ENDIT FOUNDATION
EMPOWERING EVERY INDIVIDUAL

VAPING VOICES

Exploring Tobacco Harm Reduction in Lahore

RESEARCH REPORT

Cross-Sectional Survey of 1,710 Vape Users | Ten Markets, Lahore | September 2025

AUTHOR
Dr. Ziauddin Islam
Chief Executive Officer

INSTITUTION
Endit Foundation
Islamabad, Pakistan

DATE
September 2025

VAPING VOICES

Exploring Tobacco Harm Reduction in Lahore

TECHNICAL REPORT

Cross-Sectional Survey of 1,710 Vape Users | Ten Markets, Lahore | September 2025

Endit Foundation | Islamabad, Pakistan

Prepared by: Dr. Ziauddin Islam, Chief Executive Officer
Original Research: September 2025

Executive Summary

Pakistan's tobacco problem does not need restating in broad strokes — the numbers speak plainly enough. Over 163,500 deaths a year, economic losses calculated at PKR 615 billion in 2019 alone, with projections suggesting that figure could climb toward PKR 926 billion by 2025 if current trajectories hold. Set against that backdrop, any credible harm reduction pathway deserves serious, dispassionate scrutiny rather than reflexive dismissal or uncritical endorsement.

The Vaping Voices study was designed precisely for that kind of scrutiny. During September 2025, the Endit Foundation conducted a survey of 1,710 current or recent vape users across ten retail markets in Lahore— one of the country's most commercially active urban centers. The survey aimed to understand who is vaping, why they began, how their cigarette use has changed, and how they perceive the associated risks. Importantly, it did not rely on clinical referrals or cessation program registries; instead, it was conducted directly within retail environments where vaping occurs. This approach represents both the study's methodological strength—capturing behavior in real-world settings—and its principal limitation, as findings may not extend beyond those contexts.

Among the 1,058 respondents who reported a smoking history — 918 current smokers and 140 who had quit within the past year — the headline finding is striking: 60% said vaping had helped them reduce cigarette consumption, and 13% (n = 140) had stopped smoking entirely within the twelve months preceding the survey. Of those 140 who made the full switch, 94% had done so within the first six months of taking up vaping. That is a faster transition timeline than most cessation interventions achieve under controlled conditions. Nearly one in five respondents across the full sample (19%, n = 320) also reported subjective improvements in respiratory health.

None of this is without complication. Thirty-eight percent of the sample (n = 652) had no prior smoking history — meaning their engagement with vaping represents nicotine exposure, not nicotine harm reduction. Six percent (n = 105) had first tried vaping before age sixteen, some as young as eight to twelve years old, in a market with no functioning age controls. Risk perception is poorly calibrated across the board, with only 26% of respondents believing vaping to be less harmful than smoking despite the available evidence pointing broadly in that direction. And the regulatory environment is, bluntly, absent.

The Endit Foundation holds that this situation requires proportionate, evidence-based policy engagement—neither the outright prohibition that would halt ongoing harm reduction, nor the passive indifference that has allowed the market to expand without standards or safeguards. This report sets out what the data reveal, what they cannot show, and what a rational policy response should entail.

1. Introduction

Few topics in contemporary public health generate as much heat — and as little light — as electronic cigarettes. Advocates point to a growing body of evidence suggesting that vaping delivers nicotine without the combustion-derived carcinogens and toxic gases responsible for the overwhelming majority of tobacco-related mortality. Critics raise legitimate concerns about long-term safety, about the recruitment of non-smokers into nicotine dependence, and about an industry whose marketing instincts have not always aligned with public health objectives. Both camps have legitimate points; neither has the whole picture.

What is often missing from this debate is granular, context-specific data. The evidence base on vaping has been built primarily in high-income countries — the United Kingdom, the United States, Australia — where healthcare infrastructure, regulatory capacity, and population health literacy are not easily transferable to settings like Pakistan. A country of over 230 million people with an estimated 24 million adult smokers, limited cessation infrastructure, and a vaping market that has expanded almost entirely through informal retail channels presents a rather different problem than the one studied in a Birmingham cessation clinic or a New Zealand cohort study.

The Vaping Voices study was undertaken to generate locally grounded evidence. Rather than attempting to extrapolate from international findings, the Endit Foundation recruited 1,710 vape users directly from retail environments across ten markets in Lahore, asking about their backgrounds, their habits, their health experiences, and their intentions. The result is not a nationally representative survey — it was never designed to be — but it does offer something that Pakistan's policymakers currently lack: a detailed, empirically grounded picture of who is using vaping products, and to what effect, in one of the country's largest urban centers.

2. Background and Context

2.1 The Tobacco Burden in Pakistan

To understand why harm reduction matters in Pakistan, it helps to sit with the mortality figures rather than skimming past them. Smoking-attributable deaths exceed 163,500 annually — from lung cancer, COPD, ischemic heart disease, stroke, and a range of other conditions for which combustible tobacco is a well-established causal factor. These are not statistical abstractions; they represent a disease burden concentrated disproportionately in working-age men, predominantly from lower-income households, in a country whose public health system is already stretched thin.

