Tackling the COVID-19 outbreak: assessing the public's risk perceptions and adherence to Measures (TACOM)

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Final report

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She is the PI of the project, and in this role oversaw the whole research process. In addition, she contributed to the study idea, developing the data collection methodology, questionnaire development, data collection, interpretation of findings, and critically revising the whole report.

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He co-ordinated the whole research process, co-developed the study idea, back-translated the Dutch questionnaire, performed the data cleaning, data analysis, and wrote certain parts of the report (results, conclusion, executive summary). Furthermore, contributed to developing the data collection methodology, questionnaire development, data collection, interpretation of findings and critically revising the whole report.

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1. Executive summary

Since the first case of COVID-19 was detected in December 2019, the world has experienced a pandemic of unprecedented proportions. While the development of vaccines against the disease became high priority, many countries were trying to reduce the impact and the burden on healthcare systems by implementing infection prevention and control measures. These measures are flexible, and can be adapted based on the severity of the outbreak that a country is experiencing at a given moment in time. However, the effectiveness of such measures is for a large part determined by the ability and willingness of the population to adhere to them. For Belgium, which has experienced a high infection rate over the year, there was no clear insight in overall adherence to the measures, reasons for (in)adherence, and subgroups of the population that are less likely to adhere, which we investigated in this study.

We conducted a panel-based internet survey, addressing a sample of respondents, representative for the adult Belgian population in terms of age, sex, region and socio-economic status. The questionnaire was developed by researchers with backgrounds in social sciences, epidemiology, health promotion and psychology, to account for different perspectives from these various fields. It was guided by the Protection Motivation Theory, and incorporated both threat appraisal (vulnerability, perceived severity) as well as coping appraisal (response efficacy, self-efficacy). We also measured the actual and planned level of implementation for the measures in place during the data collection, as well as knowledge level. Furthermore, we collected variables on various demographic, socio-economic and health-related characteristics of respondents, in order to identify potential risk factors for low adherence. Finally, we asked respondents about preferred channels for communication, and sources that they consider trustworthy and contributing to their knowledge. Data were collected in September 2020.

The results show that the overall level of adherence among respondents (n = 2,008) was high, and each of the measures in place received a score of at least 4 on a range of 1-5 in terms of past and future implementation. Vulnerability and perceived severity of COVID-19 were not associated with future implementation. In contrast, perceived usefulness (response efficacy) and perceived ease to implement as measure (self-efficacy) were strongly associated with implementation. Several characteristics were associated with lower levels of threat appraisal, coping appraisal, implementation and knowledge on measures. These included belonging to a younger age group (18-30 years old), having a lower education, belonging to the lowest income level, and belonging to the French-speaking community (versus the Dutch-speaking community). Respondents indicated that they prefer the television to receive information on COVID-19 measures (80%), followed by (online) newspapers (57%). Experts were the group that contributed most to informing respondents

about COVID-19 measures, and that they considered most trustworthy, followed by politicians and journalists.

Although overall adherence in Belgium is high, there are certain subgroups of the population that have lower levels of adherence, risk perception and knowledge on measures. It is important to address these groups with targeted communication, in order to increase their involvement in the COVID-19 measures. Our results show a strong association between response efficacy and self-efficacy on the one hand, and implementation on the other hand, which implies that positive communication on increasing the perceived usefulness of measures and ease to implement them are likely to improve overall adherence. Since experts, including health care providers and representatives of scientific institutions, are considered the most trustworthy group, they should always be involved in risk communication. Overall, our study filled an important gap that existed regarding ability and willingness to adhere to the COVID-19 measures in Belgium, by addressing a large representative sample of the population.

2. Introduction

The world is currently experiencing a global pandemic caused by the novel coronavirus SARS-CoV-2, which leads to the contagious disease COVID-19. After it was first detected in December 2019 in Wuhan, China, the virus spread quickly over the world. In Belgium, the first case was detected on February 3rd 2020 in one of the nine Belgians, who had been evacuated from Wuhan. By the 9th of December 2020, 94.572 cases, 17.507 deaths and 43.984 hospital admissions had been reported (Sciensano 2020a). To protect public health and slow the spread of COVID-19, as well as to reduce the burden on health care systems, the government has implemented various infection prevention and control measures (IPCM) from February 1st 2020 onwards (ACAPS 2020).

Mathematical modelling of transmission dynamics show that the success and impact of these IPCM relies heavily on the public's adherence to them (Chang et al. 2020; J. Zhang et al. 2020). Perceptions of the threat posed by COVID-19 to individuals, their families and friends, and to society at large, are key to motivating behaviour change (Lim 2011; Pennings and Grossman 2008). Two peaks in the outbreak have occurred so far (December 2020), and recurrent peaks in infections are likely to occur later in time. Until a vaccine or specific treatment option becomes widely available or a sufficient proportion of the public is immune, it must be ensured that the gross majority of the public is willing and able to adhere to IPCM that limit the spread of COVID-19 (Van den Broucke 2020). To enhance the efficiency and effectiveness of IPCM, a better understanding is needed about what citizens know about the IPCM, whether they understand the measures that are imposed by the authorities, how they perceive these measures and COVID-related risks, and whether they adhere to the measures (Varghese et al. 2020a). In this respect, there is a shortage of population-based studies at a national level in Belgium that capture such insights. The TACOM project aims to address this shortage.

3. Background

3.1. Effective risk communication

Against the background of the unfolding COVID-19 pandemic, risk communication is a key component of public health interventions and preparedness strategies (Varghese et al. 2020a; L. Zhang, Li, and Chen 2020). Since the outbreak and spread of COVID-19 in Belgium in February 2020, the Belgian federal government has issued a range of measures to protect the population against the virus, many of which included communication about the risks posed by the virus. Risk communication is the process of communicating responsibly, openly and timely about the risk factors associated with a threat, in this case COVID-19, with the aim to minimize and/or manage the health impacts through policy, legal, social and behavioural adjustments (Glik 2007; Leiss 2004; L. Zhang, Li, and Chen 2020). Risk communication is a combination of internal communication between those responsible for risk assessment and management, and external communication aimed at enhancing risk awareness and behaviour change in the public (Glik 2007). The focus of this project is on the latter. Hence, when we mention risk communication hereafter, we refer to external communication in particular.

Effective risk communication must assist the public in understanding the risks and associated cost-benefits, and in informed decision-making (Leiss 2004; Renn 2008). This usually requires the translation of technical and scientific information into a user-friendly language (Leiss 2004). Unfortunately, due to the abundance of information that is given about COVID-19 by different channels, some of which is misleading, biased or downright incorrect, it is not easy for the public to identify scientific evidence and reliable sources. These challenges should be seriously considered when engaging in risk communication, as they could have adverse consequences for public health (Bavel et al. 2020). One possible strategy to deal with these challenges is to identify credible sources for delivering evidence to different audiences and then to adjust their messaging strategy accordingly (e.g. emphasizing on the benefits for the recipient, focussing on protecting others, appealing to moral values or social norms), based on the audience's motivation (Bavel et al. 2020; Druckman and Mcgrath 2019).

Further, risk communication must address uncertainties by specifying what is (currently) unknown and what is uncertain about what is known (The World Health Organisation 2020; L. Zhang, Li, and Chen 2020). However, communicating uncertainties may have a negative effect on prosocial behaviour and moral decision-making (Bavel et al. 2020; Kappes et al. 2018). Kappes et al. (2018) reported that when presented with two scenarios about willingness to work from home when sick, people are less willing to stay home if the outcome of this choice is uncertain compared to when it is not. Uncertainty, in that sense, negatively effects people's

prosocial behavior. Yet, Kappes et al. (2018) argue that uncertainty does not always have the same negative impact on behavior. To clarify, the authors distinguish two types of uncertainty: 1) outcome uncertainty and 2) impact uncertainty, which influence pro social behaviour in distinct ways. Whereas outcome uncertainty, where a person lacks knowledge about the outcomes of a decision, decreases prosocial behaviour, impact uncertainty, where a person lacks knowledge about how a decision may impact the well-being of others, may increase prosocial behaviour (Kappes et al., 2018). Therefore, the authors suggest to focus on communicating impact uncertainty rather than outcome uncertainty, to promote prosocial behaviour (Kappes et al., 2018).

Ineffective risk communication may lead to a loss of trust in the government and/or public health officials, may damage the economy and/or may increase morbidity and mortality (The World Health Organisation 2020; Varghese et al. 2020b). For example, Zhang, Li, and Chen (2020) describe how the lack of honesty and openness in the crisis risk communication following the COVID-19 outbreak in Wuhan, China, gave rise to conspiracy theories and rumours, which impaired the government's credibility, undermined trust in risk communication and hampered the public's self-protection.

Finally, a distinction should be made between short-term risk communication during crisis and long-term crisis risk communication. During the initial outbreak of a public health crisis such as the COVID-19 pandemic, risk communication needs to be timely, accurate, direct and relevant, but also needs to reassure the public and give hope (Glik 2007). In addition, during the initial crisis, media coverage tends to be high, which instigates widespread fear and anxiety in the public and results in a high willingness to change behaviour (Ibuka et al. 2010). In the long run, on the other hand, risk communication must adapt to the changing nature of the crisis. Risks communication must therefore be a dynamic process. Not only does the risk itself evolve over time, but so do scientific knowledge, media coverage and the public's perceptions and behaviour (Ibuka et al. 2010).

Protection Motivation Theory

Risk communication can lead to a higher awareness of risk by the public, but in and by itself an increased awareness does not necessarily lead to behaviour change. Other factors that also come into play are whether or not one considers oneself at risk (e.g., if one has been in contact with others who have been contaminated), the estimated seriousness of the consequences (e.g., does one belong to a high-risk group on account of one's age or a pre-existing chronic illness), or whether or not one considers oneself as capable to perform the preventive behaviours. These factors are at the core of the *Protection Motivation Theory* (PMT), a psychological model that helps to understand how motivation to protect oneself against a threat is mediated

by threat appraisal and coping appraisal (Glik 2007; Grothmann and Patt 2005; Milne, Sheeran, and Orbell 2000). In other words, people decide whether and how to protect themselves from threats such as COVID-19, based on their perception of the risk and of their perceived capacity to adapt their behaviour (Adunlin et al. 2020). This decision is not a rational choice, as there are numerous cognitive, moral and motivational biases that make it difficult for people to accurately estimate outcome probabilities (Floyd, Prentice-Dunn, and Rogers 2000). With regard to health-related risks specifically, previous studies have found that coping appraisal is a better predictor for behaviour than threat appraisal (Floyd, Prentice-Dunn, and Rogers 2000; Milne, Sheeran, and Orbell 2000).

Seeking information about a threat can be part of both threat and coping appraisal, although the kind of information that is looked for would differ. With regard to threat appraisal, information would be sought about the hazard's characteristics; in the case of coping appraisal about the effectiveness of potential remedies (Neuwirth, Dunwoody, and Griffin 2000).

Figure 1 – Framework PMT
(adapted from (Floyd, Prentice-Dunn, and Rogers 2000; Neuwirth, Dunwoody, and Griffin 2000; Rogers 1975; Xiao et al. 2016)
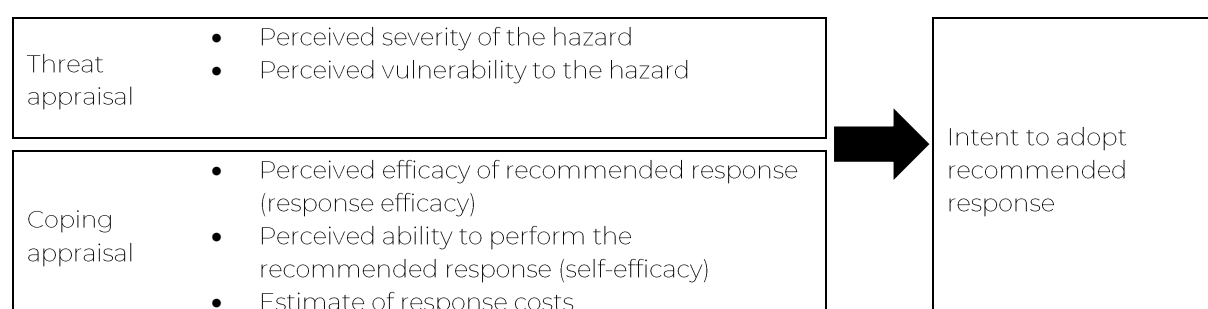
The PMT poses that risk communication will only motivate people to act when they i) believe they are vulnerable to the risk, ii) perceive the risk as severe, iii) perceive preventive action as effective to reduce the threat and iv) believe they are capable to perform the preventive action (Van den Broucke 2020). This Framework is presented in figure 1. A brief explanation of these constructs (based on (Adunlin et al. 2020; Floyd, Prentice-Dunn, and Rogers 2000; Grothmann and Patt 2005; Neuwirth, Dunwoody, and Griffin 2000) is as follows:

> **Threat appraisal** or risk perception – An individual's threat appraisal is based on how they estimate the probability and damage caused by a threat, under the condition of no change in their own behaviour. More specifically, PMT distinguishes 2 aspects:

1. **Perceived severity of the hazard –** This refers to how an individual perceives the seriousness of the possible harms that can be caused by the threat.
2. **Perceived vulnerability to the hazard –** This reflects how an individual perceives their susceptibility to the possible harms that can be caused by a threat.

Coping appraisal or perceived adaptive capacity – Coping appraisal follows after threat appraisal, and more specifically after a certain threat is considered relevant. It is based on how an individual evaluates their ability to cope with and avert the threat, which includes a reflection on the potential costs and benefits. Coping appraisal includes three judgements:

1. **Perceived efficacy of recommended response –** This refers to the belief that the recommended preventive or protective actions will be effective to protect oneself from the threat.
2. **Perceived ability to perform the recommended response –** This reflects a person's perceived ability to actually carry out the preventive or protective actions.
3. **Estimate of response costs –** The response efficacy and ability to perform a response are also influenced by the perceived costs. These can be expressed in terms of resources (money, time, effort) and/or in terms of opportunities.

Intent to adopt the recommended response – This refers to an individual's intention to perform the preventive or protective action. It is essential to distinguish between intention to act and actual behaviour, because intentions are not always put into practice.

One of the applications of the PMT is to understand and predict protective health behaviour. Hence, based on insights provided by the PMT, it is possible to increase the effectiveness of communication efforts in persuading people to adopt the recommended behaviour (Floyd, Prentice-Dunn, and Rogers 2000; Pechmann et al. 2003). In the context of this project, the PMT can help us understand the effectiveness of risk communication in the context of the COVID-19 pandemic in Belgium and can provide insights on how future communication for COVID-19 (or other health crises) can be improved.

3.2. State of the art: overview of research on COVID-19 focusing on adherence to infection prevention and control measures (IPCM)

Since the beginning of the COVID-19 pandemic, researchers around the world have conducted studies to analyse how the public is reacting to IPCM implemented or recommended by governments. This brief overview of the findings of Belgian and international studies, produced in the context of this current crisis, provides some insights about the influence of factors coming into play in adherence to IPCM.

Situation appraisal factors

Having a high-risk perception of COVID-19 seems to be strongly correlated with adherence behaviour to IPCM. This has been confirmed by several studies on COVID-19, which show that individuals who perceived greater impact of infections are more likely to adopt IPCM to avoid the disease (Bruine de Bruin and Bennett 2020; Chong et al. 2020; Dryhurst et al. 2020). Several factors are positively associated with a high level of risk perception such as having had a personal experience with the virus, having prosocial values or putting trust in science and medical practitioners (Dryhurst et al. 2020). More specifically, perceived vulnerability to COVID-19 influences how people consider the necessity of abiding by IPCM and increases adherence (Berg and Lin 2020; De Coninck, d'Haenens, and Matthijs 2020; Coroiu et al. 2020). Wanting to protect oneself and feeling responsible for protecting the community are great facilitators for the adoption of protective behaviours (Coroiu et al. 2020).

Knowledge, understanding and trust also seem to be determining factors. A low understanding regarding COVID-19 infection and transmission could hinder the adoption of protective behaviours and risk recognition (Shiina et al. 2020). A high level of health literacy seems to be associated with a higher compliance to IPCM (Sciensano 2020b). In addition, individuals who perceive the measures to be very clear and consistent show greater adherence than those who perceive the measures to be less clear or consistent (Pelletier-Dumas et al. 2020).

A lower level of understanding about the disease may also result in individuals consulting less information sources and distrusting COVID-19 information (Shiina et al. 2020). In Belgium, a low level of trust in governmental institutions and the lack of consensus between information by politicians and scientists during this crisis, have led to less motivation to comply strictly with preventive measures (Sciensano 2020b; Vansteenkiste, Soenens, Waterschoot, Morbée, and Vermote 2020b). Individuals may also reflect more critically on the government's management of the crisis, when they have a high perceived infectability (De Coninck, d'Haenens, and Matthijs 2020).

Coping factors

As studies confirm, in the context of COVID-19, self-efficacy in carrying out required health behaviour is an appropriate/ effective predictive factor of compliance with IPCM. People who feel able to and who have the resources to achieve the required measures, show better adherence to them (Berg and Lin 2020; Chong et al. 2020; Roma et al. 2020). Moreover, high perceived behavioural control influences adherence to the different measures in various degrees. To give an example, it works better on the measure of handwashing than on the measure of limiting social contacts (Bigot et al. 2020).

Perceived efficacy of the recommended or mandatory measures (also known as response efficacy) is also under investigation. Understanding the measures' necessity

and value, as well as considering them as legitimate, seem to increase the voluntary adherence to those measures (Vansteenkiste, Soenens, Waterschoot, Morbée, and Vermote 2020a). Having a positive attitude regarding the measures and believing they actually help in the fight against the virus, is linked with higher adherence to IPCM (Bigot et al. 2020). In this relation between perceived efficacy and adherence, self-efficacy has shown to be an important mediating factor (Roma et al. 2020).

In contrast, no studies were found that provided insight regarding the estimated response costs from the PMT.

Sociodemographic variables

In the studies reviewed for this report, the reported influence of sociodemographic variables on IPCM compliance is heterogeneous.

Regarding *gender*, in one of the reviewed study, there was no significant association at all (Berg and Lin 2020). In others, being female is related to an increase of the likelihood to perform some of the measures (e.g. handwashing, socializing avoidance, maintaining physical distances) (Bigot et al. 2020; Coroiu et al. 2020; Sciensano 2020b), to a greater perceived vulnerability (De Coninck, d'Haenens, and Matthijs 2020) and to a greater perceived risk (Dryhurst et al. 2020).

The same mixed situation is found with *age*. Young people tend to respect all IPCM less strictly (Sciensano 2020b). Older age seem to be linked with an increase in compliance with IPCM (Roma et al. 2020). For some researchers, being younger could be linked to a higher probability of respecting some measures like limiting social contacts, but not others, like handwashing (Bigot et al. 2020). Whereas in other studies, older individuals seem to avoid social contacts more likely than younger people (Coroiu et al. 2020). Older age also seems to be correlated to greater perceived vulnerability to COVID-19 (De Coninck, d'Haenens, and Matthijs 2020). Similarly to the gender variable, no significant correlation between age and IPCM compliance was found in Berg and Lin's study (Berg and Lin 2020).

