The United Global Alliance For Men & Boys

DATA REPORT No.1 · NOVEMBER 2026

The Pandemic of Pain

The Global Male Suicide Emergency

Global rates · Fifteen years against COVID-19 · The leading cause of death for men aged 15–49 · The undercount · United Kingdom focus

Published by The United Global Alliance For Men & Boys

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Figures marked "(our calculation)" are our own arithmetic on the published source named. All other figures are as published. Sources are numbered [S1]–[S51] in the list at the end. WHO data are reproduced from published WHO sources. WHO has not reviewed or endorsed this report.

Executive summary

Suicide is one of the largest causes of death among men worldwide, and the published figures understate it. This report brings together the latest global estimates, national statistics and peer-reviewed research on male suicide. Its purpose is to set out the scale of the problem and the gaps in how it is counted, as the basis for the first Global Alliance Round Table on 1 December 2026.

Five headline findings

1. **Close to half a million men a year.** In 2021, 486,528 men died by suicide worldwide, about 1,333 every day (our calculation: 486,528 ÷ 365). Men accounted for 68% of all suicide deaths (our calculation: 486,528 of 718,033) [S1].
2. **More than every reported COVID-19 death, and still under-counted.** "In 15 years, suicide killed 7.4 million men, more than every COVID death ever reported to WHO (7.1 million). And that's only what was counted. Just 80 of 194 countries record suicide properly, and in India official figures missed at least 1 in 4 male suicides. The real toll is far higher." [S1, S2, S3, S5]
3. **The leading cause of death for men aged 15–49 in 35 countries.** These include the UK, Ireland, Australia, France, Germany, Japan and South Korea. Suicide is among the top three causes in 79 countries (our ranking across 194 countries) [S4].
4. **Men's rate is higher than women's almost everywhere.** The male suicide rate is higher than the female rate in 191 of 192 countries with data, and at least three times higher in 112. Worldwide it is 12.2 per 100,000 against 5.6 [S1]. The country counts are our calculation.
5. **In England and Wales, three in four suicides are men: 12.7 men every day.** 4,620 of 6,162 suicides registered in 2025 were male [S9].

1. Why this report

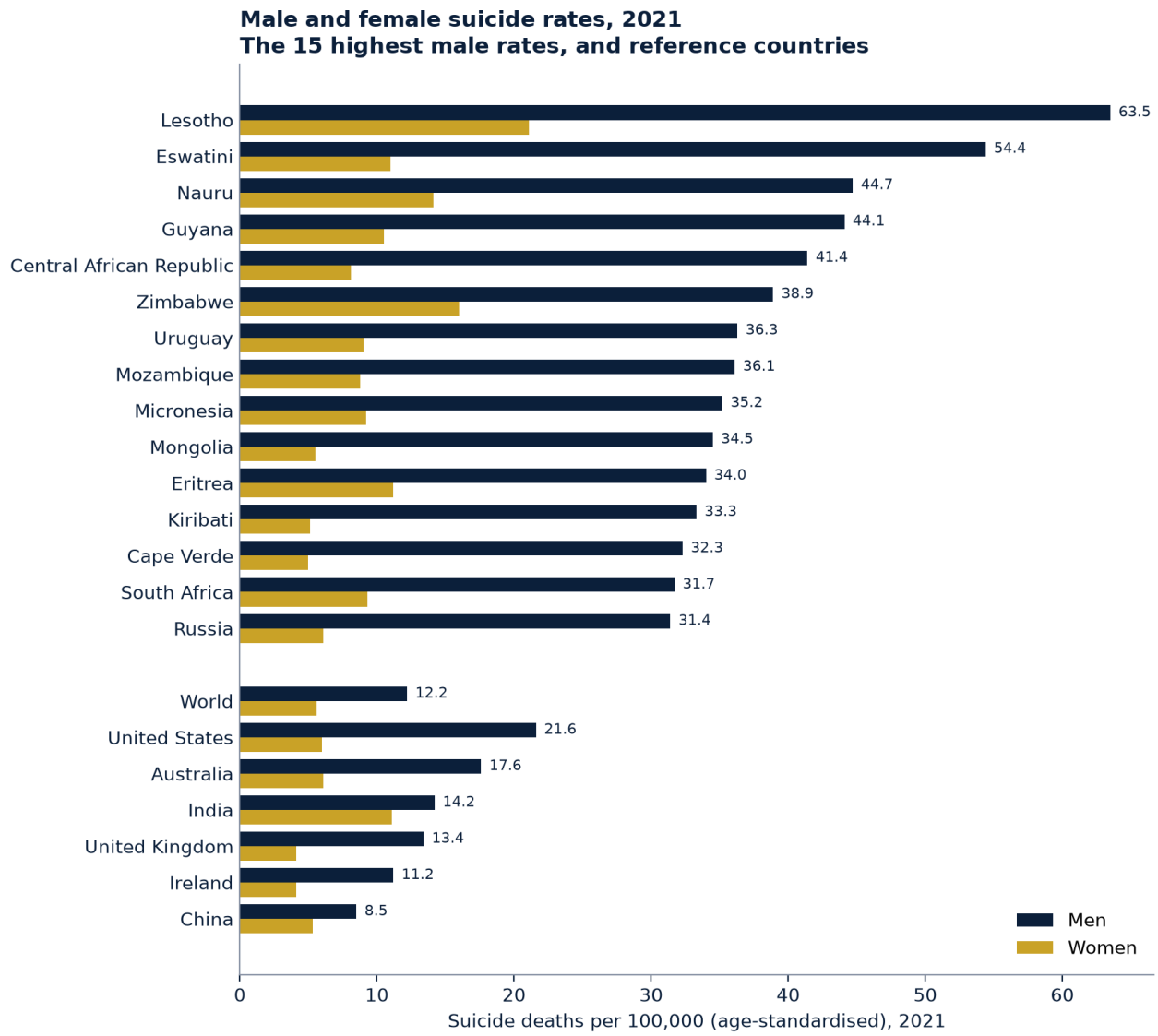
Male suicide is a long-running, large-scale cause of death that receives far less public attention than its size warrants. It falls hardest on men of working and parenting age, and in most countries it is recorded incompletely. This first DATA report puts the published evidence in one place: the global scale, how it compares with COVID-19, where suicide is the leading cause of death for younger men, and what the data does not capture.

