REVIEW ARTICLE

Youth Tobacco Use in India: Industry Strategies, Epidemiological Trends, and Policy Gaps

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Abstract

Background: Youth tobacco and nicotine uptake in India persists despite strong legislation, as industry marketing adapts to entertainment media, digital channels, and surrogate promotion. Materials & **Methods**: This narrative review synthesises surveillance evidence and published reports on youth tobacco/nicotine use in India, alongside policy and implementation literature on tobacco control, industry tactics, and health consequences. **Results**: GYTS-4 India 2019 (report published 2021) reports that 8% of students aged 13–15 years currently use any tobacco product, and 3% have ever tried an e-cigarette. These figures represent a 42% decline in current use since 2009, indicating progress. However, exposure to tobacco advertisements and related imagery remains high across media platforms: television (44.5%), movies (37.3%), internet videos (33.5%), and online/internet (23.4%) in the past 30 days. The reviewed evidence indicates that flavoured products, surrogate branding, and influencer/digital promotion can sustain youth appeal despite statutory restrictions, while implementation gaps enable continued exposure and access. Early nicotine initiation is associated with dependence risk and adverse respiratory and psychosocial outcomes. **Conclusions**: India's gains in reducing youth tobacco use will be sustained only if tobacco control implementation keeps pace with evolving marketing ecosystems, with stronger action on surrogate and digital promotion, media compliance monitoring, and youth-focused prevention and cessation support.

Keywords

Youth tobacco use, Nicotine addiction, E-cigarettes, Surrogate Advertising, India, Tobacco Industry Tactics, Public Health Policy, Adolescent Health, Harm Reduction, Digital Marketing.

Introduction

In a small suburban home, a teenager's first puff on a sleek e-cigarette marks the beginning of a journey many do not foresee: a steady slide toward nicotine dependence. Tobacco products, including e-cigarettes, are unsafe for youth (1). Nicotine is especially addictive to developing adolescents, impairing attention, learning, mood and impulse control (1). Nearly 9 in 10 adult smokers started by age 18 (2). With 8% of Indian teens using tobacco (3),

prevention must combine data and personal stories to combat early addiction and harm.

Even small percentages translate into millions affected each year. These human and statistical perspectives together underscore how the tobacco epidemic among adolescents is a critical public health concern.

The tobacco and nicotine industry aggressively targets young people worldwide with sophisticated marketing to recruit new addicts. Despite known health harms, the industry deploys "sleek marketing campaigns" using social media, candy-flavoured products and "gadget"-like devices to portray tobacco as glamorous and harmless (4,5). Major public health agencies have warned that these tactics hook the "next generation" on addiction (4,5).

From a public health perspective, available epidemiological evidence suggests that multiple structural, social, and commercial determinants influence adolescent tobacco uptake in India. Early exposure, behavioural reinforcement, digital marketing, and weak enforcement contribute to sustained incidence in a vulnerable age group. The challenge requires a multi-level public health response rooted in prevention science, behavioural surveillance, and risk factor modification across the life course.

This narrative review synthesises existing epidemiological evidence, policy analyses, and public health reports to examine three key thematic domains:

(1) tobacco industry strategies targeting youth in India;

(2) the effectiveness and implementation gaps of current tobacco control policies; and

(3) the health consequences of early nicotine initiation and implications for prevention.

We draw primarily on authoritative surveillance reports, national laws/guidelines, and peer-reviewed studies relevant to India, with a focus on implementation experience and policy gaps.

