Blueprint to achieve national exclusive breastfeeding targets by 2030 among Aboriginal Australian women

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Summary

Exclusive breastfeeding (EBF) for six months provides significant health benefits for both mothers and infants, protecting babies from infection, supporting cognitive development, and reducing the risk of obesity and chronic diseases. Additionally, EBF lowers mother's risk of postpartum complications, type 2 diabetes, breast and ovarian cancers. Globally, the prevalence of EBF among infants under six months has reached 48%, nearing the World Health Assembly's 2025 target of 50%. However, the six-month EBF rate for Indigenous mothers in Australia remains low (18.8%), falling significantly below the national target of 50% set for 2025. There are notable disparities across Australian states and territories, with only the Northern Territory (NT) meeting this target. The NT's success is attributed to substantial state-level investment in healthcare for Indigenous Australians, with the highest per capita spending ($11,082 AUD/person/annum) and the highest proportion of Aboriginal and Torres Strait Islander health practitioners (256 per 100,000 population). Additionally, Aboriginal Community Controlled Health Organisations (ACCHOs) have played a vital role in delivering culturally safe, community-led breastfeeding programs, contributing to higher EBF rates. These findings suggest that the NT's approach could serve as a 'blueprint' for improving breastfeeding outcomes nationwide. With continued federal support and a comprehensive national policy, achieving the national EBF target for First Nations Peoples by 2030 may be attainable.

Keywords: Exclusive breastfeeding; Aboriginal mothers; National breastfeeding targets; Baby-friendly hospital initiative; Northern territory; Australia

Introduction

Exclusive breast feeding (EBF) is defined as infants receiving only breast milk, no other liquids or solids except prescribed medications, vitamin or mineral supplements.[1–4] The World Health Organization (WHO) recommends exclusive breastfeeding for the first six months, followed by the introduction of complementary foods alongside continued breastfeeding for up to two years or beyond.[2,3,5] The prevalence of EBF is reported as the proportion of infants aged 0–6 months who are exclusively fed breast milk consistent with the World Health Assembly's Global Nutrition Target and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) definition.[1,4] Globally 48% of infants aged 0–6 months are exclusively breastfed approaching the World Health Assembly's 2025 target of 50%.[2] Extensive research underscores the health and economic benefits of breastfeeding for women, children, and society in both developed and developing countries.[6–8] Breastfeeding supports healthy brain development and protects infants from malnutrition, infection, and chronic diseases, while also offering long-term health benefits to mothers, including reduced risk of breast and ovarian cancers, cardiovascular disease, and type 2 diabetes.[6–9]

The 2018-19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) conducted among 10,579 people, revealed that only 18.8% of First Nations infants 0–6 months of age were exclusively breastfed.[1] There are significant differences in breastfeeding rates across states. The Northern Territory (NT) has the highest rate of 51.1%, while Victoria (VIC) had the lowest rate at 9.8% (Fig. 1).[1] Only the NT, with 7.5% of the total Aboriginal and Torres Strait Islander population, met the national breastfeeding target of 50% set by the Australian National Breastfeeding Guideline.[10] Improving breastfeeding rates in the highly populous regions such as New South Wales (NSW) and

