

In International Organizations We Trust?

Public Support for WHO Policy Recommendations

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Abstract

When does the public trust the policy recommendations of international organizations (IOs)? During COVID-19, an unprecedented number of states enacted restrictive border measures despite the World Health Organization's (WHO) recommendations against their use. Using border restrictions as an empirical case, this study explores whether and when the public trusts information from IOs. We begin by comparing trust in the WHO's recommendations to a baseline of public health experts at the domestic level. We then explore two sets of variables that influence trust and thus moderate the impact of information provision. First, we manipulate the extent to which the WHO is described as an authoritative and independent source of expert information. Second, we look at a variety of individual characteristics that previous scholarship has identified as contributing to trust in IOs. We also compare the impact of WHO recommendations to those of the UN, as a more generic multilateral alternative. Through an experimental research design that collects novel data at the individual level, this research contributes to a better understanding of responses by states during public health emergencies and of how the public evaluates IOs as trustworthy policy recommenders.

Keywords: international organizations, World Health Organization, information, health, public opinion, border restrictions, trust

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Introduction

In the wake of the COVID-19 pandemic, much attention has been directed towards evaluating the international community’s response, including the general lack of cooperation and adherence to the World Health Organization’s (WHO) recommendations and guidelines. In particular, many are concerned with the hasty and repeated enactment of nationalistic and restrictive border policies (OECD, 2022). Pre-dating COVID-19, through numerous experiences of transnational health crises, the WHO has repeatedly advised states against comprehensive border restrictions—a recommendation that is often ignored by states in practice (Lee et al., 2020; Shiraef et al., 2021). It is puzzling that states so often neglect advice from the WHO, an international organization entrusted by them with the responsibility of providing expert guidance on health issues. We note that many governments are motivated by domestic political concerns to restrict their borders, which leads us to ask: Across members of the public, what explains variation in the level of confidence placed in the WHO’s recommendations related to border closures? This relates to the broader theoretical question of when publics perceive international organizations (IOs) as legitimate and trustworthy providers of information. The influence of IOs as policy recommenders depends heavily on public perceptions of their legitimacy, which varies greatly (Dellmuth et al., 2022; Ecker-Ehrhardt et al., 2024).

The implementation of restrictive border measures during transnational health crises offers an important substantive case to examine the larger question of trust in IOs. Trust in the WHO is a critical component of coordinating an international response to global health emergencies. The decision to defect from its guidelines may lead other states to ignore internationally-agreed upon standards, undermining cooperation (Worsnop, 2019). Since border control is viewed as a central prerogative of sovereign states, deference to an IO arguably represents a hard case for the role of trust in international authority. Prior research has demonstrated that the public plays an important role in promoting restrictive border policies, both in times of disease outbreaks and not (Chilton et al., 2020; Lindholt et al., 2021; Bricker, 2020; Baldwin, 1999; Kenwick and Simmons, 2020). Thus, the perceptions of domestic constituents are crucial: they must trust the organization enough to not impose costs on their leaders for acting in accordance with WHO recommendations. We build on existing work by exploring the conditions under which members of the public are most

likely to respond favorably to WHO policy guidelines.

We make a set of related arguments about how members of the public are likely to respond to information about border closures. First, we argue that the public lacks information about the ineffectiveness of restrictive border policies. We expect that when they are informed directly about the ineffectiveness of restrictive border measures and the WHO's recommendation against them during times of transnational health crises, they will be less likely to support border closures in their respective countries. However, we also recognize that information is never propagated and received in a vacuum. In particular, we anticipate that both features of the WHO (and IOs in general) and pre-existing characteristics of the individual interact to shape trust in the organization and its guidelines. We focus on three features of the WHO, as the provider of information, that could influence perceptions of trust: its legal-formal authority, its multilateral membership, and its independent and expert bureaucracy. On the recipient side, we posit that the receiving of information is moderated by pre-existing characteristics of the individual—such as partisanship and ideology, attitudes toward globalization and nationalism, and trust in government—that make them more or less likely to value IO-provided information. We will explore the impact and interaction of these various factors by fielding a survey experiment.

The rest of the pre-analysis plan (PAP) proceeds in four sections. First, we survey the literature to identify previous explanations of the public's preference for border closures during health crises. In doing so, we demonstrate how prior work has overlooked features of the WHO and individual-level variation among the public. Second, we outline our theoretical expectations and hypotheses, highlighting that information provision, features of the WHO, and features of the public are important in understanding variation in trusting the WHO and its recommendations. Third, we describe our proposed research design, supplementing it with our full survey design in the supplementary materials. We highlight how employing a vignette survey experiment to collect data at the individual level in the U.S. is able to both build upon and expand prior work while providing a rigorous test of our hypotheses. In the last section, we outline our analysis plan. We provide a description of the data as well as the sample we anticipate gathering and, for each set of hypotheses, we describe the statistical test of choice.

The Politics of Border Restrictions

At face value, border closures are reasonable and appropriate policy tools for states to adopt in times of transnational health crises. They are relatively low-cost policy tools that states can enact unilaterally and reliably without having to coordinate with other states. However, the WHO has continually advised against border closures during global health crises. This advisement is often made in reference to two sources of authority: the WHO's Director-General and the revised International Health Regulations (IHR) (2005). For example, during the COVID-19 pandemic, Dr. Tedros Adhanom Ghebreyesus has leveraged his position to publicly urge states to not “politicize” the virus (Ghebreyesus, 2020; Young, 2020). Further, Article 43 of the IHR (2005) asserts that any measure taken unilaterally by states should not be more “restrictive of international traffic and not more invasive or intrusive to persons than reasonably available alternative” (World Health Organization, 2005).

