COSMO-SPAIN

Monitoring knowledge, risk perceptions, preventive behaviours and trust to inform pandemic outbreak response: COSMO-Spain

Version 1, July 2020

Behavioural insights on COVID-19 in Spain: COSMO-Spain

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Project summary

The Spanish Ministry of Health and the Institute of Health Carlos III plan to conduct a serial, cross-sectional study to assess the public's risk perceptions, behaviours, trust, knowledge and other variables related to the COVID-19 pandemic. Using a questionnaire, data will be gathered by a data collection company via online panels every two months extending the data collection over time as long as the epidemic continues.

The focus of the research is to inform effective and appropriate outbreak response interventions, policies and messages. Research questions relate to identify

- levels of and changes in relevant COVID-19-related variables (such as risk perceptions, knowledge, self-efficacy, confidence in institutions, health literacy, vaccine hesitancy, behaviors, affect, worry, resilience, trust in/use of information sources and more).
- whether participants report that they are aware of specific recommended behaviours and adhere to them;
- whether certain patterns can be identified through stratifying data, e.g. as relates to
    o whether changes in risk perceptions relate to characteristics or events of the pandemic and other variables;
    o whether risk perceptions or other variables relate to prevention behaviours
    o whether low knowledge and adverse behaviours relate to certain sources of information.

This approach allows a citizen-centred approach where insights into population perceptions and behaviours inform COVID-19 actions, alongside epidemiological data and considerations of economic, cultural, ethical, structural political nature and other.

Despite limitations noted in this application, this survey can have an important impact on the health and well-being of all citizens and residents in Spain.

Annex 1: Questionnaire used in round 1, in Spanish.

Rationale and background information

On January 31st, the first case of coronavirus was detected in Spain, an imported case that was immediately isolated. However, the numbers of cases rose rapidly and by March 10ththere were 1,600. On March 14th, the Spanish government declared the state of alarm for the management of the health crisis situation caused by COVID-19, which involved the lockdown of the entire population limiting their mobility to basic needs. Likewise, all productive activities that were not considered essential were closed and telework was promoted. The strict confinement lasted until May 11th, when the different regions of Spain began to downgrade their confinement according to the evolution of their epidemic. The state of alarm ended on June 21st, 2020. The highest peak of the epidemic arrived on March 20th, reaching 10,796 confirmed cases. From that date, the number of newly confirmed cases began to fall in a trend that has continued until today. Around 800 deaths per day were registered in Spain during the peak of the epidemic, while in the last week the number of deaths recorded was 8. In total, Covid19 has caused 246,752 confirmed cases in Spain and 28,325 deaths by June 24th.

Public adherence to preventive behaviour and restrictions requires that the general population understands, trusts and accepts the recommendations as well as the government and health authorities issuing such guidance. When people perceive response measures as being characterized by consistency, competence, fairness, objectivity, empathy or sincerity, this increases trust (2). When such measures are also easily understood and communicated through trusted and accessible channels, people are able to make informed choices, protect themselves and comply with recommended practices (3) (4).

Models of crisis and emergency risk communication (5) suggest that it is crucial to understand the risk perception of the population and the sources of information that they trust to enable effective communication and framing key messages. Messaging should be evidence-based to respond to misinformation and induce rational, adaptive and protective behaviour (6). However, pandemic response is not only about communication, and not enough is known about the complex interplay of changing epidemiology, media attention, pandemic control measures, risk perception and public health behaviour (7). A study conducted during the influenza A(H1N1)pdm09 pandemic in 2009/2010 showed an "asynchronicity" between media curves and epidemiological curves (…); media attention for influenza A H1N1 in Europe declined long before the epidemic reached its peak, and public risk perceptions and behaviours may have followed media logic, rather than epidemiological logic" (7). Thus, how people perceive the risk is not necessarily related to the actual risk. This perceived risk, nevertheless, influences protective behaviours (8). Nonetheless, uncertainty about the situation and perceived exaggeration were associated with a reduced likeliness to implement the recommended protective behaviours during the 2009/10 pandemic (9). During the flu pandemic, a perceived inconsistency in recommendations was identified as a critical issue for non-compliance. Exaggeration of risks often happens on social media, where especially highly emotional and often false information are shared (10). While a serial cross-sectional study involving over 13,000 participants during the 2009/2010 pandemic (11) showed that the internet was significantly less used as a source of information than traditional media, this may well have changed over the last decade. For example, the number of monthly Twitter users multiplied by ten from

