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3RD INTERNATIONAL EURASIAN CONGRESS OF SOCIAL PEDIATRICS & 7TH NATIONAL CONGRESS OF SOCIAL PEDIATRICS

16-20 NOVEMBER 2022
DEU SABANCI CULTURAL CENTER, IZMIR, TURKEY



In Memory of Prof. Olcay Neyzi



ABSTRACT BOOK



3RD INTERNATIONAL EURASIAN CONGRESS OF SOCIAL PEDIATRICS

**&
7TH NATIONAL CONGRESS OF SOCIAL PEDIATRICS**

16-20 NOVEMBER 2022 | DEU SABANCI CULTURAL CENTER, İZMİR, TURKEY



Dear colleagues,

The 3rd International Eurasian Social Pediatrics Annual Congress and the 7th National Social Pediatrics Annual Congress, organized by the Social Pediatrics Association, and hosted by the Dokuz Eylül University Rectorate will be held at the DEU Sabancı Cultural Center, in İzmir, between 16-20 November 2022.

It's every child's right to be born and grow up in the best conditions and become an adult after being supported for their growth and development. The main goal of us, pediatricians, as child advocates, is to protect and support all children's well-being who are the guarantee of our future. The first step to ensuring the appropriate developmental stages for a child is to support maternal and child health together. Thus, educating expectant parents to acquire sensitive and practical parenting skills, supporting breastfeeding, and maintaining well-child visits in line with scientific data is quite important.

On behalf of the Social Pediatrics Association in Turkey, we, the Local Organising Committee, are excited about the rich scientific and cultural programme and are pleased to invite you to register, come and join us in İzmir. We are looking forward to seeing you in November 2022 at our congress which is organized in memory of Prof. Olcay Neyzi who was one of the pioneers of Social Pediatrics in our country.

Gülbin Gökçay

President of the Social Pediatrics Association

Adem Aydın

Congress Chair

Feyza Koç

Congress Chair



Committees

Organizing Committee

Adem Aydın

Feyza Koç

Gülbin Gökçay

O. Tolga İnce

Özlem Bağ

Merve Tosyalı

Scientific Committee

Adem Aydın - TR

Özlem Bağ - TR

Sarah Blunden - AU

Perran Boran - TR

Figen Şahin Dağlı - TR

Pamela Douglas - AU

Refika Ersu - TR

Emel Gür - TR

O. Tolga İnce - TR

Jeff Goldhagen - US

Feyza Koç - TR

Rosie Kyerematang - UK

Raul Mercer - AR

Charles Oberg - US

Shanti Raman - AU

Nick Spencer - UK

Merve Tosyalı - TR

Nathan Uchtmann - US

S. Songül Yalçın - TR

Tony Waterson - UK

Courses

16 November 2022, Wednesday

Course Title: Infant and Toddlers sleep

Course Director: Perran Boran

Session time	Topic	Speaker
09:00-09:15	Opening, Meeting	
09:15-09:30	Pre-test to determine participant's pre-existing knowledge of sleep in young children	
	CHAIR: ADEM AYDIN	
09:30-10:30	Sleep and sleep problems in early childhood	<i>Perran Boran</i>
10:30-10:45	COFFEE BREAK	
10:45-11:30	Sleep related movement disorders	<i>Adem Aydın</i>
11:30-12:30	Case studies	<i>Ezgi Barış Hülya Barlak</i>
12:30- 13:30	LUNCH	
	CHAIR: PERRAN BORAN	
13:30-16:45	Responsive settling for young children	
13:30- 14:15	Gentle methods of Self-Soothing (GeMSS)	<i>Sarah Blunden</i>
14:15-15:00	Possoms for parents with babies	<i>Pamela Douglas</i>
15:00-15:15	COFFEE BREAK	
15:15-16:00	Central apnea and hypoventilation	<i>Ela Erdem Eralp</i>
16:00-16:45	Obstructive Sleep Apnea, clinical diagnosis and treatment	<i>Refika Ersu</i>
16:45-17:30	Post-test evaluation	
17:30	CLOSURE	



16 November 2022, Wednesday

COURSE TITLE: POSITIVE PARENTING

Time	Topic	Speaker
09:00-09:30	Introduction and setting up the expectations	Figen Şahin Dağlı
09:30-10:00	Brain development of the infant and importance of positive parenting	Tolga Dağlı
10:00-10:30	Attachment and resilience	Selda Karaayvaz
10:30-11:00	Coffee break	
11:00-11:30	Empowering the mother and supporting her well being	Nalan Karabayır
11:30-12:00	Empowering the father and supporting his well being	Beril Aydın
12:00-12:30	Communication with parents	Figen Şahin Dağlı
12:30-13:30	Lunch	
13:30-14:30	Developmental stages of the child and communication according to the age and developmental level - Infancy and early childhood - Importance of play in the development of infants and children - Adolescence	Nicel Yıldız Silahlı Serap Sapmaz Melike Tuğrul Aksakal
14:30-15:00	Setting the boundaries and changing negative behaviour of the child by positive parenting techniques	Figen Şahin Dağlı
15:00-15:30	Coffee break	
15:30-17:00	Case study by psychodrama technique	Figen Şahin Dağlı
17:00-17:30	Evaluation of the day and closure	Tolga Dağlı

16 NOVEMBER 2022, Wednesday

IMMUNISATION PRACTICES IN SPECIAL CIRCUMSTANCES

Time	Topic	Speaker
09.00-09:15	Opening	
Session 1	Chair : Prof.Dr.Emel Gür	
09.15-12.30	Immunisation Practices in Primary and Secondary Immundeficiencies	
09:15-10:00	Immunisation practices in children with primary immunodeficiencies	Meltem Dinleyici
10:00-10:15	Discussion	
10:15-11:00	Immunization in HIV(+) children, children under chemotherapy and biological agent treatment	Sevtap Velipaşaoğlu
11:00- 11:15	Discussion	
11:15-11:30	Coffee Break	
Session 2		
11:30-12:15	Immunization in Solid Organ and Stem Cell Transplantation	Gonca Keskindemirci
12:15-12:30	Discussion	
12:30-13:30	LUNCH	
Session 3	Chair: Prof. Dr. Emel Gür Immunisation in Chronic Diseases -I	
13:30-14:15	Immunisation in children with functional / anatomical asplenia, hemoglobinopathy, bleeding diathesis, chronic renal disease, inflammatory bowel disease	Filiz Orhon Şimşek
14:15-14:30	Discussion	
14:30-14:45	Coffee Break	
Session 4	Chair: Prof. Dr. Gülbin Gökçay Immunisation in Chronic Diseases -II	
14:45-15:15	Immunization in children with chronic lung disease, chronic heart disease, chronic liver disease, metabolic and endocrine disease, neurological disease, rheumatological disease	Feyza Koç
Session 5	Chair: Prof. Dr. Emel Gür Immunization in Unusual Situations	
15:15 -16:00	Immunization in Unusual Situations	Ahmet Ergin
16:00-16:30	Discussion	
16:30- 17:00	Closure	



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16-20 NOVEMBER 2022 | DEU SABANCI CULTURAL CENTER, IZMIR, TURKEY



Scientific Program

17 November 2022, Thursday		
MAIN HALL		
Time	Session / Chairs	Speakers
09:00-10:00	OPENING CEREMONY Dokuz Eylul University Rector President of The Social Pediatrics Association, Congress Chair, Sosped Board of Directors Congress Chair, Sosped Board of Directors President of ISSOP	Prof. Dr. Nühket Hotar Prof. Dr. Gülbin Gökçay Prof. Dr. Adem Aydın Assoc. Prof. Dr. Feyza Koç Prof. Dr. Jeffrey L. Goldhagen
10:00-11:10	SESSION I : CURRENT THREATENS FOR CHILD HEALTH Chairs: Jeff Goldhagen, Gülbin Gökçay	
10:00-10:20	Covid pandemic and children	Rosie Kyerematang
10:20-10:40	Climate change and planetary health	Nathan Uchtmann
10:40-11:00	Commercialization and marketing toward children	Raul Mercer
11:00-11:10	Discussion	
11:10-11:30	COFFEE BREAK	
11:30-12:40	SESSION- II : CHILDREN UNDER DIFFICULT CONDITIONS Chairs: Gonca Yılmaz, Nick Spencer	
11:30-11:50	Children under detention	Jeff Goldhagen
11:50-12:10	Street children and working children	Shanti Raman
12:10-12:30	Impact of armed conflict on children	Charles Oberg
12:30-12:40	Discussion	
12:40-13:30	LUNCH	
13:30-14:10	SATELLITE SYMPOSIUM - 1 Importance of Early Protection Against Meningococcus B in Turkey Speaker: Feyza Koç GSK	
14:10-15:00	SESSION III: BREAST MILK Chairs: Songül Yalçın, Nurdan Evliyaoğlu	
14:10-14:30	Factors affecting breastmilk production	Nalan Karabayır
14:30-14:50	Problems in breastfeeding and relactation (Tandem breastfeeding and weaning from breastfeeding)	Elif Ünver Korğalı
14:50-15:00	Discussion	
15:00-15:20	COFFEE BREAK	
15:20-16:10	SESSION IV : COMPLEMENTARY FEEDING Chairs: Sevgi Başkan, Selda Bülbül	
15:20-15:40	General principles of complementary feeding	Merve Tosyalı
15:40-16:00	Trend topics in complementary feeding (functional nutrition, gluten free diet, vegan and vegetarian diet)	Emel Örün



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16:00-16:10	Discussion
16:10-18:10	ORAL PRESENTATIONS Chairs:Atilla Çiftçi, Özlem Bağ SS - 001, SS - 002, SS - 003, SS - 004, SS - 005, SS - 006, SS - 007, SS - 008, SS - 009, SS - 010, SS - 011, SS - 012, SS - 013, SS - 014, SS - 015, SS - 016, SS - 017, SS - 018, SS - 019, SS - 020



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16-20 NOVEMBER 2022 | DEU SABANCI CULTURAL CENTER, IZMIR, TURKEY



18 November 2022, Saturday		
MAIN HALL		
Time	Session / Chairs	Speakers
08:00-09:00	POSTER PRESENTATION Chairs: Ayşin Taşar, Yaşar Topal	
09:00-10:10	SESSION V: VACCINES Chairs: Emel Gür, Kadriye Yurdakök	
09:00-09:20	Impacts of national vaccination programmes to public health	<i>Sevtap Velipaşaoğlu</i>
09:20-09:40	Current approaches in vaccination practices	<i>Gonca Keskindemirci</i>
09:40-10:00	Vaccine hesitancy: Evaluating with case reports	<i>Filiz Şimşek Orhon</i>
10:00-10:10	Discussion	
10:10-10:30	COFFEE BREAK	
10:30-11:40	SESSION VI: CHILDREN WITH SPECIAL EDUCATIONAL NEEDS Chairs: Elif Özmert, Ayşe Kılıç	
10:30-10:50	Approach to children with specific learning disabilities (Dyslexia, dyscalculia, dysgraphia etc..)	<i>Sevay Alşen Güney</i>
10:50-11:10	Autism spectrum disorders	<i>Sezen Köse</i>
11:10-11:30	Children with unusually well developed intellect 'Gifted children'	<i>Esra Kanlı Denizci</i>
11:30-11:40	Discussion	
11:40-12:20	SATELLITE SYMPOSIUM - 2 Men ACWY-TT Vaccine with 10-Year Antibody Persistence and Efficacy Data Speaker : Tolga İnce 	
12:20-13:20	LUNCH	
13:20-14:00	SATELLITE SYMPOSIUM - 3 Yesterday, Today, The Future in Pneumococcal Epidemiology-World Experience with Vaccination Speaker : Meltem Dinleyici 	
14:00-15:10	SESSION VII: CHILD, FAMILY AND ENVIRONMENTAL INTERACTIONS Chairs: Betül Ulukol, Serpil Uğur Baysal	
14:00-14:20	Parent-child communication	<i>Figen Şahin Dağlı</i>
14:20-14:40	Social environment, child safety and prevention of injuries	<i>Özlem Bağ</i>
14:40-15:00	Children and technology	<i>Bahar Çuhacı Çakır</i>
15:00-15:10	Discussion	
15:10-15:30	COFFEE BREAK	
15:30-16:30	CONFERENCE: RESEARCH IN SOCIAL PEDIATRICS Chair: Gülbin Gökçay, Habip Almış	Nick Spencer
16:30-18:30	ORAL PRESENTATIONS SS - 021, SS - 022, SS - 023, SS - 024, SS - 025, SS - 026, SS - 027, SS - 028, SS - 029, SS - 030, SS - 031, SS - 032, SS - 033, SS - 034, SS - 035, SS - 036, SS - 037, SS - 038, SS - 039, SS - 040	

19 November 2022, Saturday		
MAIN HALL		
Time	Session / Chairs	Speakers
08:00-09:00	ORAL PRESENTATIONS Chairs: Meltem İleri, Özlem Tezol SS - 041, SS - 042, SS - 0443, SS - 044, SS - 045, SS - 046, SS - 047, SS - 048, SS - 048, SS - 049, SS - 050	
09:00-10:10	SESSION VIII: CHANGES IN CHILD HEALTH IN THE COVID-19 PANDEMIC Chairs: Nilgün Çöl, Aysu Duyan Çamurdan	
09:00-09:20	Telemedicine practices	<i>Gökçe Celep</i>
09:20-09:40	Effects on child health follow-up	<i>Seda Topçu</i>
09:40-10:00	Use of nutritional support products	<i>Bahar Kural</i>
10:00-10:10	Discussion	
10:10-10:30	COFFEE BREAK	
10:30-11:30	CONFERENCE: PROTECTION OF BREASTFEEDING: NEW DEVELOPMENTS IN THE WORLD Chair: Songül Yalçın, Nalan Karabayır	Tony Waterston
11:30-12:30	CONFERENCE: RESPONSIVE SLEEP INTERVENTION METHODS IN YOUNG CHILDREN Chairs: Perran Boran, Adem Aydın	Sarah Blunden
12:30-13:30	LUNCH	
13:30-15:10	SESSION IX: PREVENTIVE PEDIATRIC HEALTH CARE - CHILD HEALTH FOLLOW-UP Chairs: Tolga İnce, Vefik Arıca	
13:30-13:50	Neonatal screening programme	<i>Nilgün Çaylan</i>
13:50-14:10	Child and adolescent health follow-up: What do guidelines say?	<i>Meda Kondolot</i>
14:10-14:30	Anticipatory guidance and family counseling	<i>Melda Çelik</i>
14:30-14:50	Discussion	
14:50-15:10	COFFEE BREAK	
15:10 - 16:10	ORAL PRESENTATIONS Chairs: Meltem İleri, Özlem Tezol SS - 051, SS - 052, SS - 053, SS - 054, SS - 055, SS - 056, SS - 057, SS - 058, SS - 059, SS - 060, SS - 031	



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20 November 2022, Sunday		
MAIN HALL		
Time	Session / Chairs	Speakers
09:00 - 10:00	ORAL PRESENTATIONS Chairs: Oya Baltalı Hıdır, Pınar Yılmazbaş	
10:00 - 10:30	RATIONAL DRUG USE Chairs: Özlem Bağ Speaker: Habip Almış	



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SPEAKING SUMMARIES



Problems in breastfeeding and relactation (Tandem breastfeeding and weaning from breastfeeding)

Assoc. Prof. Elif Ünver Korğalı

Cumhuriyet University, Department of Pediatrics, Sivas

Breast milk is the ideal food for the healthy growth and development of babies. It is well known that breastfeeding reduces infant morbidity and mortality rates, ensures optimal growth and development, as well as the economic benefits it brings to the family and the country. Organizations such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), which deal with child health, recommend that all babies be fed only with breast milk for the first 6 months, and that breastfeeding should be continued for at least 2 years, starting from the 6th month, with nutrient-rich complementary foods. Although the benefits of breast milk are well known, 44% of infants between 0-6 in the world and 41% in our country have been fed only with breast milk. Although the rate of breastfeeding at birth in our country is 98%, the rate of feeding with exclusively breast milk is 59% in babies aged 0-1, 45% in babies aged 2-3 months, and 14% in babies aged 4-5 months. The rate of infants receiving breast milk at the age of two is 34%. These results show that breastfeeding rates gradually decrease after delivery. 1/3 of mothers report that they have a problem with breastfeeding at any time. Knowing the problems experienced in breastfeeding will be useful in solving problems with quick and effective solutions.

Problems in breastfeeding;

1. Problems with the mother

Problems associated with the breast and nipple

-*Painful and cracked nipples* (the most common problem, 34%-96%): the most common cause is improper placement of the baby on the breast and trauma to the breast.

-*Milk duct obstruction, engorgement*: It is a state of swelling in the breast that occurs due to the increase in blood flow and tissue fluid and the inability to empty the breast well after rapid milk production. It becomes difficult for the baby to settle on the breast and take the breast into his mouth. Frequent and effective breastfeeding should be provided, warm dressing and massage to the breast will be relaxing.

-*Raynaud phenomenon*: It is the occurrence of vasospasm in the nipple due to arteriolar vasoconstriction in mothers with cold sensitivity and nipple trauma. Pain, burning and paresthesia may be seen in the breast. Triphasic discoloration of the nipple (pallor, cyanosis, erythema) may be observed. It is recommended to stay away from warm clothes, hot showers, drugs that cause vasoconstriction, and substances such as nicotine and caffeine.

-*Fungal infection in the breast*: The most common causative agent is Candida species. There may be itching, pain, redness and scaling around the nipple, as well as similar lesions in the baby's mouth or perineum.

-*Areolar dermatitis*: It is the occurrence of eczema, psoriasis, scaling and redness in and around the breast as a reaction to allergens such as soap and shampoo, vesicles in severe cases, crusting and erosion, itching, pain, burning sensation.

-*Herpes lesions*: The causative agent is H. Simplex or H. Zoster. Breastfeeding is contraindicated if there is a lesion.

-*Bloody milk*: As a result of excessive vascularization in the ducts due to increased milk production, the milk turns pink-red. It is usually observed at first birth and for a few days. If it lasts longer than a week, examination and USG should be performed.

-Mastitis: It is an inflammation of the breast. The most common cause is Staph. Aureus. It most commonly occurs in the first 6 weeks postpartum or while reducing breastfeeding. Flu-like symptoms such as breast tenderness, increased temperature, swelling, fever, chills, and diffuse myalgia are observed. Nipple cracks, infrequent breastfeeding, milk stasis, rapid weaning from the breast and tight underwear increase the tendency. A 3% breast abscess may develop.

Problems associated with the amount of milk

-Hyperlactation: Because the milk is too pressurized and too much from the breast, suffocation, obstruction and aspiration may develop while the baby is suckling. Vomiting, colic and gas pains are also common. It is recommended to breastfeed the mother in a semi-lying position and the baby in a more upright position, give one breast one by one and breastfeed until the end, partially empty the breast, express the excess milk by hand before breastfeeding, and cold compress.

-Lack of milk: The most common reason for discontinuing breastfeeding. Despite adequate milk production, mothers are concerned about their low milk supply. It is recommended to weigh the baby, breastfeed and reweigh, observe the breast, see its correct placement on the breast, increase the frequency and duration of breastfeeding, increase the amount of milk and self-confidence of the mother. A detailed pregnancy and medical history should be taken in terms of conditions that reduce milk production.

Mother's return to work

According to Labor Law 4857 in our country: Maternity leave is 8 weeks before and after birth, a total of 16 weeks. In addition, 1.5 hours of breastfeeding leave per day is arranged for mothers whose children are <1 year old. Mothers start work early due to economic concerns. While only 21% of working women have the opportunity to breastfeed or give milk at the workplace, 60% of working mothers in Turkey cannot use breastfeeding leave (inconvenience of service hours, distance between home and work, manager attitude, workload, etc.). Effective regulations are needed in this regard

2. Problems with the baby

-Sleeping baby: Particular attention should be paid to late premature babies. Each feeding period should last 15-30 minutes, in the first 10 days after birth, even if there is a loss of physiological weight, the baby should reach birth weight, and the baby should be awakened at 2-3 hour intervals, with abundant urine 5-6 times a day and stool 3-4 times a day. It is necessary not to overdress, to avoid very hot environments (ideal temperature: 21-22 C) and to lighten the clothes during breastfeeding.

-Jaundice: It should be more careful in babies who are undernourished and sleep at the breast. Jaundice, sleeping too much and not sucking affect each other. While giving jaundice treatment, nutritional precautions should also be taken.

- Breast rejection: Errors in holding position, incomplete fit on the chest, forcing the baby to breast and sucking, using a bottle, excess / low milk, conditions such as infection in the baby, moniliasis, being separated from the mother for a long time, and distress-stress situations in the family may cause. Breastfeeding should be continued patiently, while asleep and in different positions, and skin-to-skin contact should be increased by spending more time with the baby.

-Baby's health problems: prematurity, tongue tie (frenulum), cleft palate-lip, congenital anomalies, chronic diseases cause problems in sucking.

3. Other Issues

- The mother's inability to know the breastfeeding technique/lack of knowledge and experience/need for edu-



cation and assistance

- Difficulty calming the baby
- Lack of a suitable breastfeeding environment outside the home
- Starting early solid food/thinking it's time
- Cesarean births
- Late breastfeeding
- Conceiving
- Preferring/perceiving formula easily by the mother
- Lack of social support, peer pressure

RELACTATION APPLICATIONS

Relactation: Stimulation of milk secretion in a woman who has given birth but has stopped breastfeeding or has never breastfed initially. Relaxation, in women who have experienced the lactation process before; Since mammary tissues have the ability to respond to prolactin, milk production is easier. Induced lactation; It is the stimulation of milk secretion in a woman who has never been pregnant and has never breastfed.

Reasons for needing relaxation and stimulated lactation:

- Early weaning
- Inability to feed the baby with artificial feeding
- The child is sick
- Adoption
- The idea that breast milk or breastfeeding is important for all children
- same-sex relationship
- Being transgender but not being a biological mother
- Baby born to surrogate mother
- Providing breast milk for a sick relative or close friend

Relactation applications: nipple stimulation, breastfeeding support system, drip method, skin-to-skin contact and use of galactogok. The most important factors affecting the success of relaxation; It is the frequent stimulation of the breasts with the mother's desire and positive attitude.

TANDEM BREASTFEEDING

Tandem breastfeeding is defined as the situation in which the mother continues to breastfeed with her newborn baby in the postpartum period and another infant under the age of two who is still in the breastfeeding period.

In tandem breastfeeding; Although there are hesitations about the changes in milk content and amount, the growth and development of the newborn baby and the health of the older child, studies have shown that while the amount of milk decreases during pregnancy, milk gains colostrum at the time of birth. When the babies of mothers who did and did not breastfeed in tandem were compared, it was found that the birth weights were similar. While one study stated that there was no difference in the weight of babies in these two groups at 1 month, in another study, babies of mothers who breastfed in tandem gained 21% more weight in the first month. In anot-

her study, it was reported that in tandem breastfeeding, babies gain an average of 125 g less weight in the first month, and if this situation continues every month, percentile loss may occur in babies. There was no significant problem in the health of the older child, some mothers stated that their older children showed significant growth during tandem breastfeeding, while some mothers stated that they had mustard colored stools that lasted for a few weeks.

No statistical negativity was reported in terms of spontaneous abortion, premature birth, hyperemesis, growth and development of the baby and APGAR scores with breastfeeding during pregnancy. Only one study reported that mothers who breastfeed in tandem gained significantly less weight during pregnancy compared to other mothers, and that anemia and fatigue were more common.

For mothers who decide to breastfeed in tandem;

- A detailed medical and obstetric history should be taken
- She should be informed about compliance with the individual nutrition program during pregnancy.
- The laboratory findings of the pregnant woman and the growth and development of the fetus should be followed closely.
- Pregnancy follow-ups should be increased
- Newborns and older children should be followed closely by a pediatrician.

With the available information, it has been reported that mothers can continue tandem breastfeeding during and after pregnancy with appropriate nutritional recommendations, vitamin and iron supplementation.

Preventing sibling jealousy, less nipple problems, and the absence of the mother's concern about not getting milk are considered to be the positive features of tandem breastfeeding.

WEANING

The World Health Organization defines weaning as the gradual cessation of breastfeeding and the transition to complementary feeding that includes solid and liquid foods other than breast milk. The breastfeeding period is a special part where the bond of love between the mother and the baby is established and developed and strengthened. Therefore, ending this period is very difficult for both mother and baby. Usually, this decision is taken by the mother and health professionals should provide support to the mother during this period.

Separation from the breast can be done in 2 ways.

1. Weaning at once: It is the abrupt termination of day and night breastfeeding. Generally, traditional methods are used (25-71%). These methods are to cool the baby from the breast, to disgust or to remove the baby from the breast. Applying/putting scary substances on the breast (mud, hair, tomato paste, cocoa, toothpaste, tape, ketchup, lipstick, etc.) or applying substances that will spoil the taste of the breast and milk (salt, vinegar, lemon, honey, mint, petroleum jelly, bitter pepper, mustard, garlic, etc.) is applied. On the other hand, the baby is sent to someone else's house for a while to remove the baby from the breast. These methods can have negative effects on children's mental health such as crying, fear and introversion.

2. Weaning gradually by reducing: This is the recommended method. It can be applied as follows.

- For several weeks, months or longer
- Introducing the baby to a glass instead of a bottle
- It should be started with the least favorite meal of the day, this meal should be served by someone else.
- Wait a few days, changing the next least preferred meal over time



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- Termination of first day and then night breastfeeding
- Partial weaning; making some meals with a glass or bottle (starting work etc.)
- If breasts are uncomfortable, milk can be expressed, acetaminophen/ibuprofen, cold compress
- Breasts should not be tied, less fluid should not be consumed.....canal obstruction, mastitis!!!
- Follow the cues you give your baby. If you sit in the chair that you usually use while breastfeeding, he will probably want to suckle.
- baby-led weaning: never rejecting the breast and also not offering the breast when she is not interested.....2-4 years

General Principles of Complementary Feeding

Dr. Merve Tosyalı

Ege University, Faculty of Medicine, Department of Pediatrics, Division of Social Pediatrics, İzmir

Summary

The period from pregnancy to the end of two years after birth has special importance in the whole life cycle. It is a critical period for both physical and cognitive development. During this period, the growth rate of the brain is one of the fastest during the life span; consequently, the timing, dose, and duration of exposure to specific nutrients can result in both positive and negative effects.

In the first 6 months of life, only breastfeeding is sufficient for the healthy growth and development of the baby. However, after the sixth month, breast milk is not sufficient to meet all the nutritional needs of the baby. For this reason, it is recommended that breastfeeding should be continued until the age of 2 and beyond, with additional nutrients after the 6th month.

When complementary feeding is called, it is defined as the start of giving other foods or beverages to babies in addition to breast milk and covers the period between 6 and 24 months. In infants with normal growth curves, complementary foods should be given at about 6 months of age, but not before 4 months. The foods to be given to babies for the first time should be started individually and should be pureed or liquid. The average energy density of foods included in complementary feeding should be around 1 kcal/g to adequately meet the baby's energy needs. Two or three main meals should be offered each day at between 6. and 8. months, and 3 to 4 meals between 9. and 11. months. Water and other liquids should be given to the baby from the cup.

Complementary feeding is more than ensuring an adequate intake of nutrients; it also is about avoiding excess intake of calories, salt, sugars, and unhealthy fats. Meals are cultural and social events where young children observe, imitate, learn about foods to like or dislike, and form lifelong eating habits and practices. Meals are also when a child learns to touch foods and connect food tastes to how foods look and feel. Ideally, complementary feeding is responsive and promotes child autonomy, but it can also be used to manage behavior problems or overly indulge a child, resulting in long-term consequences for nutrition and health. Therefore, in addition to what a child is fed, attention to how a child is fed is also important.

Keywords: Infant; breast-milk; complementary feeding; nutrition; growth and development;

References

1. World Health Organization. infant and young child feeding: model chapter for textbooks for medical students and allied health professionals. genova, 2009, p.19-29
2. World Health Organization, United Nations Children's Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.



Trend Topics in Complementary Feeding (Functional Nutrition, Gluten Free Diet, Vegan and Vegetarian Diet)

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Beginning of complementary feeding is a critical topic because this period has been affecting on lifelong health status. Complementary foods should be introducing timely, providing sufficient energy, protein, and micronutrients, storing and preparing safely as well as properly fed. WHO recommends that infants start receiving complementary foods at 6 months of age in addition to breast milk. Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities. By 12 months, most children can eat the same types of foods as consumed by the rest of the family, while keeping in mind the need for nutrient-dense foods, including animal-sourced foods like meat, poultry, fish, eggs and dairy products. Main findings are that exposure to a variety of food antigens during early life may play a role in the development of healthy eating habits and that restrictive diets have not been found in studies to prevent allergic disease.

In many community plant-based diets have been considered safely and healthy for thousands of years. In recent years, increase in non-communicable disease (obesity, diabetes, autoimmune diseases such as coeliac disease etc.), environmental problems (climate crisis, decrease in natural resources etc.), neurodevelopmental disease (autism spectrum disorder) and tendency of animal protection are major reasons for rise in vegetarianism, functional nutrition and gluten or lactose-free diets. However, controversies have been continued on whether vegetarian and vegan diets are appropriate for children as young as infants or toddlers. The evidence basis for evaluating the nutritional appropriateness of vegetarian diets for children is inadequate. Potential deficiencies of nutrients such as protein quantity and quality, iron, zinc, selenium, calcium, riboflavin, vitamin A, D, B12 and essential fatty acids are caused for concern. North American guidelines suggest well-planned vegetarian and vegan diets are safe for all age groups. The Canadian Pediatric Society notes a vegetarian diet can be nutritionally adequate when milk and egg products are provided. Some European guidelines do not recommend vegan diet for children because of the risk of nutrient insufficiency without appropriate clinical follow-up, serum monitoring, supplement use.

All foods are functional at some physiological level, but it is the position of the American Dietetic Association (ADA) that functional foods that include whole foods and fortified, enriched, or enhanced foods have a potentially beneficial effect on health when consumed as part of a varied diet on a regular basis, at effective levels. Functional foods include conventional foods, modified foods (ie. Fortified, enriched, or enhanced), medical foods, and foods for special dietary use. Conventional foods are derived from animal or plant sources. Plant-derived foods are oats, flaxseeds, cruciferous vegetables, citrus fruits, garlic, tea, grapes, wine, etc. and the animal-derived foods include egg, meat, fish, milk, curd, cheese etc. The industrial products include nutraceuticals and chemically synthesised pro- and prebiotics.

Gluten is a complex mixture of storage proteins in cereals like wheat, barley, and rye. It consists of several proteins but mainly gliadin and glutenin. Gliadin contains peptide sequences that are highly resistant to gastric, pancreatic, and intestinal proteolytic digestion in the gastrointestinal tract. This difficult digestion is due to gliadin's high content of the amino acids, proline, and glutamine. These proline-rich residues create tight and compact structures that can mediate the adverse immune reactions in coeliac disease. European Society for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) is recommended that gluten can be introduced into infants' diet between the ages of 4 and 12 completed months. No recommendation was made regarding the



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type of gluten to be used at introduction. Also, it was suggested that the consumption of large amounts of gluten should be discouraged during the first months after gluten introduction.



Vaccine Hesitancy: Evaluating with Case Reports

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Vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy is influenced by factors such as complacency, convenience and confidence. The behavior of vaccine-hesitant individuals or communities is complex, and determinants of hesitancy are highly variable. Factors that hinder vaccine acceptance are examined in three groups: contextual effects, individual and group effects, and vaccine and vaccination-related effects. The impact of vaccine hesitancy is difficult to assess precisely across the globe and regionally due to country variations in the definition and a lack of data.

Studies showing that healthcare professionals play an active role in increasing vaccine acceptance emphasize that maintaining the physician-patient relationship will have a positive impact on the decision process in case of vaccine hesitancy. It is observed that establishing good communication and trust between healthcare professionals and parents is one of the most effective ways to eliminate hesitations about vaccination. It is important that healthcare professionals have knowledge about vaccines, their necessity, benefits and risks, and allocate sufficient time for health education. Conversations that guide the caregiver/patient to explore their reasons for hesitancy can help increase confidence and trust in vaccines and the vaccination program. The interview should adopt a guiding and reassuring style, be patient and cooperative, and not add potential concerns by talking about issues not raised by the parent. At the end of the interview, if the hesitancy or refusal continues, a re-interview should be planned, and health care should be continued uninterrupted under all circumstances.

Especially in recent years, it has been observed that anti-vaccine groups influence people's risk perception and decision about vaccines through social media and websites. Vaccine hesitant parents are more active in searching for information online than vaccine-accepting parents and are much more sensitive to unconfirmed negative information put forward by anti-vaccine campaigners. On the other hand, it is seen that the vaccination recommendations and information of healthcare professionals on social media affect parents and increase vaccination rates. Therefore, social media can be used to increase vaccinating confidence among vaccine hesitant parents and to support the dissemination of accurate information or opinions. The use of mass media and social media in informing and raising awareness of the society about the results of scientific studies on vaccines will lead to rapid progress in the fight against vaccine hesitancy.

Autism Spectrum Disorder and Early Diagnosis

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Autism/autism spectrum disorder (ASD) is a neurodevelopmental disorder with symptoms beginning in the early years of life. It is a disorder in which brain development, connections and functionality are affected and which affects functioning in many areas of life, especially social relations and communication skills. It is characterized by core symptoms that include restricted, repetitive-stereotypical behaviors, interests, and activities, as well as qualitative impairment in social interaction and communication. Sensory sensitivities/differences are also among the diagnostic criteria. Currently, it is reported that one in every 44 children has autism spectrum, that is, it affects about 2% of children.

ASD symptoms vary according to developmental periods and the developmental level of the child. While some children may have intellectual disability, significant deficits in language-speech and self-care skills, no social communication and interaction, and avoidance; some children may have normal intellectual functioning, language and speech skills, and academic success, but still have core symptoms. In other words, approximately 60-70% of the cases do not have intellectual disability.

It is accepted that ASD symptoms begin to appear between 6-12 months. It has been determined that the duration of looking at faces and insufficient brain responses at 6 months predicts autism at 36 months, and those diagnosed with autism at 36 months have a shorter time to look at faces even when they are 6 months old. In addition, it was found that insufficient attention paid to social scenes or human faces at the age of 6 months predicted the diagnosis of autism in the future (Chawarska et al. 2013). In other words, ASD symptoms can generally be understood around the age of 1 year. It is stated that the symptoms of some late-onset cases may begin to appear between 18-24 months. Poor eye contact, poor response to smiling, poor responding when called upon, not trying to attract the attention of others to a toy by pointing at it, not sharing one's interest by pointing to an event or object of interest, limited interaction, inadequacies in spontaneous imitation skills, not looking at the pointed object, and delays in language development are symptoms that are expressed as red flags in babies between 9-30 months and show the risk for ASD (Landa 2011).

Although symptoms are observed in the early stages in ASD, diagnosis delays may still occur. It is stated that with early diagnosis and timely directing to appropriate interventions, brain functioning and learning will be higher with intensive special education applied at early ages when brain development is rapid. Thus, children enter older ages more prepared and their losses decrease. It has been reported that it is possible to start treatment at 12 months, early diagnosis increases the success of treatment, and the effect of treatment programs started at the age of 3 years and before is more effective. With the contribution of early diagnosis and early intervention programs, ASD symptoms may decrease or there is a possibility of being undiagnosed. For this reason, it is wrong to think that the diagnosis cannot be made before the age of 3, or to wait and waste time by saying that those who speak late in the family will get better anyway.

Every physician should be aware of the early signs that may be warning signs in order to identify babies at risk for ASD or developmental components. In our country, ASD screening has been added to developmental evaluations and screenings at 18, 24 and 36 months in family health centers. The diagnosis of ASD is made by child and adolescent psychiatrists. Cases that are considered to be at risk for ASD should be referred to a child and adolescent psychiatry specialist for psychosocial developmental evaluation and psychiatric examination.



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Social Environment, Child Safety and Prevention of Injuries

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The human being, from the intrauterine period to death, is a part of its physical and social environment. In infancy, the importance of family and home environment is more prominent, by the time, as the child grows, friends, teachers, and other adults in playgrounds, kindergarten, and school environment take their place due to changing needs. In industrial countries, unintentional injuries (accidents) are among one of the 3 leading causes of death under 5 y of children. Arrangements should be undertaken to minimize morbidity and mortality in unintentional injuries in all environments that the child lives in.

According to Courtesy Centers for Disease and Injury Prevention, injury deaths vary by age group. Unintentional suffocation is the most common injury type causing death under 1 y of age while unintentional drowning and motor vehicle traffic accidents are the forthcoming causes among 1-4 y children. Motor vehicle traffic accidents are the most common cause of unintentional injuries leading to death among children and adolescents from 5 y to 24 y of age.

In recent years, along with technological advances, behavioral, developmental, and psychosocial conditions have become more associated with quality of life. AAP asserted to focus on normal child behavior and physical and environmental factors affecting behavior and emphasized the need to address environmental and social aspects. Thus, providing a developmentally appropriate environment is the first step to maintaining the child safety.



Child and Technology

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Technological tools are widely used in every area of daily life, such as entertainment, communication, housework, personal care, health, and transportation. Today's needs make technology a necessity instead of a preference. Although digital media has been used mostly to deliver clinical treatments, the whole society, including children often use technological devices such as televisions, mobile phones, tablets, and computers in their daily lives, and these devices shape their communication, entertainment, and learning structures. It seems that children's inappropriate use of such technological devices in terms of content, duration, frequency, and the posture they adopt while using them pose a variety of health risks, including developmental problems, musculoskeletal problems, physical inactivity, obesity, and inadequate sleep quality. According to the American Academy of Pediatrics recommendations set limits on media use, such as avoiding digital media use in children younger than 2 years old and limiting screen use to 1 hour per day of high-quality programming with their parents for 2- to 5-year-old children.



Telemedicine Practices

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Increasing population and developments in communication technology forced us to use telecommunication based healthcare services. Dizzying progress in information transfer systems and digitalization in healthcare have led to changes in the habits of healthcare quest and presentation of service. The concept of medical services had to be altered because of increasing costs and accumulating data. Digital transformation in medical services makes a significant contribution and utilization to general, complementary and preventive healthcare delivery.

Tele-health and telemedicine are the components of telecommunication based healthcare systems. Tele-health is the use of technology to deliver health care, health information and health education from a distance by using communication ways such as telephones, smartphones, etc. Telemedicine is a subtitle in this concept whose purpose is to improve the patient's health by providing specialized services remotely. However, nowadays two terms are synonymous. Videoimaging, interview with the patient, obtaining patient data, consultation with other physicians, even tele-surgery are possible. Before the COVID-19 pandemic the use of tele-health system was limited. When distance or the situation of the patient is an obstacle to reach healthcare settings, telemedicine is life or time saving. During the recent pandemic the necessity of tele-health services has become evident due to the limitations of vulnerable population to reach hospitals, including children, elderly individuals, chronic patients, pregnant women, disabled individuals, etc. It is important to expand the provision of these services which have the potential of effectiveness and efficacy of healthcare of vulnerable individuals. Tele-health contributes to the development of health through personal management and increasing the level of health literacy. Ethical framework and technical support should be provided for the sake of patients. Appropriate patient selection and information transfer can increase the benefits of telemedicine.

Telemedicine has been used in all subbranches of pediatric service, including neonatology, intensive care, chronic patient follow up and well child visits. In addition, it can facilitate the consultation, research and education between the clinicians studying in different areas and places. Outcome of studies establish that parental satisfaction is high, absenteeism due to illness, costs, time are reduced. In addition, applying to emergency department for non-urgent conditions is reduced. The service is patient centered and tailored. Tele-practice cannot replace the in-person visit, but may help to save time and money.

In this presentation we will glance the past, present and future of telemedicine and its place in pediatric practice.

Effects of Covid-19 Pandemic on Child Health Follow - up

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The last two years have witnessed an almost complete shutdown of vital child health and well care services in terms of nutritional programs, maternal and newborn care, immunization services, and community-based child protection programs. The impact of COVID-19 may not be completely reflected in indicators of morbidity and mortality of children; but this crisis can have a profound effect on the overall well-being. These effects can be primarily grouped into:

1. Transmission of the virus; mortality, morbidity;

Covid-19 deaths under 20 years old 0.4% of 4.1 million total deaths. Covid -19 is not as mortal as adults in children; however, there have been complications such as Misc, which can be fatal.

2. Health/education/economy/social impacts of emergency measures taken to prevent transmission of the virus

In the literature, it is seen that there is a decrease in child health follow-ups and vaccination between March-June 2020. While this situation recovered in a short time in developed countries, it has become an important public health problem that may increase child mortality, especially in South Asian and African countries. The World Health Organization (WHO), UNICEF and the Vaccination Alliance GAVI reported that routine immunization programs were significantly disrupted in at least 68 countries, affecting nearly 80 million children. In the first 5 months of the pandemic, some countries postponed their immunization campaigns. This has led to polio cases and occasional measles outbreaks, especially in developing countries.

Disrupted access to and delivery of health services for the care of children with life-threatening diseases, such as the treatment of children with cancer.

The percentage of exclusively breastfed infants in developed country samples decreased significantly at all time points, possibly due to the inability to provide face-to-face breastfeeding counseling services due to the Pandemic. Prolonged quarantine in developing countries has led to economic insecurity, resulting in food shortages and increased food prices. This situation was reflected in child nutrition as stunting, weakness, malnutrition, anemia and obesity. In developed countries, unnecessary and excessive vitamin and mineral supplements were used for preventing Covid-19.

Insufficient stimuli in the preschool age group; led to problems in language-cognitive development. The closure of schools and social isolation led to disruption in education, sedentary living, and physical and mental health problems due to excessive use of digital technologies. Interruption of education led to more behavioral problems in children with special needs, such as ASD, and more negative effects on parental mental health.

3. Possible long-term effects of delayed implementation of the Sustainable Development Goals in Health

Goals such as ending poverty and hunger, Clean water/sanitation, safe food, quality education, and reducing inequalities, which are among the sustainable development goals of the United Nations, have been adversely affected by the pandemic. So that governments need to carefully plan their action for future disasters.



Use of Nutritional Support Products

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Micronutrients are essential vitamins and minerals required in small amounts from the diet to maintain normal cellular and molecular functions. Nutritional supplements should be used when daily requirements are not met through diet. Those with increased requirements due to growth, chronic disease, medication use, malabsorption, pregnancy and lactation, and aging may be particularly at risk for inadequate dietary intakes. Routine and indiscriminate use of nutritional supplements for disease prevention is not recommended due to limited scientific evidence (1).

The real impact of the COVID-19 pandemic on children goes far beyond a viral infection. While malnutrition is expected to worsen in poor countries, obesity rates are expected to increase in middle- and high-income countries, especially among precarious groups, which widens the gap in health and social inequalities (2).

With the uncertainty of treatment options for COVID-19 in the early part of the pandemic, in the absence of effective drugs, alternative approaches have been sought. Micronutrients and bioactive substances thought to have immunomodulatory, anti-inflammatory, antioxidant and antiviral properties have been seen as alternative nutritional approaches to combat COVID-19 (3). Current evidence recommends the use of nutritional supplements when requirements are not met through diet. Growth, chronic disease, medication use, malabsorption, pregnancy and lactation, and aging can be risks for inadequate dietary intakes. Available scientific evidence do not recommend the routine and unnecessary use of nutritional supplements for the prevention of chronic diseases (4).

Our knowledge of the pathophysiology of COVID-19 is limited and continues to evolve. In this period of uncertainty, it is essential to reduce individual risks. It is important to emphasize that some herbal supplements may have the potential to increase the severity of COVID-19. Further studies on efficacy and safety should be conducted before supplements can be safely recommended to patients.

References

1. Marra MV, Bailey RL. Position of the Academy of Nutrition and Dietetics: Micronutrient Supplementation. *J Acad Nutr Diet.* 2018;118(11):2162-2173.
2. Zemrani, B., Gehri, M., Masserey, E. *et al.* A hidden side of the COVID-19 pandemic in children: the double burden of undernutrition and overnutrition. *Int J Equity Health* 2021; **20**, 44.
3. Keflie TS, Biesalski HK. Micronutrients and bioactive substances: Their potential roles in combating COVID-19. *Nutrition.* 2021;84:111103. doi: 10.1016/j.nut.2020.111103.
4. Hojsak I, Chourdakis M, Gerasimidis K, Hulst J, Huysentruyt K, Moreno-Villares JM, Joosten K. What are the new guidelines and position papers in pediatric nutrition: A 2015-2020 overview. *Clin Nutr ESPEN.* 2021 Jun;43:49-63.



Anticipatory Guidance and Family Counseling

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Anticipatory guidance is the education and counseling of a child health specialist or family physician to the child and his family about the expected growth and development of the child, the benefits of healthy lifestyles and practices, and the prevention of accidents and diseases during child health follow-up. It is a process where the physician anticipates the problems a child and family may face and provides guidance. When the advice is given on time, at the right age, and appropriate and relevant to the child and family in the community, it will be adopted by the family. Addressing safety issues is an opportunity to help the family handle relationship issues, access community services, and interact with the extended family, school, neighborhood, and faith communities. Every child health visit is an opportunity for family guidance. It includes the physician's asking the family questions appropriate to the child's age, growth and development period, making suggestions without judgment about the deficiencies or mistakes in the application, answering the questions of the families, and providing guidance about the situations they may encounter in the future. Questions asked by the family about future situations provide a possible scenario for discussion and help create a conversation about the family and the child (1).

Here, it is aimed to summarize some of the most frequently asked questions by families during their child health follow-up visits, which require counseling, and the evidence-based answers that can be given to them.

"How should I dress my baby?" In cold temperatures below 24°C, the baby will need several layers of clothing to keep warm (an undershirt, a pajama over panties/diaper and a blanket over it). In hot weather (above 24°C), baby's clothes can be decreased to one layer. The best rule is to dress the baby in at most one layer more than the parent is wearing to keep the baby comfortable in the same environment (1).

"What is the Ideal Room Temperature for a Sleeping Baby?" There are studies suggesting a room temperature of 20-22°C or 16-20°C. However, the AAP (American Academy of Pediatrics) recommends dressing the baby in accordance with the ambient temperatures instead of recommending a specific temperature range for the baby's bedroom. If the mother feels that the baby is warm on her breast, she should reduce the baby's clothes and the room temperature. The appropriate room temperature may depend on the climate. Babies accustomed to hot climates can withstand a higher room temperature. Strong air conditioning in the summer or overheating in the winter can also be dangerous for babies. Using air conditioning at a baby room temperature >22°C can reduce the risk of SIDS (1, 2)

"Can we sleep in the same bed with my baby?" Having the mother and baby in the same bed can make it easier to continue breastfeeding. However, Sudden Infant Death Syndrome (SIDS) also increases the risk of SIDS 3-4 times. It is recommended that the baby sleep in the same room in a crib near the mother for at least the first 6 months, but under no circumstances should they sleep in the same bed (1, 3.)

"How and where should I put my baby to bed?" To reduce the risk of sleep-related death, it is recommended that infants be placed in the supine position until they reach one year of age (including those with GER). Lying on its side or face down is not safe and not recommended, the risk of SIDS increases 2-13 times. The baby's bed, including babies with GER, should be firm, level and flat. Soft materials such as pillows, stuffed or fur toys, quilts, mattresses, mattress protectors, blankets and loose sheets should be kept away from the baby's bed (2-4).



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“What should I concern about my baby’s sleep pattern?” Babies do not have regular sleep cycles until they are around 6 months old. Newborns sleep for a total of 16 to 17 hours a day in 1-2 hour periods. Babies need less sleep as they grow, every baby’s needs are different. A 6-month-old baby can normally wake up sometimes at night, then go back to sleep soon after. After 6 months, a crying baby should be given time to learn to fall back asleep on their own, rather than immediately cuddling and soothing him. Cuddling, rocking, or breastfeeding to sleep makes it harder for him to go back to sleep when he wakes up at night. After the baby is asleep, the place should not be changed, and nighttime changing diaper or feeding should be done quietly and without waking him up. It should always be ensured that he sleeps at certain hours. There should be play time during the day and should be kept awake longer during the day. The daytime sleep time should not be too long, the evening sleep should be in the early hours. The baby’s room should be ventilated frequently and slightly darkened while sleeping. The baby should not be put into bed with a bottle (risk of tooth decay, otitis media). A favorite toy can be left with him in the bed (2,4).

“How do I know if my baby is hungry, full and well-fed?” Early signs that a baby is ready to be fed are essential. If the early signs are not responded to, the baby will likely start crying. When the baby starts to cry, breastfeeding may be difficult and the breast may be refused. Therefore, the baby must first be calmed down. After the first week, urine at least 5-6 times a day, stool with soft consistency 3-5 times; as a definite indicator, an appropriate daily, weekly or monthly weight gain indicates that a baby is adequately fed (5).

“In which month should I switch to complementary foods in my baby’s diet?” Both American and European allergy expert committee guidelines, ESPGHAN, and EFSA recommend introducing solid foods to all infants at 4-6 months. However, WHO, AAP, and Canadian Pediatric Association still recommend exclusive breastfeeding for the first 6 months of life. There is no evidence that introducing allergenic foods such as peanuts, eggs, and fish more than 4 to 6 months later prevents atopic disease (5-7).

“When will my baby’s umbilical cord fall off? What should I do for umbilicus care?” The baby’s umbilical cord falls off in about 7-14 days. In developed countries, only clean and dry care is recommended instead of using antiseptics or antibiotics. If the umbilical cord has not yet fallen; it is recommended that the bath water be boiled and warmed, and that the baby be bathed with a sponge without being completely immersed in water (1,3).

“How often and how should I bathe my baby?” Bathing 2-3 times a week is sufficient for term newborns. More frequent bathing can disrupt the skin flora and barrier. You can take a bath every day in summer, every other day during seasonal transitions, and twice a week on cold days (1, 3).

“Shall we use a pacifier?” According to the World Health Organization (WHO) and UNICEF, the pacifier should not be used until the baby is used to breastfeeding at the earliest and after 4 weeks, as it may prevent the baby from breastfeeding. The AAP recommends giving a pacifier during sleep to reduce the risk of SIDS (50-90%). Continuing the use of pacifiers after 6-12 months increases the risks of otitis media, disorder in the mouth-tooth structure and malocclusion after 18 months. Therefore, pacifier use should be discontinued at the latest around the 12th month. Mothers should be warned about hygiene, otitis media, malocclusion and nutritional tips, but the decision of using pacifier should be left to them (2, 4).

“Should I use sunscreen cream for my baby in the summer?” Sunscreen is generally not recommended for babies under 6 months, but can be used on small exposed skin areas where the sun cannot be avoided. For babies older than 6 months, sunscreen products with a Sun Protection Factor (SPF) of at least 15 and protecting from UVA and UVB should be used 15-30 minutes before going out into the sun and every 2 hours. Products containing zinc oxide or titanium dioxide (which do not come off easily) should be used on sensitive areas (nose, shoulders, ears, etc.). Sunscreen products containing oxybenzone are not recommended because of potential hormonal effects (1,3).

“When should I take my baby to have an eye exam?” For the first time, an eye examination (red reflex test, pupils, external eye structures) should be performed by the family doctor/pediatrician at every healthy child visit, shortly after birth, before 3-6 months. If a problem is detected, it is referred to an Ophthalmologist. Before 4 months, most babies can be expect to have intermittent strabismus in their eyes. After the 4th month, if intermittent, continuous shift or strabismus is seen in any month, Ophthalmologist examination is required(1).

“Can we use a baby-walker?” Baby-walkers increase the ability of young children to move and reach objects, causing accidents (falling from the stairs, burning, drowning, poisoning) and delaying walking, so they are not recommended (1,3).

“Shall we use a kangaroo/sling to carry the baby?” Kangaroo/sling with suitable features can be used until the baby is 5-6 months old (1,3).

“What should I consider before traveling with my baby in the car?” Until the age of at least 2 years, the baby should always be kept in the rear-facing car safety seat (CSS) secured with a seat belt in the back seat. The CSS should never be placed in the front seat with an airbag and the infant should not be held on the lap. Children aged ≥ 2 years and those who have exceeded the CSS in weight or height can ride on the CSS facing forward. Children who have grown up for forward-facing CSS should use a booster seat until they can properly buckle their seat belt. Children who can use the seat belt alone (usually 145 cm tall, around 12 years old) should use a seat belt with lap and shoulder support. All children under the age of 13 are recommended to travel in the back seat. The driver should always use seat belt; avoid talking on a mobile phone, and driving under the influence of alcohol / substance. To prevent heatstroke or suffocation; the baby should never be left alone in the car (1,3, 4).

“When and how should I start my child’s toilet training?” After the child turns 2 years old, toilet training can be started when signs of readiness are noticed. If he can express himself about the toilet, stays dry for 2 hour periods, knows it is wet or dry, is uncomfortable with dirty diapers, makes his toilet by hiding, and if he can pull his pants up/down himself, he is usually ready (1,3).

“My baby has a fever. What should I do?” The temperature of the baby can be measured with digital thermometers from the ear, rectum, armpit or forehead. If the child looks sick and feels uncomfortable with fever $\geq 38^{\circ}\text{C}$, an antipyretic can be given, paracetamol is the first choice for those younger than 6 months, it can be repeated every 4-6 hours. A doctor should be consulted if a child with fever has the following conditions (1,3):

- Very ill appearance, unusually sleepy or very restless,
- Found in a very hot indoor place (car etc.)
- Neck stiffness (stiff neck), severe headache, severe sore throat, severe earache, rash or recurrent vomiting or diarrhea,
- Immune system problems such as sickle cell disease or cancer or steroid use,
- Seizure,
- Smaller than 3 months (12 weeks) and with fever $\geq 38.0^{\circ}\text{C}$
- Fever repeatedly $>40^{\circ}\text{C}$ at any age
- Still “feeling sick” even after his fever drops,
- Seems to be getting worse,
- Persistent fever for more than 24 hours in a child <2 years old,
- Persistent fever for more than 3 days (72 hours) in a child aged ≥ 2 years.



“How long/how can my child watch a screen (TV/smartphone/computer)?” Children under 18 months should not watch TV or any digital media. 18 months to 4 years old can watch high quality programs of parent’s choice, with parent, for a maximum of 1 hour or less per day.

References

1. Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017
2. Ball, H. & Blair, P.S. 2017. Health professionals’ guide to: “Caring for your baby at night.” unicef. UK.2017
3. American Academy of Pediatrics. The HealthyChildren.org website.
4. Moon RY, Carlin RF, Hand I; TASK FORCE ON SUDDEN INFANT DEATH SYNDROME and THE COMMITTEE ON FETUS AND NEWBORN. Evidence Base for 2022 Updated Recommendations for a Safe Infant Sleeping Environment to Reduce the Risk of Sleep-Related Infant Deaths. Pediatrics. 2022
5. Baby-friendly Hospital Initiative training course for maternity staff: trainer’s guide. Geneva: WHO and UNICEF, 2020.
6. Nutrition Risk in Later Childhood. D’Hollander Cj et al, TARGet Kids! collaboration ,J Pediatr. 2022
7. Boswell N. Complementary Feeding Methods-A Review of the Benefits and Risks. Int J Environ Res Public Health. 2021.

