

Sex in the (Non) City:

Teen Childbearing in Rural America

SUMMARY

By Alison Stewart Ng and Kelleen Kaye



In Brief

Teen pregnancy and birth rates have been declining since the early 1990s and are currently at historic lows.¹ There has been significant progress in all 50 states and among all racial/ethnic groups. This national success story has been well documented and widely reported. Even so, many have wondered how specific segments of the population compare to others on rates of early pregnancy and childbearing. In particular, The National Campaign has received many questions about rural teens, and whether their rates were higher or lower compared to rates among more metropolitan (i.e. urban) teens.^a Speculation was essentially split down the middle—many assuming rates were higher among rural youth and others assuming the opposite.

In an effort to address this question, in 2013 The National Campaign released a first-of-its-kind analysis of teen childbearing in rural America. Our analysis showed that, in 2010 (the most recent data available by county when we began this project), the teen birth rate in rural counties was nearly one-third higher than the rate in the rest of the country, and rates have been falling more slowly in rural areas compared to metropolitan areas.²

As discussed later in this summary and in the full *Sex in the (Non) City: Teen Childbearing in Rural America* report, these higher teen birth rates reflect, among other things, more sexual activity among teens in rural areas and, among teens who are having sex, less use of contraception. Such differences raise a key question: what accounts for the disparity? Few would suggest that rural teens are intrinsically different from other teens—rather, they likely face a series of factors that increase their risk of early pregnancy and childbearing—factors that are more common, or more intense, in rural communities than in metropolitan areas.

We've heard from some rural providers that they face unique challenges in serving the needs of teens, such as teens' limited access to health services (especially those related to contraceptive care) and few transportation options for reaching those services, which in turn may raise the risk of teen childbearing in their communities. We've also been asked whether rural teen birth rates are higher because more rural teens get married and start their families early, or whether the higher birth rates are largely explained by differences in the racial/ethnic makeup of the local population. And, of course, it's common to hear that the higher rates of teen childbearing are explained by rural teens simply having too much time on their hands.

Yet, to date, there has been little in the way of empirical analysis exploring the determinants of teen childbearing across communities and across rural communities in particular. We wondered whether national data would echo the experiences of local providers, and what the data could tell us about the role of factors like marriage and race/ethnicity.

To better understand what factors account for the disparity in teen childbearing between rural and metropolitan areas, this report presents additional analysis—again, the first of its kind—that tackles three questions:

^a Throughout this report, we define rural counties to include those that are classified as “noncore” or “micropolitan” based on the Urban–Rural Classification Scheme published by the National Center for Health Statistics, while we use the term metropolitan to refer to all other counties.

- First, what factors are significant predictors of teen childbearing in *all* counties—rural and metropolitan—across the United States?
- Second, which of these risk factors are more prevalent in rural counties compared to metropolitan counties?
- Third, putting one and two together, how much does each risk factor contribute to the difference between rural and metropolitan teen birth rates?

To answer these questions, we first analyzed data on teen birth rates and numerous risk factors for all counties across the United States using a multivariate model that enabled us to look at all factors simultaneously. To the extent possible, our analyses also controlled for (or netted out) the effect of differences in access to abortion, which helps us ensure that our results primarily reflect differences in the chances that a teen will get pregnant in the first place, and not simply differences in whether a pregnant teen will obtain an abortion. This is discussed more in the full report and in the Technical Appendix (both of which are available online at <http://TheNationalCampaign.org/resource/sex-non-city>). In brief, our results indicate that:

- Reduced access to health services was linked to significantly higher teen birth rates across counties, where our measures reflect the availability of publicly funded clinics offering contraception as well as the number of doctors.
- A greater percentage of the population without health insurance was also linked to higher teen birth rates across counties, as were increased poverty and a greater percentage of female-headed households.
- Other significant risk factors included transportation barriers, fewer recreational instruction facilities, lower college enrollment, higher rates of binge drinking, and living in a county that was losing rather than attracting residents.