The WHO's rationale behind the discouragement of restrictive border policies has been widely studied by political scientists, economists, psychologists, and public health epidemiologists. Many reference the potential negative externalities that may cause more harm than good in implementing border restrictions in times of transnational health crisis (Chinazzi et al., 2020; Errett et al., 2020; Mendez-Brito et al., 2021; Shiraef et al., 2021; Chetail, 2020). For example, border closures during transnational health crises can disrupt supply chains (Pujawan and Bah, 2022; Yu et al., 2021), restrict the movement of necessary human and material resources (Fu et al., 2020), promote stigma and discrimination (Jamieson et al., 2021; Gadarian et al., 2024; Adida et al., 2020; Reny and Barreto, 2022; Dionne and Turkmen, 2020), and even provide a false sense of security (Kenwick and Simmons, 2020).

Despite numerous warnings and evidence of its ineffectiveness, the enactment of restrictive border policies continues (Grépin et al., 2021; Lee et al., 2020). Figure 1 below visualizes how widespread total border closures were during the height of the COVID-19 pandemic (Our World in Data, 2023). This is puzzling given that states have repeatedly experienced, through past occurrence of PHEICs, that restricting borders are ineffective at completely halting the transmission of an infectious disease. Information that counter the advantages of restrictive border measures are also readily available. Therefore, the question remains as to why states continue to enact restrictive

border policies despite it being ineffective in achieving the face-value expected goal. This may hint at how the reason for states enacting border policies may stem from more latent reasons. We anticipate that restrictive border policies that go against the WHO guidelines continue because, firstly, the issued guidelines themselves do not reach average members of the public. The public do not received sterile and unaltered information directly from the WHO. Rather, they receive filtered or nuanced information from domestic sources. Second, there is a general lack of trust in the organization that issues the guidelines because the public remains distant from daily WHO operations.

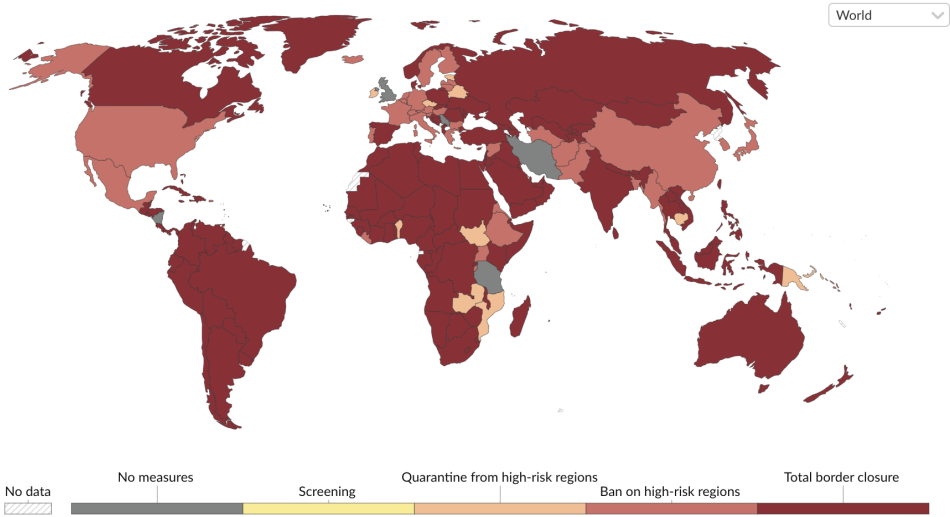


Figure 1: Extent of border closures during the COVID-19 pandemic by May 2020 (Source: *Our World in Data (Our World in Data, 2023)*). Dark red indicates total border closure.

Previous Explanations of Variation in Border Policies

Only a handful of existing studies has focused explicitly on the use of border policies during international health crises (Worsnop, 2017; Kenwick and Simmons, 2020). Both Worsnop (2017) and Kenwick and Simmons (2020) assume that restrictive border policies are a product of rational decision-making by unitary state actors. Worsnop (2017) theorizes that when states expect high domestic benefits from instituting restrictive border policies, they will impose border restrictions. She finds that democracies with weaker health infrastructure are more likely to impose border restrictions because it helps to decrease the overall level of fear and uncertainty the public has towards their government in managing the ongoing disease outbreak (Worsnop, 2017). Similarly,

Kenwick and Simmons (2020) argue that increasing the salience of border narratives—through, for example, border closures—helps to mitigate domestic costs imposed by the virus. Though moving beyond the unitary state assumption, Gadarian et al. (2024) find that during COVID-19, racial attitudes shaped individual’s preferences on entry bans. Their findings demonstrate that individuals of the public are rational and calculating, consistently rewarding states perceived to be in-groups (not imposing entry bans) while punishing states perceived to be out-groups (imposing entry bans) (Gadarian et al., 2024).

Other scholars have examined more generalized restrictive border policies (Carter and Poast, 2017; Hassner and Wittenberg, 2015; Linebarger and Braithwaite, 2022; Mudde and Kaltwasser, 2017). Carter and Poast (2017) argue that economic disparities between neighboring countries increase the likelihood of restrictive border policies. Or, Linebarger and Braithwaite (2022) argue that leaders who anticipate upcoming political losses enact popular policies such as restrictive border policies to stay in office. In numerous immigration attitude studies, scholars find that border policies are a function of group attitudes (Nelson and Kinder, 1996).

Though the latter group of scholars do not explicitly focus on restrictive border measures during times of international health crises, the two groups of scholars share the common assumption that the public is, in many different ways, integral to the domestic elites and policy makers in instituting border policies. Overall, the public is favorable to more control and restriction at the borders. This is evident in a poll conducted in March 2020 where support for border closures were extremely high (Kenwick and Simmons, 2020). Figure 2 below shows how the majority in 12 countries were pro-restricting borders. In Vietnam and India, public support for closing of borders reached close to 80%.

