Beyond Parochial Altruism:
Shared Crises and Cross-Ethnic Solidarities in Lebanon [1]

Melani Cammett[2] Amanda Rizkallah[3] Rochelle Sun [4]

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[2]Harvard University, mcammett@g.harvard.edu.

[3]Pepperdine University, amanda.rizkallah@pepperdine.edu.

[4]Harvard University, rochellesun@g.harvard.edu

Abstract

In times of crisis, do people overcome social divisions by exhibiting broad solidarity? This question is especially vital in "divided societies" given the need for broad social and political cooperation to combat natural and man-made disasters. Through a nationally representative phone survey in Lebanon with an embedded experiment, we assess how demographic and health characteristics shape the propensity to prioritize access to Covid-19 vaccines and antibiotics. In Lebanon, these two goods exhibit different demand curves due to significant vaccine hesitancy and excessive demand for antibiotics, which were increasingly out of reach for many due to a severe economic crisis. Contrary to depictions of Lebanon as a deeply divided society, our findings point to broad solidarity with fellow nationals: For both medications, respondents prioritize higher-risk and lower-income profiles regardless of ethnicity. In the highest need cases, however, a slight tendency towards coethnic favoritism obtains with respect to higher-value medications (i.e., antibiotics). Our paper contributes to studies of social solidarity in divided societies and advances research on the sociopolitical effects of crises by benchmarking social preferences around goods with distinct demand curves.

1 Introduction

In times of crisis, do people overcome social divisions and exhibit broad solidarity? Does a shared experience of an exogenous, natural threat – in this case, the Covid-19 pandemic – drive cross-cutting altruism with co-nationals or do preexisting social divisions elicit more parochial expressions of altruism? These questions are vital given the need for cooperation at all levels of politics and society to combat many natural and man-made disasters and are all the more pressing in "divided societies," in which "ethnic identity provides clear lines to determine who will be included and who will be excluded" (Horowitz, 1993, 18).[1]

We explore these questions in Lebanon, a quintessential case of a divided society where macro-level political divides have also penetrated everyday social life (Deeb et al., 2022).[2] In spring 2022, we ran a phone survey of 1,138 respondents that included a conjoint experiment aimed at understanding how different aspects of social and health status and identity characteristics shaped the propensity to prioritize access to potentially life-saving medications. We focus on two essential medications – Covid-19 vaccines and antibiotics – that have different demand curves in Lebanon. While many Lebanese received Covid-19 vaccines in the context of the ongoing pandemic, the population exhibited significant vaccine hesitancy (Al Halabi et al., 2021). Conversely, antibiotics are highly valued (and over-prescribed) in Lebanon (Talaat et al., 2022; Chaaban et al., 2024; Mallah et al., 2020), but were increasingly out of

[1]We use this term with caution, acknowledging that the very notion of a divided society is a political construction as ethnic divisions are often promoted and maintained by political actors rather than reflections of essential identities (Maged, 2022).

[2]Following standard practice in social science research on identity politics (Chandra and Wilkinson, 2008), we use the terms ethnic and sectarian interchangeably throughout this paper even though societal divisions in Lebanon are more precisely described as sectarian or ethnosectarian.

reach for many people due to a severe economic crisis, which erupted in October 2019 and has been called the world's worst economic crisis in the past 150 years (World Bank, 2022).

Our findings point to broad solidarity with fellow Lebanese nationals. For both vaccines and antibiotics, we find that higher-risk profiles are prioritized regardless of ethnicity, with respondents prioritizing sicker over healthier individuals for access to essential drugs and vaccines. The results also point to substantial reported class solidarity, as respondents favor lower income people over the wealthy for access to life-saving medications. Our results therefore belie depictions of Lebanon as a society rife with ethnic favoritism and discrimination at the mass level. Under specific conditions, however, coethnic favoritism obtains. For high-risk profiles, respondents tend to prioritize the allocation of demand inelastic goods to coethnics over non-coethnics – that is, by favoring coethnic access to antibiotics for the sickest people. Thus, people report a slight ingroup bias when thinking about distributing more valued resources for the most vulnerable.

This paper contributes to studies of social solidarity in societies with politicized ethnic divisions. Contrary to standard depictions of deep divisions in such contexts (Horowitz, 2000; Lijphart, 1977), including in Lebanon, which is arguably a hard test for general altruism (Chang and Peisakhin, 2019), we show that people demonstrate broad, cross-ethnic solidarity when it comes to life or death issues. Our findings also point to the enduring importance of class divisions in a context where ethnic politicians have worked assiduously to suppress cross-ethnic, class-based solidarity (Clark and Salloukh, 2013). We also advance the emerging body of research on the sociopolitical effects of pandemics (Argote et al., 2021; Butterworth et al., 2024; Dionne and Turkmen, 2020; Ferwerda et al., 2024; Fridman et al., 2022) by benchmarking social preferences around the allocation of vaccines against those related to other essential medications, enabling us to explore the degree to which these preferences extend to other social goods.

In the next section, we review relevant social science research informing the core questions and design of the study and present a series of hypotheses that we explore in this paper. In Section 3, we elaborate the logic of case selection, data and methods employed in the

study. Section 4 presents the results, which we discuss in more detail in 5. In Section 6, we conclude, outlining the limitations of the study and areas for further research.

2 Social solidarities in times of crisis

In societies with politicized ethnic divisions, it is widely assumed that ethnic bias is pervasive in many aspects of social and political life such as voting (Chandra, 2007), public goods provision (Alesina and Ferrara, 2005; Habyarimana et al., 2007; Miguel and Gugerty, 2005), policy preferences (Lieberman and McClendon, 2013), and others. A human tendency towards ingroup favoritism suggests that parochial altruism, self-sacrificing behavior to aid others from one's own ethnic group sometimes coupled with hostility towards outgroups (Bernhard et al., 2006; Choi and Bowles, 2007; Shayo, 2009), is almost inevitable (Brewer and Caporael, 2006; Brewer, 2019; Tajfel, 2010).[3] But people do not always favor ingroup members (Berge et al., 2015) and ethnic bias may depend on the issue at hand (Malik, 2020). Even in societies where parochial altruism seems to be the norm, people may exhibit broad solidarity with co-nationals when facing a shared crisis or threat (Bauer et al., 2016; Shayo, 2009, 18), particularly when the threat is viewed as natural rather than man-made (Zagefka et al., 2011). In crisis situations, do people overcome alleged tendencies towards parochial altruism to exhibit solidarity with outgroup members?

2.1 Parochial altruism in divided societies

The tendency to differentiate between in- and outgroup members and to prioritize the perceived interests and needs of one's own group is well established in social psychology (Pisor and Ross, 2024). The boundaries of solidarity are limited by conceptions of belonging (Lamont and Molnár, 2002), shaping a range of important processes that influence human

[3]In this paper, we use the terms "parochial altruism" and "ingroup favoritism" interchangeably, given the close connections between the two concepts (Bernhard et al., 2006). For a review, see Pisor and Ross (2024).

well-being such as redistribution (Lieberman, 2003), social welfare provision (Singh, 2015), and intergroup supprt (Van Leeuwen and Zagefka, 2017). Ingroup favoritism also appears to extend to micro-level interactions, such as clinical interactions in health care facilities (Alsan et al., 2019; Balsa and McGuire, 2003; Cammett and Şaşmaz, 2022b; Chapman et al., 2013; Hsu et al., 2014; Sabin et al., 2009; Shavers et al., 2012; Shen et al., 2018), choices of marital partners (Deeb, 2024), and other aspects of everyday life in divided societies (Brewer, 2019). Even if the mechanisms underlying apparent ingroup bias remain contested (Berge et al., 2015; Singh and Vom Hau, 2016) and reflect dynamics unrelated to ethnicity per se (Deeb, 2020), ingroup favoritism seems to operate on a surface level.

In divided societies, prosocial behavior is all the more likely to manifest as parochial altruism, particularly in countries that have experienced "ethnic" violence, where intergroup contact is often limited and mistrust is high (Bauer et al., 2016). Similarly, studies of the politics of the welfare state emphasize that extending benefits to perceived outgroups, such as immigrants, face popular backlash (Magni, 2024). In the context of a crisis like the Covid-19 pandemic, individuals might be expected to prioritize ingroup members for access to essential vaccines, particularly when some ethnic or racial groups are viewed as more susceptible to the disease than others (Lieberman, 2022). For example, in Qatar, the establishment of cordons sanitaires to separate citizens from "guest workers" exemplifies the prioritization of ingroup members for access to safe conditions during the pandemic at the macro-level (Iskander, 2020).

To be sure, not all people in a given society exhibit parochial altruism. Some studies indicate that the tendency towards coethnic bias may be most pronounced among the poor, whether because they derive self-esteem from their ethnic group more than their class or professional identity (Shayo, 2009) or prioritize the dignity of their ethnic group in political behavior, irrespective of the prospect for material gain (Malik, 2024). At the same time, studies of ethnic politics emphasize that coethnic bonds tend to trump cross-class solidarity in countries with politicized ethnic divisions, in part because ethnic elites sabotage the development of alternative forms of solidarity such as labor unions and civil society organi-

zations (Clark and Salloukh, 2013). Furthermore, opportunities for cross-ethnic, class-based interactions are more circumscribed in societies with pronounced segregation in residential patterns and schooling. Studies of parochial altruism and ethnic bias give rise to our first hypothesis:

H 1. *People are likely to prioritize access to essential medications for coethnics over noncoethnics.*

The claim of coethnic bias in prioritizing access to essential medications, however, may be overly simplistic. Perceived health risk may moderate the willingness of respondents to favor ingroup members. On the one hand, when faced with a choice between allocating medication to coethnics versus non-coethnics, people may express ingroup favoritism when the stakes are relatively low. Even in divided societies, social norms often dictate against the open expression of ethnic bias. People are rarely blatantly discriminatory and tend to underreport coethnic preferences due to social desirability bias both in everyday life and in responding to survey researchers (Adida et al., 2016). Thus, we might expect reported preferences to conform to parochial altruism when outgroup members would not be seriously jeopardized. Our preregistered hypothesis therefore holds that coethnic favoritism is likely to obtain *not* when differentiating among needier and sicker members of societies but rather when coethnics and non-coethnics are in low-risk situations.

H 2. *People are likely to prioritize access to essential medications for coethnics than noncoethnics at lower levels of risk.*

On the other hand, respondents may prioritize access to essential medications when the perceived risks are higher. If social norms dictate against the open expression of ingroup bias, favoring coethnics with access to lifesaving treatments is more like to hold when survival is more clearly at stake.[4]

H 3. *People are likely to prioritize access to essential medications for coethnics than noncoethnics at higher levels of risk.*

[4]This hypothesis, which intuitively follows from existing research on coethnic favoritism, was not preregistered and therefore can be considered exploratory.

