



COVID-19 PANDEMIC IN SLOVENIA

**Results of a panel online survey on the impact
of the pandemic on life (SI-PANDA),
20th iteration**

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INTRODUCTION

The COVID-19 pandemic has had a significant impact on all areas of human life, both in Slovenia and around the world. It has been three years since the first SARS-CoV-2 infection occurred in Slovenia on 4 March 2020. Since then, Slovenia has experienced several epidemic waves, affecting the entire country and all its inhabitants in one way or another. This time has been important for researching the impact and consequences of the pandemic on the individual and society as well as on the health system. The severity and the scope of the COVID-19 pandemic and the introduction of measures to prevent and limit the transmission of the infection have had a profound impact on the daily lives of all people in 2020 and 2021, including those not directly affected by the virus. The uncertain and long-lasting period of health and social crisis has led to a gradual exhaustion of compensatory mechanisms in humans, and thus to a lower success rate of measures to prevent the spread of SARS-CoV-2 infection among the population.

In order to better understand people's behaviour in the context of a crisis situation, both in terms of adherence to recommended measures such as vaccination against COVID-19, use of a mask, keeping safety distance, etc., as well as to gain insight into changes in their lifestyle, physical and mental health, we have already launched the SI-PANDA survey on 4 December 2020, which studies the impact of the COVID-19 pandemic on the lives of Slovenians. After 19 iterations of the survey in 2020 and 2021 (the last was carried out from 7 to 10 December 2021), a new set of 6 surveys is now on the way, with the first iteration carried out from 20 to 23 September 2022.

External circumstances have changed in the meantime. The SARS-CoV-2 virus has become our constant companion, as they call it our "new normal". We seem to have forgotten very quickly that anyone of us, at any age, can become seriously ill or even die from COVID-19. It is also true that most people who become infected with SARS-CoV-2 today, when Omicron is the predominant variant, are likely to have mild to moderate respiratory illness and will recover without special treatment. However, there are people among us, especially the elderly and those with chronic conditions, who are at greater risk from the disease. As a solidarity society, we have a duty to protect them through our behaviour. We are also facing the post-COVID syndrome or long COVID. This is a condition after SARS-CoV-2 infection, when various health problems persist for two months or longer, they cannot be explained by an alternative diagnosis, and severely affect an individual's functioning at work or at home.

The new set of SI-PANDA research aims to determine how often people have been exposed to SARS-CoV-2 infection since the beginning of the pandemic, and to study the consequences of recovering from SARS-CoV-2 infection. Given that vaccination against COVID-19 is still one of the most effective measures, we are also interested in people's attitudes towards vaccination and the reasons for their hesitation.

The results of the research presented in the report are aimed at experts and decision-makers, as well as the media and general public. This also implements the WHO recommendation¹ that countries should regularly conduct qualitative and quantitative population surveys, which should be the basis for further action.

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

METHODOLOGICAL NOTES

The research in the form of an online survey is being conducted in twenty-six iterations starting on 4 December 2020. The first set of the survey (up to and including the 12th iteration) was conducted by the Mediana Institute for Market and Media Research on behalf of the National Institute of Public Health (NIJZ) while the second and third sets are being conducted by Valicon. The first twelve iterations were conducted once every two weeks and the second part, including the 19th iteration, once a month. The third set of survey, which is being carried out after a nine-month break, will also be carried out once a month. The data are analysed at the NIJZ.

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

At the beginning of research, we used the World Health Organization (WHO)² questionnaire as a basis, which we translated and adapted to the situation in our country according to the WHO guidelines. We also used the translated MHI-5 questionnaire to measure individuals' mental health and the 7C questionnaire to determine the willingness to vaccinate. We have also included some questions that have been used in previous surveys carried out by the National Institute of Public Health and questions that members of the research team and colleagues have designed according to current needs.

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

The report presents data from the **20th iteration** of the online survey, that took place **od 20 September 2022 to 23 September 2022** on a sample of 1,037 adults aged 18 to 74 years. Some comparisons with previous iterations of the survey are also shown.

Research carried out so far:

1st iteration from 4 Dec 2020 to 6 Dec 2020

2nd iteration from 18 Dec 2020 to 21 Dec 2020

3rd iteration from 4 Jan 2021 to 5 Jan 2021

4th iteration from 15 Jan 2021 to 17 Jan 2021

5th iteration from 29 Jan 2021 to 30 Jan 2021

6th iteration from 12 Feb 2021 to 15 Feb 2021

7th iteration from 26 Feb 2021 to 1 Mar 2021

13th iteration from 8 Jun 2021 to 10 Jun 2021

14th iteration from 6 Jul 2021 to 9 Jul 2021

15th iteration from 25 Aug 2021 to 28 Aug 2021

16th iteration from 21 Sept 2021 to 23 Sept 2021

17th iteration from 12 Oct 2021 to 15 Oct 2021

18th iteration from 9 Nov 2021 to 12 Nov 2021

19th iteration from 7 Dec 2021 to 10 Dec 2021

20th iteration from 20 Sept 2022 to 23 Sept 2022

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>.

KEY FINDINGS OF THE 20TH ITERATION

➤ Supporting current recommendations

In the 20th survey iteration, the respondents gave the highest levels of support to the recommendation of effective ventilation in educational institutions (78.1%), isolation for persons with confirmed SARS-CoV-2 infection (75.1%), and the use of masks in health care facilities, pharmacies, and homes for the elderly (72.1%). People in the 30 to 49 age group give the least support to most of the current recommendations.

➤ Compliance with isolation and quarantine and action in case of cold symptoms or respiratory infection

In case of cold symptoms or respiratory infection, the majority of people would react by self-testing for SARS-CoV-2 (74.7%), with the oldest age group least likely to do so (62.7%). Upon contact with a person who tested positive for the SARS-CoV-2 virus, despite not developing symptoms themselves, 70.1% of people would get tested.

➤ Risk perception in relation to SARS-CoV-2 virus infection

Overall, the risk perception in the relation to SARS-CoV-2 virus infection is high in just under a third of 20th iteration respondents (32.1%), a good third (36.8%) rate their risk as medium, and a poor third (31.1%) rate their risk as low. The risk of SARS-CoV-2 infection is perceived as low by 26.4% of the vaccinated and 44.4% of the unvaccinated, and as high by 36.0% of the vaccinated and 20.9% of the unvaccinated.

➤ Vaccination against COVID-19

In the most recent iterations of SI-PANDA, the proportion of people who do not intend to be vaccinated against COVID-19 has been relatively stable at around one-quarter of respondents. As in previous surveys, respondents who have not been vaccinated against COVID-19 are most concerned about the safety of vaccines, and more than half of them also believe that there is too much pressure regarding vaccination. 59.1% of all respondents agree with the statement that the vaccine against COVID-19 can prevent a more severe course of the disease, which shows that the population's awareness of the benefits of vaccination against COVID-19 is still too low. Awareness and, consequently, readiness to vaccinate are the lowest in the 30 to 49 age group.

➤ Vaccination against seasonal influenza

The results of the survey on vaccination against seasonal influenza are encouraging, as the proportions of people who responded that they are likely to be vaccinated against seasonal influenza in 2022/23 (22.0% of all respondents, or 44.4% of those aged 65–74 years) are significantly higher than the prevalence of vaccination against influenza in previous seasons according to data reported by vaccination providers.

➤ Emotional response to vaccination against COVID-19

The results of the 20th iteration of the SI-PANDA survey show a different emotional response to the vaccination against COVID-19 depending vaccination status. Among the vaccinated the strongest emotions are hope (52.5%) and relief (39.2%), while among the unvaccinated strongest emotions are doubt (68.5%) and anger (46.9%). Differences in the emotional response to the vaccination against COVID-19 are also reflected by age. For those aged 50 years and over the

most expressed emotion in relation to vaccination against COVID-19 is hope, while for those under the age of 50, the most expressed emotion is doubt.

➤ Long COVID

After recovering from a COVID-19 infection, the most common problems reported by respondents are fatigue and lack of energy. The longest-lasting problems after infection last up to 3 months in just under half of people, and problems lasting longer than 3 months are more common in women (60%) than in men (42%). A good third of people consulted a doctor about the problems that occurred after recovering from the infection, either in person or without personal contact. However, the problems reported by respondents most affect the field of leisure activities.

➤ Use of SARS-CoV-2 information sources and trust in SARS-CoV-2 information sources

The results of the 20th survey iteration show significant differences between vaccinated and unvaccinated people regarding the frequency of use of information sources about the SARS-CoV-2 virus and trust in information sources about the SARS-CoV-2 virus. Vaccinated people most often use doctors and scientists as sources of information (average 4.2) and trust scientists the most (average 5.1). Unvaccinated people most often use friends, acquaintances and relatives as information sources (average 3.3), whom they also trust the most (average 3.3)

➤ Mental health

In the 20th survey iteration, we found that 18.9% of respondents feel tense, stressed or under a lot of pressure often or daily, and more of them are women, younger people, and those more educated. The majority of respondents (80.1%) manage tensions, stress and pressure with some effort or with ease, while a minority (4.0%) report that they do not manage them or manage them with great effort. There are no significant differences between genders, education and age groups. In approximately 3% (2.8%) of people, we identify risky stress behaviour – these are people who experience stress often or daily and at the same time have severe problems with stress management or do not manage it at all.

RESULTS

Supporting current recommendations to control the spread of SARS-CoV-2 infections

Within days of the declaration of a coronavirus epidemic in Slovenia (12 March 2020), a number of measures were taken to limit the spread of SARS-CoV-2 infections, which varied according to the epidemiological situation in the country. At the end of May 2022, the Government adopted a decision on the expiry of the Ordinance on the temporary measures for the prevention and control of infectious disease COVID-19. Throughout the duration of the measures, as well as after their termination, there are recommendations for protecting health and preventing the spread of infections, which are also valid in the current epidemiological situation.

In August 2022, the Expert baselines and guidelines for preparedness and response to SARS-CoV-2 infections in the autumn-winter season 2022/2023 in Slovenia³ were prepared, according to which public health measures will be adapted according to the epidemiological situation. Five possible long-term scenarios for the evolution of the epidemic have been developed, linked to: virus characteristics, population susceptibility, social factors and pharmacological measures. The objectives are based on five pillars (vaccination, transmission control, testing and treatment, SARS-CoV-2 monitoring and contact reduction measures). Each pillar has specific recommendations relating to the baseline (Phase 1) and the escalation phase (Phase 2). From 22 July 2022, we are in Phase 1, which aims to protect the most vulnerable groups of the population in order to prevent an increase in the number of people with the more severe form of COVID-19. Measures aimed at limiting the spread of the SARS-CoV-2 virus are recommended, but do not interfere significantly with the daily lives of most individuals.

Between 20 September and 23 September 2022, we asked respondents how supportive they were of the current recommendations. The highest proportion of people support effective ventilation in educational institutions (78.1%), isolation for people with confirmed SARS-CoV-2 infection (75.1%), and the use of masks in health care facilities, pharmacies and homes for the elderly (72.1%). All three of these recommendations are most strongly supported by the people in the 65–74 age group (85.7–86.8%). There is also strong support in this age group for the recommendation on the use of masks in enclosed public spaces (73.6%). Just over half of respondents also support the measure not to use masks in education process. Respondents expressed the lowest level of support for the use of the Ostani zdrav application in colleges and universities (38.5%). Those in the 30–49 age group are the least supportive of most of the current recommendations (Figure 1).

³

https://www.njz.si/sites/www.njz.si/files/uploaded/strokovna_izhodbisca_in_usmeritve_za_pripravljenost_in_odzivanje_na_okuzbe_z_virusom_sars-cov-2.pdf.

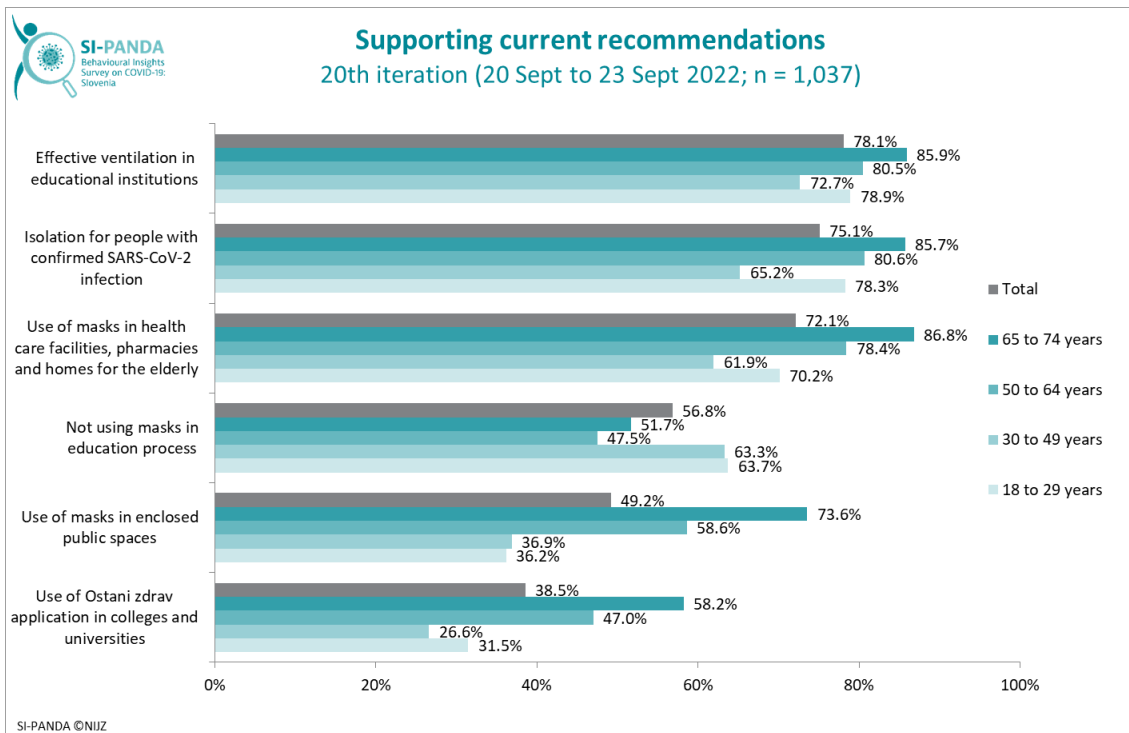


Figure 1: Supporting current recommendations, total and by age groups.

As expected, the current recommendations are supported more by people living with someone at risk of SARS-CoV-2 virus infection (Figure 2). Regardless of whether or not respondents live with a person at increased risk of infection, they are equally supportive of the recommendation regarding effective ventilation in educational institutions (79.1% and 77.7% respectively).

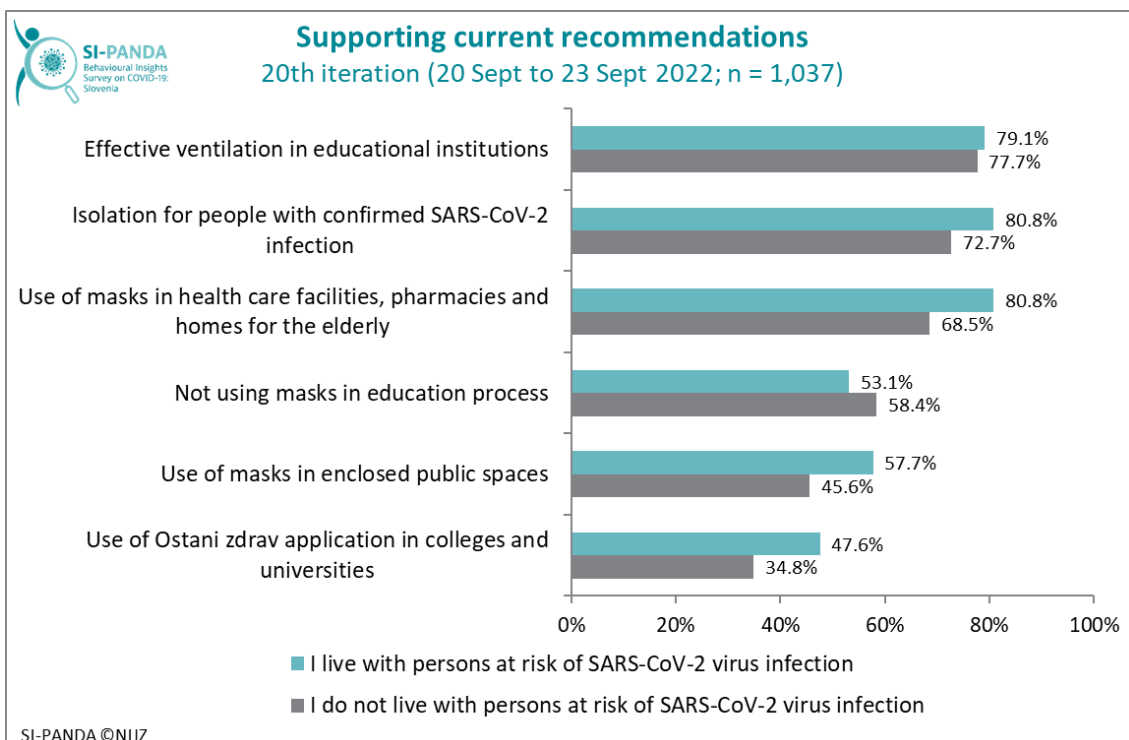


Figure 2: Supporting current recommendations, by whether they live with persons with increased risk of SARS-CoV-2 virus infection.

