

MAY 2026

NEPAL'S TOBACCO LANDSCAPE

2026

Challenges and
Future Directions



73

NEPALI DIE
EVERY DAY
from tobacco use.



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Nepal's Tobacco Landscape 2026:

Challenges and Future Directions

NEPAL DEVELOPMENT RESEARCH INSTITUTE (NDRI)

SANEPA , LALITPUR

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Foreword

Tobacco use remains one of Nepal's most pressing public health and developmental challenges. Despite notable policy advances—including the Tobacco Product (Control and Regulatory) Act, repeated tax adjustments, and graphic health warnings—our national burden of tobacco-related morbidity, mortality, and economic loss continues to be unacceptably high.

This report, *Nepal's Tobacco Landscape 2026: Challenges and Future Directions*, is the result of a systematic review of current evidence, policy implementation gaps, and emerging trends. It assesses the escalating health burden of tobacco-attributable diseases, identifies gaps in enforcement and compliance, evaluates the reach and effectiveness of cessation services, and estimates the economic toll on households—while drawing on recent health expenditure data to highlight the opportunity cost of tobacco use within Nepal's constrained public health budget.

I extend my sincere appreciation to the research team at NDRI and all collaborating partners who contributed their expertise and field insights. I hope this report will serve as a practical reference for policymakers, civil society, and development partners—guiding evidence-based decisions toward a tobacco-free Nepal.

Shikha Thapa Magar, PhD

Executive Director

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Subject: Foreword

Tobacco use remains one of Nepal's most pressing public health challenges, killing 73 people every day and costing the economy up to NPR 57 billion annually. Despite notable progress in reducing smoking prevalence over the past two decades, the overall burden of tobacco-related disease, death, and economic loss remains unacceptably high. Disparities by gender, geography, and income persist, and vulnerable populations – including the poor, women, and adolescents – continue to bear the heaviest toll.

The National Health Education, Information and Communication Center (NHEICC) is committed to translating strong tobacco control policies into effective public awareness and community action. This report, Nepal's Tobacco Landscape 2026: Challenges and Future Directions prepared, provides a rigorous evidence base to guide our efforts. I sincerely appreciate Nepal Development Research Institute (NDRI) for their meticulous research and commitment to generating evidence that informs national policy. It highlights critical enforcement gaps, industry interference, and the urgent need for accessible cessation services. The findings underscore that without multi sectoral coordination, sustained communication campaigns and community engagement, even the best laws will fail to achieve their intended impact.

I call upon all stakeholders federal, provincial, and local governments, civil society, and development partners to act decisively. The path to a tobacco-free Nepal requires political will, sustained investment, and unwavering commitment. The time to act is now.

Dr. Radhika Thapaliya

Director

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Finally, we acknowledge the various government agencies, international organisations, and research institutions whose published reports, surveys, and datasets formed the foundation of this analysis. Their collective work made this synthesis possible.

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Acronyms

AOR	Adjusted Odds Ratio
BS	Bikram Sambat (Nepali calendar year)
CBS	Central Bureau of Statistics
CI	Confidence Interval
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DALY	Disability-Adjusted Life Year
FCTC	Framework Convention on Tobacco Control
FCHV	Female Community Health Volunteer
GDP	Gross Domestic Product
GTII	Global Tobacco Industry Interference Index
HRTCN	Health Rights and Tobacco Control Network Nepal
IHD	Ischaemic Heart Disease
JNMA	Journal of Nepal Medical Association
KMC	Kathmandu Metropolitan City
LMIC	Low- and Middle-Income Country
MER	Monthly Expenditure Report
MoHP	Ministry of Health and Population
MoHFS	Ministry of Health and Food Safety
MPOWER	WHO tobacco control monitoring framework (Monitor, Protect, Offer, Warn, Enforce, Raise)
NCD	Non-Communicable Disease
NDRI	Nepal Development Research Institute
NMIS	Nepal Multiple Indicator Cluster Survey
NPR	Nepalese Rupee
NRT	Nicotine Replacement Therapy
OPMD	Oral Potentially Malignant Disorder
PMT	Pan Masala containing Tobacco
SHS	Second-Hand Smoke

Acronyms

SLT	Smokeless Tobacco
SSF	Social Security Fund
STEPS	WHO STEPwise approach to surveillance
TDS	Tax Deducted at Source
WHO	World Health Organization

Executive Summary

Tobacco use remains one of Nepal's most pressing public health and economic challenges in 2026. Despite notable progress in reducing smoking prevalence over the past two decades—from 34.0% in 2000 to 14.9% in 2024—the overall burden of tobacco-related disease, death, and economic loss remains unacceptably high. An estimated 3.1 million adults currently smoke, while smokeless tobacco use is even more widespread, affecting 18.9% of the population. Tobacco accounts for approximately 15.6% of all deaths nationwide, equivalent to 73 deaths every day, and costs the country between NPR 44 billion and NPR 57.67 billion annually in healthcare expenses and lost productivity.

The epidemiological profile reveals stark disparities. More than two in five men (41.8%) use tobacco compared to only 5.1% of women. Prevalence is highest in Karnali Province (47.8%) and among the poorest income quintile (54.1%). Alarming, 7.6% of males smoke their first cigarette before age 15, underscores the need for targeting adolescence through awareness programme. The health consequences are severe: tobacco-related cancers account for 35.3% of all cancers in men, oral cancer is the second most common cancer nationally, and chronic obstructive pulmonary disease affects 11.7% of the population, with smoking as a primary risk factor.

The economic burden is immense. Direct healthcare costs for tobacco-related diseases consume a large share of the health budget, while productivity losses represent over half of the total economic cost of tobacco consumption. Treatment for tobacco-related cancer costs nearly NPR 1 million per patient, with one-sixth of patients forced to sell property to finance treatment and care. Even after accounting for NPR 31.2 billion in annual tobacco tax revenue, Nepal suffers a net annual loss of approximately NPR 13 billion. Raising tobacco taxes to the WHO-recommended level of 75% of retail price could generate NPR 8–17 billion in additional annual revenue while reducing consumption by 4–13%, yielding substantial health and economic benefits.

Nepal has established a strong legal framework, including the Tobacco Products (Control and Regulatory) Act, 2068 (2011), and the world's first directive requiring 100% pictorial health warnings on tobacco packaging in 2025. However, the implementation of these regulations remains inadequate. "Compliance with the Act in Kathmandu Valley is only 33.1%, with eateries showing just 15.9% compliance. Only 14.7% of retailers comply with the ban on sales to minors, and only 5.8% restrict single-stick sales. Public smoking violations are widespread, local governments lack capacity and resources, and the tobacco

industry continues to exert significant influence, reflected in Nepal's high score of 43 on the Global Tobacco Industry Interference Index. Court challenges have further stalled key measures, including the 100% health warning directive.

Public awareness of tobacco's health effects remains incomplete, particularly regarding smokeless tobacco and second-hand smoke. Exposure to second-hand smoke affects 33.5% of adults at home and 22.5% at work. Cessation services are largely absent from primary care, and nicotine replacement therapy remains partially regulated by law, depriving users of evidence-based treatment. Mass media campaigns and community-based interventions are underutilised, and the network of over 52,000 Female Community Health Volunteers has not been systematically trained in cessation counselling.

In conclusion, Nepal has made commendable progress in policy development and reducing smoking prevalence, but the tobacco epidemic persists due to weak enforcement, industry interference, inadequate cessation support, and gaps in public awareness. Decisive action is urgently required to close the implementation gap, protect youth, reduce health and economic burdens, and move Nepal toward a tobacco-free future.

1. Introduction: The Tobacco Epidemic in Nepal

Tobacco use remains one of the most pressing public health challenges in Nepal. Despite significant progress in reducing smoking prevalence over the past two decades—from 34.0% in 2000 to 14.9% in 2024—tobacco continues to cause widespread disease, premature death, and economic loss. Both smoked products such as cigarettes and bidis, and smokeless forms including gutkha, khaini, and paan masala, are deeply embedded in Nepali society, with consumption patterns varying by gender, age, geography, and income (NDRI, 2024; WHO, 2025).



Figure 1: Overview of Tobacco use in Nepal

Every year, thousands of Nepalis die from tobacco-related illnesses. In 2021, smoking alone caused over 28,000 deaths, while more recent estimates show that tobacco use accounts for approximately 15.6% of all deaths nationwide (WHO, 2025). The economic burden is equally severe, with Nepal spending an estimated NPR 12.2 billion annually on treating tobacco-related non-communicable diseases, costs borne both by the government and by affected households (Generations Sans Tabac, 2026).

The Government of Nepal has taken important legislative steps to address this crisis. It has adopted the WHO Framework Convention on Tobacco Control, enacted the Tobacco Products (Control and Regulatory) Act (2011), and introduced the world’s only requirement that health warnings cover 100% of both the front and back of tobacco packs

(Generations Sans Tabac, 2026). These measures position Nepal as a regional leader in tobacco control legislation. However, weak enforcement, high levels of tobacco industry interference, and gaps in implementation continue to undermine their effectiveness. The 2025 Global Tobacco Industry Interference Index ranks Nepal among countries with high industry influence (Generations Sans Tabac, 2026).

Against this backdrop, Nepal in 2026 faces both challenges and opportunities. This report presents the latest evidence on tobacco prevalence and trends, analyses the health and economic impacts, reviews current policies and enforcement gaps, and identifies pathways to accelerate progress toward a tobacco-free Nepal. The findings underscore that while the policy framework is strong, decisive action is urgently needed to close the gap between legislation and implementation, protect vulnerable populations, and reduce the devastating toll of tobacco on health and development.

