Determinants and Prevalence of Exclusive Breastfeeding Among Thai Muslim Mothers: A Cross-sectional Analysis

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Abstract: Exclusive breastfeeding is pivotal for the health and development of infants and offers numerous benefits to mothers. However, unique cultural beliefs and practices, particularly among Muslim communities, can significantly influence breastfeeding behaviors. This study sought to elucidate the factors influencing exclusive breastfeeding among Thai Muslim mothers. The sample was 168 postpartum Muslim mothers from well-baby clinics in southern Thailand, selected through multi-stage random sampling. Data were collected from June to December 2022 employing the Demographic Data Form, Infant Feeding Intentions Scale, Breastfeeding Knowledge Questionnaire, Iowa Infant Feeding Attitude Scale, Breastfeeding Self-Efficacy Scale -Short Form, Maternal Health Literacy Scale, Islamic Belief Scale, Exclusive Breastfeeding Social Support, and Breastfeeding Practices Questionnaire. Data were analyzed using descriptive statistics, Spearman rank's correlation, and binary logistic regression analysis.

The study found that the rate of exclusive breastfeeding among Thai Muslim mothers at six months postpartum was 54.8%. Notably, breastfeeding self-efficacy emerged as the sole predictor of exclusive breastfeeding, accounting for 11% of the variance in this practice. These findings underscore the critical role of breastfeeding self-efficacy in promoting exclusive breastfeeding. It is recommended that nurses and healthcare professionals develop culturally tailored support programs that enhance breastfeeding self-efficacy, aligned with Islamic beliefs, to improve breastfeeding practices among Muslim mothers.

Keywords: Breastfeeding self-efficacy, Exclusive breastfeeding, Muslim mothers, Predicting factors, Thailand

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Introduction

Exclusive breastfeeding, defined as feeding infants solely with breast milk, excludes all other liquids or solids except for necessary supplements like oral rehydration solutions, vitamins, minerals, or medicines.[1] Exclusive breastfeeding (EBF) has been recognized for its benefits to mothers, infants, and families, and it is recommended for the first six months of life. For mothers, it significantly lowers the risk of depression, obesity, type 2 diabetes, and ovarian and breast cancers.[2] Infants benefit through enhanced growth, development, increased intelligence, and reduced hospital stays.[3] Furthermore, EBF mitigates

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the need for families to take time off work due to child illnesses, diminishes healthcare expenses related to pediatric care and hospitalizations, and cuts down on the costs associated with treating common conditions like diarrhea and pneumonia.[3] By eliminating the expense of purchasing formula, families can also conserve their monthly income.[4]

Acknowledging the myriad advantages of EBF, the World Health Organization and the United Nations Children's Fund have set an ambitious target: to achieve a 70% global rate by 2030.[5] This target reflects a widespread commitment to improving child health and nutrition by acknowledging the fundamental role of breastfeeding in sustainable development.[5] Despite this, global EBF rates for infants aged 0 to 6 months are far from the target, standing at only 44%. This discrepancy highlights the urgent need for enhanced efforts and strategies to promote EBF across different countries to meet the established goal.[6] In Thailand, the rate of EBF for infants under six months has declined alarmingly to only 14%, indicating a significant drop and underscoring the need for intensified interventions and support to reverse this trend and improve breastfeeding practices.[7] Regional analysis within Thailand reveals substantial disparities in EBF rates at six months of age, particularly in the three southernmost provinces with predominantly Muslim populations. This rate is especially low, with 1.7%, 31.75%, and 34.7% in each province, which underscores the need for targeted interventions to address cultural, religious, and social influences on breastfeeding practices.[7]

Islam intricately interweaves into the daily lives of its adherents, extending its influence to infant feeding practices. Islamic tenets prioritize breastfeeding, advocating it as an essential right for newborns and children. The Quran, specifically endorses breastfeeding, recommending the completion of a two-year cycle, thereby emphasizing its importance in the early development and nurturing of infants. This principle not only highlights the spiritual and physical benefits of breastfeeding but also underscores the commitment to child welfare embedded in Islamic teachings.[8] While religious teachings strongly motivate Muslim women to breastfeed, research indicates a premature cessation of EBF before six months and a notably low rate of EBF among Muslim mothers. This gap highlights the complex interplay between cultural beliefs, religious teachings, and practical challenges faced in adhering to EBF guidelines.[9] The discrepancy in EBF rates among Muslim mothers can be attributed to the interplay between religious injunctions on breastfeeding and prevailing cultural practices. The requirement for Muslim women to cover their bodies fully, except for the face and hands, in the presence of *non-mahram* (those with whom marriage is permissible), may pose challenges to breastfeeding in public or mixed-gender gatherings, potentially influencing their breastfeeding practices and decisions.[9] This discomfort with public breastfeeding, coupled with cultural practices, can hinder EBF among Muslim mothers. Additionally, there is a belief among some Muslim mothers that EBF might not provide sufficient nutrition, leading them to introduce foods like bananas, honey, and diluted dates before the age of six months, contrary to global health recommendations on EBF.[10] Understanding breastfeeding among Muslim mothers involves navigating the complex interplay of religious and sociocultural influences. Therefore, exploring the predictors of EBF at six months among Thai Muslim mothers becomes crucial. By examining these factors, interventions can be tailored to support and encourage EBF practices within this community, considering its unique religious and cultural context.

