Pandemics, State Capacity, and Political Violence

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ABSTRACT

In the spring of 2003, Chinese villagers all around the country got engaged in violent campaigns against quarantine introduction. SARS pandemic became a challenge for the government from both health and security perspectives, revealing healthcare management's weaknesses. A similar outcome happened during the Ebola outbreak in the countries of Western Africa when people resisted not only disease isolation and controlling measures but also had little belief in the existence of a disease threat. Consequently, in this thesis, I examine the conditions under which the 21st century's world pandemics trigger political violence and civil unrest. By focusing on the state capacity concept, which is widely used for measurement of successful policymaking (Gomide et al., 2018, Patrick, 2006), I demonstrate that low levels of it are connected with the potential risk of violent events.

This idea is proved by comparing state capacities related to China's healthcare-related policies during SARS and South Korean ones during the MERS pandemics. More evidence that supports the described pattern is found by analyzing Liberia, Guinea, and Sierra-Leone. According to this thesis's findings, lack of transparency in policymaking, weak intergovernmental coordination, and insufficient communication with society lies in the core of the politically violent events during the health emergency. Nevertheless, the factor that might mitigate the threatening social uprising is foreign assistance and cooperation with the international community from the earliest stages of the disease spread. It is demonstrated in the example of Mexico during its Swine Flu crisis.

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1. INTRODUCTION

A pandemic outbreak can be fatal and violent, but one rarely thinks it can trigger other sorts of violence – a political one. The main question of the thesis is whether pandemics increase political violence. The link between these two concepts is explained through the state capacity levels, variations of which are assumed to be determinant for the potential development of protests and riots. This topic is especially salient these days, given the current worldwide pandemic of Covid-19, which became a tremendous challenge for most national governments. In particular, recent riots in Serbia against the strengthening of quarantine measures are a vivid illustration of the suggested in this thesis idea that pandemic triggers a rise of political violence.

Surprisingly, little of the existing literature comprehensively analyzes the connection between large disease outbreaks and an increase in the incidents of violent insurgencies (with the notable exception of Gonzalez-Torres & Esposito, 2016). It is rather a common practice to separately examine the effect of pandemic outbreaks on economic growth (Correia et al., 2020, Velde, 2020) or to discuss the logic behind politically violent conflicts (Besley and Persson, 2011, Della Porta, 1995). Relying on the comparative case study analysis method, this study aims to fill this gap by exploring the situation during the major pandemics of the 21st century – SARS, MERS, Ebola, and Swine Flu in six countries of different geographical regions.

The concept of state capacity got much attention in the large numbers of excellent studies on topics varying from the protection of the territory to the governments' tax extraction functions. As Patrick (2006) suggests, state capacity is useful in relation to security and political realms, with the former one concentrating on the monopoly on the use of force and defense from internal and external threats, and the latter one explaining the government legitimacy and ensuring of basic rights for society. Overall, there is consensus about the effective policymaking lying in the core of the state capacity concept (Gomide et al., 2018, Painter and Pierre, 2005). Besides that, it is equally important to

emphasize the importance of a democratic regime type for effective policy implementation (Halperin et al., 2005, Vu, 2011), which is accountable for the potential avoiding or development of social unrest and violence. However, the findings demonstrate that democracy matters only if a country has well-developed political and economic institutions, whose performance does not depend on the endless financing from other countries.

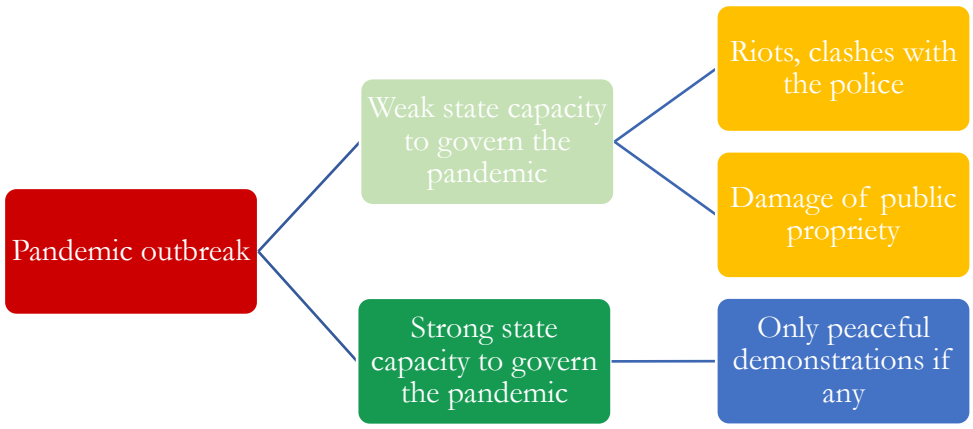
This thesis pays particular attention to health-care-related policies that a state implements before a pandemic outbreak, and on the set of decisions, the government undertakes to stop the disease outspread. Identification and analysis of the mentioned policies clarify why some states are more successful in emergency management and social unrest prevention. By mainly focusing on the case study comparison of China and South Korea that were hit by two deadly pandemics – SARS and MERS – I demonstrate how Chinese weak state capacity was a key factor to provoke different forms of political violence. Simultaneously, analysis of capacity indicators in South Korea allows us to conclude that effective pandemic governance and overall strength of a health care system prevented unwanted political violence outcomes. Comparing several healthcare indicators between China and South Korea gives a hint about the preparedness to a hazard. In particular, the number of hospital beds, medical staff per population, and access to basic water facilities are the basic features of the overall health care sustainability and efficiency.

The further analysis of risk communication with society, coordination between different levels of government, and concrete steps to stop a pandemic outbreak, on the other hand, demonstrate the efficiency of the governments to react on a threat. To illustrate that pandemic-violence pattern can happen worldwide, not only in the selected countries of the Eastern Asia region, I demonstrate supporting evidence from Western Africa. Guinea, Liberia, and Sierra Leone are examples of fragile states being on the edge of collapsing, which struggled to overcome massive Ebola spread. Having insufficient control over the population and inadequate provision of basic medical services, these

countries became the place were citizens assault medical staff because of fear and lack of knowledge, riot over quarantine restrictions, and refuse to believe in any pandemic threat. The government's overall reaction to Ebola was poor; thus, one could expect the escalation of social grievances and further violent riots through which the public would attempt to express their needs in safety and welfare. In fact, in the analysis of 19th-century cholera in Europe, Evans (1988) suggests that government quarantine measures and the state's inability to explain the nature of the disease can serve as the key factors for the public disturbances.

This thesis, relying on the main theories on the state capacity and violent insurgency connection, suggests that a core problem of public discontent after a pandemic outbreak is the public anxiety related to the perception of a new disease threat in combination with insufficient and non-democratic governance of the emergency. In other words, violence occurs because of perceived state coercion and demand for public goods. In the absence of government risk communication with citizens that would ensure the awareness about the problem and provide guidance on how to stay in safety, society is deeply stressed about the uncertainty of the situation. Consequently, once society members cannot satisfy their safety needs, and in case the government does not provide an adequate and fast response to an emergency, the frustration grows into politicized deprivation and further violent unrest. The logical chain is schematically depicted in figure 1 below.

FIGURE 1: The pandemic result under two different levels of state capacity



The schematic illustration depicts a deterministic link between the outbreak of a pandemic and an increase in political violence incidents. The deterministic approach to hazard risks allows designing the best policies to mitigate the harmful consequences since it adopts the worst-case scenario (UNISDR, 2015). Moreover, it is concluded (GFDRR, 2014) that deterministic risk analysis provides a robust estimation of the potential losses from a particular hazard scenario. Consequently, one should consider the weak/strong capacity variation as a factor that determines possibility of civil unrest.

Doubtlessly, there can be exceptional cases showing that some states, which are commonly classified to have a weak capacity in the health care government, do not suffer from the rage of political violence after a dangerous disease spread. As an illustration, I discuss the Swine Flu management in Mexico and reasons standing behind low political discontent. More specifically, the main factor of it is the willingness to cooperate with the international community from the early stages of new disease identification.

Thinking about political violence, one might imagine civil wars or bloody revolutions. This thesis, on the contrary, focuses on smaller events such as village riots that usually do not exceed thousand of individuals. Relying on the definition of political violence suggested by Della Porta - "*a particular repertoire of collective action that involved physical force, considered at that that as illegitimate in the dominant culture*" (Della Porta, 1995, p.3), I take into consideration mainly riots, clashes with the police and damage of public propriety. More precisely, this thesis concludes that in China the main form of political violence after the outbreak of SARS in 2002 was village rioting and smashing of the quarantine sites for SARS suspected individuals. They were happening in the different geographical areas of the country and did not grow into mass national-wide protests against the government.

Studying the small-scaled events as a consequence of a pandemic is important because it casts light on the potentially larger picture – when inconsiderable on the first sight social disturbances might

grow into large scale protest events with more serious demands to the government or even intentions to change it. Given the developments of the new media that allow rapid exchange of information, deprived groups in one region of a country can easily get fuelled by news about riots in other regions. Consequently, it can grow into mass mobilization leading to major social turmoil. Political violence can be as contagious as a disease, spreading all around the area if not handled immediately, hence, requires respective thinking ahead.

2. THEORETICAL FRAMEWORK AND CONCEPTUALIZATION

2.1 THE STUDIES ON LINKS BETWEEN POLITICAL VIOLENCE, AND PANDEMICS

Examining the relationship between pandemics and violence revealed a limited number of studies that focus on the causal mechanism between the outbreak of a disease and political unrest. Moreover, the previous studies do not provide a systematic analysis of how the various disease outbreaks affect state security and social behavior but rather demonstrate how some pathogens, such as HIV/AIDS, impact the demography or economic growth.

One of the explanations of the linkage between pandemics and political violence suggests that exhausted by civil and international wars, countries are more vulnerable to that sort of threat. For instance, "failing states may serve as important breeding grounds for new pandemics and – lacking the adequate capacity to respond to them – endanger global health" (Patrick, 2007, p.23). Furthermore, the author suggested that pandemics are "threats without a threatener" because they evoke without human actions and imply major challenges not only for separate countries but for the whole regions (Patrick, 2007, p. 31).

Attempting to adopt a holistic approach to finding the effects of a dangerous disease on security, the study of Bartels (2003) demonstrates how HIV/AIDS threatens the security of African states by undermining state capacity. By describing the causal links, the author states that "HIV/AIDS initially reduces an individual's human capital, which ripples to the systems levels, diminishing the overall technical capacity of an agency, bureaucracy, or military organization […] after all, citizen's frustration and anger from unmet institutional demands can result in violence and conflict" (Bartels, 2003, p.14).

Overall, conflicts become more probable as an epidemic overwhelms state capacity and causes institutional fragility and collapse. In other words, suggests a spread of a contagious disease weakens the already fragile state institutions to govern epidemics, which leads to the inability to provide citizens with necessary services causing a major deprivation in society and following violence. What is also important is that under circumstances of chaos, local criminal groups and warlords might take advantage of the situation and fill the vacuum of power all around the state territory (Herbst, 2000).

