

Educational quality of YouTube videos on enhancing lactation in postpartum mothers: a cross-sectional observational study

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ABSTRACT

Aims: YouTube is a popular source of breastfeeding advice, but the quality of videos on increasing breast milk supply remains uncertain. We assessed the reliability and educational value of such content.

Methods: In this cross-sectional study, YouTube was searched between July 2024 and January 2025 for the keyword “increasing breast milk.” An independent neonatologist and a social pediatrician evaluated each video using three validated tools: The DISCERN score (15-item quality measure, 1–5 per item; total 15–75), Journal of the American Medical Association (JAMA) benchmarks (0–4), and Global Quality Score (GQS, 1–5). Interrater reliability was evaluated with intraclass correlation.

Results: The 172 videos had a mean duration of 8.5±7.0 minutes (range 1.0–60.0 minutes) and a mean view count of 60.000±210.000 (8–1.700.000). Videos from academic institutions scored higher (DISCERN 45±12; JAMA 2.5±0.8; GQS 3.5±1.0) than those by individuals (DISCERN 25±8; JAMA 1.0±0.6; GQS 1.8±0.7; $p<0.001$). Educational videos had significantly greater quality than testimonial or promotional videos ($p<0.001$). Longer videos correlated strongly with quality ($r\approx0.55$ – 0.60 , $p<0.001$), while views/likes showed weak associations ($r\approx0.20$, $p<0.05$). Comments had no correlation.

Conclusion: Most YouTube videos on breast milk supply are poor in quality and educational value. Trusted sources (academia, healthcare) provided better content, whereas individual/promotional videos were often unreliable. Healthcare providers should direct parents to credible resources and produce evidence-based materials to enhance online breastfeeding education.

Keywords: Breastfeeding, breastmilk, galactagog, newborn, YouTube, education

INTRODUCTION

Despite breastfeeding's well-established benefits, many mothers experience perceived insufficient milk supply—the leading cause of early cessation.^{1,2} This concern drives mothers to seek lactation advice, increasingly through online platforms like YouTube. As the largest video-sharing platform, YouTube offers potential for accessible breastfeeding education through demonstrations and shared experiences, though the quality of such content warrants examination.^{2,3}

The quality of health information on YouTube is highly inconsistent, with content often prioritized for popularity over accuracy.^{4–6} Systematic reviews indicate that much of this material lacks evidence-based guidance, particularly in breastfeeding-related content. For instance, only 18.8% of YouTube breastfeeding videos were rated good/excellent, while most were suboptimal or misleading.⁶ Similar issues plague pediatric health content, with studies reporting fewer than half of videos as accurate or comprehensive (e.g., only 56% accuracy in pediatric surgery videos). Such findings highlight the risks of unreliable or contraindicated advice for parents seeking lactation support online.^{7,8}

To date, little academic attention has focused specifically on videos about increasing breast milk supply. While a recent study examined breastfeeding information on YouTube in Arabic,³ and another analyzed content related to breastfeeding during the COVID-19 pandemic,⁹ there remains a need to evaluate general content on enhancing milk production, particularly in English which has a global audience. Understanding the educational quality of these videos is important for healthcare providers who counsel postpartum mothers, as well as for identifying gaps where better resources are needed.

This study systematically evaluated the quality, reliability, and educational utility of YouTube videos on increasing breast milk supply using validated scoring tools. We analyzed how uploader type, content category, and engagement metrics influenced quality scores, hypothesizing that medical/academic sources would outperform individual uploaders and that overall quality would be variable but often suboptimal. By identifying strengths and gaps in current content, we aim to guide clinicians and educators on YouTube's utility as a patient resource and highlight areas for improvement.

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METHODS

Ethics

We conducted a cross-sectional content analysis of YouTube videos. The study did not involve human subjects and was exempt from institutional review. All procedures were carried out in accordance with the ethical rules and the principles of the Declaration of Helsinki.

