Move for Brain Health: Active Healthy Kids Scotland Report Card 2026

Active Healthy Kids Scotland

ACTIVE HEALTHY KIDS GLOBAL ALLIANCE

Contents

Acknowledgements

The Active Healthy Kids Scotland Report Card is a 'state of the nation' report on the physical activity and health of Scottish children and adolescents. It synthesises data from national surveys and assigns grades to a range of indicators related to physical activity and health (Overall Physical Activity, Organised Sport and Physical Activity, Sedentary Behaviour, Active Play, Active Travel, Diet, Sleep, Obesity, Physical Fitness, Family and Peers, Community and Environment, School, and Government and Policy).

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Move for Brain Health

The theme of this Active Healthy Kids Scotland Report Card is brain health, which can be defined as "the state of brain functioning across cognitive, sensory, social-emotional, behavioural and motor domains, allowing a person to realise their full potential over the life course, irrespective of the presence or absence of disorders" (World Health Organization, 2022, p. xii). Brain health is reflected in core cognitive functions that underpin reasoning, planning, and problem solving (Diamond, 2013), which support children's participation in school, family and community life.

A growing body of neuroscientific research has supported the link between physical activity, physical fitness and brain health from childhood throughout adolescence. Systematic reviews show that physical activity has both short-term and long-term benefits for core cognitive functions such as working memory, inhibitory control and cognitive flexibility in children and young people (Chang et al., 2025; Mavilidi et al., 2025). Since the publication of seminal papers showing that physical activity benefits children's cognition and academic performance (e.g., Hillman et al., 2008), these findings have been incorporated into health and education policies supporting physical activity promotion. Importantly, physical activity appears to benefit the brain health of specific populations, including children with obesity and those with neurodevelopmental disorders (Lubans et al., 2021; Ludyga et al., 2021).

The brain health theme also provides an opportunity to consider the Report Card indicators through a broader life-course lens. Brain health is shaped by multiple, interacting factors across childhood and adolescence, which carry through into adulthood and later life. The 2024 Lancet Commission on dementia prevention, intervention and care highlights 14 potentially modifiable risk factors for dementia across the life course, including physical inactivity, obesity, diabetes, hypertension, high LDL cholesterol, air pollution and social isolation. Although dementia most commonly occurs in later life, many of the behaviours, environments and inequalities that influence lifelong brain health begin much earlier (Livingston et al., 2024).

Several indicators in this Report Card are therefore relevant not only to children's current health, wellbeing, cognition and educational outcomes, but also to the foundations of lifelong brain health. Physical activity, active travel, active play, physical fitness and organised sport may support cognitive development, social connection and healthy cardiometabolic profiles. Diet and obesity are closely linked to later-life vascular and metabolic risk factors, including diabetes, high blood pressure and high cholesterol. Active travel and community environments also intersect with air pollution exposure, road safety and opportunities for social participation. Safe participation is also relevant to brain health, as traumatic brain injury is included in the 2024 Lancet Commission model as a modifiable dementia risk factor (Livingston et al., 2024); this highlights the importance of safe cycling infrastructure, road safety, appropriate use of helmets where relevant, and concussion-aware approaches in organised sport and physical activity.

Sleep is not currently included as a dementia risk factor in the Lancet Commission model, but sufficient sleep is important for children's brain development and brain health. Taken together, the indicators emphasise that monitoring and improving children's physical activity, diet, sleep and environments should be viewed as an investment in both current child health and lifelong brain health.

Background

Active Healthy Kids Scotland Report Cards are evidence-based state of the nation reports on physical activity and health in Scottish children and adolescents (Bardid et al., 2022; Hughes et al., 2018; Reilly et al., 2014, 2016; Tomaz et al., 2024). The report cards are based on standardised and rigorous peer-reviewed methodology which has been used in over 70 countries for over 12 years (Morrison et al., 2025). This methodology summarises evidence and produces grades for 13 key indicators. These are:

- Important health behaviours and outcomes (Overall Physical Activity, Organised Sport and Physical Activity, Sedentary Behaviour, Active Play, Active travel, Diet, Sleep, Obesity, and Physical Fitness)
- Key sources of influence on health behaviours and outcomes from the wider system which determines health (Family and Peers, Community and Environment, School, and Government and Policy)

Active Healthy Kids Scotland embodies the principle of **'better data for better health'** (Reilly et al., 2022) highlighting its commitment to improving child and adolescent health, and reducing inequalities in child and adolescent health, through robust data insights. We therefore monitor physical activity and health among children and adolescents in Scotland using national public health surveillance data. By doing so, we strive not only to support evidence-informed policy and practice for better health, but also to highlight gaps in surveillance and monitoring and formulate recommendations for better data. The report cards serve as valuable tools for knowledge exchange while also contributing to research.

The report cards are compiled by a working group of experts in child physical activity, sedentary behaviour, physical fitness, diet, obesity, sleep and policy from several Scottish universities. Producing these report cards involve wide dissemination and consultation with various stakeholder organisations and individuals and peer-review by the Active Healthy Kids Global Alliance (AHKGA) board. Scientific manuscripts based on the report cards are also externally peer reviewed.

In this report card, the following format is used for each indicator:

- **Benchmark:** The Active Healthy Kids Global Alliance globally recognised guidelines are stated.
- **Grade and Grading Summary:** Grades for each indicator are assigned based on nationally representative data from children and adolescents aged 2 to 18 years.
- **Inequalities:** Information was reported on inequalities by socioeconomic status, gender, and disability.

Information on Active Healthy Kids Scotland—including previous report cards and publications—is available at **www.activehealthykidsscotland.co.uk.** We also contribute to the AHKGA Global Matrix initiative that compares physical activity and health of children and adolescents across the globe. The grades in the current report card are included in the AHKGA Global Matrix 5.0.

Abbreviations

AHKGA	Active Healthy Kids Global Alliance
MVPA	Moderate-to-vigorous intensity physical activity
HBSC	Health Behaviours in School-Aged Children
SHeS	Scottish Health Survey
SHS	Scottish Household Survey
GUS	Growing Up in Scotland
DISH	Dietary Intake in Scotland's Children
CWCI	Children's Walking and Cycling Index

Methodology

For the current report card, the AHKGA methodology was adopted to assess 13 physical activity and health indicators—10 core indicators and 3 additional indicators relevant to Scotland. We also explored potential inequalities by socioeconomic status, gender, and disability. Please note that generally no data was found to explore ethnic or spatial (urban-rural) inequalities. Relevant data sources published between 2022 and 2025 were used to ensure findings reflect the most current evidence available. To ensure suitability for grading, data sources were also required to be nationally representative, and minimally biased. This means that the measurement methods should not substantially overstate or understate the prevalence of health behaviors or health outcomes.

