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Health Beliefs and Husband's Preparedness in Supporting Postpartum Contraceptive Use

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Abstract

Use of postpartum contraceptives is critical to the prevention of unwanted pregnancies and enhancing maternal and child health. Yet, husbands' support for the use of contraceptives is still low based on cultural beliefs and inadequate knowledge. It is important to understand how health belief influences husbands' readiness in order to improve family planning. This study will analyze the association between health beliefs and husbands' readiness to support postpartum contraceptive use. A cross-sectional correlational descriptive design was employed with 170 husbands of postpartum women in Samarinda, Indonesia. Consecutive sampling was used, and data were collected using validated tools modeled after the Health Belief Model (HBM) and a scale of a husband's preparedness. The tools were found to have high reliability, with Cronbach's alpha values ranging from 0.761 to 0.988. Data analysis included univariate descriptive statistics and Spearman's rank correlation to quantify the relationship between preparedness and the health beliefs of husbands. Researchers found a significant positive relationship between preparedness and health beliefs of husbands in support of postpartum use of contraceptives ($p = 0.01$, $r = 0.745$). The greatest correlation was between perceived susceptibility and concern ($r = 0.548$, $p = 0.00$), then self-efficacy and concern ($r = 0.534$, $p = 0.00$). Husbands' health beliefs play a crucial role in their willingness to support postpartum contraceptive use. Anchoring on education programs that reinforce health beliefs will enhance husbands' participation in family planning.

Introduction

Postpartum contraceptive use is necessary for preventing unwanted pregnancies and improving maternal and child health outcomes worldwide. However, it is underreported, especially in low- and middle-income countries, where postpartum contraception is used by only 62% of women (Asresie *et al*., 2020). This gap in contraceptive coverage is a significant public health problem warranting intensive research and targeted interventions. The most deciding factor is the poor support of husbands for standing by their wives' use of contraceptives, which largely dictates the success rate of family planning (Amuzie, Nwamoh, Ukegbu, Umeokonkwo, *et al*., 2022). The husbands primarily suggest reasons such as preferring to have additional children or resistance from the family, typically overlooking maternal and child health concerns (Bibi *et al*., 2019).

Social and cultural conventions tend to place men as key decision-makers in reproductive health issues, but their attitudes and understanding of contraception can be appalling or guided by misinformation. Additionally, religious misconceptions, including linking contraception to abortion or sin (Ali *et al*., 2022; Barro *et al*., 2021), further weaken family planning initiatives and act

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as barriers to successful postpartum use of contraception. In Uganda, for instance, parents discourage their adolescent daughters from using contraception because they perceive that it promotes promiscuity (Vuamaiku *et al*., 2023). Such religious and cultural barriers need culturally sensitive interventions that attempt to break down underlying misconceptions and beliefs. Avoiding postpartum contraception has risky consequences on maternal and child health, and its ramifications extend beyond family units.

The first 12 months after delivery are critical, and during this time, mothers are highly vulnerable to health complications like hemorrhage, infection, and malnutrition (Cleland *et al*., 2012; Engelbert *et al*., 2021; Rwabilimbo *et al*., 2021). It has been established that pregnancies occurring within 18 months of the previous delivery are associated with high risks of maternal mortality, preterm birth, and low birth weight. Short inter-pregnancy intervals are associated with low birth weight and high neonatal mortality, creating a cycle of poor health outcomes (Davanzo *et al*., 2007; Zhu *et al*., 2001). Furthermore, for those who wish for another pregnancy sooner, the risk of miscarriage and ectopic pregnancy is also higher (Lakha & Glasier, 2006). According to the Declaration for Collective Action for Postpartum Family Planning, spacing births by at least two years can reduce maternal mortality by over 30% and infant mortality by 10% (Hounkponou *et al*., 2022). Husbands' active involvement is required for the effective usage of postpartum contraception since, in the majority of cultures, they hold the final decision-making authority (Sarfraz *et al*., 2023). The patriarchal nature of the majority of societies makes women's reproductive choices contingent upon male acceptance and approval.