These studies all demonstrate the public’s role in the enactment of restrictive border policies. Most recently, Kobayashi et al. (2023) have examined how the public’s demand for border closures during pandemics could vary. The authors lay out a simplified theoretical model based on the role of uncertainty and hypothesize three conditions in which the public’s demand for border closures increases: when the number of infections from neighboring countries is high, when the health capacity of the state is low, and when the public is uninformed about the WHO’s guidance against border closures and the state’s international obligation under the IHR (2005) (Kobayashi et al., 2023). With experimental survey data from the UK and the US, the authors consistently find

Majorities agree with the closing of borders

Who agrees that we should close the borders of my country and not allow anyone in or out until the virus is proven to be contained

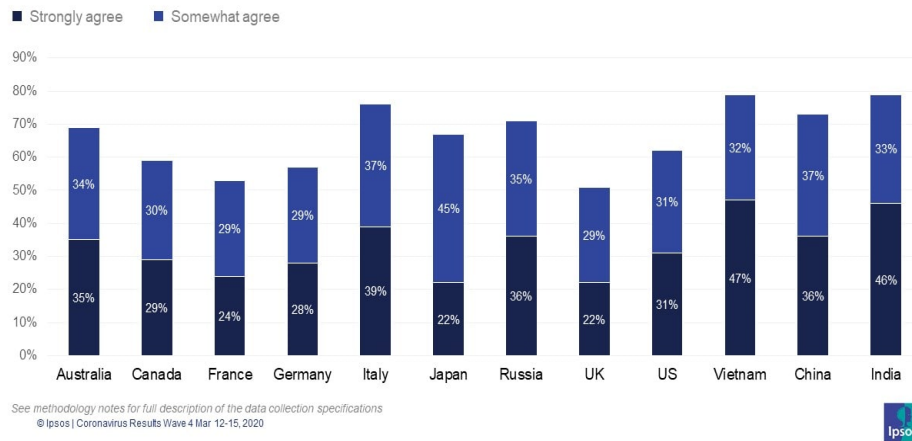


Figure 2: Poll conducted in 12 countries that demonstrate majority agree with border closure during a pandemic (*Source: IPSOS (Bricker, 2020)*).

strong support for their third hypothesis: when the public is reminded about their government’s international legal obligation under the IHR (2005) to leave borders unrestricted as well as the WHO’s recommendation against restricting borders, the public’s support for border closures decline. The authors conclude that lack of information contributed to the unprecedented number of states closing borders during COVID-19.

Our Approach

As insightful as these prior studies are, the literature on understanding public demand for restrictive border closures during transnational health remains limited. First, the pre-existing literature has been limited with aggregated data. In examining restrictive border policies during health crises, only cross-sectional comparisons across countries were possible (e.g., comparing the US and the UK in Kobayashi et al. (2023)). Additional data collection and theorizing on how preference for restrictive border policies can vary within the public is necessary to gain a deeper understanding. Second, previous research has studied restrictive border policies during transnational health crisis as an isolated and independently occurring phenomenon. However, restrictive border measures are enacted in the larger context of the WHO’s health governance structure. Thus, closing borders must be understood and conceptualized as an act indicative of diminished trust or deference to the

organization entrusted with coordinating state policies. More theoretical work needs to be done to connect the seemingly idiosyncratic phenomenon of disease outbreaks with larger governance structures. We contend that the approach of studying this seemingly isolated case of border closures in times of disease outbreaks will be informative in terms of understanding IO's legitimacy and authority as well as its role as a multilateral coordinator.

Thus, in this paper, we offer three main contributions to the literature. First, building upon prior literature, we examine how and why the public continues to be supportive of restrictive border policies in times of health crises. In agreement with previous literature, we demonstrate that there is a lack of information available about the effectiveness of restrictive border measures. By theorizing and testing the role of information provision about restrictive border policies and the WHO's position on them, we are able to examine one of the mechanisms and sources of resilience of the public's unwavering demand for border restrictions during transnational health crises. However, departing from the prior literature, we contend that information provision is not sufficient to overcome pre-existing attitudes and priors of individuals receiving the information. We argue that information provision is moderated by both features of the WHO and characteristics of the individual. We examine both the providers and recipients of the information separately to theorize how different characteristics may determine different levels of trust placed onto the WHO and subsequent receptiveness to the information. By doing so, we are able to better theorize how trust of international organizations also pervades from domestic constituents to political elites to determine policy decisions.

Second, we posit that certain features of the WHO as an organization, when made salient, make recommendations regarding open borders more attractive. We identify and highlight certain features of the organization that increases the organization's legitimacy and authority to recommend guidelines in times of transnational health crises. By engaging directly with the international institutions literature, we examine how features of the WHO magnify the effect of information on the masses. By doing so, we contextualize the enactment of restrictive border measures in the larger global health governance framework. We offer a way to understand how border restrictions during health crises are closely interlinked with trust placed onto to the WHO as a whole. That is, the organization that is disseminating the recommendations must be perceived to be trustworthy in order for the information to be tractable. Additionally, to disentangle the effect of information

provision and trust in institutions, we also examine parallel hypotheses regarding features of the organization with the United Nations (UN) as the information provider. This portion of the research design should be generative in two senses. First, it will produce additional valuable novel data for comparisons of institutions on the individual-level. Second, it will also be an opportunity to generate new theoretical predictions and hypotheses about comparisons across different organizations.

Third, by collecting individual-level data, we refine prior theoretical expectations at a disaggregated level of analysis. Drawing on prior theoretical models like the Revisionist Exposure-Acceptance Model (Zaller, 1991; Geddes and Zaller, 1989; Bleck and Michelitch, 2017), we demonstrate that certain characteristics predispose individuals to more readily accept information about the WHO's position against restrictive border policies. Further, we demonstrate that individuals take into consideration not only political concerns, but personal concerns in making their policy decisions (Hainmueller and Hopkins, 2014; Huddy et al., 2002). This, additionally, allows us to highlight how individuals receive information with pre-existing priors that determine the overall level of trust placed onto the organization. Put together, we deepen the literature's understanding of border measures, trust in institutions, information provision, and response to health crises.

Theory and Hypotheses

In our theoretical expectations, we highlight how the characteristics of both the provider and the recipient of information may result in variation in the extent to which information can elicit a change in policy preferences. In other words, there are a wide variety of reasons why individuals may not be receptive to information about the ineffectiveness of border closures during health crises from the WHO. We explore various factors that may matter. In the first part of this theoretical section, we reach a consensus with findings from scholars like Kobayashi et al. (2023) to examine how, in general, the public remains unaware of the WHO's recommendations against restrictive border measures. Therefore, providing information about the WHO's policy stance regarding restrictive border measures will decrease the public's preference for the use of restrictive border measures during transnational health crises.