BACKGROUND AND CONTEXT

Global Youth Tobacco Survey (India 2021)

GYTS-4 India 2019 (report published 2021) provides concrete data on adolescent use. It found that 8% of students aged 13–15 currently use any tobacco product (9% of boys, 7% of girls) (3), which includes 7% who currently smoke (primarily cigarettes and bidis) and 4% who use smokeless tobacco. Ever-use of any tobacco product was 18% (19% boys, 17% girls). Notably, 3% of surveyed students had ever tried an e-cigarette. These figures represent a 42% decline in current use since 2009 (3), reflecting strong tobacco control efforts. However, experts emphasise that even single-digit prevalence among youth is concerning, given nicotine's addictiveness (3). This decline reflects the impact of sustained tobacco control efforts in India; however, continued exposure to evolving marketing strategies and the emergence of novel nicotine products raise concerns about potential renormalisation of youth nicotine use. The GYTS findings underscore that continued vigilance is needed to keep tobacco and nicotine products away from young people.

Surveillance Gaps and Monitoring Challenges

While the GYTS provides valuable cross-sectional data, it is not conducted regularly in all states. There is a need to establish continuous school-based sentinel surveillance in collaboration with the School Health and Wellness Programme under Ayushman Bharat. Disaggregated data on rural/urban differences, tribal youth exposure, and emerging product use (like nicotine pouches) remain sparse. Strengthening real-time monitoring using digital platforms and AI-assisted detection of surrogate advertisements could improve enforcement and early warning.

INDUSTRY STRATEGIES TARGETING YOUTH IN INDIA

Industry Tactics

The tobacco industry has a long history of targeting youth, now visible in modern strategies. Insiders admit that "younger adult smokers are the only source of replacement smokers" (6). Globally, companies design products and marketing to appeal to children and teens (4,6). Cigarettes and e-cigarettes come in flavours resembling candy or desserts and are sold in bright, playful packaging. Single-stick sales and cartoon mascots, like the infamous Joe Camel from the 1980s, further entice youth (6). Product placements in movies, TV, and music videos, along with social media promotions, memes, and influencer

endorsements, normalise nicotine use among youth. E-cigarettes are marketed as "smoke-free" or less harmful, despite their candy-like appeal and addictive nature.

New nicotine products (e.g., e-cigarettes, heated tobacco) are often introduced faster than regulations can address them (4). Simultaneously, companies use "corporate social responsibility" campaigns—like school programs or disaster relief—to build goodwill and avoid stricter regulations (6). These tactics are effective: studies show that any exposure to tobacco advertising increases the likelihood of youth smoking or vaping. Where comprehensive advertising bans exist (WHO FCTC Article 13), youth use drops (7). Without such restrictions, it rises. Ultimately, nearly all addicted users start by age 25, showing that youth are the industry's primary target (6,4).

India-Specific Challenges

Both global and local tobacco tactics increasingly target India's large adolescent population. Although India ratified the WHO FCTC and enacted the Cigarettes and Other Tobacco Products Act (COTPA) 2003 with strict ad bans, loopholes and weak enforcement allow industry marketing to persist. The 2019 Global Youth Tobacco Survey (GYTS-4) reported that 8.4% of Indian schoolchildren (13–15 years) currently use tobacco. Worryingly, many begin early: the same survey found that 11.4% of children had smoked cigarettes, 17.2% bidis, and 24% used smokeless tobacco before age seven (5), indicating pervasive exposure at home or community levels. On average, nearly 267 million adults (15 years and above) in India (29% of all adults) are users of tobacco, according to the Global Adult Tobacco Survey India, 2016-17 (9), so social acceptance is high. Still, youth are explicitly targeted for brand loyalty.

India's tobacco epidemic is closely linked to structural determinants, including poverty, informal retail networks, and low health literacy. Adolescents from marginalised communities, particularly in urban slums and tribal belts, are disproportionately exposed to low-cost smokeless tobacco. Social norms around tobacco chewing in some regions further complicate prevention efforts, requiring culturally appropriate interventions. Despite India's advertising ban, surrogate marketing is rampant.

