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Breastfeeding counseling protocols: a scoping review

Protocolos de aconselhamento em aleitamento materno: revisão de escopo

Protocolos de asesoramiento sobre lactancia materna: revisión del alcance

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ABSTRACT

Objective: to map the evidence available in the literature on protocols used in breastfeeding counseling. **Method:** scoping review with searches carried out in March 2023, updated in February 2024, independently on the databases: PubMed/MEDLINE, LILACS, Scopus, Embase, Web of Science; CINAHL, CAPES Catalog of Theses and Dissertations and Cochrane Library, correlating the descriptors Counseling, Breast Feeding, Education, Guideline and Protocol and synonyms, without delimiting time and language. **Results:** the final sample consisted of 11 studies, from 2003 to 2022, with a predominance of studies in English and of the randomized clinical trial type, most frequently applied in the postpartum period and among couples with favorable conditions for breastfeeding. Applied in individual or group sessions, lasting 20-60 minutes and using support material, with nurses being the most cited professionals. **Conclusion:** there is a scarcity of research detailing breastfeeding counseling protocols, with a predominance of protocols applied in the puerperium.
Descriptors: Breast Feeding; Counseling; Guidelines as Topic; Education; Review.

RESUMO

Objetivo: mapear evidências disponíveis na literatura sobre protocolos utilizados no aconselhamento em aleitamento materno. **Método:** revisão de escopo com buscas realizadas em março de 2023, atualizadas em fevereiro de 2024, independentemente nas bases: PubMed/MEDLINE, LILACS, Scopus, Embase, Web of Science; CINAHL, Catálogo de Teses e Dissertações da CAPES e Cochrane Library, correlacionando os descritores *Counseling, Breast Feeding, Education, Guideline* e *Protocol* e sinônimos, sem delimitação de tempo e idioma. **Resultados:** a amostra final foi composta por 11 estudos, de 2003 a 2022, com predomínio do idioma inglês e do tipo ensaio clínico randomizado, aplicação mais frequente no puerpério e entre binômios com condições favoráveis ao aleitamento. Aplicados em sessões individuais ou grupais, com duração de 20-60 minutos e uso de material de apoio, sendo os enfermeiros, os profissionais mais citados. **Conclusão:** observou-se a escassez de pesquisas que detalham protocolos de aconselhamento em aleitamento materno, com predomínio da aplicação dos protocolos no puerpério.
Descritores: Aleitamento Materno; Aconselhamento; Protocolo; Educação; Revisão.

RESUMEN

Objetivo: mapear la evidencia disponible en la literatura sobre los protocolos utilizados en asesoramiento sobre lactancia materna. **Método:** revisión de alcance con búsquedas realizadas en marzo de 2023, actualizadas en febrero de 2024, de forma independiente en las bases de datos: PubMed /MEDLINE, LILACS, Scopus, Embase, Web of Science; CINAHL, CAPES y Catálogo de Teses e Dissertações da CAPES y Cochrane Library, correlacionando los descriptores *Counseling, Breast Feeding, Education, Guideline* y *Protocol* y sinónimos, sin delimitación de tiempo e idioma. **Resultados:** muestra compuesta por 11 estudios, de 2003 a 2022, predominaron el idioma inglés y los ensayos clínicos aleatorizados, aplicados con mayor frecuencia en puerperio y en binomios con condiciones favorables para la lactancia materna. Se aplicaron sesiones individuales o grupales, con duración de 20 a 60 minutos y utilizando material de apoyo, el enfermero fue el profesional más citado. **Conclusión:** se observó escases de investigaciones que detallaran los protocolos de asesoramiento sobre lactancia materna, y que predominó la aplicación de protocolos en el posparto.
Descriptores: Lactancia Materna; Consejo; Guías como Asunto; Educación; Revisión.

INTRODUCTION

Breastfeeding (BF) is recognized as a powerful promoter and protector of child development and health, with reported effects on maternal health as well. In order to achieve its benefits, it is recommended that it be practiced exclusively up to the sixth month of the child's life and in a mixed form (concomitant with the introduction of food) up to two years or more[1-3]. However, less than 50% of children are on exclusive breastfeeding by the sixth month of life[4,5], indicating a high rate of early weaning in infancy.

