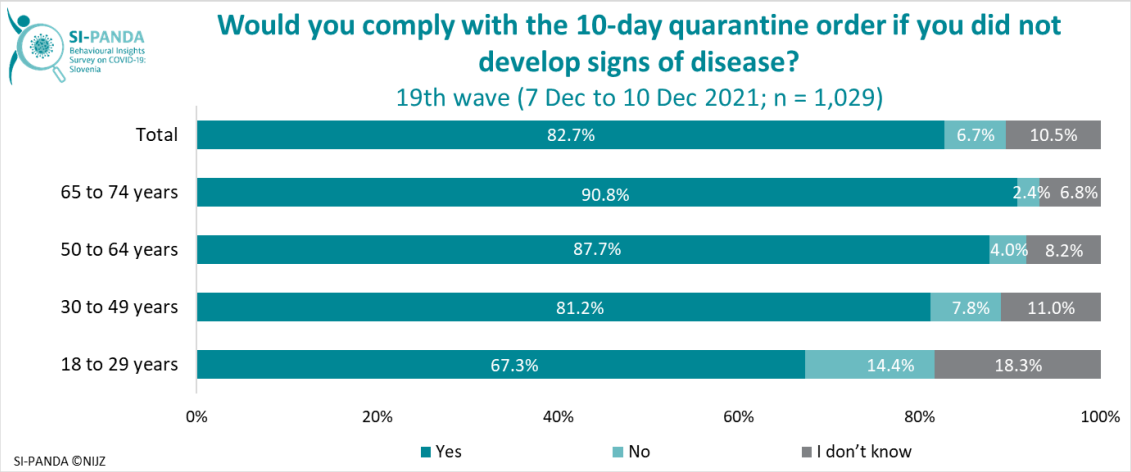

Figure 35: Compliance with 10-day ordered quarantine, total and by age groups.

In 19th wave of the survey, we also wanted to know how respondents would react if they developed symptoms of a cold or respiratory infection. There were multiple possible answers. The majority (66.5%) said they would self-test and a good half (52.9%) would call their personal physician. Only 1.7% of respondents said they would do nothing (Figure 36).

[10] At the time of the survey, the duration of the quarantine ordered was 10 days.

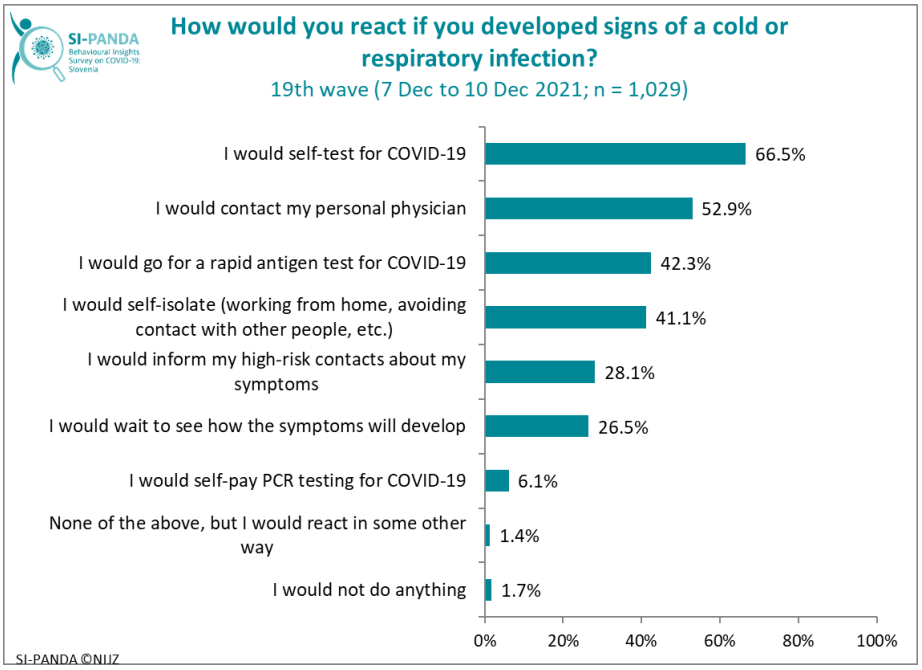

Figure 36: Reaction in the event of cold symptoms, total.

Note: multiple answers were possible.

However, if we look at the behaviour of the respondents in the event of signs of a cold or a respiratory infection depending on their age, we see that there are significant differences. Thus, for example, 73.9% of 18–29 year olds, 75.6% of 30–49 year olds and only 47.4% of the respondents from the oldest age group (65–74 years) would carry out a self-test (Figure 37). Perhaps even more interesting is the fact that half (51.2%) of the persons from the youngest age group reported that they would self-isolate. In older age groups, the share of people who would self-isolate decreases from 43.1% in the 30–49 age group to 31% in the 65–74 age group. Likewise, the most (38.7%) persons from the youngest age group stated that they would inform their high-risk contacts about their symptoms, and the least would do so in the oldest age group (23%). On the other hand, most (39.1%) of the youngest respondents would wait to see how cold symptoms develop.

