



## ■ Research Brief

# COUPLE CONCORDANCE INDEX, KENYA

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

### 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.<sup>1</sup> 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.

International examination of the CCI has shown a strong relationship between a country's CCI and its location on the mCPR S-curve. The purpose of this study is to understand regional differences in couple concordance in Kenya and the relationship between concordance and position on the S-curve.

### METHODS

We constructed the CCI using national-level data from 182 Demographic and Health Surveys (DHS) 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.

### Study Questions

How do levels of couples' concordance differ across counties in Kenya?

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



Although the CCI was initially developed at a national scale, subnational analysis is also feasible at the level of disaggregation of the DHS. We constructed the CCI for all 47 counties in Kenya and examined the relationship between a county's CCI score and its mCPR.

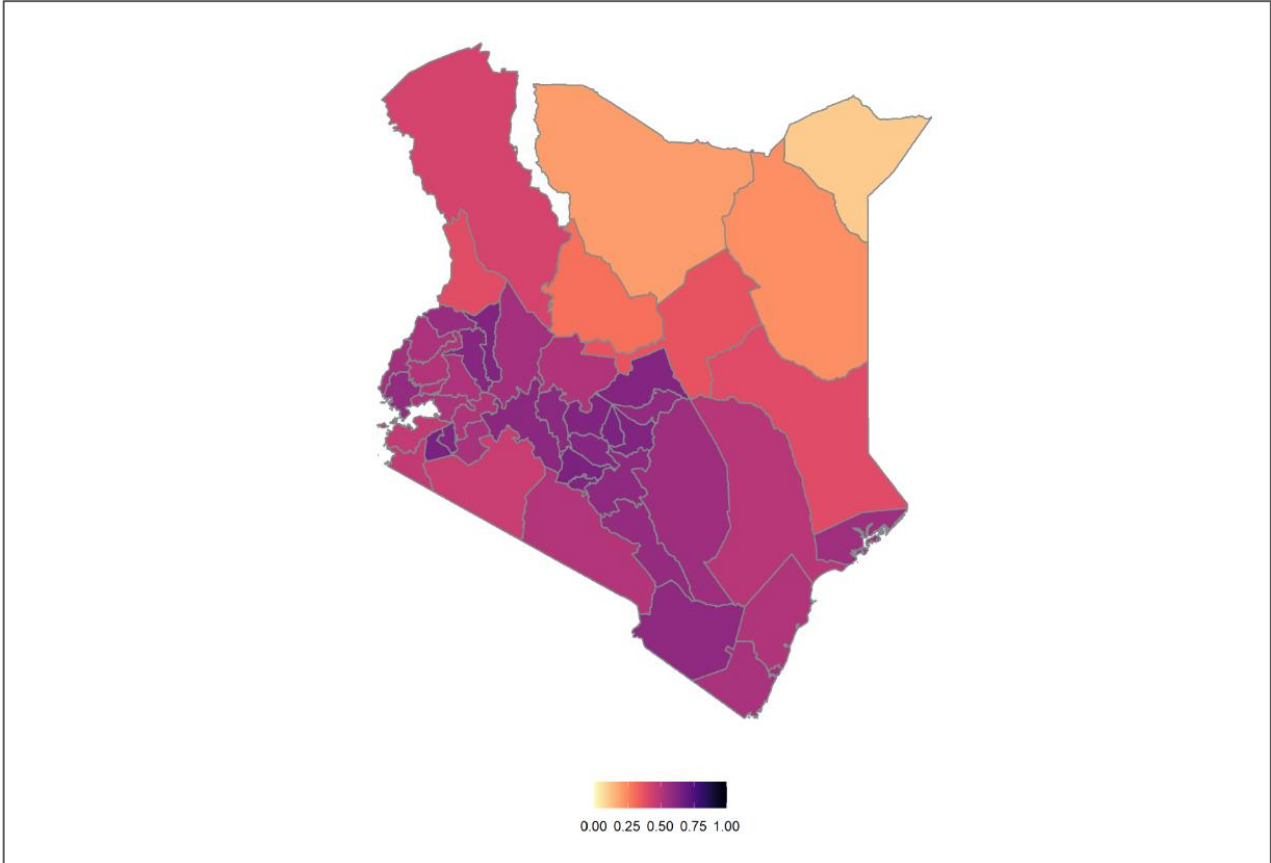
As mentioned above, subnational analysis is also feasible at the level of disaggregation of the DHS. One consideration is change in scale for the subnational analysis. For Kenya, we had to adjust four indicators to account for lower levels in counties than the international analysis. The four indicators were couples who share the same ideal number of children, both members of a couple being literate, both knowing a long-term contraceptive method, and neither member of the couple believing there is any justification for wife beating.

## RESULTS

We present global results for the CCI and mCPR of married women, and dimension-specific results for the counties in Kenya. For additional international results, see the full report.