Counseling is an intervention used to support breastfeeding, with evidence of an increase in its rates in the various modalities, especially exclusive breastfeeding, as pointed out by a systematic review study with meta-

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analysis[6]. However, there is still little evidence describing the protocols for this intervention, which is considered a soft technology, and its distinctions from health education and other approaches adopted to support BF[6,7].

BF counselling emerged on the healthcare scene in the early 1990s, characterized by horizontal and respectful dialogue between professionals, women and their families, with the aim of understanding the individual circumstances of each woman and family, their desires, realities and possibilities[8-9]. In this sense, it involves advanced interaction and communication techniques, going through conceptual aspects of Carl Rogers' theory, which proposes a therapeutic approach centered on the client's needs (counseling) and on listening, without judgment, aimed at helping people, placing them at the center[10]. Therefore, the skills of listening, learning and promoting confidence and support for women who are or intend to breastfeed are essential[8]. In short, the role of the professional is to offer elements and establish a helping relationship with the woman, so that she can decide what is best for her and her child(ren)[8,11].

The literature points to the results of counseling: an increase in exclusive breastfeeding rates[12-16], an increase in the duration of breastfeeding, including mixed breastfeeding[17,18] and exclusive and mixed breastfeeding[19]. Some studies, however, did not identify any differences with its implementation[20,21], but the large sample heterogeneity of the studies should be emphasized[8,9].

However, there are weaknesses in scientific production in relation to the definition of counseling and its distinctions between health education practices on BF, as well as in relation to the lack of standardization of protocols and a clear description of the components involved, calling for the development of research from this perspective.

Thus, the aim of this study was to map the evidence available in the literature on protocols used in breastfeeding counseling.

METHOD

This was a scoping review based on the recommendations of the Joanna Briggs Institute (JBI)[22] and the publication selection process was guided by the flowchart PRISMA-ScR[23]. The review protocol was registered in the Open Science Framework (https://osf.io/5v6um).

To develop the review question, the PCC mnemonic was used, where the population (P) was women who are breastfeeding or intend to breastfeed; the concept (C) was counseling protocols, and the context (C) was breastfeeding counseling. Thus, the review question was: “What evidence is available in the literature on breastfeeding counseling protocols for women who are breastfeeding or intend to breastfeed?”

Protocols were considered to be the detailed operational description of breastfeeding counseling, covering specific guidelines on what to do, who does it and how to do it in the face of common situations that occur during the breastfeeding process, as well as actions in the face of non-conformities, with a view to guaranteeing standardized care, in line with technical-scientific and ethical principles[24].

The searches were carried out in March 2023, updated in February 2024, independently by two reviewers, a master's student and a doctor, and validated by a librarian. The databases were searched: US National Library of Medicine National Institutes of Health (MEDLINE/PubMed), Web of Science (WOS), Excerpta Medica DataBASE (Embase), SciVerse Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Latin American and Caribbean Health Sciences Literature (LILACS), in the CAPES Catalog of Theses and Dissertations and in the Cochrane Library, correlating the descriptors Counseling, Breast Feeding, Education, Guideline and Protocol. No date, language and/or study design filters were applied.

The following strategy was used for the MEDLINE/PubMed search: (((“Breast Feeding”[Mesh] OR Breastfeeding[tw]) AND (“Counseling”[Mesh] OR “Counseling”[tw])) AND (“education”[Subheading])) AND (guideline OR protocol), used as a standard for searching the other databases, being slightly modified based on the specific criteria of each database. The descriptors were combined in different ways in order to broaden the scope of the searches. It should be noted that the variations in terminology in the different languages, as well as synonyms, were used to carry out a sensitized search using the Boolean operators [AND] for simultaneous occurrences of subjects, and [OR] for occurrences of one or other subject.

Eligibility criteria were: studies that described breastfeeding counseling protocols for women who are breastfeeding or intend to breastfeed, without delimiting time or language. The exclusion criteria were the following: duplicate publications in the databases; opinion articles, editorials, consensus(s), response letters or letters to the editor and articles that did not answer the review question. It should be noted that the evidence level was not considered an exclusion criterion, as the subject has been little explored in the literature. The Preferred Reporting Items for Systematic

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Reviews and Meta-Analysis (PRISMA)[23] methodology was adopted to systematize the process of including studies and is illustrated in a flowchart.