Pertaining to *education level*, the results are varied as well. No relationship between education level and behavioural compliance was found in the study by Berg and Lin (2020) (Berg and Lin 2020). On the other hand, other studies found that having a high level of education could increase the awareness of IPCM (Sciensano 2020b) and the probability to perform certain measures like limiting social contacts (Bigot et al. 2020). According to one study, a lower education level was positively correlated with higher adherence to IPCM (Roma et al. 2020). Besides, individuals with low educational levels also perceive themselves as more vulnerable to COVID-19 (De Coninck, d'Haenens, and Matthijs 2020).

Experiences with the virus

Some of the studies reviewed for this report give details about how experiences with the virus affect IPCM implementation. One of the studies found that having been diagnosed with COVID-19, experiencing symptoms or having been in contact with someone who was diagnosed, did not specifically impact individual's protective behaviour (Berg and Lin 2020). Working in health care or being an essential worker did not have any impact on IPCM adherence either (Berg and Lin 2020). However, having had a direct experience with the virus may increase the risk perception (Dryhurst et al. 2020).

TACOM in relation to other Belgian studies

It should also be pointed that other studies have been conducted in Belgium to investigate the factors that contribute to IPCM adherence, using diverse sampling methods and analysis models and covering different regions of the country (Bigot et al. 2020; UGent Coronastudie: de motivatiebarometer 2020). For instance, an ongoing study by Ghent University has investigated motivational support for adherence to IPCM in Flanders from April 2020 onwards (Vansteenkiste et al., 2020). Vansteenkiste et al. (2020) mention three factors, which determine people's motivational support to adhere to the IPCM: autonomy, relatedness and competence. The latter refers to having a sense of efficacy to adhere to IPCM. These three factors belong to the Self-Determination Theory, coined by Deci & Ryan in 1985, and form the three basic psychological needs, which are essential for human motivation growth (Ryan & Deci, 2000).

While the results of these previous or on-going studies on IPCM adherence in Belgium are of great interest, they have some limitations. The major one is that they are not representative for the entire Belgian population. The only studies so far that provided data on a range of COVID-19 related issue at national level are the surveys performed by the national Public Health Institute Sciensano (Sciensano COVID-19 - Situation épidémiologique 2020), yet these surveys were not informed by behavioural theories on protective behaviour. The TACOM study is meant to complement and deepen the results of the above studies by applying the Protection Motivation Theory. To our knowledge, it is the first study to use this model to analyse the behaviours related to IPCM in a large sample representative for the Belgian population.

4. Overview of prevention and control measures implemented in Belgium – August/September 2020

Box 1 provides an overview of the measures that were applicable during the period of data collection, i.e. September 2020 (taken from (ACAPS 2020))

Box. 1 - Overview of measures applicable in September 2020 (taken from the Federale Overheidsdienst Volksgezondheid Veiligheid van de Voedselketen en Leefmilieu and Crisiscentrum (2020))

A. Transport and travel
  i. In Belgium:
     - You are allowed to move around freely;
     - You have to wear a face mask or a scarf to cover mouth and nose when using public transport and above 12 years of age;
  ii. On holiday abroad
     - You are only allowed to visit countries in the EU, the UK, Switzerland, Liechtenstein, Iceland or Norway, with the exception of territories designated as red zones;
     - Follow the rules applicable in the country you are in
     - There are 3 types of travel zones:
       o You are allowed to travel to green zones;
       o You are advised not to travel to orange zones;
       o You are not allowed to travel to red zones;
     - You must fill in a passenger locator form within 48hours before returning/travelling to Belgium (see annex 1)
B. Work
  - Work from home if possible;
  - If you have to go into work, your employer must ensure that you are able to maintain a distance of 1.5m from others;
  - If you can't maintain a distance of 1.5m from others, other measures apply that can be consulted in the [guideline of the FPS Employment, Labour and Social Dialogue](#);
C. Shops and catering industry
  - All shops are open:
    - From August 24th you can go shopping with a maximum of 2 persons;
    - Night shops are open until 10pm;
    - Wearing a face mask is mandatory;
    - [Guidelines for shop owners](#);
  - Pubs and restaurants are open until 1am:
    - It is recommended to make a reservation;
    - You can visit bars and restaurants only with your family (or the people you live with) and your bubble of 5;
    - Stay seated at your table;
    - Wearing a face mask is mandatory;

- You must leave your contact details;
- [Guideline for owners of pubs and restaurants](#);

D. Social contact
- Each family (or anyone living together with others) may meet up with a maximum of 5 people. These must always be the same people;
- If you can respect the distance of 1.5m, you can do activities with a maximum of 10 people, e.g. walking or cycling;

E. Sports and leisure
- All locations have reopened (e.g. libraries, theme parks, playgrounds);
- For official events, a maximum of 100 people inside / 200 people outside are allowed. Each organization has specific rules;
- Camps for children are allowed
- Wearing a face mask is mandatory in the following places: shops and shopping malls, shopping streets, crowded places, public buildings, markets, public transport, libraries, cinemas, museums, theatres, concert halls, conference halls, auditoria, fairgrounds and religious buildings;
- You must leave your contact details when visiting a wellness centre, sports lessons in a club, swimming pools, casinos, party and reception rooms;
- Discotheques and night clubs are not yet allowed to reopen
- Big events are not allowed
- Sports:
  - If you are part of a club, you are allowed to exercise together with a maximum of 50 people;
  - You can exercise in a fitness club; sports club or swimming pool;
  - You can visit a sauna or wellness centre. Publicly accessible jacuzzis, hammams and steam rooms remain closed;
- Religion:
  - Worship services are allowed
  - A maximum of 100 people is allowed
  - Physical contact is not allowed
  - Wearing a face mask is mandatory

F. Nurseries and schools
- Nurseries are open and your nursery will provide more information;
- Your school will provide more information about the new academic year.

5. Methodology

5.1. Panel-based survey

For our survey methodology, we chose to work with an online panel. This is a type of access panel which is defined as "*a sample database of potential participants who declare that they will cooperate for future data collection if selected*" (International Organization for Standardization 2019). This type of panel is usually made up of a very large number of people who are sampled on several occasions and asked to complete surveys for generally unrelated studies. Panelists can be re-sampled and take part in other studies with varying, often pre-defined, levels of frequency. Panelists receive a financial compensation of less than € 3,- for each survey in which they participate.

Following the high internet penetration in households, panel-based survey research has become a prominent and valid way to collect data in various disciplines, including social research, psychological research and medical research (Callegaro et al. 2014). Different types of online panels exist. For TACOM, we collaborated with Dedicated who provided us with access to three panels in Belgium: their own panel and the panels from DYNASTAT and TOLUNA. Dedicated recruits their panelists via their website, publication of surveys and research results, banners, specific recruitment actions in certain media and telephone interviews. Panelists from DYNASTAT and TOLUNA were only considered for inclusion in our sample when they had not participated in a survey on a similar theme in the past four months and had not participated in more than 12 surveys (one per month) in the past year, regardless of the subject. Overall, Dedicated recruits more within middle-upper social classes, and DYNASTAT and TOLUNA also recruit from middle-lower social classes. In addition to providing access to the three panels, Dedicated also hosted and programmed the survey (see 5.3).

Combined, the three panels constitute a general population panel. Hence, the panel reflects the diversity of the general population in Belgium, which allowed us to draw a representative sample based on socio-demographic characteristics (see 5.2). In 2018, Internet penetration in Belgium was rated at 90% (Eurostat 2020). This means that a minority of people are missing in online panels because they do not have access to Internet and therefore cannot participate to these kinds of studies. These people are most likely not missing at random, but have certain characteristics that distinguish them from those who do have internet access (Callegaro et al. 2014). For instance, Dedicated does not recruit people over 75 years old, due to this group having more problems to fill out online surveys, which makes them very underrepresented within the provided panels. By knowing and considering the limitations of this sample in our research design and analyses, and by using quota

for purposefully selecting our sample, we are confident that our sample is representative, despite these limitations.

5.2. Sampling strategy

Our sample aimed to contain a minimum of 2.000 participants. These participants were drawn from the panel and only accepted to the sample if they fitted within the pre-defined quotas, fully completed the survey, and passed quality controls by Dedicated. By ensuring that all participants fitted within the pre-defined quotas, we guaranteed the representativeness of the sample. The quotas were based on the following demographic characteristics:

- region and province in which the participant lives;
- gender;
- age (Dedicated imposed quotas on six age groups, i.e. 5-year range, for the ages 18-75);

For each demographic criterion, quotas were defined in advance (see table 1).

Regarding socio-economic criteria, Dedicated defined 8 subgroups, which were to be represented equally in the survey. Group 1 represents people with the highest socio-economic background, and group 8 with the lowest. The grouping is based on three questions:

- level of education (highest degree obtained);
- current working status (yes or no, and if no: why not (e.g. pension, homemaker))?
- profession (former profession for those who are currently not working);

Based on the answer to each question, people receive a certain score, which is used to determine the socio-economic group. The exact calculation can be found in Annex 2.

Table 1 – Quota used to ensure representativeness for the Belgian population in terms of demographic characteristics

Demographic characteristics		Number of respondents sampled
Region	Brussels	209
	Flanders	1193
	Wallonia	647
Province	Antwerp	333
	Flemish Brabant	205
	West Flanders	221
	East Flanders	274
	Limburg	160
	Walloon Brabant	72
	Hainaut	239

	Liège	198
	Luxembourg	50
	Namur	88
Gender	Women	1051
	Men	999
Age	18-24	207
	25-34	332
	35-44	332
	45-54	335
	55-64	337
	65-74	486

Dedicated selected a first group of potential respondents from the panel, based on these criteria, and invited them via e-mail to participate in the survey. Those who proceeded to participate in the survey, did so via a personalized login that allowed them to quickly access the online survey and at the same time ensured that the same person did not answer the survey multiple times. After this first round, the sample was gradually completed by (re-)contacting panel members who fit those quotas that were not yet completed. The final sample was representative for the pre-defined criteria, but not necessarily for other criteria (which may require the application of weights in the analysis).

The quality controls applied by Dedicated aim to ensure the quality of responses provided by the panelists. These quality controls occurred at three points in time. Before the survey was launched, the programming and encoding of the data were verified. Quality control questions were inserted within the survey (e.g. "To ensure that you complete the questionnaire correctly, please enter the number 7") to identify and dismiss inattentive panelists. During the period in which the survey data were collected, the system automatically monitored completion time (panelists that completed the survey at least 50% below the average time were eliminated) and answered patterns (panelists who systematically gave the same scores were eliminated). The number of completed surveys was monitored on a daily basis to ensure there were no technical or other issues. Finally, at the end of the data collection phase, the quality and consistency of the answers were controlled.

5.3. Survey development

5.3.1. Survey questions

The survey was first developed in English, as this was the common language within the research team. The final version of the English survey was translated to Dutch and French, and back-translated in order to check the accuracy. The final survey in Dutch and French can be found in annex 3.

As mentioned above, the PMT was used as a theoretical framework for the development of the survey questions. Specifically, we included questions on perceived severity of the threat, perceived vulnerability, response efficacy, self-efficacy and intentions. In addition, participants were asked about their health status, sources of information on COVID-19 measures and past behaviour. As a result, the survey comprised five sections, which we briefly discuss in the following paragraphs.

Section 1 – Demographic and socio-economic characteristics. The survey included 10 questions on demographic and socio-economic characteristics (gender, age, province, professional situation, education, household composition, household income and language proficiency). These questions were inserted into the survey for two purposes: to obtain a representative sample and to break down the analysis by demographic and socio-economic characteristics. The latter serves, for example, to identify subgroups of the population who are potentially misinformed or less likely to adhere to the implemented COVID-19 measures.

Section 2 – Health status. This section aimed to gain insights in the health status of the respondents and their potential dependency on care or help from others due to their health status. This provides insight in their potential vulnerability to COVID-19. In addition, participants were asked whether they had someone in their environment who was dependent on their help or care and why, as having someone potentially vulnerable to COVID-19 in one's environment may influence risk perceptions and behavior.

Section 3 – Perceived risks of and vulnerability to COVID-19. This section aimed to gain insight in the respondents' perceived severity of the threat posed by COVID-19 and their perceived vulnerability to it. They were asked whether they or someone they knew had tested positive to COVID-19, whether the consequences of contracting the disease were/would be serious for their health and how much they considered themselves at risk of contracting COVID-19.

Section 4 – Information sources. The purpose of this section was to provide insights in the information sources on COVID-19 measures citizens use and to what degree they perceived the information that was given as understandable and trustworthy. This provides valuable information for policymakers and actors in the field on how to improve their communication on COVID-19 measures.

Section 5 – Behaviour regarding COVID-19 measures. This section aimed to provide insight in the response efficacy (are the measures useful), self-efficacy (are the measures easy to adhere to), past and intended behaviour (have respondents adhered to the measures and will they do so in the future) and their understanding of the COVID-19 measures (do they understand the measures and how do they interpret them). Furthermore, 10 statements representing situations from everyday

life were presented to the respondents, who had to indicate whether they were true or false. With these questions, we aimed to verify the respondents' actual understanding of the measures, opposed to self-reported understanding.

Finally, the survey ended with an open text field, in which respondents could make a remark about something that they wanted to address related to the topic of the survey. This question was optional.

5.3.2.   Pilot test

The survey was pilot tested on 7 September 2020 by Dedicated. The survey was completed by 50 respondents and their answers were provided to us in the same format as the final dataset. By reviewing the consistency and completeness of their answers, it was possible to evaluate the questionnaire. An additional pilot test was performed by the research team between 4 – 7 September 2020, whereby several people were asked to complete the survey and provide feedback on any issues they encountered. Based on both pilot tests, minimal changes were made to improve the survey, such as the formulation of certain questions and the programming of skip patterns.

5.4.   Formal survey – data collection

The data were collected in September 2020, between 7 and 24 September 2020. New measures were announced on the 23rd of September, which impacted some of the questions in our survey. Responses for these specific questions were removed from the 23rd of September onwards, which concerned around 6% of respondents. Responses to questions that were not affected by the new measures remained in place.

5.5.   Data analysis

The data were delivered to us by Dedicated in an Excel file. We carried out all analyses using IBM SPSS Statistics 25. Descriptive overviews were presented of all variables. For continuous variables, and questions with a 5-point Likert scale, average scores were calculated, as well as the standard deviations. For sections in which the average scores of several questions combined averaged formed a domain score, we checked the internal validity by calculating the Cronbach's alphas.

Using univariable linear regression analyses, we assessed the relationship between demographic, socio-economic and health-related variables on the one hand, and PMT scores, understanding of measures, past and intended implementation and knowledge level on COVID-19 measures, on the other hand. Finally, we built multivariable models to assess the relationship between PMT components and (past and intended) implementation. We performed uncorrected analyses, as well as

analyses corrected for potential confounders, and actual knowledge level on measures.

Finally, the open answers from the last question were analysed. As the qualitative data collected for this survey are limited to short comments made by some respondents, our results do not allow for a thorough and well conducted qualitative analysis, that would allow to generate new hypotheses, or to triangulate with the quantitative results. Therefore, we present quotations illustrative of emerging themes, without identification of the respondent.

5.6. Ethics

All respondents provided informed consent to Dedicated, in order to be invited for internet surveys. We provided a short introduction on the study, based on which respondents could decide to participate or not. Respondents could withdraw from the study at any time during the completion of the questionnaire. We submitted our study protocol to the ethical review board of UCLouvain, where it was indicated that ethical clearance was not necessary for this study, as it was considered an opinion poll among the Belgian population and not a patient survey.

6. Results

6.1. Response rate

Invitations for the survey were sent to approximately 22,000 potential respondents. In total 3,257 respondents started the survey. Out of those, 941 respondents were not accepted because quota for their socio-demographic group were full; 177 dropped out (started the survey but did not finish); 131 were refused because the survey was of insufficient quality. This leaves the final number of respondents at 2,008.

6.2. Descriptive statistics

The questionnaire was completed by 1,135 respondents in Dutch (56.5%) and 873 in French (43.5%). Most respondents completed the questionnaire between the 7th and 22nd of September (94.2%). The remainder did so on the 23rd and 24th of September. As some policy measures to address the rising COVID-19 numbers were altered on the 23rd of September, we omitted answers from respondents that relate to questions on those specific measures ('The social bubble is limited to 5 people' and 'Shop with max. one other person').

6.2.1. Demographic characteristics

The demographic characteristics of the complete study population are given in Table 1. The proportion of females in our sample was slightly higher than the proportion of men (51% vs. 49%), reflecting the composition of the Belgian population. All age groups are represented more or less equally, until 75 years of age. The proportion of respondents per province and region is also similar to the distribution of the Belgian population. In terms of household composition, almost one third of respondents lives as a couple without children, a quarter as a couple with children, and a similar percentage alone without children. Around 7% of respondents live alone with one or several child(ren), and around 11% reported to live with their parents. This group is relatively young compared to all other household compositions (average age 24.4 years old).

Table 1. Demographic characteristics of study population.

Characteristic	N	%
Gender		
Male	983	49.0
Female	1024	51.0
Other	1	0.0
Age		
18-30 years	407	20.3
31-45 years	472	23.5
46-60 years	522	26.0
61-75 years	557	27.7

76 years and over	50	2.5
Province		
Antwerp	320	15.9
Flemish Brabant	184	9.2
Limburg	154	7.7
West Flanders	219	10.9
East Flanders	263	13.1
Brussels Capital Region	206	10.3
Walloon Brabant	74	3.7
Hainaut	250	12.5
Liège	206	10.3
Luxembourg	50	2.5
Namur	82	4.1
Region		
Flanders	1140	56.8
Wallonia	662	33.0
Brussels	206	10.3
Household composition		
Alone without children	474	23.6
Alone with children	135	6.7
Couple without children	655	32.6
Couple with children	494	24.6
With parents	229	11.4
Live together / share a flat (e.g. friends, acquaintances)	21	1.0

6.2.2. Socio-economic characteristics

The socio-economic characteristics of the sample are presented in table 2. Educational level was categorized in five categories, following the classification from BelStat. The largest group of respondents consists of those with upper secondary education, over 40%. In terms of occupation, almost half of respondents had an occupation, and more than a quarter was pensioned. The respondents' educational level and type of occupation allowed to categorise respondents into socio-economic groups, where Group 1 consists of people with highest socio-economic status and Group 8 those with lowest. The proportion of respondents in each group is fairly similar with the exception of Group 8. In terms of income, most respondents fall within the two average categories.

Table 2. Socio-economic characteristics of study population.

Characteristic	N	%
Educational level		
Primary or without diploma	62	3.1
Lower secondary	240	12.0
Upper secondary	810	40.3
Superior short type and bachelors	420	20.9
Long/university level superior	471	23.5
Occupation		
Yes	920	45.8
No, incapacitated to work	161	8.0
No, pre-pension	33	1.6
No, pension	530	26.4
No, unemployed	80	4.0
No, student	180	9.0
No, homemaker	88	4.4
No, never or not yet worked	16	0.8
Socio-economic group		
Group 1	282	14.0
Group 2	284	14.1
Group 3	308	15.3
Group 4	238	11.9
Group 5	261	13.0
Group 6	241	12.0
Group 7	240	12.0
Group 8	154	7.7
Net annual household income		
Less than EUR 15,000	164	8.2
Between EUR 15,000 and 29,999	612	30.5
Between EUR 30,000 and 44,999	534	26.6
More than 45,000	319	15.9
I do not know	379	18.9

6.2.3.   Native language skills

Table 3 presents an overview of the native language skills reported by respondents. Only language(s) (groups) in which at least 4 respondents were native are presented. By far the highest proportions are for Dutch and French, which represent both the majority of the Belgian population, as well as the languages in which the questionnaire could be filled out. This was followed by English, Italian and Arabic. A very low number of respondents reported their native language as Turkish or a language spoken in Sub-Saharan Africa (e.g. Swahili, Lingala), which is less than what you would expect as a representation of the Belgian population.

