EDITORIAL

The Political Psychology of COVID-19

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The COVID-19 pandemic has given rise to unprecedented and extraordinary conditions. It represents a profound threat to health and political and economic stability globally. It is the pressing issue of the current historical moment and is likely to have far-reaching social and political implications over the next decade. Political psychology can inform our preparedness for the next phase of the pandemic as well as our planning for a post COVID-19 world. We hope that this special issue will play its part in helping us to think how we manage and live with COVID-19 over the coming decade. In this editorial, we review the key themes arising from the contributions to our special issue and, alongside existing knowledge highlight the relevance of political psychology to finding solutions during this time of crisis. The contributions to this special issue and the pandemic raise many classic topics of central interest to political psychology: leadership, solidarity and division, nationalism, equality, racism, and international and intergroup relations. In our editorial, we offer an analysis that highlights three key themes. First, the importance of sociopolitical factors in shaping behavior during

Highlights

- COVID-19 shatters the illusion that good health is about individual lifestyle and treatment choices and has revealed the structural and collective forces that determine health.
- Co-ordination of global responses to the pandemic remains a challenge. National responses led to maximise social cohesion evidence the most favourable outcomes.
- All forms of inequality, within and between nations, represent a significant challenge to health and COVID19 preventative practices. Inequalities and associated socio-political divisions will continue to be amplified by the pandemic.

this pandemic. Second, the relevance of political leadership and rhetoric to collective efforts to tackle SARS-COV-2. And third, how sociopolitical cohesion and division has become increasingly relevant during this time of threat and crisis.

A Global Pandemic Requires a Global Solution

The COVID-19 pandemic is quintessentially a global problem. And it requires a global solution. From the outset, the World Health Organization (WHO) has been at the front and center of the response to the pandemic. Initially, the WHO, the health arm of the United Nations, identified the disease as a novel coronavirus. It took about a month from when this viral pneumonia of unknown cause was first identified before it was recognized as a public health emergency of international concern, on January 30, 2020. At that time, 98 cases had been identified in 18 countries around the globe, but 99% of cases were still in China. A pandemic was probably still avoidable. But the WHO's announcement was not accompanied by effective policy recommendations. At that time, the WHO stated there was no need to "interfere with international travel and trade," nor did it "recommend limiting trade and movement."[1] In the absence of clear and consistent early advice from the WHO, there was tremendous variability in how seriously different governments and their leaders regarded the disease and how and if they acted to prevent its spread (Montiel, Uyheng, & Dela Paz, 2021). In short, there was no coordinated global response. Eventually, after infecting over 118,000 patients in over 100 countries, and causing more than 4200 deaths, the outbreak was called a "pandemic" by WHO on March 11, 2020 (Hanaei & Rezaei, 2020).

At the heart of the failure to coordinate national responses during the first months of the pandemic is politics. From the first days of this pandemic, the refrain from the WHO has been that we need to "act together." This pandemic has shown us more than ever before how interconnected we all are. To flatten the curve, we need everyone to behave in a manner that slows the spread of the SARS-COV-2. This means that people need to maintain physical distance as a precaution, protect themselves and others from airborne virus by wearing masks, wash hands and apparel frequently if exposed to areas where the virus may be present, and collectively isolate from others when infected or possibly infected. Authorities need to make sure there is adequate ventilation in enclosed public spaces, manage the public in a way that avoids large public gatherings when SAR-COV-2 is at risk of spreading, and even lockdown people's movement if necessary. These efforts minimize the emergence of new cases and variants. Of course, there are tremendous differences across cultures and between individuals in the degree of support for these actions. It remains a huge challenge for governments to order collective actions that have the potential to depress their economies and for the reluctant, the disappointed, and the politically alienated to engage in collective actions. And the working poor, detainees, refugees, low caste, indigenous and marginalized groups, the cognitively impaired, young children, and the illiterate need to be supported in efforts to adhere to these public health guidelines. Indeed "everyone" is all of humankind. Inevitably, the priorities of some are privileged over that of others, and they can produce political division.

