Rijksinstituut voor Volksgezondheid
en Milieu
*Ministerie van Volksgezondheid,
Welzijn en Sport*

Knowledge Brief

Pandemic Preparedness & Behaviour – Results of 2024 survey-based monitor

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Reference:
KN-2026-0004
DOI:
10.21945/RIVM-KN-2026-0004
19-01-2026

Synopsis

Background

Human behaviour is a key factor in the spread of infectious diseases. Washing hands regularly and avoiding close contact with others, for example, will reduce the risk of respiratory infections. This is especially important in the event of an outbreak that has pandemic potential. In the framework of pandemic preparedness, RIVM therefore works on a survey-based monitor: Pandemic Preparedness & Behaviour. We use this to monitor human behaviour that is relevant to transmission of infectious diseases, in conjunction with factors that affect behaviour and health during a pandemic. From this, it is possible to deduce the areas in which various groups in the population of the Netherlands are well or less well prepared for a possible pandemic and how that correlates over time to societal trends or policy interventions. This knowledge brief describes the key results from the first two research rounds of this survey-based monitor, along with resulting policy considerations.

Objective

The results of the survey-based monitor:

1) offer starting points for policy in a 'cold phase' to prepare people in the Netherlands as well as possible for a future pandemic or smaller-scale outbreak of infectious disease; and
2) offer insight into the broader resilience of various groups in Dutch society, so that it quickly become apparent where targeted policy intervention is needed in the event of a future pandemic or outbreak of infectious disease.

In addition, the survey-based monitor contributes to a knowledge base in the social and behavioural sciences, and research that can be rapidly scaled up during an outbreak. As a result, knowledge from the behavioural sciences can make a faster contribution to effective control measures at the outset of a new pandemic. This knowledge can also be deployed in the broader context of crisis situations.

Research method

In March and September 2024, a survey-based monitor was completed by 1238 participants, who offer a representative reflection of the population of the Netherlands (see *Explanation of the results*). The survey questionnaire was grouped into: a) outcome indicators, including perceived pandemic preparedness and current health status; b) behaviour, including preparedness behaviour (i.e. behaviours to prepare for a possible pandemic), and behaviour that contributes to preventing transmission of infectious disease; and c) factors that influence health behaviour.

Key results

Note: These results are based on the 2024 monitor, offering a description of the status quo. More research rounds are planned. After these repeated research rounds, the results will also be presented in terms of trends over time in various sub-groups.

- ***Perceived preparedness:*** Three in ten participants indicate that they would feel prepared if a lockdown were to be announced next month; three in ten also believe that the government would be sufficiently prepared in that situation.
- ***Behaviour:***
  - Preparedness behaviour: More than one-third of participants do not have an emergency supply of food/drinks and medicines sufficient to make it through three days. More than two-thirds do not have an emergency supply of water for hygiene and cooking.
  - Hygiene and self-isolation behaviour: Six in ten participants routinely cough and sneeze into their elbow. Less than half wash their hands when coming back home or after coughing/sneezing/nose-blowing. Fewer than two in ten stay home when feeling sick.
- ***Factors that affect behaviour and health:***
  - Health literacy: six in ten participants have sufficient skills to find, comprehend and apply health information. Participants find it relatively difficult to assess the reliability of information about health risks as presented in the media.
  - Resilience: One-third of the participants report high resilience – older people more than young people.
  - Social support: Over one-third feel that they receive strong social support, while one-fifth feel that they do not receive much social support. Participants that originally came from outside Europe are more likely to perceive limited social support.
  - Trust: Participants have more trust in doctors and scientists than in politicians and the government.
  - Susceptibility to conspiracy theories: One-third of participants hold beliefs that make them susceptible to conspiracy theories.
- ***Differences between groups:*** People from non-Dutch backgrounds and people who have completed primary or pre-vocational education score lower than average on various indicators (e.g. health literacy, trust, susceptibility to conspiracy theories). In terms of hygiene behaviour (specifically hand-washing), we see a more favourable starting position – i.e. more routine behaviour – among people from a non-Dutch background.
- ***Differences between countries:*** The same monitor was used in four countries: the Netherlands, Slovenia, Spain and Ireland. It is noticeable that Dutch participants are less prepared for a possible pandemic (i.e. having a first-aid kit, face masks, soap, or an emergency supply of food and water) than participants in the other three countries. People in the Netherlands also wash their hands less often, especially after coughing, sneezing or blowing their nose, and are more likely to go outside or visit family if they have symptoms. Dutch participants do have more trust in the government.

Policy considerations

Based on the results of this monitor, we arrive at the following policy considerations. When policy interventions are adapted to the target group and context, the impact is intensified.

