PORTSMOUTH 100
1926 – 2026

Portsmouth CITY COUNCIL



100 years of public health in Portsmouth 1926 – 2026

Published: September 2026

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Foreword by Helen Atkinson, Director of Public Health for Portsmouth

I am very pleased to present this year's annual public health report (APHR) which focuses on the health of our population over the last 100 years. Portsmouth is celebrating 100 years as a city throughout 2026 and we thought it would be an opportunity to look at how health has changed over this time.

The report shows us some of the major progress made over this time from fewer children dying young, adults living longer, the introduction of vaccination, antibiotics and the creation of the NHS. This progress reflects a century of progress in public health, housing, sanitation, healthcare and medical innovation. Conditions that once caused widespread illness and early death, particularly among children, are now often preventable or treatable.

However, the report also raises an important question – who has benefited most from that progress, and who is still being left behind?

Like other major cities, the history of Portsmouth demonstrates that life expectancy is closely linked to the living conditions mentioned above. The report explores our residents' life expectancy and contributing factors from 1926 to 2026, including overcrowded housing and infectious disease, through war and rebuilding, to today's challenge of helping everyone to live longer, healthier lives. Life expectancy has increased substantially over the past century. In the mid-1920s, life expectancy at birth in England was around 58 years for males and 62 years for females and was likely to have been similar in Portsmouth. However, despite substantial improvements over the last century, life expectancy at birth in Portsmouth continued to lag behind the England average for both males and females in 2024. While overall progress has been remarkable, this enduring gap shows us the importance of tackling the wider social, economic and environmental factors that continue to influence health outcomes across the city.

I hope you enjoy reading the report.



Helen Atkinson
Director of Public Health

Setting the scene: 1926 to 2026

Indicator	Portsmouth 1926	Portsmouth 2026	Interpretation
Total population[1]	246,900	214,300 ↓	Smaller resident population today.
Households[2]	53,279	88,171 ↑	More households despite fewer residents today.
People per household[3]	4.7	2.4 ↓	Much smaller average household size today.
Population density[4]	7,675 per km^2	5,307 per km^2 ↓	Lower citywide population density.
Crude birth rate[5]	18.2 per 1,000 population	9.5 per 1,000 population ↓	The birth rate was much higher a century ago.
Infant mortality (under one year of age)[6]	54.9 per 1,000 live births	3.4 per 1,000 live births ↓	Far fewer babies die in their first year of life today.
All cause age-standardised mortality[7]	1,814 per 100,000	560 per 100,000 ↓	All-age, all cause mortality rates are much lower today.
Life expectancy at birth[8]	59.9 years	80.5 years ↑	Babies born in Portsmouth today have a life expectancy around 20 years longer than a century ago.

Note: These changes from 1926 to 2026 in birth rates, infant mortality, all-cause mortality rates and life expectancy at birth are not unique to Portsmouth, but are trends that have largely been reflected nationally as well. They therefore reflect the wider social, economic, healthcare and public health changes that occurred across the country during the past century, rather than improvements specific to Portsmouth.

The Public Health team, then and now

Pictured in the right-hand side image are the City of Portsmouth staff of Public Health Department engaged on Civil Defence Main Control Duties 1939-44.

Pictured below are members of the Public Health directorate at Portsmouth City Council in 2026.



Population change

Portsmouth has fewer residents today than it did in the 1920s, but it has many more households. In 1926, the city had an estimated population of 246,900 and 53,279 inhabited houses or households. By 2024, the population was around 214,300, while the number of households had increased to about 88,171. As a result, average household size has almost halved, from 4.7 people per house or household in 1926 to 2.4 people per household today.

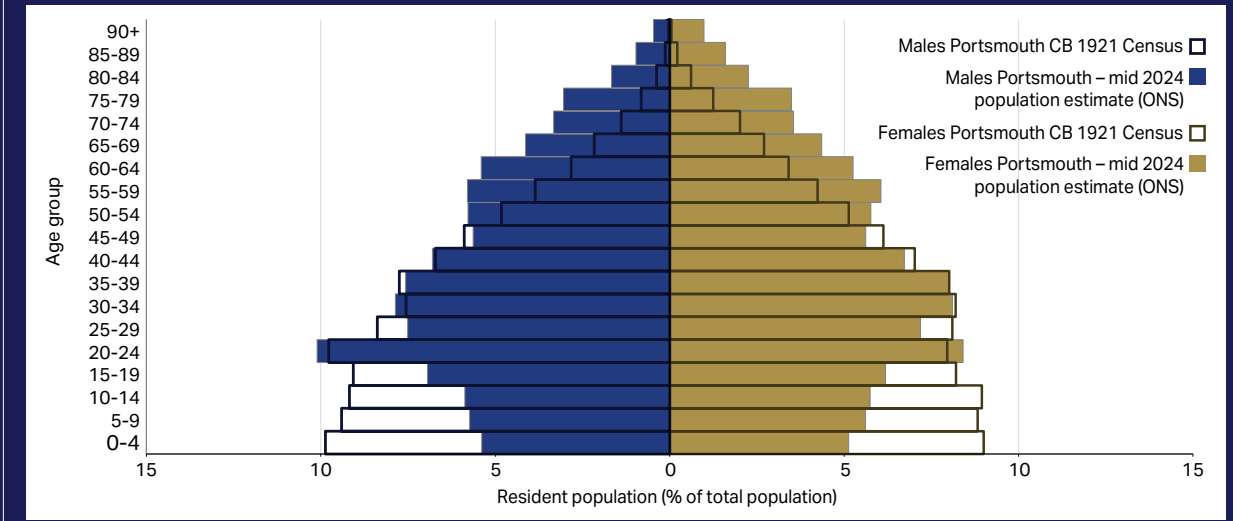
Portsmouth has long had a significant military presence. The 1921 Census recorded around 13,400 naval and military personnel, and a further 2,000 service personnel were estimated to be living in the city in 1926. A century later, Portsmouth remains the principal home of the Royal Navy, with recent Ministry of Defence statistics showing almost 8,000 regular serving personnel based locally.[9]

While Portsmouth's population is smaller than it was in 1921, the most notable change has been the way its age structure has shifted over time (Figure 1). Children and young people aged 0 to 19 years were around 89,600 in 1921, about 36% of the total population, but today the figure is smaller at around 49,900 in 2024, about 23%. People aged 65 years and over were around 14,600 in 1921, about 6%, but today the figure is around 32,000, about 15%. The number aged 85 years and over was around 500 in 1921, but today is about 4,300.[10]

The 20-to-24-year age group stands out in the current population structure. This reflects the contemporary higher education population in Portsmouth, with around 26,000 higher education students in 2022/23[11] and the 20 to 24 years age group accounting for around 9% of the current resident total. The early-1920s student population was much smaller compared to today.

Figure 1: Chart showing the population structure by 5-year age groups, comparing Portsmouth County Borough 1921 and Portsmouth UA in 2024[10]

Data table



2024 population source: MYE1: Population Estimates by single year of age and sex for local authorities in the UK, mid-2024, Office for National Statistics

© Crown copyright 2025. 1921 population source: Census 1921, Nomis. Office for National Statistics © Crown copyright reserved 2026.

The future population is projected to remain broadly stable in total size, but structurally older. The overall population was projected to be around 215,900 in 2025 and 215,100 in 2047. The older age groups are expected to increase; the 65 years and over population is projected to increase from about 31,300 in 2022 to 37,000 in 2032 and 40,600 by 2047. The 80 years and over population is projected to increase from about 8,400 to 10,600 and then 14,500.

Table 1: Resident population projections by age group, Portsmouth City, 2022-based 2022 estimate compared to 2032 and 2047 projection[12]

Age group	2022 estimate	2032 projection	2047 projection	Summary
0 to 17 years	41.9k	37.6k	34.6k	Projected decrease of about 17.4% by 2047.
18 to 64 years	136.6k	142.2k	140.7k	Broadly stable, with a peak around 2032.
65+ years	31.3k	37.0k	40.6k	Steady increase to 18.9% by 2047.
80+ years	8.4k	10.6k	14.5k	Projected increase of around 72.1% by 2047.



As the population ages, the number of people aged 80 years and over is projected to increase substantially by 2047. This could mean more people living with multiple long-term conditions, including dementia and frailty, making prevention and healthy ageing increasingly important to help residents live longer, healthier lives – remaining independent for longer and reducing future pressure on health and care services.



1 Life expectancy



Place, progress and inequality

Life expectancy has increased substantially over the past century. Babies born in Portsmouth today have a life expectancy around 20 years longer than a century ago. In the mid-1920s, life expectancy at birth in England was around 58 years for males and 62 years for females[13] and was likely to have been similar in Portsmouth.

The leading causes of death in Portsmouth in 1925 were very different from those seen today. Broncho-pneumonia was the leading cause of death among children aged one to four years, diphtheria among those aged five to 14 years, and pulmonary tuberculosis among people aged 15 to 54 years.[1] Together, these infectious diseases were among the leading causes of mortality across much of childhood and working age.

By contrast, the leading causes of death in recent decades have been very different. Nationally, in 2015, cancer was the leading cause of death among children and younger adults, while external causes such as accidents, drug misuse, self-harm and suicide account for a substantial proportion of premature mortality. Among older working-age adults, chronic diseases such as coronary heart disease, liver disease and cancer are more prominent.[14] In Portsmouth, analysis of deaths during the six-year period 2014-19 showed a similar pattern. External causes, particularly accidents and suicide, were the leading causes of death among younger adults, while liver disease and coronary heart disease became more prominent in later working age. Among women aged 45-54 years, breast cancer was the leading cause of death.[15]

Increased life expectancy reflects improvements in living conditions, public health, housing, sanitation, healthcare and the prevention and treatment of disease. Many illnesses that once caused early death, particularly in childhood, are now preventable or treatable.

However, despite substantial improvements over the last century, life expectancy at birth in Portsmouth continued to lag behind the England average and remained significantly lower in 2024 – 78.1 years for males and 82.7 years for females, compared with 79.8 and 83.6 years respectively in England.[16]

Health inequalities are unfair and avoidable differences in health between people and places. They are shaped by the conditions of daily life: including housing, income, work, education, environment and access to support. This means that where someone lives can still influence how long they live, and how many of those years are spent in good health.



A century ago: housing and early death

A century ago, many people in Portsmouth lived in housing conditions that made it harder to stay healthy. Overcrowding, damp homes, poor ventilation, shared toilets and limited sanitation all increased the risk of illness spreading quickly between families and neighbours.[17]

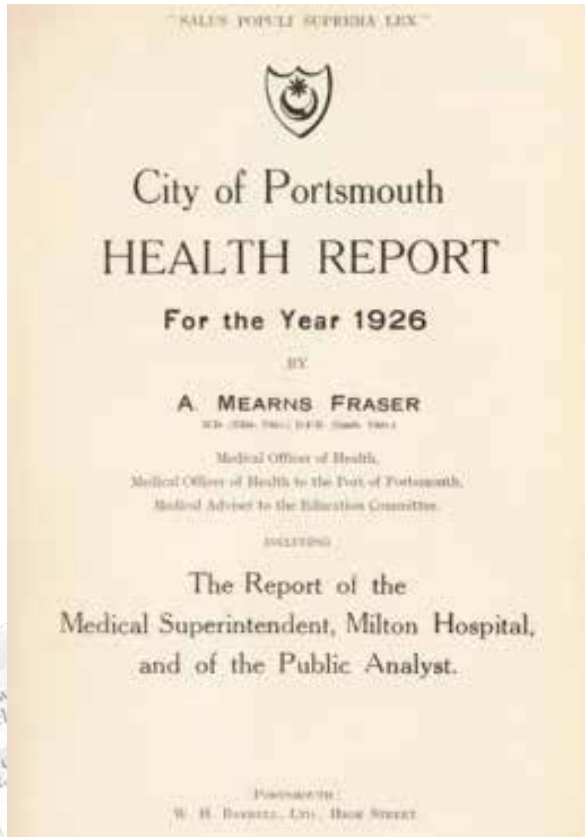
Infectious diseases such as tuberculosis, diphtheria and scarlet fever were common and could be life-threatening, especially for children. Diarrhoeal illness, linked to contaminated water and poor sanitation, was also a major cause of infant death.

Cold and damp homes increased the risk of respiratory illness.[1]

This shows how closely health was tied to place. A person's chances of surviving childhood were not only shaped by biology or medical care, but by the home they lived in, the street around them, and the wider conditions of poverty and deprivation.



Hawk Street, Portsea, looking west towards Queen Street 1924. Available from: *portsmouth.co.uk/news/nostalgia-portsea-a-population-that-bears-the-hallmark-of-poverty-1070544*



"SALUS POPULI SUPREMA LEX"

City of Portsmouth

HEALTH REPORT

For the Year 1926

BY

A. MEARNS FRASER

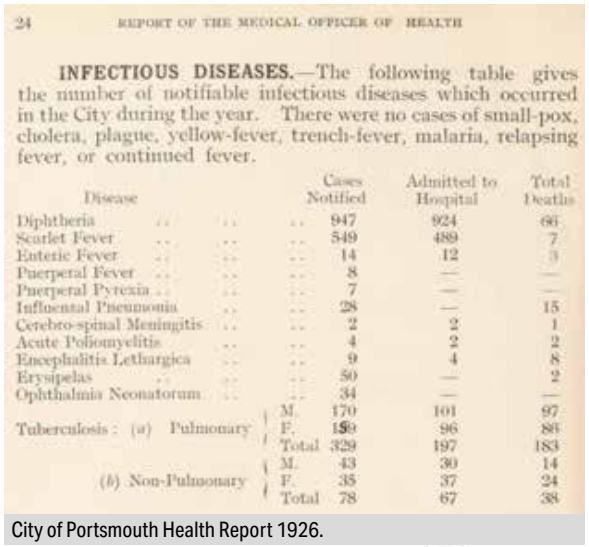
Medical Officer of Health,
Medical Officer of Health to the Port of Portsmouth,
Medical Adviser to the Education Committee.