There are a range of factors within and between nations that unite and divide the numerous cultures and peoples that inhabit our world. Where these differences are linked to fraught or inequitable relations, there are fault lines. Evidencing this, Syropoulos, Puschett, and Leidner's (2021) contribution to this issue examined how pandemic preparedness was linked to the ability to anticipate, detect, and coordinate response and recovery to the COVID-19 crisis. Using publicly available data in 155 countries in Asia, the Americas, Africa, Oceania, and Europe, this analysis demonstrates that a higher Positive Peace Index, encompassing indicators of government functioning, equitable distribution of

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[1]https://www.who.int/director-general/speeches/detail/who-director-general-s-statement-on-ihr-emergency-committee-on-novel-coronavirus-(2019-ncov)

resources, acceptance of human rights and low levels of corruption, for example, are related to the severity of the impact of COVID. Syropoulos et al., show that countries higher on indicators of peace were better prepared for the pandemic, as measured by testing capacity, number of cases, and test positivity rate (even after controlling for population size, population density, and GDP). Syropoulos et al. also note a similar effect in a within-country analysis of the United States where comparable data was available for 3,144 counties. Indeed 11 out of the 18 most recent and severe epidemics of the 20th century occurred in regions characterized by low or medium levels of positive peace. Because of our shared fate, the same way as preexisting illnesses make individuals vulnerable, pre-existing divisions and fault lines within and between nations continue to make us all vulnerable to an epidemic that can mushroom into a global pandemic.

Collective coordination is key to efforts to tackle the pandemic. Indeed, a key theme of many of the articles within this special issue is the value of solidarity and unity in the face of the crisis. Research teams working together across different countries, the prompt sharing of scientific knowledge, and wider public engagement of the scientific community have been the hallmark of the effort that has facilitated our understanding the novel coronavirus, SARS-COV-V2. Collaborative scientific effort has given rise to the swift development of vaccines, fuller understanding of viral transmission, and the psychology of behavior change. Yet despite these important and truly laudable efforts, there remains an array of social, political, economic, and governance issues that are getting in the way of global success in tackling COVID-19. And although there is evidence in this collection of articles of the importance of solidarity and coordinated and collaborative action (Cardenas et al., 2021; Gerber et al., 2021), there is similarly evidence that division and contention are the bane of effective responding (Ruisch et al., 2021; Vignoles, Jaser, Taylor, & Ntontis, 2021). These topics of unity and division alongside the centrality of sociopolitical or collective factors in shaping health are core themes of this special issue.

National Responses to the COVID-19 Crisis: The Impact of Politics and Political Leadership

Certainly the first action of governments on March 11, 2020, when the WHO declared the *global* pandemic, was *national* action to slow viral spread (Ferguson et al., 2020). These actions included closing national borders, stay-at-home directives, internal travel constraints, and curfews as well as legislative and security measures to enforce these restrictions. Many of these actions would be considered unusually authoritarian in the normal run of events. However, because of the unprecedented times, these were actions that were tolerated and even welcomed (by some). Attempts to foster national unity, especially when driven by threat of a pandemic can, however, undermine tolerance and inclusiveness (Foran et al., in press). This is because collective action often relies on amplifying the need for order, compliance, and national unity, and this is often associated with authoritarianism (Osborne, Satherley, Little, & Sibley, 2020). Even in pandemic times, authoritative (or authoritarian) actions by governments can align with preexisting political projects and hierarchical tendencies.

Montiel and colleagues' article in this issue (2021) speaks to this matter. They analyzed the speeches of national leaders across 26 countries and show that there are many shared features of the rhetoric employed by national leaders. Their analysis highlights particular constellations of rhetoric that are linked to varying levels of COVID-19 severity at the national level. Populist leaders often used rhetoric that appeared to stoke national fervor. The rhetorical performances of populists also organized the exercise of power in a hierarchical manner, and so this speaking style was associated with enforcement of policy based on (frequently inconsistent) top-down methods of pandemic control. On the other hand, other governments and their leaders around the world were mapped by Montiel et al. (this issue) into three other quadrants of rhetorical style, emphasizing respectively

institutional enforcement, universalistic collaboration, and accountable democracies. The rhetorical performances of leaders during the pandemic could be seen to link to their prior political projects. Moreover, these different methods of talking about and engaging with the pandemic were associated with different levels of success in controlling the spread of infections. Countries led by a politician using populist rhetoric fared most poorly among the four rhetorical styles, whereas countries whose leader employed a rhetoric of accountable democracy fared best.

Worldwide, it has been clear that effective responses to COVID-19 were found where leaders and their followers managed to build a sense of "we-ness," which allowed them to unlock the power of the group and to come together in solidarity against the virus. This can be best typified by the oft used mantra "being in it together." Early in the pandemic Van Bavel et al. (2020) suggested that national identities had the potential to galvanize unity at a national level at least. But nationalist sentiment can be used in many ways, and political context is always relevant for how it can be used. National sentiment stoked in support of populism does little to counter COVID-19, sometimes because these sentiments have not been accompanied by sound scientific advice, and perhaps more pervasively because this rhetoric is often targeted against an "other" (Mudde & Kaltwasser, 2018). Chan et al.'s (2021) contribution tests whether national identification in the United States and China was mobilized to protect the collective over time. A two-wave longitudinal survey in China and a five-wave longitudinal survey in the United States revealed that reliance on national identification to support preventative behavior was very much linked to the political context. Their analysis exposed the vulnerabilities in U.S. society because of Trump's equivocation, and this resulted in slower adoption of preventative behaviors particularly amongst those with high levels of national identification (who also tended to be politically conservative). And so the reciprocal relationship between identification and disease preventative practices can be seen to be contingent on the national political context and the rhetoric and actions of political leaders.