The report card working group conducted a critical evaluation of the available data to determine its representativeness and potential biases and produce draft grades using the AHKGA grading rubric. Subsequently, draft grades and rationale were disseminated widely to various stakeholders across Scotland for online consultation. Finally, the report card grades were peer-reviewed by experienced members from the AHKGA board. We also reported on grade comprehensiveness, reflecting whether grades were based on data from one or more age groups. Please see supplementary tables for all data sources and policy documents considered in this report card.

A full description of the AHKGA methodology is available at **www.activehealthykids.org.**

Active Healthy Kids Global Alliance Grading Rubric

Grade	Interpretation
A+	94%-100%
A	We are succeeding with a large majority of children (87%-93%)
A-	80%-86%
B+	74%-79%
B	We are succeeding with well over half of children (67%-73%)
B-	60%-66%
C+	54%-59%
C	We are succeeding with about half of children (47%-53%)
C-	40%-46%
D+	34%-39%
D	We are succeeding with less than half of children (27%-33%)
D-	20%-26%
F	We are succeeding with very few of children (<20%)
INC	Incomplete Grade, where Scottish data were not available or were insufficient/ inadequate to assign a grade

Summary

Indicators

Indicator	Definition
Sedentary Behaviour	Any waking behaviour characterised by an energy expenditure ≤1.5 metabolic equivalents, while in a sitting, reclining or lying posture.
Sleep	The total quantity of time a person spends asleep, either during a single night or over a 24-hour period.
Overall Physical Activity	Any bodily movement produced by skeletal muscles that requires energy expenditure.
Organised Sport & PA	A subset of physical activity that is structured, goal-oriented and competitive.
Active Play	Play is voluntary engagement in activity that is fun and/or rewarding and usually driven by intrinsic motivation. Active play is a form of play that involves physical activity of any intensity.
Active Transportation	Active transportation refers to any form of human-powered transportation walking, cycling, using a wheelchair, in-line skating or skateboarding.
Physical Fitness	Characteristics that permit a good performance of a given physical task in a specified physical, social, and psychological environment.
Diet	A healthy diet is adequate, balanced, moderated, and varied, providing essential nutrients in appropriate amounts to support health and well-being.
Obesity	Obesity is defined as excessive accumulation of body fat that poses risks for health.
Family & Peers	Any member within the family who can control or influence the physical activity opportunities and participation of children and youth in this environment.
Community & Environment	Any policies or organisational factors (e.g., infrastructure, accountability for policy implementation) in the municipal environment that can influence the physical activity opportunities and participation of children and youth in this environment.
School	Any policies, organisational factors (e.g., infrastructure, accountability for policy implementation, physical education (PE) curriculum), or student factors (e.g., PA options based on age, gender or ethnicity) in the school environment that can influence the PA opportunities and participation of children and adolescents in this environment.
Government & Policy	Any governmental body with authority to influence physical activity opportunities or participation and supporting healthy diet among children and youth through policy, legislation or regulation.

Note. Sleep, Diet, and Obesity indicators (as well as Government & Policy – Diet) are not core AHKGA indicators and were not audited by the AHKGA board.

Grades and Inequalities

Indicator	Grade	Summary
Sedentary Behaviour **(Screen Time)**	F We are succeeding with very few of children (<20%)	**Socioeconomic status:** Fewer adolescents from low-affluent families (**4%**) are engaging in less than 2 hr of screen time per day compared to those from medium- (**5%**) and high-affluent families (**7%**) (HBSC 2022). **Gender:** Fewer adolescent boys (**4%**) than girls (**7%**) are engaged in less than two hours of recreational screen time per day (HBSC 2022). **Disability:** **4%** of adolescents with long-term illness or disability engaged in less than 2 hr of recreational screen time per day compared to **6%** of those without long-term illness or disability (HBSC 2022).
Sleep	C We are succeeding with about half of children (47-53%)	**Socioeconomic status:** Fewer adolescents from low-affluent families (**41%**) met the recommended sleep time compared to adolescents from medium- and high-affluent families (**48%** and **53%**, respectively) (HBSC 2022). **Gender:** More boys (**51%**) met the recommended sleep time than girls (**45%**) (HBSC 2022). **Disability:** Fewer adolescents with long-term illnesses or disabilities (**45%**) met the recommended sleep time compared to those without long-term illness or disability (**49%**) (HBSC 2022).
Overall Physical Activity	B We are succeeding with well over half of children (67%-73%)	**Socioeconomic status:** Fewer adolescents from low-affluent families (**58%**) participated in at least 60 min of MVPA for 4 days or more per week compared to those from middle (**71%**) and high affluent families (**80%**) (HBSC 2022). **Gender:** More adolescent boys (**77%**) participated in at least 60 min of MVPA for 4 days or more per week compared to girls (**65%**) (HBSC 2022). **Disability:** The proportion of adolescents with and without long-term illness or disability participating in at least 60 min of MVPA for 4 days or more per week was similar (**71%** and **71%**, respectively) (HBSC 2022).

Organised Sport & PA	 **We are succeeding with well over half of children (67%-73%)**	**Socioeconomic status:** Fewer adolescents from low-affluent families (**54%**) participated in sports at least once or twice a month compared to those from medium (**71%**) and high (**82%**) affluent families (HBSC 2022). Similarly, fewer children and adolescents from the most deprived areas participated in sport (**55%**) compared to those from least deprived areas (**78%**) according to SHeS 2024. **Gender:** More adolescent boys (**75%**) participated in sports at least once or twice a month compared to girls (**65%**) (HBSC 2022). However, SHeS 2024 reported similar participation rates for boys and girls (**66%** each). **Disability:** Fewer adolescents with long term illness or disability (**65%**) participated in sports at least once or twice a month compared to those without long-term illness or disability (**71%**) (HBSC 2022). According to SHeS 2024, fewer children and adolescents with limiting long-term conditions (**50%**) participated in sport compared to those with non-limiting long-term conditions (**71**%) or no long-term conditions (**69%**).
Active Play	 **Insufficient evidence to grade**	Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.
Active Transportation	 **We are succeeding with about half of children (47%-53%)**	**Socioeconomic status:** Fewer children and adolescents from higher socioeconomic backgrounds (**63**%) walked, wheeled or scooted at least five times in the prior week compared to children and adolescents from lower socioeconomic backgrounds (**73%**) (CWCI 2024). **Gender:** Similar proportions of primary school boys and girls cycled to school (**12%** vs **10%**, respectively) although a higher proportion of girls walked, wheeled or scooted compared to boys (**54%** vs **48%**). A comparable pattern was observed among secondary school pupils, with cycling reported by **6%** of girls and **8%** of boys, while **46%** of girls and **40%** of boys walked, wheeled or scooted. Over the week prior to the survey, **67%** of girls and **65%** of boys walked, wheeled or scooted at least five times, whereas **16%** of girls and **22%** of boys cycled at this frequency (CWCI 2024). **Disability:** Disability inequalities could not be assessed due to a lack of surveillance data.
Physical Fitness	 **Insufficient evidence to grade**	Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Diet

We are succeeding with less than half of children (20%-26%)

Socioeconomic status: Children and adolescents living in the least deprived areas were more than twice as likely to meet the fibre goal than those living in the most deprived areas (**25%** vs **11%**). Fruit and vegetable consumption was also higher among those living in the least deprived areas compared with the most deprived areas (DISH 2024).