A brilliant study about the violent outcomes of the Ebola outbreak in Western Africa (Gonzalez-Torres & Esposito, 2016) scrutinizes a causal link between the spreading epidemic and civil violence. The authors claim that epidemics provoke violence in places with low trust in state institutions, which further decreases even more after introducing containment measures, triggering violence. Moreover, according to the findings, central drivers of civil violence are found in coercive measures to stop contagion, demand for public goods, and change in cultural practices, such as burial practices.

The bulk of other studies describes how infectious diseases undermine security by focusing on the pathogen's role as a biological weapon. For example, Elbe (2002) concludes that military forces deliberately transmit HIV through rapes in African countries. Hence, it becomes a weapon that threatens state security. In her article, Peterson emphasizes that "epidemic disease outbreak can endanger national security" (2009, p.45). Among the main reasons for the generation of violent conflicts, there is domestic and political instability and the use of biological threats by non-state actors to undermine security. One possible way to create a threat is to "deliberately target public health and spread the disease to weaken and demoralize an enemy population" (Peterson, 2009, p.79). She points out that epidemic diseases can function as war determinants if one of the rivals starts to use the biological weapon to weaken the public health an opponent. However, it seems like a not only biological weapon can be threatening. For example, during a war, one side might cut off water and

medicine supply or attack and destroy health care institutions.

Discussing the consequences of a pandemic, Price-Smith (2009) emphasizes that the spread of contagious diseases has various impacts, from demographic to phycological. Regarding the latter, the author claims that fear and anxiety caused by an epidemic "generate the construction of images of the "other", resulting in stigmatization, persecution of minorities, and even diffuse inter-ethnic or inter-class violence" (Price-Smith, 2009, p.20). Indeed, an outbreak of a contagious disease is often associated with a specific group, which becomes stigmatized. It causes prejudice and violence to its members, fuelled by fear and anxiety. Moreover, in the attempts to control the spread of disease and maintain cohesion and order, the state might impose "draconian methods," which, doubtlessly, deprive society even more, especially when people are already frightened by an image of a pandemic itself. Price-Smith suggests that "governments become increasingly paralytic as institutions become fragile and ineffective" (2009, p.21), hence an epidemic undermines state capacity to deliver essential services, which, in turn, weakens state's legitimacy.

In his study, Chow (1996) emphasizes that political instability and an epidemic reinforce each other in a sense that disease depletes government resources, which leads to political dissatisfaction and stability. Evans (1988) scrutinizes the causal link between the outbreak of cholera in major European cities and the instances of revolutions in the 1830-s. By examining the consequences of cholera's social and psychological impact and related to its measures in Europe, the author concludes that there was a little link between those two factors. However, he claims that there must be no doubt that epidemics in the 19th century was a source of public discontent and riots. Describing the violent consequences of epidemics in Russia in 1892, Evans (1988, p.143) indicates:

> The occasion for the disturbances was the usual combination of strict and harshly enforced government quarantine, isolation and disinfection measures, popular impoverishment and indebtedness, official assaults on traditional burial customs, and the inability either of the medical profession or the state to persuade what was by now one of Europe's most illiterate populations of the validity of medical theories of disease.

Contrary to that, there was not much public unrest in Western Europe's cities related to epidemics, primarily because there was an improved medical practice and no feudal obligations in the countryside. The study gives insight into the connection between the outbreak of epidemics in the states with an underdeveloped healthcare system, social grievances caused by poverty and exploitation, and violent riots and attacks. In particular, it demonstrates that one cannot expect large-scale public protests that might grow intro revolutions, but rather small-scale and short-term political violence occurrences related to the inability to fulfill the basic human needs. These findings help further analysis, aiming to show the consequences of the epidemic outbreaks in the 21st century. In particular, the link between an epidemic and the rise of political violence (protests, riots, attacks on medics) related to a state's ineffectiveness to ensure an adequate response to an epidemical threat.

2.2 THE CONCEPT OF STATE CAPACITY

Studies on state capacity can be mainly found in political science or economic literature. Both areas focus on the ability of a state apparatus to perform its functions. However, while political scientists focus attention on the state's capability to protect its citizens by maintaining, in Weberian words, the monopoly on violence, economic literature is concentrated on the state's ability to extract taxes. However, there is no consensus among scholars on conceptualizing and measurement of the state capacity. Since it is the primary variable of interest of this thesis, it is needed to discussed in detail and further analyzed from the perspective of the governments' capabilities to respond to an emergent public health hazard– the level of preparedness and efficiency of epidemic management.

In a broad sense of a concept, Hanson and Sigman (2013, p. 3) identify three standard dimensions of state capacity – extractive, coercive and administrative, which they claim are "minimally necessary to carry out the functions of contemporary states." By outlining those three dimensions, authors create a multidisciplinary approach to define the concept by using broad measures and

encompass political and economic perspectives. The dimension of state coercive capacity is often central to studies related to the stability of non-democratic regimes. Levitsky and Way (2010, p.57) suggest that "the greater a government's capacity to either prevent or crackdown opposition protest, the greater are its prospects for survival." Authors claim two factors to be crucial about coercive capacity: scope and cohesion. In line with that, Skocpol (1985) finds out that once the state's coercive apparatus is weakened, authoritarian regimes become more prone to revolutions.

Patrick (2007) suggests another approach to define the levels of state capacity. The author distinguishes between high and low capacities in developing countries and strong and low will or, in other words, the commitments of political leaders to implement policies. Accordingly, he develops a classification of states, among which there are "Good performers (Senegal, Honduras), Weak but Willing ones (Mozambique), Unresponsive/Corrupt/Repressive leaders (Burma, Zimbabwe), and Weak-Weak (Haiti, Sudan)" (Patrick, 2007, p.9). It depicts how the factors of motivation and incentives of political leaders affect the state's capacity to implement policies. Other scholars focus attention on the relationship between state capacity and human rights (Englehart, 2009; Brysk, 2005). It is widely accepted that weak and inefficient states cannot prevent violations of rights on their territories by non-governmental actors.

Englehart (2009, p.177) points out that "state capacity clearly varies spatially: typically states have the most control over the capital city and its environs, but often lose control over peripheral areas." For example, that is the case in many failed African states where local chiefs often undertake legal authorities' functions in the absence of administrating control over the terrain of a state (Herbst, 2000). These are usually despotic traditional leaders who have little if any restrains in their power. As a result, such societies suffer from weak colonial regimes' legacies, such as ethnic tensions, corruption, and uneven levels of development (Badie and Royal, 2000).

The idea of state capacity goes in line with Mann's theory of infrastructural power (1984),

which he developed to measure the scope to which a state can penetrate civil society and implement its actions across its territories. It includes access to public services in the country's administrative units, unified education system all over the territory and literacy, and the development transportation system. Opposite to that, in the state with weak civil society or absence of it, political leaders exercise despotic power – the rule over the territory with no consultations with citizens. Mann (2008) characterizes China's case as an example of a state with both strong infrastructural and despotic power because of the significant state autonomy from civil society and the penetrating function of a single mass party. In turn, South Korea combines a high level of infrastructural and low level of despotic power, which is typical for modern democratic states (Mann, 2008).

The framework of infrastructural/despotic power finally brings to an idea of epidemic governance as an inherent component of state capacity's health care sphere. More precisely, it is the way a state responds to a disease threat to preserve the power over and through the territory. Countries differ considerably in their responses to epidemic outbreaks. Among the possible explanations for various government responses to epidemic outbreaks in Vietnam, Malaysia, and Thailand, Vu (2011) points out to the level of democracy and centralization. In particular, weak democracy is assumed to be accountable for delays in making public announcements of a new disease and diagnosing the cause of an epidemic. A low degree of centralization, on the other hand, is the reason for the slow and ineffective response given the dispersity of power. Besides that, the social construction of health risks can be a crucial factor for the government.

With respect to democracy's role, in particular, a significant number of works find that a low level of democracy is associated with weak civil society (Halperin et al., 2005). If society cannot affect government policies and decision-making, there is little or none of checks and balances for the state apparatus; consequently, no accountability in actions. However, autocratic regimes can perform well in introducing harsh controlling measures, such as quarantine and isolation, though only after the first

stage when a new disease is detected, and the public is informed about it.

Democracies can better respond to the health emergency partly because of the private sector actors who can act independently from the government. Businesses, non- governmental organizations can implement successful steps to mitigate the outcomes of the pandemic. For instance, they can undertake public-education campaigns to teach society how to avoid the transmission of the disease and invest money into protective measures and surveillance.

Developed countries with a democratic regime are advantageous in hazard management because of higher technological progress. If the government encourages the development of science and invests finances in it, it is more likely to have experts who would develop disease surveillance measures and vaccines. Moreover, democracies' openness encourages the flow of information (Halperin et al., 2005), which enables to inform the public timely about any hazards and prevent social unrest. Furthermore, a state's capabilities to respond to an epidemic challenge are impossible without communication between government and society. In its guidelines for emergency risk communication, WHO (2017) emphasizes the crucial role of risk communication as an integral part of rapid response to an epidemic. Specifically, it includes "the real-time exchange of information, advice, and opinions between experts, community leaders, or officials and the people who are at risk" (WHO, 2017). Effective risk communication builds trust between authorities and the public, which allows them to engage civil society in decision-making and collaboration for the sake of an epidemic combatting. Once the communication began, the authorities can build a network of trained personnel across the territory that would possess the necessary skills for infection surveillance, monitoring, and adequate response.

Overall, the key thing for the government response to an epidemic outbreak is immediate and transparent communication with citizens. This thesis suggests that if the risk communication fails at the initial stage of a new infectious disease spread, one should expect to see the social unrest. However, it can be managed if a country effectively manages the crisis by implementing the appropriate steps in

surveillance, contact tracing, and isolation of infected and treating them from the disease. The democratic regime is crucial for effective decision-making and implementation of the pandemic mitigation strategy; however, presumably not determining when it comes to poor developing countries, which lack expert knowledge, technologies, and financial resources in general.

2.3 THE CONCEPT OF POLITICAL VIOLENCE

The concept of political violence is not as overstretched as state capacity, though it is still not easy to clarify its definition. In a broad sense, it includes all the disruptive actions that are typical for contentious politics (Tarrow, Tilly McAdam, 2001). The vast majority of studies on political violence focus on civil wars. In particular, it is typical for the studies about the Sub-Saharan Africa region. Strauss (2012, p.180) emphasizes that "civil wars have been the dominant form of warfare in Africa, but they have declined steeply in recent years so that today there are half as many as in the 1990s". Accordingly, one can observe the decline in warfare in a global context, and what is more important, the change towards the rise of small-scale insurgencies instead.