- ***Preparation for an emergency situation:*** If the government expects people to be able to stay in acute isolation for 2 to 3 days, the outcome can be improved by supporting people with clear, uniform information about what is needed for that purpose and how people can meet their own needs for that and/or receive assistance. (Note: Different preparations are required for acute isolation at home and for fleeing in time.)
- ***Good hygiene practices:*** Supporting good hygiene practices contributes to the prevention of minor outbreaks in a 'cold phase' and increases the likelihood that such behaviours will continue during a pandemic. By setting a good example, reminding people of the recommended behaviour (washing hands, which situations prompt handwashing, staying home when ill), and structuring the social setting and living environment in such a way that it is easy to perform these actions in practice (e.g. having employers state that this behaviour is important), it is possible to support the formation and retention of these routines.
- ***Resilience among young people:*** *Initiatives aimed at increasing resilience* among young people are also relevant to pandemic preparedness. In the event of a (health) crisis, it is important to take groups with less resilience, such as young people, into account from the outset. This can be achieved by monitoring how they are doing, asking them what they need, and using interventions to improve and support mental health.
- ***Social support:*** *Social support (emotional and practical) contributes to informal* care in the local neighbourhood when it is needed – now and during a crisis. In view of this correlation, it is worth considering focusing on initiatives that support social cohesion in communities.
- ***Trust:*** *People that have trust in institutions or individuals are also more likely to* use them as a source of information. This can be taken into account in the event of a new health crisis or other crisis situation. For example, recommendations from trusted experts could explicitly be taken into account in policy choices (and communicated as such), and experts could be facilitated in communicating directly about prevailing measures.

Explanation of the results

Theoretical framework

The survey-based monitor is based on a conceptual framework of pandemic preparedness from a behavioural perspective[1]. An important aspect of the conceptual framework is that behaviour exhibited by parties operating at various socio-ecological levels – i.e. individual citizens, communities, organisations, government bodies – is interdependent. The different stages of pandemic preparedness are also relevant: some behaviours are only relevant in an acute stage of a pandemic but are influenced by factors (and by actions taken by other parties) that cannot be changed from one day to the next. In that case, optimal preparedness during a pandemic necessitates taking action long before a pandemic starts. Examples include organisations that help people to make health information more accessible.

In this monitor, we assess factors related to behaviour at the level of the individual citizen[2]. The basis used here is the COM-B model[3], which identifies different categories of factors (i.e. determinants of behaviour): Capability (C), Opportunity (O), and Motivation (M), which collectively predict Behaviour (B).

A number of 'generic determinants' were selected for the survey. These are factors (taken from each of the three categories) that can be related to many different health-related behaviours, such as trust in institutions (Motivation), or health literacy (Capability). Behaviour that is relevant to pandemic preparedness is wide-ranging, after all. Moreover, it is uncertain which behaviours citizens will actually be asked to use during a future outbreak of infectious disease. The selection of determinants is based on lessons learned during the COVID-19 pandemic and what is known from literature on behavioural science. Consultation with national, international and supranational colleagues took place on this subject (see the User Guide for more information). The selection was limited due to a predetermined maximum size of the survey. That means that there are also factors that have not been covered by the current monitor but could still be relevant to understanding and supporting behaviour and broad resilience before and during a pandemic. Accordingly, we develop supplementary blocks of questions every year that can be added to the survey questionnaire on a flexible basis.

The behaviours surveyed in the monitor are a) specific behaviours that people can perform to prepare for a pandemic, such as maintaining a supply of food, drinks and medicines at home in the event of a period of acute self-isolation; and b) general hygiene behaviours that contribute to preventing the transmission of infectious diseases, such as staying home during illness. In the context of these behaviours, the survey also asks about behaviour-specific determinants: how difficult or easy do people perceive the behaviour to be, how useful do they think it is, and to what extent do they view this behaviour as the social norm.

Finally, various 'outcome indicators' are monitored. Specifically, we assess indicators of physical and mental health, as well as subjectively perceived pandemic preparedness of citizens, their employers and the government.

In combination, the monitor offers insights into the resilience of individual citizens. People will be more resilient in a crisis situation if they are healthier, have more favourable routines, and have stronger capability, motivation, and opportunity as supported by their local environment to perform preventive behaviour.

Research method

For this study, a survey was completed by 1238 people aged 18 years or older, drawn from the LISS panel of Centerdata (Tilburg University). Table 1 shows the characteristics of the survey participants. Details about the structure of the study and the exact questions asked in the survey are provided in the User Guide for this monitor.