2.2 Beyond ethnic parochialism

In the past decade, research on diversity in social and political life increasingly pushes back against claims of coethnic favoritism. Based on a series of lab experiments in Nairobi, Kenya, Berge et al. (2015) find no evidence of coethnic bias, confirming a small but growing body of research with complementary results.[5]

In contrast to the conventional wisdom in social psychology, recent research on parochial altruism also suggests that ingroup favoritism does not always maintain. The conditions under which individuals exhibit coethnic bias depend on a variety of factors such as intergroup competition, institutional contexts that heighten intergroup animosity, the perceived gains of cooperation, and other factors (Pisor and Ross, 2024, 4). Furthermore, coethnic bias may hold in some realms of social and political life, such as elections, when people vote for coethnics to benefit ingroup preferences and secure greater access to material benefits (Blaydes, 2010; Chandra, 2007; Cammett, 2014; Corstange, 2016; Lust, 2009), but not in other arenas.[6]

Moreover, coethnic bias may arise due to factors beyond shared preferences among coethnics, providing the appearance of ingroup bias when in fact other mechanisms are at play (Berge et al., 2015; Deeb, 2020; Kustov and Pardelli, 2018). In Lebanon, our research setting, Paler et al. (2020) argue that a lack of intergroup interaction, which enables people to discover common interests, hinders the discovery of shared preferences across ethnic lines. In randomly assigned discussion groups, which vary by cross-ethnic and cross-class composition, the authors find that people assigned to ethnically mixed groups were more willing to publicly oppose the sectarian power-sharing system in Lebanon, but only in discussion groups with members from the same social class. Because residential patterns and other

[5]For example, as cited in Berge et al. (2015, 4), see Carlson (2015); Michelitch (2015); Dionne (2014); Grossman and Honig (2017); Hjort (2014); Marx et al. (2019); Voors et al. (2012).

[6]We are grateful to Mashail Malik for underscoring this point.

forms of demographic sorting tend to be stratified by ethnicity, people have few opportunities to discover shared class-based concerns. The appearance of coethnic bias may arise as a result of patterns of segregation rather than coethnic preferences.

Even in divided societies, where ethnic elites as well as more structural forces hinder cross-ethnic interactions, shared class interests can trump ethnicity. Levels of intergroup inequality shape the degree to which ethnicity becomes politically salient (Horowitz, 1985). In a study of electoral behavior across different states in India, voting along ethnic lines is more likely when cross-group income differences are higher, implying that identity politics may mask class politics (Huber and Suryanarayan, 2016).

Beyond electoral behavior, people may not discriminate along ethnic lines as much as we might expect, even in societies recovering from bloody "ethnic" conflicts. Survey data from such contexts, including Bosnia (USAID Bosnia-Herzegovina, 2022), Lebanon (Paler et al., 2018), and Northern Ireland (ARK, 2023), indicate that people have relatively extensive interethnic interactions through workplaces and daily life, and report the desire to increase rather than restrict such exchanges. Patterns of intergroup exchanges and preferences for cross-ethnic interactions vary depending on the issue at hand or nature of the personal relationship (i.e., friendships versus marital partners), but by and large suggest that most people are open to mixing beyond their own groups. In day-to-day life, then, there is reason to believe that people are not driven primarily by ethnic preferences.

Thus, on average, an alternative hypothesis holds that people may not be driven by ingroup bias when it comes to aiding vulnerable populations and will "do the right thing" by prioritizing access to essential medications for the most at-risk, sick populations who need them most.

H 4. People are likely to prioritize access to essential medications for at-risk populations irrespective of ethnicity.

2.3 Lebanese Context

Lebanon is often presented as a prototypical example of a divided society (Lijphart, 1969; Horowitz, 2000). Since independence from France in 1943, Lebanon's political system has

been based on consociational power-sharing between elites from the country's many sectarian communities, the largest of which are Shia Muslims, Sunni Muslims, and Christians of various denominations. Sectarian quotas in most parts of government and administration institutionalize the powersharing system and reify the role of sect as the most politically salient identity in Lebanese politics. The Lebanese civil war (1975-1990) only reinforced these divisions. While important ideological differences were at stake, particularly at the beginning of the war, it eventually devolved into a multi-sided conflict with sectarian trappings. International intervention by regional powers turned Lebanon into a battlefield for larger proxy conflicts as well. Sectarian displacement and sorting of the population became commonplace. The war ended in the Taif Agreement, a power-sharing deal that reinstated the pre-war sectarian system with minor adjustments(Hanf, 1993).

Most journalistic and scholarly depictions of contemporary Lebanon continue to characterize it as the paradigmatic case of a divided society. In this sense, Lebanon is a hard test for the argument that a broad-based crisis has the power to generate social solidarity, and that in-group favoritism only emerges under a narrow set of conditions. In the post-war period, Lebanon has experienced chronic political tensions along sectarian lines, at times erupting into localized violence or political assassinations, that have tested communal coexistence and peace in the country's fragile post-war context(Norton, 2015; Abdo, 2016; Salloukh, 2017; Gade and Moussa, 2017). Politicians stoke ethnosectarian tensions by claiming to be protectors of their co-ethnics and casting out-groups as a threat (Riskedahl, 2007). They also work to systematically suppress cross-sectarian and non-sectarian forms of political mobilization (Clark and Salloukh, 2013; Salloukh et al., 2015). In prior surveys, Lebanese citizens express consistently high rates of co-ethnic bias regardless of gender, region, or sectarian background(Harb, 2010). Even mundane daily conversations often begin with one person asking questions for the purpose of identifying the other's sectarian background (Ziadeh, 2006).

Recent experimental research further demonstrates the enduring salience of ethnosectarian identity in shaping public opinion and behavior. Survey experiments find that coethnicity

is a more important predictor of electoral support for a candidate in Lebanon than party affiliation, provision of clientelism, or programmatic platform (Cammett et al., 2022). Another experiment asking respondents whether they would sign a petition to reform the sectarian political system finds that respondents are much less likely to sign a public than a private petition, citing pressure from their immediate social network, sectarian elites, and the wider sectarian community as reasons for their refusal to sign (Paler et al., 2018).

Scholars have begun to problematize this characterization of Lebanon, making a distinction between undoubtedly divisive politics and the more sweeping term "divided society" (Maged, 2022). The notion that identity is the singular or even most important explanatory variable underpinning any and all social and political outcomes in the country is contested (Ghosn and Parkinson, 2019). Recent scholarship on Lebanon has instead sought to uncover how the strategic logic of elections dynamics produce divergent kinds of sectarian clientelism (Salloukh, 2006; Cammett, 2014; Corstange, 2016), how wartime organizational legacies and networks shape post-war patterns of political mobilization (Rizkallah, 2019), how instances of cross-sectarian mobilization arise(Rizkallah et al., 2019), and how sectarian divisions are both reinforced by elite strategy (Clark and Salloukh, 2013; Karam, 2017) and transformed by street mobilization (Majed, 2021). New research suggests that parental bias against non co-ethnic marriage partners for their children is actually a shorthand that is masking bias against other important forms of difference such as class and region of origin (Deeb, 2020). Experimental studies have shown that for women, class is a more important roadblock to cooperation than sectarian difference (Marshall and Paler, 2021) and that even limited and temporary experiences with cross-sectarian interaction and contact results in less support for sectarian politics. However, this was only the case among focus groups where participants were of the same class. Far from being a static characteristic of Lebanese society, the intensity of sectarian bias and division is contingent upon whether it cross-cuts or reinforces class cleavages (Paler et al., 2020).

Since 2015, Lebanon has experienced a series of broad-based crises that do not have a clear sectarian character. Instead, they center on cross-cutting issues of sanitation, eco-

nomic breakdown, and public health emergencies, which have impacted all of Lebanon's communities. These included a debilitating trash crisis in 2015 (Geha, 2019), a broad-based protest movement in 2019, and an economic collapse billed as one of the top three worst economic crises since 1850 (World Bank, 2022). Lebanon was already mired in crisis when the Covid-19 pandemic began. Even in the best of times, Lebanon's public health infrastructure, which consists of a layered web of state, non-state, and international actors (Cammett, 2014; Cammett and Şaşmaz, 2022a), has been strained. This system was slow to respond to the pandemic, already reeling from the mass exodus of healthcare workers and chronic medical supply shortages due to the economic crisis. The August 2020 port explosion destroyed half of the city of Beirut and added to the list of broad-based crises experienced by the Lebanese population in recent years (Watch, 2020).

This bewildering series of crises, while devastating, did not have an overtly sectarian or polarizing dimension, but rather led to suffering and loss across all of Lebanon's communities. In fact, starting with local movements in the municipal elections of 2016 and continuing into the 2018 and 2022 parliamentary elections, activists and civil society members begun forming non-sectarian and cross-sectarian movements for social change (Geha, 2019; Nagle, 2024; Rizkallah et al., 2019).

Lebanon's recent tragedies give researchers an opportunity to study how a "divided society" reacts in times of broad-based crises and scarcity. Do people demonstrate social solidarity, prioritizing the most vulnerable, or do people circle the proverbial wagons and demonstrate favoritism toward their in-group? Our study seeks to answer this fundamental question through a survey with a set of embedded experiments. The survey was fielded in the summer of 2022, deep into Lebanon's economic collapse, while the country was still dealing with outbreaks of COVID-19 and, most importantly, at the height of an acute medicine shortage that saw nation-wide scarcity in everything from diabetes medications to cancer treatments to antibiotics (Amnesty International, 2023; Chehayeb et al., 2023).

3 Data and Methods

3.1 Survey and Experimental Design

In spring 2022, we conducted a nationally-representative telephone survey of 1,138 Lebanese adults in collaboration with the Beirut office of IPSOS, a global research and consulting firm. The survey achieved an American Association of Public Opinion Research (AAPOR) cooperation rate of 18.4% among contacted respondents, which is typical for telephone surveys in Lebanon. We chose telephone administration over in-person interviews to mitigate the risk of Covid transmission, as vaccination efforts were still ongoing. This approach also ensured a more representative sample by including more elderly respondents compared to online surveys. All surveys were conducted in Arabic.

Within the survey, we embedded two single-profile conjoint experiments designed to assess factors influencing decisions about access to vaccines in the first experiment, and antibiotics in the second. Respondents were verbally presented with hypothetical profiles varying in sectarian identity, age, socioeconomic class, and health status. To accommodate the telephone format and reduce cognitive load, we presented these profiles as verbal vignettes rather than tabular attribute lists. Vignettes have also been shown to have more external validity than tabular formats by more closely approximating how people encounter and evaluate profiles of individuals in the real world (Kirk Bansak et al., 2021). In both experiments, respondents evaluated three male profiles, with each profile representing one of Lebanon's primary sects (Shia Muslim, Sunni Muslim, Christian).[7] Social class, health condition, and age were

[7]We signaled the sectarian identity of each profile indirectly through two contextual pieces of information: the individual's name and their neighborhood of residence, cued by male names commonly associated with specific sects and residential neighborhoods in Greater Beirut that are widely known to be predominantly populated by a specific sect. This indirect approach to conveying ethnic background was designed to mitigate social desirability bias. The names and neighborhoods denoting members of each sect include Michel from Ashrafieh and Boutros from Gemmayze (Christian), Ali from Haret Hreik and Hussein from Burj al

Table 1: Attribute levels for conjoint experiments

Vaccine Experiment			
Sect	Health Condition	Age	Social Class
Shia	No health condition	20	Poor
Sunni	Mild asthma	45	Middle-class
Christian	Severe asthma		Well-off
Antibiotic Experiment			
Sect	Health Condition	Age	Social Class
Shia	Mild pneumonia	20	Poor
Sunni	Severe pneumonia	45	Middle-class
Christian			Well-off

randomized for all profiles. Table 1 summarizes the levels of each attribute. After being presented with each profile, respondents were asked whether the profile should be granted immediate access to the COVID-19 vaccine in the first experiment or antibiotics in the second experiment. The order in which respondents were presented with each experiment was randomized.