INCLUDING

The Report of the
Medical Superintendent, Milton Hospital,
and of the Public Analyst.

PORTSMOUTH:
W. H. BARRELL, LTD., HIGH STREET.

City of Portsmouth Health Report 1926.

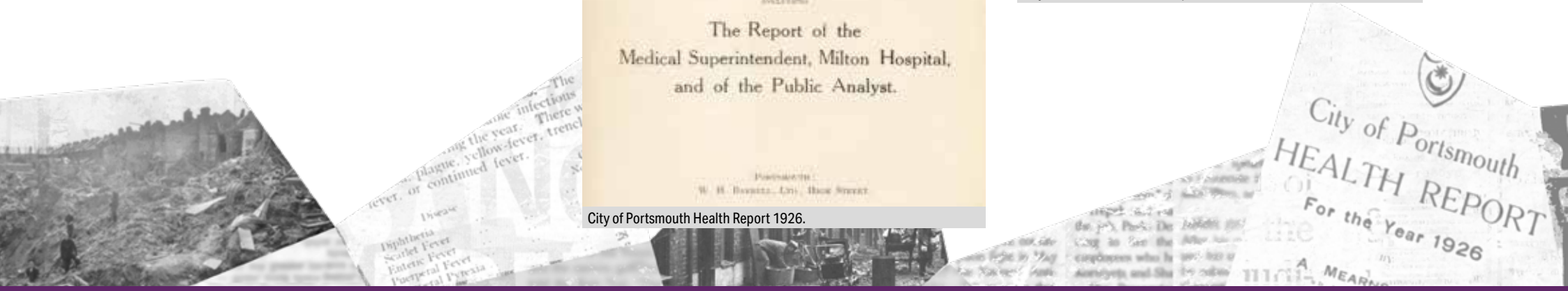


24 REPORT OF THE MEDICAL OFFICER OF HEALTH

INFECTIOUS DISEASES.—The following table gives the number of notifiable infectious diseases which occurred in the City during the year. There were no cases of small-pox, cholera, plague, yellow-fever, trench-fever, malaria, relapsing fever, or continued fever.

Disease		Cases Notified	Admitted to Hospital	Total Deaths
Diphtheria		947	924	66
Scarlet Fever		549	489	7
Enteric Fever		14	12	3
Puerperal Fever		8	—	—
Puerperal Pyrexia		7	—	—
Influenzal Pneumonia		28	—	15
Cerebro-spinal Meningitis		2	2	1
Acute Poliomyelitis		4	2	2
Encephalitis Lethargica		9	4	8
Erysipelas		50	—	2
Ophthalmia Neonatorum		34	—	—
Tuberculosis: (a) Pulmonary	M.	170	101	97
	F.	159	96	86
	Total	329	197	183
(b) Non-Pulmonary	M.	43	30	14
	F.	35	37	24
	Total	78	67	38

City of Portsmouth Health Report 1926.



Some of these issues like cold and damp housing still matter today. Housing is not just a background issue – it is one of the building blocks of health. Safe, warm, affordable homes help people live longer and healthier lives. Although housing conditions have improved significantly over the last century, the relationship between housing and health remains as important as ever.

> "I remember when heating and boilers were introduced. My dad discovered it was too expensive to run though. Everyone was really frugal."
>
> Rose, 61, lived most of her life in Drayton/Farlington.



World War II: destruction, displacement and health

The Second World War was a major turning point for Portsmouth. As a naval city, Portsmouth experienced extensive bombing. Around 6,625 houses were destroyed and more than 80,000 were damaged, creating widespread housing shortages.[17,18]

The health impacts were immediate and long-lasting. People experienced injury, bereavement, evacuation and separation from family members.[19] Overcrowded shelters, damaged homes and disrupted sanitation increased the risk of infectious disease, particularly respiratory and gastrointestinal illness.[20]

> "The doctor mostly knew me because of bronchitis – it was the illness I remember most from growing up." Tony, Paulsgrove.

Food shortages and rationing also affected nutrition, especially for children, increasing vulnerability to illness and slowing recovery. The emotional impact was significant too, with trauma, loss and uncertainty shaping mental wellbeing for many families.[21]



The aftermath of a bombing raid on Conway Street, Portsmouth 23 December 1940. Available from: *theddaystory.com/timeline_post/august-1940-may-1941*



Damage caused by a bomb. Dunbar Road, Eastney 1942. Available from: *portsmouthmuseum.co.uk/collections-stories/80th-anniversary-of-the-blitz/the-portsmouth-bomb-map*

Recovery, public health change and the NHS

The impact of the Second World War on health did not end in 1945. Poor nutrition, overcrowding, disrupted education and the trauma of war continued to affect many families for years afterwards.

> "We didn't have a fridge, so food was bought fresh every day. We'd spend all day picking fruit, then Mum turned it into pies for the family." Tony, Paulsgrove.

Children who experienced deprivation during and after the war were at greater risk of poorer health later in life, including heart disease, respiratory illness and other long-term conditions.

For Portsmouth, the war was not only a period of loss. It also became part of the city's transition from crisis and overcrowding towards rebuilding and wider public health improvement.

The war created momentum for major social change. Across Portsmouth, bomb-damaged neighbourhoods were rebuilt and thousands of families moved into new council housing with indoor toilets, running water, improved sanitation, gardens and more living space. These improvements helped reduce overcrowding, improved living conditions and lowered the risk of infectious disease, creating healthier environments for future generations.

Nationally, the creation of the National Health Service in 1948 transformed access to healthcare. For the first time, healthcare became available to everyone regardless of their ability to pay, improving access to doctors, hospitals, maternity services, vaccinations and preventive care.[22]

> "Before the NHS you used to pay for the doctors, I remember paying '2 an 6'. One day I dropped it on the way to the doctors with my mum, but they said it was ok and they'd still see my mum." Carole, 86, Buckland.

Combined with advances such as antibiotics, improved medical treatments and better public health measures, these changes helped drive the significant improvements in life expectancy seen in the decades that followed.



Paulsgrove Housing Estate 1948. Available from: *britainfromabove.org.uk/image/eaw020629*



Reflection and looking forward

Living longer in Portsmouth – but not equally

People in Portsmouth are living much longer than they did 100 years ago. This is a major public health achievement, reflecting improvements in housing, sanitation, healthcare, living standards and disease prevention.

However, these gains have not been shared equally. Life expectancy in Portsmouth remains below the national average, and there are clear differences between communities within the city. Men and women living in more deprived areas experience worse health outcomes than those in less deprived areas.

This reflects the continuing impact of poverty and deprivation in our communities. Today, the causes of early death and poor health are more complex than they were in 1926, often linked to poor lifestyle – smoking, poor diet, alcohol use and lack of physical activity – but also still strongly shaped by the conditions people live in: housing quality, income, employment, education, access to services, community cohesion and the wider environment.

The challenge has also changed. It is no longer only about helping people live longer. It is also about helping people spend more of those years in good health. In 2026 we are focused on reducing the gap in life expectancy between communities by focusing on the wider determinants of health. That means putting health equity at the centre of decisions about housing, neighbourhoods, employment, transport, services and community cohesion.

> "Health care felt local – the doctor was just down the road from home and seeing a doctor was much easier back then. Things feel different now." Celia, 82, Paulsgrove.

2 Sexual and reproductive health

KEY DATES

1917

Portsmouth's Venereal Diseases Treatment Centre established.

1941

Royal Portsmouth Hospital bombed and the treatment centre was destroyed. Services relocated to St Mary's Hospital.

1948

Lloyd's Pharmacy pioneered one of Britain's first postal contraceptive services, supplying condoms by mail order.

1961

Contraceptive pill available on NHS (only for married women with children).

1967

Family Planning Act 1967 meant local authorities can provide contraceptive advice and supplies through the NHS, inclusive of unmarried women.

1980s

HIV and AIDS emerged in the UK.

1990s/ EARLY 2000s

Post-Exposure Prophylaxis (PEP) available.

2020

Pre-Exposure Prophylaxis (PrEP) available.

2025

Opt-out testing for HIV, Hepatitis B and Hepatitis C introduced in the Emergency Department at Queen Alexandra Hospital.

Portsmouth's sexual and reproductive health story is closely tied to the city's history. As one of the world's most significant naval cities, Portsmouth has experienced unique public health challenges shaped by military populations, changing demographics and evolving social attitudes. Over the past century, sexual and reproductive health has undergone remarkable transformation. Conditions once associated with serious illness, infertility or death can now often be prevented, treated or effectively managed, while services have expanded from treating disease to promoting sexual wellbeing, reproductive choice and long-term health.

A naval city and the challenge of venereal disease

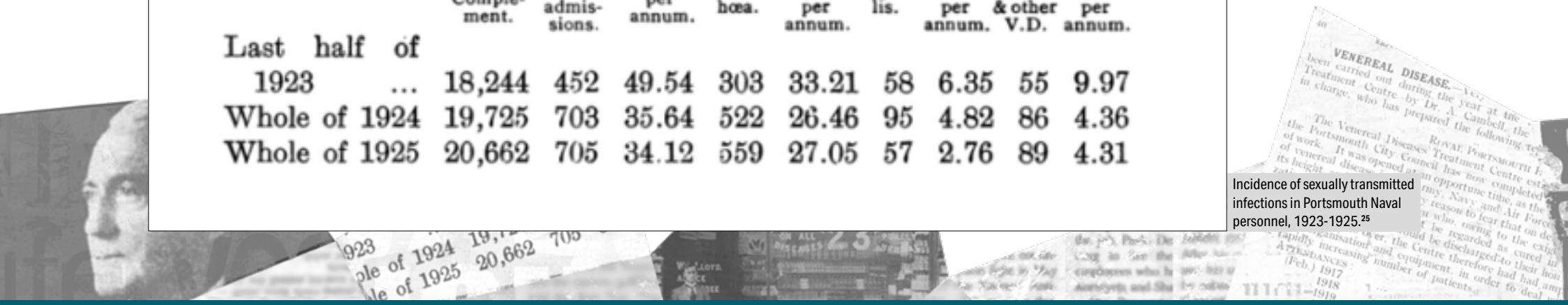
Portsmouth Naval Base has been at the heart of the city since 1194 and remains the oldest dockyard in the history of the Royal Navy. Like many international ports, Portsmouth developed areas known as 'sailor towns', where sailors arriving ashore would find accommodation, pubs and commercial sex workers.[23] Areas including The Hard and The Point in Old Portsmouth became famous for their nightlife and were sometimes referred to as "The Devil's Acre".[24]

> "Nights out were about dancing and friends, more than drinking. The Navy sent the girls free dance tickets, so Tuesday nights became party nights." Celia, 82, Paulsgrove.

The presence of large numbers of military personnel created significant challenges for controlling sexually transmitted infections (STIs), then known as venereal diseases. Syphilis and gonorrhoea were widespread during the early twentieth century, with particular impact on naval populations. A Royal Navy report published in 1926[25] found that venereal disease accounted for almost one third of sickness absence caused by illness and injury amongst naval personnel.

Year.	Average weekly Complement.	Number of cases. Fresh admissions.	Rate per 1,000 per annum.	Classification. Gonorrhœa.	Rate per 1,000 per annum.	Syphilis.	Rate per 1,000 per annum.	Chancroids & other V.D.	Rate per 1,000 per annum.
Last half of 1923 ...	18,244	452	49.54	303	33.21	58	6.35	55	9.97
Whole of 1924	19,725	703	35.64	522	26.46	95	4.82	86	4.36
Whole of 1925	20,662	705	34.12	559	27.05	57	2.76	89	4.31

Incidence of sexually transmitted infections in Portsmouth Naval personnel, 1923-1925.[25]



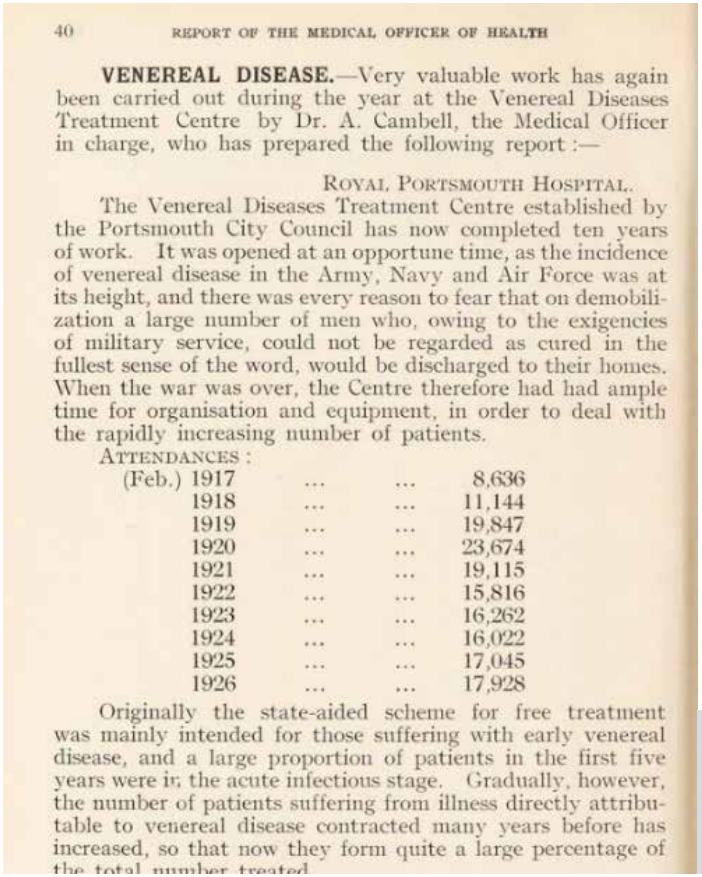
From stigma to confidential care

The development of modern sexual health services in Portsmouth emerged from growing concern about rising STI rates following the First World War. In 1917, following national legislation to provide free and confidential treatment, Portsmouth City Council and the Royal Portsmouth Hospital established the city's Venereal Diseases Treatment Centre.