However, this information is neither supplied nor received in a vacuum. Thus, we generate

hypotheses that further explain individual-level variation. On the provider’s side, certain features of the WHO may amplify or minimize the value of the provided information. We examine how characteristics that pertain to the WHO’s authority and legitimacy are able to increase the value of the information being provided about the WHO’s position against restrictive border measures, increasing receptiveness. Additionally, we also examine whether these features operate in a parallel fashion by comparing the WHO with the UN. This comparison will allow for a more intricate disentangling of the effects of information provision and features of institutions that result in the treatment effect.

On the recipient’s side, predispositional characteristics may also amplify or minimize the value of the information. We examine how pre-existing attitudes towards partisanship, globalization, nationalism, and government institutions act as priors that determine individual baseline for receptiveness of the information regarding the WHO’s recommendation and position on restrictive border measures.

All together, we generate three main sets of hypotheses that comprehensively examine not only the information regarding border restrictions itself, but also the actors involved—the WHO and the public. The hypotheses allow for a fuller picture to emerge that deepen our understanding of policy preferences regarding border measures during health crises.

Direct Line of Communication between the WHO and the Public

Our first theoretical expectation centers around the role of information, more specifically the role of information about the ineffectiveness of restrictive border policies as well as the WHO’s expert guidance against its use. We expect that one of the key reasons the public continues to demand restrictive border policies during times of transnational health crises is because the public remains unaware of the ineffectiveness of restrictive border policies. This may be due to both an overall lack of information or lack of information directly from the WHO.¹ This first hypothesis serves as a proof-of-concept.

Thus, we argue that if the public is directly informed about the ineffectiveness of restrictive border measures and the WHO’s clear position against restrictive border policies, the public’s demand for border restrictions during a transnational health crises will decrease. That is, once

¹Kobayashi et al. (2023) hint at how this was due to lack of widespread media coverage.

the public has been provided objective and factual information about the WHO's recommendation against restrictive border policies, the public will update their policy preference to reflect the new information. In order to better understand and isolate the effect of information provision from the WHO, rather than a generic source, we hypothesize:

Hypothesis 1: Compared to the baseline (information provided by scientific experts, including the government/CDC), the public will be less likely to support restrictive border policies when they are informed about their ineffectiveness and the recommendation against their use by the World Health Organization (WHO).

The WHO's Authority in Global Health Governance

However, information about restrictive border policies are never provided to the public in a politically neutral environment. Features of both the source of information provider and the receiving public will moderate the effect of information provision. In particular, in this study, we posit that certain characteristics of the WHO as an organization will affect how effective information is at changing the preferences of individual members of the public for restrictive border policies during a pandemic. This is because certain features serve as signals to the WHO's authority and legitimacy to recommend guidelines during a transnational health crisis. Our theoretical argument rests on three assumptions. First, the public, on average, remains less informed about the WHO as an entity and institution in the international society. As such, the public lacks information about the WHO's authority and legitimacy as an international organization. Second, the public values authority and legitimacy of an international organization, and comes to trust them when they perceive authority and legitimacy. Third, the public, as a whole, reaches a certain consensus regarding features of organizations that signal at their authority and legitimacy.

Drawing from a rich body of literature that examines institutional legitimacy (Dellmuth et al., 2022; Dellmuth and Tallberg, 2023; Tallberg and Zürn, 2019), in this paper, we examine three features of institutional authority and legitimacy: legal-formal authority of the organization, multilateral membership of the organization, and the independence and autonomous bureaucracy of the organization. We identify these three features of the WHO because these are characteristics

that can be made salient without the public possessing in-depth knowledge about the WHO and international organizations. They are succinct and concise signals to an organization's legitimacy. Furthermore, if effective in delivering information about ineffectiveness of restrictive border measures, these are features that the WHO can consciously appeal to in communicating with their states and their domestic constituents to coordinate policy responses.

First, we expect that when the public is informed of how the WHO's authority is derived from a legal document like the International Health Regulations (2005), they will be more inclined to respond to the information against the usage of restrictive border policies. That is, the public will take the appeal to the legal-formal authority of the WHO as a valuable heuristic to receive and internalize the provided information.

Hypothesis 2a-1 (legal-formal authority - WHO): When informed additionally about the WHO's role as a policy recommender under the International Health Regulations (IHR) (2005), the public will be even less likely to support restrictive border policies.

Second, we expect that when the public is informed that the WHO has near-universal membership from states around the world, they will be more inclined to be receptive to policy recommendations. The appeal to the organization's multilateral membership will signal how the policy recommendation against the use of restrictive border policies is reflective of near-universal consensus. This will increase the value of the information. Thus, our second hypothesis pertaining to organizational features is:

Hypothesis 2b-1 (multilateral membership - WHO): When informed additionally about the WHO's multilateral organizational structure, the public will be even less likely to support restrictive border policies.

Third, we also anticipate that when the public is informed about the independent and autonomous bureaucracy of the WHO's organizational structure, they will perceive recommendations from the WHO to be more authoritative and legitimate. That is, when the public receives more information about how the WHO operates and reaches a decision regarding border guidelines, the public will be able to move away from an amorphous conception of the WHO as an unfamiliar international

organization and will value the information from it more. Thus, our final hypothesis pertaining to the WHO's organizational features is:

Hypothesis 2c-1 (independent and autonomous bureaucracy - WHO): When informed additionally about the WHO's independent and autonomous expert advisory panel, the public will be even less likely to support restrictive border policies.

These second set of hypotheses explores the characteristics of the WHO as an international organization and its role in moderating the effect of information provision. The three hypotheses outlined above will provide further insight into how and why the public responds to the information against restrictive border policies from the WHO. Furthermore, these hypotheses will also be able to speak to how trust is placed on recommendations and guidelines from IOs.

