Supplementary File S1. Details on recruitment methods of ReSpAct 2.0 study.

Participants of the ReSpAct study, with the exception of those who withdrew consent for or those who passed away during the course of the study during, received a newsletter informing them about the follow-up study ReSpAct 2.0. If they did not want to receive an invitation for this follow-up study, they could contact the researchers by email, by telephone, or by using the answer card attached to the newsletter. Everyone who received the newsletter and did not notify that they did not want the invitation, then received an invitation to the ReSpAct 2.0 study. The invitations were sent by post or e-mail, depending on the preference of the participant and/or the available contact information. For both invitation methods, participants were asked to respond within 4 weeks after receiving the invitation. If they did not respond within this timeframe, they were reminded by telephone or email. Potential participants receiving the invitation per post received a paper-version informed consent form which they were asked to sign and send back together with the questionnaire. Potential participants receiving the invitation per e-mail, received a personal link directing them to both the participant information letter and the digital informed consent form. After giving consent for participation, participants received a new e-mail with a link to the questionnaire.

Supplementary File S2: Selection of confounders.

Age leads to a decrease in physical and mental capacity and to a growing risk of disease. Common conditions in older age include hearing loss, back and neck pain, chronic obstructive pulmonary disease, diabetes, depression, and dementia [1]. Age is therefore associated with both physical and mental health. Age is also associated with social isolation, as older adults are at increased risk for loneliness and social isolation due to being more likely to live alone, the loss of family or friends, and chronic illness ([2]. Lastly, age is also associated with lifestyle. According to Drewnowski and Shultz [3], people eat less and make different food choices as they get older. Physiological changes associated with age (slower gastric emptying, altered taste and smell) may contribute to lowered energy intake [3]. The level of alcohol consumption is also affected by age, as alcohol consumption generally declines with age, however, older drinkers typically consume alcohol more frequently than younger age groups [4].

Besides age, gender is also associated with various outcome variables in this study. In general, men have more life-threatening chronic diseases at younger ages, including coronary heart disease and substance use disorders. Women have generally higher rates of chronic conditions such as arthritis, frequent or severe headaches, and anxiety disorders [5]. Gender is associated with social isolation as well, as a study on social loneliness and emotional loneliness observed men having more social loneliness and less emotional loneliness than women [6]. Lastly, gender is also associated with lifestyle. Men and women show significant differences regarding dietary intakes and eating behaviours. Women eat more fruit and vegetables, but also more sweets and cakes, while men tend to eat food richer in fats and proteins [7]. Men also tend to drink more wine, beer, and spirits [7].

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Supplementary File S3: General health, mental health and lifestyle changes.

