COVID-19 Rapid Response Impact Initiative | White Paper 4

Building Solidarity:
Challenges, Options, and Implications for COVID-19 Responses

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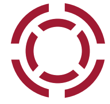
Abstract



Social solidarity is a critical tool in the response to the COVID-19 pandemic, as political leaders call for major disruptive changes to everyday life and sacrifices for collective well-being. In this white paper, we shed light on the nature of social solidarity; how it might the affect attitudinal and behavioral changes needed to confront the crisis; potential obstacles to solidarity as a result of the particular biomedical properties of the virus and of society and politics more generally; and factors aiding in the building of solidarity. We conclude with several plausible strategies to foster solidarity, including those focused on public messaging – such as cueing "linked fate" or emphasizing high-risk behaviors rather than groups— and policies – such as fair and transparent rules for public health tools, sustained economic support funds, and excess profits taxes. Promoting solidarity must supplement "technical" solutions because the efficacy of the latter will depend on the former.

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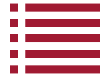

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01 Introduction

Since the early weeks of the COVID-19 epidemic, political leaders at various levels of government, from mayors to national leaders to the UN Secretary-General, have called for "solidarity," frequently pointing out that "We are all in this together."[3] Relatedly, various organizations in need of help have requested assistance in the name of solidarity, including on social media with "#solidarity."[4] Such calls relate to their more specific demands for behavior change, particularly to engage in social distancing and self-quarantine in a quasi-voluntary manner, and more generally, to make sacrifices for others and for collective well-being.[5] But what is solidarity? Is it just a slogan or can it actually be leveraged by political leaders and other influencers to encourage ordinary citizens to respond to the epidemic according to best practices?

In this white paper, we try to shed light on what social solidarity is, how it might affect attitudinal and behavioral change; and given its desirable properties, what strategies impede and which facilitate the building of solidarity, particularly given the unique circumstances of the COVID-19 pandemic. To be clear, our point is not to recommend any particular public health strategy with respect to "flattening the curve" and reducing the speed of transmission, including through the use of quarantines or specific social distancing directives. Rather, *given* any particular public health directive, we focus on solidarity as an additional strategy and resource to elicit the widespread compliance and conformity needed to boost the impact of policies.

[3] See, for example, KOIN News (Portland, OR) of March 24, 2002, *the Santa Cruz Sentinel* of March 22, 2002, and Oklahoma City News 9's posting of President Trump's statement on March 18, 2020 and the UN Secretary-General's statement of March 19, 2020.
[4] See, for example, the Twitter feed of the Little Museum of Dublin, which is selling "Solidarity Tickets" to support the museum while they are closed due to the virus: https://twitter.com/littlemuseumdub/status/1242454873678856193.
[5] See, for example, Levi 1988, on the notion of quasi-voluntary compliance as compliance based on a sense of normative obligation along with perceptions that shirkers will be punished. And see Lieberman 2007, Lieberman 2009a, and Lieberman 2009b on the application of this idea to the implementation of HIV prevention strategies.

Introduction

Because we are still in the early stages of this pandemic, we have only preliminary anecdotal evidence concerning specific efforts to build social solidarity. Instead, we draw on findings from related contexts, and theories and evidence derived from prior research—including our own—to identify relevant conclusions and to offer a set of recommendations to policy makers and opinion influencers. A notion of "shared threat" can be a compelling foundation for building solidarity, but objective differences in risk and capacity to respond, as well as underlying group-based and partisan cleavages, make building and sustaining solidarity extremely difficult under any circumstances, and especially in the current crisis. Nonetheless, policy makers and other influencers cannot neglect a focus on solidarity in favor of purely "technical" solutions, because the efficacy of the latter will depend on the former.

While social solidarity is not a magic bullet, and there are similarly no magic bullets to building social solidarity itself, it is a critical tool in the public campaigns to respond to this unprecedented global pandemic. We conclude by detailing several plausible strategies for building solidarity towards the goal of an effective response, including those that focus on public messaging and policy-making. First, policy makers and influencers need to "talk the talk" by emphasizing and providing evidence of linked fate through reminders of historical experiences of shared challenges and how they were overcome collectively; by highlighting high-risk behaviors while avoiding focus on high-risk groups as much as possible, which can inadvertently boost prejudice and exclusionary politics; and by communicating existing dangers in a way that reinforces common risks. Second, government officials need to "walk the walk" by developing and broadcasting fair and transparent rules for key public health tools, including the distribution of test kits, ventilators, and personal protective equipment (PPE); by generating concrete evidence of longer-term solidarity by providing economic support through social solidarity funds; and by considering the adoption of excess profits taxes, as the U.S. has done in the past during wartime periods.

02 Solidarity as a Useful Tool for Addressing COVID-19

At one level, the concept of social solidarity and its utility for addressing a public health epidemic are fairly intuitive. When leaders call for solidarity, citizens generally understand what they mean: Do this for the sake of the collective. Nonetheless, the prospects for actually building solidarity are less obvious. Akin to analyses that consider opportunities and tradeoffs associated with biomedical prevention, treatment, and mitigation modalities, we try to shed light on the challenge of transcending self-interest to promote collective welfare and to avoid collective tragedy.

Solidarity is a unity of feeling or sentiment among a group of people who share a common objective or interest, *even despite differences and internal inequalities* that might undermine unity.[6] Building solidarity implies the harmonization of shared interests, such that individuals come to believe that what is good for others is simultaneously perceived to be good for oneself. Solidarity is rooted both in more instrumental motivations, such as the expectation of shared material gains, and in terms of "other-regarding preferences," in the sense that the individual derives pleasure from other group members' well-being and pain from group members' losses (Cikara, Botvinick, and Fiske 2011).

Solidaristic behaviors are those actions which reflect explicit efforts to help the larger collective, especially when such actions are at odds with individual—or a more narrowly defined group—self-interest. At least from the perspective of most social science theorizing, truly solidaristic attitudes and behaviors are rare, as we mostly begin from the premise of individuals pursuing relatively narrow self-interests. While the problems of collective action and cooperation are ubiquitous within society, the "solution" to these is frequently selective incentives or institutions that seek to harmonize behavior, including legal and social sanctions for non-compliance. And political coalitions of disparate interests or parties tend

[6] In various ways, social scientists have tried to describe and to understand the causes and consequences of this concept going all the way back to Durkheim's 1893 *The Division of Labor in Society*.

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to form as the product of bargaining and *exchange*. Social solidarity is a unique solution that demands a reorientation of one's emotional or psychological orientation—to move from thinking strictly in terms of "me" towards thinking in terms of "us."