Risk perception in relation to SARS-CoV-2 virus infection

Our perceptions of the likelihood, susceptibility and severity of a threat form our perception of risk. The sum of these three variables constitutes the risk perception indicator. The perception of risk, which can act as a trigger or inhibitor to the adoption of protective practices, is influenced by many social, cultural and personal factors based on opinions, judgments, experiences, behaviours, perceptions and emotions. Decisions based on risk perception are influenced primarily by the cultural context. When planning various (public) health measures, a comprehensive understanding of people's perception of risk and its potential impact on behaviour is therefore crucial.

More than half of all respondents to the 20th SI-PANDA survey iteration (54.6%) think it is likely that they could be infected with SARS-CoV-2, a good quarter (28.0%) are neutral, and less than one-fifth (17.3%) do not think it is likely that they could be infected with SARS-CoV-2 virus. It is interesting to compare this with the findings of the 17th SI-PANDA iteration, which took place from 12 to 15 October 2021, when just over a third of all respondents (35.6%) thought it was likely that they could be infected with SARS-CoV-2, a good third (34.9%) were neutral, and just under a third (29.5%) did not think it was likely that they could be infected with SARS-CoV-2.

A good third of respondents to the 20th survey iteration (33.9%) think they are susceptible to SARS-CoV-2 infection, a good third (34.1%) are neutral, and a poor third (32.0%) think they are not susceptible. In comparison, less than a year ago (17th SI-PANDA iteration), a good quarter of respondents (26.1%) thought they were susceptible to SARS-CoV-2 infection, a good third (34.4%) were neutral and almost 40% thought they were not susceptible.

Only 16.2% of respondents to the 20th survey iteration thought that the course of their SARS-CoV-2 infection would be severe, while just under a third (29.0%) were neutral and more than half (54.8%) thought that the course of their SARS-CoV-2 infection would be mild. The findings are very similar to those from less than a year ago, when 16.3% of respondents to the 17th survey iteration thought that the course of their SARS-CoV-2 infection would be severe, just under a third (30.6%) were neutral, and more than half (53.1%) thought that the course of their SARS-CoV-2 infection would be mild.

Overall, the perception of risk related to SARS-CoV-2 infection is high among just under one-third of the respondents in 20th iteration (32.1%), with a good third (36.8%) rating their risk as medium and a poor third (31.1%) rating their risk as low. In comparison, the perceived risk of SARS-CoV-2 infection was high in just under a quarter of respondents (26.5%) in the 17th survey iteration, while almost 40% perceived their risk of SARS-CoV-2 infection to be low.

There are also interesting differences in the perception of risk associated with SARS-CoV-2 infection between vaccinated and unvaccinated people. A good half (58.4%) of vaccinated respondents consider it likely that they could be infected with SARS-CoV-2, a good third (37.2%) of vaccinated respondents consider themselves susceptible to SARS-CoV-2 infection, and half (50.9%) of vaccinated respondents consider that the course of their SARS-CoV-2 infection would be mild. At the same time, 43.8% of vaccinated respondents think it is likely that they could be infected with SARS-CoV-2, but only less than a quarter (24.5%) think they are susceptible, and two-thirds (66.4%) of unvaccinated respondents think that the course of their SARS-CoV-2 infection would be mild.

Overall, the risk of SARS-CoV-2 infection is perceived as low by 26.4% of vaccinated and 44.4% of unvaccinated, and as high by 36.0% of vaccinated and 20.9% of unvaccinated (Figure 3). In comparison, in 17th SI-PANDA survey iteration, more than half of the unvaccinated (53.2%) had a low risk perception related to SARS-CoV-2, while only less than one-seventh of the unvaccinated (15.6%) had a high risk perception related to SARS-CoV-2.

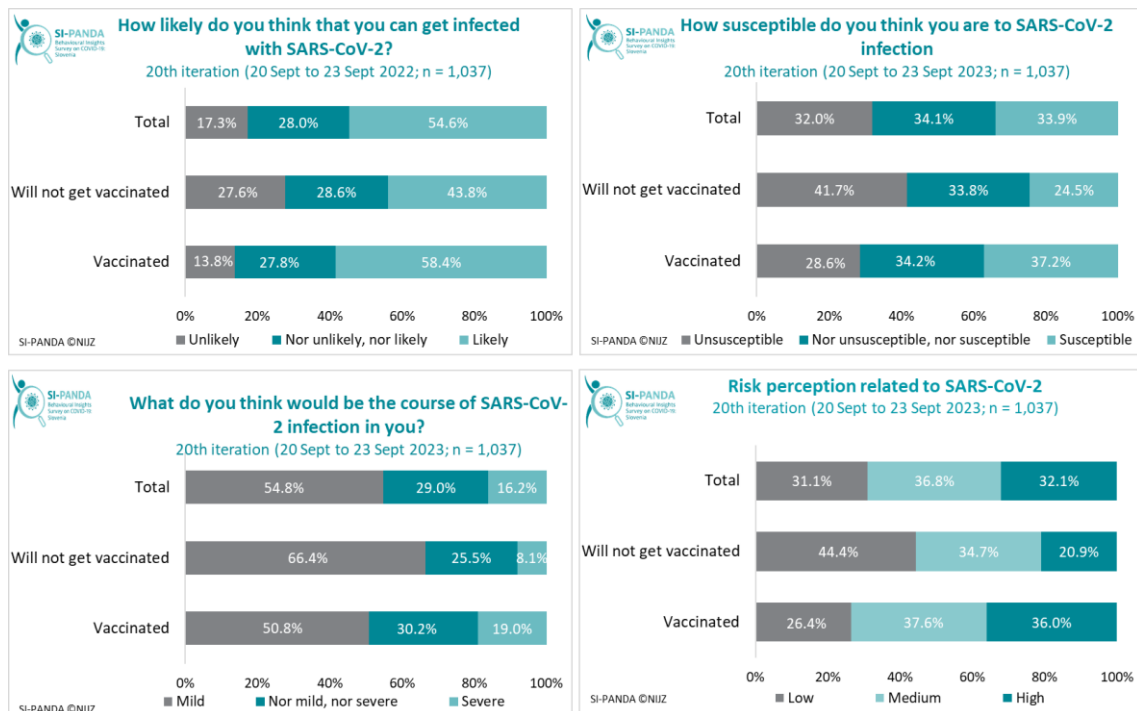


Figure 3: Perceptions of different aspects of risk associated with SARS-CoV-2, total and by vaccination status.

COVID-19 vaccination readiness

There is a relatively high level of vaccination readiness among all respondents – the average readiness on a 7-point scale, where 1 means ‘I do not agree’, and 7 means ‘I completely agree’, is 4.0 in the 20th survey iteration. In the period of several survey iterations, a higher vaccination readiness was found among men (average 4.2) than among women (3.8). Among the different age groups, those aged 65 to 74 express the highest vaccination readiness (4.6), while those aged 30 to 49 express the lowest (3.5). Men in the oldest age group are most vaccination ready (average 4.8 on a 7-point scale), while women in the 30 to 49 age group refuse vaccination the most (average 3.3 on a 7-point scale). Vaccination readiness was measured with an internationally established vaccination measurement instrument, 7C (Figure 4).

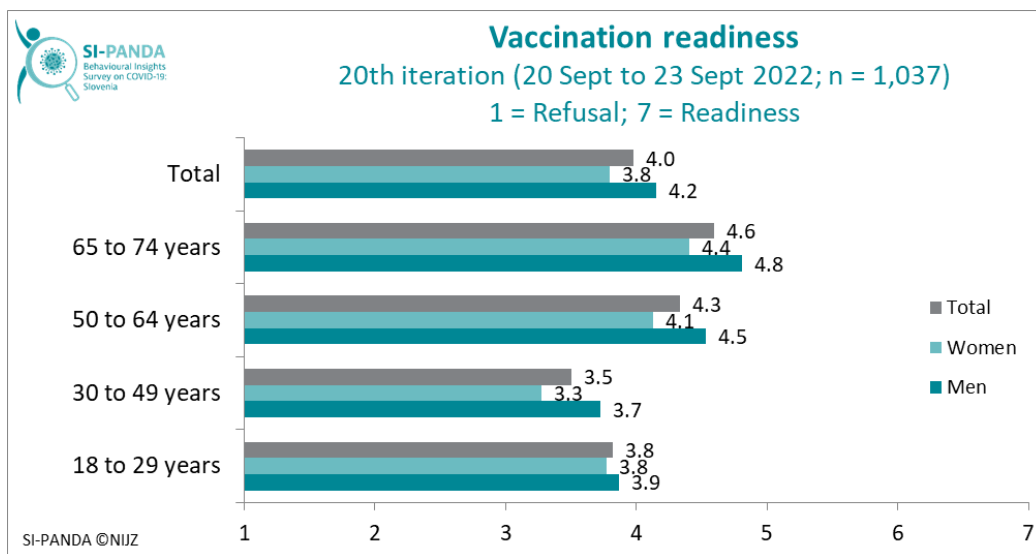


Figure 4: Vaccination readiness, total and by gender.

Vaccination against COVID-19

In the 20th SI-PANDA survey iteration, more than 74% of the respondents answered that they had already been vaccinated against COVID-19 (persons aged between 18 and 74 years). Similarly, data from the Electronic Registry of Vaccinated Persons (*slov.* elektronski register cepljenih oseb – eRCO) show that 70% of adults have received at least one dose of COVID-19 vaccine by 23 September 2022. 32.0% of the respondents responded that they had received the core vaccination and 42.2% of the respondents responded that they had also received the booster dose (Figure 5). According to eRCO, by 23 September 2022, 38% of the adult Slovenian inhabitants had been vaccinated with one booster dose. In the 20th survey iteration, 24.1% of respondents report that they do not intend to be vaccinated against COVID-19. The proportion of persons who do not intend to be vaccinated against COVID-19 has remained relatively stable in the most recent iterations of the SI-PANDA survey, hovering around one-quarter of the respondents. This proportion is lower than just over a year ago in the 14th survey iteration, which took place from 6 July to 9 July, when the share of people who do not intend to be vaccinated was 37.6%. 1.7% of respondents did not vaccinate for health reasons.

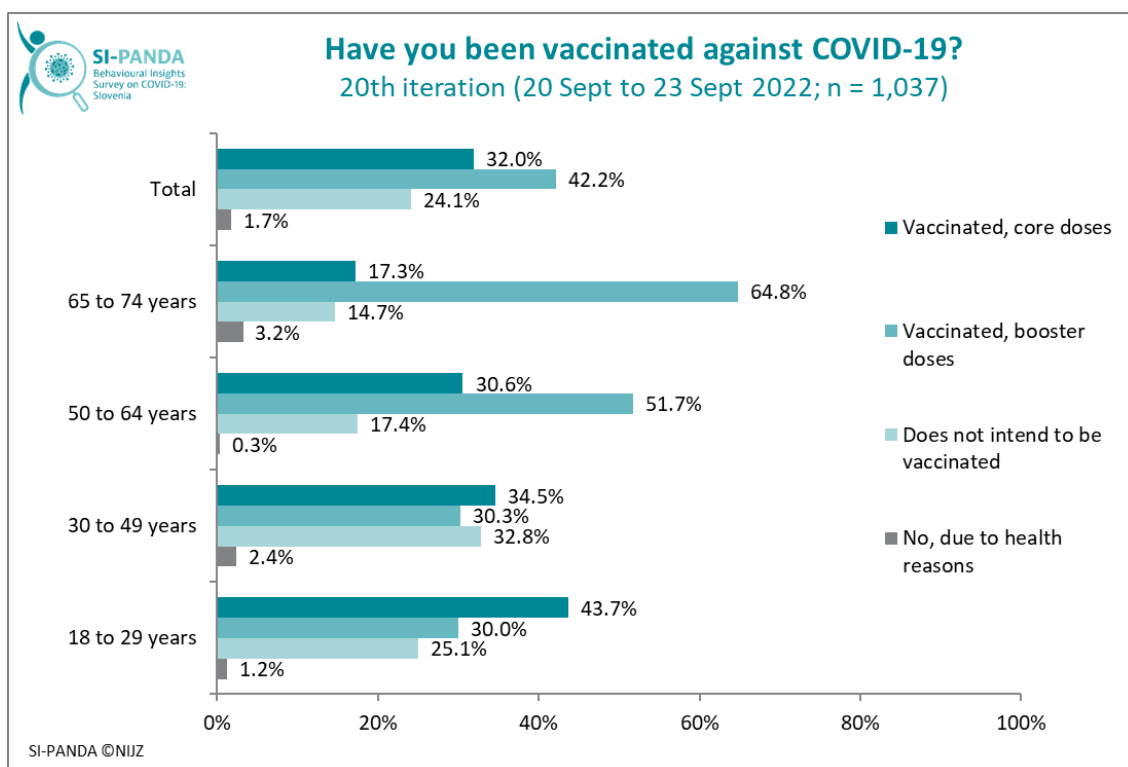


Figure 5: Vaccination against COVID-19, total and by age groups.

More than half (59.1%) of the respondents agreed that the COVID-19 vaccine can prevent the more severe course of COVID-19, 13.7% were undecided and over a quarter (27.2%) of respondents disagreed. The proportion of people who believe that the vaccine can prevent a more severe course of the COVID-19 is the highest in the 65 to 74 age group (70.9%), and the lowest in the 30 to 49 age group, where just under a half of respondents agree with the statement (48.5%) (Figure 6). This also coincides with the results shown in the previous two graphs (Figure 4 and Figure 5), where the proportion of respondents who do not intend to vaccinate is the highest and the vaccination readiness is the lowest in the 30 to 49 age group, while the greatest vaccination readiness and the lowest proportion of respondents who do not intend to be vaccinated were recorded in the oldest age group (65 to 74 years).

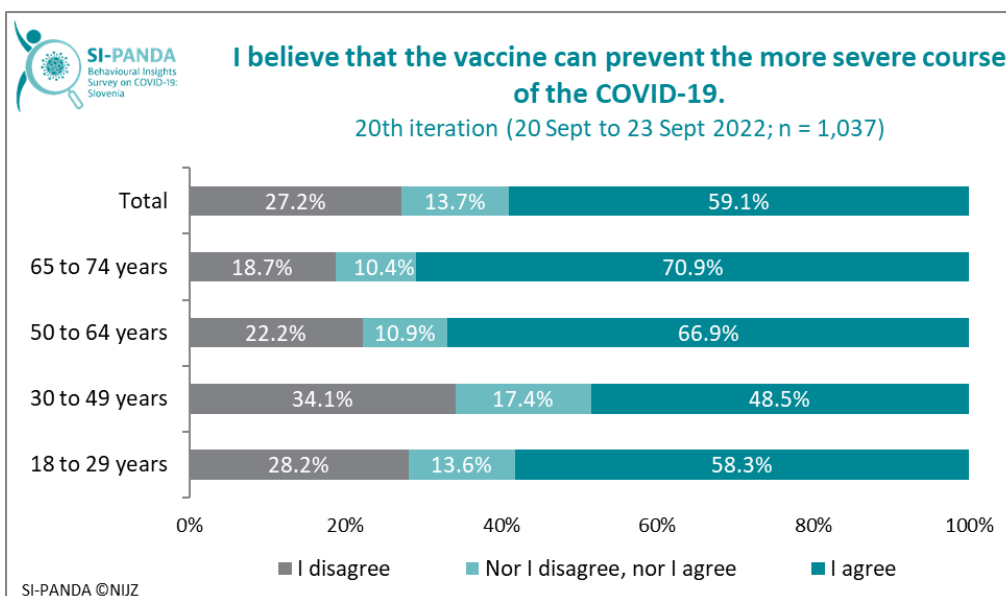


Figure 6: Opinion on whether vaccination can prevent more severe course of the disease, total and by age groups.