The survey was conducted in two parts: the first in March 2024, and the second in September 2024. A majority of participants (65%) completed both parts of the survey (March and September 2024; 16% only took part in the March survey, while 19% only took part in September). Part 1 asked about behaviours, generic determinants of the behaviours, and outcome indicators. Instead of the generic determinants, part 2 asked about behaviour-specific determinants (see *Theoretical framework*). In this knowledge brief, we present the data on behaviours, outcomes and generic determinants based on the first survey round. The data reported on behaviour-specific determinants are based on the second survey round.

We primarily report which percentage of participants scored above or below a specific limit value. Differences between groups are reported based on the participant characteristics shown in Table 1. Group differences in percentages are validated based on multivariate logistic regression and reported if the odds ratios were higher than 1.5 or lower than 0.667. In other words, the probability of a specific score (e.g. staying home during illness) versus the probability of the alternative score (e.g. not staying home during illness) is at least one-and-a-half times larger or smaller for a specific sub-group compared to a reference group.

*Table 1: Characteristics of sample (combined for part 1 and 2)**

		n	**%**
Sex	Women	644	52.2%
	Men	589	47.8%
Education level	Primary or pre-vocational education	238	19.3%
	Secondary education (senior general secondary / pre-university / senior secondary vocational)	439	35.6%
	Higher professional/university education	557	45.1%
Migration background	None	942	76.6%
	European	90	7.3%
	Non-European	198	16.1%
Age	<25	91	7.4%
	25-39	284	22.9%
	40-54	316	25.5%
	55-69	301	24.3%
	70+	246	19.9%
Urbanisation level	Rural	414	34.1%
	Suburban	410	33.8%
	Urban	390	32.1%

*Weighting was used to align characteristics of the current sample with the population in terms of sex, education level and age.

Participants on the LISS panel are recruited based on random sampling. People who do not have access to a computer or internet are offered them. This ensures a more representative reflection of society than panels where people sign up on their own initiative. Despite this, not all groups in society are represented here. People who are functionally illiterate, for example, are less inclined to take part in a text-based survey.

RIVM developed the monitor in conjunction with international partners from Slovenia, Ireland and Spain; the European Commission and the World Health Organization (WHO) are also involved.

Results

1. Outcome indicators

We assess the extent to which people believe that they themselves, their employer, and the government are well prepared if a new pandemic occurs ('perceived preparedness'), as well as various indicators of physical and mental health. Good physical and mental health at the start of a pandemic increases citizens' capacity for (independent) recovery.

Key findings:

- Three in ten participants believe that they themselves are (very) well prepared if a lockdown were to be imposed next month; three in ten believe that the government is (very) well prepared.
- Eight in ten assess their general health at a score of six (out of ten) or higher.
- Eight in ten participants feel mentally healthy. This is lower among participants under the age of 25 years (six in ten).

1.1 Perceived pandemic preparedness

Participants were asked about the extent to which they would feel prepared if a lockdown were to be imposed next month in response to the spread of a new virus (or virus variant). Three in ten participants indicate that they were (very) well prepared for such a situation. This is somewhat higher among participants with higher professional or university education (39%) compared to participants with primary or pre-vocational education (24%). We do not observe any other differences between groups based on the demographic characteristics that were surveyed. Participants who feel prepared indicate that they have experience from the past, have the basic necessities at home, and could work from home. Participants who do not feel prepared indicate that they simply have not (yet) taken any action, do not know what is needed, or are not occupied with the topic (*"There is so much going on in the world right now that we will have to adapt at that time. In short: we'll see when we get there."*).

Similarly, the survey asked about the extent to which participants who have an employer feel that their employer is prepared if a lockdown were to be imposed next month. About half of participants believe that their employer is (very) well prepared for such a situation. This is somewhat higher among participants with higher professional or university education (57%) compared to participants with primary or pre-vocational education (35%). Participants who consider their employer prepared state that lessons have been learned from past experience and that they would be able to work from home. They also think that scenarios and protocols are already in place. Participants who do not consider their employer prepared say that their sector is not suitable for this (often: working from home is impossible) or that the employer is not occupied with the topic or not communicating about it (*"I do not receive any updates about what would have to happen if a lockdown did occur").*

Finally, all participants were asked about the extent to which they feel that their government is prepared if a lockdown were to be imposed next month. Three in ten participants feel that their government is prepared for such a situation. There are no differences between different groups of participants here. Among participants who do consider the government prepared, the most common response was that lessons had (surely) been learned from the recent COVID-19 pandemic and/or that there are scenarios and protocols. (*"Systems are still fresh in the memories of government bodies and rules that were adapted at that time could fairly easily be implemented again."*) Participants who do not consider the government prepared mention that the government does not have its affairs in order, has made many mistakes in the past, is too busy with other matters, and does not communicate about plans.