Gender: Boys were more likely than girls to meet the goals for free sugars (**10%** vs **7%**) and fibre (**21%** vs **12%**) (DISH 2024). There were small differences in consumption of fruit and vegetables with **17%** of boys and **19%** of girls consuming five or more portions of fruit and vegetables per day (SHeS 2023).

Disability: Children and adolescents with limiting and non-limiting long-term conditions were less likely to consume five or more portions of fruit and vegetables per day (**14%** and **13%**, respectively) compared with those with no long-term conditions (**19%**). Those with limiting long-term conditions were also more likely to report consuming no fruit and vegetables (**15%**) compared to those with non-limiting long-term conditions (**4%**) and no long-term conditions (**6%**) (SHeS 2023).

Obesity

Insufficient evidence to grade

There was no obesity prevalence data based on body fatness to adequately assess socioeconomic, gender and disability inequalities although there was prevalence data based on BMI-for-age.

Socioeconomic status: Primary 1 BMI statistics 2023/24 showed higher obesity rates among Primary 1 children from most deprived areas compared to those from least deprived areas (**14%** vs **6%**). Similarly, according to SHeS 2024, obesity prevalence among children and adolescents from most deprived areas was higher compared to those from least deprived areas (**20%** vs **12%**).

Gender: Obesity prevalence was similar for Primary 1 boys and girls (**11%** vs **10%**) (Primary 1 BMI Statistics 2023/24). In children and adolescents aged 2-15 years, obesity prevalence was slightly higher among boys (**19%**) than girls (**17%**) although differences varied by age (SHeS 2024).

There were only small differences in obesity prevalence between boys and girls according to Primary 1 BMI statistics 2023/24 (**11%** vs **10%**) and SHeS 2024 (**19%** vs **17%**).

Disability: SHeS 2024 reported that obesity rates among children and adolescents with non-limiting long-term conditions were higher compared to those with no long-term conditions (**22%** vs **18%**). Obesity prevalence among those with limiting long-term conditions was **19%**.

Family & Peers

Insufficient evidence to grade

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Community & Environment	INC **Insufficient evidence to grade**	Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.
School	INC **Insufficient evidence to grade**	Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Indicator	Grade	Summary
Government & Policy	**Physical Activity** B- **(60%-66%)**	Evidence of leadership is most abundant for active play and for active travel (mostly for cycling). Funding exists to support children and youth PA although it is not always evident (or relevant) for all policy instruments, and the details are occasionally lacking. Several policy documents show promising synergy between politics, academics, and non-governmental organisations and/or charities. Progress through the key stages of policy making is evident, although more can be done in terms of monitoring, and better reporting would truly highlight impact of policy for children and youth PA opportunities.
	Diet B- **(60%-66%)**	There was clear evidence of leadership and commitment to providing healthy diet opportunities for children and adolescents. Evidence of allocation of funds and resources was clear for implementation of many policies, but not all. Progress through the key stages of public policymaking is evident for many policies. There was more evidence of planning of monitoring and evaluation than was evident in previous report cards. However, the commitment to continued monitoring was not entirely clear and this was still lacking in some policies. As many of these are newer policies, we are unable to assess whether this planning came to fruition.

Grade Comprehensiveness

Active Healthy Kids Scotland 2026 Report Card grades and their comprehensiveness, reflecting whether data was used from one or more age groups.

		Comprehensiveness		
Indicator	**Grade**	**≤5 y**	**5-11 y**	**11-17 y**
Sedentary Behaviour	F (<20%)	--	--	Yes
Sleep	C (47%-53%)	--	--	Yes
Overall Physical Activity	B (67%-73%)	--	--	Yes
Organised Sport & PA	B (67%-73%)	--	Yes	Yes
Active Play	INC (Incomplete)	--	--	--
Active Transportation	C+ (54%-59%)	Yes	Yes	Yes
Physical Fitness	INC (Incomplete)	--	--	--
Diet	D- (20%-26%)	Yes	Yes	Yes
Obesity	INC (Incomplete)	--	--	--
Family & Peers	INC (Incomplete)	--	--	--
School	INC (Incomplete)	--	--	--
Community & Environment	INC (Incomplete)	--	--	--
Government & Policy - Physical Activity	B- (60%-66%)			
Government & Policy - Diet	B- (60%-66%)			

Note. Age groups were selected based on Scottish education system: early years (≤5 years), primary (5-11 years), and secondary education (11-17 years).

Indicators

Sedentary Behaviour

F

(We are succeeding with very few adolescents, <20%)

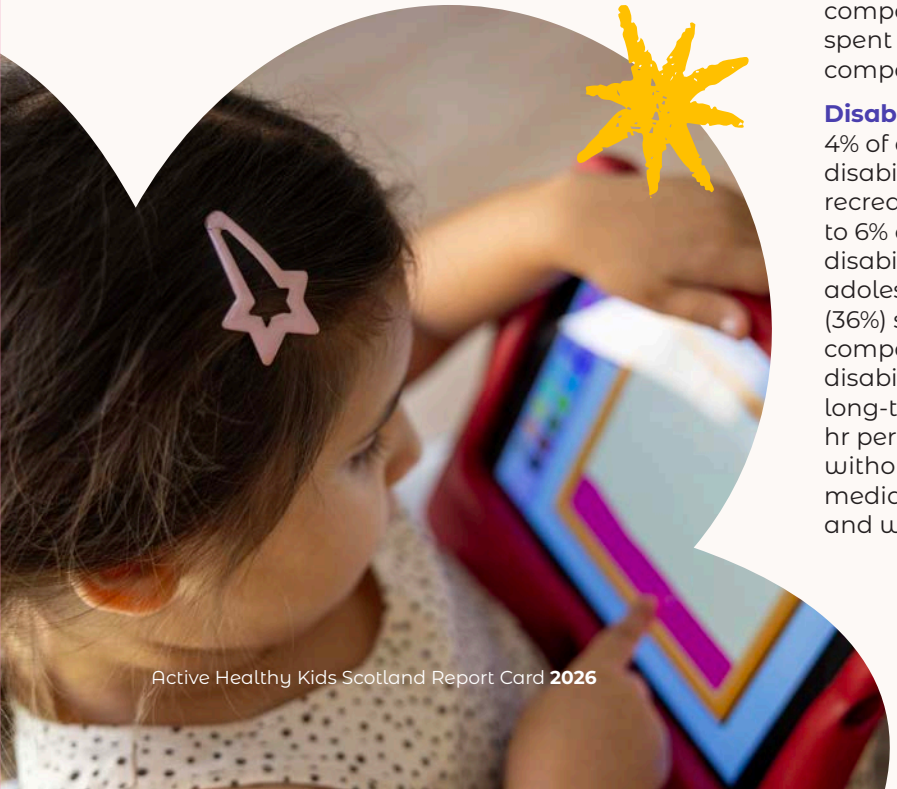
AHKGA Benchmark:

% of children and adolescents who meet the Canadian Sedentary Behaviour Guidelines (5–17-year-olds: no more than two hours of recreational screen time per day; 2–4-year-olds: no more than one hour of sedentary screen time per day). The current guidelines provide a time limit recommendation for screen-related pursuits, but not for non-screen-related pursuits.