28.3% of respondents believe that vaccination against COVID-19 is not necessary and that it is better to get over the disease naturally. This point of view was again most common in the 30 to 49 age group, in which a good third of respondents (36.7%) agreed with the statement. The fewest respondents agreed with the statement in the oldest age group (65 to 74 years), in which only a little under a fifth (19.6%) believe that vaccination against COVID-19 is not necessary and that it is better to get over the disease naturally (Figure 7).

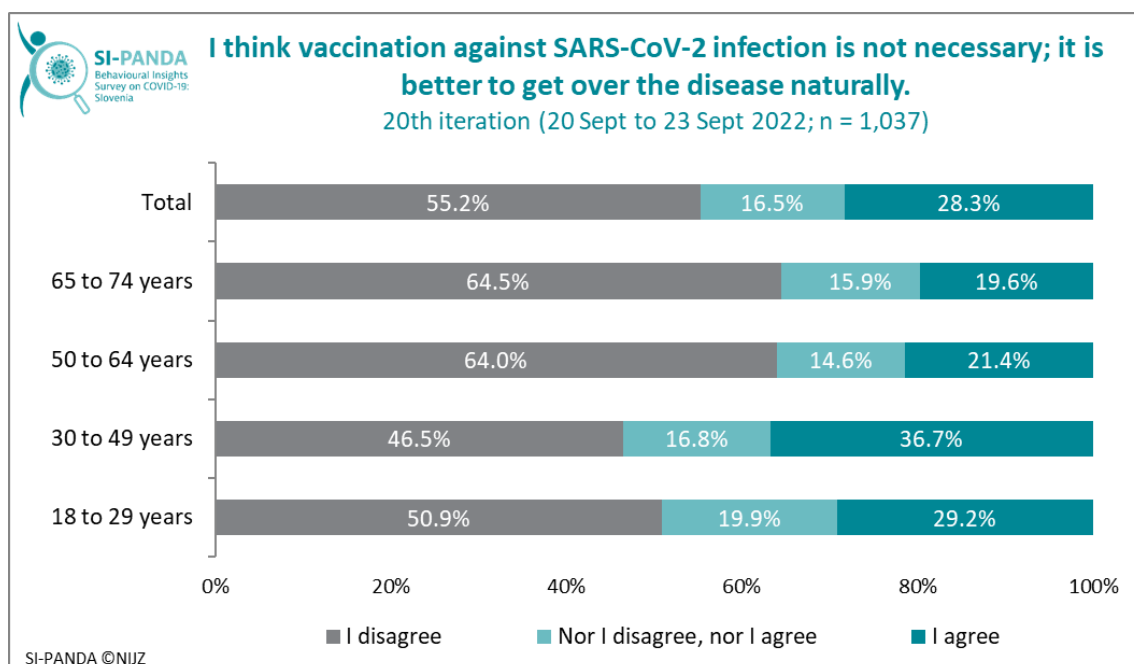


Figure 7: Opinion on whether it is better to get over the disease naturally, total and by age groups.

In the 20th survey iteration, respondents were asked again about the factors that influenced or would influence their decision to be vaccinated against COVID-19. As in previous iterations of the

survey, the 20th iteration showed that, on average, respondents were most likely to agree that their decision to vaccinate depended / will depend on whether there was / is enough information available that the vaccine is safe and effective (average score on the 7-point scale for safety is 4.6 and 4.5 for effectiveness). The decision was / is also influenced by whether the vaccine has been in use for a long time and the magnitude of the risk of SARS-CoV-2 infection at the time of vaccination. On average, respondents were least likely to agree that the decision to vaccinate depended or will depend on the recommendations of the Ministry of Health. Compared to the previous survey, in the 20th iteration, respondents on average gave more weight to the recommendations of the National Institute of Public Health when deciding whether to vaccinate (average score on a 7-point scale is 3.8, compared to the 3.5 in the 19th survey iteration), even ahead of the recommendations of their personal physician (Figure 8).

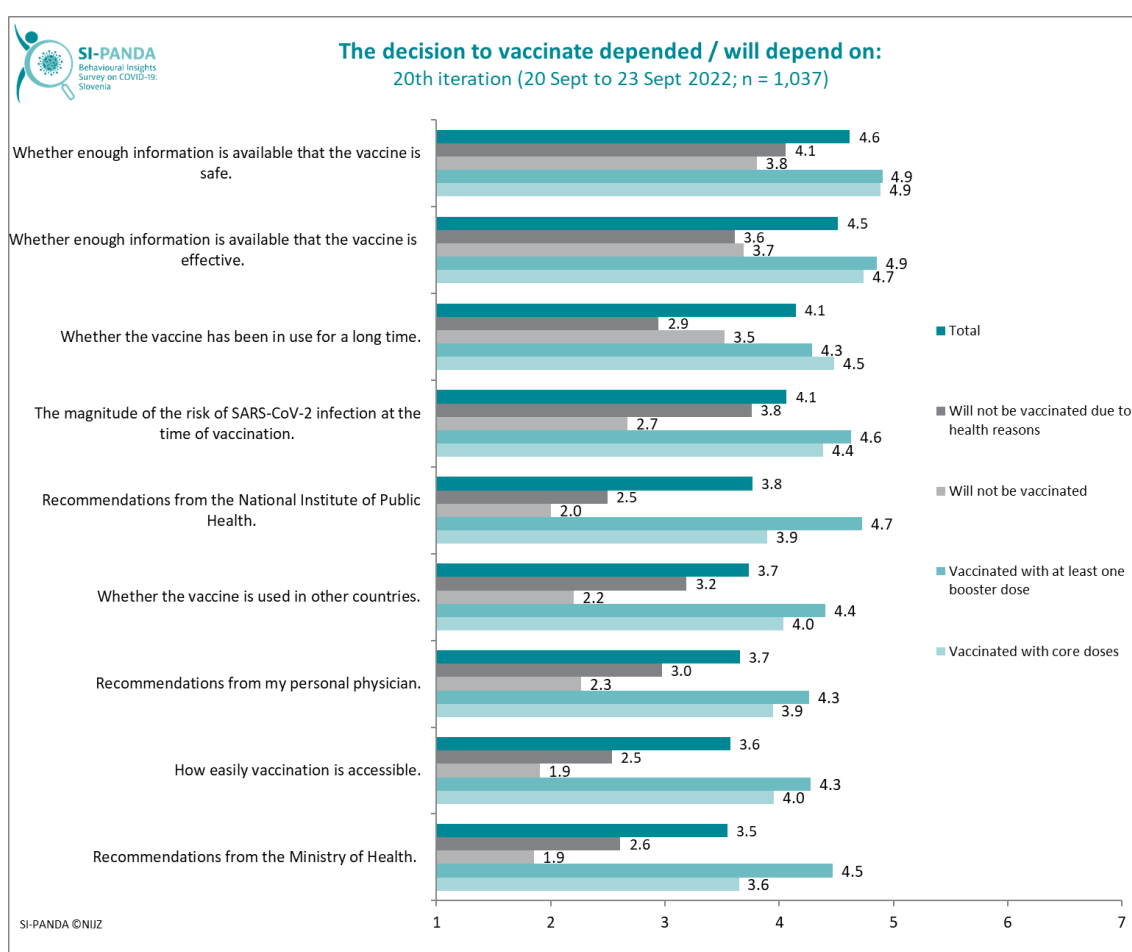


Figure 8: What the decision to vaccinate against COVID-19 depends on, total and by vaccination status.

In general, 43.4% of respondents believe that everyone should be vaccinated according to the national vaccination programme, regardless of the SARS-CoV-2 virus. In the 65–74 age group, 57.6% of respondents feel this way, while in the 30–49 age group, less than a third (31.2%) of respondents feel this way (Figure 9).

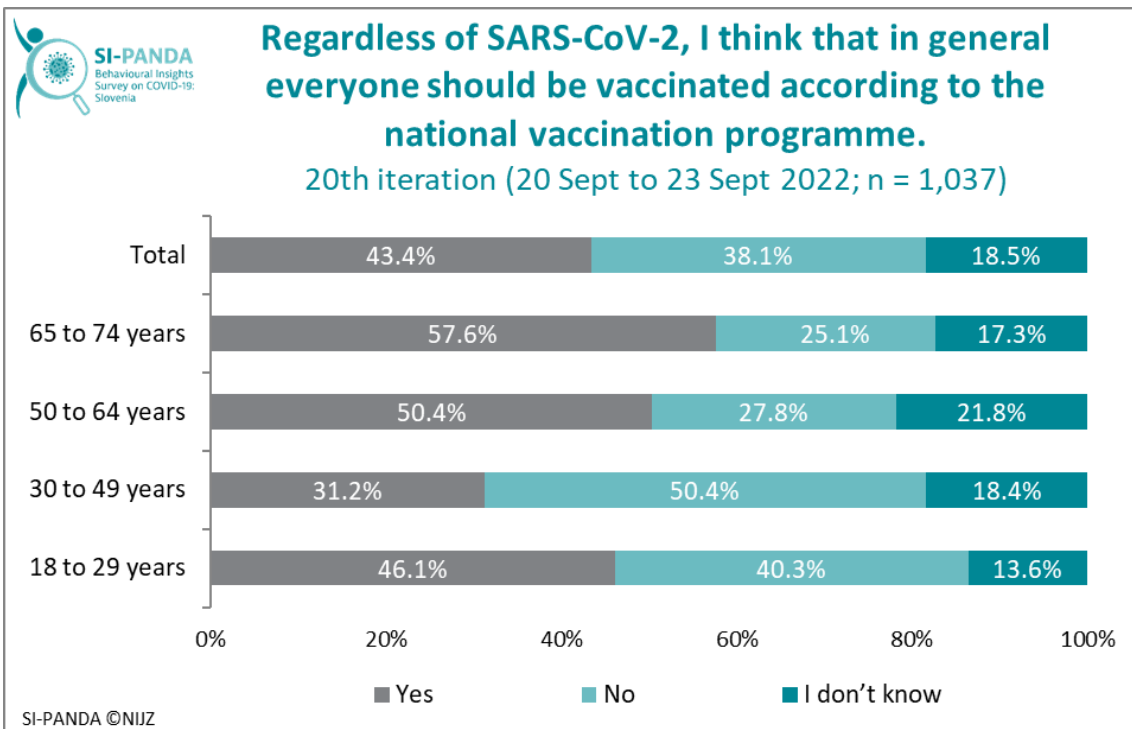


Figure 9: Opinion on vaccination in accordance with the national vaccination programme, total and by age groups.

People who had received primary doses of vaccine against COVID-19 (32.0%) were asked how likely they were to be vaccinated with the first booster dose against COVID-19: 36.4% reported they were likely to be vaccinated and 43.7% reported they were unlikely to be vaccinated with the first booster dose against COVID-19. People who had received the primary doses of vaccine were asked about their reasons for not receiving the third dose (the first booster dose). More than half of respondents (56.9%) thought that the booster dose would not give them additional protection, half of persons (49.9%) were concerned about the long-term health effects, and 43.3% were concerned about the side-effects of the booster dose (Figure 10). Respondents could give several reasons why they would not be vaccinated with the third dose (the first booster dose).

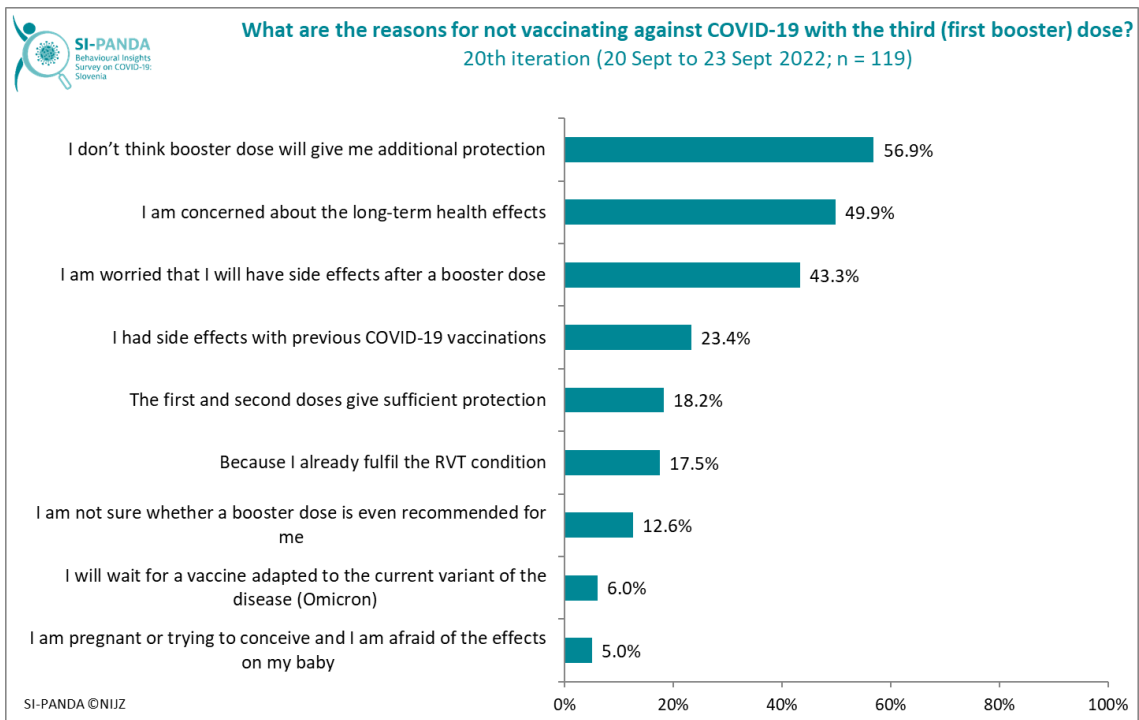


Figure 10: Reasons against vaccination with a third dose of COVID-19 vaccine among persons who received first two doses of COVID-19 vaccine and who are unlikely to be vaccinated with a third dose of COVID-19 vaccine, total.

Note: Several answers were possible.

Those who reported having received a third dose (first booster) of COVID-19 vaccine (41.2%) were asked how likely they were to be vaccinated with a second booster dose (fourth dose) of COVID-19 vaccine. 61.4% indicated that they were likely to be vaccinated, and 22.4% indicated that they were unlikely to be vaccinated with a second booster dose of COVID-19 vaccine. These were asked about their reasons for not receiving a fourth (second booster) dose of COVID-19 vaccine. A half of the respondents (49.8%) felt that a booster dose would not give them additional protection, 43.9% were concerned about long-term health effects, and 26.7% felt that the doses they had already received gave them sufficient protection (Figure 11). Respondents could give several reasons why they would not be vaccinated with the fourth dose (the second booster dose).

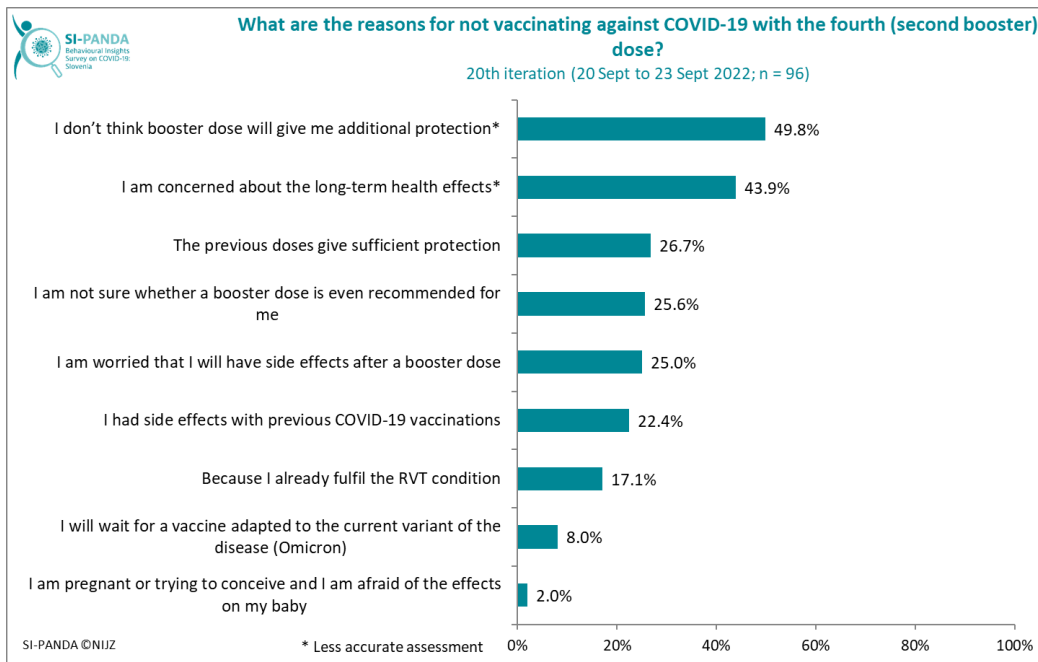


Figure 11: Reasons against vaccination with a fourth dose of COVID-19 vaccine among persons who received first two doses of COVID-19 vaccine, and who received the first booster dose COVID-19 vaccine and are not likely to be vaccinated with the fourth dose of COVID-19 vaccine, total.
Note: Several answers were possible.

