

# Obesity, Diet and Physical Activity 2025

Public Health Intelligence

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**Improve. Prevent. Protect.**

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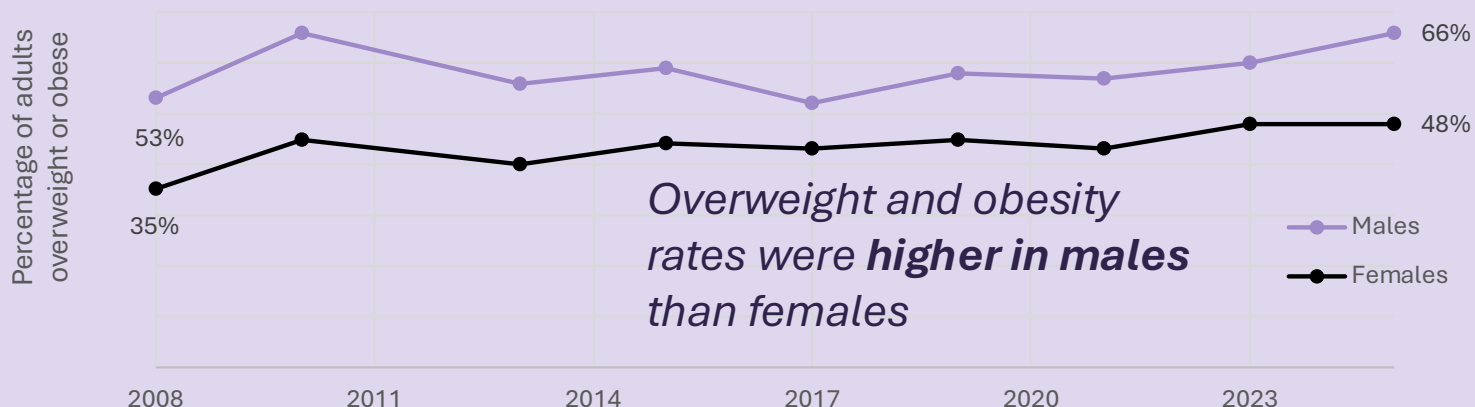
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# Obesity, Diet and Physical Activity 2025

**56%** of adults were living with **overweight or obesity**



**28%** of Reception children and **33%** of Year 6 children were **overweight or obese**



**31%** of adults meet the **5-a-day fruit & veg recommendation**



**10%** of Year 12 pupils meet the **5-a-day fruit & veg recommendation**



Food insecurity is rising: **15%** of adults went **without fruit or vegetables due to cost in 2025**

**Overweight and obesity** rates are **higher** in adults with financial strain, low education, or living in social housing



Children in non-fee-paying schools were more likely to have **excess weight**: **35%** of Year 6 pupils compared with **22%** in fee-paying schools

**32%** of adults make most journeys by **walking or cycling**, **30%** make none



**54%** of adults meet **physical activity guidelines**



Proportion of **children** meeting physical activity recommendations drops with age: **67%** in primary **27%** in Year 12



# Introduction

Maintaining a healthy weight, eating a balanced diet and being physically active are fundamental to good health. These behaviours help reduce the risk of cardiovascular disease, type 2 diabetes and several cancers, and support mental wellbeing and overall quality of life.

Obesity continues to pose a significant public health challenge, both globally and in Jersey. While international patterns provide context, this report focuses on local trends, where excess weight<sup>1</sup> remains common in both adults and children. These patterns are shaped by factors such as food affordability and availability, opportunities for physical activity, and the wider environments in which Islanders live, work and travel.

Understanding health inequalities is a central theme throughout this report. Wherever sample sizes allow, each indicator is disaggregated by factors like sex, age, financial circumstances, ethnicity and housing tenure. This approach helps identify which groups face greater barriers to healthy living and supports proportionate, evidence-based responses.

## About this report

The 2025 Obesity, Diet and Physical Activity Profile brings together data on weight status, diet and physical activity in Jersey from multiple sources, including:

- Jersey Opinions and Lifestyle Survey (JOLS)<sup>2</sup>
- Jersey Child Measurement Programme (JCOMP)
- Jersey Children and Young People's Survey (JCYPS)
- Primary care and administrative datasets (e.g., EMIS<sup>3</sup>, JQIF<sup>4</sup>)

Body Mass Index (BMI), calculated using height and weight, is used to classify weight status in children and adults (underweight, healthy weight, overweight or obese). Although BMI has recognised limitations at an individual level, it remains an essential tool for monitoring population-level trends and informing service planning.

Throughout this report, the term “excess weight” is used to refer to the combined prevalence of overweight and obesity. Category-level terms (overweight and obese) are used only where specific breakdowns are required for clarity.

## Data correction notice: 01 April 2026

Correction made to correctly label the 2015 data points in Figure 3. No trend analysis or interpretation is affected.

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<sup>1</sup> Excess weight refers to the combined prevalence of overweight and obesity.

<sup>2</sup> [Jersey Opinions and lifestyle Survey | Statistics Jersey](#)

<sup>3</sup> EMIS - the electronic clinical system used across Jersey GP practices for recording patient information.

<sup>4</sup> JQIF (Jersey Quality Improvement Framework) is the primary care clinical reporting framework used across all GP practices in Jersey. It provides routinely recorded data on long-term conditions, including obesity.

## Summary of findings

### **Excess weight (overweight and obesity) remained widespread in Jersey's population, and significant proportions of adults and children report poor quality diet and inadequate levels of physical activity.**

- over half of adults (56%) were overweight or obese in 2025, with higher prevalence in men than women (66% men vs 48% in women)
- 14% of adults had clinically recorded obesity in 2025, and multimorbidity was common; with over a quarter of adults with obesity living with at least one other long-term condition
- just over a quarter (28%) of Reception-aged pupils and a third (33%) of Year 6 pupils were overweight or obese
- overall, one third of adults reported meeting the five-a-day fruit and veg recommendations in 2025, and food insecurity affects a significant proportion of households (41% went without at least one essential food item in the previous 12 months due to cost, for example)
- physical activity levels were also suboptimal, with just over half of adults (54%) and only around one in five children (22%) meeting recommended activity guidelines

### **Excess weight levels in adults and children have remained broadly stable in recent years in Jersey, although clinically recorded obesity continued to rise, and food insecurity has worsened.**

- the number of adults on the clinical obesity register rose from 9,740 in 2016 to 12,560 in 2025
- excess weight prevalence in children has remained stable for more than a decade
- physical activity levels among children showed a slight improvement in recent years; 22% met recommendations in 2025 up from 18% 2021
- food insecurity has worsened over time, with more households reporting limited access to healthy foods. For example, in 2025 15% reported going without fresh fruit and veg due to cost, compared to 9% in 2010

### **Inequalities across the population were significant and persistent, with financial and time pressures being key factors for Jersey households.**

- adults facing financial strain, with lower educational qualification levels, or living in non-qualified or social rent housing had notably higher rates of overweight and obesity
- children in non-fee-paying schools were more likely to have excess weight (35% amongst Year 6 pupils in non-fee-paying schools compared to 22% in fee-paying schools), and 90% of children from "not at all well off" households did not meet fruit and vegetable recommendations compared to 60% in "very well off" households
- adults experiencing financial strain or in low-income households were consistently more likely to report food affordability challenges, poorer diet quality and lower levels of physical activity participation
- lack of time was a key barrier to engagement in healthy behaviours; fewer than half (46%) of adults who were very time poor met the recommended exercise guidelines, compared to two thirds (67%) of those who were time sufficient

### **The data indicates that prevalence of overweight and obesity in adults and children is slightly lower in Jersey compared to England, but a smaller proportion of Jersey's population meet physical activity guidelines compared to England.**

- overweight and obesity estimates were similar in Jersey (56%) to Guernsey (57%), but slightly lower than broadly comparable data for England<sup>5</sup> (66%)
- Year 6 excess weight prevalence was also lower than England's, indicating comparatively better (but still concerning) levels amongst children
- adult physical activity levels in Jersey remained below those reported in England (54% in Jersey vs 64% meeting guidelines in England)

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<sup>5</sup> Not exact method match. See Chapter 1b

## Chapter 1a: Obesity in Adults

Adult obesity remains a major public health concern in Jersey. To measure the prevalence of obesity, two complementary data sources are used, which together provide a comprehensive view of weight status, inequalities and clinical need in Jersey

- self-reported BMI from Jersey Opinions and Lifestyle Survey (JOLS)<sup>2</sup>
- clinically recorded BMI from primary care (JQIF)<sup>4</sup>

BMI is calculated using height and weight in both datasets, but whilst the JOLS survey data are based on self-reported height and weight, the clinical registers (JQIF/EMIS) use height and weight measurements taken by healthcare professionals.

Self-reported surveys tend to underestimate obesity compared with professionally measured data, as they are based on participants' own accounts and may be subject to recall or reporting bias. Clinical records, meanwhile, only include adults who have had their BMI measured and formally recorded in primary care.

It's important to note that the English data cited in this report (from the Health Survey for England) used professionally measured BMI, so comparisons with Jersey's self-reported survey data are indicative only.

### Key findings

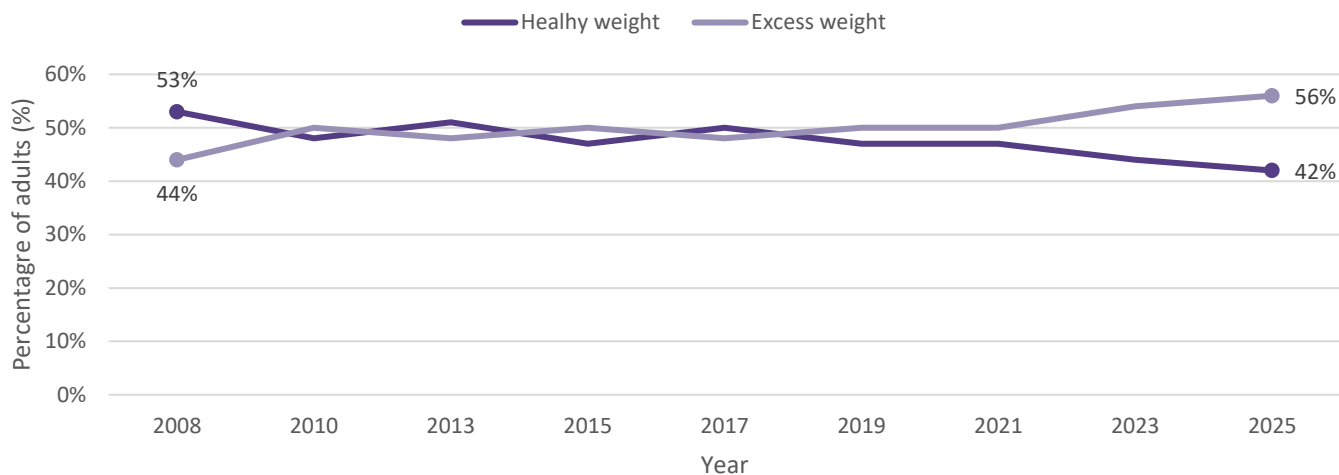
- just over half of adults (56%) in Jersey self-report living with excess weight (overweight or obesity), a level that has remained broadly unchanged in recent years
- excess weight was significantly more common among men (66% overweight or obese) than women (48%)
- socioeconomic inequalities persisted with excess weight being more common among adults experiencing financial strain, those with lower educational attainment, and those living in social rented housing
- clinically recorded obesity continues to rise, increasing from around 9,700 adults in 2016 to 12,560 in 2025 (equating to 11% to 14% of adults overall), indicating growing clinical need
- multimorbidity is common; over one quarter (26%) of adults with clinically recorded obesity having at least one other long-term conditions. Large numbers live with obesity alongside hypertension (~5,300), diabetes (~2,300) or both (~1,500)
- use of metabolic health treatments (e.g. weight management medication) is increasing, with more than 6,000 semaglutide and 2,600 tirzepatide items dispensed in 2025

## Self-reported weight status in Jersey adults

In 2025, self-reported data show that 42% of adults were a healthy weight, while 56% were living with excess weight (overweight or obese).

Long-term trend in excess weight prevalence amongst adults is fairly stable, although the proportion with excess weight has increased slightly from 50% in 2021 (Figure 1).

**Figure 1. Adult self-reported weight status, Jersey (2008 to 2025)**



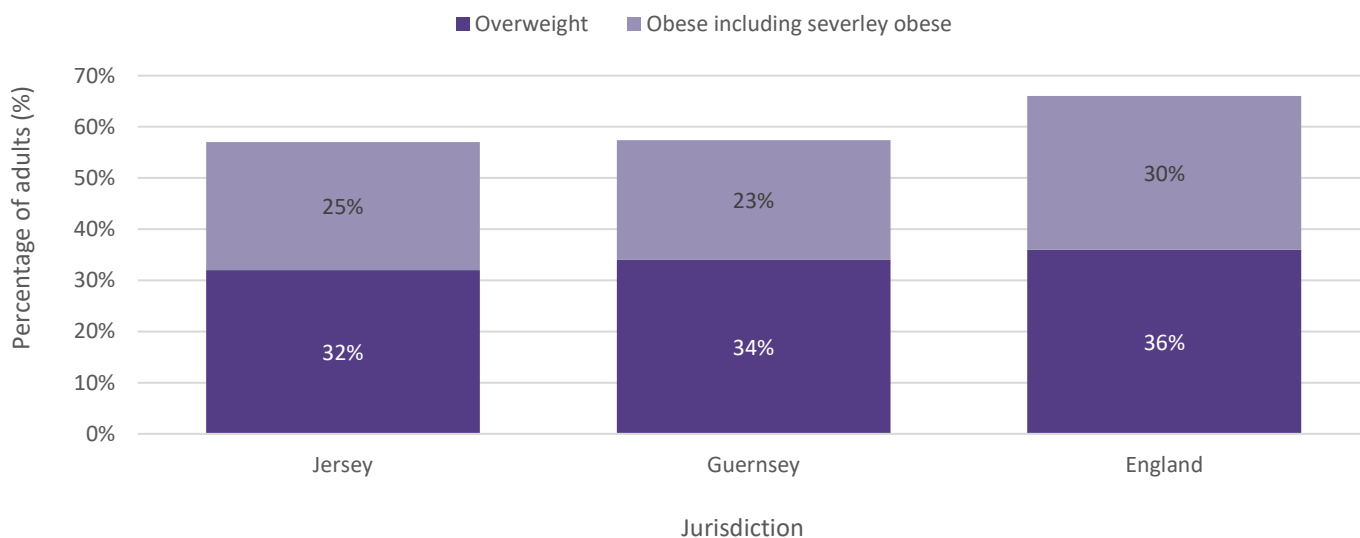
Source: JOLS

## Jersey in context: Adult BMI compared with Guernsey and England

Excess weight prevalence in Jersey and Guernsey is broadly similar (56% in Jersey, 57% in Guernsey<sup>6</sup>)

Both Jersey and Guernsey excess weight prevalence remains lower than the measured estimate in England (66%),<sup>7</sup> although this comparison is indicative only, due to different data collection methods.<sup>8</sup>

**Figure 2. Prevalence of excess weight, Jersey, Guernsey and England (2025)**



Source: JOLS 2025, NHS England; Guernsey MOH report 2024

\* Jersey/Guernsey: self-reported; England; measured

<sup>6</sup> Guernsey MOH Report 2023-24

<sup>7</sup> Adults' overweight and obesity - NHS England Digital

<sup>8</sup> Jersey & Guernsey = self-reported; England = measured; values are not directly comparable

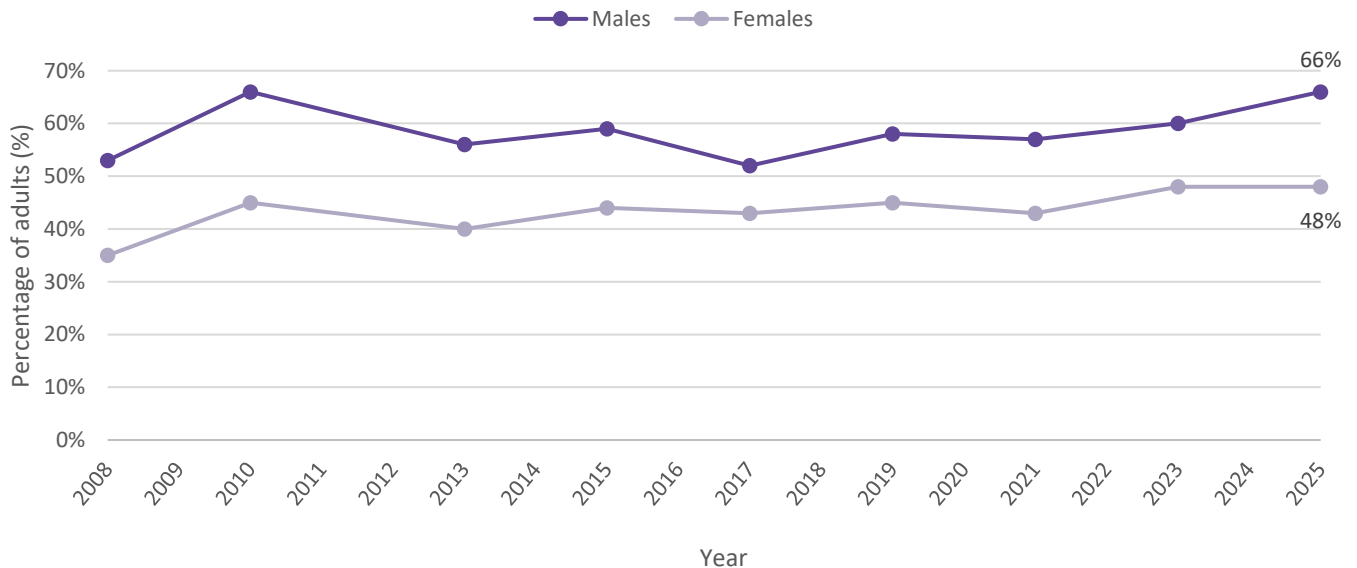
## Inequalities in adult obesity

This section examines how obesity is distributed across different groups within the population, providing insight into patterns and where certain groups may experience a higher burden of excess weight.

