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Economic, Social and Behavioural Aspects of Covid-19 in the First Wave of the Pandemic in Slovenia: Selected Results of the International Survey SEBCOV

ABSTRACT: In the spring of 2020, an international study survey entitled 'Social, ethical and behavioural aspects of COVID-19' (SEBCOV) was conducted in Slovenia, Italy, United Kingdom, Malaysia and Thailand. These countries implemented strict public health preventive measures to contain the pandemic during its first wave. The research focused on the question of which factors should guide decisions on the manner and extent of the introduction of measures such as general quarantine, isolation, social distancing and travel restrictions. This paper analyses the results of an anonymous online survey carried out in Slovenia between 1st June and 31st July 2020 and presents a set of results relating to the understanding and attitudes of Slovenian respondents in relation to the first wave epidemic and the measures taken at that time. As there was insufficient data on the social, eth-

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ical and behavioural aspects of these measures during the first wave, we analysed these aspects in order to help to adopt appropriate non-pharmaceutical interventions (NPIs) in mitigating COVID-19 and other pandemics in the future.

Keywords: COVID-19, pandemic, first wave, non-pharmaceutical interventions (NPIs), survey, Slovenia

Ekonomski, družbeni in vedenjski vidiki covid-19 v prvem valu pandemije v Sloveniji: izbrani rezultati mednarodne raziskave SEBCOV

POVZETEK: Spomladi leta 2020 je bila v Sloveniji, Italiji, Združenem kraljestvu, Maleziji in na Tajskem izvedena mednarodna raziskava z naslovom »Družbeni, etični in vedenjski vidiki COVID-19« (SEBCOV). Te države so med prvim valom pandemije uvedle stroge preventivne javnozdravstvene ukrepe za njeno zajezitev. Raziskava se je osredotočila na vprašanje dejavnikov, ki bi morali usmerjati odločitve o načinu in obsegu zajezitvenih ukrepov, kot so splošna karantena, izolacija, fizična distanca in omejitve potovanj. Članek analizira rezultate anonimne spletne ankete, izvedene v Sloveniji med 1. junijem in 31. julijem 2020 ter predstavi ugotovitve o razumevanju in odnosu slovenskih anketirancev do prvega vala pandemije in sprejetih ukrepov v tistem času. Ker je bilo v prvem valu na voljo premalo podatkov o družbenih, etičnih in vedenjskih vidikih tovrstnih ukrepov, smo pridobljene podatke analizirali z namenom, da bodo ugotovitve prispevale k oblikovanju ustreznih ukrepov za ublažitev COVID-19 in morebitnih prihodnjih pandemij.

Ključne besede: COVID-19, pandemija, prvi val, ukrepi, anketa, Slovenija

The First Wave of the Covid 19 Epidemic and Non-Pharmaceutical Measures to Limit the Spread

COVID-19 is a respiratory infection caused by severe acute respiratory syndrome coronavirus (SARS-CoV-2). The first wave of the pandemic showed that a significant proportion of patients had a more severe course of the disease, associated with a relatively high mortality rate. No effective drug or vaccine was available at the time of the first wave in 2020, and epidemiological predictions and mathematical models predicted that the number of infections would continue to increase worldwide (Wu et al. 2020). Managing the COVID-19 pandemic was a major challenge for policymakers. Governments and public health organizations across the world were forced to use non-pharmaceutical interventions (NPIs), such as quarantine, isolation, social distancing (or 'physical distancing'), and travel restrictions (Lewnard and Nathan 2020).

In the uncertain situation of further spread of the infection, it was important to present the evidence that justified such measures to the public to ensure the widest possible public support, the success of the meas-

ures, and minimal interference with people's normal lives. It was also necessary to understand how residents obtained, interpreted, and acted on dispersed information about COVID-19. Insight into this could help public health institutions select appropriate communication strategies and communication methods.

