

Towards a Healthier Canada— Narrative



Introduction

In 2010, Canada's Federal, Provincial and Territorial (F/P/T) Ministers of Health and/or Health Promotion/Healthy Living (except Quebecⁱ) endorsed *Creating a Healthier Canada: Making Prevention a Priority, A Declaration on Prevention and Promotion* (Declaration) presenting a shared vision to make the promotion of health and the prevention of disease, disability and injury a priority for action. The Ministers also endorsed *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework to Promote Healthy Weights* (Framework) as the first tangible action arising from the Declaration, making childhood obesity (and healthy weights) a priority.

This narrative has been prepared as part of the 2017 e-Report on Healthy Weights endorsed through a collaborative effort by F/P/T Ministers of Health, Healthy Living, Sport, Physical Activity and Recreation in 2017. The purpose of the narrative is to highlight the most recently available data/information on a set of national indicators related to healthy weights. The indicators provide information on healthy weights, physical activity and healthy eating, as well as information on the physical and social environments in which children live, learn and play. This report provides a snapshot of the current status of these indicators and explores possible trends in recent years.

The risk of overweight and obesity is determined by a complex and interacting system of factors—biological, behavioural, psychological, social, technological, environmental, economic and cultural—operating at all levels, from the individual to the family to society as a whole.

For many health issues, including childhood obesity and its risk factors, large and often unfair differences between groups of Canadians can also be linked to social factors like socioeconomic status, marginalization, and social exclusion. That is why this e-Report also examines key health inequalities

ⁱ Québec supports the general objectives of this framework, but does not support a Canada-wide strategy in a field that falls under its jurisdiction. Québec remains solely responsible for the development, implementation and communication of programs to promote healthy lifestyles within its borders. However, the Province intends to continue sharing information and best practices with other Canadian governments.

HIGHLIGHTS

- We face a serious problem in Canada: childhood overweight and obesity rates remain high and stable
- One in three children and youth are overweight or obese
- 37.6% of children and youth meet current physical activity recommendations
- 44.6% of children and youth report eating fruit or vegetables at least five times per day
- Children in the lowest household income group are significantly less physically active than children in the highest household income group
- Lower proportions of children from cultural/racial minority groups, especially those from Latin American and East/Southeast Asian backgrounds, were physically active compared to children identified as White
- First Nations children living off-reserve, Inuit and Métis children have physical activity levels that are similar to those of non-Indigenous children
- First Nations children living off-reserve, Inuit and Métis children experience higher levels of food insecurity than non-Indigenous children
- The conditions in which Canadians live, learn, work and play have a profound influence on how healthy they will be

in childhood obesity, physical activity, fruit and vegetable consumption, breastfeeding and food insecurity. Using information from the [Health Inequalities Data Tool](#), a new F/P/T data resource, these indicators are broken down by key population groups (i.e., income, Indigenous populations, and cultural/racial background) to illustrate the range and depth of inequalities in childhood obesity in Canada.

This narrative complements the data included in the e-Report. For further information, please consult the Data Tables or Infographic of the 2017 e-Report on Healthy Weights.

Background: Data and Indicators

In 2013, Federal, Provincial and Territorial (F/P/T) governments and experts from across the country agreed on a set of national indicators to report on every two years. These indicators were selected according to three criteria:

- > the evidence base linking them to childhood overweight or obesity or their contribution to achieving or sustaining healthy weight;
- > their alignment with the Strategies (e.g., Measuring and reporting on collective progress) of the *Curbing Childhood Obesity: A F/P/T Framework for Action to Promote Healthy Weights* (Framework); and
- > the availability of national data sources to report on them.

Gathering information on the many factors that influence childhood obesity/healthy weights can help to inform and identify actions to support change. Many factors contribute to childhood obesity. Surveillance of key indicators provides the building blocks for research, policies and programs. Appropriate data collection, analysis and reporting contribute evidence for better decision-making. Having information on the multiple varied factors which influence the achievement of a healthy weight is important to better understand the problem and to design relevant interventions.

Examining health equity and determinants of health is important to improve the health of the population, to ensure that the conditions that support health are distributed fairly, and to understand how policies and programs can be targeted to address gaps. F/P/T governments have incorporated a health inequality lens to this year's e-Report, which includes data on inequalities for a subset of the national indicators.