30 million in 2009 to 330 million in 2019 (12) and Twitter seems to be seen as an alert tool in times of a crisis and a gateway for information (13). Thus, knowledge acquired during the last pandemic is only of limited value to guide crisis responses in the current one, and real-time population insight is of critical importance.

This pandemic brings new challenges daily, to governments and citizens alike. Psychologically, this means high uncertainty regarding the likelihood of catching the disease, its potential severity and ability to take control over the process by preventive measure. These perceptions are thus likely to be updated based on changes in epidemiology, media reports, information and misinformation.

As we move ahead towards a transition phase of gradually shifting restrictions and reopening the society, population insights become increasing important to inform response measures. As the crisis evolves, the possible negative implication for mental and physical health and well-being, social and economic consequences are likely to be growing, and the risk of reactance, fatigue and resulting resistance become equally higher.

In order to understand these factors and how best to respond to the rapidly changing situation, Spain has adapted the survey tool made available by WHO/Europe to the context of the COVID-19 situation in the country. This survey will be conducted every two months, extending the data collection over time as long as the epidemic continues. Data will be gathered by a data collection company and analysed using R Notebook script. Further interpretation will happen in a collaborative process with the Spanish Ministry of Health, Institute of Health Carlos III, and with input from WHO Regional Office for Europe. Data collected will directly contribute to the COVID-19 response in Spain in the areas of communications and messaging, interventions, programmes and policy, alongside epidemiological data and considerations of economic, cultural, ethical, structural political nature and other.

Gender Considerations: While COVID-19 may have some gender differentials, this survey research is not intended to explore these issues. The survey will be conducted with gender-representative samples of people living in Spain aged 18 or older.

Study goals and objectives

The goal of this study is to gain insights into risk perception, knowledge, trusted sources of information, attitudes toward pandemic response initiatives and other variables to **inform COVID-19 outbreak response measures, including policies, interventions and communications**.

The primary objectives are to:
● Monitor variables that are critical for population behaviour to control transmission of the novel coronavirus, including risk perceptions, knowledge, self-efficacy, confidence in institutions, behaviours, affect, worry, trust in/use of information sources and more.
● Document changes over time in these factors to understand the effect of the pandemic process, new developments, events or measures taken.

- Identify relationships between variables to identify levers for effective and appropriate responses.
- Explore the relationship of psychological variables (e.g. worry, trust, affect) with the epidemiological situation and the events and measures taken.
- Identify gaps between perceived and actual knowledge.
- Evaluate the effectiveness of pandemic response measures, and the acceptance and effectiveness of policies and restrictions implemented, including the easing of such restrictions.

The secondary objectives are to:

- Contribute to post-outbreak evaluation, thereby contributing to the continued regional/global efforts to better understand mechanisms of crisis response.
- If additional research capacity is available, the data can be triangulated with data on media reporting, COVID-19 cases and other.

This approach allows a citizen-centred approach where insights into population perceptions and behaviours inform COVID-19 actions, alongside epidemiological data and considerations of economic, cultural, ethical, structural political nature and other.

Study design

A survey questionnaire will be used to conduct a serial, cross-sectional study to collect, analyse and share data from July 2020 to September 2021, on risk perceptions, knowledge, self-efficacy, confidence in institutions, behaviours, affect, worry, trust in/use of information sources and more. The survey takes approximately 20 minutes to complete. Data will be collected by a data collecting company through existing web panels online. Data will be analysed using R Notebook script.