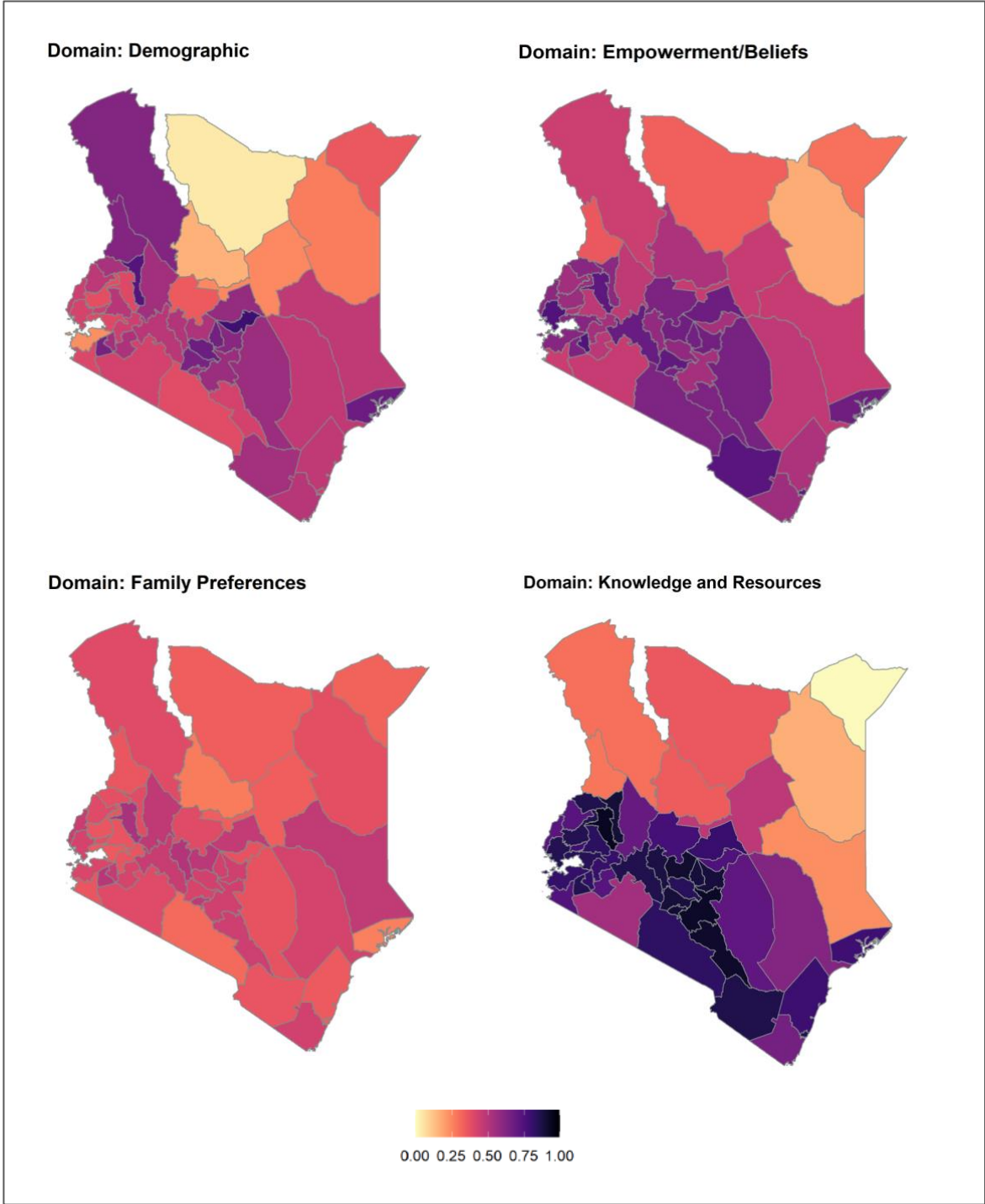
The minimum possible CCI is 0 and the maximum is 1. Of countries in the multinational analysis, the global average is 0.48, with a standard deviation of 0.17. Ukraine has the highest score of 0.84 and Guinea has the lowest score of 0.08. Kenya falls above the global average with a score of 0.55. County CCI scores in Kenya range from 0.10 in Manderu to 0.66 in Kisii (Figure 1).

**FIGURE 1. CCI SCORES BY COUNTY, KENYA**



Individual domain scores for Kenya range from 0.40 for family preferences to 0.80 for knowledge resources. Most counties in Kenya score highest in knowledge resources, but this dimension also has the largest range (from 0.00 in Manderla to 0.94 in Uasin Gishu). Family preference is the most consistently low-scoring domain across counties (Figure 2).