While medical knowledge was advancing, social attitudes often prevented people from accessing information and support. In 1920, Portsmouth's Medical Officer of Health – the equivalent of today's Director of Public Health – Dr Andrew Mearns Fraser, argued that the prevention of venereal disease was being hindered due to moral and religious concerns: "…the public have been left in ignorance of the methods of prevention of venereal diseases because of a mistaken idea that such knowledge would increase immorality."[26]

> "Most of us knew very little. We were very naive – sex education was just a few diagrams from the PE teacher. When I think about what young people learn today, our generation had hardly any information." Celia, 82, Paulsgrove.

Despite these challenges, Portsmouth's service expanded rapidly. By 1920 it was offering eight treatment sessions each week, with dedicated examination rooms, treatment cubicles and inpatient facilities to meet increasing demand. This represented one of the earliest examples of specialist publicly funded sexual healthcare in the city.



40 REPORT OF THE MEDICAL OFFICER OF HEALTH

VENEREAL DISEASE.—Very valuable work has again been carried out during the year at the Venereal Diseases Treatment Centre by Dr. A. Cambell, the Medical Officer in charge, who has prepared the following report :—

ROYAL PORTSMOUTH HOSPITAL.

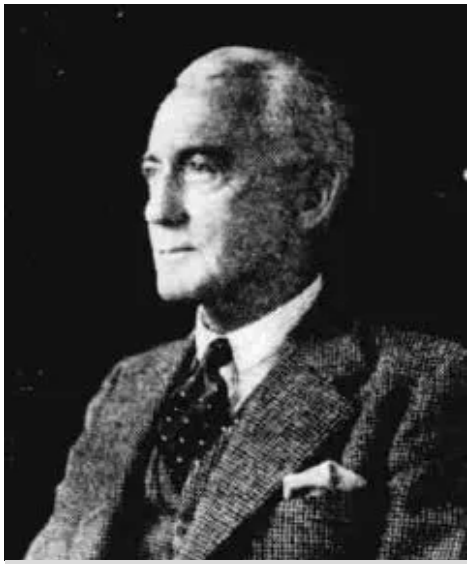
The Venereal Diseases Treatment Centre established by the Portsmouth City Council has now completed ten years of work. It was opened at an opportune time, as the incidence of venereal disease in the Army, Navy and Air Force was at its height, and there was every reason to fear that on demobilization a large number of men who, owing to the exigencies of military service, could not be regarded as cured in the fullest sense of the word, would be discharged to their homes. When the war was over, the Centre therefore had had ample time for organisation and equipment, in order to deal with the rapidly increasing number of patients.

ATTENDANCES :

(Feb.)	1917	... ...	8,636
	1918	... ...	11,144
	1919	... ...	19,847
	1920	... ...	23,674
	1921	... ...	19,115
	1922	... ...	15,816
	1923	... ...	16,262
	1924	... ...	16,022
	1925	... ...	17,045
	1926	... ...	17,928

Originally the state-aided scheme for free treatment was mainly intended for those suffering with early venereal disease, and a large proportion of patients in the first five years were in the acute infectious stage. Gradually, however, the number of patients suffering from illness directly attributable to venereal disease contracted many years before has increased, so that now they form quite a large percentage of the total number treated

Medical Officer of Health report showing attendances at Portsmouth's Venereal Diseases Treatment Centre. Available from: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Wellcome Collection *wellcomecollection.org/works/ny493aak/items?canvas=3*



Dr Andrew Mearns Fraser, pictured in 1934. Available from: *municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i*

The service faced further challenges during the Second World War. On 10 January 1941, the Royal Portsmouth Hospital suffered a direct hit during an air raid, and the treatment centre was destroyed. Services relocated to St Mary's Hospital, where sexual health services continue to operate today. A 1949 handbook promoted the clinic whilst reassuring patients that treatment was "absolutely confidential".[27] The emphasis placed on confidentiality reflects the stigma surrounding sexual health at the time and the importance of creating services people felt able to access.

Today, Portsmouth Sexual Health Service provides considerably more than treatment alone. Alongside clinical care, residents can access online STI testing, condoms by post, contraception services, outreach programmes and education, reflecting a broader focus on prevention and wellbeing.

From restriction to reproductive choice

Few developments illustrate changing attitudes to health, equality and personal choice more clearly than contraception.

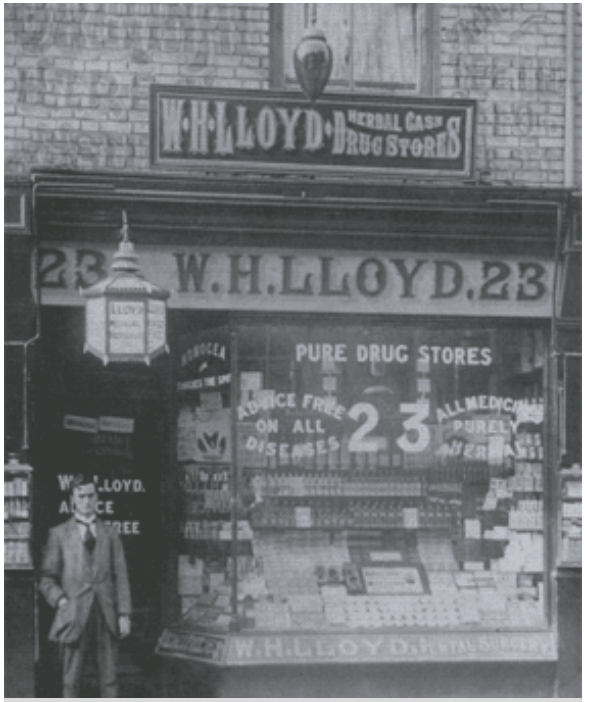
In the early twentieth century, access to contraception was heavily restricted by social, religious and medical beliefs. Family planning advice was often unavailable to those who needed it most, with access strongly influenced by marital status and financial circumstances. Women experiencing the greatest burden of poor health, poverty and repeated pregnancies frequently had the fewest opportunities to obtain reliable information or support.

The opening of Britain's first birth control clinic by Marie Stopes in 1921 marked an important turning point, helping establish contraception as a healthcare issue rather than simply a moral or social concern.[28]

Portsmouth also played a role in improving access. In 1948, Lloyd's Pharmacy pioneered one of Britain's first postal contraceptive services, supplying condoms by mail order in plain packaging to maintain discretion. At a time when sexual health products were rarely advertised openly, the popularity of the service demonstrated substantial public demand for family planning support.[29]

The introduction of the contraceptive pill during the 1960s transformed reproductive healthcare. Although initially available only to married women, access gradually expanded following the Family Planning Act 1967, which enabled local authorities to provide contraceptive advice and supplies through the NHS, including for unmarried women.

Today, Portsmouth residents can access a wide range of free contraceptive options through GP practices, pharmacies and sexual health services. Contraception is increasingly recognised not only for preventing pregnancy but also for supporting women's health through the management of conditions such as heavy



The first W. H. Lloyd store at 23 Lake Road, Portsmouth. Available from: History in Portsmouth *historyinportsmouth.co.uk/events/lloyds.htm*

menstrual bleeding, menstrual disorders and symptoms associated with perimenopause. Over the last century, contraception has evolved from a restricted and controversial subject into an important part of modern healthcare.

> "Had to learn from my sister and families didn't really talk about it."
>
> Brenda, Portsea (on sex and periods being taboo topics).

Data relating to STIs, contraception and HIV for Portsmouth can be found on our website: *portsmouth.gov.uk/services/health-and-wellbeing/joint-strategic-needs-assessment/adults-health-and-wellbeing-jsna-report/#sh*

HIV: a public health success story

When HIV emerged during the early 1980s, it was associated with fear, misunderstanding and significant stigma. With no effective treatment available, a diagnosis often carried devastating consequences for individuals and families.

Over the following decades, advances in science, medicine and public health transformed HIV from a life-limiting condition into one that can be effectively managed. Today, people diagnosed early and receiving treatment can expect to live long, healthy lives. Prevention has also been transformed through the availability of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), medicines that significantly reduce the risk of acquiring HIV.

One of the most significant developments has been the recognition that people living with HIV who achieve and maintain an undetectable viral load cannot pass HIV on to sexual partners, a principle known as Undetectable = Untransmittable (U=U). This has transformed both HIV prevention and efforts to reduce stigma.

Portsmouth Sexual Health Service continues to play an important role in HIV prevention, diagnosis and care for residents. The service provides rapid assessment for newly diagnosed patients, lifelong treatment and monitoring, psychological and peer support, specialist pharmacy advice, sexual health care and support for those affected by HIV.

In March 2025, opt-out testing for HIV, Hepatitis B and Hepatitis C was introduced in the Emergency Department at Queen Alexandra Hospital. Patients aged 18 years and over who require a blood test are routinely tested unless they choose not to be, helping identify infections earlier and improving access to treatment.

Reflection and looking forward

The sexual and reproductive health services available in Portsmouth today are markedly different to what was available 100 years ago. Yet the underlying goal remains the same: preventing ill health, improving wellbeing and ensuring that people have access to the information and support they need.

From controlling venereal disease amongst sailors to expanding contraceptive choice and transforming HIV care, the history of sexual and reproductive health in Portsmouth reflects a century of scientific progress, changing social attitudes and public health innovation. It is ultimately a story of moving from secrecy and restriction towards prevention, choice and better health for all.



See Jane's story about living with HIV at: **youtu.be/RDcJL-9Bclw**

3 Substance use and recovery

Key dates

1920, 1923, 1925, 1932, 1951

Dangerous Drugs Acts, controlled supply and possession while doctors continued prescribing within the 'British System'.

1926

The Portsmouth Medical Officer report recorded liver disease deaths but made no reference to dedicated alcohol or drug treatment, specialist substance use services or recovery support. 1926 Rolleston report – recognised addiction as a medical condition and allowed doctors to prescribe heroin or morphine for treatment.

1939

Local resident Will Bell's drawing of pubs and breweries captured the density of Portsmouth's pub landscape.

1961–1967

Rising heroin use and concerns about over-prescribing led to stronger controls on drugs.

1971

Misuse of Drugs Act – became the cornerstone of UK drug law, introducing Classes A, B and C and offences for possession, supply and production.

Late 1980s–1990s

Harm reduction – HIV/AIDS drove needle exchange, outreach and a stronger public health focus alongside enforcement.

1990s

National drug strategies – 'Tackling drugs together' introduced a cross-government focus on crime, prevention and treatment, with Drug Action Teams and greater recognition of deprivation.

2013

Portsmouth Recovery Hub became a central part of the local treatment system.

2020s

Public health narrative – the Dame Carol Black review and "From Harm to Hope" strategy renewed focus on treatment, recovery, reducing demand, stigma and harm.

Continued on next page

Key dates

2023

Portsmouth completed a women's substance misuse needs assessment to identify barriers to treatment.

2024

Project W opened as a women-only, trauma-informed safe space, providing integrated recovery, health, domestic abuse, peer and wellbeing support. Portsmouth signed the charter to become an inclusive Recovery City.

2024–25

The number of pubs in Portsmouth was estimated to have fallen to around 114, reflecting changing drinking patterns and the movement of alcohol harm into less visible settings.

2026

Portsmouth completed its Drug and Alcohol Related Death self-assessment and action plan, identifying priorities including non-fatal overdose reporting, recovery check-ups, early liver disease detection and stronger toxicology intelligence.

2026/27

Planned next steps include developing referral pathways for fibrosis testing, embedding structured recovery check-ups after planned treatment exits, and strengthening early toxicology sharing arrangements across the wider region.

2026/27

Developing a multi-agency access service supporting people with compounding intersecting needs such as substance use, homelessness and mental health and trauma.

Portsmouth's current challenge

Substance use has always reflected the wider conditions in which people live, but the challenges facing Portsmouth today are more visible, more complex than they were a century ago. Portsmouth continues to experience some of the highest rates of drug-related deaths in the country, with alcohol and drug-related mortality around twice the national average. Behind these figures are people, families and communities affected by poverty, trauma, homelessness, poor physical and mental health, and barriers to timely support.

The reasons are not simple. Substance use harms are a "wicked issue": shaped by deprivation, access to healthcare, the availability and potency of drugs, and the way different disadvantages can accumulate over a person's life. Portsmouth has a high number of people using opiates, and the local picture is increasingly affected by changes in the illegal drug market. Synthetic opioids, fake or diverted medicines, high-potency cannabis products, ketamine and polysubstance use all create greater and less predictable risks, particularly for people already experiencing exclusion or poor health.

This changing risk environment means that prevention, treatment and recovery support need to be flexible, assertive and relationship-based. It also means that reducing harm cannot sit within one service alone: it requires public health, housing, primary care, mental health, criminal justice, voluntary and community services, and people with lived experience to work together.

Looking back: what was visible in 1926?

The 1926 Portsmouth Medical Officer report[1] tells a very different story. Public health activity at that time was highly developed in relation to infectious disease, maternal and child health, sanitation and housing conditions. However, there is no clear evidence of alcohol or drug treatment, recovery support or specialist substance use services. Alcohol-related harm is only indirectly visible through mortality data such as cirrhosis (liver damage), and substance use was not yet framed as a public health priority.

This absence matters. It reminds us that what society chooses to measure, name and respond to changes over time. A century ago, any support that existed for people experiencing alcohol or drug harms was likely to be informal, voluntary or punitive, rather than medical, trauma-informed or recovery-focused. The contrast with today's system highlights the progress made.