This is an observational study with voluntary participation of the general population, with expected low risk for participants. Potential risks identified include only the inconvenience of the time taken to respond to the survey, and given the current restrictions people face, many individuals currently have more available time. The variables and information requested does not allow to identify specific ethnic or disadvantaged population groups. Due to strict data protection measures, any risk related to non-anonymous publishing of data from the survey is considered very low, and the personal harm for the individual respondent related to such unlikely event is also considered low due to the less sensitive nature of the responses provided. Benefits include the sense of contributing and being able to participate in shaping the Spanish's pandemic response. This study was approved by Ethics Committee of the Spanish National Health Institute, Carlos III (CEI PI 59_2020-v2).
Assessment of the same core variables over time will allow analyzing changes over time in this evolving pandemic situation.

This will allow to:

- Identify developments over time (e.g. a decline in trust, or a decline in motivation to follow recommended behaviours);

- Identify new issues as they emerge (e.g. related to conspiracy theories, new misperceptions, easing of restrictions) and address these;
- Detect effect or adverse responses to new restrictions, messages or actions taken, and eventually the easing of restrictive measures.

Note that the cross-sectional design will not allow the assessment of actual causal relations and will only be snapshots of a current state of the public perceptions and behaviours.

Inclusion criteria include anyone of 18 years or older living in Spain. Exclusion criteria are under 18 years of age or not resident in Spain.

Variables being surveyed include the following:

- Socio-demography
- Risk group
- Knowledge
- COVID-19 risk perception: Probability and Severity
- Health Literacy
- Perceived self-efficacy
- Knowledge and self-assessed adherence to prevention measures
- Prevention – own behaviours
- Affect
- Trust in sources of information
- Use of sources of information
- Trust in institutions (perceptions)
- Policies, interventions (perceptions)
- Resilience (perceptions)
- Lifting restrictions (pandemic transition phase)
- Worry
- Rumors (open-ended)
- Self –assessed health

Variables include a combination of knowledge and behavioural questions that can only be answered by an individual based on the current situation along with other more complex constructs. For example, measuring self-reported knowledge may indicate gaps in accurate information being provided and will show misinformation that authorities can address in a timely manner. Asking people to what degree they are following suggested prevention interventions such as hand washing and social distancing shows how many people self-report contributing to the response in these ways.

Other constructs are more complex and require validated questions to accurately assess, such as risk perception, self-efficacy, trust, affect, prevention, resilience and worry. These variables are measured using validated questions or adapted validated questions

Data analysis will be conducted using the open source R Notebook statistical package, which requires the data collected to be available in an Excel spreadsheet. Using a set of codes, the findings will be automatically and immediately transferred to a password protected webpage. The researchers will have access to this webpage, which has been developed as a subpage on an existing website of the Institute of Health Carlos III. This allows pandemic response authorities in Spain to rapidly access and use the findings to inform pandemic response measures.

Regular coordination meetings will be organized with stakeholders and can be used for sharing results with COVID-19 response leaders. Others, including WHJO Regional Office can be invited to ensure discussions of insights gained, contextual and cultural interpretation of the data and implications for outbreak response interventions, policies and messages. Recommendations for incorporating data into the national response will draw on the existing evidence-base from previous outbreaks and epidemics and ethical frameworks for decision making in public health (17,18) as findings emerge.

Methodology

A survey questionnaire (**Annex 1**) will be used to conduct a serial, cross-sectional study with rounds of data collection every two months, from July 2020 to September 2021, with the possibility of extending the data collection over time. The survey takes approximately 15-20 minutes to complete. Data will be collected by a data collection company through online surveys. Data will be analysed using R Notebook script via a webpage established for this purpose.