Calls for solidarity are easier said than realized when interests within the target population (the putative solidaristic group) diverge. It is all the more difficult in larger groups, where the coordination and accountability needed to generate and sustain collective action are more difficult to sustain (Olson 2009).

The biomedical properties of this particular pandemic make sustaining solidarity around the response all the more challenging: The effort to limit the spread of Coronavirus demands a high level of compliance from those least likely to be *directly and immediately* impacted by their own failure to follow best practice recommendations. With COVID-19, younger, healthier adults are most likely to become vectors but are not the ones most likely to immediately suffer the worst health consequences—as we know, this weighs disproportionately on the elderly and those with preexisting conditions.[7] This implies a need to encourage a sense of solidarity among the young and healthy, since public health messages cannot rely entirely on self-interest as a motivation for self-sacrificing behavior.

The contemporary political landscape map also impedes solidarity, especially at the national level. Ordinarily, very widespread and sustained solidarity is difficult in political life, which itself involves a competition for scarce and valued resources. Moreover, a strong finding from social psychology is our tendency towards group-based competition—"us" vs. "them," which is double-edged with respect to solidarity in the sense that such tendencies both unite and divide (Tajfel 2001; Tajfel and Turner 1986). It is not that individuals are incapable of group orientation, but groupness is often constituted in opposition to

[7] It does still appear to be the case that older adults are at higher risks for death from COVID-related illness, but people clearly get sick and die at all ages; Scott 2020.

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an "other" or, at a minimum, out of a strong preference for members of one's own group (Allport 1954; Brewer 1999). Exclusionary politics are on the rise across the globe (Gidron and Hall 2017). Within the U.S., partisan polarization is at an all-time high; it even initially contributed to widely varying perceptions of the threat of COVID-19 and may continue to hamper coordinated and appropriate responses to the pandemic (Gadarian, Goodman, and Pepinsky 2020).

Finally, class-based inequalities can also impede efforts to promote solidarity. Without question, the wealthy and those with more secure employment are better able to weather the economic fallout from the pandemic. If these groups also enjoy disproportionate access to testing and treatment or are more able to evade social distancing restrictions, then class divisions may undermine efforts to sustain solidarity.

03 Need as a Motivation for Compliance

Taking a step back, why is social solidarity even necessary in a modern polity with a reasonably well-functioning government?[8] Like in other health epidemics, the specific challenge for containing the contemporary COVID-19 pandemic demands extraordinary behaviors, most importantly, the practice of social distancing and highly precautionary sanitation practices. While hardly akin to serving on the front lines of battle, these are non-trivial changes to behavior, posing inconvenience, discomfort, loss of income, education, and other opportunities. Even if practices such as social distancing and collective quarantines—or what Allen et al. call "Freeze in Place" in this white paper series—evolve into a "Mobilize and Transition" policy, which entails a massive effort to ramp up public health capacity alongside more time-limited quarantines, society must maintain high levels of vigilance and be prepared to comply with behavioral dictates that require sacrifices.

Moreover, in the context of the current pandemic, citizens are being asked to behave in other pro-social or solidaristic ways: For example, it was at least initially relatively inexpensive for most American households to insure against the worst-case scenarios associated with the pandemic by purchasing significant quantities of non-perishable food, other essential items (famously now, toilet paper), and protective equipment and materials such as surgical masks and hand sanitizer. To a degree, public officials encouraged individuals to be prepared, but to the extent that individuals and families invest too heavily in their own protection (i.e., hoarding), collectively, this can contribute to food shortages, toilet paper shortages, and perhaps most pressing, shortages of equipment for medical professionals. In this case, solidaristic action means exposing oneself to greater risk of personal shortages in favor of limiting the risk of collective shortages over the longer term. Like for so many social problems, a narrowly individualistic logic would lead to a "tragedy of the commons" (Hardin 1968) in the sense that each

[8] For a like-minded discussion on the value of solidarity from the perspective of social psychologists, see Drury, Reicher, and Stott 2020.

individual can justify that their selfish behavior is not sufficiently harmful to the collective to make a difference, but if everyone acts that way, the collective is ultimately harmed.

Moreover, it is clear that additional sacrifices from the perspective of individual self-interest will be needed. Extraordinary government expenditures have already been committed to support individuals and businesses, and to underwrite the public health response, and much more will be needed. Although the bailout will not demand concrete near-term sacrifices on the part of individual taxpayers in a low-inflation environment (Blanchard 2019; Blanchard and Summers 2019), as in the current moment, and does not entail a long-term structural change in the tax code, the very idea of a national fund to support those most harmed by the pandemic and its effects is founded on a sense of "we" rather than "me." At a more micro-level, however, personal sacrifices may be more tangible. Given the limited social protections afforded American workers, the economic effects in terms of lost jobs and wages are likely to be profound and long-lasting. Wealthier segments may be called upon to shoulder new fiscal burdens. Empathy and compassion for others, and a sense that "we are in this together"—social solidarity—may be necessary for broad acceptance of these macro- and micro-level responses to the pandemic.

It is all the more essential to invest in promoting social solidarity in the face of the COVID-19 threat, we contend, because the other reasons people might obey the directives of political leaders and public health officials are unlikely to be sufficient.

First is fear of the consequences of non-compliance, especially state punishment in the form of fines or imprisonment. In Jordan, for example, over 1,600 people have been arrested for violating a government-imposed curfew aimed at stemming the tide of the infection (Arraf 2020). To date, this has been a minor consideration in the American context and in most liberal democracies because governments have, for the most part, opted not to declare martial law or even to issue penalties for violating policies.

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More recently, government officials have begun to discuss proposals for legal fines, and have been increasingly aggressive in promoting social isolation, but high levels of resistance to coercion, and its cost, make this a largely non-viable strategy on a grand scale.

Second is trust in and willingness to obey the leader who asks. This is clearly an important source of compliance today, as various leaders, ranging from the president to governors to mayors, to various non-state leaders who call upon people to take certain actions and to avoid others. In many contemporary democratic societies, particularly in a highly polarized one such as the United States, large segments of society do not trust many or most of their leaders. And this sentiment is not unique to the current administration. During the AIDS epidemic, large swaths of American society, and in countries around the world, revealed themselves to be unpersuaded by the calls of their leaders.