However, while these risk factors were linked to higher teen birth rates at the county level, not all were unique to rural counties specifically. For example:

- Although poverty rates were much higher in rural counties compared to metropolitan, risky behavior like binge drinking was only slightly higher.
- Transportation barriers existed in rural and metropolitan counties alike.
- Another risk factor associated with higher teen birth rates—the percentage of female-headed households—was actually lower in rural counties compared to metropolitan.

Taking into account which factors are significantly linked to higher teen birth rates, *and* which are more serious in rural areas, what factors explain the gap between rural and metropolitan teen birth rates?

- In the end, the most prominent factors explaining higher rates of teen childbearing in rural areas were college enrollment, poverty, access to health services, and whether the county was losing rather than attracting residents.
- Other factors such as transportation barriers, while significant predictors of teen birth rates across counties overall, played only a minor role in explaining the disparity between rural and metropolitan counties.
- Differences in the racial/ethnic composition of the population also accounted for very little of the disparity, as did marriage among teens.

Although the challenges faced by many rural communities are not easily addressed, teen childbearing among rural youth is neither culturally entrenched nor intractable. Our results, in combination with insights offered in the literature, suggest there is a way forward. Ensuring that teens have access to both contraceptive services and evidence-based programs focused on preventing teen pregnancy is an important start. Members of rural communities—particularly parents—may be more supportive of addressing topics related to teen pregnancy than some might think. Our results, along with their implications for teen pregnancy prevention efforts, are presented in a bit more detail in the rest of this summary and then discussed more extensively in the full report (available online at <http://TheNationalCampaign.org/resource/sex-non-city>).

SEX, CONTRACEPTION, AND CHILDBEARING: HOW DO RURAL TEENS COMPARE?

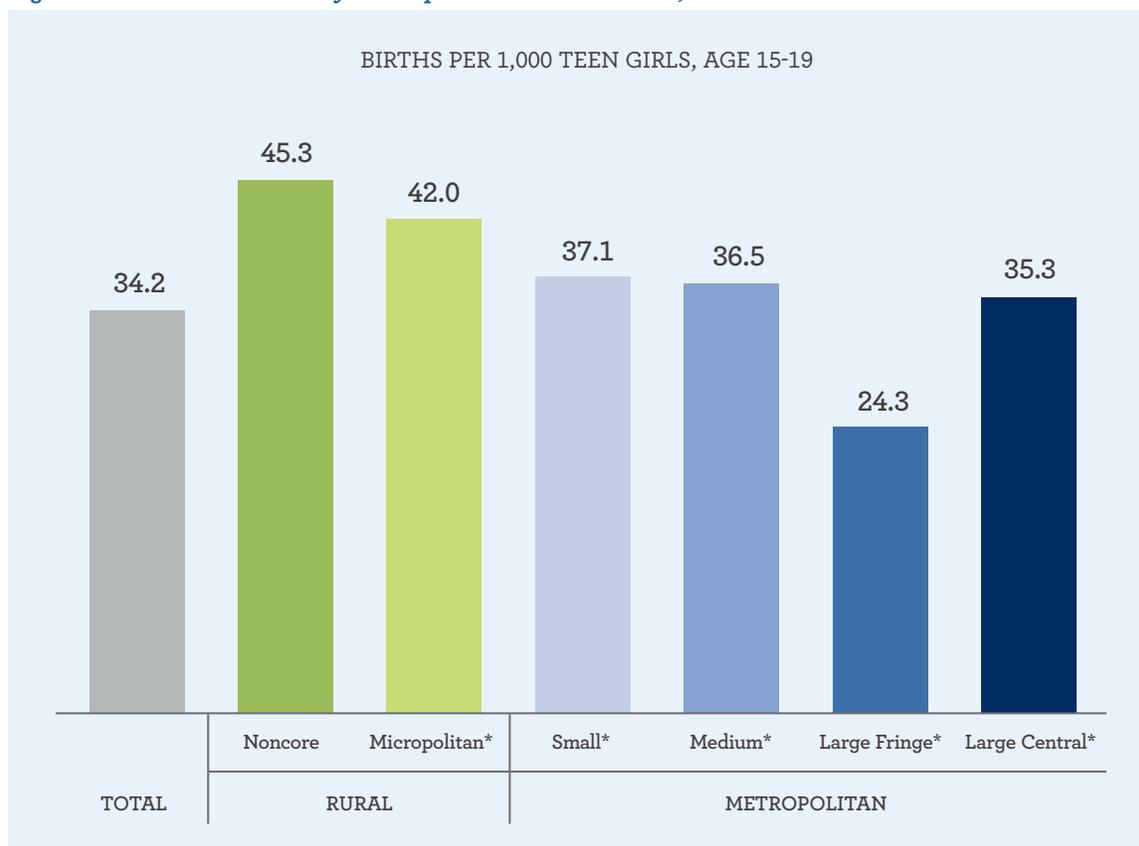
Of course, the two factors that directly put teens at risk for pregnancy are whether teens have sex and, if so, whether they use contraception effectively. Teens in rural counties are no exception. In fact, among girls age 15-19:

- Rural teen girls were significantly more likely to report they have ever had sex compared to metropolitan teen girls (55% vs. 40%), and significantly more likely to report they have had sex in the past three months (41% vs. 29%).
- Also, a significantly smaller percentage of rural teen girls used contraception the first time they had sex compared to metropolitan teen girls (71% vs. 81%).
- By contrast, among teen girls who are sexually active and using some type of contraception, those in rural areas tended to use hormonal methods more often compared to metropolitan teens, both the first time they had sex (42% vs. 24%) and the most recent time they had sex (65% vs. 49%).
- The health care safety net plays a particularly important role among rural teens. Our analysis shows that, among those seeking prescription contraception, rural teen girls were nearly twice as likely to rely on a community health center or clinic compared to metropolitan teens (24% vs. 13%).

Data on teen pregnancy rates by level of urbanization are not available, but we do have data on teen *birth* rates by urbanization, and our sense is that the two rates largely track each other.^b These data indicate that, although rural teens tended to choose more effective contraceptive methods, they remained at greater risk of teen childbearing, as shown in Figure 1, presumably due to their increased level of sexual activity and greater likelihood of using no method of birth control at all.

^b Particular counties, and possibly rural counties disproportionately, may have higher teen birth rates because pregnant teens have less access to abortion facilities and therefore may be more likely to have a birth instead of an abortion; however, for the most part, higher teen birth rates reflect the fact that a teen is more likely to get pregnant in the first place, rather than whether a pregnant teen has a birth instead of an abortion. This was the case when we compared national trends in teen birth and teen pregnancy rates over time, and when we compared teen birth and teen pregnancy rates across the subset of counties where we have measures of both rates.

Figure 1. Teen Birth Rates By Metropolitan Classification, 2010



2010 All County Natality File (Restricted Use), National Center for Health Statistics. *Differs significantly from "Noncore," p<.05

This disparity was not simply due to differences in the racial/ethnic composition of the population, and the pattern shown above is similar within every racial/ethnic subgroup.

- Furthermore, although teen birth rates have been falling across the nation over the past few decades, declines have been slower in rural counties—falling 31% between 1990 and 2010, compared to 43% for the nation overall and 50% in the most metropolitan (large central) counties.
- It should be pointed out that while teen birth rates are higher in rural areas, the majority (81%) of teen births still occur in metropolitan areas, which is not surprising given that 85% of teen girls live in metropolitan areas.

WHICH FACTORS PREDICT A COUNTY’S RATE OF TEEN CHILDBEARING?