Video Selection

We searched YouTube between December 15, 2024 and February 10, 2025 for the term “increasing breast milk.” Search results were sorted by relevance using a logged-out, non-personalized browser to minimize algorithmic bias. The first 200 video results were recorded. Videos were included if they were in English, focused on methods or tips for increasing or maintaining breast milk supply, and had a duration ≥ 60 seconds. We excluded videos that were shorter than 60 seconds (insufficient content), clearly unrelated to breastfeeding or lactation (off-topic), or had audio in an incomprehensible language or accent such that content could not be understood. After applying criteria, a total of 172 unique videos were included for analysis (**Figure 1**).

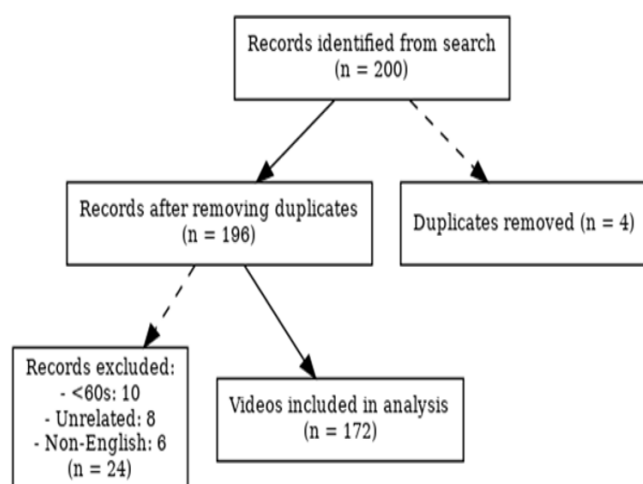


Figure 1. Flow chart of the study

Video Characteristics and Coding

For each included video, we recorded general metrics: upload date, video duration (seconds), view count, “likes” count, and number of comments. To account for varying ages of videos, we calculated engagement rates (views, likes, comments per day since upload) by dividing counts by the days since upload. We noted the uploader identity and categorized it into one of three uploader types: (1) Academic/Medical Institution (e.g., universities, hospitals, professional organizations), (2) Healthcare Professional (individual doctors, nurses, lactation consultants, or private clinics’ channels), or (3) Individual (layperson or parent bloggers/vloggers, including non-professional influencers or commercial product promoters).

We also categorized each video’s content type as educational (primarily instructional or factual information on increasing milk supply), testimonial (personal experiences or vlogs

sharing one mother’s journey or tips), or promotional (content primarily aimed at marketing a product or service, such as supplements or pumps, claimed to increase milk). Video continent of origin (based on uploader’s stated location or video context) was recorded as North America, Europe, Asia, or other, to examine geographic trends. Two researchers independently performed the initial screening and categorization, with discrepancies resolved through discussion.

Quality Assessment Instruments

Three complementary instruments were used to evaluate video quality.

- **DISCERN:** A 15-question tool (score 15–75) rating health info quality (1–5 per item). Scores: <39 (poor), 39–50 (fair), >50 (good). Higher scores=better reliability.
- **JAMA Benchmarks:** Four criteria (authorship, attribution, disclosure, currency), each scored 0/1 (total 0–4). Higher scores=greater transparency.¹⁰
- **GQS:** A 5-point Likert scale rating video educational value (1=poor, 5=excellent). Measures understandability and usefulness for patients.^{4,5,10}

A neonatologist and a social pediatrician with expertise in breastfeeding and lactation (blinded to each other’s scores) independently viewed and scored all videos using the above instruments. Raters were first trained on 10 sample videos (not in the final dataset) to calibrate their scoring approaches. They were instructed to watch each video in full and could replay or pause as needed to apply the scoring criteria. No communication between raters occurred during the scoring phase. After scoring, interrater reliability was assessed by calculating the intraclass correlation coefficient for each scoring instrument’s total scores across the two reviewers.