A cross-sectional survey is the most appropriate, direct and rapid data collection methodology given the current emergency situation. In addition, risks associated with the survey methodology are minimal. The immediate need is for insights into how citizens perceive their risk of becoming infected with COVID-19, their knowledge, behaviour and perceptions, how the pandemic affects their well-being (worry, affect, resilience), their trusted sources, use of and need of information, their perspectives on mitigation efforts, potential misinformation that may impact their response and preferences for how mitigation efforts are eventually eased. Survey responses will answer these questions and contribute directly to inform decision-making to COVID-19, alongside other data and considerations.

Data Collection

Participants will be recruited via a trusted external study sample provider. An experienced company dedicated to market and medical research and public opinion specialized in data collection applying qualitative and quantitative techniques, based in Madrid (Spain).

The ethics of the data collection company, data security and data protection are considered critical, for staff and also as part of the overall organizational culture. Staff at the data collection company as well as the panel providers are provided with specific training on ethical considerations for the collection, use and storage of data (data security, data protection) during the induction stage (upon employment) and also annually during refresher trainings.

Data collection will be implemented through a serial cross-sectional design with multiple data collections. Data will be collected every two months. In case of unexpected developments or new outbreak response measures implemented, the time frame between the data collections may change. Data collected as part of this project belong to the Institute of Health Carlos III.

Sample size

The sample will be extracted from a panel. The panel provider will draw a new sample (random, one stage, stratified sample) for each round out of the pre-existing panel

To obtain a high level of congruence between the distribution of the demographics in the sample and the adult population in Spain (age, gender, education and living area), a sample size of n = 1000 per wave will be drafted, matching the Spanish general population in in terms of age, gender and area of residence.

Survey Tool

The questionnaire was adapted from the WHO Europe Regional Office for Europe tool, originally in English. Research in Spain will be conducted in the Spanish language.

Data Quality and Protection

The data collection company will act as **data controller,** and the panel is its data sub-processor. Survey data are stored on highly secured servers for no longer than 2 years, which is monitored 24/7. Employees handling or getting in touch with panel members' personal data are required to sign a non-disclosure agreement.

After the fieldwork collection stage and data quality control stage, the data collected will be completely anonymised for further data processing and reporting in maximum one week after data are collected. No personal data (name, phone number or other contact details, address, IP or other browser generated information etc.) will be provided or uploaded in the reporting platform. The data collector complies with all European and national laws and regulations in place regarding privacy and confidentiality. They are also fully compliant with all the industry rules as defined by ICC/Esomar Code and ISO 20252.

The hosting servers are equipped with latest version of firewall. All individual information provided is held strictly confidential. History of the actions of the authorized personnel is also kept. The software uses SSL to secure all operations: sampling, panel management and information provided by panel members.

The sampling process has the following security measures:

1) Access to project information is only granted to dedicated project manager.
2) All users must sign in using a username and password.
3) Respondents reach their surveys by unique IDs.

Ethics

This study was approved by Ethics Committee of the Spanish National Health Institute, Carlos III (CEI PI 59_2020-v2). In terms of informed consent, the respondents are provided with an **information notice** regarding their personal data processing within the survey according to the GDPR requirements and Spanish Data Protection Law. All data subjects will be included in the study based in their prior **informed consent**.

The information notice will be available in the panel platform, before accessing the questionnaire the respondents must confirm (using a check box) that they have read the information notice (see questionnaire, **Annex 1**). The informed consent will be also included in the platform and the respondent must give his consent (using a check box) to participate in the study prior taking the questionnaire.

As part of the informed consent, respondents are informed that they can withdraw at any point and that this will not entail any penalty or affect the services they receive, health care services or others. As a debriefing, respondents are provided with links to trustworthy information about COVID-19, and the website were the global results of the project will be displayed.

Safety Considerations

This type of surveys is, in principle, considered low-risk research. The research contains negligible risks as there is no foreseeable risk of harm or discomfort other than potential inconvenience of the time required during participation. The study does not include deception and participants will be debriefed at the end of the survey. The study also involves only non-identifiable data about human beings. The variables and information requested does not allow to identify specific ethnic or disadvantaged population groups. There are no physical or socioeconomic risks to participation in this study. No adverse events are foreseen.

