Tobacco control in Germany: Failure to protect the right to health and women's rights in supply chains

Submission to the UN Committee on the Elimination of Discrimination Against Women

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as well as

Action on Smoking and Health (ASH US)

Deutsches Netz rauchfreier Krankenhäuser & Gesundheitseinrichtungen (DNRfK)

FACT e.V. – Women Against Tobacco

German Cancer Research Center (DKFZ)

German NCD Alliance DANK

Health Care Plus

Institute for Therapy and Health Research (IFT Nord)

Vivantes Klinikum Neukölln

VIVID – Institute for the Prevention of Addiction

1 Summary

Tobacco use kills 8 million people each year, 50,000 women in Germany alone. While smoking prevalence among women is decreasing slowly in Germany, nevertheless, 23% of women and girls older than 15 years still smoke.

Tobacco is a human rights issue as it prevents the achievement of the highest attainable standard of health.[1] Smoking and second-hand smoke exposure particularly affect women's (reproductive) health and increases their disease and mortality risk. Despite the immense health harms, Germany lacks key tobacco control measures such as tobacco tax increases, comprehensive smoke-free legislation as well as a ban on tobacco advertising, promotion and sponsorship. Political parties receive donations and sponsorship or party events from tobacco companies and related groups.

Tobacco production is also associated with women's rights violations, e.g. due to lack of protective clothing and exposure to hazardous chemicals and nicotine in tobacco leaves. Since Germany is a big exporter of cigarettes, rights abuses relating to tobacco production in the Global South affect the extraterritorial obligations of the country. However, there is no supply chain law that would ensure transparency and human rights due diligence for companies based in Germany. On a positive note, Germany supports a project for the development of alternative livelihoods to tobacco farming in Malawi.

2 Tobacco consumption in Germany

2.1 Challenges

Tobacco smoking is one of the leading risk factors for premature death and disability worldwide, causing 8 million deaths each year.[2] In Germany, the number of deaths among women due to tobacco use has risen from 43,000 in 2007 to 50,000 in 2017 (from 10.07% to 10.38% of overall deaths in 2007 and 2017, respectively).[3] Even though tobacco use rates slowly decrease, the number of deaths is expected to further increase because of the delayed effect of smoking on chronic diseases such as cardio-vascular diseases and lung cancer.[4]

Smoking and exposure to second-hand smoke (SHS) harm girls and women at all ages, causing respiratory diseases during childhood, respiratory and cardiovascular diseases such as chronic obstructive pulmonary disease (COPD) in middle age, and higher rates of cancer at older ages.[5] Tobacco smoking during pregnancy and relapse postpartum is known as a major public health concern.[6] Smoking during pregnancy has harmful effects on women's pregnancies (e.g. miscarriages, preterm births or stillbirths) as well as on infants' health, cognitive, and social development (e.g. behavioral problems). In addition, infants' exposure to SHS is associated with a number of harmful effects such as increased risk of sudden infant death syndrome or increased frequency of asthma and ear infections. Water pipe tobacco use has harmful effects on health similar to combustible cigarettes.[7] As yet, there is little evidence about the effects of electronic nicotine delivery systems use during pregnancy.[8] However, it was shown that their use is associated with an increased risk of small-for-gestational-age birth.[9]

Tobacco use prevalence among women in Germany has slowly decreased in the past decades, from 26.1% in 2000 to approximately 23% in 2017.[10] However, water pipe use has increased

among young female adults aged between 18 and 25 years. The 30-day-prevalence has more than tripled – from 4.6% in 2008 to 14.8% in 2018.[11] The 30-day-prevalence of e-cigarette consumption has increased significantly compared to 2015 in female adolescents and young women too, but at a lower level compared to water pipe use.[12] The likelihood of smoking, using water pipe and/or e-cigarettes is related to a lower school-leaving education.[13] In addition, smoking of combustible cigarettes is associated with a lower household income.[14] Unemployed women as well as those working in manual or simple service occupations such as nursing assistants, nurses for the elderly, security guards, truckers or staff in restaurants and bars have much higher smoking rates than those in highly qualified jobs.[15]

Women working in restaurants and bars are also among those professional groups that have higher rates of SHS exposure. Germany does not have a comprehensive smoke-free legislation but different laws for each of its 16 federal states with different kinds of exemptions and loopholes, leading to unequal levels of protection from SHS exposure in public places.[16]

Overall SHS exposure is associated with socio-economic status (SES) and age: Exposure rates are the highest among young female adults with low SES who are between 18 and 29 years old.[17]

Approximately one third of female smokers in Germany report a total smoking ban in their homes (32.6%). The proportion is higher among those with a non-smoking partner and among those with children. The prevalence of total smoking bans in cars when children are present was higher (72.9%). Having no rules regarding smoking in cars was more likely among female smokers at younger ages and with lower educational level.[18]

Mother's age when giving birth	**Smoking prevalence (%)**
< 25 years	22.5
25 – 29 years	12.7
30 – 34 years	7.4
≥ 35 years	7.6
Socio-economic status (SES)	
Low	27.2
Middle	9.2
High	1.6
Total	**10.9**

