

# Men's Health Profile

Part of the Suffolk Joint Strategic Needs  
Assessment (JSNA)

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**Language and terminology note:**


This profile uses the term men primarily in relation to people recorded as male. We recognise that sex (biological characteristics) and gender (how people identify and live) are distinct, and that both can shape health outcomes and experiences of services.

Where data is drawn from administrative records, it usually reflects sex as recorded in health and public service datasets, which may not fully capture gender identity.

Throughout the JSNA, we aim to use language that is respectful and inclusive, while being clear about the limitations of available data. We welcome feedback on this profile and our wider work - please contact us at [knowledgeandintelligence@suffolk.gov.uk](mailto:knowledgeandintelligence@suffolk.gov.uk).

**AI: Some information in our JSNA products may have been summarised with the help of artificial intelligence tools. Everything is carefully checked by our team to make sure it's accurate.**

JSNA-on-a-page summary




## JSNA-on-a-page summary:

### Men's health profile 2026

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#### Suffolk male population


- Suffolk population (2024): 786,231
- Males account for 387,154 residents (49.2%)
- Male population aged 65+ projected to increase by 40.9% by 2047



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#### Life expectancy and inequality


- Men in Suffolk live 3.6 years fewer than women
- Men in the 10% most deprived areas across England (73.2 years) live over 10 years fewer than those in the 10% least deprived areas (83.6 years). This is what we call the life expectancy gap
- Healthy life expectancy gap between males living in the most and least deprived areas: 19 years



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#### Cardiovascular disease


- Among Suffolk men, circulatory disease accounts for over a quarter (27.1%) of the 6.6-year difference in life expectancy between the most and least deprived areas
- Male under-75 mortality from ischaemic heart disease is 3.4 times higher than females in Suffolk
- Men are around 35% more likely than women to die from hypertensive disease



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#### Smoking


- Around 19% of male deaths aged 35+ are attributable to smoking
- Smoking prevalence varies by ethnicity and deprivation
- Highest smoking prevalence seen in White - Other and Other ethnic group males



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#### Cancer

- Cancer remains a leading cause of premature mortality among men
- Male under-75 cancer mortality in Suffolk in 2025: 122.2 per 100,000
- Prostate cancer is the leading cause (15.9%) of cancer death among men
- Lung cancer is closely behind, accounting for 15.3% of all male cancer deaths in Suffolk in 2022-24



### Respiratory disease

- Male mortality rate from respiratory disease is statistically significantly higher than females (51.4% higher)
- 35% of respiratory deaths attributable to smoking
- COPD mortality rate for males is statistically significantly higher (31.3% higher) than females in Suffolk



### Diabetes and obesity

- Male diabetes prevalence in Suffolk: 7.3% vs 5.7% in females
- Obesity prevalence across England is statistically significantly higher in Black and Mixed ethnic groups
- Men across England are more likely to be classified as overweight (including obesity) than females (69.9% compared to 59.4%)



### Mental health

- Men disproportionately affected by suicide, and self-harm. Self-harm prevalence is likely higher than reported, as many do not disclose due to stigma
- Male premature mortality among adults with severe mental illness substantially higher than females
- Some groups are at greater risk of mental ill health: men in contact with criminal justice services, younger men, fathers



### Alcohol and substance misuse

- Men experience substantially higher alcohol-related mortality and hospital admissions
- Male alcohol-related mortality rate nearly three times the female rate
- Male drug misuse mortality rate more than double the female rate
- Increasing prominence of cocaine and stimulant-related treatment need among men



### Health literacy

- Limited health literacy linked to poorer outcomes and lower engagement with prevention. One study found that men were twice as likely as women to have inadequate health literacy
- Ipswich estimated to have higher prevalence of low health literacy than the England average



### Overarching themes

- Men experience higher rates of preventable illness and premature mortality
- Deprivation remains a major driver of inequality
- Prevention, early intervention and improving engagement with services are critical
- Targeted approaches are needed for deprived communities and higher-risk groups



## Key opportunities for improving men's health in Suffolk

1. **Improve uptake of NHS Health Checks among men.** Men consistently have lower uptake of NHS Health Checks than women across all age groups in Suffolk, despite experiencing higher rates of cardiovascular disease and premature mortality. Understanding and addressing barriers to engagement represents an important opportunity for earlier identification and management of risk factors.
2. **Focus on the causes of the male life expectancy gap.** Cardiovascular disease, cancer, suicide, accidents and other external causes continue to account for a substantial proportion of premature mortality among men. Preventing illness earlier and reducing avoidable deaths remain central to improving outcomes.
3. **Target action towards men experiencing multiple forms of disadvantage.** The poorest outcomes are concentrated among men facing deprivation, homelessness, disability, social exclusion, contact with the criminal justice system, and other forms of disadvantage. These factors often intersect and contribute to widening health inequalities.
4. **Strengthen engagement with men across the life course.** Opportunities exist to improve health outcomes by engaging boys and men earlier, from childhood and adolescence through to later life, particularly around healthy behaviours, mental wellbeing, risk factor prevention and access to support.
5. **Use local intelligence to understand who is and is not being reached by services.** Variation in outcomes by deprivation, ethnicity, sexual orientation, disability and geography highlights the importance of understanding patterns of access, uptake and unmet need, ensuring services can reach men most at risk of poor health outcomes.

## What's the issue?

England's first [men's health strategy](#) was published in November 2025. It sets out an evidence-based case for action, stating that men experience poorer health outcomes than women across a range of indicators: they die younger, spend more than a fifth of their lives in ill health, and are disproportionately affected by major conditions such as cardiovascular disease, cancer and type 2 diabetes<sup>1</sup>. These inequalities are even more pronounced among men living in the most deprived areas, where life expectancy is over 10 years lower on average, and healthy life expectancy nearly 20 years shorter than in the least deprived areas<sup>1</sup>.

The strategy also highlights that men are more likely to die from external causes<sup>2</sup>, including suicide, accidents and substance misuse, and that certain groups of men – including those experiencing homelessness<sup>3</sup>, disability<sup>4</sup>, involvement with the criminal justice system<sup>5</sup>, or belonging to some ethnic minority communities<sup>6</sup>, face significantly worse outcomes<sup>1</sup>.

However, as highlighted by the King's Fund's recent research into men's health in England, the issue is not simply that men experience poorer health outcomes, but how health and care systems engage with difference groups of men. While discussions of men's health often focus on individual behaviours, such as risk-taking, stoicism, or reluctance to seek help<sup>7</sup>, these explanations alone do not account for the scale and persistence of inequalities.

The King's Fund found that men's experiences of health and healthcare are shaped by a range of social and economic factors, including employment, income, ethnicity, geography, disability, relationships and social circumstances<sup>8</sup>. These factors influence not only health outcomes, but also how men perceive, access and engage with services. Men living in deprivation, insecure employment or other forms of disadvantage may face practical barriers to accessing care, including inflexible appointment systems, limited opportunities to attend services during working hours, and difficulties navigating complex systems<sup>7</sup>. For instance, when considering severe mental illness, women were more likely to be in contact with, or accessing community mental health services for severe mental illness, while men were more likely to be admitted as an inpatient<sup>9</sup>. Also, most men have not been invited to an NHS Health Check (only 37% of eligible men), and men are less likely to seek support for friends and family for mental health support compared to women (38% compared to 45%)<sup>10</sup>.

The research also highlights that men's attitudes towards health and wellbeing are not uniform. Younger men were often comfortable discussing mental wellbeing, while older men were more likely to frame distress in relation to practical concerns such as work, finances, relationships, bereavement or physical health<sup>8</sup>. This suggests that engagement approaches which focus solely on mental health language may fail to reach some groups of men, particularly those who do not identify with traditional mental health narratives<sup>8</sup>.

Importantly, many men reported negative experiences of healthcare services, particularly around access to general practice and feeling that concerns were not listened to or resolved<sup>8</sup>, with males noting it was not worth seeking help unless a problem was particularly serious or persisted for a week or longer<sup>8</sup>. Given that men generally have fewer contacts with health services than women, these encounters can have a disproportionate impact on future help-seeking behaviour<sup>8</sup>. The King's Fund therefore argues that every contact with services should be viewed as an opportunity to build trust, support prevention and encourage earlier engagement, stating that the root cause of men's disengagement appears to be a lack of trust in receiving a positive outcome when they do seek help<sup>8</sup>.

The report advocates for a population health approach to men's health, recognising that men are not a single homogeneous group and that effective interventions need to reflect the needs of different communities and life stages<sup>8</sup>. This includes considering how services are framed, where and when they are delivered, who provides them, and whether they feel relevant and accessible to the men they are intended to reach<sup>9</sup>. It also highlights the importance of working with employers, communities and voluntary organisations, recognising that many of the factors influencing men's health sit outside traditional healthcare settings.

Disadvantage rarely occurs in isolation; factors such as deprivation, ethnicity, disability and social exclusion intersect to shape both health outcomes and access to care<sup>1</sup>. While the national strategy acknowledges these inequalities, there is a risk that intersectionality remains descriptive rather than operational – identifying who is at risk but not actually changing how services are designed and delivered to address inequalities in men's health outcomes.

As a result, there is a gap between recognising the problem and addressing it effectively. There is a need for a stronger focus on how systems are to adapt, particularly in terms of reaching, engaging and retaining men facing the greatest disadvantage. Otherwise, there is a risk that the strategy may improve outcomes for those already closest to services, while leaving underlying inequalities largely unchanged.

To deliver meaningful change, the focus must shift from describing inequalities to understanding how systems are working in practice. This means using local data to identify who is being reached, who is not, and where patterns of repeat use point to unmet need.

For Suffolk, this analysis helps build a clearer picture of how men's outcomes vary across communities and encourages a shift away from assumptions about behaviour towards how well services and systems are working for people.

## What do the statistics show?

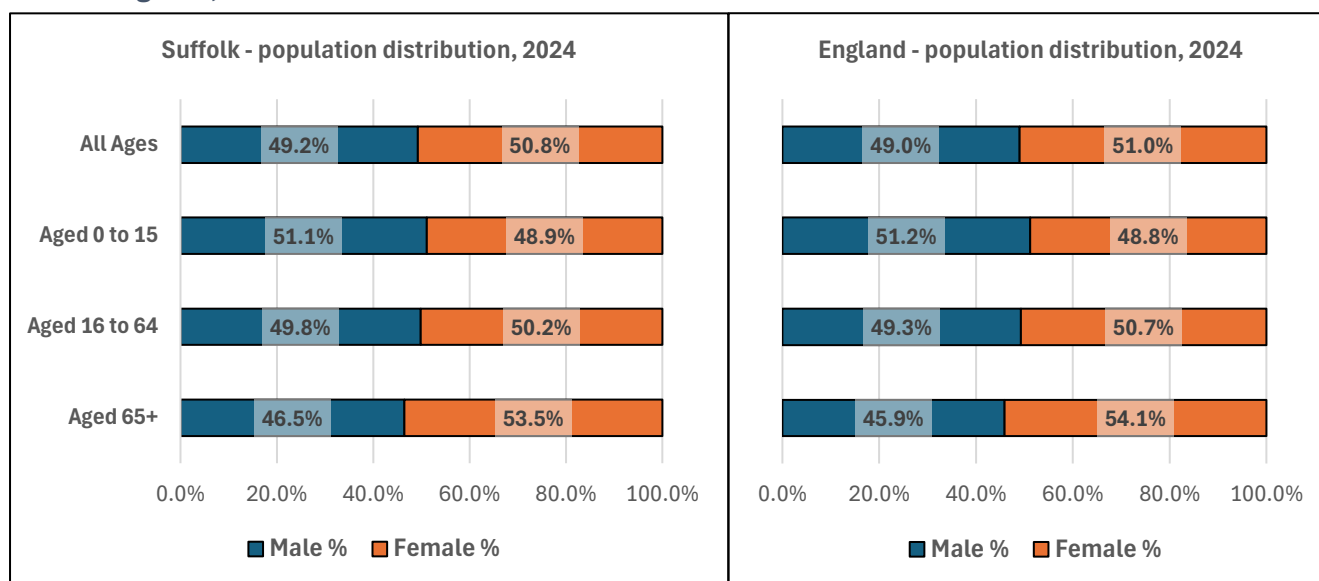
### Overview of Suffolk's male population

In 2024, Suffolk had an estimated population of 786,231 residents, of these 399,077 (50.8%) were female and 387,154 (49.2%) were male. This distribution is broadly similar to the national picture in England, where males account for 49.0% of the population.

The age profile of Suffolk's male population reflects wider demographic patterns seen nationally, with a higher proportion of males in younger age groups and a lower proportion in older age groups due to differences in life expectancy. Among children and young people aged 0 to 15 years, males account for 51.1% of the population in Suffolk, similar to England (51.2%). Within the working-age population (16 to 64 years), males make up 49.8% of Suffolk residents, compared to 49.3% nationally.

In older age groups, the balance shifts towards females. Among people aged 65 years and over in Suffolk, males account for 46.5% of the population, while females account for 53.5%. This reflects the lower life expectancy experienced by men and highlights the importance of addressing the factors contributing to premature mortality and poorer health outcomes among males across the life course.

**Figure 1. Population distribution by age group – males and females in Suffolk and England, 2024**



Source: [Office for National Statistics](#) (2025)

Suffolk's population distribution varies across its districts and boroughs, reflecting differing demographic profiles and potential health needs. In 2024, East Suffolk was the largest district, accounting for almost a third of the county's total population (249,664 residents), followed by West Suffolk (188,485) and Ipswich (140,274). Mid Suffolk and Babergh had smaller populations, at 110,775 and 97,033 residents respectively.

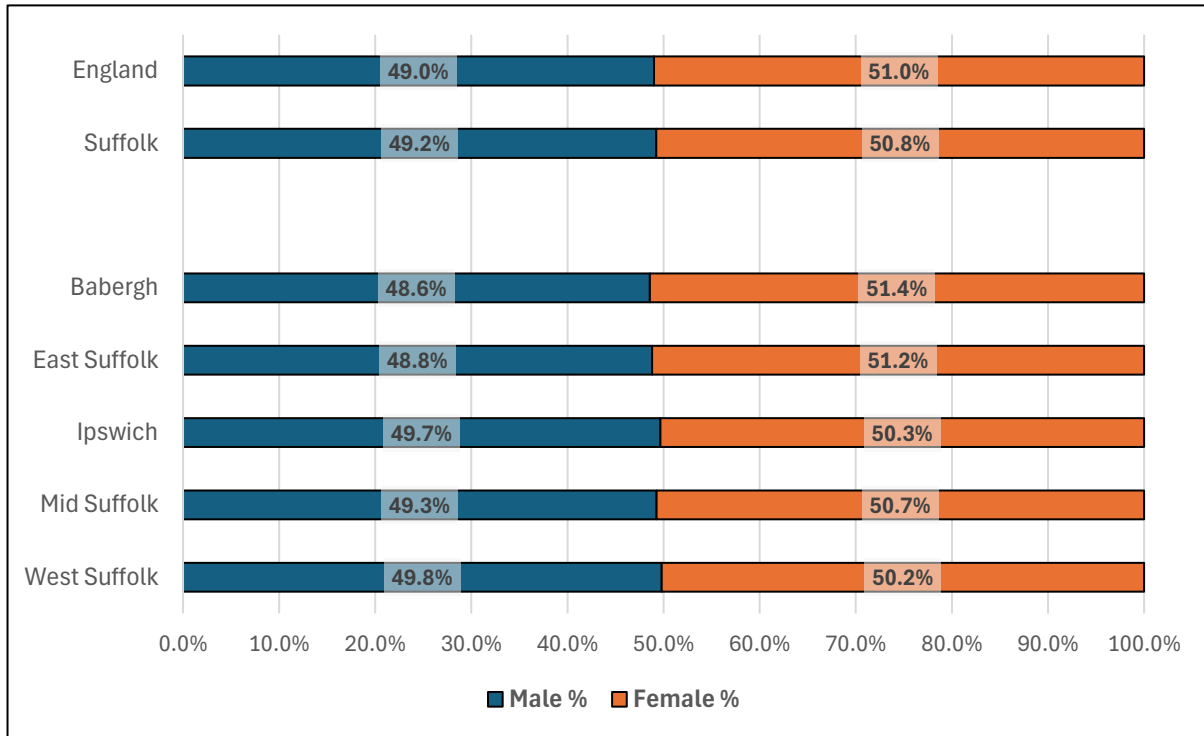
West Suffolk had the highest proportion of males (49.8%), while Babergh had the lowest (48.6%). Ipswich had the youngest age profile, with a larger proportion of residents aged under 16 and fewer older residents aged 65 and over. In contrast, Babergh, Mid Suffolk and East

## Men's Health Profile

Suffolk had older population structures, with around one-quarter to one-third of residents aged 65 years and over.

These demographic differences are important when considering men's health outcomes and potential service demand. Areas with older populations are likely to experience a greater burden of long-term conditions such as cardiovascular disease, cancer and respiratory illness, while younger urban populations may experience different patterns of health need, including poorer mental health, substance misuse and higher levels of deprivation-related ill health.

**Figure 2. Population distribution (% of males and females) for Suffolk districts and boroughs, 2024**

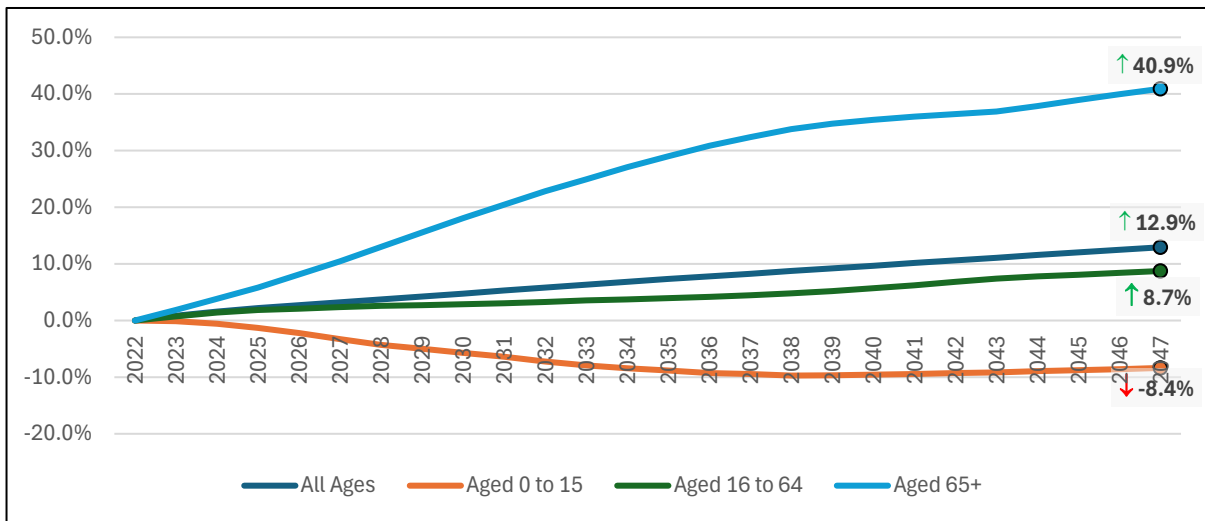


Source: [Office for National Statistics](#) (2025)

The 2022-based subnational population projections suggest that Suffolk's male population will continue to grow and age over the next 25 years. Between 2022 and 2047, the total male population is projected to increase by 12.9%, rising from 378,890 to 427,894 men.

The most substantial growth is expected among older men aged 65 years and over. This population is projected to increase by 40.9% over the period, from 85,174 in 2022, to 120,022 by 2047. In contrast, the number of boys and young men aged 0 to 15 is projected to decline by 8.4%, while the working-age male population (16 to 64 years) is expected to grow by 8.7%.

**Figure 3. Subnational population projections for Suffolk: 2022-based, predicted percentage change from baseline by age-group, Suffolk males, 2022 to 2047**



Source: [Office for National Statistics](#) (2025)

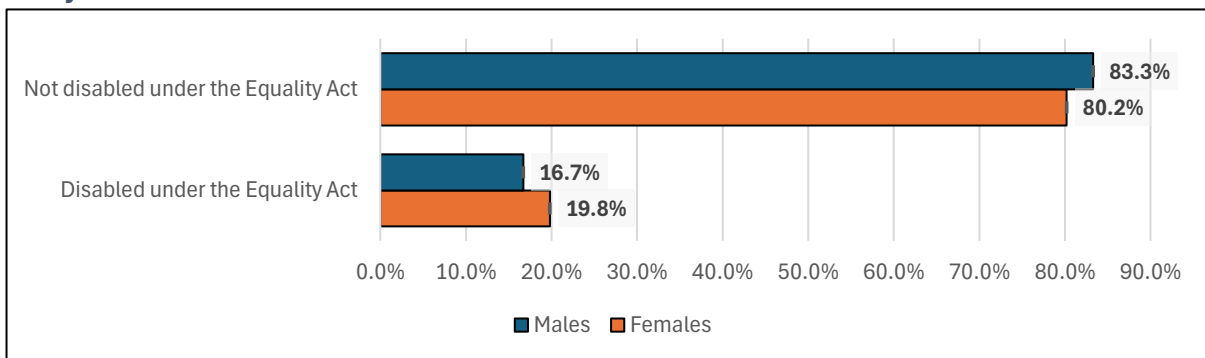
These projections highlight the growing importance of healthy ageing and prevention across the lifecycle. While an increasing older male population may place upward pressure on the prevalence of long-term conditions – including cardiovascular disease, cancer, dementia, diabetes and respiratory disease – a portion of this future burden is preventable or modifiable, alongside implications for health and social care demand. The projected demographics changes reinforce the need for early intervention and targeted prevention approaches to improve healthy life expectancy and reduce future pressures on health services in Suffolk.

### Disability

Disability is an important factor influencing men’s health, wellbeing and access to services in Suffolk. Census 2021 data showed that 16.7% of males in Suffolk were classified as disabled under the Equality Act, statistically significantly lower when compared to 19.8% of females (self-reported data).

In total, around 62,500 men and boys in Suffolk were identified as disabled under the Equality Act at the time of the Census. Disabled men may experience poorer physical and mental health outcomes, increased social isolation, barriers to employment, lower incomes, and difficulties accessing services and support<sup>11</sup>.

**Figure 4. Suffolk males and females: Disabled and not disabled prevalence, Census Day 2021**



Source: [Office for National Statistics](#) (2023)

Disability can intersect with other forms of inequality, including age, deprivation, rurality and caring responsibilities, increasing the risk of poorer health outcomes for some groups of men<sup>12</sup>. As Suffolk's population ages, the number of men living with disability and long-term conditions is also likely to increase.

### Identity

The 2021 Census estimates about 16,618 county residents identify as lesbian, gay, bisexual, queer, or another non-heterosexual orientation. This included an estimated 4,495 men (1.5% of males aged 16 years and over) who identified as gay, compared with 3,417 women (1.1%) who identified as lesbian. A further 2,029 men (0.7%) identified as bisexual, and 711 men (0.2%) identified with another sexual orientation. Sexual orientation is an important consideration for men's health as gay, bisexual and other men who have sex with men can experience different patterns of health need and inequalities, including in relation to sexual health, mental health, discrimination and barriers to accessing services<sup>13,14</sup>.

Using Census 2021 data, 2,434 residents in the county identify as a gender different than that assigned at birth, 442 identifying as trans women (a woman who was assigned male at birth), and 475 identifying as trans men (a man who was assigned female at birth)<sup>15</sup>. However, this is very limited national, regional and local quantitative data on the population of trans and non-binary groups, so it is thought these numbers may be underestimated.

The Census 2021 data also shows that ethnic communities make up 12.7% of the county's population; 87.3% of Suffolk's population reported their ethnicity as White: English, Welsh, Scottish, Northern Irish or British on Census Day 2021. This distribution of ethnic groups is similar for males and females in Suffolk, with 87.5% of females and 87.1% of males reporting their ethnicity as White: English, Welsh, Scottish, Northern Irish or British on Census Day 2021. These figures are much higher than the average across England – where 73.2% of females and 73.8% of males reported their ethnicity as White: English, Welsh, Scottish, Northern Irish or British on Census Day 2021.

## Lifecourse determinants of men's health

Men's health outcomes are shaped across the life course, from birth through childhood and adolescence. Educational attainment remains an important determinant of future health, employment opportunities, income, and wellbeing. Nationally, boys continue to achieve lower educational outcomes on average than girls across several measures, which can contribute to inequalities later in life. In England, girls achieve higher average Attainment 8 scores than boys (48.1 compared to 44.1), while Suffolk's overall Attainment 8 score (43.1) places the county within the lowest quintile nationally.

Health-related behaviours and risk factors also emerge early in life. Nationally, boys aged 10 to 11 years are more likely than girls to be overweight or living with obesity (38.5% compared to 33.7%), while among adults, men are substantially more likely than women to be overweight or living with obesity (69.9% compared to 59.4%). Although Suffolk-specific sex breakdowns are not available for childhood obesity, overall prevalence among Year 6 children in Suffolk is statistically significantly lower than the England average – despite this, more than 1 in 3 children aged 10/11 years old in Suffolk (33.6%) are classified as overweight (including living with obesity) in 2024/25. Physical activity levels are generally higher among men than women nationally, although levels remain below Chief Medical Officer (CMO) recommendations for a substantial proportion of adults, with 68.2% of Suffolk adults over the age of 18 meeting CMO recommendations in 2024/25 (statistically similar to the England average of 68.0%).

Diet and food consumption patterns established in childhood and adolescence can also contribute to longer-term health inequalities among men. National dietary survey data show that boys and men consume higher levels of some unhealthy food and drink products compared to females<sup>16</sup>. Among adults, men aged 19 to 64 years report the highest average consumption of red and processed meat, with over one quarter consuming more than the recommended 90g per day<sup>16</sup>. Men in this age group also consume the highest average volume of sugar-sweetened soft drinks among adults<sup>16</sup>. National evidence additionally suggests that boys are more likely than girls to consume high-caffeine energy drinks, which have been associated with poorer sleep, lower wellbeing, behavioural difficulties and unhealthy dietary patterns<sup>17</sup>. These behaviours emerge alongside wider patterns of overweight and living with obesity observed among boys and men and highlight the importance of early prevention and healthy lifestyle interventions across the life course.

Transitions into adulthood also influence long-term health outcomes. Young men are more likely than young women to be not in education, employment or training (NEET), increasing the risk of poorer mental health, social exclusion, lower income, and long-term disadvantage. In Suffolk, 5.3% of males aged 16 to 17 years were recorded as NEET or whose activity was unknown in 2024/25, compared to 5.1% of females. While the Suffolk figures for males and females are statistically similar, nationally, the gap is wider, with rates statistically significantly higher among young men.

**Table 1. Lifecourse determinants of men's health indicators, comparing value for Suffolk and England males and females (where available)**

Indicator	Time period	Area	Male value	Female value
Reception prevalence of overweight (including obesity) (4-5 yrs)	2024/25	England	23.6%	23.4%
Year 6 prevalence of overweight (including obesity) (10-11 yrs)	2024/25	England	38.5%	33.7%
Average Attainment 8 score	2024/25	England	44.1	48.1
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	2024/25	Suffolk	5.3%	5.1%
Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (18+ yrs)	2024/25	England	69.9%	59.4%
Percentage of physically active adults (19+ yrs)	2024/25	England	70.7%	65.7%
Life expectancy at birth (1 year range)	2025	Suffolk	81.6	84.9

**Compared to persons (Statistically significantly):**

Better 95%

Similar

Worse 95%

Not compared

Source: [Office for National Statistics](#) (2026)

These wider social and economic factors influence health behaviours, access to services, and future health outcomes throughout adulthood. This is reflected in differences in life expectancy, with Suffolk males expected to live 81.6 years compared to 84.9 years for females in 2025, a gap of 3.3 years. Although life expectancy in Suffolk remains higher than the England average for both men and women, inequalities persist across communities and population groups.

Neurodiversity and special educational needs and disabilities (SEND) are also important considerations for men's health across the life course. In Suffolk, boys and young men account for the majority of the children and young people with Education, Health and Care (EHC) plans and receiving SEN support provision. In 2024/25, 69.0% of all EHC plans in Suffolk were for males (6,096 compared to 2,741 for females). Demand for SEND support has increased substantially in recent years, with EHC plans for males increasing by 34.6% since 2020/21, alongside continued growth in SEN support provision. This could be in part due to a disparity in diagnosis for females, with gender bias in assessment and from those referring children for assessment, as well as girls being better at hiding the challenges they face from some conditions<sup>18</sup>. This is however, one of the services that boys/young males are accessing and provides an opportunity to build trust with healthcare services for the Suffolk male population at a young age. Neurodevelopmental conditions and unmet support needs can have important implications for educational attainment, employment opportunities, mental health, social inclusion, and transition into adulthood. Further detail is available within the [Suffolk SEND Needs Assessment](#).

### What Population Health Management data tells us about men's health in Suffolk (excludes Waveney)

Population Health Management (PHM) data improves population health through data-driven planning and delivery of proactive care to optimise health outcomes through prevention<sup>19</sup>. PHM provides further insight into the health needs, risk factors, and service use patterns of men across Suffolk. Although men have lower average levels of multimorbidity than women overall in Suffolk, they experience a distinct profile of health risks and outcomes. Nationally, inequalities in life expectancy are wider for men, but women spend more of the lives living in ill health<sup>20</sup>, and some evidence suggests that physical multimorbidity may be more common in men, and physical-mental multimorbidity more common in women<sup>21</sup>. Note PHM data currently excludes Waveney residents.

PHM data highlights that men in Suffolk have higher diagnosed and recorded prevalence of several major long-term conditions and risk factors such as diabetes (7.8% compared to 6.1% in women), hypertension (19.1% compared to 18.7%), stroke (1.5% compared to 1.2%), and learning disability (0.8% compared to 0.6%). Men are also more likely to smoke and experience alcohol and substance misuse, as explored later in this men's health profile.

In contrast, women have higher recorded prevalence of anxiety, depression, obesity (not including overweight), dementia and asthma. However, lower recorded prevalence of common mental health conditions among men may partly reflect lower levels of help-seeking and later presentation to services. Despite this, men experience poorer outcomes across several major cause of premature mortality including cardiovascular disease, cancer, suicide, and substance misuse.

Patterns of healthcare utilisation also differ by sex. Men have lower use of primary care, mental health, community health, and social care services than women, despite experiencing higher levels of premature mortality and lower life expectancy. This may reflect differences in help-seeking behaviour, access to services, occupational factors, and presentation at later stages of illness. Together, this PHM data reinforces the importance of adopting targeted and gender appropriate approaches to prevention, early intervention, and access to care for Suffolk's male population.

