LEGAL AND POLICY GAPS IN IMPLEMENTING WHO FCTC AND MPOWER IN INDIA

FCTC
WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL

Report
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"Supporting stronger and evidence-based tobacco control initiatives through capacity building and strengthening laws, policies and institutional mechanism with multi-stakeholder engagement towards tobacco-free India."

Legal and Policy Gaps in Implementing WHO FCTC and MPOWER in India

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GLOSSARY

COP	Conference of the Parties
COTPA	Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003
FCTC	Framework Convention on Tobacco Control
GATS	Global Adult Tobacco Survey
GYTS	Global Youth Tobacco Survey
GST	Goods and Services Tax
HMIS	Health Management Information System
MoHFW	Ministry of Health and Family Welfare
NCD	Non-Communicable Disease
NFHS	National Family Health Survey
NRT	Nicotine Replacement Therapy
NTCP	National Tobacco Control Programme
OTT	Over-The-Top
SLT	Smokeless Tobacco
SHS	Second Hand Smoke
TAPS	Tobacco Advertising Promotion and Sponsorship
TB	Tuberculosis
TCC	Tobacco Cessation Centre
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction

Tobacco use remains one of the most preventable causes of premature death globally, with tobacco-related mortality projected to exceed ten million annually by 2030. In response, the World Health Organization (WHO) adopted the Framework Convention on Tobacco Control (FCTC) in 2003, followed by the MPOWER package in 2008, comprising six evidence-based tobacco control measures. While implementation of these measures has contributed to declining tobacco use in several countries, including India, significant challenges persist. This report evaluates India's performance against the WHO's MPOWER framework using nationally representative data from the Global Adult Tobacco Survey India, Reports from 2009-10 and 2016–17 (GATS 2). The findings reaffirm tobacco consumption as a major public health and economic burden, costing India an estimated ₹1,77,340 crore in 2017 alone, and highlight the continuing challenge of translating strong policy commitments under the WHO FCTC into effective and equitable public health outcomes.

Analysis and Findings

The analysis in this report utilizes the MPOWER framework to detail India's success in establishing a system of monitoring and cessation support, while simultaneously exposing critical structural vulnerabilities in taxation, smoke-free enforcement, and advertising regulation, which are as follows:

Monitor (M) Tobacco Use and Prevention Policies:

Under the Monitor (M) measure of the MPOWER framework, India has achieved complete implementation, reflected in substantial declines in tobacco use over different rounds of national surveillance reports. Adult tobacco prevalence fell from 34.6% (2009–10) to 28.6% (2016–17), a 17.3% relative reduction. Smoking declined by 23.6% and smokeless tobacco use by 15.6%, with a notable 30.4% reduction among women. Cessation outcomes also improved, with former daily smokers increasing from 12.6% to 16.8%. However, monitoring remains constrained by long intervals between survey rounds and the absence of systematic surveillance of emerging products such as e-cigarettes, limiting timely and comprehensive policy responses.

Protect (P) People from Tobacco Smoke:

India has achieved a moderate level of implementation of smoke-free policies under COTPA, 2003, which prohibits smoking in six of eight WHO-identified indoor public places. These measures have reduced second-hand smoke exposure, with non-smoker exposure at home declining by 26.0% and exposure in restaurants falling by 34.5% between GATS 1 and GATS 2. However, exposure persists in government offices and indoor workplaces, and a key legislative gap remains in the continued allowance of Designated Smoking Areas in hospitality settings, undermining the WHO FCTC mandate for 100% smoke-free environments.

Offer (O) Help to Quit Tobacco Use:

India has achieved complete implementation of cessation support under the National Tobacco Control Programme (NTCP), fulfilling WHO FCTC Article 14 through structured public health services.

Key measures include the National Toll-Free Quitline and free Nicotine Replacement Therapy under the Essential Drugs List. However, gaps persist due to limited public-sector access to other cessation medications and uneven NTCP capacity across states, leading to disparities in service availability and quality.

Warn (W) About the Dangers of Tobacco:

India has achieved complete implementation of graphic health warnings, mandating 85% coverage on both sides of tobacco packaging, placing it among global leaders. These warnings show strong behavioural impact, with over 60% of cigarette smokers and 53.8% of bidi smokers reporting increased quitting intentions. However, declining exposure to mass media anti-tobacco messaging and the widespread sale of loose or unbranded tobacco products significantly undermine enforcement and limit consumer exposure to health warnings, particularly in rural areas.

Enforce (E) Bans on Tobacco Advertising, Promotion and Sponsorship:

Tobacco advertising, promotion, and sponsorship (TAPS) drive tobacco use, and comprehensive bans are proven to reduce consumption. While Section 5 of COTPA prohibits TAPS, permitted on-pack and point-of-sale (PoS) advertising allows continued exposure to TAPS. Evidence links PoS marketing to increased initiation among youth and heightened cravings among adults. The tobacco industry further circumvents restrictions through surrogate and covert advertising, including brand stretching, CSR activities, films, digital media, and promotional offers, with nearly 17% of adults reporting exposure to TAPS at places other than PoS. Although recent regulatory measures, such as ASCI's 2023 guidelines, mark progress, persistent enforcement gaps continue to undermine their effectiveness.

Raise (R) Taxes on Tobacco:

India has achieved a moderate level of implementation in tobacco taxation. Despite WHO recommendations that taxes should constitute at least 75% of retail prices, tobacco products have become more affordable as income growth has outpaced tax and price increases. While smoker expenditure has nearly doubled since 2014, persistent under-taxation of bidis and smokeless tobacco largely consumed by low-income and rural population continues to undermine public health goals and exacerbate inequities. Weak and fragmented taxation of smokeless tobacco, often sold loose and unbranded in rural areas, remains a critical enforcement gap.

Recommendations

To Improve "M" Measure:

To strengthen tobacco control monitoring and evidence-based policymaking, there is a need to institutionalise a National Tobacco Surveillance Cell within the Ministry of Health and Family Welfare for real-time coordination and oversight. This should be complemented by conducting biennial rounds of the Global Adult Tobacco Survey (GATS) and Global Youth Tobacco Survey (GYTS), supported by interim mini-surveys to capture emerging trends. Further, integrating tobacco-related modules into routine health and demographic surveys and leveraging digital data systems for continuous, automated monitoring would ensure timely, comprehensive, and responsive surveillance of tobacco use and policy implementation.

To Improve "P" Measure:

To advance towards the highest level of compliance with smoke-free policies, India must undertake targeted legal and institutional reforms. This includes amending COTPA to eliminate the provision for designated smoking areas, as done by state of Jharkhand, besides strengthening inspection and enforcement mechanisms particularly in rural and informal settings, and launching sustained mass-

media and community-based campaigns to promote smoke-free homes and workplaces. Additionally, integrating systematic monitoring of second-hand smoke exposure into national health surveillance systems is essential to track progress and inform responsive policy interventions. Moving beyond smokefree, public use of tobacco should be banned like already done by the states of Jharkhand and Karnataka.

To Improve "O" Measure:

To strengthen tobacco cessation services, it is essential to establish state-level cessation monitoring dashboards linked with national NTQL data to enable real-time tracking and evaluation. This should be accompanied by expanded financing for community-based cessation interventions under Ayushman Bharat, the introduction of periodic training modules for all healthcare providers across both public and private sectors, and the promotion of indigenous and psychosocial interventions as complementary therapies. Additionally, leveraging digital platforms for continuous patient engagement, follow-up, and outcome evaluation would enhance the effectiveness and reach of cessation efforts.

To Improve "W" Measure:

To build on existing gains and move towards global leadership in tobacco control, India should consider strategic legal reforms, including banning the sale of loose cigarettes to ensure universal exposure to graphic health warnings. Strengthening regulation of smokeless tobacco—often sold loose or unbranded—and enforcing packaging and labelling requirements besides introducing plain packaging and standardisation of packs with minimum quantity are essential to improve regulatory oversight and compliance.

