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Analysing India's unique subnational WHO-FCTC Article 5.3 policies and their implementation across 17 states and union territories

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Abbreviations

CSR	Corporate Social Responsibility
M.P.	Madhya Pradesh
NTCP	National Tobacco Control
FGD	Focus Group Discussion
NGO	Nongovernmental Organisation
U.P.	Uttar Pradesh
UTs	Union Territories
WHO-FCTC	World Health Organization – Framework Convention on Tobacco Control

Introduction

The World Health Organization (WHO) defines tobacco industry interference as 'a broad array of tactics and strategies used directly or indirectly by the tobacco industry to interfere with, or influence, the setting and implementation of effective tobacco control measures'.(1) Tobacco industry interference in effective tobacco control policies and programs is indeed a global challenge. The WHO Framework Convention on Tobacco Control (WHO-FCTC) is the first-ever global health treaty initiated by WHO. The treaty recognises in its preamble 'the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on tobacco control efforts'.(2) Article 5.3, which spells out the general obligations of the convention, states, 'in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law'.(2)

India is no exception when it comes to tobacco industry interference. There have been several documented instances of industry interference in tobacco control efforts, including specific examples of negative outcomes. In one case industry pressure delayed an initiative to place health warning graphics on tobacco products and made attempts to tone down the messaging. In another instance, the tobacco industry delayed or hindered attempts to ban tobacco in pan masala and/or gutka.(3,4) The Global Tobacco Industry Interference Index is one of the tools used to assess how well WHO-FCTC Article 5.3 is being implemented at the national level. It uses publicly available information to produce a score between zero and 100. The higher the score, the less WHO-FCTC Article 5.3 is being implemented. The 2023 tobacco industry interference index for India was 58 out of 100, indicating a relatively high degree of tobacco industry meddling.(5) Globally, out of 90 countries that were ranked (in increasing order of tobacco industry interference) in 2023, India stood at 43rd place.(5)

India has gotten better at reducing its Global Tobacco Index score since first being ranked in 2018. A study analysing the trend in tobacco industry interference and the level of implementation of WHO-FCTC Article 5.3 from 2018 to 2021 revealed that India decreased from 72 in 2018 to 57 in 2021.(6) This improvement has largely come from limiting unnecessary interactions between the tobacco industry and public agencies, avoiding conflicts of interest among public officials tasked with tobacco control, and taking measures to prevent tobacco industry interference. However, major gaps remain in efforts to prevent the industry from participating and influencing policy development and implementation, regulating tobacco companies' so-called corporate social responsibility (CSR) activities, blocking state efforts to provide benefits or incentives to the tobacco industry, and enhancing transparency.(6)

As of yet, India does not have a specific provision to prevent tobacco industry interference in its national legislation (Cigarette and Other Tobacco Products Act 2003) and there is no separate policy in line with WHO-FCTC Article 5.3 that applies to the whole of government at the national level. However, since 2015, starting in Punjab, several states in India have adopted policy guidelines in line with WHO-FCTC Article 5.3 (now onward referred to as '5.3 policies' in this report).(7) While the Ministry of Health and Family Welfare's Code of Conduct (July 2020) provides important guidance on implementing WHO-FCTC Article 5.3, its scope is limited to officials and institutions under the Ministry.(8) In India, health-related legislation has typically fallen to state governments.(9) In tobacco control, states in India have often initiated regulatory actions before they were adopted at the national level (e.g., banning certain forms of smokeless tobacco, as well as electronic cigarettes). Thus, state regulation represents an important promise for tobacco control, given its potential to raise demand for corresponding national regulation in the future.

Although several states and union territories in India have adopted 5.3 policies and seen some positive impacts (such as a marginal reduction in the national tobacco industry interference index score), little research has focused on effects at the state (subnational) level.(6) The limited research has focused on processes leading to these 5.3 policies and the contents of these policies.(10,11) We therefore turn our gaze to processes and practices that explain the implementation and perceived impact of these policies in order to draw lessons on how to effectively implement 5.3 policies at the state level throughout India.

Objectives

The objectives of our evaluation included:

Assessing awareness among stakeholders about 5.3 policies (their presence, scope, provisions).

Understanding barriers/challenges in adopting and implementing 5.3 policies in states.

Documenting practices that are perceived to facilitate implementation of 5.3 policies in states.

Formulating recommendations for enhanced and effective implementation of 5.3 policies in states.