# Men's Health Profile

**Figure 5. Suffolk (excluding Waveney) Population Health Management data (excluding Waveney) overview for males and females, January – December 2025**

Gender	Female	Male	Unknown	Cohort Population	Whole Population
<b>Overall Population Measures</b>					
Population	304,135	304,055	31	608,221	643,621
Age	44	43	26	43	44
Male %	0.0%	100.0%	0.0%	50.0%	50.0%
Deprivation	6.0	5.9	5.2	5.9	6.0
Minority Ethnic	11.2%	11.7%	7.4%	11.5%	11.1%
Avg. Multimorbidities	1.0	0.8	1.1	0.9	0.9
<b>Outcomes</b>					
Finance - Total	£672.8m	£549.9m	£131.3k	£1.2bn	£1.3bn
Finance PPPY - Total	£2.2k	£1.8k	£4.2k	£2k	£2k
Urgent & Emergency	£348	£286	£389	£317	£313
Acute Planned	£426	£351	£437	£389	£388
Acute Other	£205	£196	£2.5k	£200	£201
Primary Care	£448	£354	£287	£401	£401
Community Health	£151	£131	£210	£141	£138
Mental Health	£162	£117	£261	£140	£140
Social Care & CHC	£471	£374	£173	£423	£404
<b>Physical Health</b>					
Asthma	12.0%	9.8%	12.9%	10.9%	10.9%
Diabetes	6.1%	7.8%	0.0%	7.0%	6.9%
Hypertension	18.7%	19.1%	6.5%	18.9%	18.9%
Obesity	18.6%	14.5%	3.2%	16.6%	16.5%
Stroke	1.2%	1.5%	0.0%	1.4%	1.4%
<b>Mental Health &amp; Learning Disability</b>					
Anxiety	21.9%	12.2%	38.7%	17.1%	16.9%
Dementia	1.5%	1.0%	3.2%	1.2%	1.2%
Depression	16.5%	10.1%	45.2%	13.3%	13.2%
Learning Disability	0.6%	0.8%	0.0%	0.7%	0.7%
<b>Other Characteristics</b>					
Not Fit for Work (In Year)	6.3%	4.3%	6.5%	5.3%	5.2%
Opioid Prescription	7.9%	4.9%	0.0%	6.4%	6.4%

**Population**  Section  Cohort vs Whole **Outcomes**  Section  Cohort vs Whole **Health Indicators**  Section  Cohort vs Whole **Colour scale scope**  Per section  Per row

Lowest Highest Lowest Highest Lowest Highest Lowest Highest Lowest Highest

Source: Population Health Management (2026)

## Wider determinants of health

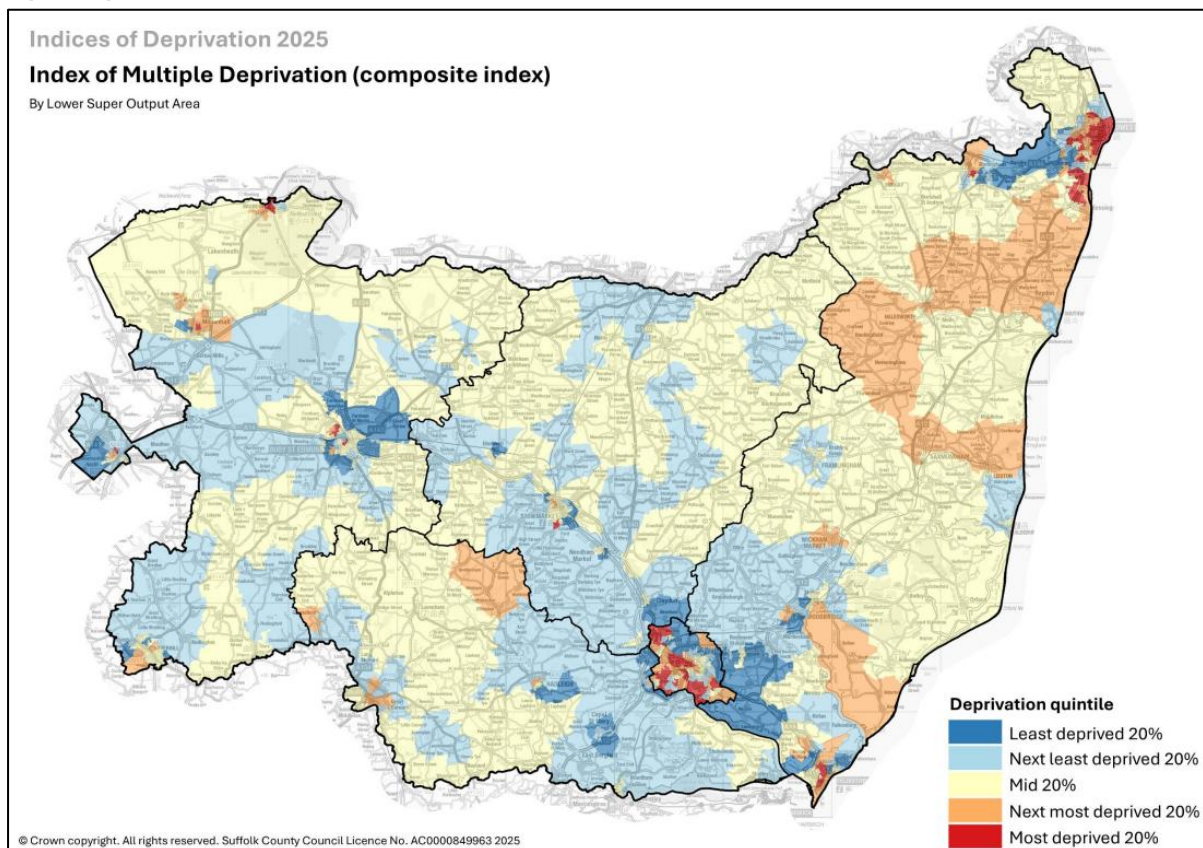
The wider determinants of health are a diverse range of social, economic and environmental factors which influence people's mental and physical health<sup>22</sup>.

### Deprivation

Poor health disproportionately affects those experiencing poverty and social exclusion. 4.6% (36,430 individuals) of the population living in Lower-layer Super Output Areas (LSOAs) in Suffolk are in the 10% most deprived areas in England in 2025. Suffolk is the 100<sup>th</sup> most deprived local authority in England out of 153 Upper Tier Local Authorities (UTLAs), where number 1 is most deprived. Suffolk is therefore just outside the top third of least deprived UTLAs in the country. Areas of higher relative deprivation in Suffolk are concentrated in Ipswich and Lowestoft, with smaller areas remaining in Beccles, Felixstowe, Stowmarket, and Bury St Edmunds.

Applying 2024 mid-year population estimates to Suffolk's LSOAs within the 20% most deprived areas nationally shows that the sex distribution is broadly similar to the overall population profile, although females make up a slightly larger proportion of residents. Across these LSOAs, there were an estimated 85,395 residents, of whom 43,334 (50.7%) were female and 42,061 (49.3%) were male. This suggests that deprivation in Suffolk does not disproportionately affect one sex overall, although local variation exists between neighbourhoods.

**Figure 6. Index of Multiple Deprivation quintile for Suffolk Lower Super Output Area (LSOA), 2025**



Source: [Ministry of Housing, Communities and Local Government](#) (2025)

## Men's Health Profile

### Suffolk's workforce and implications for men's health

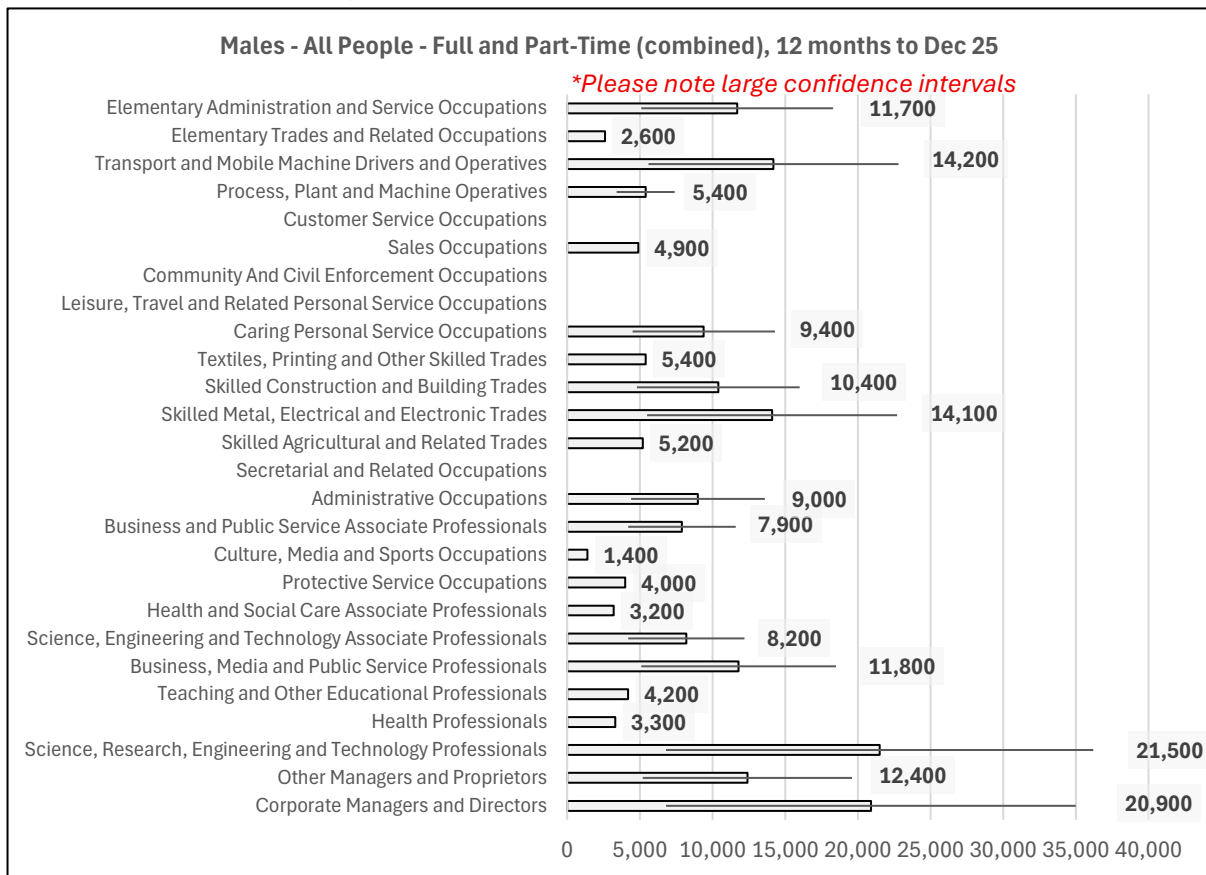
Suffolk's workforce profile includes several industries that have traditionally employed larger proportions of men, including agriculture, construction, logistics and transport, manufacturing, port-related industries, energy infrastructure, defence, and engineering. This reflects Suffolk's economic geography and major employers including the Port of Felixstowe, Sizewell-related energy activity, construction and infrastructure projects, horseracing, farming and food production, and military bases.

Local labour market data from Nomis/Annual Population Survey suggests that men in Suffolk are more likely than women to work in skilled trades, transport, construction, plant and operative occupations, consistent with national patterns seen in male-dominated industries.

Suffolk's male workforce can encounter specific health risks and barriers to support identified in the Men's Health Strategy including:

- Exposure to hazardous working environments and air quality increasing the risk of various lung diseases
- Higher smoking and alcohol consumption in some occupational groups
- Healthcare access, suitability, and availability of preventative services
- Long and irregular hours – leading to poor health outcomes if not properly managed
- Involvement in industries with a higher rate than average of work-related musculoskeletal conditions<sup>1</sup>

**Figure 7. Suffolk male population – employment by occupation (SOC 2020), part-time and full-time combined, 12 months to December 2025**



Source: [Nomis \(Annual Population Survey\)](#) (2026)

### Men's health in coastal communities

The national Men's Health Strategy identifies people living in more deprived and coastal towns often having the highest needs for the NHS, but the fewest GPs, the worst-performing services and the longest waits<sup>1,23</sup>. Suffolk's PHM data suggests similar patterns at a local level.

Compared to males living in non-coastal areas of Suffolk, men living in Suffolk's coastal communities are older on average (46.8 years compared to 42.3 years) and experience higher levels of long-term ill health and multimorbidity. PHM data also shows a higher prevalence of several chronic conditions among coastal males, including diabetes (9.2% compared to 7.7%), hypertension (22.9% compared to 18.9%), obesity (18.0% compared to 14.3%), and stroke (2.0% compared to 1.5%). This is consistent with the older population in coastal areas.

Mental health indicators are also poorer among men in coastal areas, with higher recorded prevalence of anxiety (14.1% compared to 12.1%) and depression (11.6% compared to 10.0%). Coastal males additionally show higher use of opioid prescriptions (6.1% compared to 4.9%) and greater utilisation of community health, urgent and emergency care services.

These findings highlight the importance of place-based approaches to improving men's health in Suffolk; particularly in coastal communities where older age profiles, chronic disease burden, access challenges, and wider socioeconomic factors can combine to increase health inequalities.

### Gypsy, Roma and Traveller communities

Gypsy, Roma and Traveller (GRT) communities are an important population group within Suffolk and experience some of the poorest health outcomes of any inclusion health population. Evidence nationally and locally suggests significant inequalities affecting life expectancy, long-term health conditions, mental health, education, housing security and access to healthcare services.

Suffolk's 2023 [Gypsy, Roma and Traveller Needs Assessment](#) identified a younger age profile within local Roma populations compared to the wider Suffolk population, with the median age recorded at 29 years for both males and females, compared to 44 years for males across Suffolk overall. The needs assessment also identified a growing number of children and young people from GRT communities recorded within Suffolk schools.

Educational data suggests that boys from GRT communities are disproportionately represented in younger age groups and less likely to remain in education into secondary years when compared to non-GRT pupils. In the January 2023 school census, 83.5% of male GRT pupils were recorded in Year 6 or below, compared to 68.8% of non-GRT pupils.

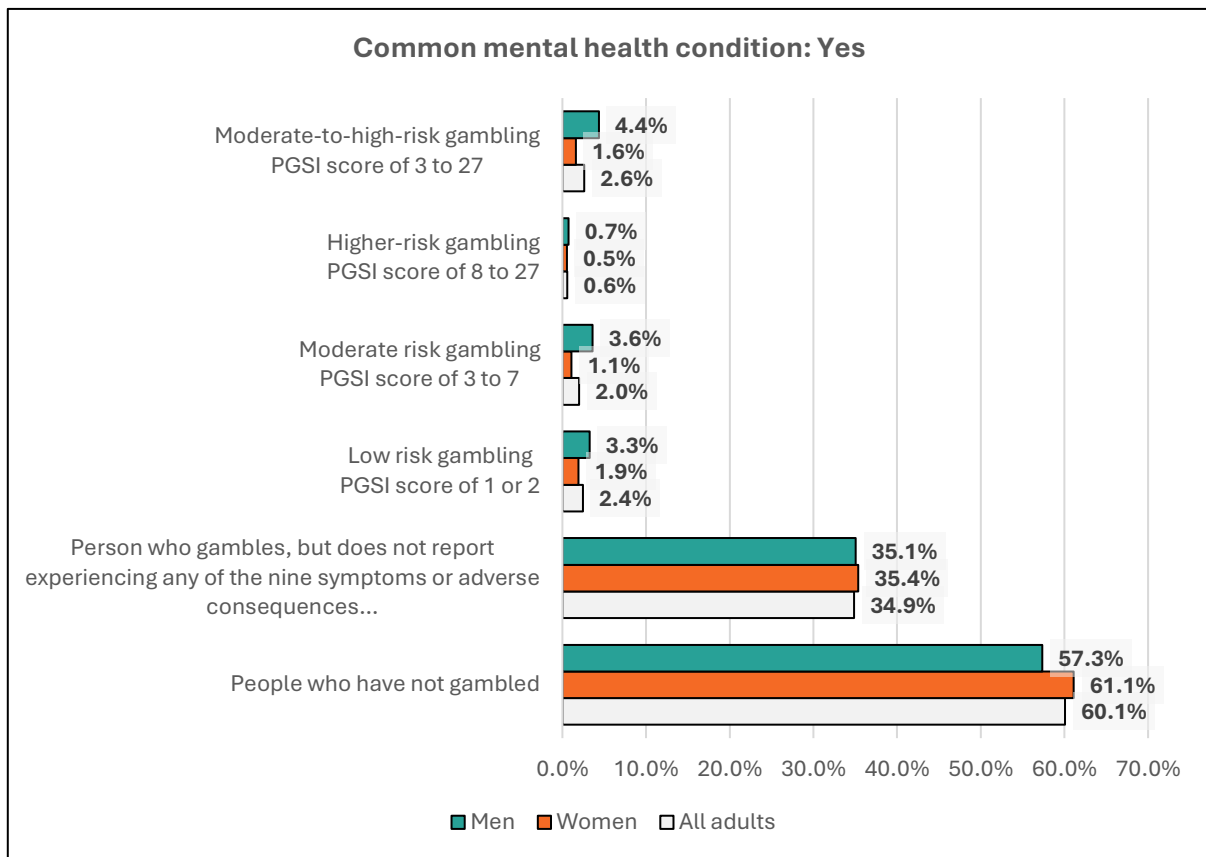
Evidence from wider UK and Irish Traveller studies highlights substantially poorer health outcomes for Traveller men, including higher mortality rates, poorer mental health, increased suicide risk, and barriers to accessing preventative and primary healthcare<sup>24</sup>. Experiences of discrimination, insecure accommodation, digital exclusion, low trust in services and cultural barriers to engagement may further contribute to poorer outcomes for men within GRT communities<sup>24</sup>. This reiterates the importance of culturally appropriate outreach, trusted community engagement, and inclusive approaches to prevention and healthcare access within Suffolk's men's health work.

Gambling

Gambling-related harm is increasingly recognised as a public health issue, and is associated with poorer mental health, financial insecurity, relationship breakdown and suicide risk. National evidence shows that men are disproportionately affected by harmful gambling behaviours, particularly younger men and those experiencing poor mental health<sup>25</sup>.

Data from the Adult Psychiatric Morbidity Survey (APMS) for England shows a clear relationship between common mental health conditions (CMHCs) and problem gambling. Men with a CMHC are more than twice as likely to experience moderate- to high-risk gambling compared with men without a CMHC (4.4% compared with 1.7%). Higher-risk gambling is also more common among this group.

**Figure 8. Problem Gambling Severity Index (PGSI) scores (age-standardised) for adults reporting a common mental health condition: Yes, by men, women and all adults, England, 2023/24**



Source: NHS Digital, [Adult Psychiatric Morbidity Survey: 2023/24](#), 7. Gambling Behaviour – Data tables. Table 7.8

Modelled estimates on [treatment need and support published in 2023](#) suggest gambling-related harm represents a significant source of unmet need in Suffolk. It is estimated that:

- around 1,700 adults may benefit from brief advice or low-intensity support
- over 12,500 adults may benefit from extended brief interventions
- around 2,100 adults may require structured psychosocial interventions
- approximately 2,300 adults may benefit from psychologist-led CBT
- around 400 adults may require intensive residential treatment for gambling disorder

While many individuals may benefit from early intervention and brief support, a smaller group experience severe and complex harms requiring specialist treatment and mental health support. Gambling-related harm will be explored in more detail through a dedicated Suffolk gambling health needs assessment/profile currently in development.

## Inequalities in health outcomes

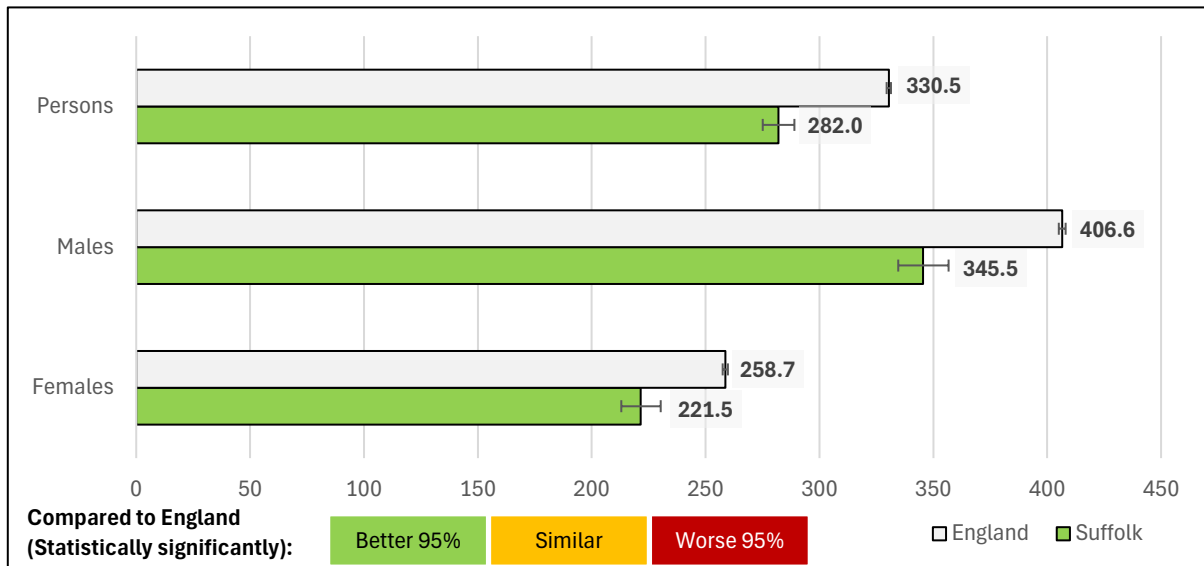
### Life expectancy and mortality

Premature mortality is defined as death occurring prior to the 'average' life expectancy, which is currently defined as 75 years of age by the Office for National Statistics in England.

The premature mortality rate refers to the under-75 mortality rate from all causes. This metric serves as a valuable overarching indicator of population health, demonstrating strong correlation with various other health measures. Inequalities in key health parameters, such as cardiovascular mortality, cancer survival rates, and suicide rates, collectively influence the overall premature mortality figure.

A substantial proportion of premature mortality can be attributed to preventable causes, including behavioural risk factors such as smoking, harmful alcohol consumptions, physical inactivity and poor diet. Preventable conditions including cardiovascular disease, some cancers, chronic respiratory disease and liver disease continue to contribute significantly to early deaths among men. Analysing disparities in mortality rates across different areas and demographic groups provides valuable insights, informing targeted public health interventions.

**Figure 9. Under 75 mortality rate from all causes (3 year range), directly standardised rate per 100,000, Suffolk and England, 2023-25**



Source: [Office for Health Improvement and Disparities](#) (2026)

As the figure above shows, males in both Suffolk and across England have statistically significantly higher under 75 mortality rates per 100,000 compared to females. In Suffolk, males are 56% more likely to die prematurely than females (345.5 compared to 221.5 per 100,000), which is broadly similar to the national pattern, where males are 57% more likely than females (406.6 compared to 258.7 per 100,000).

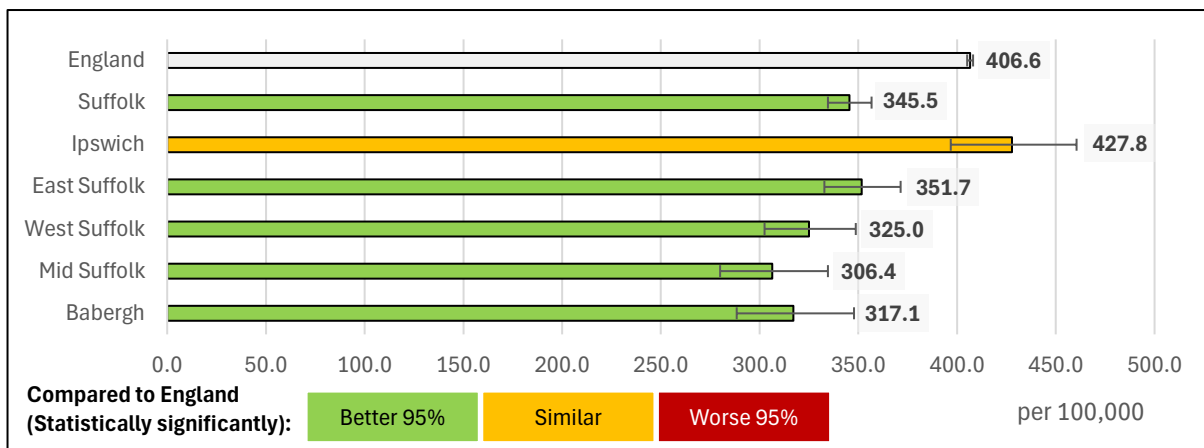
## Men's Health Profile

The data also shows that men in Suffolk are around 17% less likely to die prematurely than men across England as a whole (345.5 compared to 406.6 per 100,000).

Suffolk's rate of male premature mortality across its NHS England peers<sup>1</sup> places Suffolk 14<sup>th</sup> lowest out of 16 upper tier local authority areas in 2023-25, with the highest rate in Lincolnshire (424.9 per 100,000), and the lowest rate in Hampshire (324.9 per 100,000).

At a local level, rates of premature mortality (under 75) among males vary across Suffolk's districts and boroughs. All areas have rates that are statistically significantly lower than the England average, apart from Ipswich, where the rate (427.8 per 100,000) is statistically similar to the national figure (406.6 per 100,000). Within Suffolk, Ipswich has the highest rate of premature mortality among males, while Mid Suffolk has the lowest (306.4 per 100,000). East Suffolk also has a relatively higher rate (351.7 per 100,000) compared to other districts.

**Figure 10. Under 75 mortality rate from all causes (Male, 3 year range), directly standardised rate per 100,000, Suffolk and lower-tier local authorities, 2023-25**



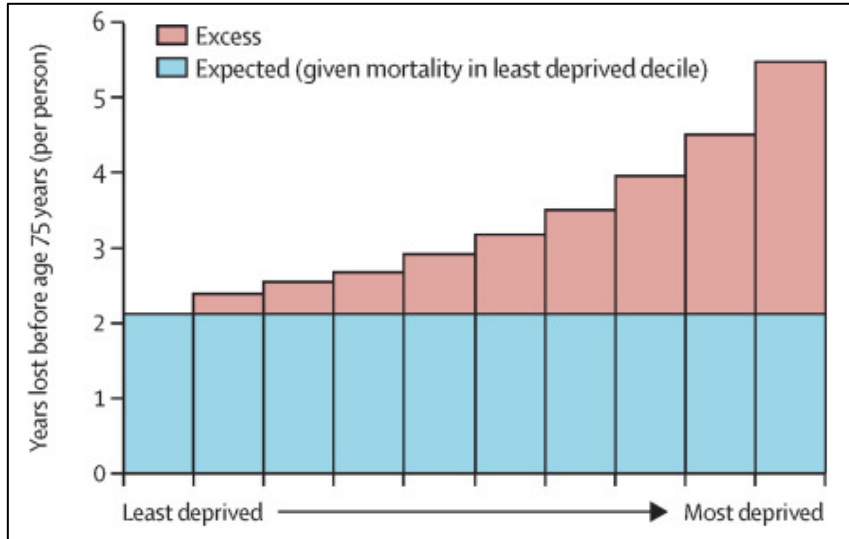
Source: [Office for Health Improvement and Disparities](#) (2026)

These patterns indicate variation within the county, with more urban areas, particularly Ipswich, experiencing worse outcomes. This suggests underlying inequalities linked to deprivation and other risk factors, despite Suffolk overall having lower premature mortality rates than England.

<sup>1</sup> NHS England Peer Groups (also known as statistical neighbours) are areas demographically similar to Suffolk with corresponding levels of deprivation, population density, and age profiles

National data shows that premature mortality (for both males and females) is strongly associated with deprivation. Premature mortality analysis from between 2003 and 2018 in England found over 1 in 3 (35.6%) of premature deaths were attributable to socioeconomic inequality<sup>26</sup>.

**Figure 11. Mortality attributable to socioeconomic inequality and years lost to inequality in England, 2003-18 by index of multiple deprivation decile**



Source: [Lewer et al., \(2020\)](#)

Life expectancy is another key measure of mortality, indicating the average length of life expected based on current patterns of death. The latest data below supports previous trends in premature mortality. The data shows that the life expectancy gap between males and females in Suffolk (3.6 years) and the East of England (3.7 years) is very similar to the average gap in life expectancy across England between 2023-25 (3.8 years).

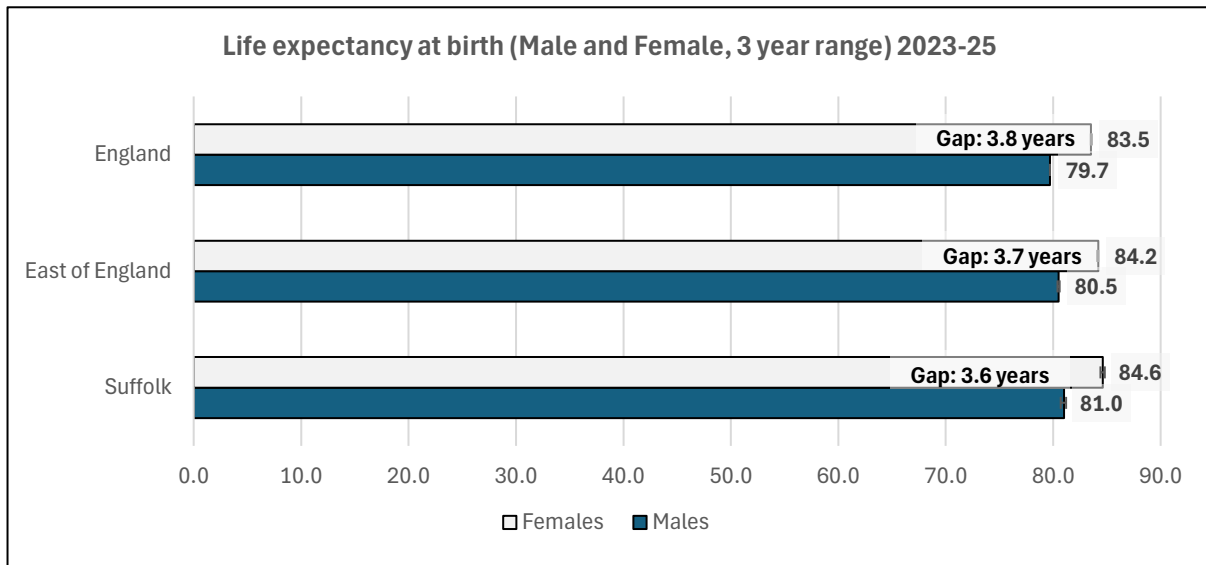
Therefore, a male baby born in Suffolk between 2023 and 2025 could expect to live on average 3.6 fewer years than a female baby born in Suffolk, but 1.3 years longer than an average English male baby.