Effective couple communication enables contraceptive planning (Owuor & Derose, 2004), and husbands' support and approval are significant in their wives' decision-making (Prata *et al*., 2017; Ruderman *et al*., 2022). However, some husbands are not concerned about family planning due to a lack of appreciation and trust in the program (Amuzie, Nwamoh, Ukegbu, Umeokonkwo, *et al*., 2022). Confidence in family planning interventions can be achieved by increased knowledge and favorable attitudes among husbands, making them more ready to facilitate the use of postpartum contraception (Hernandez *et al*., 2022). Education interventions targeting men have been reported to show promise in enhancing contraceptive uptake and continuation. Therefore, the discussion on contraception should be done during pregnancy to help couples reach consensus and strengthen the wife's attitude regarding postpartum family planning (Wuni *et al*., 2018; Zimmerman *et al*., 2021).

Husbands' approval and emotional support are key to empowering women to use contraception after delivery (Rakhshani *et al*., 2005). Also, involving families in family planning conversations can allow women to make shared decisions and reduce the emotional costs of contraceptive decision-making (Underwood *et al*., 2019). Family-centered contraceptive counseling interventions have been associated with improved communication patterns and reduced inter-spousal conflict. By appreciating the efforts of their wives, the husbands can motivate them more to use contraception without fear or anticipation of any side effects (Idris *et al*., 2021). When husbands demonstrate pride, respect, and understanding, they acknowledge the physical and emotional challenges of childbirth and support their wives' health and independence (Widyastuti *et al*., 2023).

Method

This research employed a cross-sectional correlational descriptive design to determine the correlation between health beliefs and husbands' willingness to enable postpartum use of contraceptives. This was a suitable design because it allows for the investigation of associations between variables at a point in time, which is an appropriate means of investigating relationships between psychological variables and behavioral intentions. The cross-sectional study is a precious instrument to establish up-to-date husbands' attitudes and readiness, but it is inexpensive and feasible in resource-limited settings. The study was conducted in the Community Health Center (Puskesmas) Samarinda Regency, Indonesia, which is the

central public health center for residents in the region. The reason for selecting this site was that Puskesmas centers provide the majority of Indonesia's family planning services and are the normal care setting in which postpartum contraceptive counseling is provided. The study population consisted of husbands of women who had just given birth and were attending postpartum care at the center. 170 participants were recruited using consecutive sampling, which involved enrolling all the eligible participants who fit into the inclusion criteria within the data collection time. The inclusion criteria were: (1) husbands of legal wives, (2) husbands whose wives had given birth, and (3) husbands who were ready to participate in the study. Participants who did not agree to participate were not allowed in the study to ensure voluntary participation and quality data.

Health Belief Instrument: Based on the Health Belief Model (Rosenstock, 1974), this instrument assessed husbands' beliefs about family planning programs and the use of contraceptives. The instrument was adapted to the Indonesian context and validated through expert review and pilot testing. There were 20 items on five dimensions: perceived susceptibility (4 items), perceived severity (4 items), perceived barriers (4 items), perceived benefits (4 items), and self-efficacy (4 items). The responses were scored on a 5-point Likert scale, from 1 (very unsure) to 5 (very confident) for the positive items, and reverse scored for the negative items. The greater the score, the higher the health beliefs and the more positive the family planning attitudes. The instrument was found to have acceptable reliability, with Cronbach's alpha coefficients for each factor: perceived susceptibility (0.861), perceived severity (0.837), perceived barriers (0.893), perceived benefits (0.796), and self-efficacy (0.988). Husband's Preparedness Scale: Based on research on husbands' involvement in supporting postpartum use of contraception (Owuor & Derose, 2004; Prata *et al*., 2017; Ruderman *et al*., 2022), the scale was designed to measure husbands' readiness to support their wives' contraceptive decision. It was designed to measure a number of aspects of readiness, including emotional, practical, and cognitive support. It consisted of 12 items in three dimensions: concern (6 items), ability to facilitate (3 items), and appreciation (3 items). Items were rated on a 5-point scale (1 = very unprepared to 5 = very prepared), with higher scores indicating higher levels of being prepared to help postpartum use of contraceptives. Reliability of the instrument was determined by Cronbach's alpha coefficients for each dimension: concern (0.935), ability to facilitate (0.924), and appreciation (0.761).