2. Epidemiology and Prevalence of Tobacco Use in Nepal

2.1 Current Prevalence Estimates

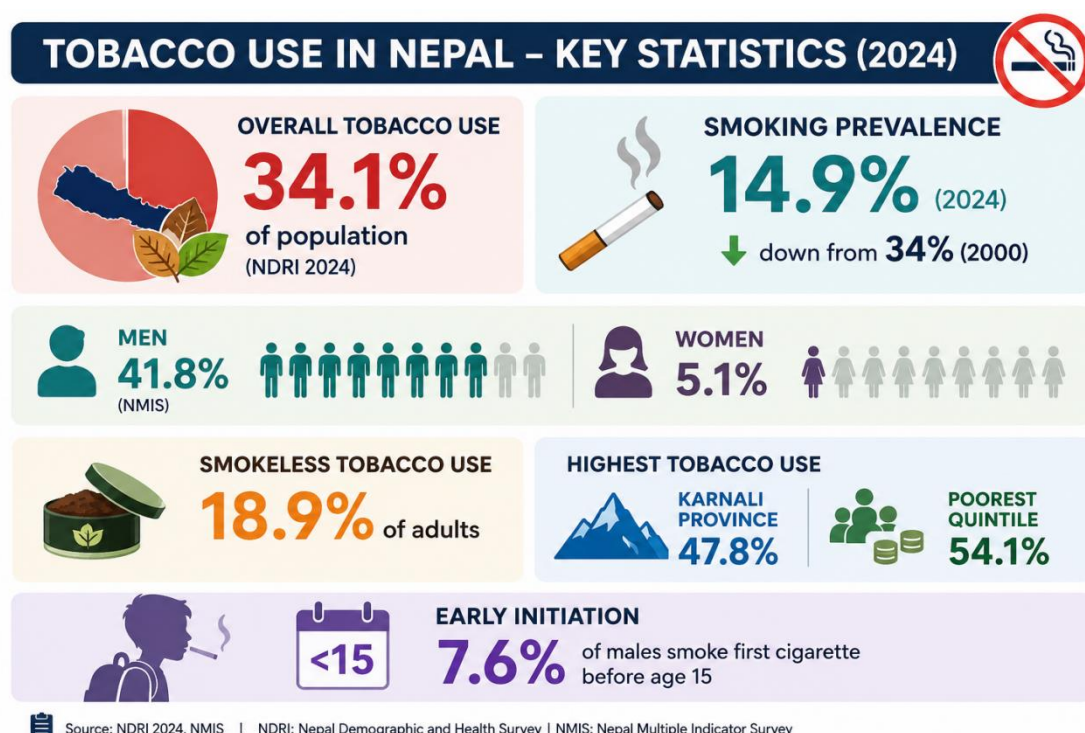


Figure 2: Prevalence of Tobacco use in Nepal

Several nationally representative surveys provide a comprehensive picture of tobacco use in Nepal. The most recent include the Nepal Development Research Institute (NDRI) survey (2024), the Nepal Multiple Indicator Cluster Survey (NMIS) 2081/82 (2025–26), the WHO STEPS survey (2019), and the WHO Global Report on Trends in Tobacco Use (2025). Together, these sources highlight the scale, trends, and disparities in tobacco consumption across the country.

Nepal Development Research Institute (NDRI) Survey 2024

The NDRI survey reported that 34.1% of Nepal's population uses tobacco in some form, an increase from 31.8% in 2020. Among users, 10.7% smoke only, 18.9% use smokeless tobacco only, and 4.5% use other forms. Gender differences are stark: 55.8% of men use tobacco compared to 11.2% of women. Tobacco use rises with age, reaching 56.7% among those aged 55–69 years. Karnali Province has the highest prevalence at 47.8%, while the poorest income quintile records the highest usage rate at 54.1%. Early initiation is common, with 17.9% of young people aged 15–24 already using tobacco (NDRI, 2024).

National Multiple Indicator Survey (NMIS) 2081/82 (2025–26)

The NMIS found that among the population aged 15–49 years, 41.8% of men and 5.1% of women had used tobacco in the month before the survey. Alarming, 7.6% of males and 2.1% of females smoked their first cigarette or bidi before the age of 15, underscoring the early onset of tobacco addiction in Nepal (CBS, 2026).

WHO STEPS Survey 2019

The WHO STEPS survey reported that 28.9% of adults aged 15–69 years used tobacco in any form, with 17.1% smoking and 18.3% using smokeless tobacco. Daily smoking prevalence was 13.3% overall, with 20.7% among men and 6.7% among women. The mean age of smoking initiation was 17.8 years (WHO, 2019).

WHO Global Report on Trends in Tobacco Use 2025

Long-term trend data show that adult smoking prevalence (age 15+) declined from 34.0% in 2000 to 20.5% in 2019, and further to 14.9% in 2024. Male smoking prevalence stood at 26.1% and female prevalence at 5.2% in 2024. The estimated number of smokers aged 15+ fell from approximately 4.0 million in 2019 to 3.1 million in 2024. Nepal is recognised as one of three countries in the WHO South-East Asia Region on track to achieve a 30% relative reduction in tobacco use by 2025 (WHO, 2025).

2.2 Trends Over Time

The graph below illustrates the decline in adult smoking prevalence in Nepal from 2000 to 2025, based on WHO data.

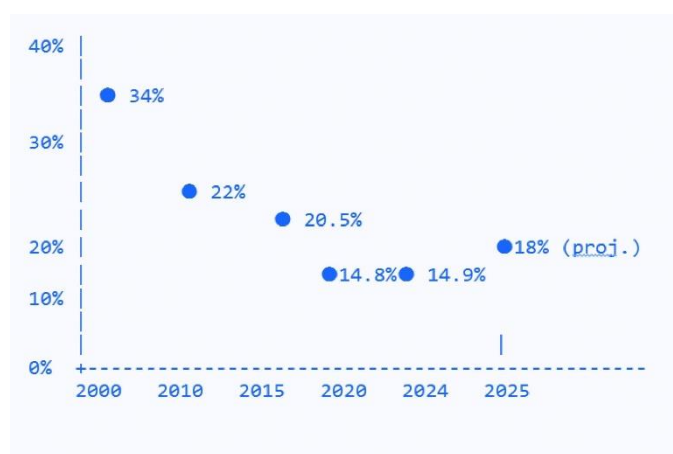


Figure 3: Adult Smoking Prevalence in Nepal (2000–2025)

Note. Data from WHO (2025). The 2025 value is a projection; the most recent estimate for 2024 is 14.9%.

Tobacco use in Nepal remains widespread, with significant disparities by gender, age, geography, and income. While long-term trends show a decline in smoking prevalence, overall tobacco use—including smokeless forms—remains high, particularly among men, older populations, and the poorest households. Early initiation among adolescents highlights the urgent need for stronger prevention, enforcement, and awareness measures to protect future generations.

2.3 Summary of Key Prevalence Estimates

Survey	Year	Population	Any tobacco use	Smoking only	Smokeless only
NDRI (2024)	2024	All ages	34.1%	10.7%	18.9%
NMIS (CBS, 2026)	2025–26	15–49 years	41.8% (M), 5.1% (F)	—	—
WHO STEPS (WHO, 2019)	2019	15–69 years	28.9%	17.1%	18.3%
WHO Global (WHO, 2025)	2024	15+ years	—	14.9%	—

Note. M = male; F = female. Dashes indicate data not reported.

3. Health Impact of Tobacco Use

Tobacco use is one of the leading causes of preventable disease, disability, and death in Nepal. It directly contributes to a wide range of non-communicable diseases (NCDs), including cancers, cardiovascular diseases, and chronic respiratory conditions, and also imposes substantial health burdens on non-smokers through second-hand smoke exposure. This section examines the multifaceted health consequences of tobacco consumption in Nepal.