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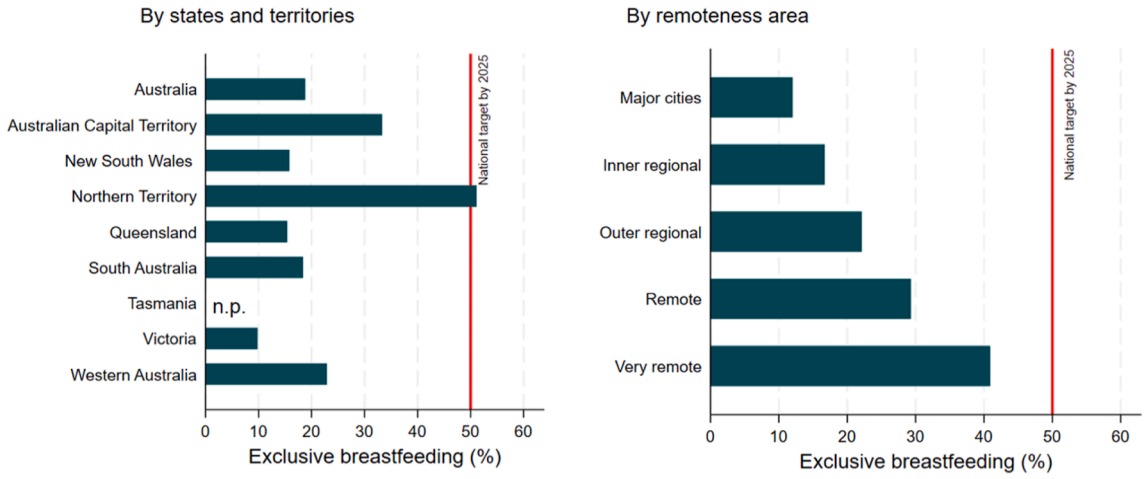

Fig. 1: Breastfeeding practice among Aboriginal and Torres Strait Islander women by state and remoteness in 2018–19. Source: ABS analysis of National Aboriginal and Torres Strait Islander Health Survey 2018–19.

Queensland (QLD) is critical because they account for almost two-thirds (63.4%) of the overall Aboriginal and Torres Strait Islander peoples (hereafter respectfully referred to as Indigenous) in Australia.[11] In these states, exclusive breastfeeding needs to increase from their current rates of 15.8% and 15.4% respectively.[1] Furthermore, exclusive breastfeeding rates varied by remoteness, with remote regions having a higher percentage of breastfed infants (40.9%) compared to urban centres (12%) (Fig. 1),[1] the possible reasons for which are described below.

Factors influencing breastfeeding

Breastfeeding practices among Aboriginal and Torres Strait Islander women in Australia are shaped by a range of interconnected factors across multiple levels: individual (mother-child), family, community, workplace, health system, and policy. Culture plays a cross-cutting role influencing each of these levels. At the individual level, Aboriginal mothers report a variety of personal and physical challenges to breastfeeding, including concerns about adequate milk supply, sore or painful nipples, and limited awareness of breastfeeding benefits.[12–14] Colonisation and the resulting loss of traditional practices have disrupted intergenerational knowledge sharing around breastfeeding.[12] Feelings of embarrassment or shame, particularly when breastfeeding in public also affects many Aboriginal mothers, especially those living in urban areas.[12–14] These feelings are often shaped by broader societal attitudes that sexualize women's bodies, including breasts, thereby discouraging public breastfeeding and contributing to lower breastfeeding rates.[13] At the family level, the involvement of partners and extended family members significantly influences breastfeeding decisions. Unsupportive or jealous partners, lack of family encouragement, and the normalisation of formula feeding within households can undermine a mother's intention to breastfeed.[13,14] In some cases, partners feel neglected due to the attention mothers give to their infants, which reduce their support for breastfeeding.[13] Historical trauma and colonisation have further eroded family-based breastfeeding knowledge and support structures.[13,14]

At the community level, social norms and environmental condition also affect breastfeeding practices.[13] The widespread promotion and acceptance of formula and bottle feeding, partly due to aggressive marketing have led some Aboriginal and Torres Strait Islander women to perceive formula as more convenient and nutritious than breastmilk.[13,14] In overcrowded housing, common in many Aboriginal communities, a lack of privacy discourages mothers from breastfeeding at home[12–14] These housing challenges stem from economic challenges rather than a cultural preference. While the proportion of Indigenous Australians living in appropriately sized housing has improved from 74.6% in 2011 to 81.4% in 2021, significant disparities remain. In very remote areas, only 45% of Indigenous Australians live in adequately sized housing.[15]