### By sex

Excess weight is more common amongst men than women in Jersey (66% vs 48% in 2025, Figure 3), consistent with England where men are also more likely to have excess weight (70% vs 62% in 2024).

**Figure 3. Adults living with self-reported excess weight, by sex, Jersey (2008 to 2025)**

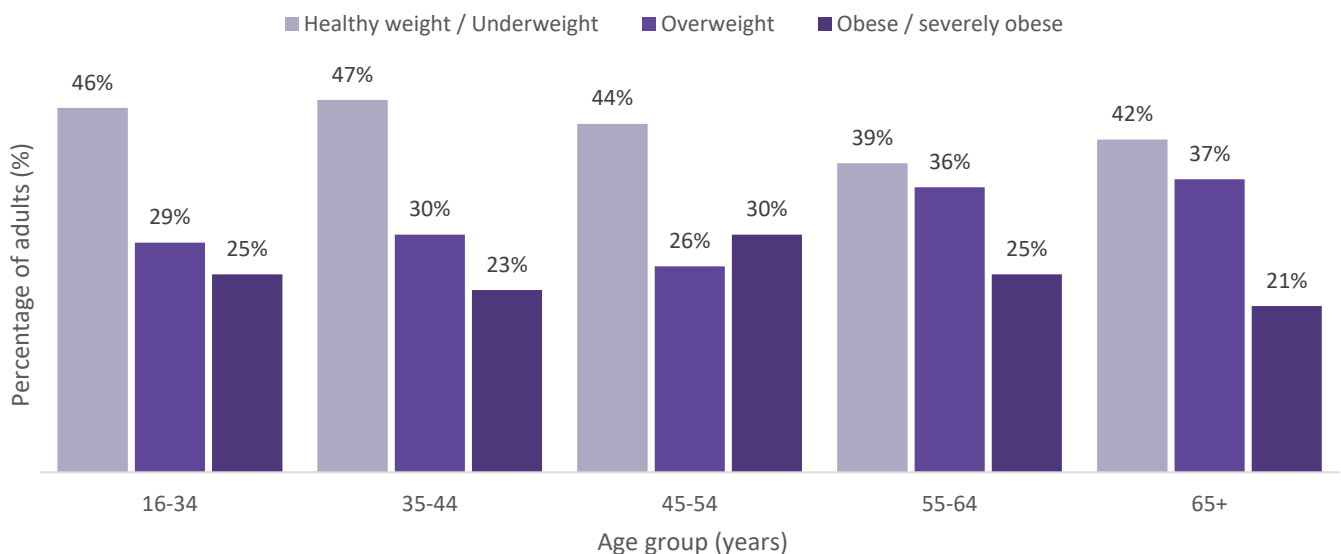


Source: JOLS

### By age

Healthy weight prevalence remains relatively stable on average up to age 54, then declines slightly in mid-life. Obesity is most prevalent in mid-life (age 45-54). England data shows a similar profile (obesity prevalence peaks age 55-74).

**Figure 4. Self-reported adult BMI classification by age group, Jersey (2025)**



Source: JOLS

## By ethnicity

Survey data indicates there are differences in average weight status across ethnic groups in Jersey<sup>9</sup>:

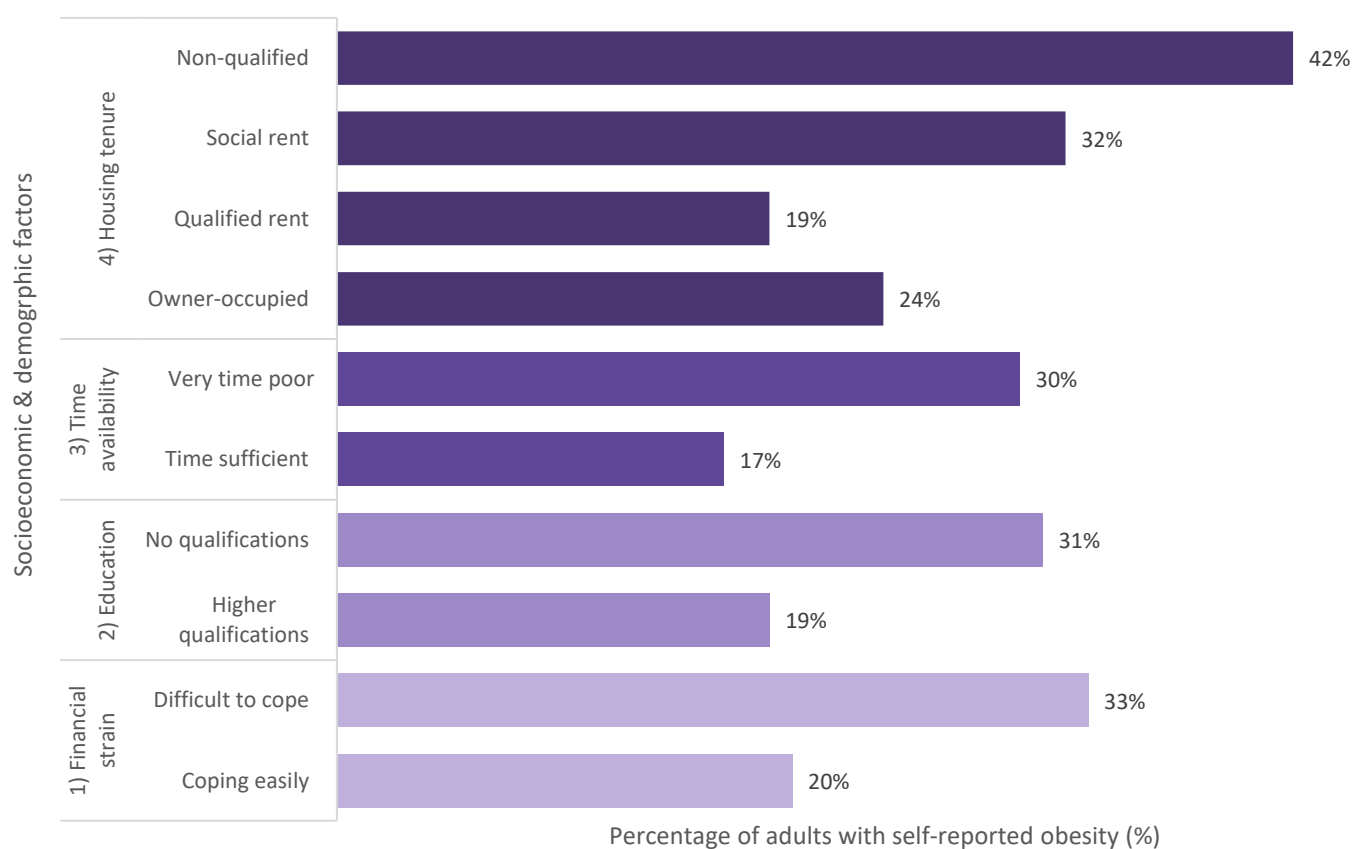
- self-reported obesity prevalence was highest among the Portuguese group (31%) and lowest among the 'Other' ethnicity group (19%), with Jersey and British & Irish groups somewhere in between (25-26%)
- healthy weight prevalence ranged from 34% in the Portuguese group, to 48% in the 'Other' ethnicity category and 42-45% in the Jersey and British & Irish groups
- overweight (as distinct from obesity) varies narrowly across ethnicity groups (between 30-35%), suggesting limited between-group difference in this category

## By socio-economic factors

Adult obesity in Jersey shows a consistent socioeconomic pattern, with higher prevalence among groups experiencing financial strain, lower educational attainment, limited time availability and less secure housing.

- obesity prevalence was higher (33%) amongst adults finding it difficult to cope financially, compared with those coping easily (20%)
- obesity prevalence was higher (31%) amongst those with no qualifications compared to those with higher qualifications (19%)
- obesity prevalence was higher (30%) among those who are very time-poor compared to those with sufficient time (17%)
- housing-related inequalities are also clear; obesity is higher among adults living in social rent (32%) and non-qualified accommodation (42%) compared with those in owner-occupied households (24%)
- there was no significant difference in obesity prevalence between different parish types

**Figure 5: Self-reported adult obesity (% prevalence) by socioeconomic factors, Jersey (2025)**



Source: JOLS<sup>10</sup>

<sup>9</sup> Please note that smaller sample sizes in some groups mean that estimates carry greater uncertainty.

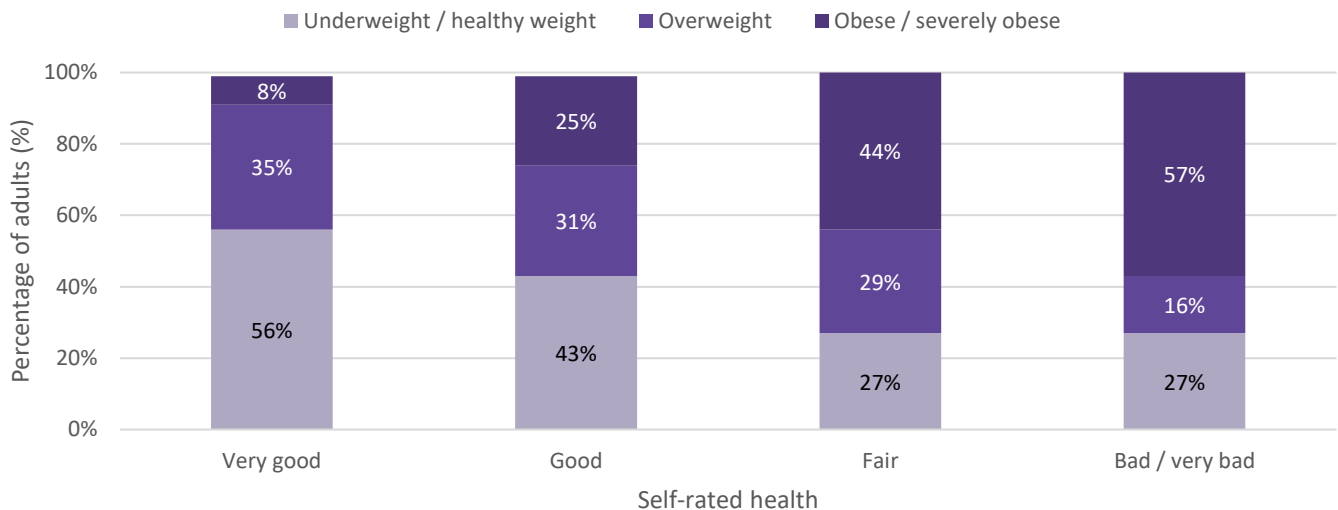
<sup>10</sup> [Jersey Opinions and Lifestyle Survey 2025 - Stakeholder reports | Statistics Jersey](#)

## By self-reported health

There is a clear correlation between BMI category and self-reported health

- those adults with “good” or “very good” health were more likely to self-report healthy weight, compared to those who describe their health as “fair” or “bad/very bad” (Figure 6)
- around three quarters (73%) of those rating their health as “fair” or “bad/very bad” fell into the overweight or obese BMI categories

**Figure 6. Adult BMI categories by self-reported general health, Jersey (2025)**



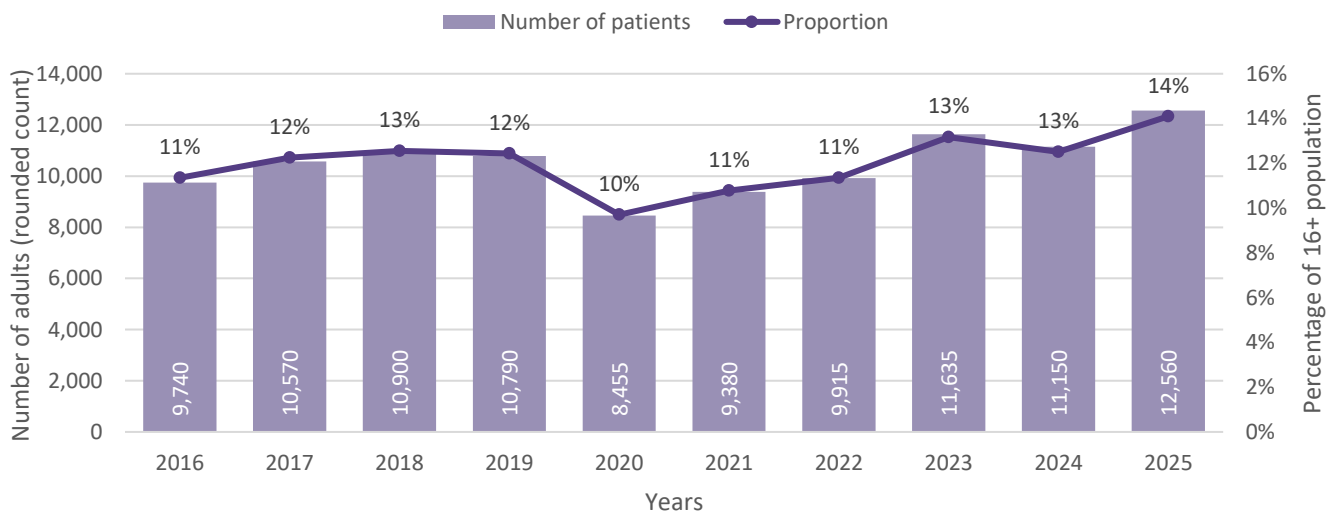
Source: JOLS Note: Bad/very bad n is small; interpret with caution

## Clinically recorded obesity (JQIF primary care register)

The Jersey Quality Improvement Framework (JQIF)<sup>11</sup> provides clinically recorded BMI data from GP practices, providing an additional measure of clinical obesity across the Island.

the number of adults aged 16+ with a recorded diagnosis of obesity has increased from approximately 9,700 in 2016 to around 12,560 in 2025 (rising from 11% to 14% of adults)

**Figure 7. Adults recorded with clinically recorded obesity, and proportion of 16+ population, Jersey (2016 to 2025)**



Source: EMIS JQIF register

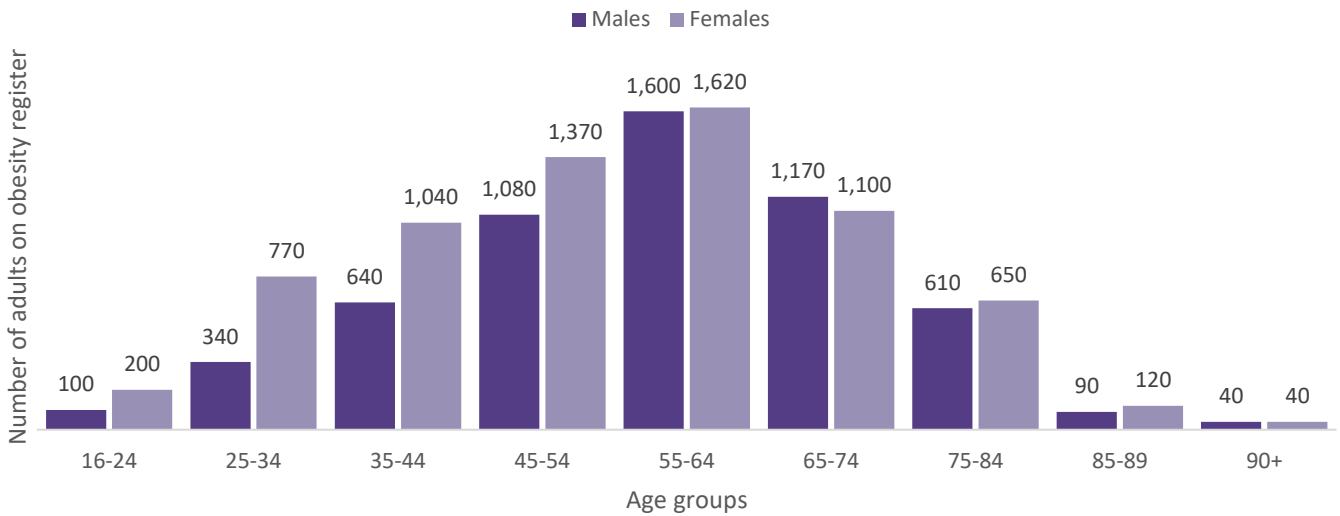
\*Numbers rounded to the nearest 5

<sup>11</sup> [Public Health Jersey Data Explorer - an interactive tool for exploring Jersey health and wellbeing data](#)

By age

Cases on the obesity register rise with age, peaking at age 55-64 for both sexes, before declining in older age groups.

**Figure 8. Adults with clinically recorded obesity, by age group and sex, Jersey (2025)**



Source: EMIS JQIF register  
 \*Numbers rounded to nearest 10

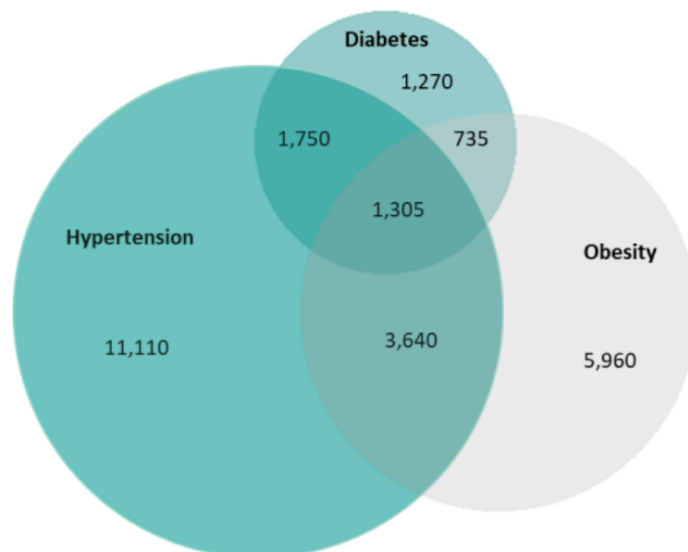
Multimorbidity and long-term conditions

Multimorbidity (having two or more long-term conditions) is common among adults with obesity. In 2025, 32% of adults with recorded obesity had one additional long-term condition, and 26% had two or more, indicating increasing clinical complexity.