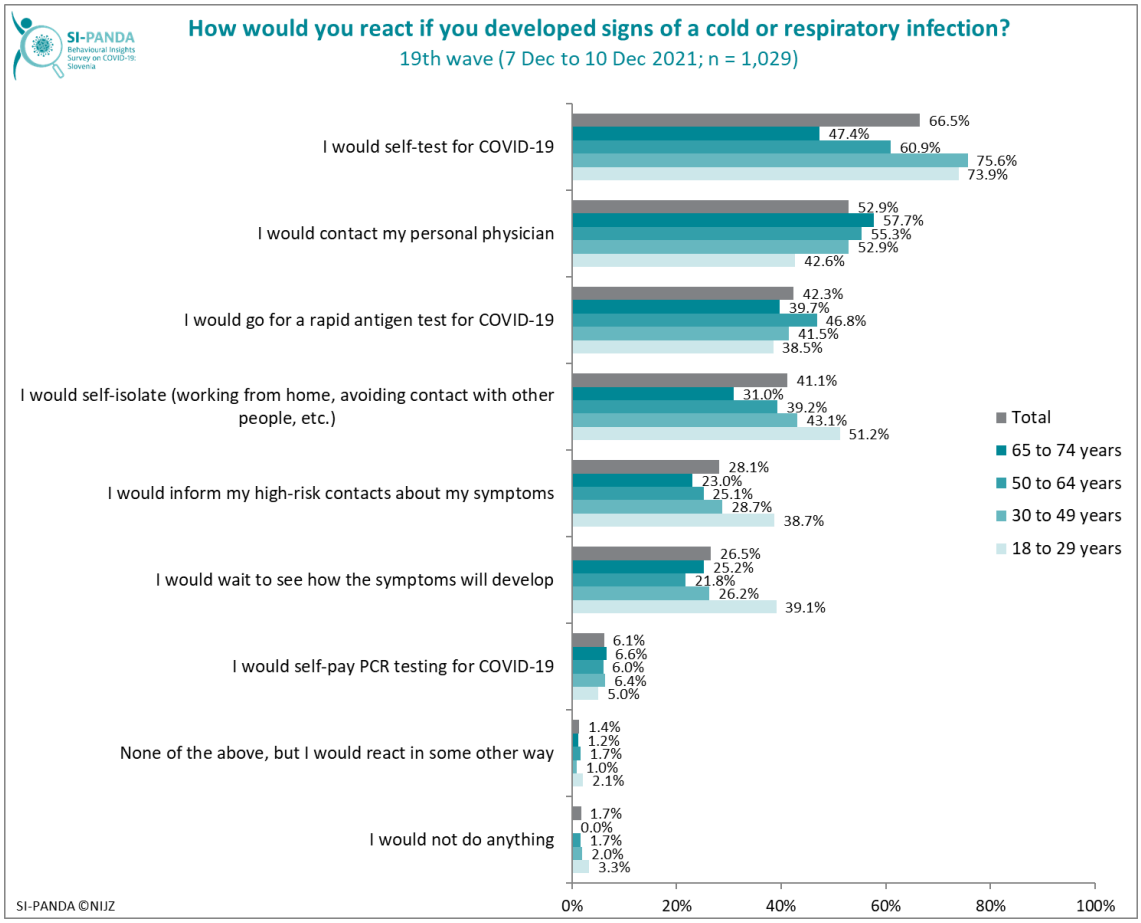

Figure 37: Reaction in the event of cold symptoms, total and by age groups.

Note: multiple answers were possible.

The use of protective masks

The use of protective masks is one of the measures that has been in force for the longest time during the COVID-19 pandemic. The mask must be properly fitted to cover the mouth, nose and chin and is intended for single use and must be changed after two hours or more often if damp. Although masks are widely available, they represent a certain cost, which in some cases can also affect the family budget more deeply. Therefore, in the 19th wave of the survey, we were interested in people's behaviour regarding disposable masks. 2.3% of people stated that they do not use mass, 37.4% of respondents use one mask or more per week, almost the same share use one mask per day, and only 22.5% of people use two masks or more per day. In the youngest age group there are the most, more than half, of those who use one mask for several days, and in the oldest age group there are the most people who use one mask per day. The largest share of people who use two or more masks per day is in the age groups of 30 to 49 years (26.7%) and 50 to 69 years (24.4%), i.e. among the working population, among whom it is likely there are quite a few people who are given masks at the workplace by their employer (Figure 38).

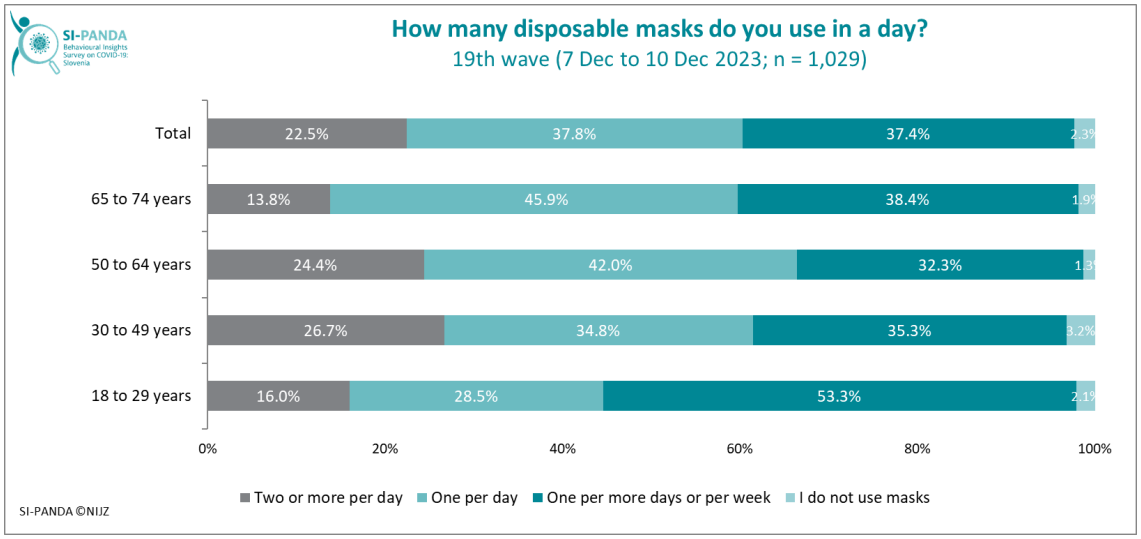

Figure 38: Number of masks used per day, total and by age groups.

On November 5, 2021, the Government of the Republic of Slovenia adopted the Ordinance on the temporary measures for the prevention and control of infectious disease COVID-19 (Official Gazette of the Republic of Slovenia, No. 33/06), which stipulates that from November 8, 2021, protective surgical masks or FFP2 masks are mandatory in schools for all students from 1st to 9th grade; protective cloth masks are no longer allowed, wearing masks is mandatory both in the classroom and in all other areas of the school for all students, including from the age of 6 onwards. Thus, we asked the respondents who are parents of school-age children how many disposable masks their child uses in one school day. Half of the parents surveyed answered that their children use one mask per day, a good quarter indicated that their children use two masks or more per week, and less than a quarter that their child uses a mask for several days (Figure 39).

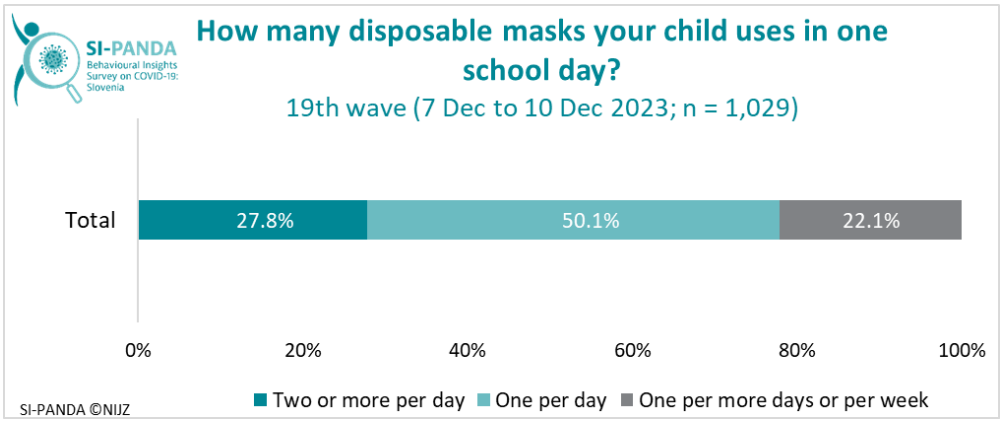

Figure 39: Number of masks used per day by schoolchildren, total.

Interest in vaccination of children under 12 years of age

The Comirnaty 10 vaccine is registered for basic vaccination of children aged 5–11 years, which is available in Slovenia since mid-December 2021. It is especially recommended for children who have a higher risk of a more severe course of the disease or are in contact with persons with a higher risk of a severe course of COVID-19 who cannot be effectively protected by vaccination (e.g. immunocompromised persons, siblings with chronic diseases). Vaccination is also reasonable and safe for other children aged 5–11 years. According to currently available data and in a situation where the SARS-CoV-2 version is predominant, children have an increased risk of infection. Vaccination protects them from a more severe course of the disease.