2. The global picture

2.1 Rates by sex

In 2021, the worldwide age-standardised suicide rate was 12.2 per 100,000 men and 5.6 per 100,000 women [S1], so men's rate is 2.2 times women's (our calculation). Across 192 countries, the male rate is higher than the female rate in 191. It is at least twice the female rate in 168 countries and at least three times it in 112 (our calculation) [S1].

Men made up 486,528 of the 718,033 suicide deaths estimated for 2021: 68% (our calculation) [S1]. A separate estimate, the Global Burden of Disease study, puts 2021 male suicide deaths at 519,000 of 746,000 [S6]. WHO also reports that 56% of all suicides occur before the age of 50, and that "Suicide was the third leading cause of death among 15-29-year-olds; second for females, third for males" [S7].



Source: WHO Global Health Estimates 2021, via Our World in Data. Chart: the Alliance.
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2.2 The ten highest male suicide rates (2021, per 100,000, age-standardised) [S1]

Rank	Country	Men	Women	Men ÷ women (our calculation)
1	Lesotho	63.5	21.1	3.0
2	Eswatini	54.4	11.0	5.0
3	Nauru	44.7	14.1	3.2
4	Guyana	44.1	10.5	4.2
5	Central African Republic	41.4	8.1	5.1
6	Zimbabwe	38.9	16.0	2.4
7	Uruguay	36.3	9.0	4.0
8	Mozambique	36.1	8.8	4.1
9	Micronesia	35.2	9.2	3.8
10	Mongolia	34.5	5.5	6.2

Adapted from WHO Global Health Estimates, CC BY-NC-SA 3.0 IGO. WHO is not responsible for this adaptation.

Reference countries (2021): United States 21.6 (40th of 192), Australia 17.6, India 14.2, United Kingdom 13.4 (88th), Ireland 11.2, China 8.5. Rankings are our calculation [S1].

2.3 The male-to-female ratio

The largest ratios are in Georgia (9.24), Jamaica (8.03), Venezuela (7.99), Kuwait (7.72) and Saint Lucia (7.61). In the UK the ratio is 3.29 and in the USA 3.62. Ratios are our calculation on WHO rates [S1].

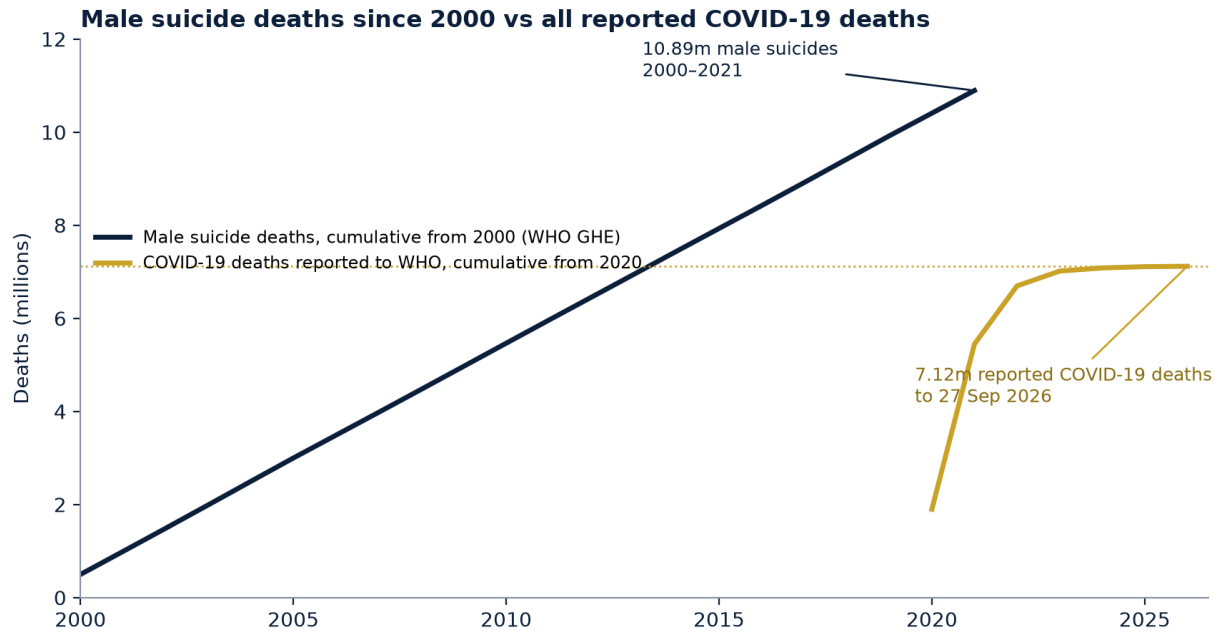
3. Fifteen years of male suicide, against COVID-19

WHO estimates that between 2007 and 2021, 7,405,195 men died by suicide (our sum of WHO yearly estimates). Between 2000 and 2021 the figure is 10,893,445 [S1]. By 27 September 2026, 7,119,281 COVID-19 deaths, both sexes, had been reported to WHO over the whole pandemic [S2]. The 22-year male suicide total is therefore about 1.5 times the reported COVID-19 total (our calculation).

> *"In 15 years, suicide killed 7.4 million men, more than every COVID death ever reported to WHO (7.1 million). And that's only what was counted. Just 80 of 194 countries record suicide properly, and in India official figures missed at least 1 in 4 male suicides. The real toll is far higher."*

The pattern is one of persistence. The yearly male toll has stayed between 486,000 and 506,000 in every year from 2000 to 2021 [S1]. COVID-19 deaths reported to WHO peaked at 3,549,358 in 2021 and fell to 67,981 in 2024 [S2]. In 2021, the most recent year of global suicide estimates, 486,528 men died by suicide [S1].