Conceptual Framework and Literature Review

The foundation of this study rests on the Social Cognitive Theory (SCT),[11] which posits that human behavior is a result of a dynamic interaction among personal factors, behavioral influences, and environmental

contexts. SCT underscores the concept of reciprocal determinism, highlighting how individuals and their environments mutually influence each other. This theoretical framework is instrumental in examining how various factors contribute to the practice of EBF among Thai Muslim mothers, considering the intricate relationship between individual beliefs, behaviors, and the surrounding sociocultural and environmental factors. Individuals' cognitive processes, such as expectations, beliefs, self-perceptions, goals, and intentions, significantly influence their behavior. These mental processes determine how individuals perceive external events, the importance and impact they assign to these events, and how they organize this information for future use. Concurrently, enacted behaviors impact one's thoughts and feelings. Social influences and the physical environment play pivotal roles in shaping and refining cognitive competencies, expectations, and beliefs by offering information and reinforcement, thereby aiding in the development of self-regulatory skills essential for behavior execution.[11] An individual's behavior shapes and is shaped by their environment, creating a dynamic interplay. The environment influences which behaviors are developed and activated, and in turn, the behaviors an individual exhibits can determine their exposure to different aspects of their environment. This reciprocal relationship highlights how behavior and environment are interdependent, with each influencing and modifying the other.[11] Thus, individuals can influence their behavior by modifying their environment and shaping their cognitive processes. This capacity for self-regulation allows people to enact changes in their behavior through deliberate adjustments in their thoughts and surroundings, emphasizing the power of personal agency within the framework of SCT.

Within this framework, EBF among Thai Muslim mothers can be viewed as a behavior influenced by both personal and environmental factors. The literature identifies seven key factors affecting this practice: six personal factors (breastfeeding intention,[12,13] knowledge,[14] attitudes,[14] maternal health literacy,[15] breastfeeding self-efficacy,[16] and Islamic belief)[8] and one environmental factor, social support.[17] This distinction underscores the multifaceted nature of breastfeeding behavior, highlighting the importance of both internal and external influences in shaping outcomes.

Breastfeeding intention is the extent to which a mother commits to exclusively breastfeed her infant from birth until six months of age.[12] This intention is crucial as it shapes the mother's ability to devise suitable action plans, motivating and guiding the execution of the behavior of EBF.[13] Breastfeeding intention significantly influences the degree of effort and commitment a mother is willing to invest in exclusively breastfeeding her baby. Research has consistently shown a strong correlation and association between a mother's intention to exclusively breastfeed and the actual practice of EBF among Muslim mothers, underscoring the importance of intention in the successful implementation of this behavior.[14,17]

Breastfeeding knowledge encompasses understanding the facts, principles, and details about breastfeeding, including the benefits of EBF and the drawbacks of formula feeding. Mothers who possess comprehensive knowledge about breastfeeding are more likely to appreciate its positive impact on a child's intelligence and the essence of EBF.[14] They also exhibit greater confidence in balancing breastfeeding with work responsibilities and in addressing breastfeeding-related challenges.[18] Previous studies have identified a positive correlation between the breastfeeding practices of Muslim mothers and their knowledge of EBF. This relationship underscores the critical role that informed awareness and understanding play in promoting effective breastfeeding behaviors within this community.[17,18]

Attitudes toward breastfeeding encompass a mother's positive or negative feelings about the act of breastfeeding. These attitudes, as cognitive structures, serve as reference points that influence how breastfeeding is perceived, evaluated, and regulated, thereby affecting

a mother's decision to initiate and continue breastfeeding.[19] Individuals with a positive attitude towards breastfeeding are more likely to engage in the behavior. A positive maternal attitude is crucial for making the decision to breastfeed and succeeding in EBF. Significant associations have been found between maternal attitudes towards breastfeeding and the practice of EBF among Muslim mothers, highlighting the importance of fostering positive perceptions and feelings towards breastfeeding to promote its practice.[14,18] Indeed, the presence of a positive attitude towards breastfeeding among Muslim mothers is significantly correlated with higher rates of EBF practice. This suggests that attitudes play a pivotal role in the decision-making process and the successful implementation of EBF.[21]

Maternal health literacy encompasses the cognitive and social skills that enable mothers to access, understand, and apply health-related information in ways that enhance their motivation and ability to exclusively breastfeed. This maternal health literacy concept underlines the importance of mothers being informed and capable of making decisions that support the health and well-being of their infants through EBF practices.[15] Women with higher maternal health literacy are more informed about the benefits of breastfeeding, possess better problem-solving skills, and have a reflective approach towards their actions. This increased literacy leads to a higher likelihood of EBF. Research among Iranian Muslim mothers has confirmed a significant link between health literacy and EBF practices, emphasizing the critical role of health literacy in promoting and sustaining breastfeeding.[22] Health literacy significantly influences mothers' readiness to exclusively breastfeed, demonstrating the vital role of understanding and utilizing health information in making informed decisions about infant feeding practices.[23]

Breastfeeding self-efficacy refers to a mother's confidence in her ability to successfully breastfeed her infant, encompassing her belief in her capacity to initiate and continue breastfeeding as planned. This confidence is crucial for overcoming breastfeeding challenges and sustaining EBF practices.[24] Self-efficacy significantly shapes individuals' actions, decision-making processes, responses to changes, abilities to face challenges, and overall accomplishments in various aspects of life, including breastfeeding. It influences not only the persistence in the face of obstacles but also the confidence with which tasks are approached and executed.[11] The higher a mother's self-efficacy in breastfeeding, the better equipped she is to navigate the challenges associated with breastfeeding. Mothers with high breastfeeding self-efficacy are more determined to initiate breastfeeding, persevere through difficulties, embrace empowering beliefs, and positively manage breastfeeding situations. Their capacity to cope with challenges contributes to successful EBF. In Indonesia, studies have shown that breastfeeding self-efficacy is a significant determinant of EBF among Muslim mothers, highlighting its importance in breastfeeding practices.[20,21,25]