Table 3. Native language skills for respondents.

Language	N	%
Dutch	1072	53.4
French	793	39.5
English	29	1.4
Other EU language	65	3.2
Arabic	19	0.9
Russian	8	0.4
Turkish	6	0.3
Sub-Saharan African language	4	0.2

6.2.4.   Health characteristics

Fig. 1 presents the score that respondents gave to their health on the day of completing the questionnaire. Around 80% of respondents gave a score of 60 or more, with an average score of 72.3 (sd 18.6).
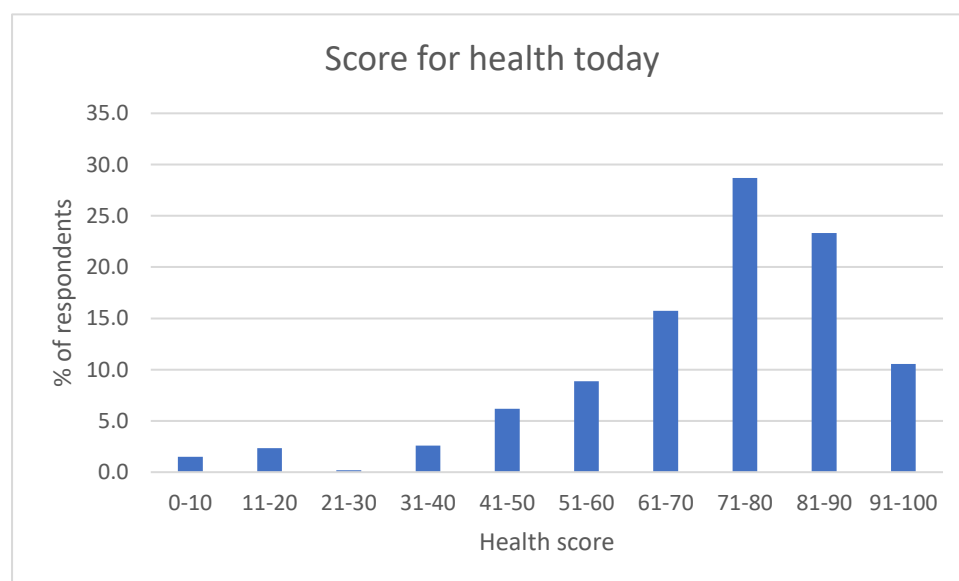
Fig. 1. Score for health today.

Table 4 gives the data on the respondents' dependency on others for care. When asked how often they were dependent on someone else's care, and for those that were dependent, what was the main reason, almost 90% of respondents reported not to be dependent on someone else's care (Table 4). Of those that were dependent, more than half indicated that this was because of their physical health, followed by mobility issues and mental health.

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Table 4. Dependency on someone's care.

Frequency	N	%
Never	1773	88.3
Less than once a month	68	3.4
1-3 times a month	81	4.0
1-3 times a week	41	2.0
More than 3 times a week	45	2.2
Reason	**N**	**% (of dependents)**
Age	27	11.4
Mobility	69	29.1
Physical health	130	54.9
Mental health	34	14.3
Other reason	13	0.6
I don't know why	20	8.4

When asked whether they take care of someone else, more than a quarter of the respondents mentioned that they were taking care of someone else (25.8%). For more than half of them, the main reason for taking care of someone is because of age, followed by reduced mobility and physical health (approximately one third and one fourth, respectively) (Table 5).

Table 5. Reasons for taking care of someone.

Reason	N	% (of caretakers)
Age	305	61.7
Mobility	164	33.2
Physical health	129	26.1
Mental health	43	8.7
Other reason	44	8.9

6.2.5.   COVID-19

At the moment of completing the survey, the majority of respondents had not been diagnosed as infected with COVID-19, and had not shown any symptoms possibly indicating an infection (Table 6). Around 10% had had symptoms that could indicate COVID-19, but had not been tested (positive). Only one respondent had been hospitalised for COVID-19. In terms of demographic and socio-economic profile between those who had not and those who had (possibly) been infected with COVID-19: the group of non-infected was older (49.4 vs. 41.7 years old) and had on average a lower education (Chi square, p = .002) than those who had possibly been infected.

Almost 70% of respondents indicated that they did not know someone close who had had COVID-19. In contrast, 6% and 12% of respondents, respectively, knew

someone who had tested positive for COVID-19 and had been hospitalized, or someone who had tested positive but had not been hospitalized.

Table 6. Positive test for COVID-19 for respondents and close contacts.

Tested positive for COVID-19?	N	%
Not tested positive and no COVID-19 symptoms	1709	85.1
Not tested positive but had COVID-19 symptoms	199	9.9
Tested positive but without COVID-19 symptoms	42	2.1
Tested positive for COVID-19 symptoms and hospitalised	1	0.0
Tested positive for COVID-19 symptoms but no hospitalisation	26	1.3
Don't know if tested positive for COVID-19	33	1.6
Someone close to you test positive for COVID-19?	**N**	**%**
Don't know someone close with COVID-19	1391	69.3
Know someone with COVID-19 symptoms but no positive test	147	7.3
Know someone with positive COVID-19 test who was hospitalised	118	5.9
Know someone with positive COVID-19 test who was ill but not hospitalised	242	12.1
Know someone with positive COVID-19 test who was not ill	87	4.3
Don't know if know someone with COVID-19	83	4.1

Respondents who had not been ill and had not tested positive for COVID-19 were asked to rate the expected health consequences on a scale of 0-100 (0 = 'not at all severe', 100 = 'very severe') in case they became infected. For those 1742 individuals, the average score was 57.3 (sd 27.5). The 266 respondents who (possibly) had been infected with COVID-19 were asked to rate how serious the consequences were that they had experienced, also on a scale of 0-100. The average of this group was 35.5 (sd 29.4), taking into consideration that it also contained individuals who tested positive but without any symptoms. Finally, the health consequences were also assessed for those respondents who had had a confirmed COVID-19 infection with symptoms (n = 27, including the one person who had been hospitalised). The average score in terms of severity for this group was 51.4 (sd 26.0).

Respondents were asked to indicate the risk of becoming infected with COVID-19 for themselves or people close to them on a 5-point Likert Scale, ranging from 'no risk' (1) to 'definite' (5). They could also indicate it if the question was not applicable to them. Overall, we see that the rating does not differ much between respondents themselves, their parents, their grandparents, their partners and their children (Annex 4). The highest scores were found for friends and colleagues (Table 7).

Table 7. Experienced risk of becoming infected with COVID-19.

Person(s)	N	Mean	sd
Yourself	1986	2.85	0.93
Your parents	1347	2.84	0.97
Your grandparents	735	2.60	1.09
Your partner	1467	2.90	0.94

Your child(ren)	1345	2.94	0.94
A friend	1805	3.14	0.84
A close colleague	1286	3.16	0.90

6.2.6. Sources of information, trust and understanding

Respondents indicated the extent to which they considered themselves informed about the current COVID-19 measures on a scale of 0-100, where 0 stands for 'not at all informed' and 100 for 'very well informed' (Fig. 2). Around 90% of respondents gave a rating of 50 or higher, with an average score of 74.9 (sd 21.3).
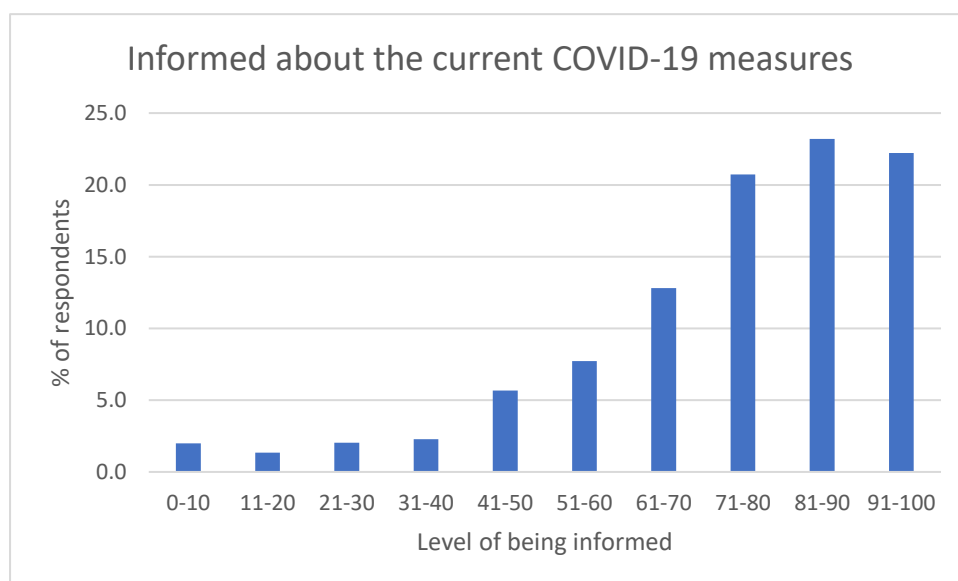
Fig. 2. Extent of feeling informed about the current COVID-19 measures.

An overall majority of respondents indicated that they preferred television as a channel to access information on COVID-19 (Table 8). More than half of them reported using newspapers or news websites, followed by radio and social media. Less than 3% indicated that they did not use any channel to access information, and 5% indicated another channel not included in the predefined list. The latter included official government websites (e.g. BE Alert) and health professionals.

Table 8. Preferred channels to access information on COVID-19 measures.

	N	%
Television	1575	80.2
Newspapers or news sites	1109	56.5
Radio	702	35.7
Social media	545	27.7
Other channel	105	5.3
No channel	57	2.9

When asked to rate the extent to which the different information sources contributed to informing them, and provided clear and trustworthy information on 5-point Likert scales ranging from 1 (completely unclear, very untrustworthy) to 5 (completely clear, very trustworthy), the highest scores, for all three aspects, were given to experts (Table 9, Figure 3). The lowest scores for clarity and trustworthiness were given to politicians. Journalists scored a bit higher than politicians.

Table 9. Sources of information on COVID-19 measures.

Source	Contributed in informing Mean (sd)	Clear information Mean (sd)	Trustworthy Mean (sd)
Politicians	2.93 (1.15)	2.73 (1.18)	2.91 (1.20)
Experts	3.70 (1.06)	3.66 (1.10)	3.86 (1.10)
Journalists	2.99 (1.09)	3.16 (1.07)	3.05 (1.08)
Close contacts	2.68 (1.05)	3.19 (0.94)	3.15 (0.94)
Others	2.05 (1.23)	2.89 (1.22)	2.62 (1.21)
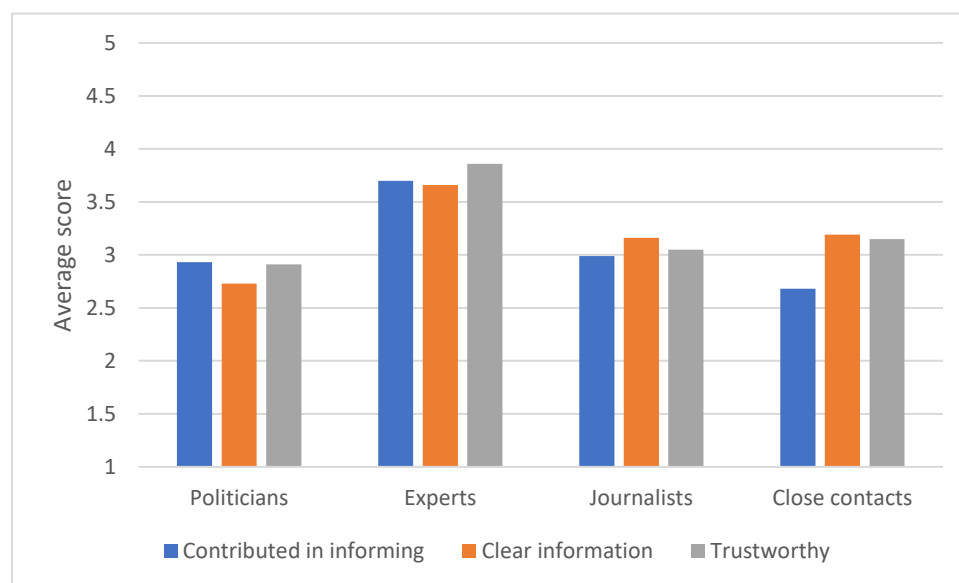
Fig. 3. The extent to which different sources contributed in informing, provided clear information and were considered trustworthy regarding COVID-19 measures.

6.2.7. COVID-19 measures

For the measures that were launched in August and still applied in September (Chapter 4), respondents were asked about five aspects: 1) whether they understood the measure; 2) whether they considered it useful; 3) whether they considered it easy to adhere to; 4) whether they had adhered to the measure in the past; and 5) whether they planned to adhere to it in the future. Each measure was scored on a 5-point

Likert scale, ranging from 1 (e.g. not at all understood, not at all useful) to 5 (e.g. very well understood, extremely useful). The average scores per measure per aspect, including standard deviation, are presented in Table 10 and Fig. 4.

6.2.7.1. Understanding, usefulness and ease to comply

Of all measures, the one about the size of official events was least well understood, closely followed by measures on private events, the social bubble and colour codes for different travel zones. Homeworking and wearing a facemask in public were best understood.

Overall, the levels for usefulness of the measures are lower than for understanding. The measures that are considered the least useful by respondents were shopping with maximum one other person, and the social bubble. The measures that were considered to be most useful (homeworking and wearing a facemask) are the same two that scored highest in terms of understanding. On average, respondents gave lower scores for ease to comply than for usefulness. The lowest usefulness score was for the measure regarding the social bubble, and the highest for shopping with maximum one other person.

6.2.7.2. Past and future adherence

To compare past behavior with future behavior, the scores for having applied each measure in the past were compared to the intention to apply it in the future, using paired-samples t-tests. Statistically significant differences were found for the measures on private events, official events, shopping and wearing a facemask. For all four these measures, scores for future adherence were lower than for past adherence. The measures for which both past and future adherence scored the highest were wearing a facemask in public, and limiting the number of people in an official event. The ones for which both past and future behavior scored lowest were the ones related to the social bubble and homeworking.

6.2.7.3. Adequacy of knowledge

To measure the adequacy of the knowledge about the COVID-19 measures, the respondents were presented with statements regarding the COVID-19 measures that were put in place in August and still applied in September (Chapter 4), and asked them to indicate whether the statement was 'True' or 'False' (with a possibility to state 'I don't know'). Table 11 shows the statements, correct answers, and the proportion of respondents who answered correctly. People that did not know the answer were not taken into account for the analyses. Three of the statements were answered incorrectly by more than 50% of respondents, two of which refer to the social bubble of 5. This is more or less in line with the previous section, where this measure was ranked relatively low in terms of reported understanding, usefulness and ease to comply with. The third measure that was answered wrongly by a large proportion of respondents was the one on wearing a facemask in public spaces. There were differences in the regulation on this between Brussels and the rest of Belgium, which might have led to confusion.

We assessed to what extent there was a relationship between self-reported understanding of measures, and actual knowledge level of respondents. We undertook a linear regression model, using self-reported understanding as the independent variable, and we found a positive, significant relationship (regression coefficient 0.4; CI 0.3-0.5).

6.2.7.4.   Support for measures

To measure the public's support for the measures, respondents were to indicate for each COVID-19 measure if they agreed with the view that the government should oblige the population to follow the measures, or whether they felt the government should recommend but not oblige it. Both statements were scored on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree).

The average score for obliging COVID-19 measures was 3.94 (sd 1.22), compared to 2.81 (sd 1.39) for recommending measures. This difference is statistically significant, as revealed by a paired-samples t-test (p < .001). For a statement on whether respondents considered environmental cues to be helpful in following COVID-19 measures (e.g. stickers on the floor), the average score was 3.85 (sd 1.11).

Measure	Understand Mean (sd)	Useful Mean (sd)	Easy to comply Mean (sd)	Complied past Mean (sd)	Comply future Mean (sd)
Social bubble limited to 5	4.11 (1.13)	3.54 (1.39)	3.00 (1.44)	4.00 (1.26)	3.99 (1.29)
Private events limited to 10	4.10 (1.14)	3.66 (1.34)	3.37 (1.35)	4.42 (1.04)	4.27 (1.11)
Official events limited to 200 (indoors) or 400 (outdoors)	4.08 (1.17)	3.63 (1.41)	3.67 (1.27)	4.58 (0.90)	4.52 (0.93)
Homeworking strongly recommended	4.52 (0.86)	4.32 (1.03)	3.81 (1.27)	4.08 (1.30)	4.16 (1.25)
Shop with max. one other person	4.38 (1.01)	3.53 (1.37)	4.00 (1.20)	4.55 (0.93)	4.45 (1.01)
Wearing a facemask in public spaces	4.50 (0.91)	4.16 (1.22)	3.94 (1.25)	4.68 (0.74)	4.61 (0.83)
Travel form	4.25 (1.07)	3.88 (1.32)	3.93 (1.13)	4.40 (1.05)	4.45 (1.00)
Travel zones	4.11 (1.14)	3.91 (1.26)	3.75 (1.19)	4.39 (1.03)	4.48 (0.99)

Table 10. Average scores in understanding, usefulness, ease to comply, past compliance and future compliance for each of the 8 current COVID-19 measures.
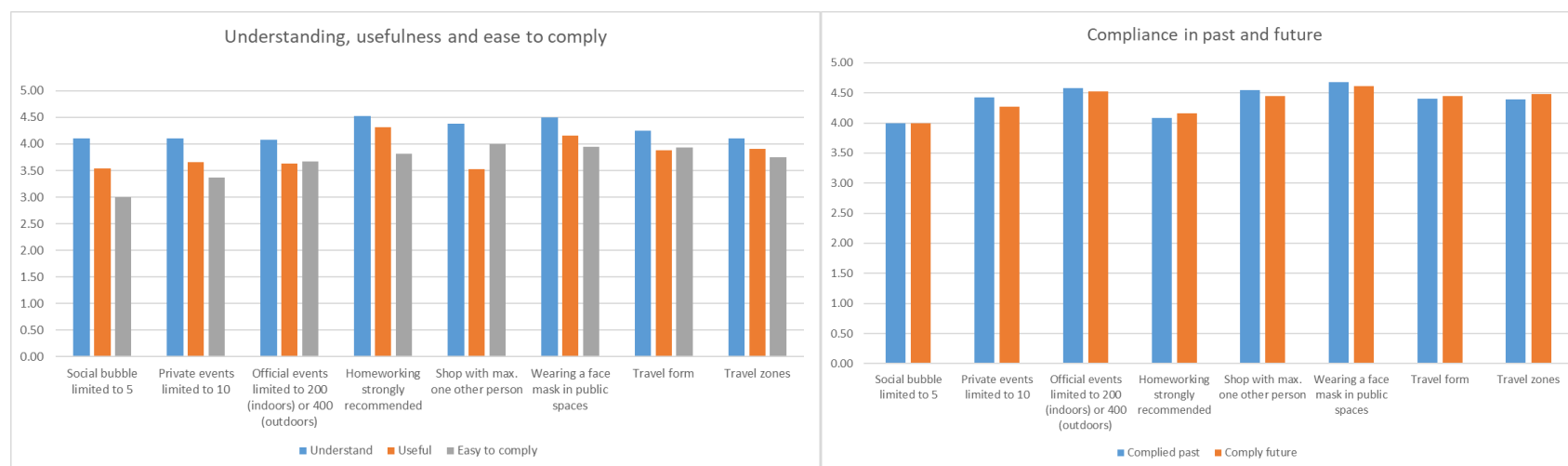
Fig 4a and 4b. Average scores in understanding, usefulness, ease to comply, past compliance and future compliance for each of the 8 current COVID-19 measures.