Life expectancy at birth varies considerably across Suffolk at Middle-layer Super Output Area (MSOA) level, with a clear social and geographical gradient evident for both males and females. For females, life expectancy ranges from 76.2 years in Lowestoft Harbour & Kirkley to 87.8 years in Broke Hall (Ipswich), a gap of over 11 years. For males, the range is similarly wide, from 72.6 years in Lowestoft Harbour & Kirkley to 84.3 years in East Bergholt, Brantham & Capel St Mary, a difference of nearly 12 years.

## Men's Health Profile

Lower life expectancy for both sexes is concentrated in more deprived urban and coastal communities, particularly in parts of Ipswich and Lowestoft, while higher life expectancy is generally observed in more rural and affluent areas such as Babergh and Mid Suffolk. Across all areas, males consistently have lower life expectancy than females, and the gap between the highest and lowest areas is slightly wider for males, indicating greater inequality in male health outcomes.

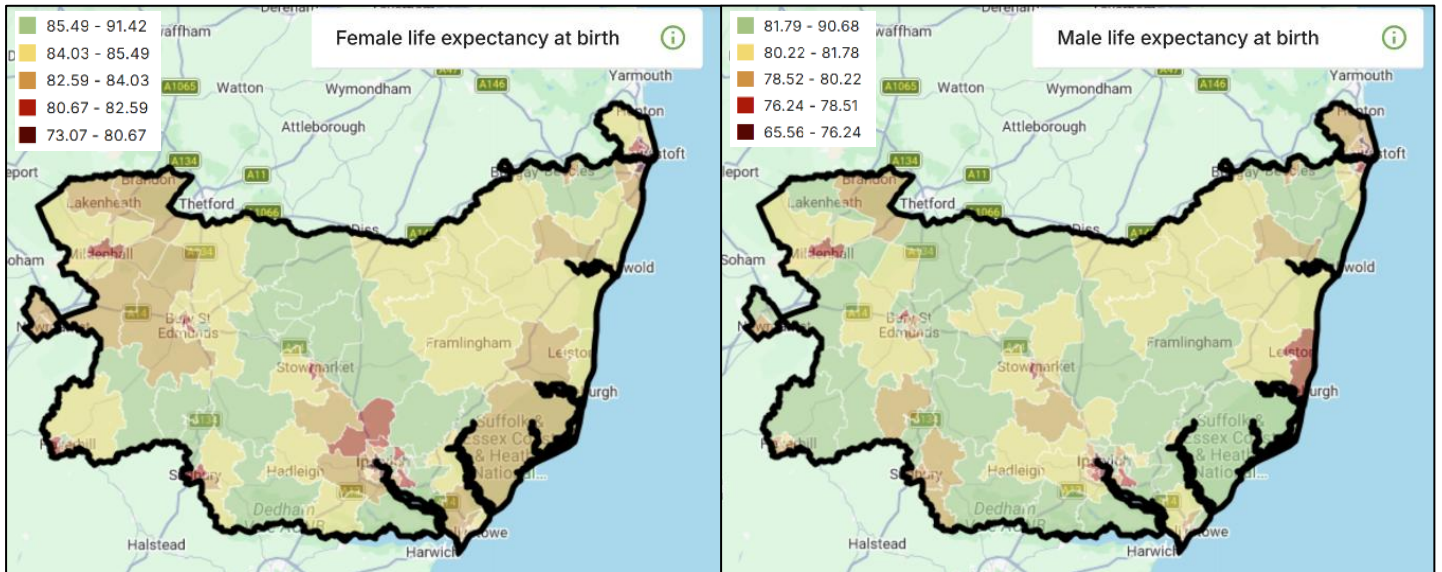
**Figure 12. Life expectancy at birth (Males and Females), England, East of England, Suffolk, 2023-25**



Source: [Office for Health Improvement and Disparities](#) (2026)

**Figure 13. Male and female life expectancy at birth (5 year pooled data), Suffolk Middle-layer Super Output Area (MSOAs), 2019-23**

*\*Please note the scales on the below maps are different*



Source: [Office for Health Improvement and Disparities](#) (2025)

Healthy life expectancy is also important to consider – with the aim not only to extend life, but to increase the proportion lived in good health. Healthy life expectancy is defined as an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.

The following table shows the disparities between average healthy life expectancy for men across England and in Suffolk.

**Table 2. Healthy life expectancy (2022-24), overall life expectancy (2023-25), and the proportion of lived in poor health, Suffolk and England**

Life expectancy and healthy life expectancy, Males			
Area	Healthy life expectancy, 2022-24	Overall life expectancy, 2023-25	Proportion of life lived in poor health
England	60.9	79.7	<b>23.6%</b>
Suffolk	<b>62.1</b>	81.0	<b>23.3%</b>

Life expectancy and healthy life expectancy, Females			
Area	Healthy life expectancy, 2022-24	Overall life expectancy, 2023-25	Proportion of life lived in poor health
England	61.3	83.5	<b>26.6%</b>
Suffolk	<b>61.7</b>	84.6	<b>27.1%</b>

Compared to England (Statistically significantly): Better 95% Similar Worse 95%

Source: [Office for Health Improvement and Disparities](#) (2026)

This data shows that Suffolk's males have statistically significantly longer lives than the national average, and also encounter declining health at a statistically similar age compared to the England average; however 23.3% of their life is spent in poor health on average.

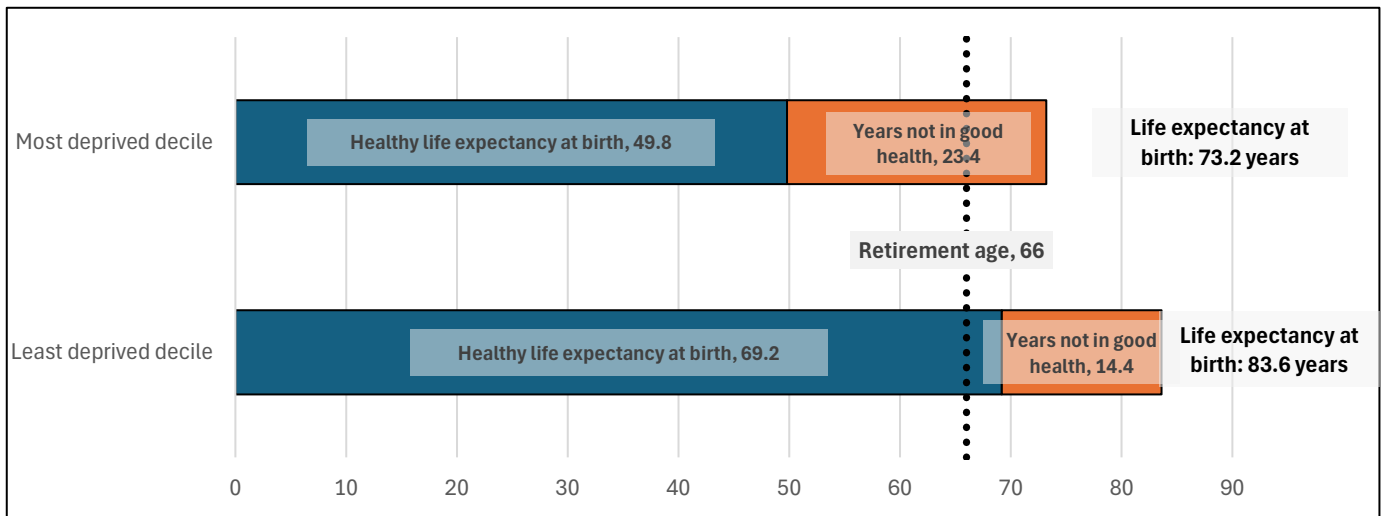
There are substantial inequalities in both life expectancy and healthy life expectancy for men living in England. Between 2022 and 2024, males living in the least deprived decile could expect to live 83.6 years on average, compared to 73.2 years for those living in the most deprived decile - a gap of more than 10 years.

The inequality is even greater when considering healthy life expectancy. Men living in the least deprived areas could expect to live 69.2 years in good health, compared to just 49.8 years for men living in the most deprived areas - a difference of 19 years.

As a result, men in the most deprived communities not only die earlier but also spend a far greater proportion of their lives in poor health. Men in the most deprived decile are expected to spend around 23.4 years in poorer health, compared to 14.4 years among men in the least deprived areas.

Whilst those in the least deprived area are likely to retire prior to declining health - this is not the case for those in the most deprived area, and if current trends persist, there is a risk that further rises in state pension age would widen inequalities in both incomes at older ages and lengths of life in retirement<sup>27</sup>.

**Figure 14. Years lived in good health, and not in good health, males, England, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2026)

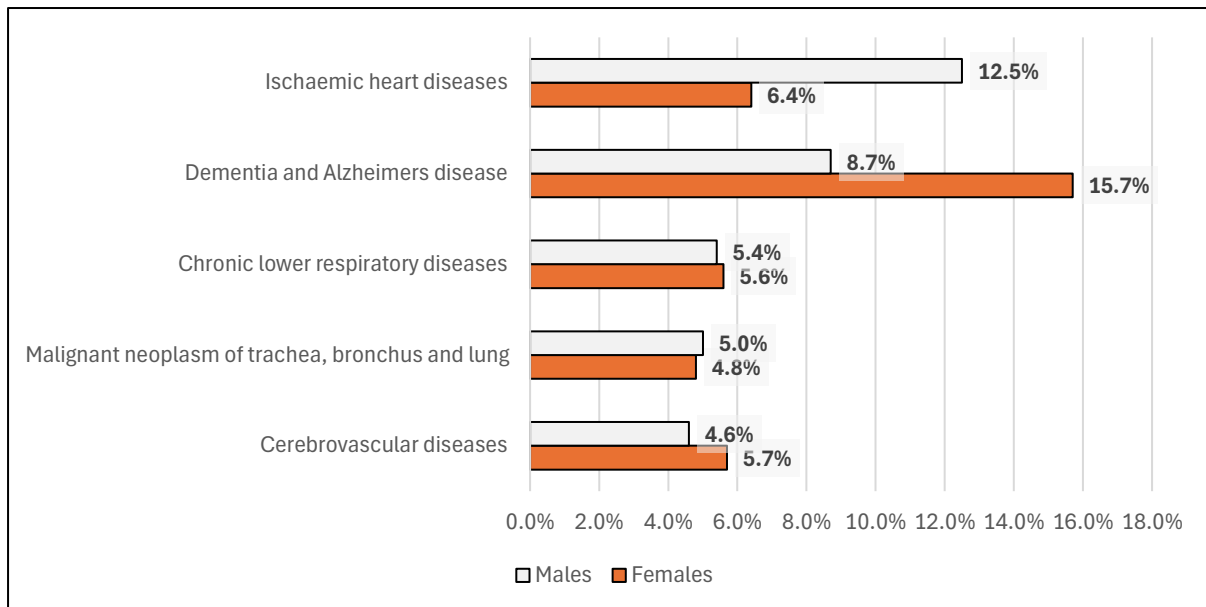
These findings highlight the significant impact of deprivation on both the length and quality of men's lives, reinforcing the importance of prevention, early intervention and action on the wider determinants of health.

### Leading causes of death

National data for England shows that the leading causes of death among males are cardiovascular disease, respiratory conditions and cancer. In 2024, the most common cause of death in men was ischaemic heart disease, accounting for 12.5% of all male deaths (33,681 deaths). This was followed by dementia and Alzheimer's disease (8.7%), chronic lower respiratory diseases (5.4%), lung cancer (5.0%), and cerebrovascular diseases such as stroke (4.6%). Influenza and pneumonia also remain a significant contributor (4.0%).

Compared to females, there are notable differences in the pattern of mortality. While dementia and Alzheimer's disease is the leading cause of death in women (15.7%), it ranks second in men and accounts for a substantially smaller proportion of deaths. In contrast, ischaemic heart disease has a much greater impact on men, accounting for nearly double the proportion of deaths seen in females (12.5% compared to 6.4%). Deaths from lung cancer and respiratory diseases also make up a slightly higher share of male mortality.

**Figure 15. Percentage of all deaths for the top 5 leading causes of death for males, compared to females, in England in 2024**



Source: [Office for National Statistics](#) (2025)

Overall, these patterns highlight the disproportionate impact of cardiovascular disease and certain preventable conditions on men, reinforcing the importance of targeting risk factors such as smoking, poor diet, physical inactivity and late presentation to services.

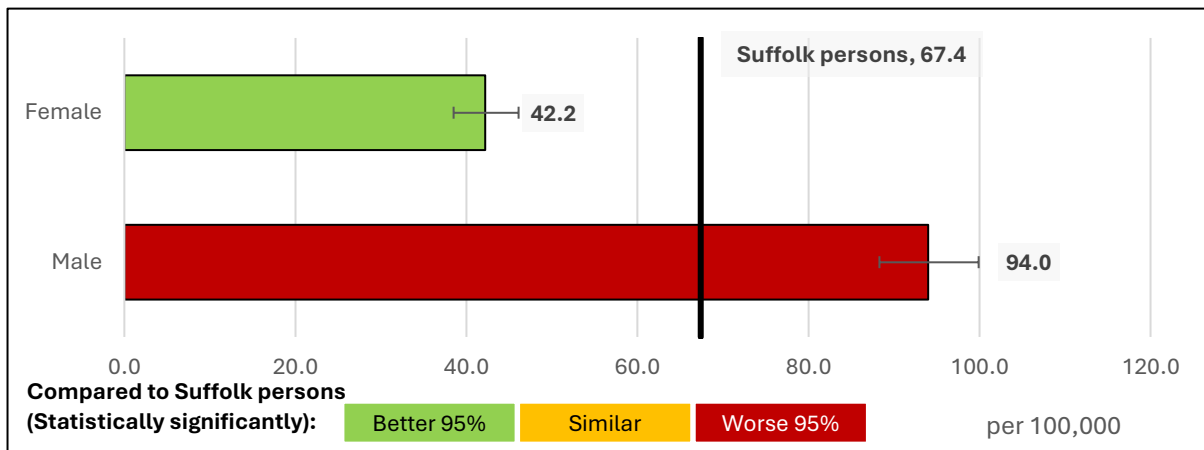
### Cardiovascular disease

Cardiovascular disease is a name for a group of conditions affecting the heart and blood vessels. These conditions include coronary heart disease (CHD) where fat blocks arteries, restricting blood flow to the heart, peripheral arterial disease (PAD), where at buildup narrows arteries, reducing blood flow to legs and feet, aortic disease: including conditions affecting the aorta, possibly causing an abdominal aortic aneurysm, and stroke; where a blockage stops blood flow to part of the brain, impacting speech and movement<sup>28</sup>.

## Men's Health Profile

On average, men develop cardiovascular disease 6 years earlier than women<sup>29</sup>, and at both local and national levels, men are significantly more likely than women to die prematurely from cardiovascular disease. In Suffolk, for every 10 women who die prematurely from cardiovascular disease, approximately 22 men will die (94.0 compared to 42.2 per 100,000). Of the 466 deaths from cardiovascular disease for individuals aged under 75 years of age in Suffolk in 2024, 70.4% (328) were for males, and 29.6% were for females.

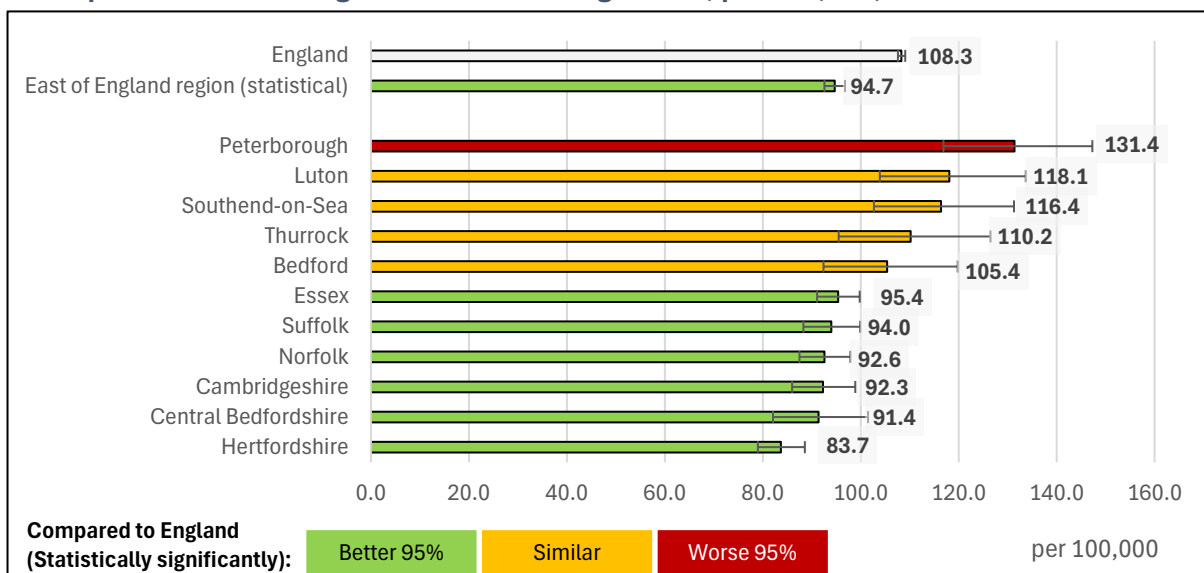
**Figure 16. Under 75 mortality rate from cardiovascular disease, males, females and Suffolk persons, per 100,000, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

However, unlike the pattern seen in some areas, men in Suffolk are less likely to die prematurely from cardiovascular disease than the average man in England. The premature mortality rate for males in Suffolk is 94.0 per 100,000, compared to 108.3 per 100,000 nationally, just over 10% lower.

**Figure 17. Under 75 mortality rate from cardiovascular disease, Suffolk males compared to East of England statistical neighbours, per 100,000, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

To better understand the difference in cardiovascular deaths between Suffolk males and females, the risk factors for cardiovascular disease need to be explored further. Studies find

that up to 80% of cardiovascular disease is estimated to be preventable<sup>30</sup>, with nine modifiable risk factors accounting for over 90% of cases of coronary artery disease<sup>31</sup>.

On average, men develop CVD approximately 6 years earlier than women<sup>1</sup>. Modifiable risk factors drive 70% of the CVD burden – these include high blood pressure, smoking, excess weight (including obesity) and drinking alcohol<sup>29</sup>. Non-modifiable risk factors include:

- Age – primarily affecting people aged over 50 years
- Gender – at all ages, men have a higher risk of CVD than women, however women with CVD may experience worse outcomes than men
- Family history of CVD – reflecting a shared environment, genetic factors, or both
- Ethnic background – people of South Asian or sub-Saharan African origin have an increased risk of CVD<sup>32</sup>

These are all explored in more detail within the [Suffolk cardiovascular disease profile](#) (published December 2025) but will be explored further within this profile in the context of men's health inequalities. The most important behavioural risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol<sup>33</sup>.

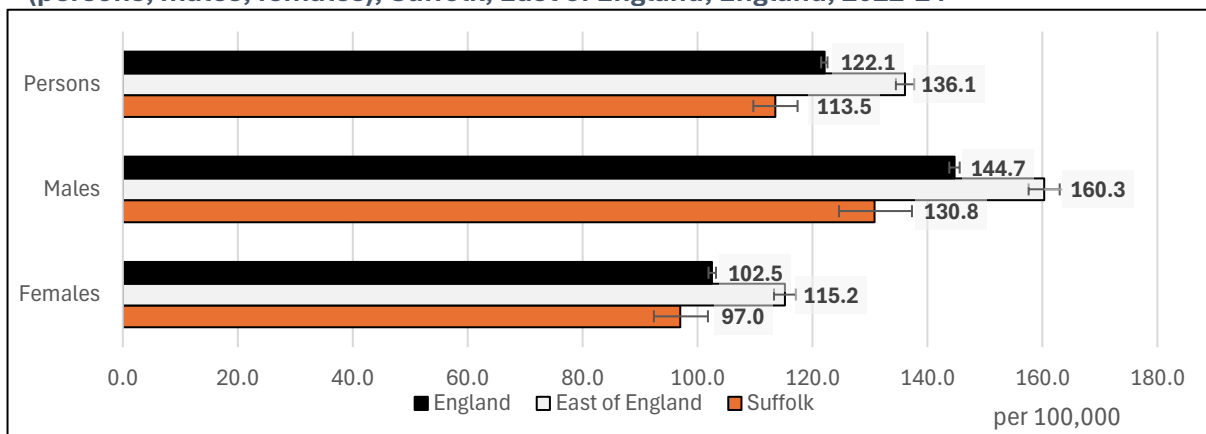
### Hypertension

High blood pressure (hypertension) is responsible for more than half of all strokes and heart attacks, and is also a risk factor for heart disease, kidney disease and vascular dementia<sup>34</sup>.

More than half of people with high blood pressure go undiagnosed, and it is properly controlled in fewer than half of those who know they have it<sup>35</sup>. Mortality rates from hypertensive diseases shows a clear gender disparity across 2022-24, with males experiencing higher rates than females at all geographical levels. In Suffolk, the mortality rate for males is 130.8 per 100,000, compared to 97.0 per 100,000 for females, meaning men are around 35% more likely to die from hypertensive diseases. This pattern is consistent with regional and national trends.

Overall, Suffolk has lower mortality rates from hypertensive diseases than both the East of England and England for males, females and persons. For example, the male rate in Suffolk (130.8 per 100,000) is statistically significantly lower than the East of England (160.3) and England (144.7). Despite this, the higher burden among men highlights the importance of prevention, early detection and management of high blood pressure as a key driver of cardiovascular disease and premature mortality.

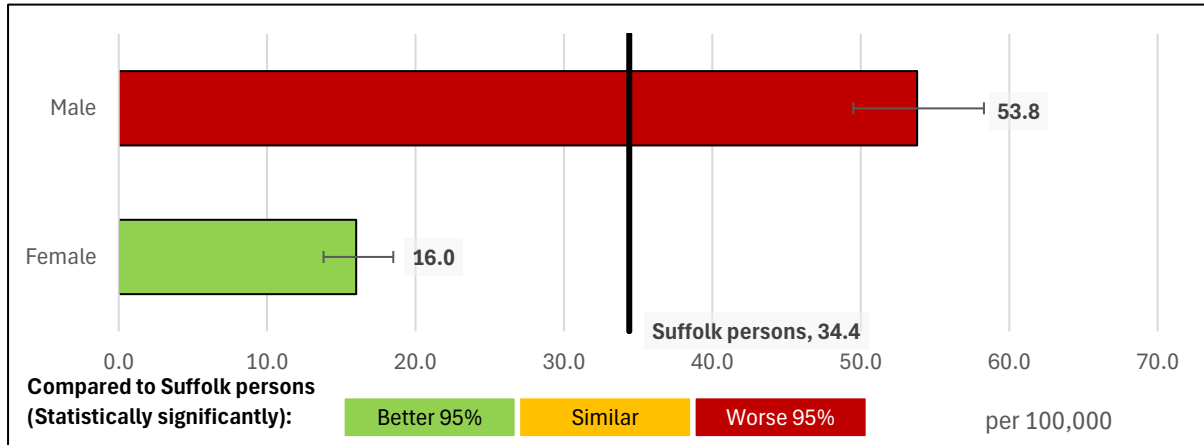
**Figure 18. Mortality rate per 100,000 for deaths involving hypertensive disease, all ages (persons, males, females), Suffolk, East of England, England, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

Despite declining over the last few decades, ischaemic heart disease (also known as coronary artery diseases) remains the single most common cause of death for men in England. The rate of under 75 male deaths from ischaemic heart disease in Suffolk between 2022-24 was 3.4 times higher (53.8 per 100,000/596 deaths) than the rate for females (16.0 per 100,000/189 deaths) over the same period.

**Figure 19. Under 75 mortality rate from ischaemic heart disease per 100,000, Suffolk males and females, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

### Smoking

Smoking is the leading preventable cause of illness and premature death, causing damage not only to smokers themselves, but also to the people around them<sup>36</sup>. Smoking is one of the main causes of health inequalities in England, with harm concentrated in disadvantaged communities and groups<sup>36</sup>. Across England, men were statistically significantly more likely to smoke than women in 2024, with those aged 25 to 34 most likely to smoke<sup>37</sup>.

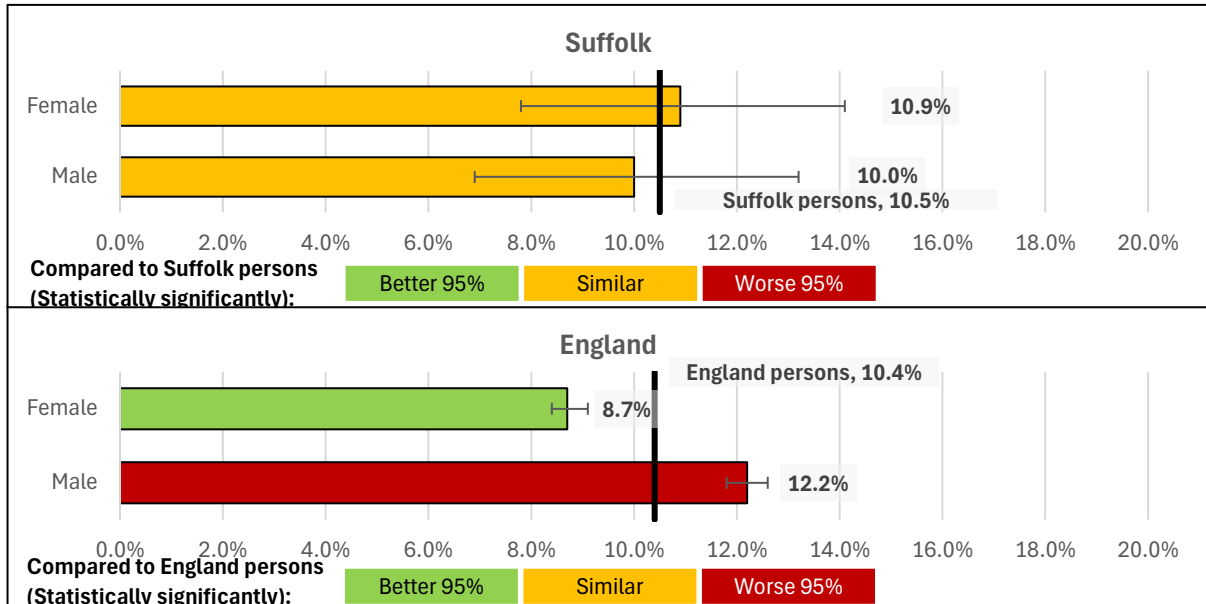
19% of all deaths (and 37% of deaths for conditions that can be caused by smoking) in men aged 35 and over can be attributed to smoking, compared to 12% for women (and 27% of deaths for conditions that can be caused by smoking)<sup>38</sup>. It is estimated that approximately 40% of cancers are preventable through elimination of potentially modifiable risk factors<sup>39</sup>, with smoking the biggest driver<sup>40</sup>. Smoking is a major risk factor for many diseases such as lung cancer, chronic obstructive pulmonary disease (COPD), and heart disease.

Smoking prevalence is higher among those in the most deprived areas (14.3% in 2023) compared to the least (9.0% in 2023), and in routine and manual workers (19.5% aged 18 to 64 smoked in 2023). On Census Day 2021, there were 83,736 people working in routine occupations in Suffolk, of which 47,463 (56.7% compared to 55.7% across England) were males, and 36,273 (43.3% compared to 44.3% across England) were females.

Smoking rates continue to fall across the country, but recent data from the GP Patient survey suggests that the overall prevalence of smoking amongst adults across Suffolk is statistically similar to the prevalence across England in 2024 (10.5% compared to 10.4%). Across England, the percentage of male smokers is statistically significantly higher than female smokers (12.2%

compared to 8.7%) in 2024, however the percentage in Suffolk for males (10.0%) compared to females (10.9%) is statistically similar.

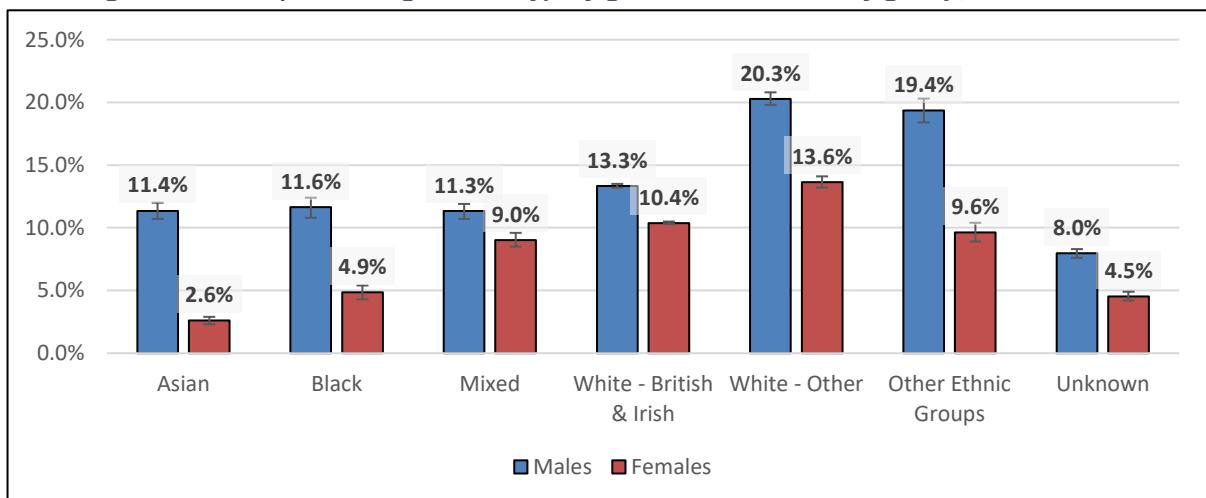
**Figure 20. Smoking prevalence in adults (aged 18 and over) – current smokers, Suffolk and England males and females, 2024**



Source: [Office for Health Improvement and Disparities](#) (2025)

While data from Fingertips reports smoking prevalence in Suffolk as higher among females (but statistically similar to males), Population Health Management (PHM) data for Suffolk (excluding Waveney) shows that smoking prevalence remains higher among men than women overall, with further inequalities evident across ethnic groups and levels of deprivation. Among men, smoking rates are generally higher than in women across most ethnic groups, with particularly high prevalence observed in men from White – Other (20.3%) and Other ethnic groups (19.4%), compared to 13.3% among White British and Irish men. In contrast, smoking prevalence among women is lower overall but still shows variation, ranging from 2.6% in Asian women to 13.6% in White – Other women.