Our choice to conduct experiments on both COVID-19 vaccines and antibiotics was motivated by several factors including those outlined in Section 2.2. At the time the survey was fielded in summer 2022, vaccines were no longer scarce in Lebanon and there were enough doses for those interested in vaccination [8]. In contrast, Lebanon in summer 2022 was in the midst of an acute antibiotic shortage due to the country's deepening economic crisis (Amnesty International, 2023; Chehayeb et al., 2023; El-Harakeh and Haley, 2022).The experiments also differ in the nature of the interventions: the COVID-19 vaccine experiment considers a relatively new preventative measure, while the antibiotic experiment involves a well-established treatment for acute infections.

People view these medications differently. While hesitancy is the central public health

Barajneh (Shia), and Uthman from Aisha Bakkar and Khalid from Tarik el Jedideh (Sunni).

[8]Reuters reported that by July 15, 2022, there were enough doses available in Lebanon to give 41% of the population two doses (Reuters, 2022)

concern with the COVID-19 vaccine, overuse is the primary concern for antibiotics.[9] In 2020, Lebanon was cited as one of the most vaccine-hesitant countries in the world (Mallapaty, 2021). Before the country's vaccine campaign, hesitancy was as high as 75%, yet by the middle of 2021 and after the initial vaccine rollout, vaccine hesitancy among Lebanese citizens was down to between 38% and 42% (Al Halabi et al., 2021; Ali et al., 2022; Hanna et al., 2022). A 2024 study puts vaccine hesitancy in Lebanon at approximately 12% (Yasmin et al., 2024). In contrast, studies document alarming increases in antibiotic consumption in Lebanon in the last 20 years (Lahoud et al., 2021), with the most recent estimates putting antibiotic misuse at 20% to 50% of all antibiotics taken in the country (Chaaban et al., 2024).

A variety of additional factors might moderate choices about which peers to prioritize for access to essential medications. As stipulated in our pre-analysis plan, we also collect a variety of pre-treatment measures related to respondent demographics (i.e., age, gender, education, and socioeconomic status), sociopolitical attitudes (i.e., trust in government and religious authorities, partisanship), confessional and other social identities; and health attitudes (i.e., trust in doctors and the health care system, vaccine hesitancy, and vaccination status).

3.2 Methods

To analyze the experimental data, we estimated Average Marginal Component Effects (AMCEs) on a probability scale using logistic regression models with robust standard errors clustered at the respondent level to account for within-respondent correlation. To evaluate whether respondents incorporate ingroup favoritism in their decision-making, we create a coethnic variable indicating when the respondent's self-reported confession matches with the

[9]In fact, recent studies have shown that vaccine hesitancy and antibiotic overuse and incorrect use are correlated and underpinned by a set of social attitudes and experiences that are still poorly understood (Anderson, 2022).

profile's cued sect. In the vaccine experiment, we also collapse the profile health condition to differentiate between severe health conditions and mild/moderate cases to evaluate whether ingroup favoritism outweighs solidarity only for profiles that are perceived as on the margin of need. We additionally explore heterogeneous effects by respondent income and by the respondent's reported vaccine acceptance or hesitancy. All analyses were conducted using R (version 4.1.0).

4 Results

We report details on the sample composition of our survey and key demographic characteristics in Table 2. The sample was well-balanced across key demographic factors, including age, sex, sect, and income. In line with recent studies suggesting a declining trend in vaccine-hesitancy, 21.4% of respondents in our sample were vaccine-hesitant and 67.4% had received at least one dose of the vaccine.

Generally, respondents showed higher rates of inclusiveness for antibiotics compared with Covid vaccines. The total number of profiles prioritized by respondents in each experiment are reported in B.1. Approximately 40% of respondents indicated that all three profiles they were presented should receive priority access to Covid vaccines, while over three-quarters of the sample prioritized all three profiles for antibiotic access.[10] These outcomes seem to be driven by respondents' positive view of antibiotics and more ambivalent view of vaccines, which accords with our priors about the Lebanese population. Indeed, whereas the plurality of vaccine-hesitant respondents prioritize no profiles for vaccination, the plurality of vaccine-acceptant respondents prioritize all profiles in the vaccine experiment. In contrast, both groups prioritize profiles at similar rates in the antibiotics experiment, as shown in Figure

[10]This pattern challenges the notion that respondents might simply approve all profiles until encountering one they deem unworthy of prioritization, as the marked difference in approval rates between the two experiments indicates that respondents were discriminating between the two interventions rather than applying a uniform response strategy.

Table 2: Sample Composition and Demographic Characteristics

Characteristic	**N = 1138**	**Proportion**
Gender		
Female	589	51.8%
Male	549	48.2%
Sect		
Sunni	365	32.1%
Shia	358	31.5%
Christian	318	27.9%
Muslim Minority	75	6.6%
Other/Not Reported	22	1.9%
Age		
25-34	262	23.0%
35-44	227	19.9%
18-24	194	17.0%
45-54	186	16.3%
55-64	151	13.3%
65+	118	10.4%
Income Level		
Low Income	477	41.9%
Middle Income	419	36.8%
High Income	242	21.3%
Education Level		
College	381	33.5%
Intermediate	315	27.7%
Secondary	250	22.0%
Elementary	185	16.3%
Not Reported	7	0.6%
Vaccine Attitudes		
Vaccine-Acceptant	894	78.6%
Not Reported	2	0.2%
Received Vaccine	767	67.4%
Not Reported	11	1.0%

B.2.

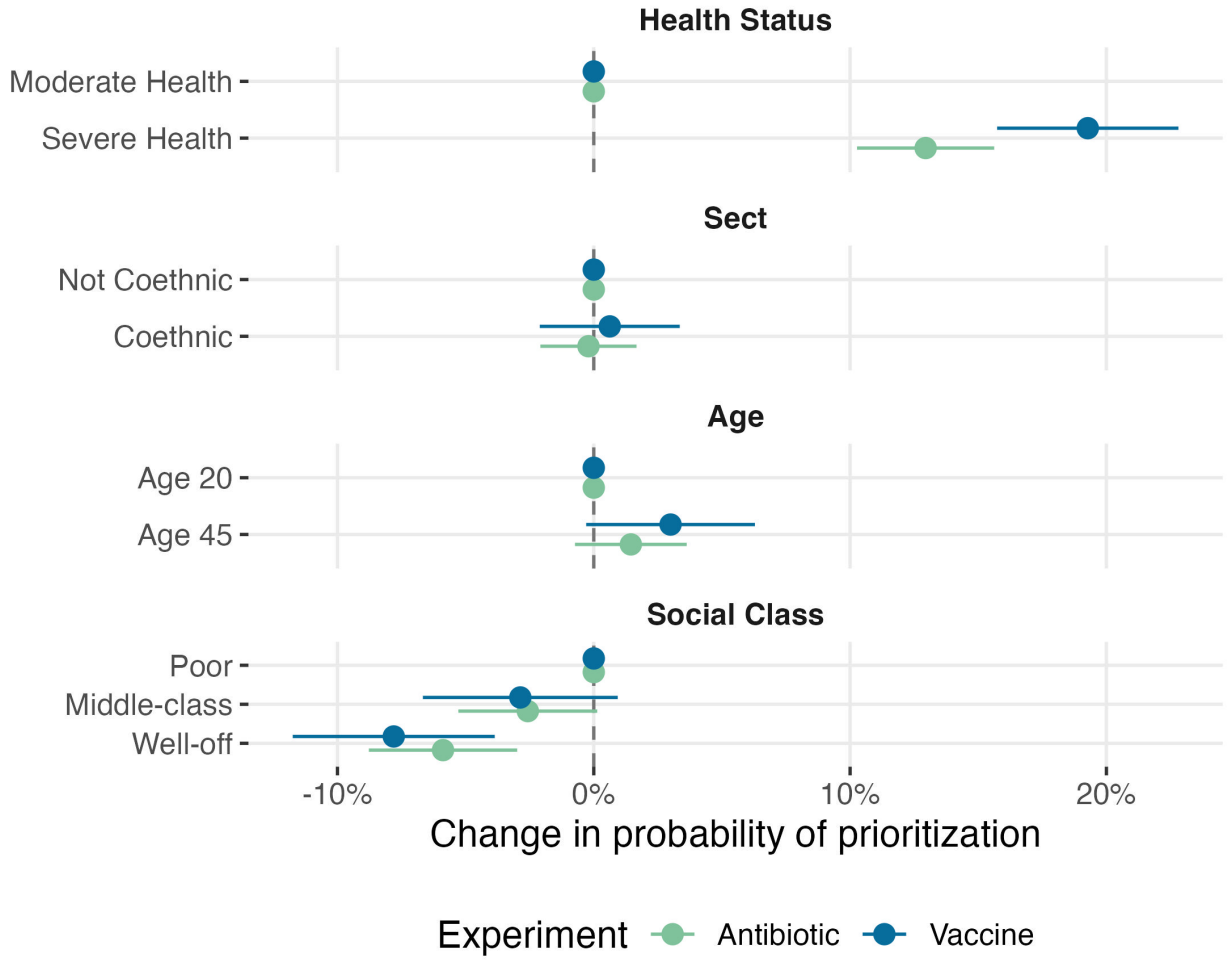
AMCEs for the included attributes in the full sample are presented in Figure 1. The results indicate that respondents exhibit a tendency to prioritize individuals with poorer health status when allocating immediate access to treatments. Respondents are 19.3% more likely to prioritize vaccine access and 12.9% more likely to prioritize antibiotic access for individuals with poorer health. Concurrently, we observe a weak yet persistent bias against profiles associated with higher social classes. This bias, while not as strong as the health status attribute, indicates that respondents may incorporate considerations of social equity into their decision-making processes.

Our baseline evaluation of sectarian dynamics in the context of in-group favoritism reveals that respondents do not demonstrate a preference for their coethnics over others. Instead, in line with Hypothesis 4, poorer health and lower social class continue to be the primary predictors of vaccine and antibiotic prioritization, suggesting stronger solidarity along need-based and class-based lines.

To evaluate heterogeneous effects by health risk-level, we show conditional AMCEs in Figure 2. The income-based preferences observed in the full sample remain stable: respondents consistently favor allocating resources to poor recipients over wealthy ones, regardless of health status. However, our analysis reveals divergent preferences for coethnic bias. For vaccine allocation, respondents show a preference for coethnic recipients with moderate health status, aligning with 2 and suggesting that ingroup favoritism emerges when stakes are relatively low. The pattern reverses for antibiotic allocation, where respondents prioritize coethnic recipients specifically when they present with severe health conditions, supporting 3. These opposing tendencies suggest contrasting perceptions of demand over the two different health interventions. We explore these differential effects in more detail in Section 5.