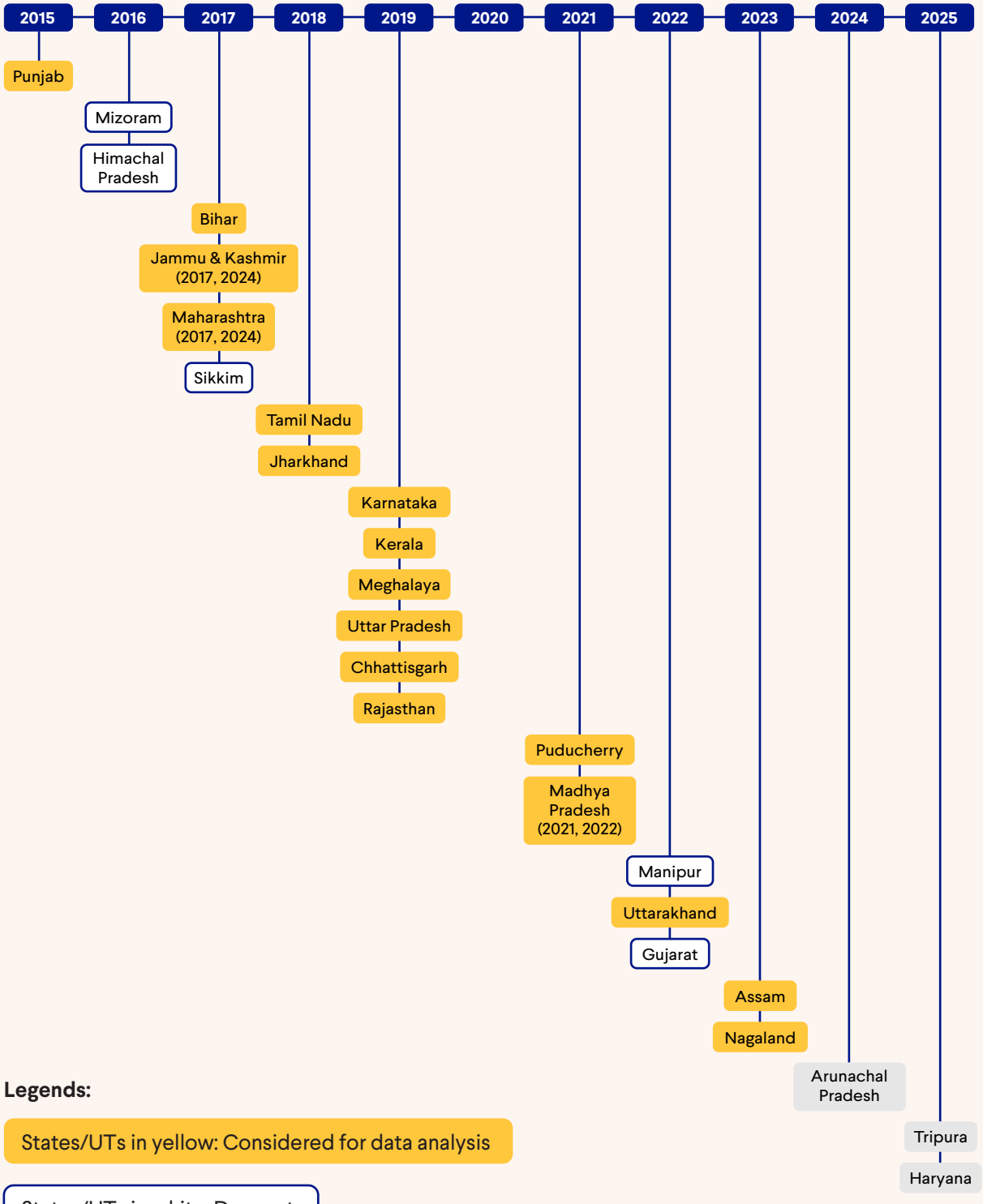
Methods

We conducted a cross-sectional observational study in Indian states that have adopted 5.3 policy in some form using a survey and focus group discussions with relevant stakeholders from the governments and civil society organisations (academia, NGOs) engaged in tobacco control in these states.

Setting

We conducted the study in states that we knew have adopted 5.3 policies in some form. Based on the earlier documentation(12) and our implicit knowledge (Vital Strategies has been working in several Indian states, supporting government and civil society partner organisations), we identified 19 states and union territories (UTs) as having 5.3 policies in some form. By the time the data was being collected, three more policies had been adopted, bringing the total number of states and UTs with such policies to 22. The principal investigator and the five co-investigators were with the Tobacco Control Division of Vital Strategies. One of the co-investigators (UB) belonged to the Institute of Public Health Bengaluru. We ended up studying 17 states and UTs after we had to drop five states because of administrative delays in securing necessary permissions, partly due to unrest in those areas. The states and UTs studied included: (1) Assam, (2) Bihar, (3) Chhattisgarh, (4) Jammu & Kashmir, (5) Jharkhand, (6) Karnataka, (7) Kerala, (8) Madhya Pradesh (M.P.), (9) Maharashtra, (10) Meghalaya, (11) Nagaland, (12) Puducherry, (13) Punjab, (14) Rajasthan, (15) Tamil Nadu, (16) Uttarakhand, (17) Uttar Pradesh (U.P.)

Box 1: Timeline for India's subnational 'bottom-up' approach for adopting WHO-FCTC Article 5.3 policy guidelines (updated till June 2026)



Survey

To start, we sent out an online questionnaire as a Google form to representatives from organisations partnering with Vital Strategies' Tobacco Control Division in each state being studied. Respondents included a representative from a partner NGO in 12 states, government representative from one state (Nagaland), with project staff supported by Vital Strategies working locally with state tobacco control cells in the remaining four states and UTs (i.e., Karnataka, Chhattisgarh, Jammu & Kashmir, and Assam). The tool was a two-part, self-administered questionnaire. One part looked at how the 5.3 policy functioned in practice, with questions about the issuing authority, the policy's scope, the process of forming and empowering an authoritative body or special committee to implement the policy, and the mechanism to report violations. The second part asked whether any complaints had been received, and what action had been taken, if any. A panel of experts was then asked to score and comment on the survey's face validity (the importance and relevance of the questions) and content validity (checking for relevance, clarity and completeness of the questions). The NGO representatives filled out the questionnaire while consulting closely with government officials from the respective state tobacco control cells with whom they had close working relationships. The resultant data was downloaded in MS Excel format. We analysed these documents, all of which had mostly yes/no or short descriptive responses.

Focus Group Discussions

The principal investigator along with the representatives of Vital Strategies' partner organisations (who also supported the survey completion) facilitated focus group discussions (FGDs). They took an online workshop to learn about the study, the purpose of FGDs and the process for conducting them. They also received a guide outlining FGD procedures. These facilitators then helped a subset of respondents who had been selected purposively to ensure there would be representation from the state tobacco control cell, other government departments active in tobacco control, and select civil society entities (NGOs and academic institutions) that were active in tobacco control in the state. The respondents were invited for an in-person group discussion at a venue located within the state capital (generally a hotel and/or meeting room within health department premises).

Facilitators briefed participants about tobacco industry interference and WHO-FCTC Article 5.3. They summarised the survey data for the participants' state, inviting feedback, updates and corrections. The facilitators then initiated and moderated the discussion by posing leading questions from the FGD guide. The guide's questions had been refined after experts analysed them for face and content validity, then refined further after being piloted in two states that were not part of the study. These questions sought to gauge whether stakeholders were aware of the policy (including its scope, contents, dissemination, sensitisation and capacity-building activities), understood the challenges of adopting and implementing the policy, knew the mechanics of implementation, observed policy compliance and impact, and could offer opinions and suggestions on how to enhance implementation.

It was not easy to convene these FGDs, especially given government officials' hectic work schedules and competing priorities. Because of this, 12 of the 17 FGDs had to be conducted in conjunction with other meetings (either a training workshop on WHO-FCTC Article 5.3 or an FGD about the Index of Tobacco Control Sustainability) that the government respondents were scheduled to participate in.

A couple of factors could have affected candid, free inquiry regarding facilitators' questions and/or participant responses. One was the hierarchical relationship among government officials within and across departments, wherein the presence of senior officers would affect how junior officers respond. The other factor was related to facilitators who came from civil society, who needed positive working relationships with government agencies and officials in order to collaborate on tobacco control work in their states. They may have held back on asking questions about implementation because of the presence of government officials whose cooperation was crucial.

The discussion groups lasted for an average of 90 minutes, ranging from 40 minutes to 130 minutes. Ten of the 17 FGD meetings were recorded. Seven meetings were not recorded, two of them because some participants refused to consent (two instances), and five because the venue was too large for it to be feasible. In those instances, a facilitator took detailed notes. The recordings were transcribed, and the handwritten notes were typed out. We organised the transcripts using MS Excel. We coded data based on predetermined questions (i.e., awareness, challenges of implementation, implementation mechanisms, and recommendations) and used thematic analysis to identify major themes.

Ethics

The study was formally reviewed and approved by the Ethics Advisory Group at The Union (Ref: 07/2022) and the Institutional Ethics Committee at the Institute of Public Health Bengaluru (Ref: IPH/23-24/E/2).

