SUPPLEMENTARY MATERIAL

VACCINE DIPLOMACY
How COVID-19 Vaccine Distribution in Latin America Increases Trust in Foreign Governments

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Online Appendix

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A.1 Overview of vaccine rollouts in Latin America

While private companies undoubtedly played a key role in the production and distribution of vaccines, particular COVID-19 vaccines are strongly associated with their country of origin. Indeed, governments played a pivotal role in developing the vaccines: the US government, for example, provided between $6 and $10 billion in funding for vaccine research;[1] the UK government made the largest contribution to the predominantly publicly-funded AstraZeneca vaccine;[2] in China and Russia, state-controlled institutes and enterprises have produced vaccines. The governments of these great power have also played an important role in facilitating vaccine acquisition contracts between non-producer governments and private vaccine producers;[3] given the initially limited supply of vaccines available to the Global South, contracts to acquire high-quality vaccines were particularly prized. Moreover, their leaders have actively engaged in credit-claiming for the development and global distribution of vaccines. The US Embassies in Colombia and El Salvador, for example, broadcast bilateral donations of US-produced doses to both countries.[4] Accordingly, vaccine-developing states are likely to receive credit for their significant investments in the development and global distribution of the vaccines produced in their country.

Rollout of vaccines across our cases generally prioritized vaccine delivery to healthcare workers and workers on the front-lines, elderly populations, and populations at-risk due to prior medical conditions. Figure 1 in the main paper shows the cumulative administration of vaccine doses per 100 residents in our six countries of interest. We next provide further information about the specific rollout in each of the countries in our study.

A.1.1 Argentina

Argentina began COVID-19 vaccinations on December 29, 2020. The federal government defined the first eligible groups in a national vaccination group that prioritized first individuals based on risk exposure and by age. Argentina started vaccinating healthcare personnel, followed by adults 70 years of age and older, then adults 60 to 69 years of age, then security personnel and prison workers, then adults 18 to 59 years of age with risk factors, and finally teachers and other staff in educational institutions. In practice, eligibility on any given week was defined by states, which would announce who from each prioritized group was eligible on a specific date.

The Argentine government officially stated that individuals would not be able to select which vaccine they received, emphasizing that vaccines would be given based on availability and that all vaccines approved in Argentina were safe and efficacious.[5]

A.1.2 Brazil

Brazil began COVID-19 vaccinations on January 18, 2021, starting with the Sinovac vaccine and followed by the AstraZeneca vaccine. The federal government delineated a vaccination calendar for the country based on type of employment, age, and comorbidities. The national-level plan consisted of four rollout stages, beginning with healthcare workers, senior citizens over the age of 75, senior citizens over 60 in long-term care facilities, and indigenous communities; the second stage included citizens between 60 to 74 years of age; the third stage opened up vaccination to people with risk factors; and the fourth stage before the general

[1] Estimates from "For Billion-Dollar COVID Vaccines, Basic Government-Funded Science Laid the Groundwork," *Scientific American*, 11/08/2020, and "Domestic Funding for COVID-19 Vaccines:An Overview," *Congressional Research Service*, 03/29/2021.

[2] "Oxford/AstraZeneca Covid vaccine research 'was 97% publicly funded'," *Guardian*, 4/15/2021.

[3] COVID-19 Vaccine Access, Global Health Center 2021, retrieved on 1/31/2022

[4] See Embajada EEUU Colombia, 2022 and Embajada EEUU El Salvador, 2022.

[5] See Sociedad Argentina de la Vacunología y Epidemiología (2021).

population included teachers, police and other security workers, inmates and people working in prisons. In practice, municipalities announced schedules for who was eligible for vaccination on any given week and this varied somewhat from municipality to municipality. For instance, municipalities could announce that on the next Monday, only 74 year olds were being vaccinated and on Tuesday, only 73 year olds and so on. For the same week, another municipality could announce that on Monday 74 and 73 year olds were to be vaccinated. Overall, however, municipalities did vaccinate within the same eligibility groups on the same months.

A.1.3 Chile

Chile began COVID-19 vaccinations for health-care workers on December 24, 2020. Eligibility was coordinated at the national level, and prioritized groups for vaccination on the basis of age, medical vulnerability, and occupation. The Chilean vaccination campaign began by vaccinating healthcare workers on December 24, 2020. Age-based eligibility began on February 3, 2021, moving from 90+ years of age and adding additional age cohorts each day. Profession-based vaccination began on February 15, 2021, with educators over 60 becoming eligible. Beginning March 14, 2021, adults with co-morbid medical conditions started to become eligible, starting with 59 year old adults and adding additional age cohorts each day. All adults 17 years and older became eligible for their first dose in Chile by July 2, 2021.

Both internal reports, by the Chilean Health Ministry, and external evaluations, by the World Bank, emphasize the programmatic implementation of Chile's vaccination program, in which individuals were assigned to specific, narrow date ranges for vaccination based on eligibility criteria, and within these days were allowed to select their vaccination site within their municipality. Neither World Bank nor Chilean government program evaluations mention the ability of individuals to select which vaccine they received, with doses applied based purely on supply.[6]

A.1.4 Colombia

Colombia began COVID-19 vaccinations for health-care workers began on February 17, 2021. Eligibility was determined at the national level, and prioritization was based on age, medical vulnerability, and occupation. Colombia's national plan for vaccination outlined 6 groups in order of prioritization: (1) health workers, COVID-affected domestic aid workers, and adults over 80; (2) Domestic care workers, adults between 60 and 70; (3) Adults between 50 and 59, educators, police and military, and individuals 16+ with co-morbid medical conditions; (4) Adults 40-49, incarcerated peoples, caregivers, at-risk populations due to sanitary conditions, non-medical first responders; and (5) People 16+ years of age not prioritized in groups 1-4. As of July 17, 2021, all Colombians over 16 years of age were eligible for at least a first dose of a COVID-19 vaccine.

The official position of the Colombian Health Ministry emphasized that individuals could not elect which vaccine they wanted to receive, but rather needed to vaccinate as soon as eligible and receive the dose which was available to them.[7] The digital tool used to display vaccination sites in Colombia does not disclose the type of doses available at different locations.[8]

A.1.5 México

México began COVID-19 vaccinations for health-care workers on December 24, 2020. México's five-cohort plan for mass vaccinations began on February 15, 2021, when adults over 60 became eligible. México's

[6] See World Bank (2021); Ministerio de Salud - Libro COVID (2022).
[7] See Vanguardia (2021).
[8] See Colombian Health Ministry (2021).

guidelines for vaccine eligibility were based on age, occupation, and health conditions, dividing the population into five cohorts: (1) health professionals, (2) adults over 60, (3) adults between 50-59 and pregnant women over 18, (4) adults between 40-49, and (5) adults over 18. During our survey period, all over over 40 were scheduled to be or become eligible.

While international evaluations found some evidence of vaccine targeting – particularly to poor, rural communities, as well as teachers,[9] the national vaccine observatory at the Autonomous National University of Mexico (UNAM) emphasized that during the mass vaccination program for first and second doses individuals were unable to select which vaccine they would like to receive, and rather received doses based on availability.[10]

A.1.6 Perú

Perú began COVID-19 vaccinations for COVID-19 on February 9, 2021. Perú's eligibility guidelines outlined eight age-based groups, with eligibility based on age decade (i.e., 80+, 70-79, 60-69, 50-59, 40-49, 30-39, 20-29, 12+). After 80+ year olds became eligible in February 2021, each cohort sequentially became eligible for two months, in which the next cohort additionally became eligible in the second month. Adults 60-69 were an exception to this, receiving three months of eligibility with both adults 50-59 and adults 40-49 becoming eligible in the third month (July 2021).

Cue-jumping scandals in Peru highlighted how political insiders gained preferential access to vaccination on several occasions.[11] However, the Peruvian government emphasized that individuals would not be able to select which vaccine they received as part of mass vaccination campaigns, messaging that the best protection from COVID-19 was the one that was available most promptly.[12]

A.2 Adherence to COVID-19 vaccine rollout protocols

We are not aware of systematic and reliable data on adherence to the rollout protocols throughout the region. At the elite level, there have been rare documented cases of people jumping the queue to get their vaccines early. In both Argentina and Perú, scandals relating to politicians getting their vaccines before they were eligible resulted in the resignations of public officials. Moreover, many individuals who could afford a trip to the US have made trips to get their vaccines in states with lax residency requirements, like Florida and Texas, but there is no data that could quantify the prevalence of such vaccine tourism. Nevertheless, for the majority of citizens without economic or political resources, it would have been difficult to game the system and get a vaccine before they were eligible. Indeed, Urdinez and Winters (2021) note that, in each country, "all individuals were given an official document with the name of the vaccine and the date of application."

At a logistical level, all countries experienced some interruptions to their rollouts. In México, challenges to vaccine distribution included militarized resistance from 14 villages, as well as slow efforts to vaccinate migrant populations, and delays due to shortages of the Sputnik V vaccine. Chile, Colombia, and Perú all experienced local vaccine shortages in certain areas, leading to temporary suspension of vaccination campaigns. Salient supply shortages included those in Valparaíso (Chile), Risaralda (Colombia), and Arequipa (Perú);. México experienced widespread delays in dose acquisition at the beginning of their vaccination campaign. Argentina experienced a shortage of Sputnik V second dose vaccines, leading to delays and ultimately the decision of the Argentinian government to provide second doses of Moderna and AstraZeneca for recipients of only one Sputnik V dose. Brazil's vaccination program was plagued by numerous issues; in ad-

[9] See UCSF (2021).

[10] See Observatorio de Vacunación (2021).

[11] See Reuters (2021).

[12] See, for example, Presidencia del Consejo de Ministros (2021).

dition to shortages of vaccines, broader delays in the schedule as well as allegations of corruption challenged Brazil's vaccine rollout.