1.2 Mental and physical health

Mental and physical health contribute to resilience (or vulnerability) in a health crisis. Moreover, health can be a predictor of behaviour: people who assess their own health at a lower level are often more motivated to perform preventive behaviours to protect their health[4]; simultaneously, they sometimes have less capacity for specific behaviours that are physically or mentally demanding[5].

Participants were asked to assess their general health on a scale of 0 to 100. On average, participants gave their general health a score of 73; participants with a higher professional or university education gave their health a slightly higher score than participants with primary or pre-vocational education. People over 70 gave their health a slightly lower score than younger participants. Most participants gave their general health a score of 60 or higher (81.5%).

Mental health was assessed by presenting participants with questions about how they felt in the past four weeks. On that basis, international standards were used to classify the mental health of participants as mentally healthy or unhealthy[6]. 79% of the participants in this study are classified as mentally healthy. Mental health is correlated to age. 92% of participants older than 70 years are classified as mentally healthy, compared to only 63% of participants younger than 25.

2. Behaviour

Various behaviours may be important to prepare for, prevent, or cope with a pandemic. In the study, we look at behaviours that people could specifically perform to prepare for a pandemic or other disaster, such as having supplies of food and water at home for several days. We also look at hygiene behaviours that help to prevent transmission of infectious diseases. These behaviours are also useful even if there is no pandemic, since infectious diseases often occur on a smaller scale (such as influenza). Moreover, it is important for people to build up routine behaviour during a 'cold phase', so they are already accustomed to performing actions that are especially important during a pandemic.

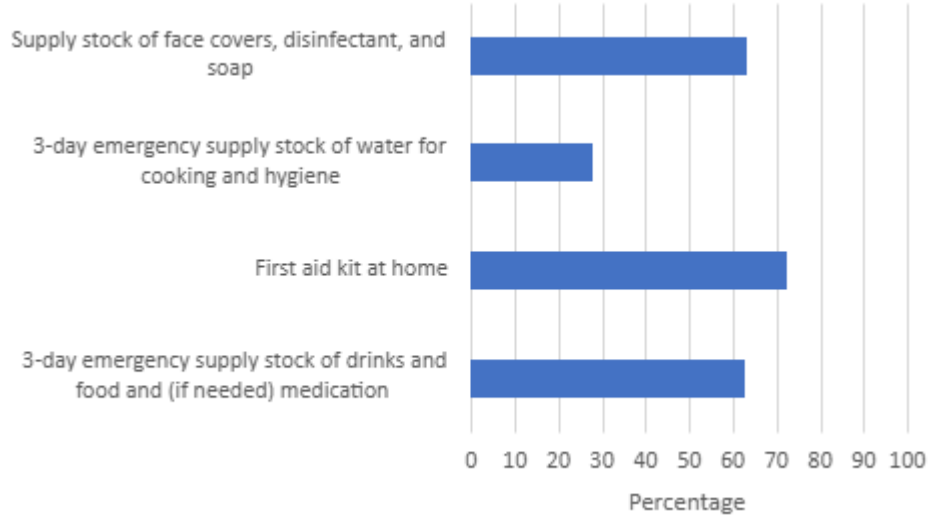
The key findings are:

- Preparedness behaviour: More than one-third of participants do not have an emergency supply of food/drinks and medicines sufficient to make it through three days. More than two-thirds do not have an emergency supply of water for hygiene and cooking.
- Hygiene and self-isolation behaviour: A majority of participants routinely cough and sneeze into their elbow. Less than half wash their hands when they come back home and after coughing/sneezing/nose-blowing. Fewer than two in ten stay home when feeling sick.

2.1 Behaviour to prepare for a future pandemic or crisis

In the study, we asked about specific activities to prepare for a future pandemic or crisis (such as having face covers or a first-aid kit at home)[i]. Figure 1 shows how many participants were doing so.

Figure 1. Percentage of participants that have adopted measures to prepare for a disaster or crisis.



Young participants (<40 years) and participants in urban areas are less likely than average to implement the preparations that we asked about. A possible explanation for that is lack of space to store emergency supplies, as was apparent from a more in-depth exploratory study on this topic[ii].