Parallel Comparison: The United Nations

We also provide parallel hypotheses that substitutes the UN for the WHO in examining the anticipated effects of institutional features. Parallel hypotheses should be helpful in disentangling the causal effect of information from features of the organization. In addition, it will also provide evidence that these effects are not idiosyncratic to the WHO, especially as an organization that has recently been highly publicized and politicized during COVID-19. Parallel findings should inform us of the larger theoretical question pertaining to trust in IO policy recommendations—moving beyond the WHO case.

We choose the UN for several reasons. First, the WHO is a specialized agency under the UN system. This means that in our experimental survey research design, we can limit the extent of deception in formulating our treatment. Consequently, we are able to maintain higher verisimilitude. Second, compared to many other more technical and epistemic international organizations, the UN is much more well known to the American public. American public attitudes toward the UN has generally been favorable (Holyk, 2010). Thus, computing the effects of institutional signals of authority and legitimacy for the UN should provide a clear baseline for understanding treatment effects. In other words, comparing the findings between the WHO and the UN should assuage any potential concerns that any findings is attributable to the WHO and the post-COVID-19 context. Third, theoretically, comparing both the magnitude and direction of the treatment effect with the

WHO will be informative. Greenhill (2020) finds that the effect of UN endorsement stands out in comparison to other intergovernmental organizations and international non-governmental organizations. By collecting this novel data, we will be able to put our findings in more direct conversation with the theoretical international institutional literature. Therefore, our second set of hypotheses that examine organizational features are the following.

The parallel hypotheses are as follows:

Hypothesis 2a-2 (legal-formal authority - UN): When informed additionally about the UN's role as a policy recommender under the International Health Regulations (IHR) (2005), the public will be even less likely to support restrictive border policies.

Hypothesis 2b-2 (multilateral membership - UN): When informed additionally about the UN's multilateral organizational feature, the public will be even less likely to support restrictive border policies.

Hypothesis 2c-2 (independent and autonomous bureaucracy - UN): When informed additionally about the UN's independent and autonomous expert advisory panel, the public will be even less likely to support restrictive border policies.

Individual Predispositions towards the WHO

Beyond characteristics of the WHO as an international organization, in line with the expectations of the Revisionist-Acceptance Model (Zaller, 1991; Geddes and Zaller, 1989), we anticipate that the effects of direct information transmission about restrictive border policies and the WHO's position on them will vary across individuals and their pre-existing characteristics. The Revisionist-Acceptance Model considers both exposure to and acceptance of information, previously overlooked in prior literature. According to the model, information acceptance largely depends on individuals' predispositions. These predispositions may facilitate or hinder the acceptance of newly given information, regardless of the degree of exposure.

Among numerous potential predispositions that may affect information acceptance, we propose four that could affect the baseline for which individuals accept or reject new information about restrictive border policies: political and ideological affiliation, attitudes towards nationalism,

attitudes towards internationalism, and trust in the government. These four attributes capture significant differences that shape public attitudes towards information from the WHO (and the UN) from a political comprehension perspective as well as psychological threats emanating from borders.

Regarding partisanship, liberal and conservative supporters have displayed contrasting political attitudes towards international cooperation, international organizations, immigrants, and border-related policies (Dellmuth and Tallberg, 2020; Gadarian et al., 2024; Abramowitz and McCoy, 2019). Traditionally, liberals have been more closely aligned with global community engagement while conservatives are more pro-US-centric. A prime example is the US' withdrawal from the WHO during the apex of the COVID-19 crisis under the Trump administration. But, once Democrats regained control of the government, the US quickly reversed their policies and re-joined the WHO, affirming their commitment towards global engagement. Consequently, we hypothesize that those affiliated with Democrats might be more receptive to exposed information that call for open borders from the WHO. Conversely, Republicans may be less likely to accept new information about the WHO's position on restrictive border policies because it presents a bigger divergence from their original political rhetoric and beliefs. Therefore, the first of our third set of hypotheses is:

Hypothesis 3a (partisanship): The effect of information about the WHO on the public is conditional on *partisanship*.

Second, we also anticipate nationalism to be related to trust in the WHO and its guidelines. Individuals that are more attached to their nation may be less inclined to defer decision-making processes to an external, multilateral organization like the WHO. Thus, we anticipate that more nationalistic individuals to be less receptive towards the WHO's guidelines.

Hypothesis 3b (nationalism): The effect of information about the WHO on the public is conditional on individual attitudes towards *nationalism*.

Third, attitudes towards internationalism (Carnegie and Gaikwad, 2022; Kertzer et al., 2021) are also expected to play a role. There are numerous studies that examine how world views and orientations towards a globalized society affect preferences on various issues (Rathbun, 2009; Bayram, 2017; Bayram and Shields, 2021). Thus, the third hypothesis in our third set is:

Hypothesis 3c (internationalism): The effect of information about the WHO on the public is conditional on individual attitudes towards *internationalism*.

Last but not least, individual levels of trust in the government are also theorized to be related to trust and deference placed onto the WHO. Individuals that trust their national governments more may be more inclined to defer policy making to multilateral organizations, which their national governments are a member of, and they may be more receptive towards both information about them and those provided by them. Jiang & Wan (2023) demonstrate how individual level of trust in the government is correlated with trust in science and institutions as a whole (Jiang and Wan, 2023). Thus, we anticipate that individuals that are more trusting of the government to be more receptive towards the WHO's guidelines.

Hypothesis 3d (trust in domestic government): The effect of information about the WHO on the public is conditional on individual level of *trust in the government*.

Research Design

We test our hypotheses through a vignette survey experiment. The experiment is structured into three main components: pre-treatment questions, treatment vignettes, and post-treatment questions. Employing an experimental survey design serves several purposes. First, we are able to collect individual-level data in response to variations of the treatment pertaining to information provision and features of the international organization. To the best of our knowledge, this research is the first to collect disaggregated, individual-level data on border preferences during transnational health crises with varying treatment on features signaling to the legitimacy and authority of IOs. Second, an experimental vignette survey allows us to examine the treatment effect independently as well as how they interact with pre-dispositional factors. With this, we are able to identify individual-level heterogeneity. This is conducive to testing our third set of hypotheses.

