videos were analyzed. Videos in other languages, duplicate videos, and live videos were excluded. A total of 218 videos were reviewed. Video demographics including number of views, likes, and dislikes were recorded. The upload source of each video was classified as news channel, health professionals, health centers, TV channels, government organisations, educational organisations and independent individual channels based on the information given at ‘about’ section of their YouTube profile. The transparency, utility, reliability and accuracy of video content was assessed using the Journal of the American Medical Association benchmark criteria (JAMA score). Quality of the videos were assessed with Global Quality Score (GQS). Results According to the video source, 30.7% of the videos were shared by health professionals including doctors, dietitians, and nurses, whereas 18.7% of them shared by independent users. Educational organisations only shared 5% of the videos. Videos shared by health centers had the highest JAMA score (2.2 ± 0.8) followed by government organisations (2.1 ± 0.7). The independent users and TV channels had the lowest JAMA score (1.7 ± 0.7). GQS was the highest for government organisations’ videos (3.5 ± 01.1) whereas it was lowest for TV channels’ videos (2.8 ± 01.1). There was a significant positive correlation between JAMA score and GQS of the videos ($r=0.201$, $p=0.05$). According to the assessment of the relationship between length, number of views, likes, dislikes, view and like ratio, there was a correlation between the length of the video, like ratio and GQS ($r=0.201$, $p=0.05$). According to the assessment of the relationship between length, number of views, likes, dislikes, view and like ratio, there was a correlation between the length of the video, like ratio and GQS ($r=0.201$, $p=0.05$).

Conclusion Health professionals, educational and government organisations need to more engage in the spread of nutrition-related COVID-19 information to internet platforms such as YouTube. This will be an effective and immediately implementable public health strategy to effectively spread the right information.

### Abstract 4 Table 1

| Author | Outcome | Vitamin D Dose | Vitamin D status (number of studies/participants) | Age (years) | Follow-up (years) | Relative risk (CI 95%) | P-Value | Key findings |
|--------|---------|----------------|-----------------------------------------------|-------------|------------------|------------------------|-------|-------------|
| Weaver et al. | Fracture risk | 400-800IU/day 500-1200mg/ day Calcium | Not reported | ≥65 | 1-7 | 0.85 (0.73-0.98) | 0.06 | 15% reduction in risk of total fracture. |
| Tang et al. | Fracture risk | 800IU/day and 1200mg calcium | (Low (10144) Normal (39167)) | 50-85 | 3.5* | 0.88 (0.83-0.95) | 0.004 | Calcium with vitamin D associated with a 12% reduction in all fractures. Greater risk reduction with low serum 25(OH)D concentration compared to normal. |
| Keum et al. | Cancer mortality | 400-2000IU/day 20,000IU/week 500,000IU/Year | 38-83 nmol/L | 58-77 | 3-10 | 0.87 (0.79-0.96) | 0.005 | 13% reduction in cancer mortality and 7% reduction in cancer incidence over 3-10 year period. |
| Han et al. | Cancer mortality | 400IU/day- 500,000IU/year | Not reported | 44-75 | 4.3-28 | 0.81 (0.71-0.93) | 0.012 | Dose-response analysis suggests 7% reduction in cancer risk and 2% reduction in cancer mortality with 20nmol/L increment of 25(OH)D. |
| Bjelakovic et al. | All-cause mortality | 300IU/day- 500,000IU/year <26ng/mL (26) | 18-107 | 0.008-7 | 0.94 (0.91-0.98) | 0.002 | 6% decrease in mortality. |
| Rejnmark et al. | All-cause mortality | 300IU/day- 500,000IU/year | Not reported | 53-98 | 3 | 0.91 (0.84-0.98) | 0.01 | 7% decrease in mortality. |
some studies through the inclusion of vitamin D replete populations.

**Conclusion** While there is some evidence of a beneficial effect of vitamin D supplementation in reducing fracture risk, all-cause mortality and cancer mortality, further research is required. Conflicting findings are likely due to the heterogeneity in study design with the inclusion of young populations, short follow-up times, and vitamin D replete participants at baseline potentially concealing the beneficial effects of supplementation. Further clinical research in vitamin D insufficient/deficient populations ≥50 years of age within the UK and Ireland is warranted, with the results informing the clinical effectiveness and cost-effectiveness of vitamin D3 supplementation at the population level.

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**Background** Intuitive Eating is an adaptive dietary behavior characterized by a reliance on internal hunger and satiety cues instead of situational and emotional cues. The construct of intuitive eating is most often measured using the 23-item Intuitive Eating Scale-2 (IES-2).

**Objectives** To develop the Greek version of the IES-2 questionnaire and to examine its psychometric properties with data collected from 379 participants aged 18–74 years.

**Methods** Forward translations to Greek and backward translation to English were performed. The finalized translated version was administered to a sample of 379 adult, Greek speaking participants in Cyprus for psychometric validation, which included assessment of internal consistency, construct, and concurrent validity. Explanatory Factor Analysis (EFA) was applied to better understand the underlying factor structure of the 23 items in IES-2. Internal consistency was assessed by Cronbach’s alpha in terms of the overall and sub-scales. The concurrent validity was assessed by evaluating the correlation among the IES-2 and the Eating Attitudes Test – 26 item (EAT-26) questionnaire.

**Results** A total of 379 participants completed the IES-2, EAT-26 questionnaire, and a demographic questionnaire. The median age of the participants was 31 (Q1=25, Q3=42) years old. About 49.7% of the participants were from the capital of Cyprus, Nicosia, 48.8% were unmarried, 92.9% had completed a higher education and about 40% were categorized as overweight or obese, respectively. EFA gave a three-factor structure with the total variance explained being 54.41%. Cronbach’s alpha as a measure of internal consistency was 0.87 for the IES-2 total score, as well as 0.90, 0.84, and 0.70 for the IES-2 subscale scores. The revised IES-2 total score was significantly correlated with EAT-26 total score (rs=-0.46, p<0.01). The factor loadings on more than one factor were excluded from the next analysis. The results of confirmatory factor analysis indicated that the factor structure on both scales had adequate fit following the elimination of items and addition of covariance.

**Conclusion** Our findings support the notion that intuitive eating is a viable concept and the IES a useful tool for assessing adult intuitive eating behaviors in empirical and epidemiological studies in the general Greek-Cypriot population.