Third is self-interest. In the current context, this is clearly a powerful motivator, as many believe that compliance with requests to stay at home and to engage in social distancing will protect oneself and one's family from infection and sickness. Collective action is always strongest when self-interest dovetails with group interests (Hardin 1997). Those who make donations to failing local establishments, such as restaurants, or who continue to pay non-working employees may do so simply as investments in future returns in terms of availability of labor or services. But as we have already seen, narrow self-interest weighs against compliance with many of the demands for best public health practices, particularly within the narrow time frame in which people need to modify their behaviors. Millions of people around the world do not perceive a very high risk of infection and/or may not view the consequences of infection as worse than the costs associated with implementing the required prevention strategies. It is easy to imagine the healthy, young restaurant worker who lives paycheck-to-paycheck preferring possible exposure and a resulting illness to guaranteed loss of income from staying at home. While potentially individually rational for a risk-accepting individual, such behaviors impose significant

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externalities as individuals become vectors of transmission, contributing to higher infection rates and surges in demands on health care, even if indirectly.

A fourth motivation for compliance is concern about sanctions and/or social approval from others in society. Individuals may quickly come to realize that certain patterns of behavior are normative, and that compliance will generate approval, perhaps status-enhancing recognition on social media;[9] meanwhile, *The Guardian* recently published an article arguing that it is "ok" to shout at strangers who do not practice social distancing (Freeman 2020). People like to be recognized for doing "good" and don't like to be publicly shamed for doing "bad," and irrespective on one's own sense of the value of such actions, such social forces can affect one's behavior.[10] But of course, this begs the question of where such social norms come from, and these only operate in contexts where they develop. Unlike "practicing safe sex," which is a normative behavior that has the additional value of preventing HIV transmission, "social distancing" is generally not a normative behavior, nor is making donations to local restaurants or refraining from buying too much toilet paper. As a result, these norms need to be developed and recognized, and their prevalence should be associated with other incentives for preventative behaviors.

Compliance may also be increased by the proper use of "nudges," popularized by psychologists and behavioral economists in recent years, which in the case of COVID-19 might include simple reminders to wash one's hands thoroughly, or making it easier for people to carry out necessary business while staying home (World Bank 2015, 119–20).[11]

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[9] See, for example, McClendon 2014, who provides evidence of pro-social, solidaristic efforts increasing when social media recognition was promised to those who acted.
[10] A vast literature from psychology and behavioral economics undergirds this claim. A nice summary can be found in World Bank 2015.
[11] On the other hand, Yates 2020 has recently criticized the British government for relying on "nudges" rather than a more thoroughgoing approach.

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All of these motivations may weigh heavily on one's decision—conscious or not—about whether to follow public health best practices and to make additional sacrifices for the collective. But to the extent that these have been tried, they appear insufficient to achieve the universal levels of compliance needed to arrest the spread and to mitigate the downstream effects of the pandemic. Social solidarity is then an important complementary source of compliance. While related to these other motivations, it is distinct: Again, the notion of solidarity in this context is *believing that one's value and fate are tied up with that of a collective*, and that one's own behaviors contribute directly to the *collective*, even if individual benefits are not guaranteed and may even be sacrificed.

Solidarity is particularly useful in situations where members operate with great risk and uncertainty: those making calculations on a solidaristic basis may adjust their perceptions to be in line with those of the most (objectively) at-risk members, adding substantial impetus to the need to take action. At the extreme, when a frontline worker risks illness by caring for a patient they don't know or a soldier risks their life in battle, these are acts of solidarity. And in a public health pandemic that requires behavior change and other forms of sacrifice, solidarity is a critical, low-cost, "contagious" resource that is at the foundation of other forms of compliance, including law-abiding behavior (Tyler 2003) as well as more informal conformity to pro-social norms (Putnam, Leonardi, and Nanetti 1994). Common perceived threat can drive in-group identity and collective behavior (Brewer 2007),and can motivate a sense of "duty" towards compliance (Hur 2017). But simply asking for it does not mean that it will be supplied within society and we must look for lessons about what works.

04 Solidarity in the Face of Prior Challenges

While the desire for social solidarity may be intuitive, building widespread solidarity, particularly in a health epidemic, tends to be extremely difficult for a variety of reasons. The actual distribution of the disease burden may be uneven, the disease itself may be stigmatized, and there may be instincts to blame and to shame some for its spread—to say “it’s their problem.” Moreover, the very notion of solidarity, that is, cooperation of spirit and action across disparate actors, still must address the underlying differences that motivate the call in the first place. In our own work, we have found important instances of building solidarity towards important social goals, as well as evidence of failures, and to a degree, these serve as models of what can be done or avoided in responding to COVID.

AIDS and Solidarity

Following the identification in the early 1980s of human immunodeficiency virus (HIV), the virus that causes AIDS, community, national, and global leaders made innumerable calls to solidarity in their demands for behavior change to prevent HIV transmission, while also upholding the human rights of those who were or were suspected to be HIV-positive. In some cases, this was a successful strategy, but in many others, the politics of AIDS succumbed to blaming, shaming, and shame avoidance—essentially the rejection of solidarity—and was in turn associated with denial of risk, the promulgation of false information, and uneven responses. The politics of COVID already shares some important parallels in these regards.

It is important to highlight that the biomedical properties of the AIDS epidemic share some important similarities, but also some important differences with the COVID pandemic, which in turn affects the social distribution of risk perception and likely responses. Both are deadly epidemics that spread on a massive scale, and in both cases one can be a carrier and transmit the virus prior to being symptomatic.

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Moreover, for both epidemics, young adults, who are active and highly social, have been the leading vectors for transmission, and in both cases, a great challenge has been to alter the lifestyles of this group, which includes the heart of the frontline workforce in the healthcare sector.

But several key aspects are different: HIV is transmitted through a range of behaviors considered in many societies to be non-normative—anal intercourse, unprotected sex with multiple partners, and the sharing of needles for IV drug use—as compared with more casual everyday interactions, which are the basis for most COVID transmissions. In the case of HIV, those young adults most likely to be vectors are also those at highest risk for suffering the health consequences of AIDS; therefore, public health messages could rely more heavily on self-interest. And while the time from infection to symptoms in the case of HIV/AIDS can be as long at ten years, for COVID, it is less than two weeks.

Bearing some of those similarities and differences in mind, we draw on some of the lessons from the AIDS epidemic for COVID. Within a few years, a common framework was developed for fighting HIV and AIDS, one that evolved with that epidemic and new technologies. But recognition of the *need* for solidarity in the face of a deadly and devastating shared epidemic nonetheless generated strongly divergent responses around the world. And that variation is plausibly due, at least in part, to differences in the levels of cohesion and solidarity of identity-based groups within and across countries, with breakdowns frequently occurring along ethnic and racial lines, as well as in terms of national origin and sexual orientation (Lieberman 2009b).