The studies were selected independently by three researchers and disagreements were resolved by consensus. There was no need to add a new reviewer at this stage. The selected articles were first analyzed by reading the title and abstract, followed by a full reading to make the final selection. The full texts were selected in a paired and independent manner, and those that met the eligibility criteria were selected for the study.

Data extraction was also carried out by three researchers, independently, considering detailed information standardized by the JBI, such as: details about the publication and the study, year; country where it was carried out; objectives; population and sample size; methodological path; outcomes; main results that answer the review question; and risk of bias. The data extracted was tabulated and presented in narrative form.

RESULTS

The search found 201 publications. In the first stage, duplicates were removed (n=22) and 166 articles were excluded after reading the titles and abstracts for not portraying the study topic. When the selected articles were read in their entirety, four publications were excluded because they: did not answer the review question (two studies did not address counseling protocols and/or components); did not address counseling (one study); and did not address the concept (one study dealt with peer counseling in the community). It should be noted that two publications were retrieved through a manual search (from the references of the selected publications). As a result, the final sample consisted of 11 studies, as shown in Figure 1.

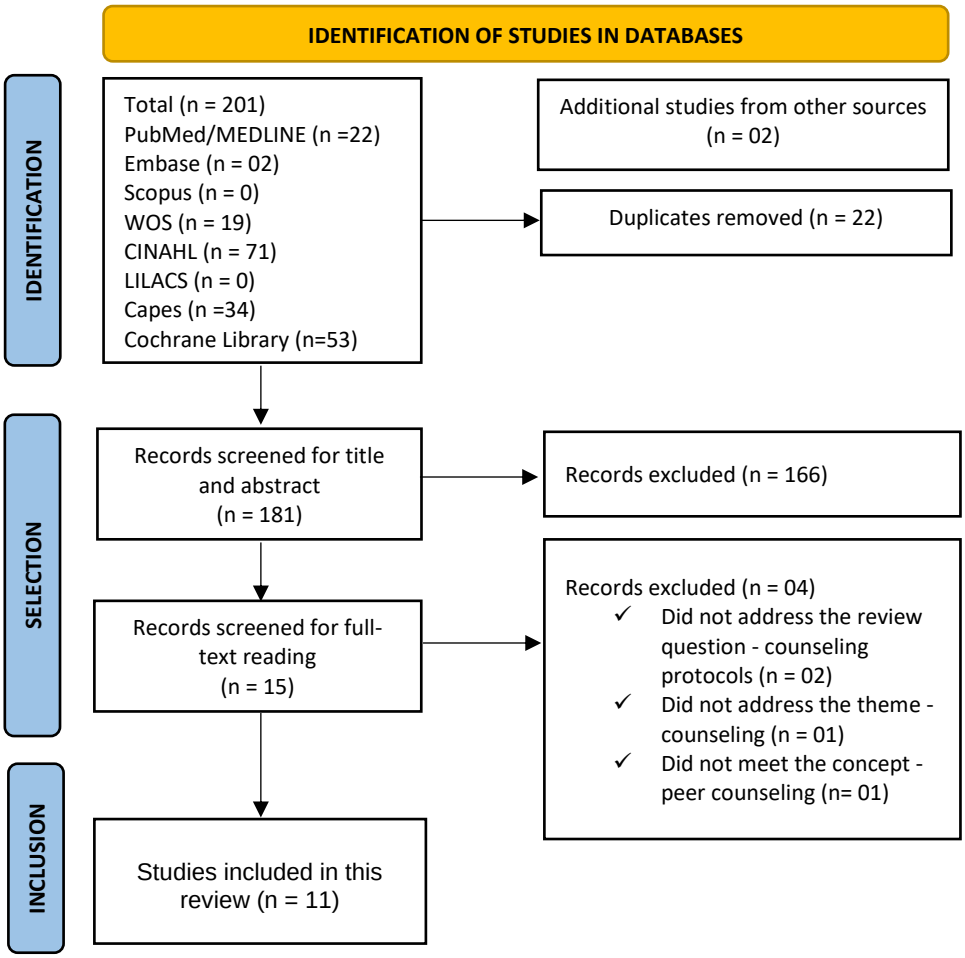

Figure 1: Flowchart according to Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA-ScR) for selecting studies. Uberaba, MG, Brazil, 2024.