Grade:

The Scottish Health Survey (SHeS) 2024 and Health-Behaviour in School-aged Children (HBSC) Scotland 2022 surveys were identified as the most suitable data sources. Unfortunately, SHeS 2024 could not be used as recreational screen time and other non-screen related sedentary time were reported together rather than separately, indicating the average amount of time children aged 2 to 15 spent on sedentary activities per day on weekdays and weekends.

Data from HBSC Scotland 2022 were used although it should be noted that this only covers adolescents aged 11-15 years. According to HBSC 2022, very few adolescents (5%) are meeting the guideline for total recreational screen time per day. Considering types of recreational screen time, 41% of adolescents aged 11–15 reported spending less than two hours per day watching TV, DVDs, or videos whilst 33% spent less than two hours per day playing computer or video games. Moreover, 37% spent less than two hours daily on social media. Based on the total amount of screen time, an F grade for adolescents was assigned.



Inequalities:

Socioeconomic status: HBSC Scotland 2022 showed that fewer adolescents from low-affluent families (4%) are meeting the guideline for total recreational screen time per day compared to those from medium- (5%) and high-affluent families (7%). Considering types of screen time, 33% of adolescents from low-affluent families spent less than 2 hr per day watching TV compared to 39% and 50% of those from medium- and high-affluent families, respectively. Additionally, 27% of adolescents from low-affluent families spent less than 2 hr per day gaming compared to 33% and 39% of those from medium- and high-affluent families. For social media, this was 35%, 37%, and 39% of adolescents from low-, medium-, and high-affluent families, respectively.

Gender: HBSC Scotland 2022 showed that fewer boys (4%) than girls (7%) are meeting the guideline for total recreational screen time per day. There were differences based on type of screen time. 41% of boys and 40% of girls spent less than 2 hr per day watching TV. However, only 21% of boys spent less than 2 hr per day gaming compared to 47% of girls. In contrast, 43% of boys spent less than 2 hr per day on social media compared to 32% of girls.

Disability: HBSC Scotland 2022 showed that 4% of adolescent with long-term illness or disability are meeting the guideline for total recreational screen time per day compared to 6% of those without long-term illness or disability. Considering types of screen time, fewer adolescents with long-term illness or disability (36%) spent less than 2 hr per day watching TV compared to those without long-term illness or disability (41%). Moreover, 28% adolescents with long-term illness or disability spent less than 2 hr per day gaming compared to 35% of those without long-term illness or disability. For social media, this was 33% and 38% of adolescents with and without long-term illness or disability.

Sleep

C

(We are succeeding with about half of adolescents, 47%-53%)

AHKGA Benchmark:

% meeting sleep guidelines based on the National Sleep Foundation and the Canadian 24-hour Movement Behaviour Guidelines. Recommended sleep durations are 9-11 hours for school-aged children (5-13), and 8-10 hours for teenagers (14-17). For children under 5 years of age, recommended sleep durations are 11-14 hours (1-2) and 10-13 hours (3-4).

Grade:

The Growing Up in Scotland (GUS) Sweep 11, and HBSC Scotland 2022 surveys were identified as the most reliable resources. The GUS Sweep 11 could not be used as data on adolescents aged 17-18 was collected as early as November 2021, making it outdated for the current report card. Data from HBSC Scotland 2022 shows 46% of adolescents are meeting the recommended sleep duration on weekdays whilst 59% are meeting the recommended sleep time on weekend/holidays. Overall, 48% of adolescents are meeting the recommended sleep time per day across 7 days. Therefore, a C grade for adolescents was assigned.

Inequalities:

Socioeconomic status: Data from HBSC Scotland 2022 shows 41% of adolescents from low-affluent families met the recommend sleep time on weekdays compared to 46% and 48% of adolescents from medium- and high-affluent families, respectively. For weekend/holidays, this was 56% of adolescents from low-affluent families compared to 59% and 64% of adolescents from medium- and high-affluent families, respectively. Overall, fewer adolescents from low-affluent families (41%) are meeting the recommended sleep time per day across 7 days compared to adolescents from medium- and high-affluent families (48% and 53%, respectively).

Gender: Data from HBSC Scotland 2022 shows 49% of boys and 43% of girls are meeting the recommended sleep time on weekdays. During the weekend/holidays, this was 60% and 59% for boys and girls, respectively. Overall, 51% and 45% of boys and girls are meeting the recommended sleep time per day across 7 days.

Disability: Data from HBSC Scotland 2022 shows 44% and 46% of adolescents with and with long-term illnesses or disabilities met the recommended sleep time on weekdays. However, there was a larger difference during weekend/holidays with 55% of adolescents with long-term illness or disability meeting the recommended sleep time compared to 60% of adolescents without long-term illness or disability. Overall, fewer adolescents with long-term illnesses or disabilities (45%) are meeting the recommended sleep time per day across 7 days compared to those without long-term illness or disability (49%).

Overall Physical Activity

AHKGA Benchmark:

% of children and adolescents who meet the Global Recommendations (WHO, 2020) on Physical Activity for Health, which recommend that children and adolescents (5-17 years) accumulate an average of at least 60 minutes of moderate- to vigorous-intensity physical activity (MVPA) per day. Children under 5 years of age who are capable of walking unaided should be physically active daily at any intensity for at least 180 minutes, spread throughout the day, and this should include 60 minutes of MVPA for children aged 3-4 years (WHO, 2019; UK Chief Medical Officers, 2019; Canadian Society for Exercise Physiology, 2017). When an average cannot be estimated, % of children and adolescents meeting the guidelines on at least 4 days per week is considered.

Grade:

SHeS 2024 and HBSC Scotland 2022 were identified as the most suitable data sources. However, SHeS 2024 provided data on physical activity levels, but no information on intensity of physical activity was collected. The data could therefore not be used to grade against the benchmark.

Data from HBSC Scotland 2022 were used although it should be noted that this only covers adolescents aged 11-15 years. Overall, 71% of adolescents participated for at least 60 min in MVPA per day on at least 4 days per week, therefore a B grade for adolescents was assigned.