**Figure 21. Smoking prevalence (current smoker flag) across Suffolk’s population health management data (excluding Waveney), by gender and ethnicity group, Jan–Dec 2025**

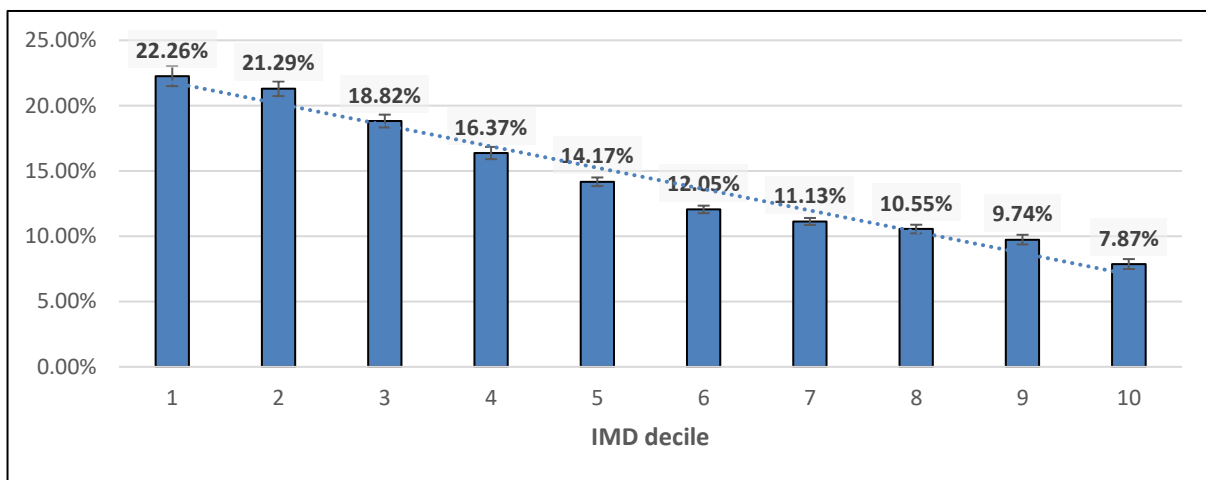


Source: Population Health Management (2026)

Using the same analysis, PHM data identifies that within the White Other group of current smokers, 54.2% of males and 51.9% of females do not have English as a first language, and of the White – Other current smoking population, 18.1% of males and 18.0% of females are Eastern European.

A strong socioeconomic gradient is also evident in smoking prevalence among Suffolk men. PHM data for 2025 shows that smoking rates are highest among men living in the most deprived communities, where more than one in five men are current smokers (22.3% in deprivation decile 1), compared to fewer than one in twelve men in the least deprived areas (7.9% in deprivation decile 10). Smoking prevalence steadily declines with decreasing deprivation, demonstrating a clear and consistent gradient across the county. Overall, 13.4% of Suffolk men are recorded as current smokers, compared to 11.6% of the total Suffolk population.

**Figure 22. Smoking prevalence in Suffolk males – current smokers (Yes) flag, Population Health Management data (excluding Waveney) by IMD decile, Jan – Dec 2025**



Source: Population Health Management (2026)

These findings reinforce the close relationship between smoking, deprivation and wider health inequalities. Given smoking's contribution to cardiovascular disease, respiratory disease, cancer and premature mortality, targeted tobacco control interventions for men in deprived communities remain a key priority for reducing inequalities in male health outcomes across Suffolk.

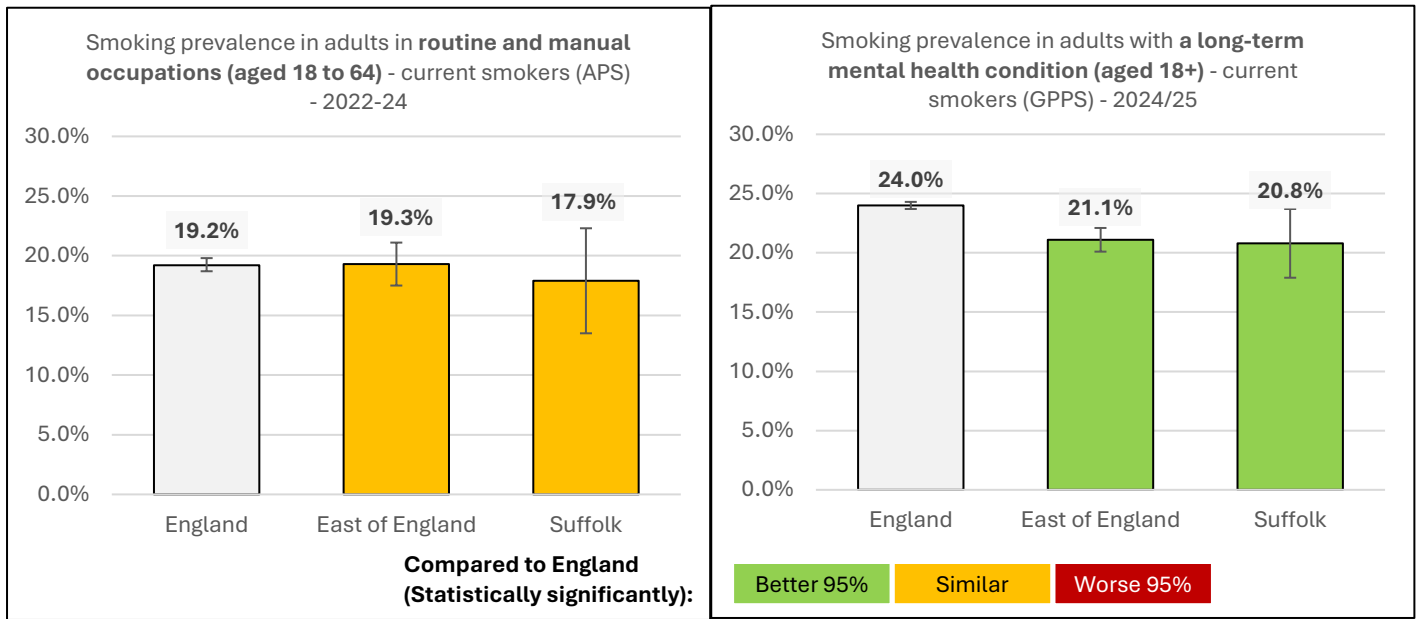
PHM data for Suffolk (excluding Waveney) also demonstrates a strong association between smoking and poor mental health among men. Male current smokers are more than twice as likely to have anxiety recorded compared to non-smokers (21.1% compared to 9.9%), and almost three times more likely to have depression (20.9% compared to 7.7%). Rates of serious mental illness (SMI) are also substantially higher among male smokers, affecting 2.4% of smokers compared to 0.6% of non-smokers.

Two groups with particularly high rates of smoking are those with routine/manual occupations, and those with long-term mental health conditions. The following figure compares how Suffolk compares to the East of England and national average for both of these groups.

Suffolk's smoking rates are statistically similar to the England rate for those in routine and manual occupations, and statistically significantly lower than the England rate for adults with a long-term mental health condition.

Smoking prevalence is higher among people in routine and manual occupations and those living with long-term mental health conditions. These groups are more likely to experience socioeconomic disadvantage, which can increase the likelihood of smoking. Contributing factors include higher levels of stress, barriers to accessing support services, and greater exposure to tobacco marketing. Together, these influences can increase vulnerability to smoking and contribute to widening health inequalities.

**Figure 23. Smoking prevalence in adults in routine and manual occupations (aged 18 to 64, 2022-24), and in adults with a long-term mental health condition (aged 18+, 2024/25)**

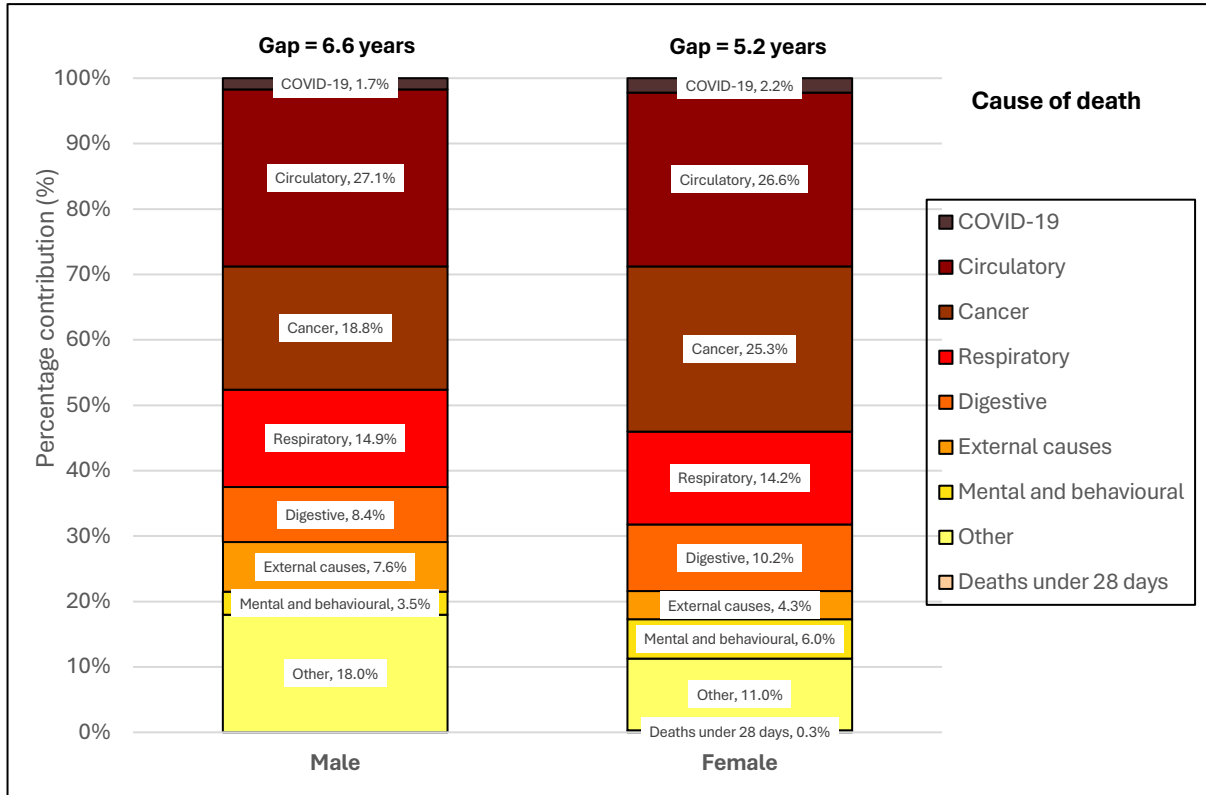


Source: [Office for Health Improvement and Disparities](#) (2025)

Cardiovascular disease is the largest contributor to inequalities in life expectancy between the most and least deprived populations in Suffolk. Analysis for 2022–23 shows that circulatory diseases account for 27.1% of the life expectancy gap in males and 26.6% in females, making it the single biggest driver of inequality for both sexes.

For men, circulatory disease contributes more to the gap than any other cause, exceeding cancer (18.8%) and respiratory disease (14.9%). This highlights the significant impact of cardiovascular conditions on premature mortality and inequality.

**Figure 24. Segment Tool: Breakdown of the life expectancy gap between the most and least deprived quintiles of Suffolk by cause of death, 2022 to 2023**



Source: [Office for Health Improvement and Disparities](#) (2025)

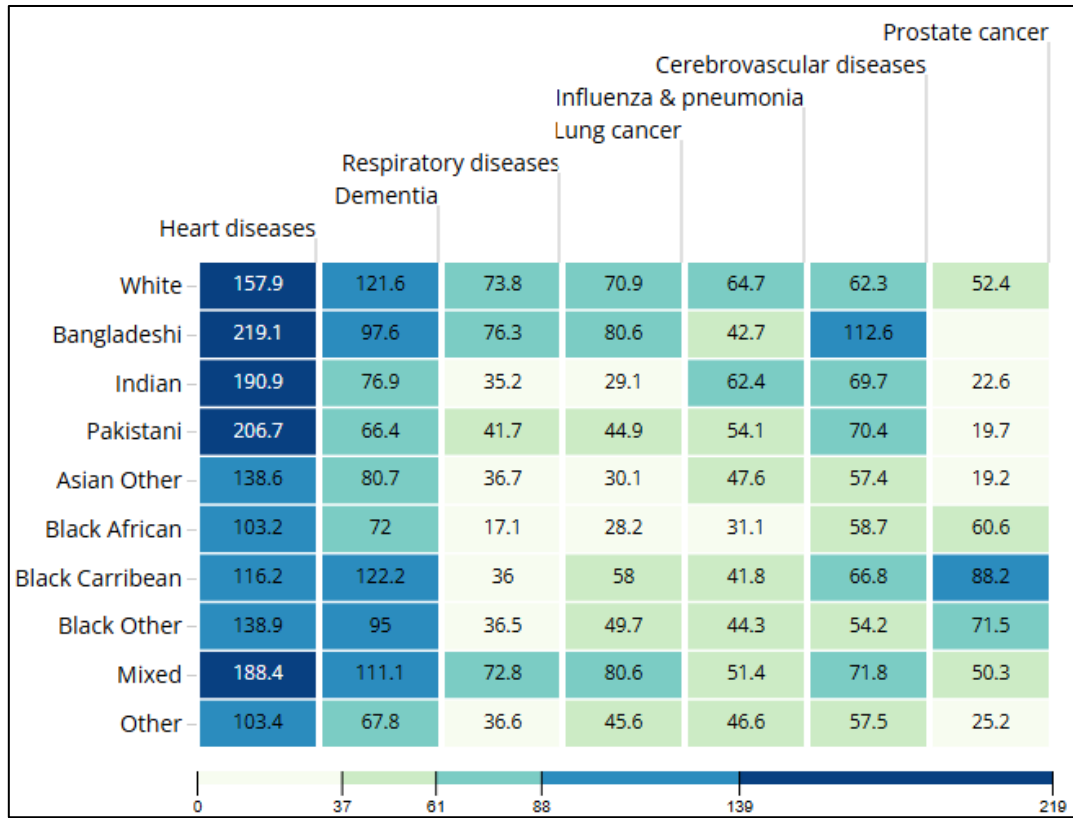
These findings demonstrate that reducing cardiovascular disease through prevention, early diagnosis and effective management, remains critical to narrowing the life expectancy gap and improving outcomes for the most deprived populations in Suffolk.

The following figure shows that heart diseases is the leading cause of death among men across almost all ethnic groups in England and Wales. The main exception is the Black Caribbean group, where dementia is responsible for a slightly higher proportion of deaths.

The data also highlights notable ethnic inequalities in cardiovascular mortality. Men from South Asian backgrounds (Bangladeshi, Indian and Pakistani) experience higher mortality rates from heart disease compared to White men. This is particularly pronounced among Bangladeshi men, whose mortality rate is around 39% higher than that of White men.

In addition, deaths from cerebrovascular disease (stroke) are substantially higher in some groups, with rates among Bangladeshi men approaching twice those seen in White men.

**Figure 25. Deaths registered in England and Wales, 2017-19, age-standardised mortality rates per 100,000 in the most common leading causes of death for each ethnic group, males aged 10 years and above**



Source: [Office for National Statistics](#) (2021)

Cardiovascular disease remains a major contributor to premature mortality and health inequalities among men in Suffolk. Although male mortality rates from cardiovascular disease in Suffolk are lower than the England average, men continue to experience substantially higher rates than women, with around twice as many premature deaths. Circulatory disease is also the single largest contributor to the life expectancy gap between the most and least deprived populations, accounting for over a quarter of this inequality.

These disparities are closely linked to modifiable risk factors, including smoking and hypertension, which are more prevalent among men and in more deprived communities. Variation in risk is also evident across population groups, including differences by ethnicity, highlighting the need for a targeted approach to prevention and early intervention.

Reducing the burden of cardiovascular disease for men in Suffolk requires a continued focus on improving identification and management of risk factors, increasing uptake of preventative services such as NHS Health Checks, and addressing inequalities in access and outcomes. Targeted approaches particularly in more deprived areas and higher-risk groups will be essential to reduce premature mortality and narrow the life expectancy gap for men.

### Cancer screening and survival

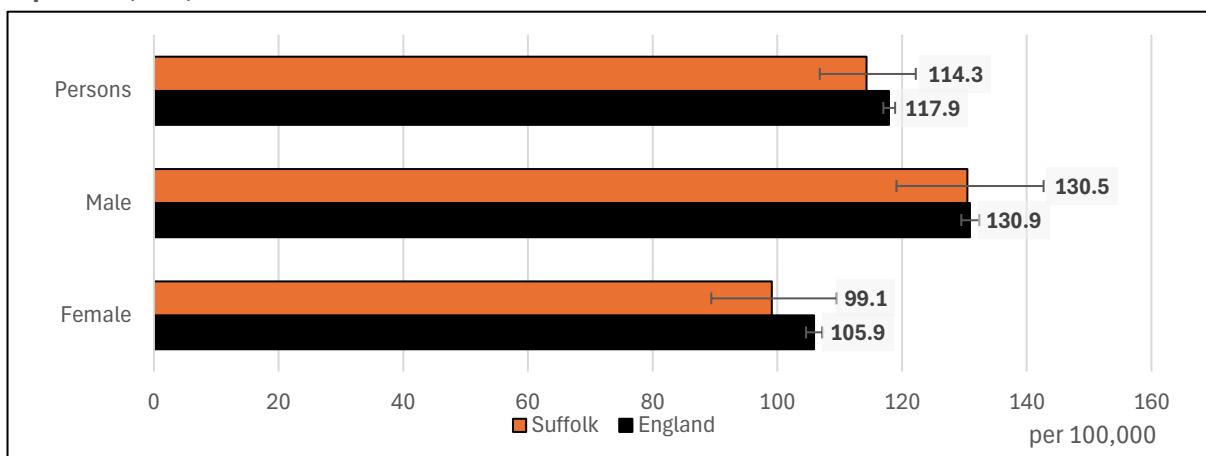
Cancer is the cause of just over a quarter of all deaths in England in a typical year<sup>41</sup>. The number of deaths across England has increased by 9% since 2001, but after accounting for the fact that the country's population is both growing and ageing, the rate of cancer deaths has fallen. The survival rate of cancer is almost half (49.8%) of individuals surviving for 10 or more years, with 38% of cancers cases considered preventable<sup>42</sup>. Smoking remains the biggest driver of preventable cancer cases (such as lung and laryngeal)<sup>43</sup>. Overweight and living with obesity represent the second-largest preventable cause of cancers, with obesity strongly linked to breast, oesophageal and many other cancer sites<sup>44</sup>. Other preventable risk factors for cancer include exposure to ultraviolet (UV) radiation, harmful alcohol consumption, and occupational exposure to hazardous substances such as asbestos, silica dust, diesel fumes and industrial chemicals<sup>45</sup>. These occupational exposures are more common in traditionally male-dominated industries including construction, manufacturing, agriculture, transport and some manual trades, and are associated with increased risks of cancers such as lung cancer and mesothelioma<sup>46-48</sup>. Cancer incidence rates are 19% higher for men in the most deprived quintile compared to the least deprived (this difference is 16% for women).

Using the segment tool (Figure 24), there were 115 excess total deaths due to cancer in Suffolk in 2022/23 (the number of deaths which would be avoided in the most deprived quintile of Suffolk if it had the same mortality rate as the least deprived quintile).

Cancer remains a leading cause of premature mortality among men. In Suffolk, the under-75 mortality rate from cancer for males is 130.5 per 100,000, which is statistically similar to the England rate (130.9 per 100,000). As seen across England, men have higher premature mortality rates from cancer than women, with the rate for males in Suffolk around 32% higher than for females (130.5 compared to 99.1 per 100,000).

While overall cancer mortality rates in Suffolk are slightly lower than the national average for persons, the persistence of higher mortality among males compared to females highlights ongoing inequalities. Improving early diagnosis, increasing uptake of cancer screening programmes, and addressing modifiable risk factors remain key to improving cancer outcomes and survival for men.

**Figure 26. Under 75 mortality rate from cancer (Persons, Males, Females, 1 year range), per 100,000, 2024**

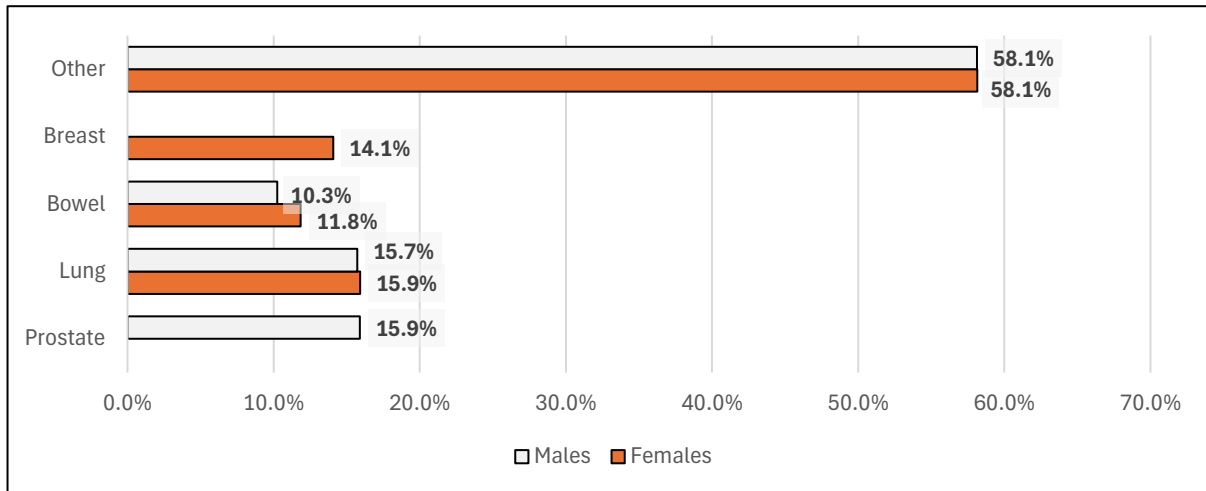


Source: [Office for Health Improvement and Disparities](#) (2025)

Analysis of cancer mortality in Suffolk (2022–24) shows variation in the leading causes of death between men and women. Among males, the most common causes of cancer death are prostate cancer (15.9%) and lung cancer (15.7%), followed by bowel cancer (10.3%). In contrast, for females, lung cancer (15.9%) is the leading cause, followed by breast cancer (14.1%) and bowel cancer (11.8%).

A substantial proportion of cancer deaths fall within a broad “other cancers” category for both sexes (58.1%), reflecting the wide range of less common cancer types. The prominence of lung cancer as a leading cause of death for both men and women highlight the ongoing impact of smoking, while prostate and breast cancers remain significant sex-specific contributors to mortality.

**Figure 27. Percentage of cancer deaths by cancer type for males and females in Suffolk, 2022-24**



Source: [Office for Health Improvement and Disparities \(2025\)](#)

### Prostate cancer

Prostate cancer does not have a national screening programme – the prostate specific antigen (PSA) test is a blood test that can help diagnose prostate problems including prostate cancer. It is not a perfect test, as it will miss some prostate cancers, will detect some that would never go on to cause harm (classified as clinically insignificant), and can show a raised PSA level when there is no prostate cancer present<sup>49</sup>.

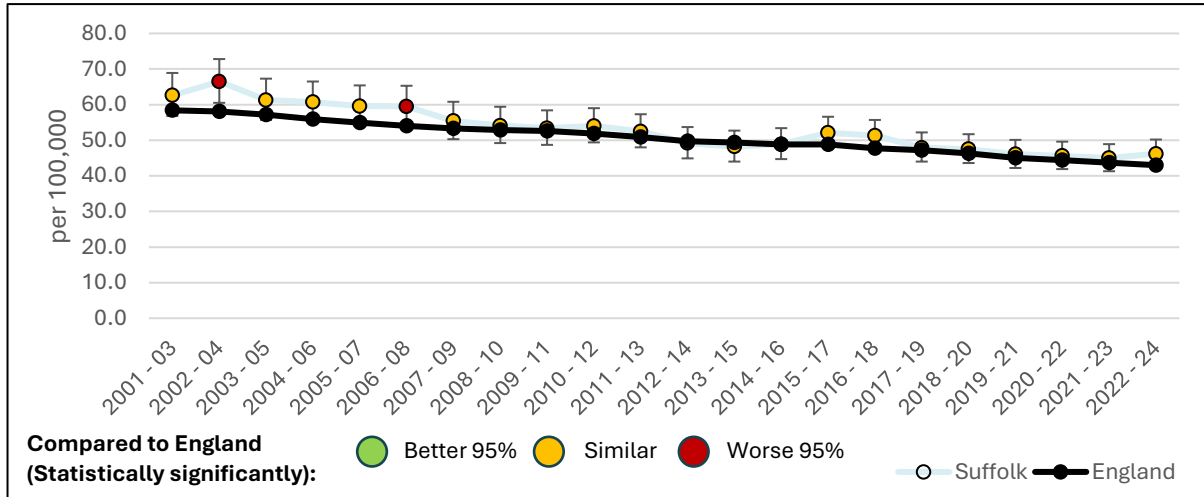
Large trials to date have failed to demonstrate a consistent mortality benefit from screening, and the UK National Screening Committee (UKNSC) continues to advise that the risks of screening outweigh any potential benefits<sup>50</sup>. These risks include high rates of false positives from PSA testing, complications from biopsy, potential overdiagnosis, uncertainty around best treatments and complications of treatments.

However, the UKNSC is considering screening for men aged 45 to 61 with BRCA1 or BRCA2 gene changes. Evidence shows that having a BRCA gene change increases your risk of developing prostate cancer, but it does not mean the individual will develop cancer. There is also strong evidence that men with BRCA2 gene changes are more likely to develop fast growing prostate cancer<sup>51</sup>.

## Men's Health Profile

Mortality from prostate cancer in Suffolk has shown a gradual long-term decline over the past two decades, despite some year-to-year fluctuation. The mortality rate decreased from 62.6 per 100,000 in 2001–03 to 46.2 per 100,000 in 2022–24. Throughout this period, rates in Suffolk have generally remained statistically similar to the England average, although the gap has narrowed over time, with England at 43.0 per 100,000 in 2022–24. This overall downward trend likely reflects improvements in awareness, earlier diagnosis, and advances in treatment, although prostate cancer remains a significant contributor to male mortality.

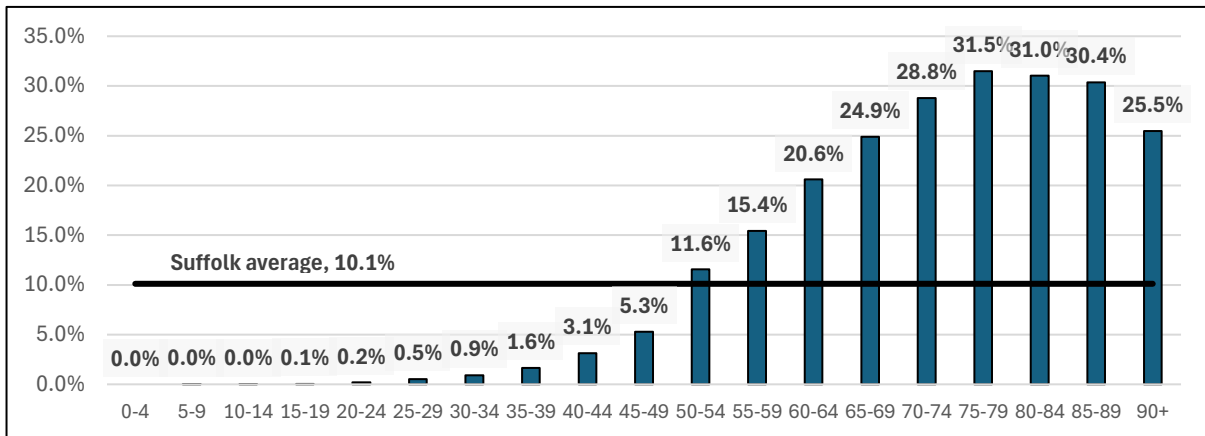
**Figure 28. Mortality rate per 100,000 from prostate cancer, all ages (Male), Suffolk and England, 2001-03 to 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

PHM data provides additional insight into patterns of prostate examination activity among men in Suffolk. Overall, 10.1% of Suffolk men had a prostate examination recorded within the previous two years. As expected, uptake increased substantially with age, rising from 3.1% among men aged 40–44 years to 20.6% in those aged 60–64 years, with the highest rate at 31.5% among men aged 75–79 years. This reflects the increasing prevalence of prostate symptoms and prostate cancer risk with advancing age.

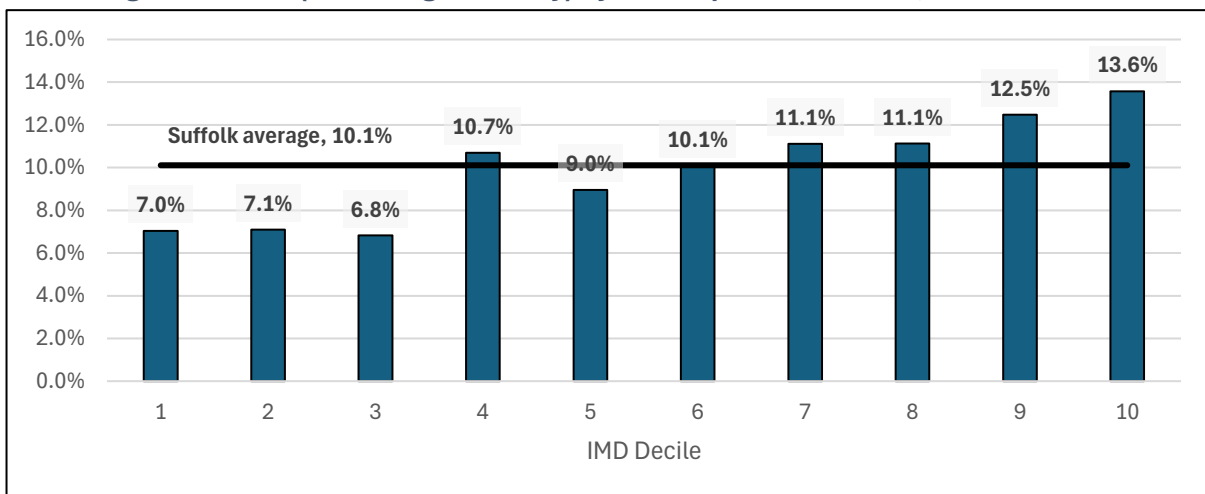
**Figure 29. Percentage of Suffolk males receiving a prostate exam in the last two years, Population Health Management data (excluding Waveney) by 5-year age group, Jan – Dec 2025**



Source: Population Health Management (2026)

The PHM data also highlights inequalities in prostate examination activity by deprivation and ethnicity. Men living in the least deprived areas of Suffolk were almost twice as likely to have a prostate examination recorded as those in the most deprived communities (13.6% compared to 7.0%), suggesting potential inequalities in awareness, health-seeking behaviour or access to primary care services.