At the workplace level, balancing exclusive breastfeeding with paid employment is a significant challenge for many Australian mothers, including Aboriginal women. Australia's Paid Parental Leave Scheme offers up to 18 weeks of leave at the minimum wage, falling short of the six months of exclusive breastfeeding recommended by the World Health Organization.[16] While employees are entitled to up to 12 months of unpaid leave, financial pressures and inflexible work environments often lead mothers to return to work earlier than desired.[16] Mothers who return to work before six months are less likely to exclusively breastfeed, mainly

due to rigid schedules, limited lactation breaks, and a lack of supportive workplace policies. These challenges are even more pronounced for Aboriginal women, who may face greater economic insecurity and limited access to breastfeeding-friendly workplaces.[1,16] A national evaluation revealed that only 39% of eligible Indigenous mothers had access to employer-paid maternity leave, a markedly lower proportion than that of non-Indigenous mothers.[17] This disparity highlights significant barriers faced by First Nations families in accessing leave entitlements, which may contribute to shorter durations of exclusive breastfeeding.

To address the various factors influencing breastfeeding, several key policy areas have been identified as essential for protecting, promoting, and supporting breastfeeding at the population level. While many policy domains exist, this paper focuses primarily on a subset namely, increased investment in breastfeeding programs, expansion of the Baby-Friendly Hospital Initiative, strengthening community support networks, and enhancing culturally appropriate healthcare services that are most relevant for improving exclusive breastfeeding rates among Indigenous Australians women. The Global Breastfeeding Collective identifies seven critical policy areas to protect, promote, and support breastfeeding at the population level: 1. increased investment in breastfeeding programs; 2. full implementation of the International Code of Marketing of Breast-milk Substitutes; 3. provision of paid family leave and breastfeeding-friendly workplace policies; 4. access to skilled breastfeeding counselling; 5. expansion of the Baby-Friendly Hospital Initiative; 6. strengthening community support networks; and 7. robust monitoring systems.[2,4] Among Aboriginal and Torres Strait Islander families, uptake of maternity leave remains limited due to disproportionately high rates of casual and precarious employment, which reduces access to paid leave and often necessitates early return to work, thereby adversely affecting exclusive breastfeeding duration.[16,17] Furthermore, aggressive and insufficiently regulated marketing of infant formula disproportionately impacts Indigenous communities by undermining breastfeeding confidence and normalizing formula use.[4,18]

Within the health system, the cultural appropriateness of services plays a critical role. Aboriginal women often encounter healthcare environments that do not align with their cultural values, which can deter engagement with maternity services and breastfeeding support.[14,19] The Baby-Friendly Hospital Initiative (BFHI), launched by the World Health Organization (WHO) and UNICEF, promotes breastfeeding through evidence-based standards such as the Ten Steps to Successful Breastfeeding.[20,21] Australia adopted the BFHI and extended it to community settings in 2006, participation remains voluntary resulting in inconsistent implementation. Many rural and remote maternity units, particularly those serving Aboriginal communities, are not BFHI-certified, despite evidence linking BEHI certification with higher breastfeeding rates.[20,22] Barriers to implementation include limited funding, inadequate workforce training, and service gaps between urban and remote areas.[22] At the policy level, the absence of national standards and the voluntary nature of breastfeeding initiatives continue to hinder progress. Strengthening enforcement mechanisms and integrating BFHI standards into national maternity care policies could substantially improve breastfeeding outcomes, particularly among Aboriginal and Torres Strait Islander communities.[20,22] Finally, culture intersects with all levels of influence. Colonisation has led to the stigmatisation of traditional practices, such as breastfeeding in public, which is often viewed as shameful or taboo among Aboriginal women in urban settings.[12–14] In contrast, women in remote areas are generally less affected by concerns of public judgment.[12,14] These cultural differences are especially important, as significant proportion of the Indigenous Australian population now lives in major cities and inner regional areas, where breastfeeding rates remain low.[1,11]

