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Response to The COVID-19 crisis: a Comparative Analysis of The Actions of Indonesia, Mexico, and Croatia

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Abstract:
The COVID-19 pandemic as a global crisis with significant consequences has caused numerous disruptions in the regular functioning of life, business processes, dynamics, and ways of working. The consequences created only in human losses are extremely high and the recession in which countries have entered, during which many companies have gone bankrupt. This crisis has shown that the world is not ready or able to solve global crises, and the response to the COVID-19 pandemic was primarily states' responses to crisis what should account for the urgency of the situation in short, medium and long-term phases. Therefore, it is necessary to research how states responded to the crisis and compare their activities and results. The reactions of countries within the same region can be assumed to be very similar because the crisis circumstances were almost the same. The research interest of this paper has been expressed according to the analysis of policy responses of Indonesia, Mexico, and Croatia. The research design is based on a quantitative-qualitative framework consisting of a desk-top analysis of available secondary data sources, crisis management theory, case study theory approach, and, cross-national analysis approach analyzing Indonesia, Mexico, Croatia the COVID-19 state pandemic preparedness and response policy.

Keywords: COVID-19 pandemic, crisis, policy response, Indonesia, Mexico, Croatia

1. Introduction

Coronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). A novel coronavirus (COVID-19) was identified in 2019 in Wuhan, China. This is a new coronavirus that has not been previously identified in humans (World Health Organization, 2022a). What is crucial and represents a global problem is the fact that the virus spread very quickly around the world and caused unprecedented challenges in all parts of the world and industries. Regarding to United Nations, the COVID-19 pandemic has brought significant disruption in everyday life, with wider socio-economic implications that advertise increasing levels of poverty and unemployment, access to education, limited digital and Internet connectivity, challenges on health, food security, global supply chain (United Nations, 2021). Lopez-Leon et al. came to the conclusion that COVID-19 caused more than 50 long-term medical effects on people and their health (2021).

The human costs in terms of lives lost is huge. According to Our World in Data platform, the COVID-19 pandemic had caused more than 5.54 million deaths by mid-January 2022 (time when writing this paper started). In consideration should be taken that for some countries the number of confirmed deaths is much lower than the true number of deaths. This is because of limited testing and challenges in the attribution of the cause of death (Our World in Data, 2022a). Considering economic indicators, “there is no way to tell exactly what the economic damage from the global COVID-19 coronavirus pandemic will be, there is widespread agreement

among economists that it will have severe negative impacts on the global economy" (Szmigiera, 2021). Regarding the UN Department of Economic and Social Affairs, the estimate was that COVID-19 would slash global economic output by $ 8.5 trillion during 2020 and 2021 (ibid). What is important is the huge consequences that have already had a significant impact on people and all different industries.

What is important to emphasize is that this is indeed the first global crisis that all of humanity has encountered. All the previous crises, despite their consequences, none of them were truly global and did not reach every corner of the world and affected all countries, business processes, and individuals. The COVID-19 pandemic as a global crisis with significant consequences required a global response. However, it did not happen in a way that it would be determined the necessary level of cooperation and coordination between global and regional institutions on the one hand and the state, economy, and citizens on the other. In the absence of a global approach and a global response to the crisis, each country reacted as it saw fit to act in the circumstances. That brings us to the problem of this research, which is expressed in the fact that the main levers of response to the global crisis were countries and their reactions, where these reactions are often very different from each other. So, since the beginning of the crisis, it has been a paradoxical situation where the developments, consequences, dynamics of the global crisis are being managed at local levels, with limited resources, opportunities, and knowledge.

Research of the problem presented here is important for several reasons. First, each crisis needs to be researched in all its phases to look at actions, activities, reveal cause-and-effect relationships between the reason and its consequences, identify critical issues, and record situations that require better action in the future. Second, this crisis has shown that the world is not ready or able to solve global crises (such as various other crises – the impact of climate change, terrorism, the causes of illegal migration, global inequality, arms race and competition, and others), especially because people like Bill Gates "warned that in the future mankind could be infected with a virus that is equally contagious, but with a much higher mortality rate" (b92, 2022). Third, as the response to the COVID-19 pandemic was primarily the responsibility of states (with very little cooperation at the beginning of the crisis, and as the crisis progressed, states began to cooperate better), it is necessary to investigate how states responded to this crisis and compare their activities and results. Fourth, the timing of this research is also important, as some countries, such as the United Kingdom and Ireland, have achieved more than 80 percent vaccination coverage and announced the imminent abolition of physical distancing and wearing masks, while some other countries are still far from targeting vaccination percent of its population. Fifth, it is necessary to draw specific lessons from this crisis that can be implemented in general prevention and preparedness activities for each subsequent crisis of this type.

Everything related to the COVID-19 pandemic has so far aroused extremely high interest of the scientific and professional public, and numerous papers have been written, various conferences have been organized, and quality recommendations have been provided. By mid-January 2022, the World Health Organization had generated links on its website to 381,996 full-text publications exploring some of the segments of the crisis (2022b). The Our World in Data platform conducts a daily analysis of all COVID-19 events and activities from 156,315 sources from 218 countries and 241 organizations (2022b). In Indonesia, although the number of research papers by Indonesian researchers has increased significantly, only a small percentage of them have been published overseas and indexed in foreign bibliographic indexes. WHO indexed these papers in the WHO COVID-19 Research Database to offer worldwide access to Indonesian national research on COVID-19 (World Health Organization, 2022c). With the help of the National Research and Innovation Agency, WHO gathered papers from two main national databases: Garuda (Garba Rujukan Digital) and SINTA (Science and Technology Index). COVID-19 relevance and national accreditation status were examined in publications from diverse disciplines, industries, and geographic levels. The WHO COVID-19 Research Database, which provides central and open access to bibliographical and full-text information, was used to compile and index articles written in English and Bahasa Indonesia. Basic and advanced search options, including Boolean operators, filters, and sort functions, are available in the Database, allowing Indonesian researchers, policymakers, and information seekers to conduct targeted literature searches in a timely way. The Database comprises about 2 000 COVID-19 publications from Indonesia as of July 2021, with the majority of the articles written in Bahasa