Keywords: anticipatory guidance, baby, child health, counseling, family



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ORAL PRESENTATIONS



SS001

Zinc Levels and Affecting Factors in Children Aged 10-18

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Introduction: Mineral deficiencies are one of the most important problems in children. One of these factors is zinc, but when the literature is examined, it is seen that there is not enough data.

Objective: This study is aimed to determine the zinc levels in children aged 10-18 years and factors affecting them.

Method: The study was carried out with 542 children aged 10-18 in a training-research hospital of a university. Institutional and ethical committee permission was obtained to conduct the study. For the study, the files of the patients who applied to the hospital between 2019-2022 and were examined for zinc were examined retrospectively. Data were collected with a form prepared by the researchers. Number, percentage, mean, median, standard deviation, chi-square analysis and regression analysis were used in the analysis of the data. The cut-off value for zinc was accepted as 70 mcg/dl. Those with a zinc level of 70 mcg/dl and below were considered to have deficiency.

Results: 60.1% (n=326) of the children participating in the study were girls and 39.9% (n=216) were boys. The average age of the children was 13.64±2.63. It was determined that 12.7% (n=69) of the children had low zinc levels. Sorted by gender, zinc level average of girls was 90.58±22.47 (min=11.30-max=188.40 mcg/dl) and 91.85±18.09 (min=52.5-max=167.30 mcg/dl) of boys. To examine the children's zinc levels, children were divided into 3 age groups: 10-12 ages, 13-15 ages, and 16-18 ages. According to age groups, 11.1% of the children in the 10-12 ages (n=24), 12% of the children in the 13-15 ages (n=12) and 15.7% of the children in the 16-18 ages (n=25) had deficiency of zinc. Although the rate of children with low zinc levels increased with increasing age, it was not found to be statistically significant (p>0.05). The mean zinc level in children aged 10-12 was 92.59±19.77 mcg/dl (min=42.9-max=167.30 mcg/dl) and the median was 92.25 mcg/dl, and the mean of zinc in children aged 13-15 was 90.06±19.91 mcg/dl (min=11.90-max=162.40 mcg/dl) and its median was 90.80 mcg/dl and the mean of zinc in children aged 16-18 was 90.12±23.03 (min=11.30-max=188.40 mcg/dl) and the median was 91.60 mcg/dl. To examine which variables plays role for zinc levels, vitamin D level, LDL cholesterol level, iron, ferritin, CRP, calcium, sodium and age group were included in the regression analysis. As a result of the regression analysis, it was determined that these variables significantly explained the zinc level (p<0.05). These variables explain 5.8% of the variation in zinc level. When the variables were examined one by one, it was determined that they were only affected by LDL cholesterol and iron levels.

Conclusion: It was determined that the factors affecting the zinc level were LDL and iron. It is seen that the variables included in the regression model explain 5.8% of the variation in zinc level. It is recommended to examine other variables that affect zinc levels.

SS002**Health of Refugee Children and Newborns at Health Sciences University, Sancaktepe Training and Research Hospital: A single-Center Study**

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Introduction

The number of refugees in the world has been increasing due to ongoing wars, national and political expulsions. Turkey has the world's largest refugee population and half of the all refugees are children who have high developmental risk by reason of dislocation and deprivation. Turkey currently hosts an estimated 3.6 million Syrian refugees, of whom 23% are reproductive-age women (15–49 years) and 14% are children aged 0–4 years. According to the 2022 data of the Ministry of Health, 754000 Syrian children were born in our country.^{1,2}

WHO recommends that infants start breastfeeding within one hour of birth and are exclusively breastfed for six months, followed by the timely introduction of adequate, safe and properly fed complementary foods with continued breastfeeding until at least 24 months of age. However, according to the 2019 Turkish Demographic and Health Survey, only 73% of Syrian babies are breastfed within one hour of birth, 24% of babies receive prelacteal food and only about half (51.6%) of children aged 0–5 months are exclusively breastfed.^{2,3}

The aim of this study is to describe the sociodemographic and medical characteristics of pediatric and newborn refugee population who were followed in our neonatal intensive care unit, delivery room, postnatal / puerperal service regarding recognize gaps in care for refugee children and to understand their specific needs.

Material/Method

This was a retrospective observational study using data from medical records of refugee children and neonates where was followed the Health Sciences University, Sancaktepe Training and Research Hospital, İstanbul at neonatal intensive care unit, delivery room and postnatal / puerperal service, between 1 January 2020 and 1 January 2022. Ethics committee approval was obtained from the non-interventional ethics committee of Sancaktepe Training and Research Hospital on 15/06/2022.

Results

Between 01/01/2020-01/01/2022, 10312 deliveries were made in our hospital, and 1754 cases consisted of Syrian and other refugee children. Of all births, 212 were preterm births and 37 cases consisted of Syrian and other refugee children. 72% of all preterm cases were followed up in the neonatal intensive care unit. 84% of the Syrian cases were followed in the neonatal intensive care unit (Table 1).

After all deliveries, mothers were given training on baby care, breast milk and breastfeeding by our expert team. Communication was established with the mothers of Syrian and other refugee children through our hospital's staff translators and health ministry translators. Breastfeeding characteristics of refugee mothers are given table 2.

It has been observed that 66% of mothers of Syrian and other refugee children have insufficient experience in breastfeeding. After the first training was given to the mothers in the delivery room, postnatal/puerperal service and neonatal intensive care unit, the mothers and their babies were called to the outpatient clinic and followed up.

Discussion

The rate of those who initiated breastfeeding within 1 hour after delivery was 61.4% for the Syrians and 71.1% for the Turkish mothers. In addition, the rates of exclusive breastfeeding (28.1 versus 34.1) and continuing breastfeeding for 12 months (55.0 versus 63.8) were lower in the Syrian refugee mothers. Maternal age and educational level were not correlated to the breastfeeding rates.⁴

The objective was to describe infant feeding practices, nutrition and related health aspects of infants under six months among Syrian refugees in Greater Beirut, Lebanon. A cross-sectional study was conducted among Syrian refugee mothers with infants under six months in July–October 2018 (N = 114). Additionally, eleven focus group discussions were conducted to explore supportive factors and barriers associated with early breastfeeding practices. The prevalence of prelacteal feeding was high (62.5%), whereas early initiation of breastfeeding was low (31%), and exclusive breastfeeding very low (24.6%).⁵

The short duration of breastfeeding in Syrian refugees was seen to be related to the cultural characteristics, and migration. Some cultural characteristics can be summarized as “believing that breastfeeding harms mother’s health”, “adolescent marriages”, “wanting to have as many children as possible”, “giving anise to infants and not breastfeeding at night”, “prelacteal feeding”, “believing that milk is not enough”, “over controlling mother–child interaction by grandmothers, which limits the interaction”, “short pregnancy intervals”, and “not using modern family planning techniques”.⁶

Conclusions

There is little data on the health status of the child migrant population and the reasons for seeking care, as fewer studies have been conducted on the child refugee population than on the adult population. More work should be done on refugee children in our country and the world, their needs should be determined and efforts should be made to increase the efficiency of the service.

Tables

Table 1. Characteristics of refugee children

Characteristics		N	%
Sex	Male	832	47.4
	Female	922	52.6
Gestational Age	Term	1717	97.9
	Preterm	37	2.1
Birth Weight	LBW	705	40.1
	VLBW	119	6.7
	ELBW	33	1.8

Table 2. Breastfeeding characteristics of refugee mothers

	N	%
Breastfed within one hour of birth	1193	68
Receive Pre-lacteal food	368	20.9
Exclusively Breastfed(0-6 months)	845	48.2
Bottle feeding	784	44.7
Breastfeeding(1 year)	940	53.6

References

1. Yalcin SS et al. Breastfeeding practices among Syrian refugees in Turkey. *International Breastfeeding Journal* (2022) 17:10 <https://doi.org/10.1186/s13006-022-00450-3>.
2. <https://www.aa.com.tr/tr/saglik/bakan-koca-ayrim-yapmaksizin-gocmenlerin-saglik-ihiyacina-iliskin-ortak-bir-yol-izlemek-hepimizin-asli-gorevi-/2537978>.
3. 2019 Turkish Demographic and Health Survey, Hacettepe University Institute of Population Studies. (2019). 2018 Turkey Demographic and Health Survey. Hacettepe University Institute of Population Studies, T.R. Presidency of Turkey Directorate of Strategy and Budget and TÜBİTAK, Ankara, Turkey.
4. Vasfiye Bayram Değer, Melikşah Ertem, and Sema Çifçi. Comparison of the Breastfeeding Practices of Refugee Syrian Mothers and Native Turkish Mothers. *Breastfeeding Medicine*. Mar 2020. 170-175. <http://doi.org/10.1089/bfm.2019.0233>
5. Abou-rizk J et al. Infant Feeding Practices, Nutrition, and Associated Health Factors during the First Six Months of Life among Syrian Refugees in Greater Beirut, Lebanon: A Mixed Methods Study. *Nutrients* 2022, 14(21), 4459; <https://doi.org/10.3390/nu14214459>.
6. WHO/Europe. Yalçın SS et al. Breastfeeding characteristics of Syrian refugees in Turkey. Document number: WHO/EURO:2021-2545-42301-58509.



SS003

Parents' Attitudes Toward Childhood Vaccines and Covid 19 Vaccines

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Objectives: With the onset of the COVID-19 pandemic, the Covid vaccine has come to the fore, and conspiracy theories or misinformation about vaccines from social networking sites have been on the agenda. The aim of this study is to investigate the effects of the Parents' Attitudes Towards Childhood Vaccines Scale (PACV) on the prevalence of child vaccination hesitancy among parents, the use of social media by parents and their attitudes towards the Covid 19 vaccine on vaccine rejection.

Methods: It was conducted with parents with 0-60 month old children who applied to the pediatric outpatient clinic. The study questionnaire included the 15-item PACV, the 9-item Attitudes Towards COVID-19 Vaccine Scale, demographic questions, Covid 19 vaccine status/intention for the participant himself, and vaccine-specific side-effect concerns. Descriptive statistics of the data obtained from the study are given with mean, standard deviation for numerical variables, and frequency and percentage analysis for categorical variables.

Results: Of the 1068 participants included in the study, 779 (72.1%) were female and 308 (27.9%) were male. The mean age of the participants was 33.66 ± 9.1 years (min-max: 18-64). Of the participants, 993 (92,18) were married, 94 (33.99%) were high school graduates and 358 (33.52%) were housewives. The income of 414 (38.14%) of the participants is 4000 TL or less, and 28.21% are between 4000-6000 TL. 108 (10.14%) of the participating parents have postponed their childhood immunizations or not. 761(70.14%) parents stated that they needed more information about childhood vaccinations. Vaccination hesitancy was detected in 102(9.38%) parents. When the scores of the participants from the Attitudes Towards COVID-19 Vaccine Scale were examined, the average positive attitude score was 3.69 ± 0.95 and the negative attitude score was 3.60 ± 0.59 on average. Men's negative attitude scores are higher than women. Those with a family member diagnosed with Covid 19 had higher positive attitude scores ($p < 0.007$). Participants who said that social media influenced their decision to get vaccinated had higher both positive and negative scores ($p < 0.002$, $p < 0.001$). A statistically significant difference was found between the positive and negative attitudes of parents who were hesitant and unhesitant towards childhood vaccines ($p < 0.002$, $p < 0.001$, respectively).

Table 1: Descriptive Characteristics of Participants

		N (1068)	%
Average age 33,21 +-8.9			
age group	<35	587	54,97
	>=35	481	45,03
gender	Male	298	27,9
	Woman	770	72,1
Marital status	single/separate/divorced	84	7,82
	married	984	92,18
Level of education	Literate/primary/secondary school	300	28,12
	High school	363	33,99
	University	327	30,63
	MSc/PhD	78	7,26
Job	Housewife	358	33,52
	Employee	113	10,61
	Retired	7	0,66
	Student	17	1,6
	Officer	167	15,59
	Small business	46	4,32
	Freelancer	40	3,76
	Farmer	269	25,16
	Other	51	4,79
Social Security	Pension fund	150	14,03
	SSK	480	44,9
	Bagkur	320	29,93
	Private insurance	28	2,62
	Non	80	7,48
	Other	11	1,03
Family's monthly income	4 thousand TL and less*	407	38,14
	4-6 thousand TL	301	28,21
	6-8 thousand TL	150	14,06
	8-10 thousand TL	92	8,62
	10 thousand TL and above	117	10,97
Assessment of Childhood Vaccine Hesitancy			
Place application of childhood vaccination	Family health center	958	89,78
	Public Hospital	35	3,28
	University Hospital	7	0,66
	Private hospital	21	1,97
	Private practice	1	0,09
	multicenter	45	4,22
Social media for vaccine information	Instagram	266	30,82
	Twitter	74	8,57
	Facebook	380	44,03
	Whatsup	40	4,63
	Other	103	11,94



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Social media influenced childhood vaccines	108	10,14
Delayed or missed to child's vaccinations	38	3,56
Need more information about childhood vaccines	761	70,14
COVID-19 -Related Variables		
Infected with Covid-19	408	37,92
Family member/s being infected Covid-19	504	46,93
Dead family member/s due to Covid-19	105	9,79
Vaccinated with Covid-19 vac.	882	82,12
Side effects related to the Covid-19 vaccine	519	51,08
Social media influenced decisions about the covid 19 vaccine	161	15,10

Table 2: The Relationship Between Parent Attitudes About Childhood Vaccines and Characteristics of Participating Parents

	Non-Hesitant		PACVgrup		p	
			Hesitant			
	n	%	n	%		
TOTAL	985	%90.62	102	%9.38		
Age group	<35	517	55,65	47	48,45	0,299
	>=35	412	44,35	50	51,55	
Gender	Male	277	28,67	21	20,59	0,083
	Woman	689	71,33	81	79,41	
Marital status	Single/separated/divorced	76	7,82	8	7,84	0,993
	Married	896	92,18	94	92,16	
Level of education	Literate/primary/secondary	272	27,98	30	29,41	0,102
	High school	341	35,08	24	23,53	
	University	290	29,84	39	38,24	
	Master's/doctorate	69	7,10	9	8,82	
Family's monthly income	4,000 TL and less	378	39,13	29	28,71	0,204
	4-6 thousand TL	273	28,26	28	27,72	
	6-8 thousand TL	132	13,66	18	17,82	
	8-10 thousand TL	81	8,39	11	10,89	
	10 thousand TL and above	102	10,56	15	14,85	
Delayed/ missed child's vaccinations	Yes	30	3,10	8	7,92	0,013
	No	937	96,90	93	92,08	
Social media for Vaccine Information	Instagram	225	28,48	41	56,16	0,001
	Twitter	66	8,35	8	10,96	
	Facebook	376	47,59	4	5,48	
	Whatsup	38	4,81	2	2,74	
	Other*	85	10,76	18	24,66	
Impact of social media child's vaccination	Yes	88	9.13	20	19.80	0,001
	No	876	90.87	81	80.20	
Impact of social media Covid 19 vaccine	Yes	134	13,89	27	26,73	0,001
	No	831	86,11	74	73,27	
Infected with Covid-19	No	377	38,71	31	30,39	0,100
	Yes	597	61,29	71	69,61	
Family member/s Infected with Covid-19	No	469	48,20	35	34,65	0,009
	Yes	504	51,80	66	65,35	
Dead family member Due to Covid-19	No	94	9,68	11	10,78	0,721
	Yes	877	90,32	91	89,22	
Vaccinated with Covid-19 vac.	No	792	81,40	90	89,11	0,054
	Yes	181	18,60	11	10,89	

Table 3: The Relationship Between the Level of Trust in COVID-19 Information Sources and Attitudes Towards Vaccine

Average Score (min-max)		30.96±12.93 (0-87)	
		COV_19_ Positive	COV_19_ Negative
Ort±SS		Ort±SS	
TOTAL		3,69 ± 0,95	3,60 ± 0,59
Age Group <35 >=35	Age Group <35	3,69 ± 0,93	3,64 ± 0,59
	>=35	3,72 ± 0,93	3,55 ± 0,58
p		0,615	0,014
Gender	Male	3,79 ± 0,83	3,69 ± 0,57
	Woman	3,65 ± 0,98	3,56 ± 0,6
p		0,022	0,001
Marital Status	Single/separate/divorced	3,65 ± 0,98	3,52 ± 0,71
	married	3,69 ± 0,94	3,61 ± 0,58
p		0,691	0,211
Level of education	Literate/primary/secondary School	3,69 ± 0,9	3,59 ± 0,57
	High school	3,69 ± 0,9	3,63 ± 0,57
	University	3,64 ± 1	3,57 ± 0,64
	Master's/PhD	3,82 ± 1,14	3,62 ± 0,59
p		0,491	0,590
Family's monthly income	4,000 TL or less	3,73 ± 0,9	3,62 ± 0,57
	4-6 thousand TL	3,67 ± 0,96	3,55 ± 0,59
	6-8 thousand TL	3,6 ± 0,94	3,66 ± 0,62
	8-10 thousand TL	3,69 ± 0,97	3,49 ± 0,68
	10 thousand TL and above	3,67 ± 1,09	3,66 ± 0,58
p		0,644	0,080
Infected with Covid-19	Yes	3,75 ± 0,91	3,59 ± 0,57
	No	3,65 ± 0,96	3,61 ± 0,61
p		0,081	0,576
Family member being infected Covid-19	Yes	3,77 ± 0,89	3,61 ± 0,6
	No	3,62 ± 0,99	3,6 ± 0,59
p		0,007	0,774
Dead family member due to Covid-19	Yes	3,6 ± 1,07	3,63 ± 0,57
	No	3,7 ± 0,93	3,6 ± 0,6
p		0,286	0,609
Vaccined with Covid-19 vac.	Yes	3,69 ± 0,97	3,61 ± 0,61
	No	3,68 ± 0,83	3,57 ± 0,53
p		0,866	0,444
The impact of social media on the Covid 19 vaccine	Yes	3,48 ± 1,12	3,43 ± 0,67
	No	3,73 ± 0,91	3,63 ± 0,58
p		0,002	0,001

Social media for Vaccine Information	Instagram	3,51 ± 1,09 ^b	3,51 ± 0,7 ^{bc}
	Twitter	3,46 ± 1,13 ^b	3,53 ± 0,57 ^{ab}
	Facebook	3,97 ± 0,46 ^a	3,74 ± 0,42 ^{ab}
	Whatsapp	3,23 ± 1,15 ^b	3,76 ± 0,75 ^a
	Other	3,57 ± 1,04 ^b	3,42 ± 0,67 ^c
p		0,001	0,001
Delayed / missed to child's vaccinations	Yes	3,53 ± 0,95	3,48 ± 0,68
	No	3,69 ± 0,95	3,6 ± 0,59
p		0,302	0,234
The impact of social media childhood vaccination	Yes	3,45±1.07	3,50±0.63
	No	3,71 ±0.92	3,60±0.59
p		0,007	0,08
PACVgrup	Non-Hesitant	3,77 ± 0,9	3,62 ± 0,59
	Hesitant	2,84 ± 0,97	3,42 ± 0,59
p		0,001*	0,001*

Conclusion: Parents who were hesitant about childhood vaccines also showed a negative attitude towards COVID 19 vaccines. Social media influences the decisions of parents with hesitant and negative attitudes. Parents need information about vaccination. The PACV questionnaire can be used by parents who need vaccine decision support and communication, and by healthcare professionals to quickly identify their beliefs or concerns. The importance of getting support from social media to encourage vaccination of experts, pediatricians and public health experts who carry out the vaccination study has been demonstrated by our study.

Keywords: vaccine hesitancy, vaccination, covid 19, social media



SS004

Knowledge of Autism and Attitudes Towards Autistic Children: Evaluation on Child Protection Service Staff in Turkey

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Objectives: In addition to early follow-up of autism symptoms in children under state protection and staying in children's homes, the growth of children with Autism Spectrum Disorder(ASD) in a positive environment is directly dependent on the care staff. In children with neurodevelopmental pathologies, it is known that the positive relationship established between the child and the caregiver is a predictor of both caregiver and child behaviors. This study examines the relationship between the knowledge and awareness levels of all personnel working in children's homes in Ankara after the training they attended about ASD and social attitudes towards autism.

Methods: A total of 217 professional personnel serving in Children's Houses in Ankara, constitute the sample of the research. The participants who volunteered to participate in the study were surveyed twice before and after the training. Two measurement tools "Autism Spectrum Disorder Scale" (SATA) and ASD Information Form" were applied to the participants.

Results: Most of the participants (91.2%) included in the study were women and caregivers (67.7%). 144 (66.4%) of the participants in the study were university graduates, and the average age of the participants was 39.07±7.36. It was observed that only 29.5% of the participants had received training on autism before, and the rate of those who had an individual with autism in their close circle was 24.5%. The rate of those who had no experience of working with a child with autism spectrum disorder was 68.7%. Since the care personnel working in children's homes are usually women, 91.2% of the sample of the study was made up of women. It was observed that female participants gave significantly more correct answers on the Autism Spectrum Disorder Information Form than male participants (p=0.041). Participants who had an experience working with a child with ASD gave statistically significantly more correct answers in the ASD Information Form (p=0.001). When examining the results of the questionnaire applied to all the participants before and after the training, statistically significant changes were observed in the ASD Information Form and SATA sub-factors and total scores.

Table 1: Socio-Demographic Characteristics of the Participants and the Status of Contact with People with OSB

		Descriptive Statistics (n=217)	
Age		Mean±SS	Median (min-max)
39,07±7,36		39 (25-63)	
		n	%
Gender			
	Female	198	91.2
	Male	19	8.8
Educational Status on Autism			
Yes		64	29.5
No		153	70.5
Existence of a person with autism spectrum disorder			
Yes		53	24.4
No		164	75.6
Experience working with a child with autism			
I don't have any experience		149	68.7
I have worked in non-governmental organizations or associations		8	3.7
I took care of/helped take care of a child with autism		60	27.6
Position at the institution			
Caregiver		147	67.7
Teacher		22	10.1
Manager/home manager		20	9.2
Child Development		9	4.1
Social worker		9	4.1
Psychologist paramedic		10	4.6
Education status			
High School		60	27.6
University		144	66.4
Post graduate		13	6.0

Table 2: Comparison of Pre-Test (t0) Scale Scores with Socio-Demographical Characteristics and Contact with Person with ASD

Comparison of scale scores by gender				
Variables		Female (n=195)	Male (n=19)	P
Correct Number of Data Sheets (t0)		5,89 ± 2,73	4,47 ± 2,97	0,041*
SATAFACTOR1 (t0)		13,95 ± 3,12	14,32 ± 3,2	0.301
SATAFactor2 (t0)		18.61 ± 3.32	16.47 ± 3.39	0.033*
SATAFactor3 (t0)		20.21 ± 3.45	19.89 ± 3.43	0.982
Total SATA (t0)		52.77±7.52	50.68±8.19	0.413
Has the participant received autism-related education before?				
Variables		Yes (n=63)	No (n=151)	P
Correct Number of Data Sheets (t0)		6.29 ± 2.51	5.54 ± 2.85	0.058
SATAFACTOR1 (t0)		14 ± 3.13	13.98 ± 3.12	0.552
SATAFactor2 (t0)		18.56 ± 3.8	18.36 ± 3.19	0.330
SATAFactor3 (t0)		19.83 ± 3.76	20.33 ± 3.3	0.710
Total SATA (t0)		52.39 ± 7.67	52.67 ± 7.58	0.917
Is there a person with autism spectrum disorder in the immediate vicinity of the participant?				
Variables		Yes (n=51)	No (n=163)	P
Correct Number of Data Sheets (t0)		6.45 ± 2.32	5.55 ± 2.87	0.020*
SATAFACTOR1 (t0)		13.36 ± 2.89	14.19 ± 3.17	0.251
SATAFactor2 (t0)		18.87 ± 3.88	18.27 ± 3.19	0.183
SATAFactor3 (t0)		19.66 ± 3.66	20.35 ± 3.36	0.235
Total SATA (t0)		51.89 ± 8.1	52.82 ± 7.42	0.231

* The Mann-Whitney u test; the significance at the 0.05 level.

Table 3: Comparison of Pre-Test (t0) Scale Scores with Educational Status and Working Experience of a Child with ASD

Educational status of the person who completed the questionnaire				
Variables	High School (n=60)	University (n=141)	Master's degree (n=13)	P
Correct Number of Data Sheets (t0)	5.82 ± 2.81	5.72 ± 2.7	5.92 ± 3.55	0.929
SATAFACTOR1 (t0)	14.85 ± 2.75	13.81 ± 3.25	12 ± 1.96	0.001*
SATAFactor2 (t0)	18.95 ± 3.61	18.42 ± 3.22	16 ± 3.06	0.006*
SATAFactor3 (t0)	21.25 ± 3.42	20.05 ± 3.26	16.77 ± 3.27	0.001*
Total SATA (t0)	55.05 ± 7.63	52.27 ± 7.15	44.77 ± 6.44	0.001*
The experience of the person filling out the questionnaire working with a child with autism?				
Variables	No experience (n=147)	Experience in NGOs (n=8)	Caring for a child with autism (n=59)	P
Correct Number of Data Sheets (t0)	5.34 ± 2.78	7.25 ± 2.25	6.61 ± 2.58	0.001*
SATAFACTOR1 (t0)	14.23 ± 3.11	14.75 ± 3.01	13.27 ± 3.07	0.073
SATAFactor2 (t0)	18.5 ± 2.86	16.75 ± 4.2	18.43 ± 4.32	0.480
SATAFactor3 (t0)	20.53 ± 3.21	18.88 ± 4.26	19.5 ± 3.78	0.086
Total SATA (t0)	53.27 ± 6.79	50.38 ± 10.07	51.2 ± 8.89	0.283

*Kruskal Wallis test; significance level at 0.05

Table 4: Comparison of Scale Scores of Participants with their Tasks in Children's Homes

		n	Mean±SD	P
Correct Number of Data Sheets (t0)	Caregiver	144	6.05 ± 2.74	0.239
	Teacher	22	5.5 ± 2.96	
	Administrative duties and household responsibility	20	4.4 ± 3.3	
	Child Development	9	5.44 ± 2.07	
	Social worker	9	5.11 ± 2.62	
	Psychologist/paramedic	10	5.8 ± 1.81	
SATAFACTOR1 (t0)	Caregiver	147	13.93 ± 3.03	0.856
	Teacher	22	13.91 ± 3.39	
	Administrative duties and household responsibility	20	14.8 ± 4.02	
	Child Development	9	13.78 ± 3.99	
	Social worker	9	13.33 ± 2.06	
	Psychologist/paramedic	10	14.1 ± 1.91	
SATAFactor2 (t0)	Caregiver	147	19.07 ± 3.35	0.001*
	Teacher	22	17.68 ± 3.03	
	Administrative duties and household responsibility	20	16.5 ± 3.47	
	Child Development	9	17.89 ± 2.15	
	Social worker	9	17.22 ± 2.64	
	Psychologist/paramedic	10	15.9 ± 3.03	
SATAFactor3 (t0)	Caregiver	147	20.5 ± 3.41	0.339
	Teacher	22	19.77 ± 4.15	
	Administrative duties and household responsibility	20	18.6 ± 3.25	
	Child Development	9	20.44 ± 3.13	
	Social worker	9	19.78 ± 2.64	
	Psychologist/paramedic	10	19.8 ± 3.26	
Total SATA (t0)	Caregiver	147	53.5 ± 7.41	0.166
	Teacher	22	51.36 ± 8.69	
	Administrative duties and household responsibility	20	49.9 ± 7.85	
	Child Development	9	52.11 ± 8.62	
	Social worker	9	50.33 ± 5	
	Psychologist/paramedic	10	49.8 ± 6.99	

*Kruskal Wallis test; significance level at 0.05

Table 5: Comparison of the Scale Scores Applied Before (t0) and After (t1) Training

Comparison of Scale Scores Before and After Training				
		Pre-test (t0)	Final test (t1)	
Scales	n	Mean±SD	Mean±SD	P
The Number of Correct Answers in Information Form	185	5.98±2.75	8.63±2.33	0.001*
SATAFactor1	190	13.93 ± 3.09	12.67 ± 3.01	0.001*
SATAFactor2	191	18.61 ± 3.38	16.53 ± 3.09	0.001*
SATAFactor3	191	20.28 ± 3.44	11.37 ± 2.56	0.001*
Total SATA	190	52.79 ± 7.63	40.55 ± 6.11	0.001*

* The Mann-Whitney u test; the significance at the 0.05 level.

Conclusion: In this study, gender, education level, and contact history with people with ASD came to the fore among the factors affecting the knowledge and attitudes of the participants about autism. In particular, female gender, having a person with autism in their close circle, and having previous experience of working with a child with ASD were associated with a higher level of knowledge about ASD. Additionally, it was revealed that as the education level of the participants increased, they reported more positive attitudes towards individuals with ASD. After the training given to 217 participants in the study, a statistically significant change was observed in both the ASD Information Form and the Social Attitudes Towards Autism Scale scores.

Keywords: knowledge, attitudes, child protection, autism

SS005

Seeing The Pandemic Through Children's Eyes: Exploring Turkish Children's Views on COVID-19 Pandemic by Focus-Group Discussions

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Objectives: The direct and indirect effects of the COVID-19 pandemic on children and youth people are well documented. Little is known about children's experiences of the pandemic in their own words. We aimed to explore Turkish children's views about the pandemic, in order to inform existing and future policies that affect children in a pandemic to promote their best interests.

Methods: Six focus group discussions were conducted online with 30 children aged between 7 to 18 years in 2021. Children were enrolled through snowball sampling technique according to developmental age groups. A thematic analysis was conducted

Results: We identified five themes: compliance with public health measures about preventing the spread of COVID-19, changes in daily routines, emotional responses to the pandemic, distance education, and adaptive responses. Overall, children were well-informed and receptive to the public health preventive measures with the exception of older children's tendency to disregard physical distancing with friends. They reported frustration with those who did not comply with measures and believed that the authorities should strictly enforce public health requirements. Participants reported negative impacts from the pandemic, which included disrupted eating patterns, sedentary lifestyle, and poor sleep. Emotional responses comprised fear of family members and themselves being infected, anxiety produced by the uncertainty of the virus, and the loss of social support. There was a perceived disparity between students from public and private schools regarding academic self-competence. Positive aspects of the pandemic included the flexibility of learning at one's own pace, increased family time, and the acquisition of new hobbies. Although most children acknowledged the support of their parents to deal with challenges, children of health workers were particularly isolated in terms of emotional support.

Conclusion: Our findings offer insights and validate previous research on the negative and positive effects of COVID-19 from a child's perspective. These findings can inform policies that address pandemic management. Perceived challenges raised by children require immediate consideration, with special emphasis on disparities in distance education and the needs of children of healthcare workers.

Keywords: Covid-19, child, school disclosure, distance learning, social isolation



SS006

The Role of Vitamin D and Vitamin D Binding Protein in SARS-CoV2 Infection in Children

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Introduction

Vitamin D is a steroid hormone that has critical roles in both bone health and the modulation of the immune system. Vitamin D deficiency (VDD), which is still more common today, is considered an important public health problem(1). Although 25-oh vitamin D levels were known as the most effective indicator of vitamin D levels, free and bioavailable levels need to take into account immunomodulatory aspects (2). In healthy subjects, ~85% of the vitamin D metabolites are bound with high affinity to Vitamin D binding protein (VDBP), whereas albumin binds ~15% with low affinity (2). Combined with the possible impact of vitamin D on the pathogenesis of SARS-CoV-2 infection, it is concluded that VDBP-regulated bioavailable and free vitamin D concentrations modulate the human immune system response to viral infections (3).

Although there are many studies investigating vitamin D levels and SARS-CoV-2 disease severity, to our knowledge there is no study investigating the relationship between disease severity and bioavailable and free vitamin D in children (3). Because of the gap in the literature, it was emphasized that studies should focus on vitamin D binding protein (VDBP) and gene polymorphism (3-4). In this study, it was aimed to investigate the relationship between SARS-CoV-2 infection severity and free and bioavailable vitamin D levels.

Material and Methods

This study was planned as a case-control study with patients hospitalized in the Haseki Training and Research Hospital Pediatric Infection Service, between 01 February and 31 October 2022. A total of 82 children, including at least 20 patients in each group were included in the study. A total of 82 children, including at least 20 patients in each group were included in the study. The study group was divided into three groups according to COVID19 WHO clinical progression Scale (5): no viral RNA detected cases were included to uninfected group (Group 1), viral RNA detected but asymptomatic cases were included to ambulatory group (Group 2) and viral RNA detected, hospitalized and no oxygen therapy needed or need oxygen by mask or nasal prong cases were included to the mild group (group 3). In order to investigate the relationship between disease severity and free and bioavailable vitamin D, 25OH vitamin d ($\mu\text{g/L}$), albumin (g/l) and VDBP levels (ELISA). Vitamin D metabolites were calculated by using Bikle and Vermeulen methods.

Patient records like age, gender and nationality were noted from patient logs on hospital information management system. And all the records were noted as ID numbers. To investigate the relationship between SARS-CoV-2 disease severity and free and bioavailable vitamin D, 25OH vitamin D ($\mu\text{g/L}$), albumin (g/l) and VDBP levels (ELISA) were measured from serum samples stored by centrifugation in a dry tube. VDBP levels were measured by manual ELISA method using the VDBP kit (Immundiagnostik AG, Cat: K2314). Free and bioavailable vitamin D levels were calculated using formulas (Bikle and Vermeulen) that were validated by previous studies (6-7).

All participants confirmed and signed the informed consent form to participate in the study. Ethics committee approval was obtained for the study from the TC Health Sciences University Hamidiye Clinical Ethics Committee with protocol decision numbered 2022/10/17 and registered with Clinical Trials (NCT05598957).

Results:

A total 82 cases enrolled the study. The mean age was 150±56.7 months and 53.3% (n: 47) of the study group was girl. The study group was divided in to three group according to COVID19 WHO clinical progression Scale and group distributions were like unaffected 24.4% (n:20), ambulatory 50% (n: 41) and mild %25.6% (n: 21) (Figure 1).

Statically significant different were found between groups by free Vitamin D (both calculated by Vermeulen and Bikle methods) and bioavailable Vitamin D levels (both of three was significant at p:0.026 level). Although there was no significant relation was found between VDBP levels of groups, albumin level was significantly higher in control group compared to ambulatory and mild group (p: <0.001) (Figure 2). On the other hand, 25OH vitamin D and VDBP levels were found similar between groups (Table 1). To evaluate the effect of free and bioavailable Vitamin D on clinical severity of Covid-19 infection, ambulatory and mild group were compared. The median 25OH vitamin D, Free Vitamin D and bioavailable Vitamin D levels were found significantly lower in moderate group (mild vs moderate respectively 25OH vitamin D 13.4 vs 11.00 p: 0.011; FVDv 4.04 vs 2.60, p: 0.007; FVDb 4.00 vs 2.58, p: 0.007; BAVD 1.61 vs 1.01, p: 0.007) and there was significant difference in VDBP (mild vs moderate 228200 vs 268500, p: 0.131) (Figure 3).

Conclusion:

Although it is known that there was a significant relationship between vitamin D levels and the severity of SARS-CoV-2 in children in previous studies, the findings of our study are noteworthy because it is the first study to show the relationship between SARS-CoV-2 symptom severity and free and bioavailable vitamin D levels. The fact that both free and bioavailable vitamin D levels were found to be significantly lower in more severe SARS-CoV-2 patients in our study, contributes to the role of VDD in the clinical severity of the SARS-CoV-2 disease found in the literature.

Vitamin D metabolism should be considered as a whole and when immunomodulatory effects are considered, free/bioavailable levels should be considered in addition to the definitions of insufficiency/deficiency. In future studies, addition to free/bioavailable vitamin D levels, the effects of DPP gene polymorphism on SARS-CoV-2 infection need to be investigated.

Keywords: Free vitamin d, bioavailable vitamin d, SARS COV2, vitamin d binding protein, children

References

- 1.Nair R, Maseeh A. Vitamin D: The "sunshine" vitamin. J Pharmacol Pharmacother. Apr 2012;3(2):118-26. doi:10.4103/0976-500x.95506
- 2.Speeckaert M, Huang G, Delanghe JR, Taes YE. Biological and clinical aspects of the vitamin D binding protein (Gc-globulin) and its polymorphism. Clin Chim Acta. Oct 2006;372(1-2):33-42. doi:10.1016/j.cca.2006.03.011
- 3.Speeckaert MM, Speeckaert R, Delanghe JR. Vitamin D Sufficiency and COVID-19: Is Vitamin D Binding Protein (and Its Polymorphism) the Missing Link? Endocr Pract. Jun 2021;27(6):645. doi:10.1016/j.eprac.2021.03.011
- 4.Speeckaert MM, Speeckaert R, Delanghe JR. Genetic polymorphisms, vitamin D binding protein and vitamin D deficiency in COVID-19. Eur Respir J. May 2021;57(5)doi:10.1183/13993003.04638-2020
- 5.Group WW. A minimal common outcome measure set for COVID-19 clinical research. Lancet Infect Dis. Aug

2020;20(8):e192-e197. doi:10.1016/s1473-3099(20)30483-7

6. Bikle DD, Gee E, Halloran B, Kowalski MA, Ryzen E, Haddad JG. Assessment of the free fraction of 25-hydroxyvitamin D in serum and its regulation by albumin and the vitamin D-binding protein. *J Clin Endocrinol Metab.* Oct 1986;63(4):954-9. doi:10.1210/jcem-63-4-954

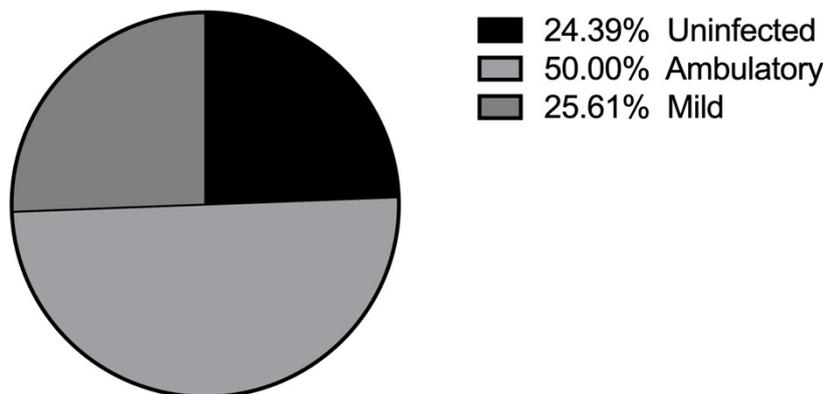
7. Vermeulen A, Verdonck L, Kaufman JM. A critical evaluation of simple methods for the estimation of free testosterone in serum. *J Clin Endocrinol Metab.* Oct 1999;84(10):3666-72. doi:10.1210/jcem.84.10.6079

Table 1. Sociodemographic and laboratory finding of groups

		Uninfected (n= 20)	Mild (n= 41)	Moderate (n= 21)	p
Age	Mean ± SD	138.85±54.21 ^a	136.17±63.55 ^a	186.24±16.54 ^b	0.02*
Gender	Female n, %	11 (55)	22 (53.7)	14 (66.7)	0.601 ^{**}
	Male	9 (45)	19 (46.3)	7 (33.3)	
25-OH Vitamin D (µg/L)	Median(25-75p)	11.60 (7.45-18.60)	13.40 (10.70-16.60)	11.00 (7.10-12.65)	0.076 ^{***}
VDBP	Median (25-75p)	265300 (221800-306375)	228200 (167900-298600)	268500 (184450-361850)	0.103 ^{***}
ALbumine	Median (25-75p)	48 (47-49) ^a	44 (43-46) ^b	44 (41-45) ^b	<0.001^{***}
Free Vitamin D (BIKLE ^β) (pg/mL)	Median (25-75p)	2.90 (1.64-5.32)	4.00 (2.52-5.58)	2.58 (1.91-3.42)	0.026^{***}
Free Vitamin D (Vermeulen [†]) (pg/mL)	Median (25-75p)	2.92 (1.65-5.38)	4.04 (2.54-5.65)	2.59 (1.92-3.45)	0.026^{***}
Bioavailable Vitamin D (pg/mL)	Median (25-75p)	1.20 (0.73-2.05)	1.61 (1.01-2.33)	1.01 (0.74-1.40)	0.026^{***}

* One-way Anova test, ** Ki-square test, ***Kruskal-Wallis test, Abrevations SD: Standart Deviation, VDBP: Vitamin D Binding Protein, ^β Bikle DD, Gee E, Halloran B, Kowalski MA, Ryzen E, Haddad JG. Assessment of the Free Fraction of 25-Hydroxyvitamin D in Serum and Its Regulation by Albumin and the Vitamin D-Binding Protein. *The Journal of Clinical Endocrinology & Metabolism* 1986; 63(4): 954-9, [†] A, Verdonck L, Kaufman JM. A critical evaluation of simple methods for the estimation of free testosterone in serum. *The Journal of clinical endocrinology and metabolism* 1999; 84(10): 3666-72.

Figure 1. Distributions of groups according to COVID19 WHO clinical progression Scale ⁵



Total=82

Figure 2. Comparison of clinical severity and albumin media

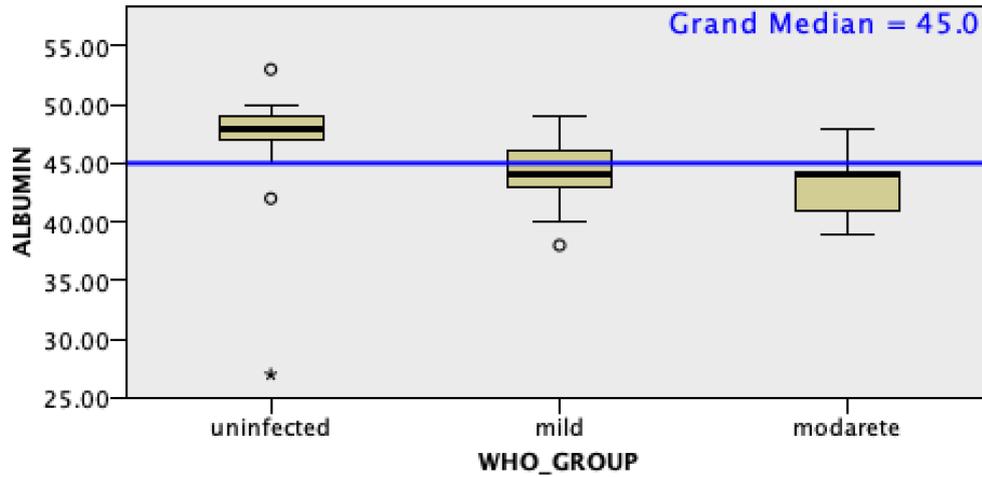
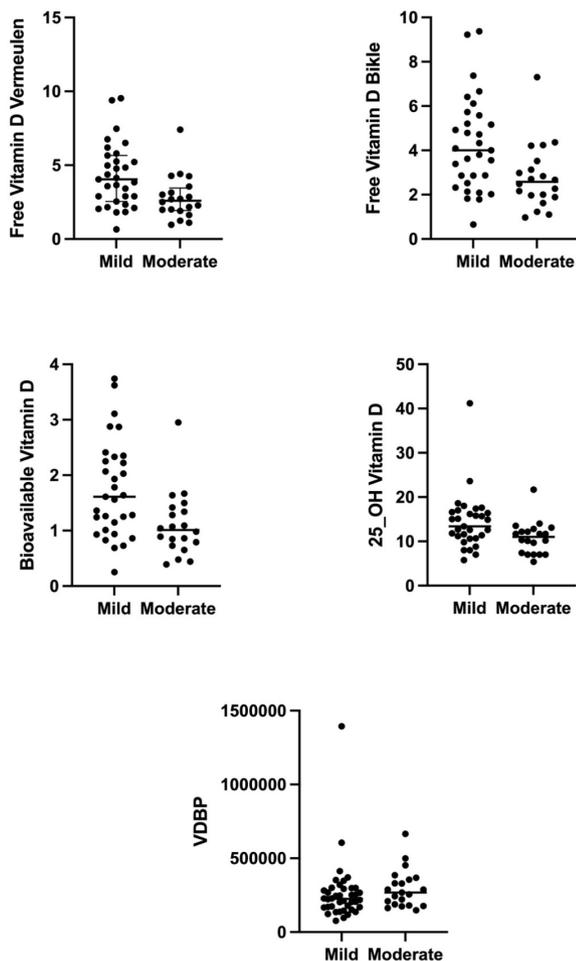


Figure 3. Vitamin D and Vitamin D metabolites values according to the severity of SARS CoV-2 infection



Median values were shown with the “---” symbol in the figures



SS007

Allergic Children's Parents' Hesitancy About COVID-19 Vaccination

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Introduction

With the approval of the use of COVID-19 vaccines for children, it has started to be applied in many countries (1). However, families have some hesitations about vaccinating their children with the COVID-19 vaccines (2,3). The aim of this study is to determine the COVID-19 vaccination rates in allergic children aged 12-18 years and to evaluate contributing factors to vaccine hesitation.

Methods

This cross-sectional study was carried out among parents of children (aged 12-18 years) with allergic diseases who were followed in a Pediatric Allergy Department of a university-affiliated hospital. Parents of children without allergic diseases, who don't speak Turkish and who did not want to participate in the study were not included in the study. A questionnaire was carried out either face-to-face or online, for which the survey link was delivered to parents through social networks (whatsapp). In the calculations made with the Minitab 18 program using the results of a similar study conducted in our country, it was determined that at least 242 people should be included in the study with a 5% type I error and 80% power.

The questionnaire consisted of 15 questions about the sociodemographic characteristics of the child and parents, type of the allergic disease of the child, having two doses of COVID-19 vaccination of the child and parents, the reasons of having or not having the COVID-19 vaccine for the child and the Perceived Stress Scale (PSS) of the parent who attended the study (4,5). Responders who vaccinated their children with COVID-19 vaccine responded the question, reason for accepting COVID-19 vaccine for their children. And responders who did not vaccinate their children with COVID-19 vaccine responded the question, the reason for refusing COVID-19 vaccine for their children.

Results

A total of 382 parents received the questionnaire, 261 completed the questionnaire and agreed to participate in the study (68.3%). Of the 261 children with allergic diseases 137 (52.4%) had two doses of COVID-19 vaccine. And 89.3% of the mothers and 92.3% of the fathers had at least two doses of COVID-19 vaccine. Perceived Stress Scale of the parent who answered the questionnaire was between 8-41 (23.2 ± 6.3).

Of the 137 children who received COVID-19 vaccine, 76 (55.5%) stated that it was their own decision to be vaccinated, 33 (24.0%) had the vaccine with the recommendation of the Ministry of Health, 28 (20.5%) had the vaccine with the recommendation of their doctor.

One hundred and twenty four children did not receive COVID-19 vaccine. Among this unvaccinated group the reasons for not vaccinating were declared as; the novelty of the vaccine (37.9%), the side effects (including allergic side effects, n:4) (25%), the vaccine is not domestic (3.8%), there may be harmful substances in the vaccine (8%), children will also have mild COVID-19 illness (8%), doctor did not recommend (4.9%), their children had already COVID-19 infection (1.6%), being against all the vaccines (0.8%).

The maternal COVID-19 vaccination rate was higher in the vaccinated group ($p < 0.05$). The paternal COVID-19 vaccination rate was higher in the vaccinated group ($p < 0.05$). The perceived stress scale score of parents in the vaccinated group was significantly ($p < 0.05$) higher than the unvaccinated group.

Discussion

In our study, the rate of getting the COVID-19 vaccine among children aged 12-18 years with allergic diseases was 52.4%. It was found that the rate of vaccination in children increases with age, and the rate of vaccinating their children is higher if the parents themselves have been vaccinated against COVID-19. According to the results of our study, the novelty of COVID-19 vaccine was the leading factor among families refusing vaccination for their children, like some other studies (6,7). 13.8% of the participants who refused to vaccinate their child, stated that the foreignness of the vaccine was the reason and this factor was also discussed in another study conducted in our country. In Yiğit et al's study it was seen that parents were more willing to vaccinate their children with a domestic COVID-19 vaccine than a foreign one (8). In our study, vaccination rate increases as the PSS level of the parents increases. It may show that having a high stress level increases vaccine demand. To understand vaccine hesitation better, we need to do more researches to evaluate individual psychologies.

In conclusion; although there is an effective and safe vaccine for children during the pandemic, vaccination rates are not yet at the desired level.

References

- 1)Centers for Disease Control and Prevention. Acceptability of adolescent COVID-19 vaccination among adolescents and parents of adolescents-United States, April 15-23,2021. Available at: <https://www.cdc.gov/mmwr/volumes/70/wr/mm7028e1.htm> (Accessed on December 2022).
- 2)Bekele F, Fekadu G, Wolde FD, Bekelcho LW. Patients' Acceptance of COVID-19 Vaccine: Implications for Patients with Chronic Disease in Low-Resource Settings. Patient preference and adherence. 2021;15 2519–2521.
- 3)Skjefte M, Ngirbabul M, Akeju O, Escudero D, Hernandez-Diaz S, Wyszynski DF et al. COVID-19 vaccine acceptance among pregnant women and mothers of young children: results of a survey in 16 countries. Eur J Epidemiol. 2021;36:197-211.
- 4)Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. J Health Soc Behav 1983; 24: 385-96.
- 5)Eskin M, Harlak H, Demirkiran F, Dereboy C. The adaptation of the perceived stress scale into Turkish: A reliability and validity analysis. New Symposium J 2013; 51(3): 132–40.
- 6)Goldman RD, Yan TD, Seiler M, Parra Cotanda C, Brown JC, Klein EJ et al. Caregiver willingness to vaccinate their children against COVID-19: Cross sectional survey. Vaccine 2020.
- 7)Bedford H, Lansey M. More Vaccines For Children? Parents' views. Vaccine 2007;25 (45):7818-23
- 8) Yigit M, Ozkaya-Parlakay A, Senel E. Evaluation of COVID-19 Vaccine Refusal in Parents. Pediatr Infect Dis J. 2021 Apr 1;40(4):e134-e136

SS008

Impact Of Breast Milk Storage on The Characteristics of Breast Milk Stem Cells

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Objectives: Breast milk (BM) has numerous well-known proven health benefits. However the mechanisms of many of these effects are still not well defined. Recent studies have shown that breast milk contains mesenchymal stem cells (MSC) which both supports the growth and development of the infant as well as their protection from acute and chronic diseases. There are some occasions where it is not possible to feed the baby by breast or enterally. In these scenarios, breast milk is expressed and stored in the refrigerator or freezer to be used later when possible. We aimed to define the impact of storage procedures on count, viability and positive markers of BM-MSC.

Methods: 15 ml of breast milk is collected on the first postpartum week from each participant to isolate MSC. 5 ml of BM is processed freshly, 5 ml is processed after being stored in the refrigerator for 72 hours and the 5 ml is processed after being stored in the freezer (-20°C) for a month and then being thawed.

Results: The study group consisted of 17 mother-baby diads. The mean value of MSC isolated from BM was 80588 ± 50431 for fresh and 28333 ± 10298 when refrigerated for 72 hours. This decrease was statistically significant ($p < 0.05$) however, there was no significant change on markers of BM MSC. When MSC is stored in the freezer for 1 month, there were no live cells on microscopic examination after being thawed

Conclusion: In the light of this study, it has been observed that when breast milk is stored in the refrigerator, even if there is a decrease in the count of live MSC, the remaining cells still preserved the characteristics of the positive markers. BM lost its content of MSC when stored in the freezer for a month.

Keywords: Breast milk, freezing, mesenchymal stem cells, refrigerator, storage of breast milk

Histogram of MSC Numbers And Viability Rates

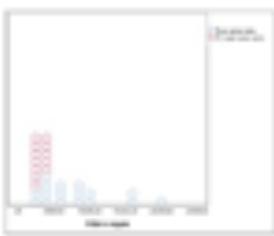


Figure 1: Histogram of MSC Numbers isolated from Fresh Breast Milk and After Refrigerated for 72 Hours.

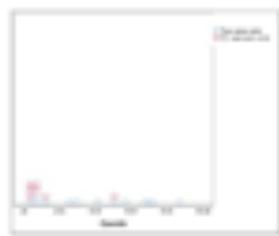


Figure 2: Histogram Displaying the Viability Rates of MSCs isolated from Fresh Breast Milk and After Refrigerated for 72 Hours.

Microscopic images



Figure 5: Microscopic image of fresh breast milk with many cell cultures



Figure 6: Confluent area cell-cultures

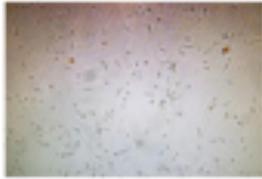


Figure 5: Microscopic image of the cell cultures results after the breast milk was stored at +4 degrees for 72 hours



Figure 6: Microscopic image of the cell cultures results after breast milk was stored for 1 month at -20 degrees

Mean and Median Values of MSC Counts, Viability and Markers in Fresh Breast Milk

(Fresh BM n:17)	Mean \pm sd.	Median
Number of MSC	80588,24 \pm 50431,96	60000,00
Viability	38,62 \pm 28,22	35,50
%CD44	69,48 \pm 22,84	69,70
%CD73	96,37 \pm 7,16	100,00
%CD90	79,84 \pm 20,81	80,50
%CD105	88,17 \pm 19,70	99,60

Comparison of MSC Values from Fresh and Refrigerated Breast Milk for 72 Hours with Wilcoxon Test

	Median Value Fresh BM (n:7)	Median Value 72 h Stored BM (n:12)
Number of MSC	60.000	20.000
Viability	51,30	5,60
%CD44	83,10	81,10
%CD73	100,00	100,00
%CD90	86,30	92,85
%CD105	94,80	98,80



SS009

Investigation of Sudden Infant Death Syndrome and Safe Sleep Awareness Among Pregnant Women

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Objectives: Establishing a safe sleeping environment is recommended to protect babies from Sudden Infant Death Syndrome (SIDS). The aim of this study is to investigate awareness of pregnant women about the safe of the sleeping environments for babies and how they are planning to create one for their newborns.

Methods: This is a cross-sectional and descriptive study. The population of the study consists of 207 pregnant women who were followed by Güngören 30 Ağustos Family Health Center (FHC). A questionnaire was prepared by the researcher to investigate the knowledge, habits, attitudes and behaviors of pregnant women about SIDS risk factors. The questionnaires were filled in by the researcher. Pregnant women who applied to the FHC between 2 March 2020 and 1 June 2020, interviewed face-to-face or by phone.

Results: It was reported that the mothers planned to put babies to sleep at back posi(23.7%) and side position (55.5%) when their babies were born. Fifty percent of the mothers stated that they have heard of SIDS before and 32.5% expressed that they had obtained information from their family elders. It has been determined that multiparous mothers exhibit the correct manners in terms of safe sleep compared to nulliparous mothers.