Healthy Weights

Childhood obesity can contribute to a number of health and social issues and lead to long-term health problems later in life. Studies have demonstrated that children who are overweight or obese show elevated rates of factors predictive of chronic disease, including elevated blood pressure, blood cholesterol, and blood glucose.^(1–4) Health problems that were previously seen only in adults, such as high blood pressure and Type 2 diabetes, are now also affecting children and youth.

Moreover, being overweight or obese in early childhood significantly increases the likelihood of being overweight or obese in adolescence and adulthood, with all the accompanying health problems. Indicators of weight status provide information on how overweight and obesity is distributed across the Canadian population for children and youth.

Rates of unhealthy weights among children have increased dramatically in past decades, but have remained stable in recent years, with more than one-in-three children and youth in Canada being overweight or obese. Boys and girls experience similar rates of overweight and obesity.

Physical Activity

Physical activity plays an important role in the health, well-being and quality of life of Canadians. People who are physically active live longer, healthier lives. Active people are more productive, and more likely to avoid illness and injury. Physical activity is essential for healthy growth and development. Regular physical activity in childhood develops cardiovascular fitness, strength and bone density and helps to prevent chronic diseases like cancer, Type 2 diabetes and heart disease later in life.

Ministers responsible for Sport, Physical Activity and Recreation continue to develop a common vision for physical activity. Once completed, this federal, provincial and territorial policy framework will aim to increase physical activity and reduce sedentary behaviours among Canadians. It is being developed for use by all sectors whose interest and/or responsibility is to address sedentary living among Canadians and to advance physical activity opportunities across the lifespan in all its forms, kinds and level of intensity in Canada, including through sport and recreation. Physical activity is inversely related to obesity levels and is an independent risk factor for many chronic diseases. Comprehensively tracking patterns of physical activity should consider the frequency, intensity, duration and types of activities undertaken by children. As a result, a variety of indicators have been reported on in the two previous e-Reports on Healthy Weights (2013/15) in order to track trends in physical activity and sedentary behaviour, including indicators of active play, organized, sport, physical education, active transportation and screen time.

The *Canadian 24-Hour Movement Guidelines for Children and Youth* were released in 2016, and provide recommendations for the amount of physical activity, sedentary behaviour (screen time) and sleep which children and youth should obtain in order to achieve health benefits.⁽⁵⁾ These guidelines replaced the 2011 *Physical Activity Guidelines for Children and Youth* and the *Sedentary Behaviour Guidelines for Children and Youth*. They also provide the first Canadian sleep recommendations for children and youth. In order to be consistent with the recommendations of the new *Canadian 24-Hour Movement Guidelines for Children and Youth*, the 2017 e-Report has revised indicators for physical activity, sedentary behaviour and sleep.

Children engage in many forms of physical activity. Active play can assist children in achieving physical activity recommendations. ‘Active play’ involves physical activity at levels above resting levels, and is not typically described as “exercise” or “sport”. Play is different from organized physical activity in that the activity is not under the control of others. With the rise in technology, active play faces competition from computer games and television viewing. Parental safety concerns also represent a key barrier to active play among children, favouring activities which can be more easily supervised such as organized and indoor activities. 52.1% (2014–15) of children (aged 6–11) accumulate less than 3 hours per week of active play.

Active modes of transportation, such as walking or cycling, can provide important opportunities for children and youth to be active and increase their overall levels of physical activity. Research shows that children and youth who engage in active transportation to and from school are more likely to achieve higher levels of daily physical activity than those who commute by car or bus.⁽⁶⁾ Many factors can impact whether or not a child commutes actively to school and to other locations within the community. There has been a measureable decline of youth (aged 11–15) who use active travel as their main form of transportation to school from 32.5% (2009–10) to 25.6% (2014), due primarily to reductions in the proportion of youth who report walking to school.ⁱⁱ These declines in active transportation have been seen among both boys and girls. Although similar proportions of boys and girls continue to report walking to school (2014: 23.6% vs 23.3%), consistently more boys than girls report cycling to school (2014: 3.6% vs 0.8%).

ⁱⁱ It is too early to determine if this is a trend given that there are only two time points available as the HBSC survey is updated every 4 years.