Indonesia. They can be easily located by applying an additional language filter and utilizing the specific filter "Indonesian Research." This COVID-19 pandemic has sparked unique collaboration between researchers from all disciplines and other countries, resulting in a wealth of wider knowledge that may be used to make universal decisions. In Croatia, according to Hrčak (the central portal that brings together Croatian scientific and professional journals that offer open access to their papers in scientific journals), 1,040 scientific papers have been produced so far in the following fields: Social Sciences – 343; Biomedicine and Healthcare – 272; Humanistic Sciences – 157; Technical Sciences – 96; Interdisciplinary Areas of Knowledge – 68; Natural Sciences – 52; Biotechnical Sciences – 34; Field of Art – 18 (Hrčak, 2022). While all in all, according to CROSBI (Croatian scientific bibliography platform), until now, 1541 scientific papers have been published (including full research papers, short analyses, reviews) related to the topic COVID-19 (CROSBI, 2022). For Mexico, we could not find data on overall scientific productivity on this topic. So we can conclude that the scientific production is extremely numerous and very different. Still, we could not find comparative analyses of countries policy responses to the coronavirus pandemic from different parts of the world that have no common ground or belong to the same region. The reactions of countries within the same region can be assumed to be very similar because the circumstances of the crisis were almost the same (when entire regions were affected by individual coronavirus waves, closing borders, limiting business processes and opportunities to move). What interest us in this research are countries' policy responses from different parts of the world. We believe that this will give us a deeper insight into the policy responses of states

Based on the above, our research interest has been expressed according to the analysis of policy responses of Indonesia, Mexico, and Croatia. Policy response analysis (or just policy analysis) "is a multi-faceted field in which a variety of different activities and ambitions have found a place. Some policy analysts conduct quantitative or qualitative research while others reconstruct and analyze political discourse or set up citizen fora… The variety and multi-faceted nature of policy analysis makes it clear that there is no single, let alone 'one best', way of conducting policy analyses. The discipline consists of many different schools, approaches, roles and methods… Various approaches criticize each other and it is very difficult to define and describe what policy analysis is… For every policy analytic style there are both proponents and critics (Mayer et al.: 2004: 2-19). There are different approaches to policy analysis. According to Collins (2005: 192) "Policy analysis is a generic name for a range of techniques and tools to study the characteristics of established policies, how the policies came to be and what their consequences are." For the purposes of this research, we decided to use the analytical framework of policy analysis according to the European Union European Training Foundation "Guide to Policy Analysis", where is stated that policy analysis is the process of systematic investigation of the implementation and impact of existing policy and it is shaped by the choice of time (before or after a policy has been implemented), and the choice of focus and associated level of detail. The initial assumption for the implementation of the analysis is collecting evidence that can be any piece of quantitative or qualitative information, the source of which is stated and can be independently verified. "In formal terms, evidence can come in the form of indicators, defined as 'an aggregation of raw or processed data that helps … to quantify the phenomenon under study and a tool that helps … to grasp complex realities'. Alternatively, it can be presented in the form of descriptive information, such as case studies, observations, reports, or protocols from focus groups" (European Training Foundation, 2018: 9). The analytical process consists of four steps: Step 1: Framing and understanding the problem; Step 2: Collecting and describing the evidence; Step 3: Interpreting (analyzing) the evidence; Step 4: Formulating recommendations and outlining the options (ibid, 2018: 11-19).

In order to continue the research, we ask the following research question: What are the similarities and differences in policy responses to the coronavirus pandemic of Indonesia, Mexico, and Croatia? In order to structure the analysis, the paper will be divided into four sections. After the Introduction, where the research problem is presented, its background, and statement how this problem deserves scientific research. In addition, a review of the number of scientific sources published so far on topics related to the COVID-19 pandemic, was presented. The following section, entitled Methods, will present the theoretical and methodological assumptions that will be used during the research. The third section, called Results, will describe the research results conducted and highlight key similarities and differences in policy responses to the coronavirus pandemic of

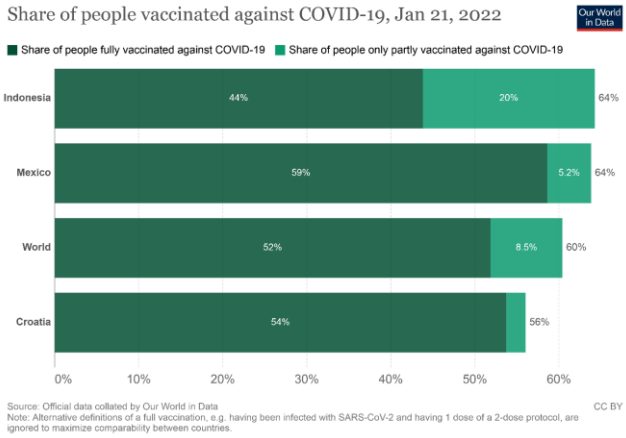
Indonesia, Mexico, and Croatia. The next section, entitled Discussion, will bring comparison of key analysis results. Finally, the final section, Conclusion, will summarize the analysis.