Islamic belief, as derived from the Quran, shapes subjective norms regarding behaviors, including breastfeeding. The influence of religious beliefs on perceptions and practices is significant; thus, Muslim mothers who recognize the impact of their Islamic faith on their feeding decisions are more inclined to exclusively breastfeed. This connection highlights the profound role of religious beliefs in shaping health behaviors and decisions, demonstrating that faith-based motivations can significantly enhance breastfeeding practices.[9] Religious beliefs play a crucial role in promoting EBF among Indonesian Muslim mothers. Faith significantly increases their willingness to exclusively breastfeed, demonstrating how deeply intertwined religious norms and health practices influence maternal behavior towards infant feeding.[26]

Social support encompasses the assistance perceived by mothers from their surroundings to facilitate EBF. This support includes instrumental help (such as providing resources or physical aid), emotional support (offering

encouragement and empathy), and informational support (giving advice, information, and guidance). These forms of support play a critical role in empowering mothers to initiate and sustain EBF practices.[27] The environment acts as a crucial source of behavioral modeling, facilitating rapid knowledge and skill acquisition through observation of others and the feedback received from such interactions. This process enables individuals to learn and adopt new behaviors by observing the actions of others and the consequences those actions receive, enhancing their understanding and ability to perform similar actions, such as EBF, effectively.[11] Social support, including networking, aids individuals in managing challenges encountered in their daily lives. This support is particularly crucial for EBF among Muslim mothers, where significant associations have been found. Social networks provide emotional, informational, and instrumental support, enhancing mothers' ability to persevere in EBF despite potential difficulties.[17]

Despite extensive research on the factors influencing EBF among Muslim mothers globally, there is a gap in understanding these dynamics within the Thai Muslim community, which may differ significantly from those in other countries. The unique cultural and religious interpretations, and practices within each Muslim society, influenced by diverse cultures and ethnicities, suggest that EBF among Thai Muslim mothers could be shaped by distinct belief systems and cultural norms. This variability underlines the need for localized research to uncover how these factors specifically affect EBF practices in Thailand.

Study Aims

This study aimed to 1) provide a detailed overview of EBF practices among Thai Muslim mothers, and 2) evaluate the predictive power of breastfeeding intention, knowledge, attitude towards breastfeeding, maternal health literacy, breastfeeding self-efficacy, Islamic belief, and social support on EBF among this demographic.

Methods

Design: The study utilized a descriptive cross-sectional design, adhering to the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) guidelines for cross-sectional studies. This approach allows for the collection and analysis of data from Thai Muslim mothers at a single point in time to assess the prevalence of EBF and identify predictive factors influencing this practice.

Sample and Setting: The sample size for this study was determined using multiple regression analysis, which requires a minimum of 20 participants per predictor for reliability.[28] Given that the study incorporated seven predictors, the initial calculation indicated a need for 140 participants. To account for a potential 20% attrition rate, the sample size was adjusted to 168 participants, ensuring a robust analysis capable of capturing the diverse influences on EBF among Thai Muslim mothers.

The participant selection involved multi-stage random sampling from Thai Muslim mothers attending well-baby clinics in a province in deep southern Thailand. Initially, three districts were chosen from eight using stratified random sampling, followed by the selection of six sub-districts through simple random sampling. Participants were then selected from each chosen sub-district's well-baby clinic, based on the proportion of postpartum mothers, ensuring a representative sample for the study. The study set specific inclusion criteria for participants: they must be Thai Muslim mothers aged 18 or older, have experienced normal labor resulting in the birth of a healthy, full-term singleton baby aged 6-9 months, have no breast abnormalities, be free from significant medical complications during pregnancy, labor, and postpartum periods, have babies without birth defects like cleft lip or palate, and possess the ability to communicate in Thai (**Figure 1**).