In our survey, which took place just before introduction of the Comirnaty 10 vaccine in Slovenia, only 13% of parents of children under the age of 12 answered that they would vaccinate their child when the vaccine was available (Figure 40); 3.7% were undecided in this regard. Significantly fewer mothers would vaccinate their children, only 4%. None of the unvaccinated parents would vaccinate their child; even 68.9% of vaccinated parents would not vaccinate their child. The data show the important role of paediatricians in informing parents about the facts regarding vaccine safety.

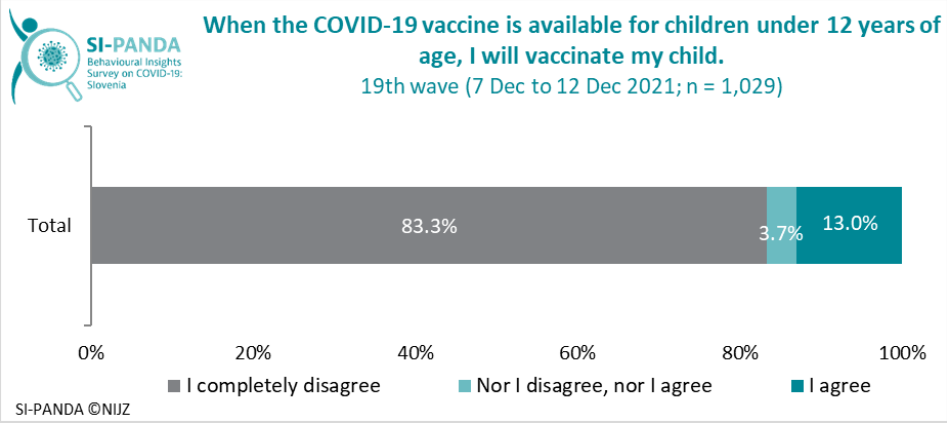

Figure 40: Decision to vaccinate children under 12 years of age, total.

Parents' decision (221 parents answered) to vaccinate a child under 12 years of age will depend most on whether there will be enough data that the vaccine is safe – the average response on a 7-point scale is 4. The decision to vaccinate the child will also be influenced by the risk of a more severe course of the disease in the child and the recommendation of the child's paediatrician. To a lesser extent, the decision will also be conditioned by the fact that kindergartens and schools would remain open, by the fact that the child would not need to self-test, and by the recommendation of the NIJZ and the Ministry of Health.

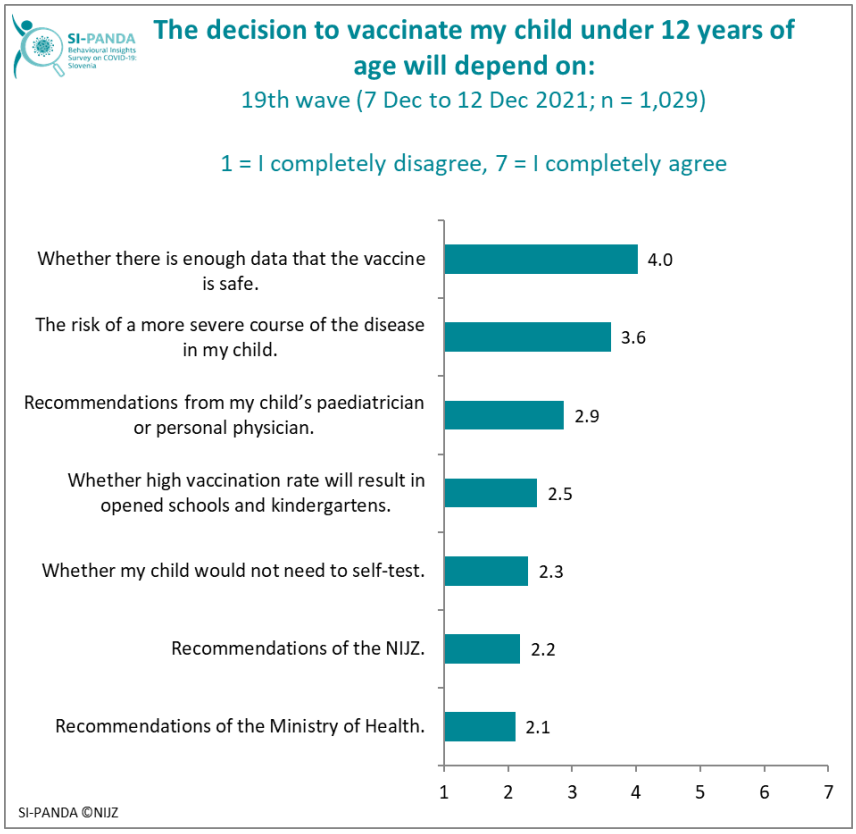

Figure 41: Reasons for decision on vaccination of children under 12 years of age, total.

On January 12, 2022, the NIJZ recorded 1,869 vaccinations with the first dose for children up to and including 11 years of age, which represents 1% of children in the 5–11 age group.

Drinking alcoholic beverages during the COVID-19 pandemic[11]

In the 19th wave of the survey, every fifth respondent (20.4%) reported that they had not drunk alcoholic beverages in the last 12 months (Figure 42), which is comparable to data from other Slovenian population surveys. Women abstained 1.7 times more often than men. A third of the respondents (32.4%) reported that they drank alcoholic beverages once per month or less, a quarter (25.2%) that they drank them 2 to 4 times per month, a seventh (14.2%) 2 to 3 times per week and less than a tenth (7.8%) 4 or more times per week. Almost half of the participants (49.2%) reported that when they drank beverages containing alcohol, they drank half to one measure[12] of alcohol, slightly less than a third (29.5%) two measures, 16.4% 3 to 4 measures, 3.5% 5 to 6 measures and 1.5% seven or more measures of alcohol. Men drank more and more often compared to women. Younger respondents drank less often, but drank more on the usual drinking occasion. More than half of the respondents (58.0%) reported drinking several measures of alcoholic beverages on one occasion (binge drinking[13]) at least once in the last 12 months, which is slightly more than the data of other Slovenian population surveys show; women as often as men, which also differs from the data of other Slovenian population surveys. The share of those who got drunk was the highest among respondents from the youngest age group (18–29 years), in which the frequency of getting drunk was also higher. Binge drinking was more prevalent among respondents from the eastern Slovenian cohesion region compared to those from the western.