Statistical Analysis

Continuous variables were summarized with means, standard deviations (SD), and ranges, and categorical variables were summarized as frequencies and percentages. The Kolmogorov–Smirnov test was used to assess normality of score distributions; all primary variables met criteria for normal distribution ($p>0.05$), justifying use of parametric tests. We compared mean quality scores between two groups using independent-samples t-tests (e.g., academic vs non-academic uploader) and among three or more groups using one-way analysis of variance (ANOVA). For multi-group comparisons (uploader type, video type, region), post hoc pairwise comparisons were performed with the Bonferroni correction to identify which groups differed. Correlations between video numeric metrics (view count, like count, comment count, duration, and daily engagement rates) and quality scores were evaluated using Pearson’s correlation coefficient (r). We interpreted correlation strength using standard guidelines: an r of 0.10–0.39 as weak, 0.40–0.69 as moderate, and ≥ 0.70 as strong correlation. Statistical significance was set at $p<0.05$ (two-tailed). All analyses were conducted using IBM SPSS Statistics (v28.0, IBM Corp).

RESULTS

Video Characteristics

The included videos were uploaded between 2015 and 2025, with a median upload year of 2020. On average, videos had been online for 4.1 ± 3.3 years (range 50 days to 15.2 years). The mean total view count per video was 60.084 ± 208.668 (range 8 to 1.700.000), with highly skewed distribution (median 5.421 views) reflecting a few extremely popular videos amid many with modest view counts. Videos received a mean of 500 ± 1.500 likes (range 0 to 12.000) and 30 ± 90 comments (range 0 to 500). **Table 1** summarizes the descriptive characteristics of the videos. Regarding uploader type, 26 videos (15.1%) were from academic or medical institutions (e.g., university channels, professional associations, major hospitals).

Characteristic	Mean $\pm$ SD/n (%)
Video duration (seconds)	508 $\pm$ 420 (61–3600)
Days since upload	1490 $\pm$ 1300 (50–5550)
Total views	60.084 $\pm$ 208.668 (8–1.700.000)
Total likes	500 $\pm$ 1500 (0–12.000)
Total comments	30 $\pm$ 90 (0–500)
Daily views*	39.0 $\pm$ 77.0 (0.1–511.0)
Daily likes*	0.13 $\pm$ 0.22 (0–1.5)
Daily comments*	0.05 $\pm$ 0.10 (0–0.8)
Source	(n=172)
Academic/medical institution	26 (15.1%)
Healthcare professional/clinic	69 (40.1%)
Individual (lay person)	77 (44.8%)
Video content	
Educational/informational	95 (55.2%)
Testimonial/personal story	52 (30.2%)
Promotional/commercial	25 (14.5%)
Broadcasted by region	
North America	80 (46.5%)
Asia	49 (28.5%)
Europe	35 (20.3%)
Other/Not clear	8 (4.7%)

SD: Standard deviation, *Daily values calculated as total count divided by days since upload (at time of analysis).

Interrater agreement between the neonatologist and social pediatrician reviewers was robust. The independent scores for each video were strongly correlated. The intraclass correlation coefficient was 0.994 for DISCERN, 0.879 for JAMA, and 0.898 for GQS ($p < 0.001$ for all).

Quality and Reliability Scores (Overall)

Across all videos, the quality scores indicated generally poor reliability and educational content. The mean DISCERN score for the 172 videos was 34.2 ± 12.5 (median 32; range 15–71 out of a maximum of 75). This falls in the category of “poor” quality consumer health information (well below the

threshold of 39 for fair quality). In fact, 72% of videos scored < 40 on DISCERN, highlighting that the majority lacked many of the elements of good-quality information (such as citing sources, discussing pros/cons of interventions, or areas of uncertainty). The mean JAMA benchmark score was 1.7 ± 0.8 (median 2; range 0–3.5 out of 4). The mean GQS was 2.4 ± 1.0 (median 2; range 0.5–5). Indeed, 60.5% of videos had $GQS \leq 2$, reflecting that most were not very useful for patient education. Only 15 videos (8.7%) were rated as good or excellent ($GQS \geq 4$).