Table 11. Proportion of respondents that answered correctly to each of 10 statements on COVID-19 measures

Knowledge questions related to COVID-19 measures in September 2020

Statement	Correct answer	%[1]
A household of 2 is allowed to organise a party or weekend trip with 10 other adults	False	70.0
When you meet a colleague after work for drinks and you maintain 1.5 meters distance, this person is not part of your household's bubble of 5	False	30.3
Your household's bubble of 5 can include people living in another city	True	87.2
It is not mandatory to wear a facemask while exercising	True	85.0
It is mandatory to wear a facemask when you go for a walk in a forest	False	81.6
When you can maintain 1.5 meters distance, it is not necessary to wear a facemask in public spaces	False in Brussels, True elsewhere	40.3
It is not allowed to visit a bar, indoors or outdoors, with people who are not part of your bubble of 5	True	41.0
If you visit a family that consists of 3 adults and 2 children under 12, you can still add 2 more adults to your bubble of 5	True	73.0
If you travel from an orange zone to Belgium, you do not need to be tested or quarantined upon return	True	60.3
For weddings, it is allowed to invite up to 100 guests	False	67.1

1) Respondents who answered 'I do not know' were not considered for the results in this table, only those who answered either 'True' or 'False'.

6.3.   Characteristics associated with PMT components

Next, the association of personal characteristics with the scores on the four PMT components were calculated, distinguishing between demographic, socio-economic and medical characteristics. However, we first focus on the internal validity of the PMT scores.

6.3.1.   Internal consistency of the PMT scores

To measure the concepts of the PMT (i.e., perceived vulnerability, severity, response efficacy and self-efficacy) scales were created by averaging the scores on the questions for each component into one value (except for severity, which already consisted of one value). The internal consistencies for these scales were checked by calculating Cronbach's alphas. For each scale, the value was higher than .800 (Table 12).

Table 12. Internal consistency of questionnaire domains.

	Number of items	Cronbach's alpha	Cronbach's alpha based on standardized items
Vulnerability	7	.897	.897
Response efficacy	8	.891	.891
Self-efficacy	8	.847	.848
Past implementation	8	.909	.912
Future implementation	8	.928	.932
Understand measures	8	.899	.900

6.3.2.   Demographic characteristics

The language in which the questionnaire was completed was significantly associated with all PMT components, in the sense that the scores for French-speaking respondents were lower for all four items than for the Dutch-speaking ones (Table 13). Similarly, the scores for Flanders are higher than for Wallonia, for all PMT components except vulnerability, while there is no significant difference between Wallonia and Brussels. Women scored higher on vulnerability of themselves and people close to them, although men scored higher for perceived severity of the threat. In terms of age, younger people score higher for vulnerability, but lower for severity and response efficacy, compared to older age groups. Surprisingly, couples without children scored the highest on all PMT components, compared to other family compositions (living alone without children was the reference group).

6.3.3.   Socio-economic characteristics

In terms of occupation, people who are working scored higher than most other groups on vulnerability, perhaps because they are on average more exposed than people who do not work (Table 14). People who were retired and those who were not capable to work scored the highest on severity, response efficacy and self-efficacy. Respondents in the highest education group had the lowest scores on severity, although they scored slightly higher on vulnerability. Similarly, people in the lowest income groups scored lower on vulnerability and response-efficacy than people in the highest income group.

6.3.4.   Health characteristics

Respondents who were dependent on care scored higher on severity than those who did not depend on care (Table 15). Respondents who gave a higher score for their overall health had lower scores on vulnerability, severity and self-efficacy. Respondents that were taking care of someone else scored slightly higher on vulnerability than respondent who did not care for someone. Finally, respondents who had a (possible) previous COVID-19 infection scored higher on vulnerability, but lower on self-efficacy and much lower on severity than respondents who did not undergo a COVID-19 infection.

Table 13. Demographic characteristics associated with PMT scores.

Characteristic		Vulnerability		Severity		Response efficacy		Self-efficacy	
		B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value
Language									
	French	-0.1 (-0.1;0.0)	.025	-0.2 (-0.3;-0.1)	<.001	-0.3 (-0.4;-0.2)	<.001	-0.4 (-0.5;-0.3)	<.001
	Dutch	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Gender									
	Male	-0.1 (-0.2;0.0)	.006	0.2 (0.1;0.3)	<.001	0.1 (0.0;0.2)	.148	0.1 (0.0;0.1)	.099
	Female	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Age			.001		<.001		<.001		<.001
	18-30 years	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
	31-45 years	0.1 (0.0;0.2)	.057	0.3 (0.1;0.4)	<.001	0.0 (-0.1;0.2)	.503	0.1 (0.0;0.2)	.144
	46-60 years	0.1 (0.0;0.2)	.145	0.7 (0.6;0.9)	<.001	0.2 (0.1;0.3)	.001	0.2 (0.0;0.3)	.005
	61-75 years	-0.1 (-0.1;0.0)	.312	0.9 (0.7;1.0)	<.001	0.5 (0.4;0.6)	<.001	0.4 (0.3;0.5)	<.001
	76 years and over	-0.3 (-0.5;0.0)	.023	1.1 (0.8;1.4)	<.001	0.4 (0.1;0.7)	.003	0.2 (-0.1;0.4)	.179
Region			.020		<.001		<.001		<.001
	Flanders	0.1 (0.0;0.1)	.132	0.2 (0.1;0.3)	.001	0.3 (0.2;0.4)	<.001	0.4 (0.3;0.5)	<.001
	Brussels	-0.1 (-0.2;0.0)	.113	-0.1 (-0.3;0.0)	.108	0.1 (0.0;0.3)	.169	0.1 (-0.1;0.2)	.251
	Wallonia	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Household composition			<.001		<.001		<.001		.001
	Alone with children	0.1 (0.0;0.3)	.139	0.1 (-0.2;0.3)	.568	-0.1 (-0.3;0.1)	.322	-0.2 (-0.4;0.0)	.014
	Couple without children	0.1 (0.0;0.2)	.038	0.2 (0.1;0.4)	<.001	0.2 (0.0;0.3)	.009	0.0 (-0.1;0.1)	.518
	Couple with children	0.2 (0.1;0.3)	<.001	-0.2 (-0.3;0.0)	.018	-0.1 (-0.2;0.0)	.125	-0.2 (-0.3;-0.1)	.004
	With parents	0.1 (0.0;0.2)	.172	-0.5 (-0.7;-0.3)	<.001	-0.1 (-0.2;0.1)	.238	-0.1 (-0.3;0.0)	.103
	Live together / share a flat	-0.3 (-0.6;0.1)	.111	-0.7 (-1.2;-0.2)	.004	-0.1 (-0.5;0.3)	.661	-0.2 (-0.5;0.2)	.427
	Alone without children	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref

Table 14. Socio-economic characteristics associated with PMT scores.

Characteristic	Vulnerability		Severity		RE		SE	
	B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value
Occupation		< .001		< .001		< .001		< .001
No, incapacitated to work	-0.1 (-0.3;0.0)	.027	0.5 (0.3;0.7)	< .001	0.2 (0.1;0.4)	.008	0.3 (0.2;0.5)	< .001
No, prepension	0.0 (-0.3;0.2)	.713	0.8 (0.4;1.2)	< .001	0.4 (0.0;0.7)	.038	0.1 (-0.2;0.4)	.478
No, pension	-0.2 (-0.3;-0.1)	< .001	0.6 (0.5;0.7)	< .001	0.4 (0.3;0.5)	< .001	0.3 (0.2;0.4)	< .001
No, unemployed	-0.2 (-0.4;-0.1)	.008	0.2 (-0.1;0.4)	.202	-0.1 (-0.4;0.1)	.226	0.0 (-0.2;0.2)	.976
No, student	-0.1 (-0.2;0.0)	.088	-0.4 (-0.6;-0.2)	< .001	-0.1 (-0.2;0.1)	.404	0.0 (-0.2;0.1)	.746
No, homemaker	-0.1 (-0.3;0.0)	.102	0.3 (0.0;0.5)	.019	0.1 (-0.2;0.3)	.610	0.1 (-0.1;0.3)	.543
No, never or not yet worked	-0.4 (-0.8;-0.1)	.021	-0.5 (-1.1;0.0)	.053	-0.3 (-0.8;0.2)	.228	-0.3 (-0.7;0.2)	.234
Yes	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Educational level		.074		< .001		.238		.427
Primary or without diploma	-0.2 (-0.4;0.0)	.083	0.5 (0.2;0.8)	.002	-0.2 (-0.5;0.0)	.104	0.0 (-0.2;0.2)	.999
Lowe secondary	-0.1 (-0.2;0.0)	.042	0.3 (0.2;0.5)	< .001	0.0 (-0.2;0.1)	.973	0.0 (-0.1;0.1)	.906
Upper secondary	0.0 (-0.1;0.0)	.281	0.2 (0.1;0.4)	< .001	-0.1 (-0.2;0.1)	.283	-0.1 (-0.2;0.0)	.216
Superior short type and bachelors	0.0 (-0.1;0.1)	.738	0.2 (0.0;0.3)	.021	-0.1 (-0.2;0.0)	.076	-0.1 (-0.2;0.0)	.116
Long/university level superior	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Net annual income		< .001		.566		.094		.489
Less than € 15,000	-0.3 (-0.5;-0.2)	< .001	0.1 (-0.1;0.4)	.173	-0.2 (-0.4;0.0)	.013	-0.1 (-0.2;0.1)	.433
Between € 15,000 and 29,999	-0.1 (-0.2;0.0)	.013	0.1 (-0.1;0.2)	.311	-0.1 (-0.2;0.1)	.337	0.0 (-0.1;0.1)	.849
Between € 30,000 and 44,999	-0.1 (-0.2;0.0)	.243	0.1 (-0.1;0.2)	.411	-0.1 (-0.2;0.0)	.178	-0.1 (-0.2;0.0)	.210
More than € 45,000	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref

Table 15. Health-related characteristics associated with PMT scores.

Characteristic	Vulnerability		Severity		RE		SE	
	B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value	B-value (CI)	p-value
Dependent on care		.235		.001		.164		.107

Less than once a month	0.0 (-0.2;0.2)	.942	0.2 (-0.1;0.4)	.247	0.0 (-0.2;0.2)	.953	0.2 (-0.1;0.4)	.172
1-3 times a month	-0.2 (-0.3;0.0)	.039	0.4 (0.2;0.7)	.001	0.1 (-0.1;0.3)	.467	0.0 (-0.2;0.2)	.695
1-3 times a week	-0.1 (-0.4;0.1)	.326	0.4 (0.0;0.7)	.037	0.3 (0.0;0.6)	.035	0.2 (0.0;0.5)	.085
More than 3 times a week	0.1 (-0.2;0.3)	.572	0.4 (0.0;0.7)	.029	0.2 (-0.1;0.5)	.176	0.2 (0.0;0.5)	.077
Never	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
Score for health today (per 100 points)	-0.4 (-0.6;-0.2)	< .001	-1.2 (-1.4;-0.9)	< .001	-0.2 (-0.4;0.0)	.084	-0.2 (-0.4;0.0)	.046
Taking care of someone								
No	-0.1 (-0.2;0.0)	.002	-0.1 (-0.2;0.0)	.111	0.0 (-0.1;0.1)	.649	0.0 (-0.1;0.1)	.466
Yes	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref
(Possibly) infected with COVID-19 before								
Yes	0.2 (0.1;0.3)	< .001	-0.9 (-1.0;-0.7)	< .001	-0.1 (-0.2;0.0)	.110	-0.1 (-0.2;0.0)	.031
No	Ref	Ref	Ref	Ref	Ref	Ref	Ref	Ref

6.4. Characteristics associated with past and intended implementation of measures

The associations between demographic, socio-economic and health characteristics with having adhered to the measures in the past and planning to adhere to them in the future (level of implementation) were also assessed. Overall, there was a strong correlation between past and future level of implementation (Pearson's r = .840), as also displayed in Annex 5.

6.4.1. Demographic characteristics

Similar to the PMT components described above, language of the questionnaire was also significantly associated with past and intended implementation, where French-speaking respondents scored lower (Table 16). There was no statistically significant difference between men and women. In terms of age, the youngest respondents had lower levels of implementation compared to all older respondents. Flanders scored higher for both past and intended implementation compared to Wallonia, and there was no difference between Wallonia and Brussels. Respondents who lived with their parents scored the lowest on past and future implementation, out of all household compositions, which is in line with the result for the youngest age group.

Table 16. Demographic characteristics associated with implementation of measures.

Demographic characteristics associated with implementation of measures				
Characteristic	**Past implementation**		**Intended implementation**	
	B-value (CI)	**p-value**	**B-value (CI)**	**p-value**
Language				
French	-0.1 (-0.2;-0.1)	.001	-0.1 (-0.2;0.0)	.002
Dutch	Ref	Ref	Ref	Ref
Gender				
Male	0.0 (-0.1;0.0)	.346	0.0 (-0.1;0.1)	.996
Female	Ref	Ref	Ref	Ref
Age		< .001		< .001
18-30 years	Ref	Ref	Ref	Ref
31-45 years	0.2 (0.1;0.3)	< .001	0.2 (0.1;0.3)	< .001
46-60 years	0.3 (0.2;0.4)	< .001	0.3 (0.2;0.4)	< .001
61-75 years	0.5 (0.4;0.5)	< .001	0.5 (0.4;0.6)	< .001
76 years and over	0.5 (0.2;0.7)	< .001	0.5 (0.2;0.7)	< .001
Region		.005		.023
Flanders	0.1 (0.0;0.2)	.005	0.1 (0.0;0.2)	.008
Brussels	0.0 (-0.1;0.1)	.694	0.0 (-0.1;0.1)	.753
Wallonia	Ref	Ref	Ref	Ref
Household composition		.002		< .001

Alone with children	0.0 (-0.2;0.1)	.629	0.0 (-0.2;0.1)	.666
Couple without children	0.0 (-0.1;0.1)	.568	0.0 (-0.1;0.1)	.495
Couple with children	-0.1 (-0.2;0.0)	.025	-0.1 (-0.2;0.0)	.018
With parents	-0.2 (-0.3;-0.1)	.003	-0.2 (-0.3;-0.1)	.002
Live together / share a flat	-0.2 (-0.5;0.1)	.246	-0.3 (-0.6;0.1)	.131
Alone without children	Ref	Ref	Ref	Ref

6.4.2. Socio-economic characteristics

The occupation groups that scored highest on the level of implementation were retirees, those who were unable to work and homemakers. There were no statistically significant differences between past and intended implementation for different education levels or income levels.

Table 17. Socio-economic characteristics associated with implementation of measures.

Characteristic	Past implementation		Intended implementation	
	B-value (CI)	p-value		
Occupation		< .001		< .001
No, incapacitated to work	0.3 (0.2;0.4)	< .001	0.3 (0.1;0.4)	< .001
No, prepension	0.2 (0.0;0.5)	.107	0.2 (-0.1;0.5)	.137
No, pension	0.3 (0.2;0.3)	< .001	0.3 (0.2;0.4)	< .001
No, unemployed	0.0 (-0.2;0.2)	.982	0.1 (-0.1;0.3)	.289
No, student	-0.1 (-0.2;0.0)	.077	-0.1 (-0.3;0.0)	.053
No, homemaker	0.2 (0.0;0.3)	.028	0.2 (0.0;0.4)	.014
No, never or not yet worked	-0.3 (-0.7;0.1)	.089	-0.3 (-0.7;0.1)	.144
Yes	Ref	Ref	Ref	Ref
Educational level		.996		.432
Primary or without diploma	0.0 (-0.2;0.2)	.977	0.1 (-0.2;0.3)	.628
Lowe secondary	0.0 (-0.1;0.1)	.796	0.1 (-0.1;0.2)	.394
Upper secondary	0.0 (-0.1;0.1)	.847	0.0 (-0.1;0.1)	.541
Superior short type and bachelors	0.0 (-0.1;0.1)	.951	-0.1 (-0.2;0.0)	.282
Long/university level superior	Ref	Ref	Ref	Ref
Net annual income		.400		.312
Less than € 15,000	0.0 (-0.2;0.1)	.535	0.0 (-0.2;0.1)	.560
Between € 15,000 and 29,999	0.1 (0.0;0.2)	.306	0.0 (-0.1;0.2)	.463
Between € 30,000 and 44,999	0.0 (-0.1;0.1)	.997	0.0 (-0.2;0.1)	.450
More than € 45,000	Ref	Ref	Ref	Ref

6.4.3.　Health characteristics

Of the different health characteristics assessed, the only one that was significantly associated with the level of implementation was having (possibly) been infected with COVID-19 before. This applies to both the past and intended implementation of measures. Respondents who had (possibly) undergone a COVID-19 infection scored significantly lower.

Table 18. Health-related characteristics associated with implementation of measures

Characteristic		Past implementation		Intended implementation	
		B-value (CI)	p-value		
Dependent on care			.496		.388
	Less than once a month	-0.1 (-0.3;0.1)	.199	-0.1 (-0.3;0.1)	.253
	1-3 times a month	0.0 (-0.2;0.1)	.572	-0.1 (-0.3;0.1)	.466
	1-3 times a week	0.0 (-0.2;0.2)	.945	0.1 (-0.1;0.4)	.413
	More than 3 times a week	0.1 (-0.1;0.3)	.249	0.2 (-0.1;0.4)	.221
	Never	Ref	Ref	Ref	Ref
Score for health today (per 100 points)		-0.1 (-0.3;0.1)	.222	-0.1 (-0.3;0.1)	.349
Taking care of someone					
	No	0.0 (0.0;0.1)	.337	0.1 (0.0;0.1)	.120
	Yes	Ref	Ref	Ref	Ref
(Possibly) infected with COVID-19 before					
	Yes	-0.2 (-0.3;-0.1)	< .001	-0.2 (-0.3;-0.1)	.001
	No	Ref	Ref	Ref	Ref

6.5.　Characteristics associated with knowledge level

For the same group of personal characteristics, it was also assessed to what extent they were associated with knowledge level, expressed as the number of True / False questions that were answered correctly by the respondent. The distribution of the number of correct answers is shown in Annex 6.

6.5.1.　Demographic characteristics

Respondents who completed the questionnaire in French had less knowledge on COVID-19 measures than those who completed it in Dutch (Table 19). In terms of age, the youngest age group was the least knowledgeable compared to all other age groups. Respondents in Flanders on average had more knowledge than those in Wallonia, with respondents from the Brussels Capital Region scoring in between. Respondents who lived together / shared a flat with non-family members had the lowest knowledge levels of the different family compositions.

Table 19. Demographic characteristics associated with knowledge.