Inequalities:

Socioeconomic status: Data from HBSC Scotland 2022 showed fewer adolescents from low-affluent families (58%) participated in at least 60 min of MVPA for 4 days or more per week compared to those from middle- (71%) and high-affluent families (80%).

Gender: Data from HBSC Scotland 2022 showed that more boys (77%) participated in at least 60 min of MVPA for 4 days or more per week compared to girls (65%).

Disability: Data from HBSC Scotland 2022 showed the percentage of adolescents with long-term illness or disability participating in at least 60 min of MVPA for 4 days or more per week (71%) was similar to those without long-term illness or disability (71%).

B

(We are succeeding with well over half of adolescents, 67%-73%) | ≥ 60 min MVPA on ≥ 4 days/week

D-

(We are succeeding with less than half of adolescents, 20%-26%) | ≥60 min MVPA daily

The B grade is based on the new AHKGA benchmark. The grade would have been a D- for adolescents if using the old benchmark of daily ≥60 min MVPA as used in previous report cards. According to HBSC Scotland 2022, only 23% of adolescents engaged in MVPA for at least 60 min every day.

Organised Sport and Physical Activity

AHKGA Benchmark:

% of children and adolescents who participate in organised sport and/or physical activity programmes. The benchmark includes sport and exercise/physical activities, so this indicator is not solely sport, and the key word is 'organised' (i.e., the indicator is organised sport and physical activity). There is no recommendation for the frequency/duration of organised sport and physical activity participation.

B

(We are succeeding with well over half of children and adolescents, 67%-73%)

Grade:

The SHeS 2024 and HBSC 2022 surveys have been identified as suitable data sources. SHeS 2024 reported that 66% of children and adolescents aged 2-15 years participated in organised sport. Similarly, according to HBSC Scotland 2022, 70% of adolescents aged 11-15 years participated in sports at least once or twice a month. Therefore, a B grade was assigned.

Inequalities:

Socioeconomic status: SHeS 2024 reported sport participation rates of 55% and 78% for those from most and least deprived areas, respectively. According to HBSC Scotland 2022, 54% of adolescents from low-affluent families participated in sports at least once or twice a month compared to 71% and 82% of those from medium and high-affluent families. This indicates that children and adolescents from less affluent families are less likely to take part in organised sport compared to their more affluent peers.

Gender: The SHeS 2024 reported sport participation rates of 66% for both boys and girls. According to HBSC Scotland 2022, 75% boys participated in sports at least once or twice a month compared to 65% of girls. This suggests that adolescent boys may be more likely to participate in organised sport and physical activity than adolescent girls.

Disability: SHeS 2024 reported 50% of children and adolescents with limiting long-term conditions participated in sport compared to 71% and 69% of those with non-limiting long-term conditions and no long-term conditions, respectively. According to HBSC Scotland 2022, 65% of adolescents with long-term illness or disability participated in sports at least once or twice a month compared to 71% of those without long-term illness or disability. This suggests that children and adolescents with disabilities may be less likely to participate in organised sport compared to adolescents without disabilities.

Active Play

INC

(incomplete grade)

AHKGA Benchmark:

% of children and adolescents who engage in unstructured/unorganised active play at any intensity for more than 2 hours per day; % of children and adolescents who report being outdoors for more than 2 hours per day.

Grade:

There is limited evidence on active play in Scotland, and the data available cannot be used for grading. HBSC (2022) did not report on active play. The SHeS (2023) also did not report on time spent in active play in their main report. We considered British Play surveys by Dodd et al. (2021, 2024), which asked parents to report on children's play. However, these were deemed ungradable as the sample sizes were too small, it was unclear when data was collected or data was collected pre-COVID-19, and any potential biases were unclear. This resulted in assigning an INC grade.

Inequalities:

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Active Transportation

C+

(We are succeeding with about half of children and adolescents, 54%-59%)

AHKGA Benchmark:

% of children and adolescents who use active transportation to get to and from places (e.g., school, park, mall, friend's house).

Grade:

The National Travel Survey, which presents Transport and Travel in Scotland results from the Scottish Household Survey (SHS) 2023, identified 46% of journeys under two miles were on foot in 2022 and 2% of journeys under five miles were by bicycle. According to Children's Walking and Cycling Index (CWCI) Scotland, 59% of all trips made by children were by active transportation (46% by walking, wheeling, scooting; 13% by cycling). Moreover, two thirds (66%) of children walk, wheel, or scoot more than five days a week. Additionally, Hands Up Scotland Survey 2024 identified that 47% of pupils are actively travelling to school. Therefore, a grade of C+ was assigned.

Inequalities:

Socioeconomic status: CWCI 2024 reported a higher number of children/adolescents from lower socioeconomic backgrounds who walked, wheeled or used a scooter at least five times in the week prior to the survey. Specifically, 63% of children from higher socioeconomic group ABC1 and 73% of children from lower socioeconomic group C2DE. This suggests that children from lower socioeconomic backgrounds (C2DE) are more likely to engage in active travel (walking, wheeling, or using a scooter) than those from higher socioeconomic backgrounds (ABC1).

Gender: CWCI 2024 reports that a greater proportion of girls walked, wheeled or scooted to school compared to boys (54% and 48%, respectively), although cycling to school rates are similar (12% of boys, 10% of girls).. For secondary school pupils, the pattern was similar: 6% of girls cycled to schools vs 8% of boys; 46% of girls walked, wheeled or scooted vs 40% of boys. The CWCI (2024) reported 67% of girls and 65% of boys walked, wheeled or used a scooter at least five times in the week prior to the survey, and 16% of girls and 22% of boys cycled at least five times in the week prior to the survey.

Disability: Disability inequalities could not be assessed due to a lack of surveillance data.

Physical Fitness

INC

(incomplete grade)

AHKGA Benchmark:

Characteristics that permit a good performance of a given physical task in a specified physical, social, and psychological environment. Data on physical fitness indicators (e.g. cardiorespiratory fitness, grip strength, balance etc) should be interpreted using sex-specific and age-specific European normative values published by Tomkinson et al. (2018).

Grade:

There is a lack of nationally representative data on physical fitness among children and adolescents in Scotland. An INC grade was therefore assigned.

Inequalities:

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Diet

(We are succeeding with 20% - 26% of children and adolescents)

AHKGA Benchmark:

% of children and adolescents meeting the Scottish Dietary Goals (SDGs) (Scottish Government, 2016), which include: (1) energy density of the diet to be ≤125 kcal/100g, (2) total fat intake to be ≤35% of food energy, (3) saturated fat intake to be ≤11% of food energy, (4) trans fat intake to be <1% of food energy, (5) free sugars intake to be ≤5% of food energy, (6) total carbohydrate intake to be ~50% of total energy, (7) fibre intake to be ≥ 15 g/day for 2-4y ≥20 g/day for 5-10y ≥25 g/day for 11-15y, (8) salt intake to be <6g/day (in adults), (9) fruit and vegetables consumption to be >400 g/day (in adults) (five or more portions per day), (10) red and red processed meat consumption to be ≤70 g/day (in adults), (11) a portion of oily fish (140g in adults) consumed at least once per week.