The economic dimension compounds the human cost. In 2019, direct healthcare expenditure and productivity losses attributable to tobacco were estimated at PKR 615 billion — roughly USD 3.85 billion at prevailing exchange rates. Without effective intervention, projections suggest this could reach PKR 926 billion by 2025. Pakistan ratified the WHO Framework Convention on Tobacco Control (FCTC) in 2004 and has introduced advertising bans, smoke-free public space legislation, and mandatory health warnings. Enforcement, however, has been uneven at best, particularly in lower-income districts and smaller cities, where illicit tobacco trades with impunity. Cessation services exist in principle; in practice, they are thinly distributed and rarely accessible to the populations most affected. As for ENDS specifically, there is no dedicated regulatory framework: vaping products occupy an ambiguous legal space, neither scheduled as medicines nor prohibited as consumer goods.

2.2 Electronic Nicotine Delivery Systems: What the Evidence Shows

The scientific literature on ENDS has grown considerably over the past decade, though it remains contested in ways that matter for policy. The often-cited 2015 Public Health England estimate — that vaping is around 95% less harmful than smoking for individual users — has been widely reproduced and almost as widely critiqued on methodological grounds. More recent systematic reviews, including the 2018 PHE evidence update and several Cochrane assessments, have largely confirmed that ENDS produce substantially lower levels of toxic constituents than combustible cigarettes and are associated with cessation outcomes comparable to, and in some trials' superior to, conventional nicotine replacement therapy.

None of that settles every question. The long-term pulmonary, cardiovascular, and oncological consequences of regular vaping remain incompletely characterized, for the straightforward reason that the devices have not been in widespread use long enough for meaningful longitudinal data to accumulate. Trial evidence on cessation is largely drawn from structured clinical settings in high-income countries, limiting its direct applicability here. And the adolescent uptake story is genuinely concerning in several markets, where vaping prevalence among young people has risen sharply; the net public health calculus becomes far more complicated than a simple substitution model would suggest. These caveats are not reasons to abandon harm reduction as a framework — they are reasons to apply it carefully.

3. Research Objectives

The Vaping Voices study was organized around five research questions, each designed to address a distinct gap in available evidence on vaping in Pakistan:

1. To characterize the demographic composition of vape users in Lahore's retail markets — specifically age, income level, educational attainment, and occupation — and assess how these characteristics bear on harm reduction outcomes.
2. To examine the relationship between vaping uptake and cigarette use among current and former smokers: whether vaping is associated with reduced consumption, cessation attempts, and successful quitting, and how quickly these transitions occur.
3. To assess risk perceptions among vape users — how they understand the relative harms of vaping versus smoking, and how those beliefs relate to their behaviour, particularly around dual use.
4. To document self-reported health changes since beginning to vape, as a proxy measure of individual-level harm reduction in the absence of clinical data.
5. To map the market and social environment within which vaping behaviour is occurring — purchase motivations, retail geography, social influences, and the extent of youth access to products.

4. Methodology

4.1 Study Design

Vaping Voices used a cross-sectional survey design, administered in person at vape retail outlets across ten major commercial markets in Lahore during September 2025. Cross-sectional designs are well-suited to prevalence estimation and the characterization of population subgroups, though they preclude causal inference — a limitation discussed in Section 14. Survey instruments were prepared in both English and Urdu, reviewed for cultural appropriateness, and piloted with a small sample before deployment. Data collectors were trained to administer the questionnaire consistently, maintain confidentiality, and handle participant queries without introducing response bias.

4.2 Market and Shop Selection

Market selection followed a systematic approach intended to capture geographic and socioeconomic diversity across Lahore's vaping retail landscape:

- **Market Identification:** Known commercial districts with documented vaping retail activity were listed — Gulberg, DHA, Johar Town, and Model Town among them.
- **Market Selection:** Ten markets were drawn from this list to represent the range of socioeconomic areas and geographic zones within the city.
- **Shop Selection:** Within each selected market, shops stocking vaping products — e-cigarettes, pod systems, mods, disposables, nicotine pouches — were identified. Ten shops per market were selected on the basis of customer footfall and product range, producing a total of 100 vape shops.

4.3 Sampling and Eligibility

Eligible respondents were current or recent users of e-cigarettes or vaping devices, confirmed through a brief screening question. Non-users were excluded. Recruitment was purposive, conducted at retail outlets rather than through random household or population-level sampling — a methodological choice that prioritizes direct engagement with the target behaviour over population representativeness. Retail clusters were most heavily concentrated in Shahdara Town, Jia Mosa, and Al-Rehman Garden in Lahore's northern districts. In total, 1,710 respondents completed the full survey.