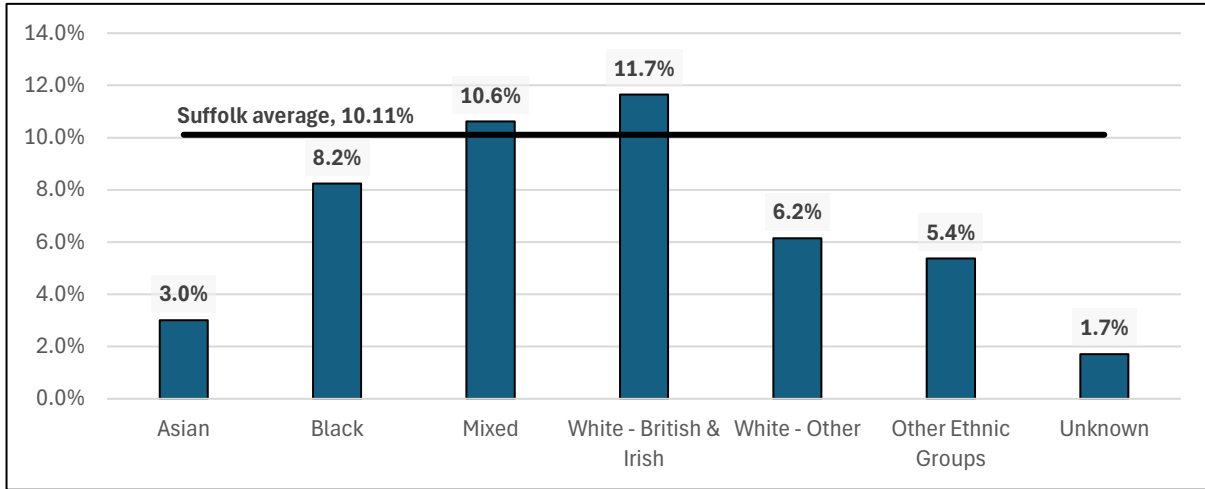
**Figure 30. Percentage of Suffolk males receiving a prostate exam in the last two years, Population Health Management data (excluding Waveney) by IMD deprivation decile, Jan – Dec 2025**



Source: Population Health Management (2026)

Variation is also evident between ethnic groups. Men from Black ethnic groups had lower recorded examination rates than White British and Irish men overall (8.2% compared to 11.7%), despite evidence that Black men are at substantially higher risk of developing and dying from prostate cancer<sup>52</sup>. Men recorded as White – Other also had lower rates of examination activity (6.2%). These findings may indicate barriers to awareness, engagement or access among some communities and reinforce the importance of targeted, culturally appropriate approaches to improving prostate cancer awareness and early diagnosis.

**Figure 31. Percentage of Suffolk males receiving a prostate exam in the last two years, Population Health Management data (excluding Waveney) by ethnic group, Jan – Dec 2025**



Source: Population Health Management (2026)

Lung cancer

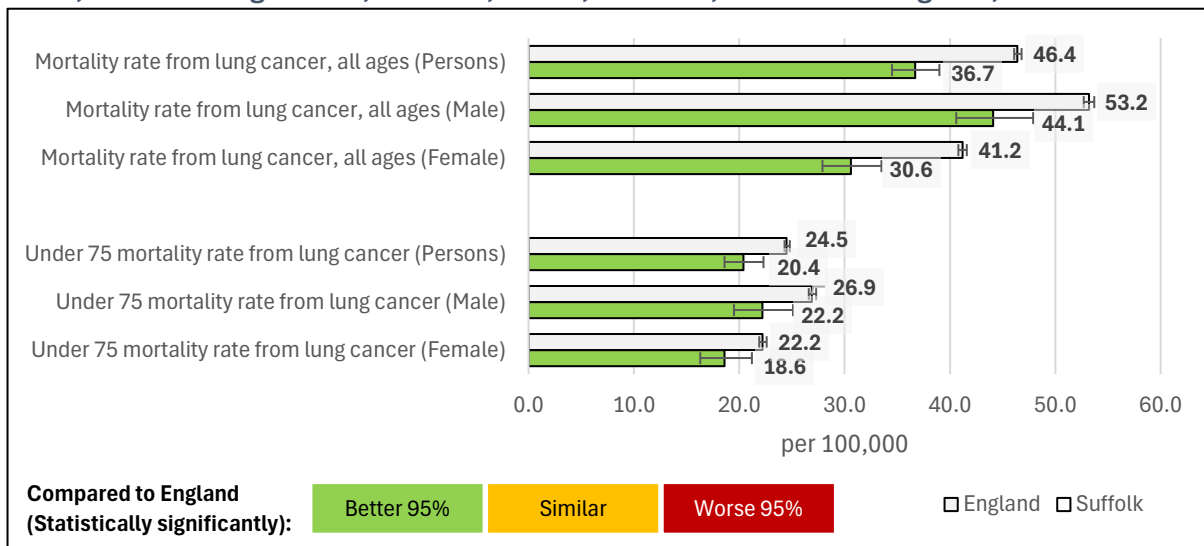
Lung cancer is the leading cause of cancer death in men<sup>53</sup>. The NHS Lung Cancer Screening Programme (formerly the Targeted Lung Health Check (TLHC) Programme) invites individuals aged 55 to 74 who currently smoke or have smoked in the past to assess their lung health, with the aim of detecting cancer at an early, more treatable stage<sup>54</sup>. It is not currently available nationwide but will expand to cover all of England by 2028-30. Individuals are invited to attend via a letter or phone call from their GP or other local NHS service. Information on the service within Suffolk is available from the [East of England NHS Cancer Screening page](#).

The Lung Cancer Screening programme focuses on areas with the highest smoking and lung cancer rates, using symptom questionnaires and low-dose computerised tomography scans, finding lung cancers at earlier stages, where treatment can be much more effective.

Lung cancer remains the leading cause of cancer-related deaths in the UK, with long-term survival rates significantly lower than for most other cancers. Only around 5% of people survive for 10 years following diagnosis, compared to approximately 50% across all cancers combined. A key factor behind these poor outcomes is late diagnosis, with around two-thirds of cases identified at an advanced stage, when curative treatment options are limited.

In Suffolk, lung cancer mortality rates are statistically significantly lower than the England average across all measures. For 2022–24, the all-age mortality rate for males was 44.1 per 100,000, compared to 53.2 per 100,000 in England. Similarly, the under-75 mortality rate for males was 22.2 per 100,000, lower than the England rate of 26.9 per 100,000. Although this indicates a comparatively better local position, lung cancer remains a major contributor to premature mortality, reflecting the ongoing impact of smoking and the importance of early detection and prevention.

**Figure 32. Mortality rate per 100,000 from lung cancer, and premature mortality rate per 100,000 from lung cancer, Persons, Males, Females, Suffolk and England, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

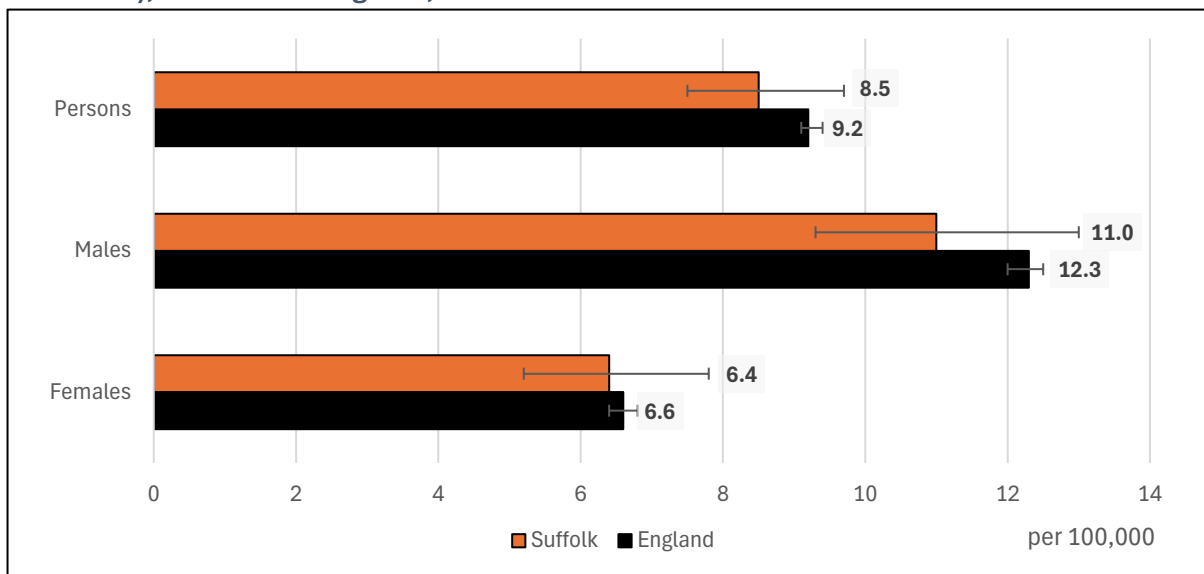
Liver cancer

Cancer mortality rates are expected to continue to decline for both men and women over the next 15 years, including reductions across the major cancer types<sup>31</sup>. However, this overall improvement is not consistent across all cancers. A small number of cancer types are projected to see rising mortality rates, most notably liver cancer. Deaths from liver cancer have increased substantially in recent years, rising by 43.5% over the past decade<sup>55</sup>.

Liver cancer is the 8<sup>th</sup> most common cause of cancer death in the UK – five-year survival for people with liver cancer is poor at only 13%. By the time a person has symptoms and consults a doctor, the disease is frequently at an advanced stage, and most commonly occurs in people who already have liver damage. The main cause of primary liver cancer is cirrhosis of the liver as a result of damage over a long period of time, from a range of causes including infections (10%), smoking (20%), alcohol use (7%), and overweight and obesity (23%)<sup>56</sup>. Notably, excess weight contributes to a substantially greater number of liver cancer cases than alcohol, with around three times as many cases linked to overweight and living with obesity. Many liver cancer risk factors are considered preventable, including chronic hepatitis B and C, excessive alcohol consumption, and metabolic dysfunction-associated steatotic liver disease (MASLD)<sup>57</sup>.

Suffolk's mortality rate per 100,000 from liver cancer for males is statistically similar to the England value between 2022-24, but the male rate is statistically significantly higher (and almost double) the rate for females in Suffolk between 2022-24.

**Figure 33. Mortality rate per 100,000 from liver cancer, all ages (Males, Females, Persons), Suffolk and England, 2022-24**



Source: [Office for Health Improvement and Disparities \(2025\)](#)

### Liver disease

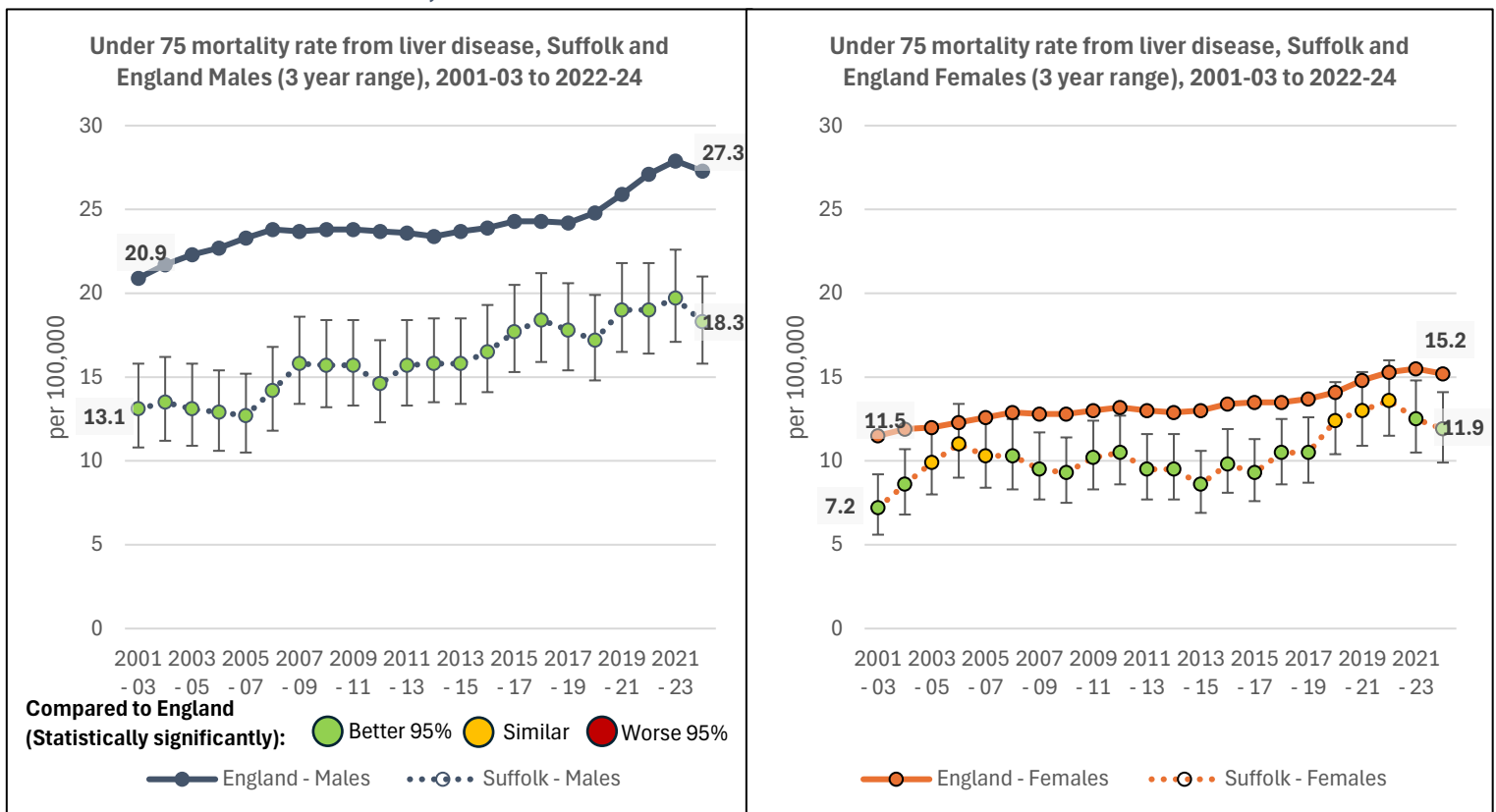
More than two-thirds (68%) of liver disease deaths are in men<sup>58</sup>. There has been a four-fold increase in death rates from liver disease over the last 50 years and liver disease is the only major disease group in the UK where death rates are rising. Liver diseases are often caused by alcohol consumption, obesity and viral hepatitis and around 9 in 10 cases of liver disease are preventable<sup>7</sup>. The risk of deaths from liver disease is 4 to 5 times higher in the most deprived areas compared with the least deprived<sup>7</sup>.

Liver disease, particularly that linked to alcohol, remains a growing public health concern and disproportionately affects men. In England, around 77% of alcohol-specific deaths are due to alcohol-related liver disease, with mortality rates in men approximately twice as high as in women<sup>59</sup>.

While overall premature mortality has declined over recent decades, deaths from alcohol-related liver disease have increased. Over the past 20 years, the number of premature deaths from these conditions has risen by over 60%, with rates increasing by more than a third to their highest levels on record. This trend contrasts with many other Western European countries, where rates have fallen over the same period<sup>60</sup>.

Under-75 mortality rates from liver disease have increased over time in Suffolk for both men and women, reflecting the national trend. However, rates remain consistently higher among men. In the most recent period (2022–24), the mortality rate for males in Suffolk is 18.3 per 100,000, compared to 11.9 per 100,000 for females, meaning men have an under 75 mortality rate from liver disease per 100,000 50% higher than the female rate.

**Figure 34. Under 75 mortality rate per 100,000 from liver disease, Suffolk and England, males and females, 2001-03 to 2022-24**



Source: [Office for Health Improvement and Disparities \(2025\)](#)

Trends should be interpreted with caution, as observed changes over time may reflect variation rather than statistically significant differences. Although rates in Suffolk are lower than the England average for both sexes, there is an upward trend over the past two decades, particularly among men, where rates have increased from around 13 per 100,000 in the early 2000s to over 18 per 100,000 in recent years. This increase mirrors wider national patterns and highlights the growing impact of liver disease as a contributor to premature mortality.

There is also a strong link with deprivation, with higher mortality rates seen in more deprived areas and significant regional variation. For example, rates in the North East of England are around twice those seen in the East of England. These patterns highlight the importance of addressing alcohol-related harm as part of efforts to reduce health inequalities and improve outcomes for men.

## Respiratory disease

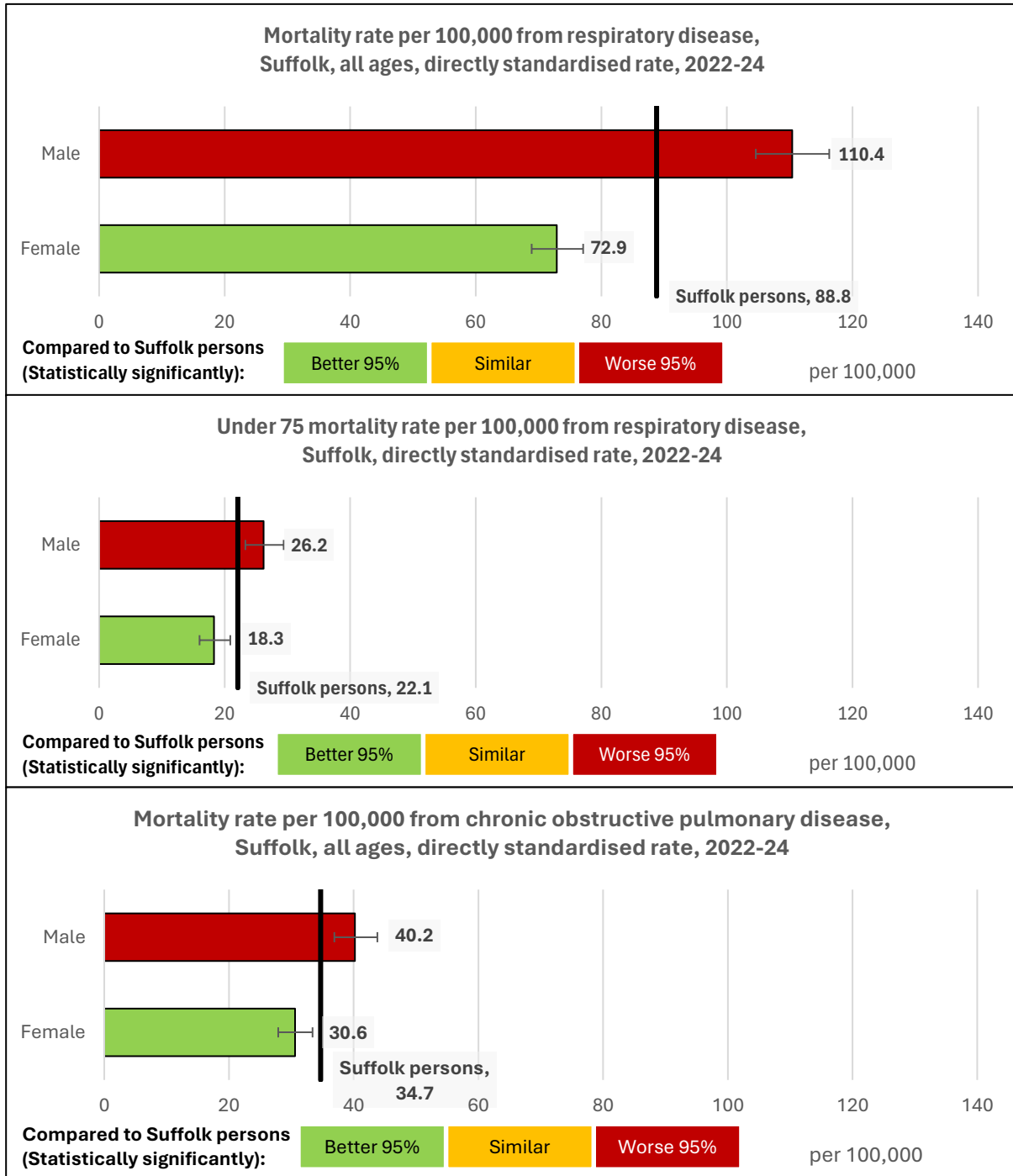
Respiratory disease is the third leading cause of premature death (after cancer and cardiovascular disease) in England, and a major pressure on the NHS<sup>61</sup>. Men, particularly former industrial workers, smokers and those in deprived communities, carry the greatest burden of respiratory disease. Occupational lung diseases have significant associated morbidity and mortality, and may present as lung cancer and mesothelioma, COPD, silicosis, asbestosis and other forms of pneumoconiosis or occupational asthma<sup>62</sup>.

Allergic airways disease related to the workplace is thought to be more common in men than women, with around two-thirds of sufferers being male<sup>63</sup>. Respiratory diseases can be caused by air quality<sup>64</sup>, smoking and occupational exposure to chemicals and particles<sup>62</sup>.

Overall, men are more likely to suffer from occupational lung disease and may experience significant morbidity and mortality, particularly if the diagnosis is delayed<sup>65</sup>. It is estimated that 35% of all respiratory deaths are due to smoking<sup>66</sup>.

In Suffolk, mortality rates from respiratory disease are statistically significantly higher in men than in women. For 2022-24, the all-age mortality rate for males was 110.4 per 100,000, compared to 72.9 per 100,000 for females. A similar pattern is seen for premature mortality (under 75), with a rate of 26.2 per 100,000 in males, compared to 18.3 per 100,000 in females. Chronic obstructive pulmonary disease (COPD) – a major component of respiratory mortality – also shows a clear gender disparity, with male mortality rates (40.2 per 100,000) statistically significantly higher than female rates (30.6 per 100,000).

**Figure 35. Mortality rate from respiratory disease, under 75 mortality rate from respiratory disease, mortality rate from COPD, Suffolk males and females compared to persons, rates per 100,000, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

## Substance misuse

### Alcohol

In England, among people aged 15 to 49 years, alcohol is the leading cause of ill-health, disability and death<sup>67,68</sup>. Alcohol misuse is a significant public health problem with major health, social and economic consequences, estimated at between £21 and £52 billion a year<sup>69</sup>.

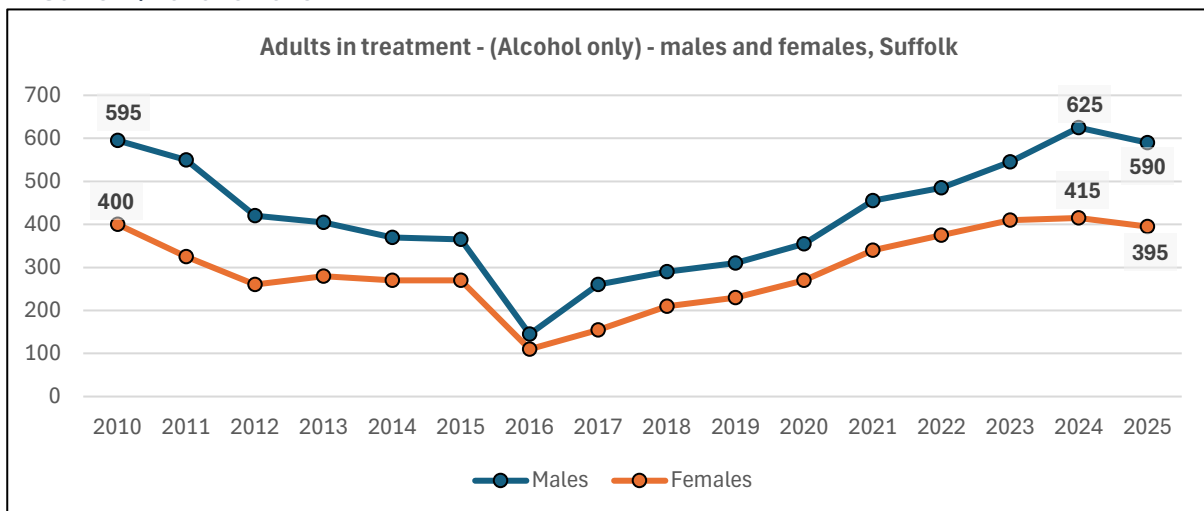
Men at all ages are more likely to drink alcohol than their female counterparts, and men are also more likely to develop dependency issues through their drinking, when compared to women<sup>70</sup>. Alcohol has a significant influence on male mental health, with men more likely than women to experience 'externalising' problems, including substance abuse<sup>70</sup>. Societal norms promoting competition, risk-taking, invincibility and courage have also been linked to heavy alcohol consumption<sup>71</sup>, with peer pressure in drinking contexts often compelling individuals to consume alcohol<sup>72</sup> even when they do not wish to and may leave those who refrain from consuming alcohol feeling socially isolated<sup>7</sup>.

Engagement with alcohol treatment services in Suffolk reflects clear and persistent gender differences. Across the time series, men consistently account for a higher number of individuals in treatment for alcohol use alone compared to women. In 2010, there were 595 males in treatment compared to 400 females, and although numbers declined for both sexes over the following years, this gap remained.

After a notable drop in 2016 - likely reflecting either changes in service provision or recording - numbers have risen steadily. By 2024, male treatment numbers had increased to 625, compared to 415 for females, before a slight decline in 2025 (590 males and 395 females). Overall, this represents an increase in demand for alcohol treatment services since the mid-2010s, particularly among men.

These trends reinforce the disproportionate impact of alcohol misuse on men, not only in terms of health outcomes but also in treatment need. The sustained higher number of men in treatment suggests both greater levels of harmful drinking and potentially higher levels of dependency, highlighting the importance of gender-sensitive approaches to prevention, engagement and recovery support.

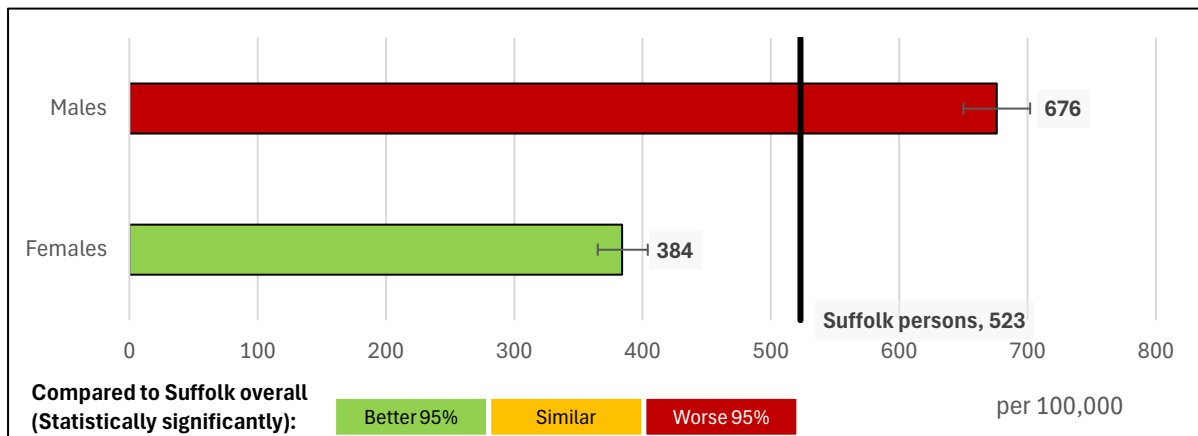
**Figure 36. Adults in treatment – all in treatment for alcohol only, males and females, Suffolk, 2010 to 2025**



Source: [National Drug Treatment Monitoring System \(NDTMS\)](#) (2026)

Hospital admission rates for alcohol-related conditions (narrow definition) show a mixed picture in Suffolk compared to the national average. For males, the rate in Suffolk (676 per 100,000) is statistically similar to England (676 per 100,000), indicating comparable levels of alcohol-related hospital admissions where alcohol is the primary cause. In contrast, females in Suffolk have a statistically significantly higher rate than the national average (384 per 100,000 compared to 340 per 100,000), suggesting a comparatively greater burden of alcohol-related harm among women in Suffolk, despite the male rate being 76% higher than the female rate in 2023/24. Please note the following figure compares the male and female rate to the Suffolk overall rate per 100,000.

**Figure 37. Admission episodes for alcohol-related conditions (Narrow), Suffolk males and females compared to Suffolk overall, 2023/24**

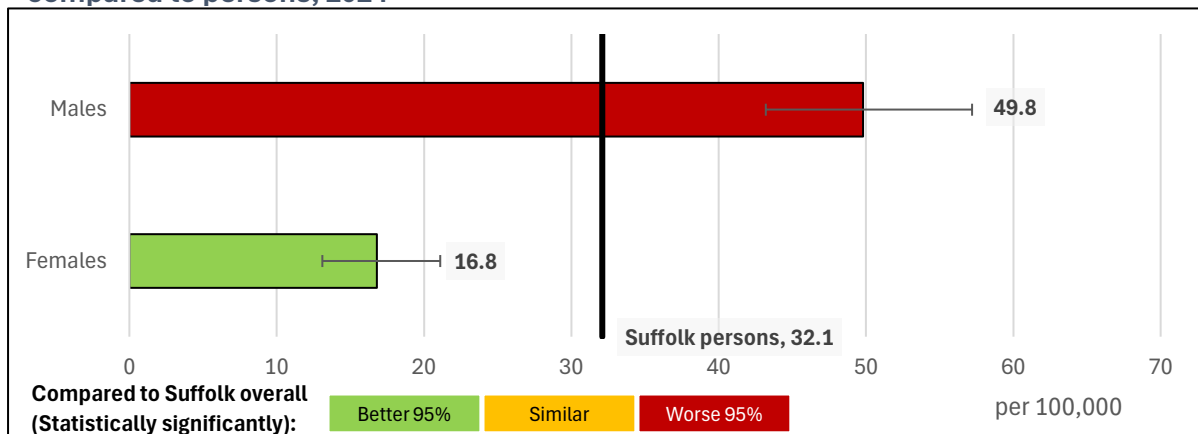


Source: [Office for Health Improvement and Disparities \(2025\)](#)

Alcohol-related mortality in Suffolk shows a marked gender variation. In 2024, the overall rate was 32.1 per 100,000, but this masks a substantially higher rate among men. Male mortality was 49.8 per 100,000, nearly three times higher than the female rate of 16.8 per 100,000.