Again, unity and division are relevant. In politically partisan societies like the United States, ideological differences have played a clear role in moderating the ability of national actors to mobilize collective action in response to the pandemic (Ruisch et al., 2021). Vignoles et al.'s article (2021) provides a powerful cross-cultural illustration that the sentiments expressed by national leaders could undermine *or* promote adherence to public health indicatives. In direct contrast to Prime Minister Johnson's use of individualistic appeals to the U.K. public, New Zealand's Prime Minister Ardern's use of identity-based rhetoric to promote solidarity amongst New Zealanders can be seen to have been much more effective (see also Sibley et al., 2020). The same article also offers an analysis that suggests that British national identity was not effectively mobilized by Boris Johnson to promote collective protective actions. In their second study, Vignoles et al. (2021) evidenced that it is a sense of inclusive national solidarity across all groups and subcultures within the nation that facilitates collective action required to flatten the curve. And so it is imperative that attempts to galvanize the nation during this crisis do not undermine national solidarity but rather harness it in a way that is inclusive and unifying rather than exclusive and divisive.

Achieving this sense of unity and solidarity in highly diverse or fractured societies in a major challenge. Semetko (this issue) in their study of the crisis during the first wave of the pandemic in India highlights that the spread of the SAR-COV-2 was linked to respondents' own religious group membership and interacted with the political, religious, or ethnic orientation of those who were implicated online as culpable for its spread. Their analysis points to the preexisting nature of the religious division in Indian society that came to the fore in the face of the SAR-COV-2 threat. Division and polarization centering on allaying and apportioning blame for the spread of the SAR-COV-2, amplified existing religious and also political divisions. This attribution of responsibility for the spread of SAR-COV-2 seemed to be a more strongly polarizing issue than a performance in response to outbreaks. These divisions, further entrenched by the scale and horror of the crisis for many, are likely to have political and social implications for some time to come.

Public Health and the COVID-19 Crisis: The Limits of Individualism and Individual Explanations of Behaviour

The Covid-19 pandemic has highlighted the integral relationship between health and agentic behavior. For the most part, this crucial role of behavior in shaping morbidity and mortality had become widely accepted across medicine and epidemiology over the last three decades. The move away from a traditional biomedical model is welcome and has facilitated the increased acknowledgment of social, cultural, and political factors in shaping health behavior and health outcomes. But lay and psychological models continue to see health behavior as a product of individual choices and actions. Strong assumptions about the role of individual factors rather than social, cultural, or political ones in shaping health behavior are evident across the literature in health psychology and epidemiology (Muldoon, Lowe, Jetten, Cruwys, & Haslam, 2021). These highly individualistic views regarding the determination of health behavior are consonant with an ideological position which implicitly supports commercialized economic Westerized models of health care, medicine, and pharma.

This positioning of health has two logical consequences. In terms of prevention, ill health is viewed as the product of health and lifestyle practices: that is, poor choices. This can give rise to the unwell being seen as masters of their own misfortune. The causes of poor health and the risk of illness is seen as residing with "problematic" individuals. Diseases can quickly become stigmatized and testing and reporting of symptoms driven underground. Another consequence is that the solution to health problems, the go-to treatments rely on individual behavior change or individual treatment. COVID-19 has brought the limitations of this position into sharp relief. Early testing and identification of cases is not helped by stigmatization as was seen in the early days of the pandemic in many countries. In Ireland, this gave rise to speculation and indeed at times ostracization of early cases even when they were health-care workers (HCWs). The highly infectious nature of the SARS-COV-2 virus together with the very clear collective and political dimensions associated with access to protective equipment, health care, and vaccines has revealed the flawed conceptualization of individualized disease risk.