Obesity frequently co-occurs with other long-term conditions. The most common combination of conditions are hypertension, diabetes, and obesity, which together affect around:

- 5,300 adults with both obesity and hypertension
- 2,300 with obesity and diabetes
- 1,500 with all three conditions

**Figure 9. Venn diagram showing the most common occurring triad of disease (Hypertension, Obesity and Diabetes), Jersey (2025)**

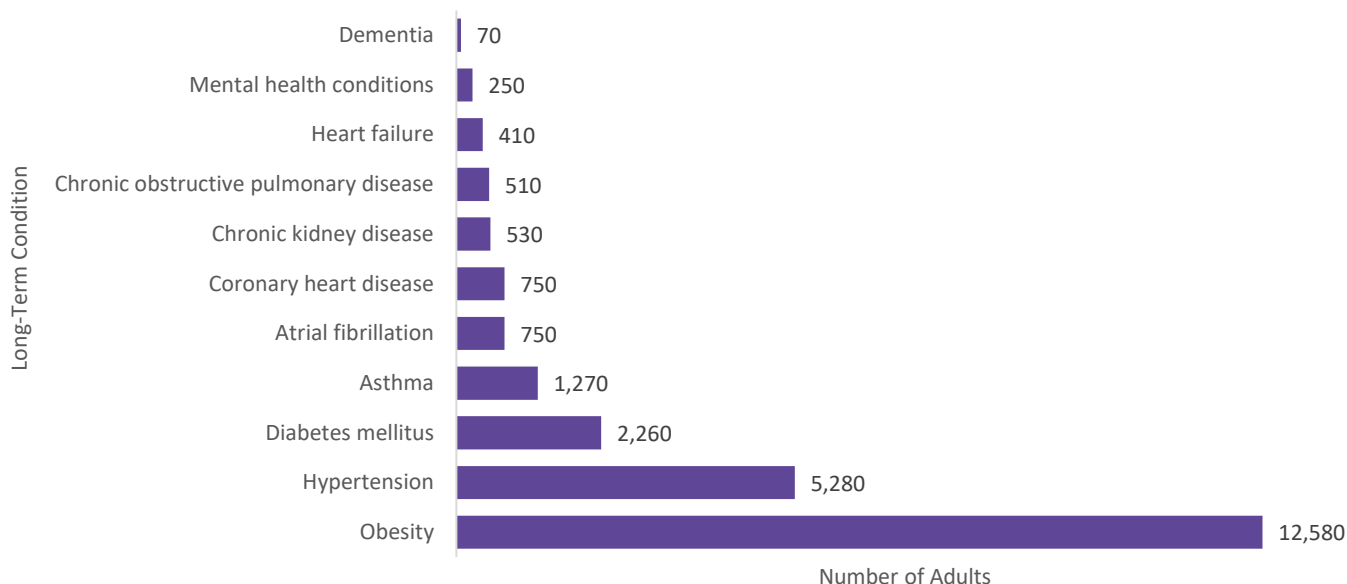


Source: EMIS JQIF register  
 Numbers rounded to nearest 5

Figure 10 shows co-occurring long-term conditions among adults with obesity; including asthma (around 1,270 adults), atrial fibrillation (around 750), coronary heart disease (around 750), chronic kidney disease (around 530), chronic obstructive pulmonary disease (around 510), and heart failure (around 410). Smaller numbers also have a recorded mental health condition (around 250) or dementia (around 70).

This pattern of overlapping conditions highlights the substantial clinical complexity experienced by many adults with obesity, reinforcing the importance of integrated, prevention-focused weight-management support across the health system..

**Figure 10. Prevalence of co-occurring long-term conditions among adults recorded with obesity, Jersey (2025)**



Source: EMIS JQIF register  
Rounded to nearest 10

## Prescribing for metabolic health

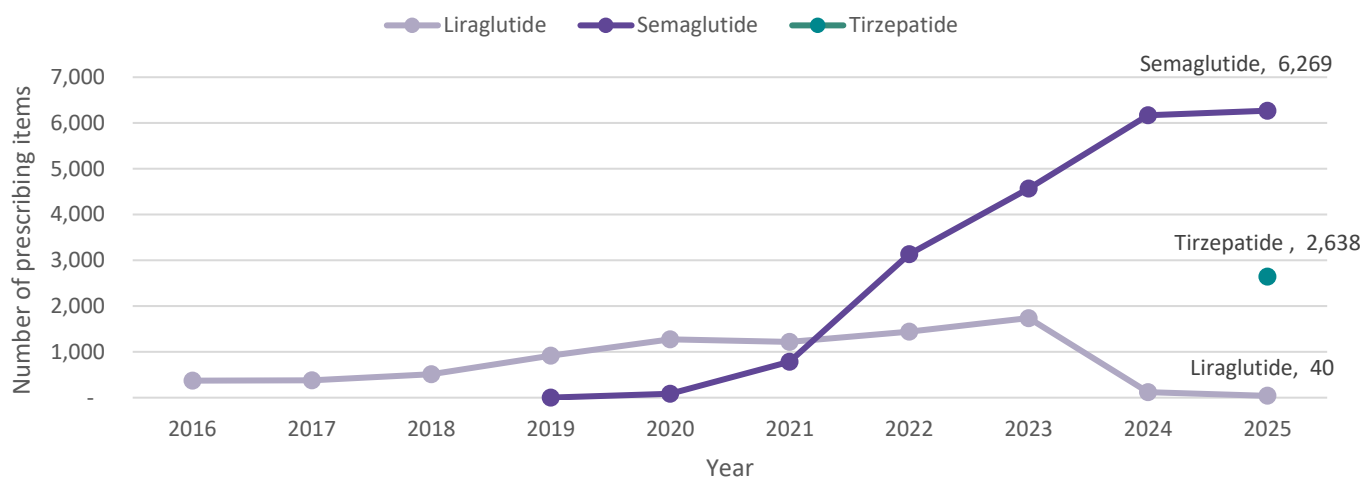
GLP-1 receptor agonists are medicines used primarily to treat type 2 diabetes. They help regulate blood sugar and, for some formulations, have additional benefits for weight. Although widely known as “weight-loss injections”, in Jersey they are funded only for type 2 diabetes, in line with NICE criteria. Their inclusion in this report is important because prescribing levels provide insight into population metabolic health and the burden of obesity-related conditions

Prescription data from Jersey’s Health Insurance Fund (HIF) show that community prescribing of GLP-1 agonists has increased substantially over time.

Prescribing of GLP-1 receptor agonists has risen in Jersey overall in recent years (Figure 11):

- dispensing of semaglutide rose from low levels in 2020 to over 6,000 items dispensed in 2025
- Tirzepatide dispensing has rapidly increased, with more than 2,600 items dispensed in its first full year of availability (2025)
- in contrast, liraglutide dispensing peaked in 2023 at around 1,700 items, before falling steeply to around 120 in 2024 and around 40 in 2025

**Figure 11. GLP-1 agonist prescribing, annual items dispensed in Jersey (2016 to 2025)**



Source: InPax (Prescribing Advisory Service, Government of Jersey)

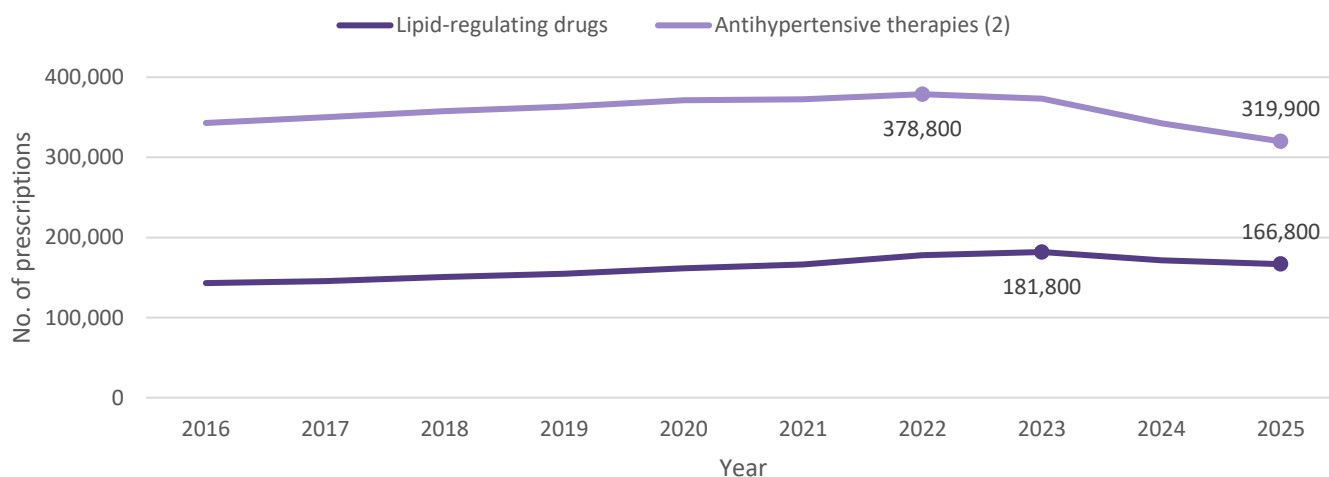
In addition to GLP-1 agonists, lipid-regulating drugs and antihypertensive therapies are included in this analysis because obesity is a major driver of high cholesterol and high blood pressure. These medicines are routinely prescribed to manage two of the most common cardiometabolic complications associated with excess weight and type 2 diabetes. As such, prescribing trends provide important context on the wider health burden linked to obesity and metabolic disease.

- prescribing activity for lipid-regulating drugs and antihypertensive medicines has remained high over the past decade; community dispensing of lipid-regulating drugs rose steadily from 2016, peaking at around 182,000 items in 2023 before reducing slightly to approximately 166,800 in 2025 (Figure 11)
- antihypertensive therapies show a similar trajectory, rising to nearly 379,000 items in 2022 before falling to around 319,900 in 2025 (Figure 12)

Prescribing volumes for lipid-regulating and antihypertensive medicines have fallen slightly in the past two years. This does not necessarily indicate reductions in underlying cardiovascular disease. Small declines in prescribing can occur for a number of reasons, including changes in prescribing practices, increased use of combination therapies, optimisation or deprescribing initiatives, or supply and pricing changes within specific drug classes. National evidence shows that prescribing activity may fluctuate even when cardiovascular disease prevalence remains stable.

HIF prescribing data do not capture privately purchased or online-sourced items, so the trends shown here should be interpreted as indicators of clinical activity rather than complete medicine use.

**Figure 12. Lipid-regulating and antihypertensive items dispensed, Jersey (2016 to 2025)**



Source: InPAX (Prescribing Advisory Service, Government of Jersey)

## Chapter 1b: Obesity in Children and Young People

Childhood overweight and obesity remain significant public health challenges in Jersey. Early excess weight affects physical, social and emotional wellbeing and increases the likelihood of obesity and long-term conditions in adulthood. The Jersey Child Measurement Programme (JCMP) provides measured height and weight for Reception (4-5 years) and Year 6 (10-11 years), and this year's analysis includes examination of height patterns alongside BMI.<sup>12</sup> A full analysis is available in the JCMP report ([Jersey Child Measurement Programme 2024-2025](#)). The key findings are summarised here.<sup>13</sup>

### Key findings

- around 28% of Reception-aged children and 33% of Year 6 children were living with excess weight (overweight or obesity) in 2024/25, based on professionally measured height and weight
- across 2007-09 to 2022-24, prevalence of excess weight in Reception has remained between 20-30%, and in Year 6 between 30-34%, indicating consistently high but stable levels over the past decade
- similar proportions of boys and girls were living with excess weight in both year groups: 28% vs 27% in Reception and 35% vs 31% in Year 6
- socioeconomic inequalities persist; Year 6 excess weight was between 34-38% in non-fee-paying schools compared with 21-24% in fee-paying schools; a similar gradient is present in Reception
- geographic differences are modest but consistent, 40% of Year 6 children in urban parishes were overweight or obese compared with 23% in rural parishes and 30% in semi-urban areas

### Children's BMI status

Children's BMI in the JCMP is derived from height and weight that are measured by trained Nurses from Family Nursing & Home Care (FNHC) using standardised equipment and procedures. These measurements are then plotted against age and sex-specific centiles from the UK/WHO growth charts to classify children into healthy weight, overweight, obese or severely obese categories. Further detail on methods and thresholds is provided in the Notes and Methods section, and full analysis is available in the JCMP 2024/25 report.<sup>14</sup>

The 2024/25 figures<sup>15</sup> indicate that excess weight prevalence is higher in Year 6 than in Reception, reflecting the typical increase seen as children age:

- in Reception, 28% of children were living with excess weight, comprising approximately 16% classified as overweight, 12% as obese including around 3% as severely obese
- in Year 6, 33% of children were living with excess weight, including around 13% classified as overweight, 19% as obese including approximately 4% as severely obese

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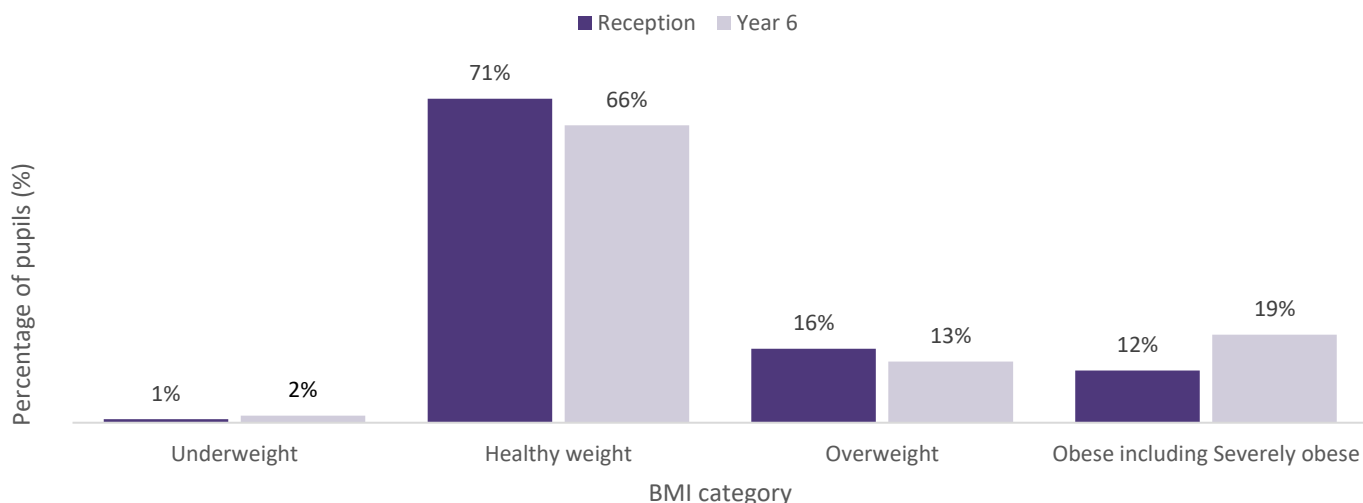
<sup>12</sup> Coverage in 2024/25 was 95%, ensuring reliable, population-level estimates.

<sup>13</sup> This report uses single-year data, while the JCMP uses three-year rolling figures. Differences between the two data sources are therefore expected.

<sup>14</sup> [Public Health Jersey Child Measurement report 2024-2025](#)

<sup>15</sup> This report presents single-year data to reflect the position within the reporting year. JCMP three-year rolling figures are designed to smooth natural year-to-year fluctuation. Because these methods offer different but complementary insights, figures may not be directly comparable.

**Figure 13 BMI categories for Reception and Year 6 pupils, Jersey (2024/25)**



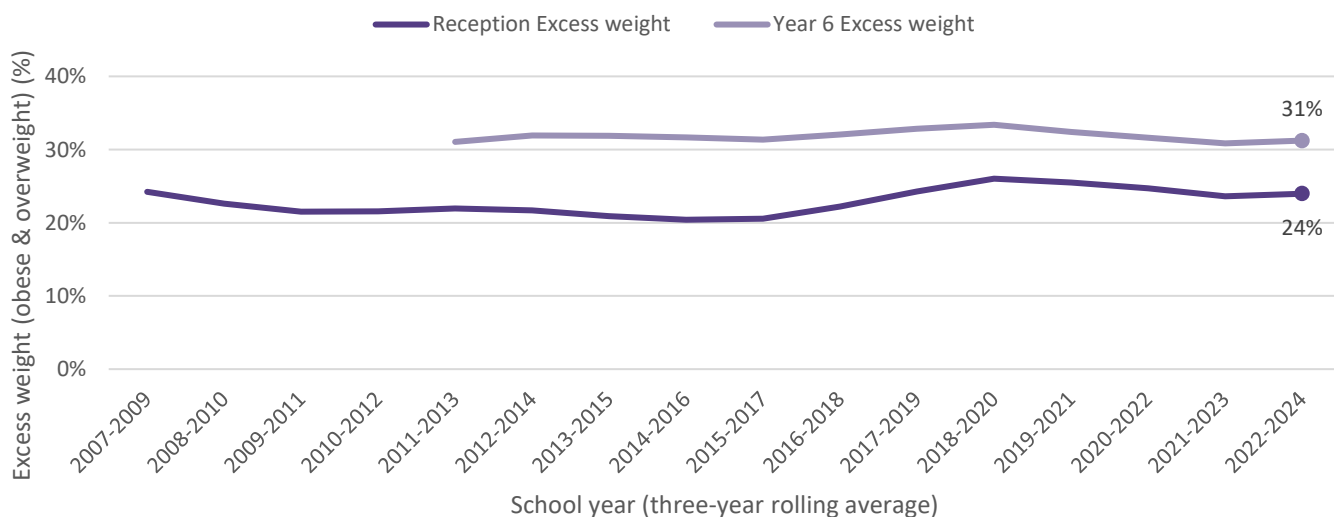
Source: JCMP, 2024/25

### Trends over time

Three-year rolling averages are used to smooth natural year-to-year variation and provide a more reliable view of long-term trends.