Conclusion: There is a need to increase awareness about the principles of a safe sleep environment for babies in our country. It would be necessary to train health workers about this subject and to expand the content of "Turkish Ministry of Health, Antenatal Birth Management Guide" used in pregnancy follow-up. Since expectant mothers exhibit the attitudes they have learned from their family members and close friends. It is observed that these behaviours do not change over time in multiparous mothers and there may be a need to establish a campaign for families and society across the country. Thus, public awareness can be raised.

Keywords: Safe sleep environment, sleeping position, Sudden Infant Death Syndrome

SS010

Allergic Diseases in Children with Behavioral Insomnia of Childhood

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Objectives: Early childhood behavioral sleep problems are common with a frequency of 25% to 40%. Sleep problems can be seen in allergic diseases. Yet, the frequency and distribution of allergic diseases in behavioral insomnia in early childhood are not known clearly. This study aims to investigate the distribution of allergic diseases in children with behavioral insomnia of childhood (BIC).

Methods: An observational cross-sectional study was designed to evaluate allergic diseases in young children with sleep problems and sleep characteristics of children with allergy. The study was conducted in Marmara University Hospital between October 2019-July 2021. Eligible study participants included children aged between 6 to 36 months. Study participants were recruited from pediatric allergy, pediatric sleep and well-child outpatient clinics. Sleep parameters and sleep environment were evaluated by the Turkish version of Brief Infant Sleep Questionnaire (BISQ). Allergic specialist diagnosis was used to evaluate food allergy, allergic rhinitis, atopic dermatitis and asthma.

Results: The frequency of allergic diseases in children with BIC was 25%. Food allergy was found in 15% of children with sleep problems, atopic dermatitis in 12%, allergic rhinitis in 6%, and recurrent wheezing/asthma in 4% of children. The prevalence of parent reported sleep problems in children with allergies was not different from healthy controls. Frequent night awakenings (>3 times) were highest in the group with sleep problems (71%), significantly higher than the group with allergies (29%) and the healthy control group (13%) ($p<0.001$). Frequent night awakenings were more common in children with allergies than in the healthy group ($p=0.005$, OR: 2.73, 95% CI: 1.32-5.64). The average nighttime awakening duration was longest in the group with sleep problems and was found to be significantly higher than the group with allergies and the healthy controls ($p<0.001$). In addition, the night awakening duration of children with allergies was found to be longer than the healthy controls ($p=0.020$). The sleep quality was worst in the group with sleep problems, and it was found to be significantly higher than the group with allergies and the healthy controls ($p<0.001$). It was determined that the sleep quality of children with allergies was worse than the healthy control ($p=0.046$).

Conclusion: It is concluded that allergy can be found in one out of four children with insomnia and food allergy is the most common allergy type. Young children with BIC should be considered for the diagnosis of food allergy. Guideline-based assessment of allergy, and trigger control should be integrated as part of behavioral insomnia management in young children.

Keywords: allergy, child, insomnia, sleep



SS011

Evaluation of Vitamin D Levels and Vitamin D Treatment in Children Aged 0 to 18 Years

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Objectives: The frequency of Vitamin D deficiency in healthy children is relatively high. Moreover, vitamin D supplementation in children is under the requested levels especially above age one. The aim of this study is to determine the frequency of vitamin D deficiency and the factors that influence vitamin D levels in healthy children.

Methods: Patients who applied to the pediatric outpatient clinic of a tertiary pediatric hospital in Ankara city, between January 2017 and December 2017 were evaluated retrospectively. Demographic data of the study group (age, gender, season, daily supplementation of vitamin D, region of residence) were obtained from electronic file records. Healthy children were divided into 5 different age categories (infancy (under 1 year old), toddler (1-2 years), preschool (2-6 years old), school age (6-11 years) and adolescent (11-18 years)) in order to determine the difference between age groups in terms of vitamin D deficiency. Furthermore, Vitamin D levels in obese children was also evaluated. Vitamin D-25(OH)D3 levels were categorized as deficiency (<12 ng/mL), insufficiency (12-20 ng/mL), sufficiency (>20 ng/mL).

Results: During the study period, vitamin D levels of 3368 healthy and 182 obese children evaluated retrospectively. The prevalence of vitamin D deficiency and insufficiency was found to be 18%-24,9% in healthy children and 37.3% -50.5% in obese children respectively. It was found that, the highest risk group for vitamin D deficiency were adolescent girls. Furthermore vitamin D deficiency was more common in spring and winter time. The frequency of Vitamin D deficiency and insufficiency was significantly lower (25.3%) in patients who were assigned to daily supplementation of vitamin D ($p<0.05$).

Conclusion: This study showed that vitamin D deficiency still remains a major problem for healthy children and daily supplementation of vitamin D is mandatory. Prophylactic vitamin D supplementation and adequate sunlight exposure should be provided for all children, in particular obese children and healthy adolescents. In addition, future studies may focus on screening for vitamin D in children who did not receive vitamin D supplementation_

Keywords: Vitamin D deficiency, Healthy children, Adolescent, Obese

SS012**Evaluation of Pediatricians' Guidance and Referral Process of the Children with Stuttering**

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Objectives: It is important that children with stuttering are diagnosed early and receive intervention, for the reason that it is not possible to predict with certainty which of the children who start to stutter will recover spontaneously and which will continue as chronic stuttering. Chronic stuttering has negative effects on the academic, social, and emotional development of a child. Thus, pediatricians should refer children with stuttering to speech and language therapists for early recognition, detailed screening, evaluation, and/or intervention. In accordance with the current recommendations, we aimed to examine on the approaches taken by pediatricians in the early detection of children with stuttering who consulted them and in referring these children and their families to a speech and language or relevant therapist.

Methods: Our descriptive study group consisted of 53 pediatricians working in Kocaeli and/or having received specialty training from Kocaeli (mean age: 36.3 ±8.2; Female: 60.4% (N=32), Male;39.6% (n=21). The project applied the Turkish version of the questionnaire used in the study conducted by Winters and Byrd(2020).The questionnaire was sent to the participants online. An SPSS 25 package program was used for the analysis of the data.

Results: 50.9% of the participants (n=27) reported that there were children with stuttering among their previous patients. In addition, 62.3% (n=33) of the participants previously referred at least one child for stuttering assessment. However, participants expressed their referring possibilities were more likely; in the items 'repeat sounds, syllables or short words' (75.5%, n=40) and '6-12 months have passed since the onset of stuttering' (69.8%, n=37) as "extremely likely".The child's gender (32.1%, n = 17) and the child's parent's concern about their child's speech fluency (32.1%) were both marked as "extremely likely" to refer children with stuttering. A speech and language therapist is the most likely professional that the participants will refer the child with stuttering to, while neurologists are the least likely professionals.

Conclusion: It has been observed that pediatricians do not have sufficient knowledge about early recognition of children with stuttering who apply to them.Pediatricians focused on the visible features of stuttering (repetition, prolongation, and block) but failed to identify the invisible features of stuttering (anxiety, embarrassment, etc.) and possible risk factors for chronic stuttering. It may be beneficial to get organized with speech and language therapists, in-clinical and on-the-field trainings in order to increase the knowledge level of pediatricians on how to better advise parents of the children with stuttering problems. Furthermore, pediatricians are recommended not only to take further training but also follow accurate guidance regarding the related signs of children with speech and language disorders during their specialty training. However, it would also be beneficial to review the guidance.

Keywords: stuttering, speech and language



SS013

Evaluation of Knowledge Levels of Pediatricians and Family Physicians About Non-Epileptic Paroxysmal Events (NEPE)

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Introduction

Non-epileptic paroxysmal events (NEPE) are common clinical findings that manifest in motor and behavioral disorders that mimic the characteristics of childhood epileptic seizures. NEPE is a complex condition involving repetitive intermittent motor movements, behavioral changes, and somatic symptoms. These events, which can last seconds or minutes, can occur at any age with sudden start and end movements (1). NEPE can present in a variety of ways during neonatal, childhood, and adolescence. Patients may present in the neonatal period with jitteriness, hyperreflexia, and benign sleep myoclonus and with breath holding, shuddering attacks, stereotyping, benign paroxysmal torticollis, benign paroxysmal tonic upward gaze, benign paroxysmal vertigo, sleep disturbances, masturbation, spasmus nutans, Sandifer syndrome, and tic in the infancy and early childhood. During puberty, patients may experience syncope, sleep disorders, psychogenic crises, tics, and migraines. Parasomnias (sleepwalking, night terrors, and nightmares), sleep-related movement disorders (periodic limb movements during sleep, nocturnal leg cramps, and rhythmic movement disorders), narcolepsy, benign paroxysmal nocturnal events (hypnic jumps and benign childhood sleep myoclonus), breath-holding spells, Sandifer syndrome, and Behavioral disorders can mimic seizures in children. There are also NEPEs of psychogenic origin where no somatic cause can be found (2,3). The diagnosis of NEPE is mainly based on a detailed study of the precipitating factors, parental opinion and direct clinical observations [4]. Electroencephalogram (EEG) and video EEG monitoring can be used when diagnosis is difficult. Additionally, if needed, additional laboratory tests such as magnetic resonance imaging (MRI), electrocardiography (ECG), and blood tests can be performed to confirm the diagnosis (4,5). Unnecessary use of antiepileptic drugs by undiagnosed patients can result in wasted time as well as irreversible labor and economic losses for the family and the child [4]. With the increasing knowledge and experience of physicians about NEPE in relation to the childhood age group, misdiagnosis of epilepsy is prevented and therefore the use of antiepileptic drugs decreases. The aim of this study is to raise awareness of non-epileptic paroxysmal events by reviewing the state of knowledge of pediatricians and family physicians in relation to clinical findings, treatment and differential diagnosis of non-epileptic paroxysmal events (NEPE).

Material and Method

For this study, research was initiated following approval by the Ethics Committee for Scientific Research of Gulhane Training and Research Hospital Decision No. 2022-65 dated 02/17/2022. The study was designed as a prospective cross-sectional study. The study was conducted between March 1, 2022 and June 1, 2022 by reaching pediatric specialist and assistants, family physicians, subspecialty assistants and sub specialist using a

Google questionnaire. A total of 314 people took part in the study. Those with missing data were excluded from the study. The study was completed with 271 people. The study data was collected using the questionnaire describing the characteristics of the participants (age, gender, professional position, level of education, place of work, duration of active employment) and detailed questions on the diagnosis, treatment and differential diagnosis of NEPE and the questionnaire was used by the researchers in prepared in accordance with the literature search. During the creation of the questionnaire, the questions were edited based on similar questionnaires in the literature (6). The survey comprised a total of 26 questions. (The questionnaire is available in Appendix 1).

The data was evaluated in the statistics package program from IBM SPSS Statistics Standard Concurrent User V 26 (IBM Corp., Armonk, New York, USA). Descriptive statistics were presented as number of units (n), percent (%), mean standard deviation (mean±sd), median (M), minimum (min), maximum (max), and interquartile range (IQR) values. The normality of the numerical variable data was assessed using the Shapiro-Wilk normality test. While total knowledge scores by gender were compared using the Mann-Whitney U-test, knowledge scores by position and hospital were compared using the Kruskal-Wallis H-test. The Dunn-Bonferroni test was used as a multiple comparison test in the Kruskal-Wallis H test. The relationship between age, length of employment and overall knowledge value was evaluated using Spearman's correlation coefficients. A multiple linear regression analysis was used to determine the factors influencing the total knowledge scores. Variables with a value of $p < 0.25$ in bivariate comparisons were included in the regression model. Categorical variables were included in the linear regression model as dummy variables. The backward elimination method was used to determine the factors affecting the total score. The suitability of the established models for linear regression analysis was checked using statistics from the Q-Q plot for normality of the residuals, Durbin-Watson for autocorrelation, tolerance for multicollinearity and variance inflation factor. It was observed that the assumptions for the model were met. A value of $p < 0.05$ was considered statistically significant.

Results

The average of the physicians participating in the study was 37 ± 8.5 , and 64.6% of the participants were women. When the working positions were evaluated, it was determined that 37.3% of them worked as specialists. Most of the participants, 41.3%, were working in Training and Research Hospitals. 44.3% of the participants had been physicians for 6-10 years. (Table-1)

Table 1: Descriptive Characteristics of the Participants

Variables	Statistics
Age, (year)	
mean±sd	37.0±8.5
M (min-max)	36.0 (25.0-69.0)
Gender, n (%)	
Female	175 (64.6)
Male	96 (35.4)
Position, n (%)	
Pediatric Specialist Doctor	102 (37.6)
Pediatric Assistant Doctor	53 (19.6)
Subspecialty Assistant Doctor	17 (6.3)
Family Physician	58 (21.4)
Subspecialist Doctor	41 (15.1)

Hospital, n (%)	44 (16.2)
Public Hospital	69 (25.5)
University Hospital	112 (41.3)
Education – Research Hospital	16 (5.9)
Health Center and Family Health Center	
Private Hospital	30 (11.1)
Duration of employment in the profession (year)	
0-5	90 (33.2)
6-10	61 (22.5)
11 and above	120 (44.3)

sd: Standard deviation, M: Median value

In Table 2, Questions were asked of the physicians to measure their knowledge of NEPE. In this table there are questions on the diagnosis and treatment of NEPE and its differential diagnosis from epileptic seizures and NEPE types by age group. There are a total of 17 information questions in Table 2. The correct answers were given 1 point, the others 0 points. A total score was calculated for 17 questions. The scores of the participants vary between 3-16. The mean and standard deviation for the total score was 10.1 ± 2.6 and the median was 10.0. No statistical correlation was found between total score and age ($\rho=0.007$, $p=0.907$).

Total scores are compared in the table below according to the gender, position and hospital of the participants they work at. What applies to NEPE?

Table 2: Frequencies of Answers to Informational Questions

Questions	n (%)
(Q8) Non-epileptic paroxysmal events (NEPE) of childhood are a complex condition involving repetitive motor movements, behavioral changes, and somatic manifestations.	
Yes	256 (94.5)
No	1 (0.4)
No idea	14 (5.1)
(Q9) Using the NEPE expression	
is suitable	193 (70.8)
is not suitable	13 (4.8)
no idea	66 (24.4)
(Q10) Which is true about NEPE?*	
It can occur in all age groups	197 (72.7)
There is a familial predisposition	198 (73.1)
It lasts lifelong	104 (38.4)
It Limits itself with age	229 (84.5)
All	98 (36.2)
(Q11) Which of the following is/are (a) NEPE event(s) in the neonatal period?*	
Jitteriness	251 (92.6)
Hyperreflexia	193 (71.2)
Benign sleep myoclonus	245 (90.4)
All	185 (68.3)

(Q12) Which of the following is/are (a) NEPE event(s) in infant and toddler periods?*	
Breath-holding spells	241 (88.9)
Shuddering attacks	205 (75.6)
Stereotypes	185 (68.3)
Benign paroxysmal torticollis	174 (64.2)
Benign upward gaze	145 (53.5)
Sleep disorders	168 (62.0)
Masturbation	187 (69.0)
Spasmus nutans	140 (51.7)
Sandifer	156 (57.6)
Tic	199 (73.4)
All	99 (36.5)
(Q13) Which of the following is/are (a) NEPE event(s) in the adolescence period?*	
Syncope	169 (62.4)
Sleep disorders	182 (67.2)
Psychogenic crises	197 (71.6)
Tics	223 (82.3)
Migraines	152 (56.1)
All	127 (46.9)
(Q14) Which is/are correct in the diagnosis of NEPE?*	
The most important step for diagnosis is to take an accurate and detailed history.	
Long-term video-EEG monitoring is the most important examination to differentiate epileptic attacks.	250 (92.3)
Smartphones and tablets have increased the speed of diagnosis of the disease.	181 (66.8)
Accurate and early diagnosis prevents unnecessary medications and examinations.	222 (81.9)

* Each category was evaluated independently. ** Those marked in red are correct answers.

Table 2: Frequencies of Answers to Informational Questions -*continues*

Questions	n (%)
(Q15) In which does NEPE occur more commonly?	
Female	93 (34.3)
Male	69 (25.5)
Equal	109 (40.2)
(Q16) People with NEPE seizures may also have epileptic seizures.	
Yes	198 (73.1)
No	23 (8.5)
No idea	50 (18.5)
(Q17) EEG should definitely be taken in NEPE.	
Yes	140 (51.7)
No	92 (33.9)
No idea	39 (14.4)
(Q18) The diagnosis of NEPE should always be confirmed by video-EEG monitoring.	
I agree	44 (16.2)
I do not agree, clinical diagnosis may be sufficient	43 (15.9)
Video/EEG is only required when the clinical diagnosis is unclear	127 (46.9)
Clinical diagnosis and video EEG should be combined	57 (21.0)
(Q20) With which departments would you evaluate a patient with NEPE?*	
Child Neurologist	94 (34.7)
Child Psychiatrist	45 (16.6)
Child Neurologist and Child Psychiatrist	203 (74.9)
Social Pediatrics	43 (15.9)
Developmental Pediatrics	59 (21.8)
Psychologist	45 (16.6)
I don't redirect, I manage the event	11 (4.1)

(Q21) What is the best treatment for NEPE?*

Counseling and psychotherapy	168 (62.0)
Antiepileptics	15 (5.5)
Psychiatric drugs	10 (3.7)
No need for medication	49 (18.1)
It limits itself with age, treatment is unnecessary	106 (39.1)

(Q22) Patients with NEPE and patients with epileptic seizures should be followed and treated in a similar way to patients with epileptic seizures.

Yes	118 (43.5)
No	104 (38.4)
No idea	49 (18.1)

* Each category was evaluated independently. ** Those marked in red are correct answers

Table 3: Comparison of the Participants' Total Scores by Gender, Positions, and Hospitals where they work

Variables	M	IQR	Test Value	p Value
Gender				
Female	10.5	3.0	1.839	0.066 [‡]
Male	10.0	4.0		
Specialty				
Family Physician	9.0 ^a	4.0	21.476	<0.001 [†]
Pediatrics Assistant Doctor	9.0 ^{ab}	3.3		
Pediatric Specialist Doctor	10.0 ^{bc}	4.0		
Subspecialty Assistant Doctor	12.0 ^c	4.3		
Subspecialist Doctor	11.0 ^c	2.2		
Hospital, n (%)				
Public Hospital	10	3.7	4.631	0.327 [†]
University Hospital	10	3.5		
Education – Research Hospital	10	4.7		
Health Center and Family Health Center	9.0	3.7		
Private Hospital	11	3.2		
Duration of employment in the profession (year), n (%)				
0-5	10.0	4.0	2.342	0.310 [†]
6-10	10.0	4.0		
11 and above	10.0	3.0		

M: Median value, IQR: Interquartile range, †: Kruskal-Wallis test, ‡: Mann-Whitney U test, a, b and c superscripts indicate differences between levels of doctors of the total scores. There is no statistical difference at the levels with the same superscripts.

According to Table 3, there is no statistical difference between male and female physician total scores. Total scores differ statistically by position. The score of family physicians is statistically lower than that of specialists, subspecialty assistants and subspecialist. The overall score of pediatrics assistant is lower than that of subspecialty assistants and specialists. The difference between pediatrics assistant and family doctors is not statistically significant. There is no statistical difference between the overall grades of pediatric specialist I subspecialty assistant and subspecialist. Total scores do not differ statistically by hospital and length of profession.

Table 4: Evaluation of the Effect of Gender and Position on the Total Score by Multiple Linear Regression Analysis

	Regression Coefficients*						
	β	se	$z\beta$	t	p	95.0% Confidence Interval for β	
						Lower Bound	Upper Bound
Constant	8.532	0.405		21.062	<0.001	7.734	9.329
Gender							
Male	Reference						
Female	0.637	0.326	0.115	1.952	0.052	-0.005	1.280
Position							
Family Physician	Reference						
Pediatrics Assistant Doctor	0.617	0.497	0.091	1.242	0.215	-0.361	1.594
Pediatric Specialist Doctor	1.372	0.423	0.251	3.245	<0.001	0.539	2.205
Subspecialty Assistant Doctor	2.437	0.690	0.230	3.534	<0.001	1.079	3.795
Subspecialist Doctor	1.892	0.505	0.269	3.745	<0.001	0.898	2.887
Modeled Variables: Gender, position							
Model Summary: $F=5.591$; $p<0.001$; $R^2=0.095$; $Adjusted R^2=0.078$, Durbin-Watson statistic=1.933							

β : Regression coefficients, se: Standard error of β , $z\beta$: Standardized coefficients

In comparisons with the total scores of the participants by age, length of employment, gender, position and hospital in which they work, the influence of variables with a $p < 0.25$ value on the total score was evaluated using multiple linear regression analysis (Table 4). Gender and position were included in the model. The reverse method was used to determine the final model. In the last model, only the position was found effective. The Durbin-Watson test statistic was recorded as 1.933 for the final model. The normality of the standardized residuals was assessed using the Q-Q plot and it was found that the residuals were normally distributed (we provide the plot on request). The tolerance values for the categories in the table range from 0.569 to 0.975, and the variance inflation factor (VIF) values range from 1.025 to 1.759. The established model is statistically significant ($p < 0.001$). Based on the table, female physicians scored 0.637 points higher than male physicians on average; Pediatric Specialists were on average 1,372 points higher than family physicians ; Subspecialty assistants doctors scored an average of 2,437 points higher than family physicians ; The values of the subspecialist doctors are on average 1,892 points higher than those of the family physicians.

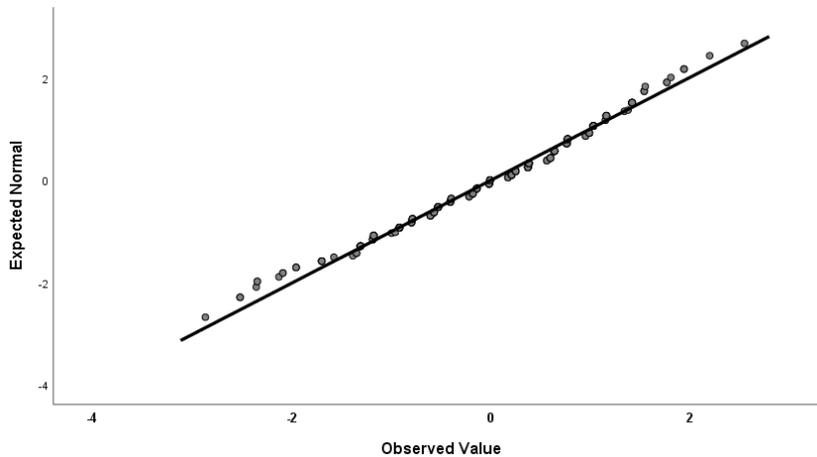


Chart 1: Normal Q-Q Plot Standardized Residuals

In **Table-5**, physicians were asked about the number of NEPEs they had encountered in their professional lives and how they dealt with NEPEs.

69.4% of physicians reported diagnosing 0-10 patients. In NEPE patients taking antiepileptic drugs, it was found that 67.2% of the participants left the decision to stop taking their medication to another clinician. 45% of doctors said they were uncomfortable with the diagnosis. 62.4% of physicians said they could easily distinguish NEPEs, but when asked about their level of knowledge, 41% of them said they were moderate.

Table 5: Frequencies of answers to other questions

Questions	n (%)
(Q19) How many NEPE diagnoses have you made so far?	
0-10	188 (69.4)
11-20	26 (9.6)
More than 20	57 (21.0)
(Q23) When a patient takes antiepileptic drugs (AEDs) for pseudo seizures,	
I stop AEDs	64 (23.6)
I continue AEDs	25 (9.2)
I leave the decision to someone else	182 (67.2)
(Q24) When my patients or most of their relatives are diagnosed with NEPE,	
They accept the diagnosis	83 (30.6)
They deny the diagnosis	66 (24.4)
I do not interrogate	122 (45.0)
(Q25) MOST OF THE TIME I feel comfortable diagnosing NEPE based on clinical history.	
I agree	122 (45.0)
I do not agree	115 (42.4)
No idea	34 (12.6)
(Q26) MOST OF THE TIME I can distinguish NEPE from epileptic seizures when I witness the event.	
I agree	169 (62.4)
I do not agree	78 (28.8)
No idea	24 (8.8)

(Q27) What level of knowledge would you say you have when you meet a patient with NEPE?

(rated from 1 to 5)

Weak	59 (21.8)
Moderate	111 (41.0)
Good	83 (30.6)
Very Good	11 (4.1)
Perfect	7 (2.5)

Discussion

Since seizures are one of the most common neurological symptoms in all clinical settings (7), all clinical practitioners, physicians working in remote areas, nurses and medical staff, and pediatric and adult neurologists should have a common knowledge of this topic. This is because these healthcare professionals are usually the ones who provide immediate care to people experiencing an epileptic seizure and are expected to initiate appropriate investigation and treatment (8). Therefore, a distinction must be made between epileptic seizures and NEPEs.

Therefore, doctors must carefully evaluate each finding to make a true diagnosis. Pediatricians (15) and family doctors are those most commonly confronted with NEPE, which is one of the most common reasons for referral to pediatric neurologists. In this study, the level of knowledge of pediatricians and family doctors of different levels on NEPE in the childhood age group was examined. What is remarkable about our study is that it is the first study on this topic conducted with family doctors, as far as can be found in the literature search.

Most symptoms in childhood NEPE are benign and self-limiting (9). Most importantly, NEPE can sometimes be misdiagnosed as epilepsy and treated unnecessarily. Changes in the electroencephalogram (EEG) are not observed during an event in NEPE (1). The duration, location, nature and timing of attacks, and the patient's level of consciousness can lead physicians to question the differential diagnosis of epilepsy. A real diagnosis is extremely important as a diagnostic error can lead to expensive treatments and unnecessary medication with various side effects (10-12). In addition, both misdiagnosis and delays in treatment can worsen outcomes (10). Because there is no laboratory test to confirm the diagnosis, careful evaluation of clinical findings and home video recordings can provide clues to the diagnosis in many patients (13,14).

As a result of the study, the participants showed a high level of knowledge about NEPE (94.5%). 70.8% of the participants also found it appropriate to use the term NEPE. While some of the NEPEs observed in the neonatal, infant and adolescent stages were well known, some of them proved to be less well known to physicians. Similar to this study, a previous study found that breath-hold seizures were more familiar to pediatricians, other NEPEs such as reflex anoxic seizures were not known, although they were common (16). In a study by Kotagal et al. the patients were separated according to age groups and NEPE diagnoses were examined. In this study, the diagnosis of NEPE was determined as stereotyped movements, hypnotic jerks, parasomnias, and Sandifer's syndrome in patients 2 months to 5 years of age; as conversion disorder (psychogenic seizures), inattention or daydreaming, stereotyped movements, hypnotic jerks and seizure type movement disorders with concomitant epilepsy in patients aged 5-12 years; and as conversion disorders in adolescence (9). Similarly, in this study, doctors knew better diagnoses in certain age groups. A detailed description of the causative factors, clear family information and clinical observations are important for the diagnosis of NEPE. EEG and video EEG monitoring are the most important tests for definitive diagnosis (4,5).

Most physicians (51.7%) incorrectly thought that an EEG should be taken to diagnose NEPE. The most common response from physicians was the misconception that counseling and psychotherapy were the best options for treating NEPE. In fact, NEPE is an age-limited disease and is not followed up like epilepsy patients (17). When NEPE is in the psychogenic group, it is more common in women, while physiological or organic NEPE is more common in men. Epileptic seizures can also occur in patients with NEPE (18). Physicians participating in the study thought that NEPE was common in both girls and boys. As indicated in other studies, they also stated



that NEPEs may be associated with epileptic seizures (18,19).

When evaluating the level of knowledge of the doctors according to gender, specialty and length of professional service, there was no statistical difference between the specialists in paediatrics and FDs and sub brunch assistants and specialists. However, the value of primary care physicians was lower than the other groups, similar to that of resident physicians. Considering that physicians and health workers who work in the first places patients first apply are the pioneers in the diagnosis and treatment of epilepsy [8], this result suggests that the awareness and level of knowledge of family doctors working in primary care should be increased. Bearing in mind that pediatric patients are cared for by pediatric neurologists and child psychiatrists, it was considered that the in-depth knowledge of the physicians working in this group could be used to provide this training.

The reason for the higher values for female and male physicians compared to males was assumed to be the fact that most specialists in paediatrics in Turkey are women (20).

The fact that physicians do not discontinue antiepileptic drugs when NEPE is detected and do not question the opinion of patients' relatives about NEPE may also be due to a lack of information on this topic. The rate of physicians who feel comfortable making the clinical diagnosis is very close to the rate who does not feel comfortable. The fact that they rate their level of knowledge as moderate (41%), even though they think it is NEPE, may indicate that physicians are struggling to identify all NEPEs.

Conclusion

The differential diagnosis of NEPEs and epilepsies is crucial to avoid misdiagnosis and unnecessary treatment. Therefore, further training can be organized specifically for family doctors. Awareness of all physicians to the rarer NEPEs should be increased.

References

- 1-Tatlı B, Güler S. Non epileptic paroxysmal events in childhood. Turkish Arch PEDIATR .2017;52(2):59.
- 2-Sullo F, Venti V, Catania R, et al. Non-Epileptic Paroxysmal Events: Clinical features and diagnostic differences with epileptic seizures. A Single Tertiary Centre Study. ClinNeurol Neurosurg. 2021;207:106739. doi:https://doi.org/10.1016/j.clineuro.2021.106739
- 3-Bodde NMG, Brooks JL, Baker GA, et al. Psychogenic non-epileptic seizures—definition, etiology, treatment and prognostic issues: a critical review. Seizure. 2009;18(8):543-553.
- 4-Arain AM, Hamadani AM, Islam S, Abou-Khalil BW. Predictors of early seizure remission after diagnosis of psychogenic nonepileptic seizures. Epilepsy Behav.2007;11(3):409-412.
- 5-Prasad M, Babiker MOE. Fifteen-minute consultation: when is a seizure not a seizure?Part 1, the younger child. Arch Dis Childhood-Education Pract. 2016;101(1):15-20.
- 6-Wichaidit BT, Østergaard JR, Rask CU. Diagnostic practice of psychogenic nonepileptic seizures (PNES) in the pediatric setting. Epilepsia. 2015;56(1):58-65.
- 7-Organization WH. Epilepsy fact sheet. 2018. URL <http://www.who.int/mediacentre/factsheets/fs999/en>. Published online 2018. [accessed 13 March 2022]
- 8-Blümcke I, Arzimanoglou A, Beniczky S, Wiebe S, Force ET. Roadmap for a competency-based educational curriculum in epileptology: report of the Epilepsy Education Task Force of the International League Against Epilepsy. Epileptic Disord.2019;21(2):129-140.



- 9-Kotagal P, Costa M, Wyllie E, Wolgamuth B. Paroxysmal nonepileptic events in children and adolescents. *Pediatrics*. 2002;110(4):e46-e46.
- 10-Reilly C, Menlove L, Fenton V, Das KB. Psychogenic nonepileptic seizures in children: a review. *Epilepsia*. 2013;54(10):1715-1724. doi:10.1111/epi.12336
- 11-Dhiman V, Sinha S, Rawat VS, et al. Children with psychogenic non-epileptic seizures (PNES): a detailed semiologic analysis and modified new classification. *Brain Dev*. 2014;36(4):287-293. doi:10.1016/j.braindev.2013.05.002
- 13-Plioplys S, Asato MR, Bursch B, Salpekar JA, Shaw R, Caplan R. Multidisciplinary management of pediatric nonepileptic seizures. *J Am Acad Child Adolesc Psychiatry*. 2007;46(11):1491-1495.
- 14-LaFrance Jr WC, Baker GA, Duncan R, Goldstein LH, Reuber M. Minimum requirements for the diagnosis of psychogenic nonepileptic seizures: a staged approach: a report from the International League Against Epilepsy Nonepileptic Seizures Task Force. *Epilepsia*. 2013;54(11):2005-2018.
- 14-Patel H, Dunn DW, Austin JK, et al. Psychogenic nonepileptic seizures (pseudoseizures). *Pediatr Rev Grove*. 2011;32(6):e66.
- 15-Menezes MA. Paroxysmal non-epileptic events. *J Pediatr (Rio J)*. 2002;78:S73-S88.
- 16-Sankhyan N. Non-epileptic paroxysmal events mimicking seizures. *Indian J Pediatr*. 2014;81(9):898-902.
- 17-Leibetseder A, Eisermann M, LaFrance WCJ, Nobili L, von Oertzen TJ. How to distinguish seizures from non-epileptic manifestations. *Epileptic Disord*. 2020;22(6):716-738. doi:10.1684/epd.2020.1234
- 18-Yılmaz Ü, Serdaroğlu A, Gürkaş E, Hirfanoğlu T, Cansu A. Childhood paroxysmal nonepileptic events. *Epilepsy Behav*. 2013;27(1):124-129.
- 19-Seneviratne U, Reutens D, D'Souza W. Stereotypy of psychogenic nonepileptic seizures: Insights from video-EEG monitoring. *Epilepsia*. 2010;51(7):1159-1168.
- 20-Sağlık Hizmetleri Genel Müdürlüğü, 2022, Entegre Kurumsal İşlem Platformu – Personel Bilgi Yönetimi (EKİP-PBY). <https://ekip.saglik.gov.tr/Account/Login?returnUrl=%2F>. [accessed 09. October. 2022].



SS014

Climate Change Awareness Among Medical Students: Recommendations for Medical Education

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Objectives: Physicians are in front line to observe the health consequences of climate change (CC) and are supposed to inform the society. Though, the competence of medical students about CC is not known. This study aimed to determine the knowledge and awareness of medical students about CC change in Turkey and their need about medical curriculum related to the CC.

Methods: A cross-sectional online study was conducted among the medical students in Turkey between April-August 2022. The survey was shared via social media groups of the medical students and weekly reminders were sent after release. Likert type and multiple-choice questions related to knowledge and awareness about CC were included. One open ended question was asked for recommendations related to medical curriculum. Descriptive analyses were performed using frequencies, mean and SD.

Results: Among the 110,331 medical students studying in Turkey, 1157 students (73.1% female) from 90 different medical faculties with a mean age of 21.4(SD:2.0) years, participated into the study. The distribution of grade 1-3 was 55.8% and grade 4-6 was 44.2%. A decrease in the reported frequency of participated activities related to CC during medical school (8.8%) as compared to before medical school (36.7%) was observed ($p<0.01$). Participants reported to have little or no knowledge about CC (75.5%) and its health effects (71.7%). They didn't attend any seminars on CC (89.5%) and feel the need of training on CC (75.5%). Most students agreed that the physicians have the responsibility to encourage green offices/hospitals (79.9%), become advocates to mitigate health effects of CC (80.6%) and point the health effects to CC to draw patients' and society's attention (77.5% and 70.4%). Students reported low confidence (77.4%) in providing their future patients counselling about CC. Only 11.2% of students reported that CC is covered in the faculty curriculum. Integration of training on CC in the medical curriculum was highly accepted (78.9%) and the highest preference on receiving education on climate change was during obligatory preclinical education (47.2%), followed by electives during preclinical (36.6%) or clinical education (6.0%). In the open-ended question regarding recommendations, "Case presentations of patients affected by the climate crisis can be effective for students to find practical responses." and "Climate change clubs in the universities can be established." were suggested.

Conclusion: Medical students in Turkey are aware of their need to be trained about CC and feel not confident to handle their future patients. Undergraduate medical education should cover CC related topics to provide knowledge and skills required by the students to practice their profession in the future.

Keywords: climate change, medical education, medical students

SS015**Secular Trends in Height, Weight and Head Circumference of Infants Aged 0-12 Months Old Between 1997 and 2021**

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Objectives: Secular trend in growth is a marker of public health and provides insights into the interaction between growth and environment. It has been shown to be affected by income, social status, environmental factors, access to the health system, infections and nutrition, Over the years, growth status of low socioeconomic group children has reached the level of those in the upper group. This situation is defined as “secular trend”. The aim of this study is to evaluate the body weight, height and head circumference measurements of healthy children who are followed regularly in a child health follow-up clinic and to compare this data with the data of children with similar characteristics who were followed up in the same clinic 24 years ago.

Methods: Sociodemographic factors, nutritional status, changes in health monitoring protocols over the years and the height, weight, head circumference measurements of 300 children’s well child visits forms from birth to aged 12 months old were analyzed. Data were compared to those of children of the same ages from previous measurements carried out in 1997 (227 children) at Ankara University Faculty of Medicine, Department of Pediatrics, Division of Social Pediatrics.

Results: A total of 300 infants (147 male /153 female) were included in our study in 2021, and compared with 227 infants (114 male /113 female) in 1997. there were no significant difference in birth weights of infants and gender groups between 1997 and 2021. It was observed that birth heights in both sexes were longer in 2021 than in 1997. The average body weight of male infants in the first 12 months of life was found to be higher in 1997 than in 2021. The average body weight of female babies was found to be higher in 2021 than in 1997. When the heights are compared, it is seen that the height measurements in 2021 for both sexes are longer than 1997. Also we reported the improvement in breast milk intake and nutritional status, prophylaxis intake, vaccination rate, education level, familial structure and socioeconomic factors of children and their families living in a similar geography over a twenty-four-year period.

Conclusion: It has been shown that there is a positive secular trend in the anthropometric measurements of infants follow-up, in the same clinic within 24 years in our study. Sociodemographic variables, nutritional status and improved health care may explain the change in growth in infants over the years.

Keywords: child health monitoring, growth, secular trend



SS016

Evaluation of Retinal Nerve Fiber Layer Thickness by Optical Coherence Tomography in Children with Vitamin D Deficiency and The Effect of Vitamin D Treatment on Findings

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Introduction: Vitamin D deficiency (VDD) is known to be associated with many diseases due to biological interactions other than skeletal system and bone mineralization disorder in recent years and studies have shown that it may have a role in the pathogenesis of these diseases (1, 2, 3). It has been suggested that the structure and visual function of the eye may also be affected by the deficiency of this vitamin. With the demonstration of the production of vitamin D binding receptor and vitamin D regulating enzymes in the eye, studies investigating the relationship between the ocular tissue and pathologies and vitamin D have gained importance (4,5). Considering the effects of VDD on tissues and systems, it is important to detect its deficiency, to determine the etiological factors and to take the necessary precautions prevention. Evidence showing that vitamin D is important in maintaining eye health is also increasing day by day (5). Although there are adults' studies in the English literature, there is no study, to our knowledge, evaluating the eye and retinal nerve fiber layer (RNFL) in children with VDD or investigating the effect of vitamin D treatment on the improvement of retinal findings in children. The aims of this study were to compare the retinal nerve fiber layer thickness by optical coherence tomography (OCT) in children with normal and low serum 25 (OH)D levels and to determine the effect of vitamin D treatment on the improvement of retinal nerve fiber layer thinning in children with VDD.

Materials and Methods: Our study is a randomized controlled prospective study and involves children diagnosed with VDD in childhood and healthy children in the same age group. This study was carried out at the Department of Pediatrics and Ophthalmology, Ufuk University Faculty of Medicine between May 1, 2020, and October 31, 2020. Ethics committee approval was obtained for the study from TOBB-ETU Faculty of Medicine Clinical Research Ethics Committee with the date 19.02.2020 and number KAEK-118/082. The study was completed with a total of 120 participants: 60 patients in the patient group and 60 healthy children in the control group. Based on the consensus report published by Endocrine Union, children with a 25 (OH) vitamin D level of <12 ng/mL were diagnosed to have VDD, and children with a level between 12 to 20 ng/mL were diagnosed to have vitamin D deficiency, and all were included in the "patient group" (6). It was planned to administer 2000 IU/day vitamin D treatment to these children for 6 weeks and to continue giving vitamin D at a protective dose of 600 IU/day after the end of the treatment. Children with a 25(OH)D vitamin level of ≥20 ng/mL (normal) were included in the control group. Detailed ophthalmological examination and the measurement of RNFL thickness with SD-OCT device were performed in all participants. Measurement of serum 25(OH)D vitamin level, eye examinations and RNFL thickness measurements with SD-OCT device were repeated at the end of the 6th month after treatment in the patients in the patient group and who were given vitamin D treatment. OCT measurements were made in "Optic Disc Cube 200x200" mode using Cirrus HD-OCT (Carl Zeiss Meditec, Model 400, Dublin, USA, Software 8.1.0.117) device and RNFL results were evaluated. Statistical analysis was performed using the SPSS 22.0 (Statistical Program Social Sciences) package program.

Results: In the study, there were no statistically significant differences regarding age, gender, monthly family

income, and education levels of the parents between the study and control groups. It is noteworthy that adolescents over the age of 12 constitute the highest proportion of the patients (36.4%) in the VDD group. BMI and RBMI values were higher in the study group ($p=0.001$ and $p<0.001$, respectively). A significant and slight reverse correlation was found between 25(OH)D vitamin level and BMI of all subjects included in the study. A significant and moderate reverse correlation was determined between 25(OH)D and RBMI. While the mean pre-treatment serum 25(OH)D level of the patients in the study group was 10.93 ± 3.6 ng/mL, it was found to increase to a mean of 23.78 ± 2.7 ng/mL after treatment but was still lower than the mean of the control group (28.25 ± 2.48 ng/mL). The mean right temporal RNFL thickness of the patients in the study group before treatment was significantly lower than that of the control group ($p<0.001$). Mean values of left superior and left inferior RNFL thickness significantly higher ($p=0.006$ and $p<0.001$, respectively). A slight reverse correlation was present between the age and RNFL thickness of right eye temporal, right eye nasal, left eye temporal, left eye nasal regions of the subjects in the control group. A moderate inverse correlation was present between the mean right eye and left eye RNFL thickness in these subjects. There was a slight inverse correlation between the age and right eye inferior RNFL thickness of the cases in the study group. The pre-treatment right temporal RNFL value of the patients with both VDD and vitamin D insufficiency was higher than that of the control group ($p=0.002$) (Table 1). The pre-treatment left superior and left inferior RNFL values of the cases with both VDD and vitamin D insufficiency in the study group were higher than those of the control group ($p=0.021$ and $p<0.001$). In the study group the post-treatment mean right eye, left eye temporal, left eye nasal and mean left eye RNFL values were significantly higher than the pre-treatment values ($p<0.001$; $p=0.002$, $p=0.001$ and $p=0.013$, respectively) (Table 2). The post-treatment left superior, left inferior and mean left RNFL values were higher than those of the control group ($p=0.005$, $p<0.001$ and $p=0.048$, respectively).

Discussion: Our study is the first study in the literature that evaluates eye and RNFL in childhood with EDC and investigates the effect of vitamin D treatment on improvement in retinal findings in children. In our study, the pre-treatment temporal RNFL thickness of the subjects with VDD were lower in comparison to healthy controls. This suggests that VDD causes dysfunction in the retina, causing a thinning in RNFL thickness, especially in the temporal quadrant. In addition, it was observed that there was a thinning of RNFL thickness with aging. Considering these findings; clinicians should consider the physiological loss associated with aging and distinguish it from early pathological RNF thinning. We demonstrated that replacing VDD in children may have a positive effect on RNFL thickness, and increase in RNFL thickness in other quadrants may be observed in increasing levels of vitamin D. To demonstrate this effect, further studies are needed in which more children are included, the treatment period is longer, and different treatment plans are applied. Considering that RNFL thickness varies between races, our study is a pioneer for multicenter longitudinal studies involving different age groups and different regions to reveal the anatomical characteristics of the Turkish population and the variations of RNFL thickness.

Keywords: Child, vitamin D deficiency, optical coherence tomography, retinal nerve fiber layer thickness.

References

1. Heaney Rpv. Long-latency deficiency disease: insights from calcium and vitamin D. Am J Clin Nutr 2003;78(9):12-9.
2. Holick Mf. Vitamin D: importance in the prevention of cancers, type 1 diabetes, heart disease, and osteoporosis. Am J Clin Nutr 2004;79:362-71.
3. Saggese G, Vierucci F, Boot Am, et al. Vitamin D in childhood and adolescence: an expert position statement. Eur J Pediatr 2015;174:565-76.



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4. Holick Mf. Vitamin D: Extraskkeletal health. Endocrinol Metab Clin North Am 2010;39:381-400.
5. Reins Ry, Mcdermott Am. Vitamin D: Implications for Ocular Disease and Therapeutic Potential. Exp Eye Res 2015;134:101-10.
6. Holick Mf, Binkley Nc, Bischoff-Ferrari Ha, et al, Endocrine Society. Evaluation, Treatment, and Prevention of Vitamin D Deficiency: an Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2011;96(7):1911-30.

Table-1. Comparison of pre-treatment OCT-RNFL measurements of the subjects included in the patient and control groups.

OCT- RNFL	Patient Group Pre-Treatment (n=60)		Control Group (n=60)		p*
	\bar{X} Median	\pm SD (IQR)	\bar{X} Median	\pm SD (IQR)	
RNFL Right Temporal	66.85 66.5	\pm 5.87 (5.8)	74.92 74.5	\pm 13.31 (21)	<0.001
RNFL Right Superior	116.33 123	\pm 17.85 (15)	118.68 121	\pm 12.67 (16)	0.985
RNFL Right Nasal	76.20 77.5	\pm 13.78 (20)	76.68 75	\pm 10.40 (18)	0.579
RNFL Right Inferior	120.55 120	\pm 10.91 (17)	117.00 117	\pm 17.87 (15.8)	0.402
RNFL Right Average	95.78 98	\pm 10.18 (12.8)	97.20 98	\pm 9.02 (11.8)	0.754
RNFL Left Temporal	70.60 68	\pm 8.54 (4.5)	75.87 75.5	\pm 14.20 (22.8)	0.057
RNFL Left Superior	126.02 125	\pm 9.73 (7)	118.53 123	\pm 15.70 (15.8)	0.006
RNFL Left Nasal	71.08 74	\pm 10.30 (15)	74.62 74	\pm 11.53 (19)	0.073
RNFL Left Inferior	126.85 124	\pm 17.54 (7.8)	116.50 117	\pm 12.94 (9.8)	<0.001
RNFL Left Average	98.52 101	\pm 8.09 (6)	96.38 98	\pm 8.76 (11)	0.114

Table-2. Comparison of pre- and post-treatment OCT-RNFL measurements of the subjects included in the patient group.

OCT- RNFL	Patient Group (n=60)				p*
	Pre-treatment		Post-treatment		
	\bar{X} Median	\pm SD (IQR)	\bar{X} Median	\pm SD (IQR)	
RNFL Right Temporal	66.85 66.5	\pm 5.87 (5.8)	66.93 65	\pm 6.12 (6.8)	0.715
RNFL Right Superior	116.33 123	\pm 17.85 (15)	116.87 121	\pm 16.14 (11.5)	0.423
RNFL Right Nasal	76.20 77.5	\pm 13.78 (20)	77.63 82	\pm 13.45 (21)	0.109
RNFL Right Inferior	120.55 120	\pm 10.91 (17)	120.63 120	\pm 10.62 (12.3)	0.628
RNFL Right Average	95.78 98	\pm 10.18 (12.8)	96.98 99	\pm 10.59 (12)	<0.001
RNFL Left Temporal	70.60 68	\pm 8.54 (4.5)	70.90 70	\pm 7.72 (3)	0.002
RNFL Left Superior	126.02 125	\pm 9.73 (7)	125.85 124	\pm 9.32 (9.3)	0.033
RNFL Left Nasal	71.08 74	\pm 10.30 (15)	72.50 76	\pm 10.09 (16.8)	0.001



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RNFL Left Inferior	126.85 124	± 17.54 (7.8)	126.83 122	± 17.55 (9)	0.113
RNFL Left Average	98.52 101	± 8.09 (6)	99.50 100	± 8.46 (7.5)	0.013

SS017**The Prevalence of Anemia in Children Aged From 1 to 18**Fadiye Gökmen Uyanık¹, Yavuz Demirçelik¹, Oya Baltalı Hıdır¹¹İzmir Tepecik Training and Research Hospital, İzmir

Objectives: Anemia is an important public health problem affecting the whole world. In particular, it should be prevented because of its negative effects on cognitive and physical development in children. In our study, it was aimed to determine the frequency of anemia in children aged 1-18 years.

Methods: This retrospective descriptive cross-sectional study was conducted at Izmir Health Sciences University Tepecik Training and Research Hospital. The target population of the study is children aged 1-18 years, who applied to the pediatric outpatient clinic with any complaint between January 1, 2019 and December 31, 2019. The patients age, sex, immigration status, diagnosis and results of the blood tests taken during the application were obtained from the MHRS records and recorded in the case report form. The blood tests were hemoglobin, Hct, RBC, MCV, RDW, MCH, serum iron, serum ferritin, total iron-binding capacity, vitamin B12, folate and C-reactive protein. Children with a hemoglobin value below the age-defined limit were defined as anemic. Data were analyzed in SPSS 26 program. Comparison of numerical variables between two independent groups was done with Student-t Test, comparison of numerical variables between more than two independent groups was done with One-WayAnova Test. Subgroup comparisons were made with the Tukey Test. P<0.05 was accepted as statistically significant.

Results: Complete blood count was measured in 13064 of 17156 patients included in our study. And of these patients, 51.2% were girls; 94.5% Turkish citizen and the average age was 8. Anemia was found in 13.1% of the patients, 55.5% of anemic patients were girls and 54.2% of them were between 1-5 years old. Anemia was found in 22.9% of immigrant children and 12.5% of Turkish children. Iron deficiency was found in 12.2% of the children, iron deficiency anemia was found in 6.2% of the children and vitamin B12 deficiency was found in 33.1% of the children.

Conclusion: The anemia prevalence was concluded 13.1% in the study group. Although anemia is most common in pre-school period, the high rate in adolescents draws attention. The high rate of anemia observed in our study, carried out in our hospital that provides service for people of low socio-economic status, strongly indicates malnutrition during childhood. In terms of anemia and its potential adverse effects, it is highly crucial that pediatricians, in particular, should be attentive and inform about the principles of healthy nutrition to parents.

Keywords: anemia, pediatrics, malnutrition, iron, immigrant



SS018

Evaluation of The Compliance in Vaccine Planning and The Serological Status After Transplant in Patients After Hematopoietic Stem Cell Transplantation

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Objectives: Infections and graft versus host disease are the two most important parameters determining the prognosis of patients undergoing hematopoietic stem cell transplantation (HSCT). Protective immunity to vaccine-preventable infectious diseases achieved after childhood immunization is lost over time following HSCT. Systematic reimmunization after HSCT is very important in the prevention of morbidity and mortality due to infections. This study aims to evaluate the compliance in the post-transplant vaccination plan in patients who underwent HSCT. In addition, the reasons for missed or delayed vaccinations were analyzed to optimize the compliance of the vaccination plan for future transplant patients. As the entire revaccination process requires some months, the date of the first revaccination was set as a reference point.

Methods: An eight-year survey, including all pediatric allogeneic HSCT patients, transplanted at the Gazi University School of Medicine Hospital, Turkey. Data were collected from the patient electronic (nursing and medical) charts. A personalized post-transplant vaccination plan for each of the cases was prepared by the Social Pediatrics Department. Demographic data, dates of diagnoses and transplants, donor types, post-transplant vaccination plans, dates, serology results and the reasons for delayed vaccination were evaluated. Patients who relapsed or died before the completion of their vaccination plans were excluded.

Results: Data on the vaccination schedules of 105 patients were collected. Thirty-one patients (31/105; 29.5%) were vaccinated timely. In 34 out of the remaining 74 patients (46%) vaccinations were postponed; due to medical problems in 28 patients (28/34; 82,5%) and without any known medical reason in six patients (6/34; 17.5%) where three of them stated that the Covid-19 pandemic was a cause for the vaccination delay. In 40 out of 74 patients (54%) only the vaccines that are not covered by the national vaccination schedule were postponed without any medical obstacle. The main explanations for the vaccination delay of the vaccines that are not covered by the national vaccination schedule were vaccine distrust and vaccine reimbursement problems.

Conclusion: There is a high level of agreement between the international guidelines and the vaccination of pediatric HSCT patients in our hospital. Because of the vaccine reimbursement difference, the compliance rates with the vaccines that are covered by the national vaccination schedule are higher than the vaccines that are not covered. Developing new strategies for vaccine reimbursement programs might increase the vaccination rates. Eventually, national health strategies and healthcare providers play a crucial role in the effectively appropriate follow-up of vaccination schedules.

Keywords: hematopoietic stem cell transplantation, immunocompromised patients, vaccination after transplantation, vaccination plan

SS019**Differences on Child Nutrition Pattern Between Ankara and Sanliurfa**Gülsüm Özen¹, Bülent Güneş², Sıddıka Songül Yalçın³¹Ankara Atatürk Sanatoryum Training and Research Hospital, Department of Pediatrics, Ankara.²Şanlıurfa Training and Research Hospital, Department of Pediatrics, Şanlıurfa.³Hacettepe University Faculty of Medicine, Department of Pediatrics, Division of Social Pediatrics, Ankara.

Objectives: Depending on the cultural differences in different geographical regions, diets also vary. With this study it is aimed to evaluate the differences in nutritional patterns of children living in Ankara and Şanlıurfa.

Methods: Behavioral Pediatrics Feeding Assessment Scale (BPFAS) and Child Feeding Questionnaire (CFQ) administered online to the mothers of 130 children aged between 2-4, with normal range of body weight, without any chronic diseases and applied to Outpatient Clinic of Hacettepe University and Şanlıurfa Training and Research Hospital. The mothers were asked about their children's current perceived weight and desired weight using a scale consisting of 7 images in increasing weight degrees. The effects of the differences of parameters between 2 cities were examined with the Student -t test and chi-square test

Results: Mothers were included the study with the body mass index in the normal range (25-75 p) of their children from Ankara (n=71) and Şanlıurfa (n=59). Average age of the children was 38.6 (±9.2) months in Ankara and 39.1 (±9.4) months in Şanlıurfa. The average time of starting to receive complementary food of children who live in Ankara was found statistically earlier from the ones from Şanlıurfa. The mean number of meals were 3.3 (±1.2) in Ankara and 2.0 (±1.6) in Şanlıurfa (p<0.001). While weights desired by mothers for their children were similar in both cities, it was determined that mothers living in Şanlıurfa saw their children as underweight (p<0.001). While no differences were found in Perceived Parent Weight, Parental Concern about Child Weight, Parental Responsibility and Pressuring Children to Eat More subdimensions of CFQ, it was determined that the Restriction were lower and Perceived Child Weight scores were higher for parents in Ankara (p=0.012, <0.001, respectively). Total BPFAS score was 39.2 (±10.7) for children living in Ankara and 48.0 (±12.0) for the ones from Şanlıurfa (p<0.001). In terms of all sub-dimensions, except toddler refusal-textured food, statistically significant differences found between two cities. Children living in Ankara had lower rates of picky eaters, toddler refusal-general and older child refusal than those living in Şanlıurfa (sincerely, p=0.026, <0.001, 0.005).