Respondents who had already been vaccinated (74.2%) reported that their main reasons vaccinating were to protect their own health (61.4%), to prevent a more severe course of the disease or its consequences (60.1%), and to protect the health of their loved ones (60.1%) (Figure 12).

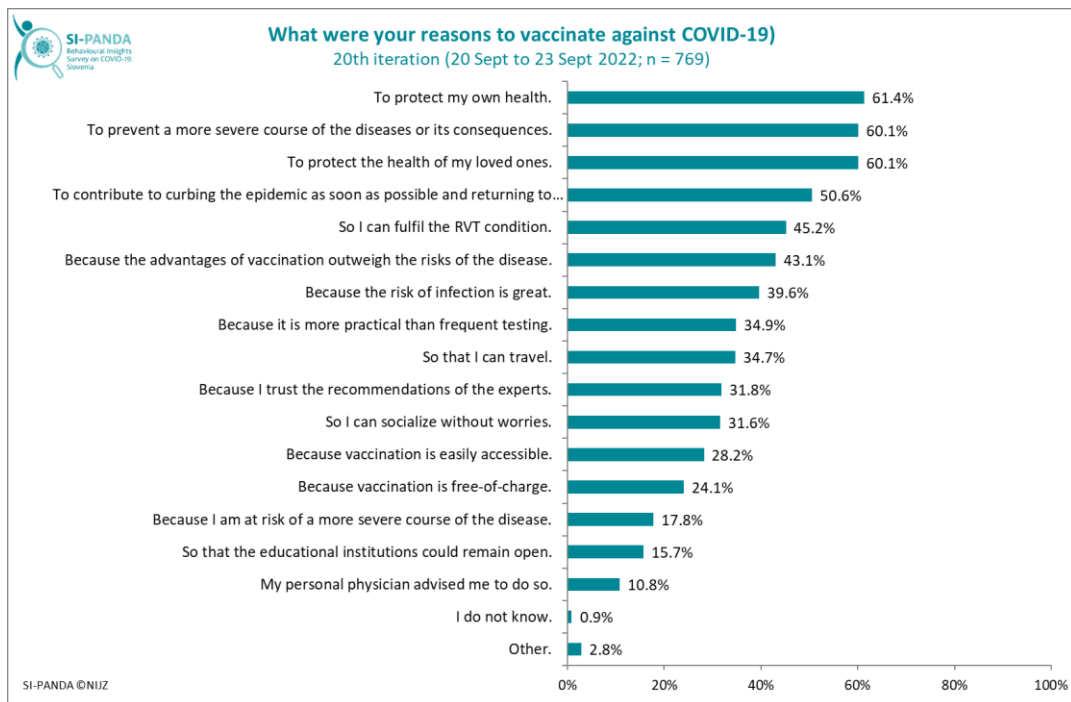


Figure 12: Reasons for vaccination against COVID-19, total.
Note: Several answers were possible.

In the 20th iteration of the survey, non-vaccinated persons (25.8%) were also asked for more detailed reasons why they did not intend to be vaccinated. As in previous iterations, in the 20th iteration, the main reasons were concerns about side effects after vaccination, concerns about the long-term impact on health, and the perception that the vaccine is unsafe. More than half of these respondents still believe that there is too much pressure regarding vaccination, and the percentage has even risen from 51.8% to 58.9% since the last survey iteration, despite the fact that vaccination against COVID-19 is not compulsory (Figure 13).

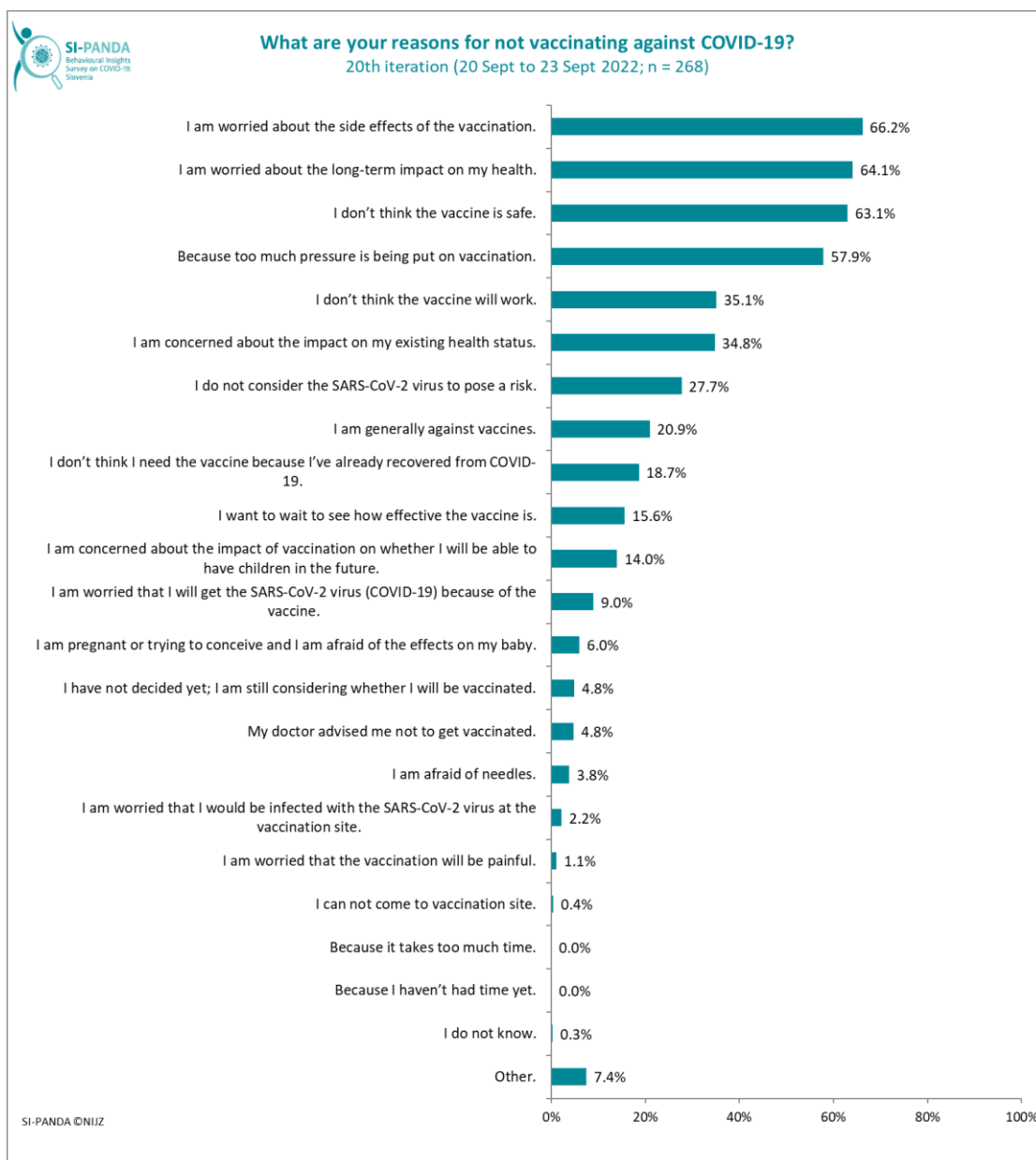


Figure 13: Reasons for not vaccinating against COVID-19, total.
Note: Several answers were possible.

Vaccination against seasonal influenza

Considering that it is time for vaccination against seasonal influenza to start, we also asked the respondents how likely it is that they will be vaccinated against seasonal influenza in the 2022/23 season. 22.0% of respondents answered that they are likely to be vaccinated against influenza. The proportion of respondents who are likely to get vaccinated against seasonal influenza was the highest in the oldest age group (65 to 74 years), where as many as 44.4% of respondents are likely to get vaccinated. This share was significantly lower for younger age groups and was only 11.0% for respondents aged 18 to 29 (Figure 14).

Despite the above, these results are encouraging, as the proportion of people who answered that they are likely to get vaccinated against the seasonal influenza is higher than influenza vaccination rates in previous seasons, according to data reported by vaccination providers. Only 8.1% of the Slovenian population was vaccinated against seasonal influenza in the 2021/22 season, or 24.5% of the population in the age group of 65 and over.

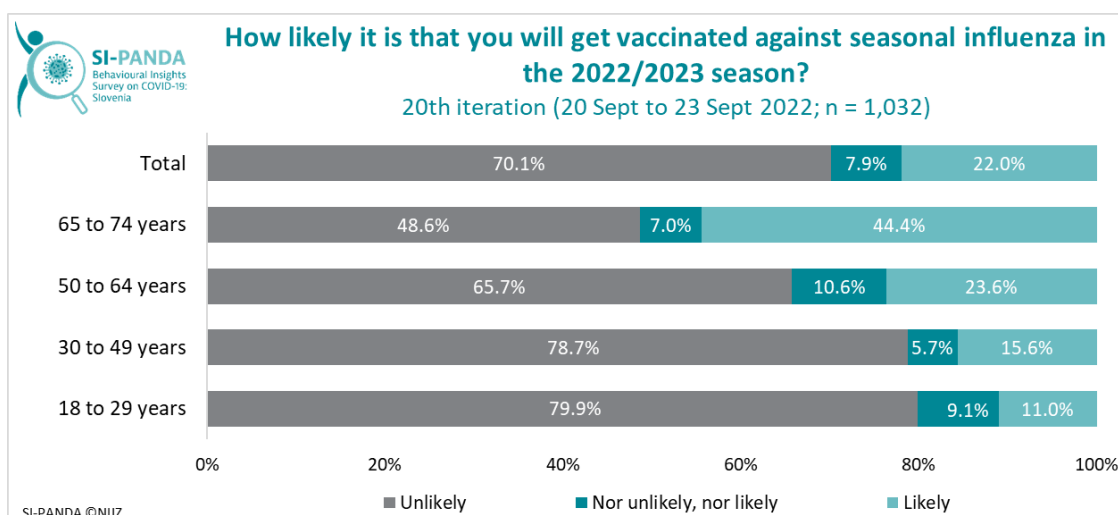


Figure 14: Vaccination against seasonal influenza in 2022/2023 season, total and by age groups.

Compliance with isolation and quarantine and action in case of cold symptoms or respiratory infection

In 20th iteration of the survey, we were interested in how people would act if they had cold symptoms or respiratory infection. Respondents could select several possible answers to this question. The majority (74.7%) indicated that they would self-test for SARS-CoV-2, where persons in the oldest age group are the least willing to do so (62.7%). A good quarter of people stated that they would wait to see how the symptoms develop and self-isolate, and people between 18 and 29 are most willing to do so. A good fifth of people would inform their high-risk contacts about the symptoms, and people in the youngest age group are also statistically characteristically more willing to do so. A fifth of people would call their personal physician or go for testing at an official testing site if they had cold symptoms or a respiratory infection. Only 2.7% of people would not do anything with cold symptoms or respiratory infection (Figure 15).

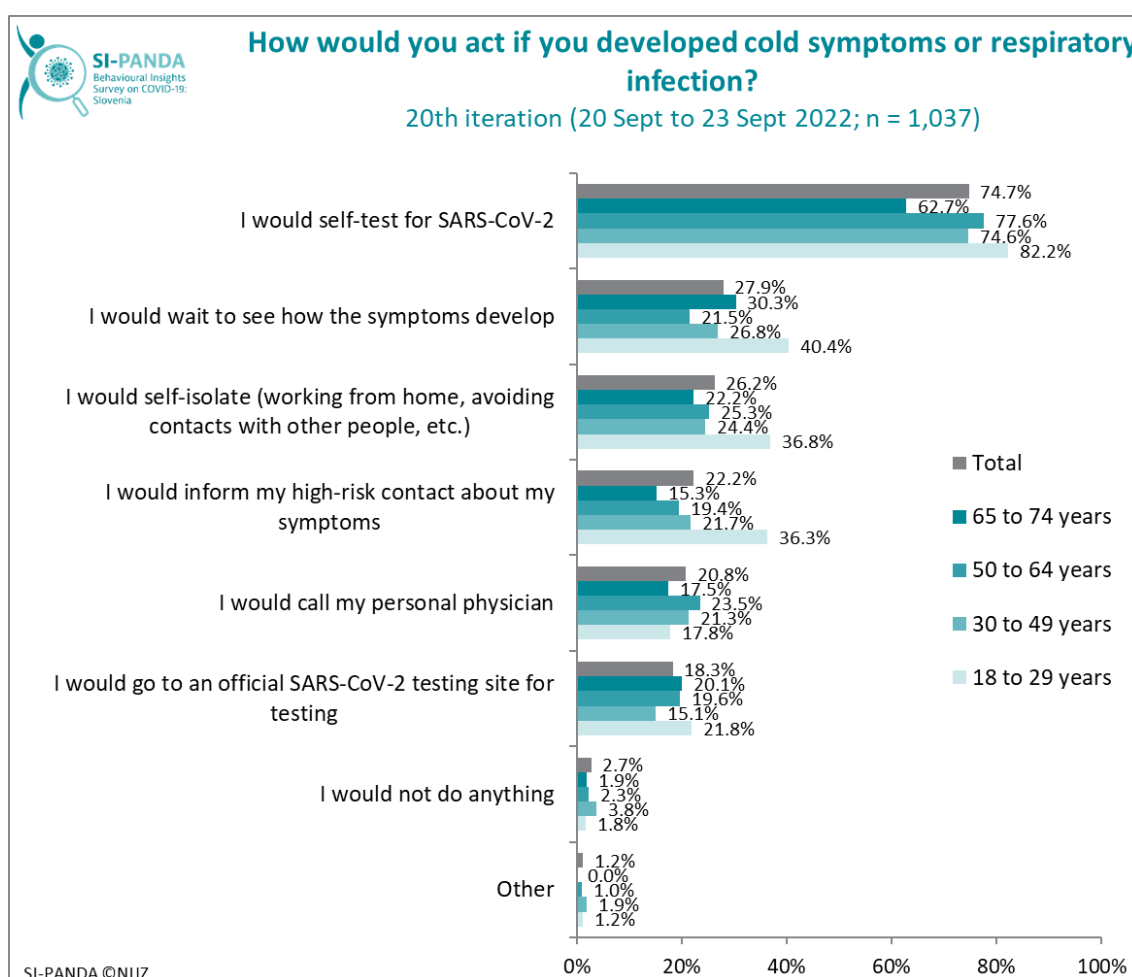


Figure 15: Acting in case of cold symptoms or respiratory infection, total and by age groups.

As many as 70.1% of people answered in the affirmative to the question whether they would get tested if they had been in contact with someone who had tested positive for SARS-CoV-2 and had not developed symptoms themselves. A statistically significantly higher proportion of people who have at least one chronic disease would get tested when in contact with an infected person, despite not developing symptoms (75.2%) compared to people without chronic diseases (66.8%).

However, statistically significantly more people who do not live alone (71.0%) compared to those who live alone (63.6%) would get tested (Figure 16).

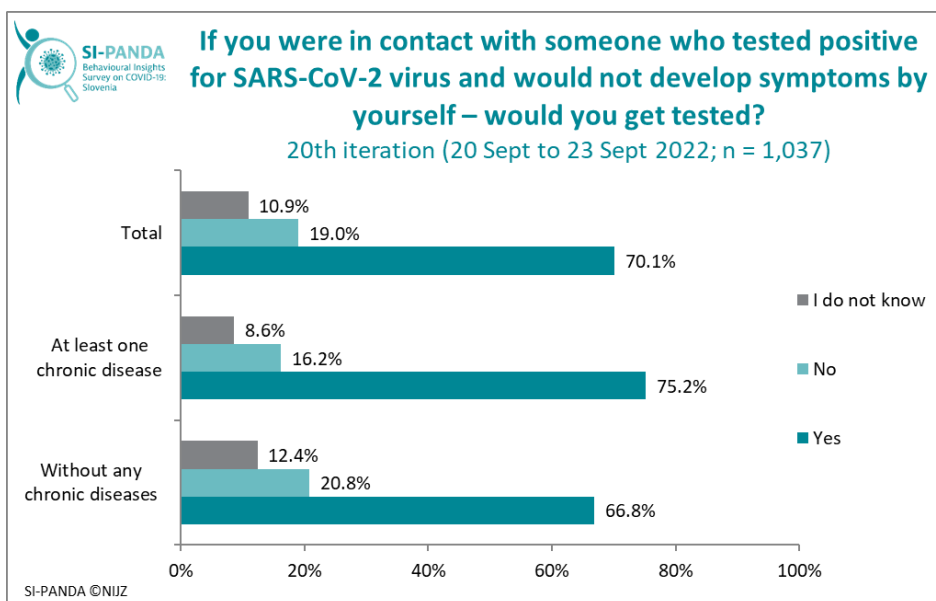


Figure 16: Decision for testing in case of a contact with infected person, total and by the presence of at least one chronic disease.