As vaccines and drugs for the treatment and prevention of COVID-19 required solid data from clinical trials before use, decisions on how to implement NPIs (quarantine, isolation, physical distancing, travel restriction) should also be evidence-based. Some empirical data and data from mathematical models were available (Koo et al. 2020; Ferguson et al. 2020); however, data on the social, ethical, and behavioural aspects of these measures were severely lacking (Brooks et al. 2020; WHO 2020). Data from relevant studies indicated that, while public health measures are essential for controlling the spread of COVID-19, their implementation and effectiveness are influenced by a complex interplay of social and ethical factors. Ethical concerns, such as the restriction of personal freedom and social discrimination, had been identified, along with the need for governments and societies to address these issues with scientific and effective measures (Peng and Chen 2021). Behavioral science evidence and theory were used to outline evidence for institutional and behaviour change measures, with an emphasis on learning from jurisdictions with low COVID-19 mortality and community transmission (Lee et al. 2021).

The adoption of NPIs was particularly crucial during the initial stages of the pandemic, when knowledge about the virus was limited, and no effective medications or vaccines were available (Xylogiannopoulos et al. 2021). While NPIs were essential in controlling the spread of COVID-19 during the first wave, their implementation and effects varied across countries. The pandemic highlighted the importance of rapid and coordinated responses to public health crises, as well as the need to balance health outcomes with economic and social impacts (Óhaiseadha et al. 2023). As the pandemic progressed, countries faced challenges in maintaining and adjusting these measures, leading to subsequent waves of infections in some regions (Xylogiannopoulos et al. 2021).

First Wave of Epidemics and Implemented Measures in Slovenia

The previous Slovenian government declared an epidemic on the 12th of March 2020 that came into force on the 13th of March 2020, the same day that the new right-wing government came into power. Slovenia responded to the COVID-19 pandemic relatively quickly and, despite its proximity to northern Italy, has been managing the situation successfully (Pišot et al. 2022).

The shutdown of schools and kindergartens, suspension of public transportation, and closure of bars and restaurants were among the first measures taken (Jesenko et al. 2022). Companies and public institutions were advised to organize telecommuting to the maximum extent possible. Slovenia entered lockdown mode on the 20th of March 2020, as the government issued a decree temporarily prohibiting public gatherings in public places. Individuals could leave their homes and go to public places, mindful of maintaining a safe distance and only for work-related activities, to eliminate immediate threats to health, life and property, to care for people in need of support, and to access shops that remained open (grocery stores, pharmacies, petrol stations, banks, post offices, cleaning services, car repair shops, etc.). People could access public parks and other areas for walks; however, in April, due to a government decree that significantly tightened lockdown restrictions, they were confined to their home municipality for most daily activities (Ružić Gorenjec et al. 2021; Pišot et al. 2022). On the 15th of May 2020, Slovenia declared that the coronavirus epidemic in the country was over, and was reopening its borders, becoming the first European country to do so. Despite the official declaration of the end of the epidemics on the 31st of May 2020 and its gradual release, some measures remained in force. During the first wave, data from the national survey on infection were presented in Slovenia, which were estimated to be at 2-4% (Petrovec et al. 2020). The low infection rate of the population indicated on one hand the high effectiveness of the adopted government measures, but also posed the possibility of a rapid spread of infections during the second wave. Therefore, non-pharmaceutical measures were re-tightened during the second wave.

The SEBCOV Study: Social, Ethical and Behavioural Aspects of COVID-19

In 2020, the international study 'Social, ethical, and behavioural aspects of the COVID-19 pandemic (SEBCOV)' was conducted in Slovenia,[8] Italy, the United Kingdom, Malaysia, and Thailand (Tropical Medicine Research Center 2025; Pan-ngum et al. 2020; Schneiders et al. 2022; Cheah et al. 2023), where strict public health measures were in place to limit the pandemic (Osterrieder et. al 2021). Italy and the United Kingdom were two of the most affected countries in Europe in terms of case numbers and mortality rates, while Malaysia and Thailand were the two countries that implemented effective strategies to control the spread of the virus and maintained relatively low case numbers and mortality rates compared to other countries in the region and globally (Pan-ngum et al. 2020; Osterrieder et al. 2021; Hashim et al. 2021; Chen and Assefa 2021). It was expected that in these, as well as in many other countries, non-pharmaceutical measures to restrict social contacts would continue in the following weeks and months, or until the discovery and availability of an effective drug or vaccine.