Grade:

The Dietary Intake in Scotland's Children (DISH) 2024 study found that diets across all demographic groups were too energy dense, with only 15% of children and adolescents meeting the energy density goal. Adolescents aged 11–15 years had significantly more energy-dense diets than younger children. Saturated fat intake also exceeded recommendations across all groups, with just 13% meeting the goal, while average free sugar intake was above the recommended level overall and across all demographic groups with only 8% meeting the goal; adolescents were significantly less likely than younger children to meet this goal. Most children and adolescents achieved the Scottish Dietary Goals (SDGs) for total fat (61%), trans fat (99%), and total carbohydrates (68%), with average intakes meeting population targets. However, fibre intake remained low, with only 16% of children and adolescents aged 2–15 years meeting the goal, including just 7% of those aged 11–15 years, and average intakes below age-specific recommendations across all demographic groups. The DISH survey did not report the proportion meeting fruit and vegetable guidelines but did report that children and adolescents did not meet the goal overall and similarly failed to meet the goals for salt and oily fish intakes but did meet the goal for red and processed meat intakes. Conclusions for these four goals however are limited by the fact there are not specific goals for children.

SHeS 2024 did not collect data on children's diets. However, SHeS 2023 reported that fewer than one in five (18%) children aged 2–15 years consumed five or more portions of fruit and vegetables per day. It did not report on other SDGs. Overall, 4 of the 11 Scottish Dietary Goals were met, although several demographic groups remained far from achieving a number of the remaining targets. Therefore, a grade of D- was assigned.

Inequalities:

Socioeconomic status: DISH 2024 reported few differences in adherence to the Scottish Dietary Goals according to socioeconomic status. The two exceptions were fibre and fruit and vegetables. Children and adolescents living in the least deprived areas were more than twice as likely to meet the fibre goal than those living in the most deprived areas (25% vs 11%). Those living in the least deprived areas also had significantly higher fruit and vegetable consumption compared to those living in the most deprived areas. According to SHeS 2023, fewer children and adolescents (ages 2-15) from most deprived areas are meeting the recommended fruit and vegetable consumption compared to those from least deprived areas (15% vs 21%).

Gender: DISH 2024 reported few differences between boys and girls in adherence to the Scottish Dietary Goals. Boys were more likely than girls to meet the goal for free sugars (10% versus 7%), fibre (21% vs 12%), and consume more fruit and vegetables. However, SHeS 2023 reported small differences in fruit and vegetable consumption with 17% of boys versus 19% of girls consuming five or more portions of fruit and vegetables per day.

Disability: No information on disability was provided in DISH 2024. However, SHeS 2023 did report that fewer children and adolescents with limiting and non-limiting long-term conditions (14% and 13%, respectively) were meeting the recommended fruit and vegetable consumption compared to those with no long-term conditions (19%). Children and adolescents with limiting long-term conditions were also more likely to report consuming no fruit and vegetables (15%) compared with those with non-limiting conditions (4%) and those with no long-term conditions (6%).

Obesity

INC

(incomplete grade)

AHKGA Benchmark:

% of children and adolescents with obesity.

Data on obesity prevalence should be based on fat mass and fat-free mass, e.g., using prediction equations (Hudda et al., 2018, 2022). As a note, body mass index (BMI) for age is widely used as a proxy marker of body fatness to estimate obesity prevalence. However, it has major limitations. BMI as a height-to-weight index cannot distinguish between fat free mass and fat mass. Furthermore, BMI-for-age has low-moderate sensitivity for detection of children and adolescents with high body fatness, thereby underestimating the prevalence of obesity (Reilly et al., 2002, 2010; Rubino et al., 2025). Additionally, BMI-for-age is found to be even more conservative in ethnic minority groups (Hudda et al., 2018).

Grade:

As in previous Active Healthy Kids Scotland Report Cards, we identified two relevant data sources on obesity prevalence in Scotland (Public Health Scotland Primary 1 BMI Statistics 2023/24 and SHeS 2024) are limited and based on BMI-for-age. The Primary 1 BMI Statistics 2023/24, which only covers Primary 1 children (age 5), indicated an obesity prevalence rate of 11%. According to SHeS 2024, the obesity prevalence rate was 18% among 2–15-year-olds although incorrect reference data was used for under-5s. Furthermore, older adolescents (16–17-year-olds) were treated as adults and included in the adult SHeS data with incorrect use of adult BMI. Given the surveillance limitations, an INC grade was assigned.

Inequalities:

There was no obesity prevalence data based on body fatness to adequately assess socioeconomic, gender and disability inequalities although there was prevalence data based on BMI-for-age.

Socioeconomic status: Primary 1 BMI Statistics 2023/24 showed higher obesity rates among Primary 1 children from most deprived areas compared to those from least deprived areas (14% vs 6%). Similarly, according to SHeS 2024, BMI-for-age defined obesity prevalence among children and adolescents (ages 2-15) from most deprived areas was higher compared to those from least deprived areas (20% vs 12%).

Gender: Among Primary 1 children, BMI-for-age defined obesity prevalence was similar for boys (11%) and girls (10%) (Primary 1 BMI Statistics 2023/24). In children and adolescents aged 2-15 years, obesity prevalence was slightly higher among boys (19%) than girls (17%) although differences varied by age (SHeS 2024).

Disability: SHeS 2024 reported that obesity rates among children and adolescents with non-limiting long-term conditions were higher compared to those with no long-term conditions (22% vs 18%). Obesity prevalence among those with limiting long-term conditions was 19%.

Family and Peers

INC

(incomplete grade)

AHKGA Benchmark:

% of family members (e.g., parents, guardians) who facilitate physical activity (PA) and sport opportunities for their children (e.g., volunteering, coaching, driving, paying for membership fees and equipment); % of parents who meet the Global Recommendations on Physical Activity for Health, which recommend that adults accumulate at least 150 min of moderate-intensity aerobic physical activity throughout the week or do at least 75 min of vigorous-intensity aerobic physical activity throughout the week or an equivalent combination of moderate- and vigorous-intensity physical activity; % of family members (e.g., parents, guardians) who are physically active with their kids; % of children and adolescents with friends and peers who encourage and support them to be physically active; % of children and adolescents who encourage and support their friends and peers to be physically active. Since child and adolescent diet and obesity are indicators in the Scottish report card, we have extended the benchmarks for the Active Healthy Kids Global Alliance Global Matrix 5.0 to also include estimates of parental diet and overweight/obesity. Adult data are used as a proxy for parental influence and the nature of the socio-ecological environment at the family level. This included: % of adults who met the adult physical activity guidelines; % of adults with overweight and obesity, % of adults who met the 5-a-day fruit and veg recommendation; % of adults reporting frequent participation in sport and physical activity and volunteering in sport and physical activity.

