Abstract 16 Table 1 Suggestions to minimise weight bias and stigma (n=83)

Comments relevant to minimising weight bias & stigma	**n=59 (71%)**
Treat individuals with obesity with respect & kindness. Show empathy	38 (64%)
Use 'Person-first Language'	11 (19%)
Promote education regarding consequences of weight bias/stigma	2 (3%)
Judge less & understand obesity is a complex disease that requires various forms of treatment	7 (12%)
Find a balance between 'body confidence & glorifying a disease'	1 (2%)
Comments related to body acceptance initiative	**n=24 (29%)**
'Love your body'	14 (58%)
'Accept that everyone comes in different sizes'	10 (42%)

suggestions were categorised into common sub-groups as shown in table 1.

Results 101 students and staff pledged their support and 83 gave a suggestion to minimise weight bias/stigma. In the latter group, the majority (71%) had a sound understanding of weight bias and stigma. However, 24 participants (29%) appeared to have confused the body acceptance initiative with reducing weight bias and stigma (table 1). This was further verified through their interaction and comments with the volunteers at the stall.

Conclusion This pilot evaluation provides empirical evidence that 'minimising weight bias/stigma' and the 'body acceptance initiative' may be easily confused and even addressed interchangeably. Education initiatives to distinguish between these concepts is warranted to reduce weight-related stigma and improve access to care for individuals with obesity.

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17 CREDIBILITY AND REACH OF NUTRITION INFLUENCERS ON SOCIAL MEDIA

[1]Melissa A Fernandez*, [2]Anne Caretero, [3]Eyasu Jacob, [3]Josh Karatha, [1]Kim D Raine. *[1]School of Public Health, University of Alberta, Canada; [2]Agriculture, Food and Nutritional Science Department, University of Alberta, Canada; [3]WISEST Summer Research Program, University of Alberta, Canada*

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Background Nutrition influencers can reach large segments of the public, regardless of formal training or credentials. Though social media is a popular source of nutrition information, it may not be credible. Furthermore, the perceived credibility of nutrition information may be enhanced through social validation (i.e., popularity of the public figure), yet this phenomenon has not been examined.

Objective To examine the credibility of nutrition influencers' websites in relation to their social media reach.

Methods Nutrition influencers identified through a key word search on popular search engines: Yahoo! Google, and Bing who had active public websites and Instagram accounts were included. 'Tips to Spot Misinformation' developed for the public by the Dietitians of Canada and PEN: Practice Evidence-Based Nutrition were used to create a credibility score for each website. Based on scores, websites were categorized as having low, moderate, or high credibility. The reach of each influencer was ascertained by combining the total number of followers/subscribers from five popular social media platforms (Instagram, Facebook, Twitter, YouTube, and Pinterest).

Results Of the 39 websites, there were 12 (31%) high, 13 (33%) moderate, and 14 (36%) low credibility sites, and the average number of followers for each group were 186 775, 547 088 and 2 153 515, respectively. There was a significant difference in followers between the three groups ($p = 0.017$) and a significantly lower number of followers for influencers with high credibility websites compared to low credibility websites ($p = 0.022$), with more than 10 times fewer followers.

Discussion Popular influencers with low credibility websites have enormous reach whereas influencers with highly credible websites lack the ability to reach large segments of the population. Further research is needed to understand how social validation influences the public's eating behaviors and to identify strategies that will increase the visibility of highly credible information.

18 MAPPING DATA OPPORTUNITIES RELATING TO FOOD, NUTRITION AND HEALTH IN THE COVID-19 PANDEMIC

Dominic Crocombe*, Luke Buckner, Marjorie Lima do Vale, Elaine Macaninch, Suzana Almoosawi, Sumantra Ray. *NNEPro Global Centre for Nutrition and Health, St John's Innovation Centre, Cambridge, UK*

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Background The COVID-19 pandemic has impacted the nutrition and health of individuals, households, and populations globally. Through exposing fragilities in food, health, and social welfare systems, the negative influence of COVID-19 continues to affect the global burden of malnutrition. The nature and scale of these impacts are not yet well understood thus the body of evidence for informing policy is limited. Collating and monitoring relevant data in real-time from multiple levels, sectors and sources is essential in preparing and responding to the ongoing COVID-19 pandemic.

Objectives To identify key data sources related to food, nutrition, and health indicators in the context of the COVID-19 pandemic.

Methods A COVID-19, food, nutrition and health framework was developed through multiple iterative rounds of online multidisciplinary discussions including the NNEdPro COVID-19 taskforce and the Swiss Re Institute's Republic of Science, which comprised researchers and clinicians with expertise in data science, food, nutrition, and health.