The SEBCOV study aimed to obtain data and evidence on economic, social and behavioural aspects that would help in future decisions on appropriate NPIs in the fight against COVID-19 (Pan-ngum et al. 2020). As the COVID-19 epidemic continued despite effective containment in the first wave, data is crucial for understanding how people perceive and experience non-pharmaceutical measures, which groups are disproportionately more affected, and how different social groups perceive communication and commitment to increasing public acceptance and compliance with the measures (Van Bavel et al. 2020). This understanding is important to improve future measures and thus reduce their negative impact on the lives of different social groups.

The Course and Results of the Survey

As there was insufficient data on the social, ethical, and behavioural aspects of these measures during the first wave, we aimed to analyse these

8 At its session on the 19th of May 2020, the Commission of the Republic of Slovenia for Medical Ethics (KME RS) considered the application for the evaluation of the ethics of the research and assessed that the proposed research was ethically acceptable.

aspects with this study in order to help adopt appropriate non-pharmaceutical interventions (NPIs) in coping against COVID-19 in the future. Below are presented the methodological approach and selected results from an anonymous online survey conducted between 1st June and 31st July, 2020, in Slovenia as part of the Social, Ethical, and Behavioural Aspects of COVID-19 study (Pan-ngum et al. 2020; Osterrieder et al. 2021). The survey in Slovenia involved 1,046 respondents over the age of 18 who were living in Slovenia at the time of the survey.

Data collection and statistical analysis was carried out as described previously (Osterrieder et al. 2021). In brief, a self-administered online survey with 36 questions (single-answer multiple choice, and five-point Likert scales) was set up using the 'JISC Online surveys' platform.[9]

The survey consisted of five sections with 36 questions on the following topics: (1) socio-demographic information; (2) income, occupational status and economic impact of COVID-19 restrictions; (3) sources, preferences and perceptions regarding COVID-19-related communications and the occurrence of 'fake news' (false information presented as news); and (4) perceived level of understanding of COVID-19 and NPIs, approval of NPIs, voluntary behavioural changes, and concerns and coping strategies related to restrictions. The survey was translated into Slovenian.

The target group was all adults who were living in Slovenia at the time of the survey and who were proficient in using a computer or mobile devices. Participants were recruited using a combination of approaches: snowballing through personal and professional networks (via email, social media and messenger apps, mailing lists and organisations such as the Medical Chamber. An invitation with a link to the survey was sent via social networks and via email (as an invitation to complete the survey and a request for assistance in disseminating the survey to various organizations and institutions). The invitation to complete the survey was sent several times. We monitored the demographic characteristics of the respondents who completed the survey and, if there was a lack of data, sent out further invitations to complete the survey more targeted in the next phase.

9 JISC, Online surveys (formerly BOS), 2020. Available: https://www.onlinesurveys.ac.uk/.

Data analysis was carried out as described previously (Osterrieder et al. 2021), using three stratifying variables available from the Statistical Office of the Republic of Slovenia, namely gender, age and level of education. Weights based on the distribution of these three variables were calculated as the ratio between the proportion of each possible combination of the three variables in the total population of the country and the corresponding proportion in the sample of respondents.