For example, particularly in the first two decades of the response, solidarity was extremely rare, and official government responses, especially in the United States and other wealthy countries, were largely characterized by blaming, shaming, and denialism (Kirp and Bayer 1992). In the United States, the identification of AIDS-related symptoms in gay men led to its clinical labeling as GRID (Gay-related immune deficiency).

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Many important public figures denounced the disease as a "punishment from God" (Shilts 2000, 311). And people suffering from AIDS were sometimes referred to as the "4-H Club," referring to hemophiliacs, homosexuals, Haitians, and heroine users. Such slurs strongly undermined the sense that HIV was really something that affected "all of us." In the United States, HIV also became highly prevalent among African-Americans relative to other segments of the population, but in the context of low trust in government public health systems in the aftermath of the Tuskegee experiments, this led to substantial denialism on the part of many African-American leaders and in turn African-American citizens, which only fueled the spread of the virus.[12] In short, a constant focus on "high-risk" groups undermined solidarity.

Similar political fault lines undermined responses in the Global South. In both South Africa and India, global best practices were met with political conflict and high levels of denialism. In both countries, political leaders frequently opted to deny the severity of the problem, and called out political rivals for suggesting that the problem was actually severe among their central constituents. In South Africa, President Thabo Mbeki famously challenged scientific claims about HIV and AIDS, accusing some of politicizing the epidemic as a way to humiliate black Africans. In India, those living in the northern "Hindi Heartland" frequently made reference to "Mumbai disease" as a way of distancing themselves from an epidemic that spread easily along national trucking routes. Lower-caste and upper-caste Indians blamed the other, that it was "their" problem. In many respects, the failings at building a true national solidarity around the epidemic, were associated with very weak policy responses (Lieberman 2009b).

On the other hand, several countries and communities were notable for extremely strong responses to the AIDS epidemic, which were effective in generating support for prevention policies and in securing resources for treatment. In this respect, Brazil was particularly notable as an early responder to AIDS;

[12] See, for example Cohen 1999; and Dunham, Lieberman, and Snell 2016.

in many ways Brazil was a model for aggressive outreach in partnership with civil society. The National AIDS program was very much built upon an explicit campaign of "Solidaridade," and despite important differences in the incidence of infections and overall burden of disease, government leaders consistently talked about and acted on the problem as one that affected all Brazilians on a national basis (Lieberman 2009b; Gauri and Lieberman 2006; Berkman et al. 2005).

Many other examples abound, but a fairly consistent finding was that in the places where pre-existing social cleavages were strong and those cleavages mapped even loosely onto the distribution of the prevalence of infection and disease, this created a blaming and shaming dynamic that undermined an effective response, at least relative to places like Brazil, Cuba, and Thailand, where the government managed thoroughgoing and timely responses (Lieberman 2009b).

Compassionate Communalism

Beyond governments, non-state actors can play a key role in responses to pandemics and other security threats. To varying degrees, non-state providers, such as non-profits, religious charities, and non-governmental organizations, are integral to welfare regimes, not only in developing countries but also in advanced, industrialized countries (Cammett and MacLean 2014). This is especially true in the United States, where the welfare system entails an extensive role for private actors and non-profits as frontline providers (Hacker 2002), especially in low-income communities (Allard 2009). Even if non-state providers, unlike national governments, lack both the capacity and the mandate to serve all citizens, at the local level they play a critical role in meeting basic needs, including in the health sector.

Non-profits and charities are well situated to provide social assistance in their respective localities, especially given the advantages of collective action for smaller groups. It is also well established that

communities rooted in a shared identity, such as religion, ethnicity, nationality, or even ideology, tend to feature higher contributions to public goods (Alesina, Baqir, and Easterly 1999; Miguel 2004) and improved service delivery (Björkman and Svensson 2010). On the demand side, citizens appear to place higher trust in and seek out care from providers from their own racial or religious communities. For example, studies of "racial concordance" in the U.S. public health literature indicate that patients either prefer or perceive that they receive better treatment from health care providers from their own groups (Hsu, Hackett, and Hinkson 2014; Shen et al. 2018). Likewise, recent research in Lebanon indicates that patients disproportionately select into health centers run by charities from their own religious communities (Cammett and Sasmaz 2019).

If solidarity is higher in organizations rooted in shared religion or other social identities, we might be concerned that such organizations are ill-suited to serve the greater good since they might favor members of their own communities. Under some conditions and for some organizations, this may be true. For example, research on Lebanon shows that parties linked to religious communities are most likely to serve in-group members when they are either trying to elicit or reward higher risk behavior, such as participating in protracted acts of civil disobedience or serving in militia organizations, among other factors (Cammett and Sasmaz 2019). But most religious and ethnic organizations do not exclusively serve their own and may even go out of their way to welcome all, whether for extrinsic motivations such as the desire to attract adherents or advance their standing in the community, or for more intrinsic motivations such as a genuine commitment to altruism and social justice. This is even true where religion, ethnicity, or other social identities are highly politicized (Brooke 2019; Cammett 2014; Thachil 2014).

We might also object that a public health response founded on an atomized fabric of community associations and non-profits is too fragmented to address the enormity of the challenge, which demands a centralized or at least centrally directed strategy for some dimensions of the response. It is true that

welfare regimes that are heavily reliant on private and not-for-profit actors can be more prone to inefficiencies and inequalities (Cammett and MacLean 2014; Hacker 2019), but this is heavily contingent on public sector regulatory capacity and the degree to which the state and non-state providers coordinate and exchange information to "co-produce" services. For example, even in Lebanon, a country renowned for low levels of state capacity and sovereignty and highly politicized ethno-religious divisions, the Ministry of Public Health has mobilized successfully to coordinate a strategy to provide a minimal package of universal health benefits to low-income citizens and to meet the extraordinary challenge of the Syrian refugee crisis (Hemadeh, Hammoud, and Kdouh 2019; Janmyr 2018). As current research on health care delivery in Lebanon shows, the fragmented non-profit health sector has even managed to provide relatively equitable care to Syrian refugees in health centers that previously served low-income Lebanese citizens almost exclusively (Cammett and Sasmaz 2020).

Thus, even in countries with far fewer resources and where the state is notoriously unable to regulate economic and social exchanges, political leaders have capitalized on non-state actors to aid in addressing massive public health threats. In the U.S. and abroad, then, mayors and other local officials should take advantage of the rich associational life in their cities and towns by coordinating extensively with local civil society. Harnessing the proven capacity and often deep relationships of trust that non-profits, religious groups, and other local actors have developed with their respective communities is a major asset in eliciting compliance from citizens with individually harmful or suboptimal behavior. For some, religious leaders will play an especially important role. Despite diminished trust in most public institutions, many Americans retain confidence in their local religious leaders. Members of the clergy (for example, UCC 2020) can and are playing an especially critical role by encouraging parishioners to comply with public health directives, opposing the demonization of certain ethnic groups as sources of the disease, and promoting efforts to support the most adversely affected by the pandemic. Localized nodes of social solidarity can also serve as the building blocks of more generalized solidarity,

especially if leaders of local organizations employ messages and model behaviors in line with this goal.