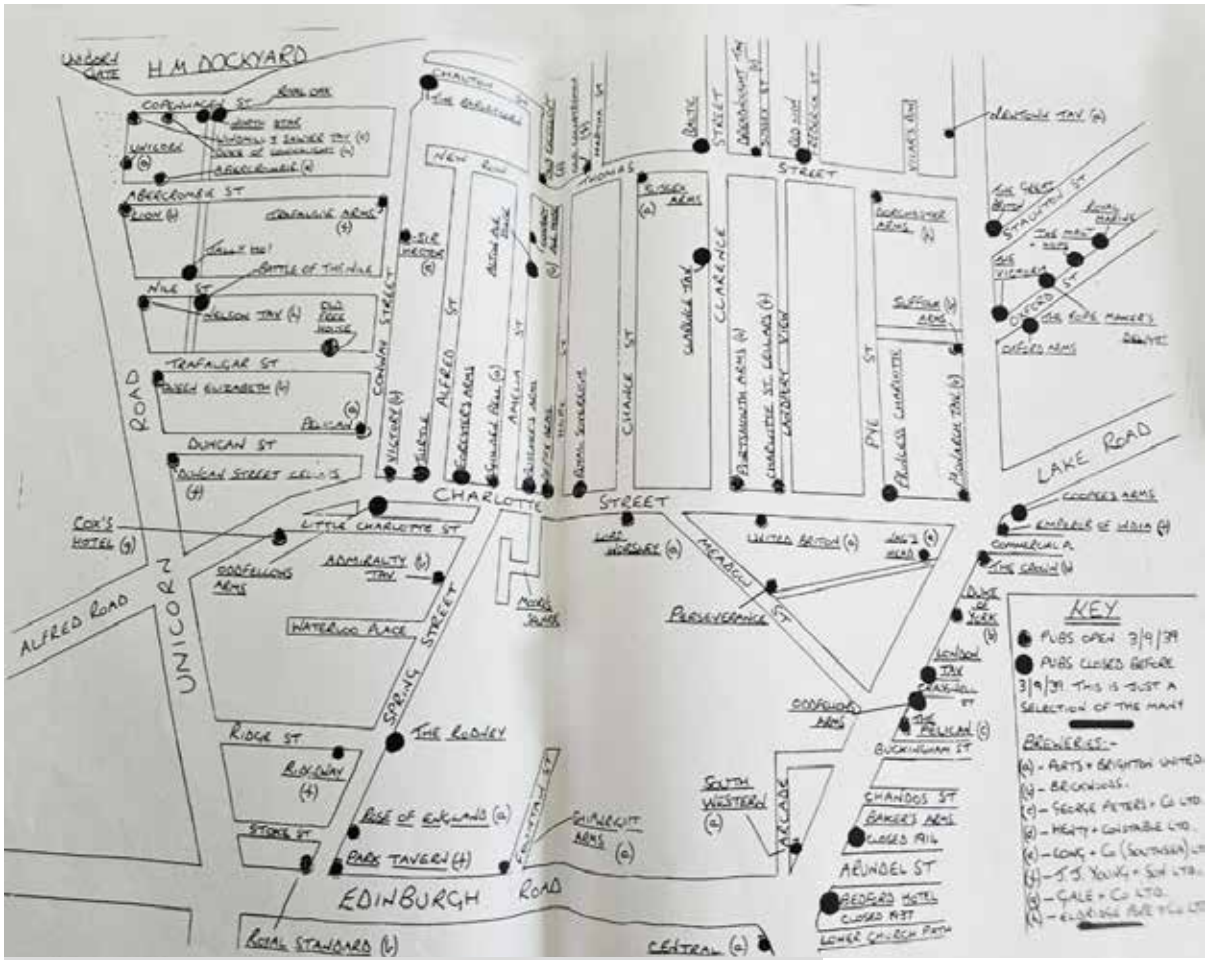


From pub culture to hidden harm

Portsmouth's identity has long been shaped by its dockyard, naval history and dense network of public houses. For much of the last century, pubs were part of the social fabric of many neighbourhoods, particularly around the city centre and communities connected to the dockyard. Local resident Will Bell's drawing of pubs and breweries around Charlotte Street, open as of 3 September 1939, captures how visible and concentrated this drinking culture once was.

That landscape has changed significantly. Pub numbers declined steadily after the Second World War, with closures accelerating from the 1990s onwards due to redevelopment, economic pressures and changing social habits. Around ten years ago Portsmouth was estimated to have around 140 pubs; by 2024–25 this had fallen to around 114.[30]

> "The pubs were the heart of the community. You could smoke in pubs... People would go there to drink and socialise. People would finish work and head to the pub instead of going straight home, and the drink driving policy didn't seem like a thing." Chris, 68.



Drawing by local resident Will Bell depicting the pubs and breweries around Charlotte Street in 1939.
Available from: *facebook.com/groups/1429837203969076/posts/4066413663644737*

The decline of pubs can appear at first to suggest a decline in alcohol harm. In reality, the pattern is more complex. In 1926, alcohol consumption was more often associated with weaker beer and public house drinking. Today, people have access to a broader range of wines, spirits and high-strength products, and alcohol is widely available through off-licensed premises and supermarkets.

Alcohol-related harm has not disappeared; in some cases, it has become less visible, with people able to consume alcohol behind closed doors. This reinforces the importance of looking beyond what is obvious in the built environment and understanding the wider commercial, social and health inequalities that shape how harm is experienced.

Portsmouth had significantly higher rates than England in 2024 for the following alcohol-related indicators[31]:

- Alcohol-related mortality.
- Mortality from chronic liver disease.
- Hospital admissions for alcohol-specific conditions.



How support has changed

From specialist treatment to harm reduction

In the early 20th century, addiction was recognised as a health condition, treatment was largely individualised and GP-led, with heroin prescribed where appropriate to stabilise dependent patients. This was known as the 'British medical system'.

From the 1960s onwards, rising heroin use led to increasing national concern and the development of specialist drug dependency services. The Misuse of Drugs Act 1971 consolidated drug legislation and classification, while specialist NHS services and prescribing models emerged alongside criminal justice approaches. This period marked the beginning of a more formal treatment response, but support was often specialist, clinic-based and separated from wider community healthcare.

The public health turning point

The HIV/AIDS epidemic in the 1980s changed the public health response. Harm reduction approaches, including needle and syringe programmes, methadone maintenance and low-threshold outreach, expanded rapidly. The focus began to shift from abstinence alone towards safety, stability, engagement and preventing avoidable deaths. This was a crucial moment in recognising that keeping people alive and connected to support is a foundation for recovery.

Expansion, recovery and renewed investment

During the 1990s and 2000s, drug treatment expanded through national targets, voluntary and community sector provision, and closer links with criminal justice. The concept of recovery became more prominent, with a growing emphasis on housing, employment, community connection and rebuilding lives. At the same time, later reductions in funding and workforce capacity contributed to a more fragmented system nationally, at a time when drug-related deaths were rising.

Inclusion health and trauma-informed practice

The current period is one of both urgency and renewal. Recent investment has strengthened treatment, harm reduction and outreach. Services increasingly recognise the importance of inclusion health, trauma-informed practice and health inequalities. This is especially important for people experiencing homelessness, contact with the criminal justice system, poor mental health, domestic abuse, or other forms of multiple disadvantage.



The Recovery Hub, Elm Grove.

Portsmouth's current provision

Portsmouth's response has developed into a city-wide, multi-agency treatment and recovery system. Public health, housing, criminal justice, NHS partners, voluntary and community sector organisations, and people with lived experience all contribute to a shared aim: reducing harm, improving access, and supporting people to build safer, healthier lives.

The Portsmouth Recovery Hub, established in 2013, became a central feature of this local system. It offers a one-stop, non-judgemental access point for drug and alcohol treatment, alongside clinical prescribing, psychosocial interventions and group-based support. The local system increasingly recognises that recovery is rarely linear. People may move in and out of treatment and benefit from long-term, flexible relationships rather than a single episode of care.

4 Tobacco control

Key dates

1939–1945
Cigarettes included in military rations during WW2.

1950
Doll and Bradford Hill published landmark UK study linking smoking to lung cancer.

1954
Follow-up study showed a higher mortality in smokers compared to non-smokers.

1965
Cigarettes banned from being advertised on TV. Taxation on cigarettes also began to increase.

1974
First national publication of smoking rates; an estimated 44% of population smoke.

1984
National No Smoking Day launched.

2007
Smokefree legislation introduced.

2015
The Portsmouth Wellbeing Service is launched. Public Health England concludes e-cigarettes are substantially less harmful than smoking and can support quitting.

2024
Portsmouth smokefree alliance created.

2026
Tobacco and Vapes Bill gained Royal Assent, aiming for a smokefree generation.

Over the last 100 years, there has been a dramatic shift in how people understand and respond to smoking. In 1926, tobacco use was commonplace and the health risks largely unknown. Despite smoking remaining the leading preventable cause of illness, premature death and a major contributor to health inequalities, Portsmouth has made significant progress in line with national trends. Smoking prevalence has fallen markedly over recent decades, and residents now have access to a broad range of evidence-based support to help them quit.

The following highlights the discoveries, policies and local action that have driven progress and continue to shape our ambition for a smokefree Portsmouth.

Normalisation: 1920s–1940s

Cigarette smoking is widely normalised across the city, including workplaces and the Armed Forces; no health warnings or restrictions and certain campaigns were endorsed by medical professionals to encourage people to use certain brands of cigarettes.

During the Second World War, with Portsmouth's long naval history, cigarettes were included in military rations and promoted for morale and stress relief.

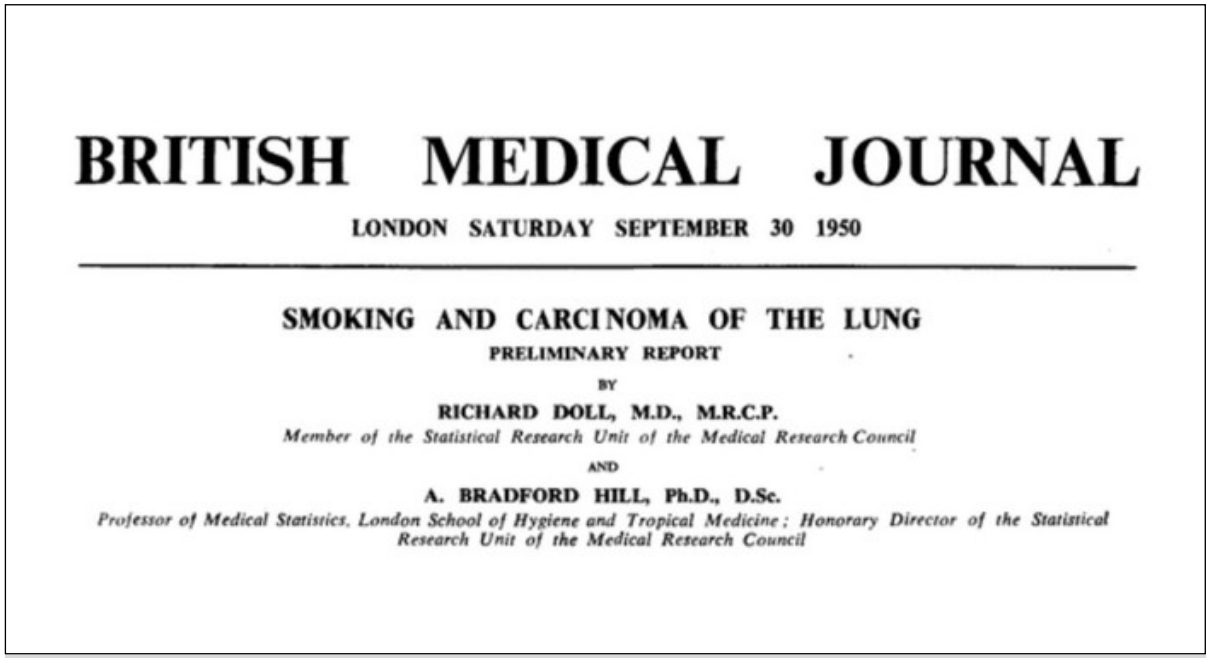
> "I started smoking at 13 and getting through 20 cigarettes a day. Lots of people smoked in Paulsgrove back then, it was what everyone did. I wish I'd never touched a cigarette, now I've got heart problems and COPD."
>
> Tony, Paulsgrove.

Scientific breakthrough: 1950s–1960s

A landmark UK study was published by Doll & Bradford Hill in 1950, linking smoking and carcinoma of the lung, which stated that smoking was an important cause of lung cancer.[32]



1946 advertisement.[33]



BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 30 1950

SMOKING AND CARCINOMA OF THE LUNG

PRELIMINARY REPORT

BY

RICHARD DOLL, M.D., M.R.C.P.

Member of the Statistical Research Unit of the Medical Research Council

AND

A. BRADFORD HILL, Ph.D., D.Sc.

Professor of Medical Statistics, London School of Hygiene and Tropical Medicine; Honorary Director of the Statistical Research Unit of the Medical Research Council

Headline in the British Medical Journal, 1952. Available from: *http://www.epi.umn.edu/cvdepi/document/a-study-of-the-aetiology-of-carcinoma-of-the-lung*

This evidence started to help shift smoking from a normal personal habit to a recognised cause of preventable illness and death. This created the argument for smokefree policies and stop-smoking support.

This was followed up with a 1954 study, which sent out over 34,000 questionnaires to male British physicians, to record details of their smoking habits. It showed a higher mortality in smokers, compared to non-smokers, and concluded that lung cancer could not be attributed to pollution exposure.[34]

Just as research helped transform our understanding of smoking and led to policies that improved population health, research continues to play a vital role in tackling today's health inequalities. Through our Health Determinants Research Collaboration (HDRC), we are strengthening how evidence, learning and community insight inform decisions across Portsmouth.

Regulation and shift in public opinion: 1960s–1990s

Throughout the late 20th century, some controls on tobacco were introduced, but many remained voluntary. In 1965, cigarettes were banned from being advertised on television and taxation on cigarettes slowly began to increase.

In 1974, the first national publication of smoking rates showed an estimated 44% of the population smoked.[35]

Public opinion began to shift and in 1984 National No Smoking Day was launched to encourage smokers to quit smoking.

During the 1980s and 1990s, evidence accumulated showing the substantial cost of smoking related diseases to the NHS and wider economy, including:

- The costs of treating smoking-related cancers, heart disease and respiratory illness.
- Productivity losses from sickness and premature mortality.
- The financial burden on public services in the city.

Smokefree environments and stop smoking support: 2000–2015

In the early 2000s legislation on tobacco really began to change.