Participants will begin by answering pre-treatment questions. The pre-treatment portion of the survey is primarily descriptive. Participants will answer questions pertaining to citizenship, age, geographic location, gender, and race. Basic demographic information unrelated to our experiment will be collected to prevent participants from forming specific impressions or intentions related to

our study, ensuring unbiased responses.

The second component of our research design involves the treatment of vignettes to participants. Our experimental survey design follows a $2 \times 3 \times 2$ between participants fully randomized post-test design, as illustrated below in Table 1. The “Experimental Groups” refer to the two groups that are of interest in comparison in this study. The “control” group is the baseline that we assume. Participants will be informed of the negative side effects of border closures from domestic sources (scientists and health experts). The “treatment” group will be informed of the negative side effects of border closures from the WHO. This first-level treatment group assesses H1. “Features of International Organizations” refers to additional treatment group subsets that will provide participants information pertaining to authority and legitimacy of the WHO and the UN (H2s). The “legal-formal authority” group will be informed that the WHO/UN recommends policy based on its IHR (2005)’s legal foundations. The “multilateral structure” group will be informed that the WHO/UN’s policy recommendation represents a near-universal consensus of countries around the world. The “independent performance” group will be informed that the WHO/UN’s policy recommendations come from independent and autonomous bodies within the organization. Each Control and Treatment group will receive a vignette in the form of a brief text resembling a newspaper article. We will emphasize that these articles are purely hypothetical scenarios written by the research investigative team. Additionally, we will emphasize that the health crisis in question is entirely distinct from previous ones.

Table 1: Randomized experimental survey design

Experimental Groups	Information provided in the vignette					
Control Group	Global health crisis + Limitation of border closures by domestic scientists and health experts					
Treatment Groups	Global health crisis + Limitation of border closures by the WHO (H1)					
	Features of International Organizations					
	Legal-formal authority (H2a)		Multilateral structure (H2b)		Independent performance (H2c)	
	World Health Org (H2a-1)	United Nations (H2a-2)	World Health Org (H2b-1)	United Nations (H2b-2)	World Health Org (H2c-1)	United Nations (H2c-1)

The final component of our experiment involves post-treatment questions. Following the reading of their assigned treatment vignette, participants will respond to five post-treatment questions. To measure participants’ support for restrictive border measures in times of transnational health

crises after reading the treatment vignettes, several measures of the outcome is employed. One measure is a multiple-choice question that includes nine potential government responses to a novel pandemic (Porcher, 2020). Respondents are asked to select two options they deem most necessary and urgent. This question indirectly gauges support for border restriction policies. Choosing a border-related policy (e.g., travel restrictions) suggests a respondent’s inclination towards supporting such measures compared to those who do not select any border restriction policies. Another measure asks participants to rate, on a scale from “1” (very necessary) to “4” (not necessary at all), how necessary they believe border restrictions are. Another outcome measure is structured as an open-ended question. This allows us to gain deeper insight into the reasoning behind respondents’ answers. The full set of questions assessing our dependent variable can be found in the appendix.² Along with the outcome measures, participants will also answer additional political and demographic questions for testing of H3s.

Subject Recruitment

We look to recruit participants from the United States via Prolific (Palan and Schitter, 2018). Prolific is an opt-in survey platform that recruits voluntary respondents. Deception will not be employed in our research design. All respondents will be informed that they vignette is “hypothetical,” prepared by the research team.

Analysis Plan

Outcome Variable: Support for Border Restrictions

We collect five variations of the dependent variable to operationalize a member of the public’s support for restrictive border measures by their government post-treatment.³ First, respondents are asked to select two courses of actions (out of nine) that are the most crucial for the U.S. government to implement. The list is adopted from the “Response2covid19” dataset which typologizes country-level governments’ response to COVID-19 from January 1 to October 1, 2020 (Porcher, 2020). This first measure allows us to indirectly gauge support for restrictive border measures.

²The current iteration of the survey design is attached.

³Specific wording of the questions and response categories can be seen in the supplementary appendix.

Second, respondents are asked to rate each of the nine potential public health measure from the “Response2covid19” dataset using a Likert scale format (1 is “Not important at all” and 7 is “Extremely important”). Choosing a border-related policy (e.g., travel restrictions) as opposed to a non-border related policy (e.g., require restaurant and bar closures) suggests respondent’s inclination towards supporting border measures. For both of these two measures, the sequence of the nine options are randomized to ensure minimization of bias.

Third, respondents are asked to rate on a scale of four how necessary they believe border restrictions are. This allows a more concise ordinal scale to emerge on the individual-level.

Fourth, respondents are then asked informed that there are different levels to border restrictions that the U.S. government to impose, ranging from general screening to highly restrictive total bans and closures. Respondents are asked to select which “level” of border restrictions should be enacted. This measure of the outcome variable allows us to unpack the term “border restrictions” more in-depth.

Last, respondents are given an open-ended question where they are asked to share their thoughts on restrictive border measures freely.

Composition of the Analysis Sample

Two manipulation check questions are used to compile our final sample for analysis. Kane and Barabas (2018) argue that factual manipulation checks (FMCs)—objective questions about key points of the experiment—are best at identifying individual-level attentiveness, allowing researchers to better compute and analyze experimental findings (Kane and Barabas, 2019). As such, we implement two FMCs. First, to check whether participants read the information about the ineffectiveness of border restrictions and the source of the policy recommendation, we ask participants to identify, based on the randomized vignette they received, the actor that issued the policy recommendation. Second, to check whether participants picked up on the organizational feature that we seek to make salient in the experiment, we ask participants why the WHO or the UN’s recommendations are viewed as important and taken seriously.

To ensure robustness of our findings and to check that our treatment works as intended, we will report both samples: the full sample as well as the sample where participants who failed to answer the FMCs correctly are dropped from the data (Mutz, 2011).