A.3 Additional information about the panel survey

Our study leverages data from an original online panel survey conducted during the COVID-19 pandemic, where first wave data was collected in January 2021 and second wave data was collected around four months later in May 2021. The baseline survey sought to address two main research questions: to examine how information about vaccines affects vaccine hesitancy; and to understand what features of a vaccine rollout would encourage vaccine uptake. Both research questions are covered in separate articles. The endline survey followed up with individuals who were vaccine-eligible by May 2021, and addressed the research question that is the focus of this article: how do the vaccines that Latin American citizens receive affect affect trust in the governments of the countries where the vaccines were developed? The study was approved by the institutional review board of the research team and complied with relevant ethical regulations for work with human participants. Written informed consent was obtained.

A.3.1 Description of recruitment and different analysis samples

Respondents in each of our six countries—Argentina, Brazil, Chile, Colombia, México, and Perú—were recruited for the baseline survey in January 2021 via Netquest's online panels between January 11 and January 29, 2021. Netquest maintains large opt-in panels of survey respondents in most Latin American countries, including at least 125,000 panelists in each of the countries in our study. Netquest's panelists are regularly invited to take surveys, although this is not their primary vocation. Dynamic enrollment protocols updated invitations to ensure that the sample frame was nationally representative in terms of sex, age category, socioeconomic status, and region. Upon clicking a link to participate, respondents reached a Qualtrics landing page, where information about the academic study was provided—including the prospect of being paid around $2 (USD)—and consent to participate in the study was obtained. Shortly after starting the survey, the 38% of participants that were willing to take a vaccine within two months of it becoming available them were screened out (to facilitate the testing of vaccine encouragements for another part of the broader research project). We also screened out 9 respondents below 18 years of age and 11 respondents who failed our attention check (by failing to correctly identify the capital city of their country). Enrollment continued until a little more than 1,000 vaccine-hesitant respondents had completed the survey from each of the six countries, producing a total of 7,080 complete surveys.

The endline survey recontacted only the baseline survey participants that had become eligible for a first dose of a COVID-19 vaccine in their country by the date of the followup survey in May 2021. We recontacted respondents based on their baseline responses to questions about their age and comorbities. Our endline respondents are thus older and more likely to possess pre-existing comorbities. The fast speed of Chile's vaccination program meant that a higher fraction of Chilean respondents were approached for the endline survey; in contrast, the slow pace of Colombia and Perú's vaccination program meant that Colombians and Peruvians are underrepresented in our endline sample relative to the baseline sample. Participants received around $1 (USD) for completing the shorter endline survey. Ultimately, 1,649 of 3,039 vaccine-eligible baseline participants completed the endline survey.

As the summary statistics in Table A1 verify, the marginal distribution of respondents who completed the baseline survey (i.e., reached our screening juncture) largely approximated the Census distribution for these variables. Unsurprisingly for an online survey, respondents are less representative in terms of education, which Netquest did not seek to balance with population averages. Due to the requirement that respondents be vaccine-eligible, the third column for each country shows that the endline sample is notably older and more likely to be of high socioeconomic status than the national average. Within the endline survey, Table

Table A1: Survey sample summary statistics

	Argentina			Brazil			Chile		
	Census	**Baseline**	**Endline**	**Census**	**Baseline**	**Endline**	**Census**	**Baseline**	**Endline**
Age	47.33	42.59 (17.09)	57.64 (15.43)	41.34	40.48 (15.53)	55.33 (15.37)	44.18	42.67 (16.29)	49.04 (15.12)
Male	0.53	0.46 (0.50)	0.52 (0.50)	0.49	0.50 (0.50)	0.51 (0.50)	0.48	0.47 (0.49)	0.46 (0.50)
Risk Factors		0.29 (0.45)	0.65 (0.47)		0.29 (0.45)	0.73 (0.45)		0.37 (0.48)	0.44 (0.50)
Catholic		0.59 (0.49)	0.66 (0.47)		0.40 (0.49)	0.45 (0.50)		0.45 (0.50)	0.47 (0.50)
Education:									
None	0.13	0.01 (0.08)	0.01 (0.08)	0.11	0.08 (0.27)	0.06 (0.24)	0	0.01 (0.11)	0.01 (0.11)
Primary	0.43	0.14 (0.34)	0.16 (0.37)	0.49	0.12 (0.33)	0.11 (0.31)	0.23	0.07 (0.26)	0.07 (0.25)
Secondary	0.32	0.51 (0.50)	0.42 (0.49)	0.27	0.54 (0.50)	0.54 (0.50)	0.46	0.48 (0.50)	0.43 (0.50)
Higher	0.07	0.20 (0.40)	0.26 (0.44)	0.13	0.16 (0.38)	0.18 (0.39)	0.22	0.25 (0.43)	0.26 (0.44)
Other Higher	0.06	0.15 (0.36)	0.15 (0.35)		0.10 (0.30)	0.11 (0.31)	0.1	0.19 (0.39)	0.22 (0.41)
SES:									
Low	0.13	0.15 (0.36)	0.17 (0.37)	0.26	0.32 (0.47)	0.19 (0.40)	0.42	0.36 (0.48)	0.32 (0.47)
Middle	0.80	0.80 (0.40)	0.73 (0.45)	0.66	0.62 (0.47)	0.69 (0.46)	0.48	0.57 (0.49)	0.59 (0.49)
High	0.07	0.05 (0.23)	0.11 (0.31)	0.08	0.06 (0.24)	0.12 (0.32)	0.1	0.07 (0.26)	0.09 (0.28)

	Colombia			Mexico			Perú		
	Census	**Baseline**	**Endline**	**Census**	**Baseline**	**Endline**	**Census**	**Baseline**	**Endline**
Age	42.54	38.22 (15.11)	66.57 (4.44)	42.44	38.09 (14.17)	54.06 (9.28)	41.99	38.22 (14.71)	52.64 (15.50)
Male	0.48	0.44 (0.50)	0.62 (0.49)	0.48	0.46 (0.50)	0.50 (0.50)	0.48	0.42 (0.49)	0.49 (0.50)
Risk Factors		0.24 (0.43)	0.45 (0.50)		0.31 (0.46)	0.42 (0.49)		0.28 (0.45)	0.70 (0.46)
Catholic		0.60 (0.49)	0.67 (0.47)		0.63 (0.48)	0.71 (0.45)		0.66 (0.47)	0.72 (0.45)
Education:									
None	0.05	0.01 (0.11)	0.06 (0.24)	0.14	0.00 (0.06)	0.00 (0.06)	0.05	0.00 (0.07)	0.01 (0.08)
Primary	0.38	0.03 (0.15)	0.06 (0.24)	0.16	0.04 (0.19)	0.05 (0.21)	0.20	0.02 (0.12)	0.00 (0.00)
Secondary	0.29	0.33 (0.47)	0.27 (0.45)	0.54	0.44 (0.50)	0.38 (0.49)	0.51	0.39 (0.48)	0.25 (0.44)
Higher	0.16	0.49 (0.50)	0.48 (0.50)	0.14	0.28 (0.45)	0.40 (0.49)	0.14	0.30 (0.46)	0.37 (0.48)
Other Higher	0.11	0.14 (0.34)	0.14 (0.35)	0.01	0.24 (0.42)	0.16 (0.37)	0.10	0.29 (0.45)	0.37 (0.49)
SES:									
Low	0.43	0.47 (0.50)	0.53 (0.50)	0.33	0.36 (0.48)	0.19 (0.39)	0.42	0.54 (0.50)	0.26 (0.44)
Middle	0.45	0.43 (0.49)	0.38 (0.48)	0.46	0.45 (0.50)	0.57 (0.50)	0.50	0.41 (0.49)	0.65 (0.48)
High	0.12	0.10 (0.30)	0.11 (0.31)	0.21	0.19 (0.39)	0.24 (0.43)	0.08	0.05 (0.21)	0.09 (0.29)

Notes: The Census data (where a variable corresponds to our survey questions) is drawn from the most recent available Census data, with the exception of the data for socioeconomic level, which was provided by Netquest. Each value is a mean; standard deviations are in parentheses.

A2 compares the vaccinated and experimental samples with the 2021 LAPOP and latest Census distributions. As noted in the main text, the mean members of our two analysis samples is relatively similar, at least in terms of observables, to the LAPOP and Census aggregates.

A.3.2 Distribution of trust in vaccine-developing countries

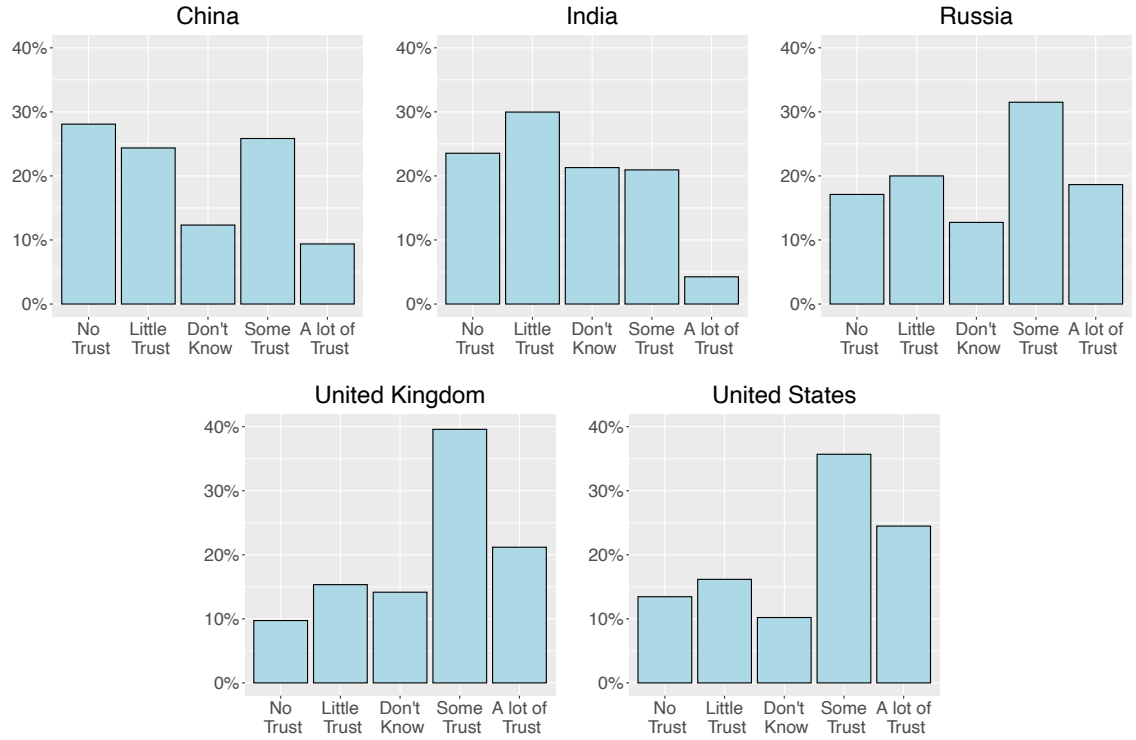
Figure A1 reports the distribution of trust by vaccine-developer country. While respondents had moderate levels of trust in each country at baseline, trust in the UK and US was notably higher than trust in Russia and China.