Likewise, Salehyan et al. (2012) stress attention that studies on conflicts in Africa overwhelmingly focus on organized and armed insurrections against the state. This fact supposedly shifts attention from other forms of violent conflicts in the area, including demonstrations, small strikes, pro-government violence, murders of political opponents, and many others. Della Porta emphasizes that the concept of political violence is ideologically loaded, hence its meaning can be interpreted differently in the areas of interest of political science and sociology.

In my analysis of the connection between epidemics outbreak and political violence, I use the definition of political violence suggested by this author. He defines it in a universal and not too narrow form by formulating it as: "*a particular repertoire of collective action that involved physical force, considered at that that as illegitimate in the dominant culture*" (Della Porta, 1995, p.3). Among the forms of political violence,

the author distinguishes rioting, damage or theft of propriety, violent confrontations, clashes with the police, and others, which all vary between low-level and high-level violence also between organized and disorganized forms. In all the cases, it is the confrontation between the state and non-state actors that include force, yet do not grow into large-scale civil wars. Besides distinguishing the forms of political violence, it is equally important to understand the reasons standing behind the rage of riots and murders.

According to Gurr (1970), political violence begins from the development of discontent, which further politicizes and finally is implemented into violent acts of deprived groups. Relative deprivation, which lies in a core of discontent, arises when there is a discrepancy between the value expectations and value capabilities. In other words, individuals united by common grievances and inability to achieve something they perceive as such deserve to have, start to demand the satisfaction of their needs through non-conventional acts. Accordingly, the bigger the deprivation, the more violent actions are expected to happen. In the case of epidemics outbreaks, one should not expect large-scaled violent actions because it is usually only the part of society that is affected.

With this in mind, the grievances during an epidemic can be related to quarantine measures that restrict people from movement, especially when individuals are not able to work and have no adequate savings for living. Another possible reason for public deprivation is the lack of trust in government that makes individuals doubt the threat to their health. In such a case, groups might perceive an epidemic threat as nothing more than just restrictions of their freedom and rights. It can indeed be happening when there is a lack of communication between governments and societies, and people mostly receive information from rumors. To conclude, this chapter summarizes the theoretical conceptualizations of state capacity and political violence and seeks to examine the connection between the two concepts and a pandemic. A somewhat limited number of theoretical works on the topic provides a springboard for establishing a logical chain: pandemic outbreak under the

weak/strong state capacity resulting or not resulting in the rise of political violence.

To sum up, Figure 2 below describes the possible consequences of pandemic outbreaks in countries with low state capacity and suggests reasons for the rise of different forms of political violence. In the following section, I will discuss the methodology of this thesis and clarify the usage of concepts and data sources.

FIGURE 2: The consequences of pandemics, reasons for political violence, and its forms

Potential consequences of pandemics	Erosion of human capital (skilled medical staff, in particular) (*Bartels, 2003, Cohen 2002)*	The disrupted ability of a state to deliver public services (*Chow, 1996, Patrick, 2007, Price-Smith, 2009)*	Restrictions of human rights on movement and communication *(Englehart, 2009)*	The state-level cover-up of information about the disease spread (*Huang, 2003)*
Reasons for political violence	Poor access to basic services (medical care, water, and sanitation) (*Herbst, 2000, Price-Smith, 2009, Ziaja 2012)*	Lack of trust in governments (*Gurr, 1970, Gonzalez-Torres & Esposito, 2016)*	Quarantine (*Evans, 1988, Rothstein, 2003*)	Insufficient public understanding of a health situation *(Gonzalez-Torres & Esposito, 2016, Huang 2003)*
Possible forms of political violence	Assaults on medical personnel and volunteers *(Allgaier and Svalastog, 2015)*	Riots *(Besley and Persson ,2011, Della Porta, 1995)*	Clashes with the police and army forces *(Fairhead, 2016)*	Protests *(Chenoweth, 2012, Della Porta, 1995)*

3. METHODOLOGY

In this section, I explain the case selection, measure the concept of state capacity, and evaluate political violence. The central discussion is related to China in 2003 and South Korea in 2015. The paired case analysis of these two countries is followed by a further discussion of three countries in Western Africa, which suffered from the Ebola epidemic from 2013 to 2016 and experienced a rise in political unrest among society. The brief case analysis of Liberia, Sierra Leone, and Guinea is supplementary for a fuller understanding of this thesis's main idea, and it should be seen rather as a stepping stone to broader comparisons of multiple cases. In addition, the discussion of Mexico and its 2009 Swine Flu pandemic management illustrates a deviant case of low levels of state capacity and political violence. All the selected cases maximize the variation in political violence outcomes – from the low to high levels.

The analysis of China and South Korea relies on a "comparable case strategy" (Tarrow, 1998, Gisselquist, 2014). This research design is best suited for country-level analysis (Przeworski and Teune, 1970). The selection of Chinese and South Korean cases, first, is determined by diverse levels of state capacity related to health care governance, classified as low in China and high in South Korea (based on Fragility State Index), which, consequently, is assumed to be explanatory for a negative or positive outcome of the dependent variable. Since very similar characteristics of both respiratory diseases, presumably, require implementing the same set of policies to combat the health emergency, the findings of the discrepancy factors would show why some countries experience civil uprising, while others do not.

Second, since both countries are in Eastern Asia, having they are interesting from a cultural-geographical perspective, and provide a ground for a loose application of the most similar systems

design (Anckar, 2008). Given the number of similarities between these two countries – varying from the prevalence of common sense of collectivism to economic development, they are fit for a paired comparison. Besides that, the national governments' initial steps required the same scope of preventive and control measures to stop the spread of contagious diseases.

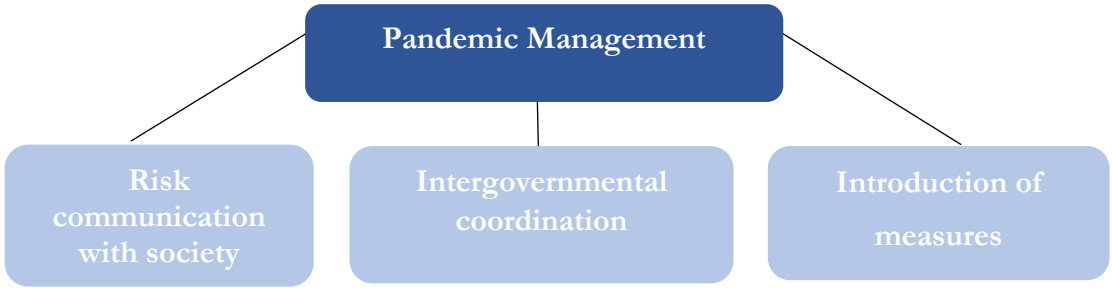
Mexico is explored as a deviant case in this thesis since its weak capacity, affected by Swine Flu, did not result in violent outcomes. Deviant case analysis helps shed light on the suggested theory's limits and clarifies the additional variable explaining the unexpected outcome – the absence of political violence. Gerring and Cojocaru (2016) emphasize that deviant case results in finding a new causal factor or contextual interaction, which can be illuminating for hypothesis building.

As mentioned several times above, the state capacity concept is not useful unless it is not subject-specific. Moreover, the conceptualizing of state capacity can be tricky because of the risk of tautology. Kocher (2010) points out that state capacity might be analytically not separable from the outcomes it is designed to explain. In this research, it is an intervening variable between an epidemic (the trigger) and political violence (the outcome). Accordingly, the primary area of interest is health care governance ***before the crisis and after it***. Related to health care before the pandemic, I describe several indicators that show the level of protection from diseases and epidemics:

- access to improved drinking water and sanitation,
- the number of hospitals and beds per population,
- access to medicine,
- the number of medical professionals per population,
- health insurance coverage.

All the mentioned fivemeasures are well-captured in the Public Services Indicator of the Fragility State Index (2018), which I used as an entry point for further interpretive analysis of different state capacity levels. Accordingly, while China got an average score of 7, Liberia and Sierra Leone – 9, Mexico – 6, and South Korea is 2 at the scale when 10 depicts the collapsed state and 1 – the strong one. The second component of the state capacity concept is related to the overall response to the pandemics crisis, which consists of three parts: risk communication with society, coordination between different levels of governments and healthcare institutions, and introduction of measures to combat the disease (see figure 3). They are all much related to a regime type, which will be discussed in case analyses as well as trust between the governments and societies, cooperation and transparency of decision making, and institutional capacity to fulfill basic functions.

FIGURE 3: Elements of the pandemic crisis management



Consequently, I conceptualize state capacity in terms of policies, which ensure health care provision throughout the country's territory, implemented by a state prior to and during the pandemic outbreak. A successful or failed implementation of the three mentioned elements of pandemic management is perceived as a criterion for theory generalizability. Thus, China and South Korea are assumed to be the typical cases of a weak and a strong capacity state, accordingly.

Regarding a **pandemic**[1], I include in my analysis four different ones that happened in the 21st century: SARS (Severe Acute Respiratory Syndrome) in China, MERS (Middle East Respiratory Syndrome) in South Korea, Ebola (Ebola Virus Disease) in Western Africa and Swine Flu (H1N1) in Mexico. I collect the data from various sources in the English language, including academic journals, articles from daily media news, reports from the UN agencies, the World Development Indicators and OECD databases, the Red Cross, by using keywords of "SARS", "MERS", "Ebola", "Swine Flu".

For understanding the concept of **political violence**, I rely on the definition of Della Porta, which is "a particular repertoire of collective action that involved physical force, considered at that that as illegitimate in the dominant culture" (Della Porta, 1995, p.3). In this thesis, I will consider only ***low-scale acts of violence****, such as riots and protests against quarantine or lock-down measures, murders of doctors and nurses, deliberate damage of public proprieties, such as hospitals or administrative buildings, arsons, terrorist attacks, clashes with police and army.* All the mentioned variety of political violence acts can take organized and disorganized forms. I expect to find only low-scaled forms of social unrest – assuming that a pandemic outbreak mostly deprives small separate groups of society that are mostly affected by a disease or government preventative measures, such a quarantine. Moreover, according to Chenoweth (2012), violent campaigns cannot attract many people as civil resistance actions. In particular, this fact is explained by lower barrier participation. Comparing the overall trend in political violence between China and South Korea before pandemic outbreaks in both countries, data from Mass Mobilisation Project suggests that in China the maximum of violent protests per year was reaching a number four, which would last no longer than half a day on average, while South Korea experienced zero violent protests during the last five years before MERS.

This thesis intends to find all the possible political violence incidents in China by searching for specific events instead of analyzing the overall trends in the countries. To reach the goal, I use the

[1] I use pandemic and epidemic terms interchangeably in this thesis

protest data from several datasets, such as NAVCO, Mass Mobilisation Project, ACLED, UCDP for the exact years of pandemic outbreaks in selected countries. There is a need to combine the data from several sources due to missing information for selected countries or years of interest. The period included in data was set to the duration of each pandemic in a country. For China, it is from November 2002 to the end of July 2003. For South Korea – from May to the end of July 2015. For Liberia, Sierra Leone, and Guinea is a period from December 2013 to June 2016. Regarding Mexico, the period of interest is from January 2009 to August 2010. It is important to emphasize that one of the possible disadvantages of the comparative method in this thesis is that it can only produce partial generalization since some variables remain not observed and not studied.