Conclusion: Geographical and cultural differences also affect nutritional characteristics of children and attitudes of families on this issue. Families should be informed about the importance of breast milk after delivery, time of receiving complementary food, adequate and balanced nutrition of children.

Keywords: Child, Feeding, Nutrition, Growth, Development



SS020

Evaluation of Perception, Avoidance and Anxiety Levels of Families Related to COVID-19 Infection

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Objectives: The aim of this study is to evaluate how parents perceive the COVID-19 pandemic, their level of anxiety about it, what they do to protect themselves and the factors affecting this situation.

Methods: This case-control study was conducted on 500 parents who routinely followed up their children at Ankara University Faculty of Medicine, Social Pediatrics Outpatient Clinic between February 2021 to September 2021. A questionnaire was applied to the parents face to face. The case group consists of 250 children who had at least one person diagnosed with COVID-19 among nuclear family or second degree relatives. Remaining 250 children who has no history of COVID-19 in the family was considered as the control group.

Results: One-fifth of the parents said that the COVID-19 caused negative effects on the health of children, one-third of them experienced delays in their health follow-ups, more than half of them said that children's education was negatively affected and about half of them stated that their emotional relationships with their children were adversely affected. While one-fifth of the parents said that they had difficulties in every field of life due to the pandemic, it was seen that the greatest effect was in the social and psychological areas. Parents' level of perception about the COVID-19 was found to be high in the case and control groups in general. It has been seen that most of the parents pay attention to personal precautions. Among other precautions were not taking part in social activities (74.4%), not sending kids to school (28.4%) and not going to hospital (20.6%). Almost half of the parents believed in conspiracy theories. There was no significant difference in perception and anxiety levels between the case and control groups. The anxiety level of parents who lost a loved one due to COVID-19 was found to be higher than those who did not. While the higher level of education and economic situation reduces anxiety; the perception level of mothers with children in 0-2 years age group was found to be higher than those with children aged 7 years and above. The perception level of non-smokers was higher than that of smokers while there was no difference in anxiety level between this two groups. While the perception level of parents who had routine childhood vaccinations was found to be higher than those who did not and there was no difference in the anxiety levels between this two groups. It was observed that maternal age, chronic health problem, total number of children and living in a large family did not cause a significant difference in perception and anxiety levels.

Conclusion: In our research, the detection of the social and psychological effects of the pandemic at a higher rate than the physical effects shows that the struggle should continue even if the pandemic is over. In line with data obtained, educating different segments of society is as important as taking measure to prevent anxiety related to contagious diseases to fight against current and possible pandemics in future.

Keywords: COVID-19, pandemic, perception, anxiety, avoidance

SS021

Examining The Effects of Postpartum Depression on Mothers and Infants

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Objectives: Postpartum depression affects 25% of mothers in our country. It is an important public health problem that prevents adequate consumption of breast milk. Children of mothers who have postpartum depression also less likely to benefit from preventive healthcare services, they are more likely to be diagnosed with gastroenteritis and upper respiratory tract infections, they are more likely to be exposed to domestic accidents. Also, their height and weight for age percentiles have been shown to be lower than other infants. With our study, we aimed to determine the rate of postpartum depression in mothers in the first year of motherhood, and we aimed to investigate the risk factors of postpartum depression and its effects on infants.

Methods: In the study, the study questionnaire " Examining The Effects of Postpartum Depression on Mothers and Infants" and Edinburgh Postpartum Depression Scale were applied to 252 mothers with children aged 1 month to 1 year who applied to Kırıkkale University Medical Faculty Hospital between the dates of January 2020-December 2020. Cut-off value for screening postpartum depression with Edinburgh Postpartum Depression Scale is determined to be ≥ 12 . In the research group, the frequency of postpartum depression, risk factors and its effects on infants were examined.

Results: The mean PPD score of the participants was 8 (0.0-25). According to the PPD scores, 189 (75.0) were below the cut-off value of 12, while 63 (25%) were equal to or above the cut-off value. The rate of smokers was lower in mothers who did not show depressive symptoms (8.5%) than mothers with depressive symptoms (20.6%) ($p=0.017$). Mothers with money problems were more common in the group with depressive symptoms (27%) than those who did not (14.3%) ($p=0.035$). Conflict with their spouses was more common in mothers with depressive symptoms (14.3%) compared to mothers who did not (2.6%) ($p=0.002$). Among mothers and their infants with or without depressive symptoms there was no significant difference in terms of week of birth, birth weight, mode of delivery, length of stay in the neonatal intensive care unit, preferred type of infant feeding (formula feeding, breastfeeding etc.), reason for admission to hospital, emergency admission number since birth, use of iron and vitamin D medication provided by the family health center, vaccination status of the baby according to the month. There was no significant difference in terms of crying crisis, duration of crying crisis, number of days per week of crying crisis and night sleep patterns ($p>0.05$ for each).

Conclusion: The incidence of postpartum depression is quite high in our city when compared to developed countries. The risk factors such as low socioeconomic status, presence of chronic disease in infants, conflict with the spouse, and unemployment of ix the spouse are important as it will guide the mothers to get the necessary help before their postpartum depression progress to critical levels.

Keywords: postpartum depression, breastfeeding, child healthcare



SS022

Lactating Mothers' Experiences on Using Silver Caps

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ABSTRACT

Background:

Breastfeeding is widely considered as the ideal method of providing nutrition for healthy infants born at term and carries undeniable benefits for both infants and mothers. However, nipple problems during breastfeeding can result in early weaning. There are many popular methods to be used during the course of breastfeeding in order to prevent and deal with these problems. Silver Cap is one of these methods which is acclaiming more popularity nowadays.

Materials and Methods:

Our cross-sectional study was carried out between February 1 and May 1, 2022. Breastfeeding mothers between the ages of 18-46 were asked to fill out a structured questionnaire consisting 33 questions to investigate their experiences with nipple problems, treatment methods and use of silver caps.

Results:

A total number of 298 women between the age of 21 and 46 were assessed with a structured questionnaire. It was reported by 36,6% (n=109) of mothers that they have not experienced any nipple problems (Nipple fissures, mastitis, fungal infection and eczema). Only 2.7% (n=8) of them using no method for nipple care. Among the 147 mothers who had used silver caps 89.9% (132) claimed that this method was effective for them. There was no difference between the frequency of nipple fissures in mothers using silver caps when compared to mothers who did not use it.

Conclusion:

Many methods are used for the prevention and treatment of nipple problems which are known to have a negative effect on breastfeeding period. Silver cap is one of the most frequently used methods by mothers and is reported to be effective in prophylaxis of nipple fissures. There is a need for large-scale, controlled studies on this subject.

Keywords: Breastfeeding, nipple pain, nipple fissures, silver cap, weaning

INTRODUCTION

Breastfeeding is acknowledged to be the ideal method of feeding infants born at term and is associated with providing benefits in terms of health, development and immunity of infants (1).

Despite the benefits of breastfeeding for both mothers and infants, breastfeeding problems such as nipple fissures and mastitis can result in early weaning. Nipple pain and damage are common during the early postpartum period and can vary from nipple lesions such as redness/eczema and cuts/wounds to mastitis and breast abscess. There are several known predisposing factors such as incorrect positioning of the baby, ineffective sucking due to organic and functional causes, nipple not being compliant to lactation and atopic skin. Treating nipple fissures and nipple traumas promptly is essential to ensure a satisfying breastfeeding and to prevent its complications as of mastitis or breast abscess (1-2).

Topical creams, solutions or sprays, time-limited breastfeeding, exposing nipple to dry heat or UV light, air drying, pre- or postnatal breastfeeding education, nipple shells, hydrogel, adhesive polyethylene film wraps and distilled water are some of the widely-used available treatments and prevention options for nipple fissures (3). Among natural measures, cup-shaped silver caps have also been using in order to prevent and heal the nipple problems.

It is speculated that the benefits of using silver cap are due to its mechanical cover effect against possible trauma and prevention of the entry of microorganisms. Along with the benefits of silver cap device, it is safe to use with no to little side effects thanks to its patented trilaminate, which prevents absorption of silver ions to systemic circulation. Silver cap device also creates a moist and hypoxic environment. The moist provided by this device would help the healing process and the hypoxic environment prevents proliferation of aerobic microorganisms (2).

In this study, we aimed to evaluate the experiences of lactating mother who use silver caps for nipple care.

MATERIALS AND METHODS

Design of the questionnaire

Our cross-sectional study was carried out between February 1 and May 1, 2022. Breastfeeding mothers between the ages of 18-46 were asked to fill out a structured questionnaire consisting 33 questions to investigate their experiences with nipple problems, treatment methods and use of silver caps via social media (Instagram and WhatsApp). Before moving on to the survey questions, the participants were asked to read about the review of the study and give consent if they agree to move forward.

Inclusion and exclusion criteria

Mothers who are between the ages of 18 and 46 and currently breastfeeding were included in our study. Prematurity is considered to be birth of the baby before 37th gestational week.

Statistical analysis

SPSS Statistics (IBM version 22.0) was used for the statistical analyses. Kolmogorov-Smirnov test was used to test the normality of the variables, Mann-Whitney U test was used for the comparison of the quantitative values of the categorical variables that were not normally distributed. Chi-square or Fisher's Exact tests were used for the comparison of the categorical variables. For all statistical analysis, if the p value was less than 0.05, the result of the comparison was considered significant.

Ethical consideration

Ethics committee approval was obtained from Istanbul Medipol University ethics committee (Approval No: E-10840098-772.02-1661). All participants were informed about the development, aim and program of the study and gave content.

RESULTS

A total number of 298 women between the age of 21 and 46 were assessed with a structured questionnaire. General information of the participants is shown in Table 1. There was no difference between the groups using and not using silver caps in terms of maternal education level, number of pregnancies, nipple fissure history, health problems in the baby, during hospital stay and after discharge. Information about participants breastfeeding are shown in the Table 2. There was no significant difference between mothers using silver cap and mother not using silver caps regarding their breastfeeding starting time, feeding frequency, length of feeding course, pacifier use, bottle use and milk expressing.

It was reported by 36,6% (n=109) of mothers that they have not experienced any of the nipple problems. Out of the remaining 189 mothers, 41,3% (n=123) of them experienced one problem, %20,1 of them experienced two problems and 2% (n=6) of them experienced more than two problems. The nipple problems experienced are shown on table 3. The most common nipple problem was nipple fissures.

Among the participants, 97.3% (n=290) of them reported using at least one method for nipple care and only 2.7% (n=8) of them using no method for nipple care. A significant correlation was found between the number of methods used and the frequency of nipple problems ($p < 0,001$).

The five most commonly used methods for nipple care among the 16 alternatives presented to participants were lanoline (52.2%), breastmilk (51.2%), silver cap (49.8%), only water (34.6%) and water and soap (34.6%). Other methods and the frequencies which were reported to be used by participants are shown in table 4.

Data about the use of silver cap is shown in Table 5. The internet was the main information source of 46.9% (69) of the mothers on using silver cap. Friends/relatives in 38.8% (57), lactation consultant in 7.5% (11) and health-care professionals in 6.8% (10) of the cases were reported as the information source on silver caps. The majority 59.2% (87) of silver cap purchases were also conducted through the internet. Silver cap usage was stopped in less than a month in 15.6% (23) of mothers using silver caps. Silver caps were used in 12.9% (19) of mothers for more than 6 months. Most mothers (21.1% (31)) used silver caps for 1 month. Among the 147 mothers who had used silver caps 89.9% (132) claimed that this method was effective for them. There was no significant difference between the frequency of nipple problems between the silver cap using group and not using silver cap group.

The comparison of nipple problems reported between two groups is shown in table 6. Nipple fissures were the most common nipple problem in both groups. However, there was no difference between the frequency of nipple fissures in mothers using silver caps when compared to mothers who did not use it.

DISCUSSION

One of the most common reasons of breastfeeding cessation is nipple pain and problems. It is estimated that 80–90% of breastfeeding mothers experience nipple pain (4). Using a pain score between 0-10, women with nipple damage reported a weighted mean of 6.2 in the first week and 5.8 after that period; women without damage reported a weighted mean of 2.7 (5).

In a study of 1323 mothers in the United States, conducted by Li et al., more than a quarter stopped breastfeeding in the first month postpartum; 29.3% reported pain and 36.8% reported sore, cracked, or bleeding nipples as an important reason (6). In a prospective cohort study of 360 primiparous women by Buck et. al., 72% of the participants experienced nipple pain 1 week after giving birth and the incidence of nipple damage during the first 8 weeks of pregnancy has been demonstrated as %58 (7). In our study, 63.4% of mothers experienced at least one of the nipple problems.

There are many methods used during breastfeeding period for prevention and treatment of nipple problems. Some of these methods are recommended by recent guidelines. Lanolin and/or breast milk to the affected nipple

can be beneficial based on the principle of healing in the moist environment (1). A systematic review by Vieira et al. on the several interventions for nipple trauma in breastfeeding mothers demonstrated that the best outcomes for the treatment of nipple fissures used lanolin and breast milk(3). The three most commonly used methods for nipple care among the mothers in our study were lanoline (52.2%), breastmilk (51.2%) and silver cap (49.8%). Also, a statistically significant correlation between the number of methods used on the nipple and the frequency of nipple problems was found in our study.

Marazzu et. al. showed that use of silver cap in the treatment of symptomatic nipple fissures resulted with a more rapid resolution of painful symptoms, bleeding and nipple fissures compared to only applying breastmilk to the affected nipple (2). A 49% usage rate of silver cap was stated among mothers participated in our study and 89.9% of silver cap user mothers reported that this method was effective for nipple care in their experience.

CONCLUSION

Nipple fissure is one of the most common causes of early cessation of breastfeeding. Mothers use many methods to prevent nipple fissures. The increasing frequency of use of the silver cap has been found to be effective by most of the mothers. However, more studies are needed to obtain more accurate evidence about the effectiveness of silver caps.

Tables:

		Silver cap User		Silver cap non-user		Total (n)	Total (%)	x ²	p
		n	%	n	%				
Breastfeeding starting time	First hour	100	68,0	98	64,9	198	66,4	0,59	0,74
	First day	35	23,8	37	24,5	72	24,2		
	After 24 hours	12	8,2	16	10,6	28	9,4		
Pacifier use	No	94	63,9	102	67,5	196	65,8	0,43	0,51
	Yes	53	36,1	49	32,5	102	34,2		
Bottle use	No	104	70,7	101	66,9	205	68,8	0,52	0,47
	Yes	43	29,3	50	33,1	93	31,2		
Feeding frequency (per day)	<5	32	21,8	41	27,2	73	24,5	3,72	0,29
	6-7	37	25,2	43	28,5	80	26,8		
	8-12	59	40,1	56	37,1	115	38,6		
	>13	19	12,9	11	7,3	30	10,1		
Feeding course (minutes)	Less than 10 minutes	39	26,5	42	27,8	81	27,2	3,82	0,43
	10-15 minutes	59	40,1	68	45,0	127	42,6		
	16-20 minutes	27	18,4	17	11,3	44	14,8		
	21-30 minutes	10	6,8	14	9,3	24	8,1		
	More than 30 minutes	12	8,2	10	6,6	22	7,4		
Milk expressing	No	101	68,7	110	72,8	211	70,8	0,62	0,43
	Yes	46	31,3	41	27,2	87	29,2		

Expressing method	Hand expression	1	2,2	2	4,9	3	3,4	2,37	0,55
	Hand pump	7	15,2	3	7,3	10	11,5		
	Electrical pump	30	65,2	31	75,6	61	70,1		
	Hospital type pump	8	17,4	5	12,2	13	14,9		
Frequency of expressing	Everyday	14	30,4	16	39,0	30	34,5	4,33	0,23
	Less than 3 days per week	6	13,0	5	12,2	11	12,6		
	More than 3 days per week	3	6,5	7	17,1	10	11,5		
	When necessary	23	50,0	13	31,7	36	41,4		

Table 1: Comparison of groups

	n	%
Nipple Fissures	166	55.7
Mastitis	78	26.2
Fungal Infection	15	5
Eczama	4	1.3

Table 2: Nipple Problems

		n	%
Methods Used ^a	Lanoline	154	52,2
	Breastmilk	151	51,2
	Silver Cup	147	49,8
	Only water	102	34,6
	Water and soap	102	34,6
	Breast Pads	87	29,5
	Breast Shield	66	22,4
	Olive Oil	48	16,3
	Quince Seed	40	13,6
	Garmastan	35	11,9
	Madecassol	33	11,2
	St. John's Wort	21	7,1
	Vitamine E	16	5,4
	Coconut Oil	12	4,1
	None	8	2,7
Wound Dressings	2	0,7	

Table 3: Used prophylactic methods for nipple fissures

		n	%
Silver cap user	Yes	147	50,7
	No	151	49,3
Information source	Internet	69	46,90
	Friend / relative	57	38,80
	Lactation consultant	11	7,50
	Healthcare professional	10	6,80
Purchased from	Internet	87	59,20
	Baby stores	27	18,40
	Gift	24	16,30
	Pharmacy	9	6,10
	Other	0	0,00
Starting time	After pregnancy	110	74,80
	During pregnancy	37	25,20
Duration time	Less than 1 month	23	15,60
	1 month	31	21,10
	2 months	25	17,00
	3 months	21	14,30
	3-6 months	28	19,00
	More than 6 months	19	12,90
Effective	Yes	132	89,80
	No	15	10,20

Table 4: Data on silver cap use

	Silver cap group		Not using group		x ²	p	
	n	%	n	%			
Nipple problem experienced	No	58	39,50	51	33,80	1,04	0,31
	Yes	89	60,50	100	66,20		
Nipple Fissures	No	67	45,60	65	43,00	0,19	0,66
	Yes	80	54,40	86	57,00		
Fungal Infection	No	139	94,60	144	95,40	0,1	0,75
	Yes	8	5,40	7	4,60		
Eczema *	No	146	99,30	148	98,00		0,62
	Yes	1	0,70	3	2,00		

Mastitis	No	113	76,90	107	70,90	1,39	0,24
	Yes	34	23,10	44	29,10		
*Fisher-Exact test							

Table-5: Comparison of groups

REFERENCES

- Jacobs A, Abou-Dakn M, Becker K, Both D, Gatermann S, Gresens R, et al. S3-guidelines for the treatment of inflammatory breast disease during the lactation period. *Geburtshilfe Frauenheilkd* [Internet]. 2013;73(12):1202–8. Available from: <http://dx.doi.org/10.1055/s-0033-1360115>
- Marrazzu A, Sanna MG, Dessole F, Capobianco G, Piga MD, Dessole S. Evaluation of the effectiveness of a silver-impregnated medical cap for topical treatment of nipple fissure of breastfeeding mothers. *Breastfeed Med* [Internet]. 2015;10(5):232–8. Available from: <http://dx.doi.org/10.1089/bfm.2014.0177>
- Vieira F, Bachion MM, Mota DDCF, Munari DB. A systematic review of the interventions for nipple trauma in breastfeeding mothers: Interventions for nipple trauma. *J Nurs Scholarsh* [Internet]. 2013;45(2):116–25. Available from: <http://dx.doi.org/10.1111/jnu.12010>
- Niazi A, Rahimi VB, Soheili-Far S, Askari N, Rahmanian-Devin P, Sanei-Far Z, et al. A systematic review on prevention and treatment of nipple pain and fissure: Are they curable? *J Pharmacopuncture* [Internet]. 2018;21(3):139–50. Available from: <http://dx.doi.org/10.3831/KPI.2018.21.017>
- Coca KP, Amir LH, Alves MDR da S, Barbieri M, Marcacine KO, de Vilhena Abrão ACF. Measurement tools and intensity of nipple pain among women with or without damaged nipples: A quantitative systematic review. *J Adv Nurs* [Internet]. 2019;75(6):1162–72. Available from: <http://dx.doi.org/10.1111/jan.13908>
- Li R, Fein SB, Chen J, Grummer-Strawn LM. Why mothers stop breastfeeding: mothers' self-reported reasons for stopping during the first year. *Pediatrics* [Internet]. 2008;122 Suppl 2(Supplement_2):S69-76. Available from: <http://dx.doi.org/10.1542/peds.2008-1315i>
- Buck ML, Amir LH, Cullinane M, Donath SM, CASTLE Study Team. Nipple pain, damage, and vasospasm in the first 8 weeks postpartum. *Breastfeed Med* [Internet]. 2014;9(2):56–62. Available from: <http://dx.doi.org/10.1089/bfm.2013.0106>

SS023

Evaluation Of Breastfeeding After-Birth Processes Of Mothers Who Attended Online Breastfeeding Education During Pregnancy

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Introduction

Breast milk is an ideal food source that alone meets psychological needs of the baby during the first 6 months after birth. Breastfeeding self-efficacy is defined as a mother's confidence in her ability to breastfeed her baby. Whether the mother can breastfeed, how much effort she will put into it, her thoughts on breastfeeding and the potential to cope with the difficulties she will encounter emotionally in this process are guiding (1-2). High self-efficacy mothers prefer to breastfeed more because they support themselves and remain upbeat in the face of challenges (3). To initiate and maintain successful breastfeeding is very important for mothers to feel adequate and competent during pregnancy and in the postpartum period.

The burden brought on the health system by the Covid-19 Pandemic necessitated the development of new methods to maintain preventive health services. The World Health Organization recommends disseminating digital health platforms such as mHealth and telemedicine to maintain essential health services and enable remote or self-monitoring of patients (4). In our country, health promotion services such as the pregnant school have also been moved to online platforms (5). In our study, we investigated the after-birth breastfeeding processes and breastfeeding self-efficacy of moms who received prenatal breastfeeding education and showed higher breastfeeding self-efficacy following the education.

Materials And Methods

The study was intended to involve 31 moms who received 2-hour online breastfeeding education in groups of three during pregnancy, however, 27 mothers were enrolled instead since 4 mothers refused to complete the data collection form. The education was prepared in the form of a presentation and was carried out interactively. The content of the education was prepared based on the "Breastfeeding Counseling Practitioner Book" published by the Ministry of Health. The importance of early breastfeeding and colostrum, the benefits of skin-to-skin contact right after birth, breastfeeding techniques (position, proper latching on the breast), the benefits of breastfeeding for mother and baby, and the techniques of expressing and storing breastmilk discussed in education.

A data collection form consisting of questions, asking their breastfeeding experiences and knowledge in the content of the education was applied to the mothers who participated in the study, along with the 'Breastfeeding Self-Efficacy Scale'. The study was approved by Ordu University Clinical Research Ethics Committee with the decision number KAEK 2022/225.

Results

Statistical analyzes were performed with the help of the IBM Statistical Package for Social Sciences (SPSS) 21 package program. In the analyzes, descriptive analyzes of the data were presented as numbers and percentages for categorical variables, mean, standard deviation, median, and 25% and 75% slice values for numerical variables. The Shapiro-Wilk test, mean and standard deviation values, and histogram graphs evaluated the conformity



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of the data to the normal distribution. Paired-t test was used when the distribution was found to be normal in the evaluation of the pregnant women before and after the online education and when the continuous variables were compared, and the Wilcoxon test was used when the distribution was not normal. Mann-Whitney u test was used because the distributions were not found to be normal in the analysis of independent variables. The statistical significance value was taken as $p < 0.05$ in the analyzes.

The mean age of the mothers participating in the study was 30 ± 4 years. All mothers graduated from colleges. The mean age of the babies of the mothers participating in the study was 15 ± 2 months. While 5 (18.5%) of the mothers participating in the study were pregnant, 6 (22.2%) received another training on breastfeeding other than our training after birth. 16 (59.3%) of them did not receive any other training other than the one we provided on breastfeeding. 22 (82%) of their babies were born via cesarean section, while 5 (18%) were born vaginally. After birth, 2 (7%) of the babies were followed up in the neonatal intensive care unit. When the birth weeks of the babies were questioned, 3 (11%) were late preterm and 24 (89%) were term. All of the births took place in the baby-friendly hospital. Skin-to-skin contact was applied to 11 (40.2%) babies after birth. 16 of the mothers (59.3%) breastfed their babies within the first hour after birth. 11 (40.7%) of the mothers fed their babies exclusively with breast milk for the first 6 months. 17 (63%) of the mothers participating in the study were still breastfeeding their babies, and 12 of them (44%) were planning to breastfeed their babies until the age of 2 years and above. 7 of the mothers (26%) stated that they gave their babies a pacifier in the first month, and 17 (63%) of them gave formula milk to their babies on the recommendation of a doctor. It was determined that the most frequently used method, other than direct breastfeeding, was the bottle (59.2%) when necessary. When questioning the problems experienced during breastfeeding, it was found that the most seen with the highest rate was nipple cracks (48.1%).

The mothers total scores on the breastfeeding self-efficacy scale were compared with their scores before and after education during pregnancy. No significant difference was found with the post-education total scores but importantly higher than the pre-education total scores ($p < 0.001$) (Table 1) Similar results were obtained in the analysis conducted with 16 mothers who participated in our training only while pregnant and did not receive any training afterward. While the current breastfeeding self-efficacy scores of the mothers who fed their babies exclusively with breast milk for the first 6 months were significantly higher than the other mothers ($p = 0,03$), there was no significant difference between the breastfeeding self-efficacy scores before and after the education ($p = 0,51$, $p = 0,13$). No significant difference was found in the comparison between the breastfeeding self-efficacy scores of mothers who still breastfeed their babies and those who discontinued breastfeeding ($p = 0,5$) There was no significant difference between the breastfeeding self-efficacy scores of mothers who intend to breastfeed their babies up to 2 years of age and above and those who think to breastfeed for less time. ($p = 0,8$)

When the mothers' deficiencies in breastfeeding education and the contribution of breastfeeding education to the pregnancy and postpartum process were questioned, 23 (85%) said that they were motivated to learn something about breastfeeding during pregnancy, 21 (77.8%) benefited from the information given in the training after the birth, 2 (7.4%) stated that they would prefer face-to-face education..

Discussion

As we expected, mothers with high breastfeeding self-efficacy are more motivated to breastfeed so exclusive breastfeeding and breastfeeding durations are more likely to be longer (6). In a cross-sectional study examining the factors affecting breastfeeding satisfaction in the 4-8 months after birth, it was found that breastfeeding self-efficacy had a higher positive effect on breastfeeding satisfaction than knowledge and attitude about breastfeeding (7). Today, the perception of breastfeeding self-efficacy has become an important criteria in examining the effectiveness of breastfeeding counseling. In a randomized controlled study conducted in Iran, it was determined that breastfeeding self-efficacy and exclusive breastfeeding rates were found to be significantly higher in the intervention group, which was given training on breastfeeding self-efficacy during pregnancy, compared to

the control group in the evaluation made at the postnatal eighth week. There was no significant difference in the rates of discontinuation of breastfeeding. In our study, the rate of babies fed only with breast milk for the first 6 months was determined as 40.7%, which is similar to the 2018 TDHS data. The self-efficacy scores of the mothers of babies who were exclusively breastfed for the first 6 months were found to be significantly higher than those of other mothers. The fact that mothers fed their babies only with breast milk within the recommended period may have increased their breastfeeding self-efficacy.

In our study, mothers who were given online breastfeeding education during pregnancy and who were shown to have increased breastfeeding self-efficacy after the education were evaluated. With the Covid-19 pandemic, online services and trainings have become very common in the field of health. In this direction, health promotion services such as the pregnant school have been moved to online platforms in our country. In our study the online pregnancy information training activity in our country during the Covid-19 pandemic process was compared with the face-to-face trainings conducted in the past, the post-test scores of both groups were found to be high in the pre- and post-test results, and no significant difference was found between the two groups in the pre- and post-test scores. The number of participants in online training was found to be higher than in face-to-face training (9). In the light of these data, it can be considered that online birth preparation training be carried out more widely.

In our study, it was observed that mothers who received online breastfeeding training and who were found to have high breastfeeding self-efficacy had high breastfeeding self-efficacy, which was also continued in the long-term after birth. One of the limitations of our study is that all of the participants were at the higher education level. There was no control group in our study, information on long-term breastfeeding experiences was shared, but no comparison could be made. The lack of early postnatal data was also a limitation of our study.

As a result, interactive online breastfeeding educations applied to pregnant women increase motivation and breastfeeding self-efficacy in obtaining information about breastfeeding during pregnancy. The increase in self-efficacy is also reflected in the after-birth period, but more studies are needed to show its positive contribution to the breastfeeding process

Table 1: Breastfeeding self-efficacy scores before and after education

	Before Education	After Education	p*
Breastfeeding Self Efficacy Total Score			
Mean ± SD	45,6 ± 11,5	57,7 ± 7,9	<0,001
Median (25p-75p)	46 (36-51)	57 (54-65)	
*paired t test			
	Before Education	After Birth	p*
Breastfeeding Self Efficacy Total Score			
Mean ± SD	45,6 ± 11,5	57,6 ± 9,7	<0,001
Median (25p-75p)	46 (36-51)	58 (53-63)	
*Wilcoxon test			
	After Education	After Birth	p*
Breastfeeding Self Efficacy Total Score			
Mean ± SD	57,7 ± 7,9	57,6 ± 9,7	0,9
Median (25p-75p)	57 (54-65)	58 (53-63)	
*Wilcoxon test			



References

1. Dennis CL. Theoretical underpinnings of breastfeeding confidence: a self-efficacy framework. *J Hum Lact* 1999; 15(3): 195-201. PMID: 10578797. DOI: [10.1177/089033449901500303](https://doi.org/10.1177/089033449901500303).
2. Otsuka, K., Taguri, M., Dennis, C. L., et al. Effectiveness of a breastfeeding self-efficacy intervention: do hospital practices make a difference?. *Maternal and child health journal*, 2014; 18(1): 296-306. PMID: 23592322. PMCID: [PMC3880483](https://pubmed.ncbi.nlm.nih.gov/PMC3880483/). DOI: [10.1007/s10995-013-1265-2](https://doi.org/10.1007/s10995-013-1265-2).
3. Aluş Tokat M, Okumuş H. Mothers Breastfeeding Self-Efficacy and Success: Analysis The Effect of Education Based on Improving Breastfeeding Self-Efficacy. *Journal of Education and Research in Nursing* 2013; 10(1): 21-29.
4. World Health Organization. Regional Office for the Western Pacific. Role of primary care in the COVID-19 response. WHO Regional Office for the Western Pacific 2020, 8p. Document number: WPR/DSE/2020/004. <https://apps.who.int/iris/handle/10665/331921>. License: CC BY-NC-SA 3.0 IGO.
5. Republic of Türkiye Ministry of Health General Directorate of Public Hospitals. Distance Education for Pregnancy School 2020. Accessed on <https://khgm.saglik.gov.tr/TR,65461/uzaktan-egitim-gebe-okulu.html>. Date of Access: 11.11.2022.
6. Wong, M. S., Mou, H., Chien, W. T.. Effectiveness of educational and supportive intervention for primiparous women on breastfeeding related outcomes and breastfeeding self-efficacy: A systematic review and meta-analysis. *International Journal of Nursing Studies* 2021; 117, 103874. PMID: 33548592. DOI: [10.1016/j.ijnurstu.2021.103874](https://doi.org/10.1016/j.ijnurstu.2021.103874).
7. Awaliyah, S. N., Rachmawati, I. N., Rahmah, H.. Breastfeeding self-efficacy as a dominant factor affecting maternal breastfeeding satisfaction. *BMC nursing*, 2019; 18(1), 1-7. PMID: 31427892. PMCID: [PMC6696667](https://pubmed.ncbi.nlm.nih.gov/PMC6696667/). DOI: [10.1186/s12912-019-0359-6](https://doi.org/10.1186/s12912-019-0359-6).
8. Araban, M., Karimian Z., Zohre KARimian K., et al. Randomized controlled trial of a prenatal breastfeeding self-efficacy intervention in primiparous women in Iran. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 2018; 47(2), 173-183. PMID: 29406289. DOI: [10.1016/j.jogn.2018.01.005](https://doi.org/10.1016/j.jogn.2018.01.005).
9. Seven B., Uzunlar Ö., Güven H., et al. Evaluation of Online Antenatal Education Efficiency During the Covid 19 Pandemic. *The Journal of Gynecology-Obstetrics and Neonatology* 2022; 19(2), 1228-1232. DOI: [10.38136/jgon.1021572](https://doi.org/10.38136/jgon.1021572).

SS024**Awareness and Attitudes of Physician Mothers About Baby-Friendly Hospital Initiative and The Code (The International Code of Marketing of Breastmilk Substitutes)**Merve Erdemir Kula¹, Özden Aksu Sayman², Emine Yurdakul Ertürk³¹Istanbul Bayrampaşa State Hospital, Department of Pediatrics, Istanbul²Alanya Alaaddin Keykubat University, Faculty of Medicine, Department of Pediatrics, Antalya³Ordu University, Faculty of Medicine, Department of Pediatrics, Ordu**Introduction**

World Health Organization and UNICEF launched the Baby-Friendly Hospital Initiative (BFHI) in 1991 to protect, promote, and support breastfeeding in facilities providing maternity and newborn services (1). Medical professionals, in particular physicians, play a crucial role in the care of mothers and newborns. Training of health workers and compliance with the Ten Steps to Successful Breastfeeding (Ten Steps) are the main purposes of BFHI.

The first step of the Ten Steps is about hospital policies and advises not promoting infant formula, bottles, or teats. It is following The International Code of Marketing of Breastmilk Substitutes (The Code), which was endorsed by the 34th World Health Assembly in 1981 to regulate the marketing of artificial baby milk products (2).

Although it has been more than forty years since it was endorsed, health workers' knowledge and awareness about The Code is still inadequate (3). This study aims to investigate the awareness and attitudes of physician mothers about BFHI and The Code.

Method

The study population was chosen from physician mothers, especially to investigate their awareness and attitudes about BFHI and The Code. The same population was also available for research on their exposure to violations of The Code at once. Physician mothers with children sixty months or younger who registered in any of the two most crowded physician mother Facebook groups in Türkiye (Doctor Moms and/or Postpartum Doctors) were invited to study on October 2023. These two social media groups accept members by reference and identity. Volunteers joined the online survey by clicking the link which had been shared by one of our researchers on Doctor Moms and Postpartum Doctors Facebook Groups. In the beginning, volunteers accepted the informed consent form then they answered the 30-question online survey, prepared by considering the guidelines of the World Health Organization about the Baby-Friendly Hospital Initiative and the Code (4, 5). Ten questions for occupational and personal data; fifteen short-answer or multiple-choice questions for awareness and attitudes about the Code and five for the ten steps to successful breastfeeding. The answers were collected by Google Forms online survey during October 2023.

Permission was obtained from the Ethics Committee of Ordu University for the study (determination number: 2022/226).

Statistical analyses were performed by SPSS 21. Descriptive analyzes of the data were presented as numbers and percentages for categorical variables and mean and standard deviation for numerical variables. The Chi-square test was used in the analysis of categorical variables. Cases, where the p-value was below 0.05, were considered statistically significant.

Results

The mean age of 202 mothers included in the study was 34±4.2. 189 (93.6%) were physicians (Figure 1: specialties of physicians) and 13 (6.9%) were dentists. 144 (%71.3) of participants declared they care for mothers and babies in their daily practice. Regarding the question of whether their working place is baby-friendly or not, 128 (63.4%) of the mothers answered yes, 25 (12.4%) no, and 49 (24.3%) do not know. 58 (28.7%) of the mothers participating in the study declared that they had received breastfeeding counseling training from one of the reliable institutions like the Ministry of Health, universities, TEMAS (The Association of Breastfeeding and Breastmilk Volunteers), La Leche League or (IBLCE) International Board of Lactation Consultant Examiners. As shown in Table 1, the rate of receiving breastfeeding counseling training was significantly higher in participants who care for mothers and children in their daily practice compared to those who do not ($p<0.001$).

While 143 mothers (70.8%) answered the question regarding the basic management practices of the baby-friendly hospitals, 99 mothers (49%) gave the correct answer to the question in which basic clinical practices were questioned. When breastfeeding recommendations were asked participants, 187 (92,5%) answered exclusive breastfeeding recommendation as “first six months”. 90 mothers (44,6%) chose “at least two years” and 105 (52%) chose “until two years” as the answer to the “How long should babies be breastfed according to WHO?” question. It was important for half of the mothers (101) that the place where they gave birth was “baby-friendly”. 54 (26,7%) of the mothers did not care about this criterion.

The first three places where the participants saw formula ads are TV and newspapers (73%), malls (41%), and social media (38%). 14% of mothers (29) declared that they saw formula ads at scientific meetings and congresses. 17,3 % (35) mentioned that logos of formulas were seen where their children’s health follow-ups were done. 27 (13,4%) mothers received free formula samples during the first six months after they gave birth. 132 (65,8%) participants gave formulas to their babies at any time and 60% of them decided which formula to use with the recommendation of health professionals. 12 (%9) of formula-using mothers used the free samples.

When asked if they were using any materials that had a formula logo on them, 134 (66%) said “No, I don’t” and 8 (4%) said, “I used to”. It was not important whether there was a logo on the stuff, they used in their clinic for 33 (16,3%) mothers. 17 (8,4%) declared they could use and 10 (5%) declared they are using the stuff which had a logo of the formula milk brand on it. There were any significant differences in terms of awareness of The Code between the mothers who answered “No” or “Used to” and the mothers who gave the other answers to this question. 65 (%32.2) of the mothers had been aware of The Code before but only 14 (21%) of them answered correctly to all questions about the legislation and scope of the Code. The rate of being aware of the code was significantly higher in participants who care for mothers and children in their daily practice compared to those who are not ($p<0.001$). The rate of being aware of The Code for the mothers who received breastfeeding counseling training was also significantly higher than the mothers who did not ($p<0.001$). 16 (24,6%) of mothers who had been aware of The Code encountered a code violation and only 9 (57,2%) of them acted about it. The rest of them (7 mothers) did nothing (3, 19%) or did not know how they would act.

Discussion

The awareness of physician mothers about BFHI and The Code was found inadequate in our descriptive cross-sectional study, although most of them (71,3%) declared they work with mothers and/or babies. The rate of mothers who had received breastfeeding counseling education from a reliable institution was significantly higher in this group ($p<0.001$), it was just 53 of them (36,8%) still (Table1). Here, we determined the lack of education among physician mothers who care for mothers and/or babies.

Despite becoming part of the first step (1), a quarter of the participants did not know whether their workplace is baby-friendly or not in our study. It was revealed that half of the health workers were knowing the “BFHI” definition

correctly in a previous study (6). 143 (70.8%) and 99 (49%) mothers gave the correct answers to the questions about the basic management and basic clinical practices of the Ten Steps respectively in our study.

We demonstrated the rate of answering “six months” to the exclusive breastfeeding duration recommendation of WHO was 92,5% (187 mothers) while it was 97% in the previous study which is different from ours by collecting all the population from baby-friendly hospitals, having health professionals like nurses additionally, and asking open-ended questions about BFHI practices (6).

Television (TV) was the channel from which mothers in most countries saw or heard formula milk marketing around the world in the current report of WHO and UNICEF (7). Our study detected TV and magazine as the first resource of the formula milk marketing exposures parallel to this report. The decision of starting a formula for babies is mostly affected by health professionals like current data from Turkey, Poland, Ecuador, and worldwide (7,8,9,10). The exposure rate to free formula samples was 7,7% in a study from Turkey (7), 11,8% in Poland, and 10% in Ecuador studies. Since the population consists of physicians, formula representatives may reach mothers easily, we found this rate higher (13,4%) from similar research.

Violations of The Code are the subjects of many studies. 25% of clinicians were using materials that had formula logos in the Ecuador study (10). In our study, 14% of the physician mothers declared they are using or could use these materials while 16% of the mothers are paying no attention if there was a logo on the materials they use. We have limitations in the study since the data insisted on declarations of participants. In the Ecuador study, the researchers visited the clinics/hospitals to investigate the violations of The Code (10).

The awareness rate of The Code among health workers was found 28% in a study in Istanbul before (6). We found 32% similarly, while it was 45% in Ecuador (10). The rate of being aware of the Code for the mothers who received breastfeeding counseling training was also significantly higher than the mothers who did not ($p < 0.001$). Like previous data, the participants who knew the code were just slightly part of the participants who heard The Code in our study (6,10).

Conclusion

The data obtained from this research shows that the knowledge and awareness of physicians about the Baby-Friendly Hospital Initiative and the Code are still not at the desired level. Education of breastfeeding counseling from a reliable institution could increase the awareness rate of The Code. Studies should be carried out for all physicians who care for babies and mothers to boost their awareness and attitudes.

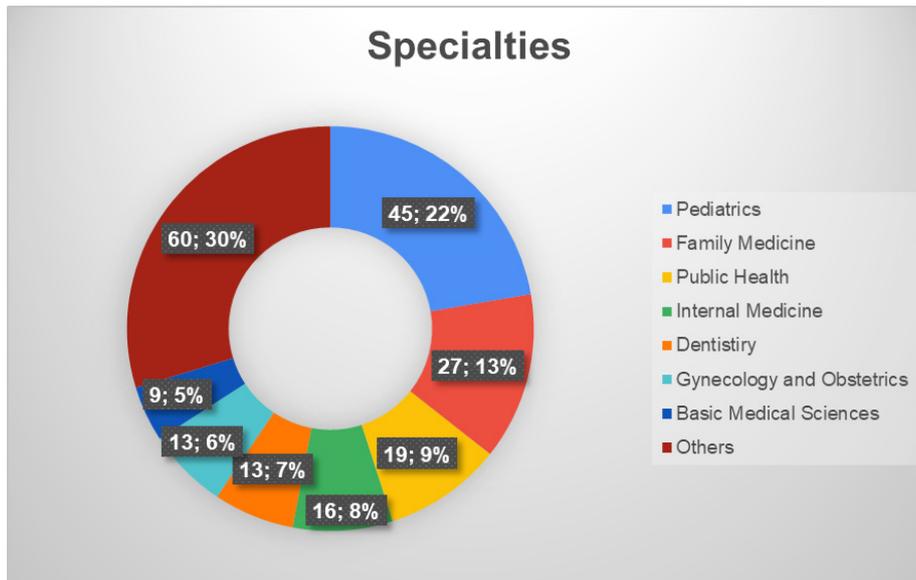
Keywords: Breastfeeding, baby-friendly hospital, code, breastmilk, awareness

References

1. World Health Organization, Wellstart International & United Nations Children’s Fund (UNICEF). The baby-friendly hospital initiative : monitoring and reassessment : tools to sustain progress / prepared by the World Health Organization and Wellstart International, 1999. Document Number: WHO/NHD/99.2. Accessed at <https://apps.who.int/iris/handle/10665/65380>. Date of Access: 14.11.2022.
2. World Health Organization. 4-22 May 1981: resolutions and decisions, annexes. Thirty-fourth World Health Assembly, Geneva, 1981. Accessed at <https://apps.who.int/iris/handle/10665/155679>. Date of Access: 14.11.2022.
3. Yılmazbaş P., Keskindemirci G., Özboru Aşkan Ö. et al. Awareness and Attitudes of Health Workers About Breastfeeding and Baby Friendly Hospital Practices. Türkiye Klinikleri Journal of Pediatrics 2020; 29(3), 153-158. DOI: 10.5336/pediatr.2019-72923.

4. World Health Organization, United Nations Children's Fund. NetCode toolkit. Monitoring the marketing of breast-milk substitutes: protocol for periodic assessments. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. ISBN: 9789241513494. Accessed at <https://apps.who.int/iris/handle/10665/259695>. Date of Access: 10.11.2022.
5. Baby-friendly Hospital Initiative training course for maternity staff: participant's manual. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020. Licence: CC BY-NC-SA 3.0 IGO. ISBN: 9789240008953 (electronic version). Accessed at <https://apps.who.int/iris/handle/10665/333675>. Date of Access: 10.11.2022.
6. Duckett LJ. Launch of New Report by the World Health Organization and United Nations Children's Fund: How the Marketing of Formula Milk Influences Infant Feeding Decisions – A Commentary. Journal of Human Lactation 2022, 38(3), 564–569. PMID: 35726490. DOI: 10.1177/08903344221099943.
7. Gülümser Şişko S., Bağ O., Kondolot M. et al. Breastfeeding and infant nutrition knowledge, attitude, and practices of parents. Turk Arch Pediatr. 2022; 57(4), 441-447. PMID: 35822477. PMCID: PMC9317703. DOI: 10.5152/TurkArchPediatr.2022.21201.
8. Baranowska B., Doroszewska A., Sys D. et al. Promotion of Human Milk Substitutes in the Opinion of Mothers of Young Children. Journal of Food and Nutrition Research, 2020; 8(7), 329-336. DOI: 10.12691/jfnr-8-7-4.
9. Caicedo-Borrás R., Díaz A., Bertha J. et al. Violations of the International Code of Marketing of Breastmilk Substitutes (WHO Code) in two Ecuadorian cities. Nutrition, 2021; 87–88, 111206. PMID: 33761442. DOI: 10.1016/j.nut.2021.111206.

Figure 1



Are Mothers and/or Babies Involved in Your Daily Work Practice?	With Breastfeeding Counseling Training		Without Breastfeeding Counseling Training		p
	n	%*	n	%*	
Yes	53	36,8	91	63,2	<0,001**
No	5	8,6	53	91,4	

* Row percentage **Chi-square test

Table 1



SS025

A Preventable Cause of Childhood Injury and Death: Television-Related Accidents

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Objectives: Involuntary injuries are called 'accidents'. The word accident describes an unforeseen, unexpected phenomenon. Injuries are not random, but occur in predictable patterns determined by distinguishable risk factors. Turkish Statistical Institute (TUİK) were published the causes of child death in Statistics on Child 2021 survey. According to 2019 data, external causes of injury and poisoning were the commonest death cause in childhood.

Methods: In this study, television (TV)-related injuries and deaths that children were exposed to were investigated online in newspapers in Türkiye (both local and national ones). News which were published between March 2003 and October 2022 were investigated. The publication date of the accident in the newspaper, the location of the injury (province/district/neighbourhood), the age and gender of the child, and the result of the injury (injury/death) were investigated. For the same case, repeated news in the newspapers were excluded, and the last published news for each case was included in the study.

Results: There were 137 cases reported in the press between 2003 and 2022. Of the cases aged between 3 months - 14 years and 44 (32.1%) resulted in injury, 115 (67.9%) resulted in death. Fifty-nine (43.1%) of the accidents occurred while the children were playing alone in the room and 43 (31.4%) were occurred while the children were climbing on the TV unit, pulling out the drawers, etc. Fifty-seven of the cases were girls and 64 of them were boys. The provinces with the highest incidence of cases were Şanlıurfa (n=21), Adana (n=11) and Kayseri (n=11).

Conclusion: The number of TV-related injuries in children is seemed to be high in Türkiye and that serious injuries and deaths are reported in newspapers. Although there is no statistical data on this subject in Türkiye, we think that TV related injuries are evaluated in the category of home accidents or falls. TV installation safety principles should be determined in order to prevent TV-related accidents and deaths in childhood.

Keywords: Television, Pediatrics, Accidents

SS026

Traditional Practices in The Treatment of Infantile Colic

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Objectives: This study aims to determine the types of traditional practices used for treatment and the benefits of these methods in infants diagnosed with infantile colic in infants aged 0-6 months.

Methods: Infants aged 0-6 months who applied to the outpatient clinics and emergency services of Adıyaman University Faculty of Medicine, Department of Pediatrics with complaints of crying, restlessness, and bloating in the abdomen were evaluated. Patients diagnosed with infantile colic according to Wessel criteria were included in the study. In the study, a face-to-face questionnaire was applied to the parents of the patients. There were 63 questions in total in this survey. The first part consisted of questions about the demographic information of the baby and the family. In the second part, the traditional methods applied in the infantile colic treatment and the duration of application of these methods, and the benefit asked by grading. Data were analyzed using the SPSS (Statistical Package for Social Sciences) 22.0 program (SPSS Inc., Chicago, IL, United States). In the evaluation of the data; Chi-square, Student T, Pearson, and Spearman tests were used. Significance was based on $p < 0.05$

Results: Of the 233 infants included in the study, 140 (60.1%) were boys and 93 (39.9%) were girls. The mean age of the babies was 3.05 ± 1.5 months. Siblings of 72 (45.2%) of 159 patients with a sibling history also had a history of infantile colic. It was determined that 118 (50.6%) of four patients used gas drops only, while 115 (49.4%) did not use gas drops but tried to treat infantile colic with traditional methods. The demographic information of those who use gas drops and those who do not use traditional methods were compared and it was found that traditional methods were applied more to those who had a sibling with a history of infantile colic. There was no significant relationship between other demographic information and the use of gas drops. It was determined that among the traditional methods, massage, changing position, pulling the legs to the stomach, avoiding gas-producing foods, giving olive oil, and giving a pacifier were the most used methods. It was stated by the families that infantile colic symptoms were relieved by massaging, giving anise, and driving around.

Conclusion: In the treatment of infantile colic, the family should first be informed that this is a temporary and benign condition and that this condition is not caused by any disease. Family concerns should be addressed. It should be said that the use of traditional methods without the advice of a physician may be harmful to the baby. There is a need for larger studies investigating the effects of traditional methods used.

Keywords: infantile colic, traditional, practice, treatment



SS027

The Anxiety Levels of Parents and Preschool Children During The Pandemic; What Was It Then, and What Is It Now?

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Objectives: At the beginning of the Covid-19 pandemic it was not known how the disease would affect different age groups. During the pandemic, which endangered health, led to deaths, was very unknown, and was intertwined with prohibitions, the level of anxiety of parents and children increased in many issues. Life threatening consequences of the disease and the mystery at the beginning combined with curfews which violated the ordinary course of life led to anxiety in all segments of the population. As we learn and practice more about the disease and the vaccines became available some precautions became unnecessary. This study is aimed to examine how the anxiety levels of parents and their children in Turkey have progressed from the beginning of the Covid-19 pandemic to the present.

Methods: This descriptive-cross-sectional study was conducted between May 2020 and September 2022. Parents of children between the ages of 3 and 6 who filled out the online questionnaire which was delivered across Turkey were included in the study. Permission for the study was obtained from the Ministry of Health of the Republic of Turkey and ethical approval was obtained from the Clinical Studies Ethics Committee of Akdeniz University Faculty of Medicine (Decision No: KAEK-368).

Results: A total of 3135 parents with children aged 3-6 years participated in the study. Most of the participants were mothers 87.3% (n=2736). The mean age of the children was 59.7 ± 11.5 months and 48% were girls. Parents were reached with an online questionnaire at 3 different time intervals; in the first 6 months after the first case was detected in Turkey, during the period when the curfew was imposed on children, and when the bans were completely lifted. Parents were asked to rate the level of anxiety they felt about themselves and their children from 0 (no anxiety) to 10 (the highest level of anxiety). The anxiety levels of children at the beginning, during curfews, and when the bans were lifted were; 4.2 ± 3 , 5.4 ± 3.1 , and 3.6 ± 2.9 , respectively ($p < 0.05$). During the same time periods the anxiety scores of parents about their children's health were 5.3 ± 3.8 ; 6.1 ± 3.2 ; 5.5 ± 3 , respectively. While the level of anxiety felt by the parents about the health of their children was highest during the curfew, no significant difference was observed between the scores at the beginning of the pandemic and today. The total anxiety scores, which consisted of the parents' concerns about health, family, work and future, were 5.2 ± 2.6 ; 5.9 ± 2.4 ; 4.5 ± 2.6 for the above mentioned periods, respectively ($p < 0.05$).

Conclusion: The peak level of anxiety due to pandemic was highest during the curfew among parents of preschool children. However their anxiety level today is similar to what they felt at the start of the pandemic. Ways of being cautious instead of being anxious can be discussed during well child follow-ups.

Keywords: Covid-19, parent, anxiety, child

SS028**The Relationship of Postnatal LATCH Score and Breastfeeding Self-Efficacy Scale with Breastfeeding in The First Six Months in Healthy Term Infants**

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Introduction

Breastfeeding of newborns is one of the most important factors that ensure healthy growth. Breast milk is the only physiological food source that contains the nutrients that infants need in the first 6 months of their life in appropriate quantity and quality. Breast milk protects babies against diseases, reduces the incidence of nutritional deficiencies and prevents food-borne infections, thanks to antibodies passed from the mother.

It is thought that showing the correct position and latching to the mother in the education given by the health personnel before the birth and in the postpartum breastfeeding evaluation will increase maternal self-efficacy and affect breastfeeding positively(1).

In our study, the relationship between the LATCH and the self-efficacy score and breastfeeding at the sixth month were investigated.

Materials and Methods

This research is an analytical-cross-sectional study conducted to examine the relationship between postnatal LATCH score and maternal self-efficacy scale and breastfeeding in the first six months in healthy and term infants.

The research population consisted of mothers who volunteered to participate in the study between March 2021 and November 2021; Over 18 years old, mother's of term babies with healthy delivery (babies with an APGAR score of 7 and above in the 5th minute, without any health problems or congenital diseases), literate, Turkish-speaking, without a chronic disease that prevents breastfeeding, and who do not use continuous medication. "Data Collection Form on Descriptive Characteristics", "LATCH Breastfeeding Diagnosis and Evaluation Scale", "Breastfeeding Self-Efficacy Scale", "Descriptive Questionnaire Conducted Six Months After Birth" were used to obtain the research data.

In the initial evaluation, 330 mothers were included in the study but 29 patients who could not be reached six months after delivery were excluded from the study. Three hundred and one mother-infant couples who met the sampling criteria were included in the evaluation (Table 1).

Mothers were evaluated in the first 48 hours after birth and the LATCH score of the patients was determined by the same experienced lactation consultant. The LATCH score is considered weak between 0-3, moderate between 4-7, and good between 8-10. The cut-off value was determined as 8, due to the high mean LATCH score in our study.

The maternal self-efficacy scale has no cut-off point and an increase in the score means higher breastfeeding self-efficacy. Since the self-efficacy score average of our study was found to be slightly higher and in line with the literature findings, the original scale sample mean (55.8) was accepted as the cut-off value.

“Descriptive Questionnaire Conducted Six Months After Birth” form was created by the researcher in order to determine some of the mothers’ introductory characteristics (working status, social support, diet, etc.) and the nutritional status of the baby six months after birth (breast milk and formula intake, pacifier and bottle use, etc.). The questionnaire was completed by the researcher six months after the birth by contacting the mothers by telephone.

In the descriptive statistics of the data, mean, standard deviation, median minimum, maximum, frequency and ratio values were used. The distribution of variables was measured with the Kolmogorov-Smirnov test. The Mann-Whitney u test was used in the analysis of quantitative independent data. Chi-square test was used in the analysis of qualitative independent data, and Fischer test was used when the chi-square test conditions were not met. SPSS 28.0 program was used in the analysis.

Ethics committee approval for the research was received from the Non-Interventional Ethics Committee of Istanbul Medipol University with the letter numbered E-10840098-772.02-9048 on 18.02.2021.