The introduction of smokefree legislation in 2007 meant smoking was no longer permitted in pubs, restaurants, workplaces and enclosed public spaces, reducing exposure to second-hand smoke for residents and workers. The legislation marked a major shift in social norms, helping make smoking less visible and less acceptable, while supporting more smokers to consider quitting.


STUBBED OUT!

MPs vote for smoking ban in pubs and clubs from 2007 (but NOT in the Commons bar)

SMOKING is all pubs, clubs, restaurants and workplaces will be outlawed by summer next year.

Front Page from The Daily Mail, 2004. Available from: *dailymail.com/news/article-13791941/how-britain-looked-2007-smoking-ban.html*

The estimated smoking prevalence in Portsmouth was 24.7% in 2011 and down to 21.5% in 2014, however the rates differed for some population groups.[36]

- **Smoking at time of giving birth**: 17.9% in 2011 and 15.9% in 2014.
- **Routine and manual workers**: 35% and down to 29.9% in 2014.
- **Adults with long-term mental health conditions**: 40.1% in 2013/2014.

The Portsmouth Wellbeing Service was launched in October 2015, with the mission of helping those who live or work in Portsmouth to stop smoking, drink less alcohol and get to a healthy weight.

The service works across some of the most deprived areas of the city and can provide free stop smoking products to residents such as nicotine replacement therapy and stop smoking medications.

In 2015, the Public Health England evidence review concluded that e-cigarettes are substantially less harmful than smoking and can support quitting.[37]



Public health message stressing the relative safety of e-cigarettes. Available from: *bbc.co.uk/news/health-66852503*

Growth of Portsmouth stop smoking support and declining smoking rates: 2016–2025

Stop smoking support increased throughout the city with the Wellbeing Service being the main provider, supporting people in-person and via telephone. Local pharmacies were also commissioned to provide support to residents as well as Tobacco Dependency Advisors being recruited to work within our hospitals.

Our local stop smoking campaigns progressed to include sharing the annual national Stoptober campaign to local stop smoking campaigns – a contrast to the advertisements promoting smoking seen in 1926.

In 2025 Portsmouth Wellbeing Service celebrated its 10-year anniversary, having supported over 10,000 quit attempts with residents.[38]

"What began as one-to-one client sessions only has now grown into a multifaceted support system, including drop-in clinics, group interventions, and telephone support ensuring we meet the diverse needs of our community. We have supported thousands of individuals in making sustainable lifestyle changes. We don't just help people quit smoking, lose weight, or reduce alcohol consumption anymore, we offer a holistic experience that helps clients explore and address underlying factors contributing to unhealthy or risky behaviours."

Sophie, Senior Practitioner, Wellbeing Service.







Above: Portsmouth City Council Wellbeing Service stop smoking campaign poster.

Far left: Stoptober campaign banner.

Left: Stoptober promotional poster for the NHS John Jenkins drop-in clinic.

Overall, smoking rates are reducing but remain high in certain population groups (shown below).

Table 2: Portsmouth smoking prevalence 2016 and 2025[36]

Smoking prevalence	2016		2025	
	Portsmouth	England	Portsmouth	England
Adult population	20.1%	15.5%	10.5%	10.4%
Smoking at time of giving birth	13.2%	11.0%	6.8%	6.1%
Routine and manual workers	25.3%	26.5%	19.3%	19.2%
Adults with long-term mental health conditions	37.1%	33.0%	28.7%	24.0%

Reflection and looking forward

Over the last century, smoking has shifted from being widely accepted to being recognised as a major preventable cause of illness and inequality. National legislation is going further in protecting future generations from the harms of smoking. Fewer Portsmouth residents now smoke, and support to quit is more available than ever.

Wider tobacco control and smokefree generation: 2026 onwards

Stop smoking support – As well as the services providing support across the city, residents now also have access to digital support via the smokefree app.

Youth vaping – A Needs Assessment with young people throughout the city was completed. 171 young people provided the public health team with feedback and recommendations on what we can do to protect them from the harms of vaping. This included training trusted adults and creating a peer-led education programme.

Trading Standards – Public Health undertake partnership work with the Council's Trading Standards team to tackle illicit tobacco, illegal vapes and underage sales continues. The team supports national initiatives such as Operation Viper and uses local intelligence to remove large quantities of illegal products from Portsmouth retailers.

Smokefree Alliance – The Portsmouth Smokefree Alliance moves into its second year. The Alliance brings together partners from local government, NHS services, pharmacies, education and VCSE organisations to deliver the **Portsmouth Tobacco Control Plan**,[39] with future priorities focused on reducing smoking-related health inequalities, supporting more people to quit, preventing youth smoking and vaping, tackling illicit tobacco and vapes, and strengthening system-wide collaboration.

Tobacco and Vapes bill – The Tobacco and Vapes Bill gained Royal Assent on 29 April 2026. This landmark Act will introduce measures to create a smokefree generation, including making it illegal to sell tobacco to anyone born on or after 1 January 2009. It will also strengthen restrictions on vape sales and marketing, as well as introducing new enforcement powers and a retailer licensing team.

> "I started smoking at 15, you could buy cigarettes in fives, and children could collect them from the shop with a note from their parents. Looking back, it's hard to believe children could walk into a shop and buy cigarettes!" Celia, 82, Paulsgrove.

5 Dental health

Key dates

1926

Dental care depended on ability to pay; decay, tooth loss and extractions were common, while school dental services were emerging.

1948

Free NHS dental care reduced the wealth divide, but tooth decay and unmet need remained high as care shifted towards treatment and restoration.

1980s–2000s

Fluoride toothpaste, brushing and public health messaging reduced decay, with dentistry focusing more on prevention, saving teeth and tackling sugar, diet and inequality.

2026

Poor oral health is largely preventable, but deprivation and access inequalities persist despite stronger prevention and targeted programmes.

From extraction to prevention

In the past 100 years there have been many positive changes around dentistry including prevention and treatment options.

In the 1920s specific dental data was limited and is difficult to obtain, but wider neighbourhood health inequalities were already visible as set out in the 1926 Medical Officer of Health report.

Population-level data on dental health only became routinely available in the late 1990s, when dental records became digitalised. However, from generic written reports we can confidently say dental health was poor 100 years ago and has been improving, due to:

- **Advancement in the dental profession** – Dentists Act 1921 formalised training and registration, aided further by the creation of General Dental Service and frameworks under the NHS in 1948.
- **Improved knowledge on preventative approaches** – i.e. regular toothbrushing, fluoride toothpaste (instead of salt powder), impact of dietary behaviours, fillings instead of teeth removal etc.

Royal Navy dentists: keeping the fleet mission-ready at sea

As a proud navy city, ensuring the health and wellbeing of serving personnel is key to keeping crews healthy, deployable and mission-ready. One area that has changed considerably in the last 100 years is dental health.[40]

- **Basic care** – 100 years ago rotten teeth and scurvy were common, with poor disinfection of instruments just as dangerous to sailors' lives. Historically, the ship surgeons carried out basic dental treatment alongside other medical duties.
- **A modern transformation** – a major turning point came in the early 1960s when purpose-designed dental surgeries were first incorporated into Royal Navy ship design. Modern vessels include dedicated dental facilities, from portable units on frigates to fully equipped surgeries and laboratories on HMS Queen Elizabeth.
- **A unique clinical environment** – Royal Navy dentistry has evolved into a specialist service with treatment delivered aboard warships, often at sea and in challenging conditions, requiring specialist skills and adaptable equipment, to help maintain operational readiness, ensuring sailors are fit to deploy anywhere in the world.



Toothpulling, a frequently performed dental procedure, was frequently staged in comedic performance, ca. 1892. National Library of Medicine #101393641. Available from: *medicineonscreen.nlm.nih.gov/2015/02/05/come-with-me-into-the-visual-instruction-room*



Has oral health and dentistry really changed?

Yes:

Dental health in 1926 = poor	Dental health in 2026 = superior, but room for improvement
○ Tooth decay was widespread, and natural teeth for life was unusual.	○ Although tooth decay is still common, advances in prevention and treatment mean most people keep the majority of their teeth for life.
○ Dental hygiene education was emerging, but not yet widespread or standardised.	○ Major improvements in oral health promotion, with regular brushing, fluoride and dietary messaging central to campaigns. Preventing tooth decay is the focus.
○ Many people delayed care until pain became severe and then tooth removal was common. NHS didn't arrive until 1948.	○ NHS dental services are available across the UK, with many treatments free or subsidised, resulting in wider engagement with dental services and earlier treatment.
○ Dentistry was often reactive, painful, and focused on removing the problem – tooth extractions – rather than saving teeth.	○ Dentistry is a recognised profession within health, with national systems and guidelines. Advanced treatments save teeth, with extractions often a last resort.

In 100 years, we moved from extraction-focused care to prevention and tooth-saving treatment.

No:

Supervised toothbrushing

The school 'Toothbrush Drill' in the 1920s has been replaced by 'supervised toothbrushing' in 2025. We currently have 32 early year settings and schools participating in our Portsmouth 'supervised toothbrushing' programme delivered by the University of Portsmouth Dental Academy and the NHS Specialist Dental Team from the local Community Health Trust.



Toothbrush Drill at a school in England circa 1920. Available from: *wellcomecollection.org/works/y79uekby*

These are similar interventions, with the emphasis of preventing poor oral health/ tooth decay in children.

> "Dentist came in to school every 6 months and you would get toothpaste in a tin and get a toothbrush, used to make it last."
>
> Carole, Brenda and Jan, Portsea Hub.



BBC News Headline March 2025. Available from: *bbc.co.uk/news/articles/cn8r4vx4j38o*

Inequalities – socioeconomic status

In 1926 the inequalities between rich and poor were in terms of ability (funds) to access dentists, however today, despite free NHS access for all, we see similar issues.

Poor oral health/tooth decay is more prevalent within our more deprived communities, with diet and access to dentists two key factors. Children living in deprived areas are three times more likely to need dental extractions in hospital.[41]

Analyses (published in 2023) carried out by the University of Portsmouth, involving data relating to local school aged children, highlights significant oral health inequalities that still exist in Portsmouth[42]:

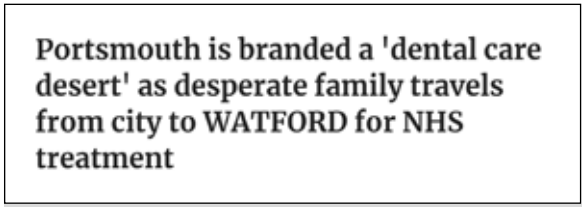
- 5,860 appointments analysed aged 0-17 years, 2018-2022.
- Nearly 3 x rise in child emergency dental pain appointments between 2018 and 2022.
- 24% of 2022 emergency pain appointments were under 18 year olds.

Limited access to NHS dentists and cost of treatment can be barriers, leading to self-administered dental care like we'd have seen 100 years ago i.e. removal of own teeth, as was reported in the news in 2025.[43] Alternatively many people are finding they have to travel long distances for an NHS dentist.[44]

> "Dental visits felt straightforward back then, but now they seem out of reach for many people." Tony, Paulsgrove.



Headline from The Guardian 2025. Available from: *theguardian.com/society/2025/dec/15/people-pulling-own-teeth-due-to-lack-of-urgent-nhs-dental-care-in-england-watchdog-finds*



Headline from The News, 2022. Available from: *portsmouth.co.uk/news/people/portsmouth-is-branded-a-dental-care-desert-as-desperate-family-travels-from-city-to-watford-for-nhs-treatment-3743629*

Reflection and looking forward

We've moved from pulling teeth to preventing disease, but as we look towards the next 100 years, we need to build on the positive preventative approaches already in place and work collaboratively to reduce the gap in oral health outcomes between our most and least deprived communities.

With extensive collaboration between partners across the city, the University of Portsmouth Dental Academy was successful in their bid to become a full dental school.[45] This secures the future of dentistry locally, increasing capacity, knowledge and skills, building a sustainable workforce to support the oral health challenges faced by Portsmouth residents in the years to come.

Whilst much focus of targeted oral health interventions is with children from deprived communities, at the other end of the scale, modern technological advances, for example, intraoral cameras are being used with our older population living in residential homes, to support earlier treatment and preventative care.[46]



University of Portsmouth Dental Academy



6 Childhood infections

Key dates

Vaccines introduced

1942 Diphtheria.

1950 BCG (TB).

1956 Inactivated polio.

1957 Pertussis.

1961 Tetanus.

1962 Live oral polio.

1968 Measles.

1970 Rubella.

1988 MMR.

1992 Hib conjugate.

Infant mortality has long been used as an indicator of the general health of the entire population, reflecting wider social, economic and environmental conditions as well as the quality of healthcare available to mothers and babies.[47] A century ago in Portsmouth childhood illness, infection and death were sadly a normal part of life.

Infant survival has improved dramatically in Portsmouth, mirroring the national picture over the past century. In 1926, there were 247 infant deaths (under one year of age), equivalent to an infant mortality rate of 54.9 deaths per 1,000 live births. By 2024, this had fallen to just seven infant deaths, with a rate of 3.4 deaths per 1,000 live births.[48] Relative to its time, Portsmouth performed better than England and Wales in 1926, where the infant mortality rate was 70 deaths per 1,000 live births. Today (2022-24), Portsmouth's rate remains statistically similar to the England average of 4.2 deaths per 1,000 live births.[46]

Poverty, crowded housing and poor sanitation were major drivers of the spread of infection in 1926. At that time, infant mortality varied substantially across Portsmouth's wards, ranging from 35 deaths per 1,000 births in Buckland to 88 in St. Mary. The highest rates were recorded in St. Mary, Mile End and Town Hall, while Buckland, St. Simon and North End experienced the lowest rates.[1] The variation between wards highlights the significant health inequalities that existed within the city.

The rate of deaths in infants under one year of age per 1,000 births was 103 in babies born to unmarried mothers compared to 52 per 1,000 births in married mothers.