Participants provide informed consent before starting the questionnaire. Text on this is included in the questionnaire in **Annex 1**.

Contact information for project managers and Principal Investigator is available to all participants should they want to seek clarification about this study or share any questions or concerns.

Follow-up

According to the design of this study, each round of data collection using the survey questionnaire will include different participants.

Following each round of data collection, thorough debriefing will provide participants with links to national trustworthy and valid information about COVID-19 and recommended behaviours.

The Institute of Health Carlos III will provide links on its website directing participants to published results of this survey.

Expected outcomes of the study

The benefit of this research is that Spain will have much better data on which to base decisions regarding next steps in response to COVID-19, particularly for the transition phase ahead where restrictions are gradually shifted and potentially re-employed, and where emergency fatigue or reactance may affect people's behaviours. By informing COVID-19 outbreak response measures, including policies, interventions and communications, this study allows for a people-centred approach where population perceptions and behaviours inform COVID-19 actions, alongside epidemiological data and considerations of economic, cultural, ethical, structural political nature and other.

This will have important impact on the health and well-being of all citizens and residents in Spain as well as impacting the world at large, given the global reach of this pandemic.

By tracking changes in risk perception and other variables over time, this survey will provide insight into how the public is responding to mitigation efforts and how the transition away from severe restrictions is impacting society. It is a WHO recommendation for pandemics that governments and teams responsible for the response use insights into how, why and the context in which humans and communities respond to pandemic interventions to design and implement effective interventions for the transition accordingly (15).

While it is not a primary goal of this study, it is hoped that multiple countries may collect and analyse at least several variables in common, which may provide useful insights for cross-country comparison. However, the main purpose of this tool is to help countries right now to determine the best approaches for their immediate COVID-19 response.

Dissemination of results and publication policy

Results will be shared monthly with the Spanish Ministry of Health and the Institute of Health Carlos III and discussed during regular meetings. As appropriate, results may be share with media or other partners, as agreed by the authorities.

Problems anticipated

The only anticipated problem is the timing of initiation of the survey, given how quickly the COVID-19 situation is changing.

Project management

This project is managed in Spain by Dr. Maria João Forjaz. Regular management of data collection is conducted by the data collection company. WHO Regional Office for Europe will be overseeing the project.

The coordination team:
- Dr Maria João Forjaz, Institute of Health Carlos III, coordinator.
- Dr Maria Romay Barja, Institute of Health Carlos III, co-PI.
- Dr Maria Falcon Romero, University of Murcia, co-PI.
- Dr Carmen Rodriguez-Blazquez, Institute of Health Carlos III, researcher.

Team members:
- Alba Ayala, Institute of Health Carlos III, researcher.
- Dr. Martina Fernandez, University of Cadiz, researcher.
- Dr. Pilar Bas Sarmiento, University of Cadiz, researcher.

Other support for the project

Extensive technical assistance has been provided by The University of Erfurt, Germany.

Experts

- Universität Erfurt (Cornelia Betsch (PI), Lars Korn, Lisa Felgendreff, Sarah Eitze, Philipp Schmid, Philipp Sprengholz)

- Robert Koch Institut (Lothar Wieler, Patrick Schmich)

- Leibniz Institute for Psychology Information (Michael Bosnjak)

- Bernhard Nocht Institute for Tropical Medicine (Michael Ramharter)

- Science Media Center (Volker Stollorz)

- Yale Institute for Global Health (Saad Omer)

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Annex 1. Cuestionario COSMO-SPAIN (Julio 2020*).

* Los ítems del cuestionario se irán modificado a lo largo del proyecto, adaptándolos a las circunstancias epidemiológicas y a las recomendaciones y restricciones vigentes en el momento en el que se realicen las encuestas.