05 War and Crisis as Sources of Social Solidarity

Public health epidemics, including the present one, are frequently characterized in terms of security threats, and responses are framed using warlike analogies: “We are in a battle against COVID” or we need to act “as if we are on a wartime footing.” To be sure, while one might wish to liken COVID to an “enemy,” this virus is ultimately an invisible microbe without a deliberate will to harm, and no capacity to bargain or to negotiate a truce. Nonetheless, the metaphor is apt in the sense that COVID poses substantial threats to loss of life, and defense requires a substantial degree of coordination and sacrifice, akin to sending soldiers to war in the case of front-line providers, and mobilizing a broader band of citizen to accept new responsibilities.

The metaphor is also apt in the sense that leaders traditionally seek to elicit high levels of solidarity, particularly in the form of nation-building strategies, to mobilize war efforts. In the short term, war, natural disasters, and other crises are known to be associated with heightened levels of altruism and other forms of prosocial behavior, especially among members of the same communities (Bauer et al. 2016).

But war efforts do not automatically generate compliant behaviors on the part of citizens. Reflecting on the history of past government demands for soldiers and other forms of citizen cooperation in war efforts, a few consistent patterns emerge that likely also apply in the case of building solidarity and support for the response to COVID-19. First, not surprisingly, government leaders clearly and frequently describe the nature and severity of the threat as the basis for a linked fate. They emphasize the threats that motivate war efforts as facing the entire nation, not making strong distinctions between levels of threat to different segments of society.

Second, as Margaret Levi has powerfully argued, compliance with demands for conscription have been more successful when citizens perceive that the rules and procedures for asking for sacrifices are

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implemented and administered fairly and evenly (Levi 1997).

Third, wartime efforts to build solidarity have given rise to the adoption of redistributive reforms such as progressive taxation or government health programs (Scheve and Stasavage 2006), which are arguably the clearest expressions of solidaristic policies. For example, the G.I. Bill, which was adopted in the wake of World War II, granted a range of benefits for returning veterans, a collective expression of social support for those who might otherwise have faced a lack of resources or opportunities (Mettler 2005).

The COVID-19 pandemic has already elicited solidaritistic responses. Across the U.S., at the neighborhood level, newspaper reports and social media posts document efforts to help more vulnerable residents to access food, medicine, and basic household items.[13] At the national level, the pandemic and its ravishing economic effects have enabled lawmakers to overcome acutely divisive partisan cleavages to pass the $2 trillion coronavirus stimulus package. While the aid package does not entail a fundamental rewriting of the tax code or introduce new permanent entitlement programs, the issues of gig workers, freelancers, and independent contractors are newly incorporated in the eligibility criteria for unemployment benefits. In general, European countries will have an easier time drawing on a reservoir of social solidarity because they already have more expansive social safety nets, which not only provide more institutionalized cushions for those adversely affected by economic shocks (Apuzzo and Pronczuk 2020) but may also generate more political trust in the first place (Cammett, Lynch, and Bilev 2015).

[13] See, for example, results of a recent survey in Massachusetts in McGrane and Stout 2020.

War and Crisis as Sources of Social Solidarity

Even as war generates greater national solidarity, it is often accompanied by animosity towards the enemy, which can manifest in discriminatory behavior toward groups even within national borders, as attested by the treatment of Japanese-Americans during World War II. To the extent that the current enemy is an invisible microbe, that by-product of wartime solidarity is less of an issue. On the other hand, if the sources of the virus are associated with certain countries or nationalities, however, the war against COVID-19 could increase global tensions—and we have already observed some simmering of this with respect to accusations of association of the virus with China and other countries. This is concerning because fighting pandemics requires not just national mobilization but also global mobilization. As the challenges of addressing climate change attest, it is difficult to elicit cooperation and establish solidarity at a global scale. Yet unlike climate change, pandemics like the Coronavirus telescope timetables for decades-long action into days or weeks, making it easier to convey the urgency of the problem and therefore, by necessity, offering a foundation for supranational cooperation to fight this war on a global scale.

06 Strategies for Building Solidarity

As we highlighted at the outset, political leaders at local, national, and supra-national levels of government, as well as those within civil society, have called for “solidarity,” which clearly holds promise as an important social and political basis for an effective response to the COVID-19 pandemic. Based on our discussion above, reflecting on both responses to prior challenges and the current situation, we recommend several public policies and especially public messaging strategies. To a degree, the audience is universal because in an age of social media, almost anyone can become an influencer and can help to promote positive messages for building solidarity. But we are especially concerned with those government and non-government leaders and members of the mass media who are interested in contributing to the successful implementation of best-practice public health strategies. We are also concerned with avoiding practices and messages that undermine solidarity and/or that promote solidarity in harmful ways.

Promote Linked Fate through Strong, Inclusive and Nested Identities

Messaging should encourage citizens to embrace shared vulnerability and shared potential for overcoming adversity around a common identity. While that may seem intuitive, the historical record and recent moves by various political leaders in the face of COVID suggests that this approach is not obvious: Many political leaders instinctively want to distance their constituents or supporters from association with the virus, fearing that such an association is a sign of weakness or stigma. Denial of risk to one’s own community is standard practice in epidemics. While “othering” is a powerful strategy for building some types of solidarity (team play, warfare), it is self-defeating in the case of public health. While politicians may find it expedient to mobilize support by emphasizing exclusionary membership in the national political community, such divisive solidarities can feed into a denial of risk, which ultimately

endangers the community. Instead, a shared sense of threat, without blaming, can offer strong benefits for building solidarity (Subasic, Schmitt, and Reynolds 2011). Given the global nature of the pandemic, shared identities should be depicted as nested and not necessarily competitive, ranging from local to subnational to national, regional, and finally, global communities. Political and public health leaders can draw on salient pre-existing identities around subnational (Singh 2015), national (Wimmer 2018; Lieberman 2007), and global (Appiah 2006) categories to reinforce commonality even in the face of within-group heterogeneity.

To be specific, we believe that it will be useful for policy makers, when communicating their desire to have citizens continue to practice challenging public health measures, to **make explicit links with solidaristic allusions, tying citizens' connection between the past and the future**.

