



■ Research Brief

COUPLE CONCORDANCE INDEX

Construction of the Couple Concordance Index and Its Relationship with Contraceptive Use

BACKGROUND

We know that changes in contraceptive prevalence follow an S-shaped curve, starting with low contraceptive use when preferences for large family size dominate and norms relating to women's participation in schooling and work are inequitable.¹ As norms shift and preferences for regulating fertility change, countries move from low levels of contraceptive use to higher levels and modern contraception use becomes more acceptable. This analysis examines levels of concordance between couples on demographics, family preferences, knowledge, and empowerment (i.e., couple concordance index [CCI]), and its relationship with country groupings along the modern contraceptive prevalence rate (mCPR) S-curve.

Study Questions

How do levels of couples' concordance differ across countries?

What is the relationship between couples' concordance and position along the mCPR S-curve?

METHODS

We constructed a CCI using national-level data from 182 Demographic and Health Surveys for 65 countries. We chose 12 variables to create four domains of concordance: demographics, family preferences, resources, and empowerment and beliefs. For most indicators, concordance was measured as the percentage of couples who both answered positively, for example, both were literate or knew a long-term method of family planning. We scaled indicators and weighted them following expert consultations. Following the creation of individual domains, we formed the CCI by taking the geometric mean of the four domains.

RESULTS

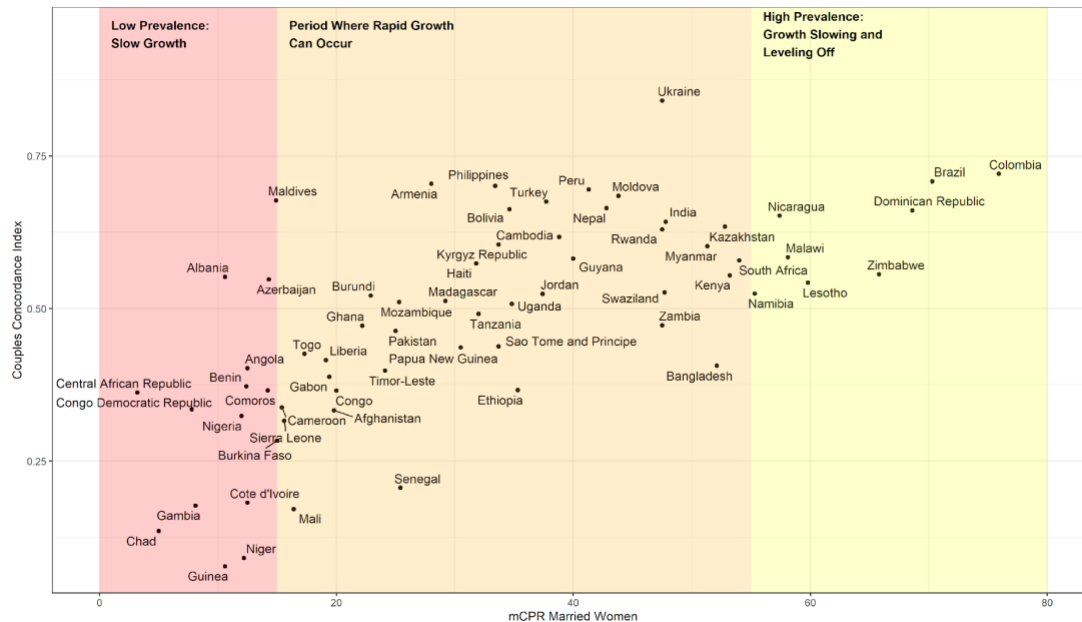
We present global results for the CCI and mCPR of married women. For additional results, see the full report.

The minimum possible CCI is 0 and the maximum is 1. Of countries in the multinational analysis, the global average is 0.48, with a standard deviation of 0.17. Ukraine has the highest score of 0.84 and Guinea has the lowest score of 0.08. Regionally, Eastern Europe has the highest mean CCI (0.76), and Western Africa has the lowest mean CCI (0.27).



We found a strong relationship between the CCI and contraceptive use. No country in the analysis reached a high prevalence (greater than 55% of married women using modern methods) without a CCI of 0.55 or greater. Several countries with high CCI given their level of mCPR are countries where traditional practices (withdrawal and periodic abstinence) are common, which require couple communication. Countries with the lowest CCI are also countries with low contraceptive prevalence.

FIGURE 1. GLOBAL COUPLE CONCORDANCE AND MCPR OF MARRIED WOMEN



CONCLUSIONS

The construction of the CCI offers policymakers a tool to capture a nuanced measure of interpersonal relationships. It allows one to observe changes at the macro level, which is where the combined effects of drivers of norms—education, skills, labor force participation—are felt substantially and create the space for movement from low prevalence to rapid growth along the S-curve.

When we look at CCI scores alongside mCPR among married women, we see that despite a few exceptions, the two indicators track closely. Countries with higher mCPR levels also have higher CCI scores and vice versa. This finding emphasizes the need for inclusive family planning programs that emphasize the role that both men and women play in contraceptive decision-making. This analysis highlights that the countries with the lowest CCI are also the ones with the lowest mCPR. If policymakers are interested in country planning, analysis of the CCI and its individual domains highlights aspects of focus for couples' programming.

References

1. Track20 Project. 2017. "The S-Curve: Putting mCPR Growth into Context."
http://www.track20.org/pages/data_analysis/in_depth/mCPR_growth/s_curve.php.

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