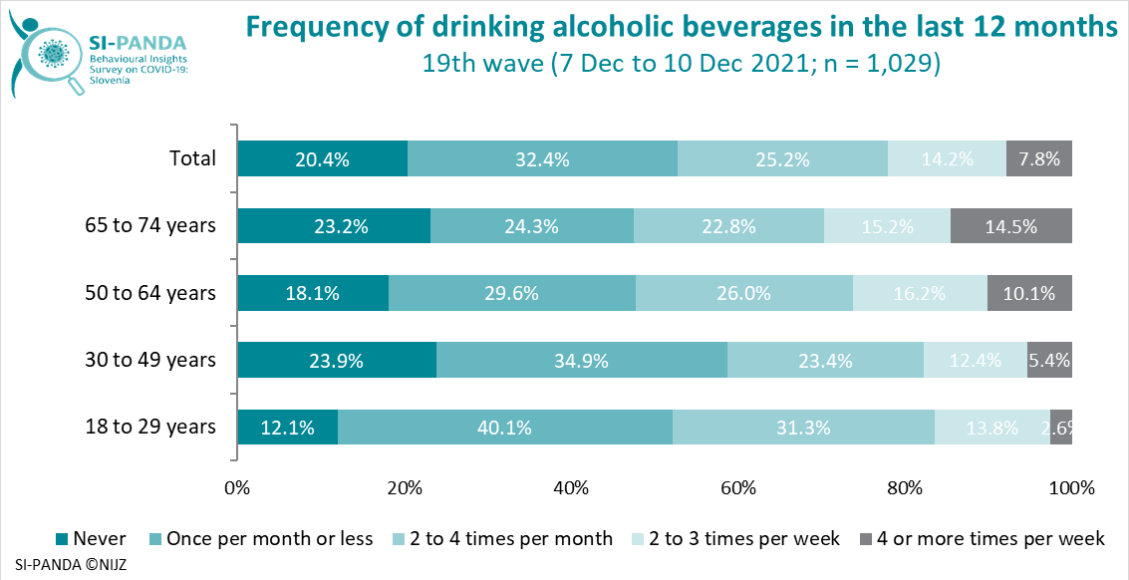

Figure 42: Frequency of drinking alcoholic beverages in the last 12 months, total and by age groups.

[11] Babor, T.F., Higgins Biddle, J.C., Sanders, J.B. in Monteiro, M.G. (2001). AUDIT – The Alcohol Use Disorders Identification. Geneva: WHO, Department of Mental Health and Substance Dependence.
Kolšek, M. (2004). O pitju alkohola. Priročnik za zdravnike družinske medicine. Ljubljana: CINDI Slovenija.

[12] 1 measure of alcohol contains 10 grams of pure alcohol, which is in 1 dl of wine or 2.5 dl of beer or 0.3 dl of spirits or 5 dl of radler. .

[13] Respondents who drank more than 40 grams of pure alcohol on one occasion at least once in the last year (applies to women) or more than 60 grams of pure alcohol (applies to men).

Based on combined answers to the above questions (about the frequency of drinking, about the usual amount of alcohol consumed and about the frequency of drinking) from the AUDIT-C[14] screening test, we estimate that there is a probability that 15.6% of the respondents have had a problem in the last 12 months with risky or harmful drinking of alcohol or with alcohol dependence[15]. The prevalence of this type of drinking was 2.6 times higher among men than among women (Figure 43), and it was also higher in the 18–29 age group (22.1%) compared to the 30–49 age group (13.6%) and 50–74 age group (15.1%).

Respondents did not differ in their AUDIT-C screening test score according to their level of education, self-assessed social class, presence of chronic conditions, presence of mental health problems, place of residence (urban, suburban or rural), cohesion region (eastern or western), place of work in the last seven days (home, mixed, workplace), COVID-19 prevalence and vaccination status, and also not by being a health professional or not. However, they differ in their self-assessment of their personal financial situation in the last three months, namely the proportion of likely risky or harmful alcohol drinking or alcohol addiction was higher among respondents who assessed their financial situation worse than before (19.0%) compared to those who rated it as the same (13.3%).

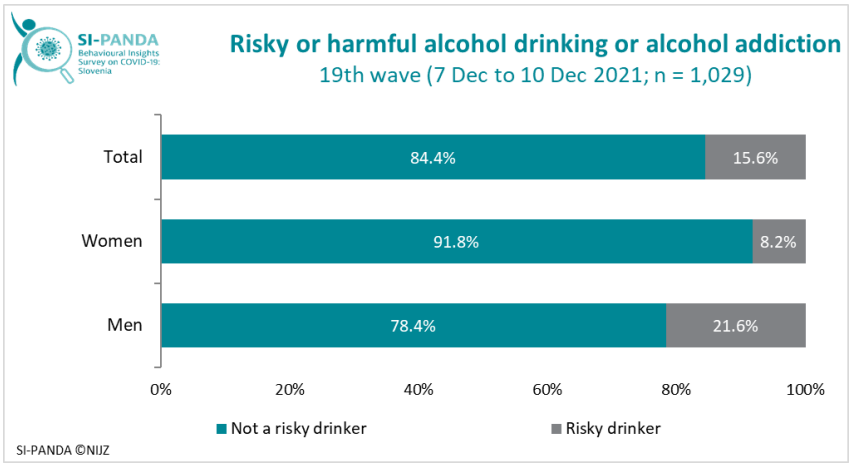

Figure 43: Risky or harmful alcohol drinking or alcohol addiction, total and by gender.

[14] The AUDIT questionnaire (Babor et al., 2001) is a screening tool developed by the WHO and used to assess the likelihood of risky or harmful drinking or alcohol dependence syndrome. Based on the questionnaire, we cannot make a diagnosis of harmful drinking or alcohol dependence syndrome, but only determine the probability that the person is a risky or harmful drinker or is dependent on alcohol. In the research, we used the Slovenian version of the shorter (AUDIT-C) questionnaire (Kolšek, 2004).

[15] A score of 6 points or more for men and 5 points or more for women indicates a person who drinks risky or harmful or is dependent on alcohol (Kolšek, 2004).

ZORA programme during the COVID-19 pandemic[16]

The national cervical cancer screening programme (ZORA) is an organized screening programme for the detection of pre-cancerous and early cancerous lesions of the cervix, managed and coordinated by the Institute of Oncology Ljubljana. It is aimed at women aged 20–64 who should have a preventive check-up with a cervical smear for cytology once every three years with their personal gynaecologist of choice. During the first epidemic wave of COVID-19, screening was suspended by government decree between 11 March and 8 May 2020. Following the improvement of the epidemiological situation, all ZORA services were resumed on 9 May 2020. Since then, the programme has been implemented without systemic constraints, as all three cancer screening programmes (ZORA, Dora and Svit) have been classified as exempted programmes, which can be implemented even during an epidemic if the provider can ensure the safe delivery of services. During the period of the most severe measures in spring 2020, the 3-year screening rate for women in the ZORA programme, which was around 72% before the COVID-19 pandemic, fell below the 70% target for the first time since the ZORA programme was launched in 2003 (69.6% on 30 June 202; data source ZORA registry). In August 2020, the screening rate increased again and surpassed 70%. Screening rates decreased in all age groups, with the largest shortfall in cervical smear screening in the 30–39 age group. It is therefore not surprising that at the end of 2020, the ZORA registry also recorded a 19% shortfall in newly diagnosed high-grade cervical precancerous changes in 30–39 year old women, while in other age groups the number was comparable to the average of previous years[17]. In the 19th wave of the SI-PANDA survey, we examined the attitude of women towards screening in the ZORA programme, how it changed during the pandemic and what problems they face.