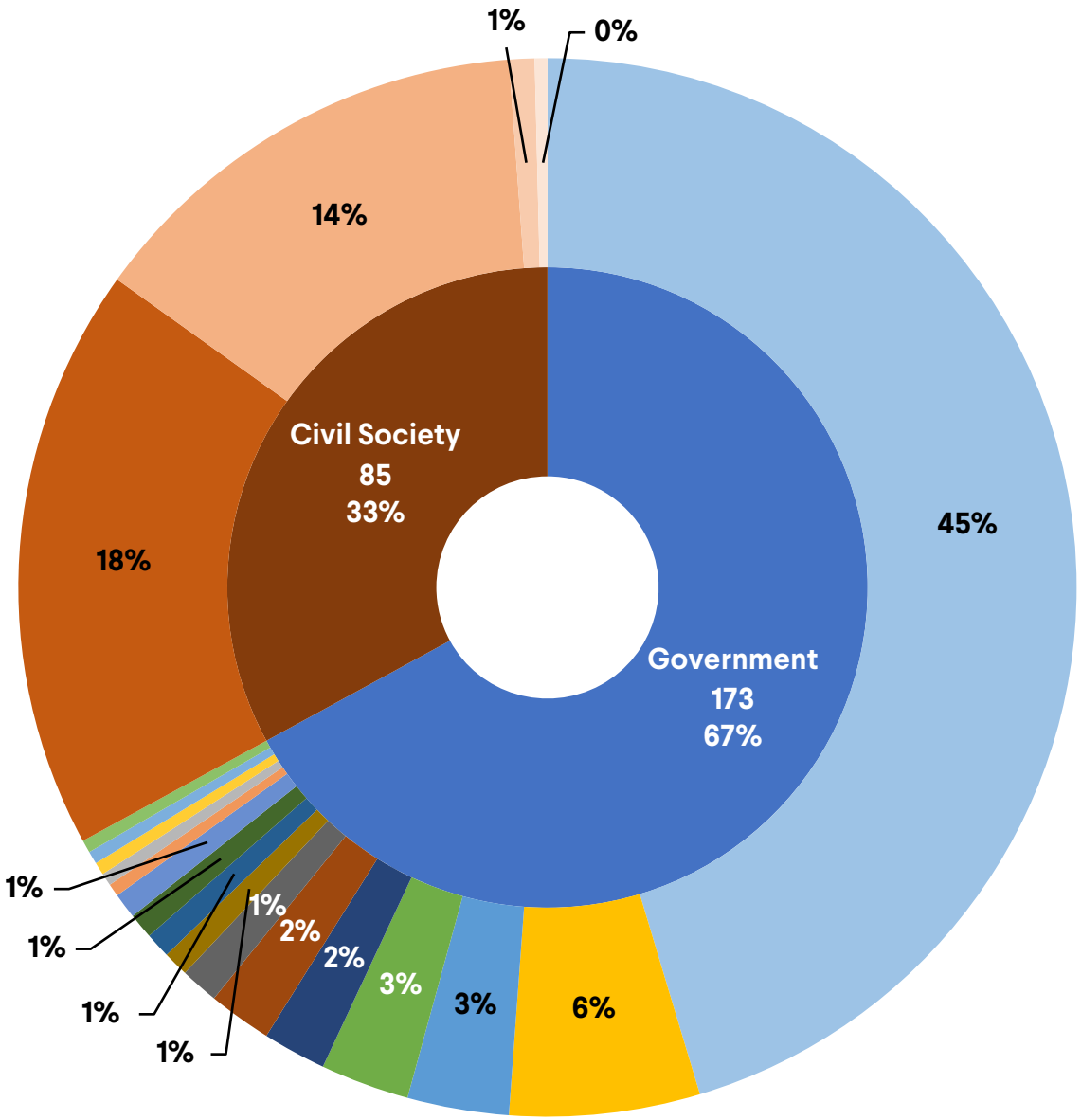
Results

Respondents' Characteristics

The survey respondents from 17 states and UTs included 10 representatives (three women, seven men) from NGOs who were working closely with state/UT governments, four government representatives (two women, two men), and three local employees of Vital Strategies who were assigned to the respective state or UT governments (three men).

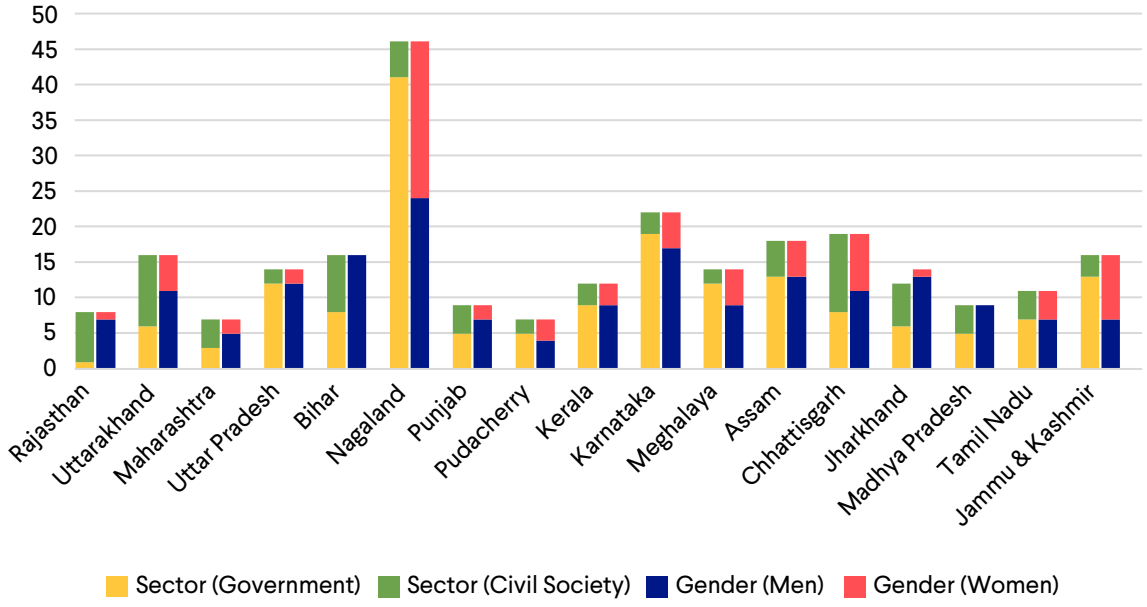
A total of 258 participants took part in 17 focus group discussions averaging 15 participants each. These comprised 181 men (70.2%) and 77 women (29.8%). About 67% (n=173) of respondents were government representatives, while the rest (n=85) came from civil society. Most government representatives were from the health department, with fewer representatives from many other departments (see Figure 1). Respondents from civil society mainly came from NGOs and academic institutions. The gender representation and the representation across sectors among respondents varied across states. Figure 1 and Figure 2 provide respondents' characteristics.

Figure 1. Sector-wise distribution of FGD participants



- Government
- Health
- Food & Drug
- Youth Development / Affairs
- Tax / Customs
- Tourism
- Information & Communication
- Child Protection
- Legal Metrology / Consumer Protection
- Nongovernmental Organisations
- Journalists
- Civil Society
- Education
- Police
- Municipal / Urban Development
- Labour
- Agriculture / Horticulture
- Transport
- Alcohol Prohibition
- Law
- Academic Institutions / Hospitals
- Elected Representative

Figure 2. Sector- and gender-based distribution of FGD respondents across 17 states and union territories



About Article 5.3 Policies in Indian States and Union Territories

In this section, we summarise some key attributes of the 5.3 policies in the 17 states that were studied (see Table 1). Starting with Punjab, which implemented 5.3 policies in 2015, several states adopted it in subsequent years, the latest being Nagaland, in June 2023. In all the states the policy was issued by a senior administrator, typically a senior bureaucrat (secretary, commissioner or other high-ranking officer) from the health department. Two exceptions were Chhattisgarh and M.P., where the policy was issued by a nodal officer of the National Tobacco Control Program (as a letter) and the director of the National Health Mission, respectively. Some survey respondents opined during their FGDs that ideally, a policy at the state level ought to be issued through cabinet approval and published in the state gazette in order to command respect and compliance from non-health departments.