Even small increases in physical activity are associated with increased health benefits. Both pedometers (to measure step counts) and accelerometers (to measure the amount and intensity of movement) have been used to objectively measure total physical activity and assess the proportion of children and youth who meet physical activity recommendations. 37.6% (2014–15) of children and youth meet the physical activity recommendations contained within the *Canadian 24-Hour Movement Guidelines for Children and Youth* by accumulating an average of at least 60 minutes of moderate to vigorous physical activity per day when measured using an accelerometer.ⁱⁱⁱ Boys are significantly more likely than girls to meet these recommendations (2014–15: 48.4% vs. 25.6%). This average has been stable in recent years, as has the proportion of children and youth obtaining 12,000 steps per day, when measured using a pedometer.

Sport is a major component of physical activity for many children and youth. Combined with other forms of physical activity such as active transportation, household chores and active play, sport participation can assist individual children in achieving physical activity recommendations. Moreover, sport participation has been linked to engaging in vigorous physical activity and other positive health behaviours.⁽⁷⁾ Children (aged 6–11) spend an average of two hours per week taking part in physical activity, outside of school while participating in lessons or league or team sports (2014–15).

Sedentary behaviours, such as watching TV, playing passive video games and using a computer, have been associated with health risks, including obesity and decreased fitness.^(8,9) This association is independent of physical activity. Specific screen-time recommendations are included within the *Canadian 24-Hour Movement Guidelines for Children and Youth*, and recommend that children and youth aged 5–17 should spend no more than 2 hours/day (no more than 1 hour/day for children aged 3–5) engaged in recreational screen time and limit sitting for extended periods in order to minimize health risks. In 2014–15, 73.1% of children and youth (aged 3–17) exceeded these recommendations for screen time,^{iv} with both boys and girls showing high rates (71.4% and 74.9% respectively).

ⁱⁱⁱ The measure used to assess the level of physical activity using a pedometer was changed in this e-Report given the new physical activity recommendations released as part of the *24-Hour Movement Guidelines*.

^{iv} Given that there was a change in the survey methodology for the 2012–13 data provided, it is not possible to provide a trend.

The after-school time period has been recognized as an important opportunity to promote physical activity, since it is typically a highly sedentary time of day for many young Canadians. Barriers for younger children such as parent availability and limited supervision often limit the opportunity for children to engage in physical activity during the after-school period. Data for 2014–15 indicated that children (aged 6–19) obtained an average of 9.2 minutes of moderate to vigorous physical activity between the hours of 3 pm and 5 pm—a number that remains stable. Although boys obtain more moderate to vigorous physical activity in this time period (10.3 minutes vs 8.0 minutes among girls), both numbers are low.

Healthy Eating

Many Canadians do not follow a healthy pattern of eating as part of a healthy lifestyle. Poor diet is the primary risk factor for obesity and many chronic diseases, which has a significant impact on the health of Canadians and on the health care system. The food environment makes it increasingly difficult for Canadians to make healthy choices.

In the absence of simple and regularly available measures of “healthy eating” on the Canadian population, the consumption of vegetables and fruit has typically been used as a proxy for healthy eating. Eating fruits and vegetables at least 5 times daily has been validated as a good indicator for overall healthy eating among Canadians. The proportion of children (aged 12–17) reporting that they consumed fruit or vegetables at least five times per day is 44.6% (2014), with more girls than boys (48.5% vs. 41.0%) reporting doing so.

Healthy eating is essential for healthy growth and development among children and is an important factor in maintaining healthy weights. As is the case for most issues, eating habits initiated in childhood are important for the establishment of life-long healthy eating behaviours.

Canada's Food Guide recommends eating breakfast every day. Research has shown that eating breakfast contributes significantly to the nutrient adequacy and quality of the whole diet and that breakfast “skippers” are less likely to engage in physical activity.^(10,11) Evidence suggests that children and youth who skip breakfast are at increased risk of overweight and obesity. This association is particularly

strong for adolescents.⁽¹²⁾ The proportion of youth (aged 11–15) who report eating breakfast on weekdays, five days/week remains stable at 59.5% (2014), with slightly more boys than girls reporting that they eat breakfast five days/week.