The COVID-19 figures are deaths reported to WHO by countries. They are not WHO's separate estimates of excess mortality. The comparison here is between counted deaths on both sides.



Sources: WHO Global Health Estimates 2021 (via OWID); WHO COVID-19 dashboard data (downloaded 31 Oct 2026). Cumulative totals: our calculation.
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4. The leading cause of death for men aged 15–49

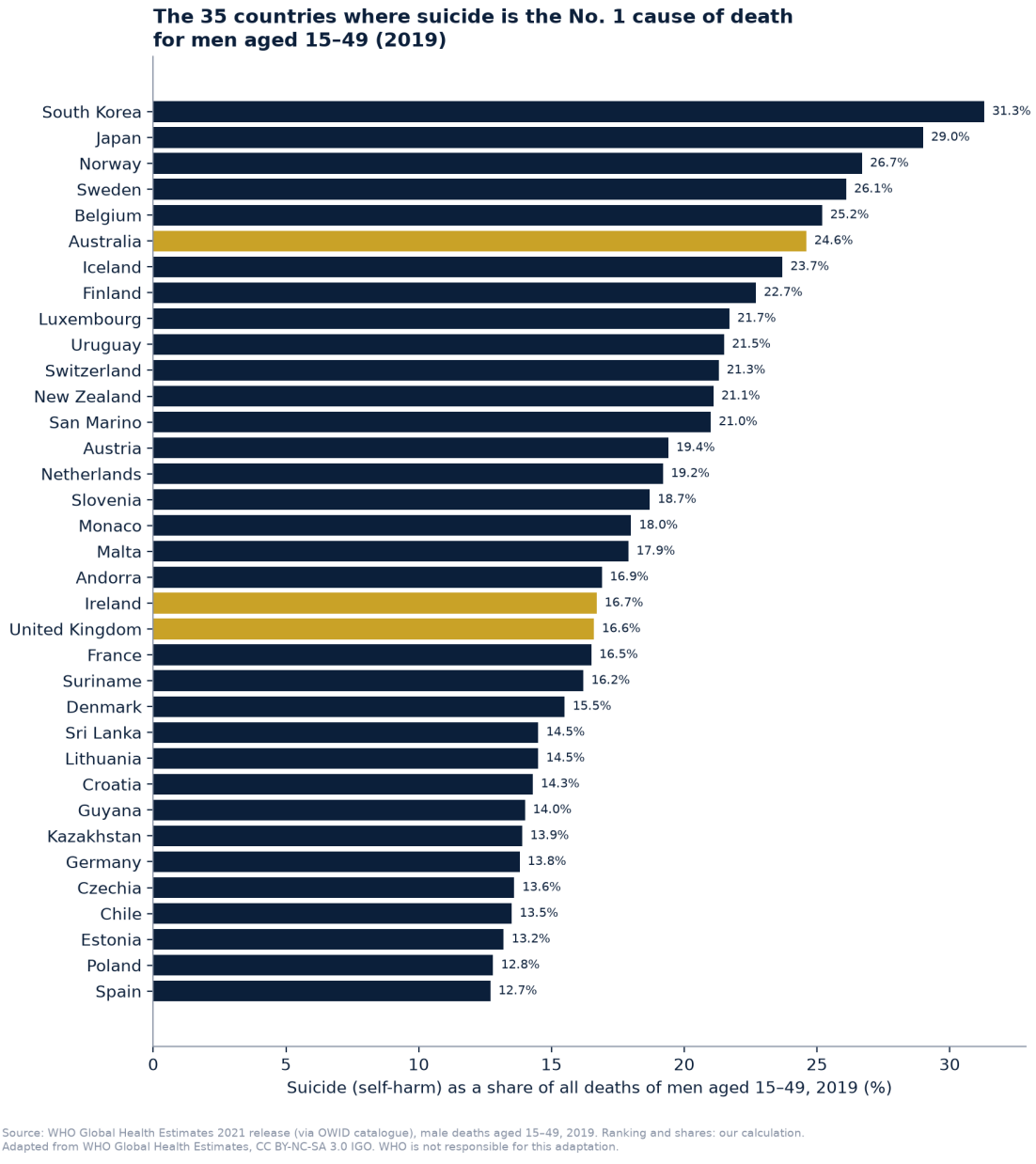
We ranked 126 specific causes of death for men aged 15–49 in each of 194 countries, using WHO Global Health Estimates for 2019, the last year before the pandemic [S4]. Suicide (self-harm) was:

- the No. 1 cause in **35 countries**;

- in the top three causes in **79 countries**;
- in the top five in **105 countries** (our calculation) [S4].

The 35 countries are Andorra, Australia, Austria, Belgium, Chile, Croatia, Czechia, Denmark, Estonia, Finland, France, Germany, Guyana, Iceland, Ireland, Japan, Kazakhstan, Lithuania, Luxembourg, Malta, Monaco, the Netherlands, New Zealand, Norway, Poland, San Marino, Slovenia, South Korea, Spain, Sri Lanka, Suriname, Sweden, Switzerland, the United Kingdom and Uruguay.

Suicide's share of all deaths of men aged 15–49 in 2019 was 31.3% in South Korea, 29.0% in Japan, 26.7% in Norway, 26.1% in Sweden and 24.6% in Australia. In the UK it was 16.6%, about 1 in 6 (2,851 of 17,149 deaths) (our calculation) [S4].



Adapted from WHO Global Health Estimates, CC BY-NC-SA 3.0 IGO. WHO is not responsible for this adaptation.

In 2021 the ranking was affected by COVID-19, which was the leading cause in 51 countries. Suicide was then No. 1 in 27 [S4].

5. The undercount

The published totals are minimum figures.