Demographic characteristics associated with knowledge		
Characteristic	**Knowledge**	
	B-value (CI)	**p-value**
Language		
French	-0.5 (-0.7;-0.3)	< .001
Dutch	Ref	Ref
Gender		
Male	-0.1 (-0.3;0.1)	.218
Female	Ref	Ref
Age		.014
18-30 years	Ref	Ref
31-45 years	0.4 (0.1;0.6)	.003
46-60 years	0.3 (0.1;0.6)	.008
61-75 years	0.3 (0.1;0.6)	.005
76 years and over	0.5 (0.0;1.1)	.046
Region		< .001
Flanders	0.5 (0.4;0.7)	< .001
Brussels	0.3 (0.0;0.6)	.052
Wallonia	Ref	Ref
Household composition		.019
Alone with children	-0.3 (-0.6;0.1)	.105
Couple without children	0.1 (-0.1;0.4)	.178
Couple with children	0.1 (-0.2;0.3)	.535
With parents	-0.1 (-0.4;0.2)	.589
Live together / share a flat	-0.9 (-1.7;-0.1)	.028
Alone without children	Ref	Ref

6.5.2. Socio-economic characteristics

In terms of occupational status, the lowest levels of knowledge were found for respondents who were unemployed and for students. Respondents from the lowest two educational levels scored significantly lower than those from the highest educational level. Similarly, respondents from the lowest income level had less knowledge than those from the highest.

Table 20. Socio-economic characteristics associated with knowledge.

Characteristic	**Knowledge**	
	B-value (CI)	p-value
Occupation		.005

No, incapacitated to work	-0.2 (-0.5;0.1)	.280
No, prepension	0.1 (-0.6;0.7)	.827
No, pension	0.1 (-0.1;0.3)	.573
No, unemployed	-0.6 (-1.0;-0.2)	.004
No, student	-0.4 (-0.7;-0.1)	.006
No, homemaker	0.1 (-0.3;0.5)	.681
No, never or not yet worked	0.6 (-0.3;1.6)	.199
Yes	Ref	Ref
Educational level		< .001
Primary or without diploma	-0.9 (-1.4;-0.4)	< .001
Lowe secondary	-0.4 (-0.7;-0.1)	.010
Upper secondary	0.1 (-0.1;0.3)	.330
Superior short type and bachelors	0.2 (0.0;0.5)	.075
Long/university level superior	Ref	Ref
Net annual income		.001
Less than € 15,000	-0.6 (-0.9;-0.2)	.002
Between € 15,000 and 29,999	-0.2 (-0.5;0.0)	.062
Between € 30,000 and 44,999	0.0 (-0.2;0.3)	.705
More than € 45,000	Ref	Ref

6.5.3.   Health characteristics

The only health characteristic that was significantly associated with knowledge was the score that respondents gave to their health on the day of completing the questionnaire: respondents who scored their health as higher on average had more knowledge (Table 21).

Table 21. Health-related characteristics associated with knowledge

Characteristic	Knowledge	
	B-value (CI)	p-value
Dependent on care		.536
Less than once a month	-0.2 (-0.6;0.2)	.375
1-3 times a month	-0.2 (-0.6;0.2)	.361
1-3 times a week	-0.4 (-0.9;0.2)	.210
More than 3 times a week	0.1 (-0.5;0.6)	.786
Never	Ref	Ref
Score for health today (per 100 points)	0.4 (0.0;0.9)	.042
Taking care of someone		
No	-0.1 (-0.2;0.1)	.571
Yes	Ref	Ref
(Possibly) infected with COVID-19 before		

Yes		-0.1 (-0.3;0.1)	.425
No		Ref	Ref

6.6. Characteristics associated with level of understanding of COVID-19 measures

Although level of understanding of COVID-19 measures is not an official item within the PMT, we assessed which personal characteristics were associated with this score.

6.6.1. Demographic characteristics

Women reported a better understanding of the measures than men (Table 22), and the youngest age group reported the lowest understanding compared to the other age groups. In terms of household composition, the lowest level of understanding was observed for respondents who lived with their parents, which is in line with the finding that the youngest age group scores lowest on this.

Table 22. Demographic characteristics associated with understanding

Demographic characteristics associated with understanding		
Characteristic	**Understanding**	
	B-value (CI)	**p-value**
Language		
French	-0.1 (-0.1;0.0)	.121
Dutch	Ref	Ref
Gender		
Male	-0.1 (-0.2;0.0)	.002
Female	Ref	Ref
Age		< .001
18-30 years	Ref	Ref
31-45 years	0.2 (0.1;0.3)	< .001
46-60 years	0.2 (0.1;0.3)	< .001
61-75 years	0.3 (0.2;0.4)	< .001
76 years and over	0.2 (0.0;0.5)	.070
Region		.249
Flanders	0.1 (0.0;0.1)	.098
Brussels	0.0 (-0.1;0.2)	.663
Wallonia	Ref	Ref
Household composition		.086
Alone with children	0.1 (-0.1;0.2)	.468
Couple without children	0.1 (0.0;0.1)	.296

Couple with children	0.0 (-0.1;0.1)	.929
With parents	-0.1 (-0.3;0.0)	.039
Live together / share a flat	0.0 (-0.4;0.3)	.815
Alone without children	Ref	Ref

6.6.2.   Socio-economic characteristics

The occupational group that reported to understand the measures best were retired respondents, while students gave the lowest score (Table 23). Respondents with a low education on average scored lower than those with a higher education. Similarly, understanding was lower in respondents from the lowest income level compared to the highest.

Table 23. Socio-economic characteristics associated with understanding.

Characteristic	Understanding	
	B-value (CI)	p-value
Occupation		.001
No, incapacitated to work	0.1 (-0.1;0.2)	.268
No, prepension	0.1 (-0.2;0.3)	.702
No, pension	0.1 (0.0;0.2)	.009
No, unemployed	-0.1 (-0.3;0.1)	.328
No, student	-0.2 (-0.3;-0.1)	.002
No, homemaker	0.0 (-0.2;0.2)	.875
No, never or not yet worked	-0.3 (-0.7;0.1)	.143
Yes	Ref	Ref
Educational level		.090
Primary or without diploma	-0.2 (-0.4;0.0)	.042
Lower secondary	-0.1 (-0.3;0.0)	.023
Upper secondary	-0.1 (-0.1;0.0)	.278
Superior short type and bachelors	0.0 (-0.1;0.1)	.493
Long/university level superior	Ref	Ref
Net annual income		.020
Less than € 15,000	-0.2 (-0.3;0.0)	.018
Between € 15,000 and 29,999	0.0 (-0.1;0.1)	.839
Between € 30,000 and 44,999	0.0 (-0.1;0.2)	.503
More than € 45,000	Ref	Ref

6.6.3. Health characteristics

Being dependent on someone's care or taking care of someone else did not affect people's reported level of understanding of the measures. Respondents who rated their health today as higher rated their level of understanding as higher. Respondents who had not yet been infected by COVID-19 scored higher for self-reported understanding than respondents who possibly had been infected.

Table 24. Health-related characteristics associated with understanding.

Characteristic	Understanding	
	B-value (CI)	p-value
Dependent on care		.497
Less than once a month	-0.2 (-0.4;0.0)	.109
1-3 times a month	-0.1 (-0.2;0.1)	.468
1-3 times a week	0.0 (-0.2;0.3)	.997
More than 3 times a week	0.1 (-0.2;0.3)	.592
Never	Ref	Ref
Score for health today (per 100 points)	0.3 (0.1;0.5)	.001
Taking care of someone		
No	0.1 (0.0;0.2)	.058
Yes	Ref	Ref
(Possibly) infected with COVID-19 before		
Yes	-0.1 (-0.2;0.0)	.012
No	Ref	Ref

6.7. PMT components associated with level of implementation

To investigate to what degree the four PMT components are associated with past and future level of implementation, a multivariate regression analysis was performed with the PMT components as independent variables (uncorrected model). In a second analysis, a number of demographic, socio-economic and health characteristics were added as confounders (corrected model).

There was no difference in the direction or significance level between past and intended implementation, neither in the uncorrected, nor in the corrected model (Table 25 & 26). Perceived vulnerability was not associated with implementation. A weak, positive relationship was found between perceived severity and implementation in the uncorrected model, which disappeared in the corrected model. Both response efficacy and self-efficacy were strongly, positively associated with the level of implementation.

Table 25. PMT Components associated with implementation – uncorrected.

PMT item	Past implementation		Intended implementation	
	B-value (CI)	p-value	B-value (CI)	p-value
		< .001		< .001
Vulnerability	0.0 (0.0;0.0)	.612	0.0 (0.0;0.0)	.505
Severity	0.0 (0.0;0.1)	.013	0.0 (0.0;0.0)	.033
Response efficacy	0.2 (0.2;0.2)	< .001	0.3 (0.3;0.4)	< .001
Self-efficacy	0.3 (0.3;0.3)	< .001	0.3 (0.3;0.4)	< .001

Past implementation: R^2 = .364; adjusted R^2 = .363
Intended implementation: R^2 = .459; adjusted R^2 = .458

Table 26. PMT Components associated with implementation – corrected.

PMT item	Past implementation[1]		Intended implementation[1]	
	B-value (CI)	p-value	B-value (CI)	p-value
		< .001		< .001
Vulnerability	0.0 (0.0;0.1)	.363	0.0 (0.0;0.0)	.834
Severity	0.0 (0.0;0.0)	.321	0.0 (0.0;0.0)	.239
Response efficacy	0.2 (0.2;0.2)	< .001	0.3 (0.3;0.4)	< .001
Self-efficacy	0.3 (0.3;0.3)	< .001	0.3 (0.3;0.4)	< .001

Past implementation: R^2 = .394; adjusted R^2 = .385
Future implementation: R^2 = .482; adjusted R^2 = .474
1) Confounders included were: sex, age, region, household composition, socio-economic group, dependent on care, score for health today, taking care of someone, previous COVID-19 infection

Additional multiple regression analyses were performed combining the four components of the PMT with knowledge, expressed as the number of correct answers in the 'True / False' statements, as independent variables and past and intended implementation as dependent variables. Similar to above, corrected and uncorrected models were tested (Table 27 & 28). In the uncorrected models, there were still strong, positive relationships of response efficacy and self-efficacy with past and intended implementation. Severity and knowledge had a weak positive relationship with past implementation, but not with intended implementation. Perceived vulnerability did not show any association with implementation. All the coefficients of the corrected model were similar to the uncorrected model, apart from severity which lost statistical significance altogether.

Table 27. PMT components and knowledge associated with implementation - uncorrected

PMT item	Past implementation		Intended implementation	
	B-value (CI)	p-value	B-value (CI)	p-value
		< .001		< .001
Vulnerability	0.0 (0.0;0.0)	.728	0.0 (0.0;0.0)	.457
Severity	0.0 (0.0;0.0)	.024	0.0 (0.0;0.0)	.060
Response efficacy	0.2 (0.2;0.2)	< .001	0.3 (0.3;0.4)	< .001
Self-efficacy	0.3 (0.3;0.3)	< .001	0.3 (0.3;0.4)	< .001
Knowledge	0.0 (0.0;0.0)	.018	0.0 (0.0;0.0)	.163

Past implementation: R^2 = .352; adjusted R^2 = .350
Intended implementation: R^2 = .448; adjusted R^2 = .446

Table 28. PMT components and knowledge associated with implementation - corrected

PMT item	Past implementation[1]		Intended implementation[1]	
	B-value (CI)	p-value	B-value (CI)	p-value
		< .001		< .001
Vulnerability	0.0 (0.0;0.0)	.459	0.0 (0.0;0.0)	.815
Severity	0.0 (0.0;0.0)	.444	0.0 (0.0;0.0)	.347
Response efficacy	0.2 (0.2;0.2)	< .001	0.3 (0.3;0.4)	< .001
Self-efficacy	0.3 (0.3;0.3)	< .001	0.3 (0.3;0.4)	< .001
Knowledge	0.0 (0.0;0.0)	.028	0.0 (0.0;0.0)	.126

Past implementation: R^2 = .381; adjusted R^2 = .371
Intended implementation: R^2 = .472; adjusted R^2 = .464
1) Confounders included were: sex, age, region, household composition, socio-economic group, dependent on care, score for health today, taking care of someone, previous COVID-19 infection

A final regression model was tested which included the four PMT components, all confounders, knowledge and past implementation, with intended implementation as the outcome variable (Table 29). Because of the strong relationship between past and intended implementation, there is a large increase in the overall fit of the model (R^2 = .745). The strong relationship between past and intended implementation was also reflected by the size of the regression coefficient (0.7). Response efficacy and self-efficacy were also still significantly associated with intended implementation, although the regression coefficients were slightly smaller than in the previous models.

Table 29. PMT components, knowledge and past implementation associated with intended implementation – corrected model.

PMT item	Intended implementation[1]	
	B-value (CI)	p-value
		< .001
Vulnerability	0.0 (0.0;0.0)	.199
Severity	0.0 (0.0;0.0)	.792
Response efficacy	0.2 (0.1;0.2)	< .001
Self-efficacy	0.1 (0.1;0.1)	< .001
Knowledge	0.0 (0.0;0.0)	.977
Past implementation	0.7 (0.7;0.8)	< .001

R^2 = .745; adjusted R^2 = .741

1) Confounders included were: sex, age, region, household composition, socio-economic group, dependent on care, score for health today, taking care of someone, previous COVID-19 infection

6.8. Qualitative results

Some comments to open questions were left by 537 respondents. These comments were looked at separately by the research team, as a distinct set of qualitative data. Although these were usually short comments, their analysis allows us to have access to some personal opinions and feelings, that usefully complement our quantitative results. These results are summarised hereafter, and illustrated with some quotes from the respondents. It should be noted that the quotes hereafter are representative of some respondents' views and perception at the time of our study, and were not corrected by the research team who might have other opinions in some cases.

6.8.1. Contrasted views regarding the usefulness and applicability of some or all measures

The respondents' views regarding the general usefulness and applicability of the measures were quite contrasted, and could be categorized into 3 groups:

(i) those who see the measures as necessary, are quite happy with them and accept to comply with them

"Even if it is not always easy, one MUST comply with the different preventive measures, in order to hopefully overcome this crisis.

"Since March, my family and I have done exactly what we were told to do. There have been some hard times, but we held firm, and none got any symptom of the disease. "

"I feel privileged… Being in pension and not in need of much contact, I am happy with my bubble of 5."

"Since the beginning of the lockdown, we have been in 3 (…) For the sake of health, we don't mind such sacrifices. "

(ii)   those who see the measures as insufficient and call for increased measures[1], control and sanctions

"I wish for an imposed curfew in towns where young people keep drinking too much and hanging out."

"If everybody had complied with the lockdown in March and April, and if travelling abroad had been prohibited (for holidays and professional reason), we would be out of the crisis by now. All these efforts in vain…"

"More control and sanctions need to be implemented for those who do not comply."

"Prevention must go on. I am a nurse (…). Non-compliance with the measures should be seriously punished as it puts other people in danger."

(iii)   those who see them as excessive

"You cannot suppress all risk… this is not how life works."

"Some measures do not make sense (wear a face mask in Bruxelles, when the streets are empty) and are discouraging for the citizens"

"I think that all this is exaggerated, in order to alarm people, when this virus is not more dangerous than other viruses for which people were

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[1] Since then, some of the measures called for by some of the participants have been implemented in Belgium

never alarmed that way. The measures that are imposed tend to sacrifice the middle class."

6.8.2.   Two measures discussed and sometimes contested…

Among the different measures that were in place at the time of our survey, the most discussed and contested measures are that of having to wear a face mask at all times, and that of restricting one's social life to a bubble of 5.

6.8.3.   Wearing a face mask under all circumstances… not always possible

Among the measures, one that was according to our quantitative results largely implemented, i.e. *Wearing a face mask*, received a lot of comments, with some people regretting that no real control was done, especially in public transports, while others claiming that there was no scientific evidence to justify that a mask should be worn in all circumstances. Here again, there are quite contrasted views among the respondents.

> *"More controls are needed on buses. People do not respect enough the requirement to wear a face mask, and I feel insecure."*

> *"The right way of wearing a mask should be explained over and again. You see too many people with their noses uncovered, their masks hanging around their neck on their chin, and who keep touching their faces with their fingers."*

On the other hands, some respondents claimed that masks maybe useless, or even detrimental to one's health:

> *"Having to wear a face mask outside is nonsense."*

> *"There is a confusion between having to wear the face mask outside and inside. It does not make sense to wear it outside. It drives people crazy because it has no sense at all. There is no evidence AT ALL of the usefulness of wearing a face mask outdoors!!!!!"*

> *"I think that with one's sweat, face masks turn into a nest of germs."*

6.8.4.   The bubble of 5, a contested notion

The comments received confirm and give more insight into the difficulties of understanding, accepting and applying the measure regarding the bubble of 5 people, as was well evidenced by our quantitative results. Indeed, quite a few

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respondents stressed that they perceived this measure as (i) particularly difficult to respect, even if one had wanted to ; (ii) a source of psychosocial difficulties and potentially, inequities ; (iii) highly inconsistent with other measures in place at the same time.

(i) A measure that is difficult to respect

"The bubble of 5 is inapplicable because you have a bubble 1) where you live, 2) where you work, 3) when you share a drink, 4) at a football match...and all these are different bubbles."

"I think the rule of 5 goes to far. I do not know of one single person who is likely to adhere to this. Normally, people do meet a maximum of 5 people, but never the same 5 people."

(ii) A source of psychosocial difficulties and inequities

"A bubble that is too small for too long creates a social distance between people"

"Hopefully all these measures are evidence-based. I do respect them, although it upsets me, but we don't have any social life anymore. "

"The bubble of 5 is the hardest, especially as I live alone. With the winter coming, I need contacts (...). It is also important to prevent depression. People living in residential care should never again be forbidden of visits!!!"

(iii) Inconsistent with other measures

"Some decisions are inconsistent : why should private events like a weddding be limited to 10, while some other events are allowed with up to 200 people indoors?"

"Coherence is needed! How can one oblige a family to stay in 5, while at the same time allow 1.000 people on a stadium?"

6.8.5. A call for more consistency, at Belgian and European level

As seen above, the measures were sometimes perceived as inconsistent. In addition, the way that politicians and experts communicated about the measures was also reported as inconsistent by quite a few respondents. The impact on motivation of inconsistent measures, or measures that change too often, was therefore reported with an expressed need that experts do not contradict each other, and that politicians develop a clear communication, with enough perspectives.

(i) General inconsistencies

"The rules are confusing and not always consistent."

"The rules are too complicated, limiting, contradictory.. and therefore difficult to apply for a part of the population."

"If I am allowed to go working, I should be allowed to visit my friends."

"There is so much uncertainty and variability between communes, towns and provices. No more than 10 people for a private event, but 50 people for a guided activity are OK!?"

(ii) Inconsistent communication about measures, between experts, and between experts and politicians

'It would be relevant to receive adequate information from the experts, as most of them regularly contradict each other in the media.'

'I find it extremely confusing when so many specialists contradict each other so often when it comes to Covid 19. Then you try to do your best as a normal citizen. Many people in my region do not know anymore what is allowed and what is not.'

'Striking to see that contradictory messages are sometimes communicated by the politicians and the experts.'

'The epidemiologists and politicians should communicate consistent messages. Right now, after a meeting of the national security committee, it happens too often that experts and politicians alike contest the measures that have just been announced. What a cacophony !'

(iii)   Call for joint and consistent decisions at European level

"I would have expected that the different measures be coordinated at European level."

"(…) According to France, it is safe to travel to France, whereas for us Belgians, it is considered unsafe and prohibited."