4. CHINA

China was hit by SARS (Severe Acute Respiratory Syndrome) in 2002. It is a viral disease with symptoms similar influenza, easily transmittable, and eventually may cause pneumonia (WHO, 2003). It has quite a lengthy incubation period, which can last up to 14 days. According to World Health Organisation reports (2003), an epidemic caused 5327 cases of infected with 349 deaths throughout the whole period of a disease outbreak from the 1st of November 2002, to the 4th of July, 2003. The capital of China Beijing was the city with almost half of the country-wide cases – 2200.

In the following case study of the Chinese response to SARS, first, I give a brief overview of the political regime, with the following description of the health care system indicators before the pandemic. It makes it possible to evaluate the preparedness of China to cope with an emergency. After that, I provide an analysis of the risk communication with society – in fact, the failure of Chinese authorities to inform the public about a deadly threat, which, consequently, triggered mass fear and panic. It is followed by a discussion of problematic intergovernmental communication and the interaction with hospitals, which altogether allows us to see the overview of the bureaucratic apparatus capacities. Next, the government's concrete steps to manage and put an end to SARS are discussed and evaluated. In short, one can see that after a slow initial reaction, the authorities implemented harsh measures to quit the spread of the infection. Finally, I describe the incidents of political violence in different regions of China that happened due to weak preparedness of health care facilities and medical staff and a result of weak communication of the government with society and the complexity of bureaucratic coordination.

4.1 THE POLITICAL REGIME OF CHINA

Chinese political regime is characterized as authoritarian or neo-authoritarian (Sautman, 1992; Moody, 2007) because there is a very limited public participation, absence of free political institutions, strict control over work of media and pro-state propaganda, and human rights abuse (Minzner, 2011, King et al., 2013). The central government has an efficient coercive apparatus to suppress social resistance, and also it does not depend on the election results given a monopoly of a ruling Communist Party of China headed by General Secretary. After a failed attempt to establish the Democratic Party after the 1989 Tiananmen Square protests and organize independent labor unions, the Communist Party of China remains in power firmly and dominative. Since the mid of 1990-s, China attempted to increase its regulatory and governance capacity to maintain stability and limit the spread of contradictory to official ideology ideas (Chung et al., 2006). In addition, the Chinese government is not sensitive to citizens' grievances and it primarily relies on repressions of most of the social discontent. Accordingly, it restricts the free flow of information, especially about any possible threats that can ruin the stability image. This fact contributed much to the uncontrollable spread of SARS because citizens were not aware of the danger and could not take any measures.

Moreover, the authoritarian nature of power imposes only one-sided communication with society when the public voice is not considered. Halperin et al. (2005) suggest that "authoritarian narrow clan- and patronage-based support on which autocratic leaders often rely for power gives them little incentive to focus on the general well-being of society". Consequently, one should not expect an excellency in public services provision, especially in relation to health care as authoritarian governments have incentives to satisfy citizens' needs at only the basic level. In total, an authoritarian regime is less advantageous than the democratic one in terms of governance, and the case of Chinese governance of the SARS pandemic is illustrative for this purpose.

4.2 THE OVERVIEW OF THE HEALTH CARE SYSTEM INDICATORS

- **Health insurance**

Since the beginning of market-oriented reforms in China in the 1980-s, one could expect the improvement of living standards in all spheres, however, the health care system did not receive enough attention. Before SARS in 2002, Chinese total expenditure on the health care sector was scant and consisted of 4. 2% of GDP, according to the World Bank Indicators data. It is crucial to emphasize that most of the spending was done by personal (around 60%) and corporate contributions (around 24,5%), while the governmental share was 15,5% (Gu, 2004). More important, there was no national full universal insurance coverage, and while urban residents could benefit from social health insurance, people in rural areas were not protected and had to pay for medical services out-of-pocket. Gu (2004) estimates that around 82% of the Chinese population in 2001 was not protected by any insurance schemes at all. Local and national governments did not devote much attention to public health care because it was viewed as an unproductive area of spending as it did not stimulate economic growth (Lai, 2004). Since the medical costs are high, people preferred not to visit doctors in non-serious cases such as flu. Since SARS had similar to flu symptoms, it is not surprising that citizens were not turning for help to hospitals and either treated themselves by own means at home or continued to go to work and spread the disease.

- **Access to medicine and the number of medical professionals per population**

In 2002, there were 1.121 physicians and 0.955 nurses and midwives per 1000 citizens (the data from the World Bank Indicators). What does this number say? The doctor population ratio, which was significantly below OECD countries average, is a common proxy to conclude the probability of mortality and morbidity reduction, readmissions, and complications. The insufficient number of doctors becomes a salient problem once an epidemic hits the population. It erodes human capital – the skilled medical staff because they are the most vulnerable category to getting infected by a new

disease. According to WHO reports (2006), the third part of all SARS infected people were health workers. Consequently, an epidemic reduces the workforce of doctors and nurses and weakens the state's ability to respond to a crisis.

Eggleston (2008, p.152) points out that qualified staff was "in short supply, especially at lower-level facilities". Since the 1960-s, the Chinese government was attempting to expand the health care coverage in rural areas and introduced a program of barefoot doctors – secondary school graduates with up to 6 months of medical training who would perform the primary care functions such as immunization, improvement of sanitation, delivery for pregnant women, prescription of antibiotics and basic surgeries (Zhang and Unschuld, 2008).

Before SARS in 2002, there were common "village doctors" who had less than two years of professional training. According to Wang et al. (2003), in 2001, 70% of village doctors had only high school education. Overall, the system was recognized as successful by WHO, however, it was hiding some other major drawbacks, besides lack of professional education of doctors. One of them is the inappropriate prescription of antimicrobial drugs by health-care workers, which develops the drug-resistant microbes. Further, it makes it more difficult to control the treatment of a disease when some patients are drug-resistant, while others are not. Wagstaff et al (2007, p. 19) conclude that less than 2% of drug prescriptions were rational based on the results of the 1998–1999 study. Another problem is that citizens usually have lack of trust to less educated doctors in rural areas and, while facing serious health problems, they rather seek for help in hospitals in bigger cities or not seek for help at all because of the high cost of treatment at the absence of health insurance. "Understaffed and unequipped clinics continue the cycle of physician distrust and lead patients to go directly to Tier II and Tier III hospitals" (The Collective Responsibility, 2018). That creates a situation when a contagious respiratory disease is not treated at all or not treated properly, and it spreads in the area fast because of the unrestricted

movement of people. In addition, there is a common perception of doctors as greedy and incompetent (The Collective Responsibility, 2018):

> Many surgeons are paid per surgery done, encouraging unnecessary operations. One patient at Zhongshan Hospital in Shanghai even said, "Doctors are too eager to perform surgery to treat you. It's like they're slaughtering pigs." Doctors are assumed to be pursuing self-interest over professional ethics and patient well-being and are known for accepting *hongbao* bribes for better or faster treatment.

- **Number of beds in hospitals**

In China, before the 2002 SARS epidemic outbreak, there were, on average 2.45 beds per 1000 citizens in the hospitals, which are a tiny number per population (The World Bank Indicators data). Moreover, there is a geographical variation in the number of available beds in hospitals. Rural hospitals, especially in remote areas, have a significantly lower number of beds compared to urban ones (The Corresponsibility, 2018). Accordingly, a person with health issues from a remote village is forced to go to a bigger town hospital because the local community clinic responsible for primary care level does not have enough resources to cover the local population's help. That causes the overburdening of bigger hospitals in the cities, which already lack the sufficient number of beds, hence the situation leads to even a more significant crisis of a health care provision.

Now, one can think about what an effect the commuters had on the spread of SARS. While the government covered up the information about the danger of a disease and was slow in its reaction to introduce quarantine restrictions, people were continuing to move from rural areas to the cities and back, and the number of infected was increasing. The New York Times in the report about SARS from the 27th of April 2003, stated that "by early February, sick and frightened patients from small cities like these were traveling to more advanced hospitals in the provincial capital of Guangzhou -- and that is when the surge of cases really began". More precisely, health care services are organized around a three-tier public provision system. In urban areas, the three-tier network consists of street clinics,

district hospitals, and city hospitals, while in rural areas, it includes village clinics, township health centers, and county hospitals.

- **Access to improved water sources and sanitation facilities**

In 2000, only 38% of the Chinese population had access to improved sanitation, according to WHO (2001). It refers to "at least adequate access to excreta disposal facilities that can effectively prevent human, animal and insect contact with excreta" (WHO, 2001) and ranges from protected pit to flush toilets. Why is this indicator important? Because WHO findings conclude that SARS can be transmitted not only from person to person by respiratory droplets but in some cases through feces, blood, and rarely urine. Hence, a considerable lack of utilization facilities is not favorable for the prevention of a disease spread. A much better situation was with access to improved water sources. WHO (2001) data suggests that 75% of the population could get at least 20 liters a person a day within one kilometer of the dwelling.

4.3 RESPONSE TO SARS

4.3.1 RISK COMMUNICATION WITH SOCIETY

China had not been informing the public about a new contagious respiratory disease for about four months since its outbreak in the mid-November in 2002, in Foshan City in Guangdong Province. Saich (2005) wittily compares China's covering up of SARS at its initial stages with the Chernobyl catastrophe in the Former Soviet Union. Indeed, only after the reports about the cases of infections and deaths from atypical pneumonia outside of China, from Singapore and Canada, the government provided the first report to WHO about the Guangdong outbreak, acknowledging the hazard. Why was the Chinese government slow in public informing about the disease? The explanation is primarily related to communist ideology. Anything that can harm the image of the Communist Party of China or its government, is perceived as a threat to social stability. It includes any news about social unrest,

corruption of authorities, economic problems.

Zhao (2016, p.194) emphasizes "the conviction by the government was that negative news could cause possible social panic and disorder". Accordingly, most of the news about a new highly transmittable disease was covered up. It was easy to do because the only central government had an authority to publicize information about an epidemic, while provincial governments were not allowed to do that before getting permission from the Ministry of Health, according to The Law on Prevention and Treatment of Infectious Diseases of China. The government has a full monopoly on the means of information and media functioning is strictly determined by Chinese Communist Party principles (Jinqiu, 2003).

Moreover, citizens' attempts to spread the information about a new dangerous disease were punished and treated as misinformation. Huang (2003, p.2) stresses that "according to the 1996 Implementing Regulations on the State Secrets Law (1988), any new diseases must be classified as a state secret before they are announced by the Ministry of Health or organs authorized by the Ministry". This regulation demonstrates not only the strictness and rigidity of the bureaucratic hierarchy but also the coercive capacity of the state to curtail any leak of information. It implies that doctors, nurses, and journalists are punished in case of making the information public about a new disease threat. Moreover, Lai (2004, p.79) points out that "many Chinese officials feared negative media publicity more than administrative and political censure because negative publicity could put an end to their own careers once for all". In addition, Huang (2004) points out that out of fear for not getting a promotion "government officials at all levels tended to distort the information they pass up to their political masters to place themselves in a good light."