The questionnaire was provided in Indonesian to ensure cultural appropriateness and respondent understanding. Translation and back-translation procedures were followed to maintain the validity of the original instruments. Demographic data, such as age, educational level, occupation, and earnings, were also collected to facilitate more comprehensive analysis and place the findings in perspective. The questionnaire link was sent to husbands with the assistance of trained nurses at the Puskesmas from January 4 to January 22, 2024, and ensured standardized data practices. The respondents provided informed consent before they completed the questionnaire, and researchers maintained strict confidentiality practices throughout the study. Researchers verified data accuracy and completeness and requested direct clarification from the respondents in the event of incomplete or unclear responses during follow-up contact. Data were statistically examined employing univariate and bivariate analysis techniques appropriate to the research objectives and data type. Univariate analysis provided descriptive statistics in the form of percentages for each health belief dimension and husband's readiness to provide a clear understanding of the nature of the sample. Normality testing was performed using the Shapiro-Wilk test to determine the appropriate statistical analysis technique. Bivariate analysis used the Spearman rank correlation test to contrast health beliefs with husbands' readiness, as the two variables were ordinal and non-normally distributed. The significance level was $p < 0.05$, and the effect sizes were interpreted based on Cohen's criteria for correlation coefficients.

Ethical approval was provided by the Muhammadiyah University of East Kalimantan Research Ethics Committee (Ref.

No. 023/KEPK-UMKT/I/2024) in upholding international standards of human research ethics. The study purpose, duration of participation, data confidentiality procedures, and participant rights as a study participant were explained to the participants. The study complied with the principles of the Declaration of Helsinki and saw to it that all ethical considerations were addressed. It was voluntary cooperation and the right to withdraw at any time without penalty or negative consequences. The questionnaire was designed not to cause distress or discomfort to answer, with sensitive questions being set in non-judgmental language.

Result and Discussion

Table 1 indicates that 45.71% of the respondents were in the age group of 36-45, the largest age group in the study sample. The prevalence of the subjects in this age bracket means the majority of the husbands were at the peak reproductive ages and perhaps with families formed and experience accumulated, which influences their family planning decisions. Besides that, there are 32.94% of 26-35 years old, and 22.35% of 17-25 years old, which is with the effect of having extensive age coverage in order to enhance the credibility of the findings. The age profile is reflective of Indonesian fertility and marriage patterns, where men wed in their late twenties and early thirties. With regard to educational attainment, 52.35% were at the Diploma or Bachelor's level, and this indicates that more than half of the respondents had higher educational qualifications. This level of education points to the fact that the sample included men with relatively good literacy levels and perhaps better exposure to health information. Further, 29.41% achieved senior high school, 10% junior high school graduation, and 8.24% primary school graduation, showing education diversity in line with that of the general population attributes. Higher educational levels have been correlated with better family planning attitudes and increased involvement in reproductive health decisions.

In relation to their employment status, 64.71% worked as self-employed employees, which is common in the Indonesian economy, where micro-enterprise labor and the informal sector are predominant. This pattern of employment may influence family planning decisions through its economic security and ability to access healthcare services. Additionally, 21.76% were government employees, and 13.53% worked in the private sector, providing representation from different employment sectors. Employment status can significantly influence men's involvement in family planning, with self-employed individuals often having more flexible schedules to accompany their wives to healthcare facilities. Economic status showed 65.3% earned above the minimum wage, while 34.7% earned below it, indicating relatively good economic conditions among participants that may facilitate access to contraceptive services.