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In relation to the characterization of the studies, the first publication dates from 2003 and the last from 2022, ten were published in English (90.9%) and one thesis in Brazilian Portuguese (9.1%). Brazil produced five studies (45.5%), while Colombia, the United States, Ghana, Iran, Italy and Malaysia produced one each (9.1%). As for the type of research, nine consisted of randomized clinical trials (81.8%) and two randomized clinical trial pilots (18.2%). In relation to the type of publication, ten were published articles (90.9%) and one was a doctoral thesis (9.1%).

Most of the studies were carried out with postpartum women (n= 7; 63.5%). In four of them (36.5%), totaling 1,942 women, there was counseling with a protocol applied during pregnancy. Eight studies included women regardless of parity (72.7%), one included only pregnant women in their second pregnancy (9.1%)[28] and two considered only primiparous women[33,34]. In addition, eight studies had a single pregnancy as inclusion criteria (72.7%). In two studies this criterion was not made explicit[33,34] and one study focused on counseling for multiple pregnancies (9.1%)[31].

Another inclusion criterion adopted in some studies, except for three (27.3%)[27,30,32], was gestational age. Four studies only included postpartum women who had full-term births[25,25,34,35] and those that considered pregnant women showed a wide variety, namely: inclusion of pregnant women between nine and 30 weeks[28]; greater than or equal to 35 weeks[29]; 18 to 34 weeks[31]; and 20 to 30 weeks[33]. Furthermore, of the seven studies carried out with postpartum women, five had a birth weight of more than 2,500 grams as a criterion (71.4%). Two studies did not specify weight as a criterion[26,35].

Thus, the inclusion criteria used most often were: application of the breastfeeding counseling protocol in the postpartum period or during pregnancy; parity; single or multiple gestation; gestational age and birth weight, when carried out in the puerperium. Specific criteria were also described, according to the objectives of each study, but also common criteria, such as living in the region, speaking the language of origin and conditions relating to maternal and/or neonatal health, as well as contraindications for breastfeeding. The inclusion criteria for the application of the breastfeeding counseling protocols are shown in Figure 2.

Exploratory	Sample (n)	Postpartum women	Pregnant women	Parity		Pregnancy		GA (without)	NB weight (g)	
				P	M	Un	Multi		≥2500	<2500
1[25]	231	Yes	No	Yes	Yes	Yes	No	36-44	Yes	No
2[26]	157	Yes	No	Yes	Yes	Yes	No	37-42	NI	NI
3[27]	323	Yes	No	Yes	Yes	Yes	No	NI	Yes	No
4[28]	41	No	Yes	No	Yes (G2P1)	Yes	No	9-30	-	-
5[29]	40	No	Yes	Yes	Yes	Yes	No	≥35	-	-
6[30]	170	Yes	No	Yes	Yes	Yes	No	NI	Yes	No
7[31]	171	No	Yes	Yes	Yes	No	Yes	18-34	-	-
8[32]	211	Yes	No	Yes	Yes	Yes	No	NI	Yes	No
9[33]	166	No	Yes	Yes	No	NI	NI	20-30	-	-
10[34]	114	Yes	No	Yes	No	NI	NI	37-41	Yes	No
11[35]	318	Yes	No	Yes	Yes	Yes	No	≥37	NI	NI

Notes: GA - gestational age; wk - weeks; NB - newborn; g - grams; P - primipara; M - multipara; Un - single; Multi - multiple; NI - not informed; G2P1 - secundigesta.

Figure 2: Inclusion criteria for the selected publications (n=11). Uberaba, MG, Brazil, 2024.

In relation to breastfeeding counseling protocols, seven studies (63.6%) showed that the sessions were carried out individually, six of which were conducted with postpartum women[26,27,30,32,34,35] and only one thesis applied individualized sessions to pregnant women[29]. Most of the studies that applied the protocols during pregnancy developed this intervention in group activities, with a composition that varied from two to ten pregnant women[25,28,31,33] and a duration of 20 to 60 minutes, and this information was not cited in one study[29].

Four studies did not mention the use of support material during the sessions[29,30,34,35]. However, the majority of studies (n=7; 63.6%) cited the use of some resource[25-28,31-33], such as: unspecified World Health Organization (WHO) support material[25]; leaflet with information on breastfeeding[26]; leaflet with information on the role of the support network[26]; video on breast complications[26]; serial album[27]; illustrated educational booklet on breastfeeding[27]; illustrated educational booklet on introducing complementary feeding[27]; manual with weekly lessons and exercises on breastfeeding[28]; illustrative images[31,32]; use of neonatal mannequins to demonstrate technique and positioning[31-32]; PowerPoint slide shows, photographs, videos and simulations during the sessions[33].