"The issue of travelling across countries should have been dealt with at European level. It would be better to stay in one's country, to support national tourism."

"I work in the Netherlands. I have to constantly adapt to different sets of measures, it's a shame."

6.8.6.   A call for improved communication

As a consequence of the various above-reported perceived inconsistencies, many comments related to the perceived need for an improved communication around the measures. Among the aspects that would contribute to a better communication, the respondents called for more clarity, more transparency, as well as more continuity and perspective.

(i)   Clarity

"The different measures should be very clearly explained to the population, which is not always the case."

(ii)   Transparency

"The contradictions need to stop. The reasons why some decisions are made should be explained very clearly, rather than creating a fuss around them."

(iii)   Continuity and Perspective

"Communicate more and better. People need perspective. Stick to the measures for a while, and update where necessary. Offer perspective!"

6.8.7.   A call for more supportive environments

The analysis of the comments from our respondents, suggest that the environment is not always perceived as supportive enough, in particular at the work-place:

> *I wish I could telework. But my employer does not allow it. Why is it not made mandatory, instead of just recommended?*

> *In the place where I work, my boss overtly under-estimates the situation.*

> *It's complicated to respect the bubble of 5, if you work at your office.*

Other suggestions for a more supportive environment were related to having visible reminders of measures at different places, offering more face-masks so that people would not have to buy or to make them themselves, etc.

In addition to calling for more supportive environments, two respondents reported worries they had for a changing environment due to the sanitary situation. One of these comments was related to our global environment, while the other was related to our social environment, with changing norms:

> *"COVID-19 carries a lot of waste... disposable face mask and gloves, with their boxes being left on the floor ; the paper to clean the trolleys in supermarket is left everywhere but in the bin meant for it."*

> *"I live with a great anxiety that to maintain distances may be perceived as "being distant". I think this will become a major problem. The virus settles in our social habits, and I am afraid that the very "society" might collapse."*

7. Conclusions

The efficiency and effectiveness of infection prevention and control measures (IPCM) can be improved by obtaining detailed insights in the understanding of and perception towards these measures by the general population. Due to differences in culture and implemented measures between countries, it is important to evaluate the situation on a country-level, and not rely only on international results. We noticed a gap in Belgian studies on a national level (opposed to regional studies), and studies informed by behavioural theories on protective behaviour. For this reason, we undertook the TACOM study, which addressed a large sample representative of the Belgian population, and investigated people's risk perception of COVID-19, and their coping appraisal on the COVID-19 measures that were at that moment in place in Belgium. This offers important insights for government stakeholders in Belgium, responsible for implementation of measures.

The main findings of our study suggest that overall, adherence to the COVID-19 measures is high among the Belgian population in general. The results show high levels of implementation and a high level of understanding of the measures: both topics score at least 4 on a scale of 1 to 5 for understanding and past implementation for each individual measure. When understanding of the measures was measured in the form of knowledge statements, half of the statements were answered correctly by at least 70% of respondents. Statements that posed the largest problems were those related to visiting bars/restaurants, and whether your company there counts as your bubble. The reason for this lower understanding might be the fact that this statement represents a combination of several measures, which is by definition les straightforward. Another question that was answered incorrectly by more than half of respondents related to wearing a face mask in public. During that time, there were different measures on mask use in place for different regions in Belgium (Brussels on one hand, Flanders and Wallonia on the other hand), which might have led to confusion. Finally, two questions related to international travel were answered correctly by slightly less than 70% of respondents. Since part of the respondents will not have travelled prior to the implementation of these measures, this could explain a lower level of familiarity with these measures. We saw a significant, positive relationship between self-reported understanding of the measures and the number of correctly answered statements, which shows that on average, respondents can correctly estimate their own level of understanding.

Our study was informed by the Protection Motivation Theory (PMT), which helps to understand how motivation to protect oneself against a threat is mediated by threat appraisal and coping appraisal. It consists of 5 domains, namely 1) perceived vulnerability, 2) perceived severity, 3) perceived efficacy of recommended response 4)

perceived ability to perform the recommended response, and 5) estimate of response costs. The PMT was particularly suitable to be used in this study, as it measures and predicts protective health behaviour, which is essential for implementing effective IPCM

Our results also revealed that various personal characteristics are related to PMT scores, level of implementation, and knowledge of respondents. An important difference was found between French- and Dutch-speaking respondents, and between the regions of Flanders and Wallonia, while Brussels did not significantly differ from Wallonia. French-speakers scored lower on all PMT scores, on the level of implementation and on the knowledge level. The reasons for these differences are not clear, but warrant further investigation. Furthermore, we found that younger people scored higher on vulnerability, and lower on severity than older people. Since older people have less activities outside of the house (e.g. they are more often pensioners), they might perceive their risk of becoming infected lower because of this reason. However, when they become infected, they expect the impact to be more severe, which is in line with overall communication about COVID-19 impact, which is shown to be highest among older age groups. People from a lower socio-economic group (e.g. with lower educational level) report lower scores on understanding of measures, and answer the statement questions incorrectly more often than people with a high educational level. This implies that the communication of measures might not be suitable for all segments of the population, and should be adapted in order to reach people from all backgrounds. Overall, our findings allow to establish a profile of inhabitants in Belgium with relatively low understanding of and compliance to COVID-19 measures. This includes the French-speaking population, the youngest age cluster (18-30-year-old), those with a lower education, and those with the lowest income level. This information should accordingly be used by policy makers to improve communication.

Our study showed that, of the four PMT components, response efficacy and self-efficacy showed a positive and significant relationship with future implementation of measures. In contrast, vulnerability and severity did not show a significant relationship, in a model that corrected for demographic, socio-economic and health-related confounders. Generally, risk communication seems to emphasise more on fear induction, but as shown by our results, this has little to no impact on whether people follow the measures. Instead, in order to increase implementation, risk communication should focus more on helping people understand why implemented measures are useful, and how people can put them into practice.

There was an interesting difference between severity scores of those who had, and those who had not been previously infected with COVID-19. Respondents who had not been previously ranked the expected severity as 57.3, while those with a (possible)

infection ranked the experienced severity at 35.5, which is much lower. Since the latter group also contained respondents who underwent an asymptomatic infection, we also calculated the score separately for only those who had had a confirmed infection with symptoms. Nonetheless, with an average score of 51.4, this was still lower than the expected severity of the non-infected, which implies that respondents expected the experience of an infection to be worse than it actually is. However, it is important to mention that the group of infected participants is not representative for all individuals with an infection, as those who have been seriously ill recently were probably less likely to participate in this survey, not to mention the people who died due to a COVID-19 infection.

Other factors that can also impact the adherence to IPCM include, for example, the **emotional state of mind** (Bigot et al. 2020; Chong et al. 2020; Shiina et al. 2020) and other psychosocial components such as **relatedness** (Vansteenkiste, Soenens, Waterschoot, Morbée, Vermote, et al. 2020) or **subjective norms** (Bigot et al. 2020). Although these factors could also be taken in account when trying to influence IPCM in Belgium during the COVID-19 crisis, they have not been included in this study.

Our study did not assess the estimated response costs (in terms of money, time, effort) of the COVID-19 measures, which was the fifth component of PMT and provides more insight into why people decide to implement measures or not. Furthermore, we did not identify any other studies that evaluated response costs of COVID-19 measures. It could be of interest to assess this aspect in a follow-up study using a qualitative approach, which might provide more detailed insights on this important aspect.

Overall, respondents considered themselves relatively well-informed about COVID-19 measures, with an average score of almost 75 out of 100. More than 80% of respondents prefer television as an information channel, which emphasises the importance of this traditional medium. In addition, more than half of respondents use (online) newspapers. The source that contributes more to people's knowledge, and that people also trust more, are experts. This is a broad term that comprises epidemiologists and other experts that appear in the media, as well as those closer to people's individual setting, such as a family doctor. The scores for politicians are quite a bit lower than those of experts, possibly due to differences in communication between different politicians that have occurred on earlier occasions. As such, it is important that communication by politicians is as consistent as possible, and should be verified beforehand by experts on the topic.

The analysis of the qualitative comments reveal that there are very contrasted views among the population regarding the usefulness and applicability of some or all measures, and that the measure related to wearing a face-mask and that of

restricting social contacts to a bubble of 5 were the most difficult to comply with at all times. Moreover, our results highlight the importance of perceived inconsistencies that make the measures more difficult to apply, and that call for better communication if the government and experts are not to be discredited. A few additional results broaden the discussion by pointing to the role of environment (work place, reminders, etc.) to better support personal choices and behaviours in relation to applying the measures, but also to possible consequences of the measures on the global environment.

Our study sample closely matched the predefined stratification targets of the survey company (Dedicated), indicating that it is a good representation of the Belgian population in terms of gender, age (adult population until 75), region and socio-economic status. The only group that was slightly less well represented are those individuals belonging to the lowest socio-economic group. Obtaining a sufficient number of responses from this particular group is often problematic in surveys, due to the fact that members of these groups do not always have easy access to internet, they have more difficulty understanding a survey, and they sometimes suffer from a feeling of inferiority ('my opinion is not important') (input Dedicated). Nonetheless, despite the lower number, we still had a representation of this group in our sample. A limitation of performing an internet survey among a sample of the adult Belgian population is that certain groups are by definition underrepresented. This includes e.g. school-aged young people, persons with a migrant background, and people from the informal sector (e.g. asylum seekers, sex workers). Since our survey was only available in Dutch and French, this also excludes a certain fraction of the expats, which contribute quite substantially to in particular the Brussels Capital Region. This group might however use specific information channels to inform themselves on COVID-19 measures, which would be interesting to investigate.

The results presented in this report reflect the findings up until December 2020. We are still investigating other analytical angles. New findings will be incorporated in future reporting.

The survey was undertaken in September 2020, during a time when the measures were lighter compared to other periods in the year, and when relatively few people had a personal experience with COVID-19. It would be of interest to retake this survey later on, when different measures apply and more people have become infected, to see to what extent this influences the results.

8. Acknowledgements

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10.Annexes

Annex 1 – passenger locator form

Public Health Passenger Locator Form

Dank u om ons te helpen uw gezondheid te beschermen

> → **Reizen met het vliegtuig.**
>
> Vul alle gegevens in en print dit formulier **vóór u aan boord gaat**. Als u dat niet doet, kan het zijn dat u de toegang tot het vliegtuig wordt geweigerd. Bij aankomst van buiten de Schengenzone moet u het formulier overhandigen aan de grenspolitie op uw punt van binnenkomst.
>
> → **Reizen met de trein, de bus of de auto.**
>
> Vul dit formulier in en e-mail het op de dag van aankomst naar PLFBelgium@health.fgov.be
>
> → **Als er valse, misleidende of onvolledige informatie wordt verstrekt, kan de binnenkomst aan de grens geweigerd worden en kan de onmiddellijke terugkeer opgelegd worden.**
>
> Aan de hand van dit formulier stemt u in met de door de Belgische autoriteiten opgelegde gezondheidsvereisten. Niet-naleving kan leiden tot burgerrechtelijke of strafrechtelijke sancties.
>
> Aan de hand van dit formulier stemt u ermee in om bij aankomst in België 14 dagen in quarantaine te blijven op het hieronder vermelde adres. Passagiers uit de 'EU+'-zone zijn vrijgesteld, op voorwaarde dat ze niet inreizen vanuit een gebied met een hoog risico zoals gedefinieerd door de Belgische autoriteiten.

Instructies

- Dit formulier moet ingevuld worden door:
  - iedereen die met het vliegtuig of per boot naar België reist, en
  - alle andere personen die naar België reizen, behalve
    - wanneer ze minder dan 48 uur in België blijven,
    - wanneer ze naar België terugkeren na een verblijf in het buitenland van minder dan 48 uur.
- Het formulier moet worden ingevuld vóór uw aankomst, maar niet meer dan 48 uur vóór u ons land binnenkomt.
- Elke passagier van 16 jaar of ouder moet een formulier invullen.
  - De gegevens van kinderen jonger dan 16 jaar moeten worden vermeld op het formulier van de volwassene die hen begeleidt.
- Indien een van de gegevens die u op dit formulier invult in de komende 14 dagen wijzigt, dient u een nieuw formulier in te dienen.
- Informatie over de gezondheidsrichtlijnen rond Covid-19 is beschikbaar op www.info-coronavirus.be.

Gegevensbescherming

Dankzij dit formulier kunnen de ambtenaren van Volksgezondheid u lokaliseren als u werd blootgesteld aan een ernstige overdraagbare ziekte. De door u verstrekte informatie kan in de komende 14 dagen worden gebruikt om contact met u op te nemen om de op dit formulier vermelde gegevens te controleren. Deze informatie kan ook gebruikt worden voor contact tracing bij bevestigde of vermoedelijke gevallen van Covid-19. De informatie die u verstrekt zal worden bijgehouden in overeenstemming met de toepasselijke wetgeving en zal enkel ten behoeve van de volksgezondheid worden gebruikt.

Opgemaakt te: op:

(E-)Handtekening:
IK HEB KENNIS GENOMEN VAN DE
INFORMATIE OP DIT FORMULIER
EN HEB HET NAAR EER EN GEWETEN INGEVULD.

---

1   https://diplomatie.belgium.be
2   Andorra; België; Bulgarije; Cyprus, Denemarken; Duitsland; Estland; Finland; Frankrijk; Griekenland; Hongarije; Ierland; IJsland; Italië; Kroatië; Letland; Liechtenstein; Litouwen; Luxemburg; Malta; Monaco; Nederland; Noorwegen; Oostenrijk; Polen; Portugal; Roemenië; Slovenië; Slowakije; Spanje; Tsjechië; Vaticaanstad; Verenigd Koninkrijk; Zweden; Zwitserland.
3   De Federale Overheidsdienst Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu is de data controller voor de informatie op dit formulier. De op dit formulier vermelde persoonsgegevens kunnen verzameld en verwerkt worden door de data controller, de grenscontrole en de regionale gezondheidsautoriteiten, in het kader van de contact tracing. De verstrekte persoonsgegevens zullen worden verwerkt in overeenstemming met artikel 6, lid 1, onder c) van de GDPR. Voor meer details en voor informatie over hoe u uw rechten in het kader van de GDPR kunt uitoefenen, kunt u terecht op https://travel.info-coronavirus.be/privacy Dit formulier en alle kopieën worden 28 dagen na uw aankomst vernietigd.

.be

✈		🪑		⬊	📅7
	Vluchtnummer * (bv: SN 2719)		Stoelnummer WAAROP U ZAT tijdens de vlucht *		Dag van aankomst (dd /mm /jjjj) *
🚆		🪑		🚶 📅7	
	Treinnummer * (bv: THA 6)		Stoelnummer WAAROP U ZAT tijdens de reis		Dag van aankomst (dd /mm /jjjj) *
🚌		🪑		🚶 📅7	
	Naam & telefoonnummer van de busmaatschappij *		Nummerplaat van de bus of auto		Dag van aankomst (dd /mm /jjjj) *

	Achternaam *	Voornaam *		♀	♂
👤≣					

Geboortedatum (dd/mm/jjjj) *	Nationaliteit *	Rijksregisternummer /paspoort- of identiteitskaartnummer *

📱 Mobiel +	📞 Thuis 🏠 of op kantoor 🏢 +

@ e-mailadres	

Verblijfplaats de afgelopen 14 dagen (land & regio) *	

	Adres tijdens de 14 dagen quarantaine in België / adres in het land van bestemming (voor passagiers in transit) (thuis, hotel, vrienden, familie): straat, nummer, appartementnummer *
🛏️❓	

Stad *	Staat/provincie	Postcode	Land *

👪 Kinderen jonger dan 16 jaar?	--- ▼	🪑 stoelnummer *	leeftijd *(1-16) 🎂
🧍			
🧍			
🧍			
🧍			

Aansluitende vlucht? *

⬊→ ✈ ✈	🪑	✈ 📅7
Vluchtnummer * (bv: XX2719)	Stoelnummer *	Dag van aankomst (dd /mm/jjjj) *

Annex 2 – Calculation of socio-economic groups

A certain number of points are given for each answer to the following three questions.

a) Exercez-vous actuellement une profession à temps plein ou à temps partiel ?

•	oui	1	**100%**	→ aller en b)
•	non, car pré-retraité(e)	3	**75%**	→ aller en b)
•	non, car pensionné(e) (65 ans et plus)	4	**60%**	→ aller en b)
•	non, car chômeur-chômeuse	6	**60%**	→ aller en b)
•	non, car invalide - incapacité de travail	2	**10%**	→ aller en c)
•	non, car étudiant(e)	5	**10%**	→ aller en c)
•	non, car homme/femme au foyer	7	**10%**	→ aller en c)

b) Quelle est votre profession actuelle (ou votre dernière/votre ancienne profession si vous n'exercez plus) ?

Indépendants			
•	Artisan, commerçant, patron de PME avec 5 salariés ou moins, indépendants...	1	**70**
•	Profession libérale ou « assimilé » (médecin, avocat, architecte, kiné, consultant…)	2	**100**
•	Industriel, commerçant avec plus de 5 salariés	3	**90**
•	Agriculteur	4	**45**
Employés (secteur public ou secteur privé)			
•	Employé de bureau ou autres type d'employés	5	**65**
•	Enseignant(s) ou « assimilé » (instituteur, professeur...)	6	**60**
•	Cadre moyen ne faisant pas partie de la direction	7	**80**
•	Membre de la direction, cadre supérieur	8	**100**
Ouvriers			
•	Ouvrier qualifié (contremaître, chef d'équipe…)	8	**50**
•	Ouvrier non-qualifié (travail manuel, …)	9	**25**
Autres			
•	Autre type de profession (préciser)	10	**50**

c) Quel est le plus haut diplôme que vous ayez obtenu ?

•	primaire ou sans diplôme	1	**10**
•	secondaire inférieur général (3 premières années)	2	**35**
•	secondaire inférieur technique, artistique professionnel (3 premières années)	3	**25**
•	secondaire supérieur général (3 dernières années)	7	**50**
•	secondaire supérieur technique ou artistique (3 dernières années)	5	**45**
•	secondaire supérieur professionnel (3 dernières années)	6	**40**
•	supérieur de type court (bachelier, graduat, candidatures)	7	**75**
•	supérieur de type long (master, licence, post-graduat)	8	**85**
•	supérieur de type long avec diplôme complémentaire	9	**90**
•	doctorat avec thèse	10	**100**
•	autre	11	**40**

The final score is calculated by multiplying the scores from questions a, b and c. According to this final score, the socio-economic group of the respondent is defined. The thresholds for each of the groups are the following :

-       group 1-2: 4101 to 10.000

-       group 3-4: 2181 to 4100

-       group 5-6: 800 to 2180

-       group 7-8: 100 to 799

Annex 3 – Survey questions

TACOM SURVEY

Demografische vragen

1. Als wat identificeert u zichzelf?
   □ man
   □ vrouw
   □ ander

2. Wat is uw leeftijd? ………. (numeric value)
3. In welke provincie woont u? (drop down list)
4. Wat is het hoogste opleidingsniveau dat u hebt behaald?
   □ Geen
   □ Lager onderwijs
   □ Lager secundair onderwijs (1ste 3 jaren)
   □ Hoger secundair onderwijs (minimaal 6 jaar)
   □ Hogere niet-universitaire opleiding / professionele bachelor
   □ Universiteit / academische bachelor, master of doctoraat
5. Buiten uzelf, hoeveel mensen maken deel uit van uw huishouden en wat is hun leeftijd?
   yes/no if yes > add person + age in table……… (numeric value)
   □ Nee
   □ + Voeg persoon toe   (button)
      1. Leeftijd: ……… (numeric value)

6. Wat is het gemiddelde jaarlijks netto-inkomen van uw huishouden (in EUR)?
   □ Minder dan €15.000
   □ Tussen €15.000 en €29.999
   □ Tussen €30.000 en €44.999
   □ Meer dan €45.000

7. Geef uw vaardigheid aan in de volgende talen. Als u vaardig bent in een of meer talen die niet voorkomen in de onderstaande lijst, gelieve deze ook toe te voegen (maximum 3).