- **Registration quality.** WHO: "Only some 80 WHO Member States have good-quality vital registration data that can be used directly to estimate suicide rates." WHO adds that "given the stigma surrounding suicide – and the illegality of suicidal behaviour in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death." [S3]
- **India.** The Million Death Study estimated about 187,000 suicides at ages 15+ in 2010, 115,000 of them men, against about 135,000 in police-based national records. The authors conclude these records under-estimate suicides in men "by at least 25%" [S5]. Until India's Mental Healthcare Act 2017 came into force on 29 May 2018, a person who survived a suicide attempt could be prosecuted under section 309 of the Indian Penal Code [S10]; section 309 itself stayed in the Code until the Bharatiya Nyaya Sanhita replaced it on 1 July 2024 [S51].
- **China.** A study of 1995–99 notes that the national mortality data "are based on an unrepresentative sample". After adjusting the Ministry of Health data "according to an estimated rate of unreported deaths", it estimated "a total of 287,000 suicide deaths per year" [S11].
- **The review evidence.** A systematic review of 31 studies found that 52% reported more than 10% under-reporting, and 39% reported more than 30% under-reporting or poor statistics. The authors conclude: "The findings support the general under-reporting of suicide." [S12]
- **Misclassification.** In a Scandinavian re-evaluation of 1,800 deaths, experts with extra information reclassified 21% of Sweden's deaths of "undetermined" intent as suicides, and 9% of Norway's natural and accidental deaths [S13].

6. United Kingdom focus

- **England and Wales, 2025:** 4,620 of the 6,162 registered suicides were men: 75%, or 12.7 men every day (our calculation on ONS figures) [S9].
- **UK total:** with Scotland (518 male suicides, 2024) and Northern Ireland (230, 2024), the latest registrations come to 5,368 male suicides, 14.7 every day (our calculation) [S9, S14].
- **Family and relationship problems:** Public Health Wales's real-time surveillance found that family and/or relationship issues were a factor in 26% of suspected male suicides in Wales between April 2022 and March 2025, about 1 in 4 [S8]. Applied to the UK male total, that would mean more than three men every day (our calculation: 26% of 5,368 ÷ 365 = 3.8).
- **Younger men:** in 2019, suicide was the leading cause of death for UK men aged 15–49, about 1 in 6 deaths in that group (our calculation) [S4].
- **Rate:** the UK male rate in WHO's 2021 estimates is 13.4 per 100,000, 3.29 times the female rate [S1].

7. Life-expectancy context

In every one of the 217 countries and territories with data, men's life expectancy at birth is lower than women's. Worldwide it is 71.1 years for men and 76.0 for women, a gap of 4.9 years. In the UK the gap is 3.8 years (79.5 vs 83.3). The largest gaps are in Russia (10.6 years), Latvia (9.9) and Ukraine (9.6) [S15].

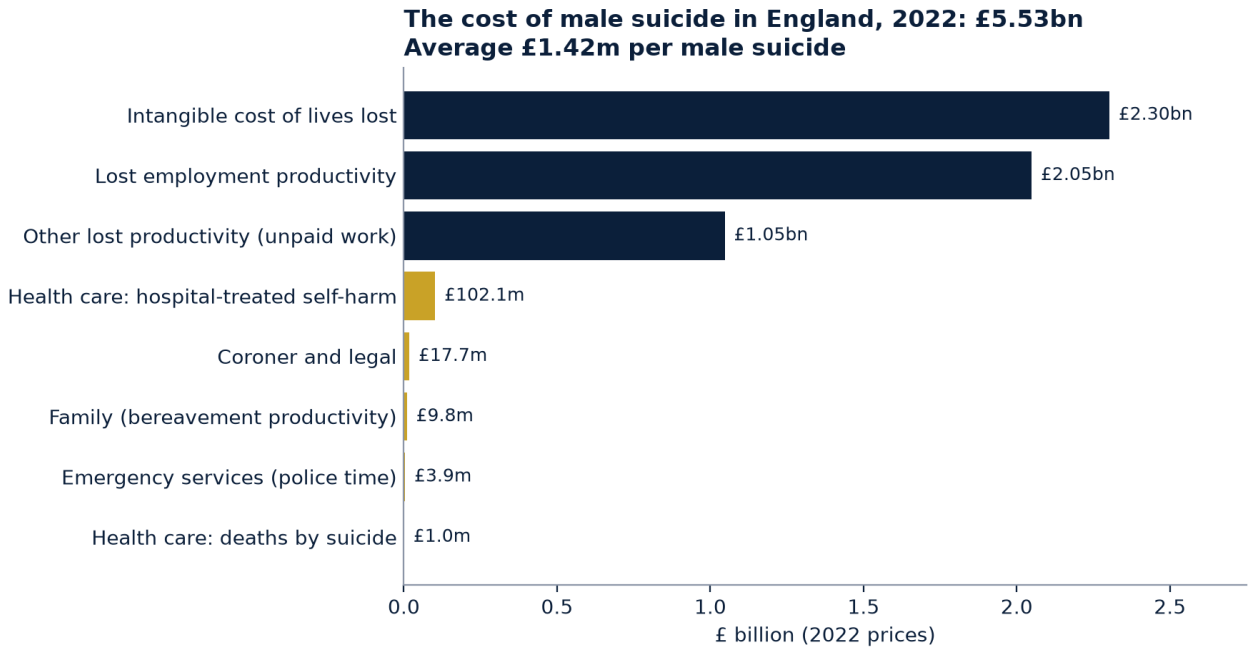
8. The economic cost

Every suicide is first a human loss. It is also an economic one. A death in working life removes decades of paid and unpaid work. It sets off a police investigation and an inquest. It places lasting strain on the family left behind. This section sets out what the published evidence can and cannot say about that cost. It is a summary, and later reports in this series will examine individual cost areas in depth.

No global estimate exists. We found no peer-reviewed or government estimate of the economic cost of suicide, or of male suicide, for the world as a whole. National estimates use different methods, price years and currencies, so they cannot be added together or compared directly. The figures below are national estimates, each stated in its own currency and price year.