The majority of female respondents (92.5%) aged 20 to 64 believe that preventive examinations within the framework of the ZORA programme are important (Figure **44**) – namely, 93.8% of female respondents aged 30–39 and 50–64 years, 93.1% of respondents aged 40–49 years and slightly fewer (83.0%*) of younger women aged 20–29 years. There were smaller differences in women's responses according to their education, social class and cohabitation with children. Screening seems slightly more important to women with at least post-secondary education (93.4%) compared to women with secondary education or less (91.1%) and women living with children under 18 (94.2%) compared to those who do not (91.3%). Screening seems to be slightly less important to women from the middle social class (92.1%) than to women from the lower (92.9% and higher (93.7%) social classes.

[16] Contact: zora@onko-i.si.

[17] Ivanuš U, Jerman T, Gašper Oblak U, Meglič L, Florjančič M, Strojan Fležar M, Premru Sršen T, Smrkolj Š, Pakiž M, Primic Žakelj M, Kloboves Prevodnik V, Pogačnik A, Josipović I, Mate T, Gobec M. The impact of the COVID-19 pandemic on organised cervical cancer screening: The first results of the Slovenian cervical screening programme and registry. Lancet Reg Health Eur. 2021;5:100101. doi: 10.1016/j.lanepe.2021.100101.
* Less accurate assessment.

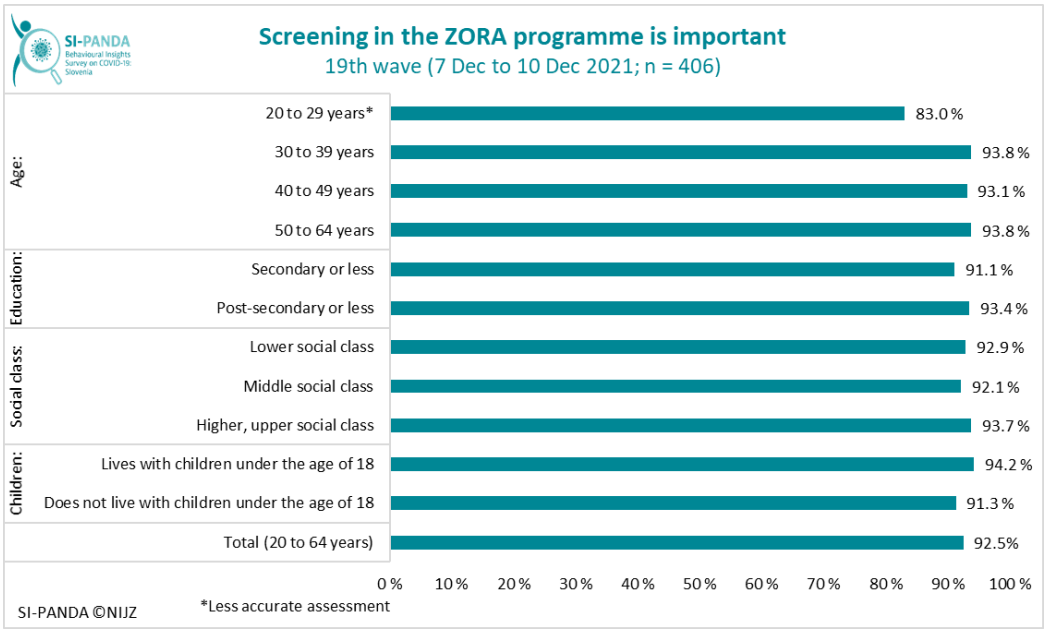

Figure 44: The importance of screening in the ZORA programme, total and by age, education, social class, and by whether they live with children under the age of 18 (% of answers that regular cervical smear screening is important).

We asked respondents in which cases they could wait a bit with a gynaecological examination during the COVID-19 pandemic (Figure 45). 40.2% of women believed that they could wait for a preventive examination; the largest share was in the youngest and oldest age group (42.6%). Only a small proportion (2.6% and 4.0%) of women thought that the examination can wait a bit in case of symptoms and signs that are suspicious for cervical cancer, or after a referral by their gynaecologist for further examinations or treatment due to precancerous or cancerous changes of the cervix, and older women were slightly more likely to do so.

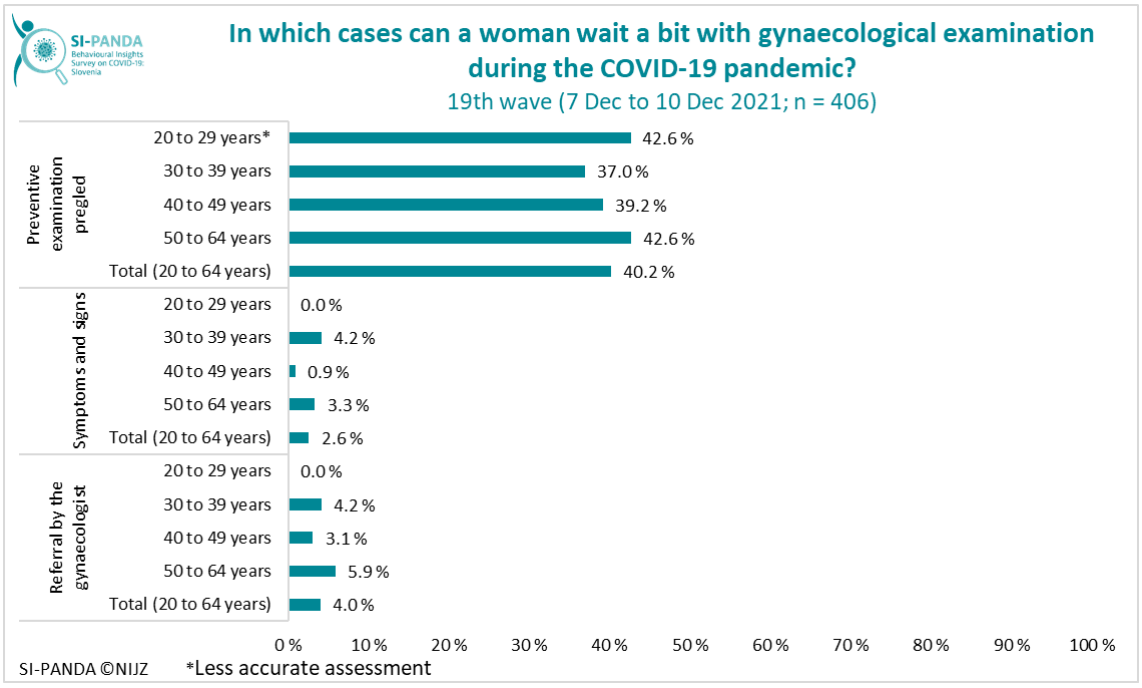

Figure 45: In which cases ca a woman wait a bit with a gynaecological examination (regular preventive examinations, examinations in case of symptoms and signs and examinations in case of referral by a gynaecologist) during the COVID-19 pandemic, total and by age group (% of answers that she can wait a bit).

Respondents who stated that a woman could wait a bit with an examination were also asked about their reasons for doing so (Figure 46). The most frequent answer was that the deferral would not worsen their health, with younger women aged 20–39 (63.4%*) more likely than older women aged 40–64 (54.0%) to say this. Older women were more likely to say that it was because it was unlikely that they would be able to have an examination at all during the pandemic (42.7 vs 36.2%*) because the risk of contracting SARS-CoV-2 virus during a visit to the gynaecologist (29.4 vs 23.9%*), because they did not want to be a burden on the health system during the pandemic (33.3 vs. 17.1%), and because the treatment would not be of the same quality (10.4 vs 4.6%).