This approach has a predictable consequence: the sample almost certainly over-represents habitual, committed vape users relative to casual experimenters. The findings should be read as a description of active vaping consumers, not as a prevalence estimate for the broader Lahore population.

4.4 Analytical Approach

Analysis is descriptive throughout. Frequencies and percentages are the primary outputs; subgroup denominators are stated explicitly wherever subgroup analyses appear. All figures are drawn from the 'Vape final working' dataset (n = 1,710) without imputation, extrapolation, or inferential modelling. The study was not powered or designed for multivariate analysis, and no such analysis has been attempted.

5. Demographic Profile of the Sample

All 1,710 respondents were confirmed vape users at the point of recruitment. Taken together, the demographic data paint a remarkably consistent picture: this is a young, predominantly lower- to middle-income urban population, with educational backgrounds spanning the full range from no formal schooling to postgraduate qualifications.

5.1 Age Distribution

The sample is skewed heavily toward young adults. Sixty-nine percent of respondents fall into the 19–24 bracket (n = 1,182), and a further 19% are aged 25–34 (n = 320). The 35–44 group accounts for 11% (n = 188), and those aged 45–54 for just 1% (n = 20). Cumulatively, 88% of the sample is under 35. This is not surprising for a behaviour that diffused through social networks and aspirational marketing, but it has implications for how we interpret both cessation data and health outcomes — younger users tend to have shorter smoking histories and lower baseline disease burden.

5.2 Education

Secondary school qualifications (Class 6–10) are the most common educational level, held by 41% of respondents (n = 701), followed by higher secondary or intermediate (FA/FSc) at 30% (n = 513). Nine percent hold bachelor's degrees (n = 154), 11% completed only primary schooling (n = 188), and 4% have no formal education (n = 68). The remainder — around 5% — hold postgraduate, professional, or vocational qualifications. The spread suggests vaping has penetrated across educational strata rather than clustering in any single group.

5.3 Occupation

Students form the largest occupational category at 38% (n = 651), which is consistent with the age profile. Employed respondents — combining full- and part-time — account for 34% (n = 588), the self-employed or business owners for 21% (n = 351), and the unemployed for 7% (n = 120).

5.4 Income

The income profile reinforces the age and occupation picture. Thirty-nine percent of respondents report annual household income below PKR 300,000 (n = 663), and a further 45% fall in the PKR 300,000–600,000 bracket (n = 762) — meaning 84% of the sample earns below PKR 600,000 a year. Just 14% fall in the PKR 600,001–1,000,000 range (n = 236), and fewer than 3% report income above PKR 1,000,000 (n = 49). Whatever else vaping is in Lahore, it is not primarily a middle-class or affluent behaviour.

Demographic Variable	Category	n (% of 1,710)
Age	19–24	1,182 (69%)
	25–34	320 (19%)
	35–44	188 (11%)
	45–54	20 (1%)
Education	Secondary (Class 6–10)	701 (41%)

Demographic Variable	Category	n (% of 1,710)
	Intermediate (FA/FSc)	513 (30%)
	Primary (up to Class 5)	188 (11%)
	Bachelor's degree	154 (9%)
	No formal education	68 (4%)
	Professional / Doctoral	51 (3%)
	Master's degree	17 (1%)
	Vocational / Technical diploma	17 (1%)
Occupation	Student	651 (38%)
	Employed (full- or part-time)	588 (34%)
	Self-employed / business owner	351 (21%)
	Unemployed	120 (7%)
Annual Income (PKR)	Below 300,000	663 (39%)
	300,000 – 600,000	762 (45%)
	600,001 – 1,000,000	236 (14%)
	1,000,001 – 2,000,000	47 (3%)
	Above 2,000,000	2 (<1%)

Table 1: Demographic profile of survey respondents (n = 1,710)

6. Vaping Behaviour and Patterns of Use

6.1 Frequency and Device Type

The frequency data leave little ambiguity about the nature of the sample. Ninety-four percent of respondents vape daily (n = 1,612); a further 4% do so several times a week (n = 62). Occasional use — once a week or less — applies to under 2% combined (n = 37). This is not a population of casual experimenters or social vapers picking up a device at a party; these are habitual, high-frequency users for whom vaping has become a daily routine.

Pod systems dominate device preferences at 87% (n = 1,488). Mods and tanks account for 7% (n = 120), and disposable devices for the remaining 6% (n = 103). The prevalence of pod systems is consistent with patterns observed in other markets where the technology has matured — they are compact, convenient, and require minimal technical knowledge to operate.