Different forms of government documents (notifications, orders, circulars, letters) were used to issue the policy—again, some forms were perceived as more commanding (notification) than others (circulars, letters). If we look at the design features within these policies that enable implementation, one can grasp their limits. For example, six of the states studied had no provision for creating a body that steers and/or oversees policy implementation. As for the rest of the states, where there was a provision for constituting what was routinely called an empowered/special committee, adherence was spotty. At least 10 of these states had assembled such a committee, but only six were reported to be operational (i.e., holding meetings, deliberating issues and taking action). Also, in two of the states studied, the policies applied only to the health department, limiting the policies' ability to address tobacco industry interference.

Table 1A Key attributes of 5.3 policy adoption and implementation

State/UT	Nature of the policy document	Policy issue date (DD/MM/YYYY)	Policy issuing office	Is policy applicable to non-health departments?	Is there a provision for constituting an empowered/special committee or a similar body to oversee implementation?	Has the empowered/ special committee or any similar body been constituted?	Is the empowered/ special committee active or operational?
Punjab	Notification	13/07/2015	Principal Secretary (Health Department)	Yes	Yes	Yes	Yes
Bihar	Notification	23/06/2017	Special Secretary (Health Department)	Yes	Yes	Yes	No
Jammu & Kashmir	Circular	27/07/2017	Additional Secretary (Health & Medical Education Department)	Yes	Yes	No response	No response
Tamil Nadu	Order	10/11/2017	Principal Secretary (Health Department)	Yes	Yes	Yes	No
Jharkhand	Notification	01/10/2018	Principal Secretary (Health, Medical Education & Family Welfare Department)	Yes	Yes	Yes	Yes
Karnataka	Notification	25/01/2019	Under Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	Yes
Kerala	Order	30/04/2019	Additional Chief Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	Yes
Meghalaya	Order	26/06/2019	Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	Yes
U.P.	Notification	16/09/2019	Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	Yes
Chhattisgarh	Letter	02/02/2021	State Nodal Officer (National Tobacco Control Program)	No	No	Not Applicable	Not Applicable
Rajasthan	Circular	28/10/2021	Secretary (Medical Health & Family Welfare Department)	Yes	No	Not Applicable	Not Applicable
Puducherry	Order	27/12/2021	Chief Secretariat (Health Department)	Yes	Yes	Yes	No
M.P.	Order	13/01/2022	Director (National Health Mission)	No	No	Not Applicable	Not Applicable
Uttarakhand	Order	05/05/2022	Secretary (Health & Medical Education Department)	Yes	Yes	Yes	No
Maharashtra	Notification	18/07/2022	Additional Secretary (Public Health Department)	Yes	No	Not Applicable	Not Applicable
Assam	Order	09/03/2023	Principal Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	No
Nagaland	Notification	16/06/2023	Commissioner & Secretary (Health & Family Welfare Department)	Yes	Yes	Yes	Yes

Table 1B Key attributes of 5.3 policy adoption and implementation

State/UT	Incidents of tobacco industry interference known after the policy is in place	Were these incidents mitigated?
Punjab	A cigarette company met the Chief Minister; Representatives of a tobacco sector trade body met the Director General of Police requesting strict action on curbing the illegal sale of foreign cigarettes and submitted a list of outlets engaged in this.	No
Bihar	Not reported	Not Applicable
Jammu & Kashmir	A cigarette company donated face masks and hand sanitizers to police personnel in two districts.	No
Tamil Nadu	A cigarette company along with an NGO partnered with a government school for a tree planting event.	Yes
Jharkhand	Not reported	Not Applicable
Karnataka	Several incidents reported (30+) including: • A cigarette company met with a health commissioner and/or state/district health authorities to (1) offer a branded annual diary and World No Tobacco Day badges; (2) request authorities to move slowly on tobacco control law enforcement; (3) requesting a strict ban on electronic cigarettes; (4) seek clarity on why the health department had withdrawn from CSR contract on solid waste management; and (5) complain about certain contents within tobacco control educational material. • A cigarette company (1) donated funds for COVID-19 relief to the Karnataka Chief Minister fund; (2) donated an ambulance to district administration; (3) donated refreshment kits to COVID-19 warriors; (4) funded the renovation of a school building and purchase of amenities; (5) constructed an anganwadi center; (6) supported a watershed development program; (7) gave laptops to university students from marginalised groups involving the Vice Chancellor and a Member of Parliament. • A beedi company representative met with health authorities to seek details on enforcement of a ban on single stick cigarette sales.	A few were mitigated, but not all.
Kerala	Smokeless tobacco and cigarette companies collaborated with a radio channel for a show on the popular cultural festival in the state.	Yes
Meghalaya	*An entity funded by tobacco industry had approached a university department to provide support/funding for organising cancer screening camps.	Not Applicable
U.P.	A cigarette company collaborated with a government agency to commemorate a national campaign/program to curb malnutrition while creating their campaign/program to address anemia among adolescent girls, and pregnant and lactating women.	Yes
Chhattisgarh	Not reported	Not Applicable
Rajasthan	A smokeless tobacco company was sponsoring the maintenance of gardens within government offices, public places, and medical colleges displaying its logo prominently at these places.	No
Puducherry	Not reported	Not Applicable
M.P.	A cigarette company representative approached a police officer with a proposal to offer support in organising the World No Tobacco Day events as well as put a complete stop to the sale of electronic cigarettes.	Yes
Uttarakhand	A cigarette company was funding an NGO to work closely with school children engaging them in various activities related to hygiene, solid waste management, and taking pledges to be proud of their schools.	Yes
Maharashtra	A cigarette company collaborated with a school and funded a competition event for school children.	No
Assam	A cigarette company collaborated with the social welfare department to support a home-based care program to address malnutrition.	No
Nagaland	Not reported	Not Applicable

*While this incident was not formally reported in the survey form by the respondent, we learnt about it in the state's FGD.

Awareness About and Dissemination of 5.3 Policy

Government department representatives

In three of the 17 states and UTs (Rajasthan, Maharashtra, Jammu & Kashmir) only health department representatives participated in FGDs. In the other 14 states, one or more of the non-health department representatives participated in FGDs. The most frequent non-health department representation came from education department (nine states), police (six states), food safety (five states) and municipal or urban administration (four states), while many more departments were represented in just one of the FGDs (drug control, madya nishedha/alcohol prohibition, labour, youth resource, tourism, legal metrology, law, transport, information and communication, horticulture, agriculture, tax, customs and child protection).

In all 17 states, health department representatives knew about 5.3 policies. In Rajasthan, a few health officers (especially from districts), including a member of the state-level coordination committee for tobacco control, had not heard of the policy. This could have meant that the higher-level health department officer who had issued the circular had sent it to districts without copying the members of the state-level coordination committee. As for district level officers participating in the FGD, it is likely that they joined/were delegated to the National Tobacco Control Program (NTCP) after dissemination of the 5.3 policy to the districts.

In the nine state FGDs attended by non-health department representatives, one or more such representatives were aware of the 5.3 policy in some detail.

Civil society representatives

All 17 FGDs had representation from civil society organisations (NGOs and academia). All the NGO representatives who participated in FGDs were aware of the 5.3 policy. Many of these NGOs were also partners of Vital Strategies for tobacco control work in the respective states and were facilitating the study. Some of the academic representatives, especially from medical and dental colleges, were not aware that the 5.3 policy had been adopted by the respective states even though they had heard of WHO-FCTC Article 5.3. Exceptions included academic representatives from cancer institutes and hospitals, and public health professionals who had been actively engaged in tobacco control research and programs for years.