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The use of a protocol in the counseling sessions was described by seven studies (63.6%)[25,27,29-33]; three studies did not mention its use[28,34-35] and one indicated that no protocol was adopted, in which the puerperal were encouraged to talk about their experiences and feelings about breastfeeding, with the subsequent observation of at least one feeding, followed by guidance on improvements, if necessary[26].

In relation to the professional who carried out the counseling, nurses were the most cited professionals in seven studies (63.6%)[25-27,30,31,33,35]. An Iranian study mentioned nurses specializing in obstetrics[30], while three studies mentioned nutritionists (27.3%)[27,28,32]. The presence of a doctor with an unspecified specialty was described in one study (9.1%)[27], one highlighted the presence of a speech therapist (9.1%)[32], and another (9.1%) described the presence of a certified consultant, but did not specify their professional training[28]. It is noteworthy that the publications mentioned the work of teams made up of between one and 12 professionals, while two studies did not provide this description[29,34].

In relation to the prior training of professionals for counseling, it was found that a 40-hour WHO course was cited in eight studies (72.7%)[25,26,29-33,35]. It should also be noted that in one study, the women in the team had to have previously breastfed in order to join the group[25]. One study from Italy described that the professionals had training, which was not specified[34] and in four studies (36.4%), the teams were made up of consultants certified by the International Board Certified Lactation Consultant[26-28,32].

In relation to when breastfeeding counseling was applied, it was found that: three studies (27.3%) reported sessions during prenatal care[25,28,33]; one applied sessions during prenatal care and one session during hospitalization in the Rooming In(9.1%)[30]; one applied sessions during prenatal care and the postpartum period, during home visits (9.1%)[29]; three applied the intervention punctually during hospitalization in the Rooming In (27.3%)[26,27,32], and studies only carried out sessions through telephone contacts after hospital discharge, during the puerperium (27.3%)[30,34,35]. On the other hand, in five studies, the researchers carried out home visits in the first week of the newborn's life (45.4%)[25-27,29,32], between two and 12 visits with different objectives.

The data on counseling protocols can be seen in Figure 3, but it should be noted that in all the studies, the control group received only standard, routine or institutional care, without detailed description.

Exploratory	Sample (n)	Intervention		Duration* (min/h)	Support material	Protocol**	Team (n)	Training / Criteria	Counseling***	VD
		I	G (n*)							
1[25]	231	No	Yes 2 - 4	20 min	Yes	Yes	2 Nurses (2) Nutritionist (1)	Yes 40 hours Having breastfed	Pre-natal	Yes
2[26]	157	Yes	No	20-30 min	Yes	No	Nurses (NI)	Yes 40 hours Two IBCLC consultants	Rooming In (first 24 hours)	Yes
3[27]	323	Yes	No	1 hour	Yes	Yes	Nurses (2) Nutritionist (1) Doctor (1)	IBCLC consultants	Rooming In	Yes
4[28]	41	No	Yes 610	1 hour	Yes	NI	Consultant (1) Nutritionist (1)	IBCLC Consultant	Pre-natal	No
5[29]	40	Yes	No	NI	NM	Yes	NI	Yes 40 hours	Prenatal and postpartum care	Yes
6[30]	170	Yes	No	20 min	NM	Yes	Obstetric nurse (1)	Training 40 hours	Postpartum period	No
7[31]	171	No	Yes 2 - 3	30 min	Yes	Yes	Nurses (2)	Yes 40 hours	Prenatal Care and Rooming In	No
8[32]	211	Yes	No	30 min	Yes	Yes	Nutritionists (2) Speech therapist (1)	Yes 40 hours	Rooming In	Yes
9[33]	166	No	Yes 10	20-30 min	Yes	Yes.	Nurse (1)	Yes 40 hours	Pre-natal	No
10[34]	114	Yes	No	NI	NM	NI	NI	NI	Postpartum period	No
11[35]	318	Yes	No	58 min	NM	NI	Nurses (12)	Yes 40 hours	Postpartum period	No

Notes: *duration of sessions; **use of protocols; ***moment; HV - home visit; n* - number of pregnant women per group; min - minutes; h - hours; IBCL - International Board Certified Lactation Consultant; NM - not mentioned; NI - not informed.
Figure 2: Description of the counseling protocol of the selected publications (n=11). Uberaba, MG, Brazil, 2024.