Identification and Estimation Strategies for Hypotheses

We will first investigate H1, whether respondents update their policy preferences regarding restrictive border measures during transnational health crisis upon being provided information from the WHO about their ineffectiveness. Relative to the baseline, we expect respondents to become less favorable towards U.S. government instituting restrictive border measures after the treatment. For comparing baseline/Control and Treatment 1, we will primarily rely on difference-in-means. Using the various outcome measures we collect, we will (i) compare the difference in proportion of respondents selecting border restrictions as one of the two course of action they believe to be most crucial for the U.S. government to implement (outcome measure Q1 in supplementary appendix), (ii) difference in average rating of the importance of border measures (outcome measures Q2 and Q3 in supplementary appendix), and (iii) difference in average level of the border restriction they believe the U.S. government should enact (Q4 in the supplementary appendix). For each outcome measure, a two-tailed difference-in-means test hypothesis testing ($\alpha = 0.05$) will be conducted. Standard errors will be clustered at the respondent level and 95% confidence intervals will be computed. The cross-validation across the different outcome measures will increase confidence in our expected findings.

To investigate H2s, we will conduct our analysis in two stages. First, to investigate whether effect of information provision is moderated by institutional features (formal-level authority, multilateral structure, independence and autonomous performance) of the WHO, we will, once again, conduct difference-in-means tests with the various outcome measures. Comparisons with the baseline and across the three treatment groups (H2a-1, H2b-1, and H2c-1) will be conducted: two-tailed with $\alpha = 0.05$. Second, to investigate whether the treatment effect is comparable across the WHO and the UN, we will conduct difference-in-means test across each version of the vignette: WHO vs. UN (e.g., comparison of H2a-1 and H2a-2). Computing difference-in-means and comparing the treatment effect coefficients' magnitude and direction will be insightful in making more generalizable claims about information provision and institutional features in understanding how members of the public trust IOs and their policy recommendations.

Finally, to investigate H3s and potential heterogeneity across individuals, we will rely on responses to the post-treatment questions on partisanship, nationalism, internationalism, and trust

in government. To compute interactive effects, we will adopt various regression models. Given that our outcome measures take different ranges (Q1 may be binary (“1” if one of the two selected policies is border-related, 0 otherwise) or ordinal (“0” if none of the two selected policies is border-related; “1” if one of the two selected policies is border-related, “2” if both of the two selected policies are border-related) ; Q2, Q3, and Q4 is ordinal) and can be manipulated, we will rely on different models. For our base model, we will adopt a linear multivariate OLS model with standard errors clustered at the respondent level to examine the interactive relationship between information provision and individuals’ pre-dispositional characteristics:

$$Y_i = \alpha_i + \beta_1(\text{WHO Information})_i + \beta_2\mathbf{Z}_i + \beta_3(\text{WHO Information} \times Z)_i + \epsilon_i \quad (1)$$

The dependent variable (Y_i) is the respondent i ’s support for restrictive border measures. The main coefficient of interest is β_3 , which interacts the treatment with the post-treatment pre-dispositional characteristic of interest Z_i . The equation can be adapted to a multinomial logistic regression depending on the range of the outcome variable.

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Supplementary Material:

Survey Questionnaire for

“In International Organizations We Trust?”

Public Support for WHO Policy Recommendations”

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1 Pre-Treatment

A1. Are you a citizen of the United States?

Yes, I am	1
No, I am not	2

A2. How old are you?

A3. Where do you live? [drop down menu for state selection]

A4. What is your gender?

Female	1
Male	2

A5. Which racial group do you identify most with?

White	1
Black	2
Asian, native Hawaiian or other Pacific Islander, non-Hispanic	3
Native American or Alaska Native, non-Hispanic	4
Hispanic	5
Other non-Hispanic including multiple races	6
I do not want to answer this question	99

A6. Which device are you using to participate in this survey?

Mobile phone	1
Tablet	2
Desktop or notebook	3
Refuse to answer	4

2 Experiment: 1 Control + 7 Treatment Groups

Assignment to experimental group is random.

Instructions: We will now present a hypothetical situation describing a potential global health scenario. Please take sufficient time to read it. Afterward, you will be asked several questions related to this issue.

- **Control Group (Baseline)** - Global health crisis + Limitations of border closures by domestic scientists and health experts

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, many health experts, including those at the federal government's Center for Disease Control and Prevention (CDC), have advised that the implementation of border closures may not be as effective as initially thought. These experts caution that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 1 (H1)** - Global health crisis + Limitations of border closures by the WHO

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the World Health Organization (WHO), an international organization created in 1948 to promote international health cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The WHO cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 2 (H2a-1)** - Global health crisis + Limitations of border closures by the WHO + WHO's legal-formal authority

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the World Health Organization (WHO), an international organization created in 1948 to promote international health cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The WHO has authority under a legally binding international agreement known as the International Health Regulation (IHR) to act as an information provider and policy recommender during global health issues. The WHO cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 3 (H2a-2)** - Global health crisis + Limitations of border closures by the UN + UN's legal-formal authority

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the United Nations (UN), an international organization created in 1945 to promote international cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The UN has authority under a legally binding international agreement known as the International Health Regulation (IHR) to act as an information provider and policy recommender during global health issues. The UN cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 4 (H2b-1)** - Global health crisis + Limitations of border closures by the WHO + WHO's multilateral structure

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the World Health Organization (WHO), an international organization created in 1948 to promote international health cooperation, has advised that the

implementation of border closures may not be as effective as initially thought. The WHO's guidance, with 194 member states, represents a near-universal consensus of countries around the world. The WHO cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 5 (H2b-2)** - Global health crisis + Limitations of border closures by the UN + UN's multilateral structure

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the United Nations (UN), an international organization created in 1945 to promote international cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The UN's guidance, with 193 member states, represents a near-universal consensus of countries around the world. The UN cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 6 (H2c-1)** - Global health crisis + Limitations of border closures by the WHO + WHO's Independent and Autonomous Bureaucracy

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the World Health Organization (WHO), an international organization created in 1948 to promote international health cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The WHO's Expert Advisory Panels and Committees, responsible for issuing this guidance, operate independently and autonomously from individual countries. The WHO cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

- **Treatment Group 7 (H2c-2)** - Global health crisis + Limitations of border closures by the UN + UN's Independent and Autonomous Bureaucracy

Month Day, Year [close to the experiment date]

Since *MONTH HERE*, a new disease X has been circulating across the globe. The exact cause and the country of origin of the disease remain unclear, however X has been identified to spread through human-to-human transmission. The international community and the individual countries are seeking solutions to prevent its further spread and damage.