This significant disparity reflects the greater exposure of men to harmful drinking patterns and alcohol-related disease, particularly conditions such as liver disease and alcohol-related cancers. The scale of the difference highlights alcohol as a key contributor to premature mortality among men in Suffolk and underlines the importance of targeted prevention and treatment interventions.

**Figure 38. Alcohol-related mortality rate per 100,000 for Suffolk's males and females compared to persons, 2024**



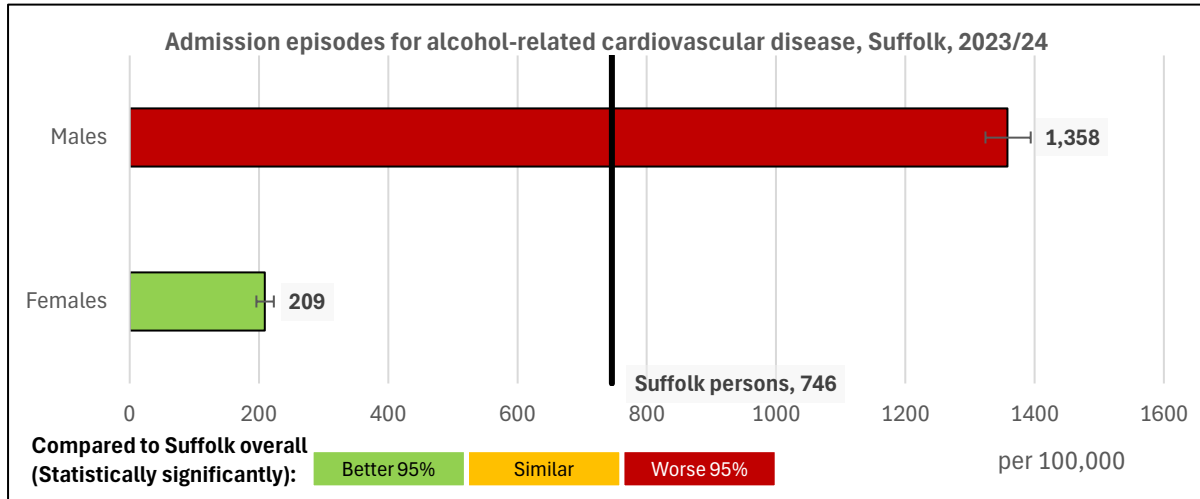
Source: [Office for Health Improvement and Disparities \(2025\)](#)

## Men's Health Profile

Alcohol-related harm continues to have a disproportionate impact on men in Suffolk, particularly in relation to cardiovascular disease, hospital admissions and premature mortality.

In 2023/24, admission rates for alcohol-related cardiovascular disease were substantially higher in men than women. Suffolk males had a rate of 1,358 per 100,000, compared to 209 per 100,000 for females. Although rates in Suffolk were statistically significantly lower than the England average for both sexes, the scale of the gender gap remains pronounced, with men experiencing a far greater burden of alcohol-related cardiovascular harm.

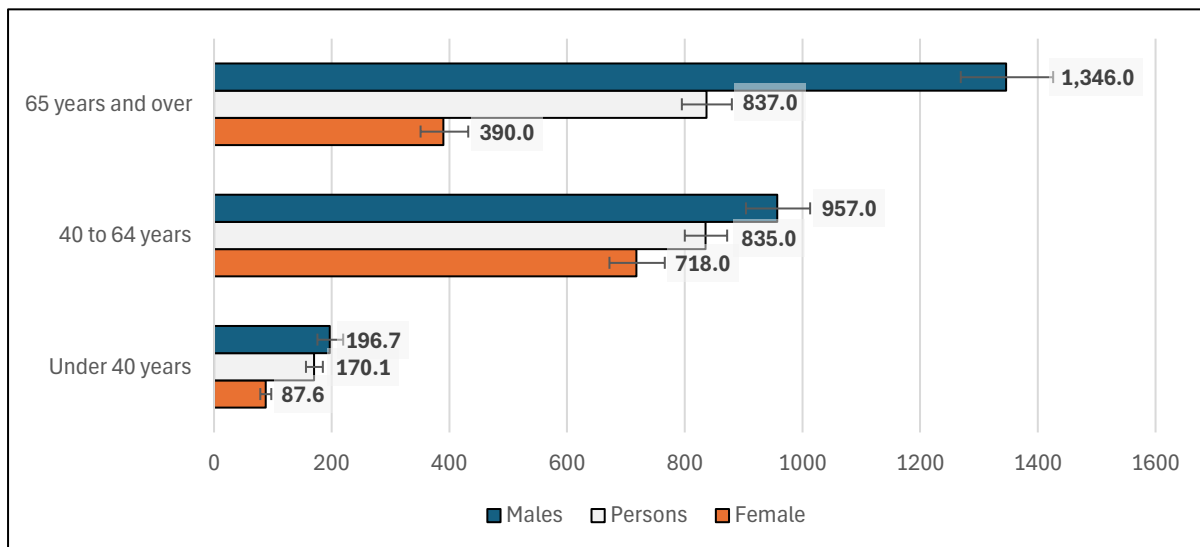
**Figure 39. Admission episodes for alcohol-related cardiovascular disease per 100,000, Suffolk males and females, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

Age-specific patterns further highlight the impact on men. Hospital admission rates increase markedly with age, particularly for males, rising from 196.7 per 100,000 in those under 40, to 957.0 per 100,000 in those aged 40 to 64, and peaking at 1,346.0 per 100,000 in those aged 65 and over. While a similar age gradient is seen in females, male rates are consistently higher across all age groups, indicating both earlier onset and greater severity of alcohol-related harm.

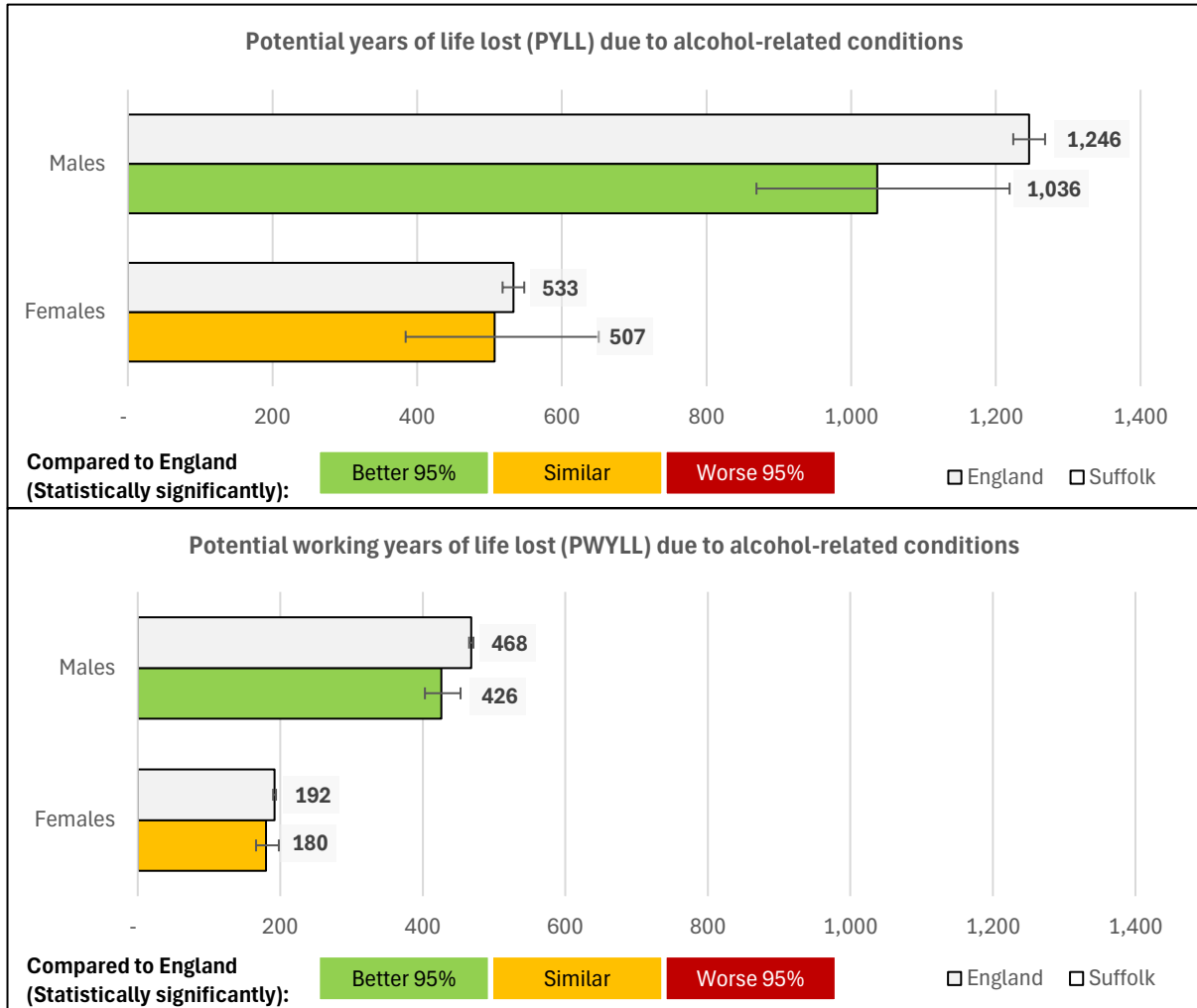
**Figure 40. Admission episodes for alcohol-related conditions (narrow), Suffolk persons, males and females, by age group, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

Measures of premature mortality reinforce this pattern. In 2023, males in Suffolk lost 1,036 potential years of life per 100,000 due to alcohol-related conditions - more than double the female rate of 507 per 100,000. A similar disparity is seen in potential working years of life lost (PWYLL) in 2024, with males losing 426 years per 100,000, compared to 180 per 100,000 for females.

**Figure 41. Potential years of life lost (PYLL) (2023) and potential working years of life lost (PWYLL) (2024) due to alcohol-related conditions, Suffolk males and females compared to England**



Source: [Office for Health Improvement and Disparities \(2025\)](#)

Although Suffolk's disease rates are generally lower than England, these findings highlight the substantial and unequal burden of alcohol-related harm among men, particularly in terms of cardiovascular disease and early mortality. This reinforces the need for targeted interventions aimed at reducing harmful drinking and its long-term health consequences among men, especially in mid to later life.

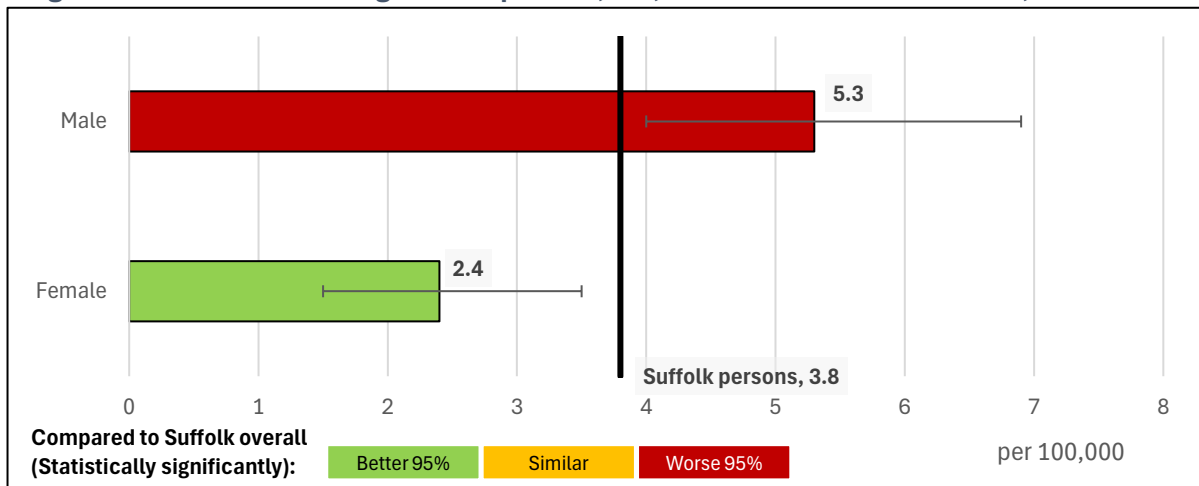
Drugs

Drug misuse remains an important contributor to premature mortality, with a clear gender disparity evident in Suffolk. Men are more likely than women to engage in unhealthy behaviours such as substance misuse<sup>73</sup>, and like alcohol, illicit drug use - especially opiates and crack cocaine - is strongly linked to poverty and deprivation<sup>74</sup>. Alcohol and drug-related harm is closely associated with socioeconomic status and social exclusion<sup>75</sup>. Risk factors for substance misuse include history of abuse in childhood, family history of substance abuse, individual risk factors vary by age group such as dealing with interpersonal trauma, poor relationships with parents, substance abuse in high stress professions, or dealing with grief<sup>76</sup>. Peer risk factors include losing family support and friends’ influence<sup>76</sup>.

Although the overall mortality rate in Suffolk (3.8 per 100,000 in 2022–24) is statistically significantly lower than the England average (5.8 per 100,000), local trends mirror the national picture of increasing drug-related harm over time.

Men are disproportionately affected. In Suffolk, the mortality rate for males is 5.3 per 100,000, more than double and statistically significantly higher than the female rate of 2.4 per 100,000. This reflects wider national patterns, where men are more likely to use drugs, experience dependency, and die from drug-related causes.

**Figure 42. Deaths from drug misuse per 100,000, Suffolk males and females, 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2026)

While absolute numbers remain relatively small, the upward trend and marked gender gap highlight drug misuse as a growing risk to men’s health, particularly in relation to premature mortality. These findings underline the importance of targeted prevention, early intervention and treatment services, alongside addressing the wider determinants of substance misuse such as mental health, deprivation and social isolation.

Patterns of drug treatment among men in Suffolk have changed considerably over time, reflecting shifts in substance use and treatment demand. Opiate and crack cocaine use remains the most common presentation to treatment services among males, increasing from 225 individuals in 2010 to a peak of 440 in 2020, before declining to 335 in 2025. Despite this recent reduction, this group continues to be one of the largest treatment cohorts.

Cannabis-related treatment presentations have also remained consistently high. Numbers increased substantially between 2010 and 2013, peaking at 345 individuals, before falling

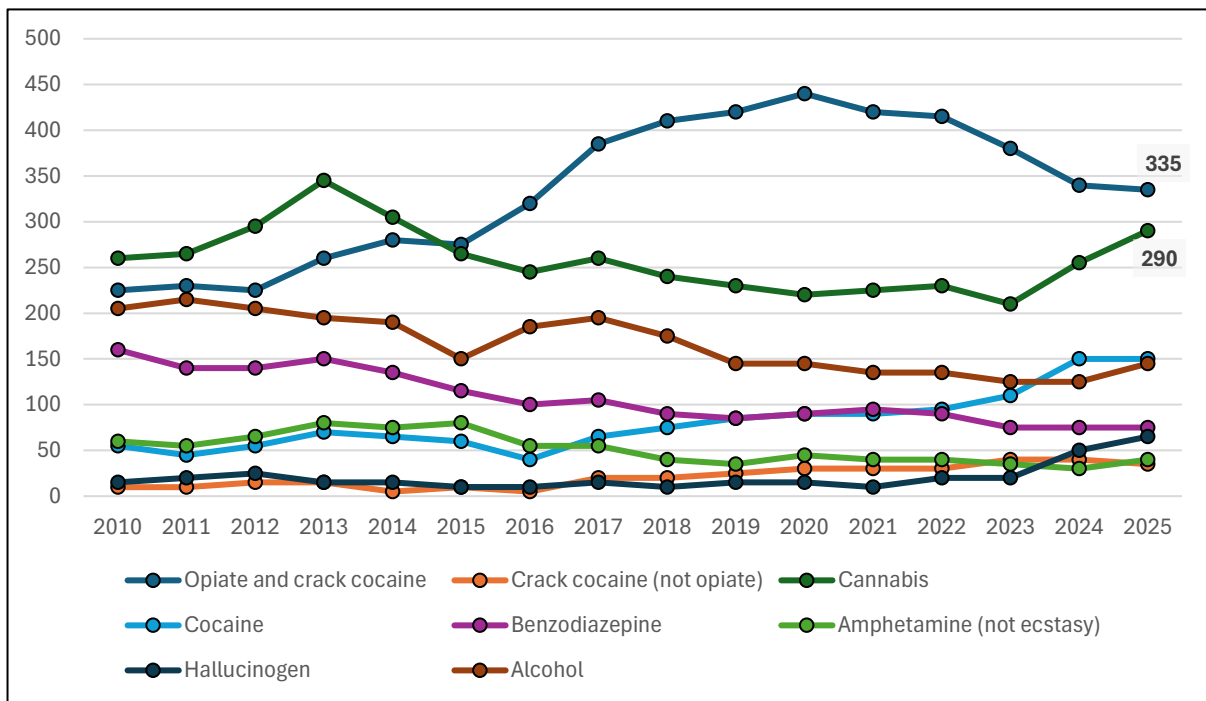
during the late 2010s and rising again in recent years to 290 in 2025. Cocaine-related treatment has shown a marked upward trend over the period, increasing from 55 men in treatment in 2010 to 150 in both 2024 and 2025, suggesting growing demand associated with stimulant use.

In contrast, treatment numbers for benzodiazepines and amphetamines have generally declined over time. Benzodiazepine-related treatment fell from 160 males in 2010 to 75 in 2025, while amphetamine-related treatment decreased from 60 to 40 over the same period. Hallucinogen-related treatment remains comparatively low in absolute numbers, although presentations increased notably in recent years, rising from 20 in 2023 to 65 in 2025.

Alcohol-related treatment among men has fluctuated over time, declining from over 200 individuals in the early 2010s to 125 in 2023 and 2024, before increasing slightly to 145 in 2025.

Overall, the data suggest changing patterns of substance misuse among men in Suffolk, with increasing prominence of stimulant use, particularly cocaine, alongside persistently high levels of opiate and crack cocaine treatment need. These trends reinforce the importance of responsive treatment services and targeted prevention approaches tailored to emerging patterns of drug use among men.

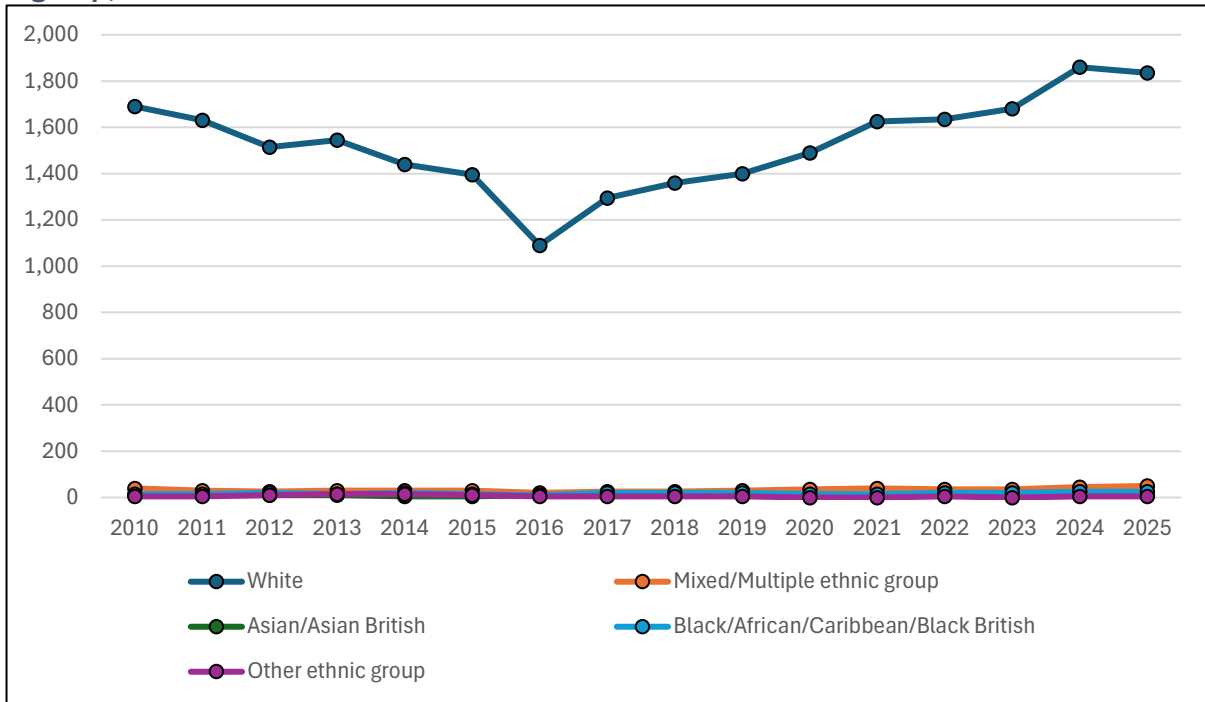
**Figure 43. All in treatment by type of substance, Suffolk males (all ages), 2010-25**



Source: [National Drug Treatment Monitoring System \(NDTMS\)](#) (2026)

According to the latest NDTMS data for 2025, White British males account for 95% of males in treatment for drug and alcohol services in Suffolk. This figure exceeds the proportion of White British males in the general male population (93.1% according to the 2021 census), suggesting potential disproportionate representation.

**Figure 44. All in treatment – all substance categories, Suffolk males (all ages), by ethnic group, 2010 - 2025**



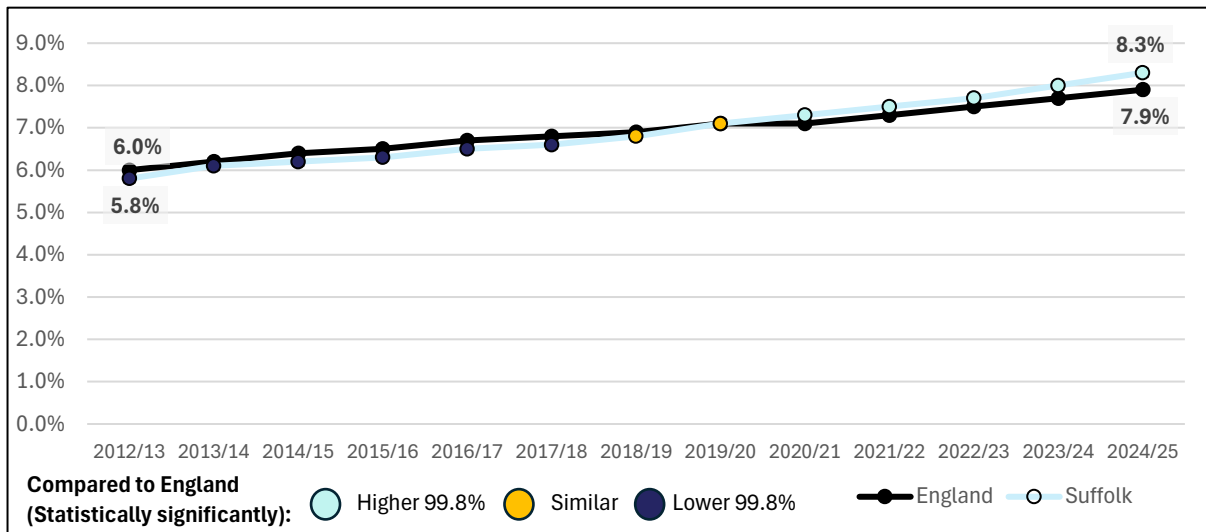
Source: [National Drug Treatment Monitoring System \(NDTMS\)](#) (2026)

## Diabetes

There are estimated to be more than 5.8 million people in the UK living with diabetes (an all-time high), with 4.6 million in the UK living with diabetes diagnoses<sup>77</sup>. Additionally, nearly 1.3 million people could be living with type 2 diabetes who are yet to be diagnosed<sup>77</sup>.

Data from the Quality and Outcomes Framework (QOF) from Suffolk's General Practices reveals that Suffolk has an adult prevalence of diabetes statistically significantly higher than England (8.3% (57,383 individuals) compared to 7.9%), which has statistically significantly increased from 5.8% in 2012/13.

**Figure 45. Diabetes: Quality Outcomes Framework (QOF) prevalence, patients aged 17 or over with diabetes, Suffolk and England, 2012/13 to 2024/25**

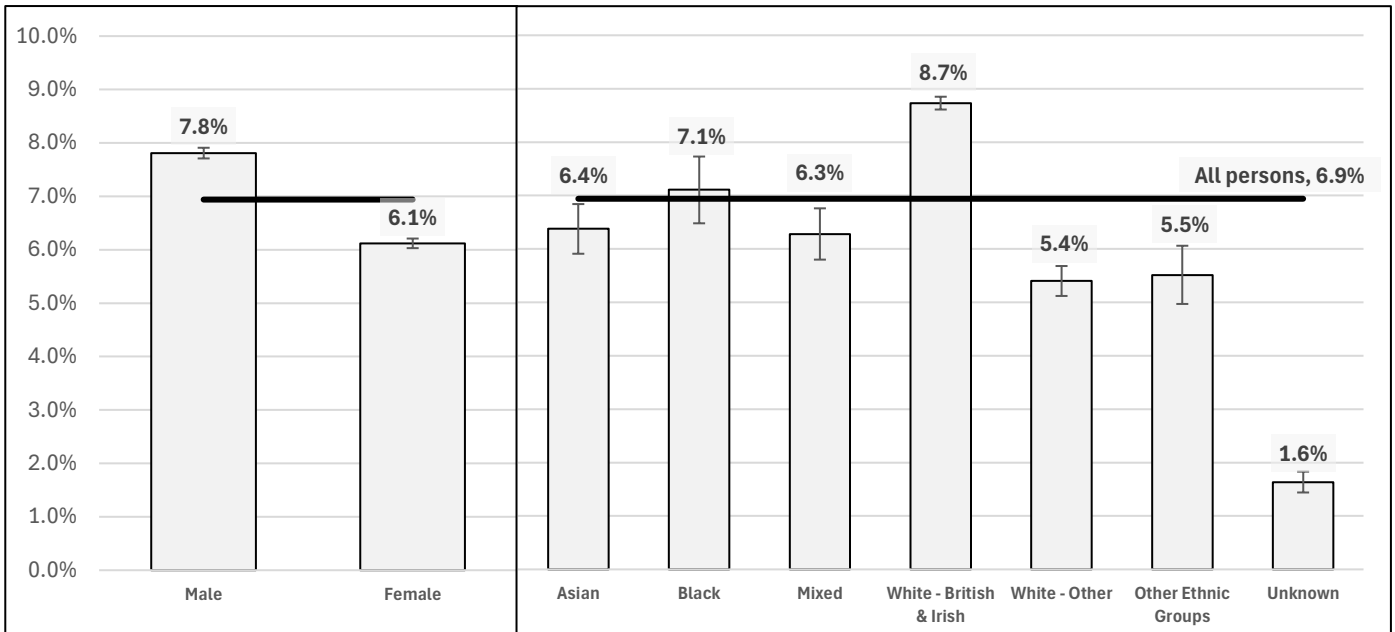


Source: [Office for Health Improvement and Disparities \(2025\)](#)

Population Health Management data for Suffolk indicates that diabetes prevalence varies by both sex and ethnicity. Overall, 7.0% of the registered Suffolk population are recorded as having diabetes. Prevalence is higher in men than women, with 7.8% of males diagnosed compared to 6.1% of females, meaning men are approximately 28% more likely to have a diabetes diagnosis than women locally. This difference is broadly consistent with national patterns.

Among Suffolk men, diabetes prevalence also varies by ethnicity. The highest recorded prevalence is highest among people White British and Irish men (8.7%), and Black men (7.1%) while lower rates are observed in White Other (4.5%) and Other ethnic groups (5.0%). Lower recorded prevalence is observed among White – Other men (5.4%), and men from Other ethnic groups (5.5%), which may reflect under-diagnosis and under-recording rather than true underlying risk.

**Figure 46. Diabetes: % of all patients with a diabetes diagnosis by gender and ethnic groups (males), Suffolk, January – December 2025**



Source: Population Health Management (2026)

National evidence shows that males from Black and South Asian backgrounds are at increased risk of developing type 2 diabetes, often at a younger age and lower body mass index compared to White populations<sup>78,79</sup>, however across Suffolk – the highest prevalence of diabetes is among the White – British and Irish population (8.7%). Local prevalence estimates may reflect Suffolk's demographic profile and differences in diagnosis, detection and age structure. The higher prevalence observed among men also reflects broader national trends linked to obesity, diet, physical inactivity and cardiovascular risk factors<sup>28</sup>.

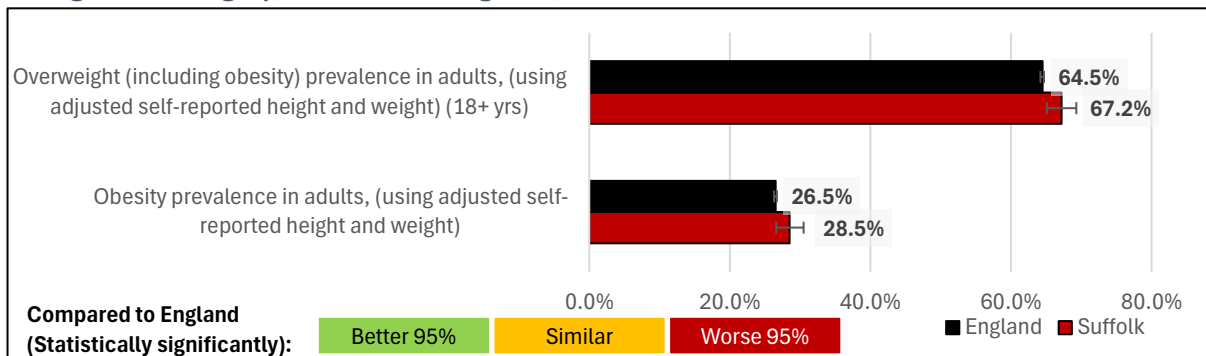
Diabetes risk in Suffolk is not evenly distributed across the population. Targeted interventions particularly for those focused on high-risk ethnic groups and for men, are essential to support earlier diagnosis, reduce complications, and address underlying health inequalities.