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DISCUSSION

The scarcity of studies presenting counseling protocols for breastfeeding was notable in this review, even though the benefits of this approach were described in the studies. It should be noted that the course "Breastfeeding counseling: a training course" was conceived by the WHO Diarrheal Disease Control Program, in collaboration with the United Nations Children's Fund, as a strategy for reducing childhood diarrhea and promoting breastfeeding. Initially held in 1991 in the Philippines, reproduced in 1992 in Jamaica and in 1993 in Bangladesh, the course was given for the first time to Brazilian health professionals in 1995[36]. Although it was conceived in the 1990s, it was observed that studies on the subject were produced from the 2000s onwards.

In this review, there was a predominance of studies carried out in Brazil. According to data from the National Child Feeding and Nutrition Study, there has been an increase in the prevalence and duration of breastfeeding in Brazil since the 1980s. The prevalence of exclusive breastfeeding increased from 4.7% in 1986 to 45.8% in 2019 and that of continued breastfeeding in the first year of life increased from 25.5% to 43.6% in the same period, contributing to the improvement of child health indicators, a reduction in hospital admissions due to diarrhea and respiratory infections in children under one year old[37]. However, the prevalence of exclusive breastfeeding up to six months of age in Brazil is 45.8%[37], similar to the global percentage of 44%[4].

There was a predominance of randomized clinical trials, followed by trial pilots. The randomized clinical trial is the most appropriate design when you want to test a particular intervention, classified as high quality evidence[38]. As BF counseling is an intervention that has been tested in different contexts, with different objectives, the predominance of the design is justified.

The breastfeeding counseling protocols were applied during pregnancy or in the puerperium. Research into educational interventions with pregnant women has identified an increase in self-efficacy for breastfeeding, a reduction in difficulties with breastfeeding in the puerperium[39] and an increase in the duration of exclusive breastfeeding[40]. Corroborating this, a review study emphasized that professional support, provided by qualified and trained personnel, starting during prenatal care, in person, using counselling skills and involving a support network of between four and eight contacts, was an effective intervention for promoting breastfeeding[7], suggesting the importance of continuity in order to achieve greater results. Also, in relation to the interventions that took place during the dyad's hospitalization in the Rooming In, one study indicated that this moment is strategic for the development of effective actions to maintain breastfeeding[41].

The counseling sessions were carried out individually or in groups, and individualized counseling had an impact on better breastfeeding indicators, as well as network support after discharge, since the women who encountered difficulties and sought help were the ones most at risk of early weaning[42]. A randomized clinical trial with 352 pregnant women found that individualized, regular and continuous prenatal education, combined with postnatal support, can effectively increase exclusive breastfeeding rates from birth to four months postpartum and change breastfeeding behavior, when compared to group health education sessions[43].

In turn, a study that used active methodologies to approach a group of pregnant women during prenatal care observed that the postpartum women in the intervention group had fewer difficulties with breastfeeding and a higher percentage of exclusive breastfeeding[44]. However, a study based on four group health education sessions during prenatal care found that there was no difference between the individual or group approach, but health education activities increased maternal intention to breastfeed[45]. Research therefore reinforces the importance of individual or group support, as long as it addresses individual circumstances and uses active methodologies.

There was a predominance of primiparous women in the studies included in the review. In this sense, this population group showed a higher risk of early weaning due to low self-efficacy for breastfeeding[46], while among multiparous women there were positive predictors for maintaining exclusive breastfeeding, and it is important to consider parity and previous experiences with breastfeeding when planning protection and promotion actions[47].

Breastfeeding single neonates was one of the predominant inclusion criteria identified in the studies. However, breastfeeding counseling has proven to be a powerful strategy in twin pregnancies[48]. At the same time, most studies have applied counseling to full-term neonates, given the challenges of breastfeeding premature newborns, mainly due to their immaturity and incoordination in sucking, swallowing and breathing[49]. The coordination of sucking-swallowing-breathing begins from the 34th gestational week and will only be established after the 36th week[50], which may require more effort from the team to continue breastfeeding in these cases. A study of 180 premature babies showed that 28.3% received mixed feeding, with breast milk predominating. However, at hospital discharge, the majority were on

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mixed breastfeeding and only 2.4% of newborns were on exclusive breastfeeding. Thus, maintaining breastfeeding at the time of discharge was associated with higher gestational age (over 34 weeks)[51,52] and higher birth weight[51].