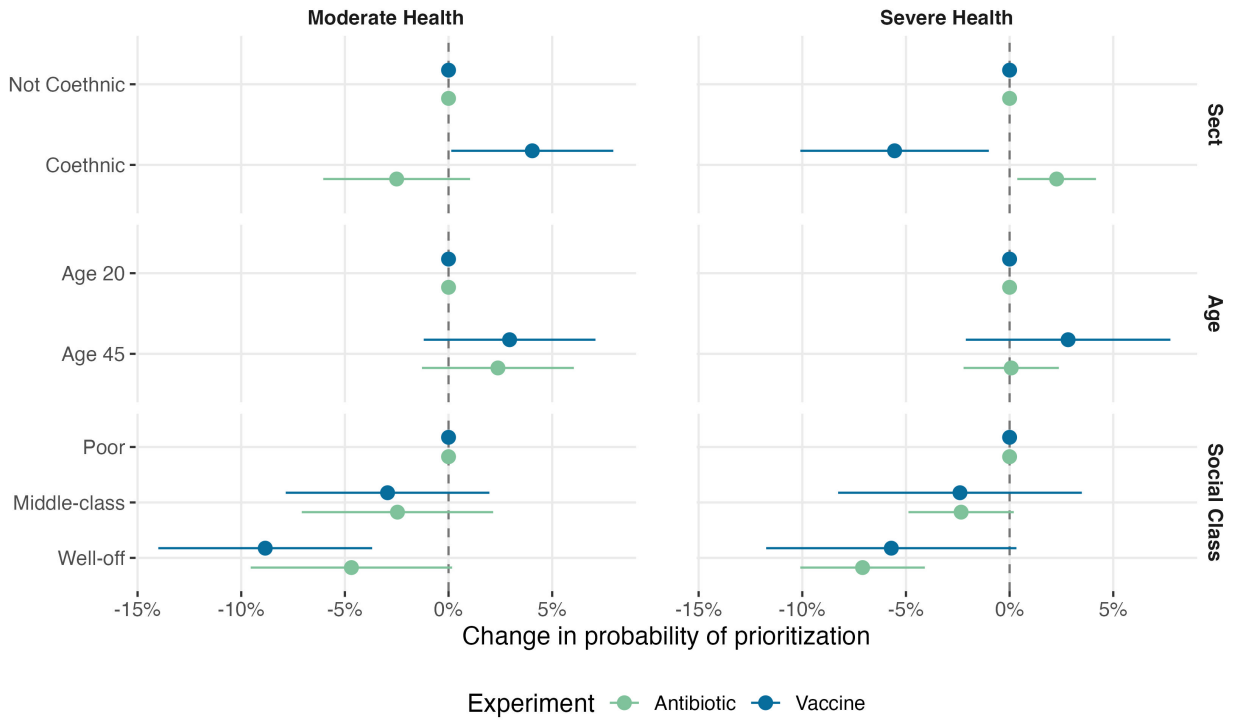
In Appendix B, we report conditional AMCEs by income level, sectarian identity, and vaccine attitudes to test whether treatment effects vary systematically across other demographic and attitudinal dimensions. Overall, these findings challenge our initial expectations

Figure 1: Conjoint experiment results in full sample



of coethnic favoritism as we do not find supportive evidence for Hypothesis 1. Instead, we find robust support for Hypothesis 4. Respondents across all subgroups consistently prioritize individuals with higher health risks in both vaccine and antibiotics scenarios, suggesting that health need drives allocation preferences. For age, we observe positive effects in both experiments favoring those who are older, although these results are not statistically significant. Part of the reason for this might be that the experiments only include profiles aged 20 and 45, rather than elderly profiles where this effect might have been more pronounced. We continue to find scant evidence of coethnic bias, with precise null effects estimated for

Figure 2: Conjoint experiment results by health risk level



the coethnic coefficient across all evaluated subgroups.

After each experiment, we also asked respondents to identify the most important profile attribute that respondents considered when deciding whether or not to prioritize the profiles.[11] Consistent with the findings from our experimental results, Figure B.10 shows that health condition was widely cited as the top priority by the majority of respondents in both experiments. Age was identified as the second priority by a plurality of respondents in both experiments.

[11]We asked respondents to choose from the following profile attributes: place of residence, health condition, age, and social class. As sect was not mentioned as an explicit attribute in the conjoint profiles, we did not include it in this question. However, in the Lebanese context, place of residence, particularly the neighborhoods and towns we included in the experiment, cue sect in a clear but less overt way.

5 Discussion

Do shared threats from crises, whether natural or man-made in origin, unite people across social cleavages or reinforce parochial attachments? The results from our survey experiments suggest broad social solidarity in the face of the Covid-19 pandemic and Lebanon's enduring economic crisis. We find compelling evidence that people "do the right thing" by prioritizing the vulnerable, even under conditions of crisis and scarcity when self-interest or ingroup favoritism might be expected to dominate.

Our results demonstrate that respondents consistently prioritize individuals with poorer health status for both Covid-19 vaccines and antibiotics, regardless of ethnicity. This pattern holds true across different social groups and among individuals with distinct perceptions of vaccine safety. While vaccine-hesitant individuals are generally less likely to prioritize any profile for vaccination, as would be expected, the overall pattern of prioritizing vulnerability remains consistent.

In addition to health status, class emerges as an important dimension of distinction. The poor are consistently prioritized over the middle class and the well-off. While the tendency to prioritize low-income recipients is most pronounced among lower-income respondents, we find that even affluent respondents demonstrate a preference for allocating resources to those of lower socioeconomic status. These findings highlight the importance of class solidarity, particularly during times of crisis, and are consistent with both classic Traboulsi (2012) and recent (Marshall and Paler, 2021; Deeb, 2020) scholarship that rejects simplistic notions of a Lebanese society defined by sectarian divisions and emphasizes the importance of cross-cutting class cleavages in Lebanon. Taken together, we interpret this as evidence of expansive social solidarity and concern for social equity in times of crisis.

The study's design allowed us to compare allocation preferences across two different medical goods with distinct demand curves in Lebanon: Covid-19 vaccines and antibiotics. Because vaccines are preventive in nature, the benefits of the intervention are conditioned by perceived risk of infection, the prospect of herd immunity, and longer time horizons over which the benefits are expected to materialize. This, coupled with high-rates of vaccine-

skepticism in the Lebanese population (Hanna et al., 2022; Al Halabi et al., 2021), suggests that the demand for Covid-19 vaccines is relatively elastic to perceived costs. In contrast, antibiotics are curative treatments that offer immediate therapeutic benefits for the treatment and prevention of bacterial infections. Furthermore, high rates of antibiotic overuse (Talaat et al., 2022; Chaaban et al., 2024; Mallah et al., 2020; Lahoud et al., 2021; Mounzer et al., 2021) and severe shortages in Lebanon render demand for the treatment relatively inelastic, particularly for patients presenting with acute bacterial infection. As such, the evaluation of vaccines and antibiotics in our study provides a robust test of social solidarity versus parochial altruism under varying conditions of perceived value and scarcity. While we find little evidence of straightforward coethnic bias in overall allocation preferences, conditional effects by perceived health risk reveal divergent ingroup preferences between the two medical interventions. For preventive vaccines, where demand is more inelastic, individuals prioritize their ingroup when stakes are lower and recipients present with moderate health conditions. For curative and scarce antibiotics, ingroup bias appears for the most vulnerable, or recipients with severe health needs. These contrasting patterns suggest a nuanced view of coethnic favoritism, varying systematically by the perceived demand for the intervention and recipients' health status.

Our study faces several important limitations inherent to survey experiments, and conjoint experiments in particular. First, while conjoint experiments allow us to estimate the comparative marginal effects of multiple treatment attributes, our design captures only a subset of the factors that might influence real-world allocation decisions in Lebanon. Second, our decision to present respondents with only one profile at a time was well justified to limit risks of disease exposure during the ongoing pandemic and to alleviate cognitive load for respondents during the phone survey. However, as a result of this design, it is possible that respondents were more generous in the allocation of medical resources to non-coethnics than they might have been if forced to choose between two profiles. Still, the persistent prioritization of health status and class over coethnicity across multiple subgroup specifications gives us confidence that social solidarity trumps coethnic bias in this context of a

broad-based crisis.

Finally, while we strategically selected Lebanon as a "hard test" for examining coethnic bias, several contextual factors may limit the generalizability of our findings. The compounding effects of the Covid-19 pandemic, Lebanon's severe economic contraction, the collapse of the healthcare system, and enduring shortages in essential medications may have heightened awareness of collective vulnerability in ways that dampened typical in-group preferences. Additionally, the timing of our study during a particular phase of the pandemic, when vaccines were newly available, may have shaped allocation preferences in ways that might not apply to other catalytic events or even to later stages of the same crisis.

Our findings suggest several important directions for future research. First, while our analysis of individual preferences offers evidence of public attitudes regarding medical resource allocation, these preferences may not be reflective of actual allocation practices by elites or distributive institutions. Understanding whether reported social solidarity from our survey affects implementation practices will be important to contextualize the salience of our findings. Our results may also suggest distinct considerations over the allocation of medical resources during acute health crises in comparison to other non-health goods and services, but future studies should directly compare preferences over health interventions and non-health goods to test whether social solidarity extends to broader resource distribution. Understanding whether healthcare represents a special domain for fairness preferences is crucial for both theory and policy.

Future studies should also work to understand the generalizability of these results by asking similar questions in other "divided societies" and in a variety of crisis and non-crisis situations. As for Lebanon, the country continues to face acute crises. At the time of writing, the economic crisis has been compounded by a war that has displaced over 1 million people. Housing is in short supply and Lebanon's various sectarian communities face decisions about whether to welcome and house the displaced population, which mostly consists of Shia Lebanese and some Syrian refugees. Reports on the ground suggest that the Lebanese have banded together, welcoming and exhibiting solidarity with the displaced.

However, this solidarity is under heavy strain as both hosts and displaced confront the realities of economic scarcity and Israeli strikes (Fawaz, 2024). Additional research should examine the limits and reaches of social solidarity in Lebanon under a variety of crisis, and hopefully someday, non-crisis conditions.

6 Conclusion

Based on a nationally representative phone survey with an embedded conjoint experiment, we find that Lebanese citizens exhibit broad solidarity with fellow nationals in the face of acute health and economic crises. To the extent that respondents exhibit parochial or ingroup favoritism, it manifests only for high-risk cases, where hypothetical recipients of essential medications are depicted as acutely ill.

These findings make important contributions to our understanding of cooperation and altruism in societies with politicized ethnic cleavages. They challenge the presumption that solidarity across social and political lines is particularly difficult to achieve in divided societies such as Lebanon. Instead, our results point to enduring class consciousness and social solidarity, even in a political environment where elites consistently work to suppress cross-cutting, national identities by highlighting ethnic divisions.

Finally, we advance research on cooperation and altruism in societies with politicized ethnic cleavages. Lebanon, and other societies like it, are not hopelessly divided or rabidly sectarian. Rather, individual preferences are multi-dimensional, exhibiting careful consideration of several characteristics beyond coethnicity. Consistent with emerging scholarship that distinguishes between varied domains of everyday life and the political sphere (Cammett, 2024), ethnic identity may be salient in some areas of life but may play little to no role in some humanitarian considerations and other shared social challenges. This study suggests that in times of acute and broad-based crisis, people do have the potential to demonstrate social solidarity and care for the vulnerable, even in the most "divided" societies.

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Appendix

A Sample

Our data come from an experiment embedded in a 1,138-person nationally representative phone survey of Lebanese citizens we conducted in partnership with the Lebanese branch of IPSOS (Institut Public de Sondage d'Opinion Secteur) in the spring of 2022. IPSOS Lebanon enumerators constructed a sampling frame using numbers from the telecommunications operators' database and official directories in Lebanon, supplemented by external databases owned by IPSOS. Numbers were then randomly selected from the frame. If it was a mobile number, enumerators interviewed the person who picked up the phone, provided they were at least 18 years of age. If it was a landline, enumerators interviewed the person in the household with the next birthday.