2. Methods

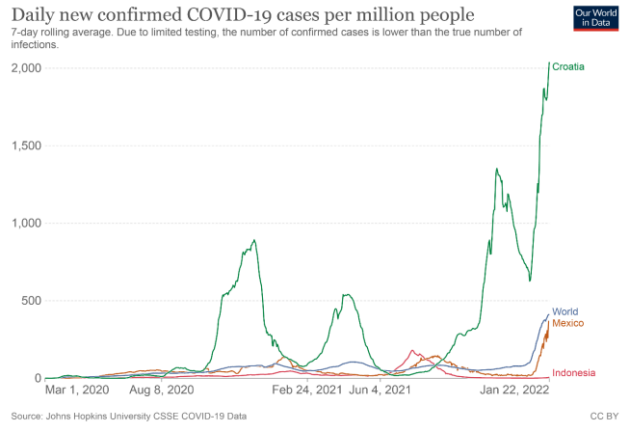
The research design of this paper is based on a quantitative-qualitative framework consisting of a desk-top analysis of available secondary data sources. In accordance with the analytical framework of policy analysis (explained in the Introduction) which we intend to use, in this research for the policy response analysis from each of the countries, as evidence, we will use the available academic sources to investigate how prepared the states were and how they reacted to the COVID-19 pandemic (qualitative indicators), and we will use aggregate indicators created by the Our World in Data and the Economist (quantitative indicators). The overall analysis is based on a literature review and a comparison of quantitative indicators made by the Our World in Data and the Economist. Through the literature review, we want to determine how the states were prepared and how they managed the crisis. While, through comparison of the quantitative indicators expressed in the number of vaccinated persons, cases, and deaths per million people we will check the results of applied policies and actions. As for the four steps in the analytical process: Framing and understanding the problem (Step 1) is done in the Introduction. Collecting and describing the evidence (Step 2), will be determined in the Methods section and the Results section. Interpreting (analyzing) the evidence (Step 3), will be made in the Discussion section. Formulating recommendations and outlining the options (Step 4) will be done in the Conclusion.

The Our World in Data platform's data was used for a common basis and comparison of indicators for the three countries in focus. The indicators we are interested in are expressed in the number of vaccinated persons, cases, and deaths per million people. We take the world average as the central value and therefore analyze the three countries in focus.

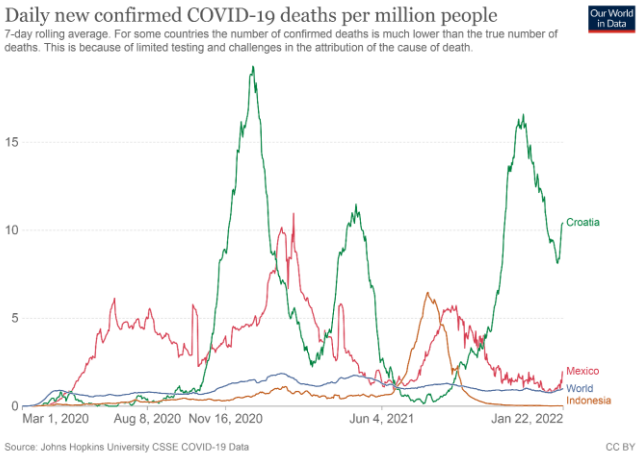
Picture 1. Share of the people vaccinated against COVID-19



Picture 2. Daily new confirmed COVID-19 cases per million people



Picture 3. Daily new confirmed COVID-19 deaths per million people



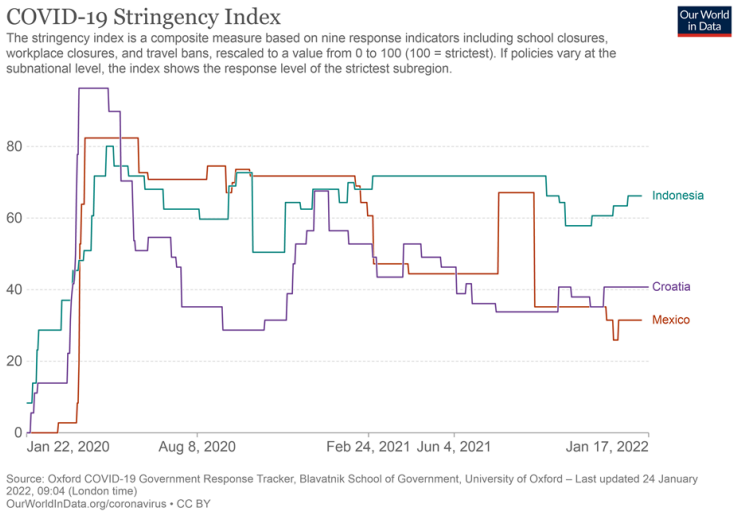
According to The Economist method of tracking changes in total mortality called "excess deaths" we can conclude that the offical number of COVID-19 related deaths are underestimated.

Table 1.

COUNTRY	OFFICIAL COVID-19 DEATHS	PER 100,000	ESTIMATED EXCESS DEATHS	PER 100,000	ESTIMATE OFFICIAL
CROATIA	15.249	374,7	21k-24k	510 to 600	+50% (562)
MEXICO	320.607	246,1	670k-750k	510 to580	+100% (492)
INDONESIA	151.413	54,8	370k-1 m	130 to 380	+500% (274)

Source: Economist (2022)

Picture 4. COVID-19: Stringency Index



The data analysis method used in this research will be based on two basic approaches. In the first approach, through a literature review, we will try to investigate how prepared the selected countries were and how they reacted to the crisis. In the second approach, we will compare quantitative indicators related to the number of vaccinated persons, cases, and deaths per million people in all three countries. Based on these two approaches and their combination, we will come to the answer to our research question.

Then, as part of the research design, we will use three theories. First one is crisis management theory. We will take the model most commonly used by the U.S. Federal Crisis Management Agency (FEMA). It consists of

prevention, preparedness, response and recovery (Kešetović and Toth, 2012: 67-71). For this research, we are interested in the stages of preparedness and response, due to reason that no single country has been able to do much in preventing a global pandemic. Also, at the same time, the recovery phase cannot be fully implemented because the response to this crisis is still ongoing. Preparedness refers to the planning of responses to emergencies and crises and the readiness of various systems and operational forces to act. Finally, response means assisting during and immediately after a crisis to save lives, reduce negative impacts on the critical values of the state and society, and reduce the likelihood of cascading events and new crises. The second theory is a case study theory approach of three countries (Indonesia, Mexico, Croatia) in which their presentation is given. "Comparative design is one of the most important research designs in political science" (Burnham et al, 2006: 58). Numerous processes are clarified and elucidated by comparing them with similar processes in other contexts or geographical areas. But as Burnham et al. note: "The main difficulty with comparative design is finding comparable cases" (ibid: 2006: 59). To solve the stated challenge of designing comparative research, researchers opt for two basic designs: first, the most similar cases design; second, the most different case design (ibid: 2006: 65; Landman, 2008). The design of the most similar cases seeks to compare certain countries and their systems that have a multitude of common features to neutralize some differences and highlight some. At the same time, the most different case design compares countries and systems with very few common features where they seek to identify and highlight some of the common features (Landman, 2008). As a form of research design, case studies allow a focus on a single individual, group, community, event, policy area, or institution. Both quantitative and qualitative data can be generated by case study design (Burnham et al, 2006). Yin (2007) states that the case study is an empirical study referring to a contemporary phenomenon within its real-life context. The third theory is a cross-national analysis approach. Interregional comparative cross-national analysis compares units of analysis in several different regions (Basedau and Köllner 2007: 110-111). In our case a comparison of the preparedness and responses of selected countries in the Asia, Latin America, and Europe, regarding their reaction to the COVID-19 pandemic.