Information channels

We refer to information channels (and not communication), since the practice largely entailed a one-way flow of information about 5.3 policies from health authorities to others within and across government departments. Typically, 5.3 policies issued at the state level were sent to the district magistrate, commissioner or collectors with an expectation that the district administration would further disseminate the policy to various department heads in districts. However, this did not always happen. For example, in Nagaland, the policy was not formally sent to districts as officers awaited the first meeting of the

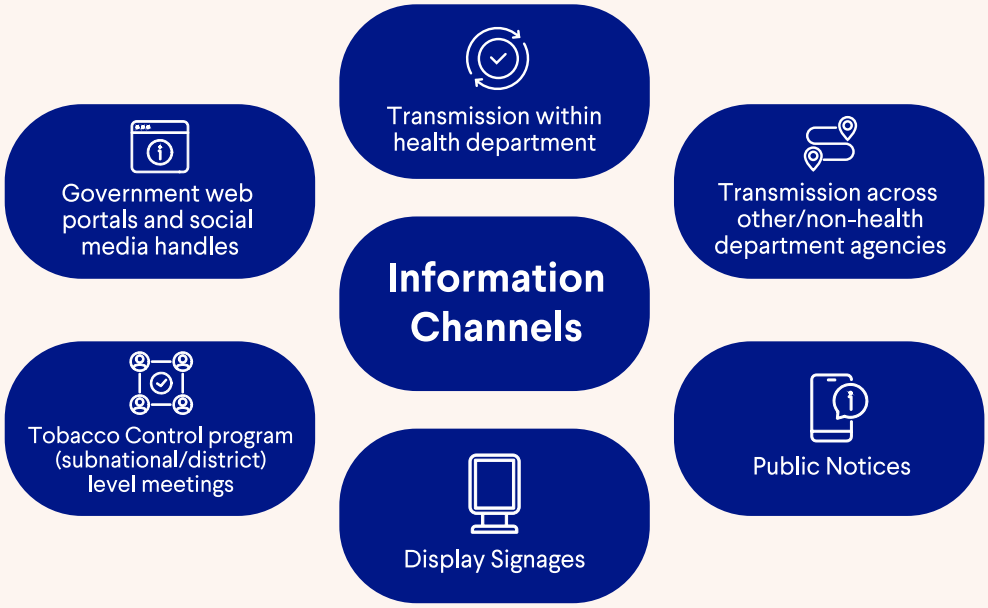
state-level empowered/special committee, which was being delayed. In Chhattisgarh, the state nodal officer suspected that none of the district commissioners had further disseminated the 5.3 policy letter, since it had not been issued by senior officers in the state health department. In Kerala, only five district commissioners had further disseminated the 5.3 policy to other departments in the districts.

Four of the 17 states (Bihar, U.P., Punjab and Jharkhand) studied the state-level coordination committee on tobacco control and have discussed 5.3 policy as an agenda item one or more times, focusing on its adoption, dissemination and/or compliance. In Karnataka, the high-powered committee on tobacco control (chaired by the chief secretary) discussed 5.3 policy as an agenda item. During the FGD, Nagaland officials organised a meeting of the empowered committee that took place later that year.

In four of the 17 states studied (Karnataka, Kerala, Jharkhand, U.P.), respondents discussed ways to display signs and boards to increase awareness of 5.3 policy among government officials. They also looked at what procedures tobacco industry representatives would need to follow, such as obtaining prior permission when meeting government officials, especially in their offices, at the state or district level.

Though not mandated by 5.3 policies, some government and civil society representatives (e.g., those from Assam) said their organisation's website displayed a notice or declaration about avoiding conflicts of interest by not partnering with or taking funds from the tobacco industry because of their tobacco control work. Many of civil society representatives (especially Vital Strategies' partners) said they had an internal policy not to take funds from the tobacco industry. None of the states studied had gone so far as to issue public notices or raise public awareness about the 5.3 policy.

Box 2: Information channels for 5.3 policy dissemination



Challenges in Policy Adoption and Implementation

Policy adoption

Not many respondents across states commented on the challenges of adopting the 5.3 policy. This could be partly because most of them were not involved in policymaking. Nonetheless, two major challenges did emerge.

Respondents (mainly government representatives) from at least seven states (Chhattisgarh, Jharkhand, M.P., Tamil Nadu, Rajasthan, Uttarakhand, U.P.) indicated that they found it difficult to convince high-level officials and decision-makers of the importance of 5.3 policies. It was not easy to make them understand the problematic aspects of tobacco industry interference, especially in the case of non-health departments and some of the political leadership. While in general this was not an easy task, a few respondents believed that 5.3 policies were a harder sell in places whose governments had conflicting interests in tobacco or where the tobacco industry did not have a substantive presence such as in cultivation or manufacturing. Decision-makers in those states were a bit harder to convince.

Respondents from at least four states (U.P., Uttarakhand, Nagaland, Puducherry) indicated it could take two to three years to move the policy proposal file from one senior government official's desk to another. Many factors—including lack of awareness and conviction about the need for such a policy, changes in high-level administrative and political leadership, and neglect in the face of other priorities (such as the COVID-19 pandemic)—accounted for such delays.

Policy implementation

Below, we describe major themes defining challenges in implementing 5.3 policies in states:

- *Lack of dissemination of and awareness about the policy*

  Inadequate dissemination of 5.3 policies, leading to low awareness among government officials, especially in non-health departments and district-level agencies, was mentioned as a major impediment to implementing 5.3 policies in several states. This theme corroborated the lack of effort put so far into channelling information to the community via public notices, display signs and boards, public awareness campaigns and capacity-building efforts such as sensitisation and training workshops around these policies (see the earlier section of this report).

- *Suboptimal functioning of empowered/special committees*

  Typically, 5.3 policies prescribe the constitution of an empowered/special committee that oversees the implementation of these policies. Respondents from certain states (e.g., Nagaland, Karnataka) specifically mentioned that such a committee had not met even once since their constitution was passed. That was likely the case for many more

states as well. Some respondents believed that the absence of an active and functioning committee was a basic hurdle that blocked state tobacco control cells from taking further steps needed for implementing 5.3 policies.

- *Lack of clear guidance for implementation*

  Respondents from many states and UTs (e.g., Jammu & Kashmir, Tamil Nadu, Meghalaya, Uttarakhand) highlighted that 5.3 policies in their present shape lacked clear guidance on many basic operational aspects concerning implementation: (1) What constitutes the tobacco industry? Is it just manufacturers and vendors? (2) To whom to report violations of the policy provisions? (3) What steps should be taken when a complaint is received or a policy violation recognised? (4) What are the precise roles and responsibilities of empowered/special committees created under 5.3 policies?

- *Low priority accorded by non-health departments*

  Some of the respondents mentioned that often non-health departments accorded low priority to implementing 5.3 policies as they either underappreciated the problematic nature of tobacco industry interference or were occupied with other departmental/sector-specific priorities.

- *Tobacco industry interference within 5.3 policies*

  Respondents from Jharkhand and Assam reported that while adopting the 5.3 policy reduced or stopped the tobacco industry's overt outreach to high-level health officials, the industry was now engaging with implementation-level officials, often in the guise of NGOs or front groups. Respondents from Karnataka flagged that tobacco industry representatives often approached political leaders to bypass senior department officials, initiating new partnerships with government agencies.