6.2 Flavour Preferences

Every single respondent — all 1,710 of them — reported a preference for fruit flavours, with pineapple, mango, and watermelon cited most frequently. Not a single respondent indicated any preference for tobacco, menthol, or dessert variants. The unanimity is unusual enough to warrant a brief comment: it likely reflects both the genuine taste preferences of a predominantly young, male urban sample and the self-reinforcing composition of Lahore's retail market, where fruit-flavoured pods dominate shelf space. Whether this unanimity is a reflection of real demand or a supply-driven artefact, it carries policy significance — these are precisely the flavour profiles that international regulatory bodies have flagged as disproportionately attractive to younger users.

6.3 Age at Vaping Initiation

Most respondents (56%, n = 955) reported first vaping between the ages of 16 and 20, with the 21–24 bracket accounting for a further 20% (n = 342) and the 25–30 group for 12% (n = 205). Six percent (n = 105) reported initiating before the age of 16 — specifically, 10 individuals between ages 8 and 12, and 95 between ages 13 and 15. Those beginning at 30 or older account for another 6% (n = 103).

The presence of pre-adolescent initiators in this sample warrants careful attention. A ten-year-old accessing vaping products in a commercial retail environment is not an anomaly — it is a system failure. Age restrictions exist in various forms across Pakistan's consumer goods landscape, including the tobacco products; what is evidently missing is any mechanism to enforce them in the vaping retail sector specifically.

7. Smoking History and Cessation Analysis

7.1 Smoking Prevalence in the Sample

Sixty-two percent of respondents (n = 1,058) reported a history of cigarette smoking. Within this group, 918 were classified as current smokers — defined as having smoked at least 100 cigarettes in their lifetime and still smoking at the time of survey (54% of the total sample) — and 140 had quit within the past year (8.2%). The remaining 38% (n = 652) had no prior smoking history. That figure is analytically important: more than a third of this vaping population came to the behaviour without combustible tobacco as a starting point, which places a significant portion of the sample outside the harm reduction paradigm altogether. They are not switching from something worse; they are starting with something whose long-term risk profile is still being established.

7.2 Current Cigarette Use Among the Smoking Subsample

Among the 1,058 current or former smokers, daily cigarette use was ongoing for 646 individuals (61%), occasional smoking for 272 (26%), and 140 (13%) had achieved complete cessation within the past year. The high proportion still smoking daily is a reminder that for the majority of dual users, vaping has functioned as an addition to the cigarette habit rather than a replacement for it.

Consumption volumes among those still smoking are relatively low: 663 individuals smoked fewer than five cigarettes a day (61% of the smoking subsample), 168 smoked five to ten (16%), 95 smoked between eleven and twenty (9%), and only 30 exceeded a pack a day (3%). A further 102 were non-daily smokers (10%). These are not heavy smokers by clinical standards, which is relevant context for interpreting any harm reduction claims based on reduction in the number.

7.3 The Impact of Vaping on Cigarette Consumption

Among the 1,058 current or former smokers, 60% reported that vaping had helped reduce how much they smoked: 53% significantly (n = 560) and 7% to a moderate degree (n = 71). Twenty-three percent reported no change in consumption (n = 239), and 17% were unsure how to characterise the effect (n = 188). These are self-reported assessments rather than clinically measured outcomes, and they carry all the associated risks of social desirability bias and motivated reasoning — factors worth holding in mind when interpreting the findings.

Among the 140 who had completely transitioned off cigarettes, 94% (n = 131) had done so within the first six months of beginning to vape. The remaining 6% (n = 9) took between six and twelve months; no one reported taking longer than a year to make the full switch. If the transition is going to happen, it appears to happen relatively early in the vaping trajectory — which has implications for cessation support design. Programmes that engage dual users in the first few months of vaping may yield better cessation outcomes than those targeting established, longer-term dual users.

7.4 Cessation Attempts and Outcomes

Among the 1,058 smokers in the sample, 65% (n = 689) had either tried to quit using vapes or were planning to do so: 140 had succeeded (13%), 252 had tried but relapsed (24%), and 297 were intending to attempt (28%). The remaining 35% (n = 369) had no current interest in quitting.

A 13% cessation rate is worth contextualizing. Unaided quit attempts — sometimes described as going 'cold turkey' — succeed at sustained abstinence rates typically below 5% at twelve months. Pharmaceutical NRT and prescription medications perform better under trial conditions, often in the 10–20% range depending on follow-up duration and support intensity. The 13% figure here, achieved

without any formal cessation support, occupies the lower end of that pharmacological range. It is not a spectacular result, but it is not trivial either.

Cessation Status	n	% of Smokers (n = 1,058)
Quit smoking successfully using vapes	140	13.2%
Attempted to quit using vapes but relapsed	252	23.8%
Planning to quit using vapes	297	28.1%
Not interested in quitting	369	34.9%
Total current/former smokers	1,058	100%

Table 2: Cessation outcomes among current and former smokers (n = 1,058)

8. Risk Perception Analysis

Risk perception data are frequently underused in health surveys — treated as supplementary colour rather than analytically significant findings. In this study, they are arguably as important as the behavioural data, because they reveal the information environment within which vaping decisions are being made.