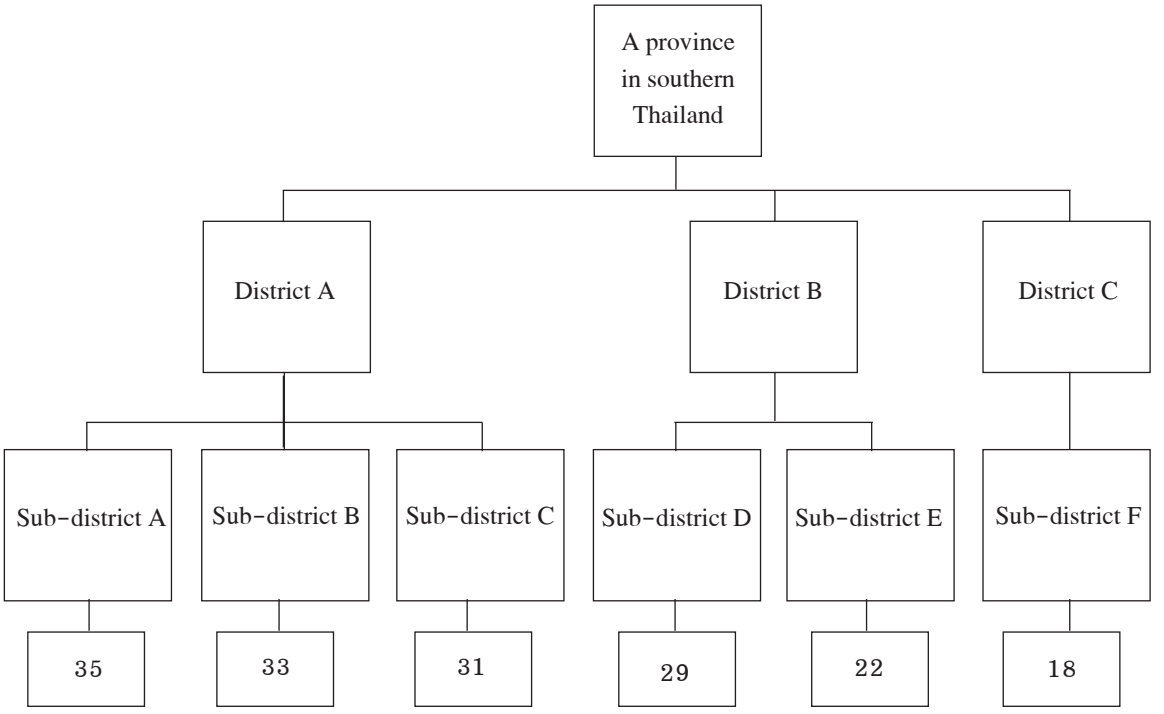

Figure 1. The multi-stage sampling process of the study

Ethical Considerations: The study received ethical approval from the Ethics Committee of the Faculty of Nursing, Chiang Mai University (FULL 031-2563). Participants were fully informed about the study's aims, rights, and the potential risks and benefits. Consent was voluntary, allowing withdrawal at any time without impacting their healthcare services. Consent forms were signed by participants who agreed to join, and each was assigned a unique code number to ensure confidentiality and privacy.

Instruments: For data collection, the study utilized nine instruments, wi th seven of these being used under the permission of their original creators. After receiving permission from the developers, the three instruments were translated into Thai based on Brislin's back translation.[29] First, the instruments were forward translated from the English language into Thai by an English-Thai bilingual translator, and the primary investigator (PI) confirmed the accuracy of the translation. After that, two bilingual experts, who had no reference to the original English version and worked independently, back-translated the Thai versions to English to enhance equivalence. Then, the PI checked the back-translated versions and the original versions for accuracy and discrepancy in item meaning. No discrepancies were noted. Finally, the instruments were pre-tested with a sample of 20 Muslim mothers to determine their appropriateness and item understandability among respondents. This ensured that the instruments would be able to measure what the researchers intended to measure. The researchers revised the wording of the instruments based on the results and suggestions of the Muslim mothers.

Details regarding the example items, along with the validity and reliability of each instrument, are outlined in **Table 1**. This approach ensures a comprehensive and methodologically sound basis for gathering the necessary data to address the study's objectives.

Table 1. Validity, reliability, and example items of the instruments

Instruments	Validity	Reliability		Example item
	Using scale content validity index	n = 20	n = 168	
Infant Feeding Intentions Scale	0.90	0.80[a]	0.85	When my baby is 6 months old, I will be breastfeeding without using formula or other milk.
Breastfeeding Knowledge Questionnaire	0.98	0.91[b]	0.82	Mothers should breastfeed their baby as much as the baby wants.
Iowa Infant Feeding Attitude Scale	0.93	0.84[a]	0.80	Breastfeeding increase mother-baby bonding.
Breastfeeding Self-Efficacy Scale-Short Form	0.98	0.96[a]	0.95	I can successfully cope with breastfeeding like I have with other challenging tasks.
Maternal Health Literacy Scale	0.94	0.97[a]	0.93	I know where to find health information.
Islamic Belief Scale	0.87	0.82[a]	0.80	The mother who stays up all night to breastfeed her baby will receive the same reward as freeing 70 slaves for the sake of Allah.
Exclusive Breastfeeding Social Support Scale	0.93	0.81[a]	0.85	Help with my routine chores so I can practice EBF.
Breastfeeding Practices Questionnaire	1	1[c]		I only breastfeed my baby without giving water or other liquids.

Note. [a] = Cronbach's alpha; [b] = Kuder-Richardson 20; [c] = inter-rater reliability kappa

The Demographic Data Form, created by the PI, gathered participants' demographic details (such as age, marital status, education, employment, income, and family type) and obstetric history (number of pregnancies, delivery type, complications during antenatal, intrapartum, and postpartum periods, number of living children, and breastfeeding experiences). This comprehensive form provided essential context for analyzing the factors influencing EBF among Thai Muslim mothers.

The Infant Feeding Intentions Scale (IFI), developed by Nommsen-Rivers and Dewey,[12] was translated by the PI into Thai following Brislin's back translation method,[29] and is designed to assess breastfeeding intentions. The IFI comprises five items, four positively worded and one negatively worded, with the latter being reverse scored. Responses are on a 4-point scale, ranging from 0 (strongly disagree) to 4 (strongly agree). The total IFI score, which ranges from 0 to 16,[12] is derived by averaging the scores of the first two items and adding this to the sum of the last three items, with scores between 0-8 indicating low breastfeeding intention and 9-16 suggesting high intention.

