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Roles of Lactation Consultant in Lactation Management

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Abstract:

Breast milk is regarded as ideal, natural and protective food for newborns. Breastfeeding is a natural and critical act that provides energy and nutrients that the child needs at first half of infancy, up to half or more and one third of the child's nutritional and energy needs during the second half of infancy and the second year of life. Global breastfeeding scorecards revealed only 41% of infants are exclusively breastfed which is far from the global target of 70% by 2030. Though in Nigeria, the initiation of breastfeeding has improved the practice and duration of exclusive breastfeeding remains low. Previous breast surgery, flat or inverted nipples, insufficient glandular development, Sheehan syndrome, unilateral involution are among the challenges of breastfeeding. There are several factors responsible for the non-compliance of mothers towards exclusive breastfeeding which include; education, social class, culture, location, nature of work, lack of time, lack of knowledge, lack of support from the husband and family members, health status of both the nursing mothers and their infants. The resurgence of professionals who has interest in promoting breastfeeding; lactation consultant is now very common. Nurses who have acquired sufficient knowledge, expertise, and experience are commonly seen as lactation educators or breastfeeding specialist. They are clinically competent to assist and support the mother-infant pair, identify common breastfeeding problems and its managements, and early identification of illness. A lactation consultant can work in many different settings like postpartum

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hospital units, freestanding birth centers, pediatric offices, and public health clinics. Some lactation consultants choose to work independently. Lactation consultants care for women of childbearing age and their newborn babies. A lactation consultant usually works during the day shift, but that may vary depending on where they work.

Keywords: Breastfeeding, Lactation Consultant, Lactation Management,

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Introduction

Clinical lactation management is the science and art of assisting women and infants with breastfeeding. Breastfeeding is now being taught, by lecture and by clinical example. Because the mother-infant pair is dynamically interrelated for breastfeeding, it is imperative to consider both individuals when attempting to assess and “manage” breastfeeding. Multidisciplinary input is desirable and often critical. Breastfeeding is a natural and critical act that provides optimally, the energy and nutrients required to satisfy all the needs of the child during the first half of infancy and subsequently providing, up to half or more and one third of the child’s nutritional and energy needs during the second half of infancy and the second year of life respectively (World Health Organization, 2018).

According to Global breastfeeding scorecards, (2018), only 41% of infants are exclusive breastfed globally in the first six months of life which is still far from the 2030 global target of 70%, Two-thirds of mothers continue breastfeeding till one year of age and by two years, the rate drops further to 45%. In Nigeria although the initiation of breastfeeding has improved, the practice and duration of exclusive breastfeeding remains low. (NPC, 2019), According to the 2018 Nigeria Demographic and Health Survey, 42% of children commence breastfeeding in the first hour of life with only 29% of children exclusively breastfed in the first six months of life.

During the past 5 years, with the resurgence of professional and lay interest in the promotion of breastfeeding, it has become increasingly common to encounter nurses who are lactation consultants. It is also becoming increasingly common for nurses to become “lactation educators” or “breastfeeding specialists” once they have acquired sufficient knowledge, expertise, and experience. These individuals have an in-depth knowledge of early breastfeeding management and problem solving; they also are clinically competent to assist and support the mother-infant pair. Their particular areas of expertise include (but are not limited to): understanding the anatomy and physiology of lactation, facilitating immediate breastfeeding postpartum; proper positioning and latch-on of the infant at the breast; preventing postpartum breastfeeding problems by frequent, effective feedings; assisting the mother in learning to recognize and respond to infant cues; and recognizing and managing common problems such as a sleepy baby, a fussy baby, latch-on difficulties, sore nipples, engorgement, and perceived low milk supply. It is imperative that these specialists have enough experience with young infants to recognize illness. As with other consultations that involve delegation of care, the physician continues to oversee and coordinate the management of the infant. If the physician refers patients to the lactation consultant for detailed feeding assessment and assistance and if communication is open, the lactation consultant can feel comfortable in working with the physician on more complex medically related feeding problems.

Concept and Importance of Breast Milk

Breast milk contains all the nutrients infant requirements in the first six months of life. It protects against common and wide spread childhood diseases such as diarrhea and pneumonia, and may also have longer-term benefits such as lowering mean blood pressure and cholesterol, and reducing the prevalence of obesity and type-2 diabetes.