For example, drawing linkages to acts of unity during World War II, such as rationing, victory gardens, and war bonds, or the collective resilience after 9/11, which elicited a deep spirit of voluntarism and altruism, as witnessed in the surge of blood donations across the country, are powerful motivators. More locally, place-specific slogans such as "Boston strong" or "Houston Strong" can resonate deeply while tapping into emotions that help to sustain commitments to the collective (Goodwin, Jasper, and Polletta 2009). While many policy makers and influencers have already adopted pro-social rhetoric, it is critical that they remain equally vigilant in issuing messages promoting social solidarity in the weeks and months to come because epidemiological models indicate that fighting the pandemic will be a marathon as much as a sprint (Boston Infectious Disease Specialists 2020). Sustained compliance will require sustained exhortations for shared sacrifices.

Identify High-Risk Behaviors, not High-Risk "Groups"

The idea of "we are all at risk" quickly bumps up against the reality that particularly in the early stages

of this epidemic, we can observe important and predictable differences across categories of individuals. As we have seen in this and prior epidemics, this opens up destructive opportunities for various political actors to advance false theories concerning immunity and pathogenesis. Nonetheless, citizens and policy makers benefit from understanding epidemiological trends at a fine-grained level. Thus, in order to avoid undermining efforts to build solidarity, it is important that public officials describe **high-risk behaviors and individual-level vulnerabilities** and **avoid discussing high-risk groups, which themselves have no physiological basis**. Along these lines, we suggest refraining from discussing risk in terms of groups—for example, "young" and "old," "black" and "white," "urban" and "rural"—because reinforcement of such potentially divisive and mutually exclusive categories can undermine solidarity and create false impressions of vulnerability or lack of vulnerability. A more promising approach for promoting solidarity, while also communicating higher observed prevalence in cities as compared with rural areas thus far, is to focus on the key behavior that puts people at greater risk of exposure: proximity to others and frequency of social contact, not the fact of living in an urban area versus a rural area per se. Moreover, constant reminders of interconnected relationships that heighten the possibility of being infected and affected increase the prospects for solidarity. A focus on behaviors and not categories offers useful public-health information (such as a reminder that those in cities are not necessarily destined to infection, but can mitigate risk by limiting social contact), and reduces boundaries to solidarity that might form when risk-related dangers take on too much social meaning.

Communicate Dangers in Formats that Reinforce Solidarity

In an analogous manner, the reality of at least initial uneven distributions of infection across space presents a dilemma for efficient public health messaging. On the one hand, the labeling of "hot spots" offers useful guidance so that those who might be at greatest immediate risk of infection can proceed with

extra vigilance, and those at lower immediate risk need not shoulder the same level of anxiety or restriction of movement. On the other hand, particularly if geographic differences begin to take "social meaning" (i.e., particular states or countries face "real" epidemics, but not others), this can lead to a premature discounting of risk and a decline in solidarity. As a result, data presentation at a fine-grained and graded level, while offering useful precision, can generate negative effects. To avoid inadvertently singling out some places as more dangerous than others, journalists and policy makers should take advantage of presentation styles that **combine accurate information in a manner that also conveys shared risk**. For example, using maps that portray all countries with at least one or ten confirmed cases of COVID, or some cutpoint of number of deaths, highlights the epidemiologically important point that the spread of vulnerability is quite wide.

Valorize Compliance and Sacrifice in Solidaritistic Terms

An additional source of productive solidarity is the valorization of group members who act in ways that reflect the desired group orientation. For example, some citizens take creative or extreme measures to live by the letter and spirit of the desired public health directives. Moreover, the COVID pandemic also requires that a segment of the population engage in additional sacrifices equivalent to being conscripted for war—namely, participating in the direct care of the infected or in other work that knowingly increases an individual's risk of infection. Ultimately, the public depends on this subset of citizens, and in a manner similar to patriotic appeals during and in the aftermath of wars, political leaders should **continue to valorize and honor those individuals who accept high risks for the public welfare** in order to reinforce and sustain solidarity and ongoing willingness to make those extra sacrifices. Public messaging around their work—communicating a high-level of status as "moral" and "dutiful" (Hur 2017; McClendon 2014; World Bank 2015, 43–44) members of the group—ought to reinforce not simply the norms of replicating particular public health-oriented behaviors, but also a sense of attachment or

solidarity to the larger group. Moreover, it is vital to **depict such selfless acts as the norm rather than the acts of exceptional individuals**. For example, research shows that emphasizing how common health-promoting behaviors actually are, such as refraining from binge drinking on college campuses (provided the information is accurate), is a successful strategy for promoting healthy behavior (Haines 1996; Polonec et al. 2006). Thus, emphasizing how many people have already followed the advice of public health experts to social distance, wash hands often, shelter in place, help their vulnerable neighbors, and donate to charities will strengthen social norms around such pro-social behavior.

Generate Concrete Evidence of Longer-Term Solidarity

While emphasizing linked fates in terms of dangers, public officials should also seek to **provide enduring social support** and **to emphasize the value of support in terms of solidarity**. If officials and community leaders call upon people to make choices that are either undesirable or harmful in the short term in order to benefit the greater good, then they must provide reasons why such sacrifices are warranted. In part, solidarity in action involves sustained economic relief and safety nets for individuals and households so that people do not have to choose between paying their rent and abiding by public health imperatives. The government should also ensure that businesses do not gain disproportionately from increased government and consumer spending during the pandemic by instituting an excess profits tax, as has been adopted in the past during wartime. But it is even more critical to emphasize that solidarity is not just based on material exchanges but is also about membership in a larger community that perceives major public health threats, such as pandemics, as shared risks requiring collective responses. When people perceive themselves as part of a larger whole, they may not only reap the psychological benefits of belonging but also may be more willing to comply with the directives and policies of their public officials.

07 References

Alesina, Alberto, Reza Baqir, and William Easterly. 1999. “Public Goods and Ethnic Divisions.” *Quarterly Journal of Economics* 114 (4): 1243–84.

Allard, Scott W. 2009. *Out of Reach: Place, Poverty, and the New American Welfare State*. New Haven, CT: Yale University Press.

Allport, Gordon. 1954. *The Nature of Prejudice*. Boston: Addison-Wesley.

Appiah, Anthony. 2006. *Cosmopolitanism: Ethics in a World of Strangers*. 1st ed. New York: W. W. Norton.

Apuzzo, Matt, and Monika Pronczuk. 2020. “Covid-19’s Economic Pain Is Universal. But Relief? Depends on Where You Live.” *New York Times*, March 23, 2020. https://www.nytimes.com/2020/03/23/world/europe/coronavirus-economic-relief-wages.html.