Table A2: Sample means, in comparison with 2021 LAPOP survey and recent census data

	Vaccinated sample	**Experimental sample**	**LAPOP 2021**	**Latest census**
Age	57.8	53.9	40.9	43.3
Male	52.3%	49.0%	49.5%	49.2%
Completed no formal education	1.3%	1.9%	1.2%	8.0%
Completed primary education	6.8%	7.9%	12.2%	31.5%
Completed secondary education	37.2%	41.4%	37.8%	39.8%
Completed tertiary education	54.7%	48.8%	48.9%	20.7%
Low socioeconomic status	23.0%	18.9%	20.8%	29.4%
Medium socioeconomic status	60.5%	60.0%	53.7%	61.9%
High socioeconomic status	16.5%	21.1%	25.5%	8.7%
Worse personal economic situation than before COVID-19	54.7%	57.9%	54.9%	
Believe COVID-19 is somewhat or very serious	76.3%	73.0%	73.0%	
Some or a lot of trust in mayor or local government	48.5%	42.9%	38.4%	
Some or a lot of trust in China	41.3%	35.4%	37.7%	
Some or a lot of trust in US	68.1%	60.3%	53.2%	

Notes: Census data is based on Netquest's sampling strategy. Our survey asked about the seriousness of COVID-19 pandemic, whereas the LAPOP survey asked about how worried people are about the COVID-19 pandemic.

Figure A1: Distribution of trust in vaccine-developing countries



Note: Each figure pools initial endline responses across respondents from all countries.

A.3.3 Measurement of key variables

We identify the country where a respondent believed their vaccine was developed using the following question (with available answers in brackets):[13]

> Do you know what country developed the vaccine that you received? [China, USA, India, UK, Russia, Don't know, Don't remember]

We then coded our treatment variable as an indicator for the country that the respondent believed their vaccine was developed in. We drop respondents who did not know or remember in our main analyses.

Our primary outcome variable—trust in a foreign government—is based on asking the following question of the Chinese, Indian, Russian, UK, and US governments (in a random order):

> How much trust do you have in the current governments of the following countries? [No trust at all, Little trust, Some trust, A lot of trust, Don't know]

This question was asked once within the baseline survey and twice within the endline survey. In the endline survey, the first question (the outcome for the observational analysis) was near the beginning of the survey and appeared again late in the survey after the information treatment had been disseminated. We coded our main outcome variable in two ways: (i) as a four-point scale ranging from "no trust at all" (0) to "a lot of trust" (4), with "don't know" responses coded at the median of the scale (2.5); and (ii) as an indicator for respondents who responded "some trust" or "a lot of trust". As Tables A7 and A8 show, the results for both outcomes are robust to dropping respondents who answered "don't know."

To illuminate respondents' perceptions of country motivations for distributing vaccines in the respondent's country, we asked the following question separately of the three developer countries from which most vaccines had been distributed after the dissemination of the information treatment:

> Indicate the statements you agree with regarding the following sentence:
>
> <Developer country> is providing vaccines to <respondent country> in order to:
>
> - Quickly stop the spread of COVID-19 around the world
> - Help the citizens of <respondent country>
> - Increase support for <developer country> among in the population of <respondent country>
> - Increase the dependence of <respondent country> on <Developer country>
> - Obtain economic profits

We used this question to code five outcome variables, each indicating whether or not a respondent selected a given statement.

A.4 Estimating the effect of personally receiving a particular vaccine

A.4.1 Identification strategy and validation

As noted in the main text, our identification strategy rests on the assumption that the country where an individual believed that their vaccine was developed is independent of potential outcomes, conditional on the individual's eligibility category within their country. Based on the eligibility rules and guidelines described in Section A.1, we constructed bins of individuals who became vaccine-eligible around the same time. To

Table A3: Vaccine eligibility blocks (by the time of the survey)

	Eligibility Blocks					
	Block 1	*Block 2*	*Block 3*	*Block 4*	*Block 5*	*Block 6*
Argentina	80+	70-79	60-69 with co-morbidities	55-59	NA	NA
Brazil	80+	70-79	60-69 with co-morbidities	40 plus	56 plus	
Chile	71+	65-70	60-65 46+ with co-morbidities	50-59 16+ with co-morbidities	40-49	17+
Colombia	80+	60-79	50-59 16+ with co-morbidities	40-49	NA	NA
México	60+	50-59	40-49	With co-morbidities	NA	NA
Perú	80+	70-79	60-69	50-59	NA	NA

create these bins, we followed national administrative guidelines and plans articulated in each country for when adults would become eligible. These groups, defined by age and risk factors, are shown in Table A3.

Given that the type of vaccine received was not actually randomized, it remains possible that individuals with higher or lower trust in certain foreign governments might have been more likely to receive or recall receiving particular types of vaccine. This could arise if individuals choose the location or timing of their vaccine to obtain a particular type of vaccine, if localities containing certain types of respondent were allocated particular types of vaccine, or if recipients were more familiar with where certain types of vaccines were developed. To assess the validity of the design, we use our baseline survey responses—which were collected before any respondent had been vaccinated—to examine whether the respondents who reported receiving vaccines developed in different countries are systematically different across a wide range of economic, health, political, etc. characteristics. Our covariate balance tests entail estimating the following regression for each baseline covariate:

$$X_{ic} = \alpha_{gc} + \tau_1 \textit{China developed vaccine}_{ic} + \tau_2 \textit{Russia developed vaccine}_{ic} + \tau_3 \textit{UK developed vaccine}_{ic} + \varepsilon_{ic},$$

where respondents who reported receiving a vaccine developed in the US are the omitted baseline category, and α_{gc} are country-eligibility group fixed effects. To test for differences across respondents in terms of characteristic X_{ic}, we calculate the p value associated with the F test of the joint restriction $\tau_1 = \tau_2 = \tau_3 = 0$. Broadly consistent with chance, the results in Table A4 show that we only reject this null hypothesis of no differences in mean characteristics across vaccine-developer groups at the 10% significance level for 10 of 86 covariates. When we further non-parametrically adjust for prior trust, by including $\sum_r \beta_{dr} \mathbb{1}[\textit{Prior trust}_{dic} = r]$ in the regression equation, the final column shows that we similarly observe only 11 statistically significant differences. This suggests that the country where an individual's vaccine was developed was assigned in a plausibly exogenous manner.

A.4.2 Effects by respondent country

Table A5 reports the estimates pooling across vaccine-developer countries by the country of the respondent country separately. While the estimates are of course noisier in these subsamples (especially in the countries where few individuals had been vaccinated at the time of our endline survey), the estimated effect in each

[13] The full survey instrument in Spanish (Argentine version) and Portuguese can be found in the replication folder.

Table A4: Covariate balance across individuals who reported receiving vaccines developed in different countries