## Obesity

Obesity is associated with a reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, cancer and musculoskeletal conditions<sup>80</sup>. Obesity can also have a significant impact on mental health and wellbeing. The prevalence of obesity is strongly linked to deprivation, reflecting the influence of wider determinants of health such as income, education, employment, housing, access to green space and opportunities for physical activity. Features of the local food environment, including the higher concentration of fast-food outlets in more deprived communities<sup>81</sup>, may also contribute to unhealthy dietary patterns and higher consumption of energy dense foods. The risk and severity of obesity-related disease increased with higher body mass index (BMI)<sup>82</sup>.

Between 2023-24, 38.7% of Suffolk residents were overweight (with a BMI of between 25-30), compared to 38.0% across England, and 28.5% of Suffolk residents were living with obesity (BMI greater than or equal to 30), statistically significantly higher than the England value of 26.5%.

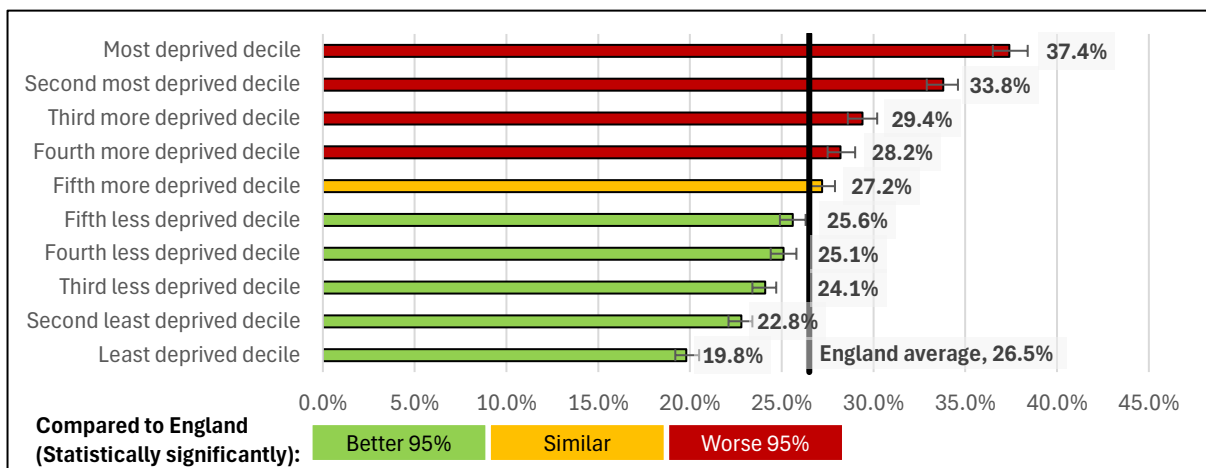
**Figure 47. Overweight and obesity prevalence in adults (using adjusted self-reported height and weight), Suffolk and England, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

There is a clear relationship between obesity and deprivation, as illustrated in the following figure. Across England, people in the most deprived decile are almost twice as likely (88%) to be living with obesity than those in the least deprived.

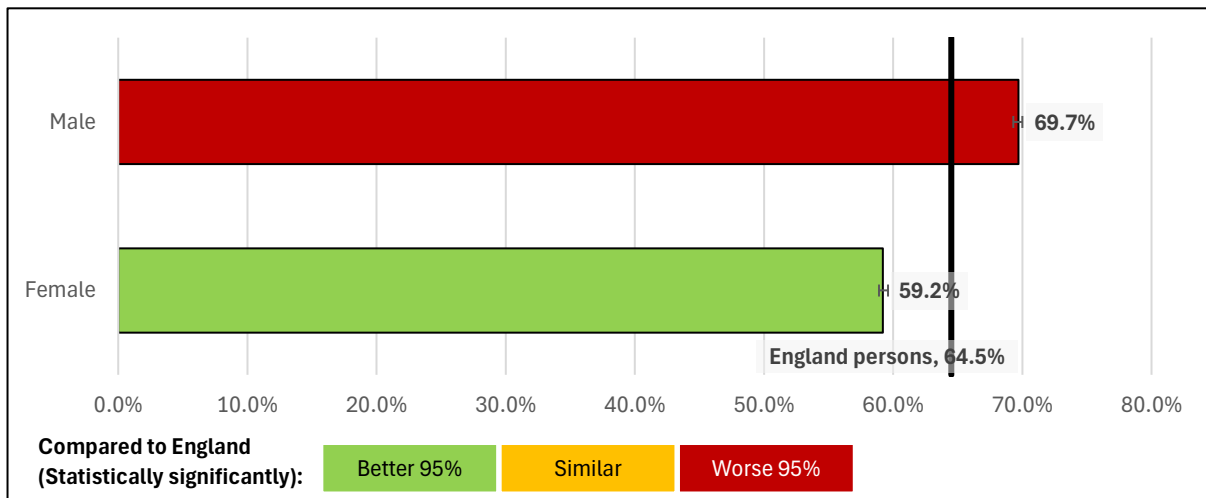
**Figure 48. Obesity prevalence in adults (using adjusted self-reported height and weight), England deprivation deciles, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

The following figure shows how overweight/living with obesity affects men and women across England, as data is not available split by gender for Suffolk. Men are 10 percentage points more likely to exceed a healthy BMI compared to women, with this primarily driven by a higher proportion of males in the 'overweight' category. Population Health Management data for Suffolk (excluding Waveney) for January to December 2025 shows 13.9% of females and 14.6% of males with a Body Mass Index (BMI) in the overweight category in the last two years (BMI  $\geq 25$  and  $\leq 29.9$  for White – British, White – Irish, White – Other or ethnicity is Unknown, or for ethnicities, BMI  $\geq 23.0$  and  $\leq 27.4$ ).

**Figure 49. Overweight (including obesity) prevalence in adults (using adjusted self-reported height and weight), (18+ yrs), England males and females, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

### Mental health

Mental health conditions arise from a complex mix of biological, psychological, social, and economic factors. Risk is shaped across the life course, including by early life experiences and wider determinants such as education, employment, housing, and financial security, which contribute to inequalities in mental health outcomes.

Alcohol and drug use are closely linked to mental health, with alcohol use disorder frequently occurring alongside other psychiatric conditions<sup>83</sup>.

Certain groups of men experience a disproportionately higher burden of poor mental health, reflecting a complex interaction of social, behavioural and structural factors. Evidence shows that gay, bisexual and men who have sex with men (GBMSM) are at increased risk of common mental health conditions, self-harm and suicide compared to heterosexual men<sup>84</sup>. Similarly, men in contact with the criminal justice system often experience significantly poorer mental health, frequently alongside co-occurring issues such as substance misuse and wider physical health inequalities<sup>85</sup>.

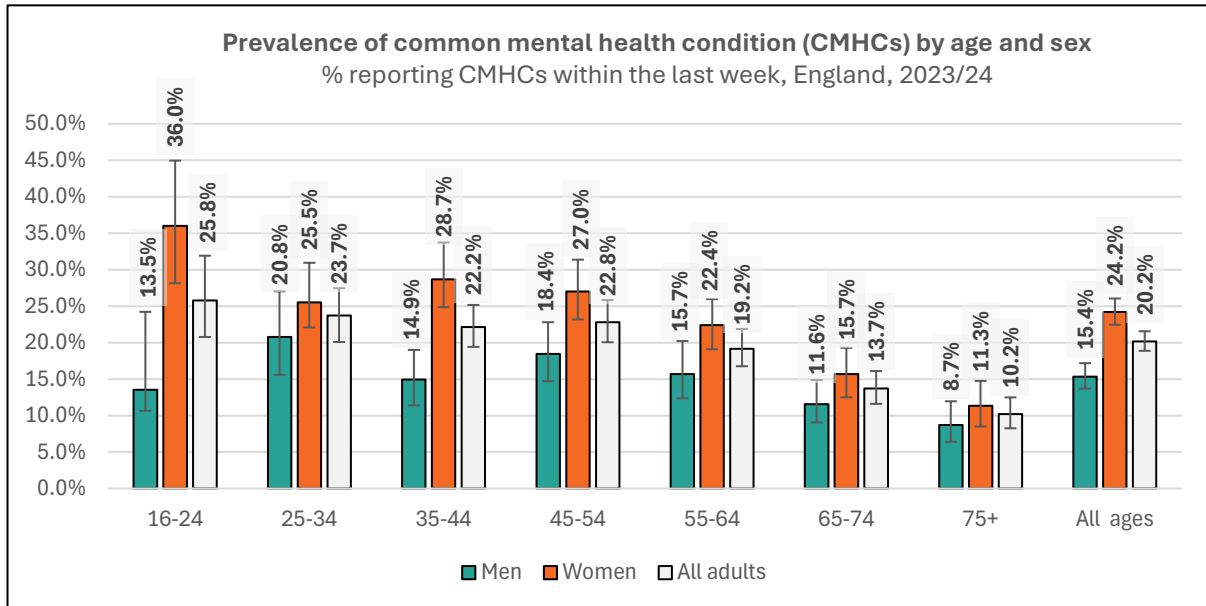
Emerging evidence also highlights the influence of social and cultural factors on young men's mental wellbeing. Exposure to online content and influencers can shape attitudes towards masculinity, success and help-seeking<sup>86</sup>, with some studies suggesting lower prioritisation of mental health and higher reporting of negative emotions among those more engaged with this content. Body image is another important but often overlooked issue, with over a quarter of men reporting anxiety related to their appearance<sup>87</sup>.

Life transitions can also present periods of increased vulnerability. During the perinatal period, an estimated 5-15% of fathers experience anxiety and 5-10% experience depression, yet men may be less likely to recognise their need for support or feel that services are accessible to them<sup>88,89</sup>. Barriers can be particularly pronounced for younger fathers or those facing additional challenges such as unstable housing or relationship difficulties<sup>88</sup>. Poor paternal mental health can also have wider impacts on family wellbeing, including parent–infant bonding and longer-term outcomes for children<sup>88</sup>.

Prevalence of common mental health conditions and SMI

Using data from the [Adult Psychiatric Morbidity Survey \(APMS\)](#), one in five adults aged 16 and over (20.2%) had symptoms of a CMHC in the week before being surveyed. CMHCs have become more widespread over time, with prevalence of symptoms rising by approximately one-fifth in both men and women between 1993 and 2023/24<sup>90</sup>. The symptoms of CMHCs are more common among women than men across all age groups, with the difference most pronounced among those aged 16 to 24.

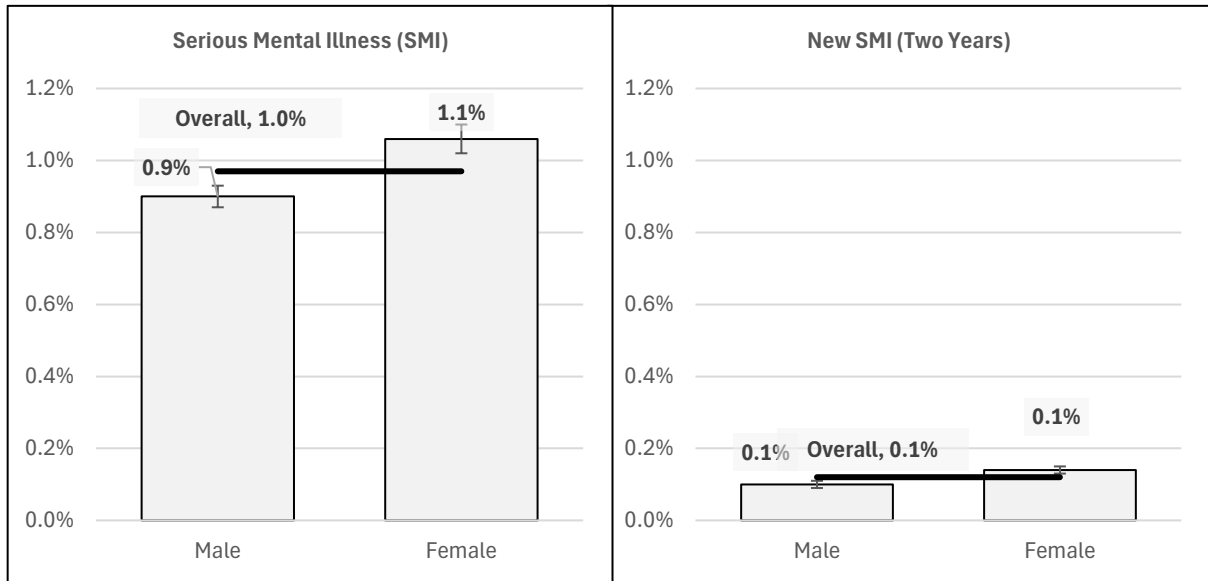
**Figure 50. Percentage of people reporting symptoms of a common mental health condition (CMHC) in the last week by age and sex in England, 2023/24**



Source: NHS Digital, [Adult Psychiatric Morbidity Survey: 2023/24](#), Table 1.3

Local PHM data for Suffolk (excluding Waveney) reflects some of these patterns. Among the GP-registered population, women have a higher recorded prevalence of depression than men (16.5% compared to 10.1%), while overall recorded mental health need is also higher among women (31.0% compared to 19.2%). Recorded prevalence of serious mental illness (SMI), such as schizophrenia or bipolar disorder, is relatively low overall but slightly higher among women than men (1.1% compared to 0.9%). Around 0.1% of both men and women were newly recorded with SMI within the previous two years. These differences may partly reflect lower levels of help-seeking and under-diagnosis among men, particularly for common mental health conditions.

**Figure 51. Percentage of Suffolk registered patients (excluding Waveney) with a Serious Mental Illness (SMI) Flag, or New SMI Flag in the previous two years, January – December 2025**

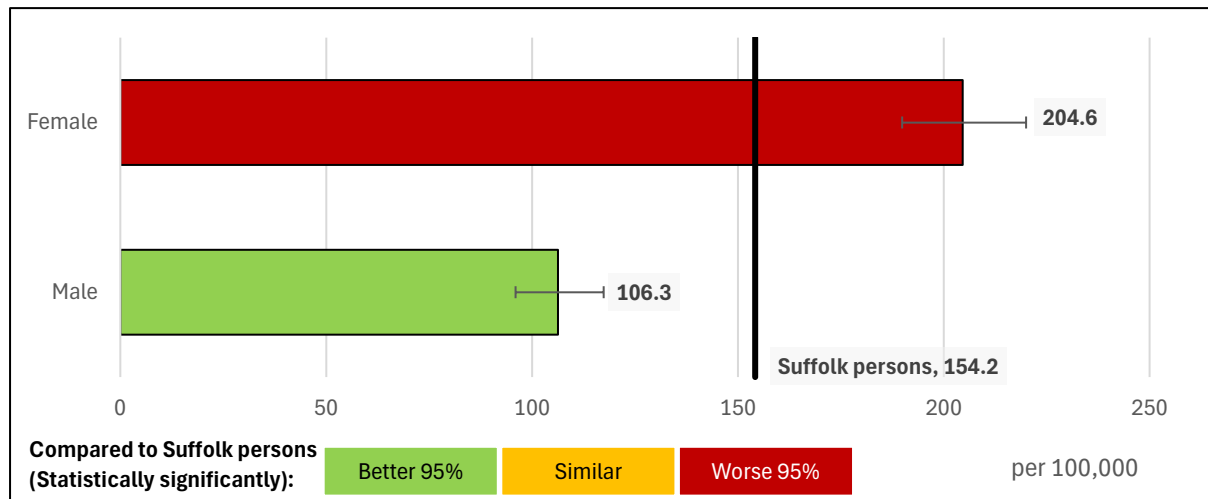


Source: Population Health Management (2026)

**Self-harm**

Emergency hospital admissions for intentional self-harm remain substantially higher among women than men in Suffolk, mirroring national patterns. In 2023/24, the admission rate for Suffolk males was 106.3 per 100,000 population (395 admissions), compared to 204.6 per 100,000 among females (740 admissions). The overall Suffolk rate was 154.2 per 100,000 population.

**Figure 52. Emergency hospital admissions for intentional self-harm (directly standardised rate per 100,000), Suffolk Males and Females, 2023/24**



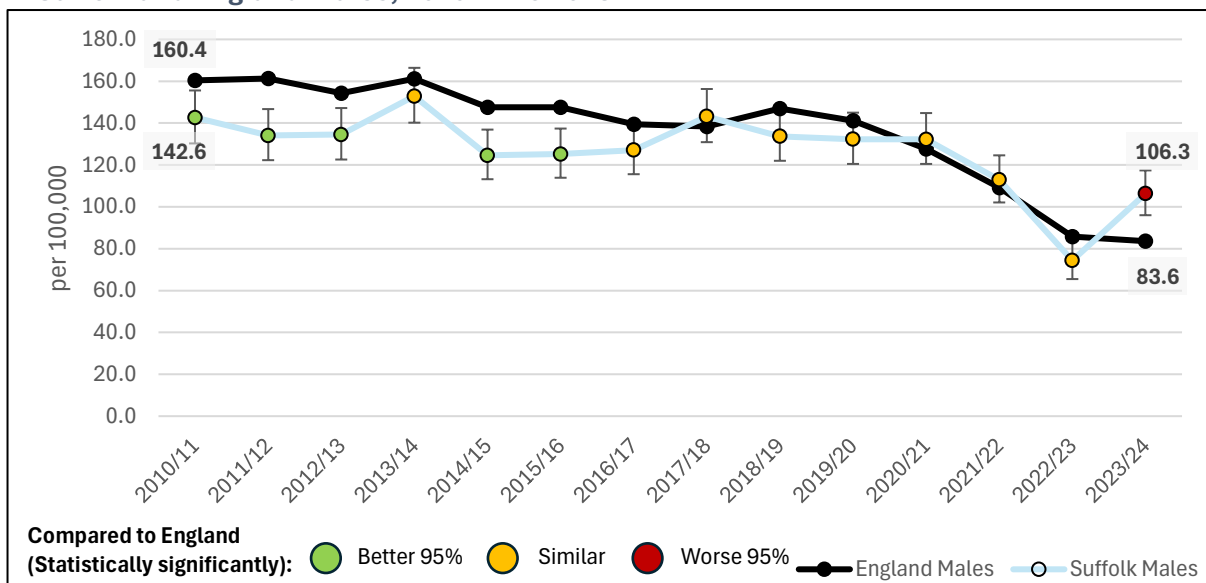
Source: [Office for Health Improvement and Disparities](#) (2025)

Although women are more likely to be admitted to hospital following self-harm, men remain at significantly greater risk of dying by suicide. Self-harm is recognised as an important indicator of acute psychological distress and is associated with an increased risk of future suicide<sup>91</sup>. Monitoring patterns of self-harm admissions therefore provides an important insight into population mental health needs and opportunities for earlier intervention.

Emergency hospital admissions for intentional self-harm among males in Suffolk have generally followed a downward trend over the past decade, although with some fluctuation in recent years. Rates declined from 142.6 per 100,000 in 2010/11 to a low of 74.4 in 2022/23, before increasing again to 106.3 in 2023/24. However, it is understood that the true prevalence for males is likely higher, as many people do not disclose self-harm due to stigma<sup>92</sup>, with research showing that men are half as likely as women to have contact with medical or mental health services after self-injuring<sup>93</sup>.

Compared to England, Suffolk's rates were consistently lower for much of the period up to 2016/17, and broadly similar between 2017/18 and 2021/22. In 2022/23, Suffolk's rate was lower (but statistically similar) compared to the national average (74.4 vs 85.8 per 100,000), but this pattern reversed in 2023/24, with Suffolk statistically significantly higher than England (106.3 vs 83.6 per 100,000). It should also be noted that Suffolk performs particularly badly for self-harm admissions for 10 to 24 year olds, with admission for 10-24 year olds accounting for 39% of all hospital admissions for self-harm in 2023/24, and being statistically significantly worse than the England average. There is also a prominent gender disparity for young people's self-harm admissions, with the 10 to 24 year old female rate (577.1 per 100,000/340 admissions) of hospital admissions for self-harm more than three times higher than the male rate (162.9 per 100,000/100 admissions).

**Figure 53. Emergency hospital admissions for intentional self-harm per 100,000, Suffolk and England males, 2010/11 to 2023/24**



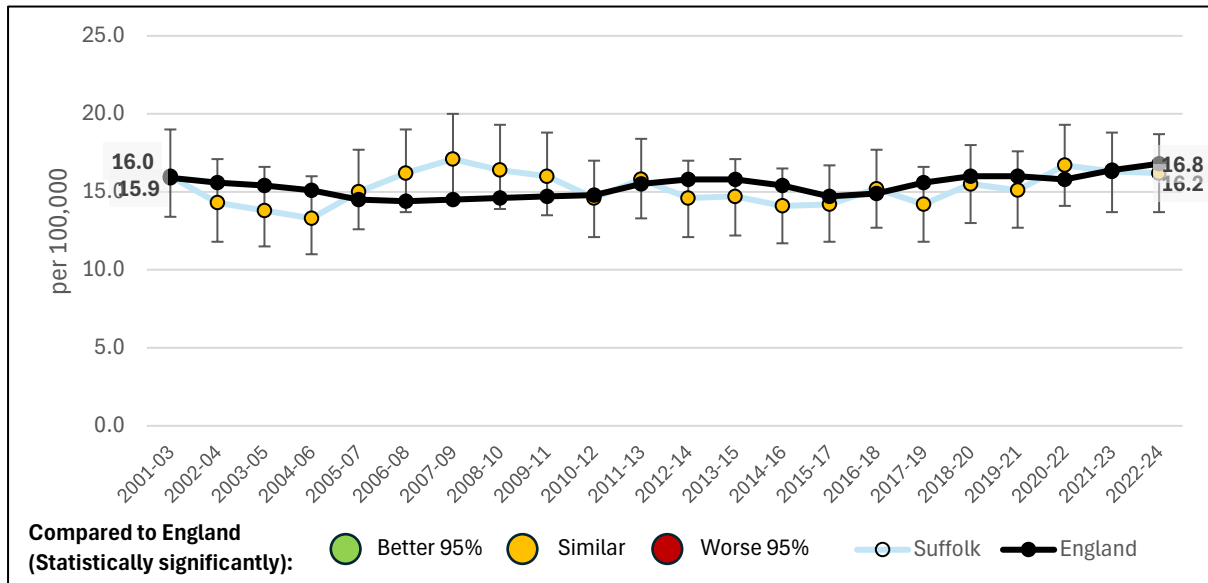
Source: [Office for Health Improvement and Disparities](#) (2025)

Overall, while long-term trends suggest improvement, the recent increase highlights ongoing volatility and the need for continued focus on prevention, early intervention, and mental health support for men.

Suicide

Between 2022-24, there were 215 deaths by suicide in Suffolk, with a rate of 10.7 per 100,000 – statistically similar to the England average (10.9 per 100,000) over the same period. Between 2001-03 (16.0 per 100,000) to 2022-24 (16.2 per 100,000), the male suicide rate in Suffolk has remained statistically similar to the England average and has not statistically significantly improved over the entire time period.

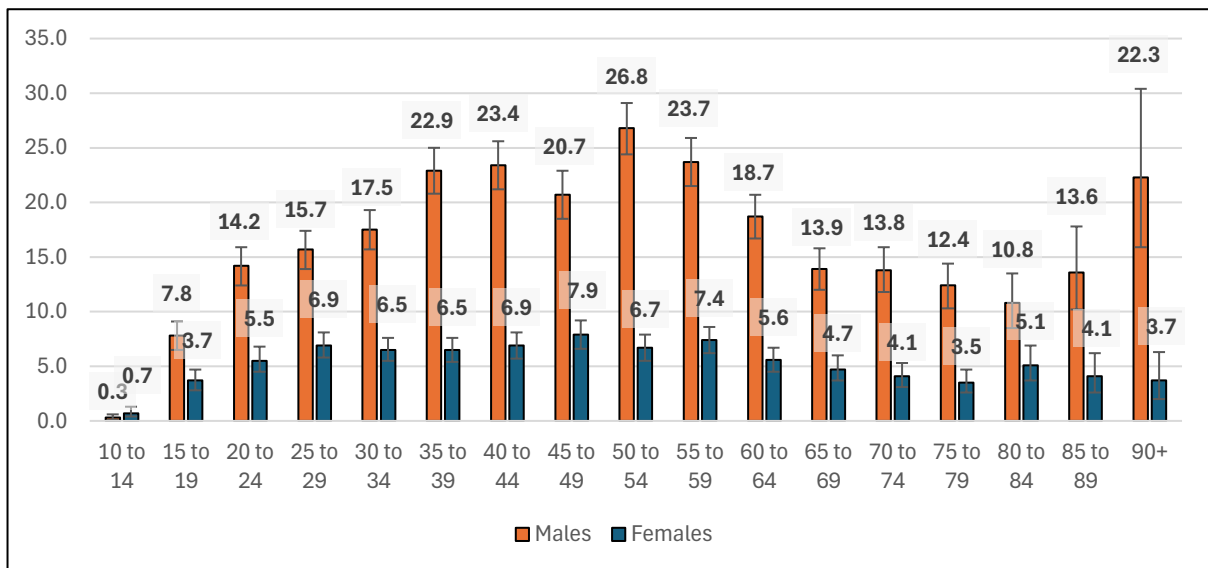
**Figure 54. Suicide rate per 100,000, males, Suffolk and England 2001-03 to 2022-24**



Source: [Office for Health Improvement and Disparities](#) (2025)

Across England, males accounted for almost 3 out of every 4 of all registered suicide deaths between 2022-24 (73.9% for Suffolk, 74.0% for England). The age-specific suicide rate across England was highest for males aged 50 to 54 years (26.8 deaths per 100,000), compared to the average across the population of 11.4 deaths per 100,000 people. Please note the 90+ group

**Figure 55. Age-specific suicide rates per 100,000 by sex and five-year age group, England 2024**



Source: [Office for National Statistics](#) (2025)

includes all adults aged 90 and over (not just the 5-year age band), and confidence intervals are larger due to the small numbers within this age group.

**Interplay with mental health: Alcohol, smoking and substance misuse**

People may use alcohol or drugs to cope with stress, but these substances can worsen existing mental health difficulties<sup>94</sup>. Between 2023 and 2024, 72% of people starting drug and alcohol treatment also had a mental health treatment need<sup>95</sup>. Therefore, reducing the number of people drinking at increasing-risk and higher-risk levels – particularly in more deprived communities – could have a positive effect of men’s mental health. In addition, higher levels of alcohol consumption increase the risk of developing dementia – including vascular dementia, which affects more men than women<sup>96</sup>.

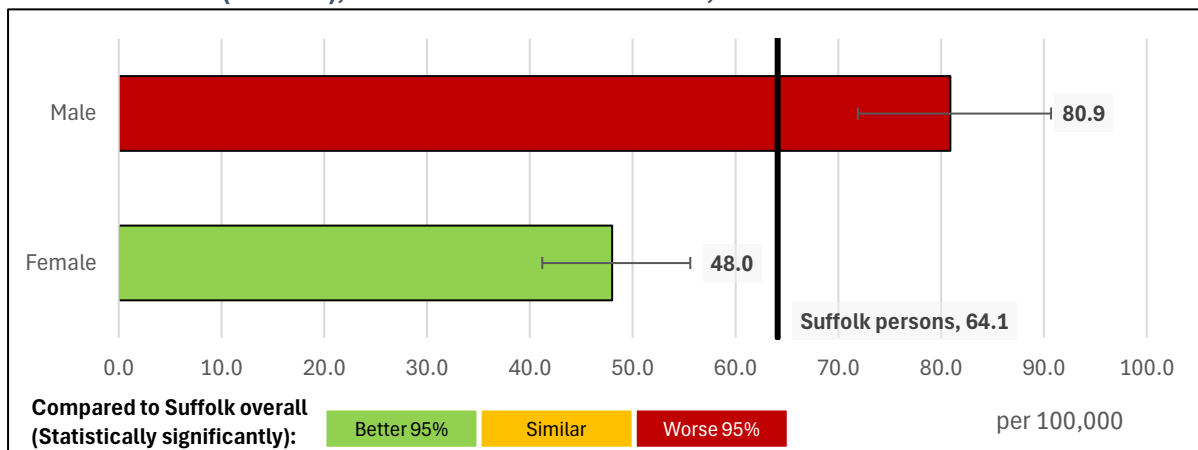
Smoking is also closely associated with poor mental health and wellbeing, with people with mental ill-health almost 2.5 times more likely to smoke when compared to the general population<sup>45</sup>. Smoking is also significantly more common among people with mental health conditions and is a major contributor to the reduced life expectancy seen in this group<sup>97</sup>. Alcohol and drug use both contribute to, and are influenced by, mental health problems, with a high proportion of individuals in treatment presenting with co-existing mental health needs<sup>94</sup>. This high smoking rate is the largest contributor to the 10-20 year reduced life expectancy among people with mental health conditions.

Poor diet and obesity are also a major driver of mental ill health – depression is shown to contribute to weight gain, with obesity also associated with an increased risk of poor mental health<sup>98</sup>, the relationship is bi-directional, where each can increase the risk of the other<sup>98</sup>.

Patterns of service use further highlight gender differences. Men are less likely to engage with community-based mental health services but are more likely to be admitted to inpatient care, which may reflect later presentation and higher acuity at the point of access<sup>99</sup>. This is reflected in findings that many men who die by suicide have had recent contact with services, indicating potential missed opportunities for earlier intervention<sup>45</sup>.

Hospital admissions for mental and behavioural disorders due to alcohol use (narrow definition) show a clear gender disparity in Suffolk. In 2023/24, the directly standardised rate for males was 80.9 per 100,000, statistically significantly higher when compared to 48.0 per 100,000 for females. The overall rate for Suffolk was 64.1 per 100,000.