To enable mothers to establish and sustain exclusive breastfeeding for 6months, WHO and UNICEF recommend:

- Initiation of breastfeeding within the first hour of life.
- Exclusive breastfeeding that is the infant only receives breast milk without any additional food or drink, not even water.
- Breastfeeding on demand that is as often as the child wants, day and night.
- No use of bottles, teats or pacifiers.

Human milk varies in its composition with the following;

- The time of day: Fat content is lowest in the morning and highest in the afternoon.
- The stage of lactation: The fat and protein content of colostrum is higher than in mature milk.
- Maternal Nutrition: Although the total amount of fat is not influenced by diet, the type of fat that appears in the milk will be influenced by what the mother eats.
- Individual variation.

Breast milk contains Fat and fatty acid 98%, Carbohydrates 40%, Protein 1.4g, Vitamin (fat soluble) 1g, mineral (trace element) 3.3mg, enzymes 1%, water 9%.

Colostrum is the first breast milk given to a baby by the mother or a wet nurse which provides all nutritional requirements of an infant birth. It continues to supply majority of a baby's nutritional needs for up to eighteen months (WHO, 2018). It contains antibodies which provide immunity against microorganisms entering the body (Palmeira & Carnoeiro-Sampaio, 2019) and critical for sustaining a new born infant's health and well-being. The colostrum (first breast milk) is pure, nutritious and rich in antibodies that shield newborns from illnesses. The colostrum is the first immunization a child receives, laced with immunoglobulin that protects the newborn, creates a mild laxative effect, and expels meconium and helps check the buildup of bilirubin (Elyas, et al., 2018). Breastfeeding aids proper mandible, dental and speech development (Okogba, 2018), enhances mothers' well-being, child - spacing, shrinks ovarian and breast cancer risks, boosts household and national resources, secures feeding and promotes environmental safety (WHO, 2019).

Breast milk is regarded as ideal, natural and protective food for newborns. Given that prolonging people's lives (by reducing mortality) and preventing disease (by reducing morbidity) are some of the goals of public health (Brulde, 2019), breastfeeding or exclusive breastfeeding has been recognized as an efficient advance to the achievement of these goals. In a study by Vennemann et al (2019) breastfeeding was found to be protective against sudden infant death syndrome by reducing the risk by 50% at all ages during infancy; these benefits have been reported to exhibit dose-response relationship, that is, health gains increases with increases in duration and exclusivity.

There is a universal consensus about the fundamental importance of breastfeeding for children's adequate growth and development and for their physical and mental health (WHO, 2019). Breastfeeding, particularly exclusive breastfeeding, and appropriate complementary feeding practices are universally accepted as essential elements for the satisfactory growth and development of infants as well as for prevention of childhood illness. Exclusive breastfeeding defined by World Health Organization (WHO) as practice of feeding only breast milk (including expressed breast milk) and allows the baby to receive vitamins, minerals or medicines and water, breast milk substitutes, other liquids and solid foods are excluded.

Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness.

These effects can be measured in resource-poor and affluent societies (Kramer et al, 2018). Breastfeeding contributes to the health and well-being of mothers; it helps to space children, reduces the risk of ovarian cancer and breast cancer, increases family and national resources, is a secure way of feeding and is safe for the environment (WHO, 2019). At the point when sufficient and significant mediations conveyed, breastfeeding are responsive and can improve quickly. Best results accomplished when intercessions actualized through a few channels (Arage & Gedamu, 2019).

Breastfeeding reduces the mother's risk of fatal postpartum hemorrhage and pre-menopausal breast and ovarian cancer. Frequent and exclusive breastfeeding contributes to a delay in the return of fertility and helps protect women against anemia by conserving iron. Breastfeeding provides frequent interaction between mother and infant, fostering emotional bonds, a sense of security, and stimulus to the baby's developing brain (WHO, 2019).

Anatomy and Physiology of Breastfeeding

Physicians must understand several essential underlying anatomic and physiologic considerations thoroughly as they assist the breastfeeding mother and baby. Pregnancy provides optimal preparation of the breasts for subsequent feeding. The only further preparation required is that of clinicians: obtaining a careful history, examining the breasts, and communicating any concerns to colleagues. A complete breastfeeding history includes exploration of the feeding decision, previous breastfeeding history, previous postpartum hemorrhage (possible Sheehan syndrome), previous breast surgery (cosmetic or reconstructive surgery, biopsies), cardiac or chest wall surgery, breast trauma (for example a burn that has caused scarring), questions regarding breast changes during pregnancy, family history of breast cancer, and any other concerns the mother may have about her breasts or about the feeding process.