Similarly, the criterion of low birth weight (less than 2,500 grams) delimited the sample of included studies, since neonates in this situation, whether or not associated with prematurity, have compromises related to organ growth, risk of feeding-related injuries and potential fragility, which can increase the risk of necrotizing enterocolitis[53,54]. A meta-analysis showed that introducing enteral feeding with breast milk within 72 hours of birth reduces the risk of mortality and neonatal sepsis, as well as reducing the length of hospital stay, although it can reduce weight at discharge[55]. The WHO strongly recommends that neonates with low or very low birth weight (<1500 grams) should receive breast milk and, if this is not possible, the alternative would be breast milk donated to human milk banks and, as a last option, artificial milk[56].

Nurses were the most cited category in the counseling studies that made up the review. In the context of breastfeeding, these professionals play a significant role in supporting the initiation of lactation during hospitalization[57]. An American study involving 184 hospital institutions and 2691 nurses indicated that exclusive breastfeeding during the dyad's hospitalization was associated with nurse assistance[58]. In turn, the absence of nursing care is related to lower rates of exclusive breastfeeding at hospital discharge[59], reinforcing the importance and relevance of nurses in promoting breastfeeding.

It is worth reflecting on the counseling protocols that are the subject of this study. It was observed that, although they focused on individual circumstances, most of the studies had a previous set of guidelines. In this way, there is a great deal of similarity with the health education actions, guidance and clinical management of breastfeeding, already pointed out in previous studies[7,41]. The lack of methodological detail does not allow us to conclude whether, in fact, the intervention proposed in the studies consisted of counseling or individualized health education.

This can lead to misunderstandings when it comes to mapping, interpreting and consolidating evidence on the subject and make it difficult to incorporate counseling skills into institutional protocols and clinical practice. A qualitative study of nurses who work to promote breastfeeding showed that they are familiar with the strategies for the clinical management of breastfeeding and that they take a humanized approach. However, their actions are not systematized, and the focus is often limited to guidance, prioritizing only high-risk dyad's[60].

It should be noted that BF counseling is a complex approach, based on an advanced technique of interaction and communication, with an emphasis on individual needs and desires[10]. Thus, its aim is to enable women to breastfeed, respecting their reality and personal wishes[7,36], and it is distinct from clinical management, health education and guidelines for successful breastfeeding[7-9,36].

Study limitations

The scarcity of studies detailing protocols for BF counseling compromises the comparability of the data. In addition, the lack of methodological detail in the protocols used does not exhaust the questions and remains a gap in the literature. However, these limitations are a potential for future studies, given the benefits of the strategy, and for the advancement of scientific knowledge in the field of health and nursing.

CONCLUSION

There is a scarcity of research detailing counseling protocols in BF. There was a predominance of application of the protocols in the puerperium, regardless of maternal parity, prioritizing care for the dyad's in situations of term birth and neonates weighing more than 2,500 grams, conditions that favor breastfeeding.

Counseling was applied at different times, during prenatal care, during hospitalization in the Rooming In or after discharge, both by telephone and by home visit. Among postpartum women, interventions in individual sessions or group activities predominate. In the case of pregnant women, there was evidence of the use of support material in the interventions, which last between 20 and 60 minutes. Nurses were the most cited professionals in the interventions, which involved between one and 12 professionals on the team, all of whom had been trained, mainly through the WHO's 40-hour course.

Most of the studies cited the use of protocols, however, for all the sessions a structured script was proposed for guidance. Thus, this review points to the need to offer an individualized approach, which differentiates it from health education, guidance or clinical management of breastfeeding.

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Author's contributions

Conceptualization, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; methodology, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; formal analysis, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; investigation, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; resources, MT.R.; manuscript writing, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; writing – review and editing, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; visualization, J.S.C., C.V.R., M.C.C., E.C.R., M.W. and M.T.R.; supervision, M.T.R.; project administration, M.T.R.; acquisition of financing, M.T.R. All authors read and agreed with the published version of the manuscript.