Despite these challenges, several enabling factors continue to support breastfeeding practices among Aboriginal and Torres Strait Islander women. Rooted in long standing cultural traditions, breastfeeding is seen as integral part of community life and is often supported by strong kinship network that prioritizes collective well-being.[1,13,14,23] Culturally appropriate healthcare services, including the involvement of Aboriginal health workers and Indigenous-led lactation support, help build trust, address maternal concerns, and promote breastfeeding within culturally safe environments.[13,24] Peer support, often guided by experienced Indigenous mothers or Elders, also play a crucial role in normalizing breastfeeding, sharing knowledge, and enhancing community acceptance.[13] The active involvement of partners and extended family members further reinforces maternal confidence and commitment to exclusive breastfeeding by creating a supportive and nurturing home environment.[13,23,25] Additionally, community-led health programs that address broader social determinants, such as housing conditions and food security, contribute to create more enabling conditions for breastfeeding.[13] These strengths highlight the importance of culturally responsive healthcare, family support, and community engagement in sustaining and promoting breastfeeding among Aboriginal and Torres Strait Islander communities.[13,14,20,22]

Healthcare expenditures

Our investigation into healthcare expenditures in Australia has revealed significant differences between state and territory governments, particularly in the allocation of resources for Indigenous Australians (Table 1). In the fiscal year 2019–20, state and territory

States/Territories	Expenditure per person (AUD)					
	Public hospital services	Patient transport services	Dental services	Community health services	Public health services	Total health expenditure
NSW	3462	243	66	408	97	4342
VIC	2904	1191	12	836	374	5545
QLD	4586	178	95	1138	86	6164
WA	5218	290	46	372	110	7794
SA	3854	282	76	711	165	5176
TAS	2353	244	68	278	75	3027
NT	6696	443	93	3001	543	11,082
Australia	4276	322	71	901	162	6048

Source: AIHW 2020. Aboriginal and Torres Strait Islander health performance framework.

Table 1: **States' health expenditure per person for Indigenous Australians.**[26]

governments allocated an average of $5328 per capita on health services for Indigenous Australians, with only 19% ($1004 AUD per person) of this expenditure directed toward community and public health services.[18] These differences vary across jurisdictions, with the Northern Territory allocating the highest per capita expenditure at $11,082 AUD, while Tasmania allocated the lowest at $3027 AUD (Table 1).[18] Additionally, expenditures differed markedly by geographical remoteness, with $9374 AUD per person in remote and very remote areas, $5166 AUD per person in inner and outer regional areas, and $4797 AUD per person in major cities.[18]

In 2015, workforce data revealed that 409 employed medical practitioners, representing 0.5% of the total Australian health workforce, identified as Aboriginal and/or Torres Strait Islander (Table 2). The Northern Territory had the highest proportion at 1.5%, while Tasmania had the lowest at 0.2%. Among nurses and midwives, only 1% (3187) identified as Indigenous Australians, with the Northern Territory (2.4%) and Tasmania (2.2%) having the highest proportions, while Victoria had the lowest at 0.5%.[29] Research shows that patients prefer healthcare professionals from the same ethnic background, which can lead to improved health outcomes.[30,31] First Nations mothers reported that the presence of Indigenous healthcare workers and access to perinatal support significantly influenced their feeding choices and encouraged breastfeeding.[13,14,19]