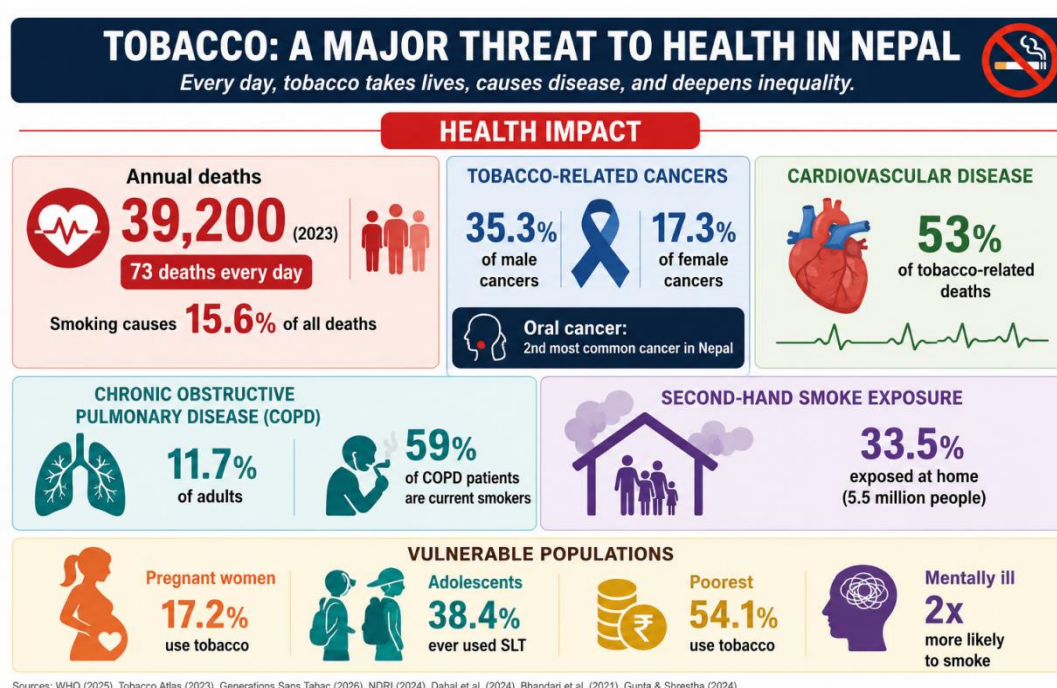


Figure 4: Health Impact of Tobacco use in Nepal

3.1 Mortality

Tobacco use continues to be a serious public health challenge in Nepal, with mortality rates rising sharply in recent years. In 2019, smoking-related illnesses were estimated to cause approximately 24,800 deaths nationwide (Generations Sans Tabac, 2026). By 2021, tobacco use accounted for 11.13% of all deaths in the country—12.65% among men and 9.2% among women—amounting to 28,110 deaths (WHO, 2025). More recent estimates highlight a sharp increase: tobacco use contributed to 15.64% of all deaths in 2023, including 17.88% of male deaths and 13.01% of female deaths (The Tobacco Atlas, 2023).

By the same year, the toll had surged to nearly 39,200 deaths (Generations Sans Tabac, 2026).

National estimates further underscore the scale of the crisis. Tobacco-induced diseases are responsible for 37,529 deaths annually, representing 19.02% of total national deaths—equivalent to 73 tobacco-related deaths every day (NDRI, 2024). This places Nepal among the countries with the highest proportions of tobacco-attributable mortality globally.

The gravity of the situation is compounded by Nepal's epidemiological transition. Non-communicable diseases, for which tobacco is a major modifiable risk factor, now account for nearly two-thirds of all deaths, compared to about 60% in 2014 (Dahal et al., 2021). Although the Global Burden of Disease Study (1990–2017) documented a 34% decline in age-standardised tobacco-attributable mortality rates, the absolute number of deaths has remained persistently high due to population growth, ageing, and sustained tobacco consumption (Shrestha et al., 2021).

3.2 Cancer Burden

Tobacco use is a leading driver of Nepal's cancer burden, with strong associations to multiple preventable malignancies. Tobacco-related cancers account for 35.3% of all cancers among men and 17.3% among women (Dahal et al., 2024). The risk is significant: one in every 36 men and one in every 65 women in Nepal is projected to develop a tobacco-related cancer before the age of 75. The most common malignancies linked to tobacco include cancers of the lung, oral cavity, oesophagus, and larynx.

The burden is particularly pronounced in urban areas, where age-adjusted incidence rates reach 33.6 per 100,000 among men and 17.0 per 100,000 among women, exceeding those in semi-urban and rural settings (Dahal et al., 2024). Mortality rates from tobacco-related cancers are disproportionately high relative to incidence, reflecting systemic challenges such as delayed diagnosis, limited screening, and inadequate access to timely treatment services.

Oral cancer represents a critical public health concern in Nepal, driven by widespread use of smokeless tobacco and areca nut products. Products such as gutkha, khaini, paan masala, and areca nut mixtures are strongly implicated in oral potentially malignant disorders (OPMDs) and oral cancer. Oral cancer is currently the second most common cancer in

Nepal and the sixth leading cause of cancer-related deaths (Bhandari et al., 2021). Data from Lumbini Province revealed that 39.28% of oral mucosal lesions were attributable to tobacco use (Gupta & Shrestha, 2024). Areca nut chewing—with or without tobacco—has been identified as one of the strongest risk factors for OPMD and oral cancer in Nepal (Rimal et al., 2019).

The link between tobacco and lung cancer is equally compelling. Increased frequency and duration of smoking are associated with progressively higher risks of lung cancer across ethnic groups. Both traditional and commercial tobacco products contribute significantly to Nepal's lung cancer burden (Raspanti et al., 2022).

3.3 Cardiovascular and Respiratory Disease

Cardiovascular disease (CVD) is the leading cause of death in Nepal, with tobacco use identified as a major modifiable risk factor driving this burden. Approximately 53% of all tobacco-related deaths in the country are attributable to cardiovascular diseases. Ischaemic heart disease (IHD) remains the primary cause of morbidity and mortality among cardiac patients, with tobacco use, hypertension, family history, and age recognized as significant risk factors (Aryal et al., 2015). Smoking and hypertension are among the most important contributors to CVD, though the relationship between cigarette smoking and blood pressure in Nepali adults remains complex (Shrestha et al., 2021). In addition, the widespread consumption of pan masala containing tobacco (PMT) contributes to oxidative stress, a condition linked to cardiovascular disease, peripheral vascular disease, hypertension, peptic ulcer, and fetal morbidity and mortality (Khanal et al., 2018).

Chronic respiratory disease represents another major health consequence of tobacco use in Nepal, with Chronic Obstructive Pulmonary Disease (COPD) emerging as a significant public health threat. COPD is the second leading cause of death, the fourth leading cause of premature death, and the third leading cause of disability-adjusted life years (DALYs) lost in Nepal (Karki et al., 2021). National prevalence is estimated at 11.7%, with cigarette smoking identified as a key risk factor, alongside old age, low education, low BMI, ethnicity, and provincial differences (Karki et al., 2021). Evidence shows that 59.4% of COPD patients are current smokers and 28.5% are former smokers (Budhathoki et al., 2022). Early initiation of tobacco use further increases risks, contributing to respiratory illnesses, asthma, reduced lung function, and COPD. Chronic respiratory diseases account for approximately 21% of all tobacco-related deaths in Nepal (Karki et al., 2024).

3.4 Second-Hand Smoke Exposure and Risk

Second-hand smoke (SHS) exposure remains a major public health concern in Nepal, disproportionately affecting non-smokers—particularly women and children—who are involuntarily exposed to toxic chemicals in tobacco smoke. SHS contains more than 7,000 chemicals, including 70 known carcinogens such as hydrogen cyanide and arsenic, and is harmful in any amount.

National surveys highlight the scale of the problem. One in three adults (33.5%) are exposed to SHS at home, while 22.5% of adults—equivalent to 3.7 million people—face exposure in the workplace (WHO, 2019). The WHO Representative to Nepal emphasized in 2021 that “nearly one in two men consume some form of tobacco products. One in three are exposed to secondhand smoke at home” (WHO, 2021). Overall, an estimated 5.5 million people in Nepal are exposed to SHS in their homes.

The health consequences of SHS exposure are severe, contributing to heart disease, lung cancer, and stroke in adults, as well as Sudden Infant Death Syndrome (SIDS), respiratory illnesses, and ear infections in children. Globally, SHS exposure is responsible for 1.2 million deaths annually (WHO, 2021).

Despite regulations mandating smoke-free public spaces, enforcement remains weak. Compliance levels are low, with reports showing only 56.4% adherence in Biratnagar Metropolitan City, and particularly poor compliance in restaurants (26.3%) and shopping centres (Basnet et al., 2022). Observations across seven provincial headquarters further revealed that 40% of public places had visible tobacco use in outdoor spaces, and 76% were selling tobacco products within 100 metres of public premises (Shakya et al., 2024).

3.5 Vulnerable Populations

Tobacco use in Nepal affects certain populations more severely, creating significant health and social inequities.

Women and Pregnant Women: Tobacco use among women in Nepal is higher than in many other South Asian countries (Khanal et al., 2021). National data show that tobacco use during pregnancy remains a serious concern, with prevalence reaching 17.2% in some regions. Despite this, only a small proportion of women receive cessation advice from health workers (Barakoti et al., 2017). Contributing factors include illiteracy, higher parity,

alcohol use during pregnancy, and the presence of tobacco users in the household (Barakoti et al., 2017). In the Terai region, one in five pregnant women use tobacco in some form, with smokeless tobacco use particularly common (Singh et al., 2017). Women from Dalit, Adibasi, Janajati, and hill-origin communities, as well as those with limited education, are disproportionately affected. Tobacco use during pregnancy is linked to maternal and infant mortality, low birth weight, preterm birth, stillbirth, and congenital heart disease (Christian et al., 2004; Shrestha, 2022).

Children and Adolescents: Adolescents are highly vulnerable to tobacco initiation, which increases risks of respiratory illness, asthma, COPD, reduced lung function, and cancers (Karki et al., 2024). Surveys among secondary school students show that nearly 38.4% had tried smokeless tobacco, with 29.5% reporting current use. Most initiation occurs between ages 10–14, with homes and public places serving as common sites of use. Paan masala and gutkha are the most preferred products (Karki et al., 2024). The mean age of initiation nationally has been reported as just 13.38 years (Bhaskar et al., 2016). Male students, those attending private schools, and adolescents with limited exposure to prevention programs are at higher risk.