There are three important contributions in this issue that highlight our need to move towards a broader political psychological understanding of health and disease. Ruisch et al. examined multiple factors that contributed to the pandemic response in the United States—across domains including personality, information, personal vulnerability on the one hand and environmental factors such as demographic factors, local COVID-19 infection rates, and ideological and attitudinal factors on the other. Among their key findings was the central role of attitude- and belief-related factors such as trust in science and trust in the Trump administration—and the relatively weaker influence of individual-level or personality factors even in the United States, a highly individualistic society. Also in this issue, Gerber et al. (2021), in two studies conducted in Chile, found perceived social norms were particularly important in determining health protective behaviors. In both studies, the power of social norms on individual behavior was evident. The influence of norms on behavior was comparable to that of living under government-mandated lockdown. Importantly these normative influences, and in particular the power of others in one's social network adhering to COVID-19 restrictions, was far greater than instrumental concerns about being punished or infected across their five-wave longitudinal study. These findings illustrate the value of collective cohesion and solidarity in mobilizing public responses against COVID-19.

A third article in our issue again places collective influences at the heart of health behaviors. In a two-wave longitudinal study in Australia, Cardenas et al. (2021) considered patterns of identification and local, state, and national level as well as indicators of social cohesion on adherence to COVID-19 health guidelines. Social identification at both neighborhood and national level was positively associated with adherence to health protective behaviors consistent with the idea that those who saw themselves as "in this together" were more likely to contribute to the suppression effort.

Political orientation was also relevant. Those with a right-leaning political orientation reported lower compliance than those with more left-leaning orientations, in much the same manner that Trump supporters were more reluctant to embrace restrictions in the United States. These findings accord with contemporary theory in political psychology which highlights the role of political ideology in determining support and engagement with government intervention, at least in societies where the political ideology of liberalism versus conservatism organizes political attitudes and behavior. Taken together, these studies indicated a clear acknowledgment of the importance of sociopolitical and collective influences in the determination of health outcomes. Even individual health behaviors do not occur in a vacuum; rather attitudes and beliefs are developed within and shaped by the wider sociopolitical landscape that can impede health protective behavior or act to support and coordinate behavior (Cardenas et al., 2021). Although our Special Issue was conspicuously missing contributions from Africa, other research has highlighted the means by which many African countries have successfully prevented the spread of the disease (Mormina & Nsofor, 2020).

The Limits of Individualism: COVID-19, Culture, and Health Behavior

In so much as COVID-19 has revealed the limits of individual explanations of health, so too has it highlighted the role of cultural, political, and social determinants of health. SARS-COV-2 is a respiratory disease and is communicated by particles of fluid expelled from a host into the air, where it is contracted by another host. Tackling the pandemic requires changes that have centered on the need for minimizing population movement from areas where there are outbreaks, routine masking, hand washing, a program of testing and contact tracing, the restriction and social isolation of those infected, and sufficient personal protective equipment and treatment facilities to manage cases if an outbreak occurs. Subsequently, access to vaccines and vaccine uptake, which have the potential to break the link between infection and the development of disease, have become important. So while this orientation to behavior is important, the reality of the pandemic is that some groups are far more vulnerable than others. Capacity and motivation lie at the heart of all behavior: You have to be both willing and able. You have to be willing and able to test and isolate all those infected. Willing and able to close your borders. Willing and able to get a vaccine.

This combination of both capacity and motivation is illustrated by the response by Taiwan which was arguably the most effective society in the world in fighting COVID-19. Despite having 850,000 of its 24 million citizens living in China in 2019, and 2.7 million tourists a year from China (normally), Taiwan as of April 18, 2021, has had only 1,072 infections and 11 deaths due to COVID-19—without locking down the economy or closing schools. Taiwan began monitoring passengers on flights from infected regions in China for fevers starting December 31, 2019, as soon as the WHO announced the discovery of unknown new viral pneumonia.[2] It put self-quarantining provisions into place for passengers coming from infected regions in China. It stopped direct flights from Wuhan on January 23, stopped Taiwanese tourists from going to China on January 25, and stopped Chinese citizens from Hubei coming to Taiwan on January 26, all while the WHO prevaricated about person-to-person transmission. Because China has blocked Taiwan from membership in international organizations (like the WHO),[3] Taiwan had to develop its own strategy, enabled by past Vice-President Chen Chien-jen, who has a doctorate from Johns Hopkins in epidemiology and was Health Minister when the SARS epidemic erupted out of a wet market in China (infecting 346 and killing 73 Taiwanese in 2003). He helped set up Taiwan's National Health Command Centre and was President Tsai Ing-wen's right-hand man in fighting the disease in 2020. Furthermore, because of SARS, many

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[2]For a timeline, see https://udn.com/newmedia/2020/covid-19-timeline/ (in Chinese).
[3]China considers Taiwan to be a province of China, but it has been de facto independent since 1949 when the Nationalists established a government in exile there after being defeated in a civil war with the Communists.

people were already wearing masks in crowded places like the subways in Taipei. Taiwan was able to mandate mask wearing by law on August 5, 2020. Essentially, strong institutional and public collective memory for SARS, followed by good policy decisions and communications about new requirements enabled Taiwan to navigate the new pandemic with a deft touch (see Liu et al., 2020, for a general account of East Asian efforts in fighting COVID-19).