Internationally, breastfeeding is recognized as the optimal method of infant feeding due to its beneficial effects on infant growth, immunity and cognitive development. (13–16) Breastfeeding initiation and, more importantly, the continuation of exclusive breastfeeding for the first six months, are recommended by Health Canada, the Public Health Agency of Canada, the Canadian Paediatric Society and Dietitians of Canada. Although a direct link to childhood obesity remains uncertain, data on breastfeeding can help assess infant exposure to optimal feeding methods and inform health promotion activities, such as breastfeeding support programs for new mothers. The proportion of women who report initiating breastfeeding is stable, while there appears to have been a slight increase in the proportion of women who report exclusive breastfeeding between 2011–12 and 2015.^v

There is strong evidence to support a link between the intake of sugar-sweetened beverages and increased risk of overweight and obesity in children.^(17–19) “Sugar-sweetened beverages” can include any drink that has added sugar, including regular/non-diet carbonated drinks, fruit-flavored drinks (e.g., fruit punch and orange drinks) and sports drinks. 14.7% (2014–15) of children (aged 3–17) report drinking soft drinks, fruit drinks or sport drinks every day.^{vi}

Supportive Environments

There is growing evidence that the physical and social environments (including the policies and organizational structures that govern them) in which individuals live, learn, work and play, have a substantial impact on healthy eating and physical activity behaviours. The built environment is part of our physical surroundings and includes the buildings, parks, schools, road systems, and other infrastructure that we encounter in our daily lives. Our physical surroundings have an impact on our health.

^v Due to a major redesign of the source survey in 2015, caution should be taken when comparing data from 2011–12 to that of 2015.

^{vi} It is not possible to determine trends in the proportion of children (aged 3–17) who report drinking soft drinks, fruit drinks or sport drinks every day, given that changes were made in the survey methodology in the CHMS 2012–13 estimates.

Certain community designs have strong potential to contribute to increased physical activity. Ecologic models of health emphasize multiple levels of influence on behaviours. They are increasingly used to describe the influencing factors of patterns of overweight and obesity in populations.

Evidence shows that short sleep duration is an important determinant of overweight and obesity in children, independent of all other factors.(20,21) Inadequate sleep has also been associated with other health conditions including mental distress, hypertension, diabetes and high cholesterol levels. For children, age-specific sleep recommendations were established as part of the *Canadian 24-Hour Movement Guidelines for Children and Youth*: 9–11 hours of uninterrupted sleep per night for children aged 5–13 years and 8–10 hours of uninterrupted sleep per night for youth aged 14–17 years, with consistent bed and wake-up times. Almost three quarters of children and youth (70.7%, 2014–15) aged 5–17 meet these recommendations.^{vii} There was no difference between boys and girls.

The availability and accessibility of recreational facilities have been associated with more physical activity and less overweight and obesity among children and youth.(22) 94.9% of parents of children aged 5–17 report that local public facilities and programs for physical activity and sports are available and adequate for their children, a similar proportion to that observed in previous years.

Marketing of unhealthy foods and beverages, such as those high in salt, sugar or fat, is a major contributor to childhood obesity.(23–26) Evidence shows that marketing influences children’s food preferences and choices, and drives consumption of unhealthy foods and beverages.(27,28) Marketing to children has evolved in recent decades. It now includes targeting multiple settings (e.g., schools, community centres) as well as exploring and developing additional tactics, including the use of the internet and different types of technology. While television ads remain a major source of marketing of unhealthy food and beverage to children, current platforms also include websites and social media from a variety of tools (e.g., smart phones, tablets). As recommended by organizations such as the World Health Organization (29), it is now important to monitor both television and digital media in order to capture the exposure

^{vii} The measure used for adequate sleep was changed in this e-Report given the new sleep recommendations released as part of the *24-Hour Movement Guidelines*.

of children to unhealthy food and beverage advertising. For the first time, this e-Report is reporting on an indicator of marketing of food and beverages. The indicator reports, that according to current data from comScore, between June 2015 and May 2016, 22.5 million unhealthy food and beverage ads targeted to children aged 2–11 years and 2.25 million targeted youth aged 12–17 years appeared on their 10 most popular websites.

Parents and family members can have a significant impact on the attitudes, beliefs, preferences and behaviours of children.(30) Parental physical activity has been associated with increased child physical activity.(31) Parents can serve as both role-models for physical activity and as necessary supports for children to be active (e.g., supervising children at play, accompanying children to sporting events).(32,33) Additionally, the enjoyment of shared activities can have a positive influence on the level of physical activity, as well as attitudes, beliefs and behaviours. The proportion of parents who report ‘often’ or ‘very often’ playing active games with their children in the past year remains stable at 36.1%.

Without regular accessibility to, and availability of, nutritious foods, healthy eating cannot be achieved. Commonly associated with a household’s financial ability to purchase sufficient food, household food insecurity is an indicator of regular food access. National data on food insecurity has not been collected since 2011–12, therefore it is not possible to provide an update for this indicator.