To Improve "E" Measure:

Effective enforcement of tobacco advertising bans requires strengthening COTPA, 2003 to prohibit all direct and indirect TAPS, including point-of-sale displays, surrogate advertising, brand stretching, CSR misuse, and digital marketing. Mandating plain and standardized packaging across all tobacco products would further curb promotional appeal and reinforce health warnings. These measures must be supported by stronger enforcement through an independent authority, deterrent penalties, civil society participation, and mandatory vendor licensing to ensure compliance and protect minors.

To Improve "R" Measure:

To enhance the effectiveness and equity of tobacco taxation, India should implement comprehensive fiscal reforms, including equalising taxes on bidis and smokeless tobacco with cigarettes, abolishing small-producer GST and excise exemptions, and indexing tax increases to inflation and income growth. Earmarking a portion of tobacco tax revenues for health, cessation services, and mass media campaigns, while integrating taxation within a broader social equity framework for bidi workers, would strengthen public health impact.

Chapter 1
Introduction

1.1 Introduction

Tobacco consumption remains one of the gravest global public health threats, causing over seven million deaths annually and contributing to a wide range of noncommunicable and infectious diseases. Beyond health impacts, tobacco use deepens poverty and economic inequality by diverting household resources and reducing productivity. The WHO projects the fastest growth in tobacco-related deaths in populous countries such as India, with many occurring during prime working years, intensifying social and economic losses. Tobacco's harm extends beyond health, reducing productivity, straining health systems, degrading the environment, and deepening poverty. Its social and economic costs far exceed any fiscal or employment benefits, making the global tobacco epidemic a major development challenge.

In India, tobacco imposes an acute health, economic, and environmental burden, accounting for nearly half of cancers among men, one-fifth among women, and about 40% of tuberculosis cases. The economic cost has risen sharply from ₹1,04,500 crore in 2011 to an estimated ₹1,77,340 crore (about 1% of GDP) in 2017–18 while tobacco tax revenues cover only a small fraction of these losses. Tobacco also causes significant ecological damage through deforestation, soil degradation, pollution, and increased fire risks.

1.1 World Health Organization Framework Convention on Tobacco Control (WHO FCTC)

The global scale of the tobacco epidemic prompted a unified legal response through the WHO Framework Convention on Tobacco Control (FCTC), one of the most widely ratified UN treaties. In force since 27 February 2005 and ratified by 183 countries, the FCTC provides a legally binding framework to reduce tobacco demand and supply by addressing transnational drivers such as cross-border advertising, trade, and illicit tobacco. Its core objective is to protect present and future generations from the health, social, environmental, and economic harms of tobacco through coordinated and comprehensive implementation at all levels.

Over the past decade, the WHO FCTC has sustained tobacco control as a global public health priority, contributing to measurable reductions in tobacco-related harm and saving lives worldwide. It advances a comprehensive approach addressing both tobacco demand and supply through coordinated measures, with strong evidence showing effective protection of adults and children from smoking initiation and related health harms.

The WHO FCTC emphasizes dual demand- and supply-reduction strategies and provides a structured framework for the adoption of tobacco control measures across national, regional, and global contexts. To support countries in implementing the demand reduction measures under the treaty, WHO introduced the MPOWER package in 2008. This package outlines six proven and cost-effective demand reduction strategies:

M	Monitor tobacco use and prevention policies
P	Protect people from tobacco smoke
O	Offer help to quit tobacco use
W	Warning about the dangers of tobacco
E	Enforcing bans on tobacco advertising, promotion and sponsorship
R	Raising taxes on tobacco

Together, these measures form a comprehensive policy framework that has consistently reduced tobacco use and guides countries on areas needing further action. WHO estimated that full implementation of all MPOWER strategies at the strongest level worldwide in 2010 could have reduced the global number of smokers by 28% by 2020.

The MPOWER framework is widely used to assess WHO FCTC implementation and policy effectiveness. Empirical studies show that higher MPOWER scores particularly for monitoring and taxation are significantly associated with reductions in smoking prevalence, with comprehensive implementation across measures producing measurable declines across countries.[1]

India was among the first few countries to ratify the WHO Framework Convention on Tobacco Control (WHO FCTC). The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) is the principal comprehensive law governing tobacco control in India. The Act was passed before India became a Party to the WHO Framework Convention on Tobacco Control. Following the passage of COTPA in 2003, various rules implementing COTPA were notified for advancing tobacco control.

The National Tobacco Control Programme (NTCP), launched by the Government of India in 2007–08, serves as the principal institutional mechanism to advance India's commitments under the WHO Framework Convention on Tobacco Control (WHO FCTC). The programme seeks to reduce tobacco use and its health burden through awareness generation, capacity building, enforcement of tobacco control laws, and systematic monitoring. It supports effective implementation of the Cigarettes and Other Tobacco Products Act (COTPA), 2003, aligns with the MPOWER framework, and fosters coordinated action across central, state, and district authorities.

Following table provides a comparative analysis of WHO FCTC vis-a-vis Indian tobacco control regime along with global best practices and policy gaps:

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 2.1	Recommending Parties to implement measures beyond those required by the Convention and its protocols.	• Tobacco Free Educational Institutions • Tobacco Free Villages • Tobacco Free Offices • Several states striving towards tobacco free generation policy	• Finland first country to adopt tobacco end-game goal, by 2040, in its national legislation. • Maldives first country to implement the tobacco-free generation policy • Canada and Australia introduced health warnings on every single cigarette • Several countries have 21 as the legal age of purchase	• Age 21 • Tobacco free generation roadmap • Tobacco endgame roadmap

1. Dubray, J., Schwartz, R., Chaiton, M., & O'Connor, S., The effect of MPOWER on smoking prevalence. *Tobacco Control*, (2015) *24*(6), 540–542. See also Gravely, S, Giovino, GA, Craig, L et al., Implementation of key demand-reduction measures of the WHO Framework Convention on Tobacco Control and change in smoking prevalence in 126 countries: an association study. *Lancet Public Health*.

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 5.3	Calling on Parties to safeguard public health policies from the commercial and vested interests of the tobacco industry.	• Ministry of Health and Family Welfare adopted code of conduct in 2019 • At the sub-national level, 25 states adopted WHO FCTC 5.3 policy guidelines	• Brunei Darussalam, Finland, Maldives among countries with minimum TII • Nine countries have included Article 5.3 into their national tobacco control legislation • 20 countries have banned TI donations • 32 countries have banned TI-related CSR	• Increasing TII • No whole of government Article 5.3 policy or code of conduct • Ban on TI Donations and CSR
Article 6	Adopt price and tax measures to reduce the demand for tobacco	• All tobacco products taxed at the highest slab of the GST @ 40% except Beedis which are taxed at 18% • Excise on tobacco products at 25% while on beedis only 10%	• Tax on cigarettes ≥ 75% of retail price in 40 countries • Cigarettes have become • less affordable in 46 countries	• Tax incidence on tobacco products is much less than recommended 75% levels • Need to tax all tobacco products including beedis wherein the tax incidence is ≥ 75% of the retail price.
Article 8	Protect people from exposure to tobacco smoke	All public places are smokefree but three exceptions in the law. Jharkhand state has adopted 100% smokefree and tobacco free public places law without any exceptions	79 countries have 100% smokefree public places	Need to remove all exceptions under the smokefree law.
Article 9	Regulate the contents of tobacco products	India has notified four national laboratories for testing of tobacco products	Australia regulates additives and emissions Singapore has strict controls on additives, flavours, and product composition EU, USA Canada and several other countries ban characterising flavours	Need to ban flavour, additives and nicotine content in tobacco products