1. Edad _____ años.

2. Sexo: Masculino/ femenino.

3. Estudios terminados.

4. ¿Incluido usted, cuántas personas viven en su casa?
    - Niños (de 0 a 13) ____

    - Adultos (de 14 a 60) __

    - Mayores de 60 años____

5. ¿Cuánto le preocupa el coronavirus/COVID-19?
Nada/ Un poco / Bastante/ Mucho/ Muchísimo

6. ¿Cómo valoraría su salud antes del coronavirus/COVID-19?
Muy buena/ Buena/Normal/Mala/Muy mala

7. ¿Ha tenido usted el coronavirus/COVID-19?
    - Sí, el test ha dado positivo.
    - Sí, pero no se ha confirmado con análisis
    - No
    - No lo sé

8. (Solo para los sí en la7) Se siente completamente recuperado de la enfermedad
    - Sí
    - No (por qué) _____

9. ¿Tiene algún familiar, amigo, compañero de su entorno cercano que tenga o haya tenido el coronavirus/COVID-19?
    - Sí
    - No
    - No lo sé

10. ¿Tiene algún familiar, amigo, compañero que haya fallecido por el coronavirus/COVID-19?
    - Sí, confirmado.

- No
- No sé si murió por coronavirus/COVID-19

11. Señale las formas de contagio más frecuentes del coronavirus/COVID-19 (Marque las opciones que considere)
    - Gotas al toser/hablar
    - Superficie contaminada
    - Por el aire
    - Contacto físico con alguien contagiado
    - Por transfusión de sangre
    - Por picadura de un insecto
    - Contacto con mascotas (perro, gato, otros)
    - Otra_____

12. ¿Cree que las personas que no tienen fiebre pueden ser contagiosas?
    - Sí
    - No
    - No sabe

13. Según usted, la mascarilla… (Marque las opciones que considere)
    - Se usa para evitar contagiar a los demás
    - Se usa para protegerse de ser infectado
    - Hay que lavarse las manos antes y después de usarla
    - Tiene que tapar nariz y boca
    - Se debe tocar solo por la cinta de las orejas
    - Se debe quitar para toser o estornudar

14. ¿Cree que todavía se podría contagiar del coronavirus/COVID-19?
    - Sí
    - No
    - No lo sé

15. ¿Qué gravedad piensa que tendría la enfermedad si se contagiara de coronavirus? Muy leve/ leve/ normal/grave/ muy grave

16. Usando una escala del 1 al 5 ¿Qué probabilidades piensa que hay de contagiarse con el coronavirus/COVID-19 al realizar las siguientes actividades?
Nada probable [1] [2] [3] [4] [5] Muy probable

- Hacer la compra

- Usar el transporte público
- Ir a un centro sanitario
- Ir a sitios concurridos
- Reunirse con amigos o familiares en casas particulares
- Trabajar fuera de casa

17. Tal y como están las cosas actualmente, conseguir evitar infectarme con el coronavirus/COVID-19 es: Muy difícil [1] [2] [3] [4] [5] Muy fácil

18. Durante los últimos 7 días marque cuál de las siguientes medidas ha tomado para evitar contagiarse de coronavirus/COVID-19:
- Lavarme las manos a menudo con agua y jabón
- Utilizar gel hidroalcohólico u otros desinfectantes para limpiarme las manos
- No ir a reuniones sociales/familiares
- Quedarme en casa si tengo síntomas
- Guardar la distancia física (mínimo de 2 metros)
- Utilizar mascarilla siguiendo las recomendaciones
- Desinfectar superficies como pomos de las puertas, timbre….
- Evitar el transporte público
- Otra____

19. Por favor, elija una repuesta en cada opción utilizando una escala del 1 al 5: Tengo la sensación de que el coronavirus/COVID-19 ……

- se está propagando despacio [1] [2] [3] [4] [5] rápido
- me produce miedo [1] [2] [3] [4] [5] no me produce miedo
- me hace sentir deprimido [1] [2] [3] [4] [5] no afecta a mi estado de ánimo