Low-Income and Marginalised Populations: Tobacco use prevalence is highest among the poorest income quintile, with rates exceeding 54% (NDRI, 2024). Lower-income groups, individuals with limited education, and marginalized ethnic communities—including Dalit and Janajati—bear a disproportionate burden of tobacco-related disease. These populations also face significant barriers in accessing healthcare services for tobacco-related illnesses, further exacerbating health inequities (NDRI, 2024).

People with Mental Illness: Individuals living with mental illness are nearly twice as likely to smoke compared to the general population, a pattern reflected in Nepal (Tobacco Atlas, 2023). Evidence shows a dose-response relationship between smoking and suicidal ideation among young people, with risk increasing alongside the number of cigarettes smoked per week (Sathian et al., 2020).

4. Economic Burden of Tobacco

Tobacco use imposes a substantial economic burden on Nepal, encompassing direct healthcare costs, indirect productivity losses, and foregone opportunities for economic development. Quantifying these costs is essential to strengthen the case for comprehensive tobacco control policies.

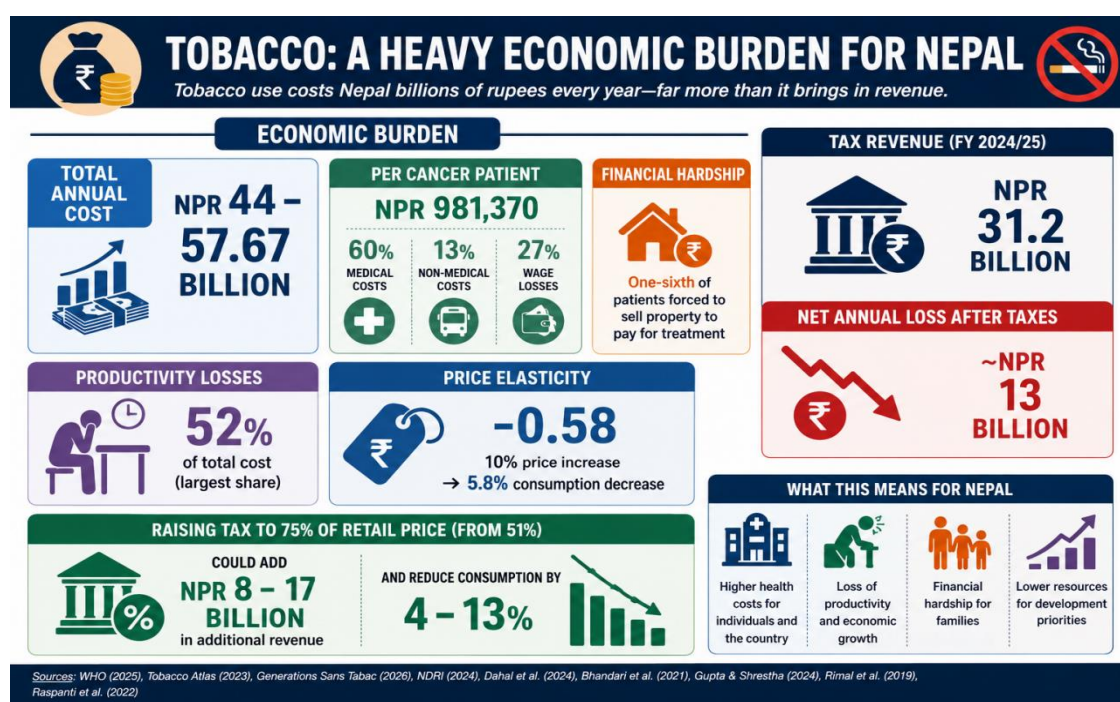


Figure 5: Economic Burden of Tobacco use in Nepal

4.1 Healthcare Costs

The direct healthcare costs of treating tobacco-related diseases in Nepal are significant and continue to rise. The cost of treating tobacco-related cancer has been estimated at NPR 9,81,370 per patient, with direct medical costs accounting for 60%, non-medical costs such as travel and accommodation contributing 13%, and wage loss from illness representing 27% of the total (Chand et al., 2023). Alarming, one-sixth of patients are forced to sell property to finance treatment, disproportionately affecting vulnerable populations with low literacy and limited education.

Among reproductive-aged women, tobacco use is strongly linked to health problems including hypertension, low birth weight, premature birth, asthma, and diabetes. Annual health expenditures for this group remain below NPR 10,000 for the majority, yet morbidity and smoking expenditures show significant associations with age (Gautam, 2025).

At the national level, the annual cost-of-illness attributable to smoking is estimated at NPR 32.8 billion, including direct healthcare expenditures and indirect costs from lost productivity due to illness and premature death (The Tobacco Atlas, 2023). Despite a 34% decline in age-standardised tobacco-attributable mortality rates between 1990 and 2017, the absolute number of deaths remains high due to population growth and sustained tobacco consumption (Shrestha et al., 2021).

4.2 Productivity Losses

The indirect costs of tobacco use—loss of productivity due to illness, disability, and premature death—represent an even larger share of the total economic burden than healthcare costs. Wage loss from illness accounts for more than one-quarter of the total cost per tobacco-related cancer patient (Chand et al., 2023). Tobacco-related diseases often strike individuals during their most productive years, amplifying the economic toll on households and the national economy.

Smoking is also associated with reduced quality of life, including poorer physical health, psychological well-being, social relationships, and environmental health, all of which translate into diminished productivity (Sagtani et al., 2019). The Tobacco Atlas estimates the annual cost-of-illness attributable to smoking at NPR 32.8 billion, while broader estimates place the total economic cost of tobacco use in Nepal at approximately NPR 57.67 billion annually in healthcare expenses and lost productivity.

4.3 Projected Savings from Effective Tobacco Control

Evidence demonstrates that effective tobacco control measures, particularly tax increases, can generate substantial savings and additional revenue while reducing consumption and saving lives. Price elasticity of demand for cigarettes in Nepal has been estimated at -0.58 , indicating that consumption decreases with price increases, while expenditure elasticity of 1.06 suggests demand is more responsive to income changes (Sapkota et al., 2026).

Global evidence confirms that tobacco tax increases and cessation counselling are among the most cost-effective interventions, with tax increases consistently identified as one of the most powerful policy tools (Jiang et al., 2022). Increasing tobacco taxes in Nepal would not only reduce consumption, particularly among youth and low-income groups, but

also provide sustainable financing for health insurance and government subsidies to protect households from poverty (Chand et al., 2023).

The Global Burden of Disease analysis reinforces this conclusion, showing that while Nepal has made progress in reducing tobacco use, continued investment in tobacco control policies is essential to further reduce the burden (Shrestha et al., 2021).

Summary Table: Economic Burden of Tobacco in Nepal

Category	Key Findings	Source
Healthcare Costs (per cancer patient)	Total NPR 9,81,370 (60% direct medical, 13% non-medical, 27% wage loss)	Chand et al. (2023)
Morbidity among reproductive-aged women	83.6% reported smoking-attributable health problems; annual health expenditure < NPR 10,000 for 83.3%	Gautam (2025)
Productivity Losses	Wage loss accounts for 27% of total cancer cost; significant negative association with quality of life	Chand et al. (2023); Sagtani et al. (2019)
Total Annual Cost	NPR 32.8–57.67 billion (healthcare + lost productivity)	Tobacco Atlas
Price Elasticity of Cigarette Demand	−0.58 (95% CI: −0.79, −0.37)	Sapkota et al. (2026)
Cost-Effective Interventions	Tax increases and cessation counselling	Systematic review (Jiang et al., 2022)

5. Public Awareness and Tobacco Cessation

The Ministry of Health and Food Safety (MoHFS), with technical and advocacy support from the National Health Education, Information and Communication Center (NHEICC), has continued to strengthen tobacco control measures through public awareness campaigns, warning label revisions, and policy advocacy.