Predetermined covariate	Mean	Std. dev.	Equality test (p value)	Equality test conditional on prior trust (p value)
Education	3.81	1.04	0.570	0.749
Education - At Least Primary	0.01	0.11	0.239	0.215
Education - At Least Secondary	0.08	0.28	0.039**	0.136
Education - At Least Other Higher	0.45	0.50	0.728	0.878
Education - At Least University	0.64	0.48	0.962	0.985
Female	0.52	0.50	0.140	0.287
Running Water in Home	0.96	0.19	0.875	0.878
Sewage in Home	0.82	0.39	0.878	0.707
Electricity in Home	0.95	0.21	0.731	0.664
No Running Water, Sewage, or Electricity in Home	0.00	0.04	0.870	0.912
Baseline COVID News Consumption - Aggregate	4.76	1.39	0.049**	0.169
Baseline COVID News Consumption - TV	5.95	1.74	0.450	0.594
Baseline COVID News Consumption - Radio	4.07	2.54	0.832	0.890
Baseline COVID News Consumption - Print	3.57	2.50	0.061*	0.118
Baseline COVID News Consumption - Word of Mouth	5.43	1.86	0.164	0.287
Baseline COVID News Consumption - WhatsApp	4.70	2.32	0.205	0.152
Baseline COVID News Consumption - Social Media	4.76	2.37	0.162	0.230
Baseline COVID News Consumption - News Websites	4.96	2.24	0.018**	0.030**
COVID Severity in Country	3.65	0.69	0.255	0.362
Percentage of vaccinated people needed to achieve herd community	83.40	19.69	0.113	0.091*
General Vaccine Hesitancy - Protect from Disease	4.09	0.96	0.120	0.047**
General Vaccine Hesitancy - Good for Community	4.18	0.90	0.520	0.382
General Vaccine Hesitancy - Trust in Government	3.14	1.29	0.345	0.378
General Vaccine Hesitancy - Follow Doctor Instructions	3.95	0.98	0.521	0.487
General Vaccine Hesitancy - Trust in International Medical Experts	3.99	0.94	0.170	0.101
General Vaccine Hesitancy - Refused Vaccine	0.13	0.33	0.997	0.994
COVID Hesitancy Reasons - Side Effects	0.54	0.50	0.989	0.973
COVID Hesitancy Reasons - Vaccine Gives COVID	0.09	0.29	0.361	0.361
COVID Hesitancy Reasons - Produced Too Quickly	0.49	0.50	0.553	0.701
COVID Hesitancy Reasons - Not Effective	0.13	0.34	0.164	0.209
COVID Hesitancy Reasons - Not At Risk of Getting COVID	0.02	0.13	0.842	0.863
COVID Hesitancy Reasons - Against Vaccines Generally	0.01	0.12	0.492	0.454
COVID Hesitancy Reasons - Prefer 'Natural' Immunity	0.04	0.20	0.131	0.183
COVID Hesitancy Reasons - Already Had COVID	0.05	0.21	0.536	0.432
COVID Hesitancy Reasons - Don't Trust Government	0.31	0.46	0.251	0.258
COVID Hesitancy Reasons - Financial Concerns	0.09	0.29	0.361	0.201
COVID Hesitancy Reasons - Other	0.10	0.29	0.102	0.160
Comorbidities - None	0.50	0.50	0.542	0.521
Comorbidities - Diabetes	0.16	0.36	0.363	0.364
Comorbidities - Cardiovascular Diseases	0.15	0.36	0.470	0.516
Comorbidities - Obesity	0.20	0.40	0.026**	0.026**
Comorbidities - Autoimmune Diseases	0.06	0.24	0.876	0.746
Comorbidities - Chronic Obstructive Pulmonary Disease	0.06	0.24	0.061*	0.059*
Comorbidities - Prefer Not To Share	0.03	0.17	0.009***	0.024**
Had COVID	0.09	0.29	0.151	0.097*
Know Someone Seriously Ill or Passed Away COVID	0.70	0.46	0.341	0.378
COVID Economic Situation	2.32	0.82	0.710	0.646
Government Vaccine Priority	3.36	1.14	0.263	0.294
Left/Right Political Scale	5.34	2.04	0.133	0.433
Satisfied with President COVID Management	2.19	1.37	0.761	0.908
Satisfied with Mayor COVID Management	2.68	1.28	0.539	0.764
Satisfied with Health Ministry COVID Management	2.44	1.30	0.271	0.447
Would Vote for Current President	0.22	0.42	0.461	0.549
Would Vote for Current Mayor	0.27	0.45	0.622	0.702
Trust in Current President	1.97	1.11	0.547	0.756
Trust in Current Mayor	2.39	1.04	0.846	0.889
Trust in National Health Ministry	2.29	1.10	0.170	0.309
Trust in National Medical Association	3.02	0.89	0.240	0.376
Trust in Left-Wing Newspaper	2.24	0.95	0.520	0.411
Trust in Right-Wing Newspaper	2.21	1.02	0.864	0.839
Trust in Religious Leader	2.03	0.89	0.387	0.210
Trust in Local Healthcare	3.27	0.77	0.133	0.206
Trust in Armed Forces	2.81	1.02	0.603	0.567
Trust in Civil Society Organizations	2.70	0.78	0.784	0.773
Trust in Government of China (baseline)	1.89	0.84	0.160	
Trust in Government of US Under Trump (baseline)	1.76	0.93	0.062*	0.04**
Trust in Government of US Under Biden (baseline)	2.59	0.91	0.621	
Trust in Government of UK (baseline)	2.59	0.88	0.894	
Trust in Government of Russia (baseline)	2.22	0.90	0.859	
Meeting Indoor With Non-Family Contributes to COVID	3.56	0.82	0.479	0.573
Risk Aversion	0.96	0.62	0.385	0.268
Discount Rate	3.28	0.79	0.635	0.748
Donation Amount	0.47	0.32	0.864	0.885
Important to Receive Respect and Recognition	2.73	0.99	0.079*	0.067*
Social Influence	2.31	0.84	0.478	0.371
Vaccine Information Treatment	0.20	0.40	0.452	0.305
Vaccine Information Treatment with Biden Endorsement	0.15	0.35	0.470	0.432
Vaccine Information Treatment with Expert Herd Immunity Prediction (60%)	0.07	0.25	0.752	0.675
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%)	0.07	0.25	0.742	0.589
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%)	0.07	0.26	0.115	0.127
Vaccine Information Treatment with Expert Herd Immunity Prediction (60%) and Current Willingness	0.10	0.30	0.206	0.178
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%) and Current Willingness	0.08	0.27	0.454	0.589
Vaccine Information Treatment with Expert Herd Immunity Prediction (80%) and Current Willingness	0.08	0.27	0.018**	0.019**
Motivation Treatment - Altruism	0.26	0.44	0.151	0.145
Motivation Treatment - Economic Recovery	0.25	0.43	0.404	0.431
Motivation Treatment - Social Approval	0.25	0.43	0.122	0.091*

Note: Each statistic is the p value associated with an F test of the null hypothesis that the mean value across respondents who reported receiving vaccines developed in different countries is the same, based on an OLS regression including eligibility group $\times$ respondent country fixed effects and (for the final column) country-specific indicators for each level of pre-treatment baseline survey trust and robust standard errors. Eligibility groups are defined in Table A3.

Table A5: The effect of receiving a particular vaccine on an individual's trust in the government of the country where the vaccine was developed, by respondent country

	Outcome: trust in foreign government (all governments)					
	Argentinean respondents (1)	Brazilian respondents (2)	Chilean respondents (3)	Colombian respondents (4)	Mexican respondents (5)	Peruvian respondents (6)
Panel A: Outcome: trust in foreign government scale						
Country developed vaccine	0.137	0.375***	0.159*	0.042	0.161	0.215
	(0.109)	(0.144)	(0.085)	(0.140)	(0.108)	(0.262)
R^2	0.32	0.32	0.22	0.31	0.22	0.29
Outcome range	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}
Control outcome mean	2.80	2.59	2.70	2.92	2.80	2.66
Control outcome std. dev.	0.92	1.02	0.90	0.79	0.86	1.06
Panel B: Outcome: some or a lot of trust in foreign government indicator						
Country developed vaccine	0.088	0.128**	0.074	-0.008	0.047	0.058
	(0.060)	(0.064)	(0.047)	(0.091)	(0.059)	(0.112)
R^2	0.26	0.27	0.18	0.22	0.15	0.28
Outcome range	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}
Control outcome mean	0.60	0.54	0.59	0.60	0.62	0.57
Control outcome std. dev.	0.49	0.50	0.49	0.49	0.49	0.50
Country developed vaccine mean	0.25	0.25	0.25	0.25	0.25	0.25
Observations	592	368	1,228	144	356	148

Notes: Each specification includes eligibility group × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment baseline survey trust, and is estimated using OLS. Eligibility groups are defined in Table A3. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

country is positive. The effect is smallest in Colombia, but relatively large and similar in magnitude in each other country.

A.4.3 Reweighting to match the population

Our main estimates do not apply population weights for each respondent to maximize the efficiency of our estimation of average treatment effects. However, as noted in the main paper, the sample is not nationally representative of adults for several reasons. To examine how the results extend to the general population, we further weight our estimates. In particular, we apply rake weights to reweight observations according to the product of in-survey marginal distribution, relative to the national marginal distribution, across age category, education level, region, gender, and (using data provided by Netquest) socioeconomic class. The results are reported in Table A6, and are discussed in the main paper. Unreported analyses show that we obtain relatively similar results if we reweight according to the joint distribution, although the estimates are far noisier (due to limited numbers of observations in some cells).[14]

A.4.4 Robustness checks

We next demonstrate that the positive effect of believing a vaccine was developed in a particular country on trust in that country's government, relative to trust in the governments of other vaccine-developing countries,

[14]The census data does not consistently include socioeconomic class, so this dimension is omitted from the joint weights.

Table A6: The effect of receiving a particular vaccine on an individual's trust in the government of the country where the vaccine was developed—with population weights

	Pooling all governments (1)	Chinese government (2)	Russian government (3)	UK government (4)	US government (5)
Panel A: Outcome: trust in foreign government scale—rake weights					
Country developed vaccine	0.166***	0.170	-0.065	0.364***	0.188
	(0.052)	(0.121)	(0.172)	(0.127)	(0.126)
R^2	0.28	0.27	0.27	0.24	0.22
Outcome range	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}
Control outcome mean	2.71	2.35	2.66	2.87	2.80
Control outcome std. dev.	0.92	0.96	0.92	0.85	0.90
Country developed vaccine mean	0.25	0.53	0.20	0.11	0.17
Observations	2,792	698	698	698	698
Panel B: Outcome: some or a lot of trust in foreign government indicator—rake weights					
Country developed vaccine	0.072***	0.077	-0.070	0.210***	0.073
	(0.026)	(0.064)	(0.100)	(0.062)	(0.077)
R^2	0.24	0.26	0.22	0.19	0.16
Outcome range	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}
Control outcome mean	0.57	0.37	0.55	0.67	0.62
Control outcome std. dev.	0.49	0.48	0.50	0.47	0.49
Country developed vaccine mean	0.25	0.53	0.20	0.11	0.17
Observations	2,792	698	698	698	698

Notes: The specification in each column includes eligibility group × respondent country (× vaccine-developer country, for the pooled specification in column (1)) fixed effects and country-specific indicators for each level of pre-treatment baseline survey trust, which are omitted to save space, and is estimated using WLS. Eligibility groups are defined in Table A3. The weights in panels A and B reflect the country-specific marginal distribution in terms of age category, education level, region, gender, and socioeconomic class. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

is robust to various alternative specifications. The pooled and country-by-country results are reported in Tables A7 and A8.