At the time, unmarried mothers and their children were more likely to have faced a life of poverty and social exclusion. Strong social stigma, limited employment opportunities, inadequate maintenance payments from fathers and restricted welfare provision left many women economically vulnerable.[49]

Apart from prematurity and congenital conditions, which were responsible for 28% of deaths in under 5s (112/395), Table 3 outlines the leading causes of death in this age group.

Table 3: Leading causes of death in 0–5-year-olds in 1926.[1]

Disease	Deaths
Broncho-pneumonia	59
Diarrhoea and enteritis	39
Diphtheria	30
Whooping cough	16
Measles	11

Vaccine-preventable diseases: then vs. now

In 1926, 98% of deaths from diphtheria were sadly in children aged under 15 years (65/66 deaths). In fact, 45% of deaths were specifically in children under five years old. That year there were 947 cases of diphtheria in Portsmouth and 924 of them were admitted to hospital.

Diphtheria was one of the most feared childhood diseases at the time, often suffocating young children through swelling in their throats. Other now vaccine preventable diseases such as polio left some children with permanent paralysis. Others like measles, scarlet fever and tuberculosis also caused significant ill health

in children and disrupted their families' lives. Many were helpless to prevent this from happening. 10% of deaths from tuberculosis in 1926 were in children under 5.

> "…Every house from which a case of diphtheria was notified was visited… nearly every case was isolated in hospital; contacts were kept away from school, and various other measures were taken that seemed likely to control the disease. The spread of diphtheria must be largely due to undetected carriers, and to children with infective nasal discharge…" Dr. A. Mearns Fraser.[1]

Today, universal routine childhood immunisations have made many of these diseases rare in Portsmouth and in the UK overall.

What changed?

The decrease in childhood infections over the last 100 years was not achieved by any one intervention or action. Decades of coordinated public health action towards prevention across healthcare, nutrition, housing, education, sanitation and maternity care has led to fewer childhood infections:

- The rollout of local vaccination campaigns initially and then widely coordinated and provided to the public via the NHS after its creation in 1948. For example, vaccination against Diphtheria was approved by the Health Committee in Portsmouth in 1935 ahead of the national roll out in 1946. Table 4 describes changes in numbers of cases and deaths over the last 100 years.
- Inspection of food and supervision of food handling to prevent contamination and improve hygiene standards and appropriate food handling.
- Improvements in housing and sanitation to limit opportunities for infection transmission.
- Improved access to health visitors and midwives to improve pre- and postnatal care for mother and baby.
- Better nutrition to improve children's health e.g. free milk and vitamins to expectant mothers and young children and the provision of meals and milk in schools.
- Better treatment for infectious disease in hospitals.

> "School vaccinations were a big event – the whole class queued up and waited their turn. After our BCG vaccinations, we were sent for chest X-rays. Today, that would seem extraordinary." Celia, 82, Paulsgrove.

> "I was a milk monitor at school (7yrs old), everyone wanted to be a milk monitor. All the children in primary school got given milk, there wasn't much healthy food, so it was a way to make sure you had something good." Carole, 86, Buckland.



Carole at school (far right).

Where are we now?

Childhood deaths from infectious diseases have fallen dramatically since 1926 and many serious infections are now rare because of routine vaccination, improved living conditions and effective healthcare and treatment.

Table 4: Diphtheria cases and deaths in Portsmouth, 1926-2025[1,50]

Year	Cases	Deaths
1926	947	66
1935	422	39
1947	15	1
1965	0	0
1970	0	0
2025	195*	0

Notifications **NOT cases for c. diphtheriae and c. ulcerans, two bacteria that cause Diphtheria. There were no cases of diphtheria in Portsmouth in 2025. From January to December 2024, toxigenic corynebacteria were isolated from 12 individuals in England; 2 Corynebacterium diphtheriae (C. diphtheriae) cases and 10 Corynebacterium ulcerans (C. ulcerans) cases; there were no deaths.*[51]

Infectious diseases have not disappeared completely so prevention remains essential. Measles outbreaks have re-emerged in several parts of England in recent years where vaccination uptake has declined.

These outbreaks show that diseases can quickly return when herd immunity fails.

What is herd immunity?

It is an indirect form of protection that occurs when a large percentage of the population has become immune to infection usually through vaccination or past infection. This prevents the spread of infection.

Portsmouth, like many parts of the United Kingdom, continues to experience inequalities that influence children's health. Some families live in more deprived areas than others and have worse health outcomes associated with infectious disease, compared to those from less deprived areas. Many of these families face different challenges like accessing healthcare and adequate housing.

Vaccination uptake varies between communities due to differences in access and delaying or declining vaccination because of confusing or misleading information about vaccine safety.

Reflection and looking forward

The past 100 years demonstrate what can be achieved when science, public health and communities work together. Diseases that once caused fear across Portsmouth have been prevented through collective public health action. These achievements have saved countless lives and allowed generations of children to grow up healthier than ever before.

This progress should not be taken for granted. Infectious diseases continue to evolve, new health threats emerge, and existing diseases can return if vaccination rates decline. Protecting children requires ongoing commitment from communities, schools, healthcare professionals, local authorities and families.

The World Health Organization (WHO) recommends a target of 95% vaccination coverage to protect vulnerable groups – like newborns, the elderly, and the immunosuppressed – who may not be able to be vaccinated themselves. In 2024-2025, 86.9% of 5-year-olds in Portsmouth received two doses of the measles, mumps, rubella (MMR) vaccine; 94.3% received at least one dose. In the same period, 86.6% received the fourth dose of the diphtheria

tetanus polio and pertussis (Dtap/IPV) vaccine booster. Although these levels were higher than the England rate, they did not meet the national target of 95% coverage, and this means that many of our children are not fully protected against these vaccine-preventable diseases.

Looking to the future, prevention remains one of the most effective investments in children's health. Maintaining high vaccination uptake, tackling health inequalities, supporting parents with trusted information and responding quickly to emerging infections will help ensure that future generations enjoy the same protection achieved over the last century.

The rapid spread of misinformation through social media presents a modern public health challenge that did not exist for previous generations. The next 100 years will depend on maintaining a strong commitment to prevention and reducing health inequalities, so every child has the healthiest possible start in life.



7 Air, water, housing and ill health

Key dates

1909
Housing and Town Planning Act empowered councils to inspect housing, plan towns and prevent substandard back-to-back homes.

1919
Addison Act introduced state-subsidised social housing and boosted council housebuilding.

1926
Public Health (Smoke Abatement) Act gave councils stronger powers to tackle smoke pollution.

1945
Water Act laid the foundations for a coordinated national water supply policy.

1956
Clean Air Act introduced smoke control areas following the deadly 1952 Great Smog.

1974
Control of Pollution Act strengthened pollution controls and the "polluter pays" principle.

1995
Environment Act introduced local air quality management duties.

2004
Housing Act introduced the HHSRS and mandatory licensing for larger HMOs.

2020
Ella Adoo-Kissi-Debrah became the first person in the UK to have air pollution listed as a cause of death.

2021
Environment Act set long-term environmental targets and duties to reduce storm overflow impacts.

2022
Building Safety Act reformed high-rise safety following the Grenfell Tower tragedy.

2025
Awaab's Law Phase 1 set strict timescales for social landlords to investigate and fix damp, mould and emergency hazards.

2025
Water (Special Measures) Act strengthened monitoring, fines and enforcement over sewage spills.

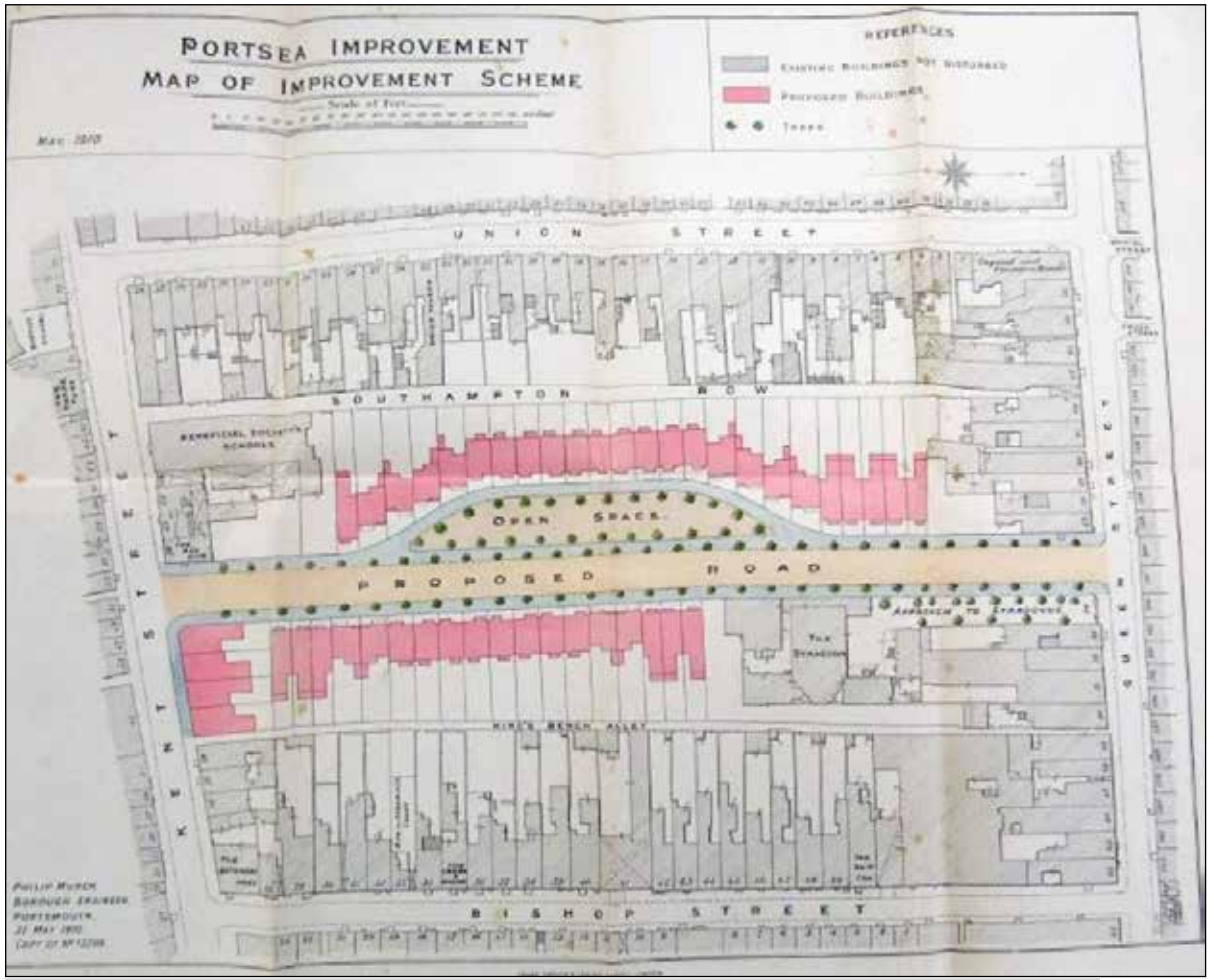
2026
Awaab's Law Phase 2 extended urgent response duties to more social housing hazards.

A lung for the neighbourhood

By 1926, the Medical Officer of Health, Andrew Mearns Fraser had already been in post for 31 years and had established himself as a progressive thinker and public health reformer.

In a 1910 report entitled 'Improvement Scheme for an Unhealthy Area in Portsea', rather than simply calling for slum clearance, he recommended an inner-city town planning scheme not unlike those proposed today, such as the Somers Orchard development.[52] A notable feature of Mearns Fraser's proposal was a central square 'planted with trees, which shall be a lung for the neighbourhood, and afford a playground for children'.[53]

This same approach – improving health and wellbeing by working with other parts of the Council (including the Transport, Planning, Housing, and the Climate Resilience and Natural Environment teams) – informs the work of public health today; our focus is on those parts of the city where the need is greatest. Parks and open spaces remain lungs for neighbourhoods, while trees and other green and natural infrastructure can protect against air pollution, soak up excess water during periods of heavy rainfall, and



Portsea Improvement Scheme Map. Available from: *municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i*

help keep the city cool during heatwaves. The Council's **Nature Positive Portsmouth**[54] programme is one way we are achieving this today.

Air quality 1926

1926 saw the introduction of the Public Health (Smoke Abatement) Act. This updated previous laws from 1875 and 1891 and gave Local Authorities expanded powers to take action against industrial and domestic smoke emissions that were causing "nuisance" to public health.

We don't have local contemporary records of what air quality was like in Portsmouth in 1926, but we can infer that levels of pollution were much higher and more harmful to health than today. Especially in winter, the air would have been filled with coal smoke from both domestic and industrial chimneys; Portsmouth dockyard was thought to be the largest industrial site on earth in the nineteenth century. Inevitably, this would have contributed to significant levels of lung disease in the city, in addition to other risk factors such as high smoking rates, and poor housing conditions.[55]

The Health Report for the Year of 1926 details that there were 376 deaths that year from respiratory diseases (14% of deaths from all causes), with 349 of those from bronchitis or pneumonia. These were spread across the age range but particularly affected the 0-5 age group and older people.[1] While it's not possible to say categorically that Portsmouth's air quality in 1926 caused these deaths – infectious diseases would also have contributed – we suspect it may have led to many dying earlier than they otherwise might. No less than 29 factories, workshops and workplaces were found to be in 'want of ventilation' during the previous year, with this lack remedied in all cases, showing that a hundred years ago, there was strong local environmental health regulation and enforcement.



Dockyardmen at outmuster crossing tram lines at the Commercial Road Junction with Edinburgh Road, circa 1920s. Available from: *portsmouth.co.uk/heritage-and-retro/retro/9-photos-of-cyclists-and-their-bicycles-through-the-years-3290283*

Although the city's air quality was afforded greater protection than London owing to offshore winds, in certain weather conditions – a layer of warm air trapping a layer of cold, polluted air – maritime fog will have transformed into a sulphurous smog. These 'pea-soupers' contributed to immediate and long-term respiratory and cardiovascular complications. City smog was eventually tackled through the Clean Air Act in 1956.

