INTERNATIONAL POLICY DIGEST
The Platform
MAKE YOUR VOICES HEARD!

India's Tobacco Policy Isn't Being Made in India

Shrey Madaan | 01.27.2026

India should reclaim control over its tobacco policy by embracing evidence-based harm reduction rather than donor-driven global prohibitions.

For too long, India's tobacco policies have been shaped less by domestic realities or scientific evidence than by distant committees and donor-driven agendas. With the World Health Organization's latest tobacco talks (COP11) now concluded, the moment is ripe for India to reassess whether it should continue deferring to one-size-fits-all global rules—or begin asserting its own public-health priorities, consumer interests, and regulatory sovereignty. The stakes could scarcely be higher.

Despite being home to one of the world's largest and most complex tobacco markets, India has repeatedly accepted global tobacco-control policies designed with little local input and even less regard for how Indians actually consume nicotine. The result is a regulatory landscape that aggressively punishes lower-risk alternatives while leaving the most harmful forms of tobacco largely untouched.

India's tobacco market is vast and heterogeneous, encompassing more than 267 million smokers and a sprawling informal sector dominated by bidis, gutkha, and other high-risk products. Yet regulatory responses have consistently flattened this complexity. The nationwide ban on e-cigarettes in 2019—celebrated internationally as a decisive public-health victory—has failed to achieve its stated aims. Smoking rates have not meaningfully declined, and nicotine demand has not disappeared.

Instead, the ban merely redirected consumers into a flourishing black market, now stocked with unregulated and often unsafe devices. Rather than reducing harm, the policy displaced it. Meanwhile, the deadliest combustible products remain legal, affordable, and widely available. If harm reduction were the objective, the outcome suggests the opposite: the policy intensified the high risks it claimed to eliminate.

Other countries have taken a markedly different approach. The United Kingdom has formally recognized vaping as substantially less harmful than smoking and incorporated it into smoking-cessation strategies. Sweden is on track to become the world's first smoke-free country, largely due to its acceptance of nicotine pouches and other alternatives. New Zealand reached record-low smoking rates before recent political reversals. These cases are not ideological experiments. They are practical demonstrations of a simple principle: when people are offered safer options, many choose them. When those options are removed, risk increases.

India, however, continues to regulate all nicotine products as if they pose identical dangers. This is not a reflection of scientific consensus. It is the result of a policy shaped by external pressure. Much of that pressure emanates from donor-driven advocacy networks that now dominate global tobacco-control discussions. The WHO's Framework Convention on

Tobacco Control, once envisioned as a cooperative, evidence-based effort, increasingly operates behind closed doors. Major philanthropic actors, most prominently Bloomberg-funded organizations, have poured billions into anti-nicotine campaigns that often conflate harm reduction with harm itself.

This financial and institutional influence has had predictable effects. Even evidence-based alternatives such as vaping and nicotine pouches are routinely framed as threats rather than tools. Debate narrows. Policy ossifies. National governments are left implementing rules that satisfy international orthodoxy while failing their own populations.

Across South Asia, resistance to this model is beginning to surface. Pakistan has frozen the accounts of several foreign-funded advocacy groups for noncompliance. In the Philippines, lawmakers have openly criticized the growing influence of externally financed NGOs on domestic legislation, warning that public health policy cannot be dictated from abroad. India itself has acted against organizations found to be in breach of foreign-funding regulations. Taken together, these moves signal a broader demand for transparency, accountability, and policy autonomy. Public health, many governments are concluding, cannot be outsourced.

India has demonstrated this confidence before. It defended access to affordable HIV/AIDS medications when global pressure mounted against it. It built the CoWIN platform domestically and championed a vaccine patent waiver during the COVID-19 pandemic. In moments of national consequence, India has shown it can balance global engagement with independent judgment. Tobacco policy should be no exception.

At COP11 and beyond, India must insist on evidence, openness, and the freedom to design regulations that reflect its own tobacco landscape. Prohibition has never succeeded where demand persists. Genuine leadership means reducing risk where possible, empowering consumers with safer alternatives, and resisting policies that drive harm underground. India's path to a smoke-free future will not be drafted in Geneva. It will be built at home—through science, innovation, and respect for informed choice.

Source: *https://intpolicydigest.org/the-platform/india-s-tobacco-policy-isnt-being-made-in-india/*