Taiwan's success can in part be attributed to preparation and coordination. Its National Health Command Centre served as a centralized hub to organize efforts from disparate institutions in society. It also offered assistance to local communities and to the many people in self-isolation (Lo, Huang, Chen, Chou, & Shieh, 2020). In this way, people were supported when they had to self-isolate. After border control was in place, a contact-tracing system connected existing relational databases from sources such as case notification, laboratory test results, and contact-tracing apps (Jian, Cheng, Huang, & Liu, 2020). Overarching all of this was successful communication from authorities: that a strong sense of cooperation (and sacrifice) from every member of society for the good of all was required to prevent the spread of the disease. This helped to create a positive sense of purpose resulting in widespread support from civil society for cell-phone triangulation, which was used to monitor and enforce home quarantine; this was used for managed isolation of 350,000 people who returned from mainland China. Among 350,000 people in managed isolation, only 800 were fined for violating self-isolation regulations. In the crucial time of the first quarter of 2020, Taiwan did not need to rely on the more celebrated, but divisive, method of lockdown. Coordination and consistent communication from the government facilitated the widespread support from civil society for each government action, creating a virtuous cycle of trust and compliance with public policy for public good.

These themes of social cohesion and cultural narratives in support of response to the COVID-19 crisis are picked up in the contribution by Moss and Sandbakken (2021). Reflecting the importance of the memory of SARS in scaffolding the response in Taiwan, their qualitative study at the height of the COVID-19 crisis in Norway shows the importance of the selection of meta-narratives encouraging people to stay with difficult restrictions. Their study highlights the challenge governments faced in balancing their COVID-19 narratives, such as freedom against restrictions and hope against fear. Their analysis also highlights how striking a tone of balance between individual freedom and collective solidarity worked in the Norwegian context, where the government's use of a meta-narrative of "voluntary work performed as a collective effort" resonated well with the belief system of citizens interviewed. Of course, the narratives political leaders use, and how these narratives are received, are always culture bound. Moss and Sandbakken (2021) demonstrate that public health narratives that fit with personal narratives supported people's ability to make sense of the crisis and ultimately their willingness to engage with the public health guidelines. Importantly in some cultures and amongst some groups, public health advice is working in contexts where freedom is valued over restrictions and individualism over solidarity. Indeed, Gelfand et al. (2021) offered evidence that cultures with stricter norms, and greater enforcement of these norms, were more effective in their response to COVID-19. On the other hand, in political contexts where social norms are less strict and state enforcement limited, clear and consistent public health messaging is likely to be particularly important, although it must continue to work with shared understandings and culturally appropriate narratives (Moss & Sandbakken, 2021; see Sibley et al., 2020, for evidence from New Zealand).

The Limits of Individualism and Individual Explanations of Behavior: Inequality and Public Health

The fatality statistics are beginning to show that COVID-19 affects different groups in very different ways. In many regards, the preventative actions advised by the WHO are luxuries of those living in more privileged circumstances and the wealthier economies of the Global North. But despite these disparities, Liu (2021) reported that the Human Development Index correlated positively

with infection rates ($r = .52$) and fatality statistics ($r = .46$). This indicates that as of the end of 2020, developing countries had reported fewer per capita infections and deaths compared to the wealthy countries such as those in the OECD. Using a smaller sample of countries with Schwartz values scores, Liu (2021) also reported that, consistent with Gelfand et al. (2021), collectivist countries had lower infection and fatality rates than individualistic countries.

There is concern that these official statistics from developing countries might reflect underreporting: Much concern has been expressed about the potential disastrous ramifications of COVID-19 in the Global South. Those who must work to live, who cannot afford the luxury of physical distancing or self-isolation due to poor housing, and who have no access to running water and soap are infinitely more vulnerable (Chung, Eckenwiler, Heilinger, & Wild, 2021). However, in so much as COVID-19 is about inequality between nations, it is also about inequality within the domestic, social, occupational, and national spheres. It is to these issues of difference and division that we now turn.