Of those who were successfully contacted and eligible, the cooperation rate was 18.4 percent. Using the AAPOR calculator worksheet,[12] the contact rate, those who were successfully contacted out of all attempts, is 42.9 percent. The refusal rate, those who have refused out of all the eligible respondents successfully contacted, is 34.1 percent. The minimum cooperation rate, which is the percent of complete surveys out of everyone that was successfully contacted and eligible, is 18.4 percent. The minimum response rate, which is the percent of complete surveys out of all phone number dialing attempts, is 7.7 percent. IPSOS confirmed that this is a typical result for a phone survey in Lebanon.

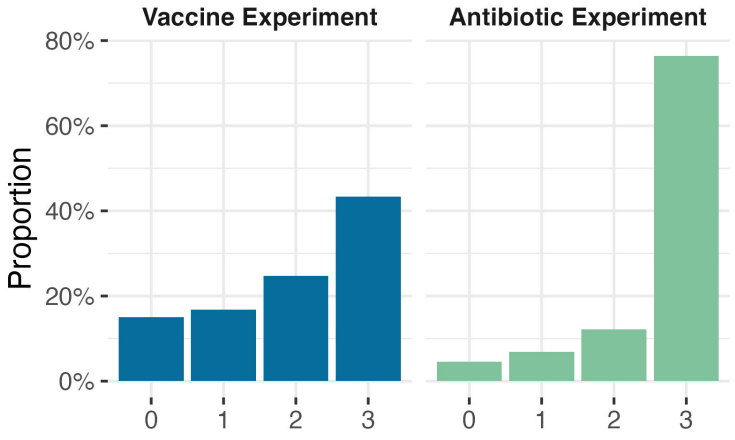
The resulting sample is well-balanced in terms of age, gender, sectarian identity, and regional representation. The sectarian distribution of the sample accurately reflects the best

[12]The American Association for Public Opinion Research (2020) Survey Outcome Rate Calculator, Version 4.1.

estimates of country's religious composition[13] Since a census has not been carried out in Lebanon since 1932, official numbers are not available.

B Additional Results

Figure B.1: Number of profiles prioritized by experiment



[13]The CIA World FactBook (2023), Lebanon Country Summary `https://www.cia.gov/the-world-factbook/countries/lebanon/` (accessed June 14, 2021).

Figure B.2: Number of profiles prioritized by experiment and vaccine attitude

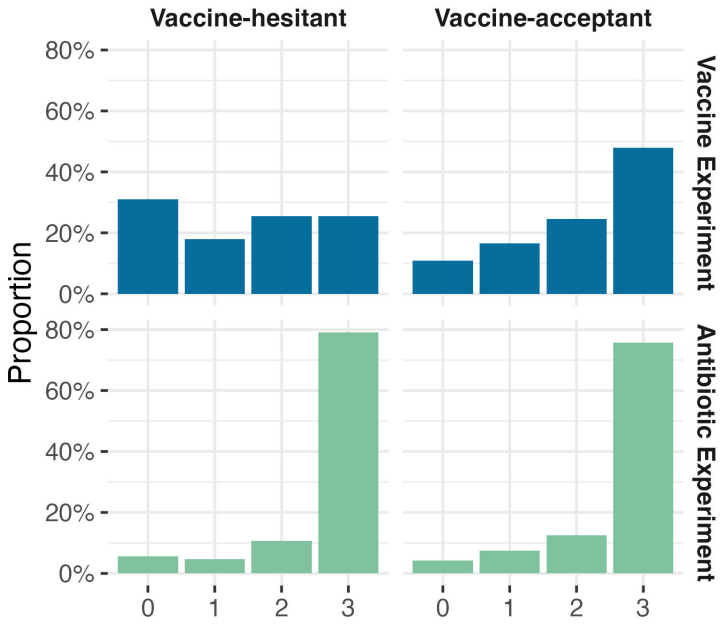


Figure B.3: Conjoint experiment results by respondent income level

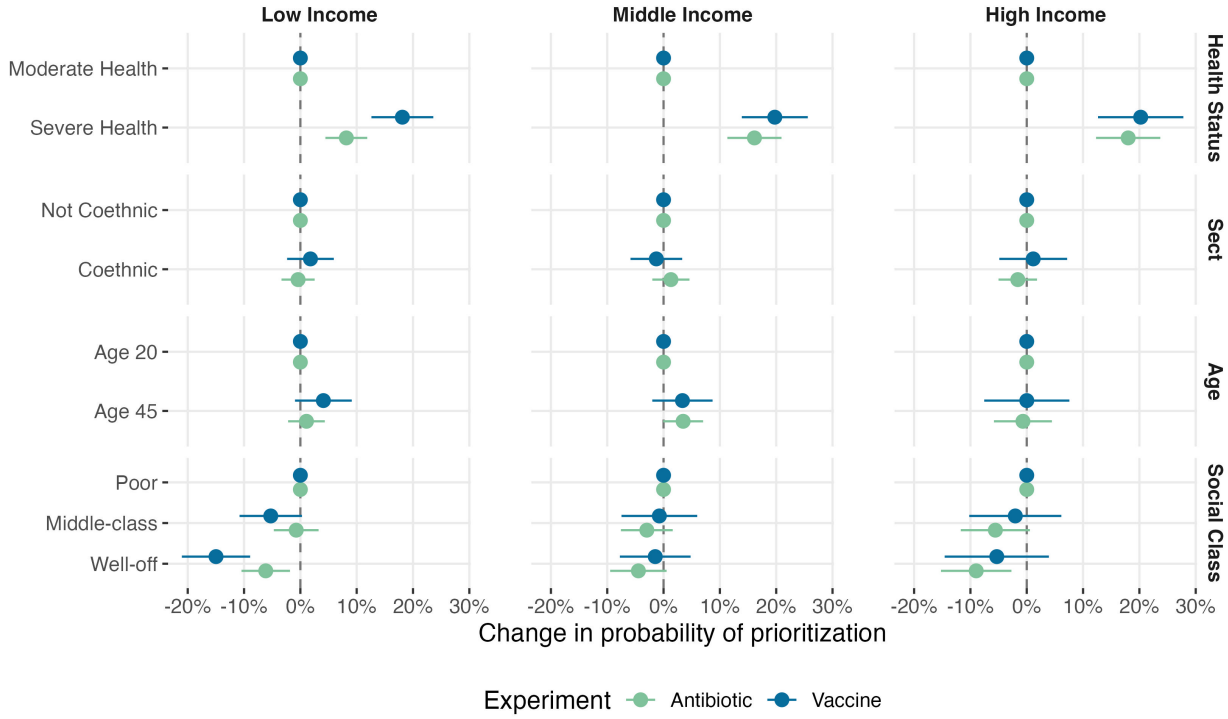


Figure B.4: Conjoint experiment results by respondent sect

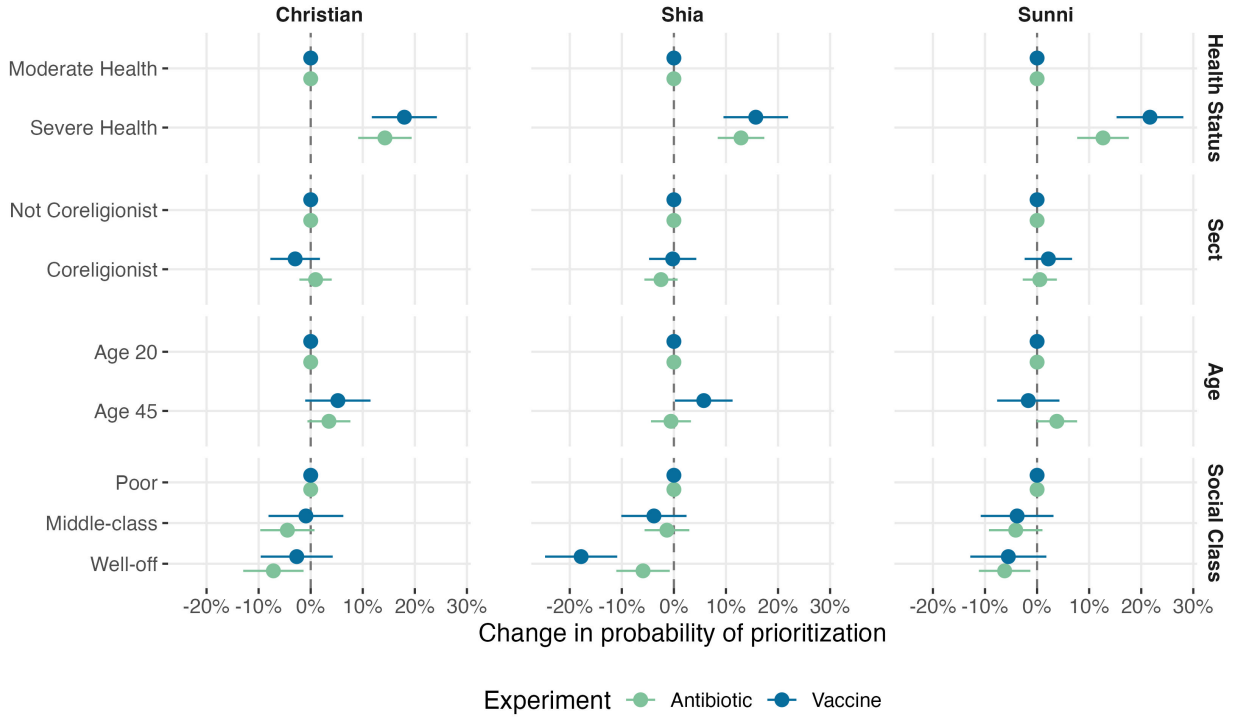


Figure B.5: Conjoint experiment results by respondent vaccine attitudes

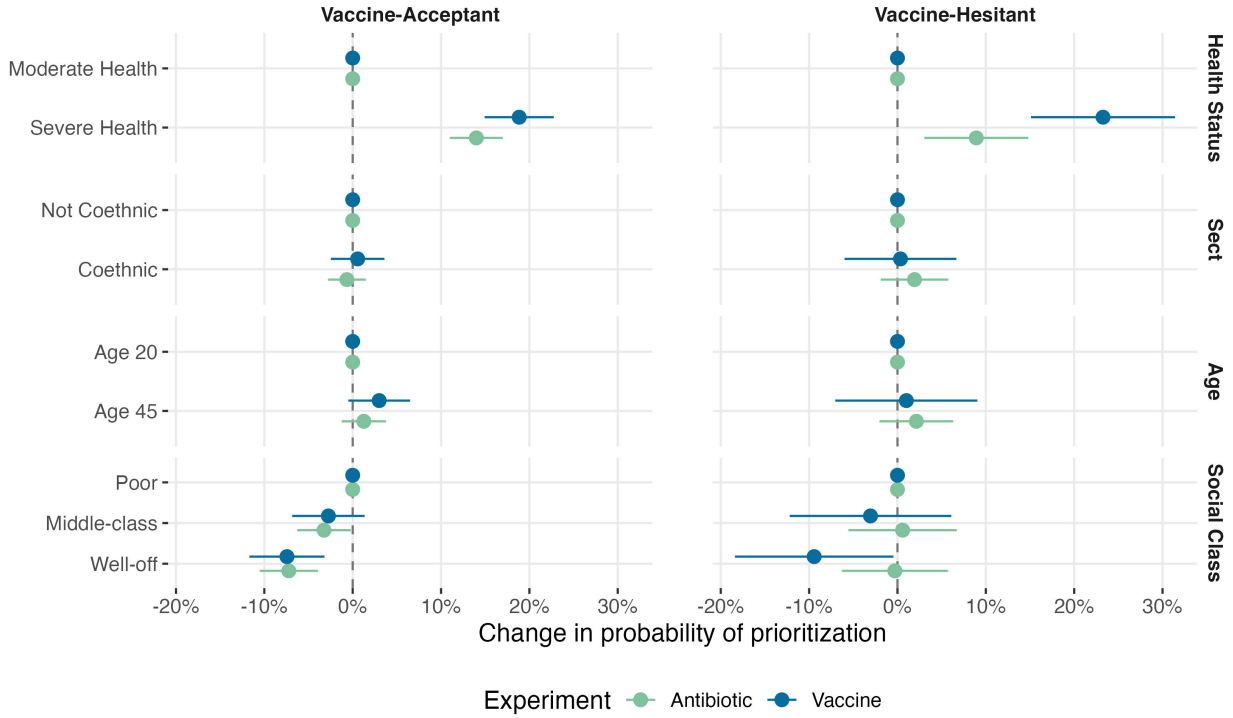


Figure B.6: Conjoint experiment results by self identification (Sect)