To understand what accounts for more prevalent teen childbearing in rural areas, we first assessed the link between various potential risk factors and teen birth rates across counties—*all* counties, both rural and metropolitan. The results, summarized here and discussed more completely in the full report (available online at <http://TheNationalCampaign.org/resource/sex-non-city>), strongly support what many experts in the field have long believed to be true:

- Teen birth rates were significantly higher in counties experiencing greater financial hardship in the prior year. Each percentage point increase in the poverty rate was associated with a 1.3% increase in the teen birth rate, while each percentage point increase in the proportion of female-headed households is associated with a 3.4% increase in teen birth rates.
- Other economic indicators, possibly signaling a county's longer term outlook, were significant predictors as well. Teen birth rates were lower in counties that were attracting rather than losing residents and lower in counties where more young adults had enrolled in college as of the prior year (a 0.9% decrease in teen birth rates for each percentage point increase in enrollment).
- Greater availability of doctors and of publicly funded clinics that offer contraception were significantly associated with lower teen birth rates—0.2% lower for each additional doctor per 10,000 people and 0.5% lower for each additional clinic within 700 square miles (or roughly a 15 mile radius).
- Having a Primary Care Health Professional Shortage Area (HPSA) designation was also associated with lower teen birth rates. Though this may seem counterintuitive, it could reflect the fact that HPSA status can trigger action aimed at strengthening the network of clinical providers.
- Conversely, a one percentage point increase in the percentage of uninsured residents was associated with a 1.1% increase in a county's teen birth rate.
- Access to both public and private transportation were significant predictors of a county's teen birth rate, with higher rates where fewer households own a second car and lower rates in counties with greater access to public transit.
- Consistent with concerns over what teens do with too much time on their hands, we found that a county's teen birth rate was 0.7% lower for each recreational instruction facility per 100,000 people.

We caution against interpreting these results too literally, as many of our indicators are likely proxies for a broader set of related issues. Nonetheless, we think these results support the notion that economic adversity, lack of health services, limited recreational outlets, and transportation barriers all put a community at risk for higher rates of teen childbearing.

WHICH RISK FACTORS ARE MORE PREVALENT IN RURAL COUNTIES?

It is not surprising that rural counties are more disadvantaged than metropolitan counties when it comes to many of these factors, such as the number of nearby clinics and the availability of public transit systems. It may be less well known that they also are more disadvantaged when it comes to poverty, college enrollment, and health insurance—more disadvantaged even than large metropolitan centers. Perhaps equally surprising are those factors that are not dramatically different in rural counties. Examples of how these risk factors compare between rural and metropolitan counties include:

- Rural counties had 29% fewer doctors per person and 77% fewer public clinics nearby that offered contraception compared to metropolitan areas.

- The poverty rate was 26% higher in rural counties, and poverty was significantly higher in the most rural counties compared to every other point along the rural/metropolitan continuum.
- Similarly, the percent uninsured averaged 17% higher and college enrollment averaged 15% lower in rural counties.
- On the other hand, there were only slight differences in rates of unemployment, binge drinking, and vehicle ownership between rural and metropolitan counties.
- The percentage of teens who were married was low in both rural and metropolitan areas, ranging from 2% to 3%.
- The percentage of households that were female headed was actually higher in metropolitan counties—8% higher on average compared to rural counties.

WHICH FACTORS ACCOUNT FOR HIGHER RURAL TEEN BIRTH RATES?