Problems after recovering from infection with the SARS-CoV-2 virus – post-COVID syndrome or long COVID

Most people who contract COVID-19 recover completely within a few weeks of the onset of the disease. However, research shows that in some people individual problems may persist long after SARS-CoV-2 infection, or may disappear and reappear (same or different problems) several weeks or months after the initial recovery. Abroad, these problems have been called post-acute COVID-19, post-COVID syndrome or long COVID. It is more common among patients with a more severe course of the disease and older patients, but also occurs in those who have overcome a milder form of the disease and also among young adults who had no health problems before the infection⁴. The symptoms of long COVID are diverse: the most common are fatigue, shortness of breath, insomnia, problems with memory and concentration (the so-called “Brain fog”), heart palpitations (an unpleasant feeling of the heartbeat), pain in various body parts, diarrhoea, nausea, etc.⁵.

In the 20th SI-PANDA survey iteration, just under half of the respondents reported having been or currently being infected with SARS-CoV-2 (47.7%). Among them, 77.5% of the respondents were infected once, 21.1% twice, and 1.4% three times. More than 60% of persons in the youngest age group (from 18 to 29 years) were infected at least once, while only 32.0% of persons in the oldest age group (from 65 to 74 years) were infected at least once.

The first (or only) infection with the SARS-CoV-2 virus was asymptomatic or mild in the majority (79.4%), while 20.6% of persons reported a more severe course of the disease, which in some cases also required hospital treatment. The course of the second infection was described by the vast majority (90.4%) as asymptomatic or mild, and by 9.6% as more severe, but none of the respondents required hospital treatment (Figure 17). A more severe course of the disease (which did or did not require hospital treatment) was statistically significantly more common in women (25.5%) compared to men (18.0%) at first infection. A more severe course of the disease, which required hospital treatment, was statistically significantly more common in the first infection in persons older than 50 years (4.9% in the 50–64 age group and 7.5% in the 65–74 age group) compared to younger people (18 to 49 years).

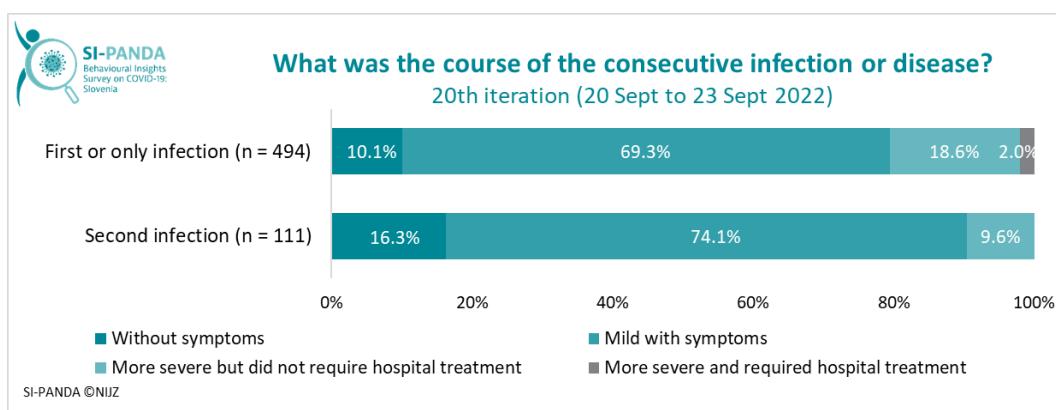


Figure 17: The course of first or only and second COVID-19 infection, total and by consecutive infection.

⁴ 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.2552>.

⁵ 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>.

According to WHO, a quarter of people infected with the SARS-CoV-2 virus still have some health problems at least one month after infection, and one in ten recovered persons even after 12 weeks⁶. Thus, we were interested in whether the respondents had or have any of the listed problems (Figure 18) three months after recovering from COVID-19; it was possible to report several problems.

Somewhat less than 60% of respondents stated that three months after recovering from first or only infection they still had or have certain problems that lasted at least two months, and there was more than half of such people after recovering from the second infection. The most common long-term problem reported both after the first (or only) and after the second infection is fatigue and lack of energy (35.8% after the first infection, 27.5% after the second). The second most common problem after the first infection was reduced physical capacity (25.1%), and headache after the second infection (18.3%) (Figure 18).

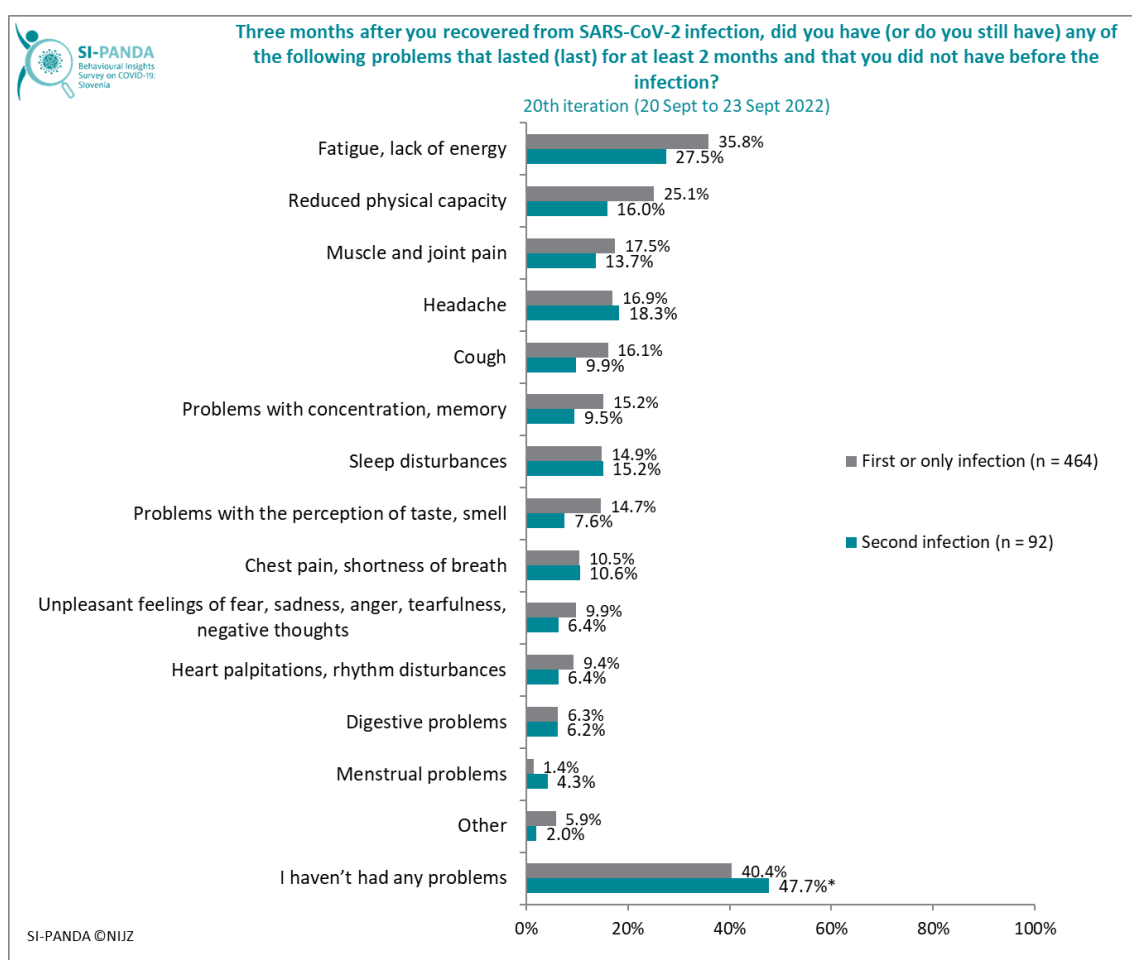


Figure 18: Health problems present three months after the infection, lasting at least two months among persons who have had an infection with the SARS-CoV-2 virus, total and by consecutive infection. Note: Several answers were possible.

After recovering from first or only infection, people had an average of two problems (1.9). women (2.3) had statistically significantly more problems after recovering from first or only infection compared to men (1.5). People with at least one chronic disease also had statistically significantly

⁶ 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>.

more problems (2.5) after recovering from their first or only infection than people who did not have chronic diseases (1.5).

When asked how long the longest-lasting problem lasted after recovering from the infection, almost half of the people answered that it lasted up to 3 months, 28.9% faced such problems for more than 6 months after recovering from the infection, and a good fifth from 3 to 6 months after infection. Problems lasting more than 6 months after recovering from an infection were present in statistically significantly higher proportion of women (34.7%) compared with men (22.6%) (Figure 19) and in a statistically significantly higher proportion of people with at least one chronic disease (35.1%) compared with people without chronic diseases (23.9%).

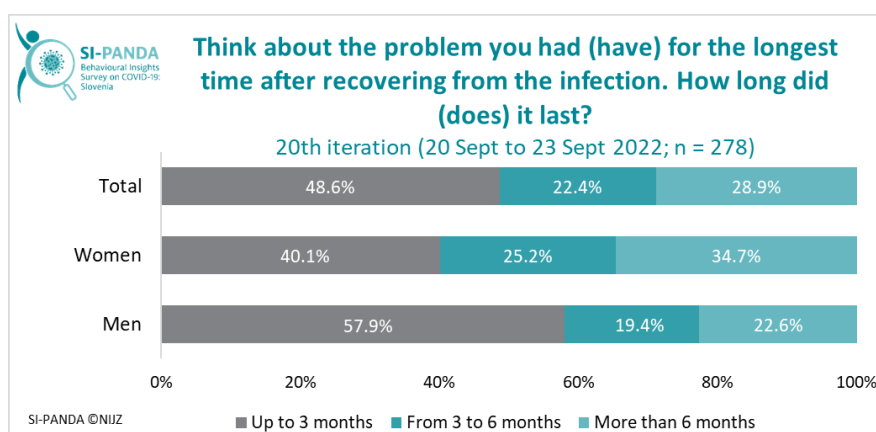


Figure 19: duration of the longest lasting problem after recovering from an infection among persons, with at least one problem after recovering from an infection, total and by gender.

Almost two-thirds of people who stated that they have or had problems did not consult a doctor regarding problems after recovering from SARS-CoV-2 infection. Statistically significantly more people with at least one chronic disease (51.3%) than people without chronic diseases (21.7%) consulted a doctor regarding problems after recovering from an infection (Figure 20).

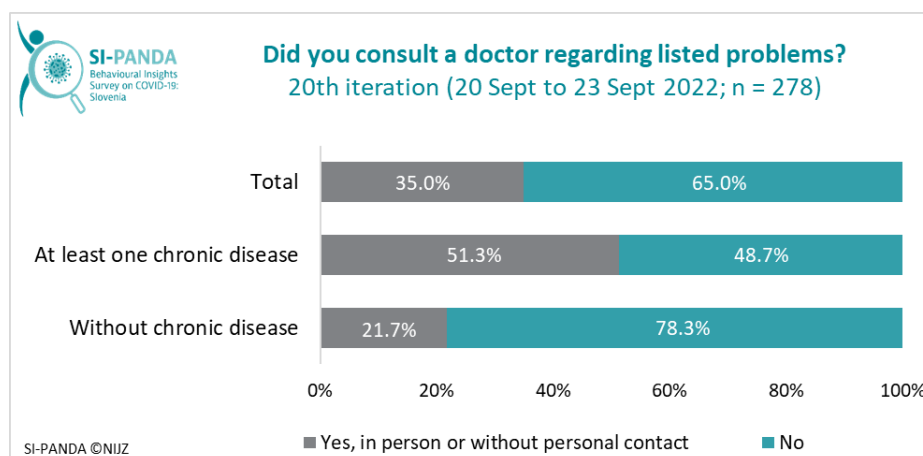


Figure 20: Consulting a doctor regarding problems after recovering from an infection among people who had at least one problem after recovering from an infection, total and by the presence of chronic disease.

The problems that people had after recovering from the infections had the greatest impact on the area of performing leisure activities, as 77.0% of people report that the problems impacted their leisure activities slightly to extremely. Approximately two-thirds of people stated that the problems at least slightly impacted their well-being and interpersonal relationships, the area of work and job

as well as their care for home and family. Statistically significantly more men than women report that the problems have had no impact at all on work and care for home and family (Figure 21).

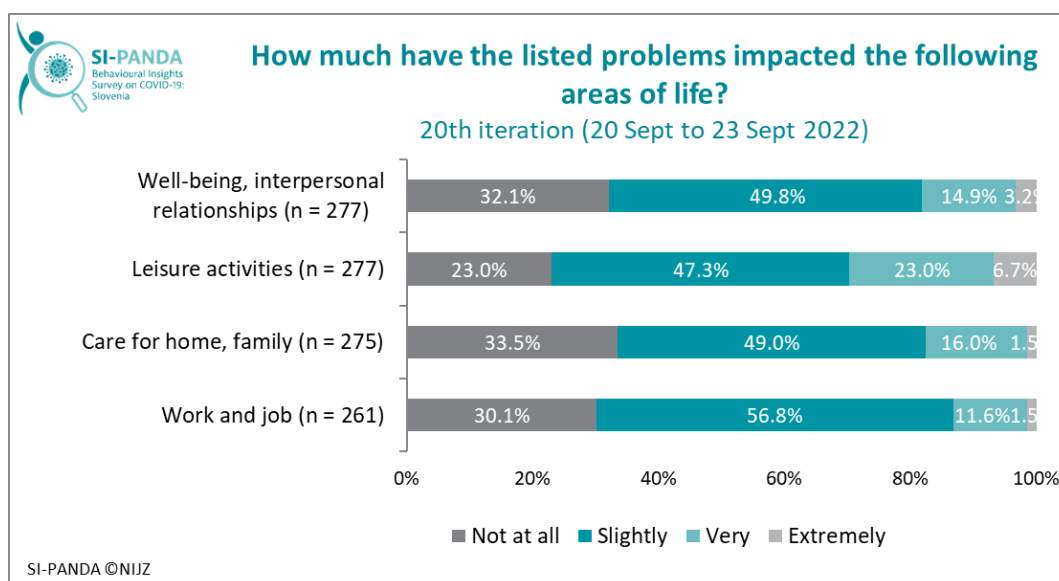


Figure 21: The impact of problems after recovering from SARS-CoV-2 infection on different areas of life among persons with at least one problem after recovering from the infection, total.

People with at least one chronic disease were asked whether, after their first or only infection, they had noticed an exacerbation of a chronic disease they already had before being infected with SARS-CoV-2. 15.6% of people experienced exacerbation of their chronic disease after their first or only infection (Figure 22).

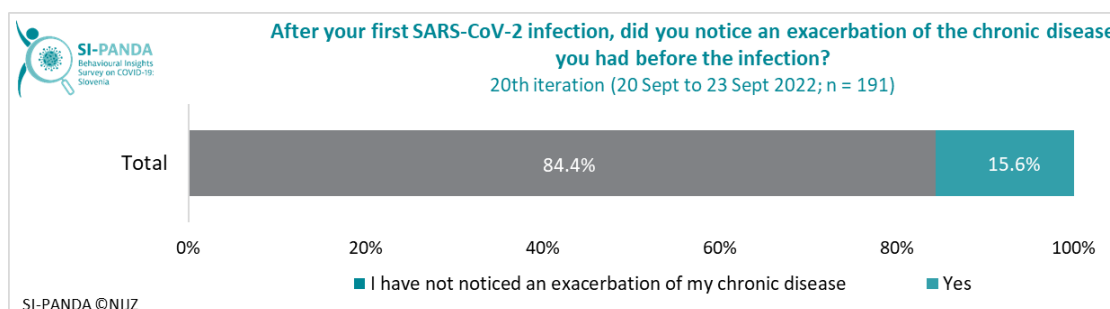


Figure 22: Exacerbation of a pre-existing chronic disease after a first or only infection, among persons with at least one chronic disease who have recovered from SARS-CoV-2 virus infection, total.

The consequences of recovering from and infection with SARS-CoV-2 virus can affect various areas of a person's life. On the one hand, these are a mild and non-specific health problems, but on the other hand, they are often quite complex and still receive insufficient attention from the profession, both from a research and a clinical point of view.

Much is still unknown about the causes and long-term consequences of SARS-CoV-2 infection, but research is ongoing. It is already clear that post-COVID syndrome 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 as a whole.