First, we address the potential concern that differences in the vaccines that survey respondents received are correlated with local differences in where different types of vaccines were delivered. Accordingly, we leverage variation in the type of vaccine received by individuals in a given eligibility group *within the same locality* by including country-eligibility group $\times$ vaccine-developer country $\times$ locality fixed effects. These fixed effects absorb all differences in trust in a particular foreign government across individuals in different eligibility groups within a particular location. We operationalize locality in terms of both region—state, province, or department—and municipality. The results in panels A and B of Tables A7 and A8 show that our findings are robust to the inclusion of either set of interactive fixed effects. Although estimate precision declines,[15] in both cases to detect statistically significant and numerically similar point estimates.

Second, we address the possibility that certain types of individuals within particular eligibility (and location) groups may have sought out or been more likely to recall receiving particular vaccines by probing whether differences in the types of individuals who reported receiving vaccines developed in different countries are driving the results. The estimates in panel C of Tables A7 and A8 show that our findings are robust to adjusting for the 10 covariates that registered statistically significant imbalances (see Table A4). Panel D shows that the results are also robust to including all 86 individual-level covariates over which we examined balance.[16]

Third, we consider an alternative approach comparing respondents who reported receiving different vaccines with respondents who reported being unvaccinated. We conduct a difference-in-differences analysis to abstract from time-invariant differences across respondents. The results in panel E of Tables A7 and A8 indicate that, relative to unvaccinated respondents and individuals who reported receiving other vaccines, individuals became significantly more trusting of the government of the country where their particular vaccine was developed. The similar point estimates suggest that our main estimates are not driven by decreases in trust in the countries that an individual did not receive a vaccine from.

Fourth, we address the possibility that the results could be driven by respondent misperceptions of the country that developed the vaccine they received. For instance, individuals with a positive view of the US might be more likely to believe that a vaccine was developed in the US. This is unlikely because—as Table A4 shows—baseline trust in a foreign government does not significantly predict the likelihood of recalling receiving a vaccine from that country. Nevertheless, to increase confidence that biased recall is not driving our results, we also define treatment by the country of the manufacturer of the vaccine that a respondent reported having received; the country is the same as our preferred definition of treatment 91% of the time. Panel F of Tables A7 and A8 reports similar results using this alternative operationalization of treatment. Although it is not clear if respondents are more likely to accurately recall the brand or the country that developed their vaccine, these results suggest that the intent to treat effect from the perspective of foreign government's vaccine distribution produces similar results. Panel G further shows that our main findings are robust to restricting our sample to the respondents for whom perceptions of the country where their vaccine was developed match the country of the manufacturer.

Fifth, we demonstrate that our findings do not depend on the coding of "don't know" responses to the trust question. For our ordinal measure of trust, the main analyses coded these responses at the median of the outcome range. Panel H of Tables A7 and A8 shows that dropping these responses does not meaningfully alter our estimates; in this specification, the increase in trust in the US government is notably larger and statistically significant. Combined with our results for the binary trust outcome—which simply categorizes "don't know" responses as not trusting—we are confident that the coding of these responses does not account

[15]The interactive fixed effects using municipality perfectly explain a substantial number of observations because there is no variation in treatment within sparsely populated fixed effect cells.

[16]The sample size declines due to non-responses for some baseline covariates.

Table A7: Robustness checks for the effect of receiving a particular vaccine on an individual's trust in the government of the country where the vaccine was developed

	Outcome: trust in foreign government scale				
	Pooling all governments (1)	Chinese government (2)	Russian government (3)	UK government (4)	US government (5)
Panel A: Developer country × country-eligibility group × region fixed effects					
Country developed vaccine	0.175***	0.295**	-0.035	0.268**	0.058
	(0.053)	(0.117)	(0.179)	(0.133)	(0.114)
Observations	2,836	709	709	709	709
Panel B: Developer country × country-eligibility group × municipality fixed effects					
Country developed vaccine	0.225**	0.283	0.284	0.134	0.185
	(0.108)	(0.221)	(0.361)	(0.251)	(0.248)
Observations	2,836	709	709	709	709
Panel C: Adjusting for imbalanced predetermined covariates					
Country developed vaccine	0.164***	0.251***	-0.027	0.229**	0.150
	(0.040)	(0.088)	(0.127)	(0.101)	(0.092)
Observations	2,788	697	697	697	697
Panel D: Adjusting for 86 predetermined covariates					
Country developed vaccine	0.181***	0.219**	0.066	0.221**	0.093
	(0.042)	(0.092)	(0.135)	(0.107)	(0.100)
Observations	2,548	637	637	637	637
Panel E: Difference-in-differences estimates including unvaccinated respondents					
Country developed vaccine	0.216***	0.264***	0.088	0.162	0.245**
	(0.042)	(0.062)	(0.107)	(0.116)	(0.101)
Observations	6,628	1,657	1,657	1,657	1,657
Panel F: Defining treatment by country of reported vaccine manufacturer					
Country of vaccine manufacturer	0.196***	0.291***	0.037	0.196*	0.135
	(0.038)	(0.083)	(0.130)	(0.105)	(0.090)
Observations	2,836	709	709	709	709
Panel G: Dropping respondents where perception and manufacturer country disagree					
Country developed vaccine	0.189***	0.242***	0.082	0.227*	0.148
	(0.043)	(0.093)	(0.132)	(0.127)	(0.102)
Observations	2,572	643	643	643	643
Panel H: Dropping respondents who answered "don't know"					
Country developed vaccine	0.191***	0.245***	-0.001	0.228**	0.169*
	(0.042)	(0.091)	(0.128)	(0.103)	(0.097)
Observations	2,548	636	709	633	647
Panel I: Ordered logit estimation					
Country developed vaccine	0.405***	0.524**	0.069	0.527*	0.351
	(0.093)	(0.187)	(0.292)	(0.256)	(0.206)
Observations	2,836	709	709	709	709

Notes: The specifications in panels A and B include the fixed effects noted in the panel title. The specifications in panel C and D include eligibility group × respondent country (× vaccine-developer country, for the pooled specification in column (1)) fixed effects, baseline survey trust, and baseline covariates. The specifications in panel E include unvaccinated respondents and implement a difference-in-differences estimates by first-differencing equation (1) with respect to the baseline survey. The specifications in panels F-H include eligibility group × respondent country (× vaccine-developer country, for the pooled specification in column (1)) fixed effects and country-specific indicators for each level of pre-treatment baseline survey trust. The specifications in panel I estimate equation (1) using ordered logit. All covariates other than the treatment variable are omitted to save space, and all specifications except panel I are estimated using OLS. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A8: Robustness checks for the effect receiving a particular vaccine on an individual's trust in the government of the country where the vaccine was developed—binary trust outcome

	Outcome: some or a lot of trust in foreign government indicator				
	Pooling all governments	Chinese government	Russian government	UK government	US government
	(1)	(2)	(3)	(4)	(5)
Panel A: Developer country × country-eligibility group × region fixed effects					
Country developed vaccine	0.082***	0.130**	-0.058	0.155**	0.045
	(0.029)	(0.058)	(0.094)	(0.067)	(0.068)
Observations	2,836	709	709	709	709
Panel B: Developer country × country-eligibility group × municipality fixed effects					
Country developed vaccine	0.108**	0.102	0.083	0.038	0.200
	(0.051)	(0.105)	(0.173)	(0.126)	(0.140)
Observations	2,836	709	709	709	709
Panel C: Adjusting for imbalanced predetermined predetermined covariates					
Country developed vaccine	0.067***	0.099**	-0.055	0.120**	0.071
	(0.022)	(0.046)	(0.070)	(0.056)	(0.050)
Observations	2,788	697	697	697	697
Panel D: Adjusting for 86 predetermined covariates					
Country developed vaccine	0.076***	0.096**	-0.007	0.100	0.028
	(0.023)	(0.048)	(0.077)	(0.064)	(0.055)
Observations	2,548	637	637	637	637
Panel E: Difference-in-differences estimates including unvaccinated respondents					
Country developed vaccine	0.090***	0.150***	-0.022	0.051	0.066
	(0.024)	(0.033)	(0.060)	(0.071)	(0.056)
Observations	6,628	1,657	1,657	1,657	1,657
Panel F: Defining treatment by country of reported vaccine manufacturer					
Country developed vaccine	0.091***	0.132***	-0.060	0.147***	0.063
	(0.022)	(0.044)	(0.074)	(0.056)	(0.049)
Observations	2,836	709	709	709	709
Panel G: Dropping respondents where perception and manufacturer country disagree					
Country developed vaccine	0.077***	0.110**	-0.028	0.122*	0.059
	(0.024)	(0.049)	(0.074)	(0.065)	(0.057)
Observations	2,572	643	643	643	643
Panel H: Dropping respondents who answered "don't know"					
Country developed vaccine	0.082***	0.107**	-0.047	0.110**	0.070
	(0.021)	(0.046)	(0.069)	(0.048)	(0.048)
Observations	2,548	636	709	633	647
Panel I: Logit estimation					
Country developed vaccine	0.363***	0.512**	-0.234	0.684*	0.352
	(0.113)	(0.226)	(0.341)	(0.380)	(0.268)
Observations	2,836	709	709	709	709

Notes: The specifications in panels A and B include the fixed effects noted in the panel title. The specifications in panel C and D include eligibility group × respondent country (× vaccine-developer country, for the pooled specification in column (1)) fixed effects, baseline survey trust, and baseline covariates. The specifications in panel E include unvaccinated respondents and implement a difference-in-differences estimates by first-differencing equation (1) with respect to the baseline survey. The specifications in panels F-H include eligibility group × respondent country (× vaccine-developer country, for the pooled specification in column (1)) fixed effects and country-specific indicators for each level of pre-treatment baseline survey trust. The specifications in panel I estimate equation (1) using logit. All covariates other than the treatment variable are omitted to save space, and all specifications except panel I are estimated using OLS. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

for our findings.