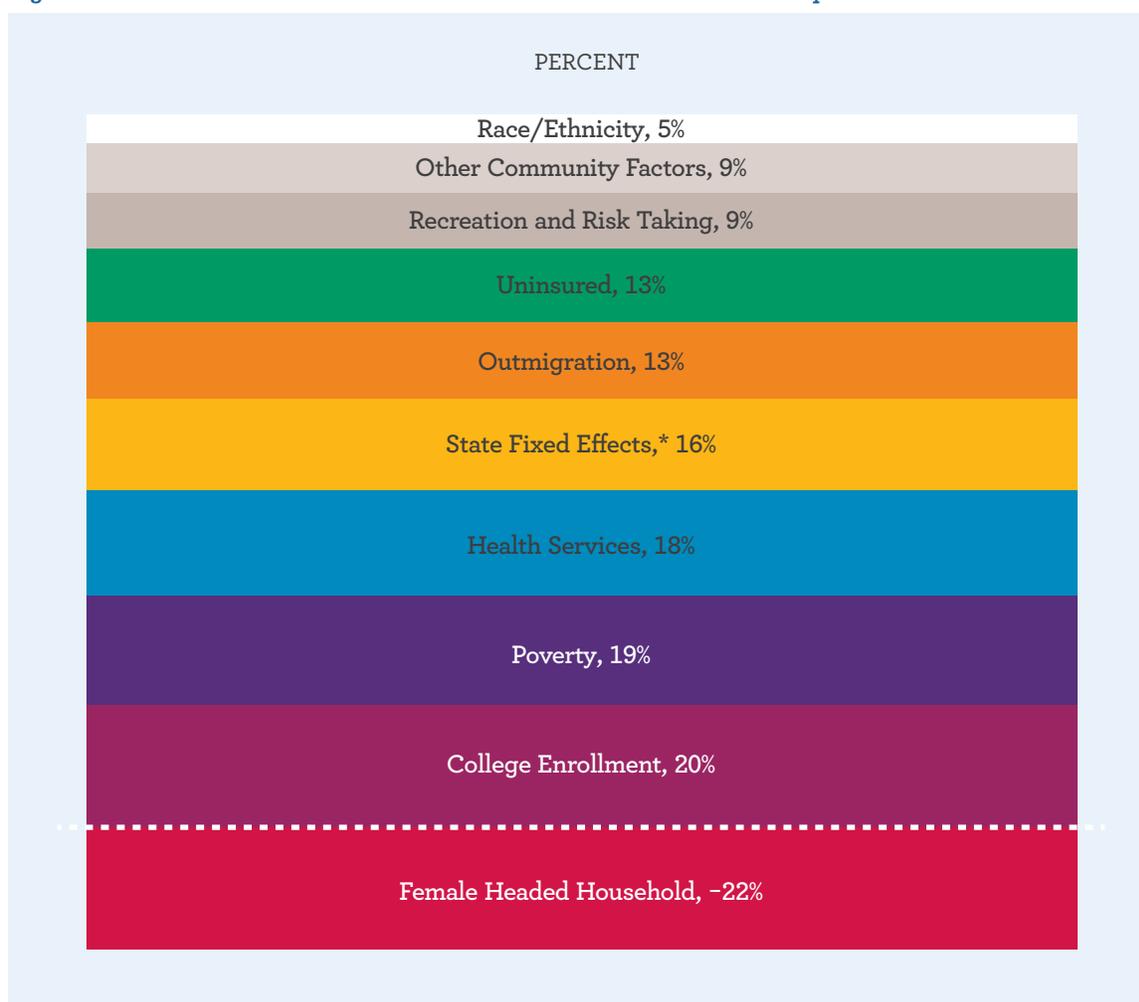
The most important contributors to the rural/metropolitan disparity in teen birth rates are those that have a large impact on teen birth rates *and* that are substantially worse in rural counties relative to metropolitan counties. Using decomposition analysis to factor in both of these criteria, we find:

- Lower rates of college enrollment among young adults in the prior year accounted for 20% of the difference between rural and metropolitan teen birth rates.
- The poverty rate accounted for 19% of the disparity.
- Another 18% can be attributed to the availability of publicly funded clinics offering contraception and other measures of health service availability.
- The percentage who are uninsured and the extent to which a county is losing or attracting residents each accounted for 13%.

Other factors contributed relatively little to the disparity between rural and metropolitan teen birth rates, either because they have a negligible impact on teen birth rates, or because they differ relatively little between rural and metropolitan counties. For example:

- Differences in the racial/ethnic composition of the population only accounted for 5% of the disparity in teen birth rates between rural and metropolitan counties.
- Some have speculated that teen birth rates are higher in rural areas because more rural teens get married and are ready to start their families at a young age. However, our results indicate that only 2% of the difference between rural and metropolitan teen birth rates was due to the rate of marriage among teens.
- Other factors that contributed relatively little to the disparity were transportation (3%), religiosity (3%), and other economic factors (1%) (which, along with marriage, make up the “Other Community Factors” in Figure 2).
- One risk factor—the percentage of households that are female headed—is actually less common in rural areas compared to metropolitan