The survey presented five attitudinal statements, each rated on a five-point agreement scale (1 = Strongly Disagree, 5 = Strongly Agree).

8.1 Vaping Versus Smoking: Relative Harm

Asked whether vaping is less harmful than smoking, just 26% of respondents agreed (n = 445). The largest single response group strongly disagreed (n = 650, 38%), with a further 21% simply disagreeing (n = 359), 9% neutral (n = 154), and 6% strongly agreeing (n = 103). At face value, this looks like a population that believes vaping is more dangerous than smoking, which would be epidemiologically inverted. More plausibly, it reflects genuine uncertainty, possible confusion about the scale direction, and a near-complete absence of credible public health messaging on the topic. People who have never been told the comparative risk picture cannot be expected to have formed accurate views about it.

8.2 Switching as a Health Strategy

Reframing the question slightly produces a different response pattern. When asked whether switching to vaping substantially reduces health risks from smoking, 39% agreed (n = 663) — making this the single most commonly endorsed position — while 21% remained neutral (n = 357). The shift from 26% to 39% agreement between questions is instructive: it suggests that respondents are somewhat more comfortable acknowledging a comparative benefit in the context of switching than they are in asserting an absolute safety claim. This is a meaningful distinction for a communication strategy.

8.3 Dual Use and Perceived Risk

On whether dual use is as harmful as smoking alone, 36% agreed (n = 616), 49% disagreed (n = 837), and 13% were uncertain (n = 222). The majority position — that dual use is less harmful than exclusive smoking — is broadly consistent with the toxicological evidence, though the magnitude of any benefit from partial substitution is debated and almost certainly smaller than the benefit of complete switching.

8.4 Long-Term Safety Concerns

Forty-nine percent reported no significant worry about the long-term effects of vaping (n = 908), while 26% expressed concern (n = 445) and 21% were neutral (n = 357). That half the sample is not particularly worried about long-term health effects — among products whose long-term effects are genuinely unknown — suggests a level of confidence that outstrips the current evidence base. It is not necessarily irrational for an individual to accept some uncertainty in exchange for a behaviour they value, but an informed choice requires knowing what the uncertainty actually is.

Attitudinal Statement	Agree / Strongly Agree	Neutral	Disagree / Strongly Disagree
Vaping is less harmful than smoking	445 (26%)	154 (9%)	1,111 (65%)
Vaping can have health risks (standalone)	560 (32.7%)	205 (12%)	911 (55.3%)
Switching to vaping reduces health risks	663 (38.8%)	357 (20.9%)	690 (40.4%)
Dual use is as harmful as smoking alone	616 (36.1%)	222 (13%)	837 (49%)
I worry about the long-term effects of vaping	445 (26%)	357 (20.9%)	908 (53.1%)

Table 3: Risk perception across attitudinal statements (n = 1,710)

9. Self-Reported Health Outcomes

We need to start with a clear warning about the method used. The health data in this study come from vape users who reported their own experiences, not from medical tests. This kind of data often has bias—people are more likely to describe results that support the choices they've already made. There are no medical checks here, such as lung function tests or blood markers of inflammation. What the survey shows is how people feel about their health. That information is useful, but it must be read carefully and not treated as hard medical evidence.

With that framing in place, among the full sample of 1,710 respondents, 74.75% (n = 1,278) reported no noticeable change in health since starting to vape. Nineteen percent (n = 320) described positive changes — 11% reported improved breathing or lung function (n = 188), 6% noticed reduced coughing (n = 98), and 2% described a recovered sense of taste or smell (n = 34). Six and a half percent (n = 111) reported adverse effects, almost uniformly described as breathing discomfort and, in most cases, transient in nature.

This pattern—more positive reports than negative, with most responses neutral—matches what short-term switching studies in other settings have also found. Transitioning from combustible to non-combustible nicotine delivery does reduce exposure to respiratory irritants, and some subjective improvement within months of switching is a plausible physiological response. The data are not inconsistent with that story. They do not, however, confirm it.

Reported Health Change	n	% of Total (n = 1,710)
Better breathing/lung function	188	11.0%
Less coughing	98	5.8%
Improved taste/smell	34	2.0%
No changes	1,278	74.8%
Negative changes (breathing discomfort)	111	6.5%

Table 4: Self-reported health changes since beginning to vape (n = 1,710)

10. Social Drivers and Initiation Patterns

10.1 Why People Begin Vaping

The initiation data are among the more analytically interesting in the study, because they reveal a striking gap between the harm reduction narrative and the actual reasons people take up vaping. When asked what motivated them to start, 40% cited trendy or modern appeal (n = 684) and 36% pointed to peer or friend influence (n = 616). Flavour enjoyment accounted for 13% (n = 222), stress relief or relaxation for 9% (n = 154), and curiosity for 2% (n = 34).