In Slovenia, there are already specialized clinics for people who have long-term health problems after recovering from COVID-19. Most people with COVID-19 recover relatively quickly. Given that research shows that the risk of long-term health problems after SARS-CoV-2 infection is not

so low, vaccination against COVID-19 is also important in this respect. More campaigns are therefore needed to promote vaccination against COVID-19 and to make people aware of the positive effects of vaccination. In order to prevent and limit the transmission of infection, it is also important to follow the recommendations for health promotion and disease prevention in the current epidemiological situation since no one is safe from the consequences of an infection.

The frequency of use of various SARS-CoV-2 information sources

Among all respondents, doctors and scientists are the most frequently used sources for obtaining information about the SARS-CoV-2 virus – the average frequency of use on a 7-point scale, where 1 means 'never' and 7 means 'very often' is 3.8 in the 20th survey iteration. They are followed by NIJZ or friends, acquaintances and relatives with an average of 3.5 and the Sledilnik website, the SARS-CoV-2 Advisory Group, television and the Ministry of Health with an average of 3.3. The least frequently used information sources are social networks (2.2), celebrities and influencers (1.9) and religious communities (1.2).

The results of the 20th survey iteration show significant differences in the frequency of use of information sources between vaccinated and unvaccinated respondents. Vaccinated people most often use doctors and scientists as sources of information (average 4.2), followed by NIJZ (4.0), the Sledilnik website (3.8), the SARS-CoV-2 Advisory Group and the Ministry of Health (3.7), television (3.6), friends, acquaintances and relatives (3.5) and nurses (3.4). Those who have been vaccinated rarely use social networks (2.2) celebrities and influencers (2.0) and religious communities (1.2) as sources of information.

Unvaccinated people most often use friends, acquaintances and relatives as sources of information (average 3.3), followed by doctors and scientists (2.6), television, and other online sources – foreign websites, blogs, nongovernmental organizations (2.4), nurses (2.3) and radio, social networks and the Ministry of Health (2.2). As sources of information, the unvaccinated least often use print media (1.8), the www.cepimose.si website and celebrities or influencers (1.7) and religious communities (1.1) (Figure 23).

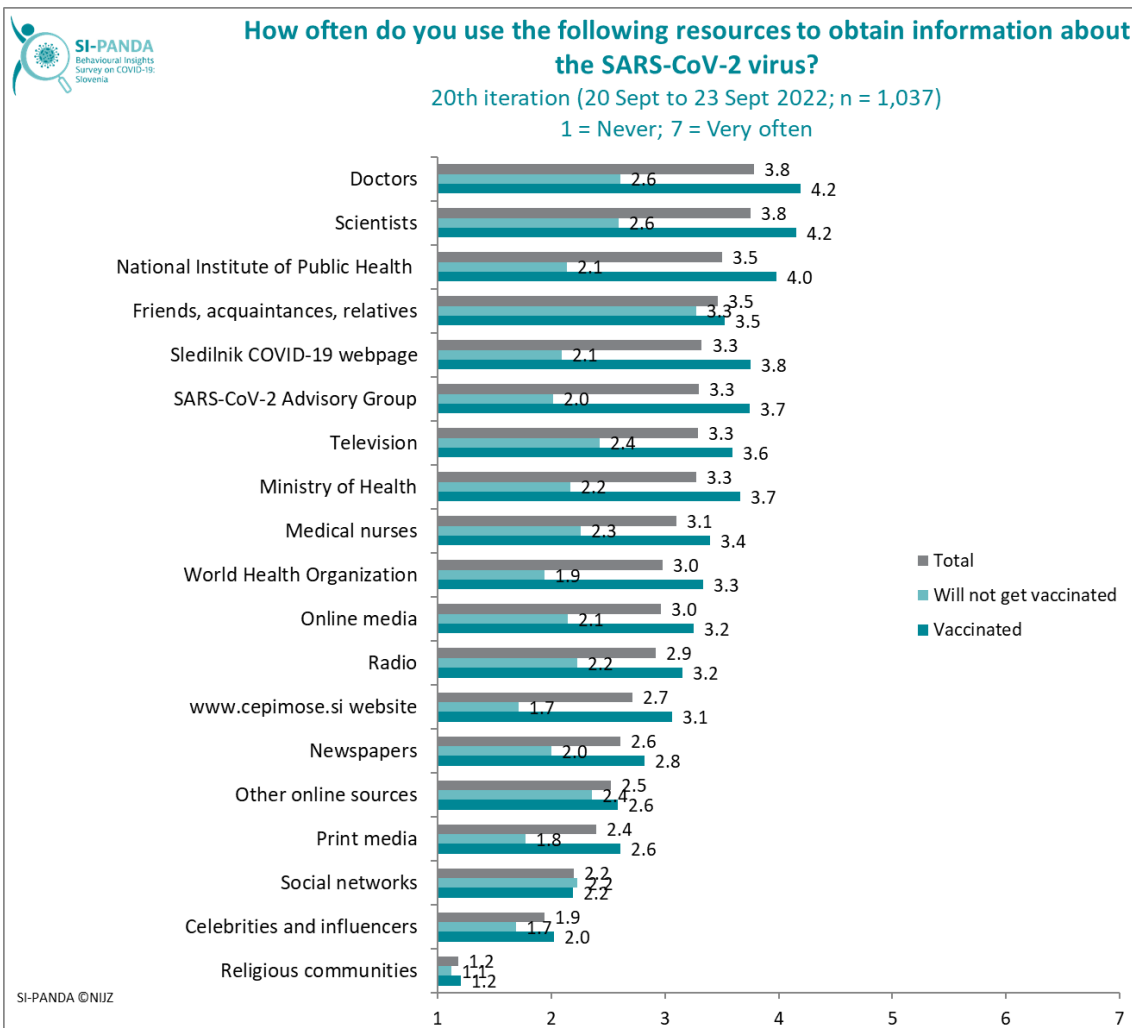


Figure 23: Use of different sources to obtain SARS-CoV-2 information, total and by vaccination status.

Vaccinated people are more likely to use the listed sources of information than unvaccinated people, and are more likely to use formal sources of information, while unvaccinated people are more likely to use informal sources of information. With the established frequent use of informal sources of SARS-CoV-2 information among the unvaccinated people, it is therefore all the more important to strengthen the ability to recognize incomplete and false information, to encourage critical thinking, to strengthen health, media, information and digital literacy, and to encourage the acquisition of information from official and authentic sources.

Trust in different SARS-CoV-2 information sources

Among all respondents, the most trusted SARS-CoV-2 information sources are scientists – the average trust on a 7-point scale where 1 means 'I do not trust at all' and 7 means 'I completely trust', is 4.5 in the 20th survey iteration. They are followed by doctors with an average of 4.4, nurses (4.0), and NIJZ (3.9). The least trusted information sources are influencers and celebrities (2.2), social networks (2.0) and religious communities (1.3).

The results of the 20th survey iteration show significant differences in trust in information sources between vaccinated and unvaccinated respondents. Vaccinated people trust scientists the most as an information source (average 5.1), followed by doctors (4.9), NIJZ (4.5), nurses (4.4), SARS-CoV-2 Advisory Group, Sledilnik website and the WHO (4.3). Vaccinated people least trust other online sources as information sources – foreign websites, blogs, nongovernmental organizations, etc. (2.9), celebrities and influencers (2.3), social networks (2.1) and religious communities (1.3).

Unvaccinated people trust friends, acquaintances and relatives the most as an information source (average 3.3), followed by scientists (3.0), doctors (2.9), nurses (2.8), other online sources – foreign websites, blogs, nongovernmental organizations, etc. (2.4) and National Institute of Public Health and Sledilnik website (2.3). Unvaccinated people least trust television, newspapers, social networks, online media and print media (1.9), celebrities and influencers (1.8) and religious communities (1.1) as information sources ([Figure 24](#)).

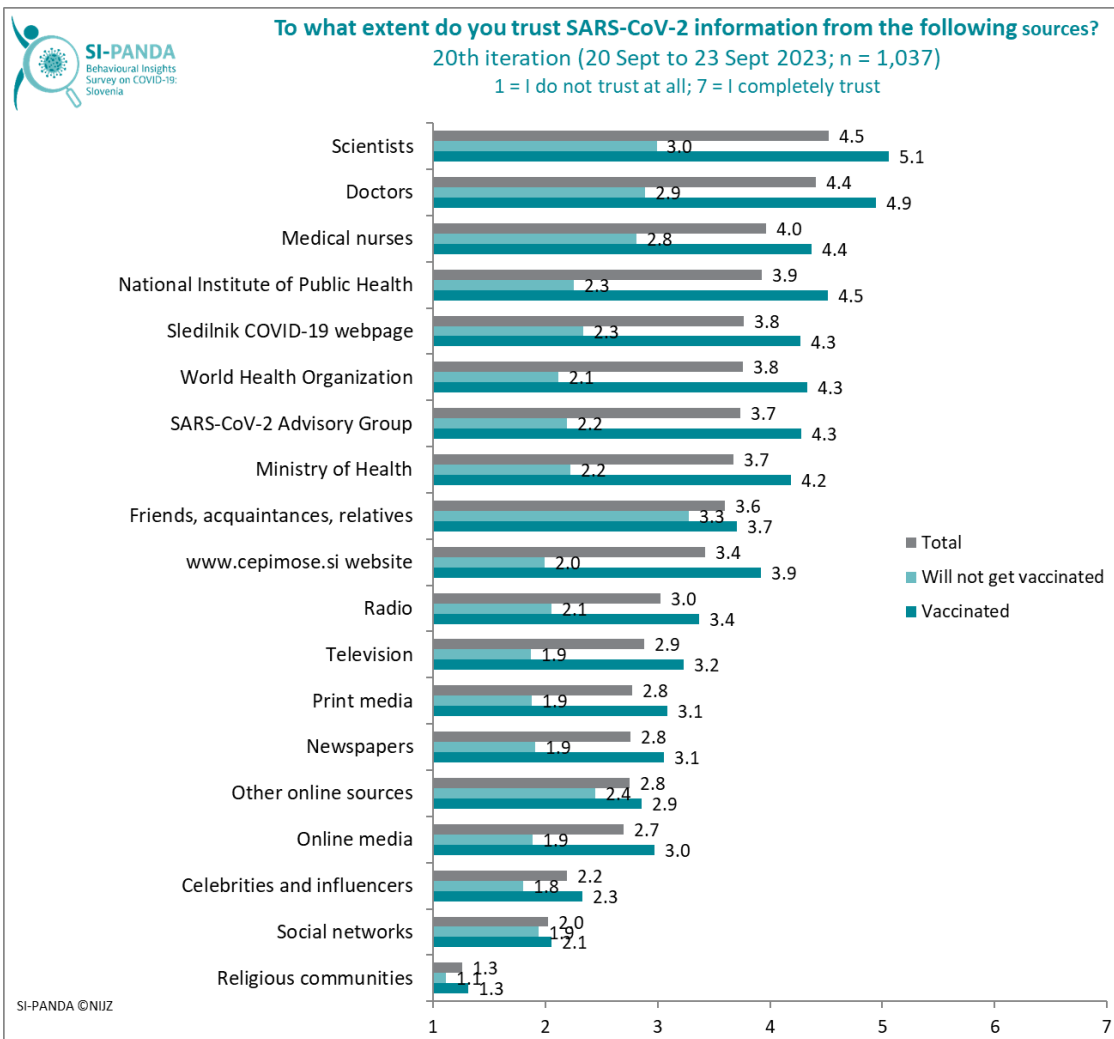


Figure 24: Trust in different SARS-CoV-2 information sources, total and by vaccination status.

Vaccinated people are more trusting of different information sources than unvaccinated people, they also have more trust in official information sources, while unvaccinated people are more trusting of informal information sources. The observed increased trust in informal information sources among the unvaccinated people highlights the importance of promoting the use of (official) credible information sources, fostering critical thinking, strengthening the ability to identify false or incomplete information, and strengthening health, digital, media and information literacy.

Emotional response to COVID-19

The COVID-19 pandemic also triggered strong emotional responses in people, which influence their willingness and motivation to adhere to (public) health measures. Therefore, the influence of emotions must be taken into account when planning and implementing measures to promote recommended behaviours – both vaccination and other protective behaviours. The effects of emotions on people's behaviour are very complex, with cultural, social and political contexts playing a major role.

It is important to know what emotions are prevailing in each segment of the target public at a certain moment and to use the emotional component in communicating protective measures in a targeted way, as the usual one-size-fits-all public health population approaches do not have an adequate impact. Effective communication of public health measures must therefore go beyond merely informing and appealing to specific population groups, taking into account the emotional component and explicitly supporting a sense of self-efficacy.⁷

Respondents were asked about their emotional response to the COVID-19 pandemic; several answers were possible, but no more than 3 could be selected.

Among all respondents, the emotional response to COVID-19 is dominated by uncertainty (55.5%), followed by anger (35.0%), hope (27.9%), fear (27.4%) and distress (20.2%). In the 20th iteration, compared to the 17th iteration, which took place from October 12 to 15, 2021, the five most dominant emotions related to COVID-19 no longer include sadness, and anger is also less expressed (49.1 in 17th iteration; 35.0% in 20th iteration).

Results of the 20th SI-PANDA survey iteration show a different emotional response to COVID-19 according to vaccination status. Among vaccinated and unvaccinated people, the most expressed emotion is uncertainty (56.7%, 51.8%), followed by hope (32.3), anger (29.6%) and fear (29.4%) among vaccinated persons, and by anger (50.6%) and sadness (28.4%) among unvaccinated persons (Figure 25).

⁷ Chou WS, Budenz A. Considering Emotion in COVID-19 Vaccine Communication: Addressing Vaccine Hesitancy and Fostering Vaccine Confidence. *Health Commun.* 2020 Dec; 35(14): 1718–22.

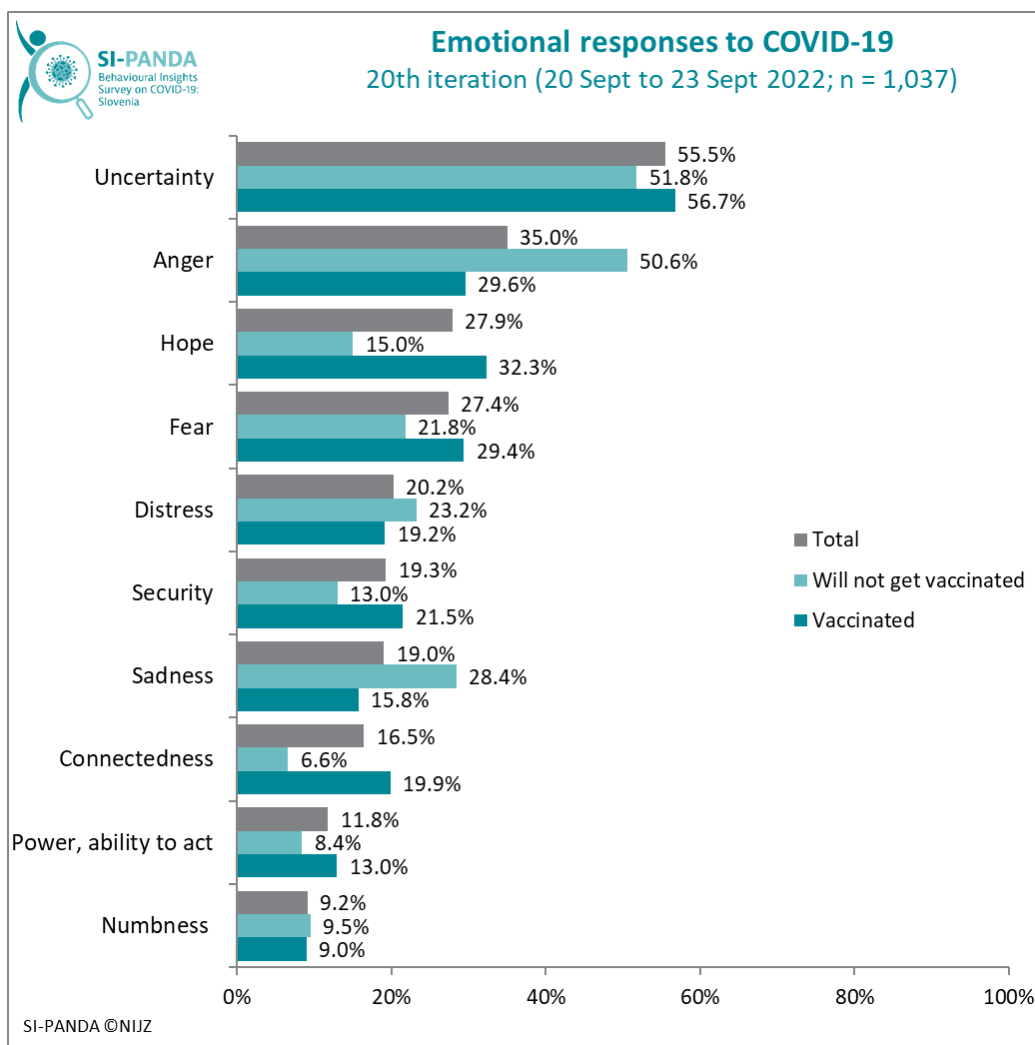


Figure 25: Emotional responses to COVID-19, total and by vaccination status.
 Note: Several answers were possible.