	Moedertaal	Vloeiend	Gemiddeld	Basis	Geen
Nederlands	□	□	□	□	□
Frans	□	□	□	□	□
Duits	□	□	□	□	□
Engels	□	□	□	□	□
Andere: ………….. (text)	□	□	□	□	□

Gezondheidssituatie

8. Welke score zou u vandaag aan uw gezondheid geven? (numeric slider 0-100, labeled "zeer slecht" en "zeer goed" aan de uiteinden)

9. Hoe vaak bent u afhankelijk van iemands hulp of zorg om uw gezondheid en welzijn te behouden (bijv. inkopen doen, wassen, medische verzorging)?
   - □ Ik ben niet afhankelijk van iemands hulp of zorg
   - □ Minder dan 1 keer per maand
   - □ 1-3 keer per maand
   - □ 1-3 keer per week
   - □ Meer dan 4 keer per week
   → 10 overslaan als het antwoord "Ik ben niet afhankelijk van iemands hulp of zorg" is

10. Waarom bent u afhankelijk van iemands hulp of zorg? (meerdere antwoorden mogelijk)
   - □ Omwille van mijn leeftijd
   - □ Ik heb moeite met lopen of bewegen
   - □ Ik heb een fysieke aandoening
   - □ Ik heb een mentale aandoening
   - □ Anders, namelijk: …………… (text)

11. Is iemand in uw nabije omgeving (bijv. familielid, goede vriend) afhankelijk van uw hulp of zorg voor zijn/haar gezondheid en welzijn (bijv. inkopen doen, wassen, medische verzorging)?
   - □ Nee
   - □ Ja
   → enkel als het antwoord "Ja" is, 12 vragen:

12. Waarom is die persoon afhankelijk van uw hulp of zorg? (meerdere antwoorden mogelijk)
   - □ Omwille van zijn/haar leeftijd
   - □ Hij/zij heeft moeite met lopen of bewegen
   - □ Hij/zij heeft een fysieke aandoening
   - □ Hij/zij heeft een mentale aandoening
   - □ Anders, namelijk: …………… (text)

Risicoperceptie en kwetsbaarheid voor COVID-19

13. Sinds het begin van de uitbraak, bent u positief getest voor COVID-19? (meerdere antwoorden mogelijk, maar niet in combinatie met "Nee, ik ben niet positief getest")
   - □ Nee, ik ben niet positief getest
   - □ Nee, maar ik heb symptomen gehad die overeenkwamen met COVID-19
   - □ Ja, ik was ziek en gehospitaliseerd
   - □ Ja, Ik was ziek maar niet gehospitaliseerd
   - □ Ja, maar ik had geen symptomen
   → als het antwoord "Nee, ik ben niet positief getest" is, vraag 14 en sla 15 over; als het antwoord "Nee, maar ik heb symptomen gehad die overeenkwamen met COVID-19" of "Ja,…" is, sla 14 over en ga naar vraag 15

14. Hoe zou u de consequenties voor uw gezondheid beoordelen indien u besmet zou raken met COVID-19? (numeric slider 0-100, labeled "helemaal niet ernstig" en "zeer ernstig" aan de uiteinden)

15. Hoe heeft u gedurende uw besmetting met COVID-19 de consequenties voor uw gezondheid ervaren? (numeric slider 0-100, labeled "helemaal niet ernstig" en "zeer ernstig" aan de uiteinden)

16. Is iemand in uw nabije omgeving (bijv. familielid, goede vriend, nabije collega) positief getest voor COVID-19 (meerdere antwoorden mogelijk)?
    - □ Nee, niemand is positief getest
    - □ Nee, maar ik ken iemand die symptomen had die overeenkwamen met COVID-19
    - □ Ja, hij/zij was ziek en gehospitaliseerd
    - □ Ja, hij/zij was ziek maar niet gehospitaliseerd
    - □ Ja, hij/zij testte positief maar had geen symptomen

17. Wat is volgens u het risico dat u of iemand in uw nabije omgeving (bijv. familielid, goede vriend, nabije collega) besmet zal raken met het virus dat COVID-19 veroorzaakt?

	Geen risico	Onwaarschijnlijk	Neutraal	Waarschijnlijk	Zekerheid	Niet van toepassing
Uzelf	□	□	□	□	□	□
Uw ouders	□	□	□	□	□	□
Uw grootouders	□	□	□	□	□	□
Uw partner	□	□	□	□	□	□
Uw kind(eren)	□	□	□	□	□	□
Een goede vriend	□	□	□	□	□	□
Een nabije collega	□	□	□	□	□	□
Anders, namelijk: …… (text)	□	□	□	□	□	□

Informatiebronnen, vertrouwen en begrip

18. In welke mate beschouwt u zich geïnformeerd over de huidige COVID-19 maatregelen? (numeric slider 0-100, labeled "Helemaal niet geïnformeerd" en "zeer goed geïnformeerd" aan de uiteinden)

19. Welke kanalen verkiest u om informatie te verkrijgen over de COVID-19 maatregelen? (meerdere antwoorden mogelijk)
    - □ Geen
    - □ Televisie
    - □ Radio
    - □ Kranten of nieuwssites
    - □ Sociale media
    - □ Anders, namelijk: …… (text)
    - □ Ik weet het niet

20. In hoeverre hebben de onderstaande groepen bijgedragen om u te informeren over de huidige COVID-19 maatregelen?

	Helemaal niet	Een beetje	Gemiddeld	Veel	Volledig	Niet van toepassing
Politici (bijv. van de nationale veiligheidsraad)	□	□	□	□	□	□

Experten (bijv. de expertengroep (GEES), dokter, epidemioloog)	☐	☐	☐	☐	☐	☐
Journalisten	☐	☐	☐	☐	☐	☐
Mensen uit uw nabije omgeving (bijv. een familielid, vriend)	☐	☐	☐	☐	☐	☐
Anders, namelijk (bijv. influencers, enz.): …… (text)	☐	☐	☐	☐	☐	☐

21. Geef voor elk van de onderstaande groepen aan in hoeverre deze volgens u duidelijke informatie verstrekken over de huidige COVID-19 maatregelen.

	Volkomen onduidelijk	Vrij onduidelijk	Neutraal	Vrij duidelijk	Volkomen duidelijk	Niet van toepassing
Politici (bijv. van de nationale veiligheidsraad)	☐	☐	☐	☐	☐	☐
Experten (bijv. de expertengroep (GEES), dokter, epidemioloog)	☐	☐	☐	☐	☐	☐
Journalisten	☐	☐	☐	☐	☐	☐
Mensen uit uw nabije omgeving (bijv. een familielid, vriend)	☐	☐	☐	☐	☐	☐
Anders, namelijk (bijv. influencers, enz.) : …… (text)	☐	☐	☐	☐	☐	☐

22. Geef voor elk van de onderstaande groepen aan in hoeverre deze volgens u betrouwbare informatie verstrekken over de huidige COVID-19 maatregelen.

	Zeer onbetrouwbaar	Vrij onbetrouwbaar	Neutraal	Vrij betrouwbaar	Zeer betrouwbaar	Niet van toepassing
Politici (bijv. van de nationale veiligheidsraad)	☐	☐	☐	☐	☐	☐
Experten (bijv. de expertengroep (GEES), dokter, epidemioloog)	☐	☐	☐	☐	☐	☐
Journalisten	☐	☐	☐	☐	☐	☐

Mensen uit uw nabije omgeving (bijv. een familielid, vriend)	□	□	□	□	□	□
Andere, namelijk (bijv. influencers, enz.) …… (text)	□	□	□	□	□	□

Gedrag omtrent huidige COVID-19 maatregelen

23. In hoeverre heeft u elk van de genoemde COVID-19 maatregelen die gelden voor augustus begrepen?

	Helemaal niet	Een beetje	Min of meer	Vrij goed	Zeer goed	Niet van toepassing
De sociale bubbel is beperkt tot 5 personen	□	□	□	□	□	□
Private evenementen zijn beperkt tot max. 10 personen	□	□	□	□	□	□
Officieel georganiseerde evenementen zijn beperkt tot 200 personen binnen en 400 personen buiten	□	□	□	□	□	□
Thuis werken is sterk aangeraden wanneer het kan	□	□	□	□	□	□
Winkel met maximaal 2 personen	□	□	□	□	□	□
Een mondmasker is vereist op plaatsen in de openbare ruimte waar het verplicht is (bijv. winkelstraten, bioscopen) of wanneer 1.5 meter afstand houden niet mogelijk is	□	□	□	□	□	□
Een formulier moet ingevuld worden wanneer u terugkeert of reist naar België vanuit het buitenland	□	□	□	□	□	□
Er zijn 3 soorten reiszones (rood, oranje, groen) die bepalen of u mag reizen en of quarantaine of testen vereist zijn bij terugkeer	□	□	□	□	□	□

24. In welke mate vindt u elk van de genoemde COVID-19 maatregelen die gelden voor augustus nuttig om verdere verspreiding van COVID-19 te voorkomen?

	Helemaal niet nuttig	Een beetje nuttig	Min of meer nuttig	Vrij nuttig	Zeer nuttig	Niet van toepassing
De sociale bubbel is beperkt tot 5 personen	☐	☐	☐	☐	☐	☐
Private evenementen zijn beperkt tot max. 10 personen	☐	☐	☐	☐	☐	☐
Officieel georganiseerde evenementen zijn beperkt tot 200 personen binnen en 400 personen buiten	☐	☐	☐	☐	☐	☐
Thuis werken is sterk aangeraden wanneer het kan	☐	☐	☐	☐	☐	☐
Winkel met maximaal 2 personen	☐	☐	☐	☐	☐	☐
Een mondmasker is vereist op plaatsen in de openbare ruimte waar het verplicht is (bijv. winkelstraten, bioscopen) of wanneer 1.5 meter afstand houden niet mogelijk is	☐	☐	☐	☐	☐	☐
Een formulier moet ingevuld worden wanneer u terugkeert of reist naar België vanuit het buitenland	☐	☐	☐	☐	☐	☐
Er zijn 3 soorten reiszones (rood, oranje, groen) die bepalen of u mag reizen en of quarantaine of testen vereist zijn bij terugkeer	☐	☐	☐	☐	☐	☐

25. Geef voor elk van de volgende stellingen aan of het volgens u juiste interpretaties zijn van de COVID-19 maatregelen die gelden voor augustus.

	Juist	Fout	Ik weet het niet
Een huishouden van 2 personen mag een feestje of weekend organiseren met 10 andere volwassenen	□	□	□
Wanneer u met een collega na het werk afspreekt om iets te drinken en u behoudt 1.5 meter afstand, dan telt deze persoon niet mee in uw bubbel van 5	□	□	□
In uw bubbel van 5 mogen personen zitten die in een andere stad wonen	□	□	□
Het is niet vereist een mondmasker te dragen wanneer u sport	□	□	□
Het is vereist om een mondmasker te dragen wanneer u gaat wandelen in een park of bos	□	□	□
Wanneer u 1.5 meter afstand kan behouden is het niet nodig om een mondmasker te dragen in de openbare ruimte	□	□	□
Het is niet toegestaan om een bar te bezoeken, binnen of buiten, met mensen die geen deel uitmaken van uw bubbel van 5	□	□	□
Als je een gezin bezoekt dat bestaat uit 3 volwassenen en 2 kinderen onder 12, mag u daarnaast nog 2 andere volwassenen aan uw bubbel van 5 toevoegen	□	□	□
Als u vanuit een oranje zone naar België reist, hoeft u niet getest te worden of in quarantaine te gaan bij aankomst	□	□	□
Voor bruiloften mag men tot 100 gasten uitnodigen	□	□	□

26. In welke mate vindt u het eenvoudig om elk van de genoemde COVID-19 maatregelen die gelden voor augustus na te leven?

	Zeer moeilijk	Vrij Moeilijk	Neutraal	Vrij makkelijk	Zeer makkelijk	Niet van toepassing
De sociale bubbel is beperkt tot 5 personen	☐	☐	☐	☐	☐	☐
Private evenementen zijn beperkt tot max. 10 personen	☐	☐	☐	☐	☐	☐
Officieel georganiseerde evenementen zijn beperkt tot 200 personen binnen en 400 personen buiten	☐	☐	☐	☐	☐	☐
Thuis werken is sterk aangeraden wanneer het kan	☐	☐	☐	☐	☐	☐
Winkel met maximaal 2 personen	☐	☐	☐	☐	☐	☐
Een mondmasker is vereist op plaatsen in de openbare ruimte waar het verplicht is (bijv. winkelstraten, bioscopen) of wanneer 1.5 meter afstand houden niet mogelijk is	☐	☐	☐	☐	☐	☐
Een formulier moet ingevuld worden wanneer u terugkeert of reist naar België vanuit het buitenland	☐	☐	☐	☐	☐	☐
Er zijn 3 soorten reiszones (rood, oranje, groen) die bepalen of u mag reizen en of quarantaine of testen vereist zijn bij terugkeer	☐	☐	☐	☐	☐	☐

27. In welke mate heeft u elk van de genoemde COVID-19 maatregelen die gelden voor augustus nageleefd?

	Helemaal niet	Een beetje	Min of meer	Vrij goed	Volledig	Niet van toepassing
De sociale bubbel is beperkt tot 5 personen	□	□	□	□	□	□
Private evenementen zijn beperkt tot max. 10 personen	□	□	□	□	□	□
Officieel georganiseerde evenementen zijn beperkt tot 200 personen binnen en 400 personen buiten	□	□	□	□	□	□
Thuis werken is sterk aangeraden wanneer het kan	□	□	□	□	□	□
Winkel met maximaal 2 personen	□	□	□	□	□	□
Een mondmasker is vereist op plaatsen in de openbare ruimte waar het verplicht is (bijv. winkelstraten, bioscopen) of wanneer 1.5 meter afstand houden niet mogelijk is	□	□	□	□	□	□
Een formulier moet ingevuld worden wanneer u terugkeert of reist naar België vanuit het buitenland	□	□	□	□	□	□
Er zijn 3 soorten reiszones (rood, oranje, groen) die bepalen of u mag reizen en of quarantaine of testen vereist zijn bij terugkeer	□	□	□	□	□	□

28. In welke mate bent u van plan om in de toekomst elk van de genoemde COVID-19 maatregelen die gelden voor augustus na te leven, tot er nieuwe maatregelen worden uitgevaardigd?

	Helemaal niet	Een beetje	Min of meer	Vrij goed	Volledig	Niet van toepassing
De sociale bubbel is beperkt tot 5 personen	□	□	□	□	□	□
Private evenementen zijn beperkt tot max. 10 personen	□	□	□	□	□	□
Officieel georganiseerde evenementen zijn beperkt tot 200 personen binnen en 400 personen buiten	□	□	□	□	□	□
Thuis werken is sterk aangeraden wanneer het kan	□	□	□	□	□	□
Winkel met maximaal 2 personen	□	□	□	□	□	□
Een mondmasker is vereist op plaatsen in de openbare ruimte waar het verplicht is (bijv. winkelstraten, bioscopen) of wanneer 1.5 meter afstand houden niet mogelijk is	□	□	□	□	□	□
Een formulier moet ingevuld worden wanneer u terugkeert of reist naar België vanuit het buitenland	□	□	□	□	□	□
Er zijn 3 soorten reiszones (rood, oranje, groen) die bepalen of u mag reizen en of quarantaine of testen vereist zijn bij terugkeer	□	□	□	□	□	□

29. Geef aan in welke mate u akkoord bent met de volgende stellingen:

	Helemaal niet akkoord	Niet akkoord	Neutraal	Akkoord	Helemaal akkoord	Niet van toepassing
Ik vind dat de overheid de bevolking moet verplichten om de COVID-19 maatregelen na te leven	□	□	□	□	□	□
Ik vind dat de overheid de bevolking moet aanbevelen, maar niet verplichten, om de COVID-19 maatregelen na te leven	□	□	□	□	□	□
Ik vind dat het helpt wanneer de omgeving me herinnert aan de huidige COVID-19 maatregelen (bijv. stickers op de grond)	□	□	□	□	□	□

Wilt u wat betreft de verschillende COVID-19 maatregelen nog andere elementen toevoegen?

………………………………………… (open vraag)

French survey

ENQUÊTE TACOM

Questions Démographiques

30. À quel genre vous identifiez-vous ?
    □ Masculin
    □ Féminin
    □ Autre

31. Quel âge avez-vous ?   ……… (valeur numérique)
32. Dans quelle province vivez-vous ? (liste déroulante)
33. Quel est le plus haut niveau d'éducation que vous ayez atteint ?
    □   Aucun
    □   Enseignement primaire
    □   Enseignement secondaire inférieur (les 3 premières années)
    □   Enseignement secondaire supérieur (minimum 6 années)
    □   Enseignement supérieur non universitaire / bachelier professionnel
    □   Enseignement supérieur universitaire bachelier/master/doctorat

34. À part vous, combien d'autres personnes vivent actuellement dans votre ménage et quel âge ont-elles ?
    oui/non, si oui > ajouter une personne + âge dans le tableau……… (valeur numérique)
    □   Aucune
    □   + Ajouter une personne (bouton)
        2.   Âge : ……… (valeur numérique)

35. Quel est le revenu annuel moyen de votre ménage après prélèvement des taxes (NET en EUR) ?
    □   Moins de €15.000
    □   Entre €15.000 et €29.999
    □   Entre €30.000 et €44.999
    □   Plus de €45.000

36. Quel est votre niveau de compétences pour les langues citées ci-dessous ? Si vous disposez de compétences dans une ou plusieurs autres langues non présentées dans la liste, veuillez les ajouter également (maximum 3).