8.1 United Kingdom

- **£9.58 billion in one year.** The suicides registered in the UK in 2022 cost the economy at least £9.58 billion (2022 prices), an average of at least £1.46 million for every life lost. The estimate counts lost paid and unpaid work, the intangible value of lives lost, health care, emergency services, coroners and families. It also includes NHS costs of treating self-harm in hospital. The authors state that "these are conservative estimates, and in reality may be even greater" [S16], so this is a floor.
- **£5.53 billion for male suicide in England alone.** In England in 2022, male suicides cost £5.53 billion (2022 prices), an average of £1.42 million for each male suicide [S16]. That is 72% of the cost of all suicides in England that year, or about £15.2 million a day (our calculation).
- **£2.05 billion in lost earnings.** Of that £5.53 billion, £2.05 billion was lost paid work (employment productivity) and £1.05 billion was lost unpaid work [S16]. Employment losses are highest for deaths at around ages 30–34, where they make up half of all suicide costs [S16].
- **Public services.** In England in 2022, all suicides together generated at least £23.87 million in coroner and legal costs, and £5.2 million in police time (assessed at 30 officer-hours per death, so a minimum) [S16].
- **The earlier benchmark.** The figure widely cited for many years was £1.67 million per suicide (2009 prices), which covered people of working age in England only [S17]. The 2024 estimate covers all ages from 10 upwards, and that lowers the average per death [S16].



Source: Samaritans / LSE, The economic cost of suicide in the UK, 2024. Chart: the Alliance.
England, men of all ages, 2022; £, 2022 prices. Total includes NHS costs of hospital-treated self-harm.

Source: Samaritans / LSE, The economic cost of suicide in the UK, 2024. Chart: the Alliance.

8.2 United States

- **US$510 billion a year.** Suicide and emergency-treated self-harm in the United States cost an average of US$510 billion a year between 2015 and 2020 (2020 dollars). Of this, US$484 billion came from the deaths themselves, valued mainly as life-years lost [S18].
- **Men are 78% of these deaths.** Men accounted for an average of 36,179 of 46,361 US suicides a year (78%) over the same period [S18]. The study does not publish a separate cost for male suicides, and we have not estimated one.

8.3 Australia

- **AUD 29 billion a year.** The Productivity Commission's 2020 Mental Health inquiry found: "The cost of diminished health and reduced life expectancy for those with mental ill-health, self-inflicted injury and death by suicide total approximately $151 billion. About 80% is attributable to mental illnesses ($122 billion) and the remainder attributable to death by suicide ($29 billion)." Its Table 9.2 puts the total cost of suicide at AUD 29.0 billion a year (2018 dollars), of which AUD 28.6 billion is intangible cost (loss of life and wellbeing), 2018 dollars. Adding non-fatal suicidal behaviour brings the total to AUD 30.5 billion [S21].
- **AUD 6.73 billion for the workforce alone.** Suicide and non-fatal suicidal behaviour among employed Australians cost an estimated AUD 6.73 billion (present value) in 2014 [S19].
- **What the government spends.** Australian Government funding for 41 suicide prevention measures run by its health department totalled over AUD 990 million from 2022–23 to 2025–26 [S20]. That is an average of about AUD 248 million a year (our calculation, nominal dollars). This total excludes state and territory spending and the measures run by other federal agencies.
- **No measure of results.** The Australian National Audit Office found in March 2026 that "there is no framework to support measuring and monitoring the impact of the Australian Government's suicide prevention investment" [S20].
- **The deaths.** In 2024, 2,529 of Australia's 3,307 suicides were men (76.5%) [S20, S22]. The male age-standardised rate was 18.3 per 100,000 in 2024 (preliminary), against 19.3 in 2015 [S22]. Suicide is the leading cause of death for Australians aged 15 to 44 [S20].

8.4 What England spends on prevention

- **£57 million.** This NHS Long Term Plan investment supports local suicide prevention plans and suicide bereavement services across England [S23].
- **£10 million.** This Suicide Prevention Grant Fund ran from 2023 to March 2025 for voluntary-sector organisations [S23].
- **£3.6 million over three years.** The GOV.UK press release "Government unveils England's first ever Men's Health Strategy" (18 November 2025, https://www.gov.uk/government/news/government-unveils-englands-first-ever-mens-health-strategy) states: "the government is investing £3.6 million over the next 3 years in suicide prevention projects for middle-aged men in local communities across areas of England where men are at most risk of taking their own lives, including some of the most deprived areas in the country" [S24]. It is about £1.2 million a year (our calculation).

These sums are not directly comparable with the cost estimates in 8.1. The cost figures value the full lifetime losses from one year's deaths, whereas the spending figures are budgets for a set period.

8.5 The cost to children and families

The economic estimates above count only a small part of what families bear. The UK estimate values family costs only as days of bereavement leave and lost work. Its authors state: "Families will be deeply affected by suicide, and it is very difficult to quantify these costs. We conservatively estimate immediate productivity losses associated with an unexpected death." [S16] It does not price the longer-term effects on children, which the research evidence shows are serious:

- **Risk passed to children.** A meta-analysis of 20 population studies found that children of a parent who died by suicide were about three times as likely to die by suicide themselves as children of two living parents (relative risk 2.97). They were also 1.76 times as likely to attempt suicide [S27].
- **Long-lasting risk.** In a cohort of 7.3 million people in Denmark, Finland and Sweden, children whose parent died by suicide before they turned 18 had 3.44 times the suicide rate of non-bereaved children. The raised risk lasted for at least 25 years [S26].
- **Wider harm.** In Sweden, children and adolescents who lost a parent to suicide had about three times the suicide risk of children of living parents. They also had higher rates of hospital admission for suicide attempt and for depressive, psychotic and personality disorders [S25].

- **Reach.** It is estimated that up to 135 people are affected by every suicide, which would mean nearly 900,000 people a year across the UK [S16].

Because men account for about three in four suicides in England and Wales and in Australia, most children bereaved by a parent's suicide have lost their father (our inference from [S9, S22]). We found no published estimate of the economic cost of this intergenerational harm.

8.6 Family breakdown

The cost of family breakdown to the UK has been estimated at over £50 billion a year (Relationships Foundation, 2018) in costs to the taxpayer alone [S28]. The Foundation describes the Index as showing "the extent of the financial cost of failed relationships borne by government – ie by the taxpayer", across five areas: "tax and benefits, housing, health and social care, civil and criminal justice and education". It adds that the figure "only shows one part of the overall picture". Suicide is not among the five areas it covers, so the full cost is higher.