The SI-PANDA results also show a different emotional response to COVID-19 in different age groups. In addition to uncertainty and anger, which are the dominant emotions in relation to COVID-19 regardless of age, hope, security and a sense of connectedness are also strongly expressed in those aged 65 and over, while hope, security and fear are strongly expressed in those aged 50 to 64, and fear, distress and sadness in those aged under 50. The strong expression of uncertainty and anger is, despite the importance of taking into account the cultural context, quite worrying, but at the same time, it also represents an opportunity to supplement possible misunderstandings or lack of knowledge as possible reasons for the feeling of uncertainty.

Among people aged 18 to 74, the dominant emotion is uncertainty (47.6%–59.2%), and uncertainty is also dominant in the 17th survey iteration, namely among people aged 18 to 64 (55.3%–60.7%), while the dominant emotion among the oldest persons in the 65–74 age group is anger. The second most frequently expressed emotion in the 17th survey iteration among 18–74 year olds (48.2%–50.2%) is anger, and this emotion is also the most frequently expressed emotion among 18–64 year olds (33.6%–40.0%) in the 20th survey iteration, while in the oldest

age group (65–74 years), hope is the second most frequently expressed emotion (45.6%–45.6%) (Figure 26).

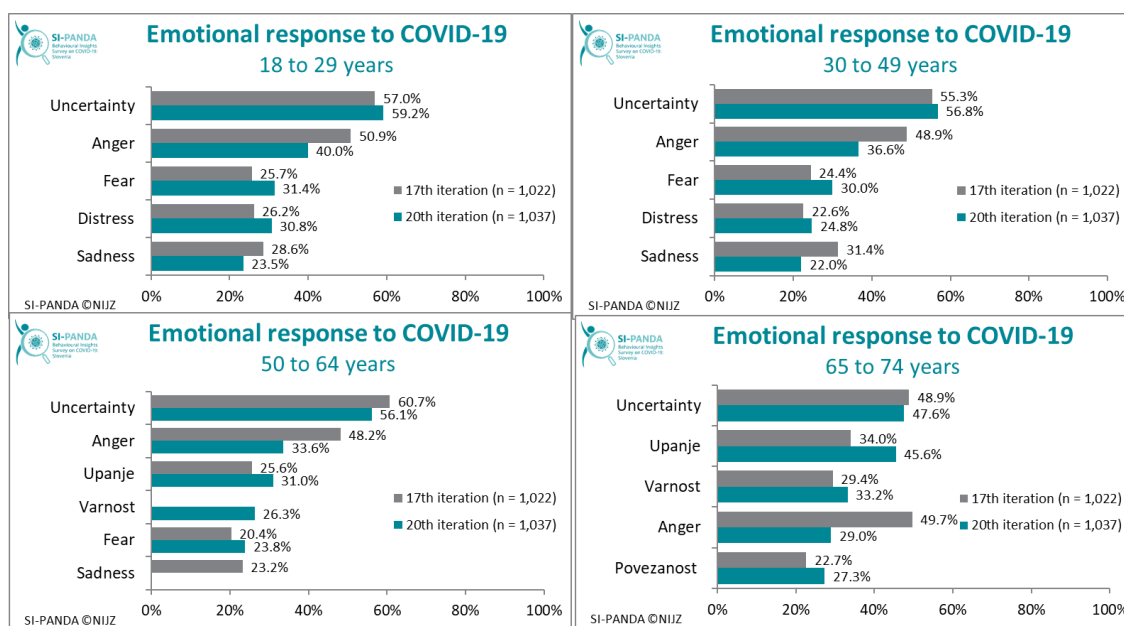


Figure 26: Emotional response to COVID-19, by age groups.
Note: Several answers were possible.

There is also a noticeable difference in the emotional response to COVID-19 according to gender, and it should be emphasized that these are statistically significant data for the emotions of fear, distress and security. While for both genders, the dominant emotion related to COVID-19 is uncertainty, for women it is followed by fear, anger, hope and distress, and for men it is followed by anger, hope, security and fear, in that order (Figure 27).

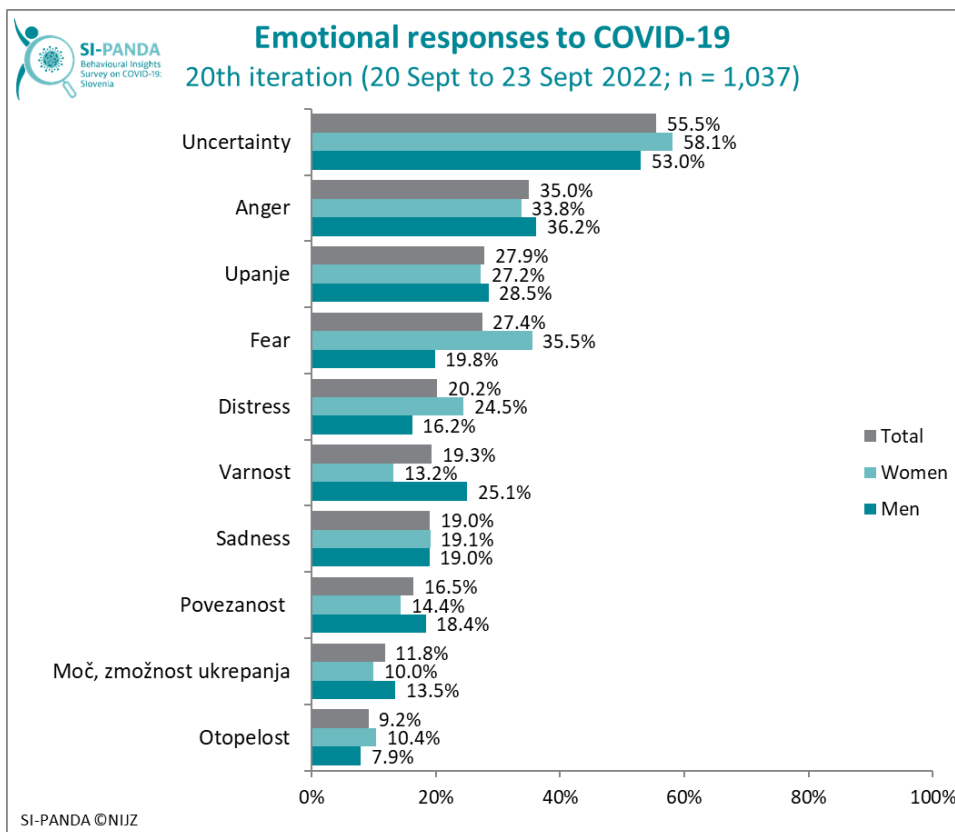


Figure 27: Emotional response to COVID-19, total and by gender.
Note: Several answers were possible.

Emotional response to vaccination against COVID-19

Among all respondents, the predominant emotional response to vaccination against COVID-19 was hope (41.1%), followed by doubt (37.2%), relief (29.4%), fear (24.4%), anger (19.9%) and belief (18.2%). Compared to the results of the 17th SI-PANDA survey iteration, which took place from 12 to 15 October 2021, among the dominant emotions in the 20th iteration, relief is less pronounced (35.7% in the 17th iteration; 29.4% in 20th iteration), and doubt more pronounced (34.2% in the 17th iteration; 37.2% in the 20th iteration).

The results of the 20th SI-PANDA survey iteration show a different emotional response to the vaccination against COVID-19 depending on vaccination status. Among the vaccinated, the most strongly expressed emotions are hope (52.5%) and relief (39.2%), followed by doubt (26.3%), belief (21.0%), self-confidence (20.8%) and fear (20.0%). Among the unvaccinated, the most strongly expressed emotions are doubt (68.5%) and anger (46.9%), followed by fear (37.0%) and distress (19.2%), while the least expressed emotions are casualness (2.5%), gratitude (1.8%) and relief (1.5%) (Figure 28).

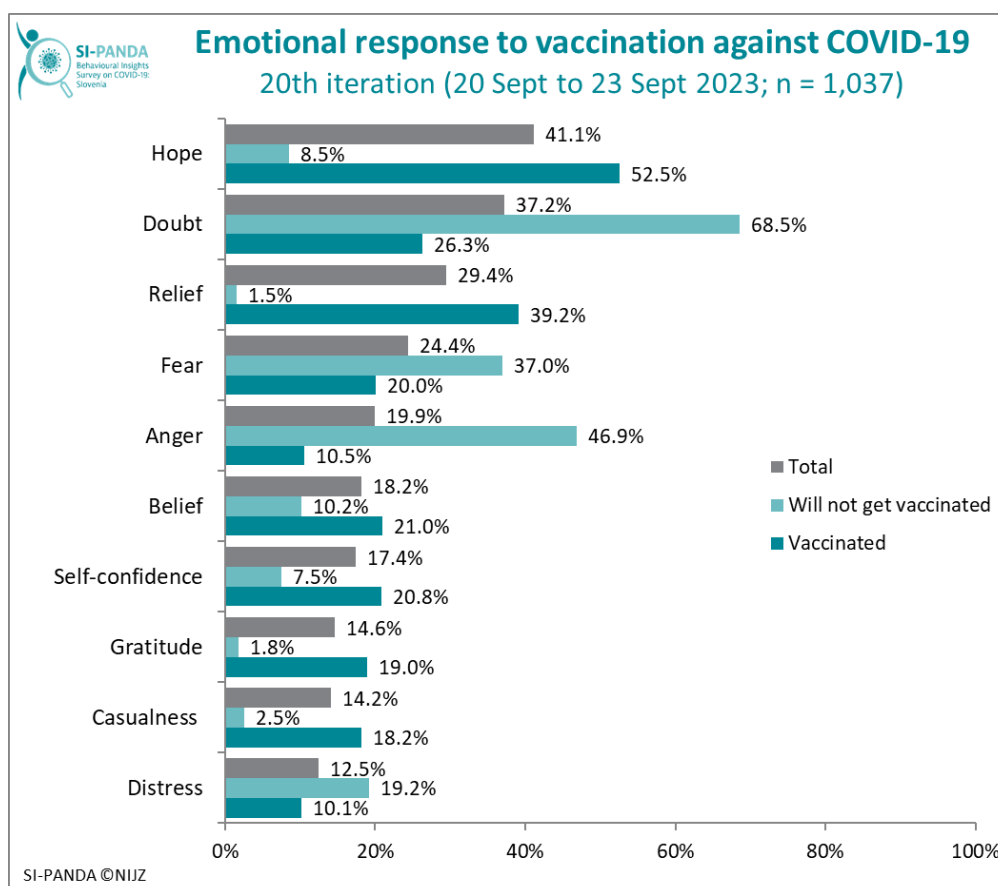


Figure 28: Emotional responses to vaccination against COVID-19, total and by vaccination status. Note: Several answers were possible.

Differences in the emotional response to vaccination against COVID-19 are also evident by age. Among those over 50, the most expressed emotion in relation to vaccination against COVID-19 is hope, and among those under 50, doubt is the most expressed. While relief, self-confidence, belief and doubt are also strongly expressed as emotional responses among people over 50, in

addition to hope, the most frequently expressed emotional responses among those under 50 are hope, fear, anger and relief.

The most frequently reported emotional response to vaccination against COVID-19 in both, the 17th and 20th, survey iterations was doubt among people aged 18 to 49 (17th iteration: 41.0%–41.2%; 20th iteration: 43.5%–46.1%), and hope among people aged 50 to 74, (17th iteration: 50.0%–57.5%; 20th iteration: 43.5%–52.5%) (Figure 29).

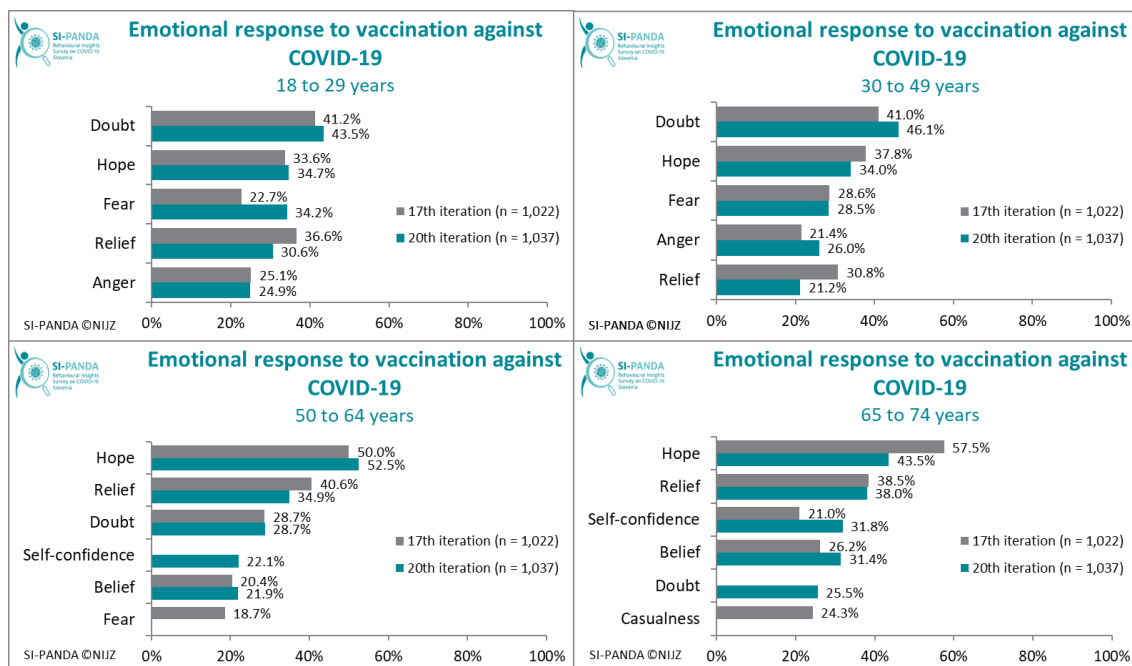


Figure 29: Emotional response to vaccination against COVID-19, by age groups.
Note: Several answers were possible.

The emotional response to vaccination against COVID-19 also shows a difference between the genders, and it should be emphasized that the emotions of anger, casualness, self-confidence and gratitude are not statistically significant data. For women, the most expressed emotion related to the vaccination against COVID-19 is doubt, followed by hope, fear, relief and anger, while for men, the most expressed emotion is hope, followed by relief, doubt, belief, self-confidence and fear.

The results of the 20th SI-PANDA survey iteration, which identify different gender-specific emotional responses to COVID-19 vaccination against COVID-19, confirm the findings of foreign research on the different experience of the COVID-19 pandemic between men and women, both in terms of health consequences and broader.⁸ Differences in emotional responses to COVID-19 and vaccination against COVID-19 are also evident across age groups and vaccination status, and the findings provide extremely useful information for professional and communicators, as well as for decision-makers (Figure 30).

⁸ Rodríguez-Besteiro, S., Tornero-Aguilera, J. F., Fernández-Lucas, J., & Clemente-Suárez, V. J. (2021). Gender Differences in the COVID-19 Pandemic Risk Perception, Psychology, and Behaviors of Spanish University Students. *International Journal of Environmental Research and Public Health*, 18(8), 3908. doi:10.3390/ijerph18083908.