3. Results and Discussion

Indonesia is the largest archipelago in the world. It consists of five major islands and about 30 smaller groups of islands. They are located at a crossroads between two oceans, the Pacific and Indian, and straddle two continents, Asia and Australia/Oceania. With an area of 1,904,569 km², Indonesia is the largest country consisting only of islands. The combined area of the archipelago is slightly smaller than Mexico or larger than five times the size of Germany. The multi-ethnic country has more than 271 million people (in 2021) (Nations Online, 2022a). Mexico belongs geographically to North America; ethnological it belongs to Latin America. The country covers an area of nearly 2 million km²; it is almost four times the size of Spain or slightly less than three times the size of the U.S. state of Texas. Mexico is the third-largest country by area in Latin America (after Brazil and Argentina). A population of 123.5 million people (in 2017) makes Mexico the second-most populous country in Latin America after Brazil (Nations Online, 2022b). Croatia is a Southeast, Central European, and Mediterranean country; it has an unusual shape (similar to a croissant!) unlike any other country in the world. The country covers a land area of 56,691 km² and has less than 4 million people (2021 census). There are 1,244 islands and islets in the Adriatic sea, although only about 50 are populated.

3.1 Indonesia policy responses to the coronavirus pandemic

Indonesia has done a relatively average if not slow phase of preparedness although it is assumed that public diplomacy that being implemented by Indonesian government in response to pandemic COVID-19 may produces some benefits, including promoting values that can increase stability countries, create mutual understanding and correct misunderstandings and build a reputation (Martha, 2020). The COVID-19 pandemic has triggered the establishment of nationwide long-term task forces at national, provincial, and local levels. “In the wake of the COVID-19 pandemic in Indonesia, which was declared a national disaster by the Government of Indonesia in early March 2020, the President of the Republic of Indonesia signed Decree number 7/2020 on the establishment of TFAC [Task Force for Acceleration of COVID-19 Countermeasures] at the national level. This aimed to (1) improve the national health system and its performance; (2) accelerate COVID-19 countermeasures through inter-ministerial synergy, as well as synergy with provincial and local governments; (3) improve

anticipation capacity to contain the spread of the pandemic; (4) improve operational decision-making synergy; and (5) improve preparedness and responses to COVID-19" (Darmastuti, 2020: 6).

"The Covid-19 pandemic has created a multidimensional crisis. It not only gave impact in the health sector, but it also influenced the economic condition. The affected victims were workers. Globally, during the COVID-19 pandemic, 94% of workers experienced layoffs. Likewise, in Indonesia, more than 3.5 million workers have been affected by layoffs" (Faedlulloh et al. 2021: 1). So, Indonesian government has issued several policies in an effort to reduce the spread and impact of the virus outbreak corona. That policies are social vaccines, namely Indonesia large-scale social restrictions, lockdown, then through diplomacy Indonesia has issued a policy such as vaccine diplomacy with a bilateral approach to involving all interested parties. Indonesia also has changed its economic diplomacy strategy by issuing several related policies while maintaining performance national export-import and withstand the negative economic impact of the COVID-19 outbreak. Overall strategy of the Indonesian government's economy during the COVID-19 pandemic was in primary activity and support, consisting of commercial and marketing activities (economic salesmanship, networking, image branding/promotion, and regulation management), business advocacy, network building, business negotiation, intelligence, services, as well as mechanisms solution to problem (Pambudi, 2021). Indonesia also has proposed collective action in overcoming the pandemic issue that threatens the security of all humanity globally that has more value as a form of diplomacy based on interests' tangible economy (Purbantina and Hapsari, 2020). For instance, Indonesia implements a new strategy of economic diplomacy in coffee exports to Russia during the pandemic, such as the use of virtual meetings, mobilize more many coffee exporters, and involves the role of the Indonesian Embassy in Moscow (Madu and Kurniawati, 2021).

The focus of Indonesian government is increasing national health resilience in services health as a way to protect Indonesia during the pandemic COVID-19. A study argues that so far, the results of the health approach Indonesia is good and in line with Indonesia's national interests. Indonesia is also a driving force in initiation of the 75th United Nations General Assembly which voiced the availability of medical equipment and vaccine equality for all countries in the world (Delanova, 2021). In support to this, another sector from health, some countries have been coordinated by the Indonesian government to facilitate this objective of public diplomacy. With United States for example, mechanism such as coordination with the Indonesian Embassy has been implemented to protect Indonesian citizens. Participation in a virtual meeting with the UN Security Council to discuss international peace and security issues, and changing the methods and tools are also been used by Indonesian government to gathering information, negotiating, and responding to international issues (Anshori, 2020). With China, Indonesian government has carried out health diplomacy to stop the spread of the virus and improve the health of their respective citizens. Indonesia and China utilize health diplomacy as one of the national health agendas and often it creates an opportunity but also a loss that has not been seen created by pandemic COVID-19 (Margono et.al, 2021). With Japan, Indonesia's environmental diplomacy is carried out before the pandemic occurred, but not much has been focused on management medical waste. International cooperation to solve the problem of waste accumulation also has been carried out with several international organization including ASEAN and WHO (Firmalasari and Rasyidah, 2020).