Challenges of Breastfeeding

Breastfeeding enhances the interaction between mother and child and help the child derive the benefits of its mother's milk provided directly from the breast to the child, and offers unique experience to them each time (Primo & Marcos, 2019). Milk production offers a use or loses it process and according to Bonyata (2018), the more often and effectively an infant is nursed, the more milk the mother will make. Human breast milk contains hundreds to thousands of distinct bioactive molecules that protect against infection and inflammation, contribute to immune maturation, organ development and healthy microbial colonization with molecules such as colostrum, fat and protein. However, there are some challenges that could hinder breastfeeding which are discussed below

Breast Surgery

Previous breast surgery has the potential to interfere with lactation. Breast reduction, in particular, usually involves significant cutting of ducts or nerves that could impair the lactation process. Breast augmentation tends to be associated with great anxiety on the part of the pregnant and lactating woman about the possibility of causing illness in her infant. Most breastfeeding experts see no strong evidence to support ill effects in the infants of these

women. If breast augmentation was performed to correct a developmental anomaly of the breasts, lactation performance may have been impaired prior to surgery. In all women who have had breast surgery, breastfeeding care should be individualized and the infant followed frequently during the first few weeks for appropriate weight gain.

Flat, Retractable or Inverted Nipples

No specific intervention is required for bilateral inverted or retractile nipples in early pregnancy. (If one nipple normally is protuberant, the infant can nurse totally from that breast.) If both nipples remain inverted near term, the woman may require extra attention to intrapartum management, should be cautioned to avoid artificial nipples and pacifiers, or may need extra skilled assistance with early feeding. Use of a breast pump just prior to feeding may be beneficial in pulling the nipple and areola out further and helping to initiate let-down. The prenatal use of breast shells (also called milk cups), although widespread, is controversial. Theoretically, the shell allows the nipple to protrude through the hole in the plastic and gradually stretch the fibers that are “tethering” the inverted nipple.

Insufficient Glandular Development

“Insufficient glandular development” of the breast (sometimes called “primary lactation failure”) is characterized by immature-appearing breast(s). Striking asymmetry is present in the unilateral form, although bilateral underdevelopment also has been documented. Some women may have had cosmetic surgery to correct the appearance of the anomaly. Other major features include little or no breast growth during pregnancy and lack of physiologic engorgement postpartum. Hormone levels, including prolactin, are normal. In general, small breasts will produce normal amounts of milk. However, small, immature, or asymmetric breasts that do not respond to pregnancy by enlarging suggest the possibility of anomalous development.

The obstetrician should inform the pediatrician of this condition and the pediatrician should incorporate questions about breast changes into the maternal history taking. Close follow-up of the infant is mandatory, with weight checks every 2 to 3 days, because these babies can develop significant dehydration or hypoglycemia quite rapidly. Because insufficient glandular development of the breast is a clinical diagnosis and is rare (probably less than 1 per 1,000 women of childbearing age), the breastfeeding experience should be encouraged until signs and symptoms are definite. Infants should receive early supplementation to avoid significant dehydration following overzealous attempts to stimulate the milk supply with frequent suckling. Despite frequent and effective milk extraction, these breasts cannot be stimulated into full production; partial breastfeeding, using a supplementer, is an option for some women.

Sheehan Syndrome

Loss of anterior pituitary function (and subsequent loss of prolactin, thyroid hormone, cortisol, and gonadotropins) following severe postpartum hemorrhage. The hypotension associated with the blood loss decreases perfusion to the pituitary. Lactogenesis does not occur due to absent or deficient prolactin levels. Frequently the diagnosis of this syndrome is delayed for years beyond the initiating event.

Unilateral Involution

One breast ceases milk production while the other continues. Because ongoing milk production is regulated locally, continued milk production is regulated independently in each

breast. The side that involutes will be somewhat smaller than the side that is producing milk until complete weaning has occurred on both sides.