- excess weight among Reception-aged children has remained stable over the last 18 years, with only modest fluctuations
- among Year 6 pupils, prevalence has shown little movement, consistently ranging between 31% and 33% since records began in 2011

**Figure 14. Long-term trends in excess weight, Reception and Year 6, Jersey (2000/01 to 2024/25)**



Source: JCMP, 2001/01-02/03 to 2022/23-24/25

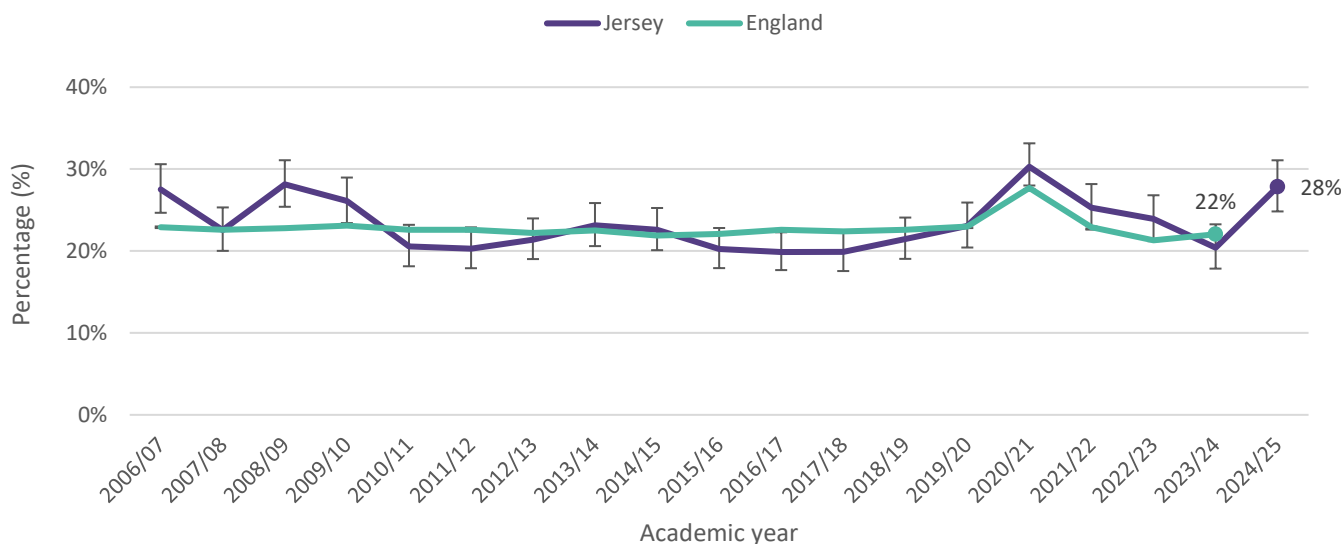
### Jersey in context: Children’s BMI compared with England

Reception excess weight has been similar between Jersey and England over time, with both typically ranging around 20-24%, and most year-to-year differences falling within expected statistical variation.

In 2020/21,<sup>15</sup> both jurisdictions saw a temporary rise linked to the COVID period (Jersey 30%, England 28%<sup>16</sup>).

<sup>16</sup> [National Child Measurement Programme, England, 2023/24 School Year - NHS England Digital](#)

**Figure 15. Reception overweight and obesity: Jersey compared with England (2006/07 to 2024/25)**

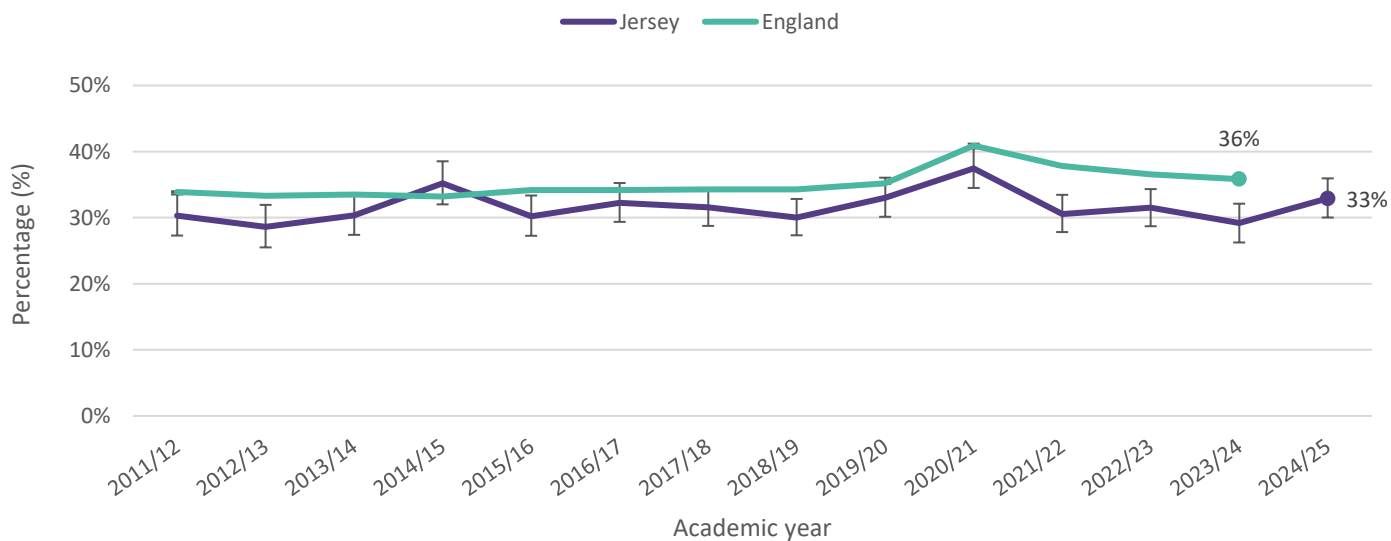


Source: JCMP; NCMP

Year 6 excess weight has been lower in Jersey than in England across most of the time period (2011/12 to 2024/25); Jersey has remained broadly 31-33%, compared with 34-41% in England.

The largest gap between the jurisdictions occurred in 2021/22, when English overweight/obesity prevalence amongst Year 6 pupils was 38% compared with Jersey's 31% (Figure 16).

**Figure 16. Year 6 overweight and obesity: Jersey compared with England (2011 to 2024)**



Source: JCMP; NCMP

## Inequalities in children’s obesity

### By sex

The proportions of girls classified as overweight or obese were similar to boys in both Reception and Year 6 (Table1).

**Table 1. BMI classifications by sex, proportion of Reception and Year 6 pupils, Jersey (2024/25)**

	Reception		Year 6	
	Boys	Girls	Boys	Girls
<b>Underweight</b>	1	<1	1	2
<b>Healthy weight</b>	71	72	64	67
<b>Overweight</b>	16	16	14	13
<b>Obese</b>	9	9	15	15
<b>Severely Obese</b>	3	2	6	3
<b>Excess weight (Combined Obese &amp; Overweight)</b>	<b>28</b>	<b>27</b>	<b>35</b>	<b>31</b>

Source: Jersey Child Measurement Programme 2024/25

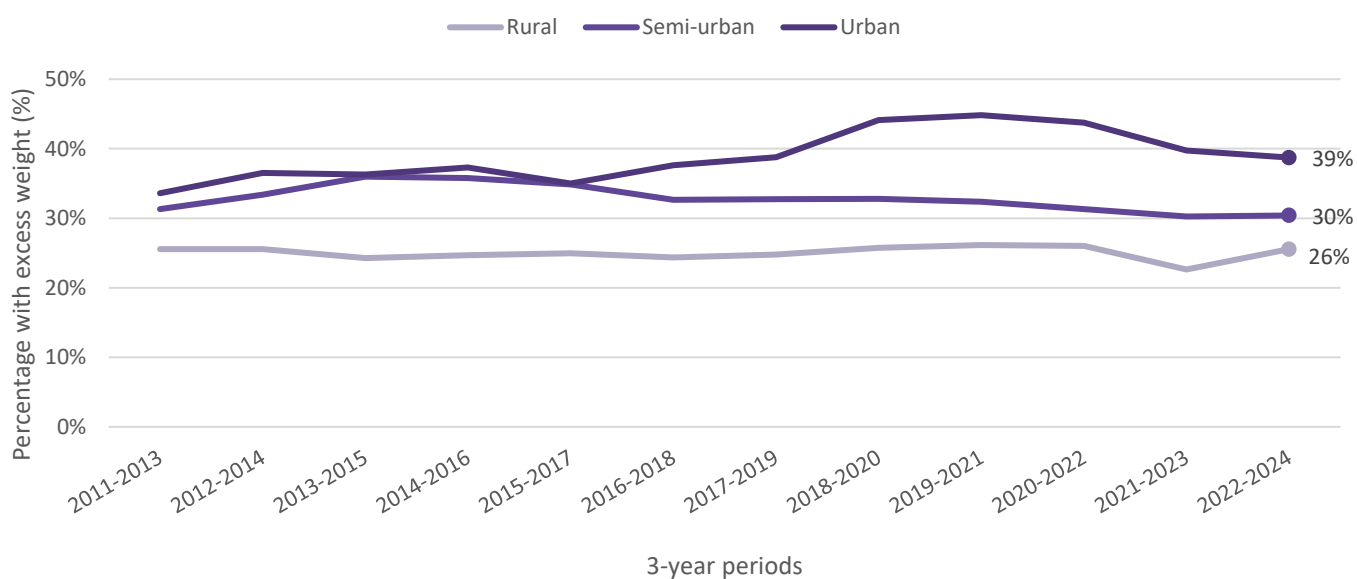
Note: percentages rounded to the nearest integer

Minor differences reflect rounding

### By area (parish type)

In 2024/25, 39% of Year 6 children in urban parishes were living with excess weight, compared with 30% in semi-urban areas and 26% in rural parishes.<sup>17</sup>

**Figure 17. Excess weight (overweight or obese) by parish type (three-year averages), Year 6, Jersey (2011 to 2024)**



Source: JCMP

<sup>17</sup> The parish of residence of each child was classified into:

- Urban - St Helier
- Semi-urban - St Brelade, St Clement, St Saviour
- Rural - Grouville, St John, St Lawrence, St Martin, St Mary, St Ouen, St Peter, Trinity

## By school fee status

There were higher rates of overweight and obesity in non-fee-paying schools in both Reception and Year 6 pupils.

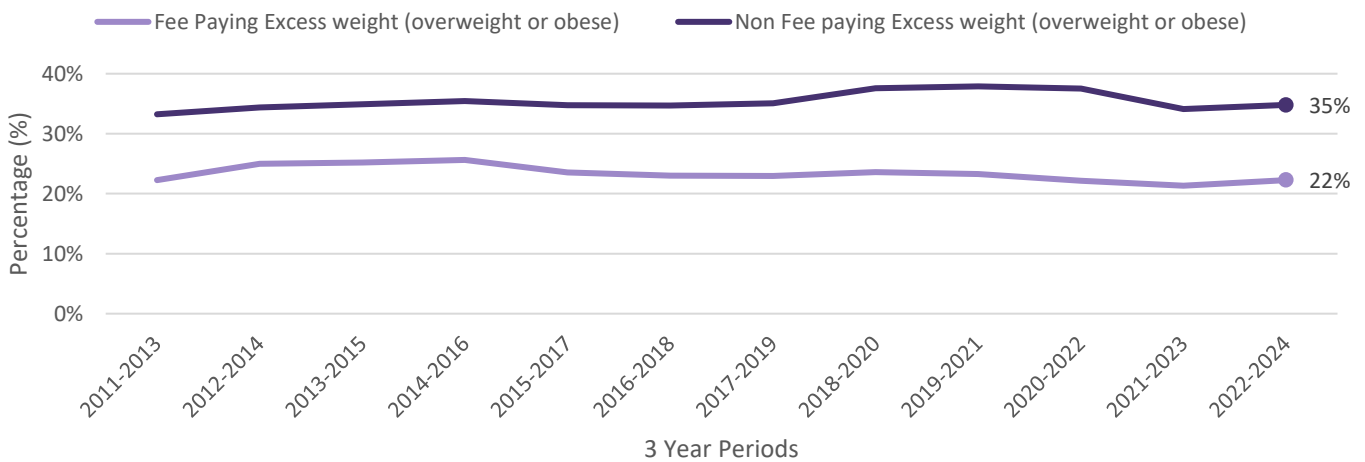
- among Reception-aged children, 25% in non-fee-paying schools were living with excess weight, compared with 22% in fee-paying schools
- in Year 6, 35% of pupils in non-fee-paying schools had excess weight, compared with 22% in fee-paying schools

This pattern is consistent over time; excess weight amongst Year 6 pupils has remained substantially higher in non-fee-paying schools, typically ranging from 34-38%, compared with 21-24% in fee-paying schools across recent three-year averages.

For Reception-aged children, the same gradient is visible, though the gap is smaller: prevalence of excess weight in non-fee-paying pupils ranged from 22-28%, compared with 14-22% in fee-paying schools.

Overall, inequalities widen with age, with differences between school types becoming more pronounced by Year 6 (Figure 18 illustrates this pattern for Year 6 pupils).

**Figure 18. Excess weight in Year 6 pupils by school fee status (three-year averages), Jersey (2011-2013 to 2022-2024)**



Source: JCMP

## Children’s height patterns

Height was included in the analysis for the first time this year to confirm whether differences in BMI reflected genuine differences in weight rather than unusual growth patterns or underlying nutritional deficits. Height is an important contextual indicator because children experiencing chronic undernutrition, illness, or other early-life disadvantage may present with lower-than-expected stature for their age, which can influence BMI and make weight-related patterns harder to interpret.

The close alignment between Jersey children’s height and UK/WHO reference medians shows no evidence of atypical growth. Average heights differ by only around  $\pm 2$  cm from the reference values, indicating normal growth patterns and providing confidence that BMI differences reflect weight, not unusual stature

**Table 2. Mean height of Jersey children compared with UK/WHO reference values (2024/25)**

Group	UK/WHO median (cm)	Jersey estimated (cm)	Difference (cm)
Reception boys	107.3	107.8	0.5
Reception girls	106.2	105.9	-0.3
Year 6 boys	146.9	148.8	1.9
Year 6 girls	147.6	149.2	1.6

Source: JCMP, 2024/25

## Chapter 2a: Diet in Adults

A healthy diet is central to preventing chronic disease and supporting overall wellbeing. UK guidance recommends at least five portions of fruit and vegetables per day, while limiting free sugars, saturated fat, and reducing intake of highly processed and energy-dense foods.<sup>18</sup> This chapter uses findings from population surveys (JOLS 2025, JCYP5 2024/25) and some administrative data on school meals and early years nutrition.