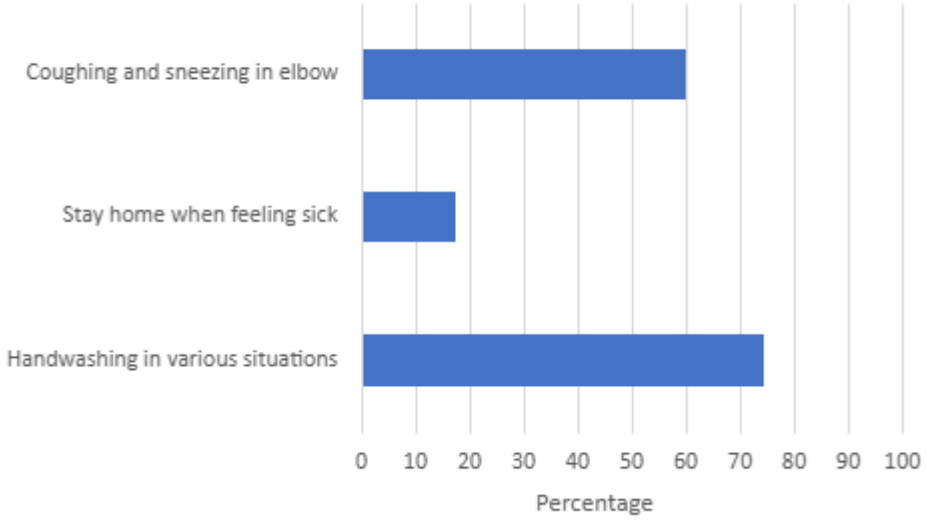
2.2 Behaviour that helps to prevent transmission of infectious disease

In the study, we specifically asked about behaviours that contribute to preventing respiratory infections[7]. Figure 2 shows how many survey participants stated that they practiced the specified hygiene behaviours.

[i] Questions based on Disaster risk awareness and preparedness of the EU population - September 2024 - - Eurobarometer survey

[ii] 'The pandemic would have to be knocking on the door; I won't arrange things until then' – Citizen preparedness for pandemics and other disasters and crises | RIVM (knowledge brief published in Dutch)

Figure 2. Percentage of participants that indicate performing the assessed behaviours (coughing/sneezing in elbow and washing hands: often to always; staying home when feeling sick: staying home if someone felt sick in the past four weeks).



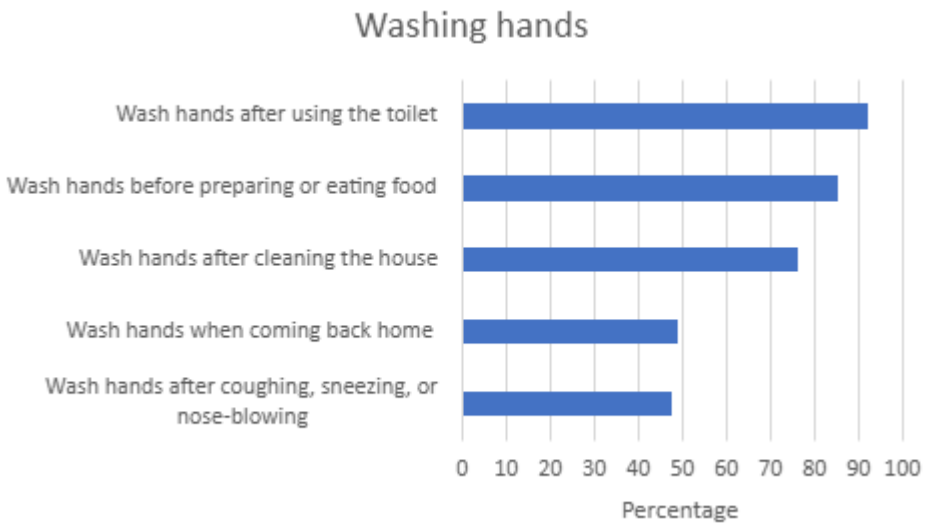
Six in ten participants often or always cough and sneeze into their elbow. Men and participants living in rural areas were less likely than average to cough and sneeze into their elbow.

Of the participants who felt sick in the four weeks before the survey (n = 226), under two in ten stayed home (17%). This group is too small to make further subdivisions based on demographic characteristics.

Three-quarters of participants often or always wash their hands in situations where this is considered important. People with an origin outside Europe are more likely to wash their hands (83%) than people with an origin within Europe (72%) or without a migration background (73%). Men (69%) are less likely than women (80%) to wash their hands in situations where this is considered important.

Figure 3 shows how many participants say that they often or always wash their hands in each situation. Hand-washing happens most often after using the toilet (9 in 10) and before preparing food (8 in 10), and least often after coughing, sneezing or nose-blowing and when coming back home (about 5 in 10).

Figure 3. Percentage of participants that often or always wash hands in specific situations.



3. Factors that influence behaviour

Behavioural determinants are factors that affect the probability that people will exhibit certain behaviour, or the extent to which they do so. The emphasis in this study is on generic determinants that are generally associated with various health behaviours. This includes such factors as trust and health literacy. These factors cannot be changed from one day to the next.