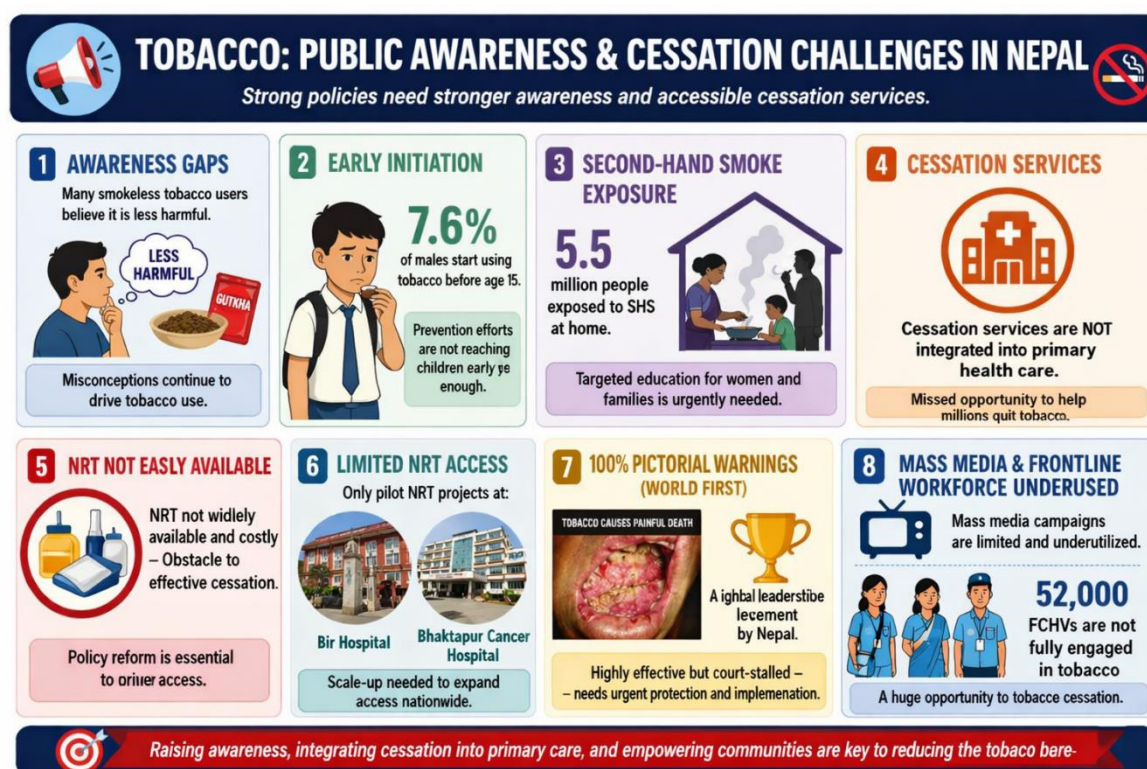


Figure 6: Public Awareness and Cessation Services on Tobacco use in Nepal

5.1 Awareness of Health Effects

Public awareness of the health risks of tobacco is a critical driver of behaviour change. In Nepal, 28.9% of adults aged 15–69 years use tobacco in some form, with 17.1% smoking and 18.3% using smokeless tobacco (WHO, 2019). Despite this high prevalence, many users—particularly those consuming smokeless tobacco (SLT)—perceive these products as less harmful than cigarettes. In reality, SLT is strongly linked to oral cancer, which is the second most common cancer in Nepal and the sixth leading cause of cancer deaths (Bhandari et al., 2021).

Awareness gaps are most pronounced among youth, women, and populations with low literacy. National data show that 7.6% of males and 2.1% of females had smoked their first

cigarette or bidi before age 15, indicating that prevention messages are not reaching adolescents early enough (CBS, 2026). Women, who have lower tobacco use rates (5.1%) but are disproportionately exposed to second-hand smoke at home, often lack access to tailored health information. Nepal's pioneering 100% pictorial health warnings on all tobacco packaging help overcome literacy barriers, but their effectiveness depends on consistent enforcement and complementary education (Vital Strategies, 2025).

5.2 Cessation Services and Behavioural Support

Despite the high burden of tobacco-related disease, cessation services are not yet fully integrated into routine primary care in Nepal. Many Primary health centres still lack trained personnel with standardised protocols, and patient demand for cessation support (Elsey et al., 2016). Nicotine replacement therapy (NRT) in the form of nicotine chewing gums was distributed in Bir Hospital and Bhaktapur Cancer Hospital as a pilot from National Health Education, Information and Communication Centre with support from WHO (WHO, 2023) but this service could not continue after stock out of Medicines. Nicotine gums itself is quite expensive, not easily available in all pharmacies but is a cost effective intervention and yet to be included in free medicine list to incorporate into primary health care services. Cytisine, a low-cost cessation medication, is under evaluation for tuberculosis patients but is not widely accessible. Meanwhile, nicotine pouches and related products are increasingly sold through grocery stores and informal retail channels without clear regulatory oversight. For tobacco dependence treatment, pharmacotherapies such as cytisine and bupropion are internationally recognized cessation medicines, although access and pharmacy availability in Nepal remain limited.

National Health, Education, Information and Communication Centre (NHEICC) is currently leading tobacco cessation efforts in Nepal- operates the country's Tobacco quit line (1132) and counselling services. Nepal Cancer Relief Society (NCRS), also provides similar services. Both centers providing counseling during office hours, despite rising demand for cessation support. the number of staff need to be increased with appropriate training and service made available out of office hours as well.

Barriers to cessation include the high cost of NRT relative to local incomes, limited insurance coverage, and the absence of systematic training for Female Community Health Volunteers (FCHVs). However, opportunities exist: training over 52,000 FCHVs in cessation counselling, integrating cessation services into the government's health insurance

scheme, and expanding mobile-based programmes such as text-message reminders could dramatically increase access.

5.3 Mass Media Campaigns and Behaviour Change Communication

Mass media campaigns are cost-effective tools to increase quit attempts and reduce smoking prevalence. Nepal's 100% pictorial health warnings act as a continuous, low-cost campaign reaching every user with every purchase (Vital Strategies, 2025). However, conventional television and print campaigns miss large segments of the population, particularly women in Madhesh Province who have limited access to mass media (MoHP, 2022).

Evidence shows that sustained mass media campaigns, combined with tax increases, have measurable impact. Following a 25% tax rise in 2022, government revenue increased by 20% and smoking prevalence declined, demonstrating the synergistic effect of fiscal policies and communication interventions (Health Rights and Tobacco Control Network Nepal, 2023).

Summary of Key Findings – Public Awareness and Cessation

Particular	Key Finding	Source
Awareness of health effects	28.9% of adults use tobacco; oral cancer is second most common cancer; 7.6% of males smoke before age 15	WHO (2019); (Bhandari et al., 2021); CBS (2026)
Cessation services	Cessation not integrated into primary care; NRT only at pilot sites	Elsey et al. (2016); WHO (2023)
Mass media campaigns	100% pictorial warnings effective; need for radio, FCHV counselling	Vital Strategies (2025); Health Rights and Tobacco Control Network Nepal (2023)

6. Legal and Policy Framework



Figure 7: Legal Framework of Tobacco Control

6.1 The Tobacco Product (Control and Regulatory) Act, 2068 (2011)

Nepal's most significant tobacco control measure is the Tobacco Products (Control and Regulatory) Act, 2068 (2011). The Act was introduced to reduce, control, and regulate the import, production, sale, distribution, and consumption of tobacco products (Government of Nepal, 2011). It prohibits advertising, promotion, and sponsorship of tobacco products in any form, including newspapers, electronic media, hoardings, signage, visuals, audio, and other mediums (MoHP, 2025). The Act also requires a license for the sale and distribution of tobacco products, with violations punishable under law (Government of Nepal, 2011; MoHP, 2025).

Despite this strong legal framework, compliance remains weak. Adherence to the Act in Kathmandu Valley has been reported at only 33.1%, with public transportation showing the highest compliance (53.2%) and eateries the lowest (15.9%). Health organizations demonstrated strong adherence to indoor smoking bans (94.7%), but "No Smoking" signage remains inadequate (Dhimal et al., 2025). Retailers near schools also show poor compliance, with 93.6% violating the ban on sales near educational facilities, and only 14.7% complying with the ban on sales to minors (Poudel et al., 2025).

6.2 Directive for Printing and Labelling of Warning Messages (2014 and 2025)

Nepal has pioneered tobacco packaging and labelling requirements under directives issued through the 2011 Act.

2014 Directive: Required pictorial health warnings covering 90% of the front and back of tobacco packaging (Government of Nepal, 2014).

2025 Directive: Introduced 100% pictorial health warnings, making Nepal the first country globally to mandate full coverage warnings (Vital Strategies, 2025). For cigarettes, 80% of the display area must contain pictorial warnings and 20% text; for chewing tobacco, 60% pictorial, 20% text at the top, and 20% text at the bottom; for bidi, the requirements mirror those for cigarettes. Packaging must use Pantone 448 C (dark brown), with brand names restricted to the underside of packs (Vital Strategies, 2025).

The directive was scheduled to take effect on 17 August 2025, but implementation was halted in November 2025 following a legal challenge from the tobacco industry. As of early 2026, its status remains uncertain pending court proceedings.

6.3 Additional Regulations

Sale near schools and hospitals: The 2011 Act prohibits sales within 100 metres of schools, hospitals, and childcare centres (Government of Nepal, 2011). Compliance remains poor, with most retailers near schools violating the provision (Poudel et al., 2025).

Kathmandu Metropolitan City ban: In September 2026, Kathmandu Metropolitan City imposed a complete ban on the storage, sale, distribution, and consumption of tobacco products across its 32 wards. The ban includes cigarettes, cigars, bidi, chewing tobacco, gutkha, and other products, with fines of NPR 100 for public smoking. Enforcement, however, remains inconsistent, and the ban has faced legal challenges.

E-cigarettes and vaping products: Nepal has taken a restrictive stance, interpreting the 2015 Tobacco Directive as prohibiting production, import, sale, distribution, and advertising of e-cigarettes. However, in July 2025, the Patan High Court ruled that the directive was not legally sufficient to justify a ban, creating ambiguity. Despite government assertions of prohibition, Nepal collected NPR 230 million in customs revenue from vape imports in FY 2023–24, leaving the legal status unresolved (Tobacco Reporter, 2025).

Nicotine Replacement Therapy (NRT): Nicotine Replacement Therapy (NRT) remains only partially regulated in Nepal. Nicotine chewing gum (2 mg and 4 mg) is available in the Nepalese market; however, other NRT products such as nicotine patches and nicotine pouches have not been formally approved or widely regulated by the Department of Drug Administration (DDA).