Since the first case of COVID-19 announced in Indonesia, many strategies were made in order to prevent transmission and death from this disease. But, Indonesia is slow to response on the pandemic (Yulianti et al. 2020: 44-46). Because of that, some policies have been stagnant in terms of its implementation. For instance, Indonesia does not have a clear agenda or blueprint for using digital diplomacy to response COVID-19. Due to the use of information technology to publish future policies and the COVID-19 pandemic is increasing, Indonesia must still learn from a lot countries in introducing the formulation of the digital economic diplomacy agenda from institutional adaptation to new approaches in foreign policy socialization through new media (Triwahyuni, 2022). During a pandemic as well, Indonesia has experienced a decline in the value of exports. In order to re-strengthen, Indonesia involves of all parties, including the provincial government to strengthen national export (Fauziansyah and Sinaga, 2021). Far more importantly, Indonesia continues to response COVID-19 by implementing number of cooperation. Collaboration and partnership between southern countries is important because more countries developing to deal with the impact of the virus. For instance, Indonesia is

currently promoting its Indo-Pacific vision for enhancing cooperation between the Indo-Pacific (Adisasmito, 2019). Indonesia with southern countries uses a triangular cooperative framework to achieve goals sustainable development and technical cooperation with member countries (Iswardhana, 2020). With the new landscape of the global economy, Indonesia is now being challenged to move forward and strengthening multilateralism partnerships amid the waning of altruism and global protectionism (Jose, 2021).

3.2 Mexico policy responses to the coronavirus pandemic

Mexico was not ready for a pandemic. The first case of COVID-19 in Mexico was recorded on February 27, 2020 at the National Institute of Respiratory Diseases in Mexico City on a patient who arrived from Italy, while the first death occurred on March 18. Mexico defined its response strategy only two months after the appearance of COVID-19 in the People's Republic of China (December 2019) and only a month after the WHO (January 23, 2020) published the Statement on the first meeting of the International Health Regulations Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (WHO, 2020). Thus, the Mexican government had only a few weeks to "to deploy a response and preparedness plan" (Bautista-González et al., 2020: 4). With the appearance of COVID-19, the Mexican government defined three COVID-19 phases in 2020:

a. Phase 1: Confirmation of imported cases from abroad (later defined for the period February 29 - March 23);
b. Phase 2: Confirmation of transversal transmission (later defined for the period March 24 - April 20);
c. Phase 3: Confirmation of community transmission (later defined for the period after April 21) (Bautista-González et al., 2020: 1-2).

After there were 475 confirmed infected people on March 24, it was decided to activate Phase 2 "Health contingencies" which included strict social distancing, closure and restriction of work. In the period from March 18 to May 5, 2020, about 3,000 people died from COVID-19, whose average age was 58 year. Most of the dead were men with comorbidities . Even then, it became clear that Mexico would have a disease problem in the group of obese Mexicans, as in 2020 almost 75% of those over 15 were obese (compared to only 20% in 1996), while almost 35% of that percentage were morbidly obese (OECD, 2020). Sapulveda et al. (2021: 116-120) concluded that Mexico did not have an elaborate model of emergency management and that the health system, in which there are large inequalities in access to and quality of health services, due to insufficient investment, recent cost cuts and poorly designed reforms, unprepared and in poor condition welcomed the pandemic. As the number tested on COVID-19 was extremely low, Escudero et al. (2020) felt it was significantly underestimated. Ibarra-Nava et al. (2020) agree with them, stating that in mid-July 2020 Mexico had confirmed 299,759 infected and 35,006 dead people, which definitely was not real situation, stressing that despite to one of the lowest numbers of testing on COVID-19 in the World, Mexico had the highest number of infected and dead in the region.

The Mexican response to COVID-19 has been controversial and criticized from the beginning of outbreak of pandemic. "Mexico has implemented a sentinel epidemiological surveillance system, instead of a massive testing strategy, to count and report cases" (Ibarra-Nava et al., 2020). Thus, in early May 2020, the Ministry of Health, using mathematical models, estimated that 104,562 people had COVID-19, while the number of confirmed cases was 23,471. The authors believe that the general population underestimated the danger of COVID-19 and that most soon continued with normal life. One of the main culprits for reducing the risk of COVID-19 was Mexican President Andrés Manuel Lopez Obrador (AMLO) who has minimized the impact of the pandemic since its start and, contrary to his government's recommendations, did not wear a protective mask. At the beginning of the pandemic, he continued to hold mass rallies across the country, and has already in early June 2020 announced the reopening of the economy. He stated that "not lying, not stealing, and not betraying" helps prevent COVID-19 infections, raising questions of whether he's more concerned about pushing his political agenda than he is about the actual pandemic (Ibarra-Nava et al., 2020). He has often criticized health workers for caring more about earnings than helping people, what caused reactions of the health community, which has often been the target of public attacks. Mexico's problem is also the existence of a large informal sector of the economy in which almost half of the population participates, who were not financially able to be in a lock down but were still forced to do their informal work as street vendors and maids. Wearing masks in Mexico was not mandatory, yet 67% of Mexicans said they wore them during 2020 (Economist, 2021).

Depending on the stage, the Government took action at the national level. It is important to note that the Mexican health care system consists of the private and public sector and there are three types of Mexican citizens: insured with state health insurers; with private health insurers; and, citizens without health insurance. The largest state public health institutions are the Instituto Mexicano del Seguro Social (IMSS), the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE) and the health institutions of state oil company Petróleos Mexicanos (PEMEX), while the uninsured citizens are covered by the Secretaría de Salud. Thus, from the very beginning of the pandemic it was evident that the social status of citizens and belonging to one of these health systems will lead to their healthcare inequalities. At the same time, the four state health institutions adopted different types of policies in different phases of the pandemic (Bautista-González et al., 2020: 1-2). The health system was in poor condition even before the pandemic, and as the emphasis was not on preventing the spread of the disease, the state tried to increase hospital capacity and procure respirators, but lacked basic health equipment and training for health workers.