Major tobacco companies in India use surrogate advertising through products like pan masala, cardamom (elaichi), and gutkha—legally distinct but similarly branded—to indirectly promote tobacco. Health NGOs have documented that Bollywood celebrities and cricketers frequently endorse these products, owned by tobacco companies. For instance, ads for “Rajnigandha Silver Elaichi” or “Vimal Pan Masala” often feature glamorous stars, building subconscious brand awareness among viewers (10). Vital Strategies reported over 2,000 social media posts with tobacco branding in early 2022, of which 12% were surrogate product promotions (8). During major events like cricket matches, mouth freshener ads—seen as proxies for tobacco—dominate airtime. Youth are equally exposed: in Delhi, 79% of school students reported seeing tobacco ads in movies and 69% in videos (3). Nationally, TV is the most common channel for such exposure (45%), followed by movies (37%), videos (34%), and online platforms (23%) (3). Sweet and fruity flavours in bidis, hookah tobacco, and gutkha also attract young users.

India has taken important policy steps. In 2019, it became one of the first countries to ban e-cigarettes, halting their production, sale, and promotion (11). Additionally, 85% of tobacco pack space is now required to display graphic health warnings. Enforcement of India’s tobacco laws has been found to be variable across states and districts. For example, the 2019 Global Youth Tobacco Survey (GYTS) found that over half of minors attempting to buy tobacco were not refused on age grounds, with about two-thirds of smokeless-tobacco purchases allowed (12). In schools, too, enforcement is weak: 15% of principals reported student tobacco use on school grounds, and independent observers found evidence of tobacco use on or within 100 yards of school premises in roughly half of schools (12). Even when violations occurred, only 70% led to any discipline (12). Field studies of retailers corroborate this: a multi-district survey found 25% of schools in

Telangana/Meghalaya had tobacco vendors within the prohibited 100-yard zone (13), and only 4% of retail outlets in Uttarakhand displayed the mandatory "no sale to minors" sign (14). National reports likewise document these gaps: the official NTCP "Report on Tobacco Control in India" notes that Section 6 bans (sale to minors/near schools) "are rarely enforced, and there are many violators" (15). NTCP's MIS dashboard shows much lower implementation of Section 6 than of the public-smoking ban (Section 4) across states (16). Together, these data demonstrate pervasive enforcement shortfalls and large state-to-state variability, supporting the conclusion that India's tobacco-control laws are enforced inconsistently (IIPS & MoHFW 2021; Goel *et al.* 2025; Aggarwal *et al.* 2022; MoHFW 2024; NAMS Task Force 2025).

New products like flavoured nicotine pouches and variants such as "Dunhill Intensify" still enter the market. Law enforcement often lacks training on tobacco laws, and illegal sales of bidis and gutkha persist (17).

Public health advocates are pushing back. Campaigns like "Tobacco-Free Kids India" urge action against surrogate ads and flavoured tobacco. The Health Ministry has asked sports bodies to stop players from endorsing such products. Still, tobacco industry lobbying and legal loopholes delay reforms (17). Experts call for empowering youth and educators, strengthening school programs, and modernising and regulating, especially online (7,5).

Taken together, the evidence indicates that youth exposure to tobacco marketing in India occurs through both traditional and digital channels, despite regulatory restrictions. Industry adaptation through surrogate branding, flavoured products, and influencer marketing demonstrates the evolving nature of these strategies.

EFFECTIVENESS AND IMPLEMENTATION GAPS OF TOBACCO CONTROL POLICIES

National Policy Landscape and System-Level Gaps

While India has demonstrated political will through COTPA, NTCP, and the e-cigarette ban, implementation remains fragmented. Tobacco control is often siloed and lacks convergence with flagship programs like Ayushman Bharat, School Health & Wellness Programme, and RKSK. Structural constraints include the absence of dedicated tobacco control officers at the district level, limited intersectoral convergence, and inadequate budgetary allocations at the state level. There is also a gap in integrating tobacco cessation into routine primary healthcare, especially through Health & Wellness Centres. These system-level issues warrant attention for scalable and sustainable change.

Although India has adopted comprehensive legislative measures aligned with the WHO FCTC, implementation and enforcement gaps persist, particularly in digital spaces and at the point-of-sale level. These gaps reduce the full preventive impact of existing policies.