Grade:

As noted in previous Active Healthy Kids Scotland Report Cards, data specific to family and peer influence has been absent, so adult data and child/adolescent data on the indicators (e.g., diet, obesity, screen time, physical activity), where available, have been used as proxies for family and peer influence in the past. Adult volunteering in sport and physical activity has also been considered in the past and used when data have been available. While the available data for the Family and Peers Indicator are very limited, the review of available data confirms that children and adolescents grow up in an environment of high adult overweight and obesity prevalence, low prevalence of meeting combined PA guidelines, high screen time among peers, so the environment (e.g., norms) are not very conducive to high report card grades among children and adolescents.

SHeS 2023 included no adult diet data in the main report or on its website. 29% of adults met both the moderate-to-vigorous physical activity (MVPA) and muscle/bone-strengthening guidelines (32% men, 26% women). Adults spent an average of 6 hours per day in sedentary leisure activities, though no screen time data were reported. The combined prevalence of overweight and obesity in adults was 66%, with obesity alone at 32%—the highest level recorded to date. Data were not disaggregated by age, gender, or other demographic factors. SHS did not include any usable data on volunteering data in main report or website, none of the volunteering options reported refer to sport/coaching/PA specifically. As a result, an INC grade was assigned.

Inequalities:

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

Community and Environment

INC

(incomplete grade)

AHKGA Benchmark:

% of children or parents who perceive their community/municipality is doing a good job at promoting physical activity (e.g., variety, location, cost, quality); % of communities/ municipalities that report they have policies promoting physical activity; % of communities/ municipalities that report they have infrastructure (e.g., sidewalks, trails, paths, bike lanes) specifically geared toward promoting physical activity; % of children or parents who report having facilities, programmes, parks and playgrounds available to them in their community; % of children or parents who report living in a safe neighbourhood where they can be physically active, of children or parents who report having well-maintained facilities, parks and playgrounds in their community that are safe to use.

Grade:

No relevant data were collected in HBSC Scotland 2022. No relevant data collected in the SHeS 2023. The CWCI reported 89% of children and adolescents felt their local environment was safe. While this survey is nationally representative, this question only meets one of the benchmarks. Based on this and the absence of surveillance data, we assigned an INC grade.

Inequalities:

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

School

INC

(incomplete grade)

AHKGA Benchmark:

% of schools with active school policies (e.g., daily physical education (PE), daily physical activity, recess, bike racks at school, traffic calming on school property, outdoor time); % of schools where the majority (≥80%) of students are offered the mandated amount of PE (for the given state/territory/region/country); % of schools that offer physical activity (PA) opportunities (excluding PE) to the majority of (≥80%) of their students; % of parents who report their children and adolescents have access to PA opportunities at school in addition to PE classes; % of Schools with students who have regular access to facilities and equipment that support PA (e.g., gymnasium, outdoor playgrounds, sporting fields, multipurpose space for PA, equipment in good condition); % reflecting the comprehensiveness of the PE curriculum (100% – national curriculum that is comprehensive; 75% – national curriculum that lacks comprehensiveness; 50% – national curriculum that is weakly implemented; 25% – no national curriculum but local/regional curricula available; 0% – no national/regional curriculum).

Grade:

There was insufficient data available to adequately assess the school environment. HBSC Scotland 2022 indicated that only 34% of primary schools and 18% of secondary schools reported having written physical activity policies; however, these school-level findings should be interpreted cautiously as the response rate was 61%, and the data were not nationally representative. The School Healthy Living Survey 2023 reported that 99.5% of primary schools and 94.7% of secondary schools are meeting the expected level of PE provision (i.e., ≥120 min per week in primary and ≥100 min in secondary) (Scottish Government, 2023). Whilst Scotland has a national expectation/target for provision of PE in schools, this is not a statutory requirement, and delivery may vary across schools. Furthermore, there is limited evidence regarding consistency and quality of PE provision and no clear mechanism for monitoring the quality of provision. Scotland has a national curriculum—Curriculum for Excellence—which includes comprehensive experiences and outcomes for PE (Education Scotland, 2017). However, there is limited guidance on inclusivity of children and adolescents with long-term conditions or disabilities to support inclusive practice. Overall, as most benchmarks could not be assessed, an INC grade has been assigned.

Inequalities:

Socioeconomic, gender and disability inequalities could not be assessed due to a lack of surveillance data.

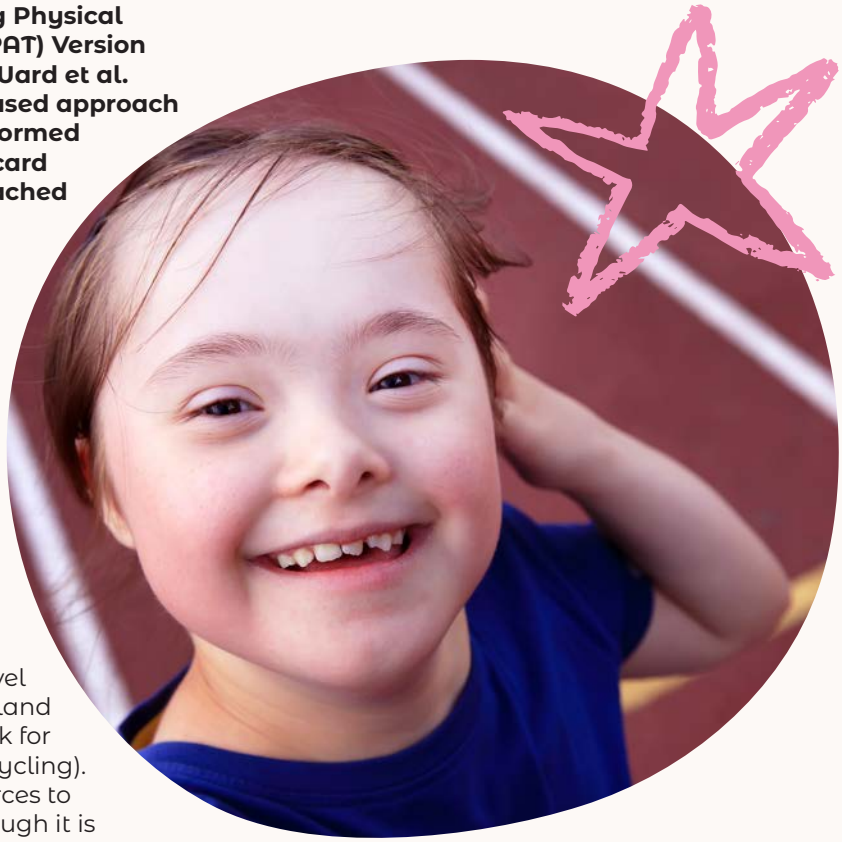
Government and Policy - Physical Activity

B-

(60%-66%)

AHKGA Benchmark:

Consensus-based grading taking into account (1) evidence of leadership and commitment in providing physical activity opportunities for all children and adolescents, (2) allocated funds and resources for the implementation of physical activity promotion strategies and initiatives for all children and adolescents, and (3) demonstrated progress through the key stages of public policy making (i.e., policy agenda, policy formation, policy implementation, policy evaluation and decisions about the future). Additionally, the Health-Enhancing Physical Activity (HEPA) Policy Audit Tool (PAT) Version 2 and scoring rubric published by Ward et al. (2021) were used. The consensus-based approach and HEPA PAT approach were performed independently by separate report card team members, with consensus reached after reviewing was complete and presented to the wider report card team.