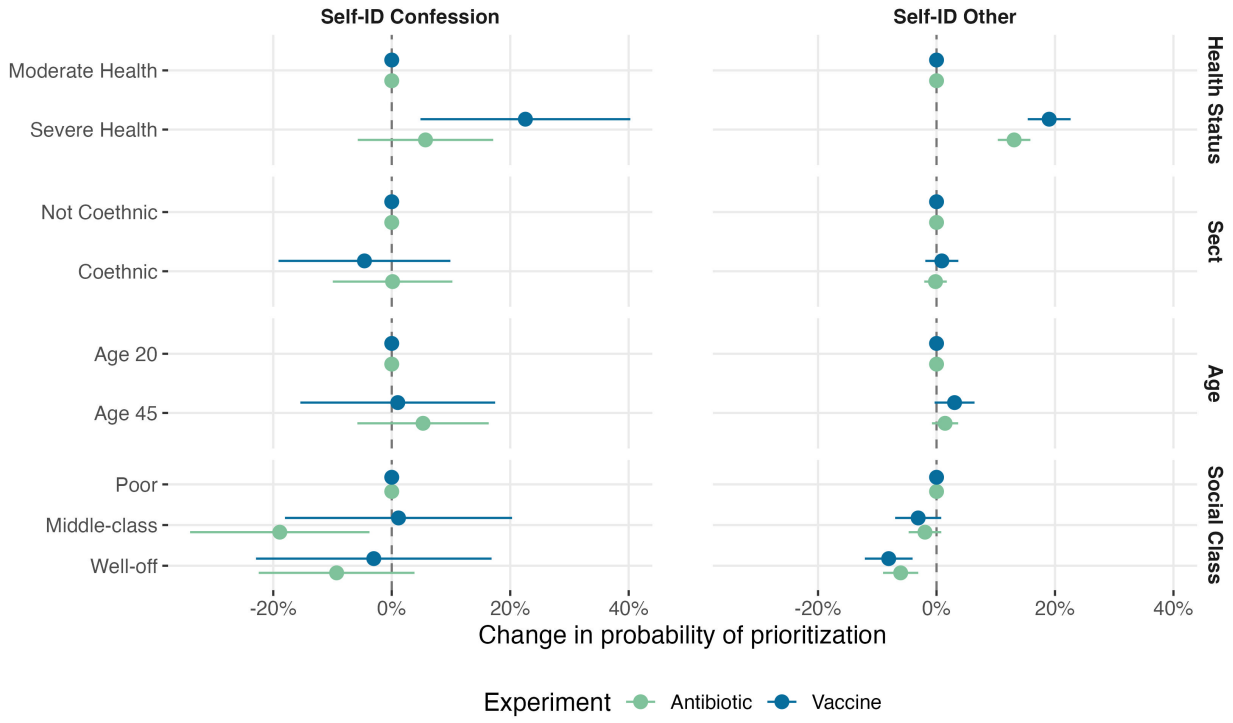


Figure B.7: Conjoint experiment results by self identification (Nation)

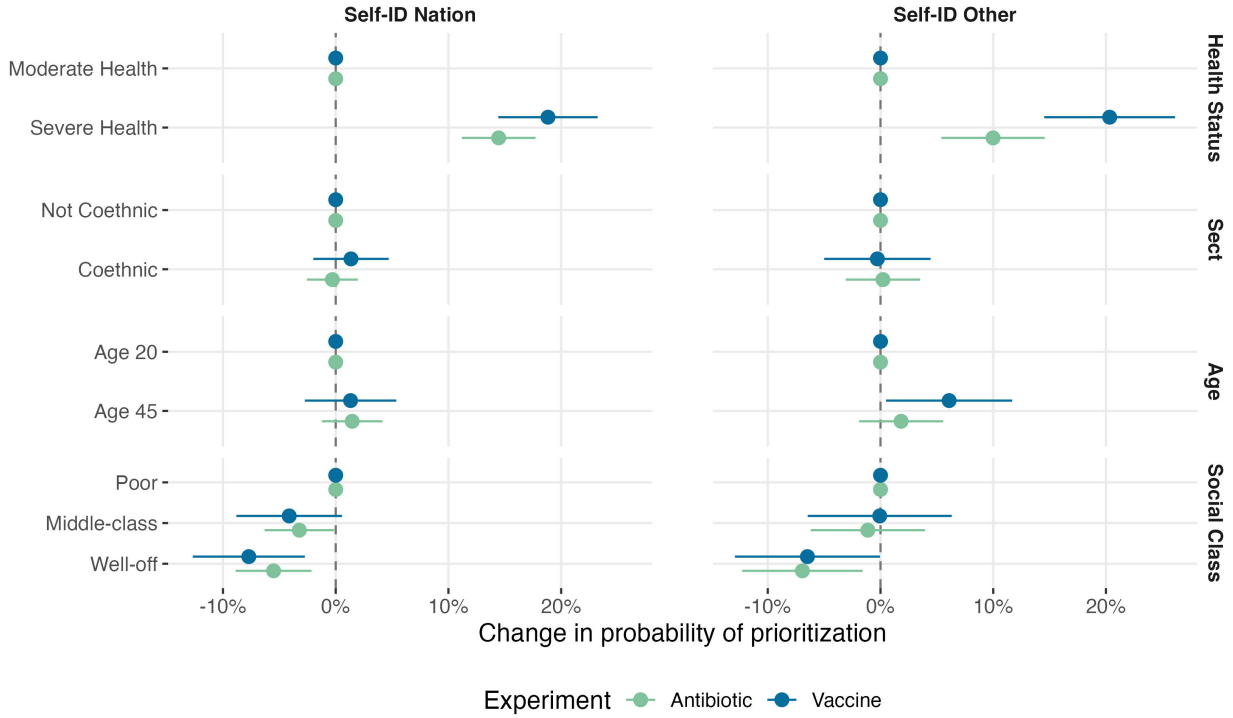


Figure B.8: Conjoint experiment results by self identification (Party)

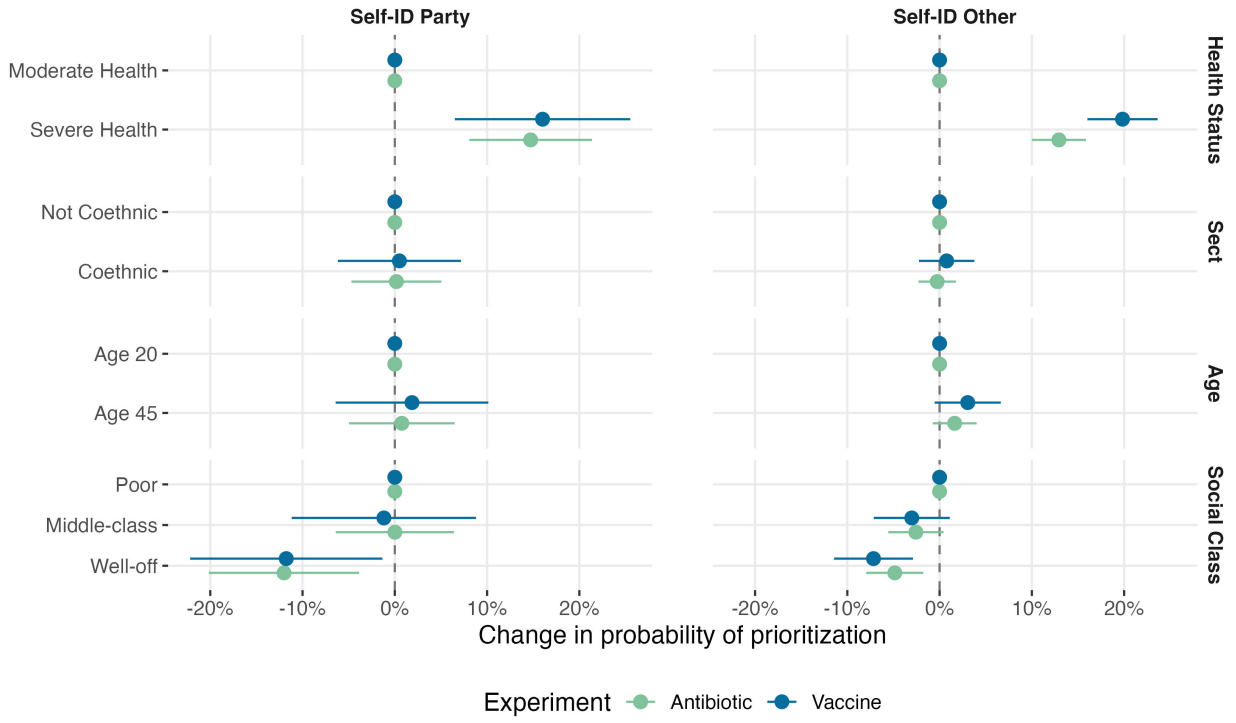


Figure B.9: Conjoint experiment results by order in which the experiment was presented