The scale of the COVID-19 crisis and comparison across countries has been hampered by inadequate testing and associated data in low-income countries. Though absolute mortality may appear higher in European countries, when corrected for age, there is a comparatively higher risk of death in South America (O'Driscoll et al., 2021). Age-related risk may inflate the mortality statistics in high-income countries where there are more older adults (O'Driscoll et al., 2021). As studies continue to emerge (Elgar, Stefaniak, & Wohl, 2020), cross-national differences in COVID-19 mortality show that mortality is positively related to income inequality. These studies suggest that some countries require a more robust public health response to contain the spread and impact of COVID-19 due to existing economic and social conditions. In the United States, for example, across all states, state-level inequality was associated with cases and deaths due to COVID-19 (Oronce, Scannell, Kawachi, & Tsugawa, 2020).

Comparisons within countries point to another important driver of SAR-COV-2 risk. In the United States, it has become apparent that low-income groups face greater barriers to minimizing their social contacts because of their need to attend work, rather than work from home. Based on mobile phone data, it is apparent that those living in high-income neighborhoods have been able to increase their days at home substantially more than individuals in low-income neighborhoods (Jay et al., 2020). Residents of high- and low-income neighborhoods visited supermarkets, parks, and hospitals in approximately equal proportions, but those resident in low-income neighborhoods were more likely to have to work outside the home. Consequently, the stay-at-home orders were associated with only small decreases in risk of exposure in low-income neighborhoods. Gerber et al. (2021) highlight how these different patterns of activity during lockdowns affect both risk perception and social norms for different income groups. In a country such as Chile, with high levels of inequality, access to health care and the possibility of staying at home during lockdown is completely stratified by income. In effect, there is a systematic impact of income group on measures designed to prevent the SAR-COV-2 infection that disadvantages the poor. If people find it more difficult to comply because of their circumstances, then interventions need to focus on making lockdown and associated restrictions viable for everyone. To be successful, interventions need to be designed with due regard to the specific risks and demands of different socioeconomic groups.

Within nations, low-income groups also have comparatively poorer access to hospital, treatments, and health care. So as well as being at a higher risk of SAR-COV-2 infection, low-income groups generally have less access to health care. At the country level, the advantage low-income countries might have due to their age profile is lost due to the higher fatality associated with underresourced health systems (Ghisolfi et al., 2020). COVID-19 outcomes are profoundly shaped by the available health infrastructure to cope with those who present in need of treatment. Across the world, doctors, nurses, and community health workers are a crucial asset to battling the pandemic. In Europe, infections among medical staff have already generated worker shortage. In low-income countries, workers are already in short supply: The average low-income country has 0.2 physicians

and 1 nurse per 1,000 people, compared to 3 and 8.8 respectively in high-income countries (Ghisolfi et al., 2020). And given the high rates of infection we have seen in HCWs in the Global North and the slow roll out of vaccines to the Global South, this situation is likely to be amplified unless concerted effort to vaccinate key workers is made a political priority.

Even within countries, there is inequality of COVID-19 risk and COVID-19 outcomes linked to socioeconomic conditions. In countries with universal health systems such as in Northern Europe, health-care demands typically outstrip supply, and this certainly has been the case over the course of the pandemic (Emanuel et al., 2020). In a limited resource model, it has been demonstrated that social capital is important for navigating the system (Stevenson, McNamara, & Muldoon, 2014). It eases the journeys of the educated and better-off through ostensibly universal systems of support. And as many are presenting the roll out of the vaccines as the great hope for seeing us through this pandemic, vaccines and vaccination rollout brings new inequity. Again, many of these problems have political psychology at their core. Access and supply of vaccines is clearly linked already to nationalism and inequality. The WHO has repeatedly expressed its concerns about the "my country first" approach adopted by many high-income countries. Without global coordination, countries bid against each other which affects supply and raises unit pricing. And even within countries, vaccine corruption is already presenting as an issue (UNODC, 2021). In countries with a weak health-care infrastructure, vaccine corruption is likely to deny many of those most at risk including front line HCWs. Without radical and rapid political thinking, income inequality will become as central a determinant of mortality and morbidity from COVID-19 as SARS-CoV-2 itself.