Quality Scores by Uploader Category

There were significant differences in video quality depending on the uploader's identity ($p < 0.001$ by ANOVA for DISCERN, JAMA, and GQS). Videos produced by academic institutions or professional medical organizations had the highest mean quality scores on all three instruments, followed by those from healthcare professionals, and lastly videos uploaded by individuals had the lowest scores (**Table 2**).

Category	n	DISCERN mean $\pm$ SD	JAMA mean $\pm$ SD	GQS mean $\pm$ SD
Academic/institution	26	45.1 $\pm$ 11.5	2.5 $\pm$ 0.8	3.5 $\pm$ 0.9
Healthcare professional	69	35.3 $\pm$ 9.8	1.8 $\pm$ 0.7	2.5 $\pm$ 0.8
Individual (lay person)	77	25.3 $\pm$ 7.8	1.0 $\pm$ 0.6	1.8 $\pm$ 0.7
ANOVA p-value	-	< 0.001	< 0.001	< 0.001
Educational	95	42.2 $\pm$ 11.0	2.3 $\pm$ 0.7	3.2 $\pm$ 1.0
Testimonial	52	27.6 $\pm$ 9.2	1.0 $\pm$ 0.5	1.8 $\pm$ 0.7
Promotional	25	29.6 $\pm$ 10.2	1.2 $\pm$ 0.6	2.0 $\pm$ 0.8
ANOVA p-value	-	< 0.001	0.002	< 0.001

SD: Standard deviation, JAMA: Journal of the American Medical Association, GQS: Global Quality Score

Academic/institutional videos achieved a mean DISCERN of 45.1 ± 11.5 , which approaches “fair” quality (though still not consistently “good”). Post hoc comparisons showed that academic/institutional videos scored significantly higher than individual videos on all metrics (Bonferroni-adjusted $p < 0.001$). Videos from healthcare professionals (mean DISCERN 35.3 ± 9.8 ; JAMA 1.8 ± 0.7 ; GQS 2.5 ± 0.8) had intermediate quality. They were significantly better than individual videos ($p < 0.001$ for DISCERN and GQS; $p = 0.014$ for JAMA) but still notably lower than academic sources (**Figure 2**).

Quality Scores by Video Type

Video content classified as educational had substantially higher quality scores than testimonial or promotional videos (**Table 2**). Educational videos (generally those structured as lectures, tutorials, or Q&A with experts) had a mean DISCERN of 42.2 ± 11.0 , compared to 27.6 ± 9.2 for testimonial videos and 29.6 ± 10.2 for promotional videos ($p < 0.001$ ANOVA). The pattern was similar for JAMA (mean 2.3 for educational vs 1.0 and 1.2 for testimonial and promotional, respectively, $p = 0.002$) and GQS (3.2 vs ~ 1.9 –2.0, $p < 0.001$).

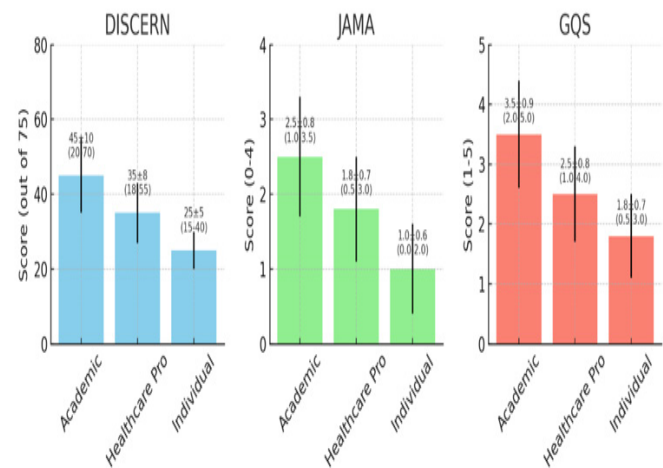


Figure 2. Mean quality scores (±SD) by uploader category
SD: Standard deviation, JAMA: Journal of the American Medical Association, GQS: Global Quality Score

Educational videos were significantly higher in quality than both testimonial and promotional videos on post hoc comparisons (all $p < 0.001$) (Figure 3).