Recently, the United Nations (UN), an international organization created in 1945 to promote international cooperation, has advised that the implementation of border closures may not be as effective as initially thought. The UN's Expert Advisory Panels and Committees, responsible for issuing this guidance, operate independently and autonomously from individual countries. The UN cautions that such measures can prove futile in preventing the spread of the disease and may instead carry unforeseen negative side effects in the long term.

3 Post-Treatment

3.1 Outcome variable: support for border restrictions

Q1. In the scenario described, where a transnational disease has been severe and widespread, which TWO actions do you think are the most crucial for the government to implement? Below is a list of possible public health measures by the government [randomize the sequence of the listed items and sustain randomized sequence for Q2.]

Bans on mass gatherings
Travel restrictions (international)
Travel restrictions (domestic)
Mandates to wear masks
Institute public testing and contact tracing
Announce a State of Emergency
Domestic lockdown
Require restaurants and bar closures
Postpone/cancel upcoming elections
I do not know

Q2. Please rate the importance of each potential public health measure listed below in the given situation. Use a scale from 1 to 7, where 1 is “Not important at all” and 7 is “Extremely important.”

Bans on mass gatherings
Travel restrictions (international)
Travel restrictions (domestic)
Mandates to wear masks
Institute public testing and contact tracing
Announce a State of Emergency
Domestic lockdown
Require restaurants and bar closures
Postpone/cancel upcoming elections
I do not know

Q3. Regarding border restrictions specifically, how necessary do you believe they are in this situation?

Very necessary	1
Somewhat necessary	2
Slightly necessary	3
Not necessary at all	4

Q4. There are different levels of border restrictions based on their severity: screening, quarantine of arrivals from high-risk regions, ban on arrivals from some regions, and total border closures. To what extent do you think the government should implement these restrictions?

First level: screening	1
Second level: Quarantine of arrivals from high-risk regions	2
Third level: Ban on arrivals from some regions	3
Fourth level: Total ban on all regions, total border closures	4

Q5. (Open-ended question) Please share your thoughts on restrictive border measures freely.

Q6. (Manipulation Check 1) In the previous hypothetical situation you just read, who is identified as providing policy recommendations against border restrictions during transnational health crisis?

World Health Organization (WHO)	1
United Nations (UN)	2
Health experts	3
Centers for Disease Control and Prevention (CDC) and health experts	4
No information provided	5
Do not remember	6

Q6. (Manipulation Check 2) In the hypothetical situation you just read, why are the WHO/UN's recommendations viewed as *important* and taken seriously? [can select multiple]

The International Health Regulations (IHR)	1
Its near-universal membership consensus	2
Its independent expert advisory panels	3
There was no information provided	4
Do not remember	5

3.2 Individual predispositions

3.2.1 Partisanship

B1. Generally speaking, do you think of yourself as a Republican, a Democrat, an Independent, or what?

Democrat	1
Republican	2
Independent	3
Other ()	4

B2. Do you think of yourself as closer to the Democratic Party or the Republican Party?

Democratic Party	1
Republican Party	2

B3. How would you describe your political ideology?

Extremely liberal	1
Liberal	2
Slightly liberal	3
Moderate	4
Slightly conservative	5
Conservative	6
Extremely conservative	7

3.2.2 Nationalism

C1. How close do you feel to America?

Not close at all	1
Not very close	2
Close	3
Very close	4

C2. How proud are you of America's arts and literature?

Not proud at all	1
Not very proud	2
Somewhat proud	3
Very proud	4

C3. How proud are you of America's history?

Not proud at all	1
Not very proud	2
Somewhat proud	3
Very proud	4

C4. I would rather be a citizen of America than of any other country in the world.

Strongly agree	1
Agree	2
Neither agree nor disagree	3
Disagree	4
Strongly disagree	5

C5. The world would be a better place if people from other countries were more likely America.

Strongly agree	1
Agree	2
Neither agree nor disagree	3
Disagree	4
Strongly disagree	5

3.2.3 Internationalism

D1. To what extent do you agree or disagree with these statements?

America needs to cooperate more with the United Nations in settling international disputes.

Strongly agree	1
Agree	2
Neither agree nor disagree	3
Disagree	4
Strongly disagree	5

D2. To what extent do you agree or disagree with these statements?

It is essential for the United States to work with other nations to solve problems such as human rights violations, hunger, and pollution.

Strongly agree	1
Agree	2
Neither agree nor disagree	3
Disagree	4
Strongly disagree	5

3.2.4 Trust in government

E1. How much of the time do you think you can trust the government in Washington to do what is right?

Just about always	1
Most of the time	2
Only some of the time	3
Never	4

3.3 Baseline individual evaluation of the WHO and the UN

F1. Evaluate how effective the World Health Organization (WHO) was in responding to the latest COVID-19 pandemic?

Very effective	1
Effective	2
Neither effective nor ineffective	3
Very ineffective	4
Don't know	5
Refuse to answer	6

F2. Evaluate how effective the UN was in responding to the latest COVID-19 pandemic?

Very effective	1
Effective	2
Neither effective nor ineffective	3
Very ineffective	4
Don't know	5
Refuse to answer	6

3.4 Additional demographic questions

D7. What was your total household income before taxes during the past 12 months?

Less than \$25,000	1
\$25,000 - \$49,000	2
\$50,000 - \$74,999	3
\$75,000 - \$99,999	4
\$100,000 - \$149,999	5
\$150,000 or more	6
Prefer not to say	7

D8. What is the highest level of school you have completed or the highest degree you have received?

Some high school or less	1
High school diploma or GED	2
Some college, but no degree	3
Associates or technical degree	4
Bachelor's degree	5
Graduate or professional degree (MA, MS, MBA, PhD, JD, MD, DDS etc.)	6
Prefer not to say	7