Smokeless Tobacco in India: A Call for Decisive Policy Action

Priorities agreed at the National Roundtable, 27 March 2026, AIIMS New Delhi

Organised by DMKM CHIP LLP, in collaboration with AIIMS, HRIDAY and Brunel University of London

KEY MESSAGE: India has over 200 million smokeless tobacco (ST) users. New ASTRA research shows that, if current policies remain unchanged, ST-related diseases will cost India over US$19 billion in lifetime healthcare spending. The National Roundtable brought together policymakers, WHO advisers, researchers, and state programme leaders who agreed on six evidence-based priorities: increase taxation, strengthen regulation, protect youth, build cessation infrastructure, train the health workforce, and decentralise strategies to local realities.

THE CHALLENGE

Smokeless tobacco is a primary driver of disease, death, and economic loss in India. Products such as khaini, gutkha, zarda, and paan with tobacco cause oral cancer, cardiovascular disease, stroke, and adverse reproductive outcomes. The ASTRA programme's economic model (ASTRAMOD) projects lifetime treatment costs exceeding US$19 billion under current policies, with the greatest burden on younger populations (Coyle et al., 2025). Globally, ST causes approximately 350,000 deaths annually; India accounts for roughly 70% of this burden (Siddiqi et al., 2020). Yet tobacco control has historically focused on smoking. Existing policies have reduced smoking prevalence but had far less impact on ST use (Chugh et al., 2023). ST products are often not perceived as tobacco by users, are deeply embedded in cultural and social practices, and are largely produced in the informal sector - making regulation, surveillance, and enforcement particularly difficult.

WHAT THE MOST RECENT EVIDENCE SHOWS

- **Economic burden:** Lifetime ST-attributable treatment costs exceed US$19 billion in India. A 15-year-old male who avoids ST could gain 0.18 life years and save US$18 in healthcare costs (Coyle et al., 2025).
- **Policy effectiveness:** Comprehensive tobacco control policies can reduce ST prevalence by 4–30%; multi-component approaches achieve 22–71% reductions (Chugh et al., 2023).
- **Cessation:** Culturally adapted behavioural support (BISCA) achieved 12.1% abstinence at 26 weeks in the first multi-country ST cessation trial in South Asia. However, nearly all existing trial evidence comes from North America, not the regions with the highest burden (Siddiqui et al., 2024; Livingstone-Banks et al., 2025).
- **Regulatory failure:** 93% of ST packs in India lacked proper pictorial health warnings (Abdullah et al., 2024).
- **Youth:** Three times as many South Asian adolescents use ST as smoke cigarettes; 90% of ST users begin during adolescence (Kanaan et al., 2024).

EIGHT AGREED PRIORITIES FOR ACTION

1. Increase Taxation and Reduce Affordability

ST sachets cost as little as ₹1–2. The Roundtable called for uniform specific excise duties based on quantity rather than price, paired with enforcement against unregistered manufacturers who evade taxation. Earmarking a portion of additional revenue for tobacco control programmes would create a sustainable funding mechanism. States such as Rajasthan and Himachal Pradesh have shown that fiscal measures combined with active enforcement can reduce access.

2. Strengthen Regulation and Close Legal Loopholes

Near-total non-compliance with packaging laws, "twin pack" loopholes, surrogate advertising, and the emergence of flavoured products targeting youth demand urgent regulatory reform. The Roundtable recommended standardised packaging, a national vendor licensing system, stronger penalties under the Juvenile Justice Act for sales to minors, and updated FSSAI enforcement. State-level models such as the "yellow line campaign" and non-display mandates at points of sale should be replicated nationally.

3. Protect Young People Through Schools and Communities

With most ST users initiating before age 15, prevention must start early. The Roundtable called for stronger implementation of the Tobacco-Free Educational Institutions (TOFEI) guidelines, training of nodal teachers through certified digital platforms, enforcing the 100-yard tobacco-free zone with community involvement, and engaging families where household ST use is normalised. Peer-led education and interactive curricula have

shown strong outcomes in reducing initiation. Rajasthan's model of reaching nearly one crore students annually through awareness campaigns offers a scalable approach.

4. Build National Cessation Infrastructure

Fewer than half of ST users are asked about their tobacco use by a health professional. Integrating ST cessation into primary healthcare through Ayushman Bharat Health and Wellness Centres—using ASHAs, ANMs, and Community Health Officers for screening, brief intervention, and referral—is essential. Rajasthan's model of over 500 trained dental officers providing cessation counselling and free NRT, with monthly reporting, was highlighted as scalable. Expanding the national Quitline to include WhatsApp and regional-language support, and deploying mobile-based cessation platforms, were also recommended. The ASTRA BISCA intervention provides a ready framework for cultural adaptation.

5. Developing a Phased Registration Roadmap:

This licensing framework should include a phased registration roadmap with simplified tax compliance for micro-units to formalize 'cottage industry' manufacturers without driving them into the illicit market,

6. Ensure Inter-Sectoral Coordination

To address potential resistance, the task force must develop economically viable alternative crop programs and transitional livelihood support for tobacco farmers and small-scale rollers

7. Train the Health Workforce at Scale

Medical, dental, and nursing curricula include minimal content on ST cessation. The Roundtable recommended integrating structured cessation modules into undergraduate education, deploying self-paced digital training for in-service workers, and establishing supervision systems to ensure training is applied in practice. An ICMR-funded trial presented at the Roundtable showed that brief, nurse-led interventions significantly improved quit rates in high-burden populations.

8. Decentralise Strategies to Local Realities

India's diversity in ST consumption—shaped by geography, culture, gender, and socio-economic status—means a single national approach will not work. In northeastern states, ST use is embedded in social customs; in Himachal Pradesh, consumption is often hidden, especially among women; urban migrant populations face distinct challenges. State-specific strategies developed with community participation are essential. Rajasthan's Ayushman Gram Yojana (financially incentivising villages for tobacco-free status) and Haryana's tobacco-free village initiative (1,100+ villages) demonstrate the effectiveness of community-driven, decentralised approaches.

THE WAY FORWARD: The evidence is clear: ST imposes a burden on India that can no longer be treated as secondary to smoking. Effective tools exist—from economic models quantifying the cost of inaction, to cessation interventions that work in South Asian settings. These six priorities provide an evidence-based roadmap. Progress will require sustained inter-sectoral coordination across health, education, law enforcement, and finance—and the political commitment to give smokeless tobacco the same urgency that has been directed at smoking.

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