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PERSPECTIVES

Legal on Paper, Uneven in Practice: A Perspective on Ground-Level Challenges in Adolescent Tobacco Protection in North India

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Abstract

India has established a comprehensive legislative framework for tobacco control, including provisions specifically intended to protect adolescents from tobacco access and exposure. However, evidence from multiple Indian settings suggests that implementation at the community and point-of-sale levels remains inconsistent. Drawing on our group's school-based fieldwork in Mathura, Agra, and Vrindavan, together with findings from the broader Indian literature, this perspective argues that strengthening implementation should be a central component of adolescent tobacco-control efforts in North India. Field observations, including the identification of adolescents with tobacco- and arecanut-associated oral mucosal changes during research activities, illustrate the practical consequences of early exposure but should be interpreted as clinical and field observations rather than population-level evidence. Three areas warrant particular attention: point-of-sale compliance, tobacco-containing dentifrices, and family-level normalization of tobacco access. Although school-based education remains an important prevention strategy, education alone is unlikely to be sufficient when adolescents continue to encounter tobacco products through retail and household environments. We therefore advocate greater investment in region-specific compliance monitoring, standardized assessment of tobacco-containing dentifrices, rigorous evaluation of school-based interventions, and prevention strategies that engage families and communities alongside adolescents. The central challenge is not simply the existence of tobacco-control legislation but its consistent implementation in the environments in which adolescents live, study, and obtain tobacco products.

Keywords: Adolescent tobacco control; COTPA implementation; Point-of-sale compliance

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1. What the Numbers Do Not Fully Capture

Adolescent tobacco use is commonly described using prevalence estimates, measures of association, and confidence intervals. Such indicators are essential for epidemiological assessment and policy planning, but they do not always convey the circumstances in which tobacco exposure and initiation occur. Our own published studies from this region have documented adolescent tobacco and arecanut use and exposure to tobacco-related marketing [1-3]. During school-based fieldwork, we have also encountered individual adolescents presenting with oral mucosal changes in the context of reported tobacco or arecanut use.

These observations should not be interpreted as evidence of population-level prevalence or causation. Nevertheless, they provide an important clinical and public health perspective on the consequences of early exposure. In some cases, adolescents reported obtaining tobacco products from retail outlets located near their schools. Such observations raise concerns about the extent to which statutory protections are reflected in adolescents' everyday experiences.

The Cigarettes and Other Tobacco Products Act, 2003 (COTPA), includes provisions prohibiting the sale of tobacco products to persons below 18 years of age and restricting tobacco sales within the specified distance of educational institutions [4]. These provisions are intended to reduce adolescents' access to tobacco products. The contrast between the protections established

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in legislation and observations from community settings therefore warrants greater attention to implementation and compliance.

2. The Field Evidence: A Persistent Implementation Concern

Evidence from multiple Indian settings indicates that challenges in implementing tobacco-control provisions are not confined to a single region. Observational research from Puducherry has reported substantial non-compliance with COTPA point-of-sale requirements [5], while a multi-state study covering Bihar, Karnataka, Kerala, Maharashtra, and Rajasthan also documented inconsistent compliance with provisions related to tobacco sales and advertising [6]. Research from Mumbai has further reported an association between vendor-level compliance, adolescents' perceived ease of obtaining tobacco products, and tobacco use [7].

Taken together, these studies provide consistent evidence that weaknesses in point-of-sale implementation are associated with an environment in which tobacco products remain accessible to adolescents. However, the available evidence should be interpreted carefully. Most studies are observational and conducted in specific geographic settings; therefore, they cannot establish that low vendor compliance alone causes adolescent tobacco use. Tobacco availability operates alongside peer influence, family exposure, marketing, socioeconomic conditions, and individual behavior.

Nevertheless, the consistency of findings across different Indian settings suggests that point-of-sale enforcement deserves greater attention within adolescent tobacco-control research. Policy discussions frequently emphasize legislative provisions, treaty commitments, and health education, whereas systematic and repeated assessment of implementation at the level of individual retailers remains comparatively limited, particularly in smaller cities and semi-urban areas.

This represents an important opportunity for research. Region-specific compliance monitoring could identify where implementation is weakest, determine which regulatory provisions are most frequently violated, and evaluate whether targeted enforcement strategies improve adolescents' protection from tobacco access.

3. The Overlooked Actors: Dentifrices, Vendors, and Families

Three interconnected factors deserve greater attention in future adolescent tobacco-control research: tobacco-containing dentifrices, tobacco vendors, and family environments.

Tobacco-containing dentifrices

Tobacco-containing dentifrices represent a potentially under-recognized source of tobacco exposure. Chemical analyses have identified nicotine in some commercially available toothpowders [8], while misconceptions regarding the perceived oral-health benefits of tobacco-containing products may contribute to their continued use. This issue is particularly relevant to epidemiological research because adolescents and their families may not classify dentifrice use as tobacco exposure.