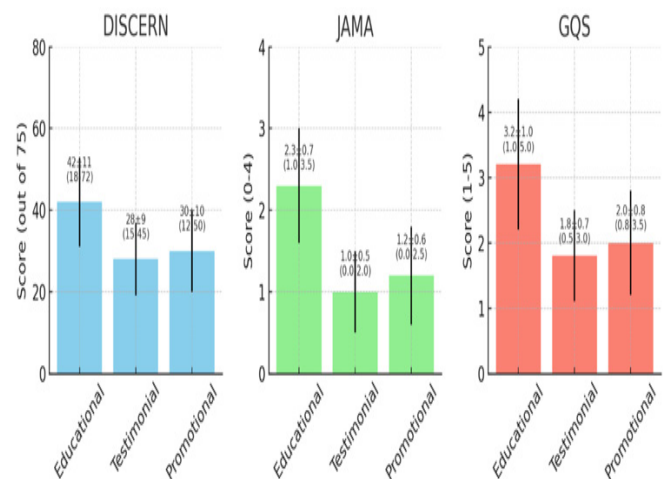


Figure 3. Mean quality scores (±SD) by video content type
SD: Standard deviation, JAMA: Journal of the American Medical Association, GQS: Global Quality Score

It was observed that the continent of video origin did not significantly affect video quality. mean DISCERN scores were similar for videos originating from North America, Europe, and Asia (ANOVA $p = 0.64$), and no differences were found in JAMA or GQS by region ($p = 0.49$ and $p = 0.72$, respectively).

Viewer Engagement vs Quality

We examined whether videos with higher quality scores also showed greater viewer engagement (Table 3). There was a weak positive correlation between video quality and the number of likes a video received per day. Specifically, the Pearson correlation between daily likes and DISCERN was $r = 0.27$ ($p = 0.001$), indicating that higher-quality videos tended to garner more “likes” from viewers. One of the most striking findings was a strong positive correlation between video length (duration) and quality scores. Longer videos tended to have substantially higher DISCERN ($r = 0.60$, $p < 0.001$), JAMA ($r = 0.58$, $p < 0.001$), and GQS ($r = 0.55$, $p < 0.001$) scores. In fact, video duration showed the strongest association with quality out of all factors analyzed (Table 3).

Table 3. Correlation of viewer engagement metrics and video duration with quality scores

Parameter	r (DISCERN)	p (DISCERN)	r (JAMA)	p (JAMA)	r (GQS)	p (GQS)
Daily views	0.18	.021	0.09	.25	0.12	.15
Daily likes	0.27	.001	0.19	.014	0.22	.005
Daily comments	0.11	.16	0.08	.30	0.06	.45
Video duration (min.)	0.6	<.001	0.58	<.001	0.55	<.001

JAMA: Journal of the American Medical Association, GQS: Global Quality Score

DISCUSSION

In this cross-sectional analysis of YouTube content on increasing breast milk supply, we found that the overall quality of information is low, with relatively few videos meeting established criteria for reliability and completeness. The average DISCERN and JAMA scores of the 172 videos indicate poor-quality, patient-targeted information, echoing findings from prior studies of health information on YouTube.^{6,11} This study is, to our knowledge, the first to specifically evaluate videos on augmenting breast milk production, and our results raise concern that mothers seeking help on this topic via YouTube may frequently encounter suboptimal advice.

Videos from academic/medical sources demonstrated superior quality (DISCERN 45.1 ± 11.5 vs. 25 ± 8 for individual uploaders, $p < 0.001$), reflecting greater expertise in presenting balanced, evidence-based strategies (e.g., latch techniques, pumping frequency, nutritional guidance).^{7,11,12} Such content frequently emphasized professional consultation, enhancing credibility. These findings align with prior research.^{7,13,14} showing medical institutions produce more accurate content across specialties, though they constituted only 15% of our sample.