The Breastfeeding Knowledge Questionnaire, adapted into Thai by Chanapai et al.[16], assesses breastfeeding knowledge through 16 items with responses categorized as true, false, or unknown. It includes both positively (14 items) and negatively (2 items) worded items, with scoring adjusted accordingly: positive items score 1 for "true" and 0 for "false" or "unknown" responses, and vice versa for negative items, which are reverse scored. The total score ranges from 0 to 16, where 0-8 indicates low breastfeeding knowledge and 9-16 suggests high knowledge.[16]

The Iowa Infant Feeding Attitude Scale (IIFAS), developed by Mora et al.[19] and translated into Thai by Chanapai et al.,[19] measures attitudes towards breastfeeding. It comprises 17 items on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree), including reverse scoring for negatively worded items. The total score can range from 17 to 85, where a score

above 61 indicates a positive attitude towards breastfeeding, and 60 or below reflects a less favorable attitude.[19]

The Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF), developed by Dennis (2003) and translated into Thai by Thussanasupap,[27] assesses breastfeeding self-confidence with 14 positive items on a 5-point Likert scale from 1 (not at all confident) to 5 (always confident). The total score ranges from 14 to 70, with 55 and below indicating low self-efficacy and 56 and above signifying high self-efficacy.[27]

The Maternal Health Literacy Scale (MaHeLi Scale), developed by Guttersrud et al.[15] and translated by the PI into Thai based on Brislin's back translation method[29], evaluates maternal health literacy across functional, interactive, and critical dimensions. This 12-item scale covers health-seeking behavior, competence and coping skills, and appraisal of health information, using a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Scores range from 12 to 60, with 12-40 indicating low health literacy and 41-60 signifying high maternal health literacy.[15]

The Islamic Belief Scale, created by the PI from literature review insights, is designed to measure Islamic belief with nine items on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Three negatively worded items are reverse-scored. Total scores range from 9 to 45, where 9-30 indicates low Islamic belief and 31-45 indicates high Islamic belief.

The EBF Social Support (EBFSS) Scale, developed by Boateng et al.,[27] and translated into Thai by the PI, measures social support for EBF with 16 positive items across three subscales: instrumental, emotional, and informational support. Items are rated on a 3-point scale from 1 (no help to much less than desired) to 3 (as much as desired). The total score ranges from 16 to 48, with 16-32 indicating low social support and 33-48 indicating high support for EBF.[27]

The Breastfeeding Practices Questionnaire, created by the PI and grounded in the WHO's definition of EBF, assesses the exclusivity of breastfeeding among participants by inquiring about the types of food given to the baby during the first six months. Participants reporting that their baby was fed only breast milk for this duration are classified under 6-month EBF. Conversely, those whose babies received any food type other than breast milk are categorized as non-EBF.

Data Collection: This took place from June to December 2022, facilitated by six research coordinators who were nurses or healthcare providers with at least a bachelor's degree and research experience. These coordinators were trained by the researcher on data collection and participant recruitment techniques. Data collection occurred through questionnaires administered in private settings, with each session lasting between 45 to 60 minutes, including a 10-minute break.

Data Analysis: The study analyzed demographic data using descriptive statistics such as frequency, percentage, mean, range, and standard deviation. Breastfeeding practices during the first six months postpartum were similarly assessed. Relationships among variables were explored using Spearman rank's correlation, categorizing the strength of relationships into very low (r = .01-.20), low (r = .21-.40), moderate (r = .41-.60), high (r = .61-.80), and very high (r = .81-1.00) levels of relationship.[31] Predictive factors for EBF were analyzed through binary logistic regression, with multicollinearity assessed via a correlation matrix. The absence of multicollinearity was confirmed as correlations between variables did not exceed .80.[32]

Results

Demographics

The study participants had a mean age of 29.72 years, with the majority being married and having educational levels ranging from lower secondary to bachelor's degree or higher. Approximately half were housewives, with a mean family income of 8,057.74 Thai baht (223.97 USD). They considered this income sufficient without savings. Two-thirds lived in nuclear

families, and were multigravida and multiparous, with a mean gestational age at delivery of 38.81 weeks. All participants had vaginal deliveries without complications, with the number of living children ranging from one to three or more, and about half had previous breastfeeding experience (**Table 2**).

Table 2. Demographic and obstetric characteristics of the participants (n = 168)

Characteristics	Frequency	%
Age (years)		
Range = 18 – 46, Mean = 29.72, SD = 6.43		
18–20	16	9.52
21–30	77	45.83
31–40	68	40.48
≥ 41	7	4.17
Marital status		
Single	2	1.20
Married	159	94.60
Separated	5	3.00
Divorced	1	.60
Other: Widowed	1	.60
Education level		
Primary	20	11.90
Lower secondary	43	25.60
Upper secondary/Vocational certificate	42	25.00
Higher vocational certificate	16	9.50
Bachelor's degree or higher	43	25.60
Other: No formal education	4	2.40
Employment status		
Government/ state enterprise employee	14	8.30
Farmer	43	25.60
Merchant	24	14.30
Self-employed	38	22.60
Company employee	3	1.80
Housewife	73	43.50
Monthly family income in baht (USD)		
Range = 0–40,000, Mean = 8,057.74 (223.97 USD), SD = 7,064.24		
0–10,000 (0–277.96)	133	79.17
10,001–20,000 (277.99–555.92)	26	15.47
20,001–30,000 (555.95–833.88)	6	3.57
30,001–40,000 (833.81–1,111.84)	3	1.79
Income sufficiency		
Sufficient with savings	29	17.30
Sufficient without savings	98	58.30
Insufficient	41	24.40

Table 2. Demographic and obstetric characteristics of the participants (n = 168) (Cont.)