The Limits of Individualism and Individual Explanations of Behavior: Gender, Power and Public Health

Another key dimension of difference during this pandemic has been gender (Bischof, Oertelt-Prigione, Morgan, & Klein, 2020). To better understand and respond to COVID-19, gender must be recognized as a crucial and intersecting component of wider structural inequalities (Hawkes, Allotey, Elhadj, Clark, Horton, & Gender and COVID-19 Working Group, 2020). The COVID-19 pandemic is exposing, most acutely, the wider social inequalities that are based on gendered social, cultural, and economic faultiness. This is evident in relation to the challenges for frontline workers (in many national contexts, these are mostly women), the disproportionate burden of unpaid care felt by women during the pandemic, and the uptick in gender-based violence, as well as the economic devastation experienced by women who are overrepresented in the poorest quintiles within and across nations. On the other hand, male dominance in COVID-19 prevalence and mortality across most countries and cultures would seem to suggest that social differences as well as potentially biological differences may be underpinning the pattern of infections and mortality statistics (Klein & Flanagan, 2016). Societal and gender norms may influence testing and reporting bias, and there may be differences in exposure due to gendered perceptions of risk, as well as differences in preexisting conditions.

Lockdown and stay-at-home orders have also had radical impact on women's work in the home. Many countries have issued guidelines that have resulted in school closures with consequent impact on women's and particularly mothers' employment burden. Using data from the Current Population Survey in the United States, Landivar, Ruppanner, Scarborough, and Collins (2020) compared unemployment, work hours, and labor-force participation before and during the first COVID-19 lockdown in the United States. Their findings illustrate that women, particularly mothers, have employment disproportionately affected by COVID-19. Mothers were more likely than fathers to exit the labor force and become unemployed. Among heterosexual married couples working from home, it was mothers who scaled back their work hours to a far greater extent than fathers. These patterns suggest that the COVID-19 advisories have worsened existing gender inequality, with long-term implications for women's health and power in the domestic and social arena. As we wrote this issue, our mind

turned to our own back yard, and so we note 24 of the author contributors to this special issue are male and 18 female. We can all do better.

Unlike academics, HCWs have been infected at alarming rates. HCWs are predominantly women across the world (Boniol et al., 2019) and in multicultural societies are often people of color. This places women at particular risk in this pandemic because of the occupational roles that they assume outside of the home. In a review of available studies, totalling 152,888 infections of HCWs, women represented 71.6% of cases, and 38.6% of cases were among nurses. Reflecting men's greater mortality risk and among 1,413 death reports analyzed, 70.8% were men, and 51% were doctors. These data suggest that although infections were mainly in women and nurses, COVID-19-related deaths were mainly in men and doctors (Bandyopadhyay et al., 2020). Emerging evidence suggests that there are also differences in fatality rates between high- and low-income countries and groups (Hawkes et al., 2020). Perhaps because of this, certain narratives have emerged. HCWs are described as "heroes" (Sumner & Kinsella, 2021). This has given rise to spontaneous expressions of gratitude but systematic concerns about payment and protection of HCWs remain (Kinsella & Sumner, 2021). The potential long-term impact of gender-related factors on mortality and long COVID morbidity, especially in diverse socioeconomic contexts, cannot be underestimated.

As governments reacted with swift and severe measures in the ongoing battle to control the pandemic, measures to encourage social distancing mean for some women more time at home with stressed-out and abusive partners. Concerns about this issue was sufficient for the WHO and UNICEF to express concerns for women and children at risk of abuse. For these women, staying home does not mean staying safe. Indeed, the fewer social interactions associated with minimizing potential close contacts leads to less accountability for perpetrators and few opportunities for family to intervene. In a systematic review of 18 studies (Piquero, Jennings, Jemison, Kaukinen, & Knaul, 2021) yielding a total of 37 estimates, an overwhelming pre-post increase in reports of domestic violence was evident. Specifically, 29 of the 37 study estimates showed a significant increase with an overall medium effect size of 0.66. In short, the evidence based on several studies from different cities, states, and several countries around the world is strong that incidents of domestic violence increased in response to stay-at-home/lockdown orders.

Pregnant women are at particular risk during any public health emergency. Not only are pregnant women more vulnerable to domestic violence, they face increased biological susceptibility to complications from some respiratory infections including MERS and SARS. Data is also emerging that there are risks to pregnant women and their babies as a consequence of SARS-COV-2. Yet few countries have put in place support measures for pregnant women and particularly those in precarious employment to minimize their work contacts. And prioritization of vaccination for pregnant women, although likely to bring challenges, has not been mandated in Western countries where the vaccine is available. Containment strategies put in place separate women from their companions during birth where infection has arisen from their baby after birth. The ongoing need for social distance from family and community networks can result in pregnant and postpartum women feeling even more vulnerable and isolated. These measures while arguably clinically relevant to reducing transmission are likely to have profound short- and long-term mental health implications for women at a time when many are placed at risk by their need to negotiate the transition to motherhood (Ceulemans, Hompes, & Foulon, 2020).