**Figure 56. Admission episodes per 100,000 for mental and behavioural disorders due to use of alcohol (Narrow), Suffolk males and females, 2023/24**



Source: [Office for Health Improvement and Disparities](#) (2025)

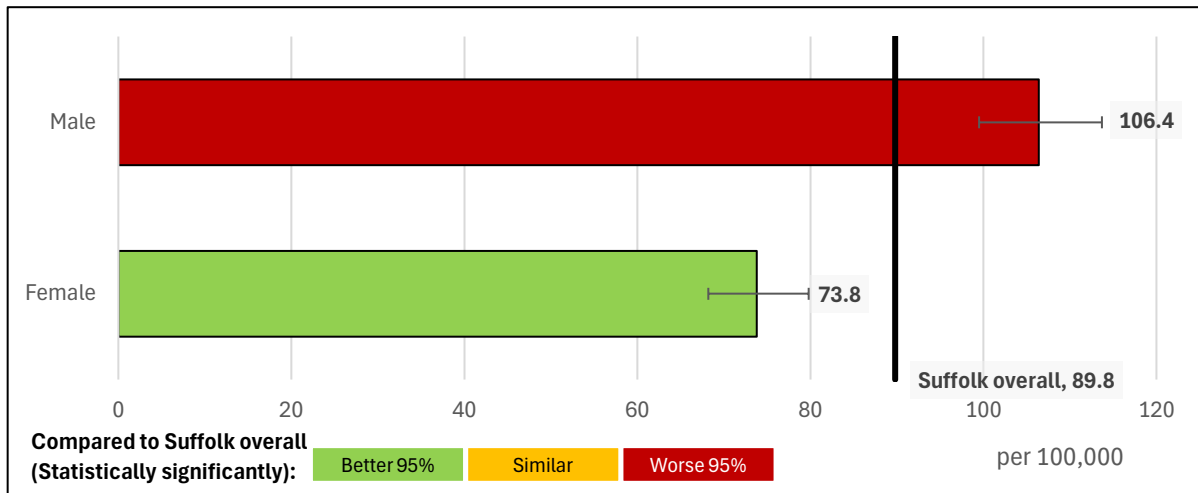
This indicates that men are substantially more likely than women to be admitted to hospital for alcohol-related mental and behavioural disorders, reflecting a higher burden of more serious alcohol-related conditions, many of which are associated with dependence and longer-term harm. As this is based on the narrow definition (primary diagnosis only), it is likely to underestimate the full impact of alcohol on hospital admissions but provides a robust indication of serious alcohol-related conditions.

These findings align with wider evidence that men are at greater risk of harmful alcohol use and alcohol-related morbidity, reinforcing the importance of targeted prevention, early identification, and access to treatment services for men.

Premature mortality in adults with severe mental illness (SMI)

In 2021-23, there was a large gender disparity in premature mortality rates among adults with SMI in Suffolk. Males had a rate of 106.4 deaths per 100,000 population, which was 44% higher than the rate for females (73.8 per 100,000). This may reflect multiple factors including higher rates of co-morbid substance misuse among males with SMI, greater prevalence of cardiovascular disease risk factors, lower engagement with preventative health services, and potentially different help-seeking behaviours.

**Figure 57. Premature mortality in adults with severe mental illness (SMI) per 100,000, Suffolk males and females, 2021-23**



Source: [Office for Health Improvement and Disparities \(2025\)](#)

Paternal mental health

The transition to fatherhood is often a positive and meaningful experience, but can also be a significant period of change for mental health and wellbeing. While perinatal mental health services have historically focused on mothers, there is increasing recognition that fathers and male partners may also experience anxiety, depression and psychological distress during the perinatal period<sup>100</sup>.

National estimates suggest that around 5-10% of fathers experience perinatal depression<sup>101</sup> and between 5-15% experience perinatal anxiety<sup>102</sup>. Risks are higher where mothers are also experiencing poor perinatal mental health, alongside wider stressors including financial pressure, relationship difficulties, sleep deprivation and social isolation<sup>100</sup>.

Furthermore, evidence suggests that paternal mental ill health can negatively affect fathers themselves, family relationships, co-parenting and child emotional and behavioural outcomes<sup>103</sup>. Research also highlights that fathers are less likely to seek help and may present distress differently to women, including through irritability, anger, substance use or other externalising behaviours<sup>104</sup>.

Another challenge that fathers face is that mental health of fathers themselves during the perinatal period is not routinely assessed, potentially resulting in fathers missing out on opportunities for diagnosis, support and interventions<sup>105</sup>. Evidence also states that fathers report feeling ignored or considered unimportant by health professionals during the perinatal period<sup>106</sup>.

Improving awareness of paternal mental health, alongside accessible and inclusive support for fathers and male partners, represents an important opportunity to improve outcomes for men, children and families in Suffolk.

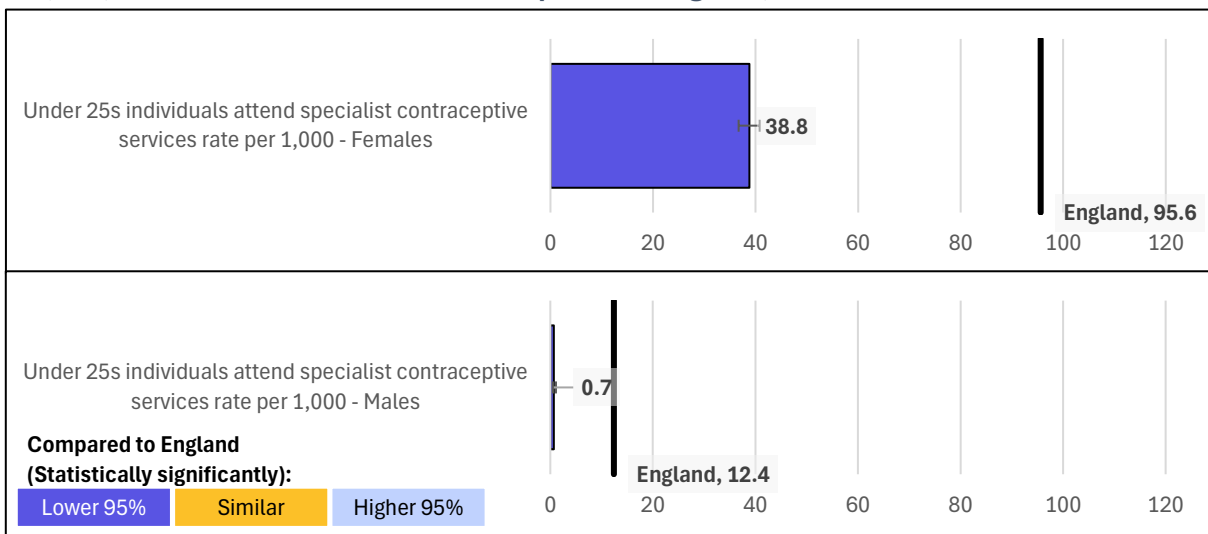
### Sexual Health

Sexual health is an important component of men's health. Men may be less likely to access contraception, screening and preventative sexual health services, and stigma, rurality and concerns around confidentiality can create additional barriers to engagement<sup>107</sup>.

In Suffolk, overall rates of diagnosed HIV and sexually transmitted infections are generally lower than national averages. However, this should be interpreted cautiously, as some indicators may reflect lower levels of testing and service engagement rather than lower underlying need.

Engagement with specialist contraceptive services among young men in Suffolk is particularly low. In 2024, the rate of males aged under 25 attending specialist contraceptive services was statistically significantly below the England average.

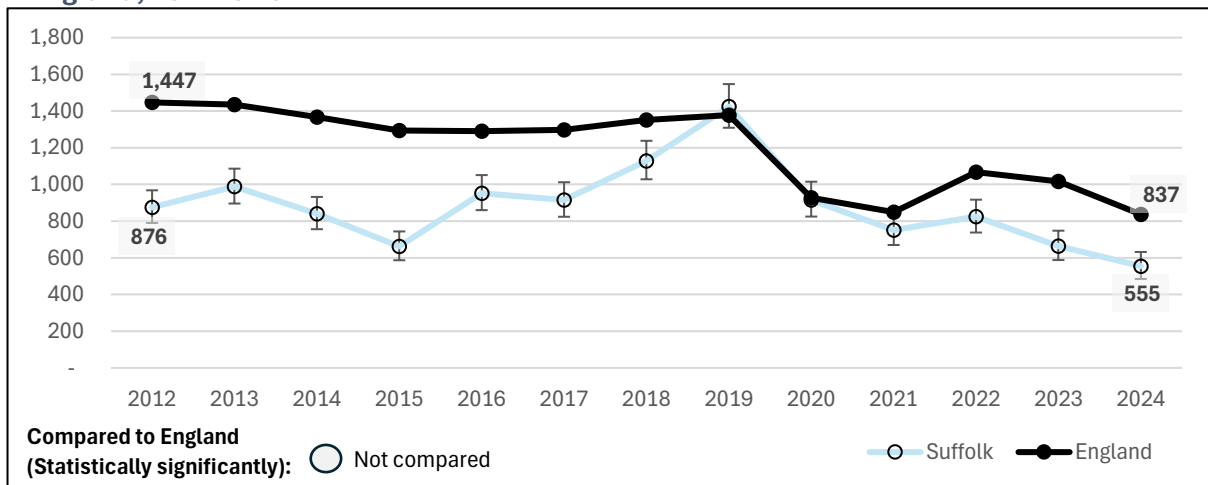
**Figure 58. Individuals aged under 25 attending specialist contraceptive services per 1,000, Suffolk males and females compared to England, 2024**



Source: [Office for Health Improvement and Disparities](#) (2026)

Chlamydia detection rates among young men have also declined over recent years, which may indicate reduced testing uptake and missed opportunities for early intervention.

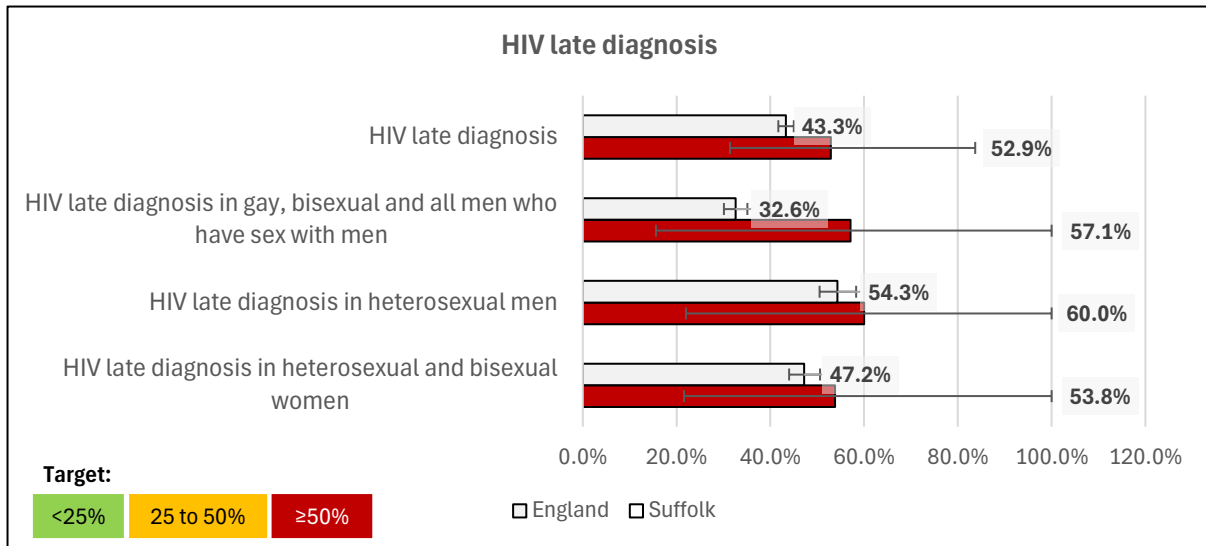
**Figure 59. Chlamydia detection rate per 100,000 aged 15 to 24 years (Male), Suffolk and England, 2012 to 2024**



Source: [Office for Health Improvement and Disparities](#) (2026)

Despite lower overall HIV prevalence, late HIV diagnosis remains a significant concern in Suffolk. Between 2022 and 2024, over half of HIV diagnoses in Suffolk were classified as late diagnoses, above the national average and above the national target threshold. Rates of late diagnosis were particularly high among gay, bisexual and other men who have sex with men (MSM), as well as heterosexual men.

**Figure 60. HIV late diagnosis indicators for Suffolk and England compared to targets, 2022-24**



Source: [Office for Health Improvement and Disparities \(2026\)](#)

Late HIV diagnosis is associated with poorer health outcomes, increased mortality risk and greater onward transmission<sup>107</sup>. Barriers contributing to delayed diagnosis may include stigma, low perceived risk, limited awareness, rural access issues, and reluctance among men to engage with healthcare services<sup>107</sup>.

This highlights the importance of improving access to inclusive, culturally competent and stigma-free sexual health services for men, including targeted prevention, testing and health promotion work for MSM and other higher-risk groups.

## Domestic abuse and violence

Domestic abuse has significant impacts on physical health, mental health, wellbeing and family relationships across the life course. Domestic abuse affects people of all genders. Women are more likely to experience domestic abuse, but men and boys are also affected. Evidence indicates that perpetrators are more often male, particularly in cases involving repeated or more severe abuse<sup>1</sup>.

National evidence highlights the strong relationship between childhood exposure to domestic abuse and later health and behavioural outcomes. Exposure to domestic abuse during childhood increases the likelihood of experiencing or perpetrating domestic abuse in adulthood and is recognised as an important adverse childhood experience (ACE)<sup>108</sup>.

Research suggests around 1.5 million children in the UK may be affected by domestic abuse, although this is likely to be an underestimate<sup>109</sup>. Under the Domestic Abuse Act 2021, children who witness domestic abuse are recognised as victims in their own right<sup>1</sup>.

In the year ending March 2025, the Crime Survey for England and Wales estimated that:

- 6.5% of men aged 16 years and over experienced domestic abuse in the previous year
- 1.8% experienced stalking
- 0.7% experienced sexual assault<sup>110</sup>

Evidence also suggests important inequalities within male populations, with the prevalence of domestic abuse is higher among gay men compared with heterosexual men<sup>111</sup>.

In addition, a National Audit Office Report for the year ending December 2023, found that over 97% of people convicted of sexual offences were male, and crimes are often committed by someone known to the victim<sup>112</sup>.

Domestic abuse can contribute to poorer mental health, substance misuse, homelessness, family breakdown, involvement with the criminal justice system and intergenerational trauma<sup>1</sup>. This highlights the importance of trauma-informed approaches, early intervention and ensuring support is accessible both for victims, survivors in addition to individuals who are displaying harmful behaviours.

## Health literacy

Health literacy plays an important role in shaping health behaviours, access to services and long-term health outcomes<sup>113</sup>. It refers not only to the ability to read and understand information, but also to the confidence and skills needed to access, interpret and use health and care information effectively<sup>113</sup>. Good health literacy enables individuals to make informed decisions, navigate services and take a more active role in managing their own health<sup>113</sup>.

National evidence suggests that many adults in the UK have limited literacy and health literacy skills, with poorer health literacy closely linked to worse health outcomes, lower use of preventative services and increased emergency healthcare use<sup>114</sup>. Limited health literacy is more common among people experiencing deprivation, lower educational attainment, social exclusion and digital exclusion, all of which are important drivers of health inequalities<sup>113</sup>.

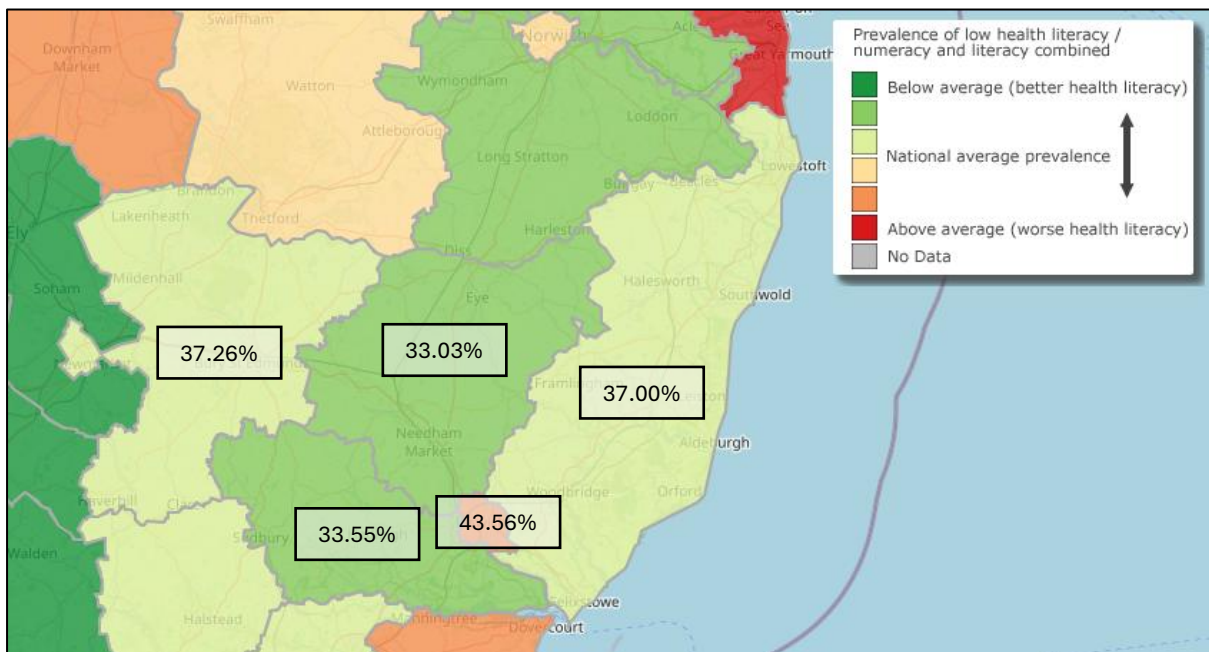
Improving men's health literacy presents challenges. Research suggests that traditional masculine norms can discourage some men from discussing health concerns, seeking support or engaging with preventative services<sup>115</sup>. Low health literacy may also contribute to delayed help-seeking, stigma around mental health, and poorer engagement with healthcare<sup>114</sup>.

Evidence indicates that men are more likely to engage with health information when it is delivered in clear, practical language and through familiar community settings such as workplaces, sports clubs and local organisations<sup>116</sup>.

Recent modelled estimates developed by the [University of Southampton in collaboration with NHS England](#) suggest that around 38.7% of adults aged 16 to 65 in England may have limited health literacy, meaning they could struggle to understand and use routine health information effectively. The estimates are based on the 2011 Skills for Life Survey, updated using 2021 Census and deprivation data, and incorporate factors including age, sex, educational attainment, deprivation and ethnicity. Systematic reviews identify that women achieve higher health literacy scores than men<sup>117</sup>, with men twice as likely to have inadequate health literacy<sup>118</sup>. Men are also less likely than women to acknowledge illness or to seek help when sick<sup>117</sup>.

Within Suffolk, Ipswich is the only lower-tier local authority estimated to have a prevalence of limited health literacy above the national average (43.6%). Estimated prevalence is lower in Babergh (33.6%), Mid Suffolk (33.0%), East Suffolk (37.0%) and West Suffolk (37.3%), but still high in these areas. These findings suggest that inequalities in health literacy are likely to mirror wider socioeconomic inequalities across the county, with implications for access to healthcare, engagement with prevention programmes and long-term health outcomes among men.

**Figure 61. Estimated prevalence of low health literacy in Suffolk's districts and boroughs, compared to the England average, 2023**



Source: [University of Southampton, NHS England](#) (2023)

In Suffolk, inequalities in life expectancy and health outcomes between more and less deprived communities highlight the importance of improving access to understandable, accessible and culturally appropriate health information. Strengthening men's health literacy could support earlier engagement with services, greater uptake of screening and prevention programmes, and improved management of long-term conditions.

## Men's Health Profile

Addressing men's health literacy requires coordinated action across health, local government and community sectors. This includes improving the accessibility of health communications, reducing digital exclusion, supporting community-based approaches, and ensuring services are designed in ways that encourage men to seek support earlier and more confidently.

Additional analysis of health literacy data for Suffolk is available in the [Suffolk health literacy profile](#) published in October 2025.

## Homelessness

Males who are homeless and currently rough sleeping are a 'young old' population – with levels of frailty comparable with much older people and an average age at death 30 years younger than the general population<sup>119</sup>. Across the UK, 1,058 men experiencing homelessness and 335 women experiencing homelessness died in 2024<sup>3</sup>. Also, in 2024 across England, there were 4,538 people (of which 3,858/83%) were male – sleeping rough in a single night in autumn<sup>120</sup>.

Local homelessness data for Suffolk shows that men are disproportionately represented among those experiencing the most severe forms of housing insecurity. During 2025/26, Suffolk's lower tier local authorities completed 4,965 homelessness assessments, of which 50.2% related to male applicants. While women were slightly more likely to be assessed as threatened by homelessness (1,410 females compared with 1,205 males), men were substantially more likely to be assessed as homeless. Across Suffolk, 1,115 male applicants were assessed as homeless compared with 695 female applicants, meaning that almost two-thirds (61.3%) of those assessed as homeless were men.

This pattern was also observed across most of Suffolk's lower tier local authority areas, where the number of male applicants assessed as homeless was considerably higher than the number of female applicants.

**Table 3. Homelessness assessments, number threatened with homelessness (including due to Section 21a Notice), and Assessed as Homeless, by sex and Suffolk lower-tier local authority, April 2025 - March 2026**

Homelessness Assessments Completed - 1st April 2025 to 31st March 2026							
Local Authority	Female	Male	Not known/other	Prefer not to say	Transgender	(blank)	Grand Total
Babergh	260	215	0	0	5	0	475
East Suffolk	630	665	0	0	5	0	1,295
Ipswich	835	1,050	0	10	0	0	1,895
Mid Suffolk	260	235	0	0	5	0	500
West Suffolk	465	330	5	5	0	0	800
<b>Suffolk</b>	<b>2,445</b>	<b>2,495</b>	<b>5</b>	<b>15</b>	<b>15</b>	<b>0</b>	<b>4,965</b>

Assessed as Threatened with Homelessness - 1st April 2025 to 31st March 2026							
Local Authority	Female	Male	Not known / Other	Prefer not to say	Transgender	(blank)	Grand Total
Babergh	170	110	0	0	0	0	280
East Suffolk	365	310	0	0	0	0	675
Ipswich	490	580	0	0	0	0	1,075
Mid Suffolk	170	105	0	0	0	0	275
West Suffolk	220	105	0	0	0	0	325
<b>Suffolk</b>	<b>1,410</b>	<b>1,205</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,625</b>

## Men's Health Profile

Assessed as Threatened with Homelessness due to Sec 21a Notice - 1st April 2025 to 31st March 2026							
Local Authority	Female	Male	Not known / Other	Prefer not to say	Transgender	(blank)	Grand Total
Babergh	35	15	0	0	0	0	50
East Suffolk	80	40	0	0	0	0	125
Ipswich	105	50	0	0	0	0	160
Mid Suffolk	35	10	0	0	0	0	45
West Suffolk	40	35	0	0	0	0	75
<b>Suffolk</b>	<b>295</b>	<b>150</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>445</b>

Assessed as Homeless - 1st April 2025 to 31st March 2026							
Local Authority	Female	Male	Not known / Other	Prefer not to say	Transgender	(blank)	Grand Total
Babergh	55	90	0	0	0	0	145
East Suffolk	180	315	0	0	0	0	495
Ipswich	200	410	0	0	0	0	610
Mid Suffolk	60	115	0	0	5	0	180
West Suffolk	200	185	0	0	0	0	390
<b>Suffolk</b>	<b>695</b>	<b>1,115</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,820</b>

*\*Numbers rounded to the nearest 5, suppressed for values below 8*

Source: Homelessness Case Level Information Collection (H-CLIC) (2026)

The findings suggest that while housing insecurity affects both men and women, men are more likely to experience circumstances that result in homelessness and the associated health risks. Homelessness and the fear of becoming homeless can result in ill health or exacerbate existing health conditions<sup>121</sup>, highlighting the importance of targeted prevention and support services for men at risk of, and experiencing homelessness.

## NHS Health Checks

The NHS Health Check is a free check-up for people aged between 40 to 74, assessing cardiovascular health. It can help detect if an individual is at higher risk of various cardiovascular health problems including heart disease, diabetes, kidney disease, and stroke. It aims to lower the risk of getting conditions that affect the heart and blood vessels – encouraging participants to take action to reduce their risk<sup>122</sup>.

For individuals aged between 40 and 74, if they do not have a pre-existing health condition, they should be invited to an NHS Health Check by their GP or local council every 5 years. NHS Health Checks last between 20-30 minutes and measure height and weight, waist circumference, blood pressure, and cholesterol, as well as questions about family illness, smoking and alcohol consumption habits, and how much physical activity the person does on average, in a week<sup>122</sup>.

Upon completion of the check, individuals will be given a cardiovascular risk score (the risk of developing a heart or circulatory problem over the next 10 years).

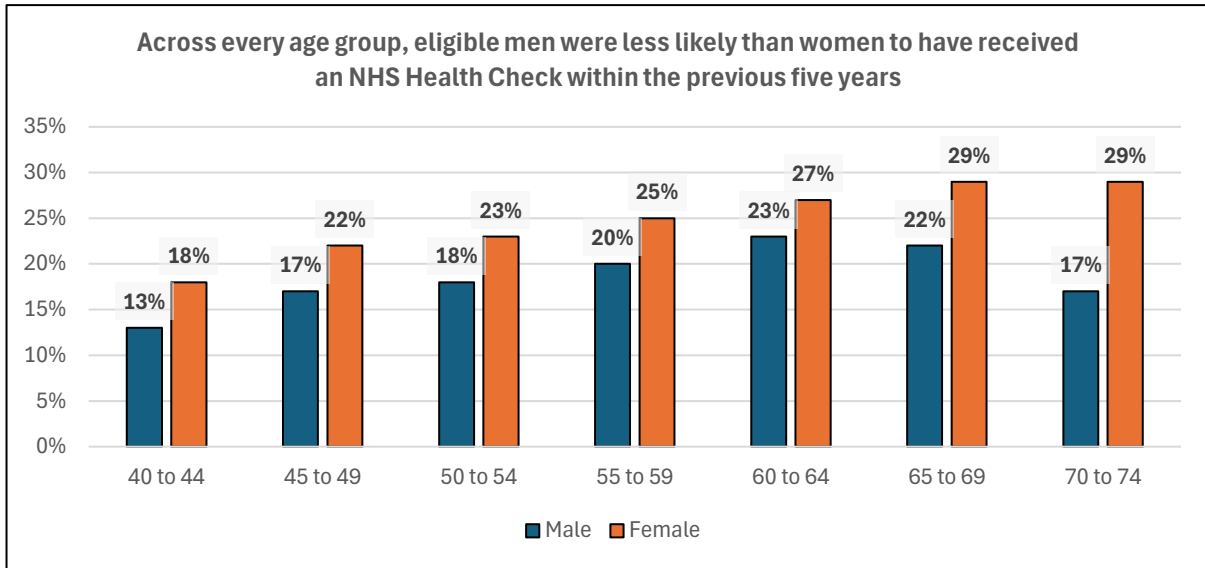
Some demographic information is also collected, allowing us to analyse NHS Health Checks data split by age, sex, and ethnicity.

The following data shows the proportion of patients that are eligible for an NHS Health Check and have had one in previous five years. Across all age groups, eligible men in Suffolk were less likely than women to have received an NHS Health Check within the previous five years. Uptake increased with age for both sexes until the early sixties but remained consistently lower among men. The largest differences were observed among older age groups. Among those aged 70 to 74 years, 17% of eligible men had received a Health Check compared with 29% of women, a gap of 12 percentage points.

These findings are consistent with national evidence suggesting that men are less likely to engage with preventative healthcare services, despite experiencing higher rates of cardiovascular disease and premature cardiovascular mortality. Lower uptake among men represents a missed opportunity for the early identification and management of risk factors such as high blood pressure, raised cholesterol, obesity and diabetes.

These data should be interpreted with caution. The dataset includes checks delivered by multiple providers and currently covers a mixed contractual period. In addition, data from the former Waveney area are not included. However, the large number of completed checks included within the dataset means that the observed differences between men and women are likely to provide a reasonable indication of overall patterns of uptake across Suffolk.

**Figure 62. Proportion of patients eligible that have had a NHS Health Check, who were invited, in the previous five years until October 2025, Suffolk (excluding Waveney)**



Source: Suffolk County Council (2026)

Nationally, Healthwatch in August 2025 conducted research which called for improvements to demographic data on Health Check uptake – the NHS publishes overall data but has not published a breakdown of uptake by sex despite men’s higher risk of CVD. The last figures from 2017/19 showed women were more likely to attend a Health Check compared to men (44% compared to 38%)<sup>122</sup>. The Healthwatch research revealed some groups of men were less likely to attend a Health Check in the future such as those struggling financially, LGBTGI+ men, and younger men<sup>123</sup>. Men were also more likely to attend if they received a call from their doctor or a member of staff at their GP surgery, had information about the Health Check before age 40, could do some tests at home, and get results virtually<sup>123</sup>.

For younger, and ethnic minority men – they were more likely to be persuaded to attend by receiving information about the Health Check at their workplace, hearing a public figure share their experience, flexibility and early awareness<sup>123</sup>.

Healthwatch’s research showed that awareness of the checks drives attendance, positive experiences lead to repeat visits, and direct encouragement from trusted sources makes a real difference<sup>123</sup>.

## Conclusion

Men in Suffolk continue to experience poorer health outcomes than women across a wide range of indicators, including life expectancy, premature mortality, cardiovascular disease, cancer, respiratory disease, substance misuse and suicide. While Suffolk generally performs better than the England average for many indicators, this overall picture masks substantial variation within the county and between different groups of men. Men living in more deprived communities experience markedly worse outcomes, including shorter lives, more years lived in poor health, and higher rates of preventable illness and premature death.

Cardiovascular disease, cancer and respiratory disease remain major contributors to male mortality and health inequality in Suffolk. Circulatory disease is the single largest contributor to the life expectancy gap between the most and least deprived populations, accounting for over a quarter of the inequality gap for both males and females.

Many of the key drivers of poor health among men are preventable or modifiable, including smoking, harmful alcohol use, obesity, physical inactivity and untreated hypertension. These risk factors are strongly associated with deprivation and are often more prevalent among men, particularly in disadvantaged communities and some ethnic minority groups.

The analysis within this men's health profile also highlights the importance of mental health and wellbeing in shaping men's health outcomes. Men are disproportionately affected by suicide, self-harm, substance misuse and alcohol-related harm, while evidence suggests some groups of men face additional barriers to seeking help or engaging with services. Wider determinants of health, including deprivation, housing insecurity, social exclusion, employment conditions and health literacy, continue to influence both health behaviours and access to care.

Suffolk's population is also ageing, with projections showing a substantial increase in the number of older men over the coming decades. This is likely to increase demand for services related to long-term conditions, frailty, cancer, cardiovascular disease and mental health, reinforcing the need for prevention and earlier intervention across the life course.

Overall, the evidence presented in this profile demonstrates that improving men's health in Suffolk requires more than focusing on individual behaviours alone. Addressing inequalities in outcomes will depend on improving access to prevention and early intervention services, strengthening engagement with men who are less likely to access support, reducing barriers linked to deprivation and health literacy, and ensuring services are responsive to the differing needs of Suffolk's male population. Continued use of local intelligence and population health management data will be essential to better understand variation in outcomes, target resources effectively, and reduce avoidable inequalities in men's health across the county.

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