Family and relationship breakdown is recognised in the evidence on male suicide. Public Health Wales found family or relationship issues were a factor in 26% of suspected male suicides [S8]. The government's suicide prevention strategy for England lists "family or relationship problems" among the factors common in men who died by suicide [S23]. No published study yet measures the share of the cost of suicide that follows family breakdown.

8.7 Why the cost cannot yet be measured in full

- **No global figure.** There is no global estimate of the economic cost of suicide, or of male suicide.
- **Male costs are rarely separated.** Only the UK estimate reports costs for men separately, and only for England [S16].
- **Spending results are not tracked.** Prevention spending is rarely reported by sex or linked to outcomes. Australia's auditor found no framework to measure the impact of spending [S20].
- **Uncounted deaths are not costed.** Every cost estimate rests on recorded suicides. Where deaths are under-counted (section 5), the cost is under-counted too.
- **Harm to families is not costed.** The long-term cost to bereaved children and families is not measured in any of the estimates above.

Measuring the full cost of male suicide needs consistent, sex-disaggregated data on deaths, services, spending and outcomes. Building that evidence base is a core aim of the Alliance.

9. What the data void means

The figures in this report are the best that exist, and they are minimum figures. This section sets out why the published totals are too low, how much higher they could be, what is not recorded at all, and what countries spend on prevention.

9.1 Why the published figures are too low

These gaps are in national death registration, not in WHO's method: WHO models suicide rates where registration is weak and redistributes some ill-defined deaths [S29, S30]. The published figures are the best available, and they are minimum figures because many deaths are never registered or recorded as suicide.

- **Most countries cannot count suicide directly.** WHO made suicide estimates for 183 Member States for 2021. Of these, "86 have good-quality (labelled as high and medium quality) vital registration data that can be used directly to estimate suicide rates." The rates for the other 97, "which account for about 61% of global suicides", are "necessarily based on modelling methods" [S29]. Good registration is concentrated in rich countries: the 37 low- and middle-income countries with good data account for "only 16.3% of all estimated suicides" in low- and middle-income countries [S29]. WHO's fact sheet puts this as "only some 80" of its 194 Member States, the figure in our standard line [S3], while the data page counts 86 of the 183 Member States for which WHO made 2021 estimates, so the two describe the same gap on different bases.
- **China.** China's national mortality surveillance system was expanded in 2013 to 605 surveillance points covering about 24% of the population [S31]. National suicide figures for China therefore rest on a sample, with the rest

estimated (our inference from [S31]). An earlier study found that the national mortality data "are based on an unrepresentative sample" and had to be adjusted for unreported deaths (section 5) [S11].

- **Deaths recorded as something else.** Suicides can be hidden in three death categories: ill-defined or unknown causes, events of undetermined intent, and accidents, notably poisoning [S34]. Where researchers have gone back to the records, the counts rise:
  - In Tel Aviv, suicide rates were 42% higher than reported once 75 probable suicides recorded under other causes were added (2005 and 2008) [S32].
  - In Pudong, Shanghai, 560 of 1,318 undetermined deaths (42.5%) were classed as probable suicides (2004–2016). The authors conclude that "the number of suicides could be 23% higher than the reported cases", and that suicides of migrants were more likely to be under-reported [S33].
  - A systematic review of 31 studies and a Scandinavian re-evaluation of 1,800 deaths point the same way (section 5) [S12, S13].
- **Stigma and money.** Life insurance policies usually exclude suicide for a set period after purchase. A study of OECD countries from 1980 to 2002 found "a positive causality from life insurance demand to suicide", and earlier Japanese data showed suicides among policyholders rising immediately after the exclusion period ended [S35]. Exclusion clauses could also create pressure for a death not to be recorded as suicide (our inference). We found no published study that measures how often this happens, which is itself a data gap.
- **Where suicide is a crime.** In at least 24 countries, attempted suicide remains a criminal offence, according to United for Global Mental Health (country list published September 2025 [S36]; the same count, "at least 24 countries", repeated in September 2026 [S50]). The 24 listed are: Afghanistan, the Bahamas, Bangladesh, Brunei Darussalam, the Gambia, Grenada, Jordan, Malawi, the Maldives, Myanmar, Nigeria, Papua New Guinea, Qatar, St Lucia, Saudi Arabia, Sierra Leone, Somalia, South Sudan, Sudan, Tonga, Trinidad and Tobago, Uganda, the United Arab Emirates and Tanzania [S36]. The compilers state that in low- and middle-income countries criminalisation "leads to the underreporting of suicides and suicide attempts" [S36]. WHO makes the same point about "the illegality of suicidal behaviour in some countries" [S3]. Ghana, Guyana, Pakistan and Malaysia have reformed their laws in recent years [S37]. In India, the Mental Healthcare Act 2017 came into force on 29 May 2018 and, under section 115, a person who attempts suicide is presumed, unless proved otherwise, to have "severe stress" and is not to be tried or punished [S10]. Stigma does not end on the day a law changes.
- **Deaths that are only now being identified.** Since April 2020, the national Domestic Homicide Project has counted suspected suicides of domestic abuse victims in England and Wales. Recorded cases rose from 51 in the first year to 72 and then 93 (April 2022 to March 2023). The Project says this "likely reflects better awareness, identification and associated submission of these cases … rather than an empirical increase" [S38]. Deaths that were there all along were simply not being identified as linked to abuse.

9.2 How much higher the true toll could be

In 15 years, suicide killed 7.4 million men, more than every COVID death ever reported to WHO (7.1 million). And that's only what was counted. Just 80 of 194 countries record suicide properly, and in India official figures missed at least 1 in 4 male suicides. The real toll is far higher.