Summary of Key Legal Provisions

Regulation	Legal Basis	Status / Notes
Tobacco Products (Control and Regulatory) Act, 2068 (2011)	Government of Nepal (2011)	Primary law; compliance average 33.1% in Kathmandu Valley (Dhimal et al., 2025)
100% pictorial health warnings	Vital Strategies (2025)	Scheduled for 17 August 2025; under court challenge
Sale within 100m of schools/hospitals	Government of Nepal (2011)	Majority of retailers violate this provision (Poudel et al., 2025)
Kathmandu complete tobacco ban	KMC Municipal Council decision	Effective September 2026; enforcement inconsistent
E-cigarette/vape ban	2015 Directive (interpreted)	Court ruled ban lacked legal basis (Tobacco Reporter, 2025); status ambiguous

7. Policy Implementation and Enforcement Challenges

Nepal has enacted comprehensive tobacco control legislation, most notably the Tobacco Products (Control and Regulatory) Act, 2068 (2011). However, a persistent gap remains between policy provisions and their implementation. Despite legal prohibitions, tobacco consumption and sales continue largely unhindered due to weak enforcement. Awareness among retailers is limited, with only one-third familiar with the Act's provisions, while violations such as sales near schools and to minors remain widespread (Poudel et al., 2025). Compliance in urban centres such as Kathmandu Valley averages just 33.1%, with eateries showing the lowest adherence (Dhimal et al., 2025). These figures highlight systemic enforcement failures that undermine the effectiveness of Nepal's tobacco control framework.



Figure 8: Tobacco Control Enforcement Challenges in Nepal

7.1 Public Smoking Violations

The Tobacco Products (Control and Regulatory) Act prohibits smoking in all public places, including government offices, educational institutions, health facilities, public transport, hotels, restaurants, and bars (Government of Nepal, 2011). Despite this, public smoking remains common. Observations across provincial headquarters revealed tobacco use in 40%

of outdoor public areas, with inadequate signage—less than one-third of indoor areas and only 13% of outdoor areas displayed “No Tobacco” warnings (Shakya et al., 2024). Compliance was particularly low in tourist hotels, bus stops, and public toilets, while outdoor compliance lagged in provinces such as Madhesh, Bagmati, and Karnali.

Weak enforcement also extends to adolescent protection. Adolescents are frequently able to purchase tobacco without age verification, even while in school uniform, and are not prevented from smoking in public places (Shakya et al., 2021). MPOWER policies, including bans on public smoking and restrictions on sales to minors, are not strictly enforced, leaving young people vulnerable to tobacco initiation (Acharya et al., 2024). Rural municipalities face similar challenges, with significant implementation gaps requiring stronger enforcement combined with community engagement (KC et al., 2025).

7.2 Local Government Enforcement

Under Nepal’s federal structure, local governments play a central role in enforcing tobacco control laws. However, uneven capacity, limited technical expertise, and weak coordination hinder effective implementation (Poudel et al., 2025). Municipalities report challenges including regulatory gaps, limited government engagement, and inadequate monitoring mechanisms (Aryal et al., 2025; Dhimal et al., 2025). While graphic health warnings are widely recognized as effective, enforcement of restrictions on sales and public smoking remains inconsistent.

Key facilitators for stronger enforcement include dedicated inspection mechanisms, multi-sectoral coordination, and public awareness campaigns. Conversely, barriers include lack of empowered officials, insufficient monitoring, and the influence of tobacco industry networks. Nepal ranks among countries with high tobacco industry interference, with a score of 43 in the Global Tobacco Industry Interference Index 2025 (Generations Sans Tabac, 2026).

7.3 Sales to Minors

Nepal’s Tobacco Products (Control and Regulatory) Act, 2068 (2011) explicitly prohibits the sale and distribution of tobacco products to minors under 18 and to pregnant women (Government of Nepal, 2011). Despite these provisions, violations remain widespread. Compliance among retailers is extremely low, with only 14.7% adhering to the ban on sales to minors, meaning that more than 85% of retailers continue to sell tobacco illegally to children (Poudel et al., 2025). Adolescents report easy access to tobacco near schools,

with shopkeepers often selling to students in uniform without age verification, even when purchases are made on behalf of family members (Shakya et al., 2021). Retailers also sell tobacco to pregnant women, with over 50% found in violation of the law, and nearly all lacking signage prohibiting sales to minors (Gupta et al., 2022).

7.4 Single Stick Sales

The Act prohibits the sale of single cigarettes, small packs, and vending machine or internet sales (Tobacco Control Laws, 2021). Despite this, single-stick sales remain widespread. Over 94% of retailers near schools continue to sell loose cigarettes, undermining efforts to reduce consumption and making tobacco more affordable and accessible to minors (Poudel et al., 2025). Evidence shows that the illicit cigarette market in Nepal is minimal, with less than one in 200 packs found to be illicit, meaning enforcement failures—not smuggling—drive single-stick sales (Nepal Health Magazine, 2024).

7.5 Broader Implementation Barriers and Enforcement Gaps

Several systemic barriers hinder effective implementation of tobacco control policies in Nepal:

Low awareness among retailers and the public: Only one-third of retailers are aware of the Act's provisions, limiting compliance and reducing community monitoring of violations (Poudel et al., 2025).

Weak inspection and enforcement mechanisms: Compliance averages just 33.1% in Kathmandu Valley, with wide variation across establishments. District-level enforcement suffers from resource constraints and lack of monitoring systems (Dhimall et al., 2025).

Tobacco industry interference: Nepal ranks among countries with high industry influence, scoring 43 in the Global Tobacco Industry Interference Index 2025. Industry tactics include lobbying against tax increases, offering incentives to policymakers, and exploiting gaps in legislation (Generations Sans Tabac, 2026).

Legal challenges: Court rulings have stalled key measures, including the directive mandating 100% pictorial health warnings on packaging, leaving enforcement uncertain and weakening the Ministry of Health and Population's ability to act (Tobacco Reporter, 2025).

Summary of Key Enforcement Findings

Particular	Key Finding	Source
Public smoking violations	Tobacco use prevalent in 40% of outdoor public places; low compliance in tourist hotels, public toilets, bus stops; outdoor compliance low in Madhesh, Bagmati, Karnali	Shakya et al. (2024)
Local government enforcement	Average adherence to Tobacco Product Control Act in Kathmandu Valley only 33.1%; eateries lowest compliance at 15.9%	Dhimal et al. (2025)
Sales to minors	Only 14.7% of retailers comply with ban on sales to minors; shopkeepers sell to adolescents in school uniform without hesitation	Poudel et al. (2025); Shakya et al. (2021)
Single-stick sales	Only 5.8% of retailers restrict sale of loose cigarettes; single-stick sales prevalent; illicit market estimated at only 0.33%	Poudel et al. (2025); Nepal Health Magazine (2024)
Broader barriers	Only 33% of retailers aware of Act provisions; industry interference (GTIII score 43); court challenges to 100% health warnings	Poudel et al. (2025); Generations Sans Tabac (2026); Tobacco Reporter (2025)

8. Conclusion

The evidence presented in this report demonstrates that tobacco use in Nepal remains a major public health, economic, and social crisis. While the decline in smoking prevalence from 34.0% in 2000 to 14.9% in 2024 reflects important progress, the absolute burden of tobacco-related disease and death remains unacceptably high. Tobacco continues to kill 73 Nepalis every day, accounts for 15.6% of all deaths, and costs the economy up to NPR 57.67 billion annually. The burden falls disproportionately on the poor, the less educated, and marginalised populations, deepening existing health and economic inequities.

Nepal has established a strong legal and policy framework, including the Tobacco Products (Control and Regulatory) Act, 2068 (2011), and the world's first directive mandating 100% pictorial health warnings. These measures position Nepal as a regional leader in tobacco control legislation. However, weak enforcement undermines their effectiveness. Compliance with the Act remains alarmingly low, with only 33.1% adherence in Kathmandu Valley, 14.7% of retailers complying with the ban on sales to minors, and just 5.8% restricting single-stick sales. Public smoking is widespread, sales to adolescents continue unchecked, and local governments lack the capacity, resources, and political will to enforce the law effectively.

The tobacco industry exerts significant influence on policy decisions, reflected in Nepal's high score on the Global Tobacco Industry Interference Index. Court challenges have stalled key measures, including the 100% health warning directive, creating legal uncertainty and delaying implementation. Limited availability of nicotine replacement therapy—a globally recognized cessation tool—further denies tobacco users access to evidence-based treatment.

Public awareness of tobacco's health effects remains incomplete, particularly regarding smokeless tobacco and second-hand smoke. Cessation services are largely absent from primary care, and the potential of the Female Community Health Volunteer network remains untapped. Mass media campaigns and community-based interventions are underutilised, while youth initiation continues at concerning levels, with 7.6% of males smoking their first cigarette before age 15.

The economic case for stronger tobacco control is compelling. Raising taxes to the WHO-recommended level of 75% of retail price would generate NPR 8–17 billion in additional

annual revenue, reduce consumption by 4–13%, and yield substantial cost recovery. Effective tobacco control would reduce out-of-pocket healthcare expenditure, protect households from medical poverty, and free resources for other development priorities.

Nepal stands at a critical juncture. The policy framework is strong, but implementation is weak. Prevalence is declining, but the absolute burden remains high. Opportunities for progress exist, but industry interference and enforcement gaps persist. Without decisive action, the tobacco epidemic will continue to claim lives, drain the economy, and perpetuate inequities. Stronger enforcement, comprehensive cessation support, and fiscal measures are urgently needed to protect public health and secure Nepal's future development.

9. Recommendations

Based on the evidences, the following recommendations are proposed for federal, provincial, and local governments, as well as civil society and development partners.



