was about to be saturated. Changes in lockdown policies were difficult to time and often lagged behind fast-changing epidemic dynamics. Border closure policies differed between countries. Contact tracing programmes proved highly successful where they were implemented stringently, early on, with coherent delivery However, catching up on contact tracing that had been introduced late and in settings of high community transmission often failed and was abandoned.

In contrast, **countries with the poorest results** in addressing COVID-19 had uncoordinated approaches that devalued science, denied the potential impact of the pandemic, delayed comprehensive action, and allowed distrust to undermine efforts. Many had health systems beset by long-standing problems of fragmentation, undervaluing of health workers and underfunding. They lacked the capacity to mobilize quickly and coordinate between national and subnational responses.

The denial of scientific evidence was compounded by a failure of leadership to take responsibility or develop coherent strategies aimed at preventing community transmission. Leaders who appeared sceptical or dismissive of emerging scientific evidence eroded public trust, cooperation and compliance with public health interventions.

In many cases, national efforts were both catalysed and amplified by regional responses. For example, the Africa Centres for Disease Control, as an organ of the African Union, was able to coordinate a continent-wide approach to the pandemic backed by requisite political support from Heads of State and Government and ministers.

4.3.2 The crisis in supplies

Part of the story of the slide of COVID-19 from an outbreak into a pandemic relates to issues of leadership, coordination and decision-making at national level. But another part of the story is the difficulties in which countries found themselves **as they scrambled to get hold of the equipment, supplies, diagnostic tests, advice, funds and workforce** they needed to respond to the exponentially growing COVID-19 caseload. There was no international system that had created accessible stockpiles sufficient for the scale of country needs, or that could trigger the flow of resources and step in to regulate orderly access.

In early February 2020, the Director-General of WHO warned of delays of 4–6 months in the supply of face masks and protective suits. By March, the shortfall between needs and manufacturing capacity was estimated at 40% [39]. Stockpiles created in the wake of the 2009 H1N1 influenza outbreak had been depleted; hoarding, price-gouging and fraud appeared in many countries; border restrictions hampered the flow of supplies; and by April 2020 controls on the export of medical supplies and medicines had been imposed by 75 countries [40]. Furthermore, supply chains were overly dependent on a few manufacturers or concentrated in a few supplier countries.