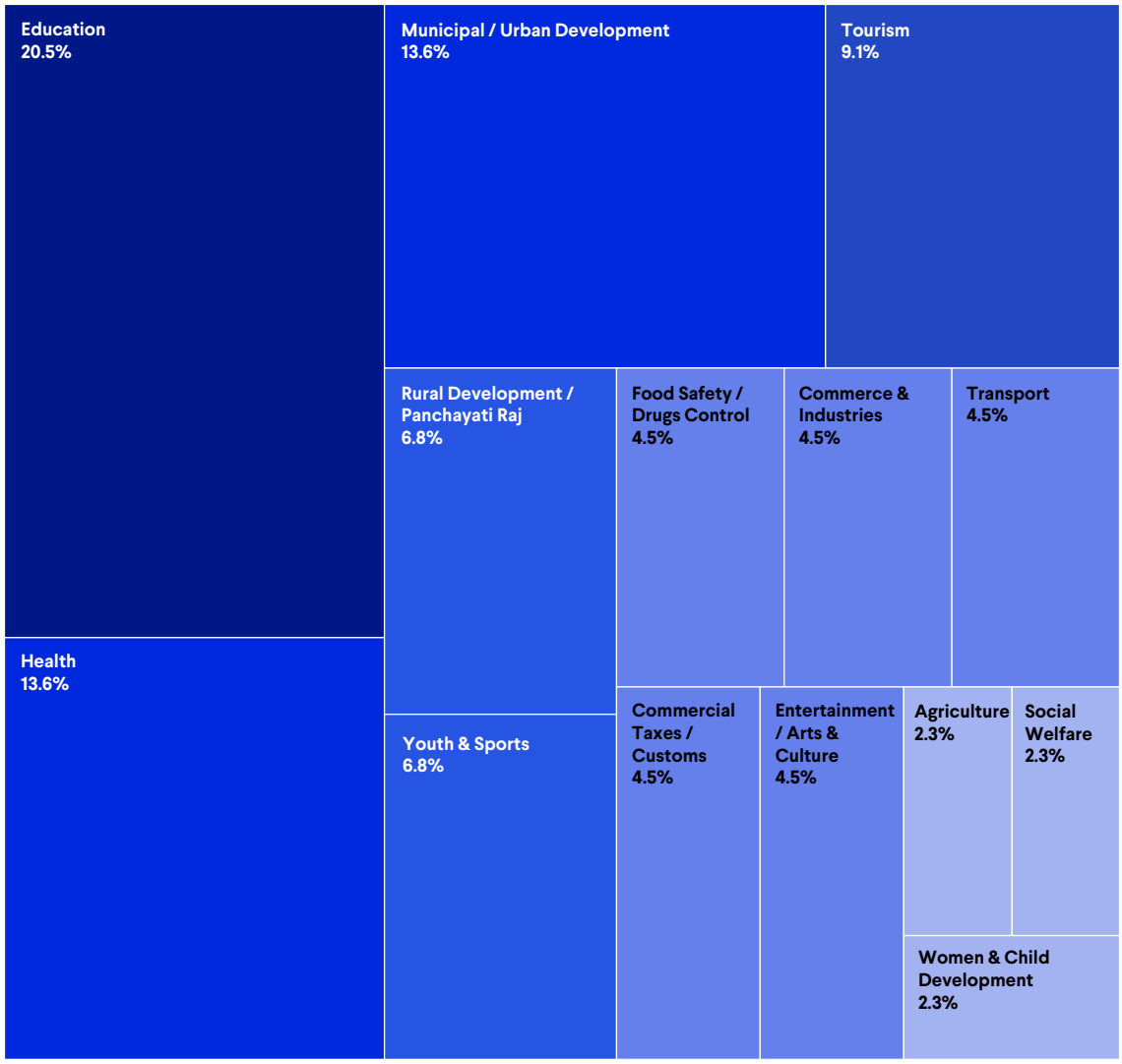
- *Lack of monitoring of industry interference*

  Respondents from many states mentioned how the lack of real-time monitoring of tobacco industry interference makes it difficult to implement and evaluate 5.3 policies. Many within state tobacco control cells and civil society sensed the interference, but lack of systematic monitoring and documentation hindered corrective action.

High Risks of Industry Interference

While many respondents opined that nearly all government agencies and departments are vulnerable to industry interference, respondents from 13 out of 17 states and UTs studied mentioned specific government departments that they felt were particularly vulnerable. Such risk perception was based on interference incidents in the past and the potential for certain departments to offer easy entry points for the industry to reach children and youth as potential consumers while enhancing the industry's image through so-called CSR funding and partnerships. Figure 3 depicts the departments and the degree of corresponding perceived risks (reflected as a percentage of times a particular state was mentioned as being vulnerable to tobacco industry interference by FGD respondents) across states.

Figure 3. Perceived vulnerability of government agencies for tobacco industry interference



Percentages refer to the frequency of times that state was mentioned as vulnerable to tobacco industry interference by FGD respondents.

Perceived Impact of 5.3 Policies

Eight of the 17 states studied reported receiving complaints about violation of the 5.3 policy. All the complaints were about tobacco industry entities partnering with government agencies or providing funds to government agencies and programs often as part of their so-called CSR. Of these eight states, most received very few—just one or two—complaints, or took up actions on a suo moto basis (of its own accord). Tamil Nadu and U.P. reported the most complaints, with eight to ten, and had acted on most of them. Typically, the state-level coordination committee for tobacco control would send a letter to the offending government agency that was receiving funds from or was partnering with the tobacco industry. One or more committee members, or an officer from the state or district tobacco control cell, would visit the government agency concerned and explain the matter in person. Those actions often got the agency to end or even prohibit further expansion of such partnership or funding. Table 2 provides examples of policy violations that were reported and acted upon and or any suo moto action taken in those states.

Apart from complaints-based actions under the 5.3 policy, some respondents reported other forms of perceived impact of this policy. In Rajasthan, the civil society representative felt that after the 5.3 policy was implemented in the state, major tobacco companies stopped publicising their so-called CSR activities as they had in the past. However, this may not necessarily mean that they reduced CSR activities. In M.P., a civil society representative mentioned how some of the high-level government officials across departments (especially health and police) had refused an offer of CSR support from the tobacco industry, indicating a positive impact of the 5.3 policy. In Karnataka, a civil society representative working closely with the state tobacco control cell indicated that tobacco industry representatives used to visit the state tobacco control cell and other high-level health department officials regularly. Such visible outreach by the tobacco industry to health officials stopped after the state adopted the 5.3 policy.

Importantly, many respondents across states mentioned how difficult it was to comment about the impact of the policy without real-time monitoring of tobacco industry interference in states. Some of them also felt that these policies would need to be widely disseminated, especially beyond officers within the health department dealing with tobacco control, for the policy to show a positive impact.