Because food environments shape what people eat, the chapter also considers exposure to fast-food and takeaway outlets, which UK evidence shows is linked with higher consumption of energy-dense foods and increased risk of obesity.<sup>19</sup>

### Key findings

- women were more likely than men to meet the five-a-day fruit and vegetable recommendation in 2025 (34% vs 28%)
- adults coping very easily financially were more likely to meet 5-a-day recommendations (43%) than those who found it very difficult to cope financially (20%)
- similar gradients across education, time availability, housing tenure and ethnicity, for example with adherence ranging from around 44% among adults with sufficient time and 34% among higher-qualified or owner-occupier groups to around 26-27% among time-poor adults and those in social rent
- fruit and vegetable intake increased steadily with age, ranging from 22% of 16-34-year-olds meeting recommendations to 43% of adults aged 65+
- food affordability pressures worsened in 2025, with 15% of households going without fresh fruit or vegetables and 41% going without at least one essential food item, both higher than in 2017
- Jersey's five-a-day intake remains similar to England but lower than Guernsey; 31% of adults in Jersey met 5-a-day recommendations compared to 42% of adults in Guernsey

### Fruit and vegetable consumption in adults

In 2025 around 31% of adults reported eating at least five portions of fruit or vegetables in the previous 24 hours

Longer-term trends show little change over the past decade:

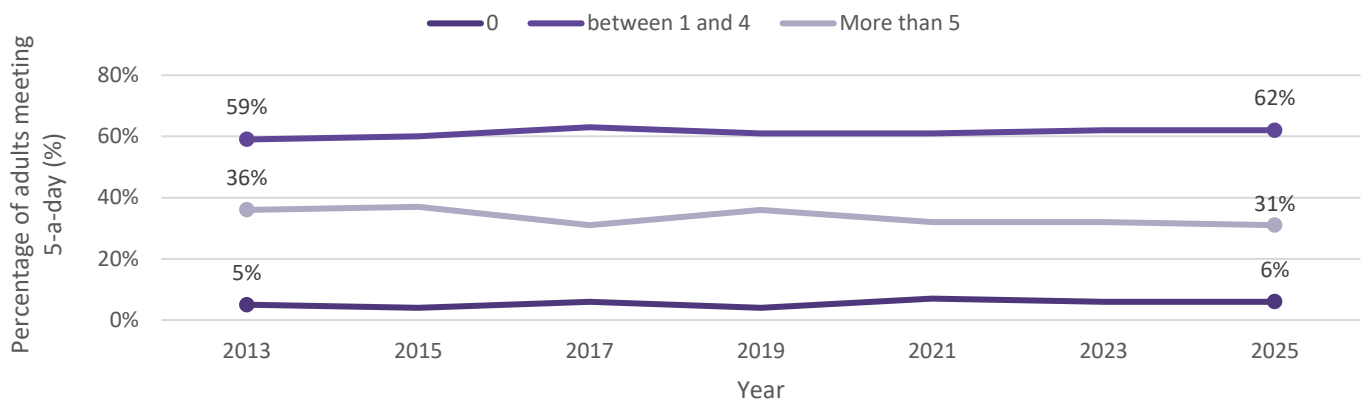
- between 2013 and 2025, the proportion of adults meeting the five-a-day recommendation has consistently ranged between 31% and 37%, with no sustained improvement
- most adults (typically around six in ten) reported eating between one and four portions, indicating that low-level consumption remains the norm

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<sup>18</sup> [The Eatwell Guide - GOV.UK](#)

<sup>19</sup> [Inequalities in concentration of fast food outlets | The Health Foundation](#)

**Figure 19. Fruit and vegetable portions consumed in the last 24 hours, Jersey (2013 to 2025)**



Source: JOLS, 2013-2025

## Inequalities in adult diet

### By sex

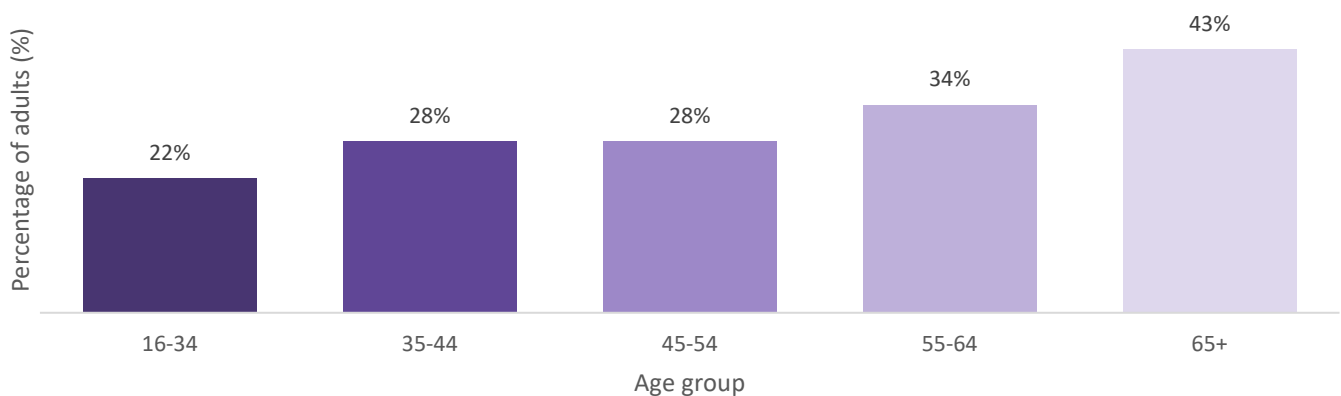
Women were more likely than men to meet the five-a-day recommendation, with 34% reporting that they ate five portions of fruit and vegetables the previous day compared with 28% of men.

### By age

Although the proportion of adults meeting recommended fruit and vegetable intake was below half in all age groups, an age gradient was observed.

Older adults were more likely to meet the five-a-day recommendation (22% of those aged 16-34, compared to 43% of those aged 65 and over); this age pattern was similar to previous years.

**Figure 20. Proportion of adults eating five portions of fruit or vegetables in the last 24 hours by age group (2025)**



Source: JOLS, 2025

### By socioeconomic factors

Clear socioeconomic inequalities were observed in fruit and vegetable intake.

- around 43% of adults coping very easily financially met the five-a-day recommendation, compared with only 20% of those finding it very difficult
- similar socioeconomic gradients were seen across other indicators; adherence was higher among adults with higher qualifications (34% vs 27-28% for those with no or secondary qualifications); among owner-occupiers (around 34% vs 26-27% in social rent), and among adults with sufficient time available (44% vs 26-27% among those who were very time-poor)

By ethnicity

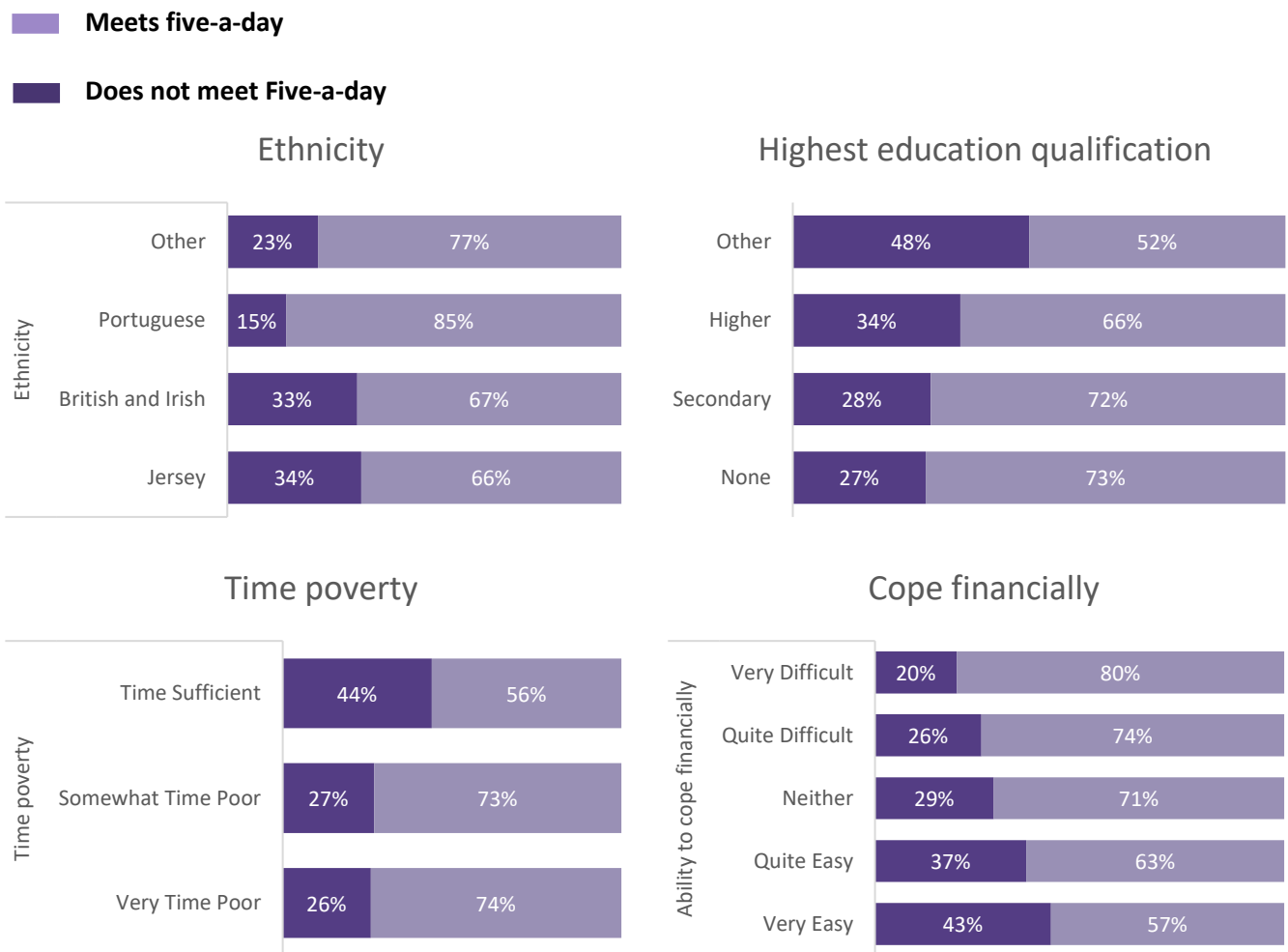
Differences by ethnicity were evident but smaller than socioeconomic inequalities. Adherence to the five-a-day recommendation was similar among Jersey and British & Irish adults (33-34%), lower among Portuguese adults (15%), and highest among those in the 'Other' ethnicity group (around 48%). Please note that small sample sizes in some ethnic sub-groups mean these estimates should be interpreted with caution.

Inequalities in adults' five-a-day intake

Adults' fruit and vegetable intake shows clear and consistent inequalities:

- five-a-day<sup>20</sup> adherence was highest among adults coping very easily financially (43%) and among those with sufficient time (44%), but fell to 20% among adults finding it very difficult to cope and 26-27% among those who were time-poor
- fruit and vegetable intake varied by educational attainment; adults with higher qualifications were more likely to meet the five-a-day recommendation (34%) than adults with no or only secondary qualifications (27-28%)

Figure 21. Adults meeting the recommended five-a-day intake, by demographic group, Jersey (2025)



Source: JOLS, 2025

Notes: "Meets five a day" refers to eating at least five portions of fruit and vegetables in the previous 24 hours, in line with UK public health guidance.

<sup>20</sup> [Why 5 A Day? - NHS](#)

## Food affordability, insecurity and self-reported health

Households experiencing food hardship reported markedly poorer health outcomes in 2025.

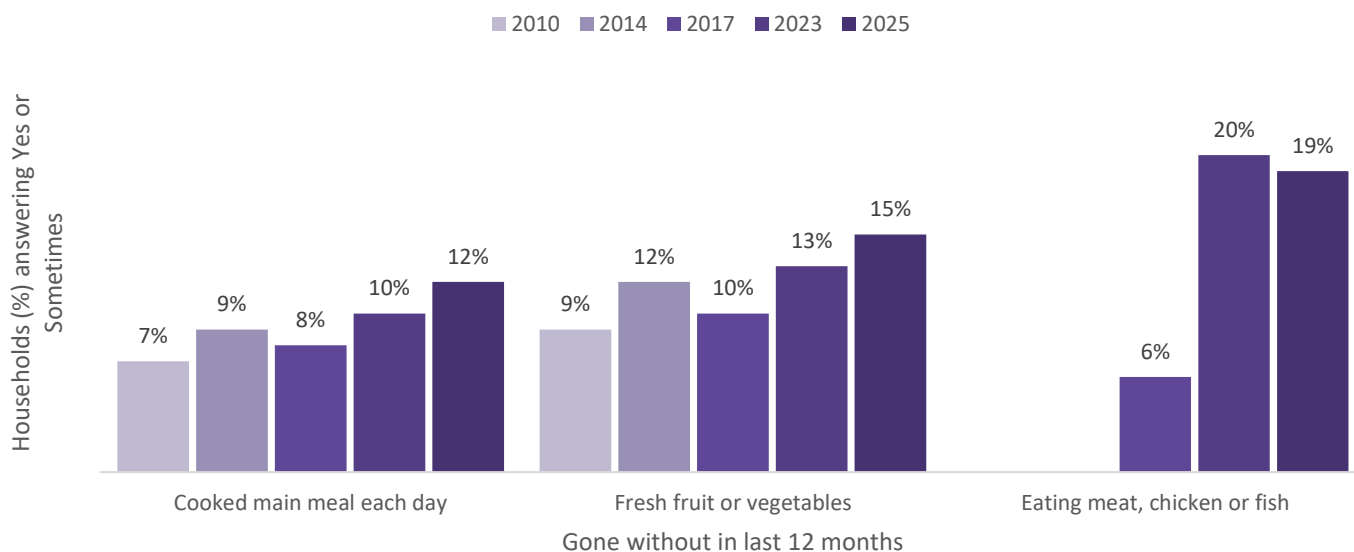
- around 16% of households went without fresh fruit or vegetables due to cost, and 41% went without at least one essential food item in the previous 12 months
- food insecurity was concentrated among lower-income households; in households with income below £40,000, 26% went without fruit or vegetables, and 29% went without a daily cooked meal, compared with much lower rates in higher-income groups
- food insecurity was strongly linked with poorer health; around four in ten adults who had gone without fruit or vegetables (40%) or a daily cooked meal (41%) reported their health as bad or very bad, compared with substantially lower levels among adults who did not experience food insecurity

These patterns highlight the close relationship between material deprivation, reduced access to nutritious food, and poorer self-reported health, reinforcing wider inequalities seen across diet and healthy behaviours in Jersey.

Food hardship has increased across all indicators since 2010.<sup>21</sup>

- the proportion of adults going without a cooked main meal rose from 7% to 12% between 2010 and 2025, and those unable to afford fresh fruit or vegetables increased from 9% to 15%
- affordability pressures were greatest for protein-rich foods, with adults going without meat, chicken or fish rising sharply from 6% in 2017 to 19% in 2025, following a peak of 20% in 2023

**Figure 22. Adults going without key food items (2017 to 2025)**



Source: JOLS, 2010-2025

<sup>21</sup> Question change: from 2017 the response option is “fruit or vegetables”. For 2010/2014, separate ‘fruit’ and ‘vegetables’ responses have been combined to align; treat 2010/2014 vs 2017+ as broadly comparable but not identical.

## Jersey in context: Diet quality compared with Guernsey and UK

Jersey's five-a-day intake is similar to England but below Guernsey:

- in England (2023/24), 31% of adults met the five-a-day recommendation (women 35%; men 28%);<sup>22</sup> in Guernsey (Wellbeing Survey 2023), around 42% of adults reported meeting the guideline, down from about 50% in 2018, but still higher than England<sup>23</sup>

Wider international indicators reflect pressures on diet quality:

- across the UK, an estimated 11% of people lived in *food-insecure households* in 2023/24, rising to 25% among people in poverty and 33% of children<sup>24</sup>
- in Guernsey, food insecurity has been highlighted in the Medical Officer of Health commentary, noting cost-of-living impacts on access to healthy food<sup>25</sup>

### Food environment: Fast-food outlet density

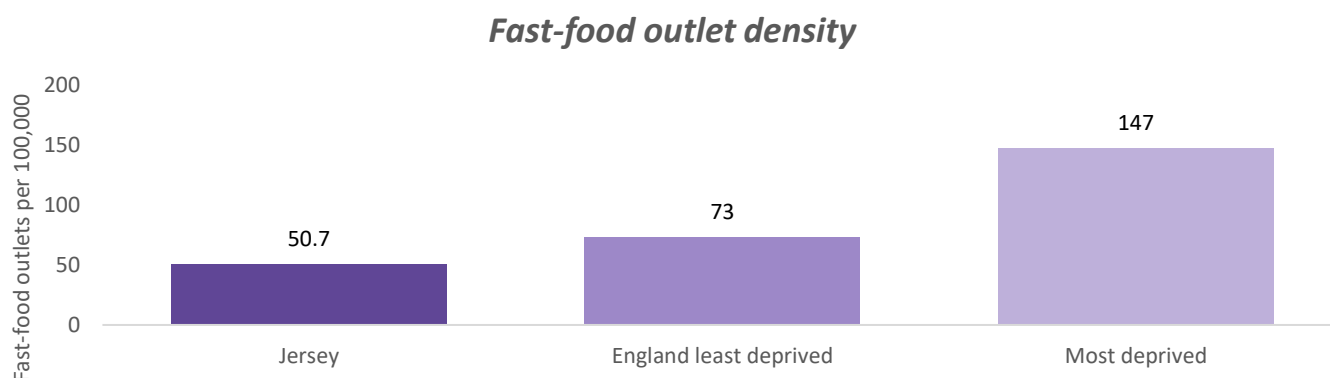
International evidence shows that the 'food environment', including the availability, affordability and marketing of foods, strongly shapes people's ability to eat a healthy, balanced diet and is a key driver of obesity trends.<sup>26</sup>

The **Food Premises Register** provides an overview of the types and distribution of food outlets operating across Jersey. Work is currently underway to improve the classification of outlets, distinguishing more clearly between healthier options and more energy-dense or fast-food-oriented premises, but data as at February 2026 has been used to give an indication of fast-food outlet density in Jersey.

Using the Department of Health and Social Care (DHSC) approach applied in England, 53 Jersey premises met the fast-food criteria in 2024. Based on a population of 104,540 (end-2024), this equates to 50.7 fast-food outlets per 100,000 residents. Applying the same method, England recorded 115.9 per 100,000 in 2024, with a strong deprivation gradient (147 per 100,000 in the most deprived areas vs 73 in the least deprived).<sup>27</sup>

Although the same Department of Health and Social Care (DHSC) methodology has been applied, caution is needed when comparing Jersey with England, as differences in geography, population density, and the classification of mixed-use premises may influence outlet counts. The data currently available suggests Jersey's fast-food outlet density is less than half England's. This is an important baseline for future monitoring of the local populations' exposure to energy-dense food options.

**Figure 23. Fast-food outlet density per 100,000 population, Jersey vs England, 2024**



Sources: Jersey Environmental Health, 2025, OHID Wider Determinants of Health, 2024

<sup>22</sup> National Diet and Nutrition Survey (2019-2023)

<sup>23</sup> Guernsey Wellbeing Survey 2023

<sup>24</sup> [Food poverty: Households, food banks and free school meals - House of Commons Library](#)

<sup>25</sup> Guernsey 117th Medical Officer of Health Report 2023-2024

<sup>26</sup> [Obesity and overweight factsheet - World Health Organisation](#)

<sup>27</sup> OHID Wider Determinants of Health, 2024

## Chapter 2b: Diet in Children and Young People

### Key findings

- girls reported slightly higher fruit and vegetable intake than boys, with 71% of girls eating fruit frequently (on 4+ days per week) compared with 67% of boys, while boys were more likely to eat meat frequently (65% vs 58%)
- socioeconomic inequalities were marked, with regular fruit and vegetable intake ranging from 47% among pupils in financially struggling households to 84% among those who were very well off, with similar gradients by school type and family structure
- diet quality declined with age, with regular fruit intake falling from 79% in Year 4 to 65% in Year 12, while consumption of sugary drinks rose (e.g., energy drink use on  $\geq 4$  days rose to 11% by Year 12, with 3% drinking them more than once a day)
- less healthy eating behaviours tended to cluster, with 60% of pupils who ate crisps on four or more days a week also consuming sweets or chocolate frequently
- ethnic and geographic differences were modest, with fruit intake slightly higher among pupils in rural areas (80%) compared with urban areas (73%), and only small differences between ethnic groups (e.g., 77% vs 73% for frequent fruit intake)

### Dietary behaviours among children and young people

This section draws on self-reported data from the Jersey Children and Young People Survey (JCYPs) to describe diet quality, fruit and vegetable intake, energy drink consumption, and related inequalities among young people.<sup>28</sup>

Dietary patterns varied by age, gender and household circumstances.