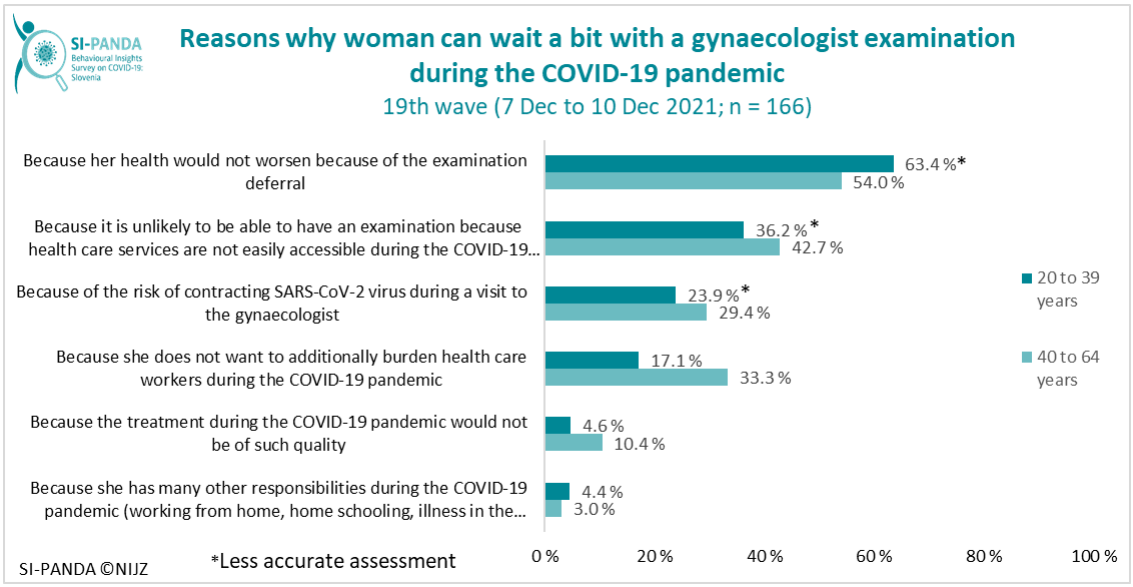

Figure 46: Reasons why a woman can wait a bit with gynaecologist examination (among women who answered that the examination can be delayed), by age group.

The percentage of women who felt that specific gynaecological services were more difficult to access during the pandemic (Figure 47) was highest in the youngest age group 20–29 and decreased with age. This is true for accessibility in the case of preventive examinations (53.9% to 32.7%), examinations in the case of symptoms or signs (36.4% to 25.3%) as well as for examinations due to a referral by a gynaecologist (42.5% to 29.2%).

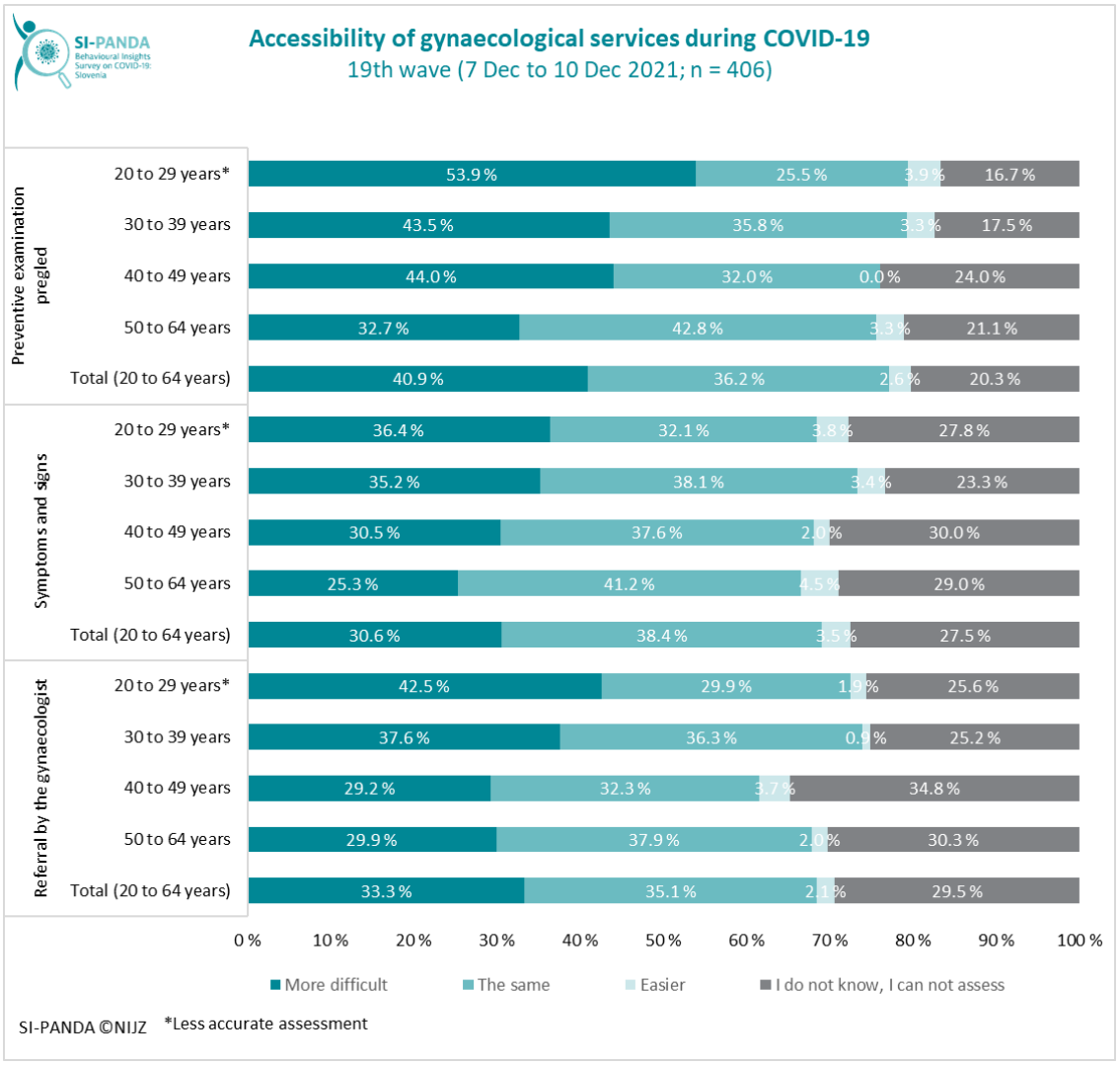

Figure 47: Accessibility of gynaecological services (regular preventive examinations, examinations in case of symptoms and signs, and examinations in case of a referral by a gynaecologist) during the COVID-19 pandemic, total and by age groups.