Published measures of the gap:

Where	What was compared	Gap	Source
India, 2010	Million Death Study v police-based national records	at least 25% more male suicides; at least 36% more female	[S5]
Tel Aviv, 2005 and 2008	probable suicides found under other causes	rates 42% higher	[S32]
Pudong, Shanghai, 2004–2016	probable suicides among undetermined deaths	about 23% more suicides (the authors: 'could be 23% higher')	[S33]
31 studies (review)	studies of under-reporting	52% found more than 10%; 39% found more than 30% or poor statistics	[S12]

Where	What was compared	Gap	Source
World, 2021	GBD estimate v WHO estimate, male deaths	519,000 v 486,528: 6.7% higher (our calculation)	[S6, S1]

An illustrative range (our calculation). No peer-reviewed study gives a single global undercount. To show the scale, we applied the two local misclassification findings above, 23% (Shanghai) and 42% (Tel Aviv), to the global estimates:

Estimate	Published figure	If 23% higher (our illustration)	If 42% higher (our illustration)
Suicides worldwide, 2021 (WHO's published total; the GHE dataset used elsewhere in this report gives 718,033) [S7]	727,000	894,210	1,032,340
Male suicides worldwide, 2021 (WHO GHE) [S1]	486,528	598,429	690,870
Male suicides, 2007–2021 (WHO GHE, our sum) [S1]	7,405,195	9,108,390	10,515,377

Method (our calculation, not a WHO figure): published figure × 1.23 and × 1.42, rounded to whole deaths. The uplifts are the misclassification findings of two local studies, Pudong, Shanghai, 2004–2016 [S33] and Tel Aviv, 2005 and 2008 [S32]. They cover all suicides, not men only, and are applied here to men on the assumption that the share is similar. This is an illustration of scale, not an estimate. The uplifts may not hold elsewhere. WHO's model already redistributes some deaths with ill-defined causes [S30], so part of any gap may already be counted. Where registration is weak or suicide is a crime, the gap could be larger.

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About 8 million in 11 years. WHO's yearly estimates add up to 7,976,316 suicides of men and women worldwide in the 11 years from 2011 to 2021 (our sum) [S1], about 8 million. That is roughly one death every 44 seconds (our calculation: the number of seconds in 11 years ÷ 7,976,316). On the same illustrative range, the 11-year total would be between 9.8 million and 11.3 million (our calculation). Even the counted total is a floor.

9.3 What is not recorded, and why it matters

A death record tells us that a man died and, at best, the method. Suicide is coded by method (ICD-10 codes X60–X84 and Y87.0) [S30]. It does not tell us what was happening in his life. Without that, nobody can see where help could have reached him first.

Where circumstances are recorded:

- **United States.** The National Violent Death Reporting System now operates in all 50 states, the District of Columbia and Puerto Rico. It links death certificates, coroner and medical examiner reports, and law enforcement reports, and records the circumstances of each death [S40]. In 27 states in 2015, among suicides of men and women with known circumstances (77% of the decedents were men) [S39]:
  - relationship problems or loss: 42%, including intimate partner problems (27.2%);
  - a crisis in the previous or upcoming two weeks: 29%;
  - job or financial problems: 16%;
  - criminal legal problems: 9%;
  - eviction or loss of home: 4%.
  - More than half (54%) of all decedents had no known mental health condition [S39].
- **United Kingdom.** A study of a 20% sample of men aged 40–54 who died by suicide in the UK in 2017 (242 men with records), drawn mainly from coroner inquests, found [S41]:
  - 57% were experiencing economic problems (unemployment, finance or accommodation) at the time of death;

  - 30% had recent financial problems, including debt (14%) and threats of court proceedings or bailiff notices (3%);
  - 20% had recently separated from their partner, and 28% had conflict with a partner or ex-partner;
  - 5% (11 men) had problems accessing their children, defined as living separately from them, loss of or restricted custody, or children taken into care, in the 3 months before death;
  - 10% were recorded as perpetrators of domestic or intimate partner violence, and 7% as victims;
  - 91% had been in contact with at least one front-line service or agency.
  - The study recorded an item as absent if no source mentioned it [S41], so these shares are minimums.
- **Domestic abuse.** The Domestic Homicide Project recorded 216 suspected victim suicides following domestic abuse in England and Wales from April 2020 to March 2023 [S38].

What the wider research shows:

- In a US cohort, divorced men had 2.38 times the suicide risk of married men (1979–1989 follow-up); the study found no significant difference by marital status among women [S43].
- Over 100,000 people in problem debt in England attempted suicide in a year (estimate from 2014 survey data) [S42].

What most countries do not collect. These studies cover one country each, one age group, or one year. Most countries do not routinely record family breakdown, loss of contact with children, domestic abuse (as victim or accused), debt, unemployment or legal proceedings at the time of a suicide. Where 97 of 183 countries lack the good-quality death registration needed to count suicides directly [S29], none of this is known.

Why it matters.

- **Early intervention.** Most of the men in the UK study had been in contact with a front-line service before they died [S41]. Most often this was primary care (82%); half (50%) had been in contact with mental health services and 30% with the justice system, but only 2% with employment services [S41]. Knowing which services, and which life events, would show where to act first.
- **Crisis and emergency response.** Three in ten US suicides involved a recent or impending crisis within two weeks [S39], so the window for help can be short. Brief interventions in emergency care are associated with fewer later attempts (odds ratio 0.69) and three times the odds of linkage to follow-up care (3.04) [S49]. Circumstance data shows where such services are needed and whether they reach men.
- **Measuring what works.** Without outcome data, spending cannot be judged. Australia's audit office found no framework for monitoring the impact of suicide prevention measures [S20].

Systematic collection of this data, country by country and by sex, age and circumstance, is the missing evidence base. Building it is the case this report makes.

9.4 What countries spend, and what works

What is spent:

- **Worldwide.** Median government spending on mental health is "just 2% of total health budgets – unchanged since 2017". High-income countries spend up to US$65 per person on mental health, and low-income countries as little as US$0.04 [S44]. On the current path, the world will achieve only a 12% reduction in suicide rates by 2030, against the Sustainable Development Goal of one third [S44]. WHO reports that "only 38 countries report having a national suicide prevention strategy" [S3].
- **England.** £57 million for local suicide prevention plans and bereavement services, a £10 million grant fund (2023 to March 2025), and £3.6 million over three years for projects for middle-aged men (section 8.4) [S23, S24].
- **Australia.** Over AUD 990 million for 41 suicide prevention measures from 2022–23 to 2025–26 [S20].
- **United States.** US$519.6 million in the federal budget for fiscal year 2025 for behavioural health crisis services (SAMHSA programme line) [S45].