Finally, when estimating equation (1) in the main paper using ordered logit or logit instead of OLS, panel I of Tables A7 and A8 reports similarly statistically significant and positive effects on a respondent's level of trust in the government of the country where a respondent's vaccine was developed. The average marginal effects within our sample imply that believing your vaccine was developed a particular country increased the probability of trusting that country's government by 1.9 percentage points and the probability of strongly trusting that country's government by 5.7 percentage points; a response in any other category became significantly less likely. These average marginal effects are computed at the means of other covariates.

A.5 Estimating the effect of information about vaccine distribution

A.5.1 Identification strategy and validation

The treatment effects of the aggregate vaccine information treatment are identified under two assumptions: (i) the stable unit treatment value assumption (SUTVA); and (ii) unconfounded treatment assignment. SUTVA almost certainly holds because interference between respondents between the start and end of the endline survey is implausible in the large countries under study and because versions of treatment were controlled by the research team. Although treatments were randomly assigned, identification could still be confounded by chance imbalances or differential attrition across treatment groups within the survey. However, as Table A9 shows, the predetermined characteristics (baseline survey responses and pre-treatment endline responses) of respondents who answered our main post-treatment trust question are well-balanced across treatment groups: in line with chance, we only reject the null hypothesis of equality of mean for 8 of 101 characteristics at the 10% significance level in our baseline specification in equation (2). The penultimate column reports 7 significant differences when predetermined trust covariates are excluded from the regression equation.

Due to time constraints, the experiment was not pre-registered and the analysis does not follow a pre-analysis plan. However, it should be noted that our statistical analyses follow standard experimental procedures: we estimate OLS regressions, including only randomization block fixed effects and lagged outcomes as covariates; moreover, we code the outcome variable in two natural ways—as a scale and binary. The heterogeneous effects by the information provided in the treatment and how it relates to prior beliefs are widespread in the belief updating literature (e.g. Dunning et al., 2019).

A.5.2 Effects by respondent country

Tables A10 and A11 report the estimates pooling across vaccine-developer countries by the country of the respondent country separately. As the estimates in panels B and C illustrate, notable changes in trust due to treatment content are induced in each country other than Perú. In the other countries, the point estimates for the interaction terms are remarkably homogeneous. Panel A shows that positive updating on average is driven by Chilean respondents.

A.5.3 Robustness checks

Tables A12 and A13 report various robustness checks for the pooled specification. Country-specific results are available upon request. First, column (1) reports our main estimates, adjusting for the few covariates that are imbalanced across treatment conditions. The results are not substantively affected.

Second, when eliciting prior beliefs about the ranking of vaccine-developing countries, the survey instrument allowed respondents to indicate ties by providing the same ranking (between 1 and 5) multiple times. While 72% of respondents provide a unique set of ranks, i.e., a different ranking for each country, others

Table A9: Covariate balance across treated and control individuals

Predetermined covariate	Mean	Std. dev.	Equality test (p value)	Equality test conditional on prior trust (p value)
Received COVID Vaccine	0.63	0.48		
Received Chinese COVID Vaccine	0.23	0.42	0.518	0.712
Received Indian COVID Vaccine	0.02	0.14	0.994	0.914
Received Russian COVID Vaccine	0.09	0.28	0.318	0.695
Received UK COVID Vaccine	0.04	0.20	0.723	0.561
Received US COVID Vaccine	0.07	0.26	0.482	0.651
Endline COVID News Consumption - Aggregate	3.76	1.40	0.847	0.609
Endline COVID News Consumption - TV	4.94	1.79	0.706	0.937
Endline COVID News Consumption - Radio	3.10	2.54	0.101	0.068*
Endline COVID News Consumption - Print	2.48	2.50	0.220	0.160
Endline COVID News Consumption - Word of Mouth	4.49	1.71	0.978	0.761
Endline COVID News Consumption - WhatsApp	3.51	2.31	0.603	0.679
Endline COVID News Consumption - Social Media	3.92	2.28	0.374	0.422
Endline COVID News Consumption - News Websites	3.86	2.30	0.467	0.702
COVID Vaccine Talked About Benefits	0.89	0.32		
COVID Vaccine Talked About Side Effects	0.81	0.39	0.079*	0.038**
COVID Vaccine Encouraged Others	2.07	1.09	0.114	0.379
Education	3.67	1.04	0.473	0.346
Education - At Least Primary	0.02	0.14	0.288	0.354
Education - At Least Secondary	0.10	0.30	0.475	0.539
Education - At Least Other Higher	0.51	0.50	0.262	0.140
Education - At Least University	0.70	0.46	0.799	0.689
Female	0.50	0.50	0.416	0.602
Running Water in Home	0.95	0.23	0.318	0.308
Sewage in Home	0.80	0.40	0.340	0.326
Electricity in Home	0.95	0.21	0.859	0.953
No Running Water, Sewage, or Electricity in Home	0.00	0.06	0.740	0.694
Baseline COVID News Consumption - Aggregate	4.59	1.49	0.122	0.190
Baseline COVID News Consumption - TV	5.75	1.88	0.192	0.310
Baseline COVID News Consumption - Radio	3.95	2.53	0.811	0.895
Baseline COVID News Consumption - Print	3.39	2.45	0.753	0.933
Baseline COVID News Consumption - Word of Mouth	5.32	1.90	0.526	0.625
Baseline COVID News Consumption - WhatsApp	4.42	2.40	0.348	0.409
Baseline COVID News Consumption - Social Media	4.70	2.41	0.102	0.093*
Baseline COVID News Consumption - News Websites	4.81	2.29	0.258	0.325
COVID Severity in Country	3.58	0.79	0.033**	0.063*
Percentage of vaccinated people needed to achieve herd community	79.64	25.18	0.135	0.181
General Vaccine Hesitancy - Protect from Disease	3.89	1.10	0.965	0.697
General Vaccine Hesitancy - Good for Community	4.01	1.03	0.924	0.739
General Vaccine Hesitancy - Trust in Government	3.01	1.30	0.413	0.529
General Vaccine Hesitancy - Follow Doctor Instructions	3.78	1.06	0.674	0.497
General Vaccine Hesitancy - Trust in International Medical Experts	3.77	1.08	0.423	0.682
General Vaccine Hesitancy - Refused Vaccine	0.16	0.37	0.295	0.492
COVID Hesitancy Reasons - Side Effects	0.56	0.50	0.292	0.337
COVID Hesitancy Reasons - Vaccine Gives COVID	0.11	0.31	0.800	0.936
COVID Hesitancy Reasons - Produced Too Quickly	0.49	0.50	0.346	0.433
COVID Hesitancy Reasons - Not Effective	0.18	0.38	0.131	0.164
COVID Hesitancy Reasons - Not At Risk of Getting COVID	0.03	0.17	0.256	0.247
COVID Hesitancy Reasons - Against Vaccines Generally	0.03	0.17	0.141	0.145
COVID Hesitancy Reasons - Prefer 'Natural' Immunity	0.06	0.24	0.779	0.749
COVID Hesitancy Reasons - Already Had COVID	0.05	0.22	0.163	0.238
COVID Hesitancy Reasons - Don't Trust Government	0.33	0.47	0.036**	0.057*
COVID Hesitancy Reasons - Financial Concerns	0.10	0.30	0.700	0.608
COVID Hesitancy Reasons - Other	0.08	0.27	0.759	0.802
Comorbidities - None	0.44	0.50	0.667	0.936
Comorbidities - Diabetes	0.16	0.36	0.325	0.228
Comorbidities - Cardiovascular Diseases	0.15	0.36	0.059*	0.055*
Comorbidities - Obesity	0.25	0.43	0.732	0.906
Comorbidities - Autoimmune Diseases	0.06	0.24	0.769	0.847
Comorbidities - Chronic Obstructive Pulmonary Disease	0.06	0.25	0.445	0.515
Comorbidities - Prefer Not To Share	0.03	0.17	0.974	0.905
Had COVID	0.09	0.29	0.235	0.275
Know Someone Seriously Ill or Passed Away COVID	0.70	0.46	0.828	0.691
COVID Economic Situation	2.26	0.86	0.224	0.256
Government Vaccine Priority	3.28	1.17	0.001***	0.003***
Left/Right Political Scale	5.20	2.05	0.399	0.416
Satisfied with President COVID Management	2.19	1.37	0.552	0.551
Satisfied with Mayor COVID Management	2.59	1.27	0.543	0.559
Satisfied with Health Ministry COVID Management	2.40	1.27	0.411	0.378
Would Vote for Current President	0.21	0.40	0.807	0.772
Would Vote for Current Mayor	0.24	0.43	0.252	0.275
Trust in Current President	1.99	1.11	0.531	0.461
Trust in Current Mayor	2.27	1.03	0.866	0.692
Trust in National Health Ministry	2.25	1.05	0.242	0.260
Trust in National Medical Association	2.90	0.93	0.244	0.367
Trust in Left-Wing Newspaper	2.17	0.94	0.643	0.825
Trust in Right-Wing Newspaper	2.18	0.98	0.717	0.897
Trust in Religious Leader	2.04	0.92	0.764	0.876
Trust in Local Healthcare	3.09	0.85	0.638	0.822
Trust in Armed Forces	2.79	1.03	0.394	0.280
Trust in Civil Society Organizations	2.62	0.82	0.526	0.490
Trust in Government of China (baseline)	1.89	0.86	0.258	0.345
Trust in Government of US Under Trump (baseline)	1.81	0.94	0.300	0.375
Trust in Government of US Under Biden (baseline)	2.46	0.91	0.798	0.743
Trust in Government of UK (baseline)	2.46	0.89	0.724	0.743
Trust in Government of Russia (baseline)	2.25	0.93	0.737	0.897
Meeting Indoor With Non-Family Contributes to COVID	3.42	0.94	0.687	0.611
Risk Aversion	0.97	0.66	0.615	0.552
Discount Rate	3.29	0.81	0.080*	0.153
Donation Amount	0.48	0.31	0.202	0.295
Important to Receive Respect and Recognition	2.66	1.01	0.107	0.198
Social Influence	2.28	0.86	0.621	0.869
Vaccine Information Treatment	0.21	0.41	0.575	0.507
Vaccine Information Treatment with Biden Endorsement	0.14	0.35	0.164	0.157
Vaccine Information Treatment with Expert Herd Immunity Prediction (60%)	0.07	0.25	0.664	0.798
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%)	0.08	0.27	0.290	0.351
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%)	0.07	0.26	0.885	0.830
Vaccine Information Treatment with Expert Herd Immunity Prediction (60%) and Current Willingness	0.08	0.27	0.614	0.540
Vaccine Information Treatment with Expert Herd Immunity Prediction (70%) and Current Willingness	0.07	0.25	0.955	0.874
Vaccine Information Treatment with Expert Herd Immunity Prediction (80%) and Current Willingness	0.08	0.27	0.302	0.280
Motivation Treatment - Altruism	0.25	0.43	0.061*	0.073*
Motivation Treatment - Economic Recovery	0.23	0.42	0.282	0.248
Motivation Treatment - Social Approval	0.25	0.43	0.818	0.880