Demographic characteristics of respondents[10]

As shown below in the Table 1, 35% of male respondents and 64% of female respondents participated in the survey, and less than 1% of respondents identified as 'other'. Among the age groups, the largest share of respondents was between 35 and 64 years old (65%), followed by younger people aged between 18 and 34 years old (30%), and the lowest was the group of the over 65 years old (5%). In terms of education level, respondents with tertiary education were strongly predominant (80%). Almost half of the respondents lived in a household with a partner and child/children, and 40% with a partner or other relatives. The largest share of respondents lived in a household with 3-5 members (59%), while 12% of respondents lived in a single-member household. According to income type, respondents with fixed incomes predominated with 82%. Almost half of the participants lived with minor children (under 18), a good quarter lived with someone who belonged to a vulnerable group and a third of respondents were healthcare providers/workers.

Table 1: Demographic characteristics of respondents

Variable and categories	Share in % (Total number: 1,046)
Gender	
Male	35
Female	64
Other	1

10 In order to understand the distribution of the basic demographic variables in the respondent sample, the observed frequencies and sample characteristics are given in unweighted percentages.

Age (years)	
18-34	30
35-64	65
65+	5
Education level	
Primary/Secondary	20
Tertiary	80
Household structure	
Living alone	9
Living only with partner/spouse	20
Living with partner/spouse and children; living as single parent with children	50
Living with other relatives/non-relatives/other	20
Household size	
1	12
2	21
3-5	59
≥6	8
Type of income	
Fixed salary/benefits/pension	82
Contract and freelance	10
Other/no income	8
Living with children under 18	48
Living with vulnerable group*	27
Healthcare provider/worker**	33

** Persons aged 70 or older; pregnant women; people with serious health conditions*

*** Including respondents who were not working before the COVID-19 pandemic*

Economic Impact

The economic impact of the pandemic is summarised in Table 2: 30% of respondents reported a loss of income, particularly among those with primary or secondary education (36%) and those over 65 years (39%). While only 3% reported losing their jobs, reduced working hours were more widespread, affecting 41% of respondents, especially men (44%); those

with primary/secondary education (46%) and the young group aged 18-34 years (47%). Job closures affected 8% of respondents, with younger adults (14%) being the most affected. Despite these challenges, 79% of respondents said that they were continuing to work, with higher rates of continued employment among men (85%) and those with tertiary education (85%).

Table 2: Economic impacts by gender, level of education and age group

Variable and Categories	Total in %	By gender in %			By level of education in %		By Age group in %		
		Male	Female	Other	Primary/ Secondary	Tertiary	18-34	35-64	65+
If you were working before COVID-19, has COVID-19 created any inconvenience for you?	N=929	N=332	N=591	N=6	N=160	N=769	N=259	N=646	N=24
Loss of earnings	30	29	31	40	36	24	31	29	39
Loss of job	3	1	4	0	4	1	3	3	0
Reduction of working hours	41	44	39	50	46	35	47	39	38
Closure of workplace	8	7	9	20	8	7	14	6	3
Did you continue to work during COVID-19?	79	85	74	67	74	85	77	81	72

Concerns during COVID-19 Restrictions

As shown in Table 3, concerns related to the pandemic were diverse, with 28% of respondents worried about finances, especially among middle aged, 35-64 years (36%). Concerns about career progression and careers were expressed by 17% of respondents, particularly among women (19%) and younger group (18-34 years, 34%), reflecting fears of career setbacks among women and young professionals.

In terms of caring responsibilities, 35% of respondents expressed concern, with a clear gender gap: 44% of women were concerned compared to only 25% of men. This illustrates the disproportionately high burden of care giving responsibilities on women during the pandemic. Similarly, people aged 35 to 64 were the most concerned about care giving (44%), which is likely due to their role in caring for children and elderly relatives. Physical health was another major concern, with 45% of respondents saying they were worried, particularly women (46%) and older adults (65+, 59%), highlighting the health vulnerability of older respondents.

Restrictions on recreational activities were a common concern affecting 65% of the sample, with men (71%) and younger people (18-34, 71%) more affected, as these activities are likely to be an important part of their social and personal lives. Mental health and well-being were an important issue for 43% of respondents, with greater concern among women (46%) and younger people (18-34 years, 52%), reflecting the psychological burden of isolation, social restrictions and economic stress.