Health-related motivations — harm reduction, desire to quit, concern about smoking — barely feature among initiation drivers. This matters for two reasons. First, it means that the harm reduction benefit of vaping, where it occurs, is largely incidental rather than intentional — an unplanned consequence of a behaviour taken up for social reasons. Second, it suggests that public health framing of vaping as a cessation tool will resonate poorly with a population whose decision to vape was shaped by WhatsApp groups and what looked cool at a gathering, not by a conversation with a pharmacist or a government health leaflet.

10.2 Ongoing Reasons for Vaping

The picture shifts somewhat when respondents are asked why they continue rather than why they started. Social influence remains the leading reason (28%, n = 483), followed closely by flavour enjoyment (27%, n = 454). The desire to quit or reduce smoking climbs to 14% (n = 232) — suggesting that for a meaningful subset, the harm reduction rationale has taken hold over time even if it was not the original motivation. Addiction accounts for 7% (n = 126), cost savings a further 7% (n = 116), with hobby or curiosity (5%, n = 77), stress management (4%, n = 68), and perceived harm reduction (3%, n = 58) making up the remainder.

10.3 Youth Access and Under-16 Initiation

Six percent of respondents (n = 105) first tried vaping before their sixteenth birthday. Ten began between the ages of eight and twelve; 95 between thirteen and fifteen. No respondent reported encountering any legal barrier to purchasing vaping products. Not one.

This finding is straightforward. Age restrictions that exist only on paper, with no evidence of enforcement, are not real restrictions—they are simply for show. The fruit flavour preferences that dominate this sample, the peer-driven initiation patterns, and the near-total absence of purchasing barriers collectively describe a market that is, in practice, open to anyone with the money to buy a pod.

11. Market and Consumer Behaviour

11.1 Vape Shop Selection

Consumer choice of retail outlet reflects straightforward pragmatics. Location and convenience topped the list at 36% (n = 612), followed by price at 30% (n = 514) and product variety at 25% (n = 431). Staff knowledge was cited by 6% (n = 97) and shop ambiance by 3% (n = 56). These are not the purchasing drivers of a consumer base conducting careful research into product quality or regulatory compliance; they are the preferences of a population buying what is close, affordable, and available in the variants they want.

The geographic clustering of the retail market — concentrated in Shahdara Town, Jia Mosa, and Al-Rehman Garden in Lahore's northern districts — is worth flagging for urban planning and regulatory purposes. Market concentration in specific areas shapes access patterns, and in the absence of regulatory oversight, concentrated retail presence also concentrates the youth access problem.

11.2 Social and Legal Restrictions

On the legal side, the picture is unambiguous: no respondent reported a single instance of legal difficulty in purchasing vaping products. On the social side, the situation is more nuanced. Thirty-nine percent (n = 667) said they had encountered social resistance — family disapproval or public judgment. In Pakistani households where intergenerational scrutiny of behaviour remains significant, that is not a trivial constraint. Yet it is a social constraint, not a regulatory one, and public health systems should not outsource their protective function to family dynamics.

11.3 Dual Use Persistence and Its Drivers

Among the 918 current active smokers in the sample, the primary reasons for maintaining both habits were habit or addiction to both products (51%, n = 464) and the subjective sense that vapes do not deliver the same satisfaction as cigarettes (31%, n = 280). Variety-seeking accounted for 18% (n = 162), and 1% reported using vapes specifically in smoke-free environments where cigarettes are restricted (n = 12).

The addiction and satisfaction deficit explanation points to a clinical reality that information campaigns alone cannot address. Someone who continues smoking because they are addicted to the specific sensory and pharmacokinetic profile of combustible cigarettes, the rapid nicotine spike, the throat hit, the ritual, is not going to be moved primarily by messaging alone. They need access to products that better match their nicotine delivery needs, and potentially to behavioural support for managing the transition.

11.4 Recommendation of Vaping as a Harm Reduction Tool

Fifty-four percent of respondents (n = 923) said they would recommend vaping to a smoker as a harm reduction option; 33% would not (n = 564); 13% were unsure (n = 222). Majority endorsement, even from a sample that includes a substantial proportion of never-smoker vapers, suggests that the peer-level narrative around vaping is broadly positive about its harm reduction potential, regardless of whether respondents themselves arrived at vaping through that lens.

12. Public Health Implications

12.1 Vaping Is Functioning as a Harm Reduction Tool — for Some

Six in ten smokers in this sample reported reducing their cigarette consumption after taking up vaping; one in eight had quit entirely within the past year; and of those who made a complete switch, **94% did so within six months**. These are not trivial findings in a country carrying Pakistan's tobacco burden. They describe **a harm reduction process that is happening organically**, at scale, without clinical facilitation, which is both encouraging and concerning, depending on which part of the sentence one emphasises.

