EtD 20. Should donor breastmilk vs. infant formula be used for preterm infants for whom there is insufficient mother's own breastmilk?

POPULATION:	Preterm infants for whom there is insufficient mother's own breastmilk
INTERVENTION:	Donor breastmilk
COMPARISON:	Infant formula
MAIN OUTCOMES:	**Critical outcomes** Mortality Necrotising enterocolitis Fully breastfed or breastmilk feeding at hospital discharge Time to full enteral feeds Faltering growth/body composition Duration of initial hospital stay **Important but not critical** Neurodevelopmental impairment Adverse effects Sepsis: proven or suspected Bronchopulmonary dysplasia Retinopathy of prematurity Anaemia of prematurity Cost: cost of intervention, cost of neonatal care and life-long cost **Less important for decision making** Time to full sucking feeds
SETTING:	Neonatal care
PERSPECTIVE:	Clinical recommendation
BACKGROUND:	Mother's own breastmilk is the ideal nutrition for preterm infants, offering essential nutrients, growth factors, and immune protection that support gut maturation, reduce the risk of necrotising enterocolitis and promote neurodevelopment. When insufficient, substitutes such as donor breastmilk or infant formula are used to meet nutritional needs. For very low birthweight (VLBW, <1500 g) infants, both the American Academy of Pediatrics and European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) recommend donor breastmilk over infant formula, primarily due to lower necrotising enterocolitis rates. However, donor breastmilk, especially if pasteurised, is associated with slower postnatal weight gain compared to preterm formula. This is because donor breastmilk has nutritional deficits due to storage and pasteurisation for safety and its origin from mothers of older infants because expressed breastmilk from mothers of more mature infants has lower amounts of key nutrients. For example, protein, immunoglobulin, lactoferrin and insulin concentrations are lower in donor breastmilk. While moderate-to-late preterm infants are less fragile than VLBW infants, they may still benefit from donor breastmilk over formula, highlighting its potential role in improving outcomes across the preterm population. In Aotearoa, donor breastmilk is increasingly being used for preterm infants instead of infant formula. However, the macro- and micronutrient composition of donor breastmilk is largely unknown and represents a critical knowledge gap for healthcare providers for preterm infants.

CONFLICT OF INTERESTS:	The following DIAMOND study authors are on the Guideline Development Group: Tanith Alexander and Frank Bloomfield The following McClintock *et al* systematic review co-authors are on the Guideline Development Group: Luling Lin and Frank Bloomfield

Assessment

Desirable Effects

How substantial are the desirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Trivial ○ Small ○ Moderate ● Large ○ Varies ○ Don't know	Evidence taken from 2 systematic reviews [1,2] Bayley II Mental Development Index. Neither review looked at gestational age or birthweight as a subgroup **Necrotising enterocolitis:** RCT: Very large reduction in NEC for donor EBM (33 fewer per 1,000; 45 fewer to 17 fewer) [Critical]. The risk was reduced whether the donor milk was the entire diet or supplemented mother's own milk. **Fully breastfed or breastmilk feeding at hospital discharge:** Cohort: No clear difference between donor EBM supplementation and infant formula supplementation on exclusive breastfeeding rates at hospital discharge (5 cohort studies). There was possible benefit of donor EBM on the rates of any breastfeeding at hospital discharge (1 cohort study) [Critical]. No faltering growth/body composition: RCT: No difference between donor EBM supplementation and infant formula supplementation for weight at 18 months (MD 0.1 kg lower; 0.35 lower to 0.15 higher). No difference between donor EBM supplementation and infant formula supplementation for head circumference at 18 months (MD 0.1 cm lower; 0.39 lower to 0.19 higher) [Critical]. One additional pilot RCT reported outcomes related to infant growth. At 6–8 weeks chronological age, there was no difference in weight and length of both groups except for higher head circumference z-score in the infant formula group (Donor EBM −0.4 (1.3) vs. infant formula 0.4 (0.9), p = 0.04). Neurodevelopmental outcomes: RCT: Donor EBM has no significant effect on Bayley Mental Development Indices at 18 months (MD 1.24 points lower; 5.09 lower to 2.62 higher); Psychomotor Development Indices at 18 months (MD 0.32 points higher; 2.79 lower to 3.43 higher); Bayley-III assessments at 18 to 22 months' corrected age: Cognitive (MD 0.84 points lower), language (MD 0.53 points lower) and motor (MD 0.92 points lower). Donor EBM has no significant effect on cerebral palsy (1 fewer per 1,000; 28 fewer to 38 more); hearing impairment (1 fewer per 1,000; 24 fewer to 78 more); visual impairment (not estimable as no events); and severe neurodevelopmental disability as assessed by the Amiel-Tison 1986 classification (15 fewer per 1000; 50 fewer to 53 more) [Important]. **Desirable effects for Māori** The benefits of breastfeeding are well established and efforts to encourage women to breastfeed exclusively or partially should be encouraged.	**Population information for included evidence** McClintock *et al* [1] healthy infants, most studies included infants >35 weeks and some included term infants. In Quigley *et al* the population is very preterm or very low birthweight infants [2]. The trials associated with growth outcomes with donor milk as the sole diet are very old trials with 4/5 being conducted in the '70s and '80s. Sample sizes in these studies are also very small. Caution may be advised when interpreting these data.

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with infant formula	Risk difference with donor breastmilk
Mortality-All cause RCT	2116 (9 RCTs)	⨁⨁⨁◯ Moderate[a]	**RR 1.00** (0.76 to 1.31)	Study population	
				87 per 1,000	**0 fewer per 1,000** (21 fewer to 27 more)
Necrotising enterocolitis RCT	2261 (10 RCTs)	⨁⨁⨁⨁ High	**RR 0.53** (0.37 to 0.76)	Study population	
				71 per 1,000	**33 fewer per 1,000** (45 fewer to 17 fewer)
Fully breastfed or breastmilk feeding at hospital discharge cohort	1966 (5 non-randomised studies)	⨁◯◯◯ Very low[b,c]	-	No clear difference between donor breastmilk supplementation and infant formula supplementation on exclusive breastfeeding rates at hospital discharge (5 cohort studies). There was possible benefit of donor breastmilk on the rates of any breastfeeding at hospital discharge (1 cohort study).	
Time to full enteral feeds - not measured	-	-	-	-	-
Faltering growth/body composition RCT assessed with: In-hospital rate of weight gain (g/kg/day) until term equivalent	1360 (9 RCTs)	⨁⨁◯◯ Low[d]	-	The mean faltering growth/body composition RCT was **21.5 g/kg/day**	MD **3.55 lower** (4.21 lower to 2.89 lower)
Faltering growth/body composition RCT assessed with: In-hospital rate of head circumference growth (mm/week) until term equivalent	1261 (9 RCTs)	⨁⨁◯◯ Low[e]	-	The mean faltering growth/body composition RCT was **9.5 mm/wk**	MD **0.69 lower** (1.01 lower to 0.36 lower)
Faltering growth/body composition RCT assessed with: Weight at 18 months post term (kg)	438 (2 RCTs)	⨁⨁◯◯ Low[a,f]	-	The mean faltering growth/body composition RCT was **10.05 kg**	MD **0.1 lower** (0.35 lower to 0.15 higher)
Faltering growth/body composition RCT assessed with: Head circumference at 18 months post term (cm)	438 (2 RCTs)	⨁⨁◯◯ Low[a,f]	-	The mean faltering growth/body composition RCT was **47.95 cm**	MD **0.1 lower** (0.39 lower to 0.19 higher)
Duration of initial hospital stay Cohort	156 (1 non-randomised studies)	⨁◯◯◯ Very low[b,c]	-	The mean duration of hospital stay cohort **2.86 days**	MD **0.09 higher** (0.32 lower to 0.50 higher)
Neurodevelopmental impairment RCT assessed with: Bayley II Mental Development Index at 18 months Scale from: 1 to 100	387 (2 RCTs)	⨁⨁◯◯ Low[a,f]	-	The mean neurodevelopmental impairment RCT: Bayley II Mental Development Index was **99.55 points**	MD **1.24 lower** (5.09 lower to 2.62 higher)
Neurodevelopmental impairment RCT assessed with: Bayley II Psychomotor Development Index at 18 months Scale from: 1 to 100	387 (2 RCTs)	⨁⨁◯◯ Low[a,f]	-	The mean neurodevelopmental impairment RCT: Bayley Psychomotor Developmental Index was **94.35 points**	MD **0.32 higher** (2.79 lower to 3.43 higher)

Neurodevelopmental impairment assessed with: Cerebral Palsy	1124 (4 RCTs)	⨁⨁◯◯ Low[a,f]	**RR 0.99** (0.66 to 1.46)	Study population	
				82 per 1,000	**1 fewer per 1,000** (28 fewer to 38 more)
Neurodevelopmental impairment assessed with: Hearing impairment	299 (1 RCT)	⨁⨁◯◯ Low[a,g]	**RR 0.98** (0.29 to 3.32)	Study population	
				34 per 1,000	**1 fewer per 1,000** (24 fewer to 78 more)
Neurodevelopmental impairment assessed with: Visual impairment	299 (1 RCT)	⨁⨁◯◯ Low[g,h]	not estimable - no events	Study population	
				0 per 1,000	**0 fewer per 1,000** (0 fewer to 0 fewer)
Neurodevelopmental impairment assessed with: Neurodevelopmental disability at 18 months	400 (2 RCTs)	⨁⨁◯◯ Low[a,f]	**RR 0.83** (0.43 to 1.60)	Study population	
				88 per 1,000	**15 fewer per 1,000** (50 fewer to 53 more)
Adverse effects - not measured	-	-	-	-	-
Sepsis proven or suspected - not measured	-	-	-	-	-
Bronchopulmonary dysplasia - not measured	-	-	-	-	-
Retinopathy of prematurity - not measured	-	-	-	-	-
Anaemia of prematurity - not measured	-	-	-	-	-
Time to full sucking feeds - not measured	-	-	-	-	-

a. Downgraded one level due to imprecision with confidence intervals that cross the line of no effect, indicating potential benefit and harm.
b. Downgraded one level for risk of bias as included data from poorer designed retrospective cohort studies.
c. Downgraded one level as unable to judge as data were not pooled.
d. Downgraded two levels due to extremely high heterogeneity I2 >80%
e. Downgraded two levels as I2 = 76% and was high for both subgroups of donor milk as entire diet or as supplement to mothers own milk.
f. Downgraded one level for risk of bias due to lack of clarity on methodology including randomisation and blinding
g. Downgraded one level for indirectness as evidence is based on a single study with low event rates.
h. Downgraded one level for imprecision as there were no events recorded

Undesirable Effects

How substantial are the undesirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
● Trivial ○ Small ○ Moderate ○ Large	Evidence taken from 2 systematic reviews [1,2] Mortality: RCT: No significant effect on all-cause mortality (0 fewer per 1,000; 21 fewer to 27 more) [Critical]. Faltering growth/body composition: RCT: Donor EBM results in slower in-hospital weight gain	

○ Varies ○ Don't know	until term equivalent (MD 3.55 g/kg/day lower; 4.21 lower to 2.89 lower); donor breastmilk results in slower head circumference growth until term equivalent (MD 0.69 mm/week lower; 1.01 lower to 0.36 lower) [Critical]. Duration of initial hospital stay: Cohort: Little or no difference between donor EBM supplementation and infant formula supplementation on admission to NICU and length of hospital stay (MD 0.09 days higher; 0.32 lower to 0.50 higher. [Critical] **Undesirable effects for Māori** The benefits of breastfeeding are well established and efforts to encourage women to breastfeed exclusively or partially should be encouraged.	

Certainty of evidence

What is the overall certainty of the evidence of effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ○ Low ● Moderate ○ High ○ No included studies	Some of the evidence is based on observational studies and some is based on older studies conducted over 40 years ago. High to very low certainty evidence overall **Certainty of evidence for Māori** There was no specific evidence relating to Māori but the overall the certainty of the evidence is very low.	

Outcomes	Importance	Certainty of the evidence (GRADE)
Mortality-All cause RCT	CRITICAL	⨁⨁⨁◯ Moderate[a]
Necrotising enterocolitis RCT	CRITICAL	⨁⨁⨁⨁ High
Fully breastfed or breastmilk feeding at hospital discharge cohort	CRITICAL	⨁◯◯◯ Very low[b,c]
Time to full enteral feeds - not measured	CRITICAL	-
Faltering growth/body composition RCT assessed with: In-hospital rate of weight gain (g/kg/day) until term equivalent	CRITICAL	⨁⨁◯◯ Low[d]
Faltering growth/body composition RCT assessed with: In-hospital rate of head circumference growth (mm/week) until term equivalent	CRITICAL	⨁⨁◯◯ Low[e]

Faltering growth/body composition RCT assessed with: Weight at 18 months post term (kg)	CRITICAL	⨁⨁◯◯ Low[a,f]
Faltering growth/body composition RCT assessed with: Head circumference at 18 months post term (cm)	CRITICAL	⨁⨁◯◯ Low[a,f]
Duration of initial hospital stay Cohort	CRITICAL	⨁◯◯◯ Very low[b,c]
Neurodevelopmental impairment RCT assessed with: Bayley Mental Development Index at 18 months Scale from: 1 to 100	IMPORTANT	⨁⨁◯◯ Low[a,f]
Neurodevelopmental impairment RCT assessed with: Bayley Psychomotor Development Index at 18 months Scale from: 1 to 100	IMPORTANT	⨁⨁◯◯ Low[a,f]
Neurodevelopmental impairment assessed with: Cerebral Palsy	IMPORTANT	⨁⨁◯◯ Low[a,f]
Neurodevelopmental impairment assessed with: Hearing impairment	IMPORTANT	⨁⨁◯◯ Low[a,g]
Neurodevelopmental impairment assessed with: Visual impairment	IMPORTANT	⨁⨁◯◯ Low[g,h]
Neurodevelopmental impairment assessed with: Neurodevelopmental disability at 18 months	IMPORTANT	⨁⨁◯◯ Low[a,f]
Adverse effects - not measured	IMPORTANT	-
Sepsis proven or suspected - not measured	IMPORTANT	-
Bronchopulmonary dysplasia - not measured	IMPORTANT	-
Retinopathy of prematurity - not measured	IMPORTANT	-
Anaemia of prematurity - not measured	IMPORTANT	-
Time to full sucking feeds - not measured	NOT IMPORTANT	-

a. Downgraded one level due to imprecision with confidence intervals that cross the line of no effect, indicating potential benefit and harm.
b. Downgraded one level as included data from poorer designed retrospective cohort studies.
c. Downgraded one level as unable to judge as data were not pooled.
d. Downgraded two levels due to extremely high heterogeneity I2 >80%
e. Downgraded two levels as I2 = 76% and was high for both subgroups of donor milk as entire diet or as supplement to mother's own milk.
f. Downgraded one level due to lack of clarity on methodology including randomisation and blinding
g. Downgraded one level as evidence is based on a single study with low event rates.
h. Downgraded one level as there were no events recorded

Values

Is there important uncertainty about or variability in how much people value the main outcomes?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Possibly important uncertainty or variability **Values for Māori** No additional research available	**Critical outcomes** Mortality Necrotising enterocolitis Fully breastfed or breastmilk feeding at hospital discharge Time to full enteral feeds Faltering growth/body composition Duration of initial hospital stay

Balance of effects

Does the balance between desirable and undesirable effects favour the intervention or the comparison?

Judgement	Research evidence	Additional considerations
○ Favours the comparison ○ Probably favours the comparison ○ Does not favour either the intervention or the comparison ○ Probably favours the intervention ● Favours the intervention ○ Varies	**Donor EBM compared with infant formula - high certainty of evidence** Large reduction in NEC **Donor EBM compared with infant formula - moderate certainty of evidence** Uncertain effect on mortality **Donor EBM compared with infant formula - low certainty of evidence** Uncertain effect on fully breastfed or breastmilk feeding at hospital discharge, weight gain and head circumference at 18 months, neurodevelopmental impairment, hypoglycaemia Reduction in weight gain and head circumference until term equivalent **Donor EBM compared with infant formula - very low certainty of evidence** Uncertain effect on duration of hospital stay.	

○ Don't know	**Balance of effects for Māori** No additional data	

Resources required

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	There are six active human breastmilk banks (all non-profit) in Aotearoa New Zealand, none of which are in Auckland (the largest, most populated city with two tertiary neonatal intensive care units). Screened unpasteurised EBM from peer-to-peer donation is available at both Auckland City and Middlemore Hospitals. Women may also rely on or rely on peer-to-peer donation via informal social networks. Donor EBM supplies (formal and informal) and milk banks are required. Other resources required include expressing and storage equipment, lactation consultant time Evidence from a mixed-method national survey (including 7.6% Māori) found that informal screening processes undertaken by parents and health professionals before informal human breastmilk donation were lifestyle including smoking status, medication, drug and alcohol intake (44% and 36%, respectively) (Harris 2024) [3]. No cost data available. **Costs (for up to 100-120 days)** Preterm infant formula $3.24 per 100 mL ($6 to $15 per day, approx. $500 to $1500 per infant per admission of 100 days) Term infant formula $1.16 to $1.56 per 100 mL ($2.08 to $4.20 per day, approx. $208 to $420 per infant per admission of 100 days) Pasteurised donor milk from a Milk Bank is $16 per 100 mL ($29 to $43 per day, approx. $2,900 to $4,300 per infant per admission of 100 days) Fortified donor breastmilk from a Milk Bank is $23 per 100 mL ($42 to $62 per day, approx. $4,200 to $6,200 per infant per admission of 100 days) **Cost difference for preterm formula vs. fortified pasteurised donor breastmilk is $3,700 to $4,700 per infant per admission (large)** **Cost difference for preterm formula vs. fortified unpasteurised donor breastmilk is negligible.** **Resources required by Māori** Need for wāhine Māori women to donate milk and access to donated breastmilk for wāhine Māori.	Pasteurised Donor EBM estimated cost is $16.00 per 100 mL (Christchurch Women's Hospital Milk Bank) Breastmilk fortifier $3.75 per 100 mL Preterm infant formula (Liquid ready to feed) $3.24 per 100 mL Term infant formula (Liquid ready to feed) $1.56 per 100 mL

Certainty of evidence of required resources

What is the certainty of the evidence of resource requirements (costs)?		
JUDGEMENT	**RESEARCH EVIDENCE**	**ADDITIONAL CONSIDERATIONS**
○ Very low ○ Low ● Moderate ○ High ○ No included studies	Costs are moderately certain. **Certainty of evidence of resource requirements for Māori** No evidence available.	Evidence from a mixed-method national survey found that costs associated with breastmilk donation are covered by a combination of health services, donor and recipient parents (5).

Cost effectiveness

Does the cost-effectiveness of the intervention favour the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favours the comparison ○ Probably favours the comparison ○ Does not favour either the intervention or the comparison ○ Probably favours the intervention ○ Favours the intervention ○ Varies ● No included studies	No economic studies were identified to address the cost-effectiveness of the intervention or the comparison; however, the costs associated with one case of NEC requiring surgery and the potential ongoing consequences are substantial **Cost effectiveness for Māori** No evidence available.	

Equity

What would be the impact on health equity?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Reduced ○ Probably reduced	**Equity for Māori** There is inequity in access to donor milk for Māori, especially if they do not live in centres where there is a breastmilk bank. Whānau Māori in smaller, rural, or under-resourced regions, where	

○ Probably no impact ○ Probably increased ● Increased ○ Varies ○ Don't know	Māori make up a significant proportion of the population, are less likely to have access to donor milk. Urban tertiary NICUs may have milk banks but may not offer consistent or equitable eligibility criteria across ethnicities or income levels. In the DIAMOND trial, which investigated nutrition interventions to support moderate-late preterm infants pending full breastmilk feeding in Aotearoa New Zealand NICUs, pēpi Māori received infant formula more frequently and earlier than European infants, despite an intention to breastfeed being an entry criterion to the trial. By 3 days after birth, almost 50% of preterm pēpi Māori had received infant formula compared with 25% of European infants, indicating divergent treatment by ethnicity. **Equity for Pacific families** Pacific families also face inequities in access to donor breastmilk, and other ethnic minority groups may experience similar challenges, though data is sparse. Language barriers, lack of culturally appropriate information and systemic bias likely affect access for infants of other ethnicities, especially refugee and migrant communities. These families may experience clinicians defaulting to formula due to time/resource constraints, lack of clear discussion about donor milk as an option, cultural misunderstandings or stigma. **Equity for underrepresented groups** Migrant, refugee and rural families often lack access to hospital donor milk due to distance or low resourcing. Language barriers can hinder understanding of its safety and benefits. Equity means making donor milk universally available and ensuring families receive information in their own language to make informed, confident decisions.	

Acceptability

Is the intervention acceptable to key interest-holders?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	Evidence from a mixed-method Aotearoa New Zealand national survey found that there was a high level of support for donor breastmilk among health professionals and donors. Almost all parents (98%) and health professionals (98%) supported the use of donor breastmilk in hospitals. Support for the use of donor breastmilk in the community was more common among parents (92%) than health professionals (87%), yet not statistically different (Harris 2024). There may be benefits to the donor for altruism (Harris 2024) [3]. The composition of donor breastmilk in Aotearoa New Zealand is unknown in relation to macro- and micronutrients.	

Feasibility

Is the intervention feasible to implement?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	Human breastmilk donation is already implemented in Aotearoa New Zealand so it is feasible but there are no national and standardised guidelines for milk sharing with informal breastmilk donation. Some regions have better access than others.	

Summary of judgements

	JUDGEMENT						
DESIRABLE EFFECTS	Trivial	Small	Moderate	**Large**		Varies	Don't know
UNDESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know
CERTAINTY OF EVIDENCE	Very low	Low	**Moderate**	High			No included studies
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability			
BALANCE OF EFFECTS	Favours the comparison	Probably favours the comparison	Does not favour either the intervention or the comparison	Probably favours the intervention	**Favours the intervention**	Varies	Don't know
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know
CERTAINTY OF EVIDENCE OF REQUIRED RESOURCES	Very low	Low	**Moderate**	High			No included studies

	JUDGEMENT						
COST EFFECTIVENESS	Favours the comparison	Probably favours the comparison	Does not favour either the intervention or the comparison	Probably favours the intervention	Favours the intervention	Varies	**No included studies**
EQUITY	Reduced	Probably reduced	Probably no impact	Probably increased	**Increased**	Varies	Don't know
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know

Type of recommendation

Strong recommendation against the intervention	Conditional recommendation against the intervention	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	**Strong recommendation for the intervention**
○	○	○	○	●

References

1. McClintock, T.; Fiddes, C.; Harris, S.; Embleton, N.; Lin, L.; Bloomfield, F.H.; Muelbert, M. Donor human milk versus infant formula for low-risk infants: a systematic review. *Pediatr. Res.* **2025**, *97*, 81-91, doi:10.1038/s41390-024-03309-x.
2. Quigley, M.; Embleton, N.D.; Meader, N.; McGuire, W. Donor human milk for preventing necrotising enterocolitis in very preterm or very low-birthweight infants. *Cochrane Database Syst. Rev.* **2024**, *9*, Cd002971, doi:10.1002/14651858.CD002971.pub6.
3. Harris, S.; Bloomfield, F.H.; Muelbert, M. Formal and informal human milk donation in New Zealand: a mixed-method national survey. *Int Breastfeed J* **2024**, *19*, 61, doi:10.1186/s13006-024-00667-4.

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