One positive observation is that videos from reputable sources—academic institutions and health professionals—scored significantly higher on quality metrics. This suggests that expertise matters: when experienced clinicians or organizations produce content, they are more likely to include balanced information, reference credible sources, and provide a more comprehensive overview of strategies. For instance, several high-scoring videos in our sample were from pediatric hospitals or well-known lactation consultants and covered multiple evidence-based techniques (ensuring proper latch, frequent nursing/pumping, treating maternal hydration and nutrition, managing stress and rest, possibly using galactagogues judiciously, etc.). These videos often mentioned the importance of consulting healthcare providers, which adds to their credibility. Our results mirror those of previous studies that found videos authored by professional organizations or medical authorities tend to be more accurate and complete.^{11,15} For example, Bezner et al.⁷ evaluated pediatric surgical videos and noted that those from medical institutions were far more likely to contain correct and comprehensive information than those from lay uploaders. Similarly, a very recent study of ear tube surgery videos found that content from universities and

hospitals had higher quality scores than that from private individuals as demonstrated in ophthalmologic YouTube content analyses.^{12,14} Our study reinforces these patterns in the context of breastfeeding: expert-driven videos are comparatively better, though unfortunately they represent a minority of what is available (only ~15% of our sample).

Another key finding is the influence of video content type on quality. We saw that structured educational videos vastly outperformed testimonials and promotional content in quality metrics. Educational videos often took a didactic approach, sometimes with slides or a talking-head expert explaining various aspects of lactation management. These videos were more likely to mention the biology of milk production, strategies like skin-to-skin contact, frequency of feeding/pumping, checking infant latch, and when to seek professional help (e.g., for possible tongue-tie or other issues). In contrast, testimonial videos, while engaging, usually focused on the individual's narrative and often omitted broader guidance—reflected in very low DISCERN scores (many scored ≤ 25). Promotional videos had slightly better scores than testimonials in our sample (though differences were not statistically significant between those two groups), possibly because some promotional content included semi-formal presentations about their product's benefits. Nevertheless, promotional videos inherently present biased information; they rarely acknowledged alternative solutions a concern echoed in other surgical domains such as podiatry,¹⁶ or any drawbacks of the promoted intervention, leading to low DISCERN sub-scores for balance and discussion of alternatives. The net effect is that a mother watching mainly testimonials or ads would receive a limited scope of suggestions, potentially skewed by personal bias or commercial interest. This underscores a concern that has been raised across various medical fields on YouTube: content intended to market or persuade often compromises on completeness and impartiality.¹¹

It is worth noting that video length showed a strong correlation with quality a pattern also observed in oculoplastic educational content.¹⁷ Longer videos tended to be more comprehensive and thus scored higher on instruments that reward completeness of information. This suggests a practical insight: a video that is just 2–3 minutes long is unlikely to adequately cover the multifaceted topic of increasing breast milk supply. Indeed, many very short videos in our dataset provided only superficial advice (e.g., “drink more water and try fenugreek”) without elaboration. On the other hand, videos in the ~15–20 minute range often included segments on multiple tips (like proper latch technique demonstration, pumping strategies, dietary advice, etc.), aligning with more criteria on the DISCERN checklist. This correlation should not be misinterpreted as length causing quality, but rather as an indicator that to present quality information one needs to devote sufficient time. Prior analyses in other domains have similarly found that videos addressing a medical topic in depth (which naturally makes them longer) tend to achieve higher reliability scores.¹¹ However, longer videos may also demand more viewer commitment and might not be fully watched by all users, which raises a challenge: the highest-

quality content is not always in a viewer-friendly format for quick consumption. This tension between depth and viewer engagement might partly explain why we did not find strong correlations between view counts (or likes) and quality—viral popularity favors brevity and catchiness over thoroughness, whereas quality favors thoroughness over brevity.⁶