The encouraging part is that vaping is clearly functioning as a substitution pathway for a meaningful share of the smoking population, producing measurable reductions in cigarette consumption without the infrastructure investments that formal cessation programmes require. The concerning part is precisely that it is happening without clinical facilitation, without quality controls, without dosing guidance, without support for the dual users who are stuck between two habits and could benefit from structured help.

12.2 Mis-calibrated Risk Perception Is a Public Health Problem in Its Own Right

Only 26% of respondents in this sample believe vaping is less harmful than smoking. This is not a neutral finding. The evidence base, imperfect as it is, broadly supports a relative harm gradient that places vaping substantially below combustible tobacco for individual users. A vaping population that does not know this cannot make genuinely informed choices about harm reduction — including the choice to prioritize full switching over indefinite dual use. Mis-calibrated risk perception is not just an academic concern; it has direct behavioural consequences, particularly for the 35% of smokers in this sample who expressed no interest in quitting despite their continued tobacco use.

12.3 Youth Access Is Not a Peripheral Issue

The temptation in harm reduction discussions is to focus on the adult smoker population, for whom the benefit-risk calculus is most favourable. But 6% of this sample initiated vaping before age sixteen, some considerably younger, and the entire sample expressed a universal preference for fruit flavours that have been specifically implicated in youth appeal in regulatory discussions worldwide. These are not background concerns. They are foreground findings that any responsible policy framework must address before the numbers get worse.

12.4 Dual Use Is the Dominant Pattern, and It Has Limits as a Harm Reduction Strategy

The majority of smokers in this sample are dual users; they vape and smoke, without having made a full transition. Addiction and dissatisfaction with vaping's nicotine delivery are the primary reasons cited for maintaining both habits. Partial substitution does reduce toxic exposure to some degree, but the public health benefits are substantially smaller than those achieved through complete switching. Dual use is not a long-term success in harm reduction; it is only a halfway stage that needs further action to reach the goal.

13. Regulatory and Policy Discussion

Pakistan's current regulatory posture toward vaping is best described as passive, not by design, but by default. There is no dedicated ENDS framework; products sit in a grey zone, neither scheduled as medicines nor prohibited as consumer goods; age restrictions on purchase are unenforced; quality and labelling standards do not exist; and government-led communication about comparative risk is absent, with a slight exception with HTTP. This is not a regulatory position — it is an absence of one.

13.1 The Case for Proportionate Regulation

The case against blanket prohibition is not primarily ideological. It is pragmatic. Banning a product that is already demonstrably reducing cigarette consumption for a sizeable share of the smoking population, without putting anything in its place, would almost certainly drive those individuals back toward combustible tobacco. Proportionate regulation, minimum safety standards, transparent constituent labelling, marketing restrictions that prevent youth targeting, and meaningful age verification at the point of sale — is the architecture that allows harm reduction to work safely rather than accidentally.

13.2 Integration into Cessation Services

Sixty-five percent of smokers in this sample had either attempted to quit using vapes or planned to do so. That is not a fringe behaviour; it is the majority. Health workers, pharmacists, and community health volunteers are currently unprepared to discuss vaping as a cessation modality because they have received no formal guidance on the topic. Bridging that gap does not require asserting that vaping is safe; it requires training frontline health workers to have accurate, balanced conversations with patients who are already using vaping as a self-directed cessation tool — and to direct those patients toward structured support that improves the probability of success.

13.3 The Role of Public Communication

The risk perception data in this study describe a population navigating harm reduction decisions in an information vacuum. When 74% of active vape users either disbelieve or are unsure whether vaping is less harmful than smoking, the communication failure is not subtle. Effective public communication in this space does not mean overstating certainty — the science is genuinely incomplete on several fronts — but it does mean providing people with the best available current understanding in language they can act on. That is a basic function of a public health system, and it is one that Pakistan has not yet exercised in relation to vaping.

14. Limitations of the Study

14.1 Cross-Sectional Design

The survey shows only one moment in time. It can highlight links between vaping and reduced cigarette use, but it cannot prove that vaping caused the reduction. It may be that people already motivated to cut down were more likely to take up vaping as a tool. Establishing causality would require a longitudinal design, ideally with randomization, a much more resource-intensive undertaking.

14.2 Retail-Based Sampling

Recruiting participants at vape retail outlets produces a sample that is almost certainly unrepresentative of the broader vaping population in Lahore, let alone Pakistan. Habitual, frequent users are substantially over-represented; occasional users, closet vapers, and those who have lapsed are not captured at all. The findings describe the committed vape consumer, not the average person who has ever tried an e-cigarette.

14.3 Self-Report Bias

Every variable in this study — smoking history, cessation outcomes, health changes, and age of initiation- is self-reported. There is no biological verification, no clinical record linkage, and no objective outcome measure. Respondents who have chosen to vape are not a neutral source of information about whether that choice has been beneficial. Social desirability effects are plausible throughout, and the cessation and health outcome data should be weighted accordingly.