Respondents who agreed that the services were more difficult to access were asked about the reasons for this (Figure 48). Both women under 40 as well as those over 40 most often cited problems related to making an appointment as a reason – unavailability of making an appointment (74.7* and 67.9%) and an altered appointing system with more electronic and less face-to-face communication (65.3* and 62.5%), followed by non-operation of clinics due to quarantines among healthcare workers (55.0 and 45.2%), the RVT condition (48.8* and 34.6%); that an individual's reason is less important for healthcare workers, although she needs treatment, was considered by 37.6% and 26.3% of respondents. The only reason given slightly more often by women aged 40–64 than younger women was that it is difficult to choose a new gynaecologist if you do not have one yet or the previous one has stopped working (21.3% and 25.2%)

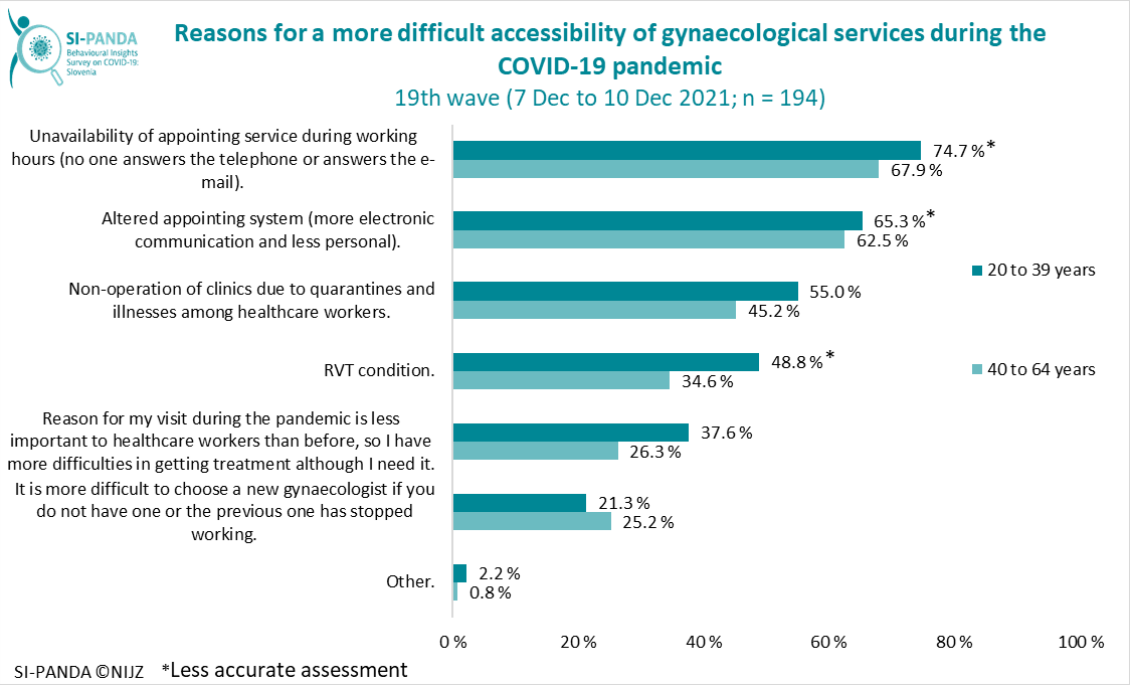

Figure 48: Reasons for a more difficult accessibility of gynaecological services (among women who stated that certain gynaecological services are less accessible), by age group.

We asked the respondents how likely they would be to attend a gynaecological preventive examination if they received an invitation to do so (Figure 49). Respondents in different age groups reported that they were 11.0–18.4% less likely to participate than before the pandemic, which was slightly more often reported by older women in the ZORA target group. Women are even less likely to make an appointment for preventive examinations during the pandemic on their own (Figure 50). This was stated most often by the youngest women (20–29 years) at 36.2%*, and least often by the next age group (30–39 years), followed by the two older groups at 26.3% and 27.9%.

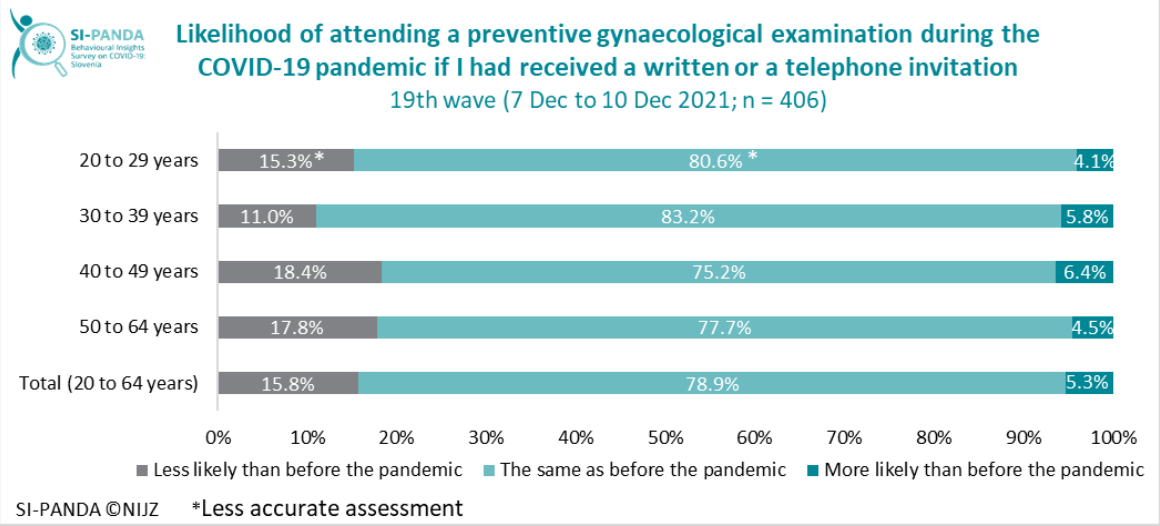

Figure 49: Likelihood of attendance at a preventive gynaecological examination during the COVID-19 pandemic, total and by age groups.