Characteristics	Frequency	%
Family type		
Nuclear	107	63.70
Extended	61	36.30
Gravidity		
Primigravida	59	35.12
Multigravida	109	64.88
Parity		
Primiparous	59	35.12
Multiparous	109	64.88
Gestational age at delivery (weeks) (Mean = 38.81, SD = .98)		
$37^{1}-38$	61	36.31
$39^{+1}-40$	105	62.50
$41^{+1}-42$	2	1.19
Delivery type		
Vaginal delivery	168	100.00
Complications during pregnancy		
No	163	97.00
Yes: Gestational diabetes mellitus, anemia	5	3.00
Number of living children (persons)		
1	62	36.90
2	42	25.00
3-5	57	33.93
> 5	7	4.17
Previous breastfeeding experience		
No	91	54.20
Yes	77	45.80

For the rate of exclusive breastfeeding, it was found that 54.8% of participants practiced EBF for six months, while 45.2% did not exclusively breastfeed. Among the non-EBF group, infants were introduced to foods other than breast milk primarily at five months (12.5%), followed by three months (9.5%), and four months (8.9%) (**Table 3**).

Table 3. Breastfeeding at the first six months postpartum among Thai Muslim mothers (n = 168)

Breastfeeding at 6 months	Frequency	Percentage
Exclusive	92	54.80
Non-exclusive	76	45.20
Age at introduction of foods other than breast milk:		
0 months	11	6.50
1 months	6	3.60
2 months	7	4.20
3 months	16	9.50
4 months	15	8.90
5 months	21	12.50

Table 4 showed a statistically significant correlation between breastfeeding self-efficacy and EBF ($p < .05$). However, other factors such as breastfeeding intention, breastfeeding knowledge, attitude towards breastfeeding, maternal health literacy, Islamic belief, and social support did not show a significant relationship with the practice of EBF.

Table 4. Relationships between independent variables and EBF among Thai Muslim mothers (n = 168)

Variables	1	2	3	4	5	6	7	8
1. Breastfeeding intention	1.00							
2. Breastfeeding knowledge	.38**	1.00						
3. Attitude toward breastfeeding	.05	.06	1.00					
4. Breastfeeding self-efficacy	.33**	.07	.08	1.00				
5. Maternal health literacy	.31**	.36**	.16*	.41**	1.00			
6. Islamic belief	.19*	.28**	-.17*	.25**	.42**	1.00		
7. Social support	.09	-.01	-.07	.15*	.05	.20**	1.00	
8. Exclusive breastfeeding	.00	.02	-.11	.16*	-.02	-.03	.11	1.00

Note. *p < .05, **p < .01

For the predictability of independent variables on EBF, the Hosmer and Lemeshow test indicated a non-significant value of 4.037 ($p < .05$), suggesting the model's predictions closely align with the observed data. This result confirms the model's adequacy in fitting the data at an acceptable level, highlighting its reliability in analyzing the factors influencing EBF among Thai Muslim mothers.

The multivariate logistic regression analysis identified breastfeeding self-efficacy as the only significant predictor of EBF ($p = .05$), with high self-efficacy mothers being 1.96 times more likely to exclusively breastfeed compared to those with low self-efficacy. This factor accounted for 11% of the variance in EBF practices, as indicated by the Nagelkerke R Square (**Table 5**).

Table 5. Multivariate logistic regression examining the prediction between independent variables and EBF among Thai Muslim mothers (n = 168)

Variable	Breastfeeding			B	SE	OR	95% CI		p-value
	Exclusive (n = 92)	Non-exclusive (n = 76)	Total				lower	upper	
	n(%)	n(%)	n(%)						
Breastfeeding intention									
unintended	25(27.17)	21(27.63)	46(27.38)						
intended	67(72.83)	55(72.37)	122(72.61)	.02	.35	1.02	.52	2.02	.95
Breastfeeding knowledge									
Low	43(46.74)	37(48.68)	80(47.61)						
High	49(53.26)	39(51.32)	88(52.38)	.08	.31	1.08	.59	1.99	.80
Attitude toward breastfeeding									
Low	51(55.43)	34(44.74)	85(50.60)						
High	41(44.56)	42(55.26)	83(49.40)	-.04	.31	.65	.35	1.20	.17
Breastfeeding self-efficacy									
Low	23(25.00)	30(39.47)	53(31.55)	ref					
High	69(75.00)	46(60.52)	115(68.45)	.67	.34	1.96	1.01	3.78	.05

Table 5. Multivariate logistic regression examining the prediction between independent variables and EBF among Thai Muslim mothers (n = 168) (Cont.)