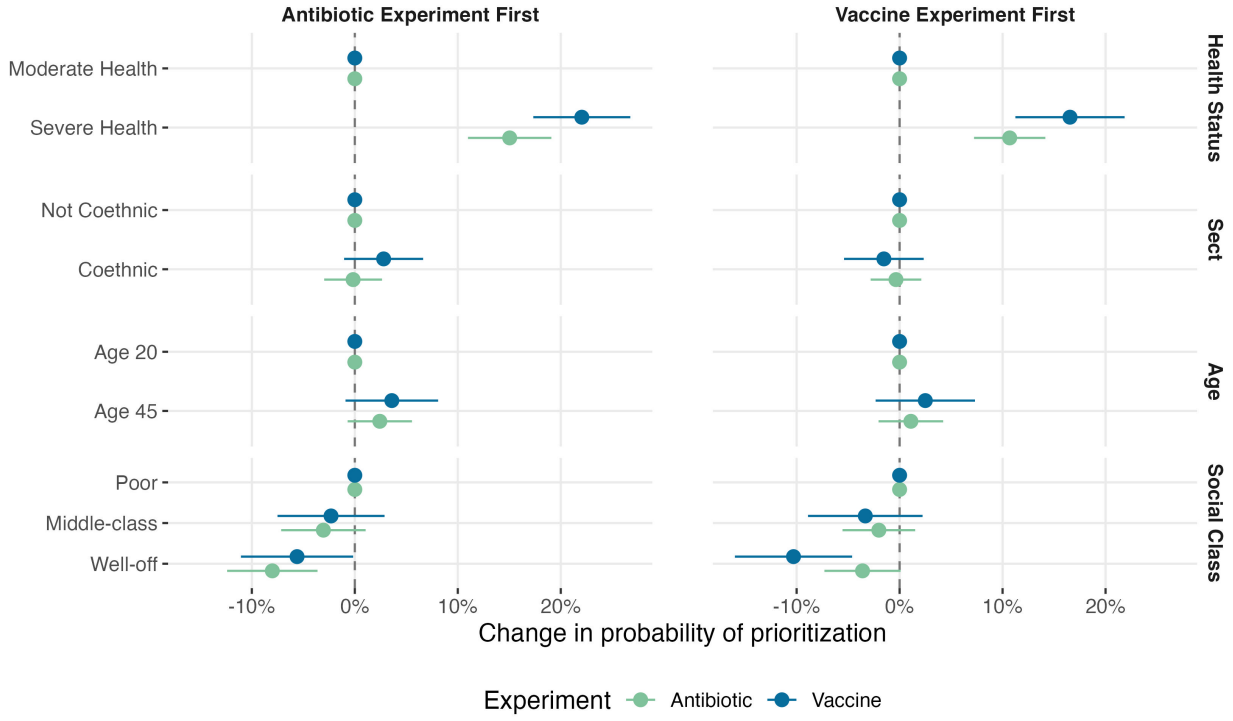
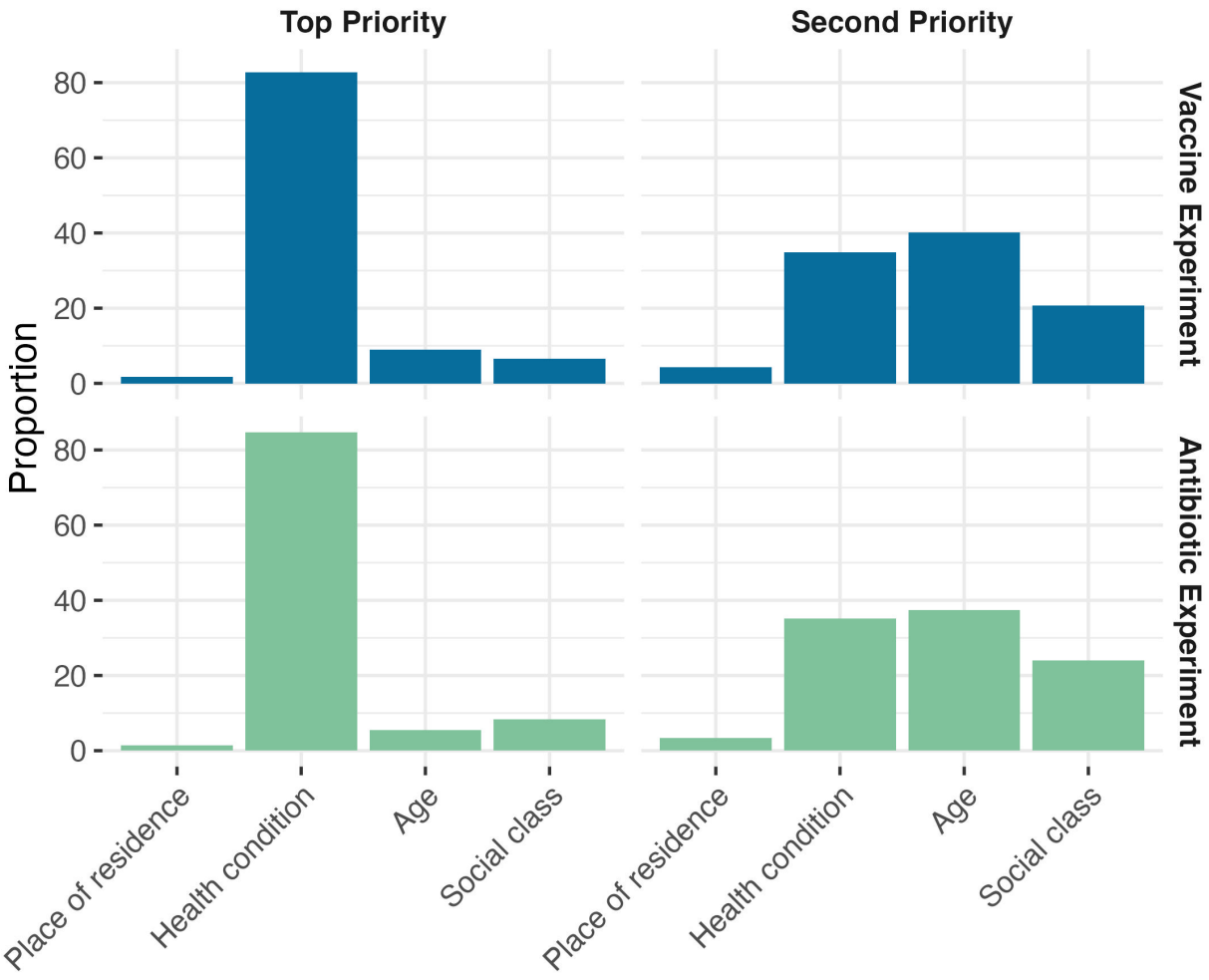


Figure B.10: Conjoint experiment attribute priorities by experiment.



After being presented with three profiles for each experiment, respondents were asked the following question: *In determining whether or not someone should get priority access to [the vaccine/antibiotics], which factor was most important in your decision – the place of residence, health condition, age, or social class of the person?*

C Survey Text

Lebanon Covid Survey

Start of Block: Block 16

Q51 Before proceeding, please change the language of the survey in the top-right corner of this page.

JS

Q49 Survey enumerator: Enter your survey enumerator ID number.

_____

End of Block: Block 16

Start of Block: Introduction

JS

Q45 **TITLE OF RESEARCH: Lebanon Covid-19 Survey**

CO- PRINCIPAL INVESTIGATORS:
• Prof. Melani Cammett, Department of Government, Harvard University
• Prof. Daniel Corstange, Department of Political Science, Columbia University
• Prof. Amanda Rizkallah, International Studies and Languages Division, Pepperdine University

Good morning/afternoon/evening. I am calling on behalf of a research team completing a study. I would like to give you some key information about the study. Please listen carefully before you decide to participate in the study.

[Key elements of the research study]
The study looks at attitudes towards Covid-19 vaccination in Lebanon. You will be asked some survey questions that can take up to 15 minutes to complete and there are no risks to participating.

[Purpose of the research study]
Through this research survey, we hope to learn about the views and experiences of Lebanese adults regarding the Covid-19 pandemic. The purpose of the survey is to better understand general opinions regarding the current public health situation, not any one individual's views or

circumstances. Answers will therefore be completely confidential and no names will be recorded in our data.

[What you will do in the study]
I will ask you a series of oral multiple choice and yes or no questions. You may skip any of the questions you do not feel comfortable answering, and you may stop the survey at any time. You will be asked a variety of questions about your family background, political views, social attitudes and values, and opinions regarding Covid-19 vaccinations.

[Time required]
The study will take about 15 minutes to complete.

[Risks]
Because the data are confidential and your name and other identifying information will not be collected unless you explicitly choose to provide it, there are no anticipated risks for your participation.

[Benefits]
Participating in the survey will give you a chance to voice your opinion about important issues facing your country.

[Confidentiality]
All records from this study will be kept confidential. Your responses will be kept private, and we will not include any information that will make it possible to identify you in any reports or publications unless you explicitly provide this information. Research records will be stored securely on password protected computers. Only members of the research team will have access to your complete data. If identifiers are removed from your identifiable private information, the information from this study may be used for future research studies or distributed to another researcher for future research studies without your additional informed consent.

[Voluntary participation]
Your participation in the study is completely voluntary.

[Right to withdraw from the study]
You have the right to withdraw from the study at any time without penalty.

[How to withdraw from the study]
If you want to withdraw from the study, inform me, your interviewer. There is no penalty for withdrawing.

[What to expect if you take part in this research]
Participating in this study entails responding to a telephone survey about the views of people in your country. When all responses to the survey are collected in summer 2021, the study team,

based at Harvard University in Cambridge, Massachusetts, Columbia University in New York, New York, and Pepperdine University in Malibu, California in the United States will analyze the data and will write reports based on the findings aimed at informing policy-makers in Lebanon about people's views on public health policy.

[Who to contact with questions]
If you have any questions, please contact the principal investigator Amanda Rizkallah, Assistant Professor, Pepperdine University, Amanda.rizkallah@pepperdine.edu, +1-951-237-5674.

If you have questions regarding your rights as a participant in this research, or if problems arise which you do not feel you can discuss with the Investigator, please contact the Pepperdine Institutional Review Board at:

Katy.carr@pepperdine.edu
+ 1 310-506-6084
Human Protections Administrator

End of Block: Introduction

Start of Block: Consent Agreement

JS

Q47 I will now summarize the information presented.

Your participation is voluntary.

If you refuse to participate, it will involve no penalty or loss of benefits to which you are otherwise entitled.

You may discontinue participation at any time without penalty or loss of benefits.

You do not waive any legal rights.

Do you give your consent to be a subject in this research?

- ○ Yes [participate] (1)
- ○ No [do not participate] (2)

End of Block: Consent Agreement

Start of Block: Lebanese

Q48 Are you a Lebanese national?

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Are you a Lebanese national? = No

Q50 Enumerator: thank the respondent for their time, then proceed to end the interview.

End of Block: Lebanese

Start of Block: Demographics

JS

Q1 What is your gender?

- ○ Male (1)
- ○ Female (2)

JS

Q2 What is your year of birth?

▼ 2004 (1) ... 1900 (106)

Q3 Below are some statements related to your household income. Which of these statements comes closest to describing your household income?

- ○ Our household income covers our expenses well and we are able to save. (1)
- ○ Our household income covers our expenses without notable difficulties. (2)
- ○ Our household income does not cover our expenses and we face some difficulties in meeting our needs. (3)
- ○ Our household income does not cover our expenses and we face significant difficulties in meeting our needs. (4)

End of Block: Demographics

Start of Block: Demographics II

JS

Q4 Do you or anyone in your place of residence own a ...?

	Yes (1)	No (2)
a. Television (1)	○	○
b. Satellite dish (2)	○	○
c. Cell phone (3)	○	○
D. Computer (4)	○	○
E. Refrigerator (5)	○	○
F. Car, moped, or motorcycle (6)	○	○

Q5 What is the highest level of education that you have completed?

- ○ Illiterate/No formal education (1)
- ○ Elementary (2)
- ○ Intermediate (3)
- ○ Technical intermediate (BT/DS) (4)
- ○ High School/Secondary School (5)
- ○ Technical advanced (TS/LT) (6)
- ○ Undergraduate (BSc/BA) (7)
- ○ Master and/or PhD (8)
- ○ Other (9) _____

End of Block: Demographics II

Start of Block: Views on foreign countries and institutions

JS

Q6 We are interested in your views on some aspects of different countries in the world. For each of these countries, we'll ask you about a few traits: please give us your opinion about each of them.

Q7 How about the country's respect for civil rights? Is it very strong, somewhat strong, neither strong nor weak, somewhat weak, or very weak?