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 10	Regulate tobacco product disclosures	National tobacco regulatory form is established Packaging rules require display of message "tobacco causes painful death" on all products	Australia also has strong product disclosure requirements	Need to provide on pack qualitative disclosure about the harmful chemical and toxins and their effects
Article 11	Regulate the packaging and labelling of tobacco products	One of the significant PHW on all tobacco products globally at 85% front and back	Eight other countries have better and larger coverage of PHW. Timor-Leste and Türkiye have PHW at 92.5% of the pack Canada and Australia require health warnings on individual cigarettes 27 countries have adopted plain packaging, 3 have it in practice, and 14 are working on it.	Same warning used across all products for a year. Rotation from a set of multiple warnings should be mandated Warnings should cover different aspects of health harms caused due to tobacco use. Enforcement of existing PHWs
Article 12	Warn people about the dangers of tobacco	National campaigns on harmful effects of tobacco products run on national and state media National tobacco control programme includes IEC as an essential component Since last three years national tobacco free youth campaign is run across the country for two months.	37 countries undertake national mass media that is planned, pretested and evaluated.	Regular national and sub national mass media campaigns which is planned, pretested and evaluated

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 13	Ban tobacco advertising, promotion and sponsorship	Ban on direct and indirect advertising under COTPA TAPS ban on film, television and OTT	68 countries have adopted comprehensive TAPS bans	Need to implement ban on CSR and corporate promotions Remove TAPS at Point of sale Enforcement of TAPS ban and surrogate TAPS
Article 14	Offer people help to end their addictions to tobacco	Meets the highest level of protection as prescribed by WHO under MPOWER	31 countries are now covered by comprehensive cessation services	Further need for brief advise on tobacco cessation at all levels of health system
Article 15	Control the illicit trade in tobacco products	Ratified the Protocol to Eliminate Illicit Trade in Tobacco Products Track and trace mechanism in the pipeline Vendor licensing adopted by more than 100 jurisdictions in the country	Track and trace operational in European Union since 2019 Several other parties to the Protocol implement track and trace. 40 countries have national tobacco vendor licensing policies in place	Adopt and implement track and trace mechanism Adopt and enforce licensing of entire supply chain of all tobacco products
Article 16	Ban sales to and by minors	Ban on sale to and by minors below 18 years Ban on sale within 100 yards of educational institutions Tobacco free educational institutions guidelines National tobacco free youth campaign since 2023	Several countries ban sale to person below the age of 21 years Maldives first country to implement the tobacco-free generation policy	Implement tobacco 21 policy as implemented by Jharkhand and Karnataka Integrate and adopt tobacco free generation policy

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 17	Support economically viable alternatives to tobacco growing	Some states provide support for tobacco farmers to grow other crops Efforts under the skill India programme to provide economically viable alternatives	Brazil recently launched its National Policy to coordinate sustainable alternatives for tobacco farmers Kenya is a prominent example of state-level support for alternatives The EU has sponsored projects identifying new crops and diversified farming systems	Need for government support for alternative crops for tobacco growers Need for supporting economically viable alternatives for beedi rollers and tendu leaf collectors
Article 18	Protection of the environment and the health of persons	National Green Tribunal call for action against cigarette and beedi butts Ban on plastic packaging of tobacco products Central Pollution Control Board taking action for plastic packaging of tobacco products	EU considers cigarette filters as single use plastic and tobacco producers financially responsible for clean-up, waste management, and awareness campaigns Mandates packaging labelling warning consumers about plastic content and environmental harm. Also implement extended producers' liability schemes	Account for environmental impacts from the **entire tobacco lifecycle**—cultivation, manufacture, consumption, and waste disposal—and strengthen national policies accordingly Filter ban Plastic ban EPR Deposit-return scheme Levies applicable to tobacco product waste

Provision	FCTC mandate	Efforts in India	Global best practice	Gaps in India
Article 19	Liability - Criminal and civil liability, including compensation where appropriate	Offences and punishments under COTPA, JJA, FSSA, CPA, PECA Offences under other general laws for violating consumer laws, tax laws etc. Central Pollution Control Board levied fine for violating plastic ban for packaging tobacco products	Several developed countries have successfully sued tobacco industry for damages in billions of dollars Columbia prosecuted tobacco company for violating child rights Ukraine took action against misleading advertising claiming heated tobacco product to be less harmful	Strengthen civil and criminal liability regime to hold tobacco industry liable for the harms caused to individuals and the society at large Further apply administrative fine and levies on tobacco industry for the violation of existing rules and regulations.

In addition, Article 7 of the Treaty requests that the Conference of the Parties (COP) propose guidelines for the implementation of the Convention, with the aim to assist Parties in meeting their obligations under the Convention. Keeping with this provision, COP has adopted several guidelines over the years for effective implementation of the various provisions of the Convention.

Despite the growing body of evidence linking individual policies or MPOWER scores to reductions in smoking, relatively few studies have comprehensively evaluated the impact of the WHO FCTC by directly connecting the MPOWER package with observed tobacco use data and by estimating the average effects of composite MPOWER scores. There is a lack of attempts that systematically measure the implementation status of tobacco control policies. Some studies have assessed the implementation of tobacco control policies in India. One study found that India's mean MPOWER score during the period 2013–2019 was 27, while another study by Malhi et al. reported a mean score of 25.33 for the period 2009–2013. Taken together, these findings suggest a gradual and progressive improvement in the implementation of tobacco control policies in India over time.

This report seeks to provide a comprehensive assessment of India's tobacco control landscape. It synthesizes and examines the implementation status of the MPOWER measures, and identifies critical gaps in policy and law. The objective is to provide policymakers with a robust analytical foundation to guide future strategies and reinforce India's leadership in global tobacco control. The report aspires to serve as both a record of progress and a roadmap for accelerating tobacco control measures through integrated, evidence-driven approaches.

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India's Position in the WHO MPOWER Data

- India is classified as having achieved the "Moderate Measure" under the "M – Monitor tobacco use and prevention policies" indicator.
- This status is based on India's conduct of nationally representative adult and youth tobacco surveys, notably the Global Adult Tobacco Survey (GATS) and the Global Youth Tobacco Survey (GYTS).
- The WHO recognises India's monitoring system for its national coverage, methodological rigour, age and gender disaggregation, and cross-round comparability.
- India's position places it among a limited group of low- and middle-income countries with institutionalised, large-scale tobacco surveillance systems.
- However, the MPOWER assessment also indicates that long intervals between survey rounds affect data recency, underscoring the need for more frequent and integrated monitoring mechanisms.
- Overall, the WHO MPOWER Data Portal reflects India's strong tobacco surveillance capacity, based on nationally representative adult and youth surveys, while simultaneously underscoring the need to transition from episodic survey-based monitoring to more regular and continuous, policy-responsive surveillance mechanisms.

Chapter 2
Monitoring Tobacco Use in India (M Measure under MPOWER)

2.1 Why Monitoring Matters

Effective tobacco control begins with knowing who uses tobacco, in what form, where, and why. In a country as diverse as India, where tobacco is smoked, chewed, sucked, and sniffed, policy without reliable data risks being blind, delayed, or misdirected. The "M" (Monitor) component of the WHO's MPOWER framework therefore, acts as the backbone of evidence-based governance. Without credible surveillance, taxation, enforcement, warnings, and cessation policies lose their precision and impact.

India's obligation to monitor tobacco use flows from Article 20 of the WHO Framework Convention on Tobacco Control (FCTC), which mandates Parties to establish systems for surveillance of tobacco consumption, determinants, and health consequences. India has responded with one of the largest and most methodologically robust tobacco surveillance systems in the developing world.