Results

Sixty two percent of the mothers, 43.2% of whom were between the ages of 26-30, were university graduates. Sixty five percent of babies were born with c/s. 55.5% of the babies were male babies. LATCH score was found to be low in 21.6% of the cases, and self-efficacy scale was low in 29.8% (Table 1). No significant relationship was found between both the self-efficacy score and the LATCH score and continuing to breastfeed at the sixth months. While there was a positive correlation between self-efficacy score and exclusive breastfeeding in the sixth week and the second month; no significant relationship was found with exclusive breastfeeding in the fourth and sixth months (Table 2). There was no significant relationship between LATCH score and exclusive breastfeeding at the sixth week, second, fourth and sixth month (Table 3). Positive correlation was found between breastfeeding at six months and maternal age, being a nuclear family, breastfeeding experience and duration of previous breastfeeding, exclusive breastfeeding for the first 48 hours, and the environment in which the mother is suitable for pumping (Table 4) and there was a negative correlation between use of pacifier or bottle during the first 48 hours and during breastfeeding, smoking while breastfeeding, and hospitalization history of the baby (Table 5).

Table 1. LATCH Score and Breastfeeding Self-Efficacy Scale Results

		Min-Max			Median	Mean.±ss/n-%		
LATCH Score		4.0	-	10.0	9.0	8.5	±	1.2
LATCH score	Low					65		21.6%
	High					236		78.4%
Self-Efficacy Scale		14.0	-	70.0	62.0	60.2	±	8.8
Self-Efficacy Scale	Low					88		29.2%
	High					213		70.8%

Table 2. The relationship between the duration of exclusive breastfeeding and the self-efficacy score

		Self Efficacy < 55.8		Self Efficacy > 55.8			p	
		n	%	n	%			
Exclusive Breast Milk at Sixth Week	(-)	61	69,3%	180	84,5%		0,004	x ²
	(+)	26	29,5%	33	15,5%			
Exclusive Breast Milk at Second Month	(-)	59	67,0%	172	81%		0,010	x ²
	(+)	29	33,0%	41	19%			

Exclusive Breast Milk at Forth Month	(-)	58	65,9%	152	71,4%	0,349	x ²
	(+)	30	34,1%	61	28,6%		
Exclusive Breast Milk at Sixth Month	(-)	40	45,5%	97	45,5%	0,989	x ²
	(+)	48	54,5%	116	54,5%		
x ² Chi – square test (Fischer test)							

Table 3. Relationship between exclusive breastfeeding time and LATCH score

		Latch < 8		Latch > 8		p	
		n	%	n	%		
Exclusive Breast Milk at Sixth Week	(-)	47	72,3%	194	82,2%	0,118	x ²
	(+)	17	26,2%	42	17,8%		
Exclusive Breast Milk at Second Month	(-)	48	73,8%	183	78%	0,532	x ²
	(+)	17	26,2%	53	22%		
Exclusive Breast Milk at Forth Month	(-)	40	61,5%	170	72,0%	0,103	x ²
	(+)	25	38,5%	66	28,0%		
Exclusive Breast Milk at Sixth Month	(-)	26	40,0%	111	47,0%	0,313	x ²
	(+)	39	60,0%	125	53,0%		
x ² Chi – square test (Fischer test)							

Table 4. The relationship between demographic information and persistence in breast milk at 6 months

		Does Breastfeeding Continue at the Sixth Month?				p	
		Yes		No			
		n	%	n	%		
Mother's age	18-25	30	11.9%	13	26.5%	0.020	X ²
	26-30	107	42.5%	23	46.9%		
	31-35	89	35.3%	10	20.4%		
	>36	26	10.3%	3	6.1%		
Mother's Education							
Literate		1	0.4%	0	0.0%	0.804	X ²
Primary School Graduate		9	3.6%	2	4.1%		
Secondary School Graduate		18	7.1%	5	10.2%		
High School Graduate		65	25.8%	12	24.5%		
University Graduate		159	63.1%	30	61.2%		
Father's Education							
Literate		3	1.2%	0	0.0%	0.309	X ²
Primary School Graduate		39	15.5%	5	10.2%		
Secondary School Graduate		20	7.9%	10	20.4%		
High School Graduate		62	24.6%	13	26.5%		
University Graduate		128	50.8%	21	42.9%		
Father's Occupation							
Workman		45	17.9%	9	18.4%	1.000	X ²
Civil servant		38	15.1%	4	8.2%		
Other		168	66.7%	35	71.4%		
Unemployed		1	0.4%	1	2.0%		
Monthly Income							
1.000-2.500		6	2.4%	0	0.0%	0.314	X ²
2.500-5.000		78	31.0%	20	40.8%		
5.000-10.000		129	51.2%	20	40.8%		
≥ 10.000		39	15.5%	9	18.4%		
Family Type							
Nuclear family		237	94.0%	41	83.7%	0.012	X ²
Extended family		15	6.0%	8	16.3%		
Years of Marriage							
0-5 years		137	54.4%	33	67.3%	0.094	X ²
5-10 years		81	32.1%	13	26.5%		
≥ 10 years		33	13.1%	3	6.1%		
Not currently married		1	0.4%	0	0.0%		
Living Child	I	124	49.2%	33	67.3%	0.060	X ²
	II	90	35.7%	13	26.5%		
	III	29	11.5%	1	2.0%		
	IV	9	3.6%	2	4.1%		
	None	252	100%	48	98.0%		
	None	252	100%	49	100%		

Addiction	None	240	95.2%	43	87.8%	0.043	X ²
	Cigarettes	11	4.4%	6	12.2%		
	Alcohol	1	0.4%	0	0.0%		
Planned Pregnancy	Yes	206	81.7%	36	73.5%	0.182	X ²
	No	46	18.3%	13	26.5%		
Social Support Before and After Birth							
Spouse		194	77.0%	39	79.6%	0.673	X ²
Family		79	31.3%	14	28.6%	0.688	X ²
Friends		2	0.8%	0	0.0%	1.000	X ²
None		16	6.3%	3	6.1%		
Mode Of Delivery							
Normal Birth		89	35.3%	20	40.8%	0.744	X ²
Cesarean (General Anesthesia)		58	23.0%	11	22.4%		
Cesarean (Epidural Anesthesia)		105	41.7%	18	36.7%		
Gestational Week	37-38	17	6.7%	1	2.0%	0.161	X ²
	38-39	179	71.0%	41	83.7%		
	≥ 40	56	22.2%	7	14.3%		
Birth Weight							
2500-3000		54	21.4%	10	20.4%	0.873	X ²
3000-4000		189	75.0%	38	77.6%		
≥ 4000		9	3.6%	1	2.0%		
Sex	Female	107	42.5%	27	55.1%	0.103	X ²
	Male	145	57.5%	22	44.9%		

Table 5. Relationship between breastfeeding factors and persistence in breast milk at 6 months

		Does Breastfeeding Continue at the Sixth Month?				p
		Yes		No		
		Mean.±ss/n-%	Mean.±ss/n-%	Mean.±ss/n-%	Mean.±ss/n-%	
Occupation	House wife	139	55.2%	28	57.1%	0.798 ^{x²}
	Civil servant	8	3.2%	0	0.0%	
	Other	105	41.7%	21	42.9%	
Have you worked before?	Yes	115	45.6%	21	42.9%	0.721 ^{x²}
	No	137	54.4%	28	57.1%	
Time to Start Work After Birth		2.7 ± 3.2		2.6 ± 3.0		0.980 ^m
Did You Use Postpartum Breastfeeding Leave?	Yes	4	3.5%	1	4.8%	0.574 ^{x²}
	No	111	96.5%	20	95.2%	
Starting a Work After Birth	Yes	57	50.9%	10	52.6%	0.870 ^{x²}
	No	58	51.8%	11	57.9%	
Was your working environment conducive to milking?	Yes	55	94.8%	6	54.5%	0.002 ^{x²}
	No	3	5.2%	5	45.5%	
Help other than father during breastfeeding?	Yes	77	30.6%	22	44.9%	0.051 ^{x²}
	No	175	69.4%	27	55.1%	
Did you smoke while breastfeeding?	Yes	30	11.9%	12	24.5%	0.020 ^{x²}
	No	222	88.1%	37	75.5%	
The Baby's Hospitalization History	Yes	3	1.2%	5	10.2%	0.004 ^{x²}
	No	249	98.8%	44	89.8%	
Do You Sleep In The Same Room With The Baby?	Yes	242	96.0%	45	91.8%	0.202 ^{x²}
	No	10	4.0%	4	8.2%	
Has Your Baby Used a Pacifier?	Yes	115	45.6%	40	81.6%	0.00 ^{x²}
	No	137	54.4%	9	18.4%	
Did you use a bottle while feeding the baby?	Yes	90	35.7%	47	95.9%	0.00 ^{x²}
	No	162	64.3%	2	4.1%	
Does Your Baby Continue To Take Formula?	Yes	59	23.4%	49	100.0%	0.00 ^{x²}
	No	193	76.6%	0	0.0%	
Stop Breastfeeding in the First 6 Months	Yes	23	9.1%	7	14.3%	0.270 ^{x²}
	No	229	90.9%	42	85.7%	

Discussion

In our study, no significant relationship was found between both the self-efficacy score and the LATCH score and continuing to breastfeed at the sixth months. Positive correlation between breastfeeding at six months and maternal age, being a nuclear family, exclusive breastfeeding for the first 48 hours, and the environment in which the mother is relaxed for pumping was detected. There was a negative correlation between use of pacifier or bottle during the first 48 hours and during breastfeeding, smoking and hospitalization history of the baby.

A study conducted by Ince et al. that evaluated breastfeeding self-efficacy and breastfeeding success of mothers, showed a positive correlation between LATCH scale mean scores and breastfeeding self-efficacy mean scores (2). Similarly, in our study, a significant relationship was found between the LATCH score and the self-efficacy score.

Sowjanya et al. found a significant relationship between the LATCH score and exclusive breastfeeding at the sixth week (3). Though, in our study, no significant relationship was found between LATCH score and exclusive breastfeeding in the first six weeks, second month, fourth month and sixth month.

As reported in one of the largest studies conducted in Spain, mothers with low self-efficacy had significantly

fewer days of exclusive breastfeeding for six months (4). In our study, a significant relationship was found between the rate of exclusive breastfeeding at the sixth week and the second month and the self-efficacy score but there was no correlation in other months.

Maternal age has been shown as a condition affecting the continuation of breastfeeding in many studies (5,6) Also, in our study, the age of the mother was found to be significantly higher in the group continuing nursing at the sixth month.

It has been reported in the literature that the probability of breastfeeding is higher in those living in a nuclear family than in those living in an extended family. It has been reported that living in an extended family has a role in acquiring established false information and the perception of insufficient milk, which causes reluctance and insecurity in breastfeeding (7). In our study, the rate of being a nuclear family was significantly higher in the group that continued breastfeeding at the sixth month than in the group that did not continue to breastfeed at the sixth month.

Ince et al. found the breastfeeding success of mothers with previous breastfeeding experience to be high and stated that having a breastfeeding experience once would be sufficient to increase breastfeeding success (2). In our study, breastfeeding experience and the longest breastfeeding duration were found to be significantly higher in the group whose breastmilk continued at the sixth month compared to the group whose breastmilk was not continued at the sixth month.

In a study of Caroline et al., the probability of not fully breastfeeding between the 30th and 60th days was found to be significantly higher when formula supplementation was provided in the hospital with a bottle compared to when it was provided with alternative feeding methods alone (8). In our study, the rate of using a pacifier or bottle for the first 48 hours was found to be significantly lower in the group whose breastmilk continued at the sixth month compared to the group who did not continue to breastfeed at the sixth month.

Howard et al emphasized that the use of pacifiers and bottles negatively affects breast milk intake and that these should be avoided in infants who breastfed (9). In our study, the rate of infant pacifier use was found to be significantly lower in the group whose breastmilk continued at the sixth month compared to the group whose breastmilk was not continued at the sixth month. The rate of using bottle while feeding the baby was significantly lower in the group whose breastmilk was continued at the 6th month compared to the group that did not continue to breastfeed at the 6th month.

There is a need for large-scale studies on the relationship between the self-efficacy scale and the LATCH score at 6 months on breastfeeding. Informing mothers about the negative effects of pacifier and bottle use will positively affect the continuity of breastfeeding.

Keywords: Breastfeeding , breastmilk , LATCH score, self-efficacy

References

- 1.Zielinska MA, Hamulka J. Reasons for non-exclusive breast-feeding in the first 6 months. *Pediatrics International* 2018;60(3):276-281. doi:10.1111/PED.13480
- 2.Ince T, Aktas G, Aktepe N et al. Evaluation of the factors affecting mothers' breastfeeding self-efficacy and breastfeeding success. *The journal of Dr. Behcet Uz Children's Hospital* 2017;7(3):183-190. doi:10.5222/buchd.2017.183
- 3.Sowjanya SVNS, Venugopalan L. LATCH score as a predictor of exclusive breastfeeding at 6 weeks postpartum: A prospective cohort study. *Breastfeeding Medicine*. 2018;13(6):444-449. doi:10.1089/bfm.2017.0142



4. Santacruz-Salas E, Segura-Fragoso A, Pozuelo-Carrascosa DP, et al. Maintenance of Maternal Breastfeeding up to 6 Months: Predictive Models. *J Pers Med.* 2021;11(5). doi:10.3390/JPM11050396
5. Health Canada, Canadian Paediatric Society, Dietitians of Canada. Nutrition for healthy term infants: recommendations from birth to six months. *Can J Diet Pract Res.* 2012;73(4):204. doi:10.3148/73.4.2012.204
6. Santacruz-Salas E, Aranda-Reneo I, Segura-Fragoso A, et al. Mothers' Expectations and Factors Influencing Exclusive Breastfeeding during the First 6 Months. *Int J Environ Res Public Health.* 2020;17(1). doi:10.3390/IJERPH17010077
7. Ozturk, R. The Effects of Education Concerning Breast Milk and Breastfeeding During Antenatal Period on Breastfeeding Success and Breastfeeding Self-Efficacy. Balikesir University Institute of Health Sciences Nursing Department Master Thesis 2018.
8. Chantry CJ, Dewey KG, Peerson JM, et al. In-hospital formula use increases early breastfeeding cessation among first-time mothers intending to exclusively breastfeed. *J Pediatr.* 2014;164(6). doi:10.1016/J.JPE-DS.2013.12.035
9. Howard CR, Howard FM, Lanphear B, et al. Randomized clinical trial of pacifier use and bottle-feeding or cupfeeding and their effect on breastfeeding. *Pediatrics.* 2003 Mar;111(3):511-8. doi: 10.1542/peds.111.3.511.

SS029**Monthly Kitchen Cost According to Different Markets For Optimal Nutrition of a Family**Selda Fatma Bülbül¹, Ebru Öztürk¹, Merve Salça¹, Zümra Bıçakçı¹¹Kırıkkale University, Faculty of Medicine, Kırıkkale

Objectives: Nutrition forms the basis of health at every stage of life. Price increases in food products have led individuals to seek the cheapest food products. In our study, we aimed to show the difference in monthly kitchen cost for the optimal nutrition of a family, between the credit cooperatives and market chains.

Methods: This study was carried out in Ankara and Malatya in February - March 2021. A family structure of 5 people was created (0-4 years old boy, 15-18 years old male, 40-49 years old adult male, 40-49 years old adult female, +70 years old female). According to the Turkey Nutrition and Health Survey (2019), the recommended nutrients and amounts for optimal nutrition of this family were calculated on weekly basis. Food prices were taken from the sales areas of three chain markets, described as cheap and relatively easy to reach, and state cooperatives/marketplace/butcher. The cheapest products were selected and the average price of a product sold in 3 markets was calculated. The monthly kitchen expenses of the family was defined by considering the optimal nutrition of the each family member.

Results: The comparison of the prices of some food products indispensable for children and elderly such as; the weekly average cost of milk and dairy products in the State Cooperative/neighborhood market was 83,075 tl, and 69.46 tl in chain markets. The weekly meat/fish cost is calculated as 165.79 tl in chain markets, and the average price for butchers and fishermen is calculated as 167 tl. No significant difference was found for egg prices. Whole grain bread was chosen for bread, which is the main carbohydrate source, and chain markets were found to be more affordable. In total, the weekly cost of milk-dairy products group, meat-chicken-fish and oilseeds group, bread-cereal group, fruit and vegetable group, oil group, which is needed by the whole family, was determined as 1.063.77 tl in state cooperatives and district markets. The cost was determined as 1.114.60 tl in chain markets. When calculated as a monthly expense, it was determined that there is 203.3 tl more kitchen cost when shopping from chain markets compared to shopping from the State Cooperative/neighborhood market and fishermen.

Conclusion: In the selected family, both the mother and father received minimum wage and grandmother a pension. The minimum wage was 4250.40 tl and the minimum pension was 2500 TL, the net income of the household was 11,000.40 tl. Assuming that this family shops from state cooperative/neighborhood markets and chain markets the share of total expence on food was 38.62%, and 40.52% respectively. There was no big difference between two shopping areas in terms of cost and percentage. However, this amount accounts the 77.3% of a minimum wage. When comparing the prices of food groups separately, it was seen that it would be more appropriate to prefer local markets/butchers, especially for the vegetable-fruit group and the meat-chicken-fish group.

Keywords: kitchen expences, healthy feeding, optimal feeding



SS030

The Relationship Between Obesity Complications and Serum Selenium and Zinc Levels of Obese Children

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Introduction

Obesity is an important and common global public health problem (1). Trace elements are involved in the structure of many cofactors and coenzymes and have important regulatory roles in the body. In addition, trace elements are involved in the production and protection against inflammation and peroxidation, which are key factors in the development of obesity, hypertension, dyslipidemia, and insulin resistance or metabolic complications of diabetes (2). Studies showing the relationship between trace elements such as zinc and selenium and obesity and obesity complications have been published recently (3,4). Studies in children on this subject are only a few (2). The aim of our study is to evaluate the relationship between serum selenium and zinc levels and obesity and its complications.

Materials and methods

In this prospective cross-sectional study, between June and December 2021, 45 obese patients aged 6-13 years with a body mass index (BMI) of the 95th percentile and above, who referred to the Health Sciences University Bağcılar Training and Research Hospital Child Health and Diseases Outpatient Clinic, were studied. Forty three, similar aged children with BMI in the normal percentile range and no complaints and who applied to the pediatric outpatient clinic for routine follow-up were selected as the control group. Syndromic children with obesity, those with endocrine disorders, those with a history of chronic drug use, those who uses any vitamin and/or mineral supplements, those who had a history of any chronic disease and/or those who has chronic drug use or those who followed a special diet were not included in the study. After obtaining written consent from the children and their families, the children's medical histories were taken and age, gender, height and weight were measured. After fasting for 10-12 hours, fasting glucose, insulin, total cholesterol, high density lipoprotein (HDL), low density lipoprotein (LDL) and triglycerides (TG) were obtained from all subjects at 08.30-09.30 in the morning. At the same time, blood samples were taken to study selenium and zinc levels. Serum was separated by centrifugation at 4000 rpm and stored at -80 degrees Celsius until studied. "Inductively coupled plasma mass spectrometry" method was used for serum selenium level measurement. Serum zinc level was measured using the colorimetric method. Obese and control groups were compared in terms of gender, age, weight, BMI and BMI percentile, as well as systolic blood pressure (SBP), diastolic blood pressure (DBP), fasting blood glucose, insulin, homeostasis model assessment of insulin resistance (HOMA-IR), total cholesterol, LDL, TG and HDL, serum selenium and zinc values. Approval for the study was obtained from the Istanbul Medipol University Non-Interventional Clinical Research Ethics Committee with the decision letter dated 05/08/2021 and numbered 812.

Results

The study was conducted with a total of 88 children. There was no statistically significant difference between the age and gender of the obese and control groups ($p>0.05$). Weight, BMI, BMI percentile, systolic blood pres-

sure and diastolic blood pressure values of the obese were significantly higher than the control group ($p=0.001$, $p=0.001$, $p=0.001$, $p=0.001$, $p=0.007$). While insulin, HOMA-IR, TG, and LDL values of obese subjects were found to be significantly higher than control subjects ($p=0.001$, $p=0.001$, $p=0.001$, $p=0.042$, respectively), HDL values were found to be significantly lower ($p=0.001$) (Table 1). In the obese group, 57.8% had hypertension, 55.6% had insulin resistance, %57.8% had dyslipidemia. There was no statistically significant difference between serum selenium and zinc levels in the obese group compared to the control group ($p>0.05$) (Table 2). When the obese and control groups were evaluated together, it was observed that 67% of all cases had selenium deficiency, 26% of all cases had zinc deficiency. There was no significant difference between the obese and control groups in terms of selenium and zinc deficiency ($p>0.05$). There was no significant difference between serum selenium and zinc levels and fasting blood glucose, insulin, HOMA-IR, total cholesterol, LDL, TG, HDL, SBP and DBP in both groups ($p>0.05$).

Discussion

Serum selenium levels in children were found to be low in both the obese and control groups, but there was no significant relationship between them in this study. Moreover, it was found that serum selenium and zinc levels were not associated with obesity complications. In a study conducted by Azab et al., serum selenium levels were found to be lower in the obese group than in the healthy control group (2). Taşçılar et al. found no significant relationship between obesity and serum selenium levels of 34 obese and 34 healthy control children (5). In our study, mean serum selenium levels were found to be low in both groups, but no correlation was found between serum selenium levels and obesity. We think that the detection of low selenium levels in both groups may be related to the low socioeconomic level and the dietary habits of our region. In a study conducted by Malik et al., involving 69 overweight/obese and 104 non-obese children, serum zinc levels were found to be significantly lower in the overweight/obese group (6). Weisstaub et al. found no relationship between between obesity and serum zinc levels in pre-school obese children (7). Also, in our study, no significant difference was found between obesity and serum zinc levels. The zinc levels may differ according to the sample type used (hair, nail, serum, plasma) or to the preferred method. For this reason, determination of zinc levels with a larger sample number and with several different methods may provide more accurate results. The most important limitation of our study is that it was single-centered, cross sectional study conducted with a small number of cases. In addition, another limitation is the lack of detailed history regarding the eating habits of the obese and control groups.

In conclusion, no relationship was found between serum selenium and zinc levels and obesity and its complications such as insulin resistance, dyslipidemia and hypertension in our study. In order to show the relationship between childhood obesity and obesity complications and serum selenium and zinc levels, it would be useful to conduct longer-term, multicenter studies involving more cases. Selenium deficiency was observed in most of both groups in our study. For this reason, we think that larger studies should be conducted to evaluate selenium deficiency for all children. In addition, the prevalence of insulin resistance, dyslipidemia and hypertension was found to be high in obese children in our study. We believe that obese children should be evaluated and followed up from the moment they are diagnosed in terms of obesity complications.

Table 1: Comparison of the obese and control groups in terms of laboratory values

	Group	n	Mean	SD	Median	p*
Triglycerides (mg/dl)	Control	43	74.51	31.90	76.00	0.001
	Obese	45	129.67	75.62	121.00	
Total cholesterol (mg/dl)	Control	43	153.86	25.28	154.00	0.078
	Obese	45	169.04	33.36	158.00	

HDL (mg/dl)	Control	43	59.63	14.45	58.00	0.001
	Obese	45	49.07	11.17	49.00	
LDL (mg/dl)	Control	43	79.56	24.37	75.00	0.042
	Obese	45	94.38	30.95	89.00	
Fasting blood glucose (mg/dl)	Control	43	93.30	9.64	92.00	0,296
	Obese	45	94.78	7.97	95.00	
Insulin (µIU/ml)	Control	43	8.23	4.29	6.60	0.001
	Obese	45	21.30	28.43	12.90	
HOMA-IR	Control	43	1.93	1.13	1.77	0.001
	Obese	45	5.15	7.32	2.92	

*Mann-Whitney U test

HDL: High density lipoprotein; LDL: Low density lipoprotein; HOMA-IR: Homeostasis model assessment of insulin resistance

Table 2: Comparison of serum selenium and zinc levels of both groups

	Group	n	Mean	SD	Median	p*
Selenium (µg/L)	Control	43	50.54	14.84	50.30	0.655
	Obese	45	51.44	11.96	50.65	
Zinc (µg/dl)	Control	43	90.34	38.27	84.20	0.512
	Obese	45	95.60	42.84	90.00	

*Mann-Whitney U test

References

- Gahagan S. Overweight and obesity. In: Kliegman RM, Blum NJ, Shah SS, Tasker Rc, Wilson KM (eds). Nelson Textbook of pediatrics. 21st ed. Philadelphia, Elsevier; 2020;345-58.
- Azab SF, Saleh SH, Elsaed WF, Elshafie MA, Sherief LM, Esh AM. [Serum trace elements in obese Egyptian children: a case-control study](#). Ital J Pediatr. 2014; 40:20.
- Tinkov AA, Skalnaya MG, Ajsuvakova OP, et al. [Selenium, Zinc, Chromium, and Vanadium Levels in Serum, Hair, and Urine Samples of Obese Adults Assessed by Inductively Coupled Plasma Mass Spectrometry](#). Biol Trace Elem Res. 2021; 199:490-9.
- Tinkov AA, Bogdański P, Skrypnik D, et al. [Trace Element and Mineral Levels in Serum, Hair, and Urine of Obese Women in Relation to Body Composition, Blood Pressure, Lipid Profile, and Insulin Resistance](#). Biomolecules. 2021; 11:689.
- Tascilar ME, Ozgen IT, Abaci A, Serdar M, Aykut O. [Trace elements in obese Turkish children](#). Biol Trace Elem Res. 2011; 143:188-95.



6. Vivek SM, Dayal D, Khaiwal R, et al. [Low serum copper and zinc concentrations in North Indian children with overweight and obesity](#). *Pediatr Endocrinol Diabetes Metab.* 2020; 26:79-83.
7. Weisstaub G, Hertrampf E, López de Romaña D, Salazar G, Buguño C, Castillo-Duran C. [Plasma zinc concentration, body composition and physical activity in obese preschool children](#). *Biol Trace Elem Res.* 2007;118:167-74.



SS031

Do We Know How to Protect Our Children from Home Accidents?

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Introduction

The World Health Organization defines an accident as 'an unexpected event that occurs suddenly against the human will and causes physical and mental damage' and classifies accidents according to the place and manner in which they occur. Traffic, industrial, work, sports, school, and home accidents are included in these groups (1,2).

Home accidents are accidents that occur in the house, garden, and surroundings. Falling, drowning, poisoning, and burns are considered unintentional home accidents (3). In addition to children, the elderly and the mentally or physically disabled are in the risk group for in-home accidents (3). The frequency of home accidents is not known exactly due to a lack of referrals. In a study conducted in the USA based on hospital admissions, it was found that two-thirds of childhood accidents and 91% of accidents in children aged five years and younger occurred at home (4). It has been reported that the percentage of home accidents increased compared to other accidents due to the increase in the time spent at home during the COVID-19 pandemic (5). In studies conducted on the records in our country, it has been shown that home accidents constitute 18-25% of all accidents and the frequency of children having home accidents is between 19-30% (6). The most common home accidents resulting in injury in children under five years of age are falls, burns, and poisoning (3).

The fact that home accidents are common and mostly preventable increases the importance of the caregiver's knowledge about home accidents. Children are not sufficiently aware of the dangers and are vulnerable to the risks of home accidents because of their curiosity to learn (4,7). According to the 2001 records of the State Institute of Statistics in our country, accidents are the fourth leading cause of death in children aged 1-4 years (7).

The age of the child, the age of the mother, the education level of the mother and father, and the number of people living at home are factors affecting the frequency and types of home accidents. In some studies, no significant difference was observed between the presence of chronic disease in the child, the educational status of the parents, the employment status of the mother, the presence of a person who needs special care due to chronic disease or old age, the average number of people living in the house, and the type of house lived in and the frequency of home accidents (1,7). In the assessment of knowledge about home accidents, scale scores have been shown to be associated with maternal age, the number of children, and child age (7).

In this study, it was aimed to evaluate the level of knowledge and related factors in the parents of children aged 0-6 years, who were considered to be in the high-risk group in terms of home accidents, by using the Scale for Identification of Maternal Safety Measures for Home Accidents.

Method

In this cross-sectional study, mothers of children aged 0-6 years who came to the pediatrics outpatient clinic for examination between March and April 2022, regardless of the presenting symptom, were included. After obtaining verbal and written informed consent from the volunteer parents, the questionnaire and scale form were completed. Mothers who did not give consent and mothers with missing data in the questionnaire or scale form were excluded from the study. The study was started after obtaining permission from the local ethics committee (15.02.2022/02-31).

In the questionnaire form, the mother's age, education level, employment status, number of individuals in the household, number of children, age of the child brought to the examination, and presence of chronic diseases in the child was recorded. In order to evaluate the mothers' knowledge about home accidents, the Scale for Diagnosing the Mother's Safety Precautions for Home Accidents in Children Aged 0-6 Years was applied.

The 'Scale for Recognizing Mothers' Safety Precautions for Home Accidents in 0-6-Year-Old Children' used in the study was developed by Çınar and Görak. The scale is a five-point Likert-type scale consisting of 40 items including 34 positives and six negative statements (questions 6, 9, 23, 26, 30, 40). Each item is scored from 1 to 5, with a maximum score of 200. The highest score indicates that the mother takes precautions to protect her child from home accidents at the highest level.

In our study, this scale was used to evaluate mothers' knowledge about the safety precautions they take to protect their children from the most common home accidents in the home environment and the relationship between mothers' approaches and factors such as maternal age, educational level, number of children, and age of the child.

Statistical analysis was performed in SPSS Software 22.0. Firstly, normal distribution was evaluated using Kruskal Wallis-H Test. Variables were expressed as percentages, chi-square test and Fisher analysis were used to compare group proportions. In the comparison of group averages, the Student-t test or Mann-Whitney U-test was used after normal distribution evaluation. As a result of data analysis, $p < 0.05$ was accepted as significant.

Results

A total of 170 mothers with children under 6 years of age who applied to the pediatrics outpatient clinic of our hospital agreed to complete the questionnaire. However, 7 questionnaires were excluded from the study due to incomplete maternal responses, and 163 questionnaires were included in the study. The mean age of the mothers was 29.4 ± 6.3 years. It was observed that 24.5% of the mothers were employed and they were predominantly primary-secondary education graduates (63.2%). It was observed that 76.1% of the mothers had one or two children and 26% of them had at least one chronic disease. The most common chronic disease was asthma (20.9%). When the caregiver was questioned, it was seen that the mother (87.7%) was most frequently responsible for the care of the child (Table 1).

The total scale score of the Scale for Diagnosing Safety Precautions of Mothers Towards Home Accidents in Children Aged 0-6 Years was 61.7 ± 16.0 . It was observed that the scale score was not associated with the mother's employment status, the mother's educational status, and the presence of chronic disease in the child. It was observed that the scores of mothers aged ≥ 30 years and those with ≥ 3 children were higher, but not at a significant level (Table 2).

Discussion

It was observed that the majority of mothers were not working and had a primary/intermediate level of education, three-quarters had one or two children, and one-quarter of the children had chronic diseases. The caregiver was mostly the mother. It was observed that the scores of mothers aged ≥ 30 years and those with ≥ 3 children were higher, but not at a significant level.

In the study, mothers scored 61.7 ± 16.0 points on a scale with a maximum score of 200 points. In the literature studies conducted in our country, the mean scores obtained by the parents varied, but the lowest and highest scores ranged between 62 and 169 points (1,7,8). These results show that the mothers who participated in our study have inadequate knowledge levels in preventing home accidents regardless of the factors.

In our study, the questionnaire was completed by mothers and the majority of caregivers were mothers. However, the majority of these mothers were unemployed and had primary and secondary education. In the studies with



high score values in the literature, when the education level and employment status of the mothers were examined, the employment status was found to be similar, and the education level was grouped as primary school and before and secondary school and before in these studies and the numbers were found to be similar (6,7). The fact that the educational status was lower in our study once again showed the importance of maternal education to reduce home accidents in children. The American Academy of Pediatrics also recommends that families should be counseled for the prevention of injuries in routine health services, especially in the first 6 months of life (9). In the study by Çapık C et al, the scale scores of the participants before and after the training were evaluated and a significant increase was observed in the scale scores (10). This shows that home accidents can be prevented with the necessary training and equipment.

In the study, it was observed that the mother's employment status, the mother's educational status, and the presence of chronic disease in the child were not associated with the scale score. Similarly, no significant difference was found between the age of the mothers, the presence of chronic diseases in the child, the educational status of the mother and father, and the working status of the mother and the scale scores (1-3,10). In a study conducted, it was observed that mothers learned about home accidents mostly from individuals who did not have sufficient knowledge about the subject such as neighbors and relatives, and physician information was ranked low as a source (10). Therefore, it was thought that the classical education process was inadequate in raising awareness on child development issues such as prevention of home accidents and that the necessary education for the protection and support of children should be initiated at home and special pieces of training should be given on these issues.

In the evaluation of the scale score in terms of maternal age and number of children, it was observed that the scores of mothers aged ≥ 30 years and those with ≥ 3 children were higher, but not at a significant level. In a study conducted, it was observed that the mean scores of mothers aged 30 years and younger were higher than those of mothers aged 30 years and older. However, it was found that children of younger mothers in these groups had more accident histories (8). These results suggest that advancing maternal age, having more children, and/or encountering more frequent home accidents increase experience and knowledge of home accidents.

Conclusion

In order to prevent home accidents, all family caregivers, especially mothers, should be trained by personnel with knowledge and authority on these issues during routine follow-ups of children and awareness should be raised in terms of necessary precautions.

The small number of mothers who participated in the survey in our study limited our study data. In addition, the fact that the patient population admitted to our hospital had a similar sociocultural structure caused limitations in evaluating the factors.

References

1. Roberts I, DiGuseppi C, Ward H. Childhood injuries: extent of the problem, epidemiological trends and costs. *Inj Prev* 1998;4:10-6.
2. Karatepe TU, Akin N. Frequency of Home Accidents in 0-6 Years Old Children and Associated Factors. *Journal of Uludag University Faculty of Medicine* 2013;39(3):165-8.
3. Bertan M, Çakır B. Accidents in terms of Public Health. *Public Health Essentials Book*. Ankara, Hacettepe Publications; 1997.
4. Ulukol B, Şimşek F, Usuteknik S, Gülnar S. The effectiveness of mother education in the protection of 0-6 age

- group children from home accidents, III. National Maternal and Child Health Congress Abstracts, 22-14 September 2005, İzmir, p:255.
5. Ferro V, Nacca R, Pisani M, et al. Children at risk of domestic accidents when are locked up at home: the other side of COVID19 outbreak lockdown. Italian Journal of Pediatrics 2022; 48, 129:2-8. <https://doi.org/10.1186/s13052-022-01318-2>
 6. Üçüncü M, Üçüncü M, Toprak D. The Knowledge, Attitude and Behavior of Mothers With Children Aged 0-6 Years on Home Accidents and Preventive Measures. J Ist Faculty Med 2019;82(4):219-28.
 7. Özmen D, Ergin D, Şen N, Çetinkaya A. Identification of Safety Precautions for Home Accidents of Mothers with 0-6 Age Group Children. Family and Society 2007;12:13-20.
 8. Erdem SS, Bolu F, Mayda AS. Definition of Safety Precautions for Mothers' Home Accidents. Konuralp Medical Journal 2017;9(2):117-123.
 9. Rumhi AA, Awisi HA, Buwaiqi MA, Rabaani SA. Home Accidents among Children: A Retrospective Study at a Tertiary Care Center in Oman. Oman Medical Journal 2020;35(1):85.
 10. Çapık C, Parlak Gürol A. The Effect of Education on Mothers' Ability to Diagnose Safety Measures for Home Accidents. Kafkas Journal of Medical Sciences 2014;4(3):87-94.

Tables

Table 1. Demographic data of mother and child

Number of children (n,%)	
≤2 children	124 (76,1)
≥3 children	39 (23,9)
Presence of chronic disease in the child (n,%)	26 (16,0)
Mother's educational status (n,%)	
Primary and secondary school graduate	103 (63,2)
High school-University graduate	60 (36,8)
Mother's employment status (n,%)	
Working	40 (24,5)
Not working	123 (75,5)
Caring parent (n,%)	
MoTHER	143 (87,7)
Father	34 (20,9)
Grandmother	22 (13,5)
Caregiver	2 (1,2)
Kindergarten	18 (11)
Mother's age (mean±SD)	29,4±6,3
Mother's age (n,%)	
<30 years	83 (50,9)
≥30 years	80 (49,1)
Number of people in the house (mean±SD)	3,9±1,2
Scale score* (mean±SD)	61,7±16,0

*: The Scale of Diagnosing the Safety Precautions for Home Accidents of Mothers in 0-6 Age Group Children

Table 2. Association with The Scale of Diagnosing the Safety Precautions for Home Accidents of Mothers in 0-6 Age Group Children with the mother's working status, mother's education level, number of children, and presence of chronic disease in the child

	Scale score* (mean±SD)	p
Presence of chronic disease in the child (n,%)		0,873
Yes	62,15±10,07	
No	61,60±16,96	
Mother's age (n,%)		0,138
<30 years	59,86±14,2	
≥30 years	63,60±17,6	
Mother's employment status (n,%)		0,138
Working	61,17±14,26	
Not working	61,86±16,62	
Mother's educational status (n,%)		0,690
Primary and secondary school graduate	62,07±16,88	
High school-University graduate	61,03±14,60	
Number of children (n,%)		0,086
≤2 children	60,09±13,12	
≥3 children	66,71±22,41	

*: The Scale of Diagnosing the Safety Precautions for Home Accidents of Mothers in 0-6 Age Group Children

SS032**Side Effects of Meningococcal Vaccines in Children**Ayse Esra Tapci¹, Bahar Cuhaci Cakir², Aysy Duyan Camurdan²¹Ankara Education and Research Hospital, Department of Pediatrics, Ankara²Gazi University Faculty of Medicine, Division of Social Pediatrics, Ankara

Objectives: Meningococcal infections have a rapid onset and can lead to serious sequelae and early death even in children who are treated early. Meningococcal infections are among the vaccine-preventable diseases, and the currently licensed and most commonly administered conjugated meningococcal vaccines are quadrivalent vaccines containing serotypes A, C, W, Y, and vaccines containing serotype B. There are two types of vaccines developed against the meningococcal B serotype. These; are Bexsero (MenB-4C) approved in Europe, Canada, Australia, and the USA, and Trumenba (MenB-FHbp) approved in the USA. Of these two meningococcal B vaccines, the Bexsero vaccine was licensed in our country in September 2018. Although the Bexsero (MenB-4C) containing serogroup B is licensed in our country, there is a hesitant attitude towards the vaccine among both families and physicians, especially due to the fear of high fever side effects. In this study, side effects of the MenB-4C vaccine were evaluated, in infants and children, in a pediatric follow-up clinic.

Methods: In our study, the frequency of local and systemic side effects of meningococcal B vaccines, which were administered at Gazi University Faculty of Medicine, Department of Social Pediatrics, Pediatric Follow-up Clinic between March 1, 2019, and March 1, 2022, were evaluated retrospectively. All infants and children aged 0-18 years (n=102) who were vaccinated in Pediatric Follow-up Clinic on the specified dates were included in the study. The patients were contacted by phone and informed about the study, and the parents/children who agreed to participate in the study filled out a questionnaire about the side effects of the vaccine by telephone.

Results: It was determined that a total of 224 doses of the Meningococcal B vaccine were administered to 102 children during the 3 years of the study, 21.6% of these vaccines were administered within the year before the pandemic, and 78.4% within the two years after the pandemic. According to the total number of doses, the rate of those with side effects was 31.7%. Side effects were observed in 41.3% of patients after the first dose of the meningococcal B vaccine, 23.3% after the second dose, and 25.9% after the third dose. Fever was most common in children aged two years and younger.

Conclusion: In our study, no serious reactions such as post-vaccine anaphylaxis and encephalopathy were observed, and it was determined that the most common side effects of the vaccine in our patients were fever and arm pain, and these side effects were short-lived and self-limiting within 2-3 days. Since the MenB-4C vaccine, which has been included in the vaccination guidelines of most countries, will lead to a significant improvement in the fight against meningococcal infections, it is recommended that physicians inform families about meningococcal vaccines and that conjugated meningococcal vaccines containing both ACWY and B serotype should be added to the national vaccine scheme.

Keywords: Meningococcal B, Childhood vaccination, MenB-4C



SS033

The Possible Effects on The Food Parenting Practices of Mothers on The Children Appetite

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Objectives: The first 1000 days of a child's life are paramount to the establishment of good health and good eating practices. Few studies have investigated the effect of maternal factors on child eating practices/appetite status. Our study aimed to explore effects on the maternal food parenting practices on the children appetite.

Methods: This study was performed with 702 healthy children aged 12-72 months those referring to the "General Pediatrics" and "Well-Child" outpatient clinics for routine health check visits, in Gaziantep University, Faculty of Medicine, Department of Pediatrics. The birth weight of the children, exclusively/total breastfeeding duration, and timing of complementary foods were questioned. The children's state of appetite was evaluated. Parental weight and height measurements were recorded. Parental loss of appetite during childhood was also questioned. Some maternal food parenting practices such as permissiveness, applying pressure was also questioned. The obtained data were evaluated in SPSS 22.00 package program and $P < 0.05$ values were considered statistically significant. The numeric values were given as mean \pm standard deviation or percentage (%). The chi-square test, and Student's T test were used for the statistical evaluation.

Results: The study was conducted on 702 healthy children (male/female 349/353) aged between 12-72 months (54.53 ± 18.43 months). The mean weight of the children was 17.66 ± 4.66 kg (8-37 kg). There was no relationship between exclusively/total breastfeeding duration, the timing of complementary foods, and appetite status of children ($p > 0.05$). When parental loss of appetite during childhood was evaluated, 19.0% (132/695) of the fathers and 25.8% (181/701) of the mothers had a loss of appetite during childhood. In children with parental loss of appetite during childhood, poor appetite was more frequent ($p < 0.001$). Poor appetite was more common in children who are fed by playing games ($p < 0.001$). Loss of appetite was more common in the children whose mothers were applying pressure during feeding ($p < 0.001$). Poor appetite was less common in children who were allowed to decide on the amount of food they would eat ($p = 0.002$). Loss of appetite was less common in children who were allowed to eat their own food ($p = 0.026$). The mother and child eating together had no effect on appetite ($p > 0.05$). In children with loss of appetite, weight/maternal age/ maternal weight were lower ($p < 0.05$).

Conclusion: The present study investigated the association of maternal behaviours on children eating practices. In the last years, parenting styles and specifically food parenting styles have been studied to a greater extent. Our study demonstrated that the presence of parental poor appetite during childhood, younger maternal age, allowing children to eat their own meals, allowing children to decide how much food to eat, and applying pressure during feeding are factors that affect children's appetite.

Keywords: Appetite, childhood, food parenting practices, maternal behaviour

SS034

The Role of Responsive Parenting Practices in The Timing of Initiating Complementary and Solid FoodsEvrin Senkal¹, Nilgün Çöl¹¹İstanbul Medeniyet University Faculty of Medicine, Department of Pediatrics, Istanbul

Objectives: Complementary feeding means that the breastfed baby receives new nutrients appropriate for age and developmental stages in order to meet the nutritional needs during the period when breast milk alone is not enough. It is very important to start complementary foods on time, as well as to ensure that the consistency of the foods is suitable for the developmental characteristics of the infant in order not to cause malnutrition in later years. Our aim is to evaluate whether mothers are progressing sensitively to their infants' developmental stages and feeding skills while initiating and maintaining complementary feeding.

Methods: This descriptive and cross-sectional study was performed with 325 healthy infants aged 3-24 months those referring to the "General Pediatrics" and "Well-Child" outpatient clinics for routine health check visits, in Gaziantep University, Faculty of Medicine, Department of Pediatrics. The mothers of these infants' were asked questions by means of a questionnaire and their demographic data, time to start complementary feeding, time to switch to lumpy and solid food and developmental stages of their babies were questioned. The obtained data were evaluated in SPSS 22.00 package program and $P < 0.05$ values were considered statistically significant. The numeric values were given as mean \pm standard deviation or percentage (%). The Pearson correlation analysis and Student's T test were used for the statistical evaluation.

Results: The study was conducted on 325 healthy infants (male/female 168/157) aged between 3-24 months (16.10 \pm 6.20 months) The age of starting complementary foods was 6.133 \pm 1.599 months (1.0-12.0) and the age of starting lumpy and solid foods was 8.148 \pm 1.835 months (4.0-18.0). There was a positive correlation between the age of starting complementary food and infant's holding head ($r=0.262$; $p < 0.001$), reaction to sounds ($r=0.229$; $p < 0.001$) and grasping the objects ($r=0.155$; $p=0.010$). There was a positive correlation between the age of starting lumpy and solid foods and infant's holding head ($r=0.141$; $p=0.020$), grasping the objects ($r=0.129$; $p=0.041$) and gripping the objects using thumb and fore finger ($r=0.177$; $p=0.017$). The age of starting complementary foods and lumpy and solid foods in infants born by cesarean delivery was earlier than those born by normal spontaneous delivery ($p < 0.05$). And also holding head and grasping the objects was earlier in infants born by cesarean delivery ($p < 0.005$).

Conclusion: Complementary feeding practices are important to ensure optimal growth in infants and are one of the main components that affect early childhood development. The present study investigated if the mothers started complementary feeding in correlation with their infants' developmental stages through responsive parenting practices. Our study demonstrated mothers' timing of starting solid foods for their babies and the age of transition to lumpy and solid foods were consistent with developmental age of the infants.

Keywords: Complementary feeding, infant, responsive parenting, solid food



SS035

Turkish Validity and Reliability Study of The Sharenting Evaluation Scale

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Objective: Parents frequently share about their children on social media. Romero-Rodríguez et al. (2022) developed “The Sharing Evaluation Scale”. The tool aimed to evaluate the degree of adults’ sharing about children on social media. We aimed to conduct the Turkish validity and reliability study of the “Sharing Evaluation Scale”.

Materials and Methods: The parents who approved to Baskent University Hospital Pediatric Clinic between October 2022 and November 2022 were included in the study. Participants who had ever shared about children on social media filled out an online questionnaire consisting of their sociodemographic characteristics, social media usage characteristics, “Internet Addiction Test” and “Sharing Evaluation Scale”.

Results: The present study was conducted on two hundred ninety-three parents. 90 of them (30.2%) who never shared child photos on social media were excluded, and the rest of the 203 (69.3%) who had shared related to the child on social media were included. The Root Mean Squared Error of Approximation (RMSEA = 0.037); the Standardized Root Mean-Square (SRMR = 0.057), Goodness-of-Fit Index (GFI = 0.994), Normalised Fit Index (NFI = 0.993), the Comparative Fit Index (CFI = 0.998). Reliability was calculated using Cronbach’s alpha coefficient (α), and the overall reliability of the scale was acceptable ($\alpha = 0.849$).

Conclusion: We found the 16-item “Sharing Evaluation Scale” to be a valid and reliable measurement tool in the Turkish parent population. “Sharenting” is a critical issue that needs to be carefully evaluated in the digital age.

Keywords: Children, Scale, Sharenting, Social Media.

INTRODUCTION

Social media platforms enable communication without the limitation of time and space. This opportunity come to the attention of mothers and they prefer these platforms. Parents can share about themselves and their children on social media (1-3). As result of parents’ sharing about their children created a new definition of “Sharenting”. Brosch (2016) defined the definition of “Sharenting” as sharing detailed information about children with photos, videos, and posts via social media that violates the privacy of children announced by parents to society” (4). Although there is an awareness of the risks posed by the sharing of children on social media in the world and in our country, many parents still share their children’s posts on these platforms. Sharing on social media belonging to the child brings many problems such as the violation of the child’s right to be forgotten, the violation of privacy of the child, and the vulnerability of the child in terms of abuse (3,5,6).

Romero-Rodríguez et al. (2022) developed a 17-item “Sharenting Evaluation Scale” to determine the adults’ shares of children on social media. With this scale, the sharing status of the child on social media by adults can

be evaluated. In our present study, we aimed to conduct the Turkish validity and reliability study of the “Sharing Evaluation Scale” (7).

METHOD

The parents who approved to Baskent University Hospital Pediatric Clinic between October 2022 and November 2022 were included in study. Participants who had ever share about children on social media filled out an online questionnaire consisting of their sociodemographic characteristics, social media usage characteristics, “Internet Addiction Test” and “Sharing Evaluation Scale”.

Inclusion criteria for the study:

- ✓ Having children between the ages of 0-13 (Because children over 13 years old can have a social media account)
- ✓ Having a social media account
- ✓ Filling out the online questionnaire
- ✓ Agreeing to be included in the research

Measures

Internet Addiction Test

Romero-Rodriguez et al. (2022) used the “Internet Addiction Test” as a confirmatory test of the “Sharenting Evaluation Scale”, in the present study, we also used the “Internet Addiction Test”. Young developed the “Internet Addiction Test” in 1998 to assess internet addiction in individuals (8). Balta and Balta and Horzum (2008) conducted the Turkish validity and reliability study (9). Internet Addiction Test is a 6-point Likert type. Responses to the test are never, rarely, sometimes, often, often, and always; Responses are scored with 0 = never, and 5 = always.

Sharing Evaluation Scale

Romero-Rodríguez et al. (2022) developed “The Sharing Evaluation Scale”. The tool aimed to evaluate the degree of adults’s sharing about children on social media (7). The scale was composed of 17 items configured in three factors: implications, social behaviour, and self-control. It is scored as 6-point Likert type (0 = never; 1 = rarely; 2 = sometimes; 3 = often; 4 = very often; 5 = always). 10-17 items are reverse coded. The minimum score is 0 and the maximum score is 85.

We planned to conduct the Turkish validity and reliability study of this scale. We got permission from Romero-Rodríguez, the corresponding author of the original study, via e-mail, in order to conduct a Turkish Validity and Reliability study of the scale.

The English “The Sharing Evaluation Scale” was translated into Turkish according to the World Health Organization guidelines through the following steps:

- 1) Forward translation into Turkish was conducted by 2 independent native Turkish speakers who spoke fluent English.
- 2) The reconciled version was designed by 2 independent Turkish pediatricians were fluent in English.
- 3) The final version was translated back into English by an independent bilingual translator whose mother tongue is English. The back-translated version was checked by an independent supervisor.
- 4) Cognitive debriefing, a pre-test face-to-face interview with parents representing the study population, was conducted on 30 parents for each age group. In this stage, no questions were misunderstood or misinterpreted by parents except a few ones.



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Data analysis

The sample size of the present study was determined as at least 170, taking into account the suggestion in the literature that the sample size should be 10 times the number of items in the evaluation of the psychometric properties of the scales (Alpar, 2020; Davergne, 2020). The pilot study was applied to 30 participants. First of all, item analyzes will be made with the pilot study data and the internal consistency coefficient will be calculated. According to the results obtained, the final version of the scale will be decided and the main work will be started. The calculation of the scale score used in the study will be based on the main studies in which the scale was developed. The compatibility of the scale scores with the normal distribution will be determined by the Kolmogorov-Smirnov normality test. Validity of scales; It will be evaluated with predictive validity and construct validity. For predictive validity; It will be evaluated whether there is a difference in the sub-dimension and total scores of the scales according to socio-demographic characteristics. Construct validity will be examined with Confirmatory factor analysis (CFA) and convergent validity. Split half and internal consistency methods will be used to test the reliability of the scales. Internal consistency will be evaluated with the Cronbach alpha reliability coefficient. The data obtained in the study will be analyzed in the IBM SPSS v25 and JASP program.

RESULTS

Two hundred ninety-three parents who agreed to participate in the study filled out the questionnaire, 90.8% of them were mothers (n=266), and 9.2% (n=27) were fathers. 90 (30.2%) who never shared child photos on social media did not fill out the "Sharenting Evaluation Scale. We included the rest of the 203 (69.3%) who had shared related to the child on social media in the present study. We found that parents (92.1%) most often share their children and most parents (77.2 %) post about their child on social media less than once a week (Table 1).

Construct validity

For the CFA, goodness-of-fit indices were collected that were appropriate for the model established in the validation of the instrument. Thus, the Root Mean Squared Error of Approximation (RMSEA = 0.037), indicated the anticipated fit with the total population value; the Standardized Root Mean-Square (SRMR = 0.057), indicated measures of model error size; Goodness-of-Fit Index (GFI = 0.994), indicated the absolute rates of best performance; Normalised Fit Index (NFI = 0.993), evaluated the decrease of the χ^2 statistic of the adopted model with respect to the base model; and the Comparative Fit Index (CFI = 0.998), indicated the percentage of covariance representativeness that could be reproduced by the model (Byrne, 2013).

Reliability analysis

Reliability was calculated using Cronbach's alpha coefficient (α), which is the most commonly used index for calculating the reliability of instruments (Ledesma et al., 2002). The overall reliability of the instrument was acceptable ($\alpha = 0.849$). On the other hand, for each of the dimensions the reliability was: implications ($\alpha = 0.914$); social behaviour ($\alpha = 0.427$); self-control ($\alpha = 0.651$). Only if item 10 were removed would the reliability increase to 0.601 in social behavior, so it was decided to decrease to 16 items of the scale due to their acceptable values in the content and construct validation (Table 2).

CONCLUSION

We found the 16-item "Sharing Evaluation Scale" to be a valid and reliable measurement tool in the Turkish parent population. "Sharenting" is a critical issue that needs to be carefully evaluated in the digital age. Turkish Sharenting Evaluation Scale is an easily applicable test to determine the degree of the parents' sharing related to their children on social media. We might have an opinion about the parent's sharenting status and give information to them about the dangers of the children's digital footprint.

REFERENCES

1. Blum-Ross A, Livingstone S. "Sharenting," parent blogging, and the boundaries of the digital self. *Popular communication* 2017; 15: 110-125.
2. Duygulu, S. Sosyal medyada çocuk fotoğrafları paylaşmanın mahremiyet ihlali ve çocuk istismarı açısından değerlendirilmesi. *TRT Akademi* 2019; 4: 428-487.
3. Günüş, S. Sharenting eyleminin psikolojik açıdan değerlendirilmesi: Türk ve İngiliz annelerinin karşılaştırılması. *Psikiyatride Güncel Yaklaşımlar* 2020; 12: 281-297.
4. Brosch, A. When the child is born into the Internet: Sharenting as a growing trend among parents on Facebook. 2016.
5. Akgül, A. Kişisel verilerin korunmasında yeni bir hak: "Unutulma hakkı" ve AB adalet divanı'nın" Google kararı. *Türkiye Barolar Birliği Dergisi* 2015; 116: 1-38.
6. Serin, H. Sosyal Medyada Çocuk Hakları İhlalleri: Ebeveynler ve Öğretmenler Farkında mı?. *Eskişehir Osmangazi Üniversitesi Sosyal Bilimler Dergisi* 2019; 20: 1005-1031.
7. Romero-Rodríguez JM, Kopecký K, García-González A, Gómez-García G. Sharing Images or Videos Of Minors Online: Validation Of The Sharenting Evaluation Scale (SES). *Children And Youth Services Review* 2022; 136: 106396.
8. Young KS. *Caught in the net: How to recognize the signs of internet addiction--and a winning strategy for recovery.* Canada, John Wiley & Sons, p 1998.
9. Balta OC, Horzum MB. İnternet Bağımlılığı Testi. *Journal of Educational Sciences & Practices* 2008; 7: 13.