Results The proposed framework encompasses five socio-ecological levels which were further sub-divided by six categories of the food and nutrition ecosystem, including food production & supply, food environment & access, food choices & dietary patterns, nutritional status & comorbidities, health & disease outcomes, health & nutrition services. A limited number of exemplar variables for the assessment of global status

Abstract 18 Table 1 Proposed data framework in relation to health, food, nutrition, and the COVID-19 pandemic

	Food Production & Supply	Food Access	Food Choices & Dietary patterns	Nutritional status & comorbidities	Health/disease outcomes	Health & Nutrition Services
Individual/ Household	Allotment use/gardening metrics; Policies and incentives	Proportion of expenditure on food; Food bank use; Food insecurity; Coping strategy index; Social mobility (across generations and in the shorter term); Numbers moving into (and out of) poverty	Food preferences; Food purchasing; Food preparation; Food consumption; Food waste; Breastfeeding	Primary/ secondary health care records	Physical activity; Mental health; Wearable device data; Chronic disease management; Health insurance data	Access to sanitation & potable water; Use of universal healthcare services; Use of nutrition/dietitian services; Use of mental health services
Regional/ National	Production indices of specific food groups; Production values; Export/ import quantities & values; Dietary energy supply adequacy; Share of dietary energy supply derived from cereals, roots and tubers; Protein supply; Protein supply of animal origin; Local food production; Organic agriculture; Policies and incentives for farmers; Local or Community initiatives	Cereal import dependency; Population living in poverty; Un/ Employment rates; Proportion of expenditure on food; Food prices (food basket & food groups); Food bank use; Financial aid for families; Food emergency services; Disruption food provision services (schools, community kitchens, etc.); Food delivery services	Purchasing patterns (supermarkets, grocery stores, take away, restaurants); Food waste; Food advertisement; Supplement sales; Policies & incentives promoting specific foods	Low birthweight; Stunting/ wasting; Overweight & obesity; Micronutrient deficiencies	Hospital admissions; Prescribed/OTC drugs purchasing; Mortality rates (disease-specific & all cause)	Provision of sanitation services & potable water; Universal healthcare services; Nutrition/dietitian part of universal healthcare; Mental health part of universal healthcare; Healthcare services disruption; Hospital admission patterns
Global	UN Food and Agriculture Organisation (FAO) surveillance data	Global Hunger Index; Global Food Security Index	Global Dietary Database	WHO, UNICEF and Global Nutrition Report surveillance data	WHO and Global Burden of Disease and CDC (with regional equivalents) surveillance data	Commonwealth Association of Dietitians and Nutritionists, European Federation of Associations of Dietitians (with regional equivalents)

of food, nutrition and health are identified under each category.

Discussion/Conclusion This collaborative framework is the first step towards the development of a better understanding of the impact of COVID-19 on food, nutrition, and health systems. Limited data availability and disruption in routine data collection as well as other nutrition assessments during the pandemic are challenges that might limit the potential of the proposed framework. Next steps will include formal research and data gap analysis and the identification, as well as utilisation, of other indicators that could be used as proxies of the variables identified.

20 LESSONS LEARNED FROM THE NNEDPRO NUTRITION AND COVID-19 TASKFORCE

Dominic Crocombe*, Shane Mcauliffe, Martin Kohlmeier, Sumantra Ray. *NNEPro Global Centre for Nutrition and Health, St John's Innovation Centre, Cambridge, UK*

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Background Nutritional issues relating to the COVID-19 pandemic span clinical nutrition in acute patients to impacts on global dietary patterns and food security. In March 2020, the NNEdPro Global Centre for Nutrition and Health established a rapid-response Nutrition and COVID-19 Taskforce to help the organisation navigate the initial phases of the pandemic and make a constructive contribution to the scientific landscape.[1–3]

Objectives To highlight lessons learned over 6 months (March-September 2020) of the COVID-19 pandemic in understanding the role(s) of nutrition.

Methods Critical and constructive reflections from Taskforce co-chairs and lead scientific members based on a 6-month summative webinar and journal club examining the strength of evidence and key gaps.

Results Successes in Taskforce operations include pooling a broad range of expertise including clinical medicine, nutrition and dietetics, research, public health, and communications. Pre-existing NNEdPro operations were predominantly online and dedicated virtual meetings supported the proactive collation of key resources relating to nutrition and COVID-19 with production of public-facing information summaries. Academic collaboration with partner organisations, including BMJ Nutrition, Prevention & Health, has focused research priorities and produced contributions to the scientific landscape.[4]

Challenges included managing the sense of urgency, particularly earlier in the pandemic and driven by an unease of the unknown, both at organisational level and in the need to