2.2 India's Surveillance Architecture: Strong Foundations

India's monitoring system rests primarily on three national data pillars:

1. Global Adult Tobacco Survey (GATS)
2. Global Youth Tobacco Survey (GYTS)
3. National Family Health Survey (NFHS)

Together, these instruments capture tobacco use across age, gender, geography, and socio-economic strata, providing policymakers with a nationally representative picture.

2.3 What the Data Reveals: Progress with Caveats

Monitoring has yielded three critical insights for governance:

- GATS(2016-17) has revealed that adult tobacco use declined from 34.6% to 28.6%, marking a 17.3% relative reduction. Smoking prevalence fell even more sharply, while smokeless tobacco has also declined at national level but have increased in some states, suggesting delayed uptake among younger cohorts. These trends validate India's investments in warnings, restrictions, and cessation support. Importantly, the average age of initiation also showed a steady decline
- First, tobacco use is declining, but not uniformly. Urban areas have seen faster reductions than rural regions. Men continue to use tobacco at significantly higher rates than women, though the decline among women has been proportionately steeper.
- Second, smokeless tobacco remains India's dominant challenge. While cigarette smoking attracts policy attention, products like khaini, gutkha, and zarda continue to evade effective regulation, particularly when sold loose or unbranded.
- Third, exposure to second-hand smoke at home has fallen substantially, yet workplace exposure has remained stagnant, signalling enforcement gaps that monitoring alone cannot fix but can clearly reveal.

Youth Surveillance: The Early Warning System

If adult surveys show outcomes, youth surveys show the future.

The Global Youth Tobacco Survey (GYTS) 2019 reports that tobacco use among students aged 13–15 has halved since 2003, falling to 8%. This is a significant public health achievement. However, the data also sends a warning signal:

- The median age of initiation for smokeless tobacco is under 10 years.
- Exposure to tobacco imagery in films, online platforms, and point-of-sale displays remains high.
- Access restrictions under law continue to be routinely bypassed.

These findings underscore the central value of surveillance: it identifies not just success, but where policy momentum is stalling. Monitoring thus functions as a policy early-warning radar, alerting the State to risks before they mature into epidemics.

Recommendations for Strengthening "M MPOWER Implementation"

- Institutionalise biennial GATS and GYTS surveys, supported by interim rapid assessments, to ensure continuity and recency of data
- Embed tobacco-use indicators within HMIS, NCD dashboards, and routine public health reporting frameworks
- Periodically update survey instruments to explicitly include emerging tobacco and nicotine delivery systems
- Introduce district-level modules and state-specific oversampling in high-burden regions
- Leverage electronic health records, HMIS, and mobile health platforms for continuous, automated monitoring

2.4 Risk Matrix: Gaps in India's Tobacco Monitoring Framework (M – MPOWER)

WHO FCTC Article 20 obligates Parties to establish and maintain national, regional and global surveillance systems for tobacco consumption, determinants, and consequences, and to promote the regular exchange of information for evidence-based policymaking.

Risk Area	Article 20 Alignment Gap	Policy Risk Identified	Risk Level
Periodic Deficiency	Article 20 requires continuous and systematic surveillance	Long gaps between GATS and GYTS rounds undermine timely policy response	High
Limited Integration	Article 20 encourages integration with health information systems	Tobacco indicators remain siloed from routine health and NCD surveillance	Medium–High
Emerging Products Gap	Article 20 mandates monitoring of determinants and evolving patterns	Novel nicotine and tobacco products are insufficiently captured	High
Subnational Data Deficit	Article 20 supports disaggregated and policy-relevant data	Absence of district-level data limits targeted interventions	High
Digital Surveillance Gap	Article 20 promotes efficient data collection and dissemination	Digital health systems underutilised for surveillance	Medium

India's Position under the MPOWER "P" Measure

- India has established a clear legal foundation for smoke-free public places under the Cigarettes and Other Tobacco Products Act, 2003 (COTPA), reinforced by subordinate rules and judicial interpretation.
- Smoking is prohibited in most indoor public places, including government buildings, educational institutions, healthcare facilities, public transport, and workplaces.
- Data from the Global Adult Tobacco Survey (GATS) shows a substantial decline in exposure to second-hand smoke, particularly within homes and public transport.
- However, India is classified at a moderate level of implementation under the MPOWER "P" indicator, primarily due to:
- continued allowance of designated smoking areas in certain hospitality settings, and
- uneven enforcement, especially in informal and rural environments.
- The MPOWER assessment therefore reflects meaningful progress, but not full compliance with the Article 8 requirement of 100% smoke-free environments.
- In effect, India's smoke-free framework is legally strong but operationally uneven, placing it in the moderate achievement category under the "P" measure.

Chapter 3
Protect People from Tobacco Smoke (P Measure under MPOWER)

3.1 Why the "P" Measure Matters

Protection from second-hand smoke (SHS) is not a matter of personal choice but a public health and constitutional obligation. The World Health Organization has unequivocally established that there is no safe level of exposure to tobacco smoke. Even brief exposure increases the risk of heart disease, stroke, respiratory illness, and cancer—particularly among children, pregnant women, and non-smokers.

Under Article 8 of the WHO Framework Convention on Tobacco Control (FCTC), States are required to ensure 100% smoke-free environments in indoor workplaces, public transport, and indoor public places. Partial measures such as designated smoking areas or ventilation systems are explicitly recognised as ineffective.

Accordingly, the MPOWER framework places "P – Protect People from Tobacco Smoke" at the core of tobacco control, linking smoke-free laws with the right to health and clean air.

3.2 India's Regulatory Framework for "P – Protect People from Tobacco Smoke"

- India's smoke-free regime is anchored in the Cigarettes and Other Tobacco Products Act, 2003 (COTPA), particularly Section 4, which prohibits smoking in public places.
- This is operationalised through the Prohibition of Smoking in Public Places Rules, 2008, mandating smoke-free public spaces, signage, and enforcement.
- The framework covers most indoor public places and public transport, but permits designated smoking areas in certain hospitality and airport settings.
- Enforcement is shared among multiple authorities, resulting in uneven compliance across states and districts.
- Consequently, India's framework constitutes a partial smoke-free regime, falling short of the 100% smoke-free standard under WHO FCTC Article 8.

3.3 What the Data Reveal: Progress with Caveats

- Data from the Global Adult Tobacco Survey (GATS) indicate that India has recorded reductions in second-hand smoke (SHS) exposure in several settings between 2009–10 (GATS-1) and 2016–17 (GATS-2), alongside persistent exposure in others.
- The proportion of households permitting smoking declined from 60.4% to 48.8%. Correspondingly, exposure of non-smokers to SHS at home decreased from 48.0% to 35.0%. These reductions suggest improved awareness and partial adoption of smoke-free norms within domestic environments.
- In public transport, SHS exposure declined from 17.5% to 13.3%. Exposure in government buildings also decreased, from 6.6% to 5.3%, indicating relatively higher compliance in formally regulated public institutions.
- By contrast, exposure in indoor workplaces remained unchanged, at 26.1% in GATS-1 and 26.2% in GATS-2, indicating limited progress in occupational settings. Overall exposure in public places showed no net change, remaining at 25.7% across both survey rounds, although variation was observed across specific venues.
- In the hospitality sector, SHS exposure in restaurants declined from 11.3% to 7.4%, but exposure persists, reflecting the continued allowance of designated smoking areas and variable enforcement.
- Overall, GATS data demonstrate that while India has achieved reductions in SHS exposure in homes, public transport, and government buildings, progress remains uneven across settings. Persistent exposure in workplaces and public places aligns with India's classification at a moderate level of implementation under the "Protect people from tobacco smoke (P)" indicator of the WHO MPOWER framework.