TABLE 1. Characteristics of Husbands Whose Wives Use Postpartum Contraception (n = 170)

Variable	Category	f	%
Age	17-25 years old	38	22.35
	26-35 years old	56	32.94
	36-45 years old	76	45.71
Education Level	Not attending school/primary school	14	8.24
	Junior high school	17	10.00
	Senior High School	50	29.41
	Diploma / Bachelor's Degree	89	52.35
Employment	Government employees	37	21.76
	Private employees	23	13.53
	Self-employed	110	64.71
Income per Month	≤ UMK Rp 3.300.000	59	34.70
	> UMK Rp 3.300.000	111	65.30

TABLE 2. Descriptive Statistics of Health Beliefs and Husbands' Preparedness to Support Postpartum Contraceptive Use (n = 170)

Variable	Dimensions	Mean	Standard Deviation
Health Beliefs	Perceived susceptibility	3.18	0.610
	Perceived severity	2.32	0.530
	Perceived barriers	2.51	0.587
	Perceived benefit	2.22	0.472
	Self-efficacy	2.36	0.535
Husband's preparedness	Concern	3.21	0.669
	Ability to facilitate	2.48	0.543
	Appreciation	2.22	0.473

Table 2 showed that perceived susceptibility had the highest mean score (M = 3.18, SD = 0.610), indicating that husbands generally recognized the risks associated with unplanned pregnancies and short birth intervals. This finding suggests that participants were aware of the potential health consequences for both mothers and children when contraception is not used appropriately. The relatively high score for perceived susceptibility is encouraging as it represents a foundation for promoting family planning behaviors. Perceived susceptibility is considered a key motivator for health behavior change, as individuals who recognize their vulnerability to health risks are more likely to take preventive actions. The second highest score was for perceived barriers (M = 2.51, SD = 0.587), followed by self-efficacy (M = 2.36, SD = 0.535), perceived severity (M = 2.32, SD = 0.530), and perceived benefit (M = 2.22, SD = 0.472). These moderate scores suggest that while husbands recognized some barriers to contraceptive use, they also demonstrated reasonable confidence in their ability to support their wives' family planning decisions. The relatively low score for perceived benefits indicates an area for improvement in family planning education programs. Research has shown that emphasizing the benefits of contraception, including health, economic, and social advantages, can significantly improve acceptance and support for family planning programs.

For husbands' preparedness dimensions, concern showed the highest mean score (M = 3.21, SD = 0.669), indicating that husbands expressed genuine care and worry about their wives' reproductive health and family well-being. This finding suggests that emotional support and concern are prominent aspects of husbands' preparedness to support contraceptive use. The high concern score reflects the importance of emotional factors in family planning decisions and suggests that husbands are motivated by care for their families. Emotional support from partners has been identified as a crucial factor in contraceptive use and continuation, particularly in cultures where male approval is important. The scores for ability to facilitate (M = 2.48, SD = 0.543) and appreciation (M = 2.22, SD = 0.473) were moderate, suggesting areas where targeted interventions could enhance husbands' preparedness.

As shown in Table 3, all health belief attributes showed significant positive correlations with dimensions of husband's preparedness, demonstrating the comprehensive relationship between cognitive factors and behavioral intentions. The strongest correlation was between perceived susceptibility and concern (r = 0.548, p = 0.00), indicating that husbands who recognized the risks of unplanned pregnancies were more likely to express concern and emotional support for their wives' contraceptive use. This finding supports the theoretical framework of the Health Belief Model, which posits that perceived susceptibility is a key motivator for health-related behaviors. The strong correlation between susceptibility and concern suggests that risk perception serves as an emotional catalyst for supportive behavior, consistent with findings from other health behavior studies (r = 0.532, p = 0.00), and self-efficacy and concern (r = 0.534, p = 0.00).