- girls were more likely than boys to eat fresh fruit (79% vs 74%) and salads and vegetables (68% vs 62%) on four or more days a week, while boys were more likely to eat meat (66% vs 56%) of girls
- less healthy snacking behaviours tended to cluster; among pupils who ate crisps on four or more days a week, 60% also ate sweets or chocolate on four or more days, compared with 30% among pupils who did not eat crisps that frequently

Unhealthy drink consumption increased with age.

- by Year 12, just over 1 in 10 pupils drank energy drinks on four or more days in the previous week (up from, with 3% reporting use more than once a day)
- regular fruit consumption declined steadily with age; 79% of Year 4 pupils ate fresh fruit on four or more days a week, falling to 65% by Year 12

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<sup>28</sup> JCYPs 2024

## Inequalities in diet

Economic circumstances strongly shaped diet quality;

- pupils from financially secure households were far more likely to eat fruit and vegetables on four or more days per week (84%) than those experiencing financial strain (47%)
- school type influenced diet with pupils in fee-paying schools reported healthier eating patterns than pupils in non-fee-paying schools; 83% of pupils in fee-paying schools reported eating fruit and 76% eating salad or vegetables on four or more days per week, compared with 73% and 60% respectively in non-fee-paying schools. Fee-paying school pupils also consumed fewer unhealthy drinks, including energy drinks (4% vs 8%) and other fizzy drinks (9% vs 14%) on four or more days per week.
- pupils living with two parents were more likely to eat fruit and vegetables regularly (around 75-80%) than those in single-parent or blended households (around 60-65%)
- geographic differences were modest; around 80% of pupils living in rural parishes ate fruit frequently and 70% ate vegetables regularly, compared with 73% and 60% respectively in urban parishes
- ethnic differences were small; regularly fruit and vegetable intake varied only slightly (differences of <5%) between ethnic groups

These patterns mirror adult inequalities, highlighting the role of social and material circumstances in shaping dietary opportunities for young people.

## Early life nutrition

Early life feeding patterns provide important context for healthy growth and later obesity risk. Breastfeeding and early feeding practices are important because they lay the foundations for healthy growth and later behaviour. Evidence consistently links breastfeeding with lower childhood obesity risk, healthier appetite regulation, and reduced exposure to free sugars in infancy.<sup>29</sup> Infants who are breastfed are more likely to develop healthier dietary patterns in later childhood,<sup>30</sup> and early growth trajectories tend to track into adolescence and adulthood.<sup>31</sup>

The Births and Breastfeeding Profile 2025<sup>32</sup> reports indicators on infant feeding and weight in Jersey:

In 2025:

- 72% of babies received breast milk as their first feed, matching the England benchmark
- 71% were breastfed at the 6-8-week review (69% of all babies born in 2025), up from 45% in 2010
- at discharge, 84% were breastfed, including 48% exclusively, with lower rates among mothers aged under 25
- at 12 months, 28% of babies were still breastfed (21% exclusively)
- 6% of babies were low birthweight, including 2% of full-term births, similar to England's 3%

These indicators show continued improvement in early feeding - particularly sustained breastfeeding - while also highlighting demographic and clinical factors that shape early growth.

## “Healthy Start” vouchers

“Healthy Start” vouchers provide low-income pregnant women and families with children under four with financial support to buy essential healthy foods such as fruit, vegetables and milk, helping to protect diet quality during critical stages of growth and development. Schemes such as this are widely recognised in UK public health as an important measure for reducing early-life nutritional inequality and supporting healthy infant feeding and weaning practices.<sup>33</sup>

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<sup>29</sup> [WHO/Health Topics/Breastfeeding](#)

<sup>30</sup> [Infant feeding and growth trajectories in early childhood: the application and comparison of two longitudinal modelling approaches. - Abstract - Europe PMC](#)

<sup>31</sup> [WHO Interventions/Exclusive breastfeeding to reduce the risk of childhood overweight and obesity](#)

<sup>32</sup> [Births and Breastfeeding Profile 2025](#)

<sup>33</sup> [Healthy Start Briefing April 2025](#)

In Jersey, the Healthy Start scheme is run, funded and administered by the Government of Jersey, with eligibility assessed through the Income Support system and additional access supported by midwives and Health Visitors (FNHC) for families identified as “living in need”.

As of January 2026, around 550 eligible parents and carers in Jersey were receiving “Healthy Start” vouchers, covering just under 700 children (including pregnancies).

The scheme therefore plays a small but important role in supporting families under financial strain during pregnancy and the early years.

## School meals & breakfast clubs

### Breakfast clubs

Breakfast clubs can play an important preventive role by ensuring children have reliable access to a nutritious morning meal, supporting concentration, behaviour and readiness to learn throughout the school day. They are particularly valuable for pupils experiencing financial strain, helping to reduce dietary inequalities and acting as a buffer against food insecurity in households under pressure.<sup>34</sup>

While centralised usage data are not yet available in Jersey, breakfast clubs remain an important early-years setting for promoting healthier dietary routines and supporting wider child wellbeing.

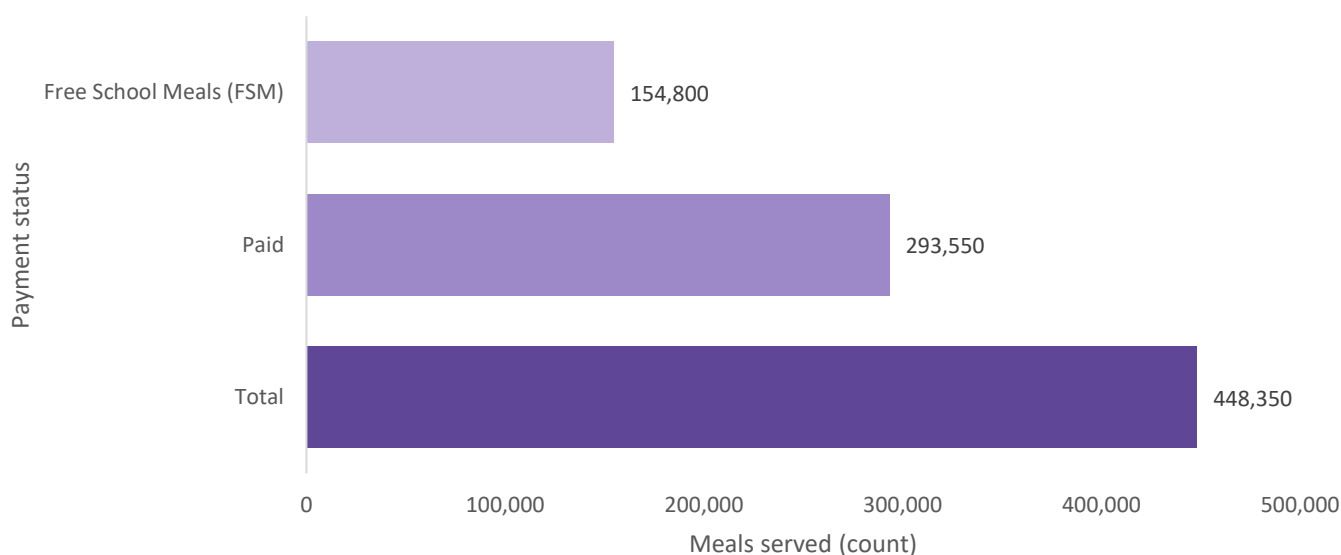
### School meals and early-years food support

School environments strongly influence children’s eating habits, physical activity and screen time routines. Free School Meals (FSM) provide a stable, nutritious meal for pupils who may otherwise face inconsistent access to healthy food, reducing some of the impact of household financial strain. Because school type and FSM uptake often correlate with socioeconomic context, differences observed by school setting can highlight broader inequalities in diet and physical activity.

In 2025:

- approximately 5,360 primary pupils received school meals
- over the year, around 448,350 meals were served in total, comprising 154,800 Free School Meals and 293,550 paid meals, with Free School Meals accounting for around one-third of all meals provided.

**Figure 24. Primary school meals served by payment status (2025)**



Source: CYPES, 2025

<sup>34</sup> [The Healthy Start scheme in England “is a lifeline for families but many are missing out”](#): National Library of Medicine

## Chapter 3a: Physical Activity in Adults

Regular physical activity helps prevent and manage long-term conditions, supports mental wellbeing and sleep, and benefits health at any weight. This chapter draws primarily on Jersey Opinion and Lifestyle Survey (JOLS) 2025 for adults. Where comparisons with England are made, they use Sport England’s Active Lives surveys<sup>35</sup> and non-comparable measures are clearly labelled (e.g., Guernsey).

The UK Chief Medical Officers recommend that adults aim for at least 150 minutes of moderate intensity activity per week, or 75 minutes of vigorous activity, or a combination of both, spread across the week.<sup>36</sup> Adults should also include muscle strengthening activities on at least two days each week and minimise long periods of sitting by breaking up sedentary time.

These guidelines reflect strong evidence that regular physical activity reduces the risk of major conditions such as type 2 diabetes, heart disease and depression, and supports good sleep, mobility and overall wellbeing.

### Key Findings

- around 54% of adults met the UK Chief Medical Officers’ activity guidelines in 2025, remaining below the level reported in England (64%)<sup>37</sup>
- a clear gender difference was evident, with higher activity among men (61% meeting guidelines) than women (48% meeting guidelines).
- inequalities persist, with higher activity among men, younger adults, those coping easily financially, adults with sufficient time, and owner-occupiers, and lower activity among women, older adults, and those facing financial or time pressure
- physical activity followed a strong health gradient; 73% of adults reporting very good health met the guidelines compared with 21% of those reporting bad or very bad health
- active travel contributed meaningfully to overall activity, with 32% of adults making most journeys by walking or cycling, particularly in St Helier and among younger adults
- time poverty remains a major barrier; fewer than half (46%) of adults who were very time poor met the recommended exercise guidelines, compared to two thirds (67%) of those who were time sufficient, and 26% of adults who were very time-poor reporting lower leisure time satisfaction

### Adult physical activity levels

In 2025, 54% of adults in Jersey met the UK Chief Medical Officers’ guidelines **Error! Bookmark not defined.** (150+ minutes of moderate activity or 75+ minutes of vigorous activity per week, plus strength on two days). In England, 64% of adults met the guidelines in 2023/24, indicating scope for improvement locally<sup>38</sup>

### Trends over time

The proportion of adults meeting the recommended weekly level of physical activity has remained broadly stable over recent years.

In 2019, 51% of adults reported being active above the recommended threshold, increasing slightly to 55% in 2023 and reaching 54% in 2025. This pattern is consistent with previous JOLS findings that adult activity levels in Jersey typically hover around half of the population reporting sufficient activity, with only modest year-to-year variation.

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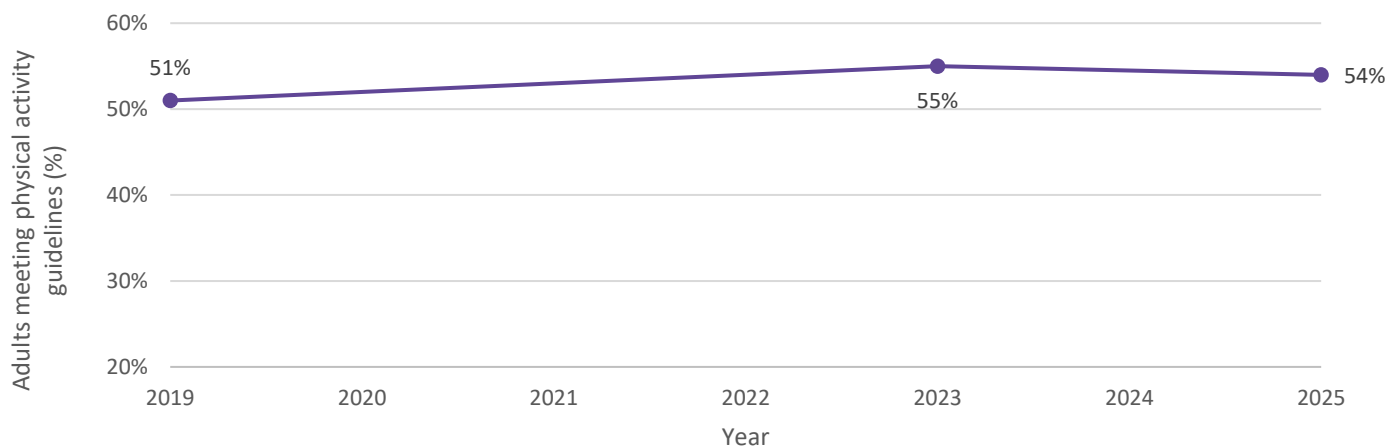
<sup>35</sup> [Active Lives | Sport England](#)

<sup>36</sup> [Physical activity guidelines - GOV.UK](#)

<sup>37</sup> [Jersey Opinions and lifestyle Survey | Statistics Jersey](#)

<sup>38</sup> [Sport England — Active Lives Adult Survey 2023/24](#)

**Figure 25. Adults meeting weekly physical activity guidelines, Jersey (2019 to 2025)**



Source: CYPES, 2025

### Jersey in context: Comparison with Guernsey and England

In Jersey, 54% of adults met the UK Chief Medical Officers’ activity guidelines in 2025, which is lower than the 64% of adults meeting the same guideline in England (Active Lives 2023/24).<sup>39</sup>

Guernsey’s measures are not directly comparable. Guernsey uses a different calculation to assess physical activity (≥30 minutes on 5 or more days per week), reported through the Wellbeing Survey.<sup>40</sup> Therefore, comparisons with other jurisdictions provide only a broad directional benchmark.

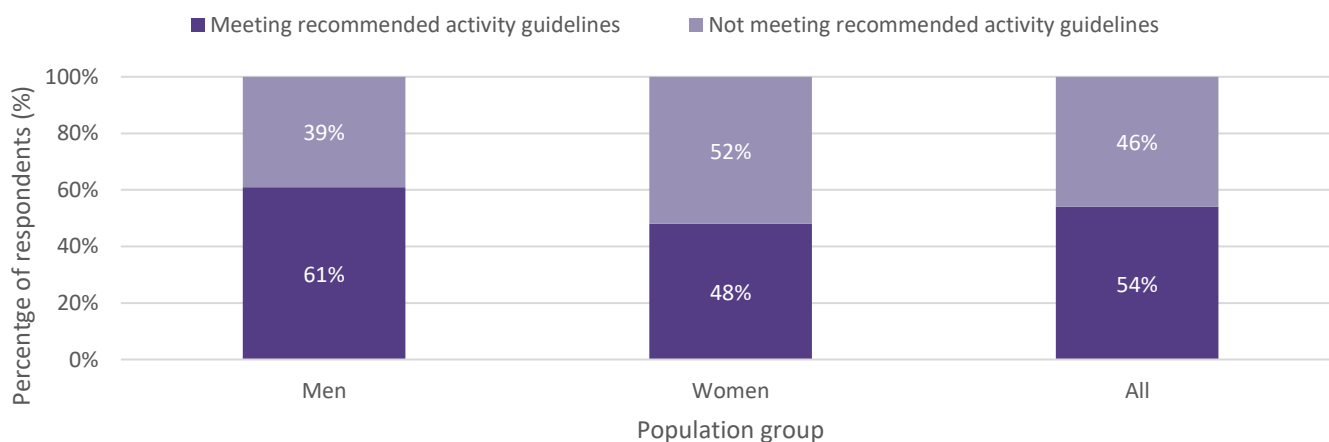
In the latest available Guernsey survey (2023), 20.8% of respondents had not been active on any day, while 18.1% had been active every day. Overall, 37.7% achieved 30 minutes or more of physical activity on five or more days per week, a proxy for meeting WHO guidance.

### Inequalities in adult physical activity

#### By sex

In 2025, 61% of men met the recommended activity guidelines compared with 48% of women, a gap consistent with long-standing patterns observed in England.

**Figure 26. Adults meeting physical activity guidelines by sex, Jersey (2025)**



Source: JOLS, 2025

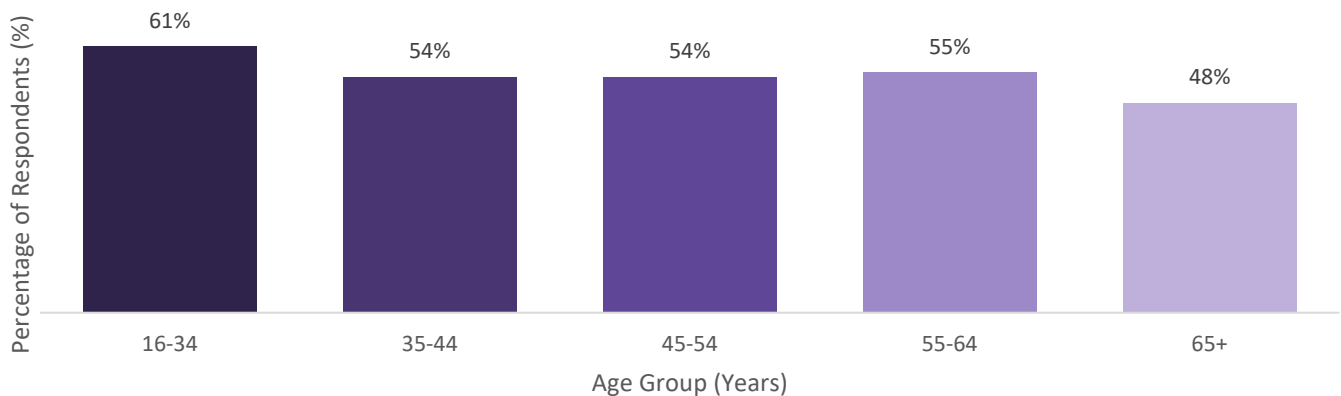
<sup>39</sup> [Record numbers playing sport and taking part in physical activity | Sport England](#)

<sup>40</sup> [Guernsey and Alderney Wellbeing Survey 2023](#)

## By age

In Jersey, 61% of adults aged 16-34 met the recommended activity levels, compared with around 54-55% of those aged 35-64 and 48% of adults aged 65+ (as shown in Figure 27).