Recommendations for Strengthening "P MPOWER Implementation"

- Amend COTPA to eliminate designated smoking areas and mandate 100% smoke-free indoor public places.
- Strengthen local enforcement capacity and standardise inspection protocols.
- Integrate smoke-free compliance checks into labour and workplace safety inspections.
- Sustained mass-media and community campaigns promoting smoke-free homes.
- Introduce routine, facility-level and local monitoring mechanisms.

3.4. Risk Matrix: Gaps in Implementing the "P" Measure (Protect)

Despite the existence of smoke-free legislation, significant implementation and enforcement risks persist under the "P – Protect people from tobacco smoke" measure. These risks limit the effectiveness of smoke-free policies in reducing exposure to second-hand smoke (SHS) across public, occupational, and domestic settings. The following risk matrix identifies structural, enforcement, and monitoring gaps that undermine full compliance with WHO FCTC Article 8, which recognises that no level of SHS exposure is safe. Addressing these risks is essential to translate legal provisions into effective population-level protection.

Risk Area	Description of Risk	Policy Implication	Risk Level
Hospitality Sector Exemptions	Designated smoking areas/ Designated smoking rooms permitted in hotels, restaurants, and airports	Continued SHS exposure; non-compliance with WHO Article 8	High
Uneven Enforcement	Variable inspection and enforcement across states and districts	Inconsistent compliance and weak deterrence	High
Workplace Exposure	Minimal decline in SHS exposure in indoor workplaces	Occupational health risks persist	Medium–High
Household SHS Exposure	Significant exposure in private homes, especially affecting women and children	Public health impact beyond formal regulation	Medium–High
Monitoring Gaps	Reliance on periodic surveys to assess SHS exposure	Delayed policy response	Medium
Hookah Bars	Exposure to SHS, especially minors	Violation of smokefree laws	High

India's Position in the WHO MPOWER Data

- India is classified as having achieved the "Complete Measure" under the "O – Offer help to quit tobacco use" indicator, reflecting compliance with Article 14 of the WHO FCTC.
- This classification is based on the national availability of tobacco cessation support, including a toll-free quitline with live counselling, cost-covered Nicotine Replacement Therapy (NRT), and cost-covered cessation services in healthcare settings.
- The WHO recognises India's cessation framework for its integration within the public health system, covering primary care facilities, hospitals, and offices of health professionals.
- However, the MPOWER assessment also highlights identified gaps, including the absence of cost coverage for advanced cessation pharmacotherapies (such as bupropion and varenicline) and limited cost-covered cessation support at the community level.
- Overall, the WHO MPOWER Data Portal reflects India's strong national cessation infrastructure, while underscoring the need to expand pharmacotherapy options, strengthen community-based support, and enhance outcome monitoring to improve long-term cessation effectiveness.

Chapter 4
Offer Help to Quit Tobacco Use (O Measure under MPOWER)

4.1 Why Offering Help to Quit Matters

Tobacco control is incomplete if it focuses only on regulation and deterrence while neglecting tobacco dependence as a health condition. Most tobacco users wish to quit but are unable to do so without structured support. In the absence of accessible cessation services, warnings, taxation, and advertising bans lose part of their effectiveness, and relapse remains common.

The "O" (Offer help to quit tobacco use) component of the WHO's MPOWER framework bridges this gap by embedding cessation within the health system. It shifts tobacco control from restriction to treatment and recovery, ensuring that users are supported rather than merely penalised.

India's obligation to provide cessation support arises from Article 14 of the WHO Framework Convention on Tobacco Control (FCTC). In response, India has developed a national cessation framework integrated into public healthcare, positioning the country among a small group of low- and middle-income nations that have institutionalised publicly supported tobacco cessation services.

4.2 India's cessation services are anchored in the National Tobacco Control Programme (NTCP) and include:

- Tobacco Cessation Centres (TCCs) in medical colleges and public hospitals;
- Integration of brief cessation advice into routine outpatient care and NCD services;
- A national toll-free tobacco quitline (1800-11-2356) providing behavioural counselling in multiple languages;
- Inclusion of Nicotine Replacement Therapy (NRT) in the Essential Drugs List, with cost coverage in the public sector.

Together, these interventions ensure that tobacco cessation support is institutionalised within India's public health system, rather than delivered as a stand-alone service. By combining facility-based care, population-level counselling, and cost-covered pharmacotherapy, the NTCP enables nationwide access to evidence-based cessation support. This integrated approach underpins India's classification as having achieved a "Complete Measure" under the MPOWER "O" indicator.

4.3 What the Data Reveals: Progress with Caveats

For smoking tobacco users:

Data from the Global Adult Tobacco Survey (GATS) indicate improvements in cessation-related indicators between GATS-1 (2009–10) and GATS-2 (2016–17).

- The proportion of former daily smokers among ever daily smokers increased from 12.6% to 16.8%, representing a 33.6% relative increase.
- Among current smokers, those interested in quitting or planning to quit increased from 46.6% to 55.4%.
- The proportion of smokers advised to quit by a healthcare provider increased from 46.3% to 48.8%.
- Quit attempts in the past 12 months remained largely unchanged at approximately 38%.

For smokeless tobacco users:

- Advice to quit by healthcare providers increased from 26.7% to 31.7%.
- Interest in quitting increased from 45.2% to 49.7%.
- Quit attempts declined marginally from 35.4% to 33.2%.

The increase in advice to quit and expressed interest in quitting among smokeless tobacco users reflects improving health-system engagement and sustained demand for cessation support. However, the marginal decline in quit attempts indicates that counselling alone is not sufficient. Bridging this gap will require stronger follow-up, wider access to pharmacotherapy, and community-level cessation support to convert motivation into successful quit outcomes.

Recommendations for Strengthening O- MPOWER

- Integrate cessation outcome indicators into HMIS and NCD reporting systems to enable routine performance evaluation
- Expand the Essential Drugs List and public financing to include bupropion and varenicline, and evaluate introduction of cytisine
- Establish cost-covered community cessation services through primary health outreach, ASHAs, and community health platforms
- Introduce structured follow-up protocols, including digital reminders and relapse-prevention counselling
- Develop national minimum service standards for cessation and link NTCP funding to state-level compliance
- Transition to routine facility-based reporting supplemented by periodic surveys for validation

4.4 Risk Matrix: Gaps in Offering Help to Quit Tobacco Use

Despite achieving a "Complete Measure" status under the MPOWER "O" indicator, operational and system-level gaps persist in India's cessation framework. The risk matrix below summarises these gaps and their associated policy risks in relation to WHO FCTC Article 14.

Risk Area	Article 14 Alignment Gap	Policy Risk Identified	Risk Level
Outcome Monitoring Deficit	Article 14 requires effective cessation programmes with evaluation	Quit success, relapse, and long-term abstinence are not routinely tracked	High
Limited Pharmacotherapy Coverage	Article 14 encourages access to evidence-based treatment	Advanced cessation medicines (bupropion, varenicline) are not cost-covered; cytisine unavailable	Medium–High
Community-Level Access Gap	Article 14 calls for broad accessibility of cessation support	Cost-covered cessation services are largely limited to clinical settings	High
Uneven State Implementation	Article 14 requires nationwide programme implementation	Variable availability and quality of cessation services across states and districts	Medium–High
Weak Continuity of Care	Article 14 emphasises sustained support for tobacco dependence	Limited follow-up and relapse-prevention mechanisms after quit attempts	Medium
Survey Dependence	Article 14 supports integration into health systems	Reliance on periodic surveys limits real-time assessment of cessation performance	Medium

India's Position in the WHO MPOWER Data

- India is classified as having achieved the "Complete Measure" under the "W – Warn about the dangers of tobacco" indicator, reflecting strong compliance with Article 11 of the WHO FCTC.
- This classification is based on India's mandate of large pictorial health warnings covering an average of 85% of the front and back of cigarette packages, placing India among global leaders in warning size.
- The WHO recognises India's health warning regime for mandating:
  - graphic photographs depicting health harms,
  - rotation of warnings,
  - use of the principal language(s) of the country,
  - standardised font style, size, and colour, and
  - display of warnings on each unit packet and all outside packaging used in retail sale.
- India's position reflects a high degree of legal and regulatory alignment with WHO best practices on packaging and labelling, ensuring that tobacco packaging functions as a public health communication tool rather than a promotional medium.
- However, the MPOWER Data Portal also identifies characteristics yet to reach best practice, including the absence of:
  - plain/standardised packaging,
  - prohibition on flavour descriptors,
  - bans on misleading emission yield information (tar, nicotine, carbon monoxide), and
  - explicit provisions ensuring that health warnings do not diminish tobacco industry liability.