Table 2: Complaints and/or actions taken concerning 5.3 policies

States and UTs	Policy violation and/or action
Jammu & Kashmir	In a few districts, the administration and police received sanitisers and protective gear from the tobacco industry during the COVID-19 pandemic. This was publicised in print media. The state tobacco control cell wrote a letter to the health department director who in turn wrote to all the districts (administration) advising against any such future funding/partnerships.
Maharashtra	Complaints were about a medical college, a general hospital, and schools receiving funding through so-called CSR activities, directly and indirectly, from the tobacco industry. The state issued letters to respective authorities, including the medical education department and concerned district nodal officers. At times, the nodal officer and/or district committee members visited the government agency in question. This resulted in the end of such funding/partnerships.
Assam	There was probably no formal complaint, but the state tobacco control cell took notice of the support being received by the social welfare department from a tobacco company for a nutrition-related program. Subsequently, a letter was sent from the health department to the social welfare department highlighting the 5.3 policy. It was unclear what if any impact the letter had on funding or partnership.
Karnataka	There were several complaint-based and/or suo moto actions aimed at government agencies that were receiving funds from or partnering with the tobacco industry (e.g., tobacco industry officials teaming up with municipal agencies on solid waste management projects; schools receiving funds from the tobacco industry for amenities; the tobacco industry linking with the watershed development department). Actions—mainly in the form of letters or notices from health and/or education departments—often ended the funding or partnerships, though not always. In one case, the state tobacco control cell alerted officials higher up in the health department that tobacco industry executives were about to propose forming public-private partnership to build a hospital. After the tobacco control cell's heads-up, the proposal never materialised.
Tamil Nadu	Complaints came through the telephone-based medical helpline, and the state reportedly took action. In one case, the tobacco industry supported a large-scale educational event on spelling talent (Classmate Spell Bee) among government schools. A letter from tobacco control officials to the schools via the education department stopped such partnerships.
Meghalaya	There was probably not a formal complaint, but the state tobacco control cell learned that the tobacco industry was approaching a university department to offer support and funding. State tobacco control cells reached out to the university and managed to prevent it to some extent.
Uttarakhand	A complaint was lodged about the tobacco industry supporting an educational institution in the state. The state tobacco control cell intervened and stopped the funding/partnership.
U.P.	The state received eight to 10 complaints of government agencies receiving CSR funds, forming partnerships and engaging in any form of unnecessary interactions of potential benefit to the tobacco industry, directly and indirectly under the 5.3 policy and except for two of these complaints, the rest were resolved. Actions—mainly in the form of letters and notices from the administration—ended or diluted most of those collaborations and got industry logos removed. The unresolved complaints included tobacco advertisements on public transport buses, as the prevailing regulations did not provide clarity on the removal of such advertisements.

Good Practices in Implementing 5.3 Policies

In this section, we highlight practices reported in some of the states that were linked with improved implementation of 5.3 policies.

- In a few states, the issue of 5.3 policies by the health department came after similar orders/notifications were issued by select non-health departments, enhancing communication and compliance with these policies within these departments. For example, in Jharkhand, the Department of School Education and Literacy Development as well as the Department of Higher Education and Technical Education issued 5.3 orders after receiving the health department's orders to do so.

- In Maharashtra, many respondents from government agencies (especially health departments) and civil society organisations (NGOs and academic institutions) reported displaying information about 5.3 policy and/or their conflict-of-interest policy on their organisational web portals. They perceived such practices as useful in signalling to visitors that these entities are mindful and cautious about dealings with tobacco industry entities.

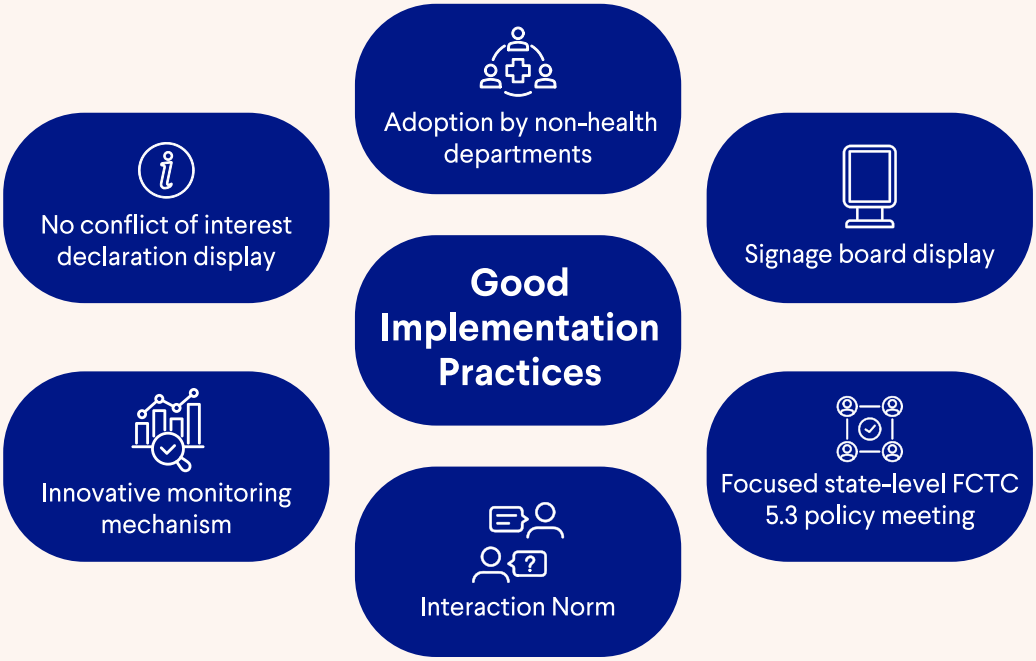
- A few states incorporated the provision of displaying boards or signages at government offices as part of the 5.3 policies and implemented this provision to varying degrees. This seemed to raise awareness about 5.3 policies within government departments and anyone visiting those offices. Karnataka, Kerala, Jharkhand and U.P. seem to have such a provision in their 5.3 policies.

- While in general, there seems to be a lack of monitoring of tobacco industry interference, a few states reported measures to enhance reporting of industry interference. For example, Maharashtra designated state and district-level tobacco control committees to also monitor implementation of 5.3 policies. U.P. and Kerala reported the use of WhatsApp groups/channels among health department staff and a phone-based medical helpline as sources of receiving complaints and/or intelligence about tobacco interference.

- In U.P., health department officials set a norm that any tobacco industry representatives wanting to engage with the department could meet only with high-level officials (secretary, department of health and or the director of the national health mission) and not engage directly with any other departmental officials. This arrangement was designed to reduce vulnerability and to ensure a focus on, and better implementation of, 5.3 policies.

- In Karnataka, in lieu of a long-pending meeting of the state-level coordination committee, the agenda related to the 5.3 policy was presented to the high-powered committee on tobacco control, chaired by the chief secretary of Karnataka, which the state had established in the past.

Box 3: Good practices for 5.3 policy implementation



Conclusion

The subnational WHO-FCTC Article 5.3 policies in India are perceived to have reduced visible tobacco industry interference and, in some instances, eliminated partnerships between government agencies and the tobacco industry. Despite the promise of these policies in reducing tobacco industry interference, their implementation remains far from effective. Major barriers to implementation include minimal dissemination of and awareness about these policies, suboptimal functioning of the committees constituted to oversee policy implementation, low priority accorded to these policies (by non-health departments), and interference by the tobacco industry. A few states demonstrated practices that facilitated 5.3 policy implementation, such as displaying signage and policy declarations, getting non-health departments to issue 5.3 policy orders, using institutional channels to receive complaints about policy violations, and normalising the practice of not accepting sponsorships offered by private entities while serving in government departments. Addressing several systemic challenges and learning from positive past practices can optimise implementation of these policies. Furthermore, there is a need for 'whole-of-government' policy at national level which will bring uniformity and improved implementation across the country.