Figure 9: Tobacco Control Recommendations

9.1 Taxation and Fiscal Policy

- Substantially increase tobacco taxes to reach the WHO-recommended level of 75% of the retail price. An immediate excise duty increase of 35–60% would generate NPR 8–17 billion in additional annual revenue while reducing consumption by 4–13% (Poudel et al., 2025; WHO, 2023).
- Earmark additional tobacco tax revenues for health promotion, cessation services, and health insurance expansion to create a sustainable financing loop.
- Simplify the tax structure by moving to a specific excise tax system based on the number of sticks, reducing opportunities for industry manipulation.
- Eliminate duty-free sales of tobacco products at airports and border points to close existing loopholes.

9.2 Enforcement and Compliance

- Establish dedicated tobacco control inspection units at the municipal level with clear mandates, trained personnel, and adequate resources (Poudel et al., 2025).
- Conduct regular inspections focusing on high-violation areas such as eateries, shops near schools, and public transport hubs (Dhimal et al., 2025).
- Enforce penalties consistently for public smoking, sales to minors, and single-stick sales, with public reporting of enforcement actions.
- Implement a licensing system for all tobacco retailers, banning sales within 100 metres of schools and health facilities, and revoke licences for repeat violators.

9.3 Protecting Youth and Preventing Initiation

- Strengthen enforcement of the ban on sales to minors through undercover inspections and strict penalties (Shakya et al., 2021).
- Ban single-stick sales through intensive enforcement and retailer education, as single sticks are a primary entry point for adolescent smokers (Poudel et al., 2025).
- Integrate comprehensive tobacco prevention education into school curricula from grade 6 onwards.
- Launch national media campaigns targeting youth, using social media, radio, and school-based events to counter industry marketing.

9.4 Cessation Services and Public Awareness

- Integrate cessation services into primary healthcare across all municipalities, including brief advice by health workers and access to nicotine replacement therapy (Else et al., 2016).
- Train Female Community Health Volunteers (FCHVs) to deliver brief cessation counselling at the household level.
- Launch national mass media campaigns highlighting the risks of smokeless tobacco and second-hand smoke (Vital Strategies, 2025).

9.5 Countering Industry Interference

- Implement FCTC Article 5.3 by adopting a code of conduct prohibiting interactions between policymakers and the tobacco industry, with mandatory disclosure of any contacts (Generations Sans Tabac, 2026).
- Prohibit tobacco industry corporate social responsibility activities in Nepal.
- Conduct public hearings and parliamentary inquiries into industry lobbying activities and their impact on health policy.

9.6 Strengthening the Legal Framework

- Resolve legal challenges to the 100% health warning directive and the Kathmandu Metropolitan City tobacco ban through judicial action or legislative clarification.
- Amend the Tobacco Products (Control and Regulatory) Act to explicitly prohibit e-cigarettes and heated tobacco products.
- Introduce plain packaging legislation to remove branding, building on the 100% pictorial warning requirement.

9.7 Monitoring, Evaluation, and Research

- Standardise survey methodologies to allow accurate trend analysis for both smoked and smokeless tobacco, with data collection every 3–5 years.
- Conduct regular compliance surveys to track enforcement progress.
- Establish a national tobacco control observatory to monitor prevalence, policy implementation, industry tactics, and economic indicators, publishing annual reports.

9.8 Local Government Action

- Encourage municipalities to replicate Kathmandu Metropolitan City's comprehensive tobacco ban, adapted to local contexts.
- Allocate local government budgets for tobacco control activities, including inspections, awareness campaigns, and cessation support.
- Integrate tobacco control into municipal disaster and climate resilience plans, recognising tobacco's role in increasing vulnerability to health shocks.

9.9 Multi-sectoral Collaboration

- Foster collaboration among community leaders, political stakeholders, and local governments to strengthen tobacco control efforts.
- Support school-based programs and ensure tobacco retailers are licensed and regulated.
- Enhance graphic health warnings to increase public awareness and deter tobacco use (Aryal et al., 2025).

9.10 Call to Action

Nepal has the policies, the evidence, and the opportunity to become a regional leader in tobacco control. What is lacking is the political will to enforce existing laws, counter industry interference, and invest in cessation. The cost of inaction is measured in lives lost—73 every day—and billions of rupees drained from the economy. The path forward is clear: raise tobacco taxes to reduce consumption and generate revenue, enforce existing laws to protect communities, safeguard children from early initiation, expand cessation services to help smokers quit, and reject industry influence that undermines public health. Every year of delay costs thousands of lives and deepens the economic burden, making decisive action an urgent necessity.

Intersectoral collaboration is essential for reducing tobacco use and improving public health outcomes in Nepal. Effective tobacco control requires coordinated efforts across multiple sectors, including health, education, agriculture, finance, and law enforcement, to address the complex social, economic, and cultural determinants of tobacco consumption. By integrating policies and resources, stakeholders can strengthen prevention strategies, enhance enforcement of tobacco regulations, and promote sustainable alternatives for communities reliant on tobacco production. Such collaborative approaches not only reduce the prevalence of tobacco-related diseases but also contribute to broader national health and development goals.

Nepal must grasp this moment to close the gap between legislation and implementation. With strong leadership, intersectoral collaboration, and unwavering commitment, the country can protect vulnerable populations, reduce health and economic burdens, and move decisively toward a tobacco-free future. The time for action is now.

References

- Gupta, A. K., Thakur, D. N., Sah, M. K., Yadav, R., & Basel, P. L. (2022). Non-compliance to the Tobacco Control and Regulatory Act among vendors in the vicinities of schools of a metropolitan city: A descriptive cross-sectional study. *Journal of Nepal Medical Association*, 60(254), 865–869. <https://doi.org/10.31729/jnma.7206>
- KC, B. B., Chand, A. B., Bam, A., & Bam, T. S. (2025). Assessing compliance with smoke-free laws in Purbakhola Rural Municipality, Nepal: A cross-sectional observational study. medRxiv. [pre-print]
- Aryal, N. L., Paudel, B. K., Pokhrel, B. R., Acharya, S., Bhandari, S., Bhandari, S., Rajbanshi, M., & Dhital, S. R. (2025). Stakeholders' awareness and perception towards graphic health warning, opportunities and challenges for tobacco control policy in Nepal: A qualitative study. *PLOS Global Public Health*, 5(7), e0004917. <https://doi.org/10.1371/journal.pgph.0004917>
- Basnet LB, Budhathoki SS, Adhikari B, Thapa J, Neupane B, et al. (2022) Compliance with the smoke-free public places legislation in Nepal: A cross-sectional study from Biratnagar Metropolitan City. *PLOS ONE* 17(3): e0264895. <https://doi.org/10.1371/journal.pone.0264895>
- Budhathoki, P., Shrestha, D. B., Sedhai, Y. R., Baniya, R., Bhatt, A., Chaudhary, K., Acharya, A., Rajkarnikar, R., Basnet, M., & Atreya, A. (2022). Prevalence and risk factors of COPD in Nepal: A systematic review and meta-analysis. *Journal of Nepal Health Research Council*, 19(4), 652–660. <https://doi.org/10.33314/jnhrc.v19i04.3543>
- National Statistics Office (NSO) and UNICEF Nepal. (2026). *Nepal Multiple Indicator Cluster Survey 2024–25, Survey Findings Report*. Kathmandu, Nepal: National Statistics Office and UNICEF.
- Chand, A. B., Thagunna, M. S., Shah, B. V., Bom, A. K., & Prasai, D. P. (2023). Cost analysis of diagnosis and treatment of tobacco-related cancer. *Journal of Nepal Health Research Council*, 20(3), 720–725. <https://doi.org/10.33314/jnhrc.v20i3.3744>
- Christian, P., West, K. P., Jr., Katz, J., LeClerq, S. C., Kimbrough-Pradhan, E., & Shrestha, S. R. (2004). Cigarette smoking during pregnancy in rural Nepal: Risk factors and effects

of β -carotene and vitamin A supplementation. *European Journal of Clinical Nutrition*, 58, 204–211. <https://doi.org/10.1038/sj.ejcn.1601767>

Dahal, S., Subedi, N., & Thapa, R. (2021). Prevalence and determinants of non-communicable disease risk factors among adult population of Kathmandu. *PLOS ONE*, 16(9), e0257034. <https://doi.org/10.1371/journal.pone.0257037>

Dahal, U. K., et al. (2024). Burden of tobacco-related cancers in urban, semi-urban and rural setting of Nepal: Findings from population-based cancer registries 2019. *PLOS ONE*, 19(5), e0300271. <https://pubmed.ncbi.nlm.nih.gov/38805435/>

Dhimal, M., Khatri, B. D., Basnet, M. B., Ghimire, S., Ghimire, N., Acharya, A., Rana, N., & Joshi, P. (2025). Compliance with the legal provision of tobacco products in Nepal. *Journal of Nepal Health Research Council*, 22(4), 764–771. <https://doi.org/10.33314/jnhrc.v22i04.5514>

Gautam, J. (2025). Impact of smoking on morbidity and attributable costs among reproductive-aged women in Dharan, Nepal. *Research Mosaic*, 5(4), 41–55. <https://doi.org/10.64428/rm/v5.i4.5>

Generations Sans Tabac. (2026, January 24). The tobacco industry, an obstacle to the effective implementation of legislation in Nepal. <https://www.generationsanstabac.org/en/actualites/lindustrie-du-tabac-obstacle-a-une-mise-en-oeuvre-efficace-de-la-legislation-au-nepal/>

Government of Nepal. (2011). Tobacco Products (Control and Regulatory) Act, 2068 (2011). Nepal Law Commission.