Table 1. Parents' Sharenting Features

The Child Who Participants Most Frequently Shared on SM	n (%)
Own Children	187 (92,1)
Children Of My Relatives	14 (6,9)
My Friends' Children	1 (0,5)
Children Who Are Not Related	1 (0,5)
The Frequency of "Sharenting" on SM	n (%)
Less Than Once A Month	157 (77,2)
2-3 Times A Month	32 (15,7)
Once A Week	6 (2,8)
2-3 Times A Week	8 (3,8)
Every Day	1 (0,5)
Total	203 (100,0)

SM: social media.



Table 2. The Cronbach's alpha coefficient (α) values of the Turkish Sharenting Evaluation Scale

Sharenting Evaluation Scale	Cronbach alfa values (Original Scale)	Cronbach alfa values (After removing 10. item)
Total	0.849	0.862
Factor 1: Implications	0.914	0.914
Factor 2: Social Behaviour	0.427	0.601
Factor 3: Self-control	0.651	0.651

SS036

Denver Developmental Test Findings in Children with Gastrointestinal Tract or Abdominal Surgical Intervention

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Objectives: Surgery under general anesthesia in infancy may increase likelihood of developmental delay. We aimed to evaluate Denver Developmental Screening Test II results in children with a history of gastrointestinal (GI) tract or abdominal surgery.

Methods: In this descriptive study, medical records and initial Denver II findings of 20 children who were admitted to the developmental follow-up outpatient clinic at a university hospital between January 2015 and December 2019 were reviewed retrospectively. Children who had undergone gastrointestinal tract or abdominal surgery once were included and preterm except late preterm or postterm infants, multiple births, and infants with chromosomal anomalies and/or anomalies of the head or brain were excluded. The study was conducted in accordance with the Declaration of Helsinki. Number and percentage values are presented as descriptive statistics.

Results: Out of 20 children [17 males, 3 females, median (min-max) age 5.3 (2-36) months], 6 (30%) had surgery for oesophageal atresia, 3 (15%) had surgery for oesophageal atresia with tracheo-oesophageal fistula, 4 (20%) had surgery for diaphragmatic hernia, and 4 (20%) had surgery for Hirschsprung's disease in the neonatal period, and 3 (15%) had surgery for biliary atresia in the second month. Mean weight- and length for age, and weight for length z-scores were -1.5 ± 1.8 , -1.0 ± 1.6 , and -0.9 ± 1.8 , respectively. Only 1 (5%) child had a normal Denver II score while 8 (40%) had an abnormal score, 8 (40%) had a suspect score, and 3 (15%) had a score of untestable. The only child with a normal Denver II result had surgery for oesophageal atresia with tracheo-oesophageal fistula. Fourteen (70%) children had a normal Denver II score in the personal-social area, 14 (70%) children had a normal Denver II score in the fine motor area, 14 (70%) children had a normal Denver II score in the language area, and 2 (10%) children had a normal Denver II score in the gross motor area. Eleven (55%) children continued with developmental follow-up and overall, median number of developmental follow-up visits was 2 (1-9). Three (37.5%) children with a suspect score, 4 (50%) children with an abnormal score, and 2 (67%) children with a score of untestable did not continue developmental follow-up visits.

Conclusion: Surgery under general anesthesia in infancy was found to be associated with developmental delay, especially with mild delay in Japan. Inconsistently, developmental outcomes for children who undergo major surgery in early infancy were reported to be satisfactory in Australia. Our results indicate that infants who had GI tract or abdominal surgery may display developmental delay in all Denver II domains and the frequency of developmental delay may be high especially in gross motor area. The neurodevelopment with the growth should be further evaluated among the children who had GI tract or abdominal surgery in early infancy and awareness of the importance of developmental follow-up among parents should be raised.

Keywords: Denver II, gastrointestinal tract, abdominal, surgery

Denver II findings by diagnosis requiring surgery

	Oesophageal atresia with/without tracheo-oesophageal fistula (n=9,%)	Hirschsprung's disease (n=4,%)	Diaphragmatic hernia (n=4,%)	Biliary atresia (n=3,%)	Total (n=20,%)
Denver II					
Normal	1 (11)	0	0	0	1 (5)
Suspect	4 (45)	1 (25)	2 (50)	1 (33)	8 (40)
Abnormal	2 (22)	2 (50)	2 (50)	2 (67)	8 (40)
Untestable	2 (22)	1 (25)	0	0	3 (15)
Personal-social area					
Normal	6 (67)	2 (50)	3 (75)	3 (100)	14 (70)
Suspect	1 (11)	0	1 (25)	0	2 (10)
Abnormal	1 (11)	2 (50)	0	0	3 (15)
Untestable	1 (11)	0	0	0	1 (5)
Fine motor area					
Normal	6 (67)	2 (50)	3 (75)	3 (100)	14 (70)
Suspect	0	0	1 (25)	0	1 (5)
Abnormal	2 (22)	2 (50)	0	0	4 (20)
Untestable	1 (11)	0	0	0	1 (5)
Language area					
Normal	5 (56)	3 (75)	4 (100)	2 (67)	14 (70)
Suspect	0	0	0	0	0
Abnormal	3 (33)	1 (25)	0	1 (33)	5 (25)
Untestable	1 (11)	0	0	0	1 (5)
Gross motor area					
Normal	2 (22)	0	0	0	2 (10)
Suspect	3 (34)	1 (25)	3 (75)	1 (33)	8 (40)
Abnormal	2 (22)	2 (50)	1 (25)	2 (67)	7 (35)
Untestable	2 (22)	1 (25)	0	0	3 (15)

Developmental follow-up status by initial Denver II findings

	Normal (n,%)	Suspect (n,%)	Abnormal (n,%)	Untestable (n,%)	Total (n,%)
Developmental follow-up					
Yes	1 (100)	5 (62.5)	4 (50)	1 (33)	11 (55)
No	0	3 (37.5)	4 (50)	2 (67)	9 (45)

SS037**Evaluation of Sleep with “Brief Infant Sleep Questionnaire” in Children with Cerebral Palsy**

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Objectives: Children with cerebral palsy (CP) are five times more likely than typically developing children to have sleep problems, resulting in adverse outcomes for both children and their families. We aimed to evaluate the sleep problems and etiologies associated with poor sleep in patients with cerebral palsy.

Methods: The extended “Brief Infant Sleep Questionnaire” which was translated into Turkish and validated by Boran et al., was applied to the parents of patients with cerebral palsy. Etiological factors in patients defined as poor sleeper were examined.

Results: Of the 112 patients included, the median age was 22 (12-30) months, and 58 (51.8%) were female. The parents of 39.3% (n=44) considered their patients’ sleep to be a very serious problem. Median number of night awakenings were 2 (0-6). Median nocturnal wakefulness was 40 (5-180) minutes. The total sleep duration of the patients was between 340-840 (median 480) minutes. According to the poor sleeper criteria, 81.2% (n=91) patients were classified as poor sleepers. The presence of etiologies associated with sleep problems was significantly higher in poor sleepers ($p<0.001$), the most common being pain and epilepsy in 75 (82.4%) and 47 (51.6%) patients, respectively.

Conclusion: Sleep problems in patients with cerebral palsy should be carefully questioned by pediatricians because of their high frequency and associated clinical conditions.

Keywords: cerebral palsy, sleep, poor sleeper, epilepsy



SS038

Parent-Child Interaction: The Effects of The Pandemic Period

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Objectives: Positive parenting skills are important for the child's development. Studies show that the child's mental, social, language and adaptive development is affected by parental interaction. The sensitive, affective and instructive interaction of the parents in early childhood has been associated with the high school success of the child. Many factors can affect positive parenting skills. The pandemic period in the past 2 years has led to changes in the home conditions and family relationships. Especially mother-child interaction seems to be affected by this change. In this study, the effect of the pandemic on mothers' interaction skills was examined.

Methods: Children without health problems and parents who applied for routine developmental evaluation were included in the study. Fifteen healthy child-mother interactions between the ages of 2-5 were evaluated. Children's development was evaluated with Denver II. Mother-child interaction was scored with a 10-minute observation. The data of the study were collected with the PIKOLO parent-child interaction form. The PIKOLO parent child interaction observation tool is a simple, short and effective assessment method created to monitor positive parenting skills (Bayoglu, Innocenti 2013). The findings were analyzed with the SSPS program. General demographic information was collected for family information.

Results: The effect of gender and age was not found significant. The developmental test results of all children were found to be normal. The sub-dimension of PIKOLO was found the lowest.

Conclusion: The necessity of monitoring and supporting infancy and early childhood development is an indisputable fact. An important part of this follow-up is to support mother-child interaction. The positive interaction of the parent can directly determine the development of the child. For this reason, it is recommended to support parenting skills as well as the development of the child, especially in challenging conditions.

Keywords: Parent-child interaction, positive parenting

SS039

Universal Depression Screening in Middle Schools in Istanbul

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Objectives: Depression is among the most common psychiatric illness in adolescents however half of the adolescents' clinical depression cannot be diagnosed before reaching adulthood. American Academy of Pediatrics recommends annual depression screening in children 12 years of age and over at regular health maintenance visits. This cross-sectional study aimed to screen depressive symptom prevalence among middle school students in Istanbul, Turkey.

Methods: Data collection was conducted between April-June 2022. Fifteen city districts were randomly assigned to reflect differing student sizes. Based on a previous study conducted in Turkey on the prevalence of depression at 4% in children, the estimated sample size was 656, with a 95% confidence level and 1.5% precision level. Each school from these provinces was randomly selected and in recognition of the education policy to provide screening services to each student, all the students from grades 6 to 8 were approached. Six schools declined to participate and 6110 students in nine schools were approached. Depression was screened by the Center for Epidemiological Studies Depression Scale for children (CES-CD), which is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Scores of CES-CD above 15 points indicate the possible depression tendency. The Strengths and Difficulties Questionnaire (SDQ) was used for screening the behavioral pattern. Higher total difficulties scores derived from SDQ indicate higher behavioral problems. Resilience was evaluated by the 12-item Child and Youth Resilience Measure (CYRM), with higher scores meaning better resilience. To reduce nonresponse bias, missing data (item nonresponse) of CES-CD, were handled by linear interpolation. Permission for the study was obtained from the research committee of the Ministry of National Education on 14.10.2021 with registration number E-59090411-44-34712301.

This study was funded by Istanbul Medipol University Scientific Research Projects Commission.

Results: 2919 questionnaires were received back (response rate 47.7%) and 139 were excluded due to missing data (Figure 1). In total 2780 questionnaires were analyzed (52.7% female, mean age 12.3±1.1 years). The mean score from CES-CD was 24.1±12.7, the total difficulties score from SDQ was 14.4±6.1, and the resilience score was 45.4±8.4. Depressive symptoms were screened positive in 71.2% of the students. Increasing CES-CD scores were associated with increasing total difficulties scores ($r:0.66, p<0.01$) and decreasing resilience scores ($r:-0.53, p<0.01$). The mean CES-CD scores of female students (26.4±13.3) were significantly higher than male students (21.5±11.6) ($p<0.01$). Multiple regression was run to predict CES-CD from gender, mother/father educational years, total difficulties score, resilience score, and perceived academic achievement in the school. Female gender, higher total difficulties score, lower resilience score, and lower perceived academic achievement significantly predicted CES-CD (Table 1) [$F(6,2279)=421, p<0.01$].

Conclusions: Our findings indicate a higher tendency for the risk of depressive symptoms in early adolescence, and female students are at significantly greater risk. Increased awareness, early diagnosis, and resilience-based

interventions have the potential to improve mental health in adolescents.

Keywords: Depression, Screening, Resilience, Children

Figure1: Flowchart

Grade 6th-8th students

** Center of Epidemiological Studies Depression Scale for children

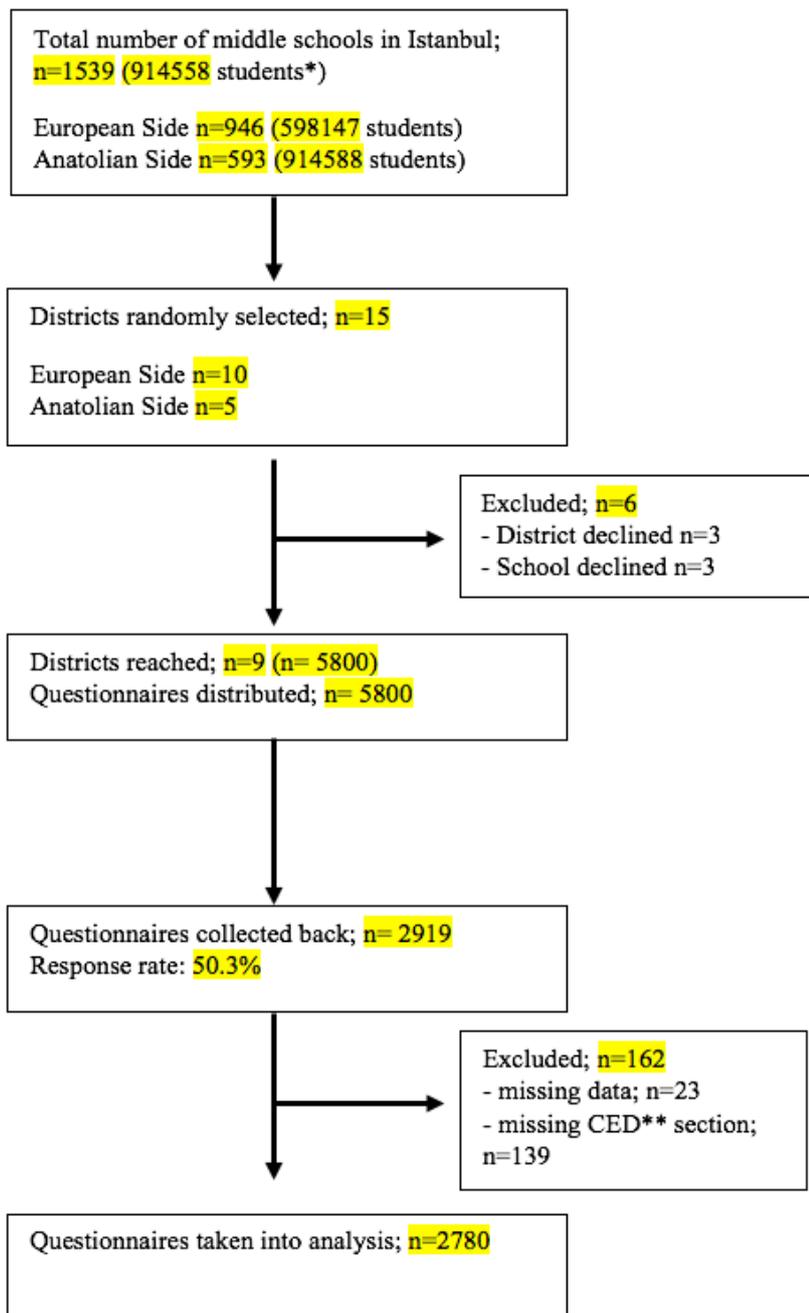
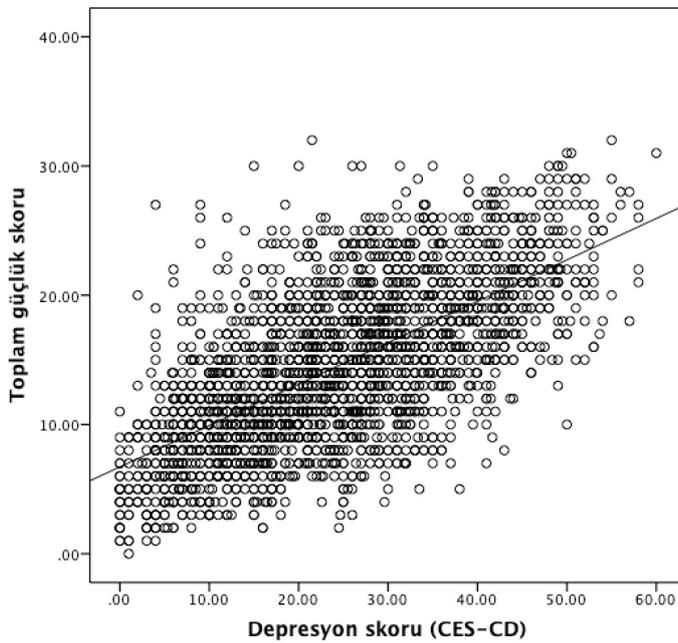


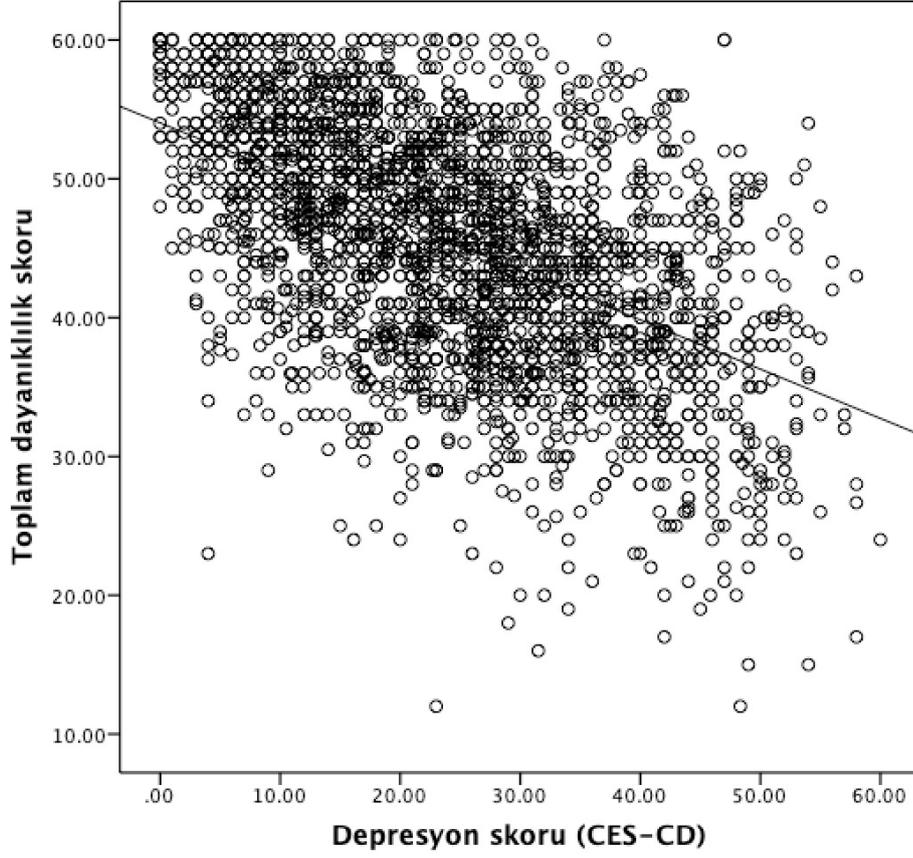
Table 1: Multiple regression model for CES-CD scores.

CED-CD scores	B	95% CI for B		SE B	β	R^2	ΔR^2
		LL	UL				
Model						0.526*	0.524*
Constant	34.693	31.169	38.217	1.797			
Female gender	-2.931*	-3.666	-2.197	0.375	-0.114		
Mother educational years	0.028	-0.075	0.132	0.053	0.009		
Father educational years	-0.002	-0.115	0.111	0.058	-0.001		
Total difficulties score	1.068*	1.000	1.137	0.035	0.511		
Resilience score	-0.423*	-0.472	-0.375	0.025	-0.284		
Perceived success	-0.678*	-1.149	-0.206	0.240	-0.043		

Note. Model = 'Enter' method in SPSS Statistics; B = unstandardized regression coefficient; CI = confidence interval; LL = lower limit; UL = upper limit; SE B = standard error of the coefficient; β = standardized coefficient; R^2 = coefficient of determination; ΔR^2 = adjusted R^2 ; SDQ = Strengths and Difficulties Questionnaire.

* $p < .0001$.





SS040

Recommendations of GPs on Protection, Promotion and Support of Breastfeeding

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Objectives: In this study, we aimed to learn the recommends and experiences of GPs about supporting and protecting breast milk and increasing breastfeeding rates.

Methods: In Turkey 26,476 family physicians was working at the time of study. Accordingly, the sample of the study was calculated as 379 with 95% confidence interval and 5% margin of error. With the stratified sample, the minimum survey number for each province was calculated according to the population of that province and the number of GPs and 564 GPs were be reached. The data were collected from October to December 2021 with an online survey. In this study, statistical analyzes were performed with NCSS (Number Cruncher Statistical System) 2007 Statistical Software (Utah, USA). Legal survey permissions were obtained from the Ministry of Health, Istanbul University, Istanbul Medical Faculty Covid-19 commission and Istanbul Medical Faculty Ethics Committee (dated 05/03/2021 and decision no: 06).

Results: The average age of the 564 physicians was 40.37 ± 8.63 , and 43.8% were male and 56.2% were female. They had been working in primary care for an average of 8.23 ± 4.88 years in the following percentages groups; 34.4% for 0-5 years; 30.5% for 6-10 and 35.11% for more than 11 years. The average of population of the GPs was 3249 ± 708.95 and the average of 0-60 months of population was 245 ± 181.37 . We asked to GPs "According to your observations "what is the breastfeeding rate in the first six months of babies" the average of their replies was $80.21 \pm 17.24\%$, and the average of answers given to the question of "what is the rate of breastfeeding with complementary feeding in first two years of babies' life " was $55.43 \pm 22.98\%$. 90.78% of GPs or family health workers had a "Breastfeeding counseling" certificate and 98.4% of Family Medicine Units have been certified as baby-friendly. To the question "What kind of counseling do you think should be given to protect, promote and support breast milk and improvements in breastfeeding rates?". the most chosen repied was " Mothers should be educated and monitored by GPs and their teams". Second popular answer was "Support should be provided on the online platform that breastfeeding mothers can access" and 46 people gave open ended response with "Other" signs.

Conclusion: The study results show that GPs voluntary to help mother to support and promote of breastfeeding and also, they have experiences and ideas how should support breastfeeding and protect breast milk. Strengthening primary health care with a multidisciplinary approach is essential to enhancing the visibility of children in health data and to improving the quality of service. The protection, promotion and support of breastfeeding must become a global health priority.

Keywords: protection, promotion and support of breastfeeding, recommendations of GPs

What kind of counseling do you think should be given to protect, promote and support breast milk and improvements in breastfeeding rates?" Other Responses

<p>Breastfeeding education should be given in obstetrics visits starting from pregnancy.</p> <p>"Pregnant schools" should be opened, organized, and expanded, participation of obstetricians should be compulsory.</p>	<p>Education should be given at birth, even starting from the delivery room.</p> <p>Breastfeeding training should be given by the delivery team.</p>	<p>The mothers come from the hospital where they gave birth with breast rejection and formula.</p> <p>Formula suggestions are made in some private centers, it should be followed and the hospitals should be inspected.</p>	<p>There should be mother and breastfeeding schools.</p> <p>New mothers should be collectively given public health education.</p> <p>New mothers should be reached and training should be provided by the provincial health directorates.</p>
<p>Pediatricians start formula early to babies (1 recommendation), in this case, families listen their babies instead of ear.</p> <p>Mothers should be encouraged and supported about breastfeeding by pediatricians.</p>	<p>Formula should not be recommended and distributed free to families (1 recommendation).</p> <p>Non-prescription formula should not be sold.</p> <p>Hospitals should not offer formula to mothers.</p>	<p>Mothers and family members should be educated about breastfeeding from social media, Public spots should be prepared.</p> <p>National media channels should be used on television.</p> <p>Something should be done to encourage breastfeeding in shopping places.</p>	<ul style="list-style-type: none"> The literacy of the people should be increased. Their socioeconomic status should be improved. Awareness of breastfeeding should be increased. Education should be given on this subject in schools and high school courses (1 recommendation).
<p>Self-confidence of women should be increased, breastfeeding decisions should be supported.</p> <p>The Ministry of Health should reward mothers who breastfeed until the age of 2.</p>	<p>The outpatient clinic time required for a patient should be increased.</p> <p>The quality of pregnant and baby follow-ups should be increased.</p>	<p>All health workers should be trained, Pediatricians and neonatal unit workers should be trained more frequently.</p> <p>Comprehensive and serious breastfeeding training should be given, such as the training given within the scope of the Baby Friendly Institution Project (10 years ago).</p>	<ul style="list-style-type: none"> There should be mother-child health centers. Cesarean section rate needs to be reduced.

The effect of the occupational year of GPs on protect, promote and support breast milk and breastfeeding

What kind of counseling do you think should be given to protect, promote and support breast milk and improvements in breastfeeding rates?"	How many years have you been working as a GP ?							p
	0-5 years		6-10 years		≥11 years			
	n	%	n	%	n	%		
Mothers should be educated and monitored by GPs and their teams	130	67,01%	119	69,19%	152	76,77%	0,083	
Mothers should be educated and monitored by pediatricians	76	39,18%	63	36,63%	96	48,48%	0,048	
Mothers should be educated and follow-up with a home visit can be provided by a team of experts in breastfeeding counseling.	78	40,21%	64	37,21%	73	36,87%	0,760	
Support should be provided on the online platform that breastfeeding mothers can access	137	70,62%	104	60,47%	117	59,09%	0,037	
The team of breastfeeding counseling should be trained and updated regularly	110	56,70%	101	58,72%	105	53,03%	0,531	
Others	12	6,19%	13	7,56%	21	10,61%	0,263	

SS041**Turkish Society for Social Pediatrics Vaccination Schedule Recommendations for Unvaccinated Children**

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Objectives: Vaccination is today the most contributing initiative to public health after clean water. Childhood vaccination services in our country are managed within the framework of the Expanded Program on Immunization Circular of the Ministry of Health. One of the important goals of the circular is to ensure the vaccination of unvaccinated children and to increase the herd immunity of the population. In recent years, two important obstacles for our country to reach these goals are 1) the presence of 3.65 million refugees, the majority of whom are Syrians, with low vaccination rates, and that half of them are in the child age group, and 2) possible incomplete routine childhood vaccinations, which are likely to be disrupted due to the Covid-19 epidemic. In the table showing the path to be followed for unvaccinated children in the most recently updated Vaccination Circular in 2011, there is no information about unvaccinated children under the age of 1 and does not include information about conjugated pneumococcal vaccine in children under 5 years of age. On the other hand, the vaccination schedule maintains the principle of “least contact” in order to vaccinate unvaccinated children in the fastest way. In this study, the Turkish Society for Social Pediatrics Working Group on Immunization aimed to create the “Immunization Schedule Recommendation for Unvaccinated Children” targeting to fulfill the gap.

Methods: The Turkish Society for Social Pediatrics Working Group on Immunization was formed by The Turkish Society for Social Pediatrics Board of Directors at the National Social Pediatrics Symposium held between 11-13 October 2019. The main purpose of the Group is to work on the protection of children from vaccine-preventable diseases in our country. The group has already collected data from the experts registered with the Turkish Society for Social Pediatrics to determine their vaccination applications, and then using a Delphi research method; “non-routine vaccinations in our country”, “vaccine hesitancy”, “missed opportunities for vaccination”, and “vaccination in special situations” consensus reports has been prepared. Taking advantage of this research, “Recommendations of the Turkish Society for Social Pediatrics on Non-routine Vaccines in Healthy Children” was published on the website of the Society on January 22, 2022, and the second schedule created by the Group mentioned in the study is to be presented here.

Results: The schedule can be accessed from the link below.<http://www.sosyalpediatri.org.tr/sosyal-pediatri-der-negi-asisiz-cocuklar-icin-asi-takvimi-onerisi---2022-84570.html>

Conclusion: Renewing the national immunization schedules based on up-to-date information, reflecting the innovations on the field and ensuring its continuity in the “vaccination of unvaccinated children”, as in every sub-title of vaccination, is a necessity in the community’s fight against vaccine-preventable diseases.

Keywords: Vaccination, Catch-up, Schedule

SS042

Evaluation of Demographic Characteristics and Responses to Oral Lactase Enzyme in Children Aged 0-6 Months with Lactose Intolerance and Positive Stool Reducing Agent

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Introduction

Lactose is a disaccharide composed of glucose and galactose linked by beta-glycosidic bonds¹. Hydrolysis of lactose occurs when the lactase fluoroidzin hydrolase enzyme in the small intestine splits it into glucose and galactose². Milk production by the mammary glands is the defining characteristic of mammals. Lactose is the main carbohydrate in the milk of all mammals except sea lions³. Lactose is the most abundant disaccharide in breast milk⁴.

Lactose intolerance is defined as having one or more complaints of abdominal pain, diarrhoea, nausea, gas, and/or bloating after ingestion of lactose or lactose-containing foods⁵. It is divided into 4 as primary, secondary, congenital and neonatal (developmental) lactose intolerance. In the diagnosis of lactose intolerance, stool reducing agents and stool pH, the lactose tolerance test, the hydrogen breath test, and intestinal biopsy methods are used. Treatment of lactose intolerance should aim at reducing malabsorption and digestive symptoms⁶.

Lactose intolerance is a clinical condition that can be seen frequently in infants as well as in adults and children and affects both the infant and the family physically and mentally. The use of oral lactase preparations is an important treatment option for infants aged 0-6 months instead of stopping or reducing breast milk.

This study was to evaluate the demographic characteristics and responses to oral lactase enzyme in children aged 0-6 months with lactose intolerance and positive stool with reducing substance.

Matherial/Method

The study included 0-6-month-old cases who applied to the DEU Faculty of Medicine Social Pediatrics Department between January 2018 and September 2021 and were diagnosed with lactose intolerance and positive stool-reducing substances. The caregiver was contacted via the internet or telephone and gender, birth week, starting time of lactase enzyme use, duration of use, an additional medication used, whether she/he benefited from lactase treatment and complaints that decreased with lactase treatment (abdominal distension, restlessness, crying attacks/duration) were noted on the questionnaire form prepared by the researcher.

Results

Of the patients included in the study, 57 (50.4%) were female and 56 (49.6%) were male. Mean gestational age was 37.9 weeks (33-41 weeks) and mean birth weight was 3026 g (1500-4100 g). The lactase enzyme was found to be effective in 98 (86.7%) of 113 patients, reducing restlessness in 73 (30%), abdominal distension in 55 (22.6%), and crying episodes and duration in 53 (21.8%). There was no statistically significant difference in lactase enzyme usage by gender, birth week, or birth weight (p=0.810, 0.103, and 0.610, respectively).

The mean age of starting lactase enzyme usage was 52 (8-179) days. The mean duration of lactase enzyme usage was 137 (30-150) days. The benefit from the treatment increased as the duration of lactase enzyme use was

prolonged (p 0.001). There was no significant difference between the age of starting the use of lactase enzyme and benefiting from the lactase enzyme (p=0,397).

The response to lactase enzyme was statistically significantly low in children who used simethicone-containing drugs together with lactase enzyme (p = 0.02). However, the use of a prebiotic containing the *Lactobacillus reuteri* strain did not affect the benefit of oral lactase enzyme (p = 0.322).

Discussion

In our study, 86.7% of the patients benefited from the lactase enzyme. In the literature, most of the studies conducted on adults have shown that patients diagnosed with lactose intolerance benefit from oral lactase enzyme^{7,8,9}. In a study conducted by Wang et al. in 60 preterm infants, it was observed that the clinical symptoms of the group receiving lactase had a significant improvement¹⁰.

When the literature was reviewed, no study was found to show a relationship between lactose intolerance and gender in infants. In our study, there was no difference in the benefit of the lactase enzyme based on gender.

In our study, 20.3% of the patient used drugs containing simethicone together with lactase enzyme, and a significantly lower response was observed in those who used it than in those who did not. In our study, it was found that as the duration of lactase use in infants increases, the benefit increases. In a study by Briet et al.¹¹ on 46 adult patients with lactose intolerance, it was reported that continuous lactose consumption reduces hydrogen production and the severity of gastrointestinal symptoms. Another view is that lactase is very low in newborns, that breast milk production is triggered by the sucking of the newborn and there is an increase in small intestine lactase enzyme in parallel with the increase in lactose production¹².

Conclusion

When necessary, oral lactase enzyme treatment provides significant health and psychological benefits to both the infant and the caregiver. Oral lactase has been shown to significantly reduce restlessness, crying episodes or duration, and abdominal distension. Surprisingly, it was found that combining the lactase enzyme with simethicone-containing drugs reduces its benefit. It should be kept in mind that the benefit increases as the duration of lactase enzyme use is prolonged.

References

1. Usai-Satta, Paolo et al. "Hydrogen Breath Tests: Are They Really Useful in the Nutritional Management of Digestive Disease?" *Nutrients* vol. 13,3 974. 17 Mar. 2021 doi:10.3390/nu13030974
2. Szilagyi A, Ishayek N. Lactose Intolerance, Dairy Avoidance, and Treatment Options. *Nutrients*. 2018 Dec 15;10(12):1994. doi: 10.3390/nu10121994.
3. Reich CM, Arnould JPY. Evolution of Pinnipedia lactation strategies: a potential role for a-lactalbumin? *Biol Lett* [Internet]. 2007;3:546–49.
4. Uraş N. The Production and the Composition of Mother's Milk. . *Türk Dünyası Uygulama ve Araştırma Merkezi Yenidoğan Dergisi* 2017; 2(2): 130 – 153.
5. Heyman MB. Lactose intolerance in infants, children, and adolescents. *Pediatrics* [Internet]. 2006 Sep [cited 2022 Jan 2];118(3):1279–86.
6. Misselwitz, B., Pohl, D., Frühauf, H., Fried, M., Vavricka, S. R., & Fox, M. Lactose malabsorption and intolerance: pathogenesis, diagnosis and treatment. *United European gastroenterology journal*,2013: 1(3), 151–159. <https://doi.org/10.1177/2050640613484463>



7. Ibba, I., Gilli, A., Boi, M. F., & Usai, P. (2014). Effects of exogenous lactase administration on hydrogen breath excretion and intestinal symptoms in patients presenting lactose malabsorption and intolerance. *BioMed research international*, 2014: 680196. <https://doi.org/10.1155/2014/680196>
8. Ojetti V, Gigante G, Gabrielli M, Ainora ME. The effect of oral supplementation with *Lactobacillus reuteri* or tilactase in lactose intolerant patients: Randomized trial NutriCatt protocol in ERAS program View project Fecal Microbiotica Donation View project [Internet].
9. Montalto M, Nucera G, Santoro L, Curigliano V, Vastola M, Covino M, et al. Effect of exogenous β -galactosidase in patients with lactose malabsorption and intolerance: a crossover double-blind placebo-controlled study. *European Journal of Clinical Nutrition*. 2005; 1;59(4):489–93.
10. Wang L, Wang YW, Tan JT, Yan J, Wu Y, Wang XM, et al. [Efficacy and safety of lactase additive in preterm infants with lactose intolerance: a prospective randomized controlled trial]. *Zhongguo Dang Dai Er Ke Za Zhi* [Internet]. 2021; 15; 23(7):671–76.
11. Briet, F., Pochart, P., Marteau, P., Flourie, B., Arrigoni, E., & Rambaud, J. C. (1997). Improved clinical tolerance to chronic lactose ingestion in subjects with lactose intolerance: a placebo effect?. *Gut*, 41(5), 632–635. <https://doi.org/10.1136/gut.41.5.632>
12. Brüssow H. (2013). Nutrition, population growth and disease: a short history of lactose. *Environmental microbiology*, 15(8),2154–2161. <https://doi.org/10.1111/1462-2920.12117>

SS043

Anxiety Levels Of Inpatient Children And Their Families During COVID-19 Pandemic And Affecting Factors

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Introduction

The COVID-19 pandemic leads to a significant threat due to its high mortality rate and socio-economic and psycho-social effects. It estimates that the social, psychological, and economic difficulties caused by the measures taken due to the pandemic, quarantine practices, social isolation, curfew, closure of schools, and mask requirements affect children and parents significantly (1-2).

The decrease in both the frequency and quality of social relations between children and adolescents during the pandemic often causes a feeling of loneliness, which brings anxiety and depression to the forefront and can lead to problems such as deterioration in eating habits, and impaired sleep quality. Reasons such as difficult quarantine conditions, being away from peers and school, not getting adequate information, fear of being infected, intense exposure to negative news about the pandemic on television and social media, fear of losing relatives, loss of income in the family and lack of personal space in the home environment stress in children and adolescents (3).

It is estimated that the COVID-19 pandemic significantly affects children and parents psychologically. This study aims to evaluate the anxiety levels, depression, and trauma symptoms experienced by pediatric patients and their families hospitalized during the COVID-19 pandemic.

Patients and Methods

A total of 132 children aged 7-18 years and their mothers were included in this study who were admitted to Erciyes University Children's Hospital, between May and December 2020. Among them, 50 children hospitalized with the suspicion/diagnosis of COVID-19 and their mothers were included in the first (Group 1), 51 children hospitalized with non-COVID-19 diagnoses and their mothers were in the second (Group 2), and 31 healthy children and their mothers were in the third group (Group 3). State Trait Anxiety Inventory Score (STAIC), Beck Depression Inventory for Children (BDIC), Post Traumatic Stress Response Scale for Children (CPTSDI) scales were used for children and Civil Version of the Post-Traumatic Stress Disorder Questionnaire (PCL-C), Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), Parenteral Attitude Research Instrument (PARI), Coping Strategy Scale (CSS) scales were used for parents.

Results

There was no difference between the groups in terms of gender and age of the children ($p=0.210$, $p=0.052$, respectively). It was determined that the SAIC, TAIC and CPTSDI scores of the children were high in all three groups, but there was no difference between the groups ($p=0.062$, $p=0.352$, $p=0.533$ respectively). There was no difference between the groups in terms of BDIC scores ($p=0.703$). PCL-C scores of the mothers were high in all



three groups, but there was no difference between the groups ($p=0.464$). BAI scores of mothers whose children were hospitalized (groups-1 and 2) were higher than mothers whose children were at home ($p<0.001$, $p=0.003$, respectively). The mothers' BDI scores were similar in all three groups ($p=0.260$). CSS-Problem solving scores of mothers whose children were hospitalized with suspected COVID-19 were lower than group-2 and 3 ($p<0.001$ for both) (Table 1). When we excluded the children who had chronic diseases from group 1 and group 2, the results were similar except BAI scores that higher in group 1 than group 2 and 3 ($p=0.039$, $p<0.001$, respectively) (Table 2).

There was a positive correlation between the SAIC and CPTSDI scores of the children in all three groups and the PCL-C, BAI, and BDI scores of the mothers, and a negative correlation between the mothers' problem-solving scores in groups 1 and 2 (Table 3).

There was a positive correlation between the CPTSDI and anxiety scores (except F2 in group 2) of the children and the all subscales of PARI (Table 3).

Discussion

There are limited studies evaluating the effects of previous pandemics on the mental health of children, adolescents, and parents, and primarily its relationship with PTSD (Post Traumatic Stress Disorder) and, less often with depression and anxiety, has been tried to be investigated (4-7). It was reported that pandemic disasters and subsequent disease-containment responses may create a condition that families and children find traumatic (4). Studies showed that COVID-19 pandemic could lead to an increase in mental health problems, as well as possible post traumatic stress in children (8). Anxiety, depression, irritability, boredom, inattention and fear of COVID-19 are also reported predominant psychological problems in children during the COVID-19 pandemic (9-11).

Similarly, our findings support that children and their mothers experiencing the pandemic are at risk of PTSD. It is understood that children at home are as anxious as children in the hospital, and mothers whose children are in the hospital experience more anxiety than those whose children are at home. Problem-solving skills of mothers whose children are hospitalized and especially who are hospitalized with the suspicion/diagnosis of COVID-19 are adversely affected.

The lack of difference between the groups in terms of SAIC and TAIC scores of children indicates that children in the home are as anxious as children hospitalized with COVID-19 or non-COVID-19 diagnoses, as is the case with their CPTSDI scores. It was determined that as the anxiety level of the children increased in all three groups, the CSS problem-solving scores of the mothers decreased.

It was determined that as the anxiety level of the children in all three groups increased and the CPTSDI scores of the children who were hospitalized increased compared to the children who were at home, their mothers' CSS problem-solving skills decreased.

During the pandemic, mothers whose children were hospitalized experienced more anxiety than mothers whose children were at home; When those with chronic diseases are excluded, it is understood that mothers whose children are hospitalized with the suspicion/diagnosis of COVID-19 experience more anxiety than both mothers hospitalized with a diagnosis other than COVID-19 and mothers whose children are at home. Depression scale scores of mothers were similar in all three groups.

A positive correlation was found between the post-traumatic stress, anxiety, and depression scores of the mothers and the post-traumatic stress and anxiety scores of the children in all three groups.

In addition, findings support that parents' family life and child-rearing attitudes, and children's post-traumatic stress and anxiety levels are affected by each other.

Conclusions

Children experiencing the pandemic and their parents are at risk of PTSD, anxiety and depression. They should be supported in terms of these findings, and clinical follow-up should be provided. Further studies are needed in which more children are included and long-term effects of the pandemic can be revealed.

Table 1. Comparison of Scale Scores of Children and Mothers by Group

Scales	Group - 1 Median (%25-%75) n=50	Group - 2 Median (%25-%75) n=51	Group - 3 Median (%25-%75) n=31	p	Group 1-2	Group 1-3	Group 2-3
Scales Filled by Mothers							
PCL - C	32.5 (28-41)	33 (29-39)	30 (27-37)	0.464			
BAI	8 (7-9)	8 (7-9)	6 (5-7)	<0.001	0.118	<0.001	0.003
BDI	6.5 (5-11)	6 (5-8)	6 (4-8)	0.260			
CSS-PS	16 (13-19)	23 (19-26)	27 (23-28)	<0.001	<0.001	<0.001	0.002
CSS-SSS	22 (18.75-26.5)	22 (20-25)	14 (12-20)	<0.001	0.948	<0.001	<0.001
CSS - A	21 (17-27)	22 (19-27)	14 (13-17)	<0.001	0.651	<0.001	<0.001
PARI-F1	29.5 (26-39.75)	32 (27-37)	31 (24-37)	0.720			
PARI-F2	13 (10-17)	14 (11-17)	13 (10-17)	0.657			
PARI-F3	18 (15-23.25)	19 (15-25)	19 (16-25)	0.794			
PARI-F4	11.5 (10-14)	14 (13-17)	12 (10-16)	0.001	<0.001	0.162	0.084
PARI-F5	27.5 (25-37.5)	30 (25-36)	30 (24-36)	0.857			
Scales Filled By Children							
CPTSDI	18 (16-22)	18 (16-20)	17 (16-21)	0.533			
SAIC	48 (44-56)	45 (43-48)	48 (45-58)	0.062			
TAIC	36 (32-42)	34 (32-38)	38 (33-42)	0.352			
BDIC	11 (9-14)	11 (9-13)	11 (9-14)	0.703			

Kruskal Wallis Variance Analysis, pairwise group comparisons were made with **Mann Whitney U** test when the difference between groups was significant; p: Significance limit level. **PCL - C**: Civil Version of the Post-Traumatic Stress Disorder Questionnaire; **BAI**: Beck Anxiety Inventory; **BDI**: Beck Depression Inventory; **CSS -PS**: Coping Strategy Scale-Problem Solving; **CSS-SSS**: Coping Strategy Scale-Social Support Search; **CSS-A**: Coping Strategy Scale-Avoidance; **PARI-F1**: Parenteral Attitude Research Instrument - Extreme motherhood dimension; **PARI-F2**: Parenteral Attitude Research Instrument - Democratic attitude and equality recognition dimension; **PARI-F3**: Parenteral Attitude Research Instrument - Rejection of housewifery dimension; **PARI-F4**: Parenteral Attitude Research Instrument - Husband-wife discord dimension; **PARI-F5**: Parenteral Attitude Research Instrument - Pressure and discipline dimension; **CPTSDI**: Post Traumatic Stress Response Scale for Children; **SAIC**: State Anxiety Inventory Score; **TAIC**: Trait Anxiety Inventory Score; **BDIC**: Beck Depression Inventory for Children

Table 2. Comparison of Scale Scores of Healthy Children and Their Mothers by Groups

Scales	Group – 1 Median (%25-%75) n=30	Group – 2 Median (%25-%75) n=19	Group – 3 Median (%25-%75) n=31	p	Group 1-2	Group 1-3	Group 2-3
Scales Filled by Mothers							
PCL – C	32.5 (27.75-41.5)	29 (26-37)	30 (27-37)	0.336			
BAI	8 (7-9.25)	7 (6-8)	6 (5-7)	<0.001	0.039	<0.001	0.081
BDI	7 (6-12)	5 (4-6)	6 (4-8)	0.05			
CSS -PS	16 (13-19)	24 (19-26)	27 (23-28)	<0.001	<0.001	<0.001	0.021
CSS -SSS	20 (18-26)	22 (20-24)	14 (12-20)	<0.001	0,673	<0.001	<0.001
CSS - A	20.5 (17-27)	23 (19-26)	14 (13-17)	<0.001	0.530	<0.001	<0.001
PARI-F1	29 (25.75-39.75)	29 (25-32)	31 (24-37)	0.886			
PARI-F2	13 (11-17)	13 (11-16)	13 (10-17)	0.970			
PARI-F3	18 (15-23.75)	17 (15-19)	19 (16-25)	0.552			
PARI-F4	11 (10-12.25)	13 (11-14)	12 (10-16)	0.054			
PARI-F5	27 (25-37.75)	27 (22-31)	30 (24-36)	0.856			
Scales Filled By Children							
CPTSDI	18 (16-22)	16 (14-18)	17 (16-21)	0.144			
SAIC	46 (43.75-52.5)	46 (43-48)	48 (45-58)	0.183			
TAIC	35 (31.75-41)	33 (31-37)	38 (33-42)	0.140			
BDIC	11 (9-14)	10 (8-13)	11(9-14)	0.623			

Kruskal Wallis Variance Analysis, pairwise group comparisons were made with **Mann Whitney U** test when the difference between groups was significant; p: Significance limit level. **PCL - C**: Civil Version of the Post-Traumatic Stress Disorder Questionnaire; **BAI**: Beck Anxiety Inventory; **BDI**: Beck Depression Inventory; **CSS -PS**: Coping Strategy Scale-Problem Solving; **CSS-SSS**: Coping Strategy Scale-Social Support Search; **CSS-A**: Coping Strategy Scale-Avoidance; **PARI-F1**: Parenteral Attitude Research Instrument - Extreme motherhood dimension; **PARI-F2**: Parenteral Attitude Research Instrument - Democratic attitude and equality recognition dimension; **PARI-F3**: Parenteral Attitude Research Instrument - Rejection of housewifery dimension; **PARI-F4**: Parenteral Attitude Research Instrument - Husband-wife discord dimension; **PARI-F5**: Parenteral Attitude Research Instrument - Pressure and discipline dimension; **CPTSDI**: Post Traumatic Stress Response Scale for Children; **SAIC**: State Anxiety Inventory Score; **TAIC**: Trait Anxiety Inventory Score; **BDIC**: Beck Depression Inventory for Children

Table 3. Correlation of Children's Scores and Mothers' Scores from Scales

		PCL - C	BAI	BDI	CSS -PS	CSS -SDA	CSS -K	PARI -F1	PARI -F2	PARI -F3	PARI -F4	PARI -F5		
Group-1 n=50	CPTSDI	r	0.472	0.459	0.567	-0.396	0.213	0.231	0.691	0.531	0.542	0.325	0.682	
		P	0.02	0.02	<0.001	0.01	0.176	0.141	<0.001	<0.001	<0.001	0.036	<0.001	
	SAIC	r	0.598	0.610	0.607	-0.529	0.481	0.536	0.590	0.553	0.586	0.749	0.574	
		P	<0.001	<0.001	<0.001	<0.001	0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	
	TAIC	r	0.494	0.506	0.406	-0.552	0.432	0.451	0.645	0.527	0.591	0.703	0.624	
		P	0.001	0.001	0.008	<0.001	0.004	0.003	<0.001	<0.001	<0.001	<0.001	<0.001	
	BDIC	r	0.338	0.131	0.275	-0.198	0.258	0.165	0.221	0.235	0.411	0.280	0.214	
		P	0.028	0.410	0.078	0.208	0.100	0.298	0.160	0.134	0.007	0.073	<0.001	
	Group-2 n=51	CPTSDI	r	0.592	0.517	0.463	-0.458	0.161	0.166	0.825	0.564	0.759	0.562	0.821
			P	0.001	0.001	0.001	0.001	0.264	0.251	0.001	0.001	0.001	0.001	0.001
		SAIC	r	0.479	0.517	0.245	-0.354	0.488	0.481	0.428	0.027	0.342	0.310	0.447
			P	0.001	0.001	0.086	0.012	0.001	0.001	0.002	0.850	0.015	0.029	0.001
TAIC		r	0.502	0.599	0.348	-0.311	0.378	0.374	0.550	0.132	0.461	0.449	0.561	
		P	0.001	0.001	0.013	0.028	0.007	0.008	0.001	0.359	0.001	0.001	0.001	
BDIC		r	-0.061	-0.23	-0.118	-0.114	-0.174	-0.260	0.099	0.037	0.034	0.149	0.096	
		P	0.675	0.877	0.412	0.429	0.226	0.068	0.492	0.800	0.816	0.302	0.506	
Group-3 n=31		CPTSDI	r	0.617	0.437	0.391	-0.275	0.548	0.488	0.875	0.777	0.830	0.692	0.897
			P	0.001	0.014	0.030	0.135	0.001	0.005	0.001	0.001	0.001	0.001	0.001
		SAIC	r	0.606	0.440	0.462	-0.401	0.393	0.497	0.880	0.643	0.613	0.664	0.879
			P	0.001	0.013	0.009	0.025	0.029	0.004	0.001	0.001	0.001	0.001	0.001
	TAIC	r	0.589	0.331	0.288	-0.369	0.276	0.364	0.836	0.606	0.563	0.657	0.822	
		P	0.001	0.068	0.117	0.041	0.133	0.044	0.001	0.001	0.001	0.001	0.001	
	BDIC	r	-0.148	-0.250	0.027	0.419	-0.006	0.029	0.024	0.064	0.055	-0.200	0.015	
		P	0.428	0.176	0.885	0.019	0.975	0.875	0.899	0.734	0.769	0.281	0.938	

Spearman Relation Analysis. P values indicated in bold were considered statistically significant ($p < 0.05$). The r value was accepted as low at 0.1-0.3 levels, moderate at 0.3-0.5 levels, and high correlations at > 0.5 levels. **PCL - C:** Civil Version of the Post-Traumatic Stress Disorder Questionnaire; **BAI:** Beck Anxiety Inventory; **BDI:** Beck Depression Inventory; **CSS -PS:** Coping Strategy Scale-Problem Solving; **CSS -SSS:** Coping Strategy Scale-Social Support Search; **CSS -A:** Coping Strategy Scale-Avoidance; **PARI-F1:** Parenteral Attitude Research Instrument-Extreme motherhood dimension; **PARI-F2:** Parenteral Attitude Research Instrument - Democratic attitude and equality recognition dimension; **PARI-F3:** Parenteral Attitude Research Instrument -Rejection of housewifery dimension; **PARI-F4:** Parenteral Attitude Research Instrument- Husband-wife discord dimension; **PARI-F5:** Parenteral Attitude Research Instrument - Pressure and discipline dimension; **CPTSDI:** Post Traumatic Stress Response Scale for Children; **SAIC:** State Anxiety Inventory Score; **TAIC:** Trait Anxiety Inventory Score; **BDIC:** Beck Depression Inventory for Children

References

1. Jiao WY, Wang LN, Liu J, Fang SF, Jiao FY, Pettoello-Mantovani M, et al. Behavioral and Emotional Disorders in Children during the COVID-19 Epidemic. J Pediatr. 2020 Jun;221:264-266.e1. doi: 10.1016/j.jpeds.2020.03.013.
2. Zhou J, Yuan X, Qi H, et al. Prevalence of depression and its correlative factors among female adolescents in China during the coronavirus disease 2019 outbreak. Global Health. (2020) 16:69 <https://doi.org/10.1186/s12992-020-00601-3>
3. Branquinho C, Kelly C, Arevalo LC, Santos A, Gaspar de Matos M. "Hey, we also have something to say": A qualitative study of Portuguese adolescents' and young people's experiences under COVID-19. J Community Psychol. 2020 Nov;48(8):2740-2752. doi: 10.1002/jcop.22453.



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4. Sprang G, Silman M. Posttraumatic stress disorder in parents and youth after health-related disasters. *Disaster Med Public Health Prep.* 2013 Feb;7(1):105-10. doi: 10.1017/dmp.2013.22.
5. Remmerswaal D, Muris P. Children's fear reactions to the 2009 Swine Flu pandemic: The role of threat information as provided by parents. *J Anxiety Disord.* 2011;25(3).
6. Tambo E, Madjou G, Khayeka-Wandabwa C, et al. Ethical, legal and societal considerations on Zika virus epidemics complications in scaling-up prevention and control strategies. Vol. 12, *Philosophy, Ethics, and Humanities in Medicine.* 2017: 12(3):1-8
7. Sharp C, Venta A, Marais L, Skinner D, Lenka M, Serekoane J. First evaluation of a population-based screen to detect emotional-behavior disorders in orphaned children in Sub-Saharan Africa. *AIDS Behav.* 2014 Jun;18(6):1174-85. doi: 10.1007/s10461-014-0739-6.
8. Loades ME, Chatburn E, Higson-Sweeney N, Reynolds S, Shafran R, Brigden A, Linney C, McManus MN, Borwick C, Crawley E. Rapid Systematic Review: The Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of COVID-19. *J Am Acad Child Adolesc Psychiatry.* 2020 Nov;59(11):1218-1239.e3. doi: 10.1016/j.jaac.2020.05.009.
9. Shrira A, Felsen I. Parental PTSD and psychological reactions during the COVID-19 pandemic among offspring of Holocaust survivors. *Psychol Trauma Theory, Res Pract Policy.* 2021;13(4).
10. Liu CH, Doan SN. Psychosocial Stress Contagion in Children and Families During the COVID-19 Pandemic. *Clin Pediatr (Phila).* 2020 Sep;59(9-10):853-855. doi: 10.1177/0009922820927044.
11. Panda PK, Gupta J, Chowdhury SR, Kumar R, Meena AK, Madaan P, et al. Psychological and Behavioral Impact of Lockdown and Quarantine Measures for COVID-19 Pandemic on Children, Adolescents and Caregivers: A Systematic Review and Meta-Analysis. *J Trop Pediatr.* 2021 Jan 29;67(1):fmaa122. doi: 10.1093/tropej/fmaa122.