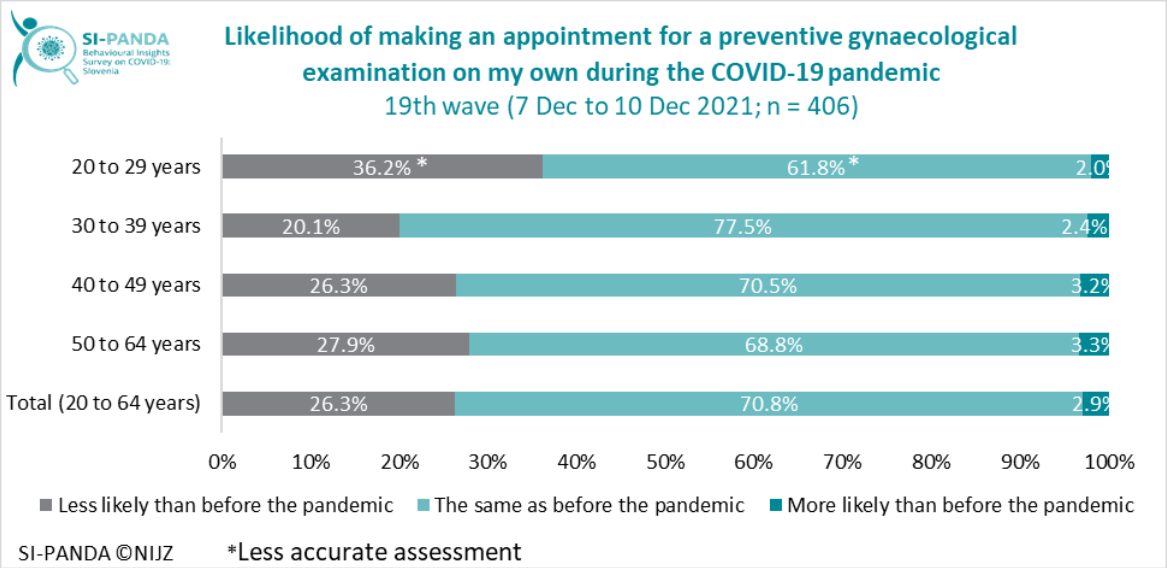

Figure 50: Likelihood that a woman would make an appointment for a preventive gynaecological examination on her won during the COVID-19 pandemic, total and by age groups.

Almost half of women in the ZORA target group find it harder to find time for a gynaecological examination during the COVID-19 pandemic, and the proportion decreases with age, from 67.3%* in the 20–29 age group to 37.9% in the 50–64 age group (Figure 51). Among those who answered that women find it harder to find time, the younger age groups (20–39 years) also gives more reasons than the older age group (40–64 years) (Figure 52). In the younger group, the most common reasons are family-related (home schooling, home childcare, quarantines in the family (66.5–68.0%)), followed by illness in the family (47.7%), lack of willpower (46.3%) and work or study commitments (44.4%). The older group (40–60 years) also most frequently cites quarantines in the family (55.7%), followed by lack of willpower (40.6%) and home schooling of children (43.3%).

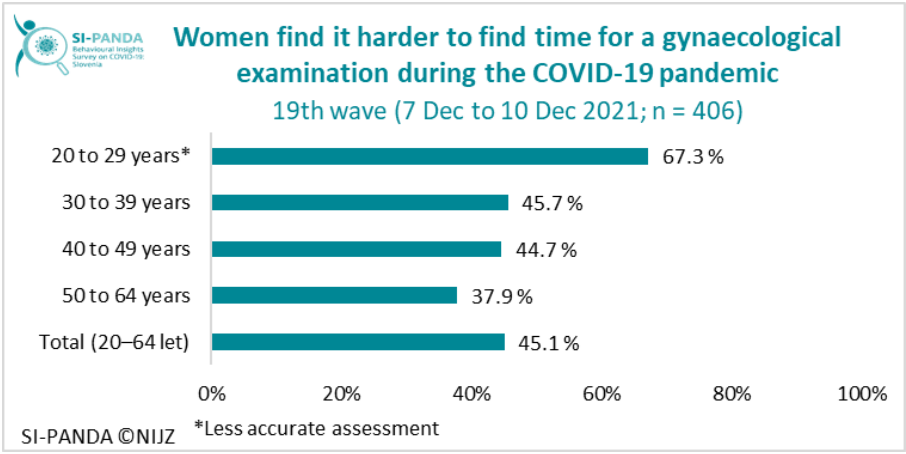

Figure 51: Answers to the question whether women find it harder to find the time or arrange for a gynaecological examination during the COVID-19 pandemic, total and by age groups (% of YES answers).

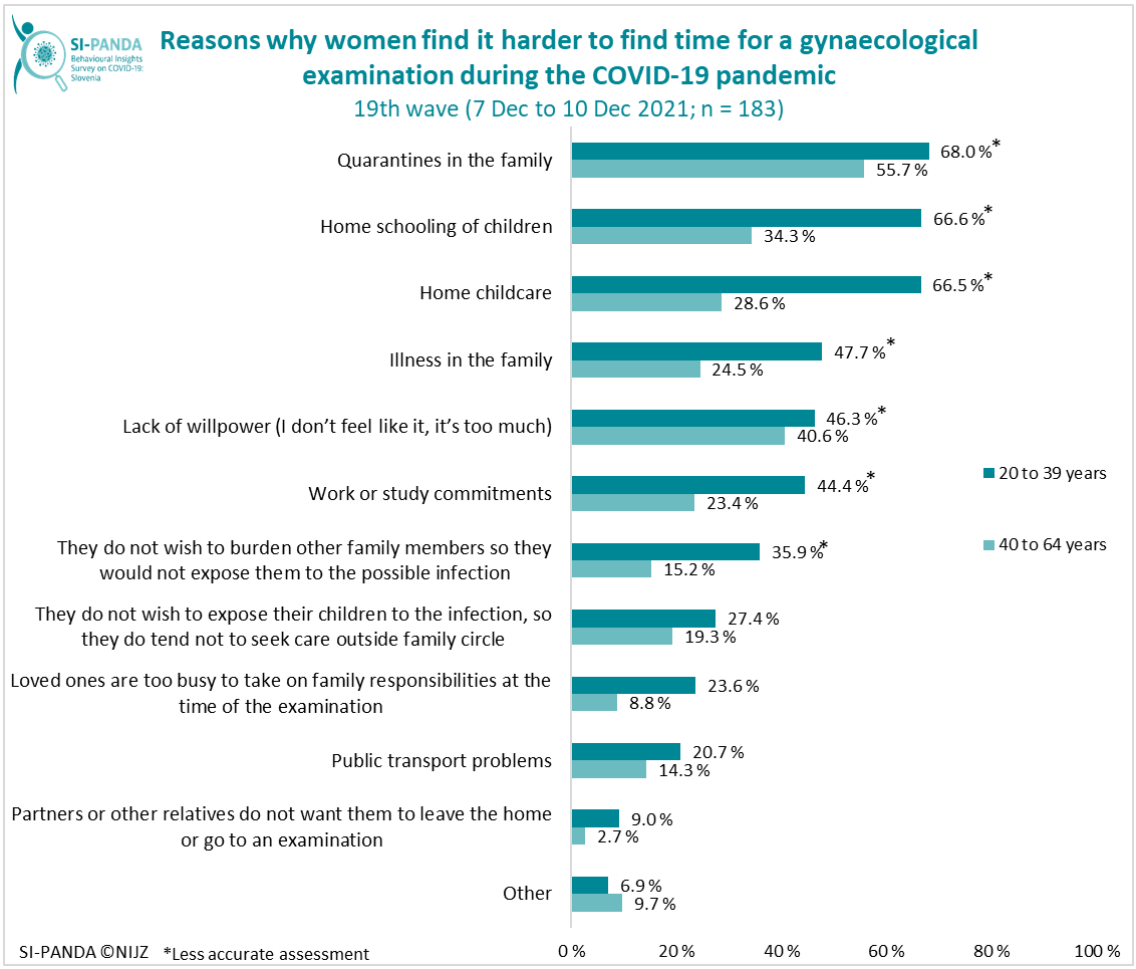

Figure 52: Reasons why women find it harder to find time for a gynaecological examination during the COVID-19 pandemic (among those, who answered that they find it harder to find time), by age groups.

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