20. Reflexione sobre su experiencia personal durante esta pandemia de coronavirus/COVID-19 y díganos si está de acuerdo con las siguientes afirmaciones Nada de acuerdo [1] [2] [3] [4] [5] Completamente de acuerdo

- Lo paso mal cuando tengo que enfrentarme a situaciones estresantes
- Tardo poco en recuperarme después de una situación estresante
- Es difícil para mí recuperarme cuando me ocurre algo malo

21. Durante esta pandemia de coronavirus/COVID-19. Usted diria que…

- En su relación con su pareja hay… Mucha tensión/ alguna tensión/poca tensión/nada de tensión/ No tengo pareja (Saltar la siguiente)

- Usted y su pareja resuelven sus discusiones con Mucha dificultad/alguna dificultad/poca dificultad/sin dificultad/No procede

22. En relación al coronavirus/COVID-19, utilizando una escala del 1 al 5: díganos cuánto le preocupa…
Nada [1] [2] [3] [4] [5] Mucho

- Perder a algún ser querido
- Saturación de los servicios sanitarios
- Mi salud física o mental
- Salir a la calle
- Perder mis vacaciones
- La conciliación de la vida laboral y familiar
- La gente que va sin mascarilla
- No poder pagar mis facturas
- El cierre de los colegios/guarderías en el próximo año escolar
- Un nuevo confinamiento
- Las discusiones y peleas con los hijos/familiares por mantener las normas durante la nueva normalidad

23. Cree que …

- Lo peor de la epidemia ya ha pasado
- Estamos viviendo lo peor de la epidemia
- Lo peor de la epidemia está por venir

24. ¿Cómo de fácil o difícil diría que es para usted…
Muy difícil/ Difícil/ Fácil/ Muy fácil/ No lo sé

- …encontrar información sobre los síntomas del coronavirus/COVID-19?
- …averiguar qué hacer en el caso de sospechar que tiene coronavirus/COVID-19?
- …entender lo que dicen las autoridades sobre el coronavirus/COVID-19?
- …entender las restricciones y recomendaciones que dan las autoridades sobre el coronavirus/COVID-19?
- …valorar si la información que dan los medios de comunicación sobre el coronavirus/COVID-19 es fiable?
- …seguir las recomendaciones sobre cómo protegerse del coronavirus/COVID-19?
- …valorar cuando necesita ir al médico por un problema sin relación con el coronavirus/COVID-19, y cuando no?
- …decidir cuándo quedarse en casa (y no ir al trabajo/colegio/actividades sociales) y cuándo no?

- …enterarse de las restricciones relacionadas con el coronavirus/COVID-19?

25. En una escala del 1 al 5 ¿Con qué frecuencia consulta la información sobre el coronavirus/COVID-19 a través de…
Nunca [1] [2] [3] [4] [5] muy a menudo

- Telediarios
- Programas de debate de radio y televisión
- Ruedas de prensa
- Prensa nacional (papel y online)
- Las redes sociales (e.g. Facebook, Twitter, YouTube, WhatsApp)
- Internet
- La web del Ministerio de Sanidad
- La OMS

26. Siguiendo con la escala del 1 al 5, ¿Cuánta confianza tiene en la información sobre el coronavirus/COVID-19 procedente de:
Muy poca confianza [1] [2] [3] [4] [5] mucha confianza.

- Telediarios
- Programas de debate de radio y televisión
- Ruedas de prensa
- Prensa nacional (papel y online)
- Consultas a los profesionales sanitarios
- Conversaciones con familia/amigos
- Las redes sociales (e.g. Facebook, Twitter, YouTube, WhatsApp)
- Internet
- La web del Ministerio de Sanidad
- La OMS
- Las líneas telefónicas de información sobre el coronavirus/COVID-19

27. Por favor, escriba cuál es la información que más le interesaría recibir sobre el coronavirus/ COVID-19:
- _____

28. Dígame si hay alguna información/noticia sobre el coronavirus/COVID-19 que le haya costado distinguir si era verdadera o falsa. Puede describir hasta 3 informaciones que haya recibido de las que tenga dudas. Use un recuadro diferente para cada una.