Living arrangements were a concern for 15% of respondents, while 69% of respondents reported having social concerns, with the highest proportion among younger people (18-34 years, 79%), highlighting the social isolation of these groups. Religious and spiritual concerns were reported by 19% of respondents overall, with men (24%) and older adults (65+, 24%) more affected.

Table 3: Concerns by gender, level of education and age group

Variable and Categories	Total in %	By gender in %			By level of education in %		By Age group in %		
		Male	Female	Other	Primary/ Secondary	Tertiary	18-34	35-64	65+
What are/were your concerns if advised no physical contact/not allowed to go out/allowed to go out only for essential needs?	N= 1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
Financial	28	27	29	67	29	27	31	36	4
Professional/	3	1	4	0	4	1	3	3	0
Career progression	17	14	19	17	13	22	34	15	1
Caring responsibilities	35	25	44	33	31	40	30	44	16
Physical health	45	44	46	33	47	43	40	42	59
Recreational	65	71	59	33	66	62	71	60	70
Sports	36	44	28	33	39	32	41	36	31
Mental health and well-being	43	40	46	50	45	40	52	40	40
Living arrangements	15	12	18	50	14	16	22	17	1
Infrastructure	19	14	24	33	18	21	18	19	19
Social	69	70	69	83	69	70	79	65	69
Religious and spiritual	19	24	14	0	18	21	15	19	24

Maximum Coping Time without Social Interaction

The ability to cope without social interaction varied, with 50% of respondents said that they would be able to manage 29 days or more without meeting family or friends. Females and those with tertiary education said that they would more likely be able to cope for extended periods. When it came to going out in public, 61% said that they could only cope for 1-14 days, highlighting the social challenges posed by the restrictions. A significant 45% of respondents replied that they could cope for 29+ days without leaving home except for essentials, demonstrating resilience, particularly among older adults and the highly educated.

Table 4: Maximum coping time by gender, level of education and age group

Variable and Categories	Total in %	By gender in %			By level of education in %		By Age group in %		
		Male	Female	Other	Primary/ Secondary	Tertiary	18-34	35-64	65+
Q23 Time to cope without meeting family or friends in person	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
1 to 14 days	34	38	31	17	41	24	29	31	49
>14 to 28 days	16	14	18	0	16	16	17	15	18
29 days+	50	48	51	83	43	60	54	54	34
Q24 Time to cope without going out in public	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
1 to 14 days	61	57	65	33	63	58	61	59	67
>14 to 28 days	13	14	12	0	12	15	11	14	15
29 days+	26	29	23	67	25	27	28	28	19
Q25 Time to cope without going out except only for essential needs/work	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
1 to 14 days	37	35	40	33	42	31	34	33	51
>14 to 28 days	18	23	13	0	17	18	17	17	19
29 days+	45	43	47	67	41	51	49	50	29

Behavioural Changes and Acceptance of Public Health Measures

Table 5 provides key insights into how different demographic groups adapted their behaviour and accepted public health measures during the pandemic. 47% of respondents said that they had changed their social behaviour before the government enforced public health restrictions, with

women (51%) and those with higher education (56%) more likely to proactively adjust their behaviour. The greatest self-reported change in behaviour was seen in the 18-34 age group (54%), reflecting the adaptability of younger people in response to the evolving health crisis. Avoiding physical contact was the predominant behaviour change: 93% of those who said that they had changed their behaviour chose not to have physical contact, with agreement even higher among men (94%) and those with primary/secondary education (96%). Similarly, 91% of respondents reported having avoided contact with vulnerable groups, with women (94%) adhering more strongly than men (88%).

Limiting outings to the bare minimum was another important behavioural change, reported by 71% of respondents. Again, women (76%) were more likely to limit their activities than men (65%), and those aged 65+ were the most likely to report compliance (87%). Interestingly, only 5% of respondents reported moving home to stay with parents or relatives, with younger adults (18-34 years) more likely to do so (8%), likely due to a desire for family support during the pandemic. The use of personal protective equipment (PPE), such as masks, was reported by 67% of respondents, with use slightly more common among men (73%) than women (63%).