Note: Each statistic is the p value associated with an F test of the null hypothesis that the mean value across treated and control respondents who answered the post-treatment trust question is the same, based on an OLS regression including experimental block $\times$ respondent country fixed effects and and (for the final column) country-specific indicators for each level of pre-treatment baseline survey trust. p values do not exist for the variables used to define blocks.

Table A10: The effect of aggregate vaccine distribution information treatment on trust in foreign governments, by respondent country

	Outcome: trust in foreign government scale (all governments)					
	Argentinean respondents (1)	Brazilian respondents (2)	Chilean respondents (3)	Colombian respondents (4)	Mexican respondents (5)	Peruvian respondents (6)
Panel A: Average treatment effect						
Treated	0.010	-0.053	0.080***	0.116*	0.034	-0.009
	(0.030)	(0.040)	(0.024)	(0.060)	(0.033)	(0.045)
R^2	0.61	0.56	0.52	0.64	0.59	0.59
Panel B: Heterogeneity by rank of vaccines received by the respondent's country						
Treated × Reversed rank	0.052**	0.054*	0.066***	0.063	0.059**	0.010
	(0.022)	(0.029)	(0.017)	(0.042)	(0.023)	(0.035)
R^2	0.61	0.56	0.53	0.64	0.60	0.59
Reversed rank range	[1.5,5]	[1.5,5]	[1.5,5]	[1.5,5]	[1,5]	[2,5]
Reversed rank mean	3.00	3.00	3.00	3.00	3.00	3.00
Reversed rank std. dev.	1.38	1.38	1.38	1.38	1.41	1.27
Panel C: Heterogeneity by the share of vaccines received by the respondent's country						
Treated × Share	0.239*	0.288*	0.299***	0.462*	0.533***	0.031
	(0.126)	(0.167)	(0.074)	(0.274)	(0.192)	(0.132)
R^2	0.61	0.56	0.53	0.64	0.60	0.59
Share range	[0,0.6]	[0,0.53]	[0,0.84]	[0,0.55]	[0,0.46]	[0,0.85]
Share mean	0.20	0.20	0.19	0.20	0.20	0.20
Share std. dev.	0.24	0.24	0.33	0.22	0.17	0.33
Panel D: Heterogeneity by rank of vaccines received by the respondent's country relative to prior belief						
Treated × Reversed rank ≥ Reversed prior	0.031	0.044	0.220***	0.166	-0.021	0.200**
	(0.064)	(0.081)	(0.050)	(0.122)	(0.070)	(0.094)
R^2	0.61	0.56	0.53	0.64	0.60	0.59
Reversed rank ≥ Reversed prior range	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}
Reversed rank ≥ Reversed prior mean	0.64	0.57	0.65	0.60	0.62	0.61
Reversed rank ≥ Reversed prior std. dev.	0.48	0.50	0.48	0.49	0.48	0.49
Panel E: Heterogeneity by rank of vaccines received by the respondent's country and prior beliefs						
Treated × Reversed rank	0.032	0.054*	0.071***	0.079	0.046*	0.022
	(0.026)	(0.030)	(0.020)	(0.049)	(0.024)	(0.037)
Treated × Reversed prior	0.037	0.000	-0.008	-0.040	0.046*	-0.030
	(0.024)	(0.027)	(0.019)	(0.042)	(0.025)	(0.033)
R^2	0.61	0.56	0.53	0.64	0.60	0.59
Reversed prior range	[1,5]	[1,5]	[1,5]	[1,5]	[1,5]	[1,5]
Reversed prior mean	3.10	3.17	3.06	3.09	3.08	3.05
Prior belief SD	1.52	1.52	1.50	1.53	1.45	1.49
Outcome range	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}
Control outcome mean	2.47	2.49	2.39	2.54	2.68	2.63
Control outcome std. dev.	0.92	0.99	0.92	0.97	0.95	0.89
Observations	1,500	1,170	2,935	425	1,405	810

Notes: The specification in each column of each panel includes experimental block × respondent country × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment endline survey trust, and is estimated using OLS. Covariates and lower-order interaction terms in panels B-D are omitted to save space. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A11: The effect of aggregate vaccine distribution information treatment on trust in foreign governments, by respondent country

	Outcome: some or a lot of trust in foreign government indicator (all governments)					
	Argentinean respondents (1)	Brazilian respondents (2)	Chilean respondents (3)	Colombian respondents (4)	Mexican respondents (5)	Peruvian respondents (6)
Panel A: Average treatment effect						
Treated	-0.018	-0.017	0.032**	0.084**	0.038**	0.032
	(0.019)	(0.022)	(0.014)	(0.036)	(0.019)	(0.026)
R^2	0.48	0.46	0.46	0.54	0.50	0.50
Panel B: Heterogeneity by rank of vaccines received by the respondent's country						
Treated × Reversed rank	0.022	0.043***	0.033***	0.046*	0.029**	0.010
	(0.013)	(0.016)	(0.010)	(0.027)	(0.013)	(0.020)
R^2	0.49	0.46	0.46	0.55	0.50	0.50
Reversed rank range	[1.5,5]	[1.5,5]	[1.5,5]	[1.5,5]	[1,5]	[2,5]
Reversed rank mean	3.00	3.00	3.00	3.00	3.00	3.00
Reversed rank std. dev.	1.38	1.38	1.38	1.38	1.41	1.27
Panel C: Heterogeneity by the share of vaccines received by the respondent's country						
Treated × Share	0.089	0.217**	0.152***	0.313*	0.266**	0.059
	(0.078)	(0.092)	(0.042)	(0.173)	(0.109)	(0.074)
R^2	0.49	0.46	0.46	0.55	0.50	0.50
Share range	[0,0.6]	[0,0.53]	[0,0.84]	[0,0.55]	[0,0.46]	[0,0.85]
Share mean	0.20	0.20	0.19	0.20	0.20	0.20
Share std. dev.	0.24	0.24	0.33	0.22	0.17	0.33
Panel D: Heterogeneity by rank of vaccines received by the respondent's country relative to prior belief						
Treated × Reversed rank ≥ Reversed prior	0.016	0.042	0.116***	0.137*	0.018	0.085
	(0.039)	(0.046)	(0.029)	(0.074)	(0.040)	(0.055)
R^2	0.48	0.46	0.46	0.55	0.50	0.50
Reversed rank ≥ Reversed prior range	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}
Reversed rank ≥ Reversed prior mean	0.64	0.57	0.65	0.60	0.62	0.61
Reversed rank ≥ Reversed prior std. dev.	0.48	0.50	0.48	0.49	0.48	0.49
Panel E: Heterogeneity by rank of vaccines received by the respondent's country and prior beliefs						
Treated × Reversed rank	0.012	0.043***	0.037***	0.063**	0.023	0.014
	(0.016)	(0.016)	(0.012)	(0.031)	(0.014)	(0.021)
Treated × Reversed prior	0.019	0.005	-0.009	-0.039	0.020	-0.010
	(0.014)	(0.015)	(0.010)	(0.026)	(0.014)	(0.019)
R^2	0.49	0.46	0.46	0.55	0.51	0.50
Reversed prior range	[1,5]	[1,5]	[1,5]	[1,5]	[1,5]	[1,5]
Reversed prior mean	3.10	3.17	3.06	3.09	3.08	3.05
Prior belief SD	1.52	1.52	1.50	1.53	1.45	1.49
Outcome range	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}
Control outcome mean	2.47	2.49	2.39	2.54	2.68	2.63
Control outcome std. dev.	0.92	0.99	0.92	0.97	0.95	0.89
Observations	1,500	1,170	2,935	425	1,405	810

Notes: The specification in each column of each panel includes experimental block × respondent country × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment endline survey trust, and is estimated using OLS. Covariates and lower-order interaction terms in panels B-D are omitted to save space. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

indicated ties or straight-lined this question. To ensure that our results are not driven by the 28% of respondents who did not provide unique rankings, column (2) demonstrates that the results are robust to excluding these respondents.

Third, column (3) reports the experimental results using ordered logit and logit estimators for the scale and binary trust outcome variables, respectively. Although the point estimates of course change, the results continue show clear and statistically significant effects on trust.