Variable	Breastfeeding			B	SE	OR	95% CI		p-value
	Exclusive (n = 92)	Non-exclusive (n = 76)	Total				lower	upper	
	n(%)	n(%)	n(%)						
Maternal health literacy									
Low	48(52.17)	38(50.00)	86(51.19)						
High	44(47.83)	38(50.00)	82(48.81)	-.09	.32	.92	.50	1.68	.78
Islamic belief									
Low	49(53.26)	38(50.00)	87(51.79)						
High	43(46.74)	38(50.00)	81(48.21)	-.13	.31	.88	.48	1.61	.67
Social support									
Low	13(14.13)	17(22.37)	30(17.86)						
High	79(85.87)	59(77.63)	138(82.14)	.56	.41	1.75	.79	3.89	.17
Constant				-.27	.28	.77			

Note. -2Log likelihood (227.34), Cox and Snell R Squared (.08), Nagelkerke R Squared (.11), percentage correct = 58.9

Discussion

The study found that the rate of 6-month EBF among Thai Muslim mothers was 54.8%, surpassing the global average but still below the targeted 70%.[5] Islamic teachings from Surah Al-Baqarah emphasize two years of breastfeeding,[8, 26] reflecting cultural and religious support for this practice. Despite this encouragement, economic conditions, as indicated by the average family income, might impact the feasibility and perceptions of EBF among the participants in this study. This finding is consistent with previous research that has reported mothers working outside to have a significantly shorter duration of EBF than housemakers.[33]

Findings indicate that EBF offers significant economic benefits for families by reducing the need to purchase infant formula. This economic advantage may contribute to the higher rate of EBF observed among Thai Muslim mothers compared to the national average for Thai mothers.[7] However, when compared with Muslim mothers in other countries, the rate of EBF among Thai Muslim mothers remains lower, suggesting cultural and possibly socio-economic differences impacting breastfeeding practices across different contexts.[21,25,26,33] Although breastfeeding is encouraged in the Quran until the age of two years,[8] Muslim mothers might face some barriers to EBF as Islam requires women to cover themselves up. Over half (56.5%) of the participants were employed, probably making it more challenging to maintain privacy for breastfeeding. Privacy and modesty of mothers during breastfeeding are crucial among Muslim mothers and can be a barrier to breastfeeding.[34]

The study's findings underscore the pivotal role of breastfeeding self-efficacy in promoting EBF among Thai Muslim mothers. This aligns with the Social Cognitive Theory, suggesting that personal cognitive factors significantly influence behavior.[11] High self-efficacy equips mothers with the confidence to begin breastfeeding, persevere through challenges, and maintain a positive mindset, thereby enhancing the likelihood of EBF success. This correlation between self-efficacy and breastfeeding practices mirrors findings from previous research within Muslim communities.[21,26] The study concludes that breastfeeding self-efficacy

significantly influences the practice of EBF among Thai Muslim mothers. This connection supports the notion that personal confidence and belief in one's ability to breastfeed are critical factors in successful EBF.[34]

The study found that despite a high rate of breastfeeding intention among participants, this did not directly correlate with or predict successful EBF. This suggests that while many mothers (72.61%) intend to exclusively breastfeed, various factors may impact their ability to follow through. This observation aligns with previous research indicating that the intention to breastfeed alone may not be a reliable predictor of EBF success.[35]

We found that despite a significant portion of participants (52.38%) having high breastfeeding knowledge, this did not significantly impact or predict the practice of EBF. This suggests that while knowledge about breastfeeding is important, it alone may not be sufficient to ensure EBF practices. This finding aligns with previous research, suggesting that breastfeeding knowledge, while related to the duration of breastfeeding,[25] is not a decisive factor in practicing EBF.[35]

The study's findings revealed that a positive attitude towards breastfeeding did not directly influence or predict EBF among Thai Muslim mothers. While nearly half (49.40%) of the participants had a favorable view of breastfeeding, over half (54.20%) lacked prior breastfeeding experience. This gap in practical experience may hinder effective problem-solving and the acquisition of necessary skills, such as proper latching and positioning, which are crucial for successful breastfeeding.[36]

The study found that maternal health literacy did not significantly influence or predict EBF among Thai Muslim mothers. Despite nearly half of the participants (48.81%) having high levels of health literacy, over half (54.20%) had no prior breastfeeding experience. The lack of practical experience may hinder their ability to address breastfeeding challenges, as successful breastfeeding involves mastering technical skills like proper latching and positioning.[36] This observation aligns with prior research indicating that maternal health literacy alone does not significantly predict EBF outcomes.[37]

The study found no significant relationship between Islamic belief and EBF among Thai Muslim mothers. Despite nearly half having a strong Islamic belief, cultural and religious practices, such as the requirement for modesty, may complicate breastfeeding, especially in public.[14] This issue might be particularly challenging for the 56.5% of employed participants. The previous study indicated that mothers working outside tend to stop breastfeeding before six months.[38] While Islam supports the practice of breastfeeding, the specifics of EBF are not detailed in the Quran, which may affect its prioritization among mothers.[17] The study suggests that cultural and religious practices among Muslim mothers may lead to early introduction of foods like bananas, honey, and dates before six months, under the belief that EBF might not provide sufficient nutrition for the infant.[33] This highlights a potential conflict between cultural beliefs and the recommended practice of EBF, emphasizing the need for culturally sensitive education on breastfeeding's nutritional adequacy for infants.[10]

Despite high levels of social support reported by the majority of participants (82.14%), this did not significantly predict EBF among Thai Muslim mothers. The presence of strong social networks, indicated by the high percentage of married participants (94.60%), suggests that family and social circles were supportive. Difficulty in completing household tasks and breastfeeding at the same time was the most common challenge in Iranian Muslim mothers.[39] However, when mothers face challenges such as insufficient milk production, family members may resort to introducing formula milk, which could undermine EBF efforts. This highlights a complex interplay between social support and breastfeeding practices, where support does not always align with EBF guidelines. Our findings suggest that despite the high levels of marital status among participants (94.60%), which could indicate the potential for supportive

environments, the influence of family members, including husbands and in-laws, might encourage formula feeding, acting as a barrier to EBF. This pattern, also observed in studies from Indonesia, indicates that while social support is prevalent, its direction may not always align with EBF practices, highlighting a nuanced understanding of social support's role in breastfeeding decisions.[40]

Limitations and Recommendations

The study's findings may not be broadly applicable due to the specific participant criteria, including mothers of single, healthy, full-term infants aged 6-9 months. The potential for response bias exists, as data were self-reported and collected under the observation of study team members, possibly influencing mothers' responses. Breastfeeding self-efficacy emerged as the primary factor influencing EBF, accounting for 11% of its implementation, suggesting that other unexplored factors also play significant roles. Maybe the Social Cognitive Theory is not appropriate to explain EBF among Muslim mothers.