Painful Feedings

Persistent pain during breastfeeding is not normal. During the first 2 weeks, brief discomfort can occur for a minute or so when the newborn is latching-on. If pain continues after the initial latch-on, the infant should be removed and reattached to ensure proper latch-on, let-down reflex, and swallowing. If pain arises during the course of feeding, the baby should be removed and switched to the other breast if still hungry.

Another cause of sore nipples during the first few days is infant oral-motor dysfunction (abnormal suck pattern). The pediatrician or lactation specialist should examine the infant completely and ensure that positioning and latch-on are optimal. After feeding, the mother's nipple may appear creased, ridged, flattened, pointed, or otherwise misshapen. The diagnosis and treatment of breastfeeding problems related to oral-motor dysfunction require consultation with a knowledgeable and skilled professional (lactation consultant or specialist, often in conjunction with an infant feeding specialist). Later in lactation, *Candida* infection of the nipple/areola complex may present as new onset of sore nipples or breast pain (the pain often is described as having a burning or stabbing quality). The clinical diagnosis is made when there is a preceding history of antibiotic usage, thrush (infant) or dermatitis (infant), or maternal candidal vaginitis in combination with maternal nipple pain and/or dermatitis.

Practice of Breastfeeding

After delivery of the healthy term infant, immediate and sustained contact between mother and infant strongly correlates with longer durations of breastfeeding. The infant can be dried, assigned Apgar scores, and visually inspected as it receives skin-to-skin contact with the mother. Both mother and baby can be covered with warm blankets if the room temperature is cool. Skin-to-skin contact also accelerates infant temperature stability and normalization of blood glucose and improves acid base status. For the healthy dyad, skin-to-skin contact should occur for at least 1 to 2 hours after delivery. Even short interruptions for cleaning, eye prophylaxis, administration of vitamin K, weighing, and other procedures have been documented to reduce breastfeeding success. These first hours following birth, when mother and infant are alert, allow time for maternal-infant bonding, imprinting, oxytocin release, and nutritive feeding with actual intake of colostrum. It is essential for an experienced health professional to observe and assist with at least one feeding in the hospital to document good latch-on. If the first feeding in the alert period is not optimal, the infant may be sleepy for up to 48 hours. Parent needs to be assisted to keep baby awake at times of feed.

According to a study conducted by Essien, et al (2018) on practices of exclusive breastfeeding in Calabar, revealed that the majority of the respondents (60%) did not practice exclusive breastfeeding while 40% practice exclusive breastfeeding. This disagrees with Maduforo, et al (2018) on the practice of exclusive breastfeeding by nursing Mothers in Owerri Metropolis, which showed that only 36.41% were practicing it in that area. Similarly, this disagrees with Leon-Cava, et al (2018), which observed that improved breastfeeding practices are crucial for child growth and development.

Kramer and Kakuma (2019) revealed that 63% initiated breast feeding immediately (30minutes) after delivery, while 37% did so long after 30minutes. This disagrees with study of baby friendly hospital Initiative (BFHI) 2018, which was designed to promote early

initiation of breastfeeding, preferably immediately after birth, this study observed that (53%) of the mothers did not initiate breastfeeding immediately after birth.

According to study carried out by Akpor, et al (2018) 46.3% of the participants breastfed their babies so as to ensure the child's wellbeing and 36.8% also signify bonding/closeness to baby has their reason. Only 10.5% and 6.3% of the participants mentioned money and family/cultural beliefs respectively as their main reasons for breastfeeding and this is compared to the study carried out by WHO 2018, indicate that the practice of exclusive breastfeeding in the first six months of life builds the child immunity, protects the child from diarrhea, respiratory diseases, bonding/closeness and improves the child response to vaccination. And also encourages uterine involutions, thus helps the mother to regain her pre-gravid body weight and shape. Also research conducted by WHO, 2019 state that 54.4% practiced it for 6months, 27% practiced it for less 6 months, while 18.6% practiced it more than 6months.