During the pandemic AMLO was twice infected with COVID-19, and a few days after being positive for the second time on covidicito (mini COVID), he returned to his presidential activities and praised the effectiveness of Vicks VopoRub. This careless approach to the pandemic has contributed to an extremely high number of infected and dead, especially more than 4,500 health workers (Economist, 2021). Initially, he opposed vaccination and was vaccinated only in April 2021. Mexico was late with the purchase of vaccines, and used different types of vaccines that had the same percentage of effectiveness of protection against COVID-19, especially Chinese Sinovac and Russian Sputnik V. In early 2022 almost 80% of the population over the age of 18 were vaccinated with both doses, and 51% of the elderly received a booster dose.

Mexico is an example of how not to treat a pandemic. With the exception of the informal sector, which was "open" throughout the whole time of pandemic, employees in public and private companies were only shut down for the first two months of the pandemic. And while restaurants and gyms soon opened, under the influence of strong teacher unions schools were closed for 17 months, demonstrating that the influence of some unions on policymaking was significantly more influential than epidemiologists (Economist, 2021). In terms of financial assistance to citizens to overcome the pandemic, Mexico has singled out the least of all emerging market. Compared to Brazil, which spent 9% of GDP on support to citizens or India with 4% of GDP, Mexico allocated only 0.65% of GDP, and in 2020 about 4 million citizens became poor (Economist, 2021). As tourism carries 9% of Mexico's GDP, tourists were free to enter the country without need to have a negative PCR test or vaccination certificate.

Sapulveda et al. (2021: 116-126) in a case study of Mexico and its response to COVID-19 concluded that: 1. Shortcomings in the emergency management model led to reduced caution in dealing with COVID-19 and the inability to correct policies that proved to be wrong; 2. National authorities have not fulfilled their crisis management functions and have not taken political responsibility for coordinating a coherent and unified national response; 3. Did not communicate clearly enough about the real danger of COVID-19 and what to do in case of infection, which contributed to the large number of infected and dead, and that the government through incoherent messages to the public and its behaviour did not promote proper public health measures; 4. The state finances (state budget) had a key impact on pandemic management strategies, that were to the detriment of the necessary public health measures and support for vulnerable social groups; 5. Continued adherence to restrictive testing policies impaired the ability to diagnose infection, control transmission and assess COVID-19 damage; 6. Epidemiological surveillance systems underestimated COVID-19 and delayed information influenced decision-making; 7. The health system is unprepared and in poor condition due to insufficient investment, recent cuts and poorly designed reforms; 8. Due to the lack of comprehensive access to health services and the lack of control over the spread of COVID-19, the authorities failed to prepare and supply the health system for emergency response and put health workers at risk and contributed to high mortality rates; 9. High inequalities in access to and quality of health services, as well as social inequalities, have led to high mortality rates for certain groups of citizens with comorbidities; 10. The vaccination plan was not sufficiently detailed and

transparent, and it is particularly worrying that vaccination priorities and decisions have been subject to party and electoral considerations.

Barrientos-Gutiérrez et al. (2020: 604-605) state that public health is inherently political and that the COVID-19 pandemic will undoubtedly mark a turning point for Mexican public health, its role and a clear need for more scientific activism to strengthen public health.

3.3 Croatia policy responses to the coronavirus pandemic

Croatia has done a solid phase of preparedness. Disaster risk assessments for the Republic of Croatia predict similar scenarios to what happened at the beginning of 2020 (Government of the Republic of Croatia, 2019). One of the significant risks that the country may face – pandemics and epidemics – is part of the national matrix of potential risks, so all relevant stakeholders were aware of such a possibility. Key institutions – the Crisis Headquarters of the Ministry of Health and the Civil Protection Headquarters of the Republic of Croatia – were activated in time and prepared for a pandemic that has already begun in neighboring countries, such as Italy (Mikac and Kravarščan, 2021). However, the real test for the Croatian crisis management system was the appearance of the first cases of coronavirus infected people in the country because, the country went through several parallel crises and events – mitigating the earthquake consequences that hit the capital and surrounding counties, exposure to severe cyberattacks to the several strategic state-owned companies, the presidency of the Council of the European Union – all of which together demanded the parallel engagement of a small number of available professional staff. This is not a justification but an indicator of the situation at the beginning of the COVID-19 pandemic. "Throughout the crises, a significant number of different institutions and individuals have been engaged, and great political, organizational and physical efforts have been made to manage them and mitigate their consequences in best way possible. It should be noted that at no time was there a risk of collapse of any system, of the institutions or of the political decision-making process, which would have led to an even greater crisis" (Mikac, 2020: 38).

Almost the same treatment marked the Croatian policy response reaction phase, as most EU member states – coordination and cooperation with EU institutions, other EU member states, as well as neighboring countries, some of which are not full members of the European Union. It is vital to point out for this analysis that very soon after discovering the vaccine and its availability, Croatia was able to procure sufficient quantities, even more than it needed – unlike many countries around the world who could not procure the necessary quantities of vaccines at the beginning of the COVID-19 pandemic. So we need to ask the question: Why has Croatia not been more successful in controlling and combating the pandemic? We are looking for part of the answer below.
Robert Barić believes that the biggest problem is that Croatia does not have an established crisis management system but has based its activity on a series of improvisations. He sees four critical problems in: 1. The unfinished institutional framework of the crisis management system; 2. Undeveloped legal framework for dealing with crises; 3. Insufficient preparations for action in crises; 4. Lack of a clear communication strategy in the initial phase of the crisis (Barić, 2020). Marijana Grbeša has a different opinion on the communication strategy at the beginning of the pandemic. Key institutions, such as the Civil Protection Headquarters of the Republic of Croatia (the main body in the country to manage the COVID-19 pandemic and the crisis) and politicians, used the following discourses: use of fear appeals, military metaphors and insistence on messages of togetherness and conversely, pandemic shaming. But they also communicated with the public daily and provided all possible information. As a result, key experts in the Civil Protection Headquarters had "overwhelmingly positive" coverage in the media, and among the population, the Civil Protection Headquarters had great public confidence and all contributed to Croatia positively overcoming the first wave of the pandemic (Grbeša, 2020).