HEALTH CONSEQUENCES OF EARLY NICOTINE INITIATION

The health consequences of youth tobacco and nicotine use are profound and long-lasting. Adolescents are especially vulnerable to addiction, as nicotine is a potent neurotoxin for the developing brain. Even small doses—like 5 mg per day (about one-quarter of a JUUL pod)—can lead to full addiction. Nicotine exposure in adolescence impairs attention, learning, and impulse control, increasing the risk of lifelong dependence (18). Studies show that teens who vape or smoke are significantly more likely to become regular smokers. For instance, a study cited by Truth Initiative found that youth who had ever vaped had seven times the odds of smoking within a year compared to non-vapers (18). This undermines the myth that e-cigarettes are "safe" for adolescents.

Tobacco use in youth also leads to serious physical harm. It impairs lung development and increases the risk of chronic respiratory illness. Dual use of cigarettes and e-cigarettes is even more harmful: a study of Indian youth found dual-users were 3.3 times more likely to have respiratory issues than non-users (19). Smokeless tobacco use, common among Indian teens, raises oral cancer risk by 5–7 times (20). Even nicotine-only products like

pouches can raise blood pressure and heart rate.

Mental health impacts are also notable. Youth tobacco users report higher rates of anxiety and depression. One study showed that adolescent vapers had double the odds of depression compared to non-users (18). Tobacco use is also linked to other risky behaviours, compounding long-term harm. In short, early addiction to tobacco leads to decades of disease and psychosocial issues, including heart disease, stroke, and multiple cancers (5,20,21).

Epidemiological evidence consistently demonstrates that early nicotine initiation increases the risk of long-term dependence, respiratory morbidity, cardiovascular harm, and psychosocial vulnerability, underscoring the need for preventive interventions during adolescence.

SOLUTIONS AND RECOMMENDATIONS

Harm Reduction Strategies

Public health uses a spectrum of harm reduction strategies to protect youth. Proven traditional approaches include:

Mass media and education: Hard-hitting media campaigns, school programs and graphic warning labels effectively deter children and teens from starting tobacco use (9). For example, the WHO notes that countries with strong anti-tobacco campaigns see fewer youth smokers.

Cessation support: Counselling services, quitlines and nicotine-replacement therapies can more than double an addicted smoker's chance of quitting (9). Integrating tobacco health education into school curricula has also been shown to shape youth attitudes against use.

Regulations (TAPS & smoke-free laws): Banning all tobacco advertising, promotion and sponsorship (TAPS) limits industry influence on young people (9). Likewise, comprehensive smoke-free laws protect youth from secondhand smoke and help de-normalise smoking behaviour (9).

Taxation: Raising tobacco taxes is one of the most cost-effective strategies. WHO reports that a 10% increase in price leads to roughly a 4–5% drop in consumption (9). Youth and low-income smokers are especially sensitive to price, so high taxes substantially reduce their ability to buy tobacco.

New nicotine products like e-cigarettes and heated tobacco products (HTPs) have sparked debate. Some studies show that nicotine e-cigarettes improve long-term quit rates more effectively than patches or gum—helping 4–6 more smokers per 100 to quit (22). However, the effectiveness of e-cigarettes as cessation tools depends on the regulatory context, product standardisation, and restricted youth access. In settings with limited regulatory oversight and rapid market expansion, concerns about youth uptake and dual use may outweigh potential cessation benefits. India's 2019 prohibition was implemented within this precautionary public health framework, prioritising the prevention of youth initiation in a rapidly evolving and weakly regulated market. The WHO warns that their aerosol contains harmful substances and that long-term health effects remain uncertain (9). Youth appeal is a major concern: around 88% of teen vapers use flavoured products (1,23), raising fears that vaping may renormalise nicotine addiction. These findings largely relate to adult smokers in tightly regulated markets and do not directly translate to youth-protection goals or to settings where informal markets and youth uptake can expand rapidly.