Table 1: Smoking rates of pregnant women in Germany, surveyed 2014-2017. *Source: Kuntz B et al 2018: Smoking during pregnancy. Results of the cross-sectional KiGGS Wave 2 study and trends. Journal of Health Monitoring.*

There is little data about the prevalence of smoking during pregnancy in Germany. Almost 11% of mothers of 0- to 6-year-old children surveyed between 2014 and 2017 in the KiGGS study of the Robert Koch Institute smoked during pregnancy. Women aged under 25 years at the time of their child's birth or with a low SES had smoked at much higher rates than their peers over 25 years old or with a high SES. For example, while only 1.6% of women with high SES smoke during pregnancy, 27.2 % of women with low SES do (see table 1), increasing their health risks and inequalities.[19] Nicotine and tobacco cessation programmes therefore have to be designed to reach marginalized groups such as women with low SES. Results of a pilot smoking cessation counseling programme implemented in pregnancy counseling centers in the state of Mecklenburg-Vorpommern indicated that women from poorer households can be reached through this channel.

Of 719 women addressed, 693 agreed to participate in the brief counselling on smoking cessation and protection from SHS exposure. 30.5% of them reported to be regular smokers, almost three times the above mentioned average German rate of smoking during pregnancy.[20]

Furthermore, trends of prevalence of a healthy lifestyle between 1990 and 2011 indicate that women with medium and high educational background show stronger increases in healthy lifestyle over time compared to those with low educational status.[21] This shows increasing inequalities in healthy lifestyle among women and is in line with research revealing increasing inequalities regarding smoking prevalence associated with different educational levels.[22]

Germany is a party to the WHO Framework Convention on Tobacco Control (WHO FCTC) that came into force in 2005. The convention requires states parties to implement smoke-free public places, tobacco advertising and sponsorship bans, regular tobacco tax increases, product packaging and ingredient regulations and other evidence based measures to reduce tobacco use prevalence. The German government has implemented some of these measures such as a partial smoking ban in restaurants and bars and most recently pictorial warnings on cigarette packs (in 2016, as required by the 2014 EU Tobacco Products Directive). However, policy making in this area has slowed down since 2010 and Germany is second to last in the 2016 European Tobacco Control Scale that compares progress in 35 European countries.[23] Germany lacks essential tobacco control measures such as a ban on tobacco advertising, promotion and sponsorship, comprehensive smoke-free legislation as well as sufficient cessation support for smokers who would like to quit. Tobacco companies regularly donate to political parties and sponsor their events, although this kind of sponsorship should be banned under Art. 5.3 and 13 of the WHO FCTC.[24] Moreover, tobacco taxes have not been increased in significant steps above the inflation level since the 2000s. In comparison with other European countries, cigarettes remain relatively cheap in Germany, making them easily accessible for vulnerable girls and women in the country.[25] Raising tobacco taxes is one of the most effective tobacco control measures: They reduce smoking uptake among adolescents and increase quit rates, especially among population groups with a low income, thereby reducing health inequalities.[26]

2.2 Recommended questions to be included in the List of Issues

Recognizing the immense harms caused by smoking among women and the high tobacco use prevalence rates still persistent in Germany,

Considering the socio-economic inequalities related to tobacco use, and

Referring to CEDAW Articles 10(h), 11(1)(f), 11(2)(d), 12(1), 14(2)(b) and 14(2)(h),

We recommend that the CEDAW Committee asks the German government to respond to the following questions:

1. How does the German government improve measures to prevent and reduce nicotine and tobacco addiction among girls and women, especially so that girls and women with lower socio-economic status benefit in the same way as their peers with higher socio-economic status? Does it intend to raise tobacco taxes to increase quit rates and decrease smoking uptake among women and girls?
2. Does the German government have a national plan for the comprehensive implementation of the WHO FCTC and what is the timeline for specific measures? If not, does it intend to develop such a plan?

3. How does the German government support the development of nicotine and tobacco cessation programmes for women, especially tailored to pregnant women, those willing to become pregnant or other vulnerable groups?

3 Womens rights‘ violations in tobacco supply chains

3.1 Challenges

Germany, one of the world‘s leading cigarette exporters with an annual export volume of about 120 billion cigarettes, profits from poor working conditions in tobacco growing countries.[27] Every year, roughly 115,000 tonnes of tobacco leaf are imported to Germany, among others from Brazil, Malawi, India, Indonesia, Tanzania and Zimbabwe.[28] The supply chains and inherent responsibilities of German tobacco companies and German subsidiaries of transnational tobacco corporations are difficult to trace as there are no publicly accessible import directories and company organisation charts. Germany lacks a supply chain law that enforces transparency and ensures that companies based in Germany can be held accountable for human rights abuses abroad.