SS044**Did Covid Adapted Life-Style Proposed new Risk Factors for Genu Varum**Fulya Coşkunol¹, Arman Vahabi², Hasan Özbek², Murat Celal Sözbilen², Erhan Coşkunol²¹Private Clinic²Ege University School of Medicine, Department of Orthopaedics, Izmir

Objectives: Pediatric genu varum is a term covering lower extremity mechanical axis changes that can develop throughout childhood. However, whether the patient's malalignment is within physiological limits or not, or whether it requires any intervention or not, should be evaluated according to the patient's age and a cluster of clinical variables. A classical physiological case of genu varum can be summarized as a child that is younger than 2 years old with bowing in both legs and in-toeing. Objective of this study was to evaluate patient characteristics in pediatric genu varum and compare these variables in terms of covid adapted life-style changes.

Methods: Cases that were diagnosed with genu varum between January 2015 and September 2022 were reviewed retrospectively by ICD-10 codes (M21.169). Ethical approval was obtained accordingly. Gender, age of admission, number of siblings, family characteristics, birth and pregnancy variables were recorded as demographic characteristics. Breastfeeding duration, vitamin-D treatment, ferritin levels, iron replacement treatment, use of swaddle, walker and kangaroo were questioned. Data of developmental hip dysplasia screening program were also analyzed. Comparative analysis between pre and post-covid admissions was made.

Results: Database search returned 318 patients. 65% of patients were younger than 18 months, %23,3 were aged 18-14 months. Educational status of mother, family type, economic status of family, number of siblings in our study group were compatible with national data. Consanguineous marriage rate was %11. %52,8 of the patients had low ferritin levels (<20). While 201 patients were diagnosed pre-covid, 117 were diagnosed after covid restrictions. There were no significant differences between these two groups in terms of family and pregnancy characteristics, age upon diagnosis and other measured variables.

Conclusion: %89,4 of the patients were younger than 24 months suggesting that most cases fit into the definition of physiologic genu varum. Consanguineous marriage rate was double the national average, and half of the patients had iron deficiency. These data could raise questions about this clinical condition and could suggest the need for further research on the risk factors of genu varum. Even though covid restrictions made a significant impact on daily life habits, it appears that it did not affect the questioned variables in pediatric genu varum.

Keywords: covid, genu varum, risk factors



SS045

What is The Contribution of Breastfeeding Counseling in Breastfeeding Problems Of Mother-Baby Dyad?

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Objectives: Breastfeeding is the most ideal form of nutrition for optimal growth and development of infants. The World Health Organization recommends exclusive breastfeeding for the first 6 months, followed by continued breastfeeding with appropriate complementary foods until the age of 2 and beyond. However, breastfeeding problems may occur due to some reasons arising from the mother or the baby. Breastfeeding counseling is a preventive health service to deal with breastfeeding problems faced by mother-baby dyads. In our study, it was aimed to evaluate the contribution of breastfeeding counseling to breastfeeding problems.

Methods: File records of 120 mother-baby dyads who applied to Samsun Gynecology and Pediatrics Hospital Breastfeeding Support Unit between April and August 2022 were evaluated retrospectively. Breastfeeding observation and history forms were filled in for each mother-baby dyad who applied, and the suggestions were recorded in the file. The sociodemographic characteristics of the mother-baby dyad who applied to the breastfeeding support unit, the reasons for admission, the problems identified, the suggestions are given and the results were evaluated.

Results: The mean age of the babies at the time of admission was 35.3 ± 46.1 days. It was learned that 68% of 120 mothers aged between 17-42 received breastfeeding training during their pregnancy, and 51% received postpartum breastfeeding support. When the reasons for application are examined; mother's concern about breastfeeding 45% (n:54), baby not sucking 27% (n:33), insufficient weight gain 10% (n:12), breast-related problems 8% (n:9). At the time of application, 62% (74) of the infants were using formula. 93% of infants using formula stated that while giving formula with a bottle, only 5 mothers gave formula with a spoon. Pacifier use was 47%. In the follow-up, formula was discontinued in 15 (20%) of 74 mixed-fed infants, and only breast milk was fed, and the amount of formula was reduced in 29 infants (39%).

Conclusion: Breastfeeding counseling makes a positive contribution to solving the problem by identifying the breastfeeding problems of the mother-baby dyad. In addition, we think that it enables institutions to review their baby-friendly practices by identifying the factors that cause breastfeeding problems.

Keywords: Breastfeeding counseling, mother - baby dyad

SS046

Evaluation of Immunization Status and Attitudes of Their Parents Towards Vaccines Among Children with Organic Acidemias and Urea Cycle Disorders

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Aim: Inborn errors of metabolism (IEM) are genetic disorders of impaired biochemical metabolic pathway(1). Urea cycle disorders (UCD) and organic acidemias are intoxication type of IEM which pose a high risk for a metabolic crisis especially during infections(2). Therefore, vaccines may play a pivotal role in infection prevention(3). This study aimed to define vaccination patterns among children with UCD and organic acidemias to assess adverse events related to immunizations and attitudes of their parents towards vaccines.

Method: Thirty-one children between the ages of 0-18 and diagnosed with UCD and organic acidemias, who were being followed up in the Pediatric Metabolism and Nutrition Department of Marmara University Hospital, were included in the study. Vaccination data of each patient were obtained from patients' vaccination cards or requested from primary care providers. Sociodemographic characteristics of patients (the status of consanguineous marriage, comorbid conditions, siblings' health etc.), vaccine-related adverse events (defined as an emergency-department visit or a hospitalization), decompensation status, metabolic attack, vaccine hesitancy were questioned.

Results: A total of 31 patients with UCD and organic acidemias had received all vaccinations according to the recommended schedule. One of them was incompletely vaccinated. Five (16,1%) patients had comorbid conditions related to their metabolic diseases. Comorbid conditions were; epilepsy, ADHD, mental retardation, hydrocephalus, cerebral atrophy. Two (6,4%) patients had additional diseases apart from metabolic disease. Additional diseases were congenital heart disease and gastroesophageal reflux. Five (16,1%) patients had undergone liver transplantation for their treatment. Only two patients with organic acidemia declared adverse events (fever and hyperammonemia) following vaccination. First patient who has been diagnosed with Holocarboxylase synthetase deficiency had fever 8 hours after 6-month vaccines (Hep-B, DaBT-IPA-Hib, OPV). Hyperammonemia was detected in the second patient with a diagnosis of methylmalonic acidemia after 2 month-vaccines (BCG, PCV and DaBT-IPA-Hib). Apart from these two patients, a previously undiagnosed 6-month-old infant who presented with symptoms of catabolic decompensation after Men B vaccine was diagnosed with Glutaric acidemia type 1. Her parents refused to get other vaccinations after the sixth month.

Discussion: As a result this preliminary analysis indicates that patients with UCD and organic acidemias have optimal vaccination rates, receive vaccines in recommended time and parents have positive attitudes towards vaccination. Parents of children with IEM should be reassured that there is no significant increased risk of side effects if their child is routinely vaccinated with recommended vaccines.

In conclusion, vaccines are safe and are an important precaution to prevent infections and metabolic decompensation in IEM patients. Full vaccination should be recommended to parents and IEM patients should be followed-up for vaccination and physicians should remind immunization schedule to the parents in every outpatient visit.

References:

1. Varghese M, Cafferkey M, O'Regan M, Monavari AA, Treacy EP. Should children with inherited metabolic disorders receive varicella vaccination? Arch Dis Child 2011;96:99–100
2. Ming JE, Stiehm ER, Graham Jr JM. Syndromic immunodeficiencies: genetic syndromes associated with immune abnormalities. Crit Rev Clin Lab Sci 2003;40:587–642.
3. F. Menni G. Chiarelli, C. Sabatini, N. Principi, S. Esposito. Vaccination in children with inborn errors of metabolism. Vaccine 30: 2012;7161–7164.

Table 1.

	Urea Cycle Disorder (n=7)	Organic Acidemia (n=23)
Age (year) Min-Max [Median]	0.6-17.6 [5.5]	0.25-17 [4.9]
Age of diagnosis (month) Min-Max [Median]	0.16-84 [2]	0.1-390 [20]
Gender (F / M)	3 / 4	14 / 9
Consanguineous marriage (n) (%)	%71.4 (n=5)	19 (%82.6)
Family history of IEM (n) (%)	%57.1 (n=4)	14 (%60)
Adverse events (n) (%)	⊖	3 (% 13)
Under-vaccinated cases (Disease / Cause)	OTC deficiency Liver tx < 12 months	Glutaric Aciduria Type 1 Vaccine hesitancy

Table 2.

Organic Acidemia	Adverse events
Glutaric Aciduria Type 1 (GA-1)	Acute encephalopathic crisis after 6th month Men B vaccine → catabolic decompensation → Diagnosis
Methyl Malonic Aciduria (MMA)	2nd month vaccine → hyperammonemia
Holocarboxylase deficiency	6th month vaccination → high fever ? Family statement documentation ⊖

SS047**Effects Of Regular Well-Child Follow Up From Birth On Adolescent Well Being: Preliminary Results**

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Introduction

The purpose of well-child visits is to monitor growth and development from birth regularly, to take protective measures, and to make the family competent for healthy individuals. Regular child follow-ups provide the opportunity for adolescents to take steps towards independence and responsibility over their health behaviors during the adolescence period. (1)

The main themes of preventive health services that should be applied in infancy, childhood, and adolescence are listed as; healthy physical development, mental health, healthy nutrition, supporting physical activity, oral health, sexual health, safe social media use, protection from accidents and injuries, supporting children and adolescents with disabilities, supporting families, supporting the health of future generations (2). It is essential and recommended practice to regularly follow up for children in the adolescence period after infancy-childhood according to the recommended preventive health services. However, it has been revealed that well-child visits are made more frequently and regularly, especially in the first two years, and these visits decrease considerably during adolescence (3).

The effectiveness of preventive health services applied in childhood and adolescence is known. However, there is a limited number of studies on the physical and mental health conditions, family communication, and the reflections during the adolescence period of individuals who continued their well-child visits in childhood (3).

Aim

The aim of this study was to examine the effects of regular well-child follow-up on physiological and psychological characteristics in adolescence.

Material/Method

Our study was conducted with the children who were followed up regularly in the Istanbul University, Istanbul Faculty of Medicine, Division of the Adolescent Health Outpatient Clinic (AHOC) between September 2015 and October 15, 2022. Personal data files of the children were evaluated retrospectively. The children who were followed up regularly at Istanbul University, Istanbul Faculty of Medicine Division of Social Pediatrics Well Child Outpatient Clinic (WCOC), continued to be followed up after the age of 9.5-10 years at the Division of the AHOC constitutes the Group 1, and the children who were not followed up regularly but followed at AHOC constitute the Group 2. Height, weight, body mass index SDS values, psychosocial assessment (by HEEADSSS; Table 1), and, if any, hemoglobin, hematocrit, vitamin B12, folate, total cholesterol, LDL, and HDL cholesterol values were recorded.

Descriptive statistics were expressed as counts and proportions for categorical data and were analyzed with the Chi-Square or Fisher's exact tests. Mean, standard deviation (SD), median and minimum-maximum were calculated.



ed for continuous data, and the distribution normality of the continuous variables was tested with Shapiro-Wilk test. Independent Samples t Test or the Mann-Whitney U test was used to test the difference between the two groups, depending on distribution of variables. All data analysis was performed with the IBM SPSS v.28, and values of $p < 0.05$ were considered significant.

Results

Group 1 (n =105) constituted 57.7% of all the children, and Group 2 (n=77) 42.3%. There was no difference between the groups regarding the education levels of the mothers and fathers. The mean age of the first administration to the Unit of AHOC was significantly lower in Group 1 than in Group 2. Weight and BMI SDS values were higher in Group 2 ($p=0.028$, $p=0.047$, respectively), but there was no significant difference between the groups regarding height SDS. In the comparisons of the laboratory data, the frequency of anemia was statistically higher in group 2 ($p=0.024$); the mean score of vitamin B12 value was significantly higher in Group 1 ($p=0.024$). However, no significant difference was found between the groups regarding lipid values. When psychosocial assessments (HEEADSSS) were compared between the groups, the risks in the areas of the home, education, nutritional behavior, suicide, and safety were found to be significantly higher in group 2 ($p=0.009$, $p=0.001$, $p < 0.001$, $p < 0.001$, $p=0.0048$; respectively). There was no difference between the groups in comparing regular physical activity. Comparisons according to the demographic and psychosocial characteristics were stated in Table 2.

Discussion

Our study's preliminary results showed that children with regular well-child follow-up within the perspective of social pediatrics applied to adolescent outpatient clinics at an earlier age, and this regular well-child follow-up increased well-being in the psychosocial evaluation of adolescence in the areas of the home, education, eating, suicide risk and safety.

Infancy and childhood well-child visits provide physicians with opportunities to screen for medical problems (including psychosocial issues), provide prospective guidance, and promote health. It also allows the physician to establish relationships with parents or caregivers (5). As a holistic approach to child health, social pediatrics considers the child's health within the context of their environment, society, family, and school; and also promotes structural factors that encourage the resilience of young's, positive youth development, social engagement, and preparation for employment (6,7). In the well-child visits, regular approaches within the perspective of social pediatrics play an important role in child and adolescent health and well-being.

Conclusion

The results of our study draw attention to the fact that regular child health follow-up within the approach of social pediatrics from birth affects adolescent health and care positively. This positivity consists of not only physiological characteristics but also psychosocial characteristics too.

Tables

Table 1: Contents of HEADSSS psychosocial assessments (4)

(H)OME	Household composition, relationships, family dynamics, and recent changes
(E)DUCATION/ (E)MPLOYMENT (E)ATING	School performance, suspensions, attendance; attitude toward school; most difficult, favorite subjects; special educational needs; future goals; work histories or afterschool job
(A)CTIVITIES	Friendships, best friends, ages of friends, dating, sports participation, physical activity, hobbies, and interests
(D)RUGS	Use of tobacco, alcohol or other substances; attitudes and peer or family substance use
(S)EXUALITY	Sexual history; knowledge of contraception and prevention of sexually transmitted infection/human immunodeficiency virus; nonconsensual intimate physical contact history
(S)UICIDE/ DEPRESSION	Feelings about self, both positive and negative; history of mental health or sleep problems; changes in weight or appetite; anhedonia; anxiety; any suicidal thoughts or attempts or other self-harming behavior
(S)AFETY	Feeling unsafe; bullying; fighting; gang membership; arrests; guns in the home; seatbelt use

Table 2: Comparisons of groups according to the demographic and psychosocial characteristics

	Group-1 (n=105)	Group-2 (n=77)	p
Age (years)			
mean±SD	10.44±0.81	12.53±1.83	<0,01 ^a
median (min-max)	10 (9.01-13.91)	12.59 (8.81-17.82)	
Weight SDS			
mean±SD	0.52±1.16	1,01±1,58	0.028 ^b
median (min-max)	0.58(-2.54-3.43)	0,83 (-3.33,4.12)	
Height SDS			
mean±SD	0.47±1.1	0.37 ±1.17	0.547 ^b
median (min-max)	0.34 (-2.22-3.42)	0.33 (-3.39-3.71)	
BMI SDS			
mean±SD	0.39±1.22	0.89 ±1.46	0.047 ^b
median (min-max)	0.61 (-3.49-2.67)	0.78 (-2.34-3.49)	
Maternal education (years)	n(%)	n(%)	
None	2 (50)	2 (50)	0.215 ^c
0-5	28 (59,6)	19 (40.4)	
5-8	5 (35.7)	9 (64.3)	
8-11	25 (59.5)	17 (40.5)	
>=12	43 (69.4)	19 (30.6)	
Paternal education (years)	n(%)	n(%)	
None	-	-	0.098 ^c
0-5	18(47.4)	20 (52.6)	
5-8	9 (69.2)	4 (30.8)	
8-11	26 (59.1)	18 (40.9)	
>=12	51 (70.8)	21 (29.2)	

Anemia n(%)	2 (2.2)	6 (11.8)	0.024 ^d
Ferritin levels (ml/ng)			
(Group1 n:57, Group2 n:28)			
mean±SD	39.02±46.53	46.21±59.10	0.392 ^a
median (min-max)	31 (2-342)	35.5 (6-333)	
B12 (pg/ml)			
(Group 1 n:74, Group 2 n:36)			
mean±SD	510.5±400	390.86±187.78	0.024 ^a
median (min-max)	478 (183-2889)	325 (181-1557)	
Non HDL cholesterol n(%)	11 (19.3)	7(24.1)	0.809 ^c
LDL cholesterol n(%)	8 (14.3)	5 (17.9)	0.752 ^d
HDL cholesterol n(%)	5 (8.8)	5 (17.2)	0.294 ^d
HEADSSS	n(%)	n(%)	
Risk in Home	10(9,5)	19(25)	0,009 ^c
Risk in Education	4(3,8)	15(19,7)	0,001 ^c
Risk in Eating Behavior	22(21)	45(62,5)	<0,001 ^c
Activities	54(51,4)	39(51,3)	0,988 ^c
Use of Tobacco/Alcohol/Drugs	0(0)	1(1,3)	-
Sexual Behavior risk	0(0)	0(0)	-
Suicide risk	2(1,9)	18(24)*	<0,001 ^c
Insecurity	9(8,7)	15(20)	0,048 ^c

Hb: Hemoglobin; Htc: hematocrit; MCV: Mean cell volume

^aMann Whitney U; ^bIndependent sample T test; ^c Chi-square test; ^d Fisher's Exact Test;

*Two of 18 have a high risk of suicide



References

1. World Health Organization. (2014). Health for the world's adolescents: a second chance in the second decade: summary. World Health Organization. Available at: <https://apps.who.int/iris/bitstream/handle/10665/112750/WHO?sequence=1>, Last accessed 02.12.2022)
2. Reyes I, Rodriguez J. The American Academy of Pediatrics Bright Futures Guidelines: An Update for Primary Care Clinicians. *Advances in Family Practice Nursing*. 2019;1:175-181.
3. Jones E, Zur J, Elam L. Off to the Right Start: Well-Child Visit Attendance Among Health Center Users. *J Pediatr Health Care*. 2016;30:435-43.
4. Krueger C, Shah H. Adolescent Medicine. In *The Harriet Lane Handbook E-Book*. Eds Kleinman K, McDaniel L, & Molloy M. Elsevier Health Sciences, Philadelphia, 2020;102.
5. Turner K. Well-Child Visits for Infants and Young Children. *Am Fam Physician*. 2018; 98:347-353.
6. Spencer N, Colomer C, Alperstein G, Bouvier P, Colomer J, Duperrex O, Gokcay G, Julien G, Kohler L, Lindström B, Macfarlane A, Mercer R, Panagiotopoulos T, Schulpen T. Social paediatrics. *J Epidemiol Community Health*. 2005;59:106-8.
7. Loock, Christine, Eva Moore, Dzung Vo, Ronald George Friesen, Curren Warf, and Judith Lynam. "Social Pediatrics: A Model to Confront Family Poverty, Adversity, and Housing Instability and Foster Healthy Child and Adolescent Development and Resilience." In *Clinical Care for Homeless, Runaway and Refugee Youth*, Springer, Cham, 2020: 117-141.



SS048

Screen Exposure and Body Mass Index Status in School-age Children

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Introduction:

Screen Exposure has been associated with childhood obesity in several epidemiologic studies (1) Obesity has become a worldwide public health problem. Considerable research has shown that the media contribute to the development of child and adolescent obesity, although the exact mechanism remains unclear. Screen time may displace more active pursuits, advertising of junk food and fast food increases children's requests for those particular foods and products, snacking increases while watching TV or movies, and late-night screen time may interfere with getting adequate amounts of sleep, which is a known risk factor for obesity. Sufficient evidence exists to warrant a ban on junk-food or fast-food advertising in children's TV programming. Pediatricians need to ask 2 questions about media use at every well-child or well-adolescent visit (2). How much screen time is being spent per day? and Is there a TV set or Internet connection in the child's bedroom? (3).

The most common broadcast medium continues to be TV. A recent study found that TV hours among school-aged children have decreased in the past decade for children younger than 8 years. 1 However, among children aged 8 years and older, average daily TV time remains over 2 hours per day (4).

A first area of health concern is media use and obesity, and most studies have focused on TV. One study found that the odds of being overweight were almost 5 times greater for adolescents who watch more than 5 hours of TV per day compared with those who watch 0 to 2 hours (5). Research has also suggested that children from low-income households are at increased risk for pediatric obesity (6).

Objectives:

Screen Exposure has been associated with childhood obesity in several epidemiologic studies Obesity has become a worldwide public health problem. Considerable research has shown that the media contribute to the development of child and adolescent obesity. Screen time may displace more active pursuits, Advertising of junk food and fast food increases children's requests for those particular foods and products, Snacking increases while watching television (TV) or movies, and late-night screen time may interfere with getting adequate amounts of sleep that is a known risk factor for obesity. Sufficient evidence exists to warrant a ban on junk-food or fast-food advertising in children's TV programming. Pediatricians need to ask 2 questions about media use at every well-child or well-adolescent visit: .How much screen time is being spent per day and Is there a TV set or Internet connection in the child's bedroom. In this paper we intent to measure the relationship between screen exposure and obesity in a large, urban sample of children and to examine the relationship is moderated by sociodemographics.

Material/Methods:

We asked parents of 956 children visiting general pediatrics clinics if the child had a TV in the bedroom and/or watched more than 2 hours of TV/computer daily. Between March 2020 and June 2021, a 14-question survey that includes children sociodemographic characteristics and screen exposure pattern, was conducted for the parents of children aged 6 to 12 who administered to general pediatrics out patient clinic, We measured children's height and weight. We used logistic regression to determine whether screen exposure indicators predicted obesity (body mass index \geq 85th percentile) and interacted with sex, age, and sociodemographics.

Results:

A total of 986 questionnaires were administered, no one refused to participate. 956 questionnaires were included in the study. Parents of 495 boys (51.7%) and 461 girls (48.3%) were included. 369 parents with children between 6y-8y years, 280 parents with children between 8-10 years, 307 parents with children between 10-12 years participated in our study. Study population divided in two groups according to body mass index. We found that children who have a TV in their room or have their own tablet / phone are more prone to obesity than children who have a daily screen exposure of 2 hours or more ($p= 0.01$). We found that eating during screen exposure is more risky in terms of eating in front of the screen at the set table ($p=0.03$). We also showed that consumption of foods away from the screen has a lower risk of obesity ($p = 0.001$).

Discussion

American Academy of Pediatrics ; There are a number of ways that watching TV could be contributing to obesity: increased sedentary activity and displacement of more physical pursuits; Unhealthy eating practices learned from both the programming and the advertisements for unhealthy foods; increased snacking behavior while viewing; and interference with normal sleep patterns(3,4,7). However, most researchers now agree that the evidence linking excessive TV-viewing and obesity is persuasive (8).

There have been dozens of longitudinal and correlational studies documenting a connection. An increasing number of these studies hold ethnicity and socioeconomic status—known to be key factors in obesity—constant and still reveal that TV-viewing is a significant contributor to obesity. Results of the longitudinal studies are particularly convincing. For example, a remarkable 30-year study in the United Kingdom found that a higher mean of daily hours of TV viewed on weekends predicted a higher BMI at the age of 30. For each additional hour of TV watched on weekends at age 5, the risk of adult obesity increased by 7%. A group of researchers in Dunedin, New Zealand, followed 1000 subjects from birth to 26 years of age and found that average weeknight TV-viewing between the ages of 5 and 15 years was strongly predictive of adult BMI. In a study of 8000 Scottish children, viewing more than 8 hours of TV per week at age 3 was associated with an increased risk of obesity at age 7. Also, in 8000 Japanese children, more TV-viewing at age 3 resulted in a higher risk of being overweight at age 6 (9). Numerous American studies have had similar findings. The presence of a TV set in a child's bedroom seems to exacerbate the impact of TV-viewing on children's weight status. A study of 2343 children aged 9 to 12 years revealed that having a bedroom TV set was a significant risk factor for obesity, independent of physical activity. A cross-sectional study of 2761 parents with young children in New York found that 40% of the 1- to 5-year-olds had a bedroom TV, and those who did were more likely to be overweight or obese (10).

Teenagers with a bedroom TV spent more time watching TV, less time being physically active, ate fewer family meals, had greater consumption of sweetened beverages, and ate fewer vegetables than did teenagers without a bedroom TV (11).

Conclusion:

Asking whether a child has a TV in the bedroom may be more important than asking about duration of screen exposure to predict risk for obesity. Also, eating during screen exposure significantly increases the risk of obesity

Keywords: Screen exposure , overweight, children, obesity

Tables

	SE by yourself		overthan 2 hours SE	
		Evet(%)		Evet
Total	956	323 (33)		491(%51)
Sex				
male	495	159 (32)		243(%49)
Female	461	161(35)		248(%53)
Age				
Group1	369	137(%37)		207(%56)
Group2	280	95(%34)		150(%53)
Group3	307	92(%30)		134(%43)
BMI				
Under 85	567	193(%34)		254(%44)
Over 85	389	129(%33)		203(%52)

Kaynaklar :

- 1- Robinson TN. Television viewing and childhood obesity. *Pediatr Clin North Am* 2001;48:1017–25.
- 2- Skelton JA , Cook SR, Auinger P, Klein JD, Barlow SE. Prevalence and trends of severe obesity among US children and adolescents. *AcadPediatr*. 2009;9(5):322–329.
- 3- Council on Communications and Media, Strasburger VC. Children, adolescents, obesity, and the media. *Pediatrics*. 2011 Jul;128(1):201-8. doi: 10.1542/peds.2011-1066. Epub 2011 Jun 27. Erratum in: *Pediatrics*. 2011 Sep;128(3):594.
- 4- Rideout VJ. *Common Sense Census: Media Use by Tweens and Teens*. San Francisco, CA: Common Sense Media; 2015.
- 5- Gortmaker SL, Must A, Sobol AM, Peterson K, Colditz GA, Dietz WH. Television viewing as a cause of increasing obesity among children in the United States, 1986- 1990. *Arch Pediatr Adolesc Med*.1996;150(4):356–362.
- 6- Singh GK, Kogan MD, Van Dyck PC, Siahpush M. Racial ethnic, socioeconomic, and behavioral determinantsof childhood and adolescent obesity in the United States: analyzing independent and joint associations. *Ann Epidemiol*. 2008;18:682-695.
- 7- Ogden CL, Carroll MD, Mc Dowell MA, Flegal KM. Obesity among adults in the United States: no statistically significant chance since 2003–2004. *NCHS Data Brief*. 2007;(1):1–8.
- 8- Strasburger VC, Wilson BJ, Jordan AB. *Children, Adolescents, and the Media*. 2nd ed. Thousand Oaks, CA: Sage; 2009.
- 9- Sugimori H, YoshidaK, IzunoT, et al. Analysis of factors that influence body mass index from ages 3 to 6 years: studybased on the Toyama cohort study. *Pediatr Int*. 2004;46(3):302–310.
- 10- Dennison BA, Erb TA, Jenkins PL. Television viewing and television in bedroom associated with overweight risk among low- income preschool children. *Pediatrics*. 2002;109(6):1028–1035.
- 11- Barr - Anderson DJ, van den Berg P, Neumark - SztainerD, Story M. Characteristics associated with older adolescents who have a television in their bedrooms. *Pediatrics*. 2008;121(4):718–724.

SS049**Prelacteal Feeding Characteristics of Syrian Refugees in Turkey**Meryem Erat Nergiz¹, Siddika Songül Yalçın²¹ Hacettepe University Social Pediatrics Doctorate Program, Ankara² Hacettepe University, Faculty of Medicine, Department of Pediatrics, Division of Social Pediatrics, Ankara

Objectives: This study aimed to determine the prelacteal feeding (PLF) characteristics of Syrian refugees and the associated factors of PLF according to observations of healthcare workers (HCWs).

Methods: In this descriptive study, an online questionnaire was created. This questionnaire included the characteristics of HCWs (nationality, occupation, province of employment) and their observations on prelacteal feeding and breastfeeding status of Syrian babies. The link of the questionnaire was sent to the HCWs working in migrant health centers (MHCs) by the Ministry of Health, Department of Migration Management, via e-mail, text message, or WhatsApp. The population of the study consisted of Syrian and Turkish physicians and nurses (midwives were also considered in this category) working in MHCs. HCWs from other nationalities were not included in the study. Additionally, other employees (translators, cleaning staff, etc.) were not included in the study. The MHCs categorized into two groups those on the Syrian border and those far from the border. The data were analysed using the SPSS 23.0 package programme (SPSS Inc., Chicago, IL). The chi-square test was used to compare the frequencies of categorical variables. P values <0.05 were considered statistically significant.

Results: 658 HCWs participated in the study; 85.9% of them were Syrian the rest were Turkish. 36.6% were physicians and 45.7% were working at the border. 58.7% of the participants said that PLF is very common among Syrians. In addition, they said that the most frequently given prelacteal foods are sugar water (43.0%), dairy products (9.1%), water (3.2%), herbal tea (3.0%) and sweet foods (2.7%). Those working in the border area observed higher rates of PLF (64,5%, 53,8%, p=0.006). Those who said that EIBF was often not achieved (81.3% and 57.0% respectively, p=0.002) and those who said that breastfeeding was continued for less than six months (75.0% and 56.8% respectively, p=0.004) observed a higher rate of PLF. Presence of PLF was not associated with HCWs' occupation, HCWs' nationality, rate of formula feeding in the first six months and time to start complementary feeding.

Conclusion: According to the observations of healthcare workers, sugar water is frequently used as a prelacteal food, especially by Syrian refugees living in the border area. EIBF and continued breastfeeding in the first six months were associated with PLF. To support breastfeeding in Syrian refugees, cultural characteristics such as PLF should be well determined and, interventions should be made in this regard.

Keywords: Syrian refugees, Prelacteal feeding, Turkey, Breastfeeding, Nutrition



SS050

Associations Between Sleep Health Dimensions and Glycemic Variability in Children and Adolescents with Type 1 Diabetes

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Objectives: Sleep duration, sleep quality and chronotypes have been associated with poor glycemic control in type 1 diabetes (T1D). This study sought to determine sleep characteristics and their associations with glycemic variability in children and adolescents with T1D.

Methods: A total of 84 children with T1D (mean aged 10.5 years; 56% male; median HbA1c 7.1%) were included. Sleep characteristics and glycemic variability were determined by actigraphy and continuous glucose monitoring, respectively. Circadian preference was evaluated by the Children's Chronotype Questionnaire. Sleep disturbances were assessed by the DSM-5 Level 2-Sleep Disorders Scale Short Form. Sleep quality was categorized using sleep parameters (wake after sleep onset [WASO], awakenings, sleep efficiency, sleep onset latency [SOL]) based on the National Sleep Foundation's criteria. Good metabolic control was defined as those who spent >70% of their time in target glucose range. This research was financially supported by The Scientific and Technological Research Council of Turkey (TUBİTAK, Project Number: 120S789).

Results: Poor sleep quality was observed in 56% of the children. The great majority of participants had insufficient sleep duration (n=74, 88.1%). Chronotype was classified as intermediate in 50%, evening in 45.2%, and morning in only 4.8%. No differences were observed between the good and poor metabolic control groups regarding sleep parameters, chronotype and DSM-V scores during daytime and overnight. In bivariate modelling, later bedtime was significantly associated with higher overnight glycemic variability (Coefficient Variation, $\beta = 0.015$, $p = 0.018$). Sleep efficiency was significantly associated with lower overnight mean glucose level ($\beta = -0.002$, $p = 0.004$), lower overnight glycemic variability (J index, $\beta = -0.001$, $p = 0.001$), less time spent in overnight hyperglycemia >180 mg/dl ($\beta = -0.001$, $p = 0.001$), >250 mg/dl ($\beta = -0.679$, $p = 0.004$), and lower overnight HBGI ($\beta = -0.355$, $p = 0.002$). WASO was significantly associated with overnight higher glycemic variability (J index, $\beta = 0.111$, $p = 0.025$) and more time spent in overnight hyperglycemia ($\beta = 0.161$, $p = 0.030$). Associations were further explored by multilevel models, a within person effect showed participants with higher WASO had significantly higher overnight glycemic variability (J index, $\beta = 0.300$, $p = 0.015$), whereas the inter-person effect showed higher WASO was associated with more time spent in overnight hyperglycemia ($\beta = 0.011$, $p = 0.047$).

Conclusion: Our results showed that poor sleep quality and insufficient sleep duration were a common problem among children with T1D. Although it is difficult to make a causal inference, analysis of individual change suggests glycemic variability was significantly associated with sleep. Our findings support the recommendations focusing on sleep hygiene as a potential modifiable target in diabetes care.

Keywords: actigraphy, children, glycemic variability, sleep, type 1 diabetes

SS051

Malnutrition; Still An Essential Problem In Pediatric Clinics: A Cross-Sectional Study From A Single UnitBurçe Emine Dörtkardeşler¹, Merve Tosyalı², Şule Gökçe¹, Feyza Koç²¹Ege University, Faculty of Medicine, Department of Pediatrics, Division of General Pediatrics, İzmir²Ege University, Faculty of Medicine, Department of Pediatrics, Division of Social Pediatrics, İzmir

Objectives: Malnutrition is a significant health problem affecting an important percentage of children under five years old, particularly in low-income and middle-income countries. According to data from the World Health Organization (WHO), there are 52 million wasted children under five years of age, 17 million severely wasted children, and 155 million stunted children worldwide. In order to reduce or prevent malnutrition that may cause mental and motor disabilities and complications in children in developing countries, it has been suggested that early identification of nutritional status in children during any visit. The aim of this study was to evaluate pediatric malnourished patients' nutritional status at the moment of their hospitalization in a pediatric hospital, to define their malnutrition stages.

Methods: We performed a retrospective, cross-sectional, single-unit study in malnourished patients admitted to the pediatric wards of Ege University, Children's Hospital, a 200-bed tertiary-care facility in İzmir, from 2017 to 2022. The children with malnutrition were enrolled in the study. Children who were followed up in our inpatient clinic and only received nutritional support were included. The children who followed up in the outpatient clinic and with insufficient data were excluded. Nutritional status was evaluated with calculated weight-for-height (WfH) by using the Olcay Neyzi scale and body mass index (BMI) z scores [used WHO Z-scores in children up to 2 years and Centers for Disease Control and Prevention (CDC) Z-scores in children over two years].

Results: Sixty-two patients were included in the study. The median age was 58.73 months (IQR 134.46), and 32 children were female. Forty-seven children were evaluated as acute malnutrition (with normal height-for-age and low weight-for-height), and 15 children as chronic malnutrition (with low height-for-age and low or average weight-for-height). According to WfH, 25 children (40.3%) were mild, 19 (30.6%) were moderate, and 9 (14.5%) were severe malnutrition. The severe malnutrition rate in children under two years was higher than in those over two years (20.0% vs. 11.9%). As an assessment of malnutrition was done according to BMI Z-scores, the severe malnutrition rate was detected at 35.0 % in children under two years and 28.6% in children over two years.

Conclusion: WHO recommends using WfH for under two years and BMI Z-scores for over two years to classify malnutrition. The index study detected a severe malnutrition rate of 20 % in children under two years and 28.6% in children over two years. Defining malnutrition and detecting the degree of malnutrition provide us with protecting children from several nutrition problems such as protein-energy deficiency, iron deficiency anemia, iodine deficiency disorders, rickets, tooth decay, obesity, etc. Therefore, establishing healthy nutrition policies and evaluating the nutritional status of each malnourished patient should be made a habit and considered as part of the examination.

Keywords: Malnutrition, Children, Inpatient Clinic, Weight-for-Height, Body Mass Index



SS052

Maternal Self Medication and Over The Counter Drug Use for Their Child During Covid-19 Pandemic

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Objectives: Covid 19 has affected every aspect of life, but it has caused more panic in vulnerable groups such as mothers with young children and mothers working in the healthcare field. People preferred self-medication ways to protect themselves and their children due to the limited access to health services during the covid 19 pandemic period. In this study it was evaluated maternal over the counter (OTC) drug use for themselves and their children.

Methods: In this descriptive study, we delivered a questionnaire to 257 mothers having children aged 2-4 years via social media. Data were collected from April 2021 to July 2021. Ethics committee approval was obtained.

Results: The mean age of mothers was 32,9±4.7 years, and 35.7±7.2 months of the children. It was found that OTC use among mothers was 42.9% and OTC use for their children was 39.3%. It was observed that, OTC use was higher in mothers with one child, working mothers, and mothers with more than 12 years of education. If the mother had use OTC drugs for herself, the proportion of using OTC drugs for her child was also found to be high. The most commonly used supplements were vitamins and micronutrients (VitD, VitC, Multipl vitamines, Zinc), followed by immune boosters (fish oil, propolis, probiotics) and herbal teas. The most commonly used supplement was vitamin D for both mothers (%31.5) and children (%22.6). Vitamin C was the second frequently (%17.1) used supplement for mothers while fish oil for their children(%17.1).

Conclusion: OTC drug use by mothers for themselves and their children was high during the covid19 pandemic period, and it was higher in highly educated mothers and in single children. It is necessary to raise awareness to prevent the inappropriate use of OTC drugs.

Keywords: Covid-19 pandemic, OTC drugs, maternal medication, children

SS053**The Level Of Knowledge Of The Families About The Newborn Screening Program**Merve Tosyalı¹, Feyza Koç¹, Mahmut Çoker²¹Ege University Medical School, Department of Pediatrics, Division of Social Pediatrics, Izmir²Ege University Medical School, Department of Pediatrics, Division of Metabolism, Nutrition, Izmir

Objectives: The national newborn screening program aims to diseases that do not show clinical signs in the neonatal period but lead to severe morbidity and mortality when the diagnosis is delayed and can be detected and treated early to prevent complications. This study aimed to determine the level of knowledge of families about newborn screening tests and their participation in screening programs.

Methods: This cross-sectional study was conducted between March 2022 and October 2022, at Ege University Child Health Follow-up Out-patient Clinics, Ege University Faculty of Medicine, in Izmir, Turkey. Parents of 500 children aged 0-18 were included in the study. Parents' information about the newborn screening program and filled out a questionnaire about the demographics of their children. The questionnaires were then transferred to the program SPSS 25.0 and statistically analyzed.

Results: The parents of 500 cases were included in the study. The ages of the children participating in the study were between 0 and 18, with a median age of 6.9 months (min-max: 0.06-207.7). 57% of the cases were male and 43% were female. Most of the respondents were mothers (%78). When asked about the mother's level of education it was determined that 76 % of the mothers were high school and university graduates, a 69% of parents who participated in the study learned about the screening program from a healthcare professional. 55.8% of the cases were the first child of the family. Families with their first child were more knowledgeable about the newborn screening program. While 55.2% of the respondents knew about the newborn screening program, the diseases included in the screening program were not known at the rate of 80.2%. 35.2% of the families stated that they were not given enough information about the screening program when blood was taken. As a result of the questionnaire, It was found that mothers had more knowledge than fathers about the newborn screening program (p=0.003). Familie's economic status and mother's education level were found to be related to the knowledge of the families about the newborn screening program (p<0.001). The percentage of parents who have formed consanguinity is 10%. Consanguineous parents were unaware of the newborn screening program (p=0.004). It was determined that mothers knew more than others about other screening tests such as hearing, vision, and developmental hip dysplasia (p=0.035).

Conclusion: In our study, it was determined that most of the families knew about newborn screening programs. However, most of the families thought that the information they received was not enough and they did not have enough information about which diseases were screened. At this point, providing parents with detailed information about the screening program by health professionals is very important. Pediatricians should also be careful in this regard, and it should be checked whether the necessary scans are made at each visit.

Keywords: newborn, screening program, mother, healthcare



SS054

The Most Watched Youtube Video Channels' Analysis for Negative Content to Children, in Turkey

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Introduction:

According to data of TÜİK (Turkish Statistical Institute) in 2013, %50,8 of children between ages of 6-15 years were reported to be internet users and the 2021 data shows the rate of internet user kids at the same age increase to %82,7 in 2021 (1-2). Researches also showed that %61 of children not only surfed on the online video sharing media platforms and also %19 uploaded their own videos. Report for Duration of Social Media Usage in Parents and Children (2019) shows that %51,8 of 3-4 years old children spend up to 8 hours 6 minutes a day using social media and the duration period of social media usage increase within age 5-7 years old, %64 8 hours 36 minutes, 8-11 years old, %74 10 hours and %89 of 12-15 years old children use social media up to 11 hours a day (3).

On the year of 2022 YouTube has over 2 billion viewers speaking 76 different languages from 88 countries. It is the second most commonly visited website after Google, and the second most popular social media platform after Facebook (4). The availability and cheapness of youtube makes it an entertainment tool that parents can use to keep their kids from getting bored.

YouTube brought a concept such 'vlogger (video blogger)' into our lives. Most of the Vlogger subscribers and fans are children and youth. As Vloggers of YouTube tend to share their daily life experiences in videos, a new market of hidden commercials arises in social media platforms, thus creating a fast, emotional and cheaper way for companies to interact with costumers (5-6).

The recommendations about appropriate screen time for children are generally defined however the researches on definition of the appropriate content are still in progress. Identification of risk factors on appropriate content selection and education of parents and children are important. It is important to take precautions and protect the child of the digital era from the negative effects of internet and visual-social platforms.

In our study, we aimed to identify the children as a subject of the video providers, determine the frequency of the negative content threatening the children and the commercial rates in the most watched videos of YouTube, the most widely used video provider in our country. By this analysis to show the risks that the children face during their screen time.

Material/Method:

Our study is designed as cross sectional and descriptive. We used the site Social Blade, which is an American website that tracks social media statistics and analytics for Youtube and other platforms all around the World, to determine Türkiye's 250 mostly watched YouTube channels. We analyzed channel types, number of videos, number of channel subscribers, video ratings were determined. View rate determined as number of videos viewed divided by number of days after upload date. The recently uploaded 10 videos of Türkiye's mostly watched 50 YouTube Channels were watched from beginning to end (500 videos). The video channels are categorised as Kids/kids Vlog, TV channel, entertainment Music, computer games, soap opera, adult-vlog channels.

The latest videos of the 50 most watched video channels (total of 500 videos) in our country were reviewed at the date and inappropriate contents and advertisements were recorded according to Turkish Radio and television supreme councils (RTÜK) negative content definitions as 'violent behaviour or words', 'slang language/profanity', 'sexuality and/or eroticism' and gender discriminations 'ethnic discrimination', and 'negative body image' are defined as the definitions in Erkanlı and Öktem's articles in the literature (7-9).

We recorded the advertisements based on where they are positioned in the video (add before- during the video or advertising with product placement) and number of advertised product.

Results:

The most viewed video channels were children channels, TV series and music channels (Table- 1). In all the 500 videos that were analyzed 24% (120/500) of it was in the children channel and the subject of the videos are children. 12.6% (63/500) (16.6% (63/380) in non children content) of the videos that are not in the children's channel category, it has been observed that they contain children's images.

26% of the videos were found to have at least one negative content. The most frequently detected negative content was violent behavior or words (21%) followed by slang language (12,8%) and sexuality and/or eroticism (9,2%) (Table-2). The rate of inappropriate content was found to be significantly lower in children's channels (%3,3) than other channels (%33,7) ($p < 0.001$).

Average viewing rate per day in children's channels were 121 324,45 and other channels was calculated as 64 128.64, Children's channels were found to have a higher rate of viewing than the other channels the viewing rate of the channels are shown in Table-3.

Although there are few negative contents in children's channels, The average number of advertisements per video is calculated as 2.7 and the average exposure of the child to advertisements was significantly more (Table-4).

Discussion

Another study that mentioned the top 100 most watched video channels in Turkey is that video channels are similar to our study 34% of them are movie/animation videos, 24% consists of entertainment videos, 20% were music videos. The legacy that education, documentaries, sports, travel/travel, food and news content are below 1% in the top 250 channels (10).

In a study in the adolescent age group shows that about 2/3 of the videos watched by adolescents were music videos and it has been determined that sexually explicit images and erotic contents are the most common negative contents in those music videos. Similar to the findings of our study, it was emphasized that most of the computer game channels included some fantasy characters, sexual images, tobacco and drug use, abusive speech, and slang words (11).

Again, in an analysis study to reveal the themes in children's channels in our country, it is seen that although the themes change in each video evaluated similar to our study, the themes of labor exploitation (children producing content on social media) and encouraging consumption are the most prominent among the related themes in the videos (12). Also more product placements are made in vlog videos and that they unwittingly direct children to consumption beyond their needs (13).

It has been revealed that parents think that their children spend a lot of time on their phones and YouTube, but they do not have enough information about what they do and watch on YouTube, although it is taking up an increasing place in their children's lives (14).

Conclusions:

Studies show that screens are places where children accumulate common experiences with their peers and that

banning the screen means breaking the child’s ties with the world and their peers¹⁵. Our study reveals the risks that children are exposed to when they are left alone with YouTube. Considering the most watched channels in our country, one out of every five channels is the children’s channel and one of every four channels contains children’s images. The most frequently watched video types are children’s, entertainment, music and series channels and one out of every four videos watched contains violence, slang, profanity and other inappropriate content, It has been shown that by watching only YouTube for Kids, children are exposed to less inappropriate content but more advertisement, even if they only watch ‘Children’s Channel’.

World Health Organization (WHO) and American Academy of Pediatrics (AAP) have similar recommendations of screen time for several years. However, recommendations on what content should be watched still remains unclear. Knowing the contents that children are exposed to is important. Parents must be aware of the negative content that children may encounter while watching YouTube videos and to take the necessary precautions against them. The results of our study revealed that the content of children’s screen time should be closely supervised by families as well as the duration.

Tables:

TABLE 1. Distribution Of Most Viewed Youtube Channels By Type

Channels Type	%	n/N
Children Channel	20,4	51/250
Vlog Channel	18,4	46/250
Soap Opera	18,0	45/250
Music Channel	10,4	26/250
Entertainment Channel	10,0	25/250
Video Gaming Channel	6,0	15/250
Film Channel	4,8	12/250
Tv Channel	3,6	9/250
Institution Channel	2,8	7/250
Tv Programes	2,0	5/250
Religion	1,2	3/250
News Channel	0,8	2/250
Food Channel	0,4	1/250
Do it Yourself (Diy)	0,4	1/250
Education Channel	0,4	1/250
Animals And Life Channel	0,4	1/250
Total	100	250/250

TABLE 2. Negative Content In Video's

Defined Negative Content	%	n/N
Violent Behaviour	21,0	105/500
Slang Language	12,8	64/500
Sexuality And/Or Eroticism	9,2	46/500
Negative Body Image'	8,8	44/500
Gender Discriminations'	7,4	37/500
Profanity	6,0	30/500
Ethnic Discrimination	2,6	13/500
Total	26,4	132/500

TABLE 3. The Watching Rate Of Videos According To Channel Content

Channel Content	Number of videos	Mean	Std. Deviation	Minimum	Maximum
Children Channel	120	121 324,45	445 412,098	56	4 377 000
TV Channel	80	115 512,55	504 740,956	59	4 374 893
Müzik Channel	60	105 065,00	237 067,986	52	1 217 736
Video Game Channel	10	51 770,00	62 472,839	2686	214 281
Entertainment Channel	60	43 434,07	95 265,077	160	628 611
Video Series	140	37 800,04	140 458,065	15	1 615 700
Vlog Channel	30	13 607,70	22 750,629	540	86 410

TABLE 4. Comparison Of Advertisement Rates And Where They Are Placed, Between Children's Channels And Other Channels

	No ads.		Ads before-during video		Product placement		Both ads and product placement		Total		P*
	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	
Other Channels	257/380	67,6	27/380	7,1	70/380	18,4	26/380	6,8	123/380	32,3	< 0,001
Children Channels	51/120	42,5	17/120	14,2	30/120	25,0	22/120	18,3	69/120	57,5	
Total	308/500	61,6	44/500	8,8	100/500	20,0	48/500	9,6	192/500	38,4	

*Pearsons Chi square

References

Turkish Statistical Institute (TUIK) Child with Statistics 2013, Household Information Technologies Use Survey, 2013, accessed on 19.09.2019, from <http://www.tuik.gov.tr/PreHaberBultenleri.do?id=13569>



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Turkish Statistical Institute (TUIK) Child with Statistics 2021, accessed on 07.10.2022, from <http://www.tuik.gov.tr/PreHaberBultenleri.do?id=13569>

Children and Parents Media Use Report 2019, , accessed on 26.04.2020, from https://www.ofcom.org.uk/___data/assets/pdf_file/0023/190616/children-media-use-attitudes-2019-report.pdf

We are Social, Turkish Social Media Usage- 2022 report, , accessed on 07.10.2022 from <https://recrodigital.com/we-are-social-2022-turkiye-sosyal-medya-kullanimi-verileri/>

Burgess J, Joshua G, YouTube's Popular Culture, Chapter 3: YouTube: Online Video and Participatory Culture. 2 ed. Cambridge: Polity Press, 2018. p.38-57.

Melody N, The Power of Influence: Traditional Celebrity Vs Social Media Influencer. Advanced Writing: Pop Culture Intersections. 32, 2018 , accessed on 19.09.2019, from https://scholarcommons.scu.edu/engl_176/32

Turkish Radio And Television Supreme Council - Definitions of Content That May Be Harmful to Children, accessed on 19.09.2019, from <https://www.rtuk.gov.tr/Media/FM/Birimler/Kamuoyu/cocuklarin-yeni-medya-kullanimlari-ve-siber-zorbalik.pdf>

Erkanli H, Topuz SK, Analysis of the Meanings Attributed to Men and Women in the Context of Gender with Metaphor Method, Alternative Politics, 2016; 8:2:300-21.

Öktem F, Sayil M, Özen SÇ, 'Protection of Children and Young People from Harmful Content of Television "Smart Signs Classification System" Academic Study Infrastructure, Online article, 2006

,accessed on 19.09.2019, from http://www.rtuk.org.tr/sayfalar/IcerikGoster.aspx?icerik_id=c1837d83-9ec8-43c3-9cce-2e23e933f151.

Geris A, Tunga Y. Examining Top 100 Turkish YouTube Channels. The Journal of Academic Social Science 2017;5;61:369-83. <https://doi.org/10.16992/ASOS.13145>

Oosten JMF, Peter J, Valkenburg PM The Influence of Sexual Music Videos on Adolescents' Misogynistic Beliefs: The Role of Video Content, Gender, and Affective Engagement. Communication Research 2015;42(7):986-1008. DOI: 10.1177/0093650214565893, 2015

Ünlükaya A, Savaş A, Sucu İ, A Study on Revealing Themes in Video Contents on YouTube Kids Channels. Journal Of Business in The Digital Age, 2021;4(1):33-49 DOI: 1046238/jobda.962705

Parsa AF, Akmeşe Z. Sosyal Medya ve Çocuk İstismarı: Instagram Anneleri Örneği. Kadem Kadın Araştırmaları Dergisi 2019;5(1):163-91. DOI: 10.21798/kadem.2019153622.

Estenberg W, The influence of YouTubers on teenagers, An overview of the influence Dutch YouTubers have on their teenage viewers and to what extent this influence is good or bad. Master Thesis, University of Twente 2016,accessed on 7.10.2022 from https://essay.utwente.nl/71094/1/Westenberg_MA_BMS.pdf

Putnick DL, Trinh MH, Sundaram R et al. Displacement of peer play by screen time: associations with toddler development. Pediatr Res. 2022 Aug 19:1-7. DOI: 10.1038/s41390-022-02261-y. Epub ahead of print. PMID: 35986149; PMCID: PMC9390097.

SS055

Factors Effecting Positive Opinion and Experience of Mothers About Breastfeeding Beyond 2 Years of Age

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Objectives: The World Health Organization (WHO) has drawn attention to the importance of breastfeeding in the first hour, exclusive breastfeeding for the first 6 months, and breastfeeding for more than two years with complementary feeding, especially in developing and underdeveloped countries, for maternal and infant health. Many health policies have been developed and implemented but there is still insufficient information and practices regarding the importance of breastfeeding beyond two years of age. In this study, we aimed to evaluate the factors affecting the perspectives and behaviour of mothers on breastfeeding beyond two years.

Methods: The study was conducted among mothers between 18-49 years who had admitted to our hospital for any reason about their children and agreed to participate in the study during the study period (01.06.2020-31.12.2020). The participants were asked to complete the survey during a face-to-face interview by the researchers. Only mothers who can understand and speak Turkish without translator were included in the study.

Results: The study included 485 mothers with mean age 34 (± 8.8) years. 56.7% of them were housewives and 7.4% were health workers. 35% of the participants were high school graduates. It was observed that 28% of the participants had 1 children, 53.4% had 2 children, 16.2% had 3 children, 2.6% had 4 or more children. In the first 6 months, the rate of exclusive breastfeeding was 46%. After the sixth month, the rate of feeding with breast milk and complementary feeding was the most common preference with 49.1%. The mothers who agreed that exclusive breastfeeding is the optimal infant nutrition in the first 6 months was 79.8% and they were asked about the optimum breastfeeding duration, 68.7% of the participants thought that it was 19-24 months. Only 1.4% of the participants thought that breastfeeding beyond 2 years is optimum. The rate of mothers who had 'heard about' the WHO's breastfeeding recommendation beyond 2 years was 13.8%. When the mothers were asked if they would prefer to breastfeed beyond 2, 29% of them stated that they would if they knew, while 17.7% of them had no idea about it. The rate of positive perspective about breastfeeding beyond 2 among mothers with young age (≤ 25 years), higher educational level (high school and higher) and previous breastfeeding experience over 1 year was more frequent than compared groups ($p < 0.05$).

Conclusion: As a result of the program of promoting breast milk and baby-friendly health institutions, which was initiated with the recommendation of the WHO has been well documented. However, the previous recommendation of WHO about total breastfeeding duration has recently been updated to 'beyond 2 years'. Our results show that the rate of knowledge about the recent recommendation among mothers was 13.8%. Mothers with young age (≤ 25 years), higher educational level (high school and higher) and previous breastfeeding experience over 1 year had positive perspective about breastfeeding beyond 2 years.

Keywords: breastfeeding, WHO, beyond two years, breast milk, experiments



SS056

Cessation Of Breastfeeding and Methods Used for Weaning from Breastfeeding in Our Country

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Objectives: Breastfeeding is the most important way of attachment between mother and baby. The importance of mothers being able to breastfeed their babies within the first hour after birth and feeding them exclusively with breast milk for the first 6 months is now much better understood. However, cessation of breastfeeding is as important as starting breastfeeding and is unique for both mother and baby pair. The methods used for weaning from breastfeeding vary according to cultural differences among countries. This study aimed to evaluate the cessation experience of breastfeeding and methods used in our country for weaning from breastfeeding.

Methods: The study was conducted among women between the ages of 18 and 65 who had experienced breastfeeding and cessation of breastfeeding. The answers were obtained by filling out the questionnaire about breastfeeding experiences, breastfeeding problems and methods of weaning from breastfeeding, retrospectively.