Today, about half the air pollution in the city results from road transport. However, car ownership was only beginning to take off in the 1920s and was yet to have a significant impact on air quality, with most people commuting to work by bike, on foot, or making use of electric trams or motorbuses run by Portsmouth Corporation Transport. Photographs from the time show workers leaving the Naval Dockyard en masse on cycles.[56]

> "It's all changed so much – you were lucky if you had a car. Most people would take public transport. Most cars were unreliable too."
>
> Rose, 61, lived most of life in Drayton/Farlington.

Air quality 2026

Today we know better than ever that our neighbourhoods need the lungs that green and open spaces provide. When we consulted Portsmouth residents about air pollution in 2025, 73% of respondents were concerned about air pollution, and 69% felt that the air in their own neighbourhoods is particularly polluted some or all the time. 91% wanted us to use trees, hedges and other planting (natural infrastructure) to improve air quality.

Understanding that there is no safe level of air pollution, and that those who are most at risk include children, pregnant women and their unborn babies, older people, people with pre-existing health conditions, and those living in the most deprived areas of the city, we have developed our **Clean Air Strategy 2026 – 2040: Improving Air Quality for a Green and Healthy Future**.[57]

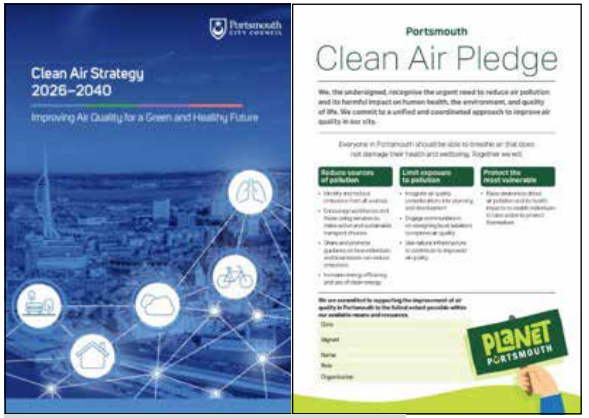
Its mission statement is:

> Everyone in Portsmouth should be able to breathe air that does not damage their health and wellbeing. We will:
>
> - Prevent sources of pollution
> - Limit exposure to pollution
> - Protect the most vulnerable

The action to use natural infrastructure to improve air quality echoes Mearns Fraser a hundred years on, as we strive to further develop the city's green lungs.

Since 2018, the estimated mortality burden associated with long-term exposure to particulate air pollution has decreased in Portsmouth. In 2024, the proportion of deaths attributable to long-term exposure to particulate matter air pollution was below the England average for the first time, accounting for 4.9% of all deaths among those aged 30 years and over in Portsmouth, compared with 5.3% in England. This is an improvement from 2020, when the corresponding figure was 6.9%, around 1.3 percentage points above the England average.

However, we must continue to further improve air quality. Through the Portsmouth Clean Air Pledge, along with our partners in the city, we have committed to a unified and coordinated approach to improve air quality in our city.



Clean Air Strategy and Clean Air Pledge documents.



Clean air pledge signing, January 2026.

Water quality 1926

In the 1920s, Portsmouth's drinking water was of excellent quality, sourced from pure South Downs chalk aquifers and treated at the Farlington filtration works. However, the city's coastal and harbour waters were highly polluted, as untreated municipal sewage and naval waste were frequently discharged directly into tidal creeks and the Solent. Built in 1865 to combat cholera epidemics, the Victorian-engineered Eastney Pumping Station used massive steam-powered beam engines to pump sewage out to sea.[58] While this kept the streets clear of sewage, the discharge of raw waste into coastal waters remained an ongoing environmental and bathing water quality challenge. In 1926, there were 14 cases of enteric or typhoid fever – a huge reduction from the 1083 cases and 92 deaths in 1900.

Flooding was also an issue in 1926, with substantial coastal flooding that year in Portchester.[59] Until flood defences were installed later in the twentieth century, areas of the city would regularly flood, particularly parts of Old Portsmouth.[60]



Portsmouth flooding in 1913. Available from: *historyinportsmouth.co.uk/events/broad-street-floods.htm*

Water quality 2026

A hundred years on, water quality remains a public health issue. Faecal bacteria (for example Escherichia coli, E.coli) can be harmful to health if ingested from bathing water or shellfish.[61] The Environment Agency monitors water quality, and current classifications for Southsea East and Eastney are considered 'poor' and 'good', respectively.[62] The source of the faecal bacteria at these bathing waters may be from several sources, including: agricultural sources, sewage, and other sources including urban runoff, dogs and birds.

Climate change has a range of water quality impacts, including changes to river flow, groundwater recharge and water temperatures. Rainfall patterns will change and winter rainfall will occur in heavy events while summer rainfall will decrease. The trend of more intense rainfall events is expected to continue.

Housing and built environment 1926

In a report to the Town Council in 1909, Mearns Fraser described the slum conditions in which people were living in the 'courts and dwellings' of Portsea:

> "... the narrowness, closeness, bad arrangement and bad condition of the streets and houses and groups of houses, together with the want of light, air, ventilation and proper conveniences, and other sanitary defects, are dangerous and injurious to the health of the inhabitants of the buildings in the said area, and that the evils connected with such

> houses, streets, courts and alleys and the sanitary defects in the area cannot be effectually remedied otherwise than by an Improvement Scheme for the re-arrangement and reconstruction of the streets and houses within said area."[63]

Mortality rates in the slums were more than double those in the rest of Hampshire, with a third of deaths from tuberculosis.[17] Often, children died before the age of two from gastric and intestinal illnesses. Overcrowding led to the spread of infectious diseases such as tuberculosis and diphtheria.[17]

In response to these concerns and stark living conditions, the Garden City Movement had been founded in Britain by Sir Ebenezer Howard. His influential book, Garden Cities of Tomorrow (1898) 'promoted self-contained communities, surrounding greenbelts, and carefully balanced areas of homes, industry, and agriculture.' His vision inspired local town planners to develop the 'garden village' estates which emerged around Wymering and Henderson Road in Eastney from the early 1920s.[17] Howard's ideals remain influential to this day.

Mearns Fraser recognised this progress but continued to advocate for better housing for all. His 1926 report states that 'Although this year witnessed a considerable increase in the output of new houses [a total of 682], there still remains a long list of applicants for housing accommodation, many of whom are in urgent need – families of five, six and seven who have at present to live in a couple of furnished rooms.'[1]

> "I didn't have a bedroom, I slept in the front room on put-me-up bed. My clothes were kept in a sideboard and every morning my bed was packed away. It became the family's Sunday best room during the day."
>
> Celia, 82, Paulsgrove.



Houses on Medina Road, Wymering, dated 1924. Available from: *municipaldreams.wordpress.com/2020/04/21/council-housing-in-portsmouth-part-i*

Housing and built environment 2026

The relationship between housing and health remains clear today. Census 2021 includes a measure of housing deprivation based on whether a household is overcrowded, lives in shared accommodation, or lacks central heating. Using this measure, analysis by the Health Foundation explored the relationship between housing deprivation and life expectancy at birth across middle layer super output areas (MSOAs), neighbourhoods of around 5,000 to 15,000 residents. The findings showed that areas with higher levels of housing deprivation generally experienced lower life expectancy at birth, highlighting the continued importance of good housing as a determinant of health.

Portsdown and Drayton West (Cosham North) MSOA is the least housing deprived area in Portsmouth, ranking within the least deprived 20% of MSOAs nationally on the housing deprivation measure. It also has one of the highest life expectancies at birth in the city, at 83.9 years for women and 81.0 years for men. In contrast, South Landport (Fratton West) MSOA is the most housing

deprived area in Portsmouth, ranking within the most deprived 10% of MSOAs nationally, and has one of the lowest life expectancies at birth in the city, at 78.7 years for women and 75.1 years for men.[64]

In 2026, we understand that good housing is not just about what our individual homes are like – it's also about the place we live in, how healthy it is and how safe it feels. Do we have easy access to a wide range of amenities, including doctors, food shops, and leisure centres? Are there good public transport links and active ways of getting around – from where we live, can we easily walk, wheel and cycle around the city? And knowing how they benefit both physical and mental health, our neighbourhoods still need the lungs provided by green and open spaces.

Public Health works with the Housing, Planning, Transport and Climate Resilience and Natural Environment teams to help ensure that we have (and can further develop) both healthy homes and healthy places, which in turn promote healthy communities. The Healthy Streets indicators tool (pictured) is one way of measuring this.[65]

Although fewer people are becoming ill or dying because of poor housing conditions than was the case in 1926, the state of our housing still has a significant impact on our health and wellbeing. Health can be harmed if homes are too cold in winter or too hot in summer, while increasingly we understand that noise and indoor air pollution can impact on health in the long-term.

In 2024/25, 2,565 households in Portsmouth were assessed as being owed a prevention or relief duty under the Homelessness Reduction Act. The rate was 28.0 per 1,000 households, significantly higher than England (13.8 per 1,000 households), the South East region (11.2 per 1,000 households) and Southampton (18.7 per 1,000 households). The Portsmouth rate has increased from 19.6 per 1,000 households in 2019/20, suggesting an increasing level of statutory homelessness need within the city.[66]



Healthy Streets Indicator Tool. Available from: *healthystreets.com/what-is-healthy-streets*

Public Health works with the Council's Housing, Neighbourhoods & Buildings team as well as the local NHS and Voluntary, Community, and Social Enterprise (VCSE) sector to address these issues and ensure that everyone can benefit from good quality, affordable, energy-efficient housing located in safe and healthy places.

Reflection and looking forward

Launched in 2021, the **Imagine Portsmouth**[67] vision of a healthy, happy and green city in 2040 remains our guiding light. While we have made progress towards this vision in the last five years, there is more to do, and more to come, as we strive to make our air and water cleaner, and our city more sustainable as well as increasingly resilient to the effects of climate change.

The vision for a healthy and happy city

We do everything we can to enhance wellbeing for everyone in our city by offering the education, care and support that every individual needs for their physical and mental health. All our residents and communities live in good homes where they feel safe, feel like they belong, and can thrive.

The vision for a green city

We have excellent air quality because of our green spaces and sustainable transport, and this means our people live healthy and active lives. We are carbon neutral, use renewable energy and actively work to address climate change. We protect and enhance both our land and maritime environment for future generations.



Artist's impression of Somers Orchard. Available from: *portsmouth.co.uk/news/politics/council-signs-off-first-phase-of-somers-orchard-redevelopment-5619021*

Supplementary Information

Density, geography and historic boundaries

Portsmouth was already a compact urban area in the 1920s, but the distribution of population within the city was very different. Before 1920, the Borough was largely limited to Portsea Island. In 1920, the boundary was extended northwards to include mainland areas such as what is now Drayton and Farlington, Cosham and Paulsgrove.

Although the Borough boundary had expanded by 1926, much of the population remained concentrated on Portsea Island, particularly in the built-up neighbourhoods stretching from Stamshaw through central Portsmouth to Southsea. Many mainland areas that now contain large residential communities were comparatively lightly populated at the time.

Overall population density was around 7,675 people per km² in 1926 and today is lower at about 5,307 people per km². The highest ward density in 1926 was about 33,817 people per km² in historic St Mary and today it's about 15,868 people per km² in the most densely populated ward. The lowest ward density in 1926 was around 338 people per km² (Cosham) and today is about 2,450 people per km².

The historic Cosham ward should not be interpreted as equivalent to the modern ward. The 1926 Cosham ward covered a much larger and geographically different area and had a very different population distribution. Direct comparison with today therefore needs caution.[68]

Table 5: Electoral Ward Population Density comparing 1926 to today[1]

Density measure	1926	2024	Interpretation
Overall density	7,675/km²	5,307/km²	Lower overall city density today.
Highest ward density	33,817/km²	15,868/km²	Historic St Mary was far denser than the highest-density ward today.
Lowest ward density	338/km²	2,450/km²	Formerly low-density northern mainland areas are now more urbanised.

Overcrowding

Housing conditions have improved substantially since the 1920s. Large households and very high inner-city densities made overcrowding a much more widespread public health concern in the early twentieth century. Today, lower household size and lower overall population density point to major long-term improvement in living conditions and health protection.

However, improvement does not mean that overcrowding has disappeared. Census 2021 data show that some households in Portsmouth still have at least two fewer rooms than required under the Census occupancy standard. Severe overcrowding affected 0.8% of Portsmouth households overall, but the distribution was uneven across the city. The highest rates were found in neighbourhoods within St Thomas, Charles Dickens and Nelson wards (Table 6). Although these wards contained the most affected areas, above-average levels of severe overcrowding were also evident in neighbourhoods across other parts of Portsmouth, including Paulsgrove and Hilsea.