HTPs are also marketed as "reduced harm," but evidence does not support this. WHO states there's no proof HTPs are less harmful than cigarettes (9). Some toxicants are lower, but others may be higher, and many unknown compounds are present in emissions (9). In summary, while such tools may aid adult cessation, they still expose users to harmful substances and require strong regulation to prevent youth uptake (9).

While prevention of tobacco uptake among youth remains critical, strengthening cessation services is equally essential to reduce long-term disease burden. Under the National Tobacco Control Programme (NTCP), India has established National Tobacco Quitline Services (NTQL), mCessation services, and tobacco cessation centres across selected districts. However, awareness and utilisation of these services remain limited, particularly among

adolescents and young adults. Tobacco cessation is not yet fully integrated into routine primary healthcare delivery through Health and Wellness Centres under Ayushman Bharat. Expanding access to evidence-based behavioural counselling, integrating brief cessation advice into school and adolescent health platforms such as RKSK, strengthening digital cessation tools, and training frontline healthcare providers in tobacco cessation interventions could significantly improve quit outcomes. A balanced public health approach must combine prevention, enforcement, and accessible cessation support to curb both current and future tobacco burden effectively.

Policy and Advocacy Recommendations

Protecting youth from tobacco marketing requires a multi-pronged, evidence-based approach. First, full implementation of FCTC Article 13 (TAPS bans) is essential. India's laws must cover all forms of advertising—digital, point-of-sale, and brand extensions like pan masala and cardamom (7). Banning surrogate ads and regulating youth-attracting additives (e.g. candy or menthol flavours) is critical. Single-stick sales should also be prohibited to reduce access. Surveillance must improve through regular youth surveys (e.g. GYTS) and digital tools to track online ad exposure.

Second, enforcement must be strengthened. Police, municipal staff, and shop inspectors should be trained in tobacco laws, with accountability systems in place. International experiences demonstrate that structured enforcement training is feasible in low- and middle-income settings. For example, in Mauritius, following strengthened tobacco control regulations in 2022, dedicated training workshops were conducted for police officers to improve their understanding of legal provisions and enforcement procedures aimed at protecting minors from tobacco access (24). Such capacity-building initiatives illustrate how systematic training can enhance the implementation of youth protection provisions. Local governments could appoint "tobacco control officers" to inspect shops and seize illegal promotions. Given the covert nature of online marketing, India should collaborate with social media platforms to flag and remove content targeting minors. Together, these steps can reduce youth exposure and curb tobacco industry influence. The mandate for tobacco-free campuses must be enforced in schools, and the sale of smokeless products near schools must be eliminated. WHO welcomed India's 2019 e-cigarette ban as a precautionary measure aimed at protecting youth from nicotine initiation in an emerging market context (11); similar decisive action is needed against emerging products (e.g. nicotine pouches) and against tobacco industry interference in policy-making itself. Further, India must institutionalise Article 5.3 of the WHO FCTC, which protects health policies from commercial and vested interests of the tobacco industry. Experiences from other low- and middle-income countries demonstrate the feasibility of institutionalising Article 5.3. In Thailand, the Ministry of Public Health issued a formal regulation in 2010 outlining procedures for interactions between government officials and tobacco industry representatives, specifying that such interactions should occur only when strictly necessary and must be documented transparently (25,26). Subsequent legislative measures, including provisions under the Tobacco Products Control Act B.E. 2560 (2017), further restricted tobacco industry corporate social responsibility activities and strengthened safeguards against commercial interference in health policymaking (26). These institutional mechanisms illustrate how Article 5.3 principles can be operationalised within administrative and legislative frameworks. Similar approaches could be adapted within India's federal governance structure to enhance transparency and accountability.

A code of conduct for public officials and transparent reporting of industry interactions at all levels—national, state, and district—are necessary to safeguard policy-making from covert influence.

Third, public education and youth empowerment are essential. National campaigns, including World No Tobacco Day 2024's theme—"protecting children from tobacco industry interference"—should expose industry tactics. Schools must teach students to identify manipulative marketing.