During the first COVID-19 wave (first half of 2020), Croatia implemented one of the strictest measures to curb the spread of the pandemic in the world (school closures; workplace closures; cancellation of public events; restrictions on public gatherings; closures of public transport; stay-at-home requirements; restrictions on internal movements and international travel). This resulted in partly good results in stopping the pandemic and the number of cases of infected and the dead people. As a counter effect, many companies have faced significant

business problems. This is the turning point for understanding Croatia's reaction to the COVID-19 pandemic and how to manage the crisis. Croatia is a highly tourism-oriented country, with more than 20 percent of GDP coming from tourism. Due to the above and the need to reduce very restrictive measures, the Government of the Republic of Croatia decided, and the Civil Protection Headquarters operatively implemented that from mid-2020 will be exceptionally liberal towards restrictive measures and adjust them to the current pandemic situation and economic needs. Part of the reason is that the number of infected and dead people was significantly higher in the next pandemic waves than in the first one.

Some authors, such as Katerina Fotova Čiković, believe that Croatia has conducted the reaction phase very solidly, properly addressed the seriousness of the situation, and implemented timely the healthcare, economic and social measures. Although it has been shown that early easing of restrictive measures has been seen as counter-productive (Fotova Čiković, 2021). Đorđe Gardašević, analyzing the situation from the legal aspect, believes that "in the face of the COVID-19 epidemic Croatian authorities decided to avoid activation of constitutional emergency clauses and opted to act through modifications of special laws" (2021: 104). That led to polarization on the political scene and significant disputes between the executive and opposition political parties. Everything then influenced public opinion on how best to manage the crisis and pandemic. Therefore, in the middle of 2021, there was significant pressure from the part of the public, the media, and opposition parties on the executive branch on how best to manage this crisis. In addition, there were quite clumsy statements by the Prime Minister and the Minister of Health that the Civil Protection Headquarters is a political body of the Government. That provoked public attitudes in part of the population that the pandemic and the crisis are not managed primarily from the health discourse but also under the influence of political needs. Such thinking was supported by certain moves and decisions of the Civil Protection Headquarters, which could not be explained by health reasons, but primarily by political measures that best suited the executive branch. We assess this as a second important reason for the epidemiological deterioration of the situation in Croatia because it caused a rift between politicians from the ruling coalition and opposition parties and distrust among the part of the population in the measures taken by the Civil Protection Headquarters, whose leaders in 2021 public opinion lost much of the trust they had at the start of the pandemic.

All this brings us to the third key reason why the epidemiological situation in Croatia is worse than in most other countries. This reason is related to the previous two, which significantly influenced it, and we consider it crucial for the development of pandemic and crisis. With all the positive efforts of the executive branch and the Civil Protection Headquarters – although with some of their wanderings and mistakes that they admitted – the most important actors in resolving this crisis are the citizens. While some citizens accepted the introduced measures to prevent and suppress coronaviruses, according to Damir Primorac, "there are many irresponsible citizens who took these measures lightly and violated them" (2021: 381). The next part of the same problem is the strong growth of the anti-vaccine movement, which has not been bypassed in Croatia. Despite the fact that "vaccination has proven to be one of the most successful public health measures, and the vaccine is the most effective global strategy to end the COVID-19 pandemic"..."In Croatia, internet portals that promote conspiracy theories, as well as social networks, play a crucial role in strengthening the anti-vaccination movement and directly influencing individuals in making their vaccination decisions" (Kelam and Dilica, 2021). That brings us to the next important factor: the coronavirus vaccine is widely available to Croatian citizens. Still, a significant part of the population resists vaccination, refuses to be vaccinated, which deepens the crisis, prolongs the pandemic and causes additional unnecessary infections and deaths.

After the research we've conducted, in this section we will compare the collected data – quantitative and qualitative indicators. We first refer to aggregated data from Our World in Data platform and from the Economist. The number of vaccinated persons at the beginning of this research (picture 1) on the world average was 60 percent. Indonesia and Mexico had 4 percent more vaccinated people, and Croatia 4 percent fewer vaccinated people than the world average. In all cases, it is a sum of people fully vaccinated and only partially vaccinated against COVID-19. Regarding daily new confirmed COVID-19 cases per million people (picture 2) Indonesia and Mexico were at the world average throughout the pandemic, while Croatia had significantly higher numbers of confirmed COVID-19 cases during the pandemic waves. As for the daily new confirmed

COVID-19 deaths per million people (picture 3), Indonesia is below the world average, while Mexico and Croatia are above, with Croatia recording extremely large numbers in this case as well, especially in the duration of its pandemic waves. Considering the absolute figures (Table 1), Croatia has the least officially confirmed COVID-19 deaths, Indonesia ten times more than Croatia, while Mexico twenty times more officially confirmed COVID-19 deaths than Croatia. But number of officiall COVID-19 deaths by 100.000 for Croatia was on the first place (374,7), Mexico on the second (246,1) and Indonesia on the third place (54,8). According to the Economist method of tracking changes in total mortality called „excess deaths" we can conclude that the official numbers of COVID-19 related deaths are underestimated in all three countries – by 50 percent in Croatia, 100 percent in Mexico and even 500 percent in Indonesia. So, when we calculated excess COVID-19 deaths per 100.000 people, Croatia was still on the first place (562), Mexico on the second (492) and Indonesia on the third place (274). Such numerical indicators may be partially close to the level of the COVID-19 stringency index (picture 4), which shows that except at the beginning of the pandemic, Croatia and Mexico had more liberal measures to prevent the spread of the infection than Indonesia. From this we can assume that Croatia due to a smaller percentage of people fully vaccinated and only partially vaccinated against COVID-19, and more liberal measures to prevent the spread of infection compared to Indonesia, and lesser extend Mexico, had significantly more daily confirmed COVID-19 cases and deaths per million people. While in absolute numbers Mexico has by far the largest number of officially confirmed COVID-19 deaths, and for Indonesia it is estimated that the number of deaths is actually 500 percent higher than official statistics. So all three countries had significant aftermaths, depending on how we perceive the indicators.