Table 6: Top five neighbourhoods (LSOAs) with the highest percentage of households with at least two fewer rooms than required[69]

Area (Lower super output areas)	Severe overcrowding, Census 2021
Somers Town	4.6%
Landport	3.8%
Sultan Road South	3.7%
Portsmouth Church Road	2.9%
Buckland Kingston Crescent	2.6%
Portsmouth average	**0.8%**

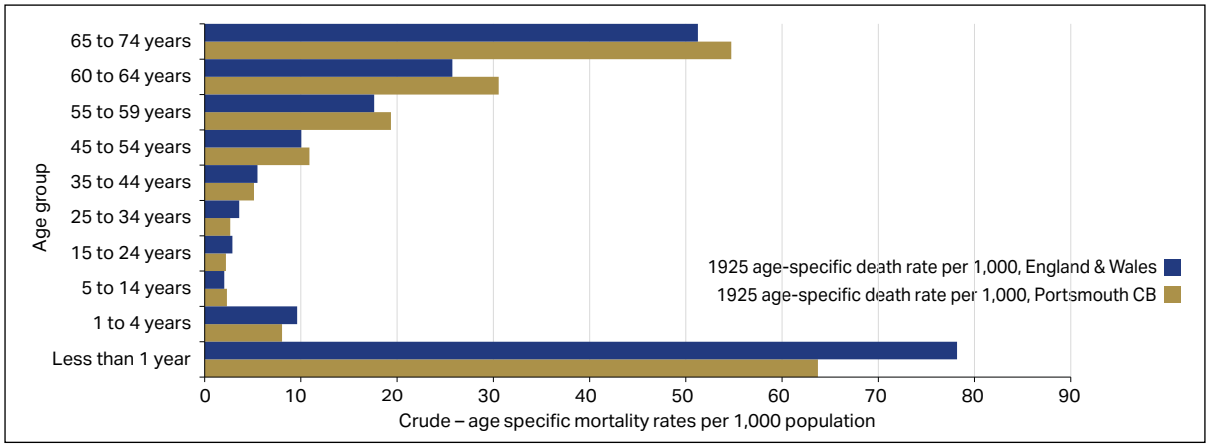
Births

Birth rates in Portsmouth, as in the rest of the country, are substantially lower than they were a century ago. In 1926, there were 4,496 live births in Portsmouth, compared with 2,039 in 2024.[1] The crude birth rate was 18.2 in 1926 to 9.5 per 1,000 population in 2024. This should be treated as a broad indicator rather than a fully comparable fertility measure, because crude birth rates do not adjust for the age and sex structure of the population. Relative to the national picture at the time, Portsmouth's birth rate in 1926 was slightly higher than the England and Wales rate of 17.8 births per 1,000 population. Today, Portsmouth's rate is broadly similar to the England average of 9.7 per 1,000 population.[70]

Age-specific mortality: Portsmouth and England in 1925

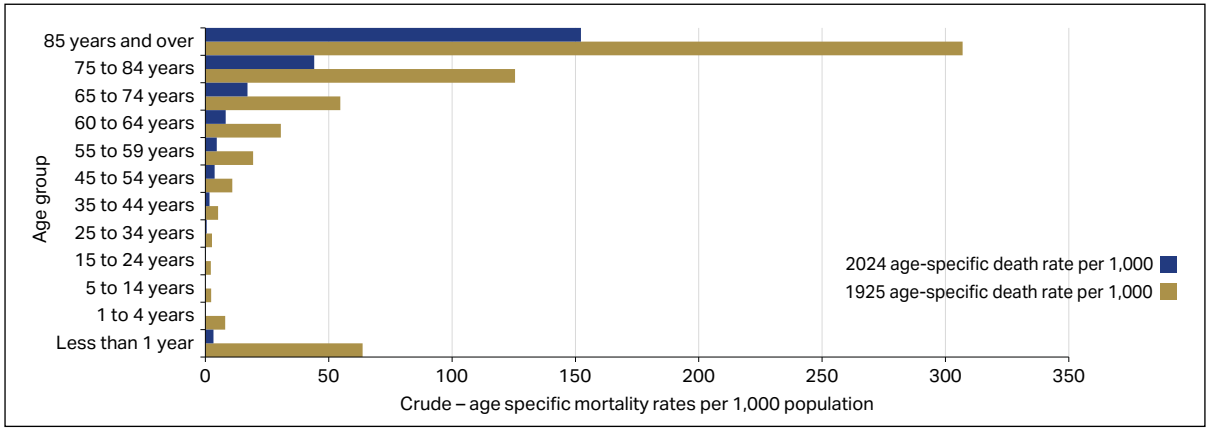
Age-specific mortality rates in 1925 were substantially higher than those seen today, particularly in infancy and older age. Figure 2 shows that Portsmouth and England and Wales shared a very similar mortality profile in 1925, with mortality highest in infancy, lowest during childhood and early adulthood, and increasing progressively with age. Figure 3 demonstrates how mortality rates have fallen across every age group over the past century. Mortality rates among children aged one to 14 years are now much lower than they were in 1925. Mortality rates at older ages have also declined substantially, although older people continue to experience the highest mortality rates. Together, these figures show that Portsmouth broadly reflected national mortality patterns in 1925 and that the risk of death at all ages is now considerably lower than it was a century ago.[71]

Figure 2: Chart showing the age-specific mortality rates per 1,000 population for Portsmouth compared to England in 1925 Data table



1925 sources: Portsmouth 1921 population, Census 2021, Nomis, ONS. Portsmouth 1925 deaths via [Report 1925] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection.Both the population and deaths for England and Wales obtained from Historic Mortality Data Files database, The National Archives. However, only 80+ years was available for E&W so ages 75 years and above cannot be compared to Portsmouth in 1925.

Figure 3: Chart showing the age-specific mortality rates per 1,000 population for Portsmouth CB in 1925 to Portsmouth UA in 2024 Data table



2024 sources: 2024 population, mid-year estimate, ONS. 2024 deaths by year of registration, Nomis, ONS. Note: Portsmouth number of deaths aged 1-14 years are suppressed due to small numbers.

Life expectancy and inequalities

A baby born in Portsmouth today has a life expectancy around 20 years longer than a century ago. Sex-specific life expectancy estimates are not available for Portsmouth in the 1920s, but it is possible to estimate that life expectancy at birth for Portsmouth residents overall increased from around 59.9 years in 1925[72] to 80.5 years today.

For England, life expectancy at birth in 1925 was around 57.7 years for males and 62.2 years for females,[73] compared with 79.8 and 83.6 years respectively today.[16] While direct sex-specific comparisons with Portsmouth are not possible for Portsmouth in 1925, the estimated life expectancy of 59.9 years for Portsmouth residents overall in 1925, together with the age-specific mortality patterns presented earlier, suggests Portsmouth was broadly similar to the national picture at the time. While life expectancy has increased substantially over the past century in both Portsmouth and England, in 2024, life expectancy at birth in Portsmouth remains below the national average, at 78.1 years for males and 82.7 years for females.[16]

Life expectancy also varies considerably within Portsmouth. In 2022-24, life expectancy at birth for males living in the most deprived 10% of Portsmouth neighbourhoods was 9.4 years lower than for those living in the least deprived 10%, an increase from 8.5 years in 2021-23. For females, the gap was 7.8 years, up from 6.0 years.[74]

Healthy life expectancy could not be estimated for Portsmouth in the 1920s. In 2022-24, healthy life expectancy at birth is 57.5 years for males and 58.2 years for females, both statistically similar to England. Healthy life expectancy estimates the average number of years a person can expect to live in good health, assuming current patterns of health and mortality continue throughout their lifetime.

However, substantial inequalities remain. In 2009-13, the gap in healthy life expectancy between residents living in Portsmouth's most and least deprived areas was estimated at 15.1 years for males and 14.2 years for females.[75] This means that while people are living longer than a century ago, the number of years spent in good health varies considerably across the city. The overall picture is therefore one of remarkable progress in both length and quality of life since the 1920s, but the benefits have not been shared equally across all communities in Portsmouth.

Table 7: Healthy Life Expectancy

Measure	Historic Portsmouth or England context	Current Portsmouth / current context
Life expectancy at birth, persons	Portsmouth estimate: 59.9 years	Portsmouth: 80.5 years
Life expectancy at birth, males	England 1925: 57.7 years	Portsmouth 2024: 78.1 years; England today: 79.8 years
Life expectancy at birth, females	England 1925: 62.2 years	Portsmouth 2024: 82.7 years; England today: 83.6 years
Healthy life expectancy at birth	Not estimated for Portsmouth in the 1920s	57.5 years for males and 58.2 years for females

References

1 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024 mid-year estimate) source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).

2 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: 2022-based household projections for local authorities and higher administrative areas within England, Migration category variant, Household projections: 2022-based – Office for National Statistics, Office for National Statistics (ONS).

3 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) sources: 2024 mid-year population estimate source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS). Households in 2024 source: 2022-based household projections for local authorities and higher administrative areas within England, Migration category variant, Household projections: 2022-based – Office for National Statistics, Office for National Statistics (ONS).

4 1926 source: Converted from per Acre to km^2 [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).

5 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Live births in England and Wales: birth rates down to local authority areas. Office for National Statistics (ONS) via Nomis. Nomis – Official Census and Labour Market Statistics – Nomis – Official Census and Labour Market Statistics (*nomisweb.co.uk*). ONS Crown Copyright Reserved. Note, both 1926 and 2024 crude birth rates do not take account of the composition of the population, in particular the age and sex distribution, so note caution when comparing between years and areas.

6 1926 source: [Report 1926] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection. '2026' (2024) source: Calculated from deaths aged under one year and total births in 2024, Nomis, Office for National Statistics (ONS).

7 Portsmouth deaths from the Medical Officer of Health Report for Portsmouth Borough, 1925 (Wellcome Collection) and population data from the 1921 Census (Nomis, ONS). The 1925 all-age, all-cause age-standardised mortality rate was estimated using age-specific mortality rates derived from 1925 deaths and 1921 population data, standardised to the 1976 European Standard Population. The 2024 all-age, all-cause age-standardised mortality rate was calculated using age-specific mortality rates derived from deaths registered in 2024 and ONS mid-2024 population estimates (Nomis, ONS), standardised to the 1976 European Standard Population. Historic estimates should be interpreted as approximate due to differences in data sources, age-group classifications and the assumptions required to map historic records to modern standard population age bands.

8 1926 source: Approximate life expectancy estimate calculated from 1925 Portsmouth deaths data and 1921 Census population data using standard life table methods. 1925 Portsmouth deaths source: [Report 1925] / Medical Officer of Health, Portsmouth Borough. Source: Wellcome Collection; and Census 1921 population, Nomis, ONS. '2026' (2024) source: Calculated using life expectancy calculator with the final age interval of 85+ (most recent life expectancy calculations use 90+ years as the final interval, but this data was not available in 1926). 2024 mortality data sourced from: Civil Registration Data via Primary Care Mortality Database (PCMD), Copyright ©2024, re-used with the permission of NHS England. All rights reserved. Mid-2024 population data sourced from: Estimates of the population for England and Wales – Office for National Statistics, Office for National Statistics (ONS).

9 Source note: Historic population, household and average household size estimates are from the Medical Officer of Health Report for Portsmouth Borough, 1926 (Wellcome Collection *wellcomecollection.org/works/ny493aak*). Current population estimates are from ONS mid-year population estimates for 2024, while household estimates are from Census 2021 (Nomis *nomisweb.co.uk/default.asp*, ONS). Information on UK regular armed forces personnel is from MOD Location Statistics for UK Regular Armed Forces and Civilian Personnel: 2026 *gov.uk/government/statistics/location-statistics-for-uk-regular-armed-forces-and-civilians-2026*

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Appendix 1

Population structure by 5-year age groups, comparing Portsmouth County Borough 1921 and Portsmouth UA in 2024 Graph

Age band	Portsmouth – mid-2024 population estimate (ONS)			Portsmouth CB 1921 Census			% difference between Portsmouth 2024 and Portsmouth 1921		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	5,779	5,494	11,273	11,939	11,365	23,304	-4.5	-3.9	-4.2
5-9	6,149	6,012	12,161	11,385	11,142	22,527	-3.7	-3.2	-3.4
10-14	6,293	6,150	12,443	11,110	11,297	22,407	-3.3	-3.2	-3.3
15-19	7,444	6,626	14,070	10,978	10,361	21,339	-2.1	-2.0	-2.1
20-24	10,837	9,007	19,844	11,826	10,042	21,868	0.3	0.5	0.4
25-29	8,052	7,697	15,749	10,144	10,228	20,372	-0.9	-0.9	-0.9
30-34	8,433	8,676	17,109	9,143	10,347	19,490	0.3	-0.1	0.1
35-39	8,114	8,559	16,673	9,377	10,112	19,489	-0.2	0.0	-0.1
40-44	7,292	7,204	14,496	8,128	8,866	16,994	0.1	-0.3	-0.1
45-49	6,039	6,014	12,053	7,129	7,734	14,863	-0.3	-0.5	-0.4
50-54	6,197	6,172	12,369	5,837	6,479	12,316	1.0	0.6	0.8
55-59	6,214	6,485	12,699	4,669	5,348	10,017	1.9	1.8	1.9
60-64	5,795	5,627	11,422	3,417	4,305	7,722	2.6	1.8	2.2
65-69	4,429	4,667	9,096	2,617	3,411	6,028	2.0	1.7	1.8
70-74	3,567	3,799	7,366	1,683	2,542	4,225	1.9	1.5	1.7
75-79	3,263	3,736	6,999	991	1,574	2,565	2.2	2.2	2.2
80-84	1,788	2,415	4,203	455	772	1,227	1.3	1.6	1.5
85-89	1,040	1,709	2,749	159	277	436	0.8	1.4	1.1
90+	496	1,051	1,547	33	62	95	0.4	0.9	0.7
All ages	**107,221**	**107,100**	**214,321**	**121,020**	**126,264**	**247,284**			

Appendix 2

Age-specific mortality rates per 1,000 population for Portsmouth compared to England in 1925 Graph

Age group	1925 age-specific death rate per 1,000, Portsmouth CB	1925 age-specific death rate per 1,000, England & Wales
Less than 1 year	63.72	78.18
1 to 4 years	8.05	9.61
5 to 14 years	2.31	2.04
15 to 24 years	2.22	2.88
25 to 34 years	2.66	3.60
35 to 44 years	5.13	5.50
45 to 54 years	10.89	10.05
55 to 59 years	19.37	17.62
60 to 64 years	30.56	25.75
65 to 74 years	54.72	51.25

Age-specific mortality rates per 1,000 population for Portsmouth CB in 1925 to Portsmouth UA in 2024 Graph

Age group	2024 age-specific death rate per 1,000, Portsmouth UA	2024 age-specific death rate per 1,000, England & Wales
Less than 1 year	3.27	4.22
1 to 4 years	0.00	0.14
5 to 14 years	0.00	0.08
15 to 24 years	0.15	0.30
25 to 34 years	0.55	0.51
35 to 44 years	1.67	1.18
45 to 54 years	3.77	2.75
55 to 59 years	4.65	4.91
60 to 64 years	8.23	7.18
65 to 74 years	17.07	14.79
75 to 84 years	44.10	39.70
85 years and over	152.23	141.96

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