Información: _____
Información: _____
Información: _____
No, no hay ninguna información de la que no esté seguro/a

29. ¿Cuánta confianza le generan las siguientes instituciones/organizaciones a la hora de abordar los desafíos que supone el coronavirus/COVID-19? Utilizando una escala del 1 al 5. Ninguna confianza [1] [2] [3] [4] [5] Mucha confianza

- Su centro de salud
- Su médico privado
- Su empresa
- Su hospital
- El Ministerio de Sanidad
- Su comunidad autónoma
- Los científicos
- Los centros educativos
- El transporte público
- Las compañías aéreas
- Los trenes y autobuses de larga distancia
- La prensa

30.   En general, piensa que hasta ahora las decisiones que se han tomado en España para reducir la propagación del coronavirus/COVID-19, ...
Nada de acuerdo [1] [2] [3] [4] [5] Totalmente de acuerdo
-
- Han sido adecuadas
- Han sido improvisadas
- Se han tomado siguiendo criterios sanitarios
- Se han tomado siguiendo criterios políticos
- Se han tomado siguiendo criterios económicos

31. Las medidas relacionadas con el coronavirus/COVID-19 se han ido cambiado a medida que pasábamos de fase. Utilizando una escala del 1 al 5, valore hasta qué punto está de acuerdo con las siguientes decisiones:
Nada de acuerdo [1] [2] [3] [4] [5] Totalmente de acuerdo

- Uso obligatorio de mascarilla
- Que se celebren clases y exámenes
- Apertura de bares y restaurantes al público
- Apertura comercios
- Apertura de playas para el baño
- Apertura de gimnasios /instalaciones deportivas
- Apertura de grandes superficies
- Libertad de movimiento entre provincias

- Libertad de movimiento entre países
- Apertura de cines/teatros/salas de conciertos/competiciones deportivas
- Que sean las comunidades autónomas las que determinen las normativas

32. Valore hasta qué punto está de acuerdo con las siguientes afirmaciones. Utilice una escala del 1 al 5. Nada de acuerdo [1] [2] [3] [4] [5] Totalmente de acuerdo

- Si hubiera una vacuna disponible para el coronavirus y fuera indicada para mí, me la pondría.

- Si hubiera disponible una aplicación gratuita de rastreo para el teléfono móvil, que garantizara la protección de datos y me advirtiera si puedo haber sido infectado con el coronavirus, me la descargaría.

33. Utilizando una escala del 1 a 5, si se produjese un rebrote generalizado de casos de coronavirus/COVID-19 cree que el gobierno debería:

Nada de acuerdo [1] [2] [3] [4] [5] Totalmente de acuerdo

- Proclamar otra vez el estado de alarma
- Confinar a las provincias más afectadas
- Confinar los núcleos urbanos más afectados
- Confinar a los mayores de 70 años
- Volver a cerrar la actividad empresarial no esencial
- Permitir salir solo para comprar y pasear al perro
- Volver a los horarios de salidas por edades/actividades
- Volver a limitar el aforo de bares/restaurantes/teatros/museos/reuniones
- Volver a cerrar playas para el baño
- Volver a cerrar los gimnasios /instalaciones deportivas
- Prohibir los eventos de masas de cualquier tipo

Para terminar, necesitamos saber

34. ¿Cuál es su situación laboral actual?
Trabajando por cuenta propia / por cuenta ajena / estudiante / ama de casa o sus labores/ jubilado / pensionista/Parado de larga duración/Parado desde el coronavirus/COVID-19/ERTE

35. Si trabaja, Tipo de Trabajo:
- Trabajo presencial de alto riesgo
- Trabajo presencial de riesgo moderado
- Trabajo presencial sin riesgo
- Teletrabajo

36.   Provincia (desplegable)