Chapter 5
Warn about the Dangers of Tobacco (W Measure under MPOWER)

5.1 Why Warning About the Dangers of Tobacco Matters

Tobacco products are unique among legal consumer goods in that they cause serious harm when used as intended. In the absence of clear, prominent, and credible warnings, consumers underestimate the risks of tobacco use, and industry messaging fills the information gap. Effective health warnings therefore play a critical role in shaping risk perception, discouraging initiation, and encouraging cessation.

The "W" (Warn about the dangers of tobacco) component of the WHO's MPOWER framework operationalises Articles 11 and 12 of the WHO Framework Convention on Tobacco Control (FCTC), which obligate Parties to ensure that tobacco packaging, labelling, and public awareness measures clearly communicate health risks and do not mislead consumers. By transforming packaging and mass communication into public health instruments rather than marketing tools, warning measures provide one of the most cost-effective and equitable interventions in tobacco control.

5.2 India's Communication Framework: Beyond Packaging

- Mandatory health spots, static warnings, and audio-visual disclaimers in films and television programmes depicting tobacco use.
- Enforcement through licensing mechanisms, applicable across languages and genres.
- Extension of warning requirements to OTT platforms under the COTPA Amendment Rules, 2023.
- Recognition of digital media's influence on youth in tobacco normalisation.
- High-impact national mass-media campaigns under the National Tobacco Control Programme (e.g., **"Tears You Apart"**).
- Collectively, these measures place India among a limited group of countries regulating tobacco depiction across entertainment media.

5.3 What the Data Reveal: Progress with Caveats

India has achieved one of the highest global standards in tobacco health warnings. Since 2016, all tobacco product packages are required to display graphic health warnings covering 85% of the front and back surfaces, placing India among global leaders in warning size and visibility.

Data from the Global Adult Tobacco Survey (GATS) demonstrate the behavioural impact of these measures:

- Among current cigarette smokers, the proportion who thought about quitting because of health warnings increased to 61.9% in GATS-2 (2016–17), representing a 62.9% relative increase compared to GATS-1.
- Among bidi smokers, 53.8% reported that warnings prompted thoughts of quitting.
- Among smokeless tobacco users, 46.2% reported a similar impact.
- Awareness of tobacco-related diseases—such as lung cancer, heart disease, stroke, and tuberculosis—also increased between survey rounds, confirming the role of warnings in improving risk perception.
- However, exposure to anti-tobacco messaging through mass media declined. Between GATS-1 and GATS-2:
- Exposure to smoking-related promotion declined by 28.4%, and
- Exposure to smokeless tobacco promotion declined by 35.2%.

These trends suggest that while packaging-based warnings remain strong, broader communication

Data on Audiovisual and Media-Based Warnings

Studies cited by WHO show that on-screen health spots and disclaimers in films and television significantly increase:

recall of health harms,

negative attitudes toward tobacco use, and

support for tobacco control policies.

In India, exposure to tobacco imagery through films and digital content remains high; however, mandatory audio-visual warnings reduce the promotional effect of such depictions, particularly among youth.

Post-2023 extension of warning requirements to OTT platforms addresses a major exposure pathway for adolescents and young adults, a demographic identified by WHO as highly susceptible to tobacco marketing cues.

Recommendations for Strengthening "W Measure Implementation"

- Introduce plain packaging legislation prohibiting logos, colours, brand imagery, and promotional elements
- Statutorily prohibit flavour descriptors and imagery on all tobacco packaging
- Ban quantitative emission yield disclosures on packaging and branding
- Insert explicit provisions clarifying that health warnings do not limit or offset industry liability
- Ensure uniform application of advanced warning standards across all tobacco products
- Prohibit sale of loose cigarettes and loose smokeless tobacco

5.4 Risk Matrix: Gaps in Warning About the Dangers of Tobacco (W – MPOWER)

Despite achieving a "Complete Measure" status under the MPOWER "W" indicator, the WHO Data Portal highlights specific structural gaps that limit the full impact of tobacco health warnings. The risk matrix below summarises these gaps and their associated policy risks.

Risk Area	Identified Gap (as per MPOWER Data Portal)	Policy Risk Identified	Risk Level
Absence of Plain Packaging	Plain/ standardised packaging is not mandated	Tobacco packaging continues to function as a marketing tool	High
Use of Flavour Descriptors	Packaging does not prohibit flavour-related descriptors	Flavour cues dilute health warnings and increase youth appeal	High
Misleading Emission Information	Emission yields (tar, nicotine, CO) not expressly prohibited	Consumers may misinterpret products as "less harmful"	Medium–High
Industry Liability Dilution Risk	Health warnings do not explicitly preclude industry liability	Potential weakening of legal accountability of tobacco companies	Medium
Limited Health Risk Coverage in rotation	Best-practice warning characteristics of multiple health risks warnings for rotation as option not available	Specific and different health risks of cigarettes, bidis, and smokeless tobacco should be covered and notified for rotation	High
Circumvention via Loose Sales	Warnings are bypassed when products are sold loose	Loss of warning exposure at point of consumption	High

India's Position in the WHO MPOWER Data

- India is classified as having achieved a "Moderate Measure" under the "E – Enforce bans on tobacco advertising, promotion and sponsorship" indicator, reflecting partial compliance with Article 13 of the WHO FCTC.
- This status is based on India's statutory bans on multiple forms of direct tobacco advertising, including:
  - advertising on national television and radio,
  - advertising in newspapers and magazines,
  - billboard and outdoor advertising,
  - promotional discounts, and
  - product placement in films and television.
- India has also prohibited brand sharing and brand stretching, including the use of tobacco brand names for non-tobacco products and vice versa, and imposed restrictions on sponsorship-related promotion.
- However, the MPOWER Data Portal identifies key gaps preventing a comprehensive ban, including the absence of:
  - a complete ban on point-of-sale advertising and product display,
  - a comprehensive ban on sponsorship and Corporate Social Responsibility (CSR) activities by tobacco companies,
  - restrictions on tobacco industry funding of prevention or youth-focused media campaigns, and
  - a ban on internet sales of tobacco products.
- These gaps enable indirect, surrogate, and retail-level promotion, particularly affecting youth and undermining the effectiveness of existing advertising bans.

Chapter 6
Enforce Bans on Tobacco Advertising, Promotion and Sponsorship (E Measure under MPOWER)

6.1 Why Enforcing Bans on Tobacco Advertising Matters

Tobacco advertising, promotion, and sponsorship directly shape social norms and are a powerful driver of youth initiation and continued tobacco use. In the absence of comprehensive and effectively enforced bans, the tobacco industry adapts by shifting marketing to indirect, surrogate, and cross-border channels, undermining public health protections.

The "E" (Enforce bans on tobacco advertising, promotion and sponsorship) component of the WHO's MPOWER framework operationalises Article 13 of the WHO Framework Convention on Tobacco Control (FCTC). It recognises that partial bans are inherently ineffective and that only comprehensive, consistently enforced prohibitions can prevent industry influence and protect children and non-users from exposure to tobacco marketing.