Besides that, the Chinese government was fearing the political and economic influence of SARS, which was causing the under-reporting of the cases and hiding the real scope of an outbreak. A similar situation repeated with the COVID-19 outbreak when China was providing false information

about the number of cases, but after the huge number of reported cases from other countries, it provided statistics with a sudden spike of infected cases increase. Lai (2004) suggests that the suppression of information about a new disease helped Guangdong keep its economic prosperity at the time of the touristic season before the Chinese New Year when people actively do the shopping and go out on entertainment.

Considering all the mentioned above, one can conclude that Chinese authorities failed its communication with the public about the SARS threat. In particular, at the first stage of response to SARS, there were no announcements about a new respiratory disease, only assertations that the situation was under control. Moreover, the trust relationship between society and the government worsened. In the absence of official news about the health situation, the situation was ambiguous and led to social panic. Citizens could rely on one means of communication – the news from rumors. They were widely circulated through emails, cell phone-based short message services (SMS), internet-mediated chat rooms, and bulletin board systems (BBS) (Tai and Sun 2007). It was the main way an individual got to know about the symptoms of a new disease and preventative measures to avoid getting infected. Thornton (2009, p. 10) emphasizes that "on the average, 40.9 percent of Beijing dwellers had first learned of the disease through the grapevine, ranging from a high of 59 percent in Guangzhou to a relatively modest 29.4 percent of those in Chongqing".

No doubt, the rumors often distorted information, accordingly, people were becoming even more anxious and frightened. Huang (2004) claims that "residents in Guangzhou and other cities cleared pharmacy shelves of antibiotics and flu medication. In some cities, even the vinegar was sold out." Vinegar fumes were perceived to disinfect the air and kill the disease. It all contributed to further development of political violence – when people started to express grievances and dissatisfaction with strict governmental measures at the second stage of response to SARS.

4.3.2 COORDINATION BETWEEN DIFFERENT LEVELS OF GOVERNMENTS AND HEALTH CARE INSTITUTIONS

Communication between different levels of government and hospitals was problematic given the complexity of the bureaucratic apparatus. The government consists of a three-level hierarchy: central, provincial, and local governments. The major administrative apparatus of the central government is the State Council headed by the Premier and includes different ministries, among which there is the Ministry of Health. The central government includes three other important institutions: The National People's Congress, The Supreme People's Court, and the Supreme People's Procuratorate (information from the Chinese Central Government's Official Web Portal). All the legal and political authorities of these four institutions are replicated on the lower levels of governments. To be able to introduce an alert about a contagious disease for citizens, there is a requirement to get approval from the Ministry of Health, which, in turn, must negotiate the issue with other ministries (Pomfret, 2003). I

n addition, as was mentioned before, the authorities in the provinces were not allowed to publicize the information about a new disease before the guidance from the highest level of government. Consequently, the Health Ministry might be not have been acknowledged the situation in the remote areas at all until very late. Still, the initial problem was to detect that a pathogen started to spread and was itself a new dangerous disease. The main obstacle was the lack of communication between hospitals. At a press conference during the SARS crisis, Gao Qiang, China's Executive Vice-Minister of Health, explained why there was an under-reporting of SARS cases in Beijing (Liu, 2004, p.533):

> "There are 175 tertiary hospitals in Beijing: 131 are run by the city, district and county governments; 14 are run by the Ministry of Health and Ministry of Education; 16 belong to the military; 14 are run by the enterprises. These hospitals do not share information and are not under the same administration. SARS patients are admitted to more than 70 hospitals. The city government of Beijing did not have comprehensive and accurate statistics."

Indeed, there is a variation in types of hospitals, which not only creates a competition for the patients between them but also contributes to a lack of coordination between different levels of health authorities and territorial government units. Moreover, it raises the question about the role and responsibility of different government levels when it comes to health care services delivery. Furthermore, it causes a crucial delay in up-to-date informing and disrupted abilities of health workers to control the spread of an epidemic. For instance, Wong and Yongnian (2008, p.182) stress that "some localities like Zhongshan and Guangzhou (two cities Guangdong province) were not able to take effective measures against the infections disease due to lack of first-hand information in the city where the first case of SARS was found".

4.3.3 Introduction of measures to combat SARS

Since the first case of atypical pneumonia in Guangdong Province on the 16th of November, 2002, there was no official reporting about a contagious disease until the beginning of February in 2003 when more than 100 deaths were reported (WHO, 2003). Soon after that, China made an announcement that the peak of disease outbreak was in mid-February, which turned out to be false information because the actual peak happened in the second half of spring (WHO, 2003). After Chinese Communist Party and all top leaders got fully acknowledged about the scope of SARS threats and could not cover up the information anymore because of the international community pressure to investigate the outbreak, the authorities started to implement rapid decisions to stop the spread of an epidemic and take the situation under control. On the 8th of April, the Chinese Ministry of Health listed SARS as infectious disease (WHO, 2003), which enabled the government to start the controlling measures throughout all the country territory. Since then, "all the provisions of the Prevention and Treatment Law could be used to control the spread of SARS through Decree 84 from the Ministry of Health" (Rothstein et al., 2003, p.68).

In particular, SARS task forces were set up at different levels and start coordinated surveillance and communication, including introducing quarantine and travel restrictions. Earlier in February, China introduced a contact tracing system in Guangdong, which was based on the completion of a questionnaire. However, at that stage, it was not as efficient as it could have been if the tracing system worked in other areas of outbreak too. Since the government got an authority to introduce quarantine and set isolation measures in late April, it started to isolate individuals with symptoms or those who were in close contact with infected. Mostly, it was a home quarantine for 10-14 days, however, in some cases, big groups were quarantined together. It was a case for university dormitories, construction sites, and hospitals. For example, it happened with the Jinggang Mansion construction site, which became the first quarantined place in Beijing, affecting 399 persons in succession for three weeks. (Rothstein et al., 2003).

Moreover, villages in rural areas of Hebei province were entirely cordoned off (Rothstein et al., 2003). These were the quarantine restrictions to become a trigger for social unrest and violence because they were introduced after a long phase of public information vacuum fuelled by fear, panic, and rumors about the level of SARS danger. Besides that, in the mid-April Ministries of Health, Finance, Railway, and Transportation and Civil Aviation arranged a notice of instruction for other governmental units at local levels to establish control points at railways stations and airports to check people with symptoms of a disease (Rothstein et al., 2003). Once a supposedly infected person was detected, primarily by thermal scanning using infrared scanners, the transport vehicle had to be disinfected immediately, and a person sent on a quarantine (Ahmad et al., 2009). In addition, the government introduced harsh measures to combat disobedience. For example, individuals who would refuse to voluntarily get isolated or be quarantined could be sentenced to up to 10 years in prison because it would mean that they intentionally spread a dangerous pathogen (Article 114 of the Criminal Code). Even more, Rothstein et al (2003, p.73) provide some evidence that "a person instigating a riot

on a train quarantined during an epidemic might be sentenced to death if that person had destroyed property and used a gun to rob and kill someone during the disturbance". Thus, authorities initiated strong measures to ensure the public health measures are implemented and that a disease outbreak can be controlled.

4.4 INCIDENTS OF POLITICAL VIOLENCE

In China, all the forms of political violence, which public officials call "mass incidents", have risen dramatically from the beginning of the 1990-s, especially in the countryside. Jianrong (2007, p.3) explains it by "a combination of the central government's inability to control the vast and remote areas of China, and the lack of a clear set of common interests among the highly diverse populations of rural China". In most cases, rural protests are related to land-rights disputes. According to Mass Mobilization Data, there was an increase in the number of protests in 2003 compared to several previous years in China. However, the data includes only protests that exceed 50 actors, hence it does not embrace the whole specter of events associated with political violence. Lai (2006) points out that in the period from 1993 to 2005, there was an increase of "collective public security incidents" from 8,700 to 87,000, with 3.1 million participants in 2003. Moreover, the author emphasizes that incidents "have also become more violent in recent years, while peaceful protests in the forms of "sit-ins", "petitions" and "rallies" till take place, these types of protests have become increasingly rare" (Lai, 2006, p. 8), and in terms of geographical distribution, the half of political violence cases were in the countryside. Since it is rather impossible to find detailed records about all the events given the media censorship in China, it is a better idea to scrutinize several vivid examples of incidents that demonstrate how SARS pandemic triggered unrest.

There is a clear connection between the beginning of governmental response to SARS in April – the introduction of strict controlling and preventing measures and the beginning of riots and social

unrest. After a failed risk communication about the precautious measures to stay safe, the perceived threat of SARS was much higher than the actual one, and it mobilized the most deprived individuals to demonstrate their disapproval of the government.

- On the 24th of April, in Hebei province, which is very close to Beijing, the local government set up a quarantine station at Xiongfeng Hotel of Guzhuang. "In the afternoon of the 25th of April, some villagers in Guzhuang assembled in the Hotel and obstructed the work of the government. A few people even set fires and smashed government vehicles. On the 1st of May, the public security bureau of Xiong County arrested six individuals on the basis of warrants issued by the Xiong County People's Procuracy" (Rothstein, 2003, p.75).

- On the 28th of April, approximately ten thousand residents of Chagugang city and neighboring villages went on a night riot against the rebuilding of school into a quarantine facility for individuals who were in close contact with infected and for travelers (The New York Times, 2003, the 26th of April). The school was closed one week before to become a site with 200 individual bedrooms. People panicked because of the perceived danger and ransacked the building despite the paramilitary and police troops all around. "This disease is exactly what everyone wants to avoid, and they want to throw it right at us" – one of the protesters told The New York Times reporter. People were confident that a facility is rebuilt for SARS patients with conformed diagnosis, and since the local government did not provide a sufficient explanation of its decision when closed the school, they were trusting rumors. "The government never communicated with us, but just suddenly decided to build a facility here" (The New York Times, 2003, the 26th of April), said a participant of the riot.

- From the 25th of April to 28 in Linzhou city, central Henan province, there was another village riots incident. They ransacked a planned SARS quarantine center and other medical facilities, according to the China Post news report from the 6th of May, 2003. This riot resulted in the

sacking of the director of the city's health bureau Wang Songlin and the city's infectious diseases station head Wang Yuxi on the 2nd of May. Moreover, about 13 people were arrested because of the incident.

