Frequently Asked Questions: COVID-19 and Smoking

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The following questions are answered in this document:

1. Are smokers more at risk of becoming infected with COVID-19? new

Because cigarette smoking negatively impacts lung health, reduces lung capacity, contributes to underlying health conditions, inhibits the body’s responsiveness to infections, and suppresses immunity, smokers are particularly susceptible to bacterial and viral pulmonary infections, including COVID-19.

More specifically, smoking paralyzes and even kills cilia in the lungs. These tiny follicles trap viruses and debris, such as dust particles, and move them out of the lungs so they don’t cause damage. Without cilia, smokers are particularly susceptible to COVID-19.

In addition, the World Health Organization (WHO) has noted that the physical act of smoking—bringing fingers to the lips—increases the possibility of hand-to-mouth virus transmission. Smoking products that are used in communal or social settings, such as water pipes, are also problematic because they are shared and can facilitate virus transmission from one user to another.

2. Are smokers more likely to have severe complications from COVID-19?

Yes: the data are already showing this. The most recent epidemiological study, published in the New England Journal of Medicine in February, shows that compared to non-smokers, smokers are 2.4 times more likely to be admitted to an intensive care unit, need mechanical ventilation, or die.

In this same study of 1,099 people with COVID-19, nearly 17 percent with the most severe symptoms were current smokers and just over five percent were former smokers.

3. What about vaping and COVID-19—are there specific or heightened risks for vapers?

Because vaping is still a relatively new practice, research is limited on its health effects, and it has not yet been determined if the practice contributes to conditions such as chronic obstructive pulmonary disease. There is, however, emerging evidence that exposure to the
aerosols produced by e-cigarettes—regardless of whether the substance being vaped is nicotine, tetrahydrocannabinol or even just flavourings—harm lung cells, damages lung tissue and increases inflammation, thereby diminishing the ability of the lungs to respond to infections. This concern extends to COVID-19.

On a related note, there is concern that vapour may contain virus particles, posing a risk to people in proximity to people who are using e-cigarettes.

4. People are already anxious and stressed, and nicotine withdrawal can be very unpleasant. Is this really the right time to quit smoking?

There is no disputing that quitting smoking is difficult and that nicotine withdrawal is uncomfortable, but there has never been a better or more urgent time to stop using tobacco.

The good news—and the really encouraging piece—is that while it is difficult to undo all the damage from years of smoking, positive results from quitting tobacco are immediate, starting the second the lungs are no longer exposed to toxic chemicals. Within 20 minutes of stopping smoking, heart rate and blood pressure drop; after 12 hours, the blood’s carbon monoxide level drops; after two weeks, circulation improves and lung function increases; and after one month, cilia, which move mucus out of the lungs, begin to regain normal functioning, increasing the lung’s ability to self-clean and reduce infection risks.

Because smoking has such adverse consequences on lung health, and because quitting smoking almost immediately improves lung health, The Union believes that tobacco cessation should be included among the preventive actions—washing hands, social distancing, avoiding contact with eyes, mouth and nose—that are frequently cited and urgently recommended as effective against COVID-19.

5. What can governments do to incentivise and facilitate smoking cessation efforts?

First, and perhaps foremost, governments have an obligation to make smokers aware that they may be at increased risk for both COVID-19 and adverse disease progression. This is particularly important in the low- and middle-income countries where The Union works, and where many people still don’t understand that tobacco seriously compromises lung health and general immunity. Messaging must be disseminated in all kinds of communication channels—social media, radio programmes, television, print publications and in speeches and guidance from elected officials—to reach people with varying literacy levels and access to technology.

The Union also encourages governments to pay particular attention to the “O-W-E” portion of WHO’s MPOWER package – a set of six policy measures recommended to reduce tobacco use. This means offering smokers help to quit tobacco, warning about the danger of tobacco and enforcing bans on tobacco advertising, promotion, and sponsorship. Governments must pay careful attention to the tobacco industry, making sure that it is not using the pandemic to push products by offering free delivery services or other incentives.

Finally, if they haven’t already done so, where feasible, governments need to staff toll-free smoking cessation hotlines. They must also ensure that supportive counselling services are
offered in conjunction with nicotine replacement therapies, such as patches, gums, lozenges, and prescription medications to help smokers contend with, and better manage, nicotine cravings.