Aboriginal Medical Services

Aboriginal Medical Services (AMS) general practitioners (GPs) play a crucial role in delivering primary healthcare to Indigenous Australians, particularly in remote areas, where usage increases from 15% in major cities to 75% in very remote regions.[32] In contrast, GPs not working with an AMS are the predominant healthcare providers in urban settings.[32] These contrasting healthcare providers are largely influenced by the accessibility and availability of services. According to the 2018–19 National Aboriginal and Torres Strait Islander Health Survey, 46% of Indigenous Australians in major cities reported a lack of local AMS facilities, whereas only 7% in very remote areas encountered such barriers.[32] The greater reliance on AMS in remote regions reflects not only their stronger presence but also their delivery of culturally safe care. Conversely, Indigenous Australians in urban areas, with limited access to AMS, often face cultural and linguistic barriers.[29] This suggests that healthcare choices among Indigenous Australian are driven more by service availability than inherent provider preference. To address these disparities, there is a need to expand AMS facilities in urban areas while further strengthening Indigenous-led primary care in remote regions.[32] Increasing the representation of Aboriginal and Torres Strait Islander healthcare workers within AMS, particularly in urban areas, could also enhance access to culturally safe care. In support of this, the 2017 Aboriginal and Torres Strait Islander Health Performance Framework report noted that 11% of Indigenous Australians aged 15 and older primarily speak Indigenous languages, while 38% reported difficulties understanding and being understood in English only settings.[29] Evidence from the Northern Territory further indicates that a stronger Indigenous healthcare workforce foster greater trust, community engagement, and service utilization, ultimately leading to improved health outcomes, including higher adherence to breastfeeding.[1,12–14]

Aboriginal Community Controlled Health Organisations

The Aboriginal Community Controlled Health Organisations (ACCHOs) are comprehensive primary healthcare services established and operated by local Aboriginal communities. These organisations provide holistic, comprehensive, and culturally appropriate care, guided by a locally elected Board of Management.[33] The National Aboriginal Community

States/Territories	Indigenous Australians population	Total % of Indigenous Australians population	Aboriginal health practitioners in 2022	Male (%)	Female (%)	Number of Aboriginal practitioners per 100,000
NSW	339,710	35	227	46 (20)	181 (80)	67
VIC	78,696	8	44	11 (25)	33 (75)	56
QLD	273,119	28	163	31 (19)	132 (81)	60
WA	120,006	12	157	34 (22)	123 (78)	131
SA	52,069	5	96	23 (24)	73 (76)	184
TAS	33,857	3	4	1 (25)	3 (75)	12
ACT	9525	1	0	0 (0)	0 (0)	0
NT	76,487	8	196	58 (30)	138 (70)	256
Australia	983,709		887	204 (23)	683 (77)	90

Source: Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards 2022/23: supplementary tables.

Table 2: **Representation of Aboriginal and Torres Strait Islander health practitioners in Australian states and territories in 2023.**[27,28]

Controlled Health Organisation (NACCHO) acts as the apex body representing all ACCHOs. There are 147 ACCHOs across Australia, distributed throughout various levels of remoteness.[34] They play a vital role in addressing the employment gap for Aboriginal and Torres Strait Islander people within the healthcare sector, with 54% of ACCHO staff identifying as Aboriginal and Torres Strait Islander. This representation enhances the organisations acceptance among First Nations peoples and significantly contributes to promoting health and wellbeing within these communities.[33,34] The Northern Territory has the second-highest coverage of ACCHOs, with 32.70 per 100,000 population, reflecting their importance in the region.[11,34]

By contrast, NSW and QLD, which together account for nearly two-thirds of Aboriginal and Torres Strait Islander population,[11,34] rank amongst the lowest presence of ACCHOs (Fig. 2). Overall, the prominent role of Aboriginal and Torres Strait healthcare workers, along with the presence of ACCHOs, significantly contributes to promoting exclusive breastfeeding practices among First Nations mothers in the Northern Territory.