These sums are not directly comparable: they cover different periods, services and populations.

What the evidence supports. WHO's LIVE LIFE guidance names four interventions as effective and evidence-based [S47]:

1. limiting access to the means of suicide;
2. working with the media on responsible reporting;
3. fostering socio-emotional life skills in young people;
4. early identification, assessment, management and follow-up of anyone affected by suicidal behaviour.

Strength of the evidence by intervention:

Intervention	Evidence	Source
Restricting lethal means	Strengthened since 2005. Control of painkillers: overall decrease of 43%; suicide hot-spots for jumping: 86% reduction. Sri Lanka's pesticide bans are estimated to have prevented 93,000 suicides from 1995 to 2015. Pesticides account for about 20% of suicides worldwide.	[S46, S48, S47]
School mental health awareness programmes	Shown to reduce suicide attempts (odds ratio 0.45) and suicidal ideation (0.50).	[S46]
Follow-up after a suicide attempt or crisis	Brief acute-care interventions: odds ratio 0.69 for later attempts; 3.04 for linkage to follow-up.	[S49]
Treating depression; lithium and clozapine	Supported, but possibly less specific than once thought.	[S46]
Educating doctors	Needs further study.	[S46]
Gatekeeper training	Not yet shown to reduce suicides; needs further study.	[S46]
Telephone and internet support	Low levels of evidence; needs further study.	[S46]
General public education	Insufficient evidence.	[S46]
Screening in primary care; media guidelines alone	Insufficient evidence.	[S46]

The review's authors note that "the paucity of RCTs is a major limitation" and that "no single strategy clearly stands above the others" [S46]. Many of the services that receive funding have not been tested against suicide outcomes. That is another reason to collect the data.

9.5 In short

- **The figures lag.** The most recent global suicide estimates describe 2021 [S1].
- **No global correction exists.** We found no peer-reviewed study that gives a single global estimate of the undercount, so every global total, including those in this report, should be read as a floor.

Without consistent counts by sex, age and circumstance, the scale of male suicide stays under-recognised and policy cannot be measured against it. The Alliance brings the scattered, missing and hidden data together in one place, so that the evidence can be seen in full.

10. Recommendations and questions for the first Global Alliance Round Table

Recommendations

1. Male suicide should be recognised in national and international health policy as a major, persistent cause of premature death among men.
2. Every country should publish suicide deaths each year by sex, age and, where recorded, circumstance.
3. Countries without good-quality registration should be supported to build it, with suicide counted alongside other causes of death.

4. National suicide prevention strategies should include specific measures for men aged 15–49, the group in which suicide leads causes of death in 35 countries.
5. Family and relationship breakdown should be addressed explicitly in prevention planning, in line with the Welsh surveillance findings.

Questions for the first Global Alliance Round Table (1 December 2026)

1. Should male suicide be treated with the urgency given to other mass causes of death?
2. What would it take for every WHO Member State to record suicide by sex, age and cause each year?
3. What do the 35 countries where suicide leads causes of death for men aged 15–49 have in common?
4. How should family and relationship breakdown be reflected in national prevention plans?
5. Which data gaps should be closed first, and who should close them?

11. Methodology

- **Global counts and rates:** WHO Global Health Estimates (GHE), 2021 release, accessed via the Our World in Data catalogue. Counts are male deaths from self-harm, all ages. Rates are age-standardised per 100,000. These are modelled WHO estimates and can differ from national statistics. WHO's own 2025 report gives 727,000 total suicides for 2021; the dataset used here gives 718,033. We use the dataset for consistency across years.
- **Multi-year totals:** our sums of WHO's yearly estimates.
- **COVID-19:** cumulative deaths reported to WHO, from the WHO COVID-19 dashboard data, downloaded 31 Oct 2026 (latest report date 27 Sep 2026). The yearly figures are sums of reported new deaths.
- **Leading cause, men 15–49:** our ranking of 126 specific GHE causes (mostly GHE level 3) for each of 194 countries. Parent aggregates and residual "other" groups are excluded. Drug use disorders and accidental poisonings are counted separately from self-harm. 2019 is used as the main year because 2021 rankings are dominated by COVID-19. The 15–49 band is the one the dataset provides for all causes.
- **UK:** ONS registrations (England and Wales, 2025), NRS (Scotland, 2024) and NISRA (Northern Ireland, 2024). ONS includes deaths of undetermined intent at ages 15+. UK totals and daily figures are our calculation. The Welsh 26% is applied to the UK total as an illustration, and is stated as such.
- **Life expectancy:** World Bank WDI, from UN World Population Prospects, 2024.
- **Rounding:** daily figures are divided by 365 and rounded.
- **Undercount illustration (s9.2):** published global figures multiplied by 1.23 and 1.42, the two local misclassification uplifts in [S33] and [S32]. Illustrative only; not an estimate.
- **Economic cost (s8):** every figure stays in its source's own currency and price year; no inflation or currency conversion is applied. Our calculations: 72% = £5,532,152,870 ÷ £7,704,790,325; £15.2m a day = £5.53bn ÷ 365; AUD 248m a year = AUD 990m ÷ 4 financial years; £1.2m a year = £3.6m ÷ 3.

Sources

WHO data are reproduced from published WHO sources. WHO has not reviewed or endorsed this report.

Data licences: WHO Global Health Estimates: *Global Health Estimates 2021: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2021*. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO. Accessed via Our World in Data (World Health Organization (2024) – with major processing by Our World in Data). Charts, tables and rankings derived from these data are our adaptation and are shared under the same licence. WHO COVID-19 data: World Health Organization, WHO COVID-19 dashboard data (global daily file), accessed 31 October 2026, data provided by WHO Member States. Licence: CC BY 4.0.

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Published by The United Global Alliance For Men & Boys. Operator: Sentient OS Ltd (company no. 17264941, registered in England and Wales).

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