	Very Strong (1)	Somewhat Strong (2)	Neither Strong nor Weak (3)	Somewhat Weak (4)	Very Weak (5)	Don't Know (enumerator: don't read) (6)	No Response (enumerator: don't read) (7)
${e://Field/country1} (1)	○	○	○	○	○	○	○
${e://Field/country2} (2)	○	○	○	○	○	○	○
${e://Field/country3} (3)	○	○	○	○	○	○	○
${e://Field/country4} (4)	○	○	○	○	○	○	○

Q8 How about the country's foreign policy? Are your views strongly positive, somewhat positive, neither positive nor negative, somewhat negative, or very negative?

	Strongly Positive (1)	Somewhat Positive (2)	Neither Positive nor Negative (3)	Somewhat Negative (4)	Very Negative (5)	Don't Know (enumerator: don't read) (6)	No Response (enumerator: don't read) (7)
${e://Field/country1} (1)	○	○	○	○	○	○	○
${e://Field/country2} (2)	○	○	○	○	○	○	○
${e://Field/country3} (3)	○	○	○	○	○	○	○
${e://Field/country4} (4)	○	○	○	○	○	○	○

Q9 How about the quality of the country's healthcare system? Is it very high quality, somewhat high quality, neither high nor low quality, somewhat low quality, or very low quality?

	Very High Quality (1)	Somewhat High Quality (2)	Neither High nor Low Quality (3)	Somewhat Low Quality (4)	Very Low Quality (5)	Don't Know (enumerator: don't read) (6)	No Response (enumerator: don't read) (7)
${e://Field/country1} (1)	○	○	○	○	○	○	○
${e://Field/country2} (2)	○	○	○	○	○	○	○
${e://Field/country3} (3)	○	○	○	○	○	○	○
${e://Field/country4} (4)	○	○	○	○	○	○	○

Q10 How about the quality of the country's educational system? Is it very high quality, somewhat high quality, neither high nor low quality, somewhat low quality, or very low quality?

	Very High Quality (1)	Somewhat High Quality (2)	Neither High nor Low Quality (3)	Somewhat Low Quality (4)	Very Low Quality (5)	Don't Know (enumerator: don't read) (6)	No Response (enumerator: don't read) (7)
${e://Field/country1} (1)	○	○	○	○	○	○	○
${e://Field/country2} (2)	○	○	○	○	○	○	○
${e://Field/country3} (3)	○	○	○	○	○	○	○
${e://Field/country4} (4)	○	○	○	○	○	○	○

End of Block: Views on foreign countries and institutions

Start of Block: Block 12

Q44 I’m going to name a number of institutions. For each one, please tell me how much trust you have in them.

	Refuse to answer (1)	Don't know (2)	No trust at all (3)	Not a lot of trust (4)	Quite a lot of trust (5)	A great deal of trust (6)	Don't Know (enumerator: don't read) (7)	No Response (enumerator: don't read) (8)
${e://Field/inst1} (1)	○	○	○	○	○	○	○	○
${e://Field/inst2} (2)	○	○	○	○	○	○	○	○
${e://Field/inst3} (3)	○	○	○	○	○	○	○	○
${e://Field/inst4} (4)	○	○	○	○	○	○	○	○
${e://Field/inst5} (5)	○	○	○	○	○	○	○	○

Q45 If it became available, how likely are you to get the vaccine if it was available for free?

- Very likely (1)
- Somewhat likely (2)
- Somewhat unlikely (3)
- Very unlikely (4)
- I already got the vaccine (5)
- Don't know (6)
- Refuse to answer (7)

End of Block: Block 12

Start of Block: Social and political identity and behavior

JS

Q12 What is your confession as officially listed on your registration card?

▼ Sunni (1) ... Other (12)

Q13 If you are asked to identify yourself, with which of the following do you most closely identify yourself?

- Your nationality (1)
- Confession (2)
- Ethnicity (3)
- Arab world (4)
- Local community, city where I live (5)
- Your tribe or extended family (6)
- Other (7)

Q14 Are you a supporter or member of a political party?

- Yes (1)
- No (2)

Display This Question:

If Are you a supporter or member of a political party? = Yes

Q15 Which party?

- ○ Future Movement/Saad Hariri (1)
- ○ Amal Movement/Nabih Berri (3)
- ○ Hizballah/Hassan Nasrallah (4)
- ○ Progressive Socialist Party/Walid Jumblatt/Taymor Jumblatt (5)
- ○ Free Patriotic Movement/Michel Aoun/Jibran Bassil (2)
- ○ Lebanese Forces/Samir Geagea (6)
- ○ Kataib Party/Amin Gemayel/Sami Gemayel (7)
- ○ March 14 Forces (8)
- ○ March 8 Forces (9)
- ○ Tashnaq (10)
- ○ No One (11)
- ○ Other (12) _____

End of Block: Social and political identity and behavior

Start of Block: SARS CoV-2 experiment 1: Vaccine nationality and trust in foreign states

Q17 Which vaccine did you get?

Check all that apply if you received two or more different vaccines.

- [ ] Sputnik V, the Russian vaccine (1)
- [ ] Sinopharm, the Chinese vaccine (2)
- [ ] Pfizer, the American vaccine (3)
- [ ] AstraZeneca, the British vaccine (4)
- [ ] One of the vaccines but I do not remember the country (5)
- [ ] Moderna, the American vaccine (enumerator: don't read) (6)

Page Break

End of Block: SARS CoV-2 experiment 1: Vaccine nationality and trust in foreign states

Start of Block: Recommend

Q18 Would you be willing to recommend Sputnik V, the Russian vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

Q19 Would you be willing to recommend Sinopharm, the Chinese vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

Q20 Would you be willing to recommend Pfizer, the American vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

Q21 Would you be willing to recommend AstraZeneca, the British vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

Q22 Would you be willing to recommend a vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

End of Block: Recommend

Start of Block: Take

Q23 Are you willing to take Sputnik V, the Russian vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

Q24 Are you willing to take Sinopharm, the Chinese vaccine for Covid?

- ○ Yes (1)
- ○ No (2)
- ○ Don't Know (enumerator: don't read) (3)
- ○ No Response (enumerator: don't read) (4)

Q25 Are you willing to take Pfizer, the American vaccine for Covid?

- ○ Yes (1)
- ○ No (2)
- ○ Don't Know (enumerator: don't read) (3)
- ○ No Response (enumerator: don't read) (4)

Q26 Are you willing to take AstraZeneca, the British vaccine for Covid?

- ○ Yes (1)
- ○ No (3)
- ○ Don't Know (enumerator: don't read) (2)
- ○ No Response (enumerator: don't read) (4)

Q27 Are you willing to take a vaccine for Covid?

- Yes (1)
- No (2)
- Don't Know (enumerator: don't read) (3)
- No Response (enumerator: don't read) (4)

End of Block: Take

Start of Block: SARS CoV-2 experiment 2: Vaccine altruism

Q28 Lebanon has a limited supply of Covid vaccines. There is a lot of discussion about who should have priority for the vaccine. We are trying to get a sense of how the Lebanese people think the ongoing vaccination campaign should be structured. I will present you with a few hypothetical profiles of Lebanese citizens, and ask you if they should receive immediate access to a vaccine.

Q29 Michel is a ${e://Field/choice1_age} year old man from a ${e://Field/choice1_social_class} family in Ashrafieh in Beirut who has ${e://Field/choice1_health_condition}.

Should this person get immediate access to the vaccine?

- Yes (1)
- No (2)

Q30 Ali is a ${e://Field/choice2_age} year old man from a ${e://Field/choice2_social_class} family in Haret Hreik in Greater Beirut who has ${e://Field/choice2_health_condition}.

Should this person get immediate access to the vaccine?

- Yes (1)
- No (2)

Q31 Uthman is a ${e://Field/choice3_age} year old man from a ${e://Field/choice3_social_class} family in Aisha Bakkar in Beirut who has ${e://Field/choice3_health_condition}.

Should this person get immediate access to the vaccine?

- Yes (1)
- No (2)

End of Block: SARS CoV-2 experiment 2: Vaccine altruism

Start of Block: Manipulation check

Q32 In determining whether or not someone should get priority access to the vaccine, which factor was most important in your decision -- the place of residence, health condition, age, or social class or place of residence of the person?

- Place of residence (1)
- Health condition (2)
- Age (3)
- Social class (4)

Q33 What was the second most important factor in your decision?

Enumerator: do not read the respondent's choice from the previous question.

- Place of residence (1)
- Health condition (2)
- Age (3)
- Social class (4)

End of Block: Manipulation check

Start of Block: Medication Altruism Experiment

JS

Q34 Now I'd like to ask you some questions about the availability of medications in Lebanon. Lebanon has a limited supply of antibiotics. This raises questions about who should have priority access to these medications. We are trying to get a sense of how the Lebanese people think about how to allocate basic medications like antibiotics. I will present you with a few hypothetical profiles of Lebanese citizens, and ask you if they should receive immediate access to antibiotics.

Q35 Boutros is a ${e://Field/choice1_age_two} year old man from a ${e://Field/choice1_social_class_two} family in Gemmayze in Beirut who has ${e://Field/choice1_health_condition_two}.

Should this person get immediate access to antibiotics?

- Yes (1)
- No (2)

Q36 Hussein is a ${e://Field/choice2_age_two} year old man from a ${e://Field/choice2_social_class_two} family in Burj al Barajneh in Greater Beirut who has ${e://Field/choice2_health_condition_two}.

Should this person get immediate access to antibiotics?

- Yes (1)
- No (2)

Q37 Khalid is a ${e://Field/choice3_age_two} year old man from a ${e://Field/choice3_social_class_two} family in Tarik el Jedideh in Beirut who has ${e://Field/choice3_health_condition_two}.

Should this person get immediate access to antibiotics?

- ○ Yes (1)
- ○ No (2)

End of Block: Medication Altruism Experiment

Start of Block: Manipulation Check Two

Q38 In determining whether or not someone should get priority access to antibiotics, which factor was the most important in your decision -- the place of residence, health condition, age, or social class or place of residence of the person?

- ○ Place of residence (1)
- ○ Health condition (2)
- ○ Age (3)
- ○ Social class (4)

Q39 What was the second most important factor in your decision?

Enumerator: do not read the respondent's choice from the previous question.

- ○ Place of residence (1)
- ○ Health condition (2)
- ○ Age (3)
- ○ Social class (4)

End of Block: Manipulation Check Two

Start of Block: Experiment 2: SARS CoV-2 Vaccine Hesitancy

Q44 ${e://Field/hesitancy_field} support vaccination against Covid-19 on the grounds that it will help stop the virus and will have minimal side effects. We'd like to ask about your perspectives on this issue.

Q41 How likely do you think that vaccines can effectively curb the virus?

- Vaccines are not at all likely to curb the virus (1)
- Vaccines are somewhat unlikely to curb the virus (2)
- Vaccines are somewhat likely to curb the virus (3)
- Vaccines are very likely to curb the virus (4)

Q42 How worried are you about dangerous side effects from the vaccine?

- Are you not at all worried? (1)
- Are you worried just a little bit? (2)
- Are you somewhat worried? (3)
- Are you extremely worried? (4)

End of Block: Experiment 2: SARS CoV-2 Vaccine Hesitancy

Start of Block: Enumerator Input

Display This Question:

If If Survey enumerator: Enter your survey enumerator ID number. Text Response Is Not Empty

Q48 Please indicate any errors and enter any corrections to the responses input into the survey form here.

_____

End of Block: Enumerator Input