14.4 Geographic Scope

Ten markets in Lahore provide a reasonable picture of local vaping trends, but they are not enough to represent the whole country. Markets in Karachi, Islamabad, Peshawar, and rural areas may differ greatly in who participates, what products are available, how much they cost, and the social attitudes around them. National policy should be based on data that represent the country as a whole—something this study does not provide, but strongly recommends for future research.

14.5 Absence of a Comparator Group

Without a comparison group of smokers who have not adopted vaping, it is not possible to assess whether the outcomes observed here — the cessation rates, the health reports, the consumption reductions — are attributable to vaping specifically or would have been observed anyway in a population of motivated smokers over the same time period. This is a structural limitation of the design, and the cessation findings in particular should be read with it in mind.

15. Recommendations

This report offers five clear recommendations. They are aimed mainly at national policymakers and public health authorities, but they are also relevant for healthcare providers, civil society groups, and researchers.

Recommendation 1: Develop an Evidence-Based Regulatory Framework for ENDS

Pakistan currently has no dedicated standards for electronic nicotine delivery systems. A regulatory framework is needed that addresses product safety, constituent disclosure, labelling, and retail accountability — developed through consultation with public health experts and consumer representatives, and calibrated to reduce harm rather than simply restrict access. Both outright prohibition and total deregulation are, on the available evidence, the wrong answer.

Recommendation 2: Enforce Age Restrictions at the Point of Sale

Not a single respondent in this study encountered a legal barrier to purchasing vaping products. That finding alone makes the case for immediate, enforceable age verification at the retail level. Six percent of this sample — 105 individuals — first accessed vaping products before the age of sixteen. Without enforcement, age restrictions are meaningless. Mechanisms might include mandatory retailer licensing, point-of-sale ID checks, and meaningful penalties for non-compliance.

Recommendation 3: Launch a Targeted Public Information Campaign on Relative Risk

Three-quarters of vape users in Lahore do not believe vaping is less harmful than smoking. This is an information problem, and information problems have information solutions. The Ministry of National Health Services, working with medical associations and civil society, should develop accessible, evidence-based communication materials that explain, honestly and without exaggeration, what is currently known about vaping's relative risks compared with combustible tobacco.

Recommendation 4: Integrate Vaping into Cessation Support Frameworks

Sixty-five percent of smokers in the sample had either attempted to quit using vapes or planned to do so. These individuals are not waiting for permission to use vaping as a cessation tool — they are already using it, without clinical guidance or structured support. Training frontline health workers to have informed, non-judgmental conversations about vaping and directing self-directed quitters toward evidence-based cessation support would meaningfully improve outcomes for a population that is already trying to help itself.

Recommendation 5: Commission Longitudinal and Nationally Representative Research

A cross-sectional study of 1,710 retail customers in Lahore is a starting point, not an endpoint. Pakistan needs longitudinal research that can track smoking and vaping trajectories over time, and nationally representative sampling that extends beyond Lahore. The causal questions that this study raises — does vaping cause cessation, or do motivated quitters simply gravitate toward vaping? — cannot be answered without a research design capable of addressing them.

16. Conclusion

The Vaping Voices data do not provide a definitive verdict on electronic cigarettes. That verdict does not yet exist, and anyone claiming otherwise, in either direction, is overstating the evidence. What the data do provide is a detailed, locally grounded account of how vaping is actually functioning in Lahore: the demographics of who is doing it, the social dynamics that drive initiation, the variable effects on cigarette use, and the significant gaps in risk knowledge that characterize the population.

The harm reduction picture is genuinely mixed. Among the smokers in the sample, a majority report meaningful reductions in cigarette consumption, and 13% have quit entirely within the past year — without clinical support, without formal cessation programmes, without any governmental infrastructure designed to facilitate that outcome. Those are real public health gains, however imperfect the methodology that captures them.

At the same time, 38% of this vaping population (n = 652) had never smoked; they arrived at nicotine dependence through vaping rather than departing from it through vaping. Six percent (n = 105) started before the age of sixteen. The majority of dual users remain stuck in a pattern driven by addiction and sensory dissatisfaction rather than a deliberate harm reduction strategy. And a market that has expanded rapidly across northern Lahore continues to operate without quality standards, age controls, or any meaningful regulatory oversight.

Vaping alone will not solve Pakistan’s tobacco problem. Yet as a harm-reduction tool already widely used—and already helping many smokers reduce or quit—it cannot be left to regulatory neglect. A product delivering measurable cessation outcomes for a significant share of smokers deserves proportionate, evidence-based oversight. Thoughtful regulation can ensure safety and standards while preserving its role as a practical pathway out of smoking. It deserves the standards, the safeguards, the clinical integration, and the honest public communication that would allow it to deliver what it demonstrably can deliver — while containing the very real risks that the current data also make visible. That is not a complicated policy ask. It is, in many ways, the minimum that public health leadership requires.