Reflections on lesson learnt from the Northern Territory

The Northern Territory has achieved significantly higher rates of breastfeeding among Aboriginal women compared to all other states in Australia.[1] Based on this

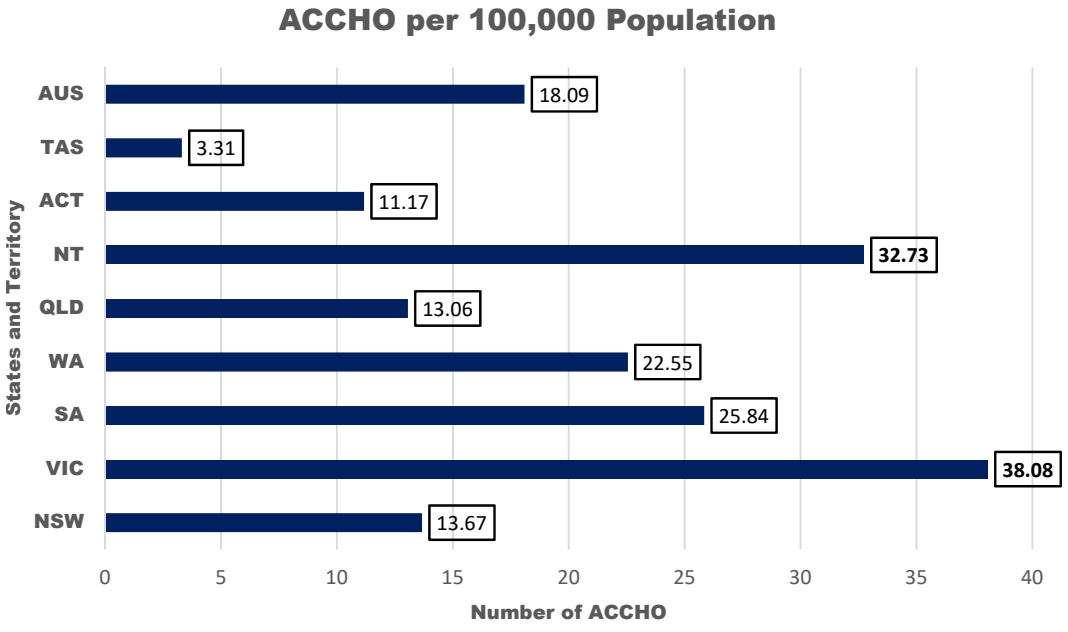

Fig. 2: Distribution of Aboriginal Community Controlled Health Organisations (ACCHO) across states and territories.

analysis, the authors propose a 'blueprint' for improving breastfeeding rates among Indigenous Australians nationwide, drawing on the NT's successful strategies. Table 3 summarises some key initiatives that have contributed to this success.

The importance of culturally safe and secure health services is vital.[35,36] These services are specifically designed to meet the cultural needs and preferences of Aboriginal communities, fostering an environment of acceptance and trust. By acknowledging and respecting the diversity of cultures, histories, and values of Aboriginal and Torres Strait Islander peoples, healthcare providers in the NT have facilitated greater access to healthcare services and improved adherence to breastfeeding recommendations.[35–37] Strong community and family support, along with close-knit networks prevalent in the NT, have further strengthened exclusive breastfeeding rates.[35,37,38] Family and community support enhance exclusive breastfeeding by offering practical help with daily tasks, emotional encouragement, and the sharing of cultural knowledge creating an environment where mothers feel supported and confident to breastfeed.[12,25,39] Economic hardship and limited availability of commercial infant formula, in remote Aboriginal communities contribute to the continued reliance on breastfeeding.[36,40] The high cost of formula, its limited availability in remote stores, and inadequate access to clean water make formula feeding both less feasible and less safe, reinforcing breastfeeding as the more practical and secure option.[41] In this context, breastfeeding is not only a cultural practice but also a practical response to local circumstances.