The key findings are:

- Health literacy: six in ten participants have sufficient skills to find, comprehend and apply health information. Participants find it relatively difficult to assess the reliability of information about health risks as presented in the media.
- Resilience: One-third of the participants report high resilience. High resilience occurs approximately twice as often among older participants (55–69 years: 45%) than among young participants (<25 years: 23%).
- Social support: Over one-third (35%) perceive significant social support, while one-fifth (21%) do not perceive much social support. Over one in three (35%) of participants who originally come from outside Europe report limited social support, compared to only approximately one in six (17%) among participants without a migration background.
- Risk perception: One-quarter consider it likely that there will be an outbreak of a highly infectious disease in the next five years. More people consider it likely that there will be a natural disaster (four in ten).
- Trust: Participants have more trust in doctors and scientists than in politicians and the government.
- Susceptibility to conspiracy theories: One-third of participants hold beliefs that make them susceptible to conspiracy theories. This is more likely than average among participants with primary or pre-vocational education, and among participants with a non-Dutch background.

Health literacy

Health literacy refers to whether people can find, comprehend and apply information that is relevant to their health. Health literacy is important during a pandemic in order to cope with new (and sometimes rapidly changing) information and recommendations[8]. 61% of participants show sufficient health literacy (score of 3 or higher, max = 4), 35% have limited health literacy (score >2 and <3), and 4% have insufficient health literacy (score of 2 or lower)[iii]. Participants between the ages of 40 and 54 years are more likely to have sufficient health literacy (69%), while young participants (<25 years) and older participants (70+) are less likely than average to report this (47% and 52%). Migrants or children of migrants from countries outside Europe are less likely to report sufficient health literacy (55%) than participants without a migration background (62%). Other than that, participants from urban areas are more likely (65%) to report sufficient health literacy than participants from rural areas (59%).

Looking at the specific items used to ask about health literacy, participants have the most difficulty assessing the reliability of information about health risks as presented in the media (68% consider it easy).

Resilience

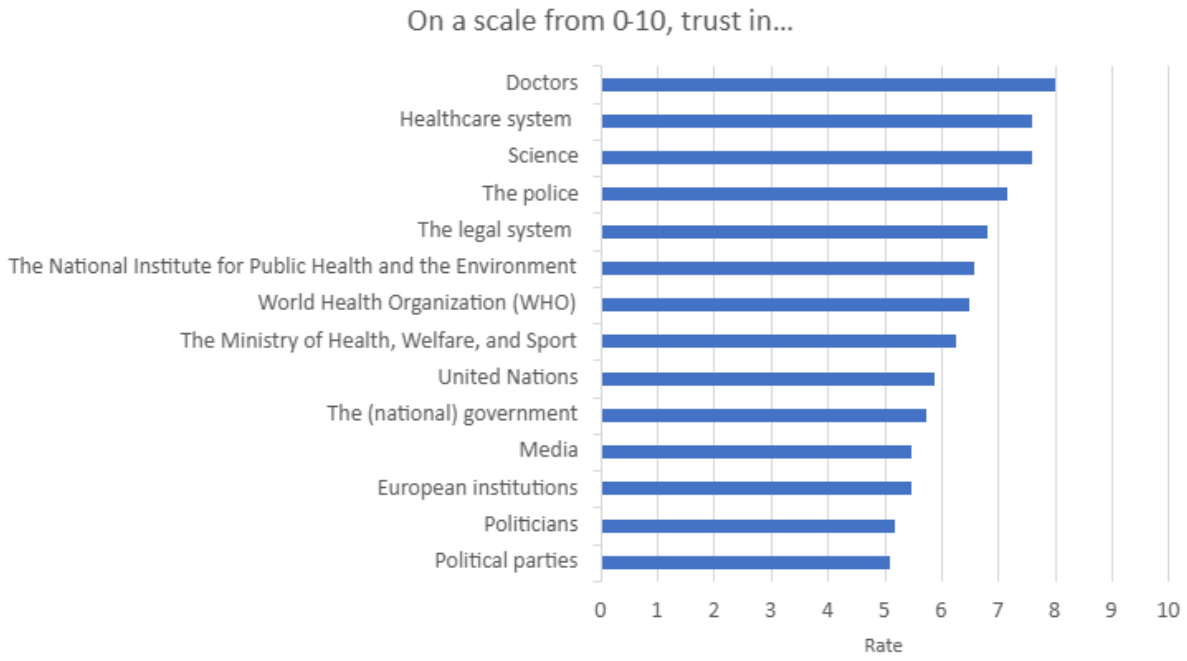
Resilience is about the capacity to recover from stress and setbacks. In this way, it contributes to how well people can cope with a crisis situation[9]. Participants indicated the extent to which they agreed with various statements. For example: "It does not take me long to recover from a stressful event". One-third (33%) of the participants report a high degree of resilience (on average over multiple statements). High resilience is relatively more common among older people (aged 55–69 years: 45% versus 23% among <25 years), men (40% versus 27% among women) and participants with a higher professional or university education (38% versus 31% among participants with primary or pre-vocational education).