There is one final way in which this pandemic is gendered, and it is in relation to decision-making. Across a wide range of national and international decision-making bodies, there is a clear lack of gender and diversity in decision-making. Women are users of health services, and they are agents of change in health, making critical contributions as parents, frontline responders, health promoters, influencers, researchers, and scientists. Despite their major role, however, an interplay of power and privilege prevents women, and particularly women of color, from being adequately represented in health and humanitarian leadership. Gender-equal representation is more than just a moral

imperative. We know from peace and security research that peace processes led by women were 35% more likely to last, although less than 13% of peace negotiators selected are women (O'Reilly, Súilleabháin, & Paffenholz, 2015). Stability and security, community trust and financial accountability, innovative and ethical decision-making, and a reduction in fraud and cognitive biases all show a strong association with gender diversity with innovative and ethical decision-making and with reduction in fraud and cognitive biases (Phillips et al., 2014). Furthermore, Purkayastha, Salvatore, and Mukherjee (2020) found that women were more effective as national leaders in preventing pandemic spread, although the sample of female national leaders is small. A lack of diversity in decision-making and failure to leverage women's expertise and talent in decision-making invariably limits the effectiveness of any response. Greater gender representation brings faster and better-quality decisions (Phillips et al., 2014). Again, contrary to the assertions that we are all in it together, from the first days of the pandemic, the assumptions underlying the approach to keeping people safe have been gendered. Indeed, over the last decade we have seen many analyses which have highlighted how medicine, medical research, drug regulation, and product design inadvertently and implicitly orients to men. The default that informs decisions in medicine and indeed public health is men, men's lives and practices and male bodies. This can have dangerous and even fatal consequences for women.

Conclusion and Looking Forward

COVID-19 shows us collective sociopolitical processes are central to people's attitudes and health behaviors. More generally, COVID-19 has made very clear that an effective response to a major crisis requires a psychological understanding of the collective dimensions of human behavior. COVID-19 shatters the illusion of autonomy and individualism in determining health. It reveals profoundly how good health is about far more than individual lifestyle and treatment choices. Structural and collective forces determine health. Pricing health care for individuals may facilitate individual intervention, but it will never deliver good preventative health care: a fundamentally collaborative and collective enterprise.

Choices by political leaders were evidenced to strongly impact on not only the overall effectiveness of pandemic responses for their nations, but also individual-level actions, attitudes, and beliefs in several studies in this Special Issue. Populist styles of rhetoric and leadership were associated with the less effective pandemic responses, probably because they were associated with sociocultural biases rather than being grounded in medical science and sound scientific strategy in combatting SAR-COV-2 spread. The most effective initial responses were taken by East Asian societies, perhaps because they had previously been hit by SARS. Taiwan and other East Asian societies (as of December 30, 2020) had infection and mortality rates two orders of magnitude lower than those in Europe and the Americas (Liu, 2021). Taiwan was the only advanced economy in the world whose GDP grew in 2020 (by 4.6% according to the IMF[88]). We can choose to learn or we can choose to be oblivious and wilfully ignore the evidence from different cultures that have had success due to collective effort and history of investment in public health. Even where individualism is prized, good leadership needs to work with culturally appropriate narratives regarding the value of shared investment in health and solidarity over autonomy. It requires an in-depth understanding of how to manage, lead, and coordinate people *as* members of collectives and to attend to collectives and groups as important drivers of health and social behavior.

There is no doubt that the consequences of the COVID-19 pandemic will be with us for the years and probably decades to come. When the final analysis is undertaken, there will be countries and communities that will have fared better than others. Already it is apparent that the effectiveness of attempts to control the SAR-COV-2 has differed widely and deep-seated sociostructural factors are central to the effectiveness of efforts to curb disasters. Some global and international organizations will assess the final human cost of the pandemic in terms of lives lost, disability, and

suffering. Others will orient to calculating the economic and political costs. This review will deliver a reckoning. We hope this reckoning will affect public sentiment and tolerance for inequity within and between nations. Inequality is an important driver of SAR-COV-2 risk, morbidity and mortality outcomes, and vaccine access and uptake. Pandemic experience is also profoundly shaped by economic security, nationality, race, and gender. These issues represent a significant challenge to health and cohesion at a local, national, and global level. There are likely political consequences of these very different experiences for health and social care, national politics, and global governance in the years ahead. It is likely that the very different experiences different groups of people have had during the pandemic will fuel a huge appetite for social change. Without good leadership, governance, and international cooperation, this appetite for social change has the potential to become violent. With good leadership, governance, and international cooperation, this desire for change has the potential to unfreeze some of the disparities of the present and foster institutional reform and news ways in which our collectives can work, and work together.

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