**Figure 27. Adults meeting physical activity guidelines by age group, Jersey (2025)**

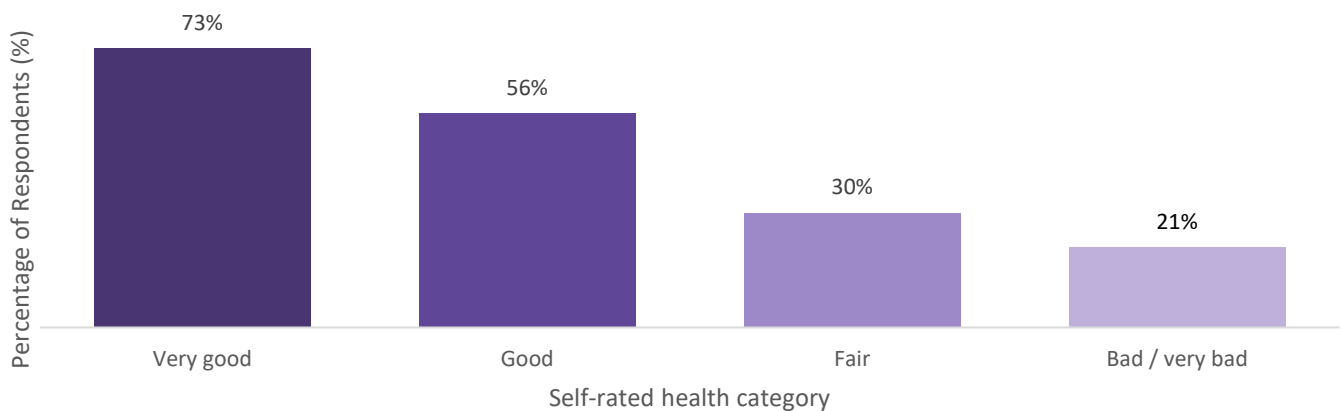


Source: JOLS, 2025

## By self-reported health

Physical activity levels tend to follow overall health status, and UK evidence consistently shows that people reporting poorer general health are less likely to meet recommended activity levels. This pattern is also seen in Jersey, where 73% of adults reporting very good health met the guidelines, compared with 56% of those reporting good health, 30% among those reporting fair health, and 21% among those reporting bad or very bad health.

**Figure 28. Adults meeting physical activity guidelines, by self-rated health category, Jersey (2025)**



Source: JOLS, 2025

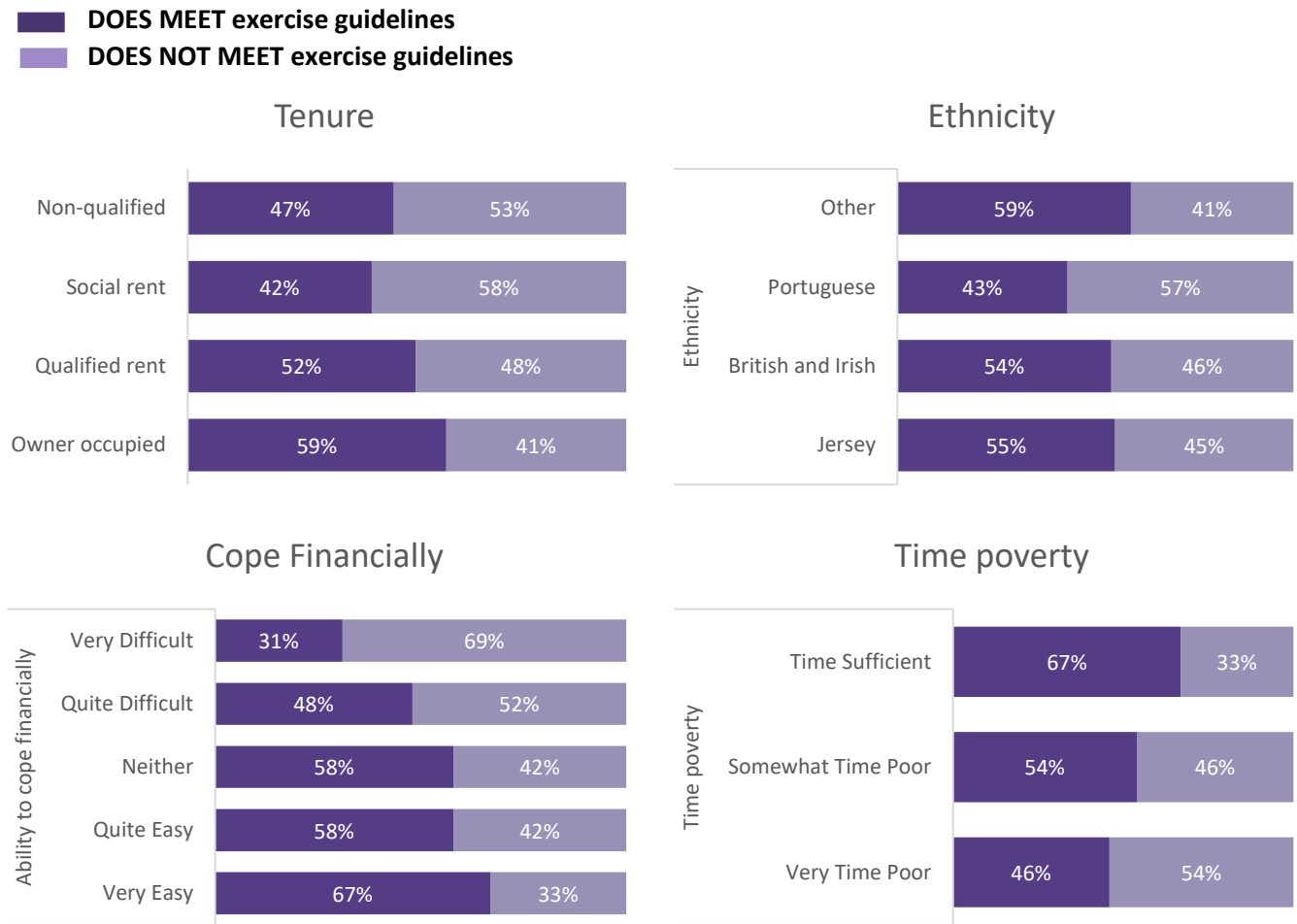
## By socioeconomic and demographic inequalities

Clear inequalities in physical activity persist across socioeconomic and demographic groups:

- financial circumstances influenced activity levels, with physical activity ranging from 67% among adults coping very easily financially to 31% among adults who were finding it very difficult to cope
- time availability was strongly related to activity, with 67% of adults who had enough time meeting the guideline compared with 46% of adults who were very time poor
- housing tenure also shaped activity levels, with 59% of adults who owned their homes being active at recommended levels and 42% of adults living in social rented housing meeting the guideline
- ethnicity was associated with differences in adherence, with around 55% of adults identifying as Jersey or British meeting the guideline compared with 59% of adults from other ethnic backgrounds

These patterns mirror national evidence showing lower activity levels among more disadvantaged groups.

**Figure 29. Adults meeting weekly physical activity guidelines by socioeconomic and demographic group, Jersey (2025)**



Source: JOLS, 2025

### Active travel among adults

Active travel is an important contributor to daily physical activity, and patterns typically reflect the design of local environments, distances to destinations, and access to transport.

In Jersey, 32% of adults made most of their journeys by walking or cycling in 2025, while 38% made some, and 30% reported none, illustrating a mix of travel behaviours shaped by geography and convenience

Patterns:

- levels were higher among younger adults, with adults aged 16 to 34 more likely to walk or cycle for travel compared with older adults.
- levels were also higher among St Helier residents, reflecting shorter distances and greater access to amenities
- levels were lower in rural areas, where longer distances and more limited infrastructure made walking or cycling for transport less practical

## Barriers and enablers

Among those open to increasing active travel, commonly cited enablers were better facilities (21%), financial support (21%), secure cycle storage (19%), confidence-building courses (8%) and shared bicycles (7%). However, 38% reported that nothing would encourage them - pointing to the importance of infrastructure, safety and route convenience.

Public transport and daily movement. Public transport supports daily routines and incidental activity. Findings from the 2025 Liberty Bus customer satisfaction survey indicate that many Islanders choose the bus for convenience and cost, and that walking to and from stops helps some passengers maintain their health and independence. These factors are relevant to wider determinants of activity, particularly for households under financial strain or without access to a car.<sup>41</sup>

## Objective monitoring of active travel

- automatic counts at First Tower recorded around 50,800 pedal cycles during June 2025, with an average of about 2,000 cycles per weekday (24-hour)
- St Helier morning peak cordon counts (07:30-09:00, mid-May 2025) recorded roughly 2,060 pedestrians and 1,010 cyclists entering Town across 15 strategic corridors, with cyclists making up around one-third of inbound active travellers<sup>42</sup>

*Source: Infrastructure Dept, Government of Jersey, 2025*

## Use of natural environments and leisure time

Natural environments provide accessible and low-cost opportunities for movement and recreation. In 2025:

- 54% of adults reported visiting beaches weekly, making coastal spaces the most frequently used natural setting
- 32% used coastal or inland paths each week, reflecting regular engagement with Jersey's walking routes
- around one in ten adults, approximately 10%, reported never using natural outdoor spaces, highlighting a small but important group who did not access these environments at all

## Time availability and leisure constraints

Limited time remained a key barrier to being physically active and enjoying leisure time.

- 26% of adults were very time-poor overall
- fewer than half of adults who were very time poor met the recommended exercise guidelines, compared to two thirds of those who were time sufficient
- only 25% of adults reported having sufficient time for leisure

These findings highlight that time pressure directly restricts opportunities for regular physical activity, contributing to inequalities in activity levels across the population.

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<sup>41</sup> Liberty Bus: 2025 Independent Customer Satisfaction Survey

<sup>42</sup> Counts represent specific locations and time periods and should not be interpreted as island-wide totals.

## Safety and the travel environment

Road safety remains a major consideration for active travel.

- recent collision data indicate that around 64% of all road casualties in Jersey involve vulnerable road users - pedestrians, cyclists, and riders of motorcycles or mopeds - compared with 39% in Great Britain

Cyclists and motorcyclists are particularly over-represented, underscoring the importance of safe infrastructure when promoting walking and cycling.<sup>43</sup>

## Community-based physical activity programmes

Jersey Sport’s community-based programmes continue to support groups facing barriers to activity (financial constraints, disability, long-term conditions, low confidence, limited access to organised sport):

**Table 4. Community programme participation and outcomes (2024 to 2025)**

<b>Programme</b>	<b>Participation (N)</b>	<b>Outcome (%)</b>	
<b>Ability Sessions</b>	2,530 (2025)	+59% vs 2024	Ability Sessions are specially-designed activity sessions delivered by Jersey Sport to support people with: <ul style="list-style-type: none"> <li>physical disabilities</li> <li>learning disabilities</li> <li>neurodiverse conditions</li> <li>long-term conditions</li> <li>additional support needs</li> </ul>
<b>Cycle Without Limits</b>	2,960	68% increased activity	A specialist cycling programme delivered by Jersey Sport that provides inclusive, adapted cycles for people with disabilities or mobility challenges.
<b>Walking Groups</b>	5,430	—	Organised group walks, typically supported by Jersey Sport, designed to increase daily movement and social connection.
<b>Couch to 5K</b>	—	87% more active	A structured, progressive running programme designed to support inactive people to build up to running 5 kilometres.
<b>Cycling (children + adults)</b>	>4,600	—	General participation in Jersey Sport’s recreational and skills-based cycling sessions for children and adults.
<b>Exercise Referral Scheme (ERS) - Referrals</b>	930	—	A clinically supported programme where GPs or health professionals refer patients with long-term conditions to supervised, tailored physical activity programmes.
<b>Exercise Referral Scheme (ERS) Participants</b>	490	80% improved Activity & mental health	
<b>Pathways</b>	150 adults + 380 YP	—	Pathways (Jersey Sport) refers to Jersey Sport’s activity-and-wellbeing support programme designed specifically for people who may face mental-health challenges, low confidence, or barriers to getting active.

Source: Sports Jersey, 2025

These offers play a key role in reducing inequalities and sustaining behaviour change among those least likely to meet guidelines.

<sup>43</sup> [GOJ - 2023 Road Traffic Collision and Casualty Update](#)

## Chapter 3b: Physical Activity in Children

Regular activity supports healthy growth, mental wellbeing and lifelong habits.

Children and young people should be active for an average of at least 60-minutes of moderate-to-vigorous physical activity each day, with activities that build muscle, bone and movement skills across the week. They should also minimise long periods of sitting and break up sedentary time.

### Key Findings

- around 22% of young people met the daily 60-minute activity guideline in 2024, up from 18% in 2021, with activity levels declining sharply with age
- girls face a consistent and widening disadvantage across multiple activity measures, with only 16% meeting the daily guideline, very low cycling levels (1%), and the steepest age-related decline in sport participation
- socioeconomic inequalities are evident, with adherence to physical activity guidelines ranging from 14% among pupils who felt “not at all well off” to 31% among those “very well off,” and similar patterns across material deprivation and school type
- participation in school-based activity drops steeply with age, peaking at 87% in Year 6 before falling to 27% in Year 12
- behavioural clustering is strong - pupils not meeting sleep or physical activity guidelines were more likely to record high screen use

### Young people meeting physical activity recommendations

In 2024, the proportion of young people achieving the UK guideline of at least 60-minutes of moderate-to-vigorous physical activity per day generally decreased with age, with differences between year groups broadly consistent with previous survey patterns.

- in 2024, around 22% of pupils met the UK physical activity recommendation, an increase from 18% in 2021
- activity levels were highest among younger pupils, with around one third of males in Years 4, 6 and 8 meeting the guideline
- the lowest levels continued to be recorded among older secondary school females, especially those in Years 10 and 12
- a clear gender difference remained across year groups, with around 28% of males meeting the guideline in 2024 compared with around 16% of females
- between 2021 and 2024, most year groups saw an increase in the proportion meeting the guideline, with the largest improvements among younger pupils, although the overall age pattern and gender gap persisted

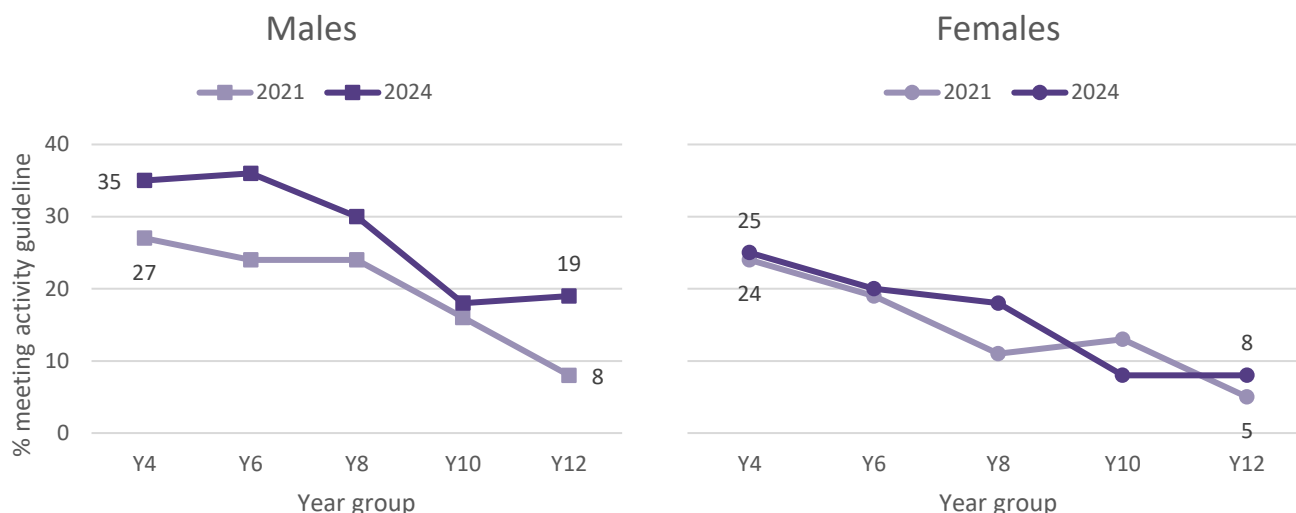
### Gender differences in physical activity

Girls are consistently the least active group. Only 16% of girls met the daily activity guideline in 2024, compared with 28% of boys. Activity levels among girls drop rapidly during adolescence, with older secondary girls reporting the lowest activity of any group measured.

Participation in school sport shows the same pattern- girls’ participation falls from 75% in Year 6 to only 32% in Year 12, and cycling remains extremely rare (1%)

These findings indicate a sustained gender gap that widens with age and affects multiple aspects of physical activity.