Trust

Participants were asked about the extent to which they have trust in various institutions, such as the government, on a scale from 0 (no trust at all) to 10 (complete trust). Participants report having the most trust in doctors, the healthcare system and science (average approximately 8; Figure 4). Political parties, politicians, European institutions, and the media achieved the lowest scores (averages between 5 and 6). Participants with a higher professional or university education and participants in urban areas generally have more trust in institutions. For example, participants with a higher professional or university education give an average score of 7.5 for trust in the legal system, compared to 6.2 among participants with only primary or pre-vocational education and 6.8 among participants with secondary education (senior general secondary / pre-university / senior secondary vocational). Trust in institutions is generally lower than average in participants who originally come from outside Europe. For example, participants who originally come from outside Europe give an average score of 6.7 for trust in the healthcare system, while participants who originally come from a European country other than the Netherlands and participants with a Dutch background give an average score of 7.5 and 7.8, respectively.

[iii] Health literacy was measured using a tool that is widely used internationally for this purpose: HLS-EU-Q6. Relevant literature uses various definitions of 'sufficient' health literacy. The current definition was chosen in line with the definition of sufficient health literacy adopted by international collaboration partnership from the pandemic preparedness network and researchers who developed the scale (Pelikan et al., 2014).

Figure 4. Participants' average trust in various institutions (scale from 0–10)



Accessibility of care

Access to care is important in a health crisis[10]. To measure this, people were asked whether they had needed a medical examination or treatment in the past 12 months, and if so, whether they actually received it. If people indicate that they did not have the examination or treatment, that is marked as an unmet need for care. This is a proxy for perceived accessibility of care.

45% of survey participants indicate that they had needed a medical examination or treatment at least once in the past year. This was more likely than average among older people (53% among people aged 55–69 years and 64% among over-70s) and less likely than average among migrants and children of migrants who originally came from outside Europe (30%). Out of all the survey participants, 4% had a perceived unmet need for care. The percentage is higher than average among participants younger than 25 years of age (9%).

Social support

Social support makes it easier to perform health-related behaviour[11], for example because people can discuss their questions or concerns with someone else, or because people can receive practical help from neighbours if they need it. Social support also contributes to good mental health, for example by preventing loneliness.

35% of participants in this study perceive a strong degree of social support. 44% perceive some social support, and 21% perceive little support. People are more likely to perceive little support if they have a non-European background (35% versus 17% with a Dutch background), have only completed primary/pre-vocational education or secondary (senior general secondary / pre-university / senior secondary vocational) education (24% and 22% versus 16% among participants with a higher professional or university education), or live in a suburban area (25% versus 15% in rural areas).

Looking at specific sub-indicators of social support, it is apparent that older participants (over-70s) are more likely to find it easy or very easy to receive practical assistance from neighbours (61%) compared to younger participants (<25 years: 42%).

Risk perception

Participants were asked about how likely they think it is that a disaster will occur in their immediate region in the next five years and how seriously this would affect them personally. Over one-quarter (27%) think that an outbreak of a highly contagious disease is quite likely or very likely. More people consider it likely that there will be a natural disaster (43%) or terrorist attack (32%). Women are more likely to consider it quite likely or very likely that an outbreak of a highly contagious disease will take place in the near future (34% versus 20% among men). This also applies to participants from urban areas (31% versus 24% among participants from rural areas).

The majority of participants indicate that they would be moderately or severely affected by an outbreak of highly contagious disease (80%). Women (84%) report this more often than men (75%). Participants aged 55 years or older also report this more often (83%) than participants younger than 25 (70%).

Susceptibility to conspiracy theories

In crisis situations – as in other uncertain circumstances – specific conspiracy theories often surface[12]. For that reason, it is relevant to pandemic preparedness to monitor how many and which people in the Netherlands may be susceptible. Participants were presented with five statements about their susceptibility to conspiracy theories. For example: 'I think that many very important things happen in the world, which the public is never informed about', and 'I think that government agencies closely monitor all citizens'. General susceptibility to conspiracy theories is associated with belief in specific conspiracy theories[13].

About one-third (32%) of participants agree or strongly agree with the statements on average. This is lower among participants aged 25 years or younger (21%). Susceptibility to conspiracy theories seems higher than average among participants with primary or pre-vocational education (49%) and people who are originally from outside the Netherlands (outside Europe: 40%; within Europe: 47%).