- On the 3rd of May, a crowd of approximately 300 villagers obstructed construction of SARS hospital in the Baimiao village. The three leaders of the protest were sentenced to fixed-term imprisonments of 1.5 years, one year, and six months respectively (Rothstein, 2003).
- On the same day, the local government of Dashiqiao Village in Hebei Province sent a construction team to facilitate Tongji Hotel into a SARS quarantine station. Soon after the beginning of work, the village locals started to block the activity, which caused the injuries of one worker. In addition, protesters assaulted the policemen, which came at the site and damaged the police cars.
- On the 5th of May, villagers of Xiandie in Zhejiang Province protested against quarantine of suspected SARS patients near their homes and against the government's inability to control SARS' spread in general. WHO estimated about 1,000 residents that surrounded a local government office with demands to relocate the quarantine facility. They also smashed the building. In its report from the 6th of May, 2003, the Guardian suggests that protesters were angry because the building lacked the medical equipment and trained staff to protect the community.

All the described above incidents of political violence are clearly associated with the fear of SARS and lack of trust to the authorities that had not managed to set a risk communication with people to prepare them for possible isolating and quarantine necessary measures to stop the spread of the pathogen.

This chapter provides a case study of China and concludes that the Chinese level of state

capacity was low before and during the SARS outbreak in 2002-2003. By thoroughly examining the health care system indicators – access to medical help – one concludes the insufficiency of basic services in the country, which could have affected a rise of public grievances. Moreover, analysis of the overall state response to respiratory disease (see figure 4) shows that weak communication between central and local levels and, more importantly, lack of transparency in the state decision making contributed to sparks of riots all around the country. In particular, since the disease's preventative and control measures were late to implement, they were especially harsh and could not be perceived by society with no resistance.

FIGURE 4: The Chinese response to SARS pandemic

The Chinese response to SARS pandemic		
Risk communication with society	**Intergovernmental coordination**	**Introduction of measures to handle health emergency**
- Several months delay in public informing about the new disease; - Underreporting the real number of disease infected cases; - Rumours as a main source of information for citizens.	- Complex bureaucratic system that creates barriers in communication between central and local governments; - No accountability of certain types of hospitals to the same government.	- Untimely but efficient surveillance and isolation measures; - Strong punishment for violation of quarantine rules.

5. SOUTH KOREA

South Korea detected MERS (Middle East Respiratory Syndrome) in May 2015. Similar to SARS, described before, it is a viral disease, which has influenza-like symptoms, easily transmittable through the interpersonal contact, and eventually may develop into pneumonia. The incubation period can continue up to 14 days. The WHO (2020) reported that the overall number of infected reached 2994 of cases in the world by the end of 2019. In South Korea in 2015, the number of laboratory-confirmed cases was 186 , causing 36 deaths throughout the whole period of a disease outbreak from the 20th May to the 19th of July 2015 (WHO, 2015).

In the further case study of South Korean response to MERS, first, as in a previous case study, I provide an overview of the regime type, which helps to understand the reasons behind effective pandemic governance. After that, I describe the health care system indicators before the pandemic outbreak, which demonstrates the readiness of the system to the infectious disease outbreak, with some insignificant drawback, though. Next, analysis of the risk communication with society is provided. Although it turned out to be not sufficient to prevent social fear and panic, it had not triggered any violent contention. After that, there is an overview of intergovernmental communication and interaction with hospitals. Following that, the governmental measures to stop the spread of MERS are discussed and evaluated. One can see that given a fast and coordinated response of authorities and non-governmental organizations involved in the emergency response, the outbreak lasted for less than three months and did not cause many victims. Moreover, even though the overall response to MERS was not very smooth, it was effective enough to prevent social unrest and violence.

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5.1 THE POLITICAL REGIME OF SOUTH KOREA

South Korea is a democratic country with general respect for the political and civil rights of citizens. There is a freedom of media and expression with only minor flaws and restrictions related to the defamation law that authorizes imprisonment (Freedom House, 2015). The free flow of

information is perceived to be the one to facilitate the management of calamities. More precisely, it is not related only to the spread of information but also includes various educative programs for the public, such as keeping the social distance and washing hands to avoid different diseases. Halperin et al. (2005) emphasize that democratic societies, which promote the free flow of information, have a distinctive advantage in efficient policymaking. Apparently, the reason for that is that in open societies, there is a cooperation between the public and private authorities, which results in more effective policymaking through the process of trial and error. Besides that, democratic structures adjust well to changing circumstances (Halperin et al. 2005). For example, once citizens got to know that one of the medical centers in Seoul was withholding information about MERS infected people and started to express their grievances, the authorities immediately recognized the mistake and improved decision-making transparency. The government's accountability to society is a crucial determining factor of a democratic regime. It means that citizens have the power to affect policymaking and reach the most beneficial situation for them.

5.2 THE OVERVIEW OF THE HEALTH CARE SYSTEM INDICATORS

- **Health insurance**

There is a universal health coverage of the entire population since 1989 by either national health insurance (97%) or the tax-based Medical Aid Program (3%), which is designed for low-income citizens (OECD, 2020). Overall, health care is defined to be highly affordable for the population with minor barriers in accessing primary care for the most vulnerable categories of society. The healthcare sector spending as a percentage of GDP was medium - 7% (OECD, 2015). Patients were not required to register with primary care doctors and have the freedom to visit any doctor. Besides that, patients were free to choose between clinics and hospitals as long as they pay a higher co-payment (OECD, 2020). This factor contributed to a fast spread of MERS at its initial stages when the patients used to

go "doctor-shopping" from one hospital to another, while the disease transmission risk was high. Scholars (Kim et al., 2017; Cho et al., 2016) emphasize that it is common in South Korean society.

- **Access to medicine and the number of medical professionals per population**

In 2015, there were 2.25 doctors and 6 nurses per 1,000 people (from the World Bank indicators data). It is slightly below the average of OECD countries, which was 3,3 doctors and 9,5 nurses per 1,000 people in 2015. However, according to the Korean Medical Association (KMA), the number of physicians increases fast, and compared to the size of the territory, the country has a high physician density. Nevertheless, there is a discrepancy between regions and hospitals in the medical workforce, and most doctors and nurses are concentrated in the capital and metropolitan area.

- **Number of beds in hospitals**

In South Korea, before the MERS epidemic outbreak in 2015, there were 11,5 beds per 1000 people in the hospitals, according to the World Bank Indicators data. Compared to other developed countries' scores, this number is one of the highest in the world. However, despite being on top of a list, South Korean high density of population is challenging for hospitals' capacity, which is often described as overcrowded by patients waiting in emergency rooms to get a bed (Cha et al., 2016). Moreover, citizens often choose to seek treatment in advanced prestigious medical institutions. While health care insurance allows us to choose different hospitals and pay the same price for the same services across the country, that is not surprising that some clinics that have better facilities and technologies are overcrowded, while others are not. To be able to work as a doctor, one needs to obtain a national license. It only becomes possible after four or six years of studying in a medical school, passing a Medical Licensing Examination, and spending four years on a medical internship (Moon, 2020). Overall, it indicates a serious approach to the education of the medical staff to ensure the quality of

health care services. The expenses related to prescribed drugs are not fully covered by the National Health Insurance and usually require cost-sharing. However, the government attempts to regulate the prices and make them more affordable and includes some medicine in the discount-list. The WHO report on the Health System of Korea (2015) points out that antibiotics' overall consumption is much higher in South Korea than the average on OECD countries.

- **Access to improved water sources and sanitation facilities**

According to the World Bank Data Indicators, in 2015, 98% of the population had access to drinking water facilities, and 99% had access to safely managed sanitation services. The availability of utilization facilities does not posit the risk to get a dangerous disease transmitted through human excretion.

5.3 RESPONSE TO MERS

5.3.1 RISK COMMUNICATION WITH SOCIETY

The government provided an official report to the public and to WHO about the first case of MERS in South Korea the next day, on the 20th of May 2015, after testing an index patient on a disease (Chowel et al., 2015). The index patient was not identified as a disease transmitter for about a month since he arrived from the Middle East, consequently, it contributed to a significant spread of MERS, primarily, in the hospitals he visited when he was seeking medical help. South Korea had no strong incentives and intentions to leave the public without news about MERS in the country. There was relative freedom of media in South Korea in 2015.

Freedom House (2016) reported that "South Korean online media remain vigorous and innovative. Aside from the ban on pro-North Korean content and blocks on access to North Korean websites, the internet is fairly unrestricted in practice". Hence, there was a rapid flow of news about MERS through the Internet and NGOs. According to Jack's report in BMJ, the 24th of June 2015,

Kevin Kee-Jong Hong, team head at the Institute Pasteur Korea, emphasized: "It is important to provide balanced, reliable information. A lot of people want to know [what is happening] and many citizens may want [to] go to these accounts to gather information." Even though Korean authorities provided daily reports about the new cases of infected and deaths caused by a disease, they were widely criticized for covering the exact hospitals where MERS infections were detected. A scandal burst out around Samsung Medical Center, where around half of the total MERS infected persons were identified. The main concern was related to the fact that the hospital admitted new patients and covered up the information about MERS infected. This situation, though, was very soon solved, triggered public dissatisfaction with the government. However, it never grew into violent protests given the government's fast response in its attempts to solve the conflict.

Since the detection of the first MERS cases, the public was acknowledged to wear face masks and keep social distancing. Jack (2015) points out that "well-known public figures were pictured wearing face masks, encouraging copycat behavior". Besides that, the experience of other countries facing MERS in the past few years contributed much to understanding safety and disease prevention measures. The citizens had full access to the means of information about symptoms, ways of infection transmission, and risks of getting ill. To illustrate, the Korea Center for Disease Control (KCDC), which is the central operational agency for infectious disease prevention and control, had guided sixteen local governments to conduct the number of training exercises against emerging infectious diseases crises each year since 2010 (Lee et al., 2013). They consist of virtual scenarios, education, and evaluations for the exercises' successful execution, including a yearly large-scale drill (Lee et al., 2013).

Moreover, telecommunication companies and broadcast media provided warnings to society through different channels. Besides that, a special application called The Safemap was launched to reach out to citizens with useful information. OECD report (2020) points out that citizens, in turn,

could report about the emergency back through the application, which allowed them to collect sources for making the picture of the situation clearer.

5.3.2. Coordination between different levels of governments and health care institutions

Two ministries in South Korea are responsible for managing a disaster and disease outbreaks - The Ministry of Public Safety and Security and the Ministry of Health and Welfare (MOHW). The latter takes charge once there is an emergency with a pandemic (Seo et al. 2015). Since 2010, there is a regulation to have an established Infectious Disease Control Committee that is accountable to MOHW, and which "specifies the responsibilities of the various levels of governments and health institutions for the national infectious disease surveillance and detection system, the vaccination program, the various infection control countermeasures, the stockpiling policy for medical countermeasures as well as a set of financing and compensation regulations" (OECD, 2020).

Overall, the government system is quite decentralized, however, the local governments, despite possessing much freedom in developing their medical institutions, fire services, and rescue teams, are entirely under the control of the central command once there is a hazard in the country. Local and regional governments are required to have specific plans for the control and prevention of infectious diseases to detect and surveil the territories effectively. However, according to the Infectious Disease Control and Prevention Act of 2004, the local governments bear the main responsibility for emergency responses, and only when local capacities get overburdened, there can be an intervention from the national government.