Arraf, Jane. 2020. “Jordan Keeps Coronavirus In Check With One Of The World’s Strictest Lockdowns.” *Morning Edition*, March 25, 2020. National Public Radio. https://www.npr.org/sections/coronavirus-live-updates/2020/03/25/821349297/jordan-keeps-coronavirus-in-check-with-one-of-world-s-strictest-lockdowns.

Bauer, Michal, Christopher Blattman, Julie Chytilová, Joseph Henrich, Edward Miguel, and Tamar Mitts. 2016. “Can War Foster Cooperation?” *Journal of Economic Perspectives* 30 (3): 249–74.

Belluck, Pam. 2020. “Younger Adults Make Up Big Portion of Coronavirus Hospitalizations in U.S.” *New York Times*, March 18, 2020.

Berkman, Alan, Jonathan Garcia, Miguel Muñoz-Laboy, Vera Paiva, and Richard Parker. 2005. “A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries.” *American Journal of Public Health* 95 (7): 1162–72.

Björkman, Martina, and Jakob Svensson. 2010. “When Is Community-Based Monitoring Effective? Evidence from a Randomized Experiment in Primary Health in Uganda.” *Journal of the European Economic Association* 8 (2–3): 571–81.

Blanchard, Olivier. 2019. “Public Debt and Low Interest Rates.” *American Economic Review* 109 (4): 1197–1229.

Blanchard, Olivier, and Lawrence H Summers. 2019. Evolution Or Revolution?: *Rethinking Macroeconomic Policy After the Great Recession*. Cambridge, MA: MIT Press.

References

Boston Infectious Disease Specialists. 2020. "Boston's Infectious Disease Specialists' Message to the Public: Fighting Coronavirus Is a Sprint—and a Marathon." *Boston Globe*, March 27, 2020. https://www.bostonglobe.com/2020/03/27/opinion/bostons-infectious-disease-specialists-message-public-fighting-coronavirus-is-sprint-marathon/

Brewer, Marilynn B. 1999. "The Psychology of Prejudice: Ingroup Love and Outgroup Hate?" *Journal of Social Issues* 55 (3): 429–44.

———. 2007. "The Importance of Being We: Human Nature and Intergroup Relations." *American Psychologist* 62 (8): 728–38.

Brooke, Steven. 2019. *Winning Hearts and Votes: Social Services and the Islamist Political Advantage*. Ithaca, NY: Cornell University Press.

Cammett, Melani. 2014. *Compassionate Communalism*: Welfare and Sectarianism in Lebanon. Ithaca, NY: Cornell University Press.

Cammett, Melani, Julia Lynch, and Gavril Bilev. 2015. "The Influence of Private Health Care Financing on Citizen Trust in Government." Perspectives on Politics 13 (4): 938–57.

Cammett, Melani, and Lauren M. MacLean. 2014. *The Politics of Non-State Social Welfare*. Ithaca, NY: Cornell University Press.

Cammett, Melani, and Aytug Sasmaz. 2019. "Navigating Welfare Regimes in Divided Societies: Diversity and the Quality of Service Delivery in Lebanon." Unpublished manuscript. Cambridge, MA.

———. 2020. "Equity with Prejudice: Access to Social Services for Syrian Refugees in Lebanon." Cambridge, MA.

Cikara, Mina, Matthew M. Botvinick, and Susan T. Fiske. 2011. "Us Versus Them: Social Identity Shapes Neural Responses to Intergroup Competition and Harm." *Psychological Science* 22 (3): 306–13.

Cohen, Cathy J. 1999. *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics*. Chicago: University of Chicago Press.

Drury, John, Stephen Reicher, and Clifford Stott. 2020. "From Me to We: In an Emergency, Collectivise to Survive." Novara Media. March 22, 2020. https://novaramedia.com/2020/03/22/from-me-to-we-in-an-emergency-collectivize-to-survive/.

References

Dunham, Y., E. S. Lieberman, and S. A. Snell. 2016. "Does Stigmatized Social Risk Lead to Denialism? Results from a Survey Experiment on Race, Risk Perception, and Health Policy in the United States." *PLoS One* 11 (3): e0147219.

Freeman, Hadley. 2020. "Is It OK to Shout at Strangers Who Aren't Social Distancing? Absolutely." *The Guardian*, March 23, 2020. https://www.theguardian.com/fashion/2020/mar/23/is-it-ok-to-shout-at-strangers-who-arent-social-distancing-absolutely.

Gadarian, Shana Kushner, Sara Wallace Goodman, and Thomas B. Pepinsky. 2020. "Partisanship, Health Behavior, and Policy Attitudes in the Early Stages of the COVID-19 Pandemic." SSRN, posted March 30, 2020. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3562796.

Gauri, Varun, and Evan Lieberman. 2006. "Boundary Politics and Government Responses to HIV/AIDS in Brazil and South Africa." *Studies in Comparative International Development* 41 (3): 47–73.

Gidron, Noam, and Peter A. Hall. 2017. "The Politics of Social Status: Economic and Cultural Roots of the Populist Right." *British Journal of Sociology* 68 (S1): S57–84.

Goodwin, Jeff, James M. Jasper, and Francesca Polletta. 2009. *Passionate Politics: Emotions and Social Movements*. Chicago: University of Chicago Press.

Hacker, Jacob S. 2002. *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. Cambridge: Cambridge University Press.

———. 2019. *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream*. Oxford: Oxford University Press.

Haines, Michael P. 1996. "A Social Norms Approach to Preventing Binge Drinking at Colleges and Universities." Newton, MA: Higher Education Center for Alcohol and Other Drug Prevention. https://eric.ed.gov/?id=ED421930.

Hardin, Garrett. 1968. "The Tragedy of the Commons." *Science* 162 (3859): 1243–48.

Hardin, Russell. 1997. *One for All: The Logic of Group Conflict*. Princeton University Press.

Hemadeh, Randa, Rawan Hammoud, and Ola Kdouh. 2019. "Lebanon's Essential Health Care Benefit Package: A Gateway for Universal Health Coverage." *International Journal of Health Planning and Management* 34 (4): e1921–36.

Hsu, Becky, Conrad Hackett, and Leslie Hinkson. 2014. "The Importance of Race and Religion in Social Service Providers." *Social Science Quarterly* 95 (2): 393–410.

References

Hur, Aram. 2017. "Is There an Intrinsic Duty to Vote? Comparative Evidence from East and West Germans." *Electoral Studies* 45 (February): 55–62.