The next important comparison – based on literature review – relates to the policy responses to the coronavirus pandemic of the three countries analyzed. Indonesia has done a relatively average if not slow phase of preparedness although it is assumed that public diplomacy was being implemented by the Indonesian government in response to COVID-19 pandemic. The reaction phase was still slow and marked by a great number of activities within the country to prevent the spread of the infection, as well as cooperation with a number of other countries. A major challenge for Indonesia in preventing the spread of the infection and the delivery of medical equipment is the country's indentation and the delivery of all necessary resources to numerous islands. As for Mexico, the state was not ready for a pandemic and did not use the time to prepare systems, institutions and people. So Mexico began to develop plans and prepare to prevent the infection, just when the first cases of the infection began to occur within the country itself. In the reaction phase, Mexico had significant internal political challenges as the president minimized problems and diverted attention in the other direction. This certainly affected the final outcome of preventing the spread of the infection. In addition, the problem was with the late purchase of vaccines, as well as the fact that a significant number of Mexicans work in the informal sector of the economy and could not go in lock down, and that citizens have different levels and access to health care. Croatia has implemented the preparedness phase quite well. In Croatia, there are established assessments and plans for dealing with pandemics, institutions and crisis headquarters are formed and functional, so Croatia took the pandemic quite seriously and prepared as much as it could since the moment when the outbreak in China happened, then spreading to other parts of the world and finally arrival to the country. The reaction phase was marked by the active work of all state, regional and local institutions to prevent the spread of the infection, and in that part, regardless of certain challenges, there were no major issues. We assume that there are two key reasons why Croatia has high numbers daily new confirmed COVID-19 cases and deaths per million people – liberal measures to prevent the spread of infection (due to tourism and the economy in general) and because a significant number of people do not want to be vaccinated (although vaccine is available and vaccination system very well organized).

When we compare quantitative and qualitative indicators, we come to the realization that in all three countries the share of people vaccinated against COVID-19 is close to the world average (Picture 1). While Croatia has significantly higher peaks in cases of daily new confirmed COVID-19 cases per million people (Picture 2), and daily new confirmed COVID-19 deaths per million people (Picture 3) compared to Indonesia, Mexico and the world average. The reasons for the above can be found in the fact that for most of the duration of the pandemic (except for the initial few months), Croatia had more liberal measures compared to the other two countries (Picture 4). Indonesia had a relatively average if not slow reaction in the phase of pandemic preparedness, Mexico was not ready for a pandemic, and although during that time, Croatia was solidly prepared for the

pandemic and reacted well in the first wave, challenges began to appear during the pandemic in the form of very liberal restrictive measures by the state and the refusal of a small but significant part of the population to be vaccinated. The combination of these two factors caused a significant number of deaths in Croatia.

4. Conclusion

The COVID-19 pandemic is one of the biggest crisis humanity has ever faced. The pandemic overtook the entire world and no one has been exempted from the direct or indirect consequences of this crisis. Although the crisis is of a global nature, there was no response at the global level, and countries had to deal with it independently, in different ways. In this research, we were interested to find how three very different countries on three different sides of the world reacted to this crisis and how they dealt with it.

In order to get the most quality insight into the situation in each country, the research was based on a quantitative-qualitative framework consisting of a desk-top analysis of available secondary data sources. Two databases were used: from Our World in Data platform and the Economist. This gave us an insight into statistics made from two different sources but in the same way for each of them, so that we could compare the figures and policies of the three countries. Regarding the policy response analysis, we used a literature review for all three countries, where we were interested in how the countries reacted in the preparedness and reaction phase. As part of the research design, we have used three theoretical approaches; crisis management theory; case study theory approach; and, cross-national analysis approach. Using these theoretical approaches, we explored the specifics of each country. We can conclude that the overall research design is well set up and has significantly contributed to the conducting of the research.

Regaring the answer to the research question: What are the similarities and differences in policy responses to the coronavirus pandemic of Indonesia, Mexico, and Croatia?, we have a few observations. First, it is important to point out that all three countries have suffered significant losses in the number of fatalities – in the case of Croatia this is best seen when looking at indicators of daily new confirmed COVID-19 cases and deaths per million people, while in Indonesia and Mexico total death toll. As for the preparedness phase, we can point out that Croatia was better prepared than Indonesia and Mexico because it had all the institutions, crisis headquarters and procedures in place so that it could be more prepared than Indonesia and Mexico, which established task forces and procedures in the beginning of the pandemic. As for the reaction phase, there are differences here as well. Indonesia has been slow in its reaction, but has constantly taken measures internally and externally to protect the population as much as possible and prevent the spread of the infection. Mexico had a significant challenge in failing to respond well to the pandemic with a pronounced situation of minimizing problems by the president, which significantly affected policy implementation. Croatia, on the other hand, reacted well at the beginning of the pandemic, but due to liberal measures to prevent the spread of the infection and the part of the population that does not want to be vaccinated, it became a country with a high percentage of infected and dead per million inhabitants. We can conclude that in all three countries the similarities in the preparation and response to the COVID-19 pandemic are in the way how they made certain preparations, Croatia more than the other two countries, but they were annulled in the response phase for the reasons already described. The differences between these countries are that in the way of policy response to the pandemic, Mexico had structural reasons, while in Indonesia the primary reason is geographical because of the large number of islands, and in Croatia in the official liberal approach and the part of the population that does not want to be vaccinated.

Everything related to the COVID-19 pandemic has many aspects of analysis and discussion, and it can be viewed from very different dimensions and angles. So this analysis is a contribution to that, with an effort to compare the policy approach of three different countries from different parts of the world. The analysis showed certain similarities and differences in the approach to preventing the spread of infection and can be used for further analyses of this type. As for the recommendations that apply to all three countries, more attention should be paid to preparing for potential crisis situations. Furthermore, it is necessary to work more and communicate with citizens and educate them about the risks that surround them and they live with and how to effectively confront crises. Then, it is necessary to document everything that happened and create an institutional memory

from this crisis so that the same or similar inadequate action do not happen again in the next big crisis. And finally, it is necessary to improve cooperation and communication between countries in order to solve such crises on a regional and global level.

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