Tailored healthcare services specifically designed for Aboriginal populations are pivotal in promoting breastfeeding,[36,37] especially when they work well at the local level and with other services. Therefore, a critical element in the NT's success is the partnership between NT Health and ACCHO to co-design and implement the NT's Maternal Early Childhood Sustained Home Visiting (MECSH) program. This program employs Aboriginal health practitioners to support parents in providing safe and responsive care for their children.[36,37] Additionally, the NT benefits from a dedicated healthcare workforce focused on the health of Indigenous Australians, delivering culturally appropriate care and support, including breastfeeding services.[35,37,38,42,43] Collaboration between ACCHOs and the Australian Breastfeeding Association (ABA) has provided educational training and support to parents during early parenthood.[42,43] The NT government's focus on enhancing primary healthcare and community-based interventions has further supported breastfeeding practices. One such initiative, the Indigenous Remote Service Delivery Traineeship Program, offers training and career pathways for Aboriginal and Torres Strait Islander people through a specialised Diploma of Leadership and Management.[37,38,43] To further support breastfeeding, the NT established the 'Breastfeeding Services Support Program', which offers Indigenous mothers' essential advice and access

Area of action	NT example	Recommendations for achieving national target
Culturally Appropriate and Safe Healthcare Service	Culturally appropriate safe practices implemented through ACCHOs, increasing access for Indigenous mothers	Establish a culturally appropriate breastfeeding support network, that actively engages partner, extended family, and community members to provide practical support and create an enabling environment for exclusive breastfeeding.
Integration of Indigenous Health Practitioners	NT has the highest percentage of Indigenous Australians healthcare practitioners in Australia	Create training pathways and scholarships for Indigenous Australians to enter health professions, ensuring culturally sensitive support
Community-Based Breastfeeding Support	Home visits and transport services by ACCHOs have provided tailored antenatal support, enhancing adherence to exclusive breastfeeding	Enhance community breastfeeding support groups by incorporating home visits and regular follow-ups from Aboriginal healthcare workers, alongside initiatives that promote peer education among young first-time mothers
Funding for Healthcare Services	High per capita health expenditure allocated for Indigenous Australians enhances breastfeeding support	Allocate adequate resources, particularly in rural and remote areas, to enhance breastfeeding initiatives. Target major cities with low breastfeeding rates through tailored programs and community outreach service
Health Education	Intergenerational knowledge transmission within families fosters a deep sense of responsibility for breastfeeding, making it a natural part of motherhood	Implement targeted public health campaigns in schools and communities to promote breastfeeding education and support, empowering young mothers to make informed choices
The Baby-Friendly Hospital Initiative (BFHI)	Northern Territory have higher rates of exclusive breastfeeding at discharge compared to non-accredited facilities, reflecting the effectiveness of BFHI implementation	Strengthening the monitoring, enforcement, and integration of BFHI standards into national maternity policies could significantly improve breastfeeding outcomes, with a particular focus on supporting Aboriginal and Torres Strait Islander communities.

Table 3: **Blueprint for achieving the national breastfeeding target by 2030.**

to lactation consultants for addressing breastfeeding challenges.[10,42,43]

Policy implications

Our analysis has revealed promising evidence of policies and strategies likely to improve the rates of exclusive breastfeeding for First Nations Peoples in Australia. Some require action at state and national levels, while others are more local, consistent with the metaphor of policy as a nutcracker-simultaneously exerting top-down and bottom-up pressure to crack the policy nut.[44–46] Frances Baum (1990) emphasizes that effective public health interventions necessitate coordinated action at both higher policy levels and within local communities, highlighting the complex power dynamics inherent in health promotion. She critiques the assumption that change can be accomplished solely through consensus, arguing instead that structural transformation involves inevitable conflict and negotiation between bureaucratic authorities and community participation.[44,45] Policy, however, is more than the technical application of evidence. Instead, it has been described as a stance which, once articulated, guides a succession of decisions: usually based on the allocation of values.[44]