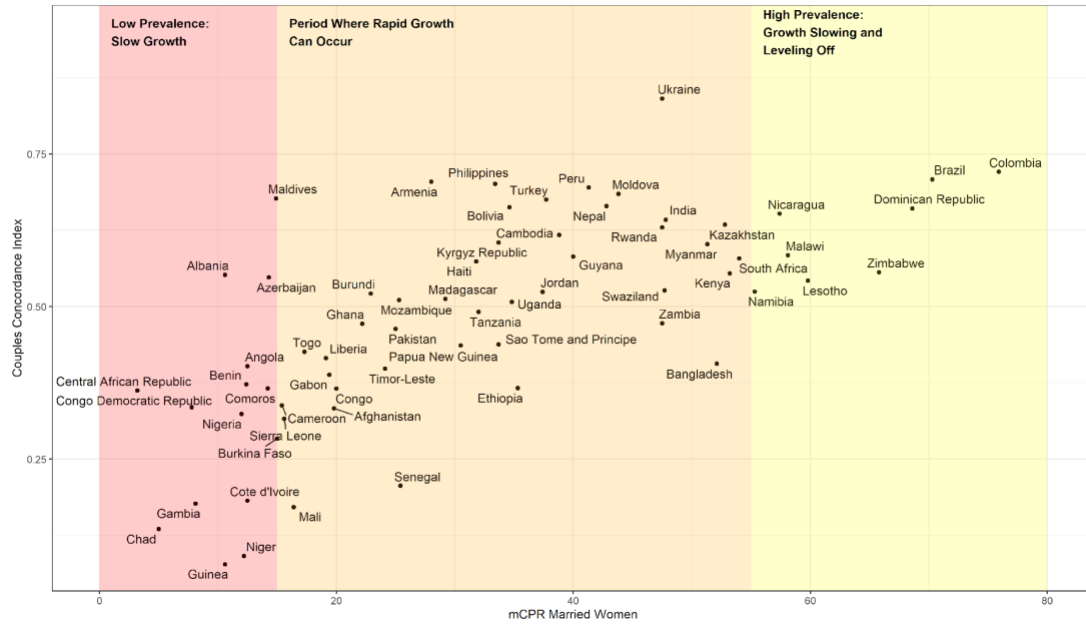
**FIGURE 2. DOMAIN SCORES BY REGION, TOGO**



## CCI AND CONTRACEPTIVE USE

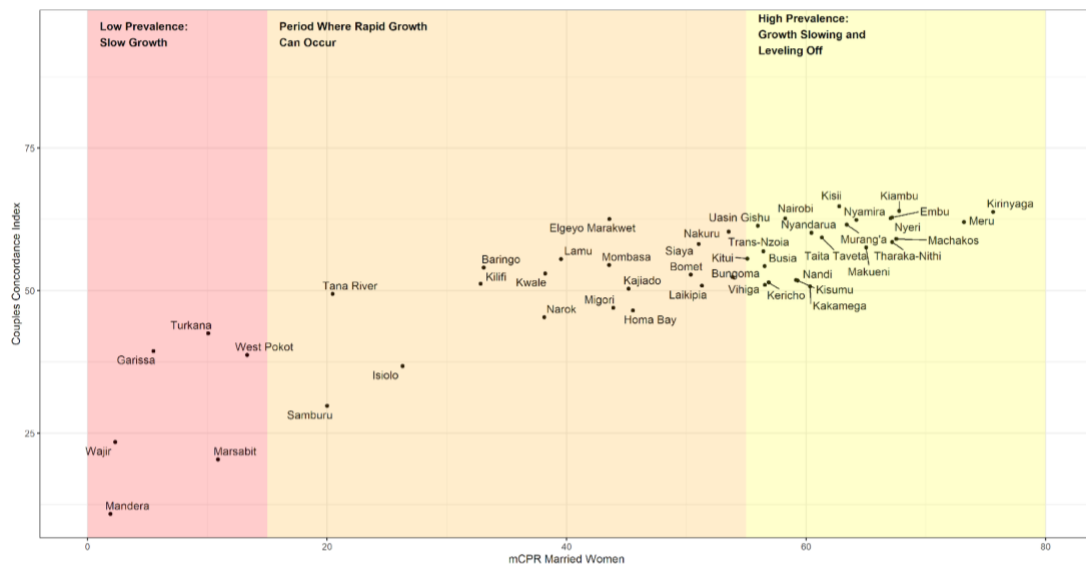
We found a strong relationship between the CCI and contraceptive use. No country in the analysis reached a high prevalence (i.e., greater than 55% of married women using modern methods) without a CCI of 0.55 or greater. Countries with the lowest CCI are also countries with low contraceptive prevalence.

**FIGURE 3. GLOBAL COUPLE CONCORDANCE AND MCPR OF MARRIED WOMEN**



Looking at the results for Kenya, we see a similar pattern, with the counties with higher CCI scores also having higher mCPR levels and vice versa.

**FIGURE 4. COUPLE CONCORDANCE AND MCPR OF MARRIED WOMEN, KENYA, 2014**



## 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. Further disaggregation of the CCI into the four domains allows policymakers to identify areas of focus for couples programming.

When we look at CCI scores alongside mCPR among married women, we see that despite a few exceptions, the two indicators track closely. The same pattern was true across counties in Kenya. This finding emphasizes the need for inclusive family planning programs that emphasize the role that both men and women play in contraceptive decision-making. The county-level analysis highlights that the regions with the lowest CCI also have the lowest mCPR. If policymakers are interested in lower-level planning, analysis of the CCI at the county level 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](http://www.track20.org/pages/data_analysis/in_depth/mCPR_growth/s_curve.php).

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