Recommendations

This section provides specific actions that could be taken at the state and/or district level to enhance the implementation of 5.3 policies. These recommendations are based on the good practices of the states studied (as outlined in the earlier section), suggestions made by the study respondents, and what is now known from the published literature on this matter in India.

1. Plugging Gaps in Policy Design

Certain gaps in policy design/content seem to be creating barriers to its effective implementation. Ideally, such policy in the state shall be notified by the state government through cabinet approval and published in the state gazette instead of within a department or circulated among officers within the department. This can ensure due recognition and credibility for the policy at various levels within governments and across departments. Such a policy shall include the following provisions to address the prevailing design gaps.

1.1. 5.3 policies shall clearly define what constitutes the tobacco industry (and their representatives) for the purpose of better operationalisation of these policies.

1.2. 5.3 policies shall contain provisions outlining how violations and complaints must be reported and received, which authorities will adjudicate these complaints, and what sort of punitive/corrective actions should be taken under the policy, including timelines for those actions.

1.3. 5.3 policies shall prescribe the constitution of the empowered/special committee to oversee the implementation of these policies. Such a provision shall create room for making further rules and/or looping in high-level officers from a wide range of government departments and agencies that are specifically seen as vulnerable to tobacco industry interference, with the possibility of including representatives from civil society with expertise on this issue. It shall clarify the role of such a committee, including the role of civil society.

1.4. 5.3 policies shall prescribe the constitution of a body that ensures regular and/or periodic monitoring of tobacco industry interference in the state, issues periodic reports on the same and provides intelligence to the empowered/special committee.

1.5. 5.3 policies shall mandate the display of signage and boards about these policies (including cautions against and procedures governing meetings between tobacco industry representatives and government agencies or officials) at conspicuous places at government agencies in the state.

1.6. 5.3 policies should provide safeguards for the whistleblowing function that is crucial in this matter.

2. Operationalising Empowered/Special Committees

In many states the empowered/special committee created under the 5.3 policies have yet to convene their first meeting. It is important to initiate such meetings early on and that certain norms are established around the role and functioning (including periodic meetings) of such committees. Such committees shall ideally include representatives from a wide range of government departments that are particularly at risk of tobacco industry interference and as such are crucial when it comes to implementing these policies. Civil society representatives are also essential, for transparency's sake and for their expertise.

3. Raising Awareness About 5.3 Policies

At present, a lack or low level of awareness about 5.3 policies seems to be a major impediment to its implementation. There is a need to disseminate the policy across all government departments, at all levels. This shall include, but not be limited to, periodically issuing circulars to district magistrates and commissioners for further dissemination to all departments. The policies should be distributed to academic institutions and civil society actors through appropriate channels. There is a need to raise general awareness among the public via public notices and mass media. Displaying signage and boards about the policy at conspicuous places in government offices is an important way to raise awareness about these policies. Also, organising state- and district-level sensitisation workshops and trainings is crucial.

4. Integrating 5.3 Policies Within Departmental Practices

Issuing appropriate circulars from various departments whose officials can explain relevance of 5.3 policies and emphasise the need to implement them is important. Other measures could include (1) creating a list of locally relevant tobacco industry entities that enables officers to recognise tobacco business entities; (2) inserting an exclusionary clause within standard templates (contracts and/or memorandums of understanding) for partnerships between government and other agencies, and (3) integrating communication of industry interference or related intelligence within existing communication and reporting channels within departments.

5. Monitoring Tobacco Industry Interference

It is crucial to organise real-time or at least periodic monitoring of tobacco industry interference. This could be done through existing committees or their subcommittees or by creating bodies that integrate committee members, experts from academia and civil society representatives. Such a forum shall provide intelligence to the empowered/special committee for suo moto action beyond the complaints received by the committee. Such a forum shall bring out periodic reports (something in line with the annual tobacco industry interference index) that help people understand the changing scenario and the policy relevance/impact.

6. Evaluating 5.3 Policies

It has been some years since this 'experiment' of several states bringing state-level policies in line with WHO-FCTC Article 5.3. Depending on how long it has been since a given policy was enacted, it is a good idea to conduct internal and/or external evaluation of processes, outcomes and impacts of 5.3 policies, leading to lessons for their enhanced and effective implementation.

References

1. World Health Organization. Tobacco industry interference with tobacco control. Geneva; 2018.

2. World Health Organization. WHO Framework Convention on Tobacco Control. Geneva; 2003.

3. Arora M, Yadav A. Pictorial health warnings on tobacco products in India: sociopolitical and legal developments. Natl Med J India 2010;23(6):357–9.

4. Dsouza R, Bhojani U. Strategic and contested use of food laws to ban smokeless tobacco products in India : a qualitative analysis of litigation. Tob Control. 2021;0:1–5.

5. Assunta M. Global Tobacco Industry Interference Index 2023. Bangkok, Thailand; 2023. Available from: www.globaltobaccoindex.org (accessed on Dec 10 2025)

6. Bassi S, Chopra M, Chugh A, Das S, Bhojani U, Nazar GP, et al. Trends in level of implementation of the WHO FCTC Article 5.3 in India. Preprint (yet to be Published) Lancet Reg Heal - Southeast Asia. 202AD;1–17. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4665820 (accessed on Dec 10 2025)

7. Bhojani U, Goel S, Kar S, Lal P, Chugh A. Tobacco Industry Interference (Chapter 7.1). In: Swasticharan L, Arora M, Sinha P, Ray C, Munish V, Shrivastav R (editors). Report on Tobacco Control in India 2022 New Delhi; 2022. p. 105–11.

8. Ministry of Health & Family Welfare (Government of India). Code of Conduct for Public Officials in Compliance to Article 5.3 of the WHO-FCTC [Internet]. New Delhi: Ministry of Health & Family Welfare; July 2020. Available from: https://smokelesstobaccocontrolindia.com/wp-content/uploads/2020/07/Code-of-Conduct-for-Public-Officials-6th-July.pdf (accessed on Dec 10 2025)9.
Panchamukhi P. Health in the Indian Constitution. In: Health and the Indian Constitution [Internet]. Dharwad: Centre for Multi-Disciplinary Development Research; p. 3–16. Available from: http://cmdr.ac.in/editor_v51/assets/Mono-7.pdf (accessed on Dec 10 2025)

10. Ralston R, Hirpa S, Bassi S, Male D, Kumar P, Barry RA, et al. Norms, rules and policy tools: understanding Article 5.3 as an instrument of tobacco control governance. Tob Control. 2022;31(1):S53–60.

11. Bassi S, Ralston R, Arora M, Chugh A, Nazar GP, Collin J. Understanding the dynamics of notification and implementation of Article 5.3 across India's states and union territories. Tobacco Control. 2022 Jun 1;31(Suppl 1):s18-25.

12. ICMR National Institute of Cancer Prevention and Research. Notifications on article 5.3 of WHO FCTC. 2024. Available from: https://smokelesstobaccocontrolindia.com/orders-notifications/#1592559640120-7af65f67-5bae (accessed on Dec 10 2025)