Most of the world‘s tobacco is grown in low- and middle-income countries where low labour standards are prevalent and smallholder farmers have difficulties to earn a living from it.[29] Women working in tobacco fields are exposed to hazardous chemicals (pesticides, fertilizers etc.) as well as to nicotine from tobacco plants. Lack of protective clothing is widespread, increasing the risk of chemical as well as acute nicotine poisonings (Green Tobacco Sickness, GTS), among others leading to dizziness, nausea, vomiting, diarrhoea and headache. Severe GTS cases need emergency hospital care to treat the resulting dehydration. Studies in tobacco growing areas suggest that women are at higher risk to be affected by GTS than men.[30] Despite these health hazards, women often have to continue working in tobacco fields during pregnancy due to the family’s economic dependency on the crop. Thus, GTS, chemical poisonings as well as hard physical work affect the health of mothers and their unborn children and can lead to miscarriages.[31] Women working in tobacco growing should be provided with adequate protective clothing as well as information about their specific health risks relating to chemicals and other risks in tobacco farming, in line with their rights to safe working conditions and information.

Additionally, women in tobacco growing households often lack control over finances and decision-making although they are as involved in tobacco production as men. It is also a huge challenge to achieve gender equality in terms of land and dwelling ownership.[32] To break the vicious cycle of health risks, poverty and gender inequality in tobacco growing, women should be empowered, involved in decision-making processes and supported in switching to alternative livelihoods to tobacco cultivation. The German development agency GIZ currently supports a training programme for rural extension advisors on diversifying agriculture with crops such as soybean and sunflower in Malawi.[33] Following this first positive example, the German government should support more such programmes in tobacco growing regions as part of its development cooperation. This would also be in line with its obligations under Article 17 of the WHO FCTC).

3.2 Recommended questions to be included in the List of Issues

Recognizing the occupational risks of women in tobacco growing combined with a widespread lack of financial and decision-making power as well as the lack of transparency and accountability in the tobacco supply chain,

Considering the extraterritorial obligations of the Federal Republic of Germany, and

Referring to CEDAW Articles 10(f), 11(1)(f), 11(2)(d), 12 and 14,

We recommend that the CEDAW Committee asks the German government to respond to the following questions:

1. How does the German government ensure and enforce that Germany based companies and German subsidiaries of transnational corporations, e.g. tobacco companies, adhere to their human rights due diligence in their supply chains? Which legal steps can claimants take to obtain compensation from German companies in case of the violation of women‘s rights in the supply chain?
2. How and to which extent does the German government support tobacco growing countries in efforts to find alternative livelihoods for tobacco farmers willing to switch and how are women’s needs, perspectives and rights included?
3. In which countries does the German government explicitly incorporate women‘s rights in their development cooperation programmes? How does the German government support gender equality in these programmes with a special emphasis on land ownership, health care and decision-making processes?

4 Organizations submitting this report

In alphabetical order:

Founded in 1967, **Action on Smoking and Health (ASH)**, an organization with ECOSOC Status, is the United States’ oldest organization devoted to fight the harms caused by tobacco, both in the US and globally, and dedicated to a world with zero tobacco deaths. ash.org

The **Berlin Working Group on Environment and Development (BLUE 21)** with its project **Unfairtobacco** exposes how tobacco industry harms farmers, consumers and the environment. The project was recognized with a WHO World No Tobacco Day Award in 2017. unfairtobacco.org

The **Deutsches Netz Rauchfreier Krankenhäuser & Gesundheitseinrichtungen** supports healthcare services to implement comprehensive tobacco control according to international standards. Its members are healthcare services and the network collaborates with other organizations in tobacco control. www.dnrfk.de

Frauen aktiv contra Tabak (FACT e.V.) – Women Against Tobacco was founded in 2006 by women tobacco control leaders. FACT e.V. distributes information regarding women tobacco issues and supports the development of women-centered tobacco use prevention and cessation programs. fact-antitabak.de

The **German Cancer Research Center (DKFZ)** is the largest biomedical research institute in Germany. Its more than 3,000 employees, of which more than 1,200 are scientists, are investigating the mechanisms of cancer, are identifying cancer risk factors and are trying to find

strategies to prevent people from getting cancer. www.dkfz.de

The **German NCD Alliance DANK** unites 23 medical organisations such as German Diabetes Association, German Cancer Society, German Obesity Association and Association of General Practitioners. www.dank-allianz.de

The purpose of **Health Care Plus** – Collaboration, Coordination, Sharing and Learning is to establish and coordinate networks to create, share and disseminate good practice in health promotion, health literacy and quality in health care service.

The **Institute for Therapy and Health Research (IFT-Nord)** is a non-profit organization located in Kiel, Germany. Core objective is the promotion of public health. www.ift-nord.de

The municipal **Vivantes Hospital Neukölln** in Berlin was founded more than 100 years ago and has about 1300 beds and almost all disciplines, including lung cancer treatment and a smoking cessation unit. www.vivantes.de

VIVID – Institute for the Prevention of Addiction is an Austrian institution, based in the federal state Styria. Its focus is the prevention of addiction in general and it was nominated for the EU Health Award 2018 for its tobacco prevention work. www.vivid.at

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