6.2 India's Legal and Regulatory Framework

India's primary legal instrument for TAPS regulation is the Cigarettes and Other Tobacco Products Act, 2003 (COTPA). Section 5 of COTPA prohibits all forms of direct and indirect tobacco advertising, promotion, and sponsorship.

However, the statutory framework permits limited "on-pack" and "point-of-sale (PoS)" advertising, subject to specified restrictions. This has resulted in a partial ban, rather than the comprehensive prohibition envisaged under FCTC Article 13.

In response to evolving marketing practices, India has supplemented COTPA through:

- Cinematograph and broadcasting rules mandating health warnings in audio-visual media;
- The COTPA Amendment Rules, 2023, extending certain obligations to digital and OTT platforms; and
- Industry-facing self-regulatory measures, including recent guidelines issued by the Advertising Standards Council of India (ASCI) addressing surrogate advertising.

6.3 What the Data Reveal: Exposure and Impact

Evidence from the Global Adult Tobacco Survey (GATS) 2016–17 indicates continued exposure to tobacco promotion despite statutory restrictions.

- Approximately 2.0% of adults reported noticing surrogate promotions for smokeless tobacco products, reflecting indirect brand visibility.
- Exposure to tobacco marketing remains higher among youth and young adults, particularly through films, digital media, and point-of-sale displays.

International evidence cited in WHO reports confirms that PoS advertising and product displays are associated with:

- Increased susceptibility to tobacco use among children and adolescents;
- Higher likelihood of experimentation and initiation; and
- Increased cravings and relapse among current and former users.

These findings underscore that partial bans allow residual promotional exposure, diluting the effectiveness of advertising restrictions.

6.4 The Enforcement Gap: Surrogate and Indirect Advertising

A central challenge under the "E" measure is the persistence of surrogate advertising, whereby tobacco brands are promoted through non-tobacco products or brand extensions, including:

- Pan masala, mouth fresheners, and "lifestyle" products;
- Corporate social responsibility (CSR) activities linked to tobacco brands;
- Brand placement in films, web series, and influencer-driven digital content;
- Discounts, free gifts, and cross-promotion at retail points.

These practices exploit definitional and enforcement gaps within existing law and shift promotional activity to less regulated digital and informal spaces.

The ASCI's 2023 guidelines, which link advertising expenditure on brand extensions to actual product turnover, represent a regulatory step forward. However, as self-regulatory instruments, their impact depends on compliance and does not substitute for statutory prohibition.

6.5 Public Spitting of Smokeless Tobacco: An Enforcement Blind Spot

- Public spitting linked to smokeless tobacco use remains widespread in streets, markets, transport hubs, workplaces, and institutional spaces, despite existing legal prohibitions.
- Although spitting is restricted under municipal, sanitation, and public nuisance laws, enforcement is uneven and episodic, particularly outside major urban centres.
- Visible spitting acts as indirect promotion, normalising smokeless tobacco use and exposing children and adolescents to tobacco consumption cues in everyday public spaces.
- Pandemic-era enforcement demonstrated that behavioural compliance is achievable, but the post-pandemic resurgence highlights the absence of routine, institutionalised enforcement mechanisms.

Recommendations for Strengthening "E Measure Implementation"

- Adopt plain/standardised packaging to eliminate brand promotion and prioritise health warnings.
- Ban flavour descriptors and misleading brand elements to reduce youth appeal and warning dilution.
- Prohibit emission yield disclosures (tar, nicotine, CO) to prevent false harm perceptions.
- Preserve tobacco industry liability by clarifying that health warnings do not limit accountability.
- Tighten controls on surrogate advertising and brand extensions to prevent indirect promotion.
- Apply advanced warning standards uniformly across cigarettes, bidis, and smokeless tobacco.
- Prohibit loose tobacco sales to ensure warning exposure at purchase and use.

6. 6 Risk Matrix: Gaps in Enforcing Bans on Tobacco Advertising, Promotion and Sponsorship (E – MPOWER)

Risk Area	Article 13 Alignment Gap	Description of Risk	Policy Implication	Risk Level
Point-of-Sale (PoS) Advertising and Display	Article 13 requires a comprehensive ban on all forms of advertising	Permitted PoS displays and on-pack promotion continue to expose consumers, particularly youth, to tobacco branding at retail outlets	Normalisation of tobacco use; increased initiation and impulse purchases	High
Surrogate and Brand-Extension Advertising	Article 13 prohibits indirect advertising and brand stretching	Tobacco brands are promoted through pan masala, mouth fresheners, lifestyle products, and brand extensions	Circumvention of statutory bans; continued brand recall despite formal prohibition	High
Corporate Social Responsibility (CSR) Activities	Article 13 guidelines discourage all forms of promotional sponsorship	Tobacco companies engage in CSR initiatives that enhance brand legitimacy and public visibility	Reputational laundering of tobacco industry; dilution of public health messaging	High
Digital and Influencer-Based Promotion	Article 13 extends to cross-border and digital advertising	Online marketing, influencer content, and algorithm-driven promotions evade traditional enforcement mechanisms	High youth exposure; weak traceability and enforcement	High
Entertainment Media Exposure	Article 13 read with Articles 11 and 12 discourages promotional depiction	Tobacco imagery in films, web series, and OTT content persists despite health warnings	Continued social normalisation of tobacco use	Medium–High
Self-Regulatory Dependence (ASCI Guidelines)	Article 13 requires statutory, not voluntary, enforcement	Reliance on industry-facing self-regulation lacks binding force and uniform compliance	Weak deterrence; inconsistent enforcement outcomes	Medium–High
Absence of Vendor Licensing for Advertising Compliance	Article 13 supports strong regulatory oversight mechanisms	Retailers are not uniformly licensed or monitored for TAPS violations	Enforcement gaps at the last-mile retail level	High
Cross-Border and Online Sales Promotion	Article 13 covers cross-border advertising and promotion	Internet sales and online promotion are not comprehensively prohibited	Jurisdictional enforcement challenges; youth access	Medium–High

Chapter 7
Raise Taxes on Tobacco (R Measure under MPOWER)

7.1 Why Raising Tobacco Taxes Matters

Price and tax measures are the most effective tools for reducing tobacco consumption, particularly among youth and low-income populations, who are most sensitive to price changes. When tobacco products remain affordable, gains achieved through warnings, advertising bans, and cessation services are substantially weakened.

The "R" (Raise taxes on tobacco) component of the WHO's MPOWER framework operationalises Article 6 of the WHO Framework Convention on Tobacco Control (FCTC) by promoting sustained tax increases that reduce affordability. WHO guidance recommends that tobacco taxes account for at least 75% of the retail price, ensuring that taxation functions as a public health instrument rather than a revenue measure alone.

7.2What the Data Reveal: Progress with Caveats

India has undertaken multiple fiscal interventions on tobacco, particularly through excise duties and the Goods and Services Tax (GST) framework. However, WHO assessments indicate that tobacco products in India have generally become more affordable over time, as income growth has outpaced tax increases.

Data from the Global Adult Tobacco Survey (GATS) show a sharp rise in consumer expenditure between 2009–10 and 2016–17:

- Average monthly expenditure of daily cigarette smokers increased from ₹609.9 to ₹1,192.5 (a 95.5% increase).
- Average monthly expenditure of daily bidi smokers increased from ₹142.7 to ₹284.1 (a 99.1% increase).

Despite higher absolute spending, affordability has not declined proportionately due to rising incomes, limiting the deterrent effect of taxation.

India's Position in the WHO MPOWER Data Portal – R (Raise Taxes on Tobacco)

India is classified as having achieved a "Moderate Measure" under the "R – Raise taxes on tobacco" indicator, reflecting partial alignment with Article 6 of the WHO FCTC.