Finally, column (4) of each table reports the experimental results, reweighting to match observable characteristics of the population. We again report estimates that reweight observations to match the marginal population distribution; this method is described in Section A.4.3. The results suggests that the unweighted effects in our sample are relatively similar to the reweighted effects.

A.5.4 Additional mechanism results

Table A14 reports the results for the binary trust outcome of our mechanism test splitting respondents with a public good orientation from respondents primarily perceiving cynical motives for a given country.

Table A12: The effect of aggregate vaccine distribution information treatment on trust in foreign governments, outcome scale—robustness tests for specifications pooling across foreign governments

	Outcome: trust in foreign government scale			
	Adjusting for imbalanced covariates	Excluding non-unique rankings	(Ordered) logit estimation	Rake population weights
	(1)	(2)	(3)	(4)
Panel A: Average treatment effect				
Treated	0.050**	0.059**	0.091	0.030
	(0.021)	(0.023)	(0.061)	(0.031)
R^2	0.58	0.59		0.59
Panel B: Heterogeneity by rank of vaccines received by the respondent's country				
Treated × Reversed rank	0.051***	0.052**	0.176***	0.044***
	(0.009)	(0.010)	(0.027)	(0.012)
R^2	0.58	0.60		0.59
Reversed rank range	[1,5]	[1,5]	[1,5]	[1,5]
Reversed rank mean	3.00	3.00	3.00	3.00
Reversed rank std. dev.	1.37	1.37	1.38	1.37
Panel C: Heterogeneity by the share of vaccines received by the respondent's country				
Treated × Share	0.248***	0.276***	0.840***	0.223***
	(0.047)	(0.051)	(0.139)	(0.059)
R^2	0.58	0.60		0.59
Share range	[0,0.85]	[0,0.85]	[0,0.85]	[0,0.85]
Share mean	0.19	0.19	0.19	0.19
Share std. dev.	0.27	0.27	0.27	0.27
Panel D: Heterogeneity by rank of vaccines received by the respondent's country relative to prior belief				
Treated × Reversed rank ≥ Reversed prior	0.092***	0.100***	0.351***	0.090**
	(0.031)	(0.034)	(0.089)	(0.043)
R^2	0.58	0.60		0.59
Reversed rank ≥ Reversed prior range	{0,1}	{0,1}	{0,1}	{0,1}
Reversed rank ≥ Reversed prior mean	0.63	0.63	0.65	0.63
Reversed rank ≥ Reversed prior std. dev.	0.48	0.48	0.48	0.48
Panel E: Heterogeneity by rank of vaccines received by the respondent's country and prior beliefs				
Treated × Reversed rank	0.049***	0.051***	0.169***	0.053***
	(0.012)	(0.014)	(0.031)	(0.010)
Treated × Reversed prior	0.005	0.008	0.016	0.006
	(0.011)	(0.013)	(0.033)	(0.011)
R^2	0.58	0.60		0.57
Reversed prior range	[1,5]	[1,5]	[1,5]	[1,5]
Reversed prior mean	3.09	3.08	3.00	3.09
Reversed prior std. dev.	1.50	1.50	1.41	1.50
Outcome range	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}	{1,2,2.5,3,4}
Control outcome mean	2.51	2.51	2.50	2.47
Control outcome std. dev.	0.94	0.94	0.94	0.93
Observations	7,430	6,010	8,245	8,060

Notes: The specification in each column of each panel includes experimental block × respondent country × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment endline survey trust. The specifications in column (1) adjusts for the imbalanced covariates from Table A9, and are estimated using OLS. The specifications in column (2) exclude respondents with non-unique prior rankings, and are estimated using OLS. The specifications in column (3) are estimated using ordered logit. The specifications in column (4) is estimated using WLS; the weights reflect the country-specific marginal distribution in terms of age category, education level, region, gender, and socioeconomic class. Covariates and the lower-order interaction terms in panels B-E are omitted to save space. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A13: The effect of aggregate vaccine distribution information treatment on trust in foreign governments, binary outcome—robustness tests for specifications pooling across foreign governments

	Outcome: trust in foreign government scale			
	Adjusting for imbalanced covariates (1)	Excluding non-unique rankings (2)	(Ordered) logit estimation (3)	Rake population weights (4)
Panel A: Average treatment effect				
Treated	0.024**	0.024*	0.164*	0.030*
	(0.012)	(0.014)	(0.088)	(0.018)
R^2	0.48	0.49		0.50
Panel B: Heterogeneity by rank of vaccines received by the respondent's country				
Treated × Reversed rank	0.028***	0.029***	0.237***	0.023***
	(0.005)	(0.006)	(0.040)	(0.008)
R^2	0.48	0.49		0.50
Reversed rank range	[1,5]	[1,5]	[1,5]	[1,5]
Reversed rank mean	3.00	3.00	3.00	3.00
Reversed rank std. dev.	1.37	1.38	1.37	1.37
Panel C: Heterogeneity by the share of vaccines received by the respondent's country				
Treated × Share	0.131***	0.141***	1.155***	0.110***
	(0.027)	(0.030)	(0.197)	(0.038)
R^2	0.48	0.49		0.50
Share range	[0,0.85]	[0,0.85]	[0,0.85]	[0,0.85]
Share mean	0.19	0.19	0.19	0.19
Share std. dev.	0.27	0.27	0.27	0.27
Panel D: Heterogeneity by rank of vaccines received by the respondent's country relative to prior belief				
Treated × Reversed rank $\geq$ Reversed prior	0.057***	0.061***	0.526***	0.044
	(0.018)	(0.020)	(0.129)	(0.027)
R^2	0.48	0.49		0.50
Reversed rank $\geq$ Reversed prior range	{0,1}	{0,1}	{0,1}	{0,1}
Reversed rank $\geq$ Reversed prior mean	0.63	0.65	0.63	0.63
Reversed rank $\geq$ Reversed prior std. dev.	0.48	0.48	0.48	0.48
Panel E: Heterogeneity by rank of vaccines received by the respondent's country and prior beliefs				
Treated × Reversed rank	0.028***	0.028***	0.235***	0.030***
	(0.007)	(0.008)	(0.044)	(0.006)
Treated × Reversed prior	0.000	0.003	0.005	0.001
	(0.006)	(0.008)	(0.045)	(0.006)
R^2	0.49	0.57		0.48
Reversed prior range	[1,5]	[1,5]	[1,5]	[1,5]
Reversed prior mean	3.08	3.00	3.08	3.09
Reversed prior std. dev.	1.50	1.41	1.49	1.50
Outcome range	{0,1}	{0,1}	{0,1}	{0,1}
Control outcome mean	0.48	0.48	0.47	0.46
Control outcome std. dev.	0.50	0.50	0.50	0.50
Observations	7,430	6,010	8,245	8,060

Notes: The specification in each column of each panel includes experimental block × respondent country × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment endline survey trust. The specifications in column (1) adjusts for the imbalanced covariates from Table A9, and are estimated using OLS. The specifications in column (2) exclude respondents with non-unique prior rankings, and are estimated using OLS. The specifications in column (3) are estimated using logit. The specifications in column (4) is estimated using WLS; the weights reflect the country-specific marginal distribution in terms of age category, education level, region, gender, and socioeconomic class. Covariates and the lower-order interaction terms in panels B-E are omitted to save space. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table A14: The pooled effect of the aggregate vaccine distribution information treatment on trust in foreign governments across public good-oriented and cynical respondents, binary outcome

	Outcome: some or a lot of trust in foreign government indicator				
	(1)	(2)	(3)	(4)	(5)
Panel A: Public good respondents					
Treated	0.043***	-0.149**	-0.006	-0.026	-0.123*
	(0.015)	(0.068)	(0.023)	(0.031)	(0.072)
Treated × Reversed rank		0.049***			0.051***
		(0.017)			(0.017)
Treated × Share			0.153***		
			(0.051)		
Treated × Reversed rank ≥ reversed prior				0.090**	
				(0.036)	
Treated × Reversed prior					-0.010
					(0.012)
R^2	0.44	0.44	0.44	0.44	0.44
Control outcome mean	0.63	0.63	0.63	0.63	0.63
Control outcome std. dev.	0.48	0.48	0.48	0.48	0.48
Moderator range		[2,5]	[0,0.85]	{0,1}	[2,5], [1,5]
Moderator mean		3.94	0.32	0.77	3.94, 3.50
Moderator std. dev.		0.90	0.30	0.42	0.89, 1.40
Observations	2,446	2,446	2,446	2,446	2,446
Panel B: Cynical respondents					
Treated	0.046***	-0.048	0.022	0.069**	-0.092
	(0.015)	(0.072)	(0.022)	(0.035)	(0.073)
Treated × Reversed rank		0.023			0.010
		(0.018)			(0.019)
Treated × Share			0.076		
			(0.051)		
Treated × Reversed rank ≥ reversed prior				-0.030	
				(0.099)	
Treated × Reversed prior					0.028**
					(0.011)
R^2	0.48	0.48	0.48	0.48	0.48
Control outcome mean	0.35	0.35	0.35	0.35	0.35
Control outcome std. dev.	0.48	0.48	0.48	0.48	0.48
Moderator range		[2,5]	[0,0.85]	{0,1}	[2,5], [1,5]
Moderator mean		3.99	0.31	0.8	3.99, 3.43
Moderator std. dev.		0.85	0.29	0.40	0.85, 1.41
Observations	2,488	2,488	2,488	2,488	2,488
Outcome range	{0,1}	{0,1}	{0,1}	{0,1}	{0,1}

Notes: The specification in each column of each panel includes experimental block × respondent country × vaccine-developer country fixed effects and country-specific indicators for each level of pre-treatment endline survey trust, and is estimated using OLS. Moderator descriptive statistics in column 5 reflect reversed rank and reversed prior, respectively. Covariates are omitted to save space. Standard errors clustered by respondent are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.