In a cross - sectional study done in South Sudan, Warille (2019) found that 63.2% of mothers practice exclusive breastfeeding for the first six months, 70% had skin-to-skin contact immediately after birth and 76.8% of mothers actually initiated breastfeeding in the first hour of delivery. Antenatal visits to hospitals/ health care units educate mothers on the significance and benefits of breastfeeding, and influences the decision to breastfed and boosts mothers' confidence in breastfeeding. Piro and Ahmed (2020) posits that mothers who attended antenatal classes are more likely to breastfeeding than those who did not attend the classes. Studies have revealed that infants whose mothers did not attend prenatal breastfeeding class were five times more likely to receive infant formula supplement in the hospital than the infants whose mothers attended (Habtewold, et al, 2019). It has been reported that mothers who delivered normally are likely to breastfeed than those who delivered through caesarian (Saco, et al, 2019).

Evidence from Shrimpton (2018), shows that in developing countries the greatest risk of nutritional deficiency and growth retardation occurs in children between 3 and 15 months of age, a period noted for sub optimal breastfeeding and inadequate complementary feeding practices and this agrees with the findings from recent studies of Edmond, et al (2020) stressed the risk of delayed onset of breastfeeding on neonatal mortality in sub-Saharan Africa and showed that neonatal mortality could be significantly reduced by 16% if the mothers started breastfeeding at day one and 22% when breastfeeding was commenced within the first hour. Evidenced from Ogunleye, et al (2018) revealed that 40% of the respondents breastfed their babies on demand in a day, 38% breastfed their babies between the ranges 5-8 times, while 22% breastfed between the ranges 0-3 times in a day.

Agunbiade and Ogunleye (2020) studied exclusive breastfeeding and has concluded that there are several factors responsible for the non-compliance of mothers towards exclusive breastfeeding which include; education, social class, culture, location, nature of work, and health status of both the nursing mothers and their infants. Prominent among these values and behaviors are western education and formal employment. However, some constraints were identified to be responsible e.g. lack of time, lack of knowledge, lack of support from the husband and family members. Also Eze, et al (2019) conducted a research on reasons why some mothers did not practice exclusive breastfeeding their babies/ infants and it was revealed that Majority 63.3% of the respondents responded that it was due to house chores,

11.7% mentioned work schedules as the reason for not practicing Exclusive Breastfeeding, 9.50% mentioned that it was due to low breast milk production, 10.90% indicated that it was due to family influence, while 4.50% mentioned that it was due to swollen breasts or sore nipples.

Roles of a Lactation Consultant

A lactation consultant nurse is a nurse that specializes in the clinical management of lactation and breastfeeding. Lactation consultants are specialists who train mothers how to breastfeed their babies. The lactation consultant provides the majority of breastfeeding education during the postpartum period but may begin their consultation and education during a woman's pregnancy. A lactation consultant provides breastfeeding support, assists with lactation care, and educates patients to overcome obstacles and concerns with breastfeeding.

A lactation consultant can work in many different settings like postpartum hospital units, freestanding birth centers, pediatric offices, and public health clinics. Some lactation consultants choose to work independently. Lactation consultants care for women of childbearing age and their newborn babies. A lactation consultant usually works during the day shift, but that may vary depending on where they work. Some hospital-based lactation consultants will work on holidays and weekends, but will typically be compensated at a higher rate for these shifts.

A lactation consultant is skilled in caring for patients who are experiencing breastfeeding issues like painful nursing, decreased milk production, latching difficulties, and babies with low weight gain. The lactation consultant works closely with the patient to understand how to latch their baby to the breast, the various breastfeeding positions, and how to tell if a baby is transferring and drinking enough milk. Lactation consultants are familiar with breast pumping equipment that assists with babies who are unable to transfer milk or moms who must return to work or be separated from their child. They also give mothers breast milk storage tips, tips for how to deal with painful and cracked nipples, and how to make sure their baby is getting enough milk.

Lactation consultants must be familiar with chronic and acute conditions and if there are any implications with breastfeeding a newborn baby. A lactation consultant must possess a considerable range of knowledge regarding the compatibility of medications with breastfeeding. Hence, lactation consultants must possess a broad range of clinical knowledge and when to appropriately refer a client. A lactation consultant can make or break the difference in a breastfeeding relationship between mother and baby. They are compassionate, patient, and empowering.

Conclusion

In conclusion, exclusive breastfeeding help in dispersing number of child since it is one of the family planning techniques as it defers the arrival of the fruitfulness pace of mother and in long haul, likewise decreases type-2 diabetes, breast ovarian, and the uterine malignant growth. There is need for lactation consultants to continuously educate women on lactation management and benefits of breastfeeding.

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