In our own research, inconsistent classification of dentifrice-based use across questionnaire items highlighted the potential for exposure misclassification. However, this observation should be investigated systematically rather than assumed to represent a widespread pattern. Future prevalence studies should explicitly identify tobacco-containing dentifrices and other less conventional products to improve the completeness and comparability of tobacco-exposure assessment.

Tobacco vendors

Retailers represent an important point of intervention because they directly control access to commercially available tobacco products. Evidence from Indian point-of-sale studies indicates that compliance varies considerably between settings. This suggests that interventions directed toward retailers including regular compliance monitoring, appropriate enforcement measures, retailer education, and mechanisms for age verification may complement demand-side interventions directed at adolescents.

Importantly, such strategies should be evaluated rather than assumed to be effective. Research comparing different enforcement approaches could help determine whether repeated inspections, educational interventions, penalties for repeated violations, or combinations of these measures produce sustained improvements in compliance.

Families

Adolescent tobacco exposure also occurs within family and household environments. Previous research has documented associations between tobacco use by household members and adolescent tobacco behavior. In some settings, adolescents may also be exposed to tobacco products when they purchase products on behalf of adult family members. Such practices may increase familiarity with tobacco products and contribute to their normalization within the household.

These observations suggest that adolescent-focused interventions may have limited reach when household-level exposure remains unaddressed. Prevention strategies should therefore consider parents and other household members as potential targets for intervention rather than treating adolescents as independent decision-makers isolated from their social environment.

4. Why School-Based Messaging Alone Is Insufficient

We do not argue against school-based tobacco education. Schools remain an important setting for reaching adolescents, and available Indian evidence suggests that school-based interventions can improve tobacco-related knowledge and attitudes and may reduce tobacco use, particularly when programs involve repeated contact and follow-up rather than a single educational session.

However, education operates primarily at the level of knowledge, attitudes, and behavior. It cannot by itself eliminate adolescents' access to tobacco products or change tobacco-related practices within households. An adolescent may understand the health risks of tobacco while continuing to encounter tobacco products through peers, family members, or nearby retailers.

The limited evaluation of school-based interventions in India is an additional concern. A systematic review published in 2022 identified only 13 methodologically eligible India-specific school-based tobacco-prevention studies from nearly 8,000 records screened, highlighting the relatively limited intervention evidence available for the country [9]. Our own school-based prevention activities in the Mathura region operate within this broader evidence gap and have not yet been evaluated using a formal controlled or prospective design.

Future programs should therefore move beyond the simple delivery of educational sessions and incorporate measurable outcomes, appropriate comparison groups where feasible, and follow-up assessments. Evaluation should determine whether improvements in knowledge and attitudes translate into reductions in tobacco initiation and use.

5. A Call for Ground-Level Enforcement Research

The central argument of this perspective is that strengthening tobacco-control implementation should be considered a major priority alongside continued legislative and educational efforts. India has already established important statutory protections for adolescents through COTPA and related tobacco-control measures. The challenge is to determine how consistently these protections are implemented in the environments where adolescents encounter tobacco products.

This does not mean that legislation is irrelevant or that no further regulatory development is required. Rather, implementation research should receive greater attention so that existing provisions can be assessed, enforced, and refined on the basis of empirical evidence.

Several priorities emerge from the available evidence and our field experience. First, region-specific vendor compliance studies are needed in comparatively under-studied areas such as Mathura and Agra. Second, prevalence surveys should use standardized, product-specific definitions that include tobacco-containing dentifrices and other potentially overlooked sources of exposure. Third, school-based prevention programs should be formally evaluated rather than relying on assumptions about effectiveness. Fourth, prevention strategies should incorporate families and community environments alongside adolescents themselves.

The most effective approach is therefore unlikely to be a choice between legislation, enforcement, and education. Rather, adolescent tobacco control requires coordination across these levels. Legislative protections establish the framework; enforcement determines whether those protections are implemented; schools provide an important setting for prevention; and families and communities shape the social environment in which adolescents make behavioral choices.

For North India, particularly in areas where region-specific evidence remains limited, the next stage of tobacco-control research should move closer to the point at which policy meets everyday behavior: the local retailer, the school environment, the household, and the adolescent. Generating evidence at these levels may provide a more practical foundation for translating existing tobacco-control protections into meaningful reductions in adolescent tobacco exposure and initiation.

In conclusion, our perspective is informed by direct clinical and field-based engagement with adolescents in North India, complemented by evidence from the broader tobacco-control literature. This experience highlights an important distinction between the existence of legal protections and their implementation in the environments where adolescents encounter tobacco products. India has established a legislative framework intended to restrict adolescent access to tobacco; the remaining challenge is to ensure that these protections are consistently implemented and experienced at the community level.

Future efforts should therefore complement legislative measures and school-based education with stronger implementation research and enforcement strategies. Particular attention should be given to point-of-sale compliance, tobacco-containing dentifrices, household exposure, and the evaluation of locally adapted prevention programs. Strengthening evidence in these areas may help translate existing legal protections into more effective protection of adolescents from tobacco exposure and initiation.

Conflict of Interest

The authors declare no conflict of interest.

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