

## Original Research Article

# Acceptance of donor breastmilk by mothers in Lagos: a cross-sectional survey

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## ABSTRACT

**Background:** Human breast milk meets the nutritional needs of babies and reduces the incidence of infection. Not all babies benefit from this nature's gift. WHO recommends that such babies should receive the next preferred choice of donor breast milk (DBM), which is not common in Nigeria. This study aimed to determine the acceptance of donor breast milk by the mothers in Lagos State, South-Western Nigeria.

**Methods:** A questionnaire-based, descriptive, cross-sectional study. Questionnaires were administered to mothers of babies attending the immunization and neonatal clinics at seven Lagos State government-owned hospitals from September to November 2021.

**Results:** A total of 1750 questionnaires were analyzed. The mean age of the respondents was 30.9±6.3 years. Most respondents (59.2%) had a tertiary education. Most (88.8%) had no prior knowledge of DBM, and 83.5% would not allow their babies to receive DBM. Maternal education ( $p=0.031$ ) and the mode of delivery ( $p=0.049$ ) are significantly associated with the knowledge of DBM, and a significant association exists between knowledge of DBM and perception of receiving DBM ( $p=0.001$ ). All mothers who had heard of DBM (100%) were willing to allow their babies to receive DBM, compared to only 5.9% of mothers who had not heard of DBM.

**Conclusions:** Mothers in Lagos are not willing to give their babies DBM. Religious and cultural reasons strongly influence acceptance of DBM. These mothers, however, are willing to donate their milk for other babies.

**Keywords:** Breastmilk donation, Donor breast milk, Exclusive breastfeeding, Human milk bank

## INTRODUCTION

Breastmilk is beneficial for every newborn, and exclusive breastmilk without additional feeds or fluids except medicines and vitamin supplements is recommended from birth up to six months of life.<sup>1</sup> Breastmilk has been found to adequately supply all nutritional needs of babies in the first half of infancy.<sup>2</sup> Thereafter, complementary feeds should be introduced because breastmilk alone can no longer supply the caloric requirements for growth and development. According to the World Health Organisation (WHO), breastfeeding should be continued for the first two years of life.<sup>3</sup> Breastmilk protects the baby from infections as it contains immune cells, bacteria (lactobacillus, bifidobacteria), immunoglobulins (IgA), human milk oligosaccharides (HMOs), immune cytokines, and lysozyme. These confer an appreciable amount of protection against offending organisms.<sup>4</sup> Breast milk is therefore considered to be the first form of passive immunisation for the baby. Exclusively breastfed babies are less likely to suffer or die from diarrheal diseases and pneumonia compared to those not exclusively breastfed or not breastfed at all.<sup>1</sup> Early initiation of breastfeeding within the first 30 minutes of life and exclusive breastfeeding may lead to the prevention of about 20% of neonatal deaths.<sup>5</sup> In the low- and medium-income countries (LMICs), optimal breastfeeding prevents 13% of under-five deaths.<sup>5</sup> Nigeria currently has one of the highest neonatal mortality rates in the world and an exclusive breastfeeding rate of only 29%. Perhaps a higher rate of exclusive breastfeeding would reduce the neonatal mortality rate, as achieved in Brazil when neonatal mortality was reduced by 73% between 1990 and 2013, once the availability of breastmilk banks was incorporated into its newborn health policy.<sup>6</sup>

Some babies do not receive breast milk for reasons including chronic maternal illness or demise. The WHO recommends that infants who cannot receive breast milk from their own mothers should receive donated human breastmilk.<sup>3</sup> The National Institute for Health and Clinical Excellence (NICE) defines donated breastmilk as milk expressed by a mother that is then processed by a donor milk bank for use by a recipient that is not the mother's own baby.<sup>5</sup> A human milk bank is a service established to (i) recruit and screen human milk donors, (ii) collect donated human milk, (iii) screen, process and store donor human milk, and (iv) distribute this milk to meet an infant's specific needs for optimal health.<sup>7</sup> While human donor milk is not the same as the mother's fresh milk, because of the loss of micronutrients and anti-infective factors during pasteurisation, and decomposition over time, there are sufficient bioactivity and immunological properties in it to guarantee that donated breast milk is superior to formula feeds.<sup>8</sup>