Our study has important implications for clinical practice and patient education. First, healthcare providers should be aware that patients may form impressions or follow advice from YouTube videos that are not evidence-based. Many postpartum mothers struggling with milk supply turn to platforms like YouTube out of convenience or desperation. If a mother reports she has been trying certain remedies she saw online (such as herbal supplements, lactation cookies, or extreme pumping regimens), clinicians should gently inquire about the source and help her distinguish which advice is sound and which may be unproven or counterproductive. For example, excessive emphasis on lactation teas could distract from more effective measures like improving latch or frequency of feeds. Pediatricians, neonatologists, and lactation consultants may need to proactively guide mothers to reputable online resources. There are a few high-quality videos (some from this study's sample) produced by certified lactation consultants and medical centers – sharing links to those, or to trusted organizations (La Leche League, UNICEF breastfeeding videos, etc.), could help patients get better information. Additionally, our findings suggest that professional organizations could consider creating more engaging, shareable content to fill the current void. Given that expert videos were relatively few, increasing their presence on YouTube might improve the overall quality mix available to the public.

For the YouTube platform and content creators, our results reinforce the recommendation that popularity should not be the sole metric of usefulness. The weak correlation between view counts/likes and quality underscores that viewer engagement metrics do not reliably signal accuracy.⁶ This has been noted in prior research and was echoed by the systematic review authors who suggested incorporating expert evaluations into video rankings.⁶ YouTube's algorithms could potentially be adapted to elevate content that meets certain quality criteria (perhaps via partnerships where health institutions are verified). In the meantime, creators of breastfeeding content who want to provide value should consider collaborating with healthcare professionals to ensure accuracy, and include references or citations for claims (which was rarely done in our sample, but would improve JAMA scores and trust). Even simple steps like stating one's credentials and citing sources (e.g., World Health Organisations (WHO) recommendations,¹⁸ for breastfeeding could improve a video's credibility.

Finally, it is notable that our analysis did not find regional differences in quality—the misinformation problem transcends borders. Whether a video was made in the U.S. or in India, its quality depended on the content and creator rather than the country. This suggests that global collaboration and standards may be beneficial. International lactation consultant associations or pediatric societies could work together to

produce multi-language video content that meets high quality standards, to serve as reliable alternatives across regions.

Limitations

This study has important limitations. The sample size, though focused on top-viewed content, was limited and a broader analysis would strengthen the findings. As a snapshot in time, this study cannot capture the constantly changing nature of YouTube. Our exclusion of non-English videos limits the cross-cultural relevance of the results. While we used validated tools, assessing video quality involves some subjectivity. Crucially, we did not verify the medical accuracy of the advice or measure the videos' real-world impact on breastfeeding behaviors.

CONCLUSION

As a result, our evaluation shows that while YouTube contains some high-quality videos on increasing breast milk supply, the majority are neither reliable nor comprehensive. Videos from academic and healthcare-affiliated sources offer the best information but are vastly outnumbered by lower-quality personal or promotional videos. Many mothers seeking help online may therefore be at risk of receiving incomplete or misleading advice. It is crucial for healthcare professionals to be cognizant of the information their patients may encounter and to help direct them to trustworthy resources. Efforts should be made to increase the presence and visibility of accurate, evidence-based breastfeeding educational videos on platforms like YouTube. Multidisciplinary collaboration between medical experts, lactation consultants, and skilled communicators could yield content that is both engaging and informative, to better support breastfeeding mothers in the digital age. As online media becomes increasingly influential inpatient health behaviors, ensuring the quality of such information is a responsibility that the medical community cannot afford to overlook.

ETHICAL DECLARATIONS

Ethics Committee Approval

The study did not involve human participation or animal testing, and since the information was obtained from a publicly available platform, no ethics committee approval was required.

Informed Consent

The study did not involve human participation or animal experiments, and informed consent was not required as the information was obtained from a publicly available platform.

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Financial Disclosure

The authors declared that this study has received no financial support.

Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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