	Langue maternelle	Maîtrise	Intermédiaire	Basique	Aucun
Français	□	□	□	□	□
Néerlandais	□	□	□	□	□
Allemand	□	□	□	□	□
Anglais	□	□	□	□	□
Autre : …… (texte)	□	□	□	□	□

Situation Sanitaire

37. Comment évalueriez-vous votre santé aujourd'hui ? (Curseur numérique 0-100, de "très mauvaises" à "très bonne")

38. À quelle fréquence dépendez-vous de l'aide ou des soins d'une personne pour maintenir votre santé et votre bien-être (par exemple, pour faire les courses, faire la lessive, recevoir des soins médicaux) ?
    □ Je ne suis pas dépendant de l'aide ou des soins de quelqu'un
    □ Moins d'une fois par mois
    □ 1 à 3 fois par mois
    □ 1 à 3 fois par semaine
    □ Plus de 4 fois par semaine

    → Passer la question 10 seulement si la réponse est "Je ne suis pas dépendant des soins de quelqu'un »

39. Pour quelle(s) raison(s) êtes-vous dépendant de l'aide ou des soins d'une autre personne ? (Plusieurs réponses possibles)
    □ À cause de mon âge
    □ J'ai des difficultés pour bouger ou me déplacer
    □ J'ai un problème de santé physique
    □ J'ai un problème de santé mentale
    □ Autre: .... (texte)

40. Avez-vous un·e proche (par exemple, un parent, un·e bon·ne ami·e) qui dépend de votre aide ou de vos soins pour maintenir sa santé et son bien-être (par exemple, pour faire les courses, faire la lessive, recevoir des soins médicaux) ?
    □ Non
    □ Oui
    → Si la réponse est "oui", alors poser la question 12 :

41. Pour quelle(s) raison(s) cette personne est-elle dépendante de votre aide ou vos soins ? (Plusieurs réponses possibles)
    □ À cause de son âge
    □ Elle a des difficultés pour bouger ou se déplacer
    □ Elle a un problème de santé physique
    □ Elle a un problème de santé mentale
    □ Autre : .... (texte)

PERCEPTION DES RISQUES ET VULNÉRABILITÉ À LA COVID-19

42. Depuis le début de l'épidémie, avez-vous été testé·e positif à la COVID-19 ? (Plusieurs réponses possibles, pas en combinaison avec « Non, je n'ai pas été testé positif/positive »)
    □ Non, je n'ai pas été testé positif/positive

□ Non, mais j'ai eu des symptômes correspondant à la COVID-19

□ Oui, mais je n'ai pas eu de symptômes

□ Oui, j'ai été malade, mais pas hospitalisé·e

□ Oui, j'ai été malade et hospitalisé·e

→ Si la réponse est 'non', poser la question 14 et passer la 15, si la réponse est 'Non, mais j'ai eu des symptômes correspondant à la COVID-19 ' ou 'oui, ...', passer la 14 et poser la 15

43. Comment évalueriez-vous les conséquences pour votre santé, si vous deviez être infecté par le virus de la COVID-19 ? (Curseur numérique 0-100, de "pas du tout grave" à "très grave")

44. Comment avez-vous vécu les conséquences pour votre santé lorsque vous avez été infecté par le virus de la COVID-19 ? (Curseur numérique 0-100, de "pas du tout grave" à "très grave")

45. L'un·e de vos proches (par exemple, un parent, un ami, un collègue proche) a-t-il/elle été testé·e positif/positive à la COVID-19 ? (Plusieurs réponses possibles)

□ Non

□ Non, mais je connais quelqu'un a eu des symptômes correspondant à la COVID-19

□ Oui, quelqu'un qui a été malade et hospitalisé

□ Oui, quelqu'un qui a été malade, mais pas hospitalisé

□ Oui, mais il/elle n'avait pas de symptômes

46. Selon vous, quel est le risque que vous ou l'un·e de vos proches (par exemple, un parent, un·e bon·ne ami·e, un·e collègue proche) soyez infecté par le virus de la COVID-19 ?

	Aucun risque	Peu probable	Ni improbable, ni probable	Probable	Certain	Non applicable
Vous-même	□	□	□	□	□	□
Vos parents	□	□	□	□	□	□
Vos grands-parents	□	□	□	□	□	□
Votre partenaire	□	□	□	□	□	□
Votre/vos enfant(s)	□	□	□	□	□	□
Un·e bon·ne ami·e	□	□	□	□	□	□
Un·e collègue proche	□	□	□	□	□	□
Autre: …… (texte)	□	□	□	□	□	□

SOURCES D'INFORMATION, CONFIANCE ET COMPRÉHENSION DE L'INFORMATION

47. Dans quelle mesure vous considérez-vous informé·e des mesures de prévention actuelles de la COVID-19 ? (curseur numérique 0-100, de "pas du tout informé·e" à "très bien informé·e")

48. Quel **canal** préférez-vous utiliser pour accéder aux informations sur les mesures de prévention de la COVID-19 ?? (plusieurs réponses possibles
    □ Aucun
    □ Télévision
    □ Radio
    □ Journaux ou sites internet d'information
    □ Les médias sociaux et réseaux sociaux
    □ Autres: …… (texte)
    □ Je ne sais pas

49. Dans quelle mesure les groupes cités ci-dessous ont-ils contribué à vous informer sur les mesures de prévention actuelles de la COVID-19 ?

	Pas du tout	Un peu	Moyennement	Beaucoup	Entièrement	Non applicable
Les femmes et hommes politiques (par exemple, le Conseil national de sécurité)	□	□	□	□	□	□
Les experts (par exemple, le groupe d'experts GEES, des médecins, des épidémiologistes)	□	□	□	□	□	□
Les journalistes	□	□	□	□	□	□
Des personnes proches (par exemple, de la famille, des amis)	□	□	□	□	□	□
Autres, à préciser (par exemple, des influenceurs, etc.) : …… (texte)	□	□	□	□	□	□

50. Dans quelle mesure considérez-vous que les informations à propos des mesures de prévention actuelles de la COVID-19 fournies par chacun des groupes cités ci-dessous sont claires ?

	Pas du tout claires	Pas vraiment claires	Ni claires, ni pas claires	Assez claires	Tout à fait claires	Non applicable
Les femmes et hommes politiques (par exemple, le Conseil national de sécurité)	☐	☐	☐	☐	☐	☐
Les experts (par exemple, le groupe d'experts GEES, des médecins, des épidémiologistes)	☐	☐	☐	☐	☐	☐
Les journalistes	☐	☐	☐	☐	☐	☐
Des personnes proches (par exemple, de la famille, des amis)	☐	☐	☐	☐	☐	☐
Autres, à préciser (par exemple, des influenceurs, etc.): …… (texte)	☐	☐	☐	☐	☐	☐

51. Dans quelle mesure considérez-vous que les informations à propos des mesures de prévention actuelles de la COVID-19 fournies par chacun des groupes cités ci-dessous sont fiables ?

	Pas du tout fiables	Pas vraiment fiables	Ni fiables, ni pas fiables	Assez fiables	Tout à fait fiables	Non applicable
Les femmes et hommes politiques (par exemple, le Conseil national de sécurité)	□	□	□	□	□	□
Les experts (par exemple, le groupe d'experts GEES, des médecins, des épidémiologistes)	□	□	□	□	□	□
Les journalistes	□	□	□	□	□	□
Des personnes proches (par exemple, de la famille, des amis)	□	□	□	□	□	□
Autres, à préciser (par exemple, des influenceurs, etc.) : …… (texte)	□	□	□	□	□	□

COMPORTEMENTS CONCERNANT LES MESURES de prévention ACTUELLES DE LA COVID-19

52. Dans quelle mesure avez-vous compris les mesures de prévention de la COVID-19 citées ci-dessous qui s'appliquent au cours du mois d'août ?

	Pas du tout	Un peu	Moyennement	Assez bien	Très bien	Non applicable
La bulle sociale est limitée à 5 personnes	☐	☐	☐	☐	☐	☐
Les événements privés sont limités à maximum 10 personnes	☐	☐	☐	☐	☐	☐
La limite de participants aux événements publics est de max. 200 personnes à l'intérieur et max. 400 personnes à l'extérieur	☐	☐	☐	☐	☐	☐
Le télétravail autant que possible est hautement recommandé	☐	☐	☐	☐	☐	☐
Faire ses achats avec maximum 1 autre personne	☐	☐	☐	☐	☐	☐
Porter un masque dans les lieux publics lorsque cela est obligatoire (par exemple, dans les rues commerçantes, les cinémas) et quand le respect de la distance	☐	☐	☐	☐	☐	☐

d'1,5 mètre n'est pas possible						
Compléter le formulaire obligatoire lorsque vous venez ou revenez en Belgique après un voyage à l'étranger	□	□	□	□	□	□
Il existe trois types de zones de voyages (rouge, orange, verte) qui déterminent les conditions d'autorisation pour s'y rendre et si la quarantaine et le dépistage sont requis après le retour en Belgique	□	□	□	□	□	□

53. Dans quelle mesure pensez-vous que les mesures de prévention citées ci-dessous, qui s'appliquent au cours du mois d'août, sont utiles pour prévenir la propagation de la COVID-19 ?

	Pas du tout	Un peu utiles	Moyennement utiles	Assez utiles	Extrêmement utiles	Non applicable
La bulle sociale est limitée à 5 personnes	□	□	□	□	□	□
Les événements privés sont limités à maximum 10 personnes	□	□	□	□	□	□
La limite de participants aux événements publics est de max. 200 personnes à l'intérieur et max. 400 personnes à l'extérieur	□	□	□	□	□	□
Le télétravail autant que possible est	□	□	□	□	□	□

hautement recommandé						
Faire ses achats avec maximum 1 autre personne	□	□	□	□	□	□
Porter un masque dans les lieux publics lorsque cela est obligatoire (par exemple, dans les rues commerçantes, les cinémas) et quand le respect de la distance d'1,5 mètre n'est pas possible	□	□	□	□	□	□
Compléter le formulaire obligatoire lorsque vous venez ou revenez en Belgique après un voyage à l'étranger	□	□	□	□	□	□
Il existe trois types de zones de voyages (rouge, orange, verte) qui déterminent les conditions d'autorisation pour s'y rendre et si la quarantaine et le dépistage sont requis après le retour en Belgique	□	□	□	□	□	□

54. Considérez-vous les déclarations suivantes comme étant des interprétations correctes des mesures de prévention de la COVID-19 qui s'appliquent au cours du mois d'août ?

	Vrai	Faux	Je ne sais pas
Un ménage de 2 personnes est autorisé à organiser une fête ou un week-end avec 10 autres adultes.	☐	☐	☐
Lorsque vous rencontrez un collègue après le travail pour boire un verre et que vous maintenez une distance d'1,5 mètre, cette personne ne fait pas partie de la bulle de 5 personnes de votre ménage	☐	☐	☐
La bulle de 5 personnes de votre ménage peut inclure des personnes vivant dans une autre ville	☐	☐	☐
Il n'est pas obligatoire de porter un masque lors de séance de sport	☐	☐	☐
Il est obligatoire de porter un masque lors d'une promenade dans un parc ou une forêt	☐	☐	☐
Lorsque vous pouvez maintenir une distance d'1,5 mètre, il n'est pas nécessaire de porter un masque dans les lieux publics	☐	☐	☐
Il n'est pas permis de se rendre dans un bar, à l'intérieur ou à l'extérieur, avec des personnes qui ne font pas partie de votre bulle de 5	☐	☐	☐
Si vous visitez une famille composée de 3 adultes et de 2 enfants de moins de 12 ans, vous pouvez encore ajouter 2 adultes à votre bulle de 5	☐	☐	☐
Si vous voyagez d'une zone orange vers la Belgique, vous n'avez pas besoin d'être testé ou mis en quarantaine à votre retour	☐	☐	☐
Pour un mariage, il est autorisé d'inviter jusqu'à 100 personnes.	☐	☐	☐

55. Dans quelle mesure estimez-vous que les mesures de prévention de la COVID-19, citées ci-dessous, qui s'appliquent au cours du mois d'août, sont faciles à respecter ?

	Très difficiles	Assez difficiles	Neutre	Assez faciles	Très faciles	Non applicable
La bulle sociale est limitée à 5 personnes	☐	☐	☐	☐	☐	☐
Les événements privés sont limités à maximum 10 personnes	☐	☐	☐	☐	☐	☐
La limite de participants aux événements publics est de max. 200 personnes à l'intérieur et max. 400 personnes à l'extérieur	☐	☐	☐	☐	☐	☐
Le télétravail autant que possible est hautement recommandé	☐	☐	☐	☐	☐	☐
Faire ses achats avec maximum 1 autre personne	☐	☐	☐	☐	☐	☐
Porter un masque dans les lieux publics lorsque cela est obligatoire (par exemple, dans les rues commerçantes, les cinémas) et quand le respect de la distance d'1,5 mètre n'est pas possible	☐	☐	☐	☐	☐	☐
Compléter le formulaire obligatoire lorsque vous venez ou revenez en Belgique après un voyage à l'étranger	☐	☐	☐	☐	☐	☐
Il existe trois types de zones de voyages (rouge, orange, verte) qui déterminent les	☐	☐	☐	☐	☐	☐

conditions d'autorisation pour s'y rendre et si la quarantaine et le dépistage sont requis après le retour en Belgique

56. Dans quelle mesure avez-vous respecté les mesures de prévention de la COVID-19, citées ci-dessous, qui s'appliquent au cours du mois d'août ?

	Pas du tout	Un peu	Moyennement	Assez bien	Tout à fait	Non-applicable
La bulle sociale est limitée à 5 personnes	□	□	□	□	□	□
Les événements privés sont limités à maximum 10 personnes	□	□	□	□	□	□
La limite de participants aux événements publics est de max. 200 personnes à l'intérieur et max. 400 personnes à l'extérieur	□	□	□	□	□	□
Le télétravail autant que possible est hautement recommandé	□	□	□	□	□	□
Faire ses achats avec maximum 1 autre personne	□	□	□	□	□	□
Porter un masque dans les lieux publics lorsque cela est obligatoire (par exemple, dans les rues commerçantes, les cinémas) et quand le respect de la distance d'1,5 mètre n'est pas possible	□	□	□	□	□	□
Compléter le formulaire obligatoire lorsque vous venez ou revenez en	□	□	□	□	□	□

Belgique après un voyage à l'étranger

Il existe trois types de zones de voyages (rouge, orange, verte) qui déterminent les conditions d'autorisation pour s'y rendre et si la quarantaine et le dépistage sont requis après le retour en Belgique

□   □   □   □   □   □

57. Dans quelle mesure avez-vous l'intention de respecter les mesures de prévention de la COVID-19 citées ci-dessous, qui s'appliquent au cours du mois d'août, jusqu'à ce que de nouvelles mesures soient émises.

	Pas du tout	Un peu	Moyennement	Assez bien	Tout à fait	Non-applicable
La bulle sociale est limitée à 5 personnes	□	□	□	□	□	□
Les événements privés sont limités à maximum 10 personnes	□	□	□	□	□	□
La limite de participants aux événements publics est de max. 200 personnes à l'intérieur et max. 400 personnes à l'extérieur	□	□	□	□	□	□
Le télétravail autant que possible est recommandé	□	□	□	□	□	□
Faire ses achats avec maximum 1 autre personne	□	□	□	□	□	□
Porter un masque dans les lieux publics lorsque cela est obligatoire (par exemple, dans les rues commerçantes, les cinémas) et quand le respect de la distance d'1,5 mètre n'est pas possible	□	□	□	□	□	□
Compléter le formulaire obligatoire lorsque vous venez ou revenez en Belgique après un voyage à l'étranger	□	□	□	□	□	□

Il existe trois types de zones de voyages (rouge, orange, verte) qui déterminent les conditions d'autorisation pour s'y rendre et si la quarantaine et le dépistage sont requis après le retour en Belgique

☐   ☐   ☐   ☐   ☐   ☐

58. Dans quelle mesure êtes-vous d'accord avec les déclarations suivantes ?

	Pas du tout d'accord	Pas vraiment d'accord	Ni pas d'accord, ni d'accord	Assez d'accord	Tout à fait d'accord	Non applicable
Je pense que le gouvernement devrait obliger le public à respecter les mesures COVID-19	□	□	□	□	□	□
Je pense que le gouvernement devrait recommander, mais pas obliger, le public à appliquer les mesures COVID-19	□	□	□	□	□	□
Je pense qu'il est utile que des éléments de l'environnement me rappellent les mesures de prévention actuelles de la COVID-19 (par exemple, les autocollants sur le sol)	□	□	□	□	□	□

59. Concernant les différentes mesures de prévention de la COVID-19, souhaitez-vous ajouter d'autres éléments ? ………………………………………….(Question ouverte)

Annex 4. Perceived risk of respondents or people close to them becoming infected with COVID-19.

Person(s)	No risk	Unlikely	Neutral	Likely	Definitite	Not applicable
	%	%	%	%	%	%
Yourself	7.6	25.3	42.8	20.2	3.0	1.1
Your parents	6.0	17.0	27.9	13.7	2.4	32.9
Your grandparents	6.8	9.8	13.2	5.1	1.7	63.4
Your partner	6.0	16.0	32.5	16.4	2.1	26.9
Your child(ren)	5.4	13.7	29.2	16.8	1.8	33.0
A friend	3.7	12.5	44.4	26.4	2.8	10.1
A close colleague	3.8	7.6	30.0	19.9	2.8	36.0

Annex 5. Scatterplot between past and future level of implementation of COVID-19 measures.

Simple Scatter of FutureImplementation by PastImplementation
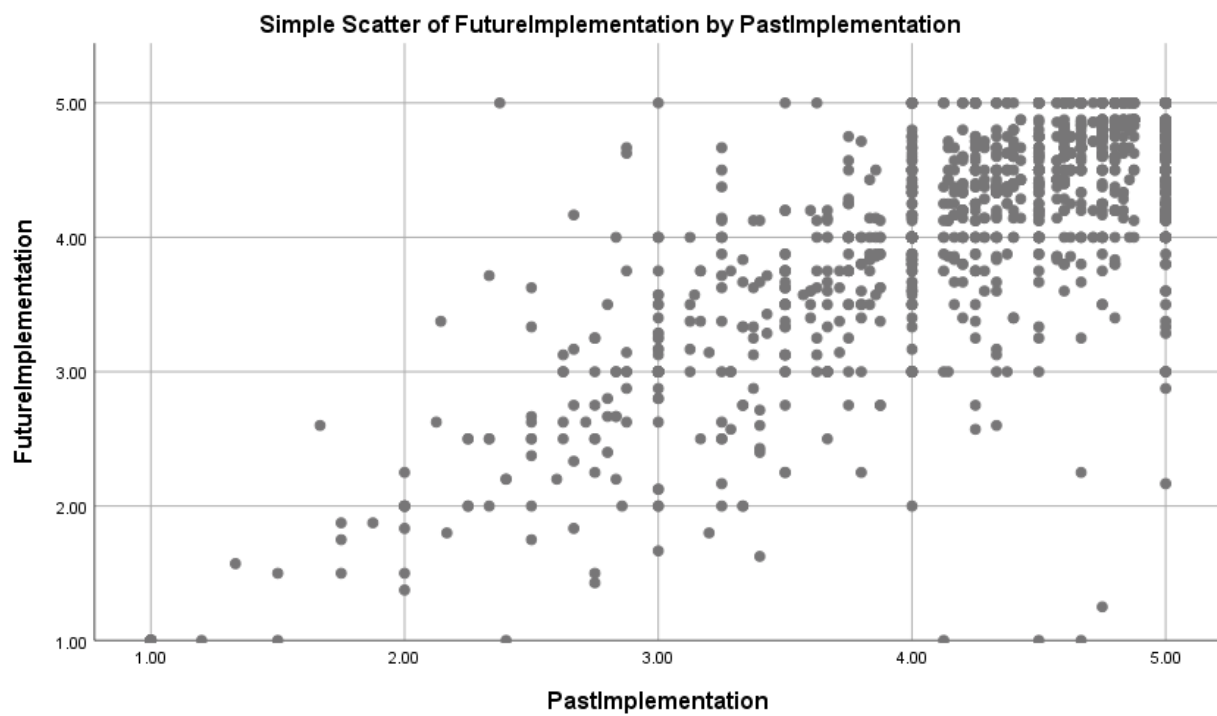
Annex 6. Correct number of answers to ten 'True / False' statements on current COVID-19 measures in Belgium.

Simple Histogram Count of Correct number of answers