Political theorists often describe policy change as a matter of setting the agenda where only a limited number of issues can receive attention at any given time, and then the most pressing ones are typically prioritised. For new or contentious proposals to gain a place on this agenda, other items must be pushed down the list or removed entirely.[47] Interviews with former Australian health ministers uncovered the difficulties faced when attempting to place on the health agenda policies to address the social and cultural determinants of health and wellbeing. They reflected that it was only possible to introduce innovation, involving different value systems, when the hospital and illness system was functioning smoothly. Even then, they gave examples of powerful medical and health advocates resisting attempts to shift priorities within the policy agenda to make room for new issues.[48] Across Australian politician, media and advocates are currently preoccupied with numbers of hospital beds, ambulance services, access to general practitioners and the availability of services outside capital cities.[49,50] If these concerns dominate the agenda, it becomes difficult to make room for initiatives aimed at improving breastfeeding outcomes. This underscores a critical point that without strong political will and commitment, policy changes that support exclusive breastfeeding and address broader social determinants will continue to be sidelined.

Our analysis has highlighted the critical need for collaborative efforts between policymakers and local communities, founded on cultural respect and community leadership to drive meaningful improvements in Indigenous health outcomes. Encouragingly, ACCHOs have demonstrated success in delivering comprehensive primary healthcare despite significant challenges. Evaluations indicate that the ACCHO model is globally recognized for its community-driven approach, which prioritizes holistic healthcare, accessibility, equity, and multidisciplinary collaboration.[51] At the policy level, Fisher et al. (2019)[52] examined how high-level Australian health policies were shaped and found that a combination of academic research, strong advocacy movements, and collaborative coalitions successfully contributed to the development of the Australia's National Aboriginal and Torres Strait Islander Health Plan.[53] This plan integrates social and cultural determinants alongside principles of community leadership and self-governance. Our findings reinforce the importance of balancing advocacy from the community level with supportive policy actions from higher levels of governance to enhance self-governance at the local level.[46]

Key lessons from our analysis highlight the importance of expanding the reach of ACCHOs, significantly strengthening the healthcare workforce particularly by increasing the number of Aboriginal and Torres Strait Islander professionals and fostering strong partnership and trust at national, regional, and local levels. Language barriers remain a significant obstacle to maternal healthcare access for many Indigenous Australian women often leading to reduced engagement and poorer health outcomes.[29] The involvement of Aboriginal female healthcare workers plays a critical role in addressing these barriers by providing culturally safe and linguistically appropriate care.[54] This form of culturally congruent support builds trust and encourages Indigenous Australian mothers to access and continue engaging with maternal health services, including breastfeeding assistance. Advancing these priorities requires a nationally coordinated policy approach that is responsive to regional and local contexts, with First Nations leadership guiding the process. Given the diverse healthcare needs across states and territories, tailored strategies will be essential. There is reason for optimism, as First Nations peoples in Australia have demonstrated their capacity to influence health policy in ways that reflect cultural, geographic, and service-specific realities. The ACCHO model will remain central to this progress, promoting a broader and more culturally grounded understanding of health and playing a key role in meeting national breastfeeding targets.[55]

Conclusion

Achieving the national exclusive breastfeeding target for Indigenous Australian women in Australia by 2025 is unlikely. However, meeting this target by 2030 remains possible with strong political commitment,

coordinated federal support, and sustained investment in culturally responsive, community-led healthcare. Exclusive breastfeeding is a powerful, low-cost intervention that can transform the health and wellbeing of both Indigenous mothers and their children. It significantly reduces the risk of chronic conditions such as type 2 diabetes, cardiovascular disease, and obesity which are conditions that disproportionately affect Aboriginal and Torres Strait Islander populations. Prioritising breastfeeding not only enhances maternal and infant health, but also contributes to family stability, community resilience, and long-term health equity. The success of the Northern Territory offers a compelling model of culturally safe and effective care that could be adapted nationally. If implemented with leadership from First Nations communities, this approach holds the potential not only to close the health gap in Australia but also to serve as a global reference point for advancing health equity through exclusive breastfeeding.

Contributors

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Declaration of interests

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