Civil society and student groups can advocate for no-advertising policies. Youth-led initiatives like "Children Against Tobacco" help resist peer pressure and report violations. Continued investment in adolescent-focused cessation support—hotlines, apps, and trained paediatricians—can reduce harm among those already using tobacco.

Tobacco control efforts must also align with broader adolescent health platforms. The Rashtriya Kishor Swasthya Karyakram (RKSK), National Mental Health Programme, and the School Health and Wellness Programme offer underutilised channels for integrated messaging, early intervention, and counselling. Embedding tobacco awareness in these programs can create continuity between preventive education and behavioural risk screening. Link school health platforms and RKSK peer educator networks with referral pathways to NTQL/mCessation and nearby cessation services, with simple IEC and follow-up

Drawing on evidence and experience, a coordinated approach is essential. Campaign for Tobacco-Free Kids' (CFTK's) success in helping India reduce adult tobacco use (a 17% decline from 2010–2017) (17) shows progress is possible with policy resolve. Advocacy must now urgently emphasise youth protection, enforcing existing laws, closing promotional loopholes, and countering the industry's cunning campaigns. As the WHO warns, "tobacco companies have increasingly preyed on children and adolescents" with ever-new tactics (4); only a robust, science-driven defence can break this cycle and keep the next generation tobacco-free.

Table 1. Exposure of Indian Students (13–15 years) to Tobacco Advertisements (past 30 days, GYTS-4 India 2019)

Media Source	% of Students Exposed
Television	44.5%
Videos (internet)	33.5%
Movies	37.3%
Online/Internet	23.4%
Point-of-Sale	17.2%

Source: Global Youth Tobacco Survey (GYTS-4), India 2019 (3)

The exposure levels reported in Table 1 indicate that a substantial proportion of Indian adolescents continue to encounter tobacco-related imagery across multiple media platforms despite statutory advertising restrictions under COTPA. The finding that nearly half of students report exposure through television and over one-third through movies and online videos suggests that indirect promotion, entertainment media depiction, and digital content remain significant channels of influence. Such widespread exposure may contribute to the normalisation of tobacco use and undermine the intended impact of advertising bans. These findings underscore the need for stronger monitoring of media compliance and regulation of surrogate and digital marketing strategies.

Sustainable Financing for Tobacco Control

Despite the high economic burden of tobacco-related diseases, tobacco control financing in India is minimal. Allocation of dedicated funds from health cess or taxation surcharges, such as through earmarked excise on tobacco products, can support IEC, enforcement, and cessation programs. Further, integrating tobacco control indicators into the National Health Mission's Programme Implementation Plans (PIPs) can institutionalise accountability and funding at the state level.

CONCLUSION

The tobacco industry has developed increasingly sophisticated marketing strategies that intersect with broader social and structural vulnerabilities among youth. Through flavours, digital media, branded giveaways and misleading messages, companies have been "sweet-talking our kids" into nicotine dependence. This strategy poses a preventable but persistent public health challenge: once hooked, children face a lifetime of elevated disease risk and reduced quality of life. Epidemiological evidence and authoritative reviews leave no doubt that early tobacco use harms children's brains, bodies and futures (18,20). Yet policy responses have been tentative. India (and other nations) must now act decisively: seal policy gaps, crack down on hidden marketing, and empower youth with truthful information. Only by unmasking the industry's deceptive tactics and protecting our children with strong public

health measures can we ensure that the generation growing up today is genuinely tobacco-free.

Epidemiologists and public health researchers must lead in generating granular data, evaluating interventions, and advocating for policy coherence. Strengthening cross-sector surveillance and engaging with social media platforms to restrict youth-targeted content will be key to halting the current trajectory.

A comprehensive response that combines enforcement, youth-centred prevention and cessation, and protection from industry interference is essential to sustain gains and reduce future nicotine dependence.

Authors Contribution

All authors have contributed equally.

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The authors haven't used any generative AI/AI-assisted technologies in writing.

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