Conclusions and Implications for Nursing Practice

Given that breastfeeding self-efficacy is a significant predictor of EBF among Thai Muslim mothers, nurses and healthcare providers are encouraged to create breastfeeding promotion strategies that not only boost self-efficacy but also respect Islamic beliefs. Tailoring these interventions to align with cultural and religious values can enhance their effectiveness and support mothers in achieving their breastfeeding goals. Further research is required on this topic, especially qualitative studies, to understand the experiences, perceptions, beliefs, and facilitating and barrier factors of Muslim mothers related to breastfeeding. Nurses are in a prime position to undertake such studies, and collaboration with other health professionals and Muslim communities is required for meaningful, rich findings.

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อัตราและปัจจัยทำนายการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดาชาวไทยมุสลิม: การศึกษาภาคตัดขวาง

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บทคัดย่อ: การเลี้ยงลูกด้วยนมแม่อย่างเดียวได้รับการยอมรับว่ามีประโยชน์มากมายต่อมารดาและทารก มารดามุสลิมมีความเชื่อและการปฏิบัติที่มีเอกลักษณ์เฉพาะตัวซึ่งอาจส่งผลต่อการเลี้ยงลูกด้วยนมแม่อย่างเดียว ปัจจุบันพบว่ามีความเข้าใจที่ไม่ชัดเจนเกี่ยวกับปัจจัยที่ทำนายการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดามุสลิม การวิจัยแบบภาคตัดขวางนี้มีวัตถุประสงค์เพื่อศึกษาอัตราการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดาชาวไทยมุสลิม และอำนาจการทำนายของความตั้งใจในการเลี้ยงลูกด้วยนมแม่ ความรู้ในการเลี้ยงลูกด้วยนมแม่ ทัศนคติเกี่ยวกับการให้นมทารก การรับรู้สมรรถนะแห่งตนในการเลี้ยงลูกด้วยนมแม่ ความรอบรู้ด้านสุขภาพของมารดา ความเชื่อของอิสลาม และการสนับสนุนทางสังคมเพื่อการเลี้ยงลูกด้วยนมแม่อย่างเดียวต่อการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดาชาวไทยมุสลิม กลุ่มตัวอย่างเป็นมารดาที่พาบุตรมารับวัคซีนที่โรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดภาคใต้ของประเทศไทย จำนวน 168 คน ในเดือนมิถุนายน - ธันวาคม 2565 คัดเลือกโดยใช้การสุ่มแบบหลายขั้นตอน เก็บรวบรวมข้อมูลโดยใช้แบบสอบถามข้อมูลส่วนบุคคล แบบประเมินความตั้งใจในการให้นมทารก แบบสอบถามความรู้ในการเลี้ยงลูกด้วยนมแม่ แบบวัดทัศนคติเกี่ยวกับการให้นมทารก แบบวัดการรับรู้สมรรถนะแห่งตนในการเลี้ยงลูกด้วยนมแม่ แบบวัดความรอบรู้ด้านสุขภาพของมารดา แบบสอบความเชื่อของอิสลาม แบบวัดการสนับสนุนทางสังคมเพื่อการเลี้ยงลูกด้วยนมแม่อย่างเดียว และแบบสอบถามการเลี้ยงลูกด้วยนมแม่ วิเคราะห์ข้อมูลด้วยสถิติเชิงพรรณนา สถิติทดสอบความสัมพันธ์สเปียร์แมน และสถิติการถดถอยโลจิสติกส์

ผลการศึกษาพบว่า ในช่วง 6 เดือนแรกหลังคลอด อัตราการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดาชาวไทยมุสลิมอยู่ที่ร้อยละ 54.8 การรับรู้สมรรถนะแห่งตนในการเลี้ยงลูกด้วยนมแม่สามารถทำนายการเลี้ยงลูกด้วยนมแม่อย่างเดียวของมารดามุสลิม และสามารถอธิบายความแปรปรวนของการเลี้ยงลูกด้วยนมแม่อย่างเดียวได้ร้อยละ 11 ดังนั้นพยาบาลหรือผู้เชี่ยวชาญด้านสุขภาพควรพัฒนาโปรแกรมสนับสนุนการเลี้ยงลูกด้วยนมแม่ที่มุ่งเน้นการเพิ่มการรับรู้สมรรถนะแห่งตนในการเลี้ยงลูกด้วยนมแม่ โดยปรับให้เหมาะกับความเชื่ออิสลามของมารดามุสลิม

Pacific Rim Int J Nurs Res 2024; 28(2) 390-406

คำสำคัญ: การรับรู้สมรรถนะแห่งตนในการเลี้ยงลูกด้วยนมแม่ การเลี้ยงลูกด้วยนมแม่อย่างเดียว มารดามุสลิมไทย ปัจจัยทำนาย ประเทศไทย

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