- This classification is based on the fact that total tobacco taxes account for approximately 58.3% of the retail price of the most widely sold brand of cigarettes, which remains below the WHO-recommended benchmark of 75%.
- The MPOWER Data Portal further indicates that the per capita GDP required to purchase 2,000 cigarettes has decreased between 2014 and 2024, suggesting that cigarettes have become more affordable over time despite tax increases.
- India's position reflects the presence of a national tobacco tax structure, but also highlights that tax levels have not kept pace with income growth, limiting the public health impact of taxation.
- Overall, the WHO MPOWER Data Portal underscores that while India has made measurable progress in tobacco taxation, stronger and sustained tax increases are required to reduce affordability and achieve the highest level of implementation under the "R" measure.

7.3 Structural Inequities and Reform Imperatives in India's Tobacco Taxation

Bidi under-taxation ("bidi paradox")

- Over 72 million adults consume bidis (GATS-2, 2016–17).
- The effective tax incidence on bidis is approximately 22%, compared to 58% for cigarettes.
- Following GST reforms, the bidi tax rate was reduced from 28% to 18%, lowering the effective tax burden to around 16%.
- Bidis deliver higher levels of tar and carbon monoxide than cigarettes.
- Bidi smoking accounts for approximately 11.7 million DALYs and nearly 478,000 deaths annually, exceeding the disease burden attributable to cigarettes.

Small-producer exemptions

- Bidi manufacturers producing fewer than 2 million sticks per year are exempt from excise duty.
- Approximately 31% of total bidi production (around 125 billion sticks) escapes taxation (BMJ Tobacco Control, 2020).
- Closing this exemption could:
- reduce consumption by 6%,
- eliminate 2.2 million smokers, and
- generate approximately ₹15 billion annually in additional revenue.

Smokeless tobacco (SLT) taxation gaps

- Smokeless tobacco products are often sold loose or unbranded, particularly in rural markets.
- Significant tax differentials exist across SLT product categories.
- Tobacco leaves used for chewing are taxed at only 5% GST (2.5% CGST and 2.5% SGST).
- SLT taxation remains under-researched, weakening enforcement and policy design.
- The WHO recommends that at least 75% of the retail price should be constituted by taxes, a benchmark most SLT products do not meet.
- There is a need for uniform high tax rates, minimum floor prices, and larger pack sizes across all SLT products.

Rising affordability

- Per capita GDP increased by approximately 80% between 2014 and 2024.
- Average cigarette prices increased by only about 45% during the same period.
- As a result, tobacco products have become more affordable, weakening the deterrent effect of taxation.

Analytical Insights

- Cigarettes are heavily taxed but represent only a fraction of total tobacco use.
- Bidis and SLT, used mainly by the poor, remain under-taxed.
- Results in regressive health outcomes: highest disease burden among the poorest.
- Higher bidi taxes could:
- reduce consumption by nearly 50%, and
- generate >₹116 billion annually.
- Employment arguments overlook exploitative bidi labour, often involving women and children.

Budget Highlights: Tobacco Tax Reform (2026–27)

- Flat Demerit Rate Introduced:

  Tobacco products have been brought under a uniform 40% GST rate, replacing fragmented rate structures and levies

- Tax Structure Simplified:

  The reform reduces classification disputes, compliance burden, and improves certainty in indirect tax administration

- Uniform Application:

  A single rate applies across tobacco products, correcting distortions arising from differential taxation

- Tax Base Safeguarded:

  While TCS on tendu leaves has been rationalised, revenue focus is retained at the finished tobacco product stage

- Revenue & Fiscal Stability:

  The measure supports predictable revenues and aligns with the Budget's broader objective of indirect tax rationalisation and fiscal consolidation

Recommendations for Strengthening "R Measure Implementation"

- Equalise tax incidence across all tobacco products, ensuring bidis and smokeless tobacco face tax burdens comparable to or higher than cigarettes, reflecting relative health harm.
- Abolish small-producer excise exemptions for bidis to close the 31% evasion gap, reduce consumption, and improve fiscal efficiency.
- Reform smokeless tobacco taxation by applying the highest applicable tax rates uniformly, including on tobacco leaves, and introducing minimum floor prices and larger pack sizes.
- Introduce automatic tax indexation, linking annual increases to inflation and per capita income growth, in line with WHO best practice.
- Reduce affordability through sustained real price increases, ensuring that tax hikes outpace income growth.
- Earmark a portion of tobacco tax revenues for cessation services, NCD prevention, and treatment of tobacco-related diseases.
- Leverage the GST 2.0 / 40% Special Demerit Rate transition to simplify structures, eliminate cess dependence, and move toward the WHO 75% tax benchmark.
- Improve administrative coordination and transparency, harmonising data across excise, GST, and states to strengthen compliance and monitoring.

Risk Matrix: Gaps in Raising Taxes on Tobacco (R – MPOWER)

Despite reforms under GST, systemic tax design and enforcement gaps persist, limiting the effectiveness of tobacco taxation as a public health tool. The table below summarises the principal risks undermining compliance with WHO FCTC Article 6.

Risk Area	Description of Risk	Policy Implication	Risk Level
Bidi Under-Taxation ("Bidi Paradox")	Bidis consumed by 72 million adults; effective tax incidence ~22% vs 58% for cigarettes; post-GST burden fell to ~16%	Bidis remain highly affordable despite higher health harm	High
Small-Producer Exemptions	Producers with annual turnover of Rs 40 lakhs remain exempt from GST net	Large-scale tax evasion; weakened price deterrence	High
Smokeless Tobacco (SLT) Tax Gaps	SLT often sold loose/ unbranded; tobacco leaves taxed at 5% GST	Informality, weak enforcement, continued affordability	High
Rising Affordability	GDP ↑ ~80% (2014–24) vs cigarette prices ↑ ~45%	Tobacco more affordable; reduced deterrent effect	High
Absence of Indexation	No linkage of taxes to inflation or income growth	Real value of taxes erodes over time	Medium–High
Weak Revenue Utilisation	No earmarking; health losses ₹805.5 bn (~0.5% GDP) exceed tax revenue	Missed opportunity for health financing	Medium–High
Administrative Fragmentation	Coexistence of excise, GST, and cess	Compliance gaps, evasion, weak transparency	Medium

How to meet MPOWER highest level compliance

M – Timely and regular surveillance report at least every two to three years for all population groups with more emphasis on vulnerable population groups. District and state level data and monitoring and evaluation reports on progress and implementation of tobacco control programme, laws and policies at regular intervals.

P – Implementation of 100% smokefree policies for all indoor areas and public places with no exemption for creation of designated smoking area or space. Need to remove the exemptions under proviso to section 4 as done by state of Jharkhand and banning of hookah bars as already done by twelve states.

O – India is already at the highest level of 'O' as a policy measure but its effective implementation with wide reach to all tobacco users in the country needs to be ensured. Identifying all opportunities to expand and integrate tobacco cessation including brief advise needs to be adopted at all levels.

W – India is at the highest level of implementation of the 'W' measure, however several health risks are still missing from inclusion in the health warnings notified for rotation. Further plain packaging and standardisation of packs is important for the desired impact of the larger pictorial health warnings.

E – Effective enforcement of tobacco control laws, especially those related to TAPS ban are essential to protect the minors and vulnerable group of population from the tobacco industry marketing tactics. The exemption to advertise in an on pack and at point of sale under COTPA should be withdrawn to meet the global best practices in TAPS ban. The ban should also extend to CSR by tobacco companies and their corporate promotions.

R – While GST 2.0 has tried to increase tobacco taxation, but it too failed to bring all tobacco products to a uniform and recommended tax incidence of 75%, beedi being the least taxed tobacco product in the country.

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