The other significant correlations were

TABLE 3. Description of the Relationship Between Health Belief Attributes and Husbands' Preparedness to Support Wives' Postpartum Contraceptive Use (n = 170)

Sub-variable attributes	p-value	Correlation Coefficient (r)
Perceived susceptibility → Concern	0.00	0.548
Perceived susceptibility → Ability to facilitate	0.00	0.522
Perceived susceptibility → Appreciation	0.00	0.524
Perceived severity → Concern	0.00	0.472
Perceived severity → Ability to facilitate	0.02	0.386
Perceived severity → Appreciation	0.02	0.462
Perceived barriers → Concern	0.01	0.437
Perceived barriers → Ability to facilitate	0.00	0.487
Perceived barriers → Appreciation	0.00	0.532
Perceived benefit → Concern	0.03	0.432
Perceived benefit → Ability to facilitate	0.00	0.524
Perceived benefit → Appreciation	0.00	0.468
Self-efficacy → Concern	0.00	0.534
Self-efficacy → Ability to facilitate	0.00	0.487
Self-efficacy → Appreciation	0.02	0.421

TABLE 4. Distribution of the Relationship Between Health Beliefs and Husbands' Preparedness to Support Wives' Postpartum Contraceptive Use (n = 170)

Variable	p-value	Correlation Coefficient (r)
Husband's Health Beliefs and Preparedness	p = 0,01	r = 0,745

perceived benefit and facilitation capability (r = 0.524, p = 0.00), which suggests that husbands who were aware of the benefits of contraception were more capable of providing pragmatic support for their wives' planning choices. This relationship points to the necessity of emphasizing the positive effects of family planning in educational programs. Moreover, the correlation between perceived barriers and appreciation (r = 0.532, p = 0.00) indicates that husbands who were conscious of the barriers to contraceptive use were more likely to appreciate the effort taken by their wives in enrolling in family planning programs. It can be an indicator that if the awareness of barriers is taken into consideration, then empathy and appreciation become essential in supportive relationships. The correlation between self-efficacy and concern (r = 0.534, p = 0.00) verifies that husbands who believed in their ability to provide care to their wives were more likely to indicate concern and emotional support.

Table 4 presents the overall correlation analysis, which demonstrated a strong positive relationship between health beliefs and husband's preparedness for supporting postpartum contraceptive use (r = 0.745, p = 0.01). This robust correlation indicates that health beliefs serve as significant predictors of husbands' preparedness to support their wives' contraceptive decisions. The strength of this relationship suggests that interventions targeting health beliefs could be highly effective in improving husbands' involvement in family planning.

This study demonstrates a significant relationship between health beliefs and husbands' preparedness to support postpartum contraceptive use, with implications for family planning programs and policies. The strong positive correlation (r = 0.745, p = 0.01) aligns with previous research (Chekole *et al*., 2019; Widyastuti *et al*., 2023) that emphasizes the importance of male involvement in family planning decisions. Such interaction has been found to enable greater utilization

and continuation of contraceptive use and maternal and child health service use. That the relationship is strong is an indication that health beliefs are not only associated with readiness but can also be predictors of healthy behavior. This engagement plays a crucial role in facilitating access to maternal and child health (Davis *et al*., 2016) and overall family well-being through enhanced economic security and better health outcomes (Muntifering *et al*., 2013).

Successful couples' communication is necessary before postpartum contraception decision-making, specifically for young couples who are less experienced in making decisions on family planning (Bhattacharya *et al*., 2023; Challa *et al*., 2020; Hartmann *et al*., 2012). It has been proven that successful couples' communication on contraception results in more consistent method use and greater satisfaction with the chosen method. Since there has been a recent introduction of a new family member, the economic needs are high, which tends to impact family stability and must be well planned so that they can prepare sufficient care and resources for child development (Aslam *et al*., 2016). In countries like China, strict birth control policies impose fines that can negatively impact individual well-being and family economic status (Pan & Liu, 2021). The economic implications of family planning decisions extend beyond immediate costs to include long-term investments in child health, education, and development opportunities**.** Meanwhile, postpartum contraception allows mothers to recover physically and emotionally while providing children with the opportunity for optimal growth and development through adequate spacing between pregnancies (Mookerjee *et al*., 2023).