The benefits of physical education classes in schools go above and beyond the benefits of the physical activity obtained by children during class time. Quality physical education programs can help increase knowledge about physical activity and contribute to the development of behaviours and skills needed to establish a physically active lifestyle that can be maintained throughout childhood, adolescence and adulthood.(34,35) Two hours (2014–15) was the average number of hours per week of physical activity obtained by children (aged 6 to 11) during class time, a level similar to that observed in recent years.

Concern about children’s safety is frequently cited as a major barrier to physical activity. “Stranger Danger”, concern about play-time injury and motor vehicle traffic have all been hypothesized as potentially reducing the number of opportunities for children to engage in active play, to participate in sports or to use active modes of travel to

school. Although the vast majority of injuries from all forms of physical activity are minor and the benefits of active play outweigh the risk of minor injuries,(36) a number of studies support that a link exists(37) and that safety concerns appear to be changing the nature of children's physical activity. One's own perception of safety is also an important factor for youth. A very slight increase in the proportion of youth who agree or strongly agree that it is safe for younger children to play outside during the day was observed between 2009–10 and 2014.^{viii} Efforts to prevent serious injury through appropriate levels of education, supervision and hazard reduction remain important to overcoming these concerns.

In schools, the presence of healthy eating and physical activity policies is essential to creating supportive environments that will enable children and youth to be active and make healthy food choices. The impact that any policy has depends on the nature and level of implementation of that policy and the support that it receives for implementation throughout the school. For high level surveillance of school policies aimed at developing supportive environments, the priority placed on healthy eating and/or physical activity policies by a school's administration was identified as the best, currently available measure. In 2014, 50.8% of schools had a committee that oversees policies and practices concerning physical activity or healthy eating, and 50.5% of schools had an improvement plan for the current school year containing any items related to physical activity or healthy eating.

Inequalities in Childhood Obesity and Related Factors: Highlights from the Health Inequalities Data Tool

The conditions in which Canadians live, learn, work and play have a profound influence on how healthy they will be. In addition to biological risk factors and personal choices and behaviours, health and wellbeing across the lifespan—from the earliest years to the later stages of life—are shaped by a range of social and economic factors, including income, education, employment, housing, and social identities. These factors, often referred to as the 'social determinants of health', also contribute to health inequities, or avoidable inequalities or differences in health between groups of people.

^{viii} It is too early to determine if this is a trend given that there are only two time points available as the HBSC survey is updated every 4 years.

Current evidence on health inequalities in childhood obesity confirms that some groups of children in Canada continue to face poorer outcomes than others in terms of healthy weights, healthy physical activity levels, healthy eating habits, and healthy living conditions. This section will illustrate the scope and magnitude of these inequalities by income, Indigenous populations, and cultural/racial background. For additional data on these and other health inequalities, please visit the [Health Inequalities Data Tool](#).(38)

Results by Household Income

Income is a well-known determinant of childhood obesity, among other physical and mental health outcomes.(39) Among Canadian children aged 6–17, obesity, physical activity, fruit and vegetable consumption, and food insecurity all show similar gradients of inequality by income: generally, the higher the level of household income, the better the outcomes. This overall pattern results in important health gaps between children in different socioeconomic groups. Children in the lowest household income group are significantly less physically active than among children in the highest household income (69.5% compared to 79.6%) and tend to be more often obese (15.1% versus 9.8%). Moreover, children in the lowest household income group are less likely to consume the recommended five daily servings of fruits or vegetables, and are more frequently exposed to household food insecurity compared to those in the highest income groups (27.2% versus 1.1%). With respect to breastfeeding, the proportion of women who reported breastfeeding exclusively tended to be lower among those in the lowest household income group compared to other income groups, but the observed difference was not conclusive.

Results for Indigenous Peoples

Levels of physical activity were similar between First Nations children living off-reserve, Inuit, Métis and non-Indigenous children. However, inequalities in a number of healthy weights indicators were seen between children who identify as First Nations (living off-reserve), Inuit, or Métis and those who identify as non-Indigenous.

Among Inuit mothers, breastfeeding initiation was lower compared to non-Indigenous mothers. Additionally, compared to non-Indigenous children, Inuit children report significantly higher levels of food insecurity (33.6% of Inuit children compared to 9.5% among non-Indigenous children) and lower rates of consuming fruits or vegetables five or more times per day.