Grade:

There is substantial evidence of leadership and commitment to creating PA opportunities for children and adolescents in Scotland. Evidence of leadership is most abundant for Active Play (or just play, e.g., Scotland's Play Vision Statement and Action Plan 2025-2030, Play Sufficiency Assessment Regulations 2023) and for Active Travel (mostly for cycling, e.g., Cycling Scotland Strategy 2023-28, Cycling Framework for Active Travel - A Plan for Everyday Cycling). There are allocated funds and resources to support children and youth PA although it is not always evident (or relevant) for all policy instruments to include this, and/or the details are occasionally lacking. However, several policy documents show promising synergy between politics, academics, and non-governmental organisations and/or charities, e.g., Physical Activity for Health Framework, Let's get Scotland Walking - The National Walking Strategy. Progress through the key stages of policy making is evident and demonstrated, although more work can be done in terms of PA surveillance (e.g., see above Active Play indicator which is graded as 'INC' but is evidently a Scottish priority), and better reporting is warranted to truly highlight impact of policy for children and youth PA opportunities. Overall, the work that has been done in the policy space indicates a concerted effort to reduce the policy-implementation gap identified in previous Active Healthy Kids Scotland Report Cards.

Only a few policy instruments reviewed had addressed or mentioned inequalities in a way that was through/directly linked to physical activity (e.g., Play Vision Statement and Action Plan mentions children whose rights to play are at greatest risk), and in documents not targeted to children, this point was made generally and not specifically to children's physical activity (e.g., Cycling Frame work for Active Travel - A plan for Everyday Cycling).

Government and Policy - Diet

B-

(60%-66%)

AHKGA Benchmark:

Consensus-based grading taking into account (1) evidence of leadership and commitment in providing healthy diet opportunities for all children and adolescents, (2) allocated funds and resources for the implementation of healthy diet promotion strategies and initiatives for all children and adolescents, and (3) demonstrated progress through the key stages of public policy making (i.e., policy agenda, policy formation, policy implementation, policy evaluation and decisions about the future). Additionally, the HEPA PAT v2 and scoring rubric published by Ward et al. (2021) were used. The consensus-based approach and HEPA PAT approach were performed independently by separate report card team members, with consensus reached after reviewing was complete and presented to the wider report card team.

Grade:

There was clear evidence of leadership and commitment to providing healthy diet opportunities for children and adolescents, as Scotland has several relevant policies, strategies and targets in place, with consultations on further actions also in the process. There was evidence of allocation of funds and resources for implementation of many policies, but for some this was unclear. There was evidence of progress through the key stages of public policymaking (policy agenda; policy formation; policy implementation; policy evaluation; decisions about the future) for many policies, with evidence of clear planning. More recent policies showed an improvement compared to those assessed in earlier Active Healthy Kids Scotland report cards. There was better evidence of planning of monitoring and evaluation than was evident in previous report cards, and the fact that we are able to grade the diet indicator this time, was evidence of improved monitoring. However, the commitment to continued monitoring was not entirely clear, and this was still lacking in some. As many of these are newer policies, we are unable to assess whether this planning actually came to fruition. Some planned policies had been halted but with clear justification, e.g., lack of funding or concerns over impact on vulnerable groups.

There was clear consideration of inequalities, with impact assessments conducted of potential impact on various population subgroups. However, policies seemed to focus more on the early years, and whilst this is a crucial phase and can establish longer term habits, the current evidence is that diets are poorest amongst adolescents, and this group is less of a focus in current policies.

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Data sources

Main data sources used for the 2026 Active Healthy Kids Scotland Report Card.

Source	Publication Year	Reference
Health Behaviours in School-aged Children (HBSC) Scotland 2022	**2023**	Inchley J, Mabelis J, Brown J, Willis M, Currie D. *Findings from the HBSC 2022 survey in Scotland*. MRC/CSO Social and Public Health Sciences Unit, University of Glasgow; 2023. https://www.gla.ac.uk/media/Media_976054_smxx.pdf
Scottish Health Survey 2024	**2025**	Scottish Government. *The Scottish Health Survey 2024: Volume 1 main report*. Scottish Government; 2025. https://www.gov.scot/publications/scottish-health-survey-2024-volume-1-main-report/ See also https://scotland.shinyapps.io/sg-scottish-health-survey/
Scottish Health Survey 2023	**2024**	Scottish Government. *The Scottish Health Survey 2023: Volume 1 main report*. Scottish Government; 2024. https://www.gov.scot/publications/scottish-health-survey-2023-volume-1-main-report/ See also https://scotland.shinyapps.io/sg-scottish-health-survey/
Scottish Health Survey 2022	**2023**	Scottish Government. The Scottish Health Survey 2022: Volume 1 main report. Scottish Government;2023. The Scottish Health Survey 2022 – volume 1: main report - gov.scot
Public Health Scotland Primary 1 Body Mass Index Statistics 2023/2024	**2024**	Public Health Scotland. *Primary 1 body mass index (BMI) statistics Scotland: School year 2023 to 2024*. Public Health Scotland; 2024. https://publichealthscotland.scot/publications/primary-1-body-mass-index-bmi-statistics-scotland/ See also https://publichealthscotland.scot/publications/primary-1-body-mass-index-bmi-statistics-scotland/primary-1-body-mass-index-bmi-statistics-scotland-school-year-2023-to-2024/dashboard/
Children's Walking and Cycling Index Scotland 2024	**2025**	Sustrans. *Children's Walking and Cycling Index Scotland 2024*. Sustrans; 2024. https://www.walkwheelcycletrust.org.uk/the-walking-and-cycling-index/childrens-walking-and-cycling-index/children-s-walking-and-cycling-index-scotland/
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Scottish Household Survey 2023	**2024**	Transport Scotland. *National Travel survey Transport and Travel in Scotland 2023*. Results from the Scottish Household Survey 2023. 2024. Transport and Travel in Scotland
Dietary intake in Scotland's Children (DISH) 2024	**2025**	Foods Stands Scotland. Dietary Intake in Scotland's Children (DISH) research report. 2025. Dietary Intake in Scotland's Children (DISH) research report | Food Standards Scotland

Note. Please see supplementary tables for all data sources considered.

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