**Figure 30: Children meeting the 60-minute daily activity guideline by age and sex, Jersey (2024)**



Source: JCYPs, 2021 & 2024

### What would help young people be more active

- young people identified more free time, someone to exercise with, and better facilities as the main things that would encourage them to be more active
- the most common reasons for not participating were that activities offered did not appeal, having other commitments, or being unable to stay after school

### Extra-curricular school-based sport

Participation in extra-curricular school-based sport followed a similar pattern.

In 2024:

- two-thirds (67%) of pupils took part in weekly extra-curricular sport at school, peaking in Year 6 (87%) before falling sharply to 27% in Year 12<sup>44</sup>
- males (73%) were more likely than females (63%) to participate, and pupils in fee-paying schools (63%) were more likely to take part than those in non-fee-paying schools (52%)
- students from more affluent households also reported higher participation (58% not deprived vs 46% deprived)

### Inequalities in school-based sport and physical activity

- materially deprived pupils were less likely to meet the guideline (17%) than those not deprived (21%), and there was a strong gradient by family finances, rising from 14% among pupils who rated their family “not at all well off” to 31% among those “very well off”
- school context also mattered - pupils in fee-paying schools were more likely to meet the guideline (25%) than those in non-fee-paying schools (21%); differences by parish type were modest (20% urban vs 22-23% elsewhere), and a small gap was observed by ethnicity (23% Jersey/British vs 19% non-Jersey/British)

Overall, financial and material circumstances, and school setting, are the strongest correlates of meeting the daily activity guideline, with smaller differences by place and ethnicity.

<sup>44</sup> JCYPs 2024

## Inter-school sport participation

In 2024:

- Participation in inter-school sport peaked in Year 6 and declined through secondary school.
- around three-quarters of pupils took part in inter-school sport in Year 6 (75% of females; 78% of males), falling to around two in five by Year 12 (32% of females; 40% of males)
- overall, males (61%) were more likely than females (54%) to have taken part, with the gap most marked in Year 4 and Years 10-12
- pupils in fee-paying schools (60%) were slightly more likely to participate than those in non-fee-paying schools (56%)

*These patterns underline the drop-off in competitive school sport with age and the persistent participation gap between boys and girls.*

## Organised sport outside school

Organised sport outside school was common, with the majority of pupils taking part at least weekly.

- team sports were the most popular activity for both males and females, though participation was consistently higher among males (66%) than females (44%), and this pattern held across all year groups
- fitness classes and gym-based activities were the only category to increase with age, becoming noticeably more common by Year 10 and Year 12

Frequency of participation varied across groups.

- a quarter (23%) of young people took part in organised sport four or more times per week, while two-thirds (66%) participated at least weekly
- household finances showed a strong gradient - only 47% of pupils whose families were “not at all well off” participated weekly, compared with 78% among those “very well off”
- pupils in fee-paying schools reported higher weekly participation (78%) than those in non-fee-paying schools (60%)
- differences between sexes were smaller, with 69% of males and 64% of females taking part weekly

Overall, organised sport outside school is widespread, but participation frequency is strongly shaped by family finances and school context, with age and gender differences also evident

## Screen use and physical activity

Screen use continues to shape young people’s daily routines and shows clear associations with physical activity, sleep and wellbeing.

In 2024:

- three-quarters (75%) of pupils spent more than three hours on screens on the previous day, and 39% accumulated five hours or more
- patterns varied by activity type - 36% of boys spent  $\geq 3$  hours gaming, while 40% of girls spent  $\geq 3$  hours browsing or socialising online

Screen exposure was closely linked with physical activity.

- pupils who did not meet the recommended 60-minutes of activity per day were more likely to report high screen use (more than 5 hours: 40%, compared with 36% among those who met the guideline)
- in contrast, pupils who achieved the activity guideline were more likely to report low daily screen use ( $\leq 2$  hours: 32% vs 22%)
- short sleep and heavy screen use also clustered, 55% of pupils sleeping  $< 3$  hours had  $\geq 5$  hours of screen time, compared with 28% of those sleeping  $\geq 8$  hours, suggesting overlapping behavioural pressures

Clear socioeconomic differences were also visible.

- pupils in non-fee-paying schools were substantially more likely to report greater than 5 hours of screen use (46%) than those in fee-paying schools (27%) and less likely to report  $\leq 2$  hours (18% vs 34%)
- differences by gender, material deprivation and parish type were present but smaller once sampling variation is considered

Overall, high screen use is common among young people in Jersey and is linked with lower physical activity, shorter sleep and lower wellbeing - patterns that mirror wider behavioural inequalities highlighted throughout this report.

## Active travel among children and young people

Active travel refers to walking, cycling or other forms of human-powered movement used to get to and from school or other destinations. It includes everyday activities such as walking all or part of the journey, cycling, scooting or using a balance bike. Active travel contributes to children and young people's daily physical activity and supports healthier travel habits.

Travel to school continues to be shaped by convenience, geography and transport access.

In 2024, 49% of pupils travelled by car, van or taxi, a slight decrease from 53% in 2021. Walking remained stable at 32%, while bus use increased across secondary year groups. 32% of secondary pupils travelled by school bus on the survey day, up from 23% in 2021, with the largest rise in Years 8 and 10.

Active travel modes showed clear gender differences.

- cycling remained very low overall, with 6% of boys and 1% of girls cycling to school; moped use showed a similar pattern (5% vs 1%)
- inequalities also emerged by school type, with pupils in non-fee-paying schools more likely to walk or use the bus, while those in fee-paying schools were more likely to travel by car; younger pupils were more likely to walk, whereas cycling remained limited across both primary and secondary phases

Safety concerns are an important contextual factor. Between 2019 and 2023, around three-quarters (76%) of child road casualties occurred among vulnerable road users, including child pedestrians and cyclists.<sup>45</sup>

This aligns with the very low cycling rates among pupils, particularly girls, and underscores the importance of safer routes and supportive infrastructure to enable active travel.

Overall, opportunities for active travel vary by age, gender and school context. Improving perceived safety, infrastructure quality and cycling confidence, especially for girls and younger pupils, will be essential for increasing safe, active and independent travel.

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<sup>45</sup> GOJ Road Safety Report R.91/2024

## Chapter 4: Combined Healthy Behaviours Index

Healthy behaviours do not occur in isolation. Patterns in activity, diet, alcohol use and smoking reflect the social and economic conditions people live in.

The JOLS 2025 Healthy Behaviours Index shows that opportunities to live healthily in Jersey are strongly shaped by income, housing, education and wellbeing. These wider conditions matter for obesity because they influence access to healthy food, time for activity and the ability to sustain healthier routines.

### Combined Healthy Behaviours Index

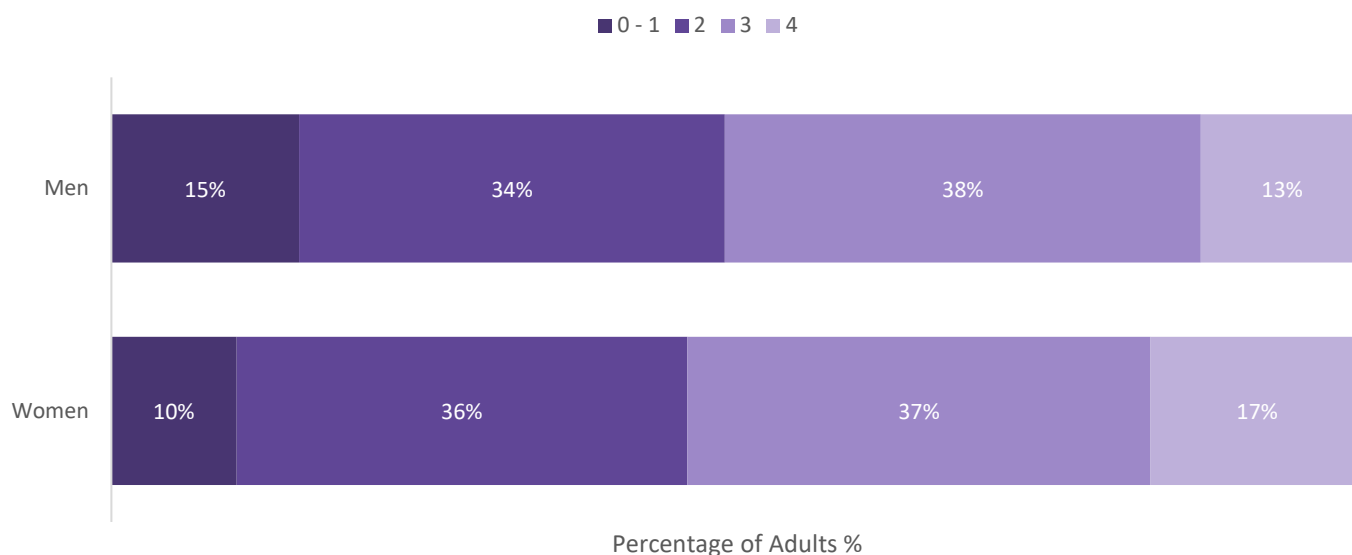
The Index combines four behaviours linked to healthier weight:

1. meeting physical activity guidelines,
2. eating five portions of fruit or vegetables,
3. not smoking, and
4. drinking at low-risk levels.

In 2025:

- most adults reported a mix of healthy lifestyle habits, with 72% achieving two or three of the behaviours included in the Combined Healthy Behaviours Index
- 15% of adults met all four behaviours, representing the group with the most consistently healthy routines
- 12% met none or only one behaviour, highlighting a smaller group with limited engagement in healthy lifestyle practices

**Figure 31. Distribution of healthy behaviours (0-4) among adults, Jersey (2025)**



Source: JOLS 2025

## Inequalities in healthy behaviours

Healthy behaviours tend to cluster where people have stability. Adults with financial security, supportive environments and enough time in their week were much more likely to meet multiple healthy behaviours.

- around 20% of adults coping very easily financially met all four behaviours, compared with 10% of those finding it difficult,
- only 6-7% of adults with low wellbeing met all four behaviours, compared with 24-27% of those reporting very high wellbeing

Older adults and those with higher socioeconomic advantage report healthier behaviour profiles.

- 22% of adults aged 65+ met all four behaviours, compared with 8% aged 16-34
- 59% of adults with higher qualifications reported 3-4 healthy behaviours (vs 38% with none)
- 17% of owner-occupiers met all four healthy behaviours (vs 12% in social rent)

Reducing obesity inequalities will require action on structural barriers. Cost pressures, time constraints and unequal access to safe, active spaces limit people's ability to eat well and be active.

These wider determinants shape lifestyle opportunities and therefore directly influence obesity risk at a population level.

### By place

19% of rural residents met all four behaviours, compared with 11% in St Helier. This may reflect differences in access to green space and active environments.

### Positive profile of adults meeting all four behaviours

Adults achieving all four behaviours reported:

- better general health
- more positive wellbeing
- lower screen time
- greater satisfaction with leisure time
- more frequent use of natural outdoor spaces

Healthy behaviours tend to reinforce one another, supporting healthier weight, more regular activity and better-quality diets.

## Sources

### **Jersey Child Measurement Programme (JCMP)**

The JCMP annually measures height and weight of children in Reception (ages 4-5) and Year 6 (ages 10-11) using standardised protocols. BMI categories follow UK/WHO epidemiological classifications.

The most recent data used in this report is from the 2024-2025 JCMP, published July 2025.

Source: [Public Health Jersey Child Measurement report 2024-2025](#)

### **Jersey Children and Young People's Survey (JCYPs)**

JCYPs (formerly HRBQ) monitors behaviours among children and young people including diet, physical activity, screen use, wellbeing and safety.

The 2024 wave (published March 2025) underpins children's diet and physical activity indicators in Chapters 2 and 3.

Source: [Jersey children and young people survey | Statistics Jersey](#)

### **JOLS (Jersey Opinions and Lifestyle Survey)**

The JOLS survey provides representative self-reported data from adults on lifestyle behaviours, health, wellbeing and social circumstances.

The 2024 wave underpins several adult indicators in this report, including diet, physical activity and wider determinants.

Source: [Jersey Opinions and Lifestyle Survey 2025 | Statistics Jersey](#)

### **EMIS Primary Care Clinical System**

EMIS is used across all Jersey GP practices and JDOC. It supplies coded clinical data for public health monitoring, including diagnoses of obesity, hypertension, and type 2 diabetes.

These data underpin the clinically-recorded obesity and multimorbidity analyses in Chapter 1a.

### **Jersey Quality Improvement Framework (JQIF)**

JQIF incentivises high-quality GP care and provides annual indicators for long-term conditions, including obesity. 2025 JQIF registers and multimorbidity extracts were used in Chapter 1a.

Source: [ID FOI 6426 JQIF 2023 Clinical Indicators 20230515](#)

### **InPax (Pharmaceutical Advisory Service)**

InPax provides analysis of primary-care prescribing including GLP-1 agonists used for diabetes and obesity management.

Prescribing trends (2016-2025) in Chapter 1a are derived from InPax extracts.

### **Living Costs and Household Income Survey (LCHIS)**

LCHIS provides household income and expenditure data used to interpret affordability trends.

The 2021/22 survey is the latest available and underpins financial-strain and expenditure context in Chapters 1-4.

Source: [Living costs and household income survey | Statistics Jersey](#).

The **Food Premises Register** provides an overview of the types and distribution of food outlets operating across Jersey. Work is currently underway to improve the classification of outlets, distinguishing more clearly between healthier options and more energy-dense or fast-food-oriented premises. As this classification work develops, the register will increasingly support trend monitoring, parish-level analysis, and clearer assessment of exposure to different types of food outlets. Future reports will incorporate time-series analysis and more detailed area profiling as data completeness improves.

## **National Comparators (England) Health Survey for England (HSE)**

HSE provides nationally-representative measured BMI for adults. Used for adult overweight/obesity comparisons.

Source: NHS England Digital; Health Survey for England 2024. [Health Survey for England, 2024 - NHS England Digital](#)

## **National Child Measurement Programme (NCMP)**

NCMP provides measured BMI for Reception & Year 6 pupils used for like-for-like comparison with JCMP.

Source: [National Child Measurement Programme \(NCMP\) annual report, academic year 2024 to 2025, England - GOV.UK](#)

## **UK Comparators: OHID / Fingertips Profiles**

Used for adult five-a-day and physical activity comparators.

Source: [Obesity, physical activity and nutrition | Fingertips | Department of Health and Social Care](#)

## **Guernsey Comparators**

Used for contextual comparisons where appropriate (self-reported adult weight status, diet, and food insecurity).

Source: States of Guernsey; Medical Officer of Health Report 2023/24 [Guernsey MHH Report 117](#) and Wellbeing Survey 2023 [Guernsey & Alderney Wellbeing Survey 2023](#)

## Notes

### **BMI Calculation and Classification (Adults)**

Adult BMI is calculated as:

$$\text{BMI} = \text{weight (kg)} \div \text{height (m)}^2$$

BMI categories (WHO / UK epidemiological definitions):

- Underweight: <18.5
- Healthy weight: 18.5-<25
- Overweight: 25-<30
- Obesity Class I: 30-<35
- Obesity Class II: 35-<40
- Obesity Class III: ≥40

### **Limitations:**

BMI does not distinguish fat from lean mass, may underestimate risk in some ethnic groups, and does not describe fat distribution. National guidance recommends interpreting BMI alongside waist-to-height ratio (not currently collected in Jersey population surveys).

### **Child Body Mass Index classification**

CMP uses age- and sex-specific BMI centiles from UK/WHO growth standards.

Epidemiological thresholds:

- Overweight: ≥85th centile
- Obesity: ≥95th centile
- Severe obesity: typically, ≥99.6th centile

### **Fast-food outlet density methodology**

To estimate the density of fast-food outlets, food hygiene registration data were reviewed and classified using clear inclusion and exclusion criteria. Outlets listed under “Takeaway and Sandwich Shop” were fully included, and restaurant-type businesses that also commonly sell takeaway food were identified using a set of key search terms. These included terms such as *fish, India, Tand, Thai, chin, pizza, burger, chicken* and *kebab*, enabling identification of likely fish and chip shops, Indian, Chinese, pizza, burger and chicken outlets that provide takeaway food.

All other business types (for example hotels, schools, supermarkets, mobile caterers, distributors and manufacturers) were excluded. Once the full list of eligible outlets was established, the number of outlets was divided by the latest available population estimate to produce a rate per 100,000 population.

### **Confidence Intervals, Statistical Significance & Language**

Survey estimates (JOLS, JCYPs) carry sampling uncertainty.

- JOLS whole-population 95% CI  $\approx \pm 3$  percentage points.
- Subgroups (e.g., age, income) have wider or narrower CIs depending on sample size.
- Only statistically significant differences are described as higher/lower/increase/decrease.
- Non-significant differences are described as similar, broadly similar or no clear difference.

Administrative datasets (JCMP, EMIS, JQIF) are based on whole-population or near-complete coverage and therefore are not subject to sampling error, though year-to-year changes may still reflect natural variation.

### **Rolling Averages and Trend Presentation**

JCMP trends are presented using three-year rolling averages to reduce volatility and increase reliability. Where this approach is used, it is explicitly stated in figure notes.

### **Measurement Mode Differences**

- JOLS: self-reported height/weight → tends to underestimate BMI.
  - JCMP/NCMP/HSE: measured height/weight → considered the gold standard.
- Comparisons between self-reported and measured datasets should be interpreted cautiously.

### **Food Security Measures**

Food affordability and food insecurity measures follow Statistics Jersey wording used in JOLS. “Going without” refers to not having an item due to shortage of money in the last 12 months.

### **Disclosure Control**

All published data adhere to Statistics Jersey disclosure rules. Small counts are suppressed or aggregated to protect confidentiality.

### **Data Validation**

All datasets are validated for completeness, consistency and accuracy before publication. Data are checked against previous years for unexpected anomalies and structural breaks.

## Feedback

If you would like to provide feedback, then please contact us on the following address or email us at: [healthintelligence@gov.je](mailto:healthintelligence@gov.je)

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