World Health Organization

WHO Director-General's opening remarks at the media briefing on COVID-19 - 3 March 2020

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Good afternoon, and thank you once again for joining us in person and also online.

Today is my birthday, and I've been given a very good gift from DRC, from my own continent Africa. We have now had two weeks without a single reported case of Ebola, and there are currently no patients receiving treatment.

This is very good news not just for me, but for the whole world – I remember how the whole world was worried about Ebola – and especially for the thousands of health workers who have sacrificed so much in the fight against Ebola, and for making sure we're where we are. But as one epidemic looks like ending, one front of the fight closing, another is becoming increasingly complex.

There is now a total of 90,893 reported cases of COVID-19 globally, and 3110 deaths.

In the past 24 hours, China reported 129 cases, the lowest number of cases since the 20th of January.

Outside China, 1848 cases were reported in 48 countries. 80% of those cases are from just three countries: the Republic of Korea, the Islamic Republic of Iran and Italy.

12 new countries have reported their first cases, and there are now 21 countries with one case.

122 countries have not reported any cases.

The actions these newly-affected countries take today will be the difference between a handful of cases and a larger cluster.

We understand that people are afraid and uncertain. Fear is a natural human response to any threat, especially when it's a threat we don't completely understand.

But as we get more data, we are understanding this virus, and the disease it causes, more and more.

This virus is not SARS, it's not MERS, and it's not influenza. It is a unique virus with unique characteristics.

Both COVID-19 and influenza cause respiratory disease and spread the same way, via small droplets of fluid from the nose and mouth of someone who is sick.

However, there are some important differences between COVID-19 and influenza.

First, COVID-19 does not transmit as efficiently as influenza, from the data we have so far.

With influenza, people who are infected but not yet sick are major drivers of transmission, which does not appear to be the case for COVID-19.

Evidence from China is that only 1% of reported cases do not have symptoms, and most of those cases develop symptoms within 2 days.

Some countries are looking for cases of COVID-19 using surveillance systems for influenza and other respiratory diseases.

Countries such as China, Ghana, Singapore and elsewhere have found very few cases of COVID-19 among such samples – or no cases at all.

The only way to be sure is by looking for COVID-19 antibodies in large numbers of people, and several countries are now doing those studies. This will give us further insight into the extent of infection in populations over time.

WHO has developed protocols on how these studies should be done, and we encourage all countries to do these studies and share their data.

The second major difference is that COVID-19 causes more severe disease than seasonal influenza.

While many people globally have built up immunity to seasonal flu strains, COVID-19 is a new virus to which no one has immunity. That means more people are susceptible to infection, and some will suffer severe disease.

Globally, about 3.4% of reported COVID-19 cases have died. By comparison, seasonal flu generally kills far fewer than 1% of those infected.

Third, we have vaccines and therapeutics for seasonal flu, but at the moment there is no vaccine and no specific treatment for COVID-19. However, clinical trials of therapeutics are now being done, and more than 20 vaccines are in development.

And fourth, we don't even talk about containment for seasonal flu – it's just not possible. But it is possible for COVID-19. We don't do contact tracing for seasonal flu – but countries should do it for COVID-19, because it will prevent infections and save lives. Containment is possible.

To summarize, COVID-19 spreads less efficiently than flu, transmission does not appear to be driven by people who are not sick, it causes more severe illness than flu, there are not yet any vaccines or therapeutics, and it can be contained – which is why we must do everything we can to contain it. That's why WHO recommends a comprehensive approach.

These differences mean we can't treat COVID-19 exactly the same way we treat flu.

But there are enough similarities to mean that countries are not starting from scratch. For decades, many countries have invested in building up their systems to detect and respond to influenza.

Because COVID-19 is also a respiratory pathogen, those systems can, should and are being adapted for COVID-19.

But we are concerned that countries' abilities to respond are being compromised by the severe and increasing disruption to the global supply of personal protective equipment – caused by rising demand, hoarding and misuse.

Shortages are leaving doctors, nurses and other frontline healthcare workers dangerously ill-equipped to care for COVID-19 patients, due to limited access to supplies such as gloves, medical masks, respirators, goggles, face shields, gowns, and aprons.

We can't stop COVID-19 without protecting our health workers.

Prices of surgical masks have increased six-fold, N95 respirators have more than tripled, and gowns cost twice as much.

Supplies can take months to deliver, market manipulation is widespread, and stocks are often sold to the highest bidder.

WHO has shipped nearly half a million sets of personal protective equipment to 47 countries, but supplies are rapidly depleting.

WHO estimates that each month, 89 million medical masks will be required for the COVID-19 response; 76 million examination gloves, and 1.6 million goggles.

WHO has guidelines on how to rationalize the use of personal protective equipment in health facilities and manage supply chains effectively.

We're also working with governments, manufacturers and the Pandemic Supply Chain Network to boost production and secure supplies for critically affected and at-risk countries.

Globally, it is estimated that PPE supplies need to be increased by 40 per cent.

We continue to call on manufacturers to urgently increase production to meet this demand and guarantee supplies.

And we have called on governments to develop incentives for manufacturers to ramp up production. This includes easing restrictions on the export and distribution of personal protective equipment and other medical supplies.

Once again, this is a question of solidarity. This cannot be solved by WHO alone, or one industry alone. It requires all of us working together to ensure all countries can protect the people who protect the rest of us.

I thank you.