Regarding the acceptance of government-imposed quarantine and social distancing measures, 75% of respondents agreed, with acceptance being equally high among men and women (75%). However, approval was significantly higher among those with higher education (87%) and younger adults (18-34, 85%), indicating a strong sense of civic responsibility in these groups. A similar percentage (76%) agreed with voluntary compliance with quarantine and social distancing out of social or personal responsibility, with similar demographic patterns.

The level of agreement with these public health measures shows that the government's actions during the pandemic met with strong approval overall, particularly among younger adults and highly educated individuals. 74% agreed with quarantine and social distancing. However, there was a notable 15% disagreement overall, with men (18%) and older adults (65+) showing greater resistance.

Table 5: Behavioural changes and acceptance of government public health measures by gender, level of education and age group

Variable and Categories	Total in %	By gender in %			By level of education in %		By Age group in %		
		Male	Female	Other	Primary/ Secondary	Tertiary	18-34	35-64	65+
Q22 Did you change your social behaviour before the implementation of government	47	42	51	50	41	56	54	53	25
If you answered 'yes' to the previous question: how you changed your social behaviour	N=584	N=179	N=402	N=3	N=99	N=485	N=178	N=386	N=20
No physical contact with anyone	93	94	89	100	96	90	87	94	100
No physical contact with vulnerable groups	91	88	94	100	93	90	90	92	87
Going out only for essential needs	71	65	76	100	75	67	55	75	87
Moving home to stay with parents/relatives	5	3	6	33	3	6	8	4	0
Use of PPE	67	73	63	100	67	68	52	68	97
Use of sanitizers	94	94	94	100	96	92	92	94	100
Q26a "I would comply with government enforced quarantine/ isolation/ social distancing"	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
Agree	75	75	75	83	68	87	85	75	65
Neither agree nor disagree	14	10	17	0	19	6	7	8	34
Disagree	11	15	8	17	14	7	8	17	1
Q26b "I would enter voluntary quarantine/ isolation/social distancing for social/self-responsibility."	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
Agree	76	76	77	83	72	82	80	75	74
Neither agree nor disagree	13	9	15	0	15	9	9	11	20
Disagree	11	15	8	17	13	9	11	13	7
Q27a "How much do you agree with quarantine/ isolation/social distancing?"	N=1,034	N=366	N=662	N=6	N=202	N=832	N=308	N=676	N=50
Agree	74	75	74	67	77	85	79	76	67
Neither agree nor disagree	11	7	15	17	14	6	12	7	18
Disagree	15	18	12	17	19	9	10	17	15

Discussion and Conclusion

This article presents an in-depth analysis of the selected Slovenian survey results from the international SEBCOV study (Osterrieder et al. 2021),

providing a more detailed analysis and discussion of the Slovenian findings within their contextual framework. The first wave of the pandemic represented a unique situation in Slovenia, as it was the only case (compared to subsequent waves) in which the measures covered practically the entire society. In general, it can be stated that the respondents mostly showed understanding of COVID-19 and the associated measures, and largely agreed with the measures that were implemented by the government. This aligns with research suggesting that knowledge of COVID-19 transmission and attitudes towards state measures significantly influence socially responsible behaviours (Singkun et al. 2020). The observed high levels of compliance, especially among the educated, reflect a collective commitment to mitigating the effects of the pandemic, which is crucial for an effective public health response (Singkun et al. 2020; Schneiders et al. 2022).

Nevertheless, it is important to acknowledge the limitation of the sample. The data collection process introduces bias due to the inclusion of a substantial proportion of healthcare workers, who encountered frontline challenges during the pandemic. This factor has influenced the results to a certain degree and warrants consideration. Additionally, the sample is restricted to respondents with access to the internet and mobile devices, which may exclude certain populations, in particular older people.