First Nations children living off-reserve reported similar levels of physical activity and breastfeeding initiation as non-Indigenous children, but significantly lower levels of fruit and vegetable consumption (9 percentage points less among First Nations children living off-reserve compared to non-Indigenous children) and were exposed to more household food insecurity than non-Indigenous children (27% compared to 9.5%).

Métis children had a similar percentage of household food insecurity compared to that of non-Indigenous children, and a lower percentage compared to other Indigenous children. However, their fruit and vegetables consumption and breastfeeding initiation rates were lower than non-Indigenous children.

Standard indicators of health and health inequalities, including those for healthy weights highlighted in this e-Report, are generally based on Western-centric concepts and assumptions about health and its determinants. While valid for the general Canadian population as a whole, they may not always be appropriate when applied directly to Indigenous and other non-Western cultural and socio-economic contexts. It is therefore important to situate findings about health inequalities among First Nations, Inuit, and Métis peoples within an understanding of heterogeneous Indigenous cultures and the unique social and economic barriers to food security, healthy eating and healthy weights that these communities often encounter. For example, while fruit and vegetable consumption is a commonly used indicator of healthy eating habits among Canadians, this may be less clear for Inuit, whose traditional diets may be more centred on country food (wild animal or plant species sourced from the local environment).

Results for Cultural/Racial Background

Important inequalities also exist among children of different cultural/racial backgrounds in Canada. For example, lower proportions of children from cultural/racial minority groups, especially those from Latin American and East/Southeast Asian backgrounds, were physically active compared to children identified as White.

Likewise, the proportion of East/Southeast Asian children who consumed fruits and vegetables five or more times per day was significantly lower than among children of other cultural/racial backgrounds. Children who were identified as Black faced the highest prevalence of food insecurity—three times higher than for children identified as White (25.6 % versus 8.4%).

Addressing inequalities

When considering health inequalities such as those highlighted above, it is important to keep in mind the broader context in which people live, especially those from historically marginalized communities. Research has documented the intersecting role of various social determinants of health—such as household income and the quality of school and neighbourhood environments—in explaining the excess risk of obesity and related risk factors among groups defined by, for example, cultural/racial background.(40,41)

Sensitivity to intersecting determinants of health and health inequality can help improve the effectiveness of healthy weights strategies both overall and for disproportionately affected groups. For instance, the higher risk for living in poverty among racialized Canadians should be considered when tailoring interventions aiming at reducing health inequalities between White children and those belonging to different cultural/racial groups.(42) Similarly, given the unique history of systematic oppression and disadvantage faced by First Nations people living off-reserve, Inuit and Métis in Canada, it is particularly important to understand and contextualize these patterns of health inequalities from an Indigenous-specific social determinants of health perspective in order to ensure that future interventions aimed at improving Indigenous health outcomes and health equity are culturally appropriate and sensitive to historical injustices.(43,44)

Conclusion

We face a serious problem in Canada. Childhood overweight and obesity rates remain high and stable. A complex and interacting system of factors contributes to the development of overweight and obesity—biological, behavioural, social, psychological, technological, environmental, economic and cultural—operating at all levels from the individual to the family to society as a whole. The conditions in which Canadians live, learn, work, and play have a profound influence on how healthy they will be.

Childhood obesity rates remain high and stable since the endorsement of the Framework in 2010. National data in this report describing the factors associated with unhealthy weights reinforce the need to strengthen efforts to support healthy living. The reality is that it will take time to see significant change. If the broader factors (e.g., environments, social, and physical) are targeted and governments continue to invest in upstream prevention, this will ensure sustained and wide-spread change in the long run. It is important that governments continue to work together in partnership with others to help build environments that are more supportive of physical activity and healthy eating; and help Canadians make healthier and more informed choices.

Social determinants of health not only shape individuals' health outcomes. They also contribute to health inequities, or avoidable inequalities or differences in health between groups of people. Some groups of children in Canada continue to face poorer outcomes than others in terms of healthy weights, healthy physical activity levels, healthy eating habits, and healthy living conditions.

Yet, progress is possible. There are measures in place all across the country to help children and youth be more active and eat healthier; unplug and play; and walk, run and get active before and after school. There's a solid foundation to build on.

We all have a role to play in promoting healthier living, including governments, businesses, non-profits, parents and communities.

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