Government of Nepal. (2014). Directive on printing warning messages and pictures on tobacco product boxes, packets, cartons, parcels and packaging materials, 2014. Ministry of Health and Population.

Health Rights and Tobacco Control Network Nepal. (2023). Impact of tax increase and mass media campaigns on tobacco use in Nepal. Kathmandu: HRTC/N.

Bhandari, A., & Bhatta, N. (2021). Tobacco and its Relationship with Oral Health. *Journal of Nepal Medical Association*, 59(243), 1204–1206. <https://doi.org/10.31729/jnma.6605>

- Karki, K. B., Poudyal, A., Shrestha, N., Mahato, N. K., Aryal, K. K., Sijapati, M. J., Bista, B., Gautam, N., Subedi, R., Siddiquee, N. K. A., Gyanwali, P., Kuch, U., Groneberg, D. A., Jha, A. K., & Dhimal, M. (2021). Factors associated with chronic obstructive pulmonary diseases in Nepal: Evidence from a nationally representative population-based study. *International Journal of Chronic Obstructive Pulmonary Disease*, 16, 1109–1118. <https://doi.org/10.2147/COPD.S295321>
- Jiang, X., Jackson, L. J., Syed, M. A., Avşar, T. S., & Abdali, Z. (2022). Economic evaluations of tobacco control interventions in low- and middle-income countries: A systematic review. *Addiction*, 117(9), 2374–2392. <https://doi.org/10.1111/add.15821>
- Karki, K. B., et al. (2024). Smokeless tobacco use and its associated factors among secondary school students of Rangeli Municipality of Morang district, Nepal. *PLOS ONE*, 19(11), e0313288. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11554087/>
- Acharya, J., Prutipinyo, C., Sirichotiratana, N., & Amnatsatsue, K. (2024). Assessment of Smoking Behaviour of Adolescents in Two Districts of Nepal and Implications of the MPOWER Policy Measures: A Mixed Method Study. *Journal of Nepal Medical Association*, 62(273), 315–322. <https://doi.org/10.31729/jnma.8575>
- Khanal, G. N., et al. (2021). Burden, prevention and control of tobacco consumption in Nepal: A narrative review of existing evidence. *International Health*, 13(2), 115–123.
- Khanal, S., Khan, S. A., Baral, D., Shrestha, S., Baral, N., & Lamsal, M. (2018). Oxidant-antioxidant status and assessment of cardiovascular morbidity in Pan Masala containing tobacco users: a cross-sectional study. *BMC Research Notes*, 11(1), 727. <https://doi.org/10.1186/s13104-018-3832-5>
- Barakoti R, Ghimire A, Pandey AR, Baral DD and Pokharel PK (2017) Tobacco Use during Pregnancy and Its Associated Factors in a Mountain District of Eastern Nepal: A Cross-Sectional Questionnaire Survey. *Front. Public Health* 5:129. doi: [10.3389/fpubh.2017.00129](https://doi.org/10.3389/fpubh.2017.00129)
- Else, H., Khanal, S., Manandhar, S. et al. Understanding implementation and feasibility of tobacco cessation in routine primary care in Nepal: a mixed methods study. *Implementation Sci* 11, 104 (2015). <https://doi.org/10.1186/s13012-016-0466-7>

Ministry of Health and Population. (2022). Nepal Demographic and Health Survey 2022. Government of Nepal.

Ministry of Health and Population. (2025, February 27). Health Ministry concerned over promotion of tobacco products in festivals. Radio Nepal Online. <http://radionepalonline.com/en/2025/02/27/402913.html>

Nepal Development Research Institute. (2024). National survey on socio-economic and policy aspects of tobacco use in Nepal. Kathmandu: NDRI.

Nepal Health Magazine. (2024, March 9). Illicit trade of tobacco in Nepal. <https://nepalhealthmag.com/illicit-trade-of-tobacco-in-nepal/>

Poudel, A., Kaphle, H. P., Poudel, S., Parajuli, S., Bhurtel, K., & Dhital, S. R. (2025). Awareness and compliance with tobacco control policies among retailers near schools in Arghakhanchi, Nepal: A mixed-methods study. *PLOS Global Public Health*, 5(7), e0004780. <https://doi.org/10.1371/journal.pgph.0004780>

Raspanti, G. A., et al. (2022). Ethnic variation in consumption of traditional tobacco products and lung cancer risk in Nepal. *Asian Pacific Journal of Cancer Prevention*, 23(4), 1321–1328.

Rimal, J., et al. (2019). Risk assessment of smokeless tobacco among oral precancer and cancer patients in eastern developmental region of Nepal. *Asian Pacific Journal of Cancer Prevention*, 20(2), 541–546.

Sagtani, R. A., Thapa, S., & Sagtani, A. (2019). Smoking and quality of life – Is there really an association? Evidence from a Nepalese sample. *PLOS ONE*, 14(9), e0221799. <https://doi.org/10.1371/journal.pone.0221799>

Sapkota, V. P., Bhusal, U. P., & Raut, N. K. (2026). Price elasticity of demand for cigarettes in Nepal: Evidence from a lower middle-income country in South Asia using Deaton's demand model. *PLOS ONE*, 21(3). <https://doi.org/10.1371/journal.pone.0345594>

Bhaskar, R.K., Sah, M.N., Gaurav, K. *et al.* Prevalence and correlates of tobacco use among adolescents in the schools of Kalaiya, Nepal: a cross-sectional questionnaire based study. *Tob. Induced Dis.* 14, 11 (2016). <https://doi.org/10.1186/s12971-016-0075-x>

Sathian, B., et al. (2020). Cigarette smoking dose-response and suicidal ideation among young people in Nepal: a cross-sectional study. *Nepal Journal of Epidemiology*, 10(1), 853–861. doi: [10.3126/nje.v10i1.28277](https://doi.org/10.3126/nje.v10i1.28277)

Gupta, S., & Shrestha, P. M. (2024). A research study on tobacco associated oral potentially malignant disorders (OPMDs) prevalent in oral mucosa of Lumbini Province/District Rupandehi population of Nepal. *Athens Journal of Health and Medical Sciences*, 11(4), 197–204. <https://doi.org/10.30958/ajhms.11-4-2>

Shakya, A., KC, B. B., & Shrestha, R. (2024). Compliance status of smoke-free public places law in Nepal. *Journal of Environmental and Public Health*, 2024, 9184499. <https://doi.org/10.1155/2024/9184499>

Shakya S., Shrestha I., & Pradhan P. M. S. (2021). Understanding the Situation and Effectiveness of Adolescent Focused Tobacco Control Policies in Nepal : A Qualitative Study. *Journal of Nepal Health Research Council*, 19(03), 563-567.

Shrestha G, Phuyal P, Gautam R, et al. (2021). Burden of tobacco in Nepal: A systematic analysis from the Global Burden of Disease Study 1990–2017. *BMJ Open*, 11(8), e047847. <https://doi.org/10.1136/bmjopen-2020-047847>

Shrestha, M., Mandal, A., Kumari Gupta, S. ., & Baidya, M. (2022). Maternal Smoking during Pregnancy and its Association with Low Birth Weight. *Journal of Nepal Paediatric Society*, 42(1), 92–96. <https://doi.org/10.3126/jnps.v42i1.37197>

Singh, J. K., Acharya, D., Kadel, R., Adhikari, S., Lombard, D., Koirala, S., & Paudel, R. (2017). Factors associated with smokeless tobacco use among pregnant women in rural areas of the southern Terai, Nepal. *Journal of Nepal Health Research Council*, 15(1), 12–17.

Tobacco Atlas. (2023). Nepal fact sheet. <https://tobaccoatlas.org/factsheets/nepal/>

Tobacco Control Laws. (2021). Nepal legal summary. <https://www.tobaccocontrolaws.org/legislation/nepal/>

Tobacco Reporter. (2025, July 1). Nepal Court lifts ban on e-cigarettes. <https://tobaccoreporter.com/2025/07/01/nepal-court-lifts-ban-on-e-cigarettes/>

Tobacco Reporter. (2025, November 26). Nepal Court leaves packaging warning in limbo. <https://tobaccoreporter.com/2025/11/26/nepal-court-leaves-packaging-warning-in-limbo/>

Vital Strategies. (2025, February 7). Nepal is the first country in the world with 100% health warnings on tobacco packaging. <https://www.vitalstrategies.org/nepal-is-the-first-country-in-the-world-with-100-health-warnings-on-tobacco-packaging/>

World Health Organization. (2019). 2019 STEPS fact sheet Nepal (tobacco). <https://www.who.int/publications/m/item/2019-steps-fact-sheet-nepal-tobacco>

World Health Organization. (2021, May 31). World No Tobacco Day 2021: Remarks by WHO Representative to Nepal. <https://www.who.int/nepal/news/speeches/world-no-tobacco-day-2021>

World Health Organization. (2023). 45,000 Nicotine Gums handed over to Nepal for tobacco cessation pilot. WHO Nepal. <https://www.who.int/nepal/news/detail/xx-xx-2023-45-000-nicotine-gums-handed-over-to-nepal-for-tobacco-cessation-pilot>

World Health Organization. (2025). WHO global report on trends in prevalence of tobacco use 2000–2024 and projections 2025–2030 (6th ed.). <https://www.who.int/westernpacific/publications/i/item/9789240116276>



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