Results: The study included 263 cessation experience of breastfeeding belonging to 140 mothers who applied to our hospital for any reason between 01.01.2021-01.06.2021. The mean age was 34 (± 8) years. 44.4% of the participants were housewives and 5.7% were health workers. 26.4% of participants had 1 child, 56.4% had 2 children, 15.7% had 3 children, and 2.1% had 4 or more children. Total breastfeeding durations were found to be 12.5 months (± 8.2) for the first child, 15 months (± 8.7) for the second child, 18 months (± 10.2) for the third child, and 24 months (± 0.0) for the fourth child. It was observed that mothers more frequently (43.6%) terminated breastfeeding in an unplanned experience without a weaning plan, as a result of the decrease in the mother's milk over time that caused them to stop breastfeeding before 24 months. The most common reason to wean from breastfeeding was the mother's starting to work. The 15% of the participants stated that they left the baby to grandmothers or other caregivers for a few days which is an unrecommended way of weaning. 14.7% of the mothers stated that they calm the baby down by singing songs/lullaby when the baby wants to suckle, obtaining objects such as sleeping companions/toys to prevent the baby from sucking before bedtime, for each. Some of the most preferred methods were found to be interrupted by gradual transition methods such as stopping breastfeeding first during the day and then at night with 14.7% as well as by expressing the breast milk and giving it with a bottle. Less frequently, we found that the baby was weaned without breastfeeding, by sticking tape/stretch film on the breast, applying objects such as tomato paste/olive oil/cream that will change the taste of the breast, and reciting prayers.

Conclusion: Our results show that most of the cessation of breastfeeding experience occur in unplanned way in our population due to reduced milk before 2 years. Among planned weanings from breastfeedings, the most common reason was starting to work. Traditional methods are still common in our population.

SS057**Turkish Society for Social Pediatrics's Consensus Guidelines on Non-routine Immunization of Turkish Children**

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Objectives: In Turkey, current Expanded Programme on Immunization for children includes BCG, DTaP-IPV-Hib (combined diphtheria, tetanus, acellular pertussis, inactivated polio, haemophilus influenzae type b), pneumococcal conjugate vaccine, hepatitis a, hepatitis b, MMR (measles, mumps, rubella), oral polio and varicella vaccines. Last childhood vaccine is tetanus-diphtheria toxoid (Td) given at 13 years of age. All routine vaccines are funded by the state and introduced to children free of charge. There are other vaccines on the market which are not funded by the state and can be included in the immunization schedule of children if paid by their parents. This so called "non-routine vaccines" which can be added to the immunization programme of healthy children include different brands of conjugated meningococcal serogroup ACWY vaccines (Menveo, Menactra, Nimenrix), meningococcal serogroup B vaccine (Bexsero), rotavirus vaccines (Rotarix, Rotateq), human papilloma virus vaccine (Gardasil), Tdap vaccines (Adacel, Boostrix) and inactive influenza vaccines. The lack of uniformity about the timing and schedule of these vaccines among physicians frequently leads to confusion not only on the provider side but also among the parents. The aim of this study was to develop a schedule for non-routine immunizations of children in Turkey which can be used easily by health care providers during well-child visits.

Methods: In order to clarify the confusion and provide a time table for offering non-routine vaccines to children Working Group on Immunization of Turkish Society for Social Pediatrics had carried out two rounds of surveys among the members of the society by using Delphi method. Eventually the answers were consolidated and a schedule was produced by the members of our working group. After presenting and discussing the suggested schedule with the steering committee of Turkish Society for Social Pediatrics, our working group organized a workshop which was open to all social pediatricians in Turkey. After this workshop final schedule for introducing non-routine vaccines to healthy children in Turkey was shaped and announced on the website of Turkish Society for Social Pediatrics.

Results: The finalized schedule can be accessed through our society's website through the following URL. <http://www.sosyalpediatri.org.tr/uploads/ocak2022/sospedasi.pdf>

Conclusion: Having a consensus based schedule for non-routine vaccines can provide consistency among non-routine immunization practices of health care providers in Turkey. The schedule may also serve as a job aid for physicians from different specialties.

Keywords: vaccines, immunizations, childhood, non-routine, schedule



SS058

Delayed Umbilical Cord Separation and Associated Factors

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Objectives: Timing of umbilical cord separation is variable and normative data is lacking. Delayed separation has been linked to umbilical cord care practices and rarely immune deficiencies including neutropenias and leukocyte adhesion defects. We aimed to determine timing of umbilical cord separation in healthy children and factors influencing it.

Methods: The study consisted of a sample of 5131 newborns who were followed up in well child clinic of University Hospital between 2011-2022. Timing of umbilical cord detachment (UCD), demographic data and laboratory features were collected from medical records. Newborns with cord separation over 15 postnatal days were evaluated as delayed-UCD group and were compared to gender and delivery mode matched control group (UCD timing <15 days) to explore the factors affecting timing of UCD.

Results: The mean UCD timing in newborns (M:50.5%, vaginal-delivery 50.6%), was 8.1±3.0 days. Timing of UCD did not differ by gender (male (8.2±3.0 days) vs female (8.1±3.0 days) (p=0.44)), whereas differed by delivery mode (cesarean (8.3±3.0 days) vs vaginal (8.0±3.0 days), p<0.001). In 80 children (M: 51.3%, vaginal delivery 42.5%) with delayed-UCD had a mean of 18.94±3.2 days for cord separation when compared to gender and delivery mode matched control having a mean of 8.54 ±3.2 days (p<0.001). Birth weight did not significantly differ between two groups. Newborns having delayed-UCD were resulted to have neither delayed-UCD over 4 weeks nor leukocyte adhesion defects.

Conclusion: In conclusion, although, umbilical cord detachment timing in healthy infants is variable, it was found to be 8.3 days on average in our cohort. UCD timing was significantly higher in cesarean delivery. Based on our data, an algorithm to approach delayed cord detachment in newborns were accordingly created for well-child-clinics' daily practice.

Keywords: Umbilical cord detachment, Delayed cord separation, Cord separation time

SS059**Knowledge, Attitude and Behaviour of Parents About National Immunization Programme and Private Childhood Vaccines**

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Introduction: In this study, we aimed to learn the level of knowledge of the parents about the private vaccines of childhood and their attitudes about vaccine hesitancy.

Method: A cross-sectional prospective study was held between 1st to 30th October 2022. Questionnaire with 16 questions regarding basic demographic data, vaccination history, and parent's level of knowledge and general attitudes about non-routine vaccines was prepared. After giving consent they were asked to fill in the questionnaire by using Google survey.

Results: A total of 1131 parents participated in the survey. 90.2% of the participants were mothers. 68.1% had a higher education. 93.9% of the participants thought that the vaccines were necessary, 6.1% thought that they were unnecessary. All of those who thought that the vaccines were unnecessary also stated that there was no benefit of vaccines ($p < 0.05$). 97.2% of the participants had their vaccinations regularly. 94.3% of the participants said that they knew about vaccines other than those in national immunization programme (NIP). From non-routine vaccinations; 91.8% of the participants knew rotavirus vaccine, 79.5% of the flu vaccine, and 82.8% of the meningitis vaccines. Only 4.1% of the participants knew about the HPV vaccine. Of the non-routine vaccines, 23.1% of the participants had the flu vaccine, 57.9% had the rota vaccine, 50.3% had the meningitis vaccine, and 11.2% had not had any of the non-routine vaccines. 22.1% stated that vaccines are expensive, 1.8% stated that they had never heard these vaccines before. 90.8% of the participants stated that vaccines should be included in the NIP. It was determined that mothers were more competent in childhood non-routine vaccination than fathers ($p < 0.05$). As the education level increased, it was observed that the level of knowledge about non-routine vaccination was significantly higher ($p < 0.001$).

Conclusion: Although most of the parents in Turkey had their vaccinations regularly in our study, it was observed that minority had vaccine hesitancy. Anti vaccine group considered that vaccines are unnecessary, also they did not believe their benefits. Majority of the participants knew about non-routine vaccinations in our study. The least known non-routine vaccine was the HPV vaccine. For this reason, we think periodic training of healthcare workers is needed on this subject. The most effective factor for avoiding non-routine vaccination was that families found the vaccines expensive. It was supported by the majority of the participants that non-routine vaccinations should be included in the NIP.

INTRODUCTION

Vaccination is accepted as one of the most effective and safe preventive health care measures and is an intervention directly related to reducing the mortality and morbidity of infectious diseases (1,2). In a report of WHO published in 2019, vaccine hesitancy was included in the top 10 items that threaten global health (3). Studies and data on non-routine vaccines which are not included in the routine vaccination calendar and are applied in our country and in other part of world, but have been approved and licensed by international organizations and the Ministry of Health, and are recommended to be made are scarce. There is also insufficient data about imple-



mentation of non routine vaccines in our country. Since it is expected that non-routine vaccines will be included in the scope of the Ministry of Health, we aimed to evaluate the attitudes and behaviours of parents regarding non-routine vaccination in our study.

METHOD

The research is a cross-sectional prospective study held between 1st October 2022 to 30th October 2022. Data were obtained by applying a Google survey to parents, which was shared over the internet and social media with the snowball technique. The questionnaire consisting of 16 questions about demographical data, parents' general attitude about vaccination, their level of knowledge, and thoughts about non-routine vaccinations were analyzed. SPSS-25 package program was used for statistical analysis. Frequency, percentage and mean values were calculated as descriptive statistics. Pearson chi-square test was used for intergroup comparisons of categorical variables. It was discussed and accepted by the Central Scientific Research Evaluation Board (CSERB) and Education Planning Board (EPB) at its meeting dated 01.12.2022 and numbered 23 (E-50687469-799).

RESULTS

A total of 1131 parents were participated. 87.5% of the participants were mothers and 9.5% were fathers. The median age of the parents was 34.18 years. The number of children was at least 1, at most 4, and the number of those who had only one child was 48.1%. Demographic data of the participants are shown in Table 1. 93.9% of the participants thought that the vaccines were necessary and 6.1% thought that they were unnecessary. Comparisons were made between the groups that deemed necessary and those that did not. It was determined that the level of education and amount of income (per month) was higher in the group who considered vaccination is necessary than in the other group. All of those who thought that the vaccines were unnecessary also stated that there was no benefit of vaccines ($p < 0.05$), (Table 2). All those who had regular vaccination thought that the vaccines were necessary and this result was found to be statistically significant. Again, the 'for immunization' option was found to be statistically significant as a reason for vaccination ($p < 0.05$). 91.4% of the participants said that they had heard of non-routine vaccines. All participants were asked whether they had heard of the non routine vaccines; we found that 90% heard about Rotavirus vaccine, 77.9% heard influenza vaccine, 81.1% heard meningitis vaccine and only 4% of participants heard about HPV (Human Papillomavirus) vaccine. Participants were then asked 'which of these vaccines have you had?'. 23% of participants had their children get the influenza vaccine, 57.4% the Rotavirus vaccine, and 49.8% the meningitis vaccine. 11% of the participants had their children to be vaccinated against HPV. It was observed that the level of knowledge about non-routine vaccination increased significantly as the education level and income level increased ($p < 0.001$) (Table 4). 56.6% of the participants stated that they found the cost of non-routine vaccines to be high, and 16.1% stated that they did not have them done because they were afraid of their side effects. 90.1% of the participants stated that they think that these vaccines should be included in the routine vaccination program of Ministry of Health.

Table 1 Demographical Features of Participants

Age (year)	Min	Max	Mean
	19	60	34.18
Parent		N	%
	Mother	1020	87.5
	Father	111	9.5
Occupation	Housewife	539	46.7
	Tradesman	17	1.5
	Laborer	54	4.7
	Government officer	89	7.7
	Teacher	149	12.9
	Healthcare workers	149	12.9
	Others	134	11.6
Education level	Primary school	25	2.2
	Midschool	62	5.4
	High school	274	23.7
	University	770	68.7
Income(TL)	0-5500	242	21.0
	5500-10000	381	33
	10000 and more	507	43.9
Number of children	1	555	48.1
	2	430	37.2
	3	123	10.6
	4 and above	23	2

Table 2 Are Vaccines Necessary? (Comparison of Groups)

n		Yes (n=1062)		No (n=69)		p
		%	n	%		
Mother/father	Mother	959	84.7	61	5.3	0.60
	Father	103	9.1	8	0.7	0.53
Occupation	Housewife	508	47,8	31	44,9	0.11
	Healthcare worker	148	13,9	1	1,4	
	Government officer	84	7,9	5	7,2	
	Teacher	134	12,6	15	21,7	
	Laborer	52	4,9	2	2,9	
	Others	136	12,8	15	21,7	
Level of Education	Primary school	22	2,1	3	4,3	0.006
	Midschool	56	5,3	6	8,7	
	High school	264	24,9	10	14,5	
	University	720	67,8	50	72,5	

Income(TL)	0-5500	217	20,4	25	14,8	0.001
	5500-10,000	360	33,9	22	23,3	
	10,000 <	485	45,7	22	30,9	

Table 3 : Comparison of answers related to necessity of vaccines.

		Are vaccines necessary?				
		Yes		No		p
		n	%	n	%	
Why are vaccines needed?	For good health	402	37,9	5	10,5	0.03
	For prevention of disease	767	72,2	14	20,1	0.02
	For immunization	418	39,4	4	14,3	0.001

Table 4 Education level and income status of the participants and their knowledge about non-routine vaccination

		Did you hear private vaccines?				
		Yes		No		p
		n	%	n	%	
income (TL)	0-5500	215	20,2	27	41,5	0.001
	5500-10,000	353	33,1	29	44,6	
	10,000 <	498	46,7	9	13,8	
		n	%	n	%	0.001
Level of Education	Primary school	21	2	4	6,2	0.001
	Midschool	51	4,8	11	16,9	
	High school	252	23,6	22	33,8	
	University	242	69,6	28	43,1	

DISCUSSION

In the current study we aimed to determine level of knowledge, attitudes of parents about childhood non-routine vaccination and the factors that may affect implementation of non-routine vaccination. In our study, most of the

participants (93.9%) said that vaccines were necessary. It was determined that 6.1% of participants who thought that the vaccines were not necessary, stated that they have no health benefit. We also found that those who said vaccines are done for immunization purpose were more likely to say it was for disease prevention and promotion of health.

Similarly, studies from Turkey found that mothers accepted the fact that vaccinations protect them from diseases, and the frequency of the disease may increase or progress if children are not vaccinated (4). It was observed that most of the mothers in our study thought positively about vaccines. In parallel with the literature, Seskute et al. (5) found that 75.3% of the mothers accepting the benefits of the vaccines which is more than their risks. Odusanya et al. (6) also observed that 99.1% of the mothers had positive thoughts about vaccination, they thought that vaccination was beneficial and their children were fully vaccinated.

In low and middle income countries like South American countries and even in western societies, the main reason of vaccination hesitancy was due to their side effects, while in our study 16.1% of participants stated that they were afraid of the side effects of non-routine vaccines (7-12)

In our study, it was observed that education levels and amount of income was increased proportionally with the level of knowledge about non-routine vaccination. In a previous study conducted in Kenya (13), there was a direct correlation between maternal education level and full vaccinated number of children, and in a case-control study conducted in the United States of America in 2001 (14) it was determined that high maternal education level had a positive effect on fully vaccinated status of children.

As a conclusion our study had similar results with studies conducted in Turkey. As with routine vaccinations, mothers were found to be more competent in non-routine vaccinations. However, the high percentage of lack of knowledge of mother in some studies regarding non routine vaccination may be due to the difference in the region and education level. In our study, the rate of those who had knowledge about non-routine vaccination was higher than previous studies. This might be due to increase perception of families about non routine vaccination by time. In addition, the percentage of those who had implemented the non-routine vaccinations was found to be higher than other studies supporting the increase awareness about non routine vaccines. Similar to other studies, we found that parental education and amount of income is correlated with awareness of vaccination. Since HPV is the least known vaccine from the non routine vaccines in our study we think that more campaigns should be made on this vaccine to increase awareness and implementation.

REFERENCES

- 1- Adeyinka DA, Oladimeji O, Adeyinka FE, Aimakhu C. Uptake of childhood immunization among mothers of under five in southwestern Nigeria. *The Internet Journal of Epidemiology* 2009;7:1-9.
2. Miller MA, Hinman AR. Economic Analyses of Vaccine Policies. In *Vaccines*, 4th ed.; Plotkin SA, Orenstein WA, Eds.; Elsevier Inc.: Philadelphia, PA, USA, 2004; Chapter 57.
3. World Health Organization. Immunization coverage. Erişim Adresi; <https://www.who.int/data/gho/data/themes/topics/immunizationcoverage>. Erişim Tarihi: 06/12/2022
- 4-Çıklar S, Güner PD. Knowledge, Behavior and Attitude of Mother's about Childhood Immunization and Reasons of Vaccination Rejection and Hesitancy: A Study of Mixt Methodology. *Ankara Med J* 2020;1:180-95.
- 5-Šeškutė M, Tamulevičienė E, Levinienė G. Knowledge and Attitudes of Postpartum Mothers towards Immunization of Their Children in a Lithuanian Tertiary Teaching Hospital. *Medicina (Kaunas)* 2018;12;54:2.
- 6-Odusanya OO, Alufohai EF, Meurice FP, Ahonkhai VI. Determinants of vaccination coverage in rural Nigeria. *BMC*



Public Health 2008;8:381.

7- Garcia LD, Velandia-Gonzalez M, Trumbo SP, Pedreira MC, Bravo-Alcantara P, Danovaro-Holliday MC. Understanding the Main Barriers to Immunization in Colombia to Better Tailor Communication Strategies. BMC Public Health 2014;14:669.

8-Cobos Munoz D, Monzon Llamas L, Bosch-Capblanch X. Exposing Concerns About Vaccination in Low- and Middle-income Countries: a Systematic Review. Int J Public Health 2015;60:767–80.

9-Vonasek BJ, Bajunirwe F, Jacobson LE, Twesigye L, Dahm J, Grant MJ, et al. Do Maternal Knowledge and Attitudes Towards Childhood Immunizations in Rural Uganda Correlate with Complete Childhood Vaccination? PloSone 2016;11:255-62.

10-Kumar MV, Anjaneyulu G, Sree VN, Sai WMG. Immunization Status and Knowledge Regarding Ewer Vaccines Among Mothers in a Rural Area of Rangareddy District, Telangana, India. Community Med Public Health 2016;3:3157-60.

11-Benin AL, Wisler-Scher DJ, Colson E, Shapiro ED, Holmboe ES. Qualitative Analysis of Mothers' Decision-making About Vaccines for Infants: the Importance of Trust. Pediatrics 2006;117:1532-41.

12-Williams SE. What Are the Factors That Contribute to Parental Vaccine-hesitancy and What Can We Do About It? Hum Vaccin Immunother 2014;10:2584-96

13-Onsomu EO, Abuya BA, Okech IN, Moore D, Collins-McNeil J. Maternal Education and Immunization Status Among Children in Kenya. Matern Child Health 2015;19:1724-33.

14-Gust DA, Strine TW, Maurice E, Smith P, Yusuf H, Wilkinson M, et al. Underimmunization Among Children: Effects of Vaccine Safety Concerns on Immunization Status. Pediatrics 2004;114:16-22.



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POSTER PRESENTATIONS

PS001

The Effect of Mothers' Anxiety Levels on The Transition Period to Complementary Feeding

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Objectives: The aim of this study is to determine whether mothers' anxiety levels before and after complementary feeding (CF) initiation negatively affect infants' transition period to CF. Another aim is to determine the factors that influence mothers who are anxious about feeding their infants and have difficulty.

Methods: In this study, we prospectively enrolled infants who applied to the Well-Child Clinic at Gazi University School of Medicine, between June 2018 to January 2020. The study was conducted with 150 mothers and their infants of 5 months of age who met the inclusion criteria and had not yet started complementary feeding. Patients were called for control when the infant was 5 and 7 months old. The Beck Depression Inventory was administered to mothers on admission when the infant was 5 months old age. The State-Trait Anxiety Inventory (STAI) and a questionnaire were administered to mothers at the fifth and seventh months. The accepted statistical significance level in this study was < 0.05 .

Results: Of the 150 infants included in the study, 49.3% (n=74) were girls, and 50.7% (n=76) were boys. According to the results of mothers who were administered the Beck Depression Inventory was statistically significant that mothers with depressive symptoms (n=20) were more anxious about feeding their babies than mothers without depressive symptoms (n=13) (34.5% vs. 14.1%, $p=0.006$). The mean STAI-1 and STAI-2 score of mothers when the infant was 5 months old and 7 months old was not found statistically significant ($p=0.567$, $p=0.149$). It was found that mothers who had anxiety about feeding their infants also had difficulty feeding them, and the association between these variables was significant ($p < 0.001$). When STAI-1 and STAI-2 were examined for the presence of anxiety, no significant association was found between the transition to CF and the presence of anxiety among mothers at the fifth and seventh months ($p=0.185$). 28.7% (n=43) of infants gained less than 15 g/day, whereas 71.3% (n=107) gained ≥ 15 g/day. The association between eat snack and inadequate weight gain was found significant ($p=0.020$). In multivariate logistic regression analysis, female gender ($p=0.039$) and giving snacks between meals ($p=0.015$) were risk factors for inadequate weight gain during the transition to CF. Weight gain of formula users compared to non-users was statistically significant ($p=0.010$).

Conclusion: Since the transition period to CF is a new process for both mother and infant, mothers were expected to be anxious, but in our study, mothers' anxiety levels did not increase. This result may be due to the regular well-child visits that allow frequent monitoring and intervention at each problematic stage and the standard written feeding documents in the CF period. Although there is no statistical significance, the presence of anxious mothers requires a unique approach and support for mother-infant pairs. It is thought that the results of our study will contribute to the current practical applications on CF.

Keywords: Complementary feeding, anxiety, mother, infant

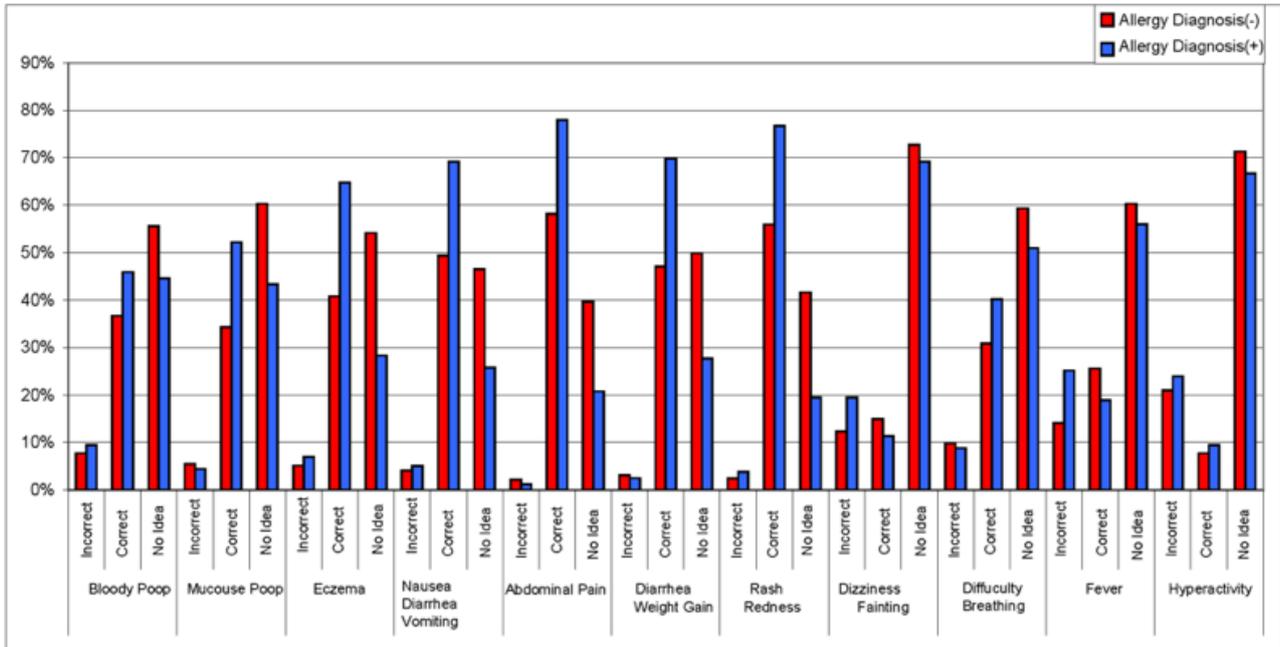
PS003**Parents' Knowledge Levels and Awareness Regarding Cow's Milk Allergy and Cow's Milk Allergy-Associated Anaphylaxis**Gökçen Cerrah¹, Zeynep Ülker Tamay²¹Istanbul University, Faculty of Medicine, Child Health Institute, Department of Social Pediatrics, Istanbul²Istanbul University, Faculty of Medicine, Department of Pediatrics, Istanbul

Objectives: Cow's milk allergy is one of the most common allergies in early infancy and childhood. Our aim is to evaluate the knowledge level of parents about cow's milk allergy and especially early type food allergy and to create social awareness. Because cow's milk allergy can cause various symptoms, it is recognized late and can pose great risks, up to the development of fatal anaphylaxis.

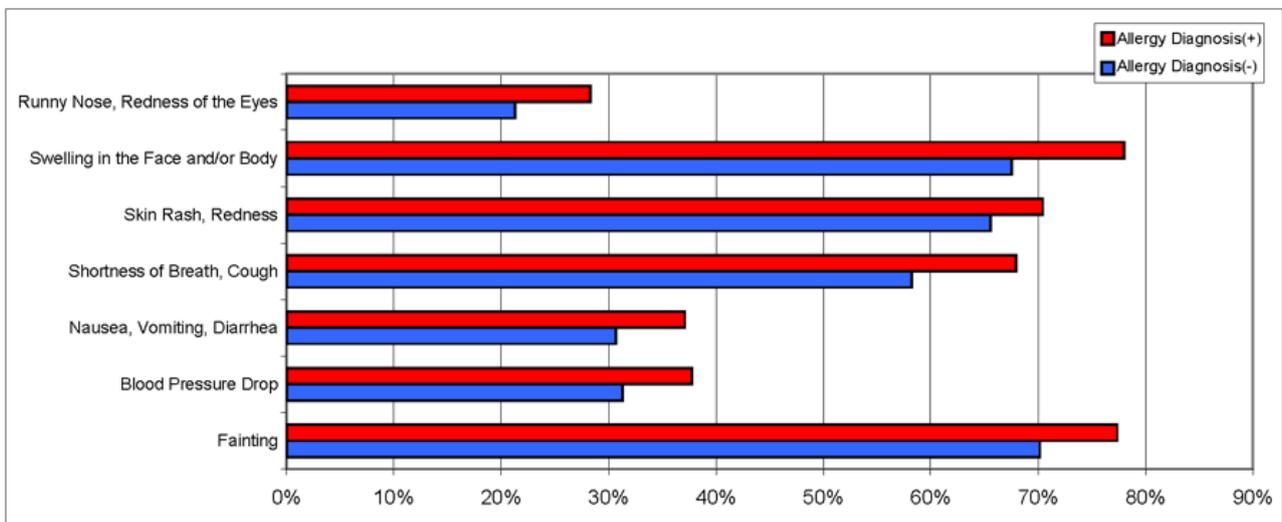
Methods: The study population consisted of parents who applied to our Istanbul Selamiçeşme Family Health Center and volunteered to participate in the study with children aged 18 and under. Questionnaires were applied to the parents who applied to our center between 15.03.2021 and 15.09.2021, face to face and through google forms application. Questions were asked about the sociodemographic characteristics of the participants, the knowledge levels of the parents about cow's milk allergy and anaphylaxis.

Results: In the Allergy Diagnosis (+) group of the patients included in the study, the educational status of the Mother and Father, Literacy, Primary and Secondary Education were found to be statistically significantly lower than the Allergy Diagnosis (-) group (p=0.0001). Which of the following symptoms can a cow's milk allergy cause? In the Allergy Diagnosis (+) group, the presence of bloody poop, mucous poop, eczema, nausea, vomiting, abdominal pain, diarrhea, weight gain, failure to thrive, itching, redness, rash, swelling was found to be statistically significantly higher than the Allergy Diagnosis (-) group. In the Allergy Diagnosis (+) group, the presence of dizziness, fainting, and fever were found to be statistically significantly higher than the Allergy Diagnosis (-) group. No statistically significant difference was observed between the distribution of tongue swelling / difficulty in breathing, presence of hyperactivity in the Allergy Diagnosis (-) and (+) groups (p=0.078)(p=0.509). What might be the signs of anaphylaxis/allergic shock? No statistically significant difference was observed between the distributions of the Allergy Diagnosis (-) and (+) groups in the distribution of fainting, ecstasy, low blood pressure, nausea, vomiting, presence of diarrhea, skin rash, redness, runny nose, and redness in the eyes (p=0.073), (p=0.124), (p=0.120), (p=0.247)(p=0.061). Shortness of breath, cough, swelling in the face and/or body in the Allergy Diagnosis (+) group, the presence of Yes was found to be statistically significantly higher than the Allergy Diagnosis (-) group (p=0.026)(p=0.011).

Which of the Following Symptoms can a Cow's Milk Allergy Cause?



What could be the Signs of Anaphylaxis



Conclusion: Despite the increase in the disease, we think that parents know very little about cow's milk allergy knowledge. National,comprehensive publications emphasizing the awareness of cow's milk allergy in parents are insufficient.It's expected that our study will raise awareness about cow's milk allergy in participating parents.

Keywords: Cow's milk allergy, Food allergy

PS004

Comparison of Screen Time and Digital Gaming Habits of Turkish Children Before and During The Coronavirus Disease 2019 Pandemic

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Objectives: The aim of this study is to compare the screen time and digital gaming habits of Turkish children before and during the coronavirus disease 2019 (COVID-19) pandemic.

Methods: This cross-sectional descriptive study was carried out in a university hospital between May 7, 2020 and June 27, 2020. Healthy children aged 3–10 years who applied to the pediatrics clinics for outpatient care were included in the study. A structured survey was applied to the parents who agreed to participate.

Results: A total of 253 children were included in the study. It was found that the ratio of children with screen time of ≥ 1 hour during the pandemic was significantly higher than before the pandemic ($p < 0.001$). It was determined that the ratio of children watching both adult and children's programs increased during the pandemic ($p < 0.001$). The ratio of children playing digital games during the pandemic was also found to be increased significantly compared with that before the pandemic ($p < 0.001$).

Conclusion: This study demonstrated that screen and digital gaming time increased independently of sociodemographic characteristics during the COVID-19 pandemic compared with before the pandemic.

Keywords: Children; coronavirus disease 2019; digital game; pandemic; screen time.



PS008

The Limits of Vaccine Refusal: A Parental Right or Medical Neglect? An Ethical Discussion About A Case of Neonatal Tetanus

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Introduction: The parents have the legal right to decide on behalf of their children. But their decision may not always accord with the recommendations of health care professionals. Several conditions have been described to diagnose medical neglect when the parents' decision is not 'the best' for their children (1). The aim of this case presentation is to point to difficult cases of childhood vaccine refusal, ethical issues and legal loophole for mandatory vaccination.

Case: A one-month-old baby girl admitted to our clinic with increasing difficulties in sucking and swallowing for last 2-3 weeks and bending her head to the backward for 10 days. She was asymptomatic for the first 10 days of her life but difficulty in sucking and bending her head backward had started during the second week. By the third week, she had acquired a stiffness that prevented her from sucking and swallowing, and her mother had to hospitalize her. In prenatal history, the mother had refused to be vaccinated against tetanus; routinely administered two doses of tetanus toxoid containing vaccines for prenatal care. In natal history, the baby was born at home by spontaneous delivery and the umbilical cord was cut by boiled scissors. The mother had also objected to giving a blood sample of her baby for neonatal screening program carried out by the government. At admission, the baby was in opisthotonos and had muscular spasms in extremities especially with touch. In a few minutes, tonic seizures of upper extremities and "bicycling" movements of the limbs occurred. The patient was diagnosed as neonatal tetanus upon the prenatal immunization and birth history. Kernicterus, ischemic diseases and inborn errors of metabolism were also considered in differential diagnosis. All tests performed for the differential diagnosis were negative. The treatment protocol included muscle relaxants, human Tetanus Immunoglobulin, and antimicrobial therapy for tetanus in addition to attentive supportive care. The patient was clinically well after being treated for neonatal tetanus. Vaccinations in the national vaccination program including tetanus containing vaccines was recommended to the parents. Neither medical team nor the social service staff could convince the parents for vaccination. We reported the case as a 'medically neglected child' to the Family and Social services of the government and are waiting for the process.

Conclusion: We present a case of neonatal tetanus, resulting from maternal vaccine refusal in pregnancy, treated successfully with antitetanus treatment but discharged without being vaccinated upon parental vaccine refusal because of a legal loophole. We suggest that the limits of childhood vaccine refusal should be determined and the legal infrastructure should be established for mandatory vaccination when required, to prevent predictable harm (2-4). Moreover, multidisciplinary hospital ethics committees are required to evaluate complicated cases with different aspects.

Key words: Vaccine refusal, neonatal tetanus, medical neglect

References

1. Dubé E, Gagnon D, MacDonald NE; SAGE Working Group on Vaccine Hesitancy. Strategies intended to address vaccine hesitancy: Review of published reviews. *Vaccine*. 2015;33(34):4191-4203. doi:10.1016/j.vaccine.2015.04.041
2. Rossi R, Rellosa N, Miller R, et al. A Complicated Case of Vaccine Refusal. *Pediatrics*. 2020;146(4):e20200768. doi:10.1542/peds.2020-0768
3. Hadjipanayis A, Dornbusch HJ, Grossman Z, Theophilou L, Brierley J. Mandatory vaccination: a joint statement of the Ethics and Vaccination working groups of the European Academy of Paediatrics. *Eur J Pediatr*. 2020;179(4):683-687. doi:10.1007/s00431-019-03523-4
4. Dubowitz H. Neglect of children's health care. In: Myers JEB, Berliner L, Briere J, Jenny C, Hendrix CT, Reid T, eds. *The APSAC Handbook on Child Maltreatment*. Thousand Oaks, CA: Sage; 2002:269– 292

Figure 1. The patient in the opisthotonus position



Video 1. Bicycling movements of the limbs





PS010

Transient Hypogammaglobulinemia of Infancy Diagnosed with BCG Scar Examination in Routine Well-Child Care Visits: A Case REport

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Introduction: BCG vaccine is a safe vaccine administered in the 2nd month of the Ministry of Health vaccination schedule in Turkey. After vaccination, there may be reactions classified as early (before 2 weeks)/late (after 6 months), severe/mild, or local/systemic. Here we present a case who had late BCG reaction and was diagnosed with transient hypogammaglobulinemia of infancy.

Case: A male baby born at 39+4 gestational age and 4000gr of weight as LGA by C-section was under routine well-child follow-up. He got vaccinated according to the Ministry of Health in Turkey vaccination schedule by his age, additionally Rotavirus vaccine was applied in the 3rd month. He was exclusively breastfed for the first 6 months. He had no infections or hospitalization during the first 6th months. No growth retardation was detected. Developmental milestones were normal for his age. At the 6th month's visit, it was noticed that the BCG scar was still not formed, and a 0.5x0.5 cm lesion with discharge in the vaccination area was observed. BCG scar was evaluated as a late vaccine reaction. Further evaluation was done for immune deficiencies. Blood levels were as follows: IgG:74mg/dL (N: 240-440), IgM:38.8mg/dL (N:34-114), IgA:10.7mg/dL (N:27-86) WBC:7400/μL, neu:1400/μL, lymph:4900/μL. His evaluation for classification of the immune deficiency started because of low levels of IgG and IgA. He was given intravenous immunoglobulin (IVIG) treatment (0.5 g/kg/dose). Lymphocyte subgroups, CD40-CD40L, and WES genetic panel (for HyperIgM syndrome) were performed, and all of them resulted as normal. He was given IVIG for 3 times either until 14th months old. Hypogammaglobulinemia was improved after 14 months old. With all findings, he was diagnosed with transient hypogammaglobulinemia of infancy. He received his last IVIG at 14 months of age and received live-attenuated vaccines when he was 20 months old.

Conclusion: It is important to recognize what are the local and systemic side effects of vaccines and the time of the side effects. BCG late reaction can be the first finding for immune deficiencies. For this reason, it will be better to evaluate the BCG scar at each examination in routine well-child visits.

Keywords: vaccine reactions, BCG, transient hypogammaglobulinemia, infant

PS011

Induced Lactation and Relactation: Case Reports of Two Adoptive Mothers

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Objectives: Induced lactation (IL) is the process of producing milk by a woman who has not previously been pregnant or breastfeeding another child. The main purpose of IL is to provide interaction between mother and baby. Relactation is the process by which a mother reestablish lactation after stopping for several periods. Here we report two adopted baby-mother dyads who successfully experienced breastfeeding counseling.

Case: Case 1A baby who was born at 40 6/7 gestational age and adopted by a foster parent when he was 2 months old. The foster mother, who had never been given birth and hadn't breastfed, applied to Social Pediatrics well-child outpatient clinic relactation unit to ask if she could breastfeed or not. The baby and mother dyad was evaluated, and the first skin-to-skin contact was initiated by touching the mother's breasts by the baby. A successful latching was provided at the same visit. Skin-to-skin contact and latching trials were recommended. The baby started feeding with a supplemental nursing system (SNS) one week later. Fifteen days after feeding with the SNS from the mother's breast in every feeding period (6 to 8 times a day), the mother felt that her breast started to get slightly tension. Feeding the baby with an SNS was continued, and at the 4th week after the first application, milk started to drop. Domperidone could not be started as a medical galactagogue because the mother was using prednisolone and hydroxychloroquine medications for systemic lupus erythematosus, so fenugreek was recommended as a herbal galactagogue. Colostrum-colored milk dripped from both breasts for nearly 3 weeks, and e milk dripped after 3 weeks. For 4 months mother breastfed her baby to provide interaction, and complementary feeding was started at the sixth month of the baby. Case 2 A 17 days-old baby boy was adopted by a foster parent. The foster mother had two more children, but the last time she breastfed was 22 years ago. The baby and mother dyad was evaluated, and the first skin-to-skin contact was initiated by touching the mother's breasts by the baby. A successful latching was provided at the same visit. A supplemental nursing system was ordered, and the mother started breastfeeding with this system at least 8-10 times a day. After one week, the mother started to use domperidone as a galactagogue. When the baby was 45 days, the milk started to drip from one of her breasts. The amount of milk gradually increased. The baby is now 3 months old, and the mother breastfeeds her baby in addition to the formula.

Conclusion: Conclusion There are two paramount requirements for lactation: a strong desire by the mother to feed the infant and the stimulation of the nipple. In our cases, the baby's latching and breastfeeding seem to be the most effective mechanical stimulus for nipple stimulation. Providing skin-to-skin contact, proper positioning, and latching is a priority in breastfeeding counseling for both relactation and IL.

Keywords: Induced lactation, relactation



PS012

The Use Of Multivitamin-Minerals, Omega -3, Immune Supporting Products Among 1- To 18-Year-Old Children and Knowledge Of Their Families In Izmir, Turkey

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Objectives: Vitamins and minerals, omega-3 fatty acids, immune supporting products are may used to treat, prevent or support in certain diseases. The aim of this study is to determine the frequency of intake of vitamins, minerals, omega-3 fatty acids and immune supporting products in children and the level of knowledge of their families on this subject.

Methods: This study was carried on between August 2022 and October 2022 in Ege University Child Health Follow-up Out-patient Clinics. In this study, prespecified questionnaires were administered to the parents of 200 children aged 2 to 18 years. Demographic data of the children and their families, use of vitamin-mineral, omega 3, immune-supportive products, knowledge levels about supplementary products, how they use were evaluated.

Results: Of the 200 patients enrolled in the study, 97 (48.5%) were female and 103 (51.5%) were male. The average age of the cases was 7.23 years (minimum: 2.0 - maximum: 17.8). When examining the educational level of the parents who participated in our survey, 93 (46.5%) were university graduates. 20% of mothers and 7.5% of fathers were health care workers. While 116 (58%) of the cases did not take any supplements, 33% actively used at least one of the products containing vitamins and minerals, omega-3 and immune system support. When looking at those who use supplements, it appears that vitamin supplements were the most commonly used at 43.3%. The proportion of those using omega-3 was 33%, and the proportion of those using products to support the immune system was 23.3%. As the educational level of parents was related to the rate of use of vitamin-mineral, omega-3, and immune-supportive products, but economic status of families were not effective. It was found that families (88%) who did not use support products for themselves tended not to use support products for their children ($p=0.00$). Children attending kindergarten and elementary school were found to use support products to a greater extent ($p=0.047$). Mothers and fathers who were health care workers were found to use support products to a greater extent ($p < 0.00$). The proportion of those who consulted a physician before taking supplements was high. Doctor's recommendation was the first choice in vitamin preference. Most of the families with low educational level and economic status were not consult a doctor for vitamin and mineral use.

Conclusion: There are not enough data on the use of multivitamins, omega -3, immune supporting products in children in Turkey. The supportive products used unknowingly may endanger children's health. If people do not have sufficient knowledge about vitamins, it is also important that they act by seeking information from health care professionals who are experts in their field. So, vitamin supplementation to the childs should be reviewed in a detailed manner in each health care visits and the families should be informed about the importance of supplementation to prevent other micronutrients deficiency.

Keywords: immune support product, Multivitamin, omega 3 fatty acids

PS013**Meningococcal Vaccine Through An Oral Route With Rotavirus Vaccine: Administration Error and After**

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Objectives: Neisseria Meningitidis (Meningococcus) is an important gram negative bacteria causing meningitis and septicemia with high morbidity and mortality rates. Case-fatality rates from invasive meningococcal disease are 10% to 15%, rising as high as 50% to 60% among patients with meningococemia (blood stream infection) and shock . For survivors, there are persistent neurological defects including hearing loss, speech disorders, loss of limbs, mental retardation and paralysis in as many as 10% to 15%. It is spread by person-to-person contact through respiratory droplets. Meningococcus inhabits the nose and throat mucosa where it usually causes no harm. It is a preventable disease via vaccination.

Methods: Vaccines are applied via intramuscular route including the vaccine used in our case(Nimenrix, conjugated (A,C,W,Y) vaccine). In this case, a 3 months old baby received Nimenrix through an oral route and we evaluated whether or not it would cause serious side effects. However there are no other cases regarding oral route of administration of Nimenrix in current literature. In our opinion, it's the first case to evaluate Nimenrix's safety when administered via oral route.

Results: Case: In June 2022, 3 months old twin babies were brought to the local healthcare institute for routine follow up and the parents of the twins were recommended for oral rotavirus(Rotarix) and intramuscular meningococcal vaccines(Nimenrix). The parents agreed upon administration of the vaccines. One of the twins got Nimenrix vaccination via oral route together with Rotarix vaccine instead of the correct intramuscular administration of the vaccine. While the other twin's vaccinations were administered appropriately(IM Nimenrix, and oral Rotarix). The situation was reported to the ministry of health of Turkey and the manufacturer of the vaccine and the patient was followed up after the incident regularly. On Day 0 after the administration , there were no symptoms while on Day 1 softening of stool was observed, but it's attributed to a change of his diet that consists of mother's milk and formula to only mother's milk. And no other symptoms were seen at subsequent visits.The patient was followed up through telephone daily after initial few days after the incident. The patient is called to be vaccinated by meningococcal vaccine after one month.

Conclusion: In our case, 3 months old twin babies came to local health care institute for Nimenrix (meningococcal) and Rotarix (rotavirus) vaccination. Rotarix is given via oral route. Nimenrix on the other hand, is only given IM. Due to the mistake of a nurse working in the facility, Nimenrix vaccine is given orally with Rotarix. The baby was followed for (HOW LONG??). On day 0, no extraordinary symptom is seen. On day 1, consistency of stool was observed to be softer than usual. This change is attributed to the change of babies diet from a mix of mother's milk and formula to only mother's milk. In the following days, the baby did not experience any side effects

Keywords: meningococcus, vaccine, administration error



PS014

Toilet Training Method and Primary Nocturnal Enuresis Coexistence in Children

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Objectives: Primary Nocturnal Enuresis (PNE) is a prevalent condition in childhood. PNE is defined by the International Children's Continence Society (ICCS) as isolated urinary incontinence during sleep in children aged five years and older, with no associated clinical condition and occurs in children and adolescents who have never achieved a period greater than six continuous months of nighttime dryness. The etiology is multifactorial, and the pathophysiology is not fully understood. In this study, we investigated the relationship between the toilet training (TT) process and PNE in children and adolescents.

Methods: This is a case-control study in which 79 children and adolescents, aged between 5 and 12 years, with PNE were initially evaluated as cases. The study was approved by the ethics committee of Tekirdağ Namık Kemal University and the legal guardians of the patients signed an informed consent form. Children and adolescents with intellectual disorder, congenital anomalies of the nervous and urogenital system, diabetes mellitus, secondary enuresis were excluded. The control group consisted of 100 children and adolescents with normal neuropsychomotor development who followed up in pediatric outpatient clinics. The diagnosis of PNE was based on the ICCS criteria and Turkish Pediatric Urology Association guidelines. The questionnaire included the signs of readiness, the age at which the child started and completed the TT, child-oriented approach and the type of equipment.

Results: The study included 79 children and adolescents with PNE and 100 participants with normal psychomotor development without PNE (control group). Readiness signals were less frequent in participants with PNE ($p=0.001$) when compared to control group. No differences were found between the groups regarding the onset age of the daytime TT and nocturnal TT ($p= 0.29$, $p=0.12$) and the type of equipment used for the TT ($p=0.87$). The use of Child-Oriented approach in group of children with enuresis was lower than in controls [73.4% (58/79) versus 91% (91/100)], respectively (OR= 0.37, 95% CI 0.31-0.89, $p = 0.028$).

Conclusion: As a result; expecting readiness symptoms and giving toilet training with a child-oriented approach were found to be protective factors for PNE. On the other hand, it is thought that it is very valuable for health professionals to discuss the TT process with parents and to evaluate family dynamics and risk factors for failure.

Keywords: Enuresis, Children, Toilet Training

Index

A

- Abdullah Bereket 161
Abdullah Emre Askin 83
Adem Aydın 2, 3, 4, 7, 10, 130, 139
Ahmet Ergin 6, 138, 172
Ahmet Küçük 100
Ahmet Oğuzhan Özen 58, 173
Ahmet Şengün 73
Ahsen Erim 60
Alev Bakır Kayı 152
Ali Osman Köksal 181
Arman Vahabi 148
Aslı Sezal Çubukçu 185
Atilla Çiftçi 8
Aybüke Kaçır 102
Aylin Yetim Şahin 152
Ayşe Aydın Uysal 60
Ayşe Emel Önal 136
Ayşe Esra Tapcı 120
Aysegul Bukulmez 184
Ayşe Kılıç 9
Ayşe Oflu 184
Ayşe Rodopman Arman 132
Ayşin Nalbantoğlu 191
Ayşin Taşar 9
Aysu Çolakoğlu 99
Aysu Duyan Çamurdan 10, 59, 61, 79, 120, 181
Azar Pashayev 142

B

- Bahar Çuhacı Çakır 9, 24, 61, 120, 181
Bahar Güçöz Doğan 163
Bahar Kural 10, 27, 57, 99
Bahar Öztelcan Gündüz 61, 174
Bekir Aktura 83, 190
Belgin Ünal 139
Belma Haliloğlu 161
Benhur Sirvan Çetin 142
Beril Aydın 5
Betül Orhan Kılıç 123
Betül Ulukol 9, 123, 165
Birgül U.Bayoğlu 131
Bülent Güneş 80
Burak Ütük 132
Burçe Emine Dörtkardeşler 162
Burçin Nalbantoğlu 191
Burçin Yorgancı Kale 132, 150
Burcu Aygün 161, 173
Burcu Özge Erdoğan 81
Burcu Öztürk Hişmi 150
Buse Günyel 187, 188

C

- Çağatay Günay 130
Cansu Kaymakci 82
Ceren Tanç 191
Charles Oberg 3, 7
Cüneyt Karagöl 59

D

- Demet Alaygut 33
Demet Deniz Bilgin 102
Demet Soylu 73
Deniz Genç 55
Deniz Özçeker 53
Derya Öztuna 72
Dilara Yağmur Işınkaralar 99
Dilek Konuksever 123
Dilek Orbatu 33

E

- Ebru Elmas 184
Ebru Öztürk 110
Ece Aslan Müştaoğlu 187, 188
Ece Çetin 55
Ecem Can 161
Ekin Say Yıldırım 139
Ela Erdem Eralp 4
Elif Eviz 161
Elif Güler 79
Elif Karakoç Aydın 58, 173
Elif Özmert 9
Elif Perihan Öncel 170, 171
Elif Ünver Korgalı 7, 13
Emel Gür 3, 6, 9, 138, 172
Emel Örün 7, 19, 37
Emine Yurdakul Ertürk 90, 94
Eren Güzeloğlu 34
Eren Özek 55
Erhan Coşkunol 148
Ertan Direnç 71
Esin Aydın Aksoy 163
Esra Kanlı Denizci 9
Esra Özek Yüce 187
Evrin Gürhan Tahta 184
Evrin Senkal 121, 122
Eylem Gül 123
Ezgi Barış 4
Ezgi Çağlar 128
Ezgi Çeliker 191

F

- Fadiye Gökmen Uyanık 78
Fatma Daşdemir 33
Fatma Nur Baran Aksakal 181
Fezay Koç 2, 3, 6, 7, 138, 162, 164, 172, 189



Figen Şahin Dağlı 3, 5, 9
Filiz Orhon 6, 21, 72, 81, 138, 172
Filiz Şimşek Orhon 9, 73
Filiz Tubaş 61
Firdevs Baş 152
Fulya Coşkunol 148

G

Gamze Güzel 188
Gökçe Celep 10, 25
Gökçen Cerrah 182
Gonca Keskindemirci 6, 9, 138, 152, 172, 187, 188
Gonca Yılmaz 7
Gözde Kandemir 43
Gülberat İnce 115
Gülbin Gökçay 2, 3, 6, 7, 9, 152, 187, 188
Gülsüm Özen 80
Gül Yeşiltepe Mutlu 161

H

Habip Almış 9, 11, 100
Hasan Özbek 148
Hatice Ezgi Barış 58, 71, 132, 161, 173
Hatice Kübra Dursun 102
Hatice Sena Somuncu 111
H. Ezgi Barış 150
Hilal Akalın 187, 188
Hilal Parıldar 152
Hülya Barlak 4
Hülya Özdemir 55

I

İlkay Yurtseven 170, 171, 185

J

Jeff Goldhagen 3, 7

K

Kadriye Yurdakök 9
Kamile Ötiken Arıkan 185
Kazım Kutlutürk 174
Khatuna Makharoblidze 128

L

Lubna Quatranji 132

M

Mahmut Caner Us 161
Mahmut Çoker 164
Meda Kondolot 10, 142
Mehmet Çeleğin 184
Mehmet Cengiz 174
Mehmet Gündüz 61
Melda Çelik 10, 28

Melda Karavuş 132
Melike Tuğrul Aksakal 5, 152
Melis Öztürk Aykaç 191
Meltem Çetin 185
Meltem Çobanoğulları Direk 128
Meltem Dinleyici 6, 9, 138, 172
Meltem Erol 111
Meltem İleri 10
Merve Erdemir Kula 90, 94
Merve Salça 110
Merve Tosyalı 3, 7, 18, 162, 164, 189
Meryem Erat Nergiz 160
Mine Başibüyük 83, 102
Mine İnal Akkaya 131
Murat Bektas 33
Murat Celal Sözbilen 148
Murat Ersoy 37
Murat Suman 37
Musa Harun Göçmen 190

N

Nahide Haykır 157
Nalan Karabayır 5, 7, 10, 83, 102, 190
Nathan Uchtmann 3, 7
Necla İpar 161
Neslihan Gökmen İnan 161
Nesrin Ceylan 61
Nicel Yıldız Silahlı 5, 132
Nick Spencer 3, 7, 9
Nihal Durmaz 37, 43
Nilgün Çaylan 10
Nilgün Çöl 10, 121, 122
Nisa Eda Çullas İlarıslan 123
Nükhet Hotar 7
Nurdan Evliyaoglu 7
Nur Ecem Öztop Gündoğdu 55
Nurşah Özkan Bayrakçı 136

O

Ömer Faruk Sevim 190
Orkut Koç 189
Osman Kuleli 152
Osman Tolga İnce 139
O. Tolga İnce 3
Övgü Büke 102, 111
Oya Baltalı Hıdır 11, 78
Öykü Özbörü Aşkan 58, 152, 187, 188
Özden Aksu Sayman 90, 94
Özge Günal 132
Özge Yendur Sezer 60
Özlem Bağ 3, 8, 9, 11, 23, 60, 170, 171, 185
Özlem Bostan Gayret 111
Özlem Öçal Doğan 102
Özlem Tezol 10, 128
Özlem Üzüm 115
Öznur Gökçe Nizam 71



P

Pamela Douglas 3, 4
Perihan Sencer 188
Perran Boran 3, 4, 10, 58, 71, 132, 150, 161, 173
Pınar Özer 73
Pınar Yılmazbaş 11, 53

R

Rabia Kefeli 149
Ramazan Dulkadir 61
Raul Mercer 3, 7
Refika Ersu 3, 4
Rosie Kyerematang 3, 7

S

Sabire Karakuşoğlu 57
Safa Barış 58, 173
Sarah Blunden 3, 4, 10
Sebnem Bektas 83
Şebnem Soysal Acar 181
Seda Topçu 10, 26, 72, 81
Selda Fatma Bülbül 82, 110
Selda Hançerli Törün 187
Selda Karaayvaz 5
Semra Hız Kurul 130
Şenay Türe 101
Serap Sapmaz 5
Serdar Ümit Sarıcı 73
Serhat Kılıç 123
Serpil Uğur Baysal 9
Sevay Alşen Güney 9
Sevgi Başkan 72, 81
Sevgi Özmen 142
Sevtap Velipaşaoğlu 6, 9, 101, 138, 172
Seyhan Çelik Merteşe 72
Şeyma Karatekin 149
Sezen Köse 9, 22
Shanti Raman 3, 7
Sinem Gülcan Kersin 55
Songül Yalçın 3, 7, 10, 80, 160, 163
Şükrü Hatun 161
Şule Gökçe 162

T

Tolga Dağlı 5
Tolga İnce 3, 9, 10
Tony Waterson 3, 10
Tufan Torun 58
Tuğba Gökçe 161
Tuğba Kartal 43
Tunç Akkoç 55

U

Ülker Koçak 79
Uluç Yiş 130

V

Vefik Arıca 10

Y

Yaşar Topal 9
Yavuz Demirçelik 78
Yeşfa Şebnem Özbay 57, 99
Yunus Emre Doğan 142

Z

Zekeriya Akıncı 72
Zeynep Gizem Ergün Özdel 165
Zeynep İzem Peker Bulğan 33
Zeynep Karakaya 174
Zeynep Ülker Tamay 182
Zeynep Varol 139
Zühre Kaya 79
Zümra Bıçakçı 110



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