The data from the tables show the diverse impact of the COVID-19 pandemic on different demographic groups, illustrating the significant inequalities in economic, social and psychological consequences. As is also evident from some other studies, the pandemic has disproportionately affected women, younger adults and those with lower levels of education, resulting in greater financial losses, job insecurity and heightened concerns about mental health and well-being (Lee et al. 2023; Andrade et al. 2022; Pierce et al. 2020). The psychological impact of the pandemic has been profound, with studies indicating increased levels of anxiety and depression, particularly among younger populations (Tso and Park 2020; Lee et al. 2021).

Despite these challenges, as evidenced by the SEBCOV results, there was a strong sense of resilience and adaptability, with the majority of respondents continuing to work and adapting their behaviour to public health measures. The high acceptance of quarantine and social distancing rules, especially among the highly educated, emphasises the collective commit-

ment to mitigating the effects of the pandemic during the first wave. As also indicated in other studies, this adaptability is essential for the success of public health strategies, highlighting the importance of community engagement and the role of social cohesion in promoting mental well-being during crises (Lee et al. 2023; O'Connor et al. 2021). These findings emphasize the importance of targeted support to vulnerable groups and the crucial role of public health strategies in managing such crises. Nevertheless, future research should focus on understanding the factors that contribute to resilience and how these can be harnessed to more effectively support vulnerable populations.

In addition, the COVID-19 pandemic has exposed the challenge of balancing public health measures with individual freedoms (Flood et al. 2020; Graeber et al. 2024; Orzechowski et al. 2021). The tension between public health imperatives and individual freedoms is a recurring theme, with some studies highlighting that fear can lead to greater acceptance of restrictive measures, potentially at the expense of trust in the government (Vasilopoulos et al. 2022). Policy makers need to prioritise flexible, evidence-based strategies (Flood et al. 2020) and ensure timely, effective interventions to manage pandemics while upholding democratic practices (Komaroff and Belhouchet 2020).

The SEBCOV study provided valuable data on the social, ethical, and behavioural aspects of the measures taken during the pandemic, also enabling international comparisons. Countries and governments responded to the pandemic in diverse ways, with varying degrees of success (Cheah et al. 2023; Naemiratch et al. 2022; Schneiders et al. 2022). Additionally, it addresses a gap in Slovenian research on the economic, social, and behavioural aspects of COVID-19 during the first wave. While some studies in Slovenia have examined specific aspects (Ružić Gorenjec et al. 2021; Jesenko et al. 2022; Pišot et al. 2022), they mostly lacked a comprehensive, multidimensional approach. By integrating these perspectives, the SEBCOV study provides a more comprehensive understanding of the pandemic's impacts, offering important insights for both localized and comparative contexts.

Ultimately, understanding the factors associated with uneven impacts can help to more effectively inform future public health interventions. This study explored the factors that contribute to effective coping, empha-

sizing that the pandemic was not solely a health crisis, but a broader social one that further deepened inequalities, particularly among vulnerable groups. The key contribution of the research results was primarily that they represent the basis for the formulation of more effective measures and guidelines to combat the COVID-19 pandemic (especially in the light of new waves of spread), and future pandemics. It is essential to capture the opinions and experiences of different groups of people, because in this way only will we be able to respond more appropriately and in a targeted manner in the future. Therefore, it is important to present the evidence justifying such measures to the public, in order to ensure the widest possible public support, the success of the measures and the least possible interference with people's normal lives.

Ethics Approval

Ethics approval was granted by Oxford Tropical Research Ethics Committee (OxTREC, reference no. 520-20) and the National Medical Ethics Committee of the Republic of Slovenia (0120-237/2020/7).

Data Availability Statement

Data underlying this publication are available upon request to the Mahidol Oxford Tropical Medicine Research Uni Data Access Committee at https://www.tropmedres.ac/units/moru-bangkok/bioethics-engagement/data-sharing.

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