Behaviour-specific determinants

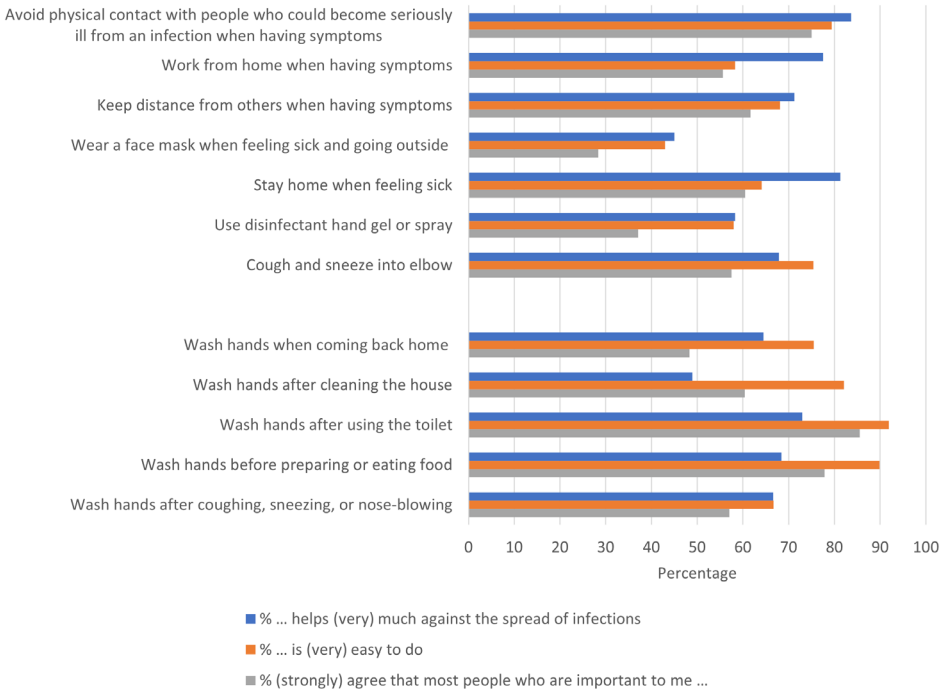
In the second survey round, we also measured behaviour-specific determinants. These are: response efficacy (how useful you believe a specific behaviour is), self-efficacy (how easy or difficult you think the behaviour is), and perceived social norm (to what extent do others around you exhibit the behaviour)[7]. We know that these determinants are associated with the specific behaviours: for example, the easier people think that a behaviour is, the more likely they are to do it themselves[iv]. This knowledge helps in interpreting why people do or do not perform some behaviours during an outbreak. Based on insight into these behavioural determinants, interventions can be developed that target the key factors that determine behaviour. See Figure 5 for the results of the determinants measured here.

[iv] Regression analyses that show the correlation between these determinants and the behaviours are available from the authors upon request.

Most participants (81%) feel that staying home when feeling sick helps (very) much in preventing infections from spreading, but the percentage of participants who consider it (very) easy and the percentage of participants who state that this happens in their social environment are lower (64% and 61%). Wearing a face mask when feeling sick is least often viewed as effective against disease transmission (45%).

Young people (<25 years) and older people (>70 years) often indicate a higher efficacy for staying home when feeling sick, distancing and working from home when having symptoms. The older participants are, the more likely they are to believe that avoiding physical contact with people who could become seriously ill from an infection helps (very) much. Compared to younger participants, older participants are also more likely to report that it is (very) easy to stay home when feeling sick, wear a face mask, keep distance from others, work from home, and avoid contact with people who could become seriously ill. Participants who are over 70 are particularly likely to report that these behaviours are the norm in their social environment. Coughing and sneezing into their elbow is a behaviour that young participants find easier than older participants, and young participants are more likely to indicate that this is standard practice in their social environment.

Figure 5. Psychosocial determinants of specific behaviours.



4. Comparing international results

The questions in this monitor were also asked in Slovenia, Spain and Ireland. By collecting data in various countries, it is possible to place the Dutch findings in context and validate the monitor. An article that addresses the comparisons between countries in detail will follow beginning of 2026. Examples of results include:

- Perceived preparedness: Participants in the Netherlands, Spain and Ireland feel less prepared for a pandemic than in Slovenia. Participants in Slovenia feel more prepared themselves, but they also feel that the government is less well prepared.

- Preparedness behaviour: Behaviours aimed at preparing for a possible pandemic (i.e. having a first-aid kit, face masks or soap, or a supply of water) are much less common in the Netherlands than in the other three countries.
- Hygiene and self-isolation behaviour: People in the Netherlands are less likely to wash their hands in various situations than in the other three countries, especially after coughing, sneezing or blowing their nose. Dutch participants are more likely than participants in other countries to state that they would go outside or visit family if they have symptoms.
- Factors that influence behaviour: Dutch participants have more trust in the government than participants in the other countries.

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