For this reason, the husband's preparedness behavior needs to be shown to the wife by always fully supporting the family planning program that the wife participates in after giving birth. This support is particularly important because the wife's consent to use contraception after giving birth is often contingent upon the husband's decision and approval (D'Exelle & Ringdal, 2022). Male involvement in family planning decisions can reduce the burden on women and promote shared responsibility for reproductive health outcomes**.** Positive appreciation from the husband accorded to the wife who participates in family planning programs following delivery ensures the wife is not worried or apprehensive about the program enrollment (Idris *et al.*, 2021). Psychological support matters to contraceptive continuation as women who perceive they are supported by their partners are likely to maintain contraceptive use regardless of potential side effects or challenges. Therefore, couples and families must understand, communicate, and support one another in a bid to realize mutually acceptable decisions for the benefit of maternal and child health (Underwood *et al*., 2019).

Concern, facilitation capacity, and gratitude were discovered by the research to be core features of preparedness among husbands, attesting to the complexities of supportive behavior (Owuor & Derose, 2004; Prata *et al*., 2017; Ruderman *et al*., 2022). All of these dimensions are necessary for effective participation in family planning, and they are all expressed in various forms of support: emotional support (concern), practical support (capacity to facilitate), and psychological support (appreciation). The highest correlation was found between perceived susceptibility and concern, and it was identified that husbands who are aware of the risk of unplanned pregnancies are likely to emotionally and psychologically support their wives (Sarfraz *et al*., 2023). This finding suggests that risk communication activities should focus on helping men understand the health consequences of poor birth spacing among children and mothers. However, husbands still view family planning as the responsibility of the majority of the wife, focusing on their economic provider role and not as decision-makers in reproductive health (Amuzie, Nwamoh, Ukegbu, Chukwuma, *et al*., 2022; Cheng *et al*., 2015; Gonalons-Pons & Gangl, 2021). Perceived obstacles were significantly associated with appreciation, which indicates that husbands who notice the limitations to contraception are most likely to provide support for their wives' participation in family planning programs.

This association, therefore, indicates that education on contraceptive side effects and coping strategies is actually able to increase and not diminish support because knowledge

leads to understanding and empathy. Where the husbands are conscious of the physical and psychological challenges the wives may face while using contraception, they are likely to facilitate and provide more functional assistance (Chekole *et al*., 2019). Appreciation here includes comprehension of the sacrifice and effort required in using contraception, which can strengthen the marital relationship and promote more use of family planning. Self-efficacy was also significantly related to concern, which means that husbands who trust themselves and that they can provide for their wives are more actively involved in family planning decisions and are likely to support their wives emotionally when life gets tough (D'Exelle & Ringdal, 2022). The five components of health beliefs—perceived susceptibility, perceived severity, perceived barriers, perceived benefits, and self-efficacy—are core components of Rosenstock's theoretical model (1974). Each component has a distinctive role in shaping behavior: susceptibility creates motivation, severity provides urgency, benefits supply incentives, barriers provide challenges to be overcome, and self-efficacy supplies confidence to behave.

Perceived susceptibility ranked the highest with the mean score of 3.18 ± 0.610, showing concern among husbands for unwanted pregnancies and their wives' and children's health implications. This finding is particularly relevant because perceived susceptibility is the first step of the process of altering health behavior, the driving force for action that comes next. This agrees with evidence indicating that women who do not use postpartum family planning are vulnerable to severe consequences like failure in birth spacing, maternal health complications, and negative child development (Damtie *et al*., 2021; Mookerjee *et al*., 2023). Other research indicates that perceived susceptibility plays an important role in behavior change across various health situations. When individuals feel that they are threatened with harm to their health, they will apply measures to prevent this and persuade others to take preventive measures as well (Jones *et al*., 2015).