Janmyr, Maja. 2018. "UNHCR and the Syrian Refugee Response: Negotiating Status and Registration in Lebanon." *International Journal of Human Rights* 22 (3): 393–419.

Kirp, David L., and Ronald Bayer. 1992. *AIDS in the Industrialized Democracies: Passions, Politics, and Policies*. New Brunswick, NJ: Rutgers University Press.

KOIN News Staff. 2020. "Portland Leaders: 'We're all in this together.'" *KOIN News* (Portland, OR), March 24, 2020. https://www.koin.com/news/health/coronavirus/ted-wheeler-coronavirus-press-conference-03242020/.

Levi, Margaret. 1988. *Of Rule and Revenue*. Berkeley: University of California Press.

———. 1997. *Consent, Dissent, and Patriotism*. New York: Cambridge University Press.

Lieberman, Evan S. 2007. "Ethnic Politics, Risk, and Policy-Making: A Cross-National Statistical Analysis of Government Responses to HIV/AIDS." *Comparative Political Studies* 40 (12): 1407–32.

———. 2009a. *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS*. Princeton: Princeton University Press.

———. 2009b. "The Politics of Demanding Sacrifice: Applying Insights from Fiscal Sociology to the Study of AIDS Policy and State Capacity." In *The New Fiscal Sociology: Taxation in Comparative and Historical Perspective*, edited by Isaac Martin, Ajay Mehrotra, and Monica Prasad, 105–19. New York: Cambridge University Press.

McClendon, Gwyneth H. 2014. "Social Esteem and Participation in Contentious Politics: A Field Experiment at an LGBT Pride Rally." *American Journal of Political Science* 58 (2): 279–90.

McGrane, Victoria, and Matt Stout. 2020. "Unprecedented Crisis Is Met with Extraordinary Resolve: Mass. Residents United in Support of Coronavirus Restrictions." *Boston Globe*, March 28, 2020. https://www.bostonglobe.com/2020/03/28/nation/against-stealthy-virus-united-front/.

Mettler, Suzanne. 2005. *Soldiers to Citizens: The GI Bill and the Making of the Greatest Generation*. Oxford: Oxford University Press.

Miguel, Edward. 2004. "Tribe or Nation? Nation Building and Public Goods in Kenya versus Tanzania." *World Politics* 56 (3): 327–62.

References

Olson, Mancur. 2009. *The Logic of Collective Action: Public Goods and the Theory of Groups*. Rev. ed. Harvard Economic Studies 124. Cambridge, MA: Harvard University Press.

News 9. 2002. “President Trump on Coronavirus: ‘We Are All In This Together’ (video).” *News 9* (Oklahoma City), March 18, 2020. https://www.news9.com/clip/15029191/president-trump-on-coronavirus-we-are-all-in-this-together.

Polonec, Lindsey D., Ann Marie Major, and L. Erwin Atwood. 2006. “Evaluating the Believability and Effectiveness of the Social Norms Message ‘Most Students Drink 0 to 4 Drinks When They Party.’” *Health Communication* 20 (1): 23–34.

Putnam, Robert D., Robert Leonardi, and Raffaella Y. Nanetti. 1994. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, NJ: Princeton University Press.

Santa Cruz Sentinel Staff. 2002. “Guest Commentary: We’re all in this together.” *Santa Cruz Sentinel*, March 22, 2020. https://www.santacruzsentinel.com/2020/03/22/guest-commentary-were-all-in-this-together/.

Scheve, Kenneth, and David Stasavage. 2006. “The Political Economy of Religion and Social Insurance in the United States, 1910–1939.” *Studies in American Political Development* 20 (2): 132–59.

Scott, Dylan. 2020. “The Covid-19 Risks for Different Age Groups, Explained.” *Vox*, March 22, 2020. https://www.vox.com/2020/3/23/21190033/coronavirus-covid-19-deaths-by-age (accessed March 26, 2020).

Shen, Megan Johnson, Emily B. Peterson, Rosario Costas-Muñiz, Migda Hunter Hernandez, Sarah T. Jewell, Konstantina Matsoukas, and Carma L. Bylund. 2018. “The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature.” *Journal of Racial and Ethnic Health Disparities* 5 (1): 117–40.

Shilts, Randy. 2000. *And the Band Played On: Politics, People, and the AIDS Epidemic*. New York: St. Martin’s Press.

Singh, Prerna. 2015. *How Solidarity Works for Welfare: Subnationalism and Social Development in India*. Cambridge: Cambridge University Press.

Subasic, Emina, Michael T. Schmitt, and Katherine J. Reynolds. 2011. “Are We All in this Together: Co-victimization, Inclusive Social Identity, and Collective Action in Solidarity with the Disadvantaged.” *British Journal of Social Psychology* 50 (4): 707–25.

References

Tajfel, Henri. 2001. "Experiments in Intergroup Discrimination." In Intergroup Relations: Essential Readings, edited by Michael A. Hogg and Dominic Abrams, 178–87. Key Readings in Social Psychology. Philadelphia: Psychology Press.

Tajfel, Henri, and John C. Turner. 1986. "The Social Identity Theory of Intergroup Behavior." In *Psychology of Intergroup Behavior*, edited by Stephen Worchel and William G. Austin, 7–24. Chicago: Nelson-Hall.

Thachil, Tariq. 2014. *Elite Parties, Poor Voters: How Social Services Win Votes in India*. Cambridge: Cambridge University Press.

Tyler, Tom R. 2003. "Procedural Justice, Legitimacy, and the Effective Rule of Law." *Crime and Justice* 30: 283–357.

UN News staff. 2002. "'Solidarity, hope' and coordinated global response needed to tackle COVID-19 pandemic, says UN Chief." *UN News*, March 19, 2020. https://news.un.org/en/story/2020/03/1059752

United Church of Christ. 2020. *Coronavirus and the Church*. Website, no date. https://doi.org/10.2105/AJPH.2004.054593.

Wimmer, Andreas. 2018. *Nation Building: Why Some Countries Come Together and Others Fall Apart*. Princeton, NJ: Princeton University Press.

World Bank. 2015. World Development Report 2015: *Mind, Society, and Behavior*. World Bank Group Flagship Report 92863. Washington D.C.: The World Bank. http://documents.worldbank.org/curated/en/645741468339541646/pdf/928630WDR0978100Box385358B00PUBLIC0.pdf.

Yates, Tony. 2020. "Why Is the Government Relying on Nudge Theory to Fight Coronavirus?" *The Guardian*, March 13, 2020. https://www.theguardian.com/commentisfree/2020/mar/13/why-is-the-government-relying-on-nudge-theory-to-tackle-coronavirus.