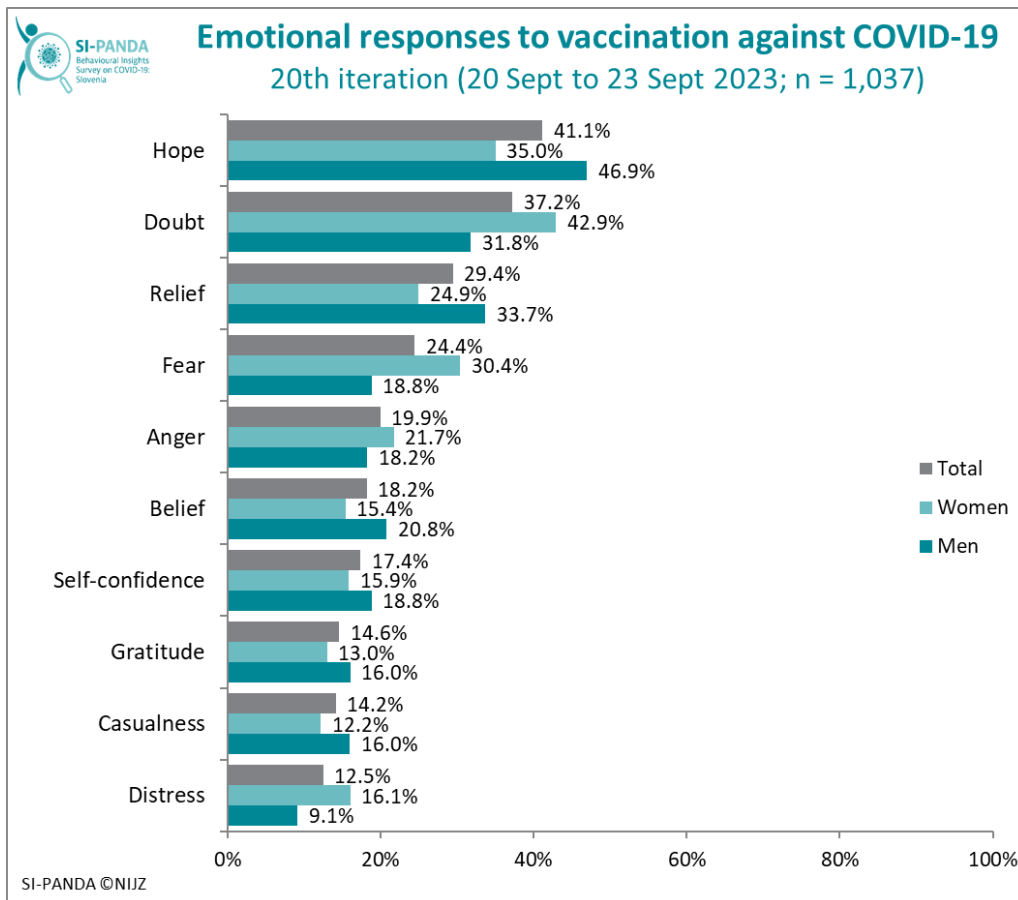


Figure 30: Emotional response to vaccination against COVID-19, total and by gender.
Note: Several answers were possible.

The emotional response also needs to be considered in the context of infodemic, or the rapid dissemination of information that (un)intentionally misleads the public about various aspects of the pandemic^{9,10}. Research shows that conspiracy theories thrive in times of crisis, when people are looking for ways to cope with uncertain and difficult circumstances¹¹. People are more likely to believe conspiracy theories when they feel powerless¹² and when they are anxious or worried¹³, which is particularly the case in social crises such as the COVID-19 pandemic^{14,15}.

⁹ Duplaga, M. (2020). The determinants of conspiracy beliefs related to the COVID-19 pandemic in a nationally representative sample of internet users. *International Journal of Environmental Research and Public Health*, 17(21), 1–18. <https://doi.org/10.3390/ijerph17217818>.

¹⁰ Sharma, D. C., Pathak, A., Chaurasia, R. N., Joshi, D., Singh, R. K., & Mishra, V. N. (2020). Fighting infodemic: Need for robust health journalism in India. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, 14(5), 1445–7. <https://doi.org/10.1016/J.DSX.2020.07.039>.

¹¹ van Prooijen, J. W., & Douglas, K. M. (2017). Conspiracy theories as part of history: The role of societal crisis situations. *Memory Studies*, 10(3), 323–33. <https://doi.org/10.1177/1750698017701615>.

¹² Abalakina-Paap, M., Stephan, W. G., Craig, T., & Gregory, W. L. (1999). Beliefs in conspiracies. *Political Psychology*, 20(3), 637–47. <https://doi.org/10.1111/0162-895X.00160>.

¹³ Grzesiak-Feldman, M. (2013). The Effect of High-Anxiety Situations on Conspiracy Thinking. *Current Psychology*, 32(1). <https://doi.org/10.1007/s12144-013-9165-6>.

¹⁴ van Prooijen, J. W., & Douglas, K. M. (2017). Conspiracy theories as part of history: The role of societal crisis situations. *Memory Studies*, 10(3), 323–333. <https://doi.org/10.1177/1750698017701615>.

¹⁵ Imhoff, R., & Lamberty, P. (2020). A Bioweapon or a Hoax? The Link Between Distinct Conspiracy Beliefs About the Coronavirus Disease (COVID-19) Outbreak and Pandemic Behavior. *Social Psychological and Personality Science*, 11(8), 1110–8. <https://doi.org/10.1177/1948550620934692>.

Experiencing stressful events and coping with them

We recognize and experience stress, tensions and pressures in our lives in different ways. Over time, the experience of stressors, the stress reaction and the intensity change, and the stress reaction can be present in the form of feelings of tension, vulnerability or fear. Most people cope easily with everyday stressful events. But some people experience stress very often and at the same time they are unable to cope with it. This is when we talk about risk stress behaviour, which is associated with many negative consequences for health and quality of life¹⁶. In recent years, we have seen the emergence of new challenges and significant changes in the prevalence of both known and new stressors. The COVID-19 pandemic has particularly highlighted the importance of stress management for maintaining mental health, research shows that most people are successful in adapting to new stressors in our environment. At the same time, they also point out that this is not the case for everyone and that we need to provide adequate support to those who are not able to do so, and to design appropriate approaches for stressors that change over time in terms of their prevalence or the intensity of their impact on the population¹⁷.

In the 20th survey iteration, we asked how often adult respondents had felt tense, stressed or under a lot of pressure in the last 14 days, and how they coped with tension, stress and pressure. We find that 18.9% feel tense, stressed or under a lot of pressure often or on a daily basis (Figure 31). In the 16th survey iteration, which was carried out about a year ago – from 21 September to 23 September 2021 – at a time when the situation was much more uncertain, so, as expected, the percentage expected was slightly higher (24.8%). In the 20th survey iteration, about a third feel tense or stressed occasionally and a third very rarely. The proportion of people who feel tense, stressed or under a lot of pressure often or daily is higher for women than for men; it is the highest in younger age groups. Almost a quarter of people aged 18–29 (24.5%) and 30–49 (24.1%) feel this way often or daily (Figure 31). Those with higher education attainment are more likely to feel tense or stressed compared to those with lower educational attainment. Our previous research as well as foreign research show similar results – both before and during the pandemic, namely a higher level of stress is associated with younger age, female gender, lower educational attainment, single status, etc.¹⁸

¹⁶ Barry V, Stout ME, Lynch ME, et al. The effect of psychological distress on health outcomes: A systematic review and meta-analysis of prospective studies. *Journal of Health Psychology*. 2020; 25(2): 227–39. <https://doi.org/10.1177/1359105319842931>.

¹⁷ Fu, S. (Q.), Greco, L. M., Lennard, A. C., & Dimotakis, N. (2021). Anxiety responses to the unfolding COVID-19 crisis: Patterns of change in the experience of prolonged exposure to stressors. *Journal of Applied Psychology*, 106(1), 48–61. <https://doi.org/10.1037/apl0000855>.

¹⁸ Kowal, M., Coll-Marin, T., Ikizer, G., Rasmussen, J., Eichel, K., Studzinska, A., ... Ahmed, O. (2020). Who is the most stressed during the COVID-19 pandemic? Data from 26 countries and areas. *Applied psychology: Health and well-being*, 12(4), 946–66. <https://doi.org/10.1111/aphw.12234>.

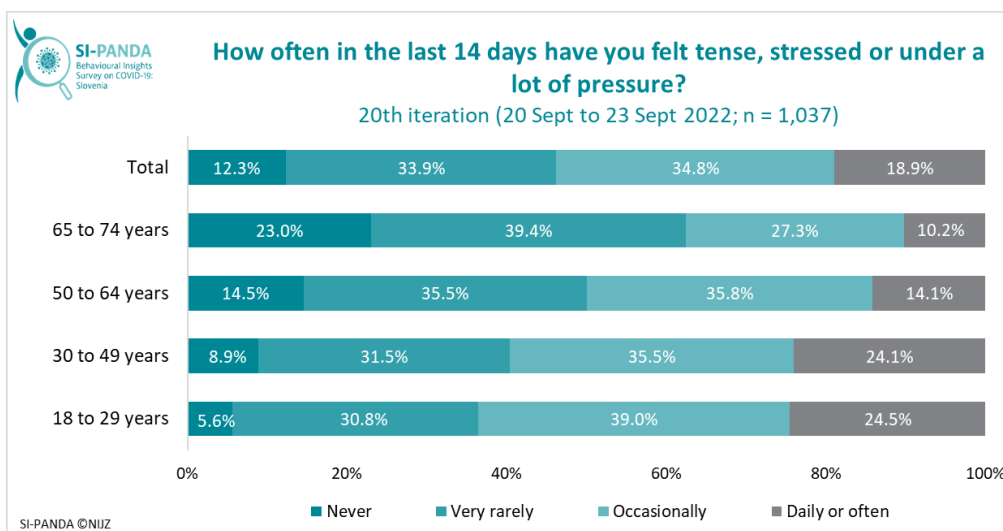


Figure 31: The frequency of experiencing stress in the last 14 days, total and by age groups.

Most respondents (80.1%) manage tension, stress and pressure with some effort or easily (Figure 32). A minority (4.0%) reports that they do not control them or control them with a great effort, and almost 16% report that they control them with greater effort. There are no significant differences between genders, educational attainment and age groups in the proportion of people who could not manage stress or who managed it only with great effort. Slightly larger differences are observed in the proportion of people who manage stress with greater effort. There are more of them in younger age groups. Similar to the frequency of experiencing stress in the last 14 days, coping problems are also more common in those under the age of 50.

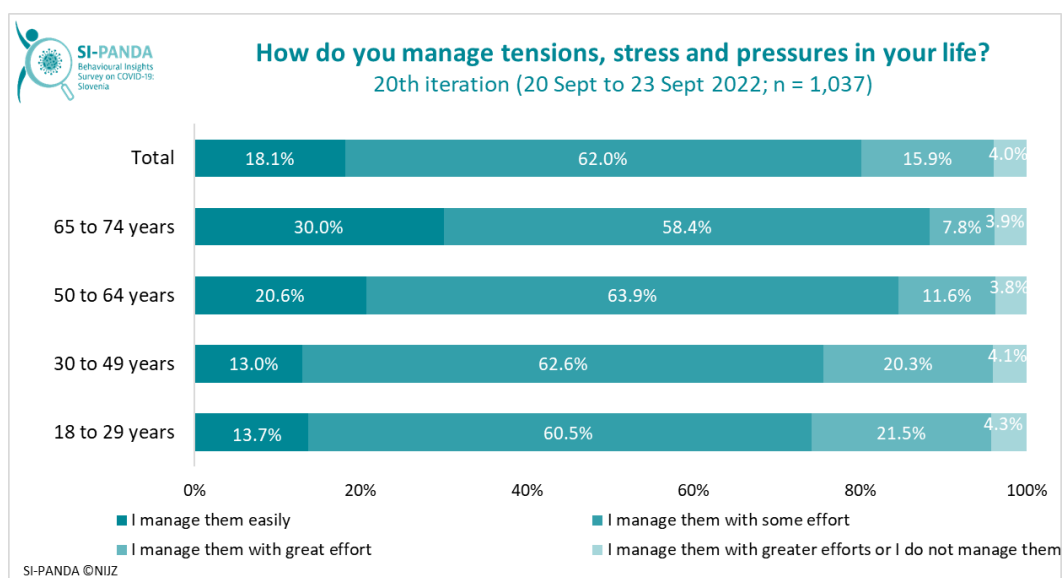


Figure 32: Stress management, total and by age groups.

The connection between financial security and health is well researched and proven¹⁹. Based on the data of the 20th survey iteration, we recognize the connection between experiencing stress and the self-assessment of the financial situation in the past three months. The least frequent experience of stress is reported by those who assess their financial situation as the same

¹⁹ Neiloy R. Sircar & Eric A. Friedman (2018) Financial security and public health: How basic income & cash transfers can promote health, *Global Public Health*, 13:12, 1878–88, DOI: 10.1080/17441692.2018.1460383.

compared to the situation three months ago (Figure 33). Although we cannot conclude causal links between the self-assessed financial situation in the past three months and the experience of stress, the importance of the financial situation stability is indicated. Experiencing stress more often is reported both by those who had a better financial situation in the past three months and by those who report that they had a worse financial situation compared to the previous time. Meanwhile, poorer stress management is mainly seen in those whose financial situation worsened in the last three months.

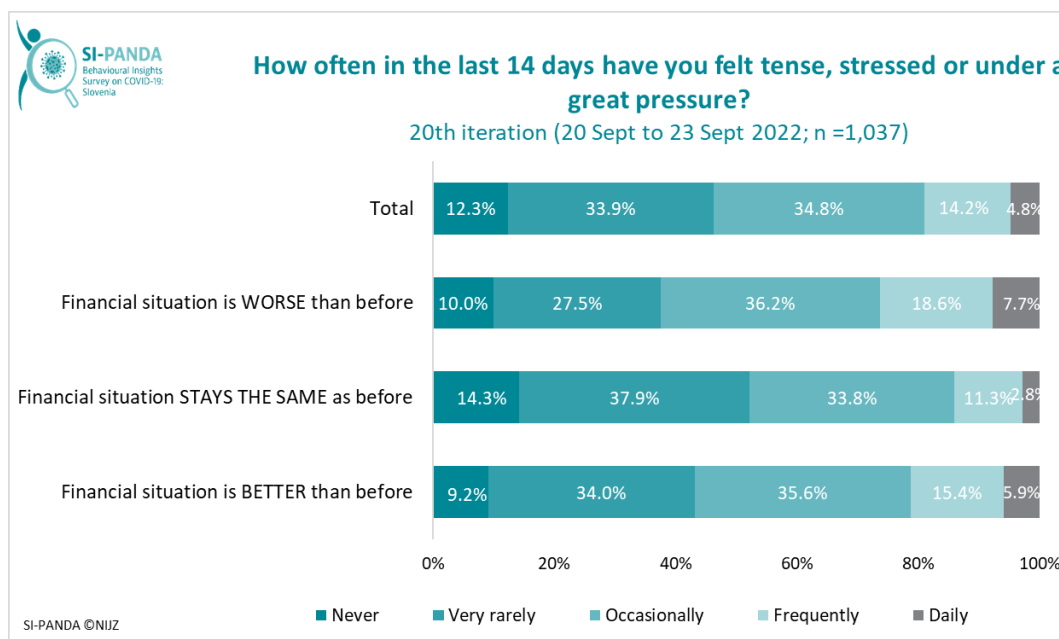


Figure 33: Frequency of experiencing stress in the last 14 days, total and by the self-assessment of the financial situation in the last three months.

The proportion of people with risky stressful behaviour – that is people who experience stress often or daily and at the same time have severe problems with stress management or do not manage it at all – was 2.8%. The variable in which we detected a very large difference in the proportion of risky stressful behaviour is daily physical activity. People who defined themselves as being physically active for less than 30 minutes a day or 150 minutes a week reported risky stressful behaviours in 7.1%. People who were physically active more often had less risky stressful behaviour (2.0%) (Figure 34).

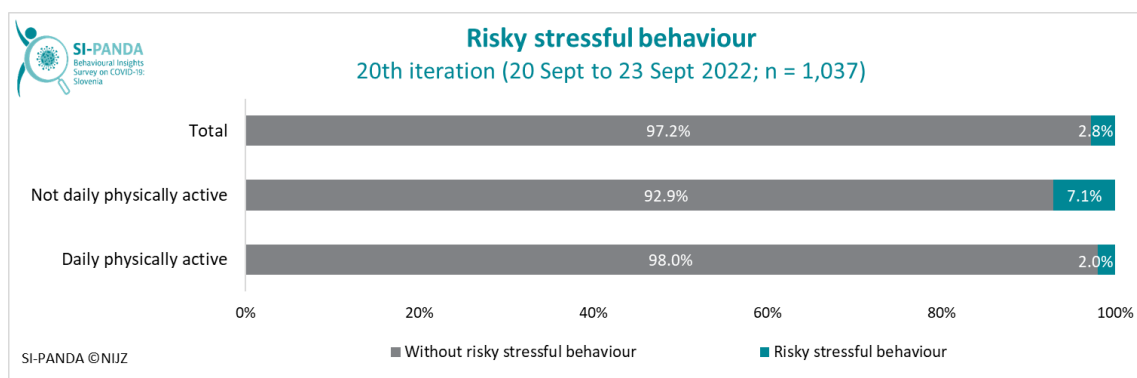


Figure 34: Risky stressful behaviour, total and by daily physical activity.



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