The perceived susceptibility is an element that transcends personal risk perception to include family vulnerability, and the latter needs consideration when it comes to married men who need to consider their children's and wives' health. Create space for birth through family planning programs such that families will be able to manage their economy and allocate resources better, prioritizing the platform for achieving long-term family stability and prosperity (Canning & Schultz, 2012). Economic benefits of family planning are reduced healthcare costs, greater educational and career opportunities for women, and improved child health and educational attainment. In addition, by spacing children, they are accorded more care and a greater likelihood of healthy development, e.g., better nutrition, access to healthcare, and access to education (Chakraborty & Sprockett, 2018). While perceived benefits and perceived severity were relatively lower in correlation with preparedness dimensions, they influence husbands' preparedness and hence must be considered in the planning of interventions. Perceived severity refers to the individual's subjective estimation of the seriousness of likely health consequences, while perceived benefits refer to the good consequences of action that are expected (Rosenstock, 1974). The perceived benefits and ability relationship points toward the necessity of focusing on long-term benefits of contraception in educational programs, such as improved maternal health, child development, and financial security of the family (Prata *et al*., 2017).

Educational interventions need to establish clear, direct, and long-term benefits of family planning, including health, social, and economic advantages of the entire family. Given that family well-being is enhanced significantly by contraception through multiple avenues, a focus on the health beliefs of husbands and husband empowerment through family planning program interventions is more relevant to global reproductive health programs (Kriel *et al*., 2019). As the awareness grows that male involvement is a critical component of successful family planning programs, more research and intervention resources have been devoted to the study of men. The findings of the present study, showing a high correlation between health beliefs and husbands' preparedness ($p = 0.01$, $r = 0.745$),

strongly support this perspective and attest to the effectiveness of belief-based interventions.

This finding suggests that the effectiveness of health belief targeting programs would be greater than that of programs that are singularly focused on knowledge transfer or service provision. In addition, husbands' beliefs serve as a buffer for desirable psychological characteristics, especially regarding caring about facilitating their wives' use of contraception on a consistent and efficient basis (Sarfraz *et al*., 2023). These behaviors are paramount because husbands are more likely to hold the last word regarding family planning decisions, especially in patriarchal societies where male approval is required for health care decisions (Owuor & Derose, 2004). The findings emphasize the need for psychoeducation interventions addressing perceived self-efficacy and perceived susceptibility among husbands to improve their emotional support and active involvement in postpartum contraceptive decision-making. Counseling conducted at the community level also mitigates cultural and religious misconceptions, therefore minimizing perceived barriers and increasing appreciation for family planning (Underwood *et al*., 2019). Health care workers should also involve husbands in couple counseling sessions during antenatal care to promote improved communication and joint decision-making about postpartum contraception. Policymakers can develop supportive policies that encourage male involvement in family planning initiatives. Despite the significant findings, this study has some limitations. First, the cross-sectional design limits the ability to establish causal relationships between health beliefs and husbands' preparedness. Future research with a longitudinal approach is recommended to assess changes over time. Second, the study relied on self-reported data, which may introduce social desirability bias. Incorporating qualitative interviews could provide deeper insights into husbands' experiences and perceptions.

Conclusion

This research demonstrates significant, positive direct relationships between health beliefs and the willingness of husbands to support postpartum contraceptive use. The strongest correlations were between perceived susceptibility and concern, and self-efficacy and concern, suggesting the need for emotional support and confidence in decision-making. In addition, perceived barriers were also strongly correlated with appreciation, suggesting that husbands who are aware of the challenges of contraceptive use are more willing to show support for their wives to visit family planning programs. These findings emphasize the requirement for specific interventions that strengthen husbands' health beliefs. Enhanced psychoeducation programs focusing on increasing perceptions of susceptibility and self-efficacy can establish emotional support and active involvement of husbands in postpartum contraceptive choices. Furthermore, community-level counseling addressing cultural and religious misconceptions presents significant potential for reducing perceived barriers and fostering recognition of family planning efforts. The insights provide healthcare providers and policymakers with valuable information for designing effective strategies to promote active husband participation in postpartum family planning, thereby enhancing maternal and child health outcomes.

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