Moving to the discussion about health care institutions, at the initial stage of the disease spread, the hospitals made reports to the Centers for Disease Control and Prevention under the Ministry of Health and Welfare and, aiming to protect hospitals from losses, they were recommended not to share

the information with public (Ha, 2016). However, despite the initial withheld of the vital information from society, one could observe that there was rather smooth coordination between hospitals, emergency units, and governments.

There is a comprehensive country-wide system of National Notifiable Infectious Disease Surveillance, which collects the reports from all the medical institutions - 298 hospitals, 256 Public Health Centers, 13 quarantine stations, and 17 Research Institutes on Health and Environment with complementary national lab capacities. (OECD, 2020). More importantly, according to the WHO (2017) report on Korea, medical staff is required to report 80 types of infectious diseases by all public and private healthcare facilities and laboratories, and also to local governments through sentinel surveillance system within seven days.

5.3.3 Introduction of measures to combat MERS

The Framework Act determines emergency management in South Korea on the Management of Disasters and Safety. It instructs all the governments' levels on how to plan and implement policies related to disaster and safety measures. However, not only the government contributes to the emergency response. Non-governmental actors, such as Clinical laboratories, Credit Card Companies, and Mobile Telecommunication Companies were also involved in the response. For instance, business establishments measured their customers' body temperature and distributed sanitizers for hands as a preventative measure. which nonetheless constituted an incomplete preventive measure. Mass media also attempted to trace and find the sources of rumors that caused social panic and overreaction on the situation (Ha, 2016). Immediately after detecting the first MERS case, border quarantine measures were strengthened against returning travelers from the Middle East from self-declaration to thermal screening system (WHO report, 2015). After that, all the indexed case's close contacts were traces and put under quarantine for two weeks. Soon after the scandal about withheld of information at Samsung hospital, the government decided to disclose hospitals' names, which MERS infected had visited.

Besides that, they intensified contact tracing, launched the nationwide cross-sectional pneumonia survey, and expanded the MERS CoV testing laboratories.

Overall, there were 16,993 individuals to be quarantined for 14 days throughout the outbreak (Myoung-Don et al., 2018). South Korean government adopted a harsh strategy to isolate individuals given such a situation. Furthermore, as The Guardian reported on the 8th of May 2015, authorities decided to track hundreds of people's mobile phones under quarantine to prevent the spread of the deadly disease. Besides that, schools all over the country were closed on the quarantine for a few weeks to prevent the spread of disease. It is worth noticing that it was implemented due to public pressure on authorities triggered by panic and fear of a deadly disease. Hence, one can see that civil society can play a crucial role in crisis management. Moreover, Jack (2015) reports that "doctors' children, in particular, were told to stay at home". The reason for that is that MERS circulation was mainly in hospitals and between doctors.

Just like in China during the SARS outbreak, Korean authorities introduced a strict punishment for disobedience under the state of infectious disease emergency. The government passed a law that would authorize to imprison people up to two years who would neglect quarantine requirements or spread lies about their possible exposure to MERS. The New York Times, in the report from the 26th of June 2015, informed about a new law, according to which public health investigators got an authority to close the site of a possible outbreak of infectious disease and to quarantine individuals. By the end of the MERS outbreak, all the infected cases were detected, and their contacts with other people were traced. More importantly, this information was put in free public access in the Korea Centers for Disease Control & Prevention reports and includes the necessary data about the diagnosis, age, sex, and infection source. The competent surveillance and detection of infected made it possible to build the network of MERS cases and stop the transmission of disease on its early stage.

5.4 Political Violence?

Even though the government was widely criticized for withholding the names of hospitals with infected MERS patients, the country's political situation did not escalate to such an extent to provoke any violent incidents. Only a peaceful, non-violent protest organized by health-workers took place next to Samsung Medical Centre in mid-May 2015. It was a facility, which became the epicenter of the MERS outbreak, and its inability to control the spread of the virus was said to be the trigger for public dissatisfaction. This evidence illustrates that the state's overall capacity to govern the health emergency is crucial for keeping the social order.

This chapter emphasizes the crucial role of transparent and timely policy implementation during the emergency that prevents social upraise and violence occasions. South Korea is an example of the country that managed to overcome the MERS epidemic without riots, first, due to democratic governance and, second, because of the high level of health care provision around the territory. The participation and assistance of non-governmental actors in introducing contact tracing played an essential role in the epidemic management's overall success. Furthermore, since MERS' surveillance and detection had started right from the beginning of the first case detection, it allowed avoiding the introduction of rough quarantine for the large part of the population (see figure 5).

FIGURE 5: South Korean response to MERS pandemic

South Korean response to MERS pandemic		
Risk communication with society	**Intergovernmental coordination**	**Introduction of measures to handle health emergency**
- Fast announcement of the new disease spread; - Free flow of news about the new cases of infected; - Provision of detailed instructions on how to avoid the disease and what to do once infected	- The local governments, even though quite a freedom in decision making, are entirely under the control of the central command once there is a hazard for the state; - Smooth and transparent communication between institutions.	- Highly developed contact tracing, mobile phones tracking; - Strict punishment for violation of quarantine rules; - Quarantine for schools and isolation of suspected in being infected.

6. THE CASE OF THREE AFRICAN COUNTRIES

In this chapter, I want to demonstrate some supporting evidence of the pandemic-violence pattern on the example of three Western African countries, which were hit by Ebola – Liberia Sierra-Leone and Guinea. The brief analysis provided in this chapter plays a supplementary role in this thesis aiming to explore the countries being on the lowest side of the capacity scale.

Although it is widely accepted that fragile states are more conflict-prone than others, this thesis explores only specific, pandemic-related, incidents of political violence, which can be recognized by a closer examination of single cases. Even though they are all classified as free and democratic according to the recent reports of the Freedom House and Polity IV indicators, they are in a fragile development phase and are heavily dependent on the international aid and constant flows of money from the developed countries. The prominent studies on the effects of foreign aid to developing countries of Africa (Alesina 2000, Schraederet al 1998) emphasize a harmful impact mainly because of the poor performance of the institutions of the receiving countries and corruption. More importantly, the financial aid to these countries was mostly allocated for coercive apparatus strengthening instead of improving the local health care capacities and emergency preparedness. In addition, since the governments are relaxed about getting money from foreign aid, they do not need to care about revenue from taxes. Consequently, they stop being accountable to citizens and are unlikely to pay much attention to the views and opinions of people about their actions.

Gonzalez-Torres & Esposito (2016) emphasize a causal link between the Ebola spread and civil violence. The authors claim that epidemics provoke violence in places with low trust in state institutions, further decreasing even more after introducing containment measures, triggering violence. Moreover, according to the findings, Ebola increased conflict incidence, and only after the significant international emergency assistance, the situation became more stable.

According to the Fragile States Index, all three African states, in relation to public services provision, can be classified as weak as they are rated as 9/10, where 10 depicts a collapse. Societies in Western African countries have a low level of trust in state physicians, and they are more likely to turn to traditional means of treatment at home (Afrobarometer, 2011/13), which are not sufficient in Ebola treatment as it causes fatality in

up to 90% of cases (WHO, 2020). In 2013, less than 20% of the population in each of the countries had access to basic sanitation services (World Bank Indicators data). Given that Ebola is primarily transmitted through bodily fluids of infected (WHO, 2020), the lack of sanitation facilities was a tremendous weakness in attempts to stop the transmission of a contagious disease.

The reasons standing behind the violent riots in these Western African countries during the Ebola outbreak were the same as in China during SARS pandemic in 2003 – disrupted trust relationship between the government and society, failed risk communication, no transparency in decision-making, inability of the government to control the territory to ensure adequate prevention and detection of a disease spread, and also the military and police coercive measures abuse. All the riots had a similar repertoire – people stood against quarantine sites for Ebola suspected patients and turned to ransack, clashes with the police, and put buildings on fire. Gonzalez-Torres and Esposito (2017) point out that Ebola treatment centers were misunderstood by the population and through the spread of rumors and seen as a forced detainment against their rights. In particular, Guinea was the case where "the biggest source of rumors and conspiracy theories was around what was happening inside Ebola treatment units" (Gonzalez-Torres and Esposito, 2017, p.11).

Moreover, even the Ebola contact tracing "was also experienced as highly intrusive political surveillance" (Fairhead, 2016), causing a violent local response. That is not surprising given that only approximately 16% of the population in Sierra Leone and Guinea, and 25% in Guinea, expressed trust in the police, according to data from Afrobarometer round 5 for 2011/2013 years.

The failed communication with citizens about a new disease and disrupted trust to government caused a significant societal deprivation about setting the quarantine center for suspected patients in the Liberian capital Monrovia – the West Point. It was one of the most violent periods in Liberia during the Ebola pandemic when the angry crowd of people attacked and looted the clinic out of fear. The PBS article from August 18, 2014, reports about the clashes of protesters with the police. Few days after that, the district of approximately 50 000 citizens was put under quarantine, which led to another wave of riots with the police and army, causing deaths. Al-bakri Nyei (2016) emphasizes that "people refused to comply with public health regulations, continued traditional burial rites and resorted to traditional healing methods" mainly because they did not believe in a

threat, which they perceived as a plan of the government to gain foreign aid. Accordingly, there was trust neither to authorities nor health workers and volunteers from the international humanitarian organizations. To illustrate it in more detail, in Guinea, according to Red Cross reports, the volunteers of the humanitarian organizations used to be victims of attacks from locals on average ten times per month in 2014. Meanwhile, in Sierra Leone, according to the Reuters report from July 26, 2014, in Freetown, "the thousands marched on the clinic following allegations by a former nurse the deadly virus was invented to conceal "cannibalistic rituals."

FIGURE 6: The number of conflicts (riots, protests and violence against civilians), before and during Ebola pandemic in selected countries

	Pre-Ebola 2012-2013	During Ebola 2014-2016/5	During Ebola 2014-15	All 2012-2016/5
Number of Conflicts				
Guinea	89	91	73	180
Liberia	72	168	146	240
Sierra Leone	18	53	43	71
TOTAL	179	313	262	491

Source: Gonzalez-Torres, A. and Esposito, E. (2016). Epidemics and Conflict: Evidence from the Ebola Outbreak in Western Africa

One can notice from figure 6 that Guinea demonstrated a lower level of political violence among the three countries, which did not change significantly during an epidemic. This fact can be primarily explained by the fact that Guinea had the lowest rate of Ebola cases per population - 3,814 (*Gonzalez-Torres and Esposito*, 2017), compared to the other two countries. However, it did not prevent the public madness related to the disease's fear. For example, the BBC reported the health care team murder on September 19, 2014, due to the attack of locals.