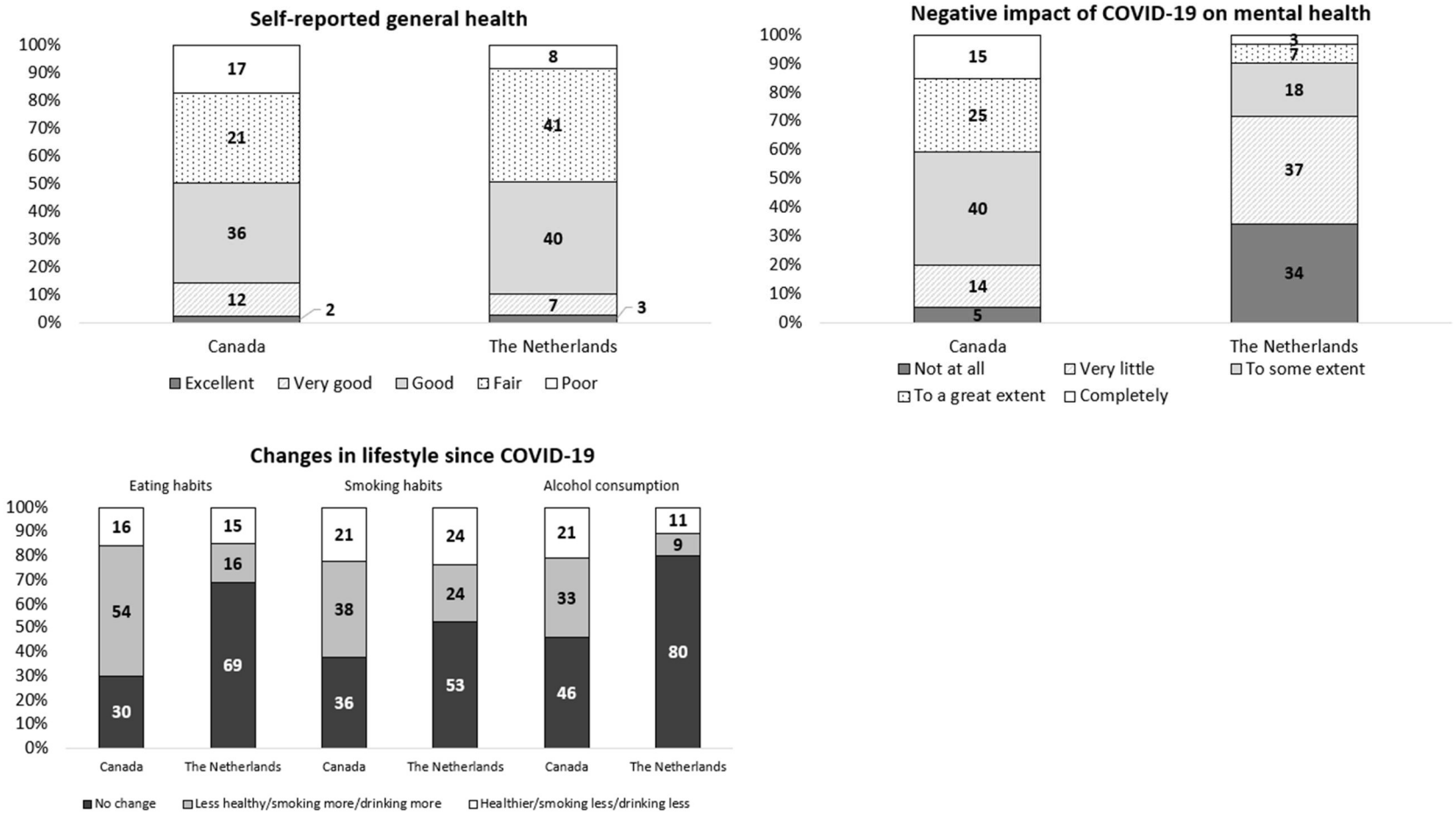

Figure S1. General health (left top), impact on mental health (right top), and change in lifestyle (left bottom) among Canadian and Dutch participants.

Supplementary File S4: Change in physical activity in Canada and the Netherlands.

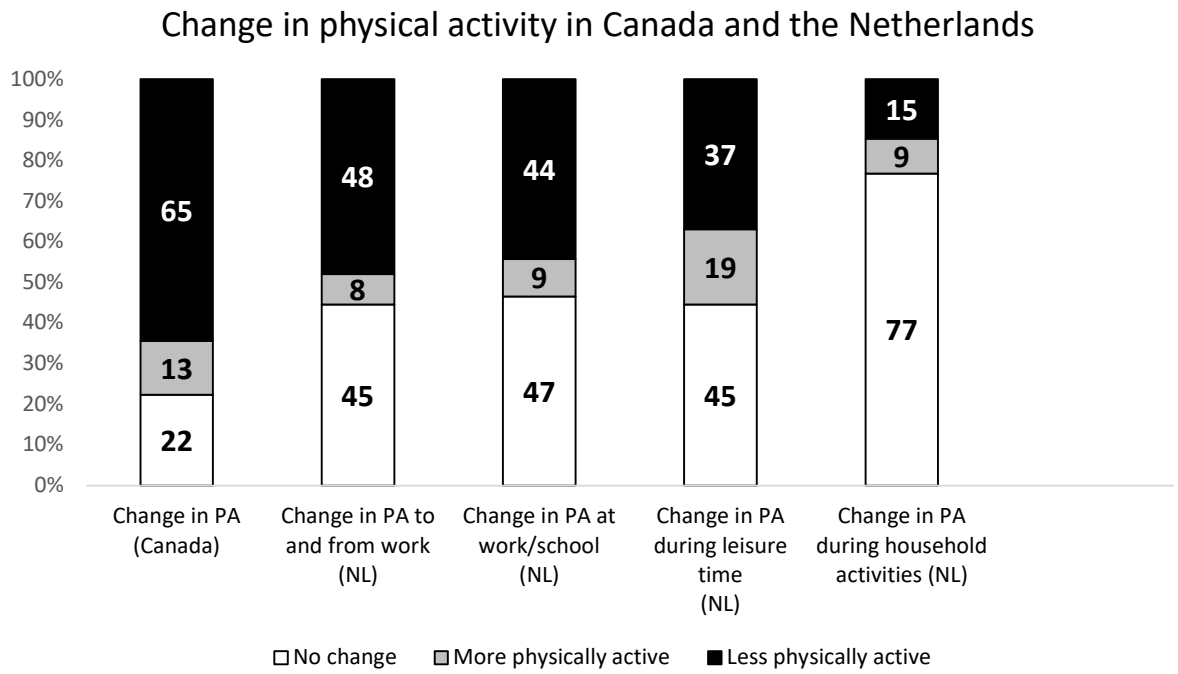

Figure S2. Change in physical activity among Canadian and Dutch participants.