Donor breast milk or breast milk banking has not been widely practised in Nigeria. The reasons for this may be multiple. In a multicenter study in Southeast Nigeria, Iloh

et al found a low knowledge of breastmilk donation, but a high willingness to give donor breastmilk to their babies.<sup>9</sup> Some reasons for unwillingness to receive donor breast milk included cultural unacceptability, unhygienic preparation, fear of transferring bad genetic traits to the child and societal stigma.<sup>10,11</sup> Another study conducted in the same region of the country by Abulimen et al examined mothers' knowledge of the use of banked human milk and found similar results despite a smaller sample size.<sup>10</sup> Studies from other cultures and ethnic regions of the country that have different beliefs, practices and values may differ in results and conclusions. There is, therefore, a need to study the mother's perception of donor breastmilk and acceptability in different geographical parts of Nigeria, as there are different cultures and beliefs among the various ethnic groups with dominance in different geographical parts of the country. This study aimed to determine the acceptance of donor breastmilk among mothers in Lagos State, South-Western Nigeria.

## METHODS

### *Study design*

A cross-sectional study was conducted to assess the acceptance of donor breast milk in Lagos State among mothers

### *Study setting*

Lagos State is the fastest-growing state and the most populous city in Nigeria. It has a population of over 21million people. It is a coastal city surrounded by water. The state has 20 local government areas (LGAs) and 37 local council development areas (LCDAs). Each of the study sites (participating hospitals) is located in an LGA: Massey Street Children Hospital (Lagos Island LGA), Lagos Island Maternity Hospital (Lagos Island LGA), General Hospital Ifako-Ijaye (Ifako Ijaye LGA), General Hospital Isolo (Oshodi/Isolo LGA), General Hospital Alimosho (Alimosho LGA), General hospital Eti-Osa (Eti-Osa LGA) and General hospital Ikorodu (Ikorodu LGA).

Lagos has a diverse population comprising people from different cultural, ethnic and socio-economic backgrounds. It has different levels of health facilities: primary health care centres (PHCs), General hospitals, Tertiary hospitals and several private hospitals that offer similar healthcare services.

### *Study period*

The study period was from September to November 2021

### *Inclusion criteria*

Mothers who attended the immunisation and neonatology clinics of the study centres with their babies

## Exclusion criteria

Mothers who did not give consent for the study

## Data collection tool

A structured questionnaire, adapted from a previous study, was used.<sup>9</sup> The questionnaire had sections on sociodemographic characteristics, mothers' perception of donor breast milk and its acceptance.

## Data collection

Sociodemographic characteristics of mothers such as mother's age, level of education, occupation, father's age, level of education, occupation, religion, ethnicity, marital status and mode of delivery. Apart from demographic variables, the tool was also used to collect maternal health variables, knowledge, attitudinal, behavioural and psychosocial variables. These variables included: previous breastfeeding experiences among study participants, current breastfeeding status (exclusive and non-exclusive), knowledge of DBM (benefits and safety), sources of information about DBM, Attitude towards DBM compared to formula feeds, cultural beliefs about DBM, and willingness to accept or reject DBM. The health workers and trained research assistants administered the questionnaires.

## Sample size

This was calculated using the formula:

$$n = \frac{z^2 \times p(1-p)^2}{E^2}$$

Where;  $z$  was the standard deviation set at 1.96,  $p$  was the breastfeeding rate in Nigeria of 25%<sup>6</sup>,  $E$  represented the error of the mean set at 5%.

This gives a sample size of 288. An attrition rate of 10% was added, giving a minimum sample size of 317 subjects. We therefore aimed to recruit 250 subjects from the seven study sites for a total of 1750.

## Data analysis

Data collected was input and stored in a Microsoft Excel spreadsheet, and was analysed using the statistical package for social sciences version 21 (SPSS 21). Descriptive statistical techniques such as mean, standard deviation, frequency, percentages, and inferential statistical techniques, particularly chi-square, were used to analyse the data derived from the study.

## Ethical considerations

Ethics approval (NHRE04/04/2008) was obtained from the Health and Research and Ethics Committee of LASUTH. Informed consent was obtained from each

participant. Permission to conduct the research in the seven (7) state government-owned hospitals was granted by the Lagos State Health Service Commission.

## RESULTS

### Sociodemographic analysis

The sociodemographic analysis of the study participants is shown in Table 1. The mean age of the respondents and their husbands was  $30.9 \pm 6.3$  and  $37 \pm 6.9$ , respectively. The highest frequency age range for fathers was 30 to 35 years (30.5%), while for mothers it was 26 to 30 years (32.9%). The majority of fathers (66.7%) and mothers (59.2%) have a tertiary education. Approximately 63% of respondents were Christians and 37.3% were Muslims. Yoruba, Igbo, Hausa and other ethnic groups constituted 68.1%, 25.2%, 5.6% and 1.1% of the respondents, respectively. Most of the respondents (59.3%) were delivered by Caesarean section. More than half of the respondents (56.7%) had previously breastfed a child, and approximately 63% had breastfed exclusively.

Most respondents stopped breastfeeding between 13 and 18 months, and only 44 respondents breastfed for two years, according to the WHO guideline. All respondents replied that babies who do not have access to breastmilk at birth should receive infant formula feeds.

### Descriptive data

Among the respondents, 11.2% had some knowledge of DBM. Sources of information were healthcare providers (60.2%), friends (23%) and social media (16.8%). Most of the respondents (83.5%) would not allow their babies to receive DBM. The reasons for not accepting DBM were religious beliefs (77.5%), cultural practices (15.9%), risk of infection (2.1%), and their husbands or family not agreeing to it (4.4%). Most of the respondents (98.3%) were, however, willing to donate breast milk for other babies.

Bivariate analysis was performed to examine associations between knowledge of DBM and various socio-demographic characteristics, and the perception of DBM and selected characteristics. This association is highlighted in Table 2.

Maternal education and the mode of delivery were significantly associated with the knowledge of donor breast milk. The association between knowledge of DBM and selected characteristics reveals that mothers' educational level is significantly associated with knowledge of DBM ( $\chi^2=6.948$ ,  $p=0.031$ ). Similarly, the mode of delivery was significantly associated with knowledge of DBM ( $\chi^2=3.867$ ,  $p=0.049$ ), with mothers who had caesarean sections being more likely to have heard of DBM.

**Table 1: Socio-demographic and clinical characteristics of participants.**

| Variables                                       | Frequency (1750) | Percentage (%) |
|-------------------------------------------------|------------------|----------------|
| <b>Age group of fathers (years)</b>             |                  |                |
| ≤25                                             | 26               | 1.5            |
| 26-30                                           | 252              | 14.4           |
| 31-35                                           | 533              | 30.5           |
| 36-40                                           | 481              | 27.5           |
| 41-45                                           | 271              | 15.5           |
| >45                                             | 187              | 10.7           |
| Mean±SD                                         | 37.32±6.9        |                |
| <b>Educational level of fathers</b>             |                  |                |
| None/primary                                    | 27               | 1.5            |
| SSCE                                            | 556              | 31.8           |
| Tertiary                                        | 1167             | 66.7           |
| <b>Occupation of fathers</b>                    |                  |                |
| Skilled                                         | 559              | 31.9           |
| Unskilled                                       | 1086             | 62.1           |
| Unemployed                                      | 105              | 6.0            |
| <b>Age group of mothers (years)</b>             |                  |                |
| ≤25                                             | 327              | 18.7           |
| 26-30                                           | 628              | 32.9           |
| 31-35                                           | 414              | 23.7           |
| 36-40                                           | 273              | 15.6           |
| >40                                             | 108              | 6.2            |
| Mean±SD                                         | 30.93±6.3        |                |
| <b>Educational level of mothers</b>             |                  |                |
| None/primary                                    | 31               | 1.8            |
| SSCE                                            | 683              | 39.0           |
| Tertiary                                        | 1035             | 59.2           |
| <b>Religion of mothers</b>                      |                  |                |
| Christian                                       | 1097             | 62.7           |
| Islam                                           | 653              | 37.3           |
| <b>Ethnic group of mothers</b>                  |                  |                |
| Yoruba                                          | 1192             | 68.1           |
| Igbo                                            | 441              | 25.2           |
| Hausa                                           | 98               | 5.6            |
| Others                                          | 19               | 1.1            |
| <b>Mode of delivery</b>                         |                  |                |
| Caesarean section                               | 1038             | 59.3           |
| SVD                                             | 712              | 50.7           |
| <b>Previously breastfed a child?</b>            |                  |                |
| Yes                                             | 993              | 56.7           |
| No                                              | 757              | 43.3           |
| <b>Previously exclusively breastfed (n=993)</b> |                  |                |
| Yes                                             | 623              | 62.7           |
| No                                              | 370              | 37.3           |

There was a significant association between knowledge of DBM and perception of receiving breastmilk, as shown in Table 3 ( $\chi^2=1120.46$ ,  $p<0.001$ ). All mothers who had heard of DBM (100%) were willing to allow their babies to receive DBM, compared to only 5.9% of mothers who had not heard of DBM.

**Table 2: Association between knowledge of donor breast milk and selected characteristics.**

| Variables                        | Ever heard of DBM?<br>Yes | Ever heard of DBM?<br>No | $\chi^2$ | P value |
|----------------------------------|---------------------------|--------------------------|----------|---------|
| Age group (years)                |                           |                          |          |         |
| ≤25                              | 37 (18.9)                 | 290 (18.7)               | 2.009    | 0.734   |
| 26-30                            | 64 (32.7)                 | 564 (36.3)               |          |         |
| 31-35                            | 51 (26.0)                 | 363 (23.4)               |          |         |
| 36-40                            | 34 (17.3)                 | 239 (15.4)               |          |         |
| >40                              | 10 (5.1)                  | 98 (6.3)                 |          |         |
| Educational level                |                           |                          |          |         |
| None/primary                     | 8 (4.1)                   | 23 (1.5)                 | 6.948    | 0.031*  |
| SSCE                             | 72 (36.7)                 | 611 (39.3)               |          |         |
| Tertiary                         | 11 (59.2)                 | 920 (59.2)               |          |         |
| Mode of delivery                 |                           |                          |          |         |
| Caesarean section                | 129 (65.8)                | 909 (58.5)               | 3.867    | 0.049*  |
| SVD                              | 67 (34.2)                 | 645 (41.5)               |          |         |
| Previous breastfeeding history   |                           |                          |          |         |
| Yes                              | 118 (60.2)                | 875 (56.3)               | 1.077    | 0.299   |
| No                               | 78 (39.8)                 | 679 (43.7)               |          |         |
| Previous exclusive breastfeeding |                           |                          |          |         |
| Yes                              | 68 (57.6)                 | 555 (63.4)               | 1.497    | 0.221   |
| No                               | 50 (42.4)                 | 320 (36.6)               |          |         |

$p<0.05$ ; statistically significant.

**Table 3: Association between knowledge of DBM and perception of receiving breastmilk from a human milk bank.**

| Would you allow your baby to receive breast milk from human milk bank? | Ever heard of DBM? Yes (n=196) | Ever heard of DBM? No (n=1554) | $\chi^2$ | P value |
|------------------------------------------------------------------------|--------------------------------|--------------------------------|----------|---------|
| Yes                                                                    | 196 (100.0)                    | 92 (5.9)                       | 1120.46  | <0.001* |
| No                                                                     | 0 (0.0)                        | 1462 (94.1)                    |          |         |

$p<0.05$ ; statistically significant.

## DISCUSSION

This study revealed that only about a tenth of respondents had some knowledge of DBM. Two previous studies, a cross-sectional multicenter study from Southeast Nigeria by Iloh et al, and a descriptive-analytic study from Turkey by Gurol et al, also reported a low knowledge of DBM among mothers.<sup>9,11</sup> These findings are similar to ours. Knowledge of DBM among respondents in our study was mostly from healthcare workers. This is similar to studies from other parts of Nigeria and Poland, where health care providers were major sources of information about DBM.<sup>9-10,12</sup> This reveals that although knowledge of DBM was mostly from healthcare workers, it may not often be discussed with all mothers of newborns as a

choice of human milk for their babies when their milk supply is inadequate or unavailable, hence the paucity of DBM knowledge among the respondents.

This study findings show that more than three-quarters of mothers would not allow their babies to receive DBM for various reasons. It is evident that religious beliefs strongly influence mothers' decisions made for their newborns. Cultural beliefs take a distant second place in the decision not to allow babies to receive DBM. Some reasons are "it is a taboo, witchcraft can be transmitted through breast milk, the child will become a thief if the donor is a thief, and infections can be transmitted through breast milk." These reasons reflect a lack of information, and misconceptions contribute to a low acceptance of DBM. This is also similar to a study in Eastern Ethiopia and among women in Turkey.<sup>11,13</sup> In contrast, however, the study in South-East Nigeria shows that mothers declined DBM majorly due to fear of infection transmission, and another in South-south Nigeria, shows that mothers declined use of DBM because they disliked the idea and not for cultural or religious reasons.<sup>9,10</sup> Mothers may be willing to accept DBM if told the milk will be screened, and if religious leaders support human milk donation/use for newborns.

Interestingly, the vast majority of mothers in our study were willing to donate breast milk to the bank for use by other babies while declining to use DBM for their own babies. A study conducted in Southeast Nigeria, Kenya and Turkey also found that more respondents were willing to donate breast milk to other babies than to use DBM for their babies.<sup>10,11,14</sup> The findings in another Turkish study differ, as a lesser proportion of women were willing to donate breast milk. Perhaps this difference is related to trust and self-knowledge more than others, and a reduction in breastmilk for their own baby.<sup>15</sup>

Maternal education and mode of delivery were significantly associated with the knowledge of DBM in our study. Similarly, a study among middle-income women in the United States of America (USA) reported an association between maternal education and DBM.<sup>16</sup> Our study also showed a significant association between knowledge of DBM and willingness to allow babies to receive breastmilk. This finding complements reports from a cross-sectional survey in Southeast China, where knowledge of human milk banking was associated with willingness to receive donor human milk.<sup>17</sup>

This study has some limitations. First, the cross-sectional study design limits the ability to establish temporal or causal relationships between the variables assessed. Second, data collected through self-administered questionnaires may be subject to social desirability and reporting biases, as participants may have provided responses that they perceived to be socially acceptable. Finally, the study was conducted in Lagos State, located in the Southwest geopolitical zone of Nigeria, where

social, cultural, and religious characteristics may differ from those of other regions of the country. Therefore, the findings may have limited generalizability to other geopolitical zones of Nigeria, where differences in sociocultural contexts may influence the study outcomes.

## CONCLUSION

Mothers in Lagos are not willing to give their babies donor breast milk (DBM). Religious and cultural reasons strongly influence the acceptance of DBM. However, these mothers are willing to donate their breast milk for other babies.

## Recommendations

The need for public health education at the community level with a focus on educating mothers, intending mothers, fathers, and intending fathers, community leaders, and religious leaders on the benefits and safety of DBM. This can be a useful strategy to dispel negative attitudes and misconceptions about DBM.

Health workers should also educate and recommend DBM for mothers of newborns who are unable to breastfeed their babies to promote exclusive breastfeeding.

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