Despite the progress in democratization over the last ten years before the Ebola outbreak in 2014, all three countries lacked transparency and civil society. In fact, during the health care crisis,

Liberia's authorities abused the power of the emergency state. They restricted the freedom of information and press by forcefully barricading and shutting down the National Chronicle newspaper's office and arresting the journalists (CEMESP, 2014). Moreover, quarantined people were observed not to receive food, potable water or healthcare treatment, "and when they escape the health care facility, are hunted down, sprayed with disinfectant, and violently forced in vehicles to be returned to the facility" (OHCHR report, 2014, p.6).

Even though all three countries received considerable assistance from WHO, Red Cross and other humanitarian organizations to combat Ebola, it did not help to prevent the incidents of violence because of the long period of exhausting conflicts and civil wars, underdeveloped civil society and inability of states to reach out citizens at the beginning of the pandemic outbreak.

This chapter illustrates the states with weak capacities that struggled to deter political violence once affected by the contagious and deadly disease. Liberia, Guinea, and Sierra Leone serve as examples of states having the weakest state capacity, which low degree, according to the idea of this thesis, contributes to limited control and supervision of the territory and population, Hence, it is the factor of failure when it comes to political and social violence. Accordingly, one can generalize that weak states hit by a pandemic are violence-prone to a broader range of countries. The litmus test for predicting politically violent events in a country is an introduction of quarantine measures. In case the state is incapable of managing the pandemic, such a restriction would trigger social anger and resistance.

7. MEXICO

Despite various cases that demonstrate the existence of the described mechanism, there are exceptions where a pandemic outbreak does not necessarily lead to political violence even if the level of state capacity is low. To illustrate, I will further describe Mexico's deviant case, where the Swine flu pandemic emerged in 2009. Why were there only a few incidences of social resistance? The key explanation is the extensive but pandemic-oriented foreign aid and willingness to cooperate with the international community that helped compensate for the insufficiency of the national health care system and determined an efficient response to a health crisis. Recent studies emphasize the commandability of the Mexican government's response to a pandemic (Ear, 2012, Hernández-Ávila & Alpuche-Aranda, 2020).

Contrary to described Western African countries, which are highly dependent on international aid for decades and have underdeveloped political institutions, Mexico was in a more advantageous situation because of the already existing developed bureaucracy all over the country territory (Espinosa, 1999) and improved information exchange between authorities and society, such as e-government (Lau et al., 2008). Furthermore, since Mexican society has been long experiencing the violence from the non-governmental actors, such as drug cartels (Calderon et al., 2015) , I assume that the government's curtailments related to isolation and quarantine measures were not perceived with a significant resistance as the society worked out an "immunity" even to more severe incidents of coercive measures. In addition, during the pandemic in Mexico, it was observed that the overall crime rate in the country reduced, according to data from Mass Mobilization Project.

The overall healthcare capacity, including doctor per population ratio, number of hospitals and beds, health care insurance, and access to water and sanitation, was only slightly better than China before SARS. More precisely, 1.6 hospital beds; 1.9 physicians and 2,3 nurses per 1000 people (the World Bank Development Indicators, 2009) indicate a low sufficiency of the system to ensure the care

of people once the contagious disease starts to spread all around, especially given a high density of population in the cities. Compared to China, Mexico overall had almost the same values of the indicators with a slightly lower number of hospital beds per population. By summarizing the overall features, Armando and Najera-Aguilar (2009, p.2825) suggest that Mexican health system, which "throughout its history has sought to act according to the principles of social justice (equity and accessibility), in practice turns out to be one which is inequitable: those who pay the most for health care in terms of care, transport, drugs, and laboratory tests are the families with the lowest incomes".

However, despite having a health care system far from perfect, authorities launched a transparent information campaign about the risks of a new disease, accessibility of medicine, and precautious measures (Córdova-Villalobos et al., 2009, Ear, 2012). In particular, "press conferences were held on a daily and ongoing basis, with the support of all the mass media, including the internet and telephone lines", which made it possible to maintain people calm. The efficient response to Swine Flu also included closing schools in the worst-affected areas for several weeks, the shutdown of museums, theatres, concerts, and any public events (Wilkinson and Maugh, 2009). The Swine Flu cases' accurate reporting was crucial for the international community to keep track of the disease threat so that other countries developed preventative measures and got prepared for an outbreak. It would have been impossible without the financial resources allocated to laboratories and trained personnel. In particular, the USA decided to distribute 400,000 treatment courses to Mexico, which were of $10 million value and represented less than 1% of the total American stockpile (Salaam-Blyther, 2010). USAID has provided $6.1 million for international Swine Flu assistance, with approximately $0.9 million directed to Mexico (Salaam-Blyther, 2010). Besides that, staff workers to facilitate in laboratories and health emergencies were sent to Mexico. The cooperation with Canada helped to receive the necessary vaccines as well. Ear (2012, p.58) stressed that "the U.S. helped with laboratory capacity, equipment, and technicians, but Canada was the easier country to which to send samples". Hence,

extensive foreign aid and transparent health crisis management made it possible for Mexico to cope with the health emergency and avoid violent social unrest. However, as Ear (2012, p.56.) points out, the fruitful cooperation partly resulted from personal networks of top-ranked officials, "when some of the key actors happened to know each other because of interaction over the course of several year". Consequently, it can be important to establish further formal relationship with the partner countries institutions in the future to have more stable and predictable situation.

Overall, the level of political violence did not increase during the health emergency. The political situation remained peaceful except for a prison riot against restrictions on visits in Mexico City, according to the San Diego Union-Tribune report from 19th May 2009. This peaceful outcome is surprising from this thesis perspective; however, it is explainable and demonstrates how weak states can manage pandemics without losing much of public loyalty.

8. DISCUSSION AND CONCLUSIONS

This thesis scrutinizes the chain between **pandemics, state capacity, and political violence** in the number of countries, having the primary focus on the paired case-study comparison of China and South Korea. Discussion of the Western African countries supports the suggested pattern and outlines that countries being on the edge of collapse are most likely to experience violent riots once affected by a new threatening pathogen. The two components of state capacity to govern the pandemic crisis are highlighted – the preparedness of the health care system before a disease outbreak and the actual response of authorities. They both, first, allow to draw the line of distinction between the weak and strong levels of the capacity and, second, determine whether a country will experience the political violence incidents. The development of democracy and the willingness to cooperate (but not to depend) with the international community, on the other hand, demonstrates how the transparency of policymaking and free flow of information facilitates in governing the pandemic.

The selected indicators of the state health care system preparedness to an infectious disease outbreak signal whether a system would suffer from an overwhelming number of infected patients and lack of medical staff. However, the findings demonstrate that the overall weakness of the health care system does not play a crucial role as the governmental response to a contagious disease outbreak. The overburdened hospitals, the lack of beds for the patients, and the insufficiency of the doctors were a fact, successfully hidden from the public in China, thus, did not trigger the public discontent. In the described countries of Western Africa, the insufficiency in health care provision was the most tremendous one among the selected cases, however, it was not determinant since societies had little trust in non-traditional means of treatment.

The risk communication of authorities with the public is more important. Both South Korea and China were slow in the initial informing of the public about the threat, however, while in South Korea the delay in delivering the essential information about the hospitals with MERS infected was

only a few weeks, the Chinese society lived in the information vacuum for months, which significantly contributed to the growing anxiety and fear of SARS, fuelled by rumors. In the case of Sierra Leone, Liberia, and Guinea, which all similarly struggled from Ebola, the mentioned insufficiency in public informing was also critical for the development of violent outcomes.

The insufficient intergovernmental communication in the complex bureaucratic system in China was also accountable for the slow implementation of steps to start the surveillance, tracing, isolation, and treating the patients. At the same time, South Korean already strong national-wide system of surveillance and accountability made it easier to start the contact tracing, build the network of infected individuals and, consequently, stop the spread of MERS at its initial stage. Partly, it was easier for South Korea to conquer MERS since it was already detected as a dangerous pathogen in other countries before, so the most important task was to recognize it.

Nonetheless, the measures implemented by governments to combat pandemics were determining political violence outcomes. In China, most of the described incidents of riots happened because of the decision to introduce quarantine and construct quarantine facilities. Once the whole villages were cordoned off and isolated, at the absence of governmental clarifications, the public deprivation was released in violent riots, clashed with the police, smashing of quarantine sites and disobedience. No doubt, the preexisting grievances of people also played the role. Since all the mentioned riots were happening in the rural areas, one might recall the long-time disputes for the land rights among the villagers. Once triggered by a new restriction, the people were ready to mobilize and show their disapproval, which is a very risky decision given the strong coercive capacity of China. In South Korea, the only case of public expression of grievances during the whole period of the MERS outbreak was peaceful and related to the insufficient information about the hospitals with infected patients. The examination of Mexico as a deviant case brings additional clarity to findings. It is concluded that the immediate beginning of cooperation with the international community, which is

possible only if a government is open in telling about the health emergency, mitigates the harm from a pandemic and prevents the development of civil uprisings. Figure 7 below provides a summary of the examined cases.

FIGURE 7: Summary

Pandemic	Country	Outcome in terms of political violence
SARS	China	Riots and protests
MERS	South Korea	Single peaceful demonstration
Ebola	Liberia, Sierra Leone, Guinea	Riots and murders
Swine Flu	Mexico	Single protest in a prison

The finding of this thesis, first, fill the gap in the existing literature by suggesting a framework that combines health governance capacity and state security threat, which can both be challenging for the national governments. In addition, it contributes to a literature on the role of spread of contagious disease on political change Second, it can serve well for further policy implications because it examines political phenomena shaping our lives in the present and future. Even small-scaled events of political unrest can spark tremendous changes in economic and political development, such as disruption of supply chains, thus, causing major losses for the international economy. Moreover, social grievances related to pandemic handling, once intensified, might overgrow into larger dissatisfaction and put the worldwide political stability at stake.

Thinking about the Covid-19 pandemic, it is not yet possible to observe the whole specter of consequences it will bring, however, one might predict that in case of the quarantine measures renewal in the national states, there will be much more chances of violent social resistance. One can already observe that some countries managed to avoid disastrous political and health disruptions better than others. Lessons learned from the Covid-19 and other examined in this thesis outbreaks can provide valuable insight for the national governments. First, there is a need to pay more attention to investing in the health sector and science instead of focusing on retaining and enforcing practice (Nosrati and

Marmot, 2020). Second, the current pandemic and the previous ones show the lack of transparency between government officials and the public (Peeri et al., 2020). However, Covid-19 is new in terms of daily online exchange of information about the number of infected individuals worldwide, which creates a common ground for international cooperation.

Policymakers can prevent the potential political crisis by thorough calculation of the risks and considering weaker states' previous mistakes experiencing violent riots. Furthermore, states should consider the importance of international cooperation for the sake of common benefit (McKee and Stuckler, 2020). After all, the globalized world we live in today requires stronger states to assist weaker ones out of a risk contagion and insurrection spread everywhere around.

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