NEPAL
Country Profile

World Health Organization
South-East Asia Region

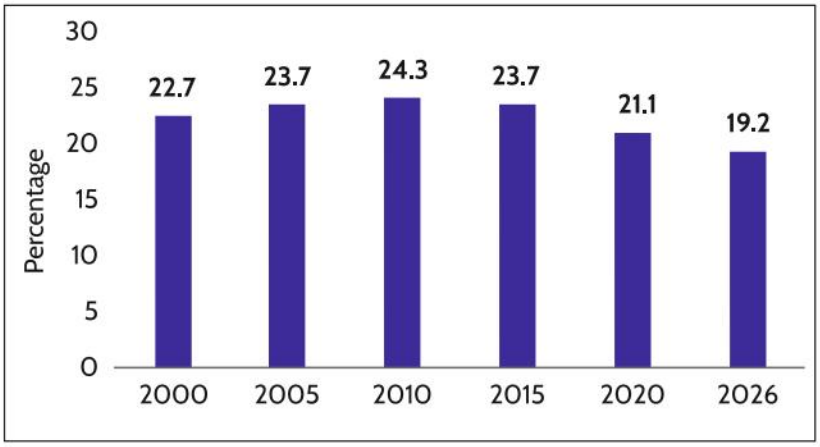
Demographic Profile, 2026

Total Population 29 629 000

	Value	Percentage of total population
Total under–five population	2 672 000	9.0
Total 5–9 years population	2 712 000	9.2
Total adolescent population (10–14 years)	2 814 000	9.5
Total adolescent population (15-19 years)	2 863 000	9.7
Total adolescent population (10–19 years)	5 676 000	19.2

Source: World Population Prospects accessed on 30 May 2026

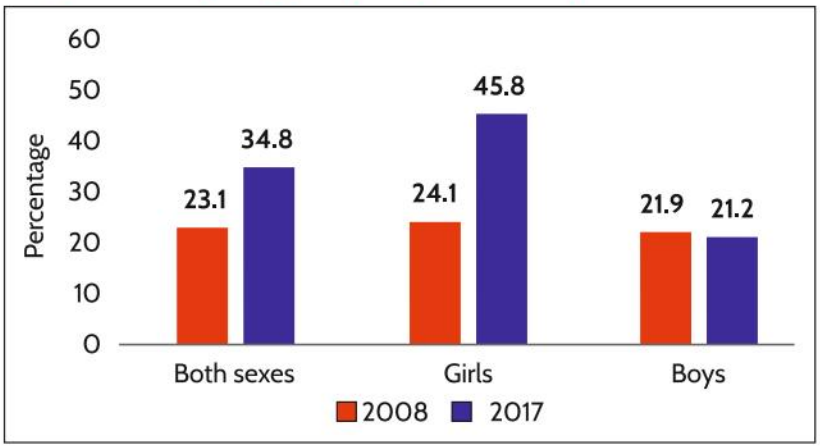
Adolescent (aged 10–19 years) population as percentage of total population



From 2000 till 2010, the share of adolescents in country's total population had increased marginally (from 22.7% to 24.3%); however, after 2015, the proportional share has gradually decreased and in 2026 it was 19.2% adolescents contributing to the country's total population.

Source: World Population Prospects accessed on 30 May 2026

Proportion of young people aged 15 –24 years not in education, employment, or training (NEET) by sex

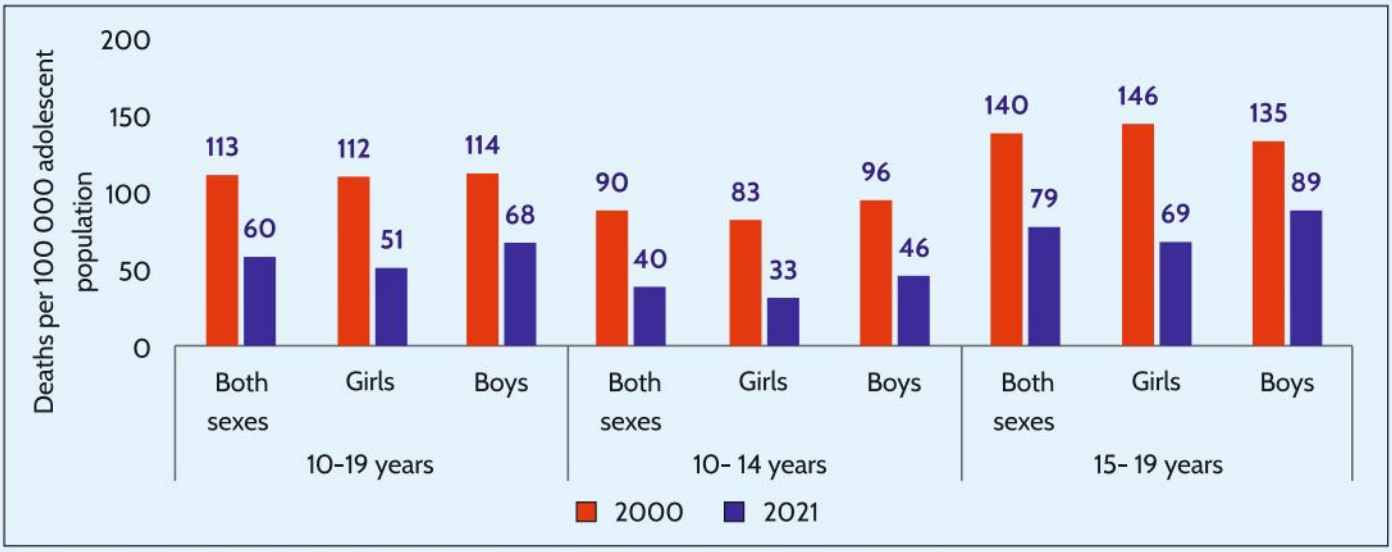


Between 2008 and 2017, the proportion of young people aged 15–24 years not in education, employment, or training increased from 23.1% to 34.8%. This increase was driven largely by girls, whose proportion rose sharply from 24.1% to 45.8%, while the proportion among boys remained almost similar.

Source: ILOSTAT accessed on 16 December 2025

Mortality

All-cause mortality rate for adolescents aged 10–19 years by sex



Source: Global Health Estimates-World Health Organization accessed on 16 December 2025

Top causes of mortality among adolescent girls in 2021

Age group	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
10–19 years	Self-harm	Tuberculosis	Road injury	Maternal conditions	Cirrhosis of the liver
10–14 years	Road injury	Tuberculosis	Poisonings	Lower respiratory infections	Diarrhoeal diseases
15–19 years	Self-harm	Tuberculosis	Maternal conditions	Road injury	Cirrhosis of the liver

Top causes of mortality among adolescent boys in 2021

Age group	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
10–19 years	Road injury	Self-harm	Tuberculosis	Drowning	COVID-19
10–14 years	Road injury	Drowning	Tuberculosis	COVID-19	Falls
15–19 years	Road injury	Self-harm	Tuberculosis	Drowning	Interpersonal violence

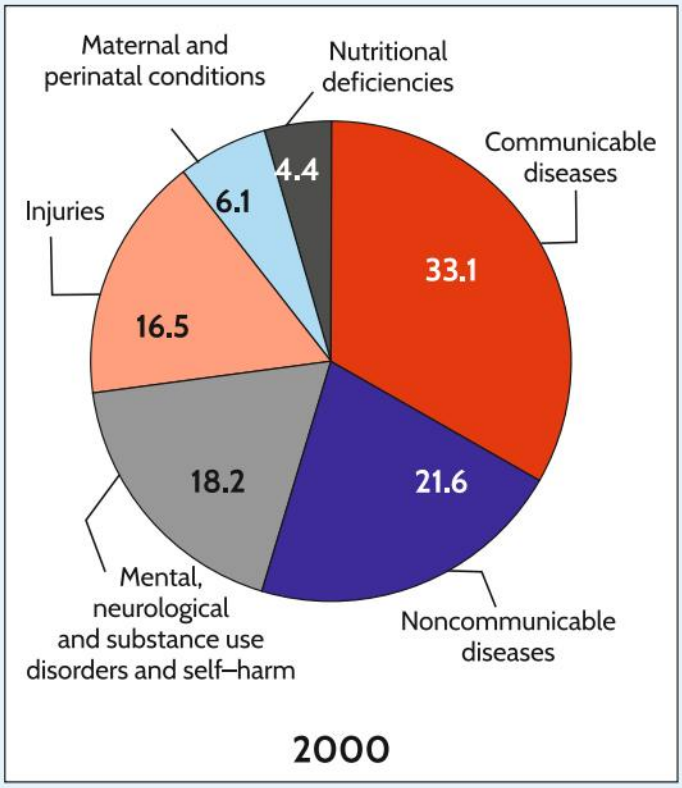
Source: Global Health Estimates-World Health Organization accessed on 16 December 2025

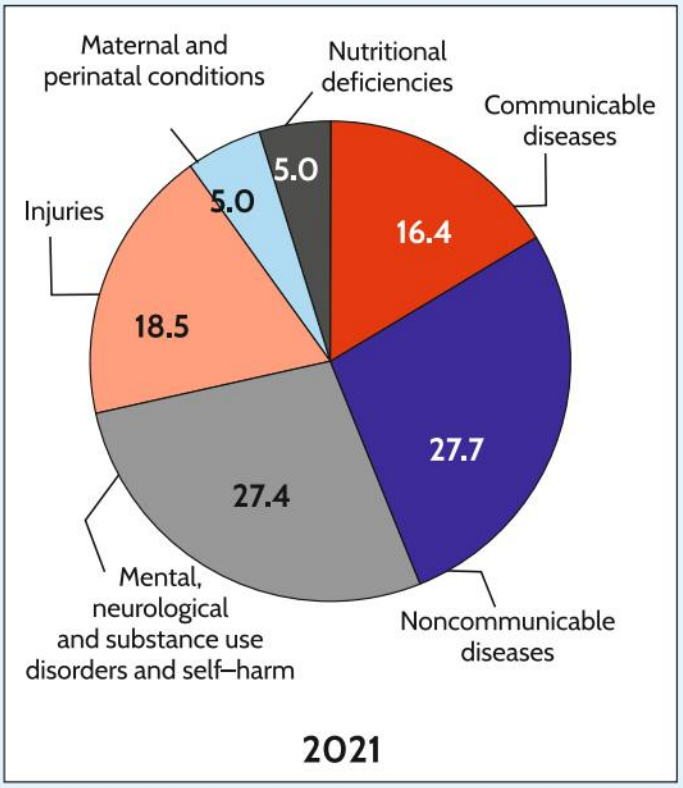
Adolescent mortality rate declined by 47% between 2000 and 2021, with higher mortality reduction seen among girls compared to the boys (54% in girls vs. 40% in boys). In 2021, mortality rate was two times higher among older adolescents aged 15–19 years compared to the younger adolescents aged 10–14 years, and 30% higher among boys compared to the girls.

In 2021, self-harm, road injury and tuberculosis are the three leading causes of adolescent mortality among girls and boys. Maternal conditions (or maternal complications of pregnancy) remain an important cause of mortality among older adolescent girls.

Morbidity

Distribution of DALYs* among adolescents (10–19 years)





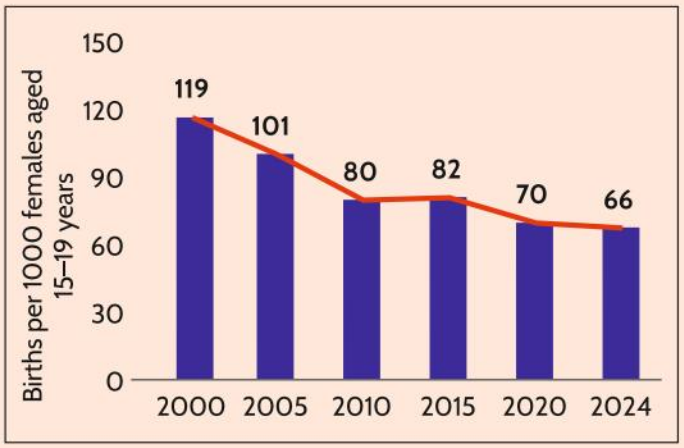
*DALYs stands for Disability-Adjusted Life Years.

Source: Global Health Estimates-World Health Organization accessed on 16 December 2025

Over the past two decades, the burden of adolescent morbidity has changed significantly. While the burden from communicable diseases has reduced by more than half, morbidity burden due to mental, neurological and substance use disorders including self-harm has increased by 50% and that due to NCDs by 30%. This indicates a changing epidemiological profile in the health needs of the adolescent population.

Sexual and Reproductive Health

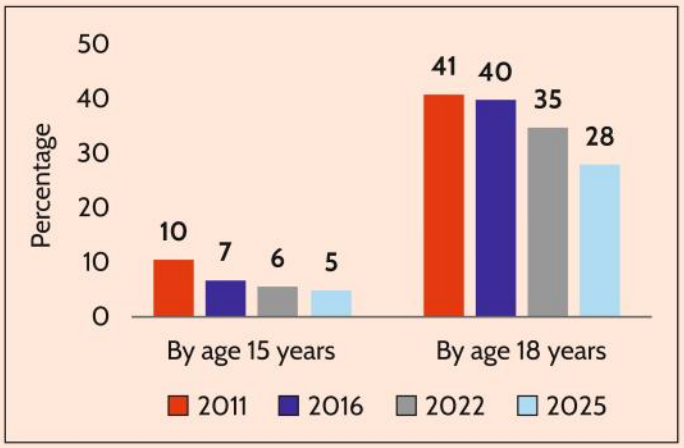
Adolescent birth rate (per 1000 females aged 15–19 years)



Source: WHO maternal, newborn, child and adolescent health and ageing data portal accessed on 16 December 2025

*As per Nepal MICS report 2025, Adolescent birth rate is 48 per 1000 females aged 15-19 years.

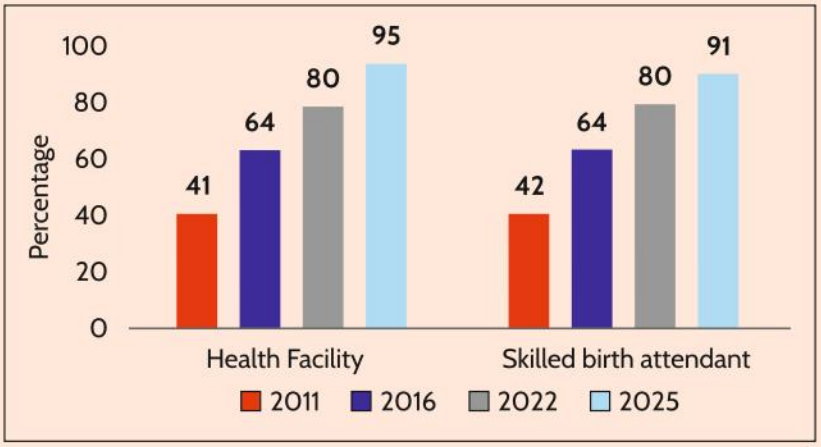
Percentage of women aged 20–24 years married before age 15 and before age 18 year



Source: Demographic Health Survey, 2011, 2016, & 2022; Multiple Indicator Cluster Survey 2025

The adolescent birth rate per 1000 females aged 15-19 years declined substantially during the past two decades, from 119 in 2000 to 66 in 2024. There was also a significant decline in child marriage between 2011 and 2025, although 28% of women aged 20–24 years still reported marriage before the age of 18 years and 5% reported marriage before the age of 15 years.

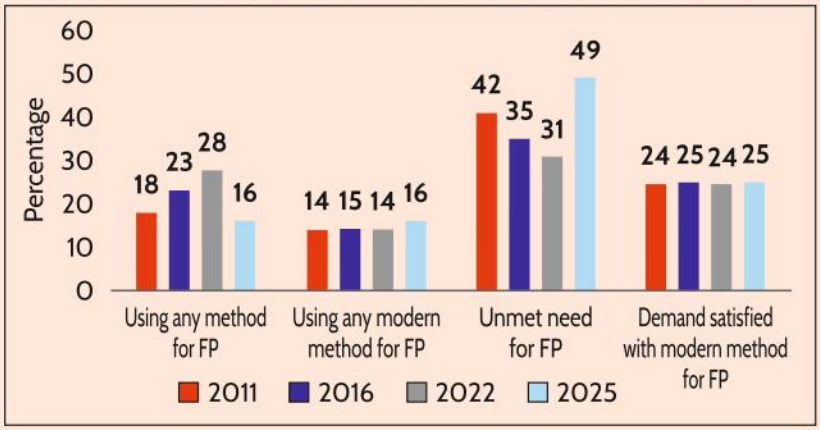
Percentage of women (aged less than 20 years) delivered at health facility and deliveries by skilled birth attendant



Source: Demographic Health Survey, 2011, 2016, & 2022; Multiple Indicator Cluster Survey 2025

Among girls aged less than 20 years, the proportion of institutional deliveries and deliveries attended by skilled birth attendants have more than doubled between 2011 and 2025, with institutional deliveries increasing from 41% to 95% and skilled birth attendance increasing from 42% to 91% respectively.

Percentage of currently married adolescent girls (aged 15–19 years) using any method, any modern method, unmet need, and demand satisfied with modern methods for family planning

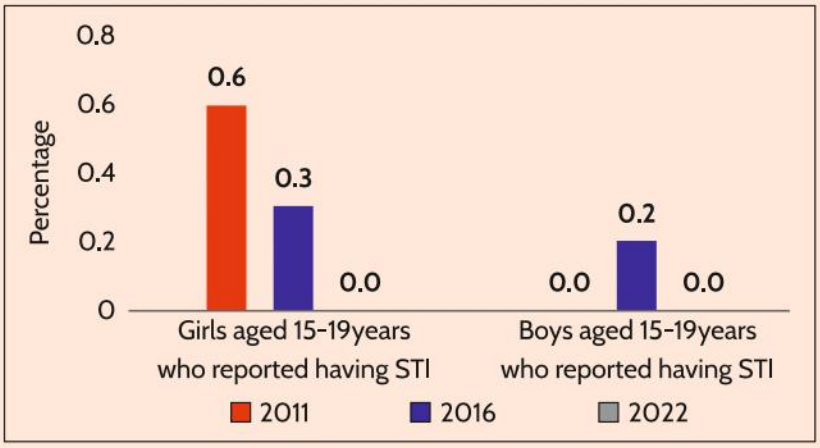


Family planning use among married adolescent girls aged 15-19 years is quite low, with only 16% using any method or any modern method in 2025 while nearly half (49%) reported unmet need for family planning.

Source: Demographic Health Survey, 2011, 2016, & 2022; Multiple Indicator Cluster Survey 2025

Sexually Transmitted Infection (STI) and Human immunodeficiency viruses (HIV)

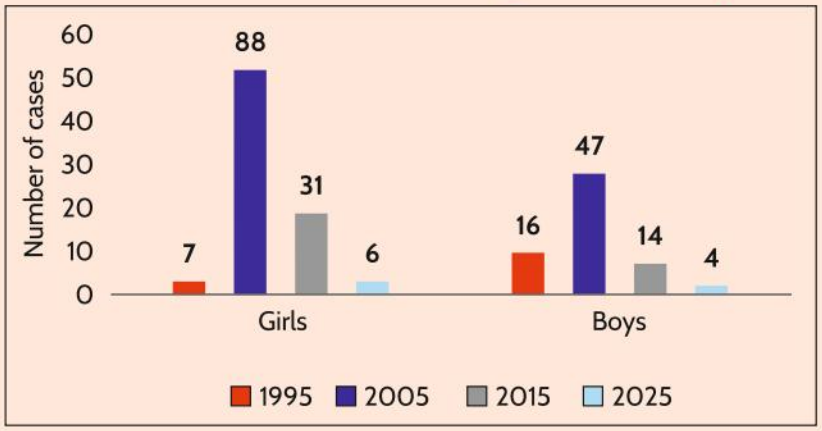
Percentage of adolescents (15–19 years) who reported having STI by sex



STI prevalence as reported by adolescents aged 15-19 years has remained low during the past one decade. There was no reported case of STI in the DHS 2022.

Source: Demographic Health Survey

Number of new HIV infections among adolescents aged 10–19 years by sex

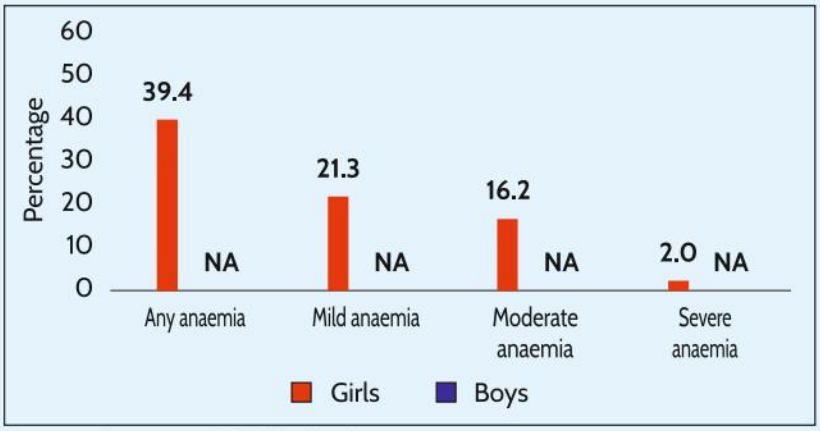


Number of new HIV infections among adolescents peaked in 2005 for both girls and boys, with higher numbers in girls (88 cases) compared to boys (47 cases). Since then, number of new HIV infections have reduced significantly with 6 cases among girls and 4 cases among boys in 2025.

Source: WHO maternal, newborn, child and adolescent health and ageing data portal accessed on 16 December 2025

Nutrition and physical activity

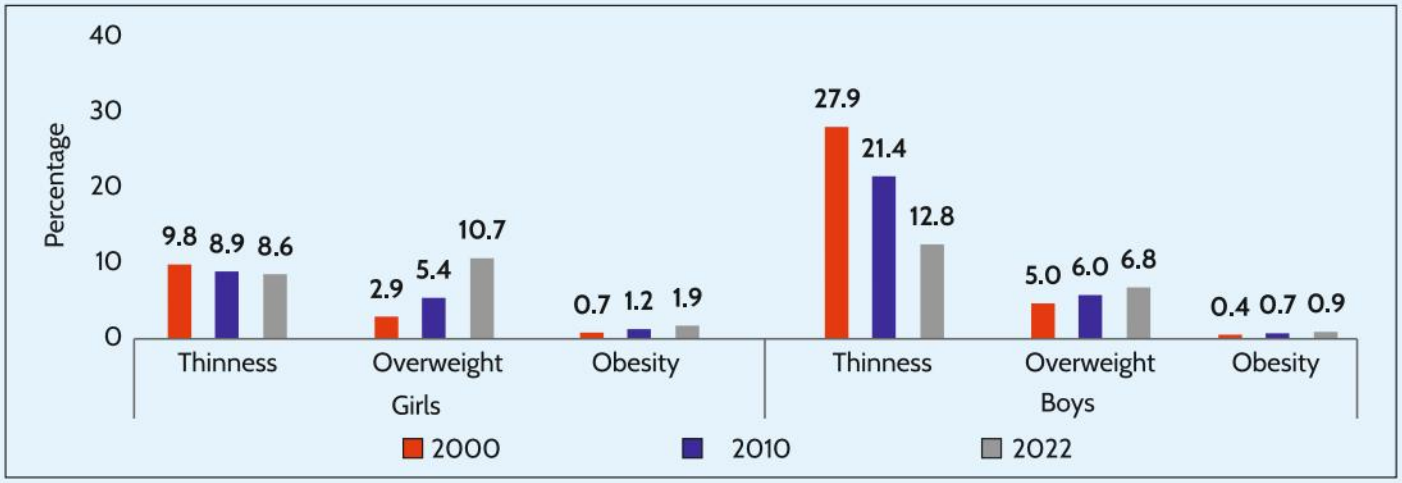
Percentage of adolescents aged 15–19 years with anaemia by sex, 2022



Anemia remains a major concern. Nearly 4 in 10 adolescent girls aged 15–19 years were anemic in 2022, with more than 18% having moderate to severe anemia.

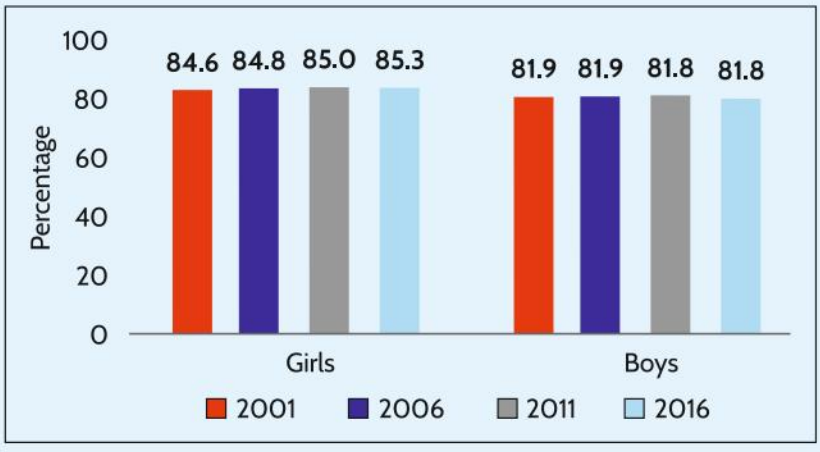
Source: Demographic Health Survey, 2022;
NA: Data not available

Nutritional status among adolescents aged 10–19 years by sex



Source: WHO Maternal, newborn, child and adolescent health and ageing data portal accessed on 16 December 2025

Prevalence of insufficient physical activity among school going adolescents aged 11–17 years by sex



During the past two decades, thinness declined modestly in adolescent girls and by more than half in adolescent boys. At the same time, overweight and obesity prevalence has increased significantly in both sexes. In adolescent girls, overweight and obesity increased by 3.7 times and 2.9 times respectively, while in adolescent boys it increased by 1.4 times and 2.1 times respectively.

More than 80% of adolescent girls and boys reported insufficient physical activity.

Source: WHO Maternal, newborn, child and adolescent health and ageing data portal accessed on 16 December 2025

The Government of Nepal introduced the national HPV immunization in 2025, covering both school-going and out-of-school girls aged 10-14 years. The HPV immunization coverage rate was 94%

Source: Family Welfare Division, Department of Health Services, Ministry of Health and Food Safety, Department of Health Services Annual Health Report 2081/82 published in May 2026.

Mental health and substance use

	Girls	Boys	Year of data	Data source
Students (13–17 years) who seriously considered attempting suicide	13.9	12.7	2015	GSHS
Students (13–17 years) who attempted suicide one or more times	10.7	8.9		
Students (13–17 years) who did not have close friends	5.0	3.7		
Proportion of students (aged 13–17 years) who were in a physical fight one or more times	35.2	44.6		
Percentage of students (aged 13–17 years) who were bullied on one or more days	46.0	56.1		
Percentage of students (aged 13–17 years) who ever used cannabis or marijuana one or more times during their life	2.5	5.0		
Percentage of students (aged 13–17 years) who currently smoked cigarettes	3.3	8.4		
Percentage of students (aged 13–17 years) who currently used any tobacco products	5.0	11.0		
Prevalence of current drinking among adolescents (15–19 years)	10.1	12.3	2019	WHO- MNCAH and ageing data portal

Source: Global School Health Based Survey (GSHS); WHO Maternal, newborn, child and adolescent health and ageing data portal accessed on 16 December 2025

Among students aged 13–17 years, 13.9% of girls and 12.7% of boys seriously considered suicide, while 10.7% of girls and 8.9% of boys reported attempting suicide one or more times. Bullying on one or more days was reported by 46.0% girls and 56.1% boys, while physical fight one or more times was reported by 35.2% girls and 44.6% boys.

Substance use was notably higher among boys. Among students aged 13–17 years, 5.0% of boys had ever used cannabis or marijuana compared with 2.5% of girls, 8.4% of boys currently smoked cigarettes compared with 3.3% of girls, and 11.0% of boys used any tobacco product compared with 5.0% of girls. Current alcohol use among adolescents aged 15–19 years was also higher among boys than girls (12.3% vs. 10.1%).

Key gaps from 2024 health system assessment

Leadership and Governance: A national policy exists but there is no designated full-time national or subnational focal point for national adolescent health programme. The national package of services does not cover all the seven key areas of adolescent health and types of care. Policies allowing adolescents to make informed consent for their medical treatment and services are unclear. While national standards for delivery of services exist and are monitored, adolescent engagement in ensuring accountability of health systems is occasional.

Service delivery: Adolescent health services mainly provided in health facilities and are curative, with limited community-level activities. Quality improvement processes are in place but applied. Inconsistently. Referral system between different health facilities is limited to certain areas only, while there is no system to support movement of adolescents from health to non-health services.

Health Workforce: There are no dedicated adolescent health staff, and national competencies are not defined or systematically integrated into pre-service education. Continuous education is limited in coverage and scope.

Health Information: Adolescent health specific indicators are included in HMIS but are not aligned with Global Action for Measurement of Adolescent Health (GAMA) guidance, and reporting of data by five-year age disaggregation is incomplete. There is no systematic process by which health system uses data to improve coverage, quality, and equity of health services.

Financing: Adolescents are required to make formal or informal out-of-pocket payments for some selected services in the public sector. There are national and subnational budget allocation, but it is not proportionate to the needs of the adolescent population.

Partnership: Health system has a formal mechanism to engage with the adolescents, but the process is not followed regularly while engagement with family and community is in an ad-hoc manner. Health and education systems work collaboratively in improving school health services, but the partnership is not systematic. Multisectoral coordination remains limited and inconsistent.

Recommendations

- Revise/update the national adolescent health strategic plan based on recent data, findings from the regional 2024 assessment, and global Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance; adopt adolescent-responsive health systems approach to consolidate the gains made while moving forward.
- Strengthen leadership and governance by designating a dedicated focal point for national adolescent health programme with clear role for coordination, implementation, monitoring, and multisectoral engagement.
- Upgrade the essential package of services at both facility and community level prioritizing preventive, promotive services and information sharing to cover emerging priorities under adolescent health while accelerating efforts on preventing adolescent pregnancies and promoting family planning.
- Ensure all services under the public health system are provided free of cost to adolescents (irrespective of age, socio-economic status, sexual orientation, marital status, parity) aligned with the UHC approach.
- Ensure availability of trained health workforce at both the facility and community level by integrating adolescent health competencies for all relevant cadres in pre-service education and in-service training.
- Incorporate adolescent-specific indicators in the national HMIS as recommended by the GAMA in the national health management information systems. Ensure data collection and analysis using five-year age and sex disaggregation. Build capacity of managers for systematic use of data for planning, quality improvement and equity monitoring.
- Strengthen partnerships by institutionalizing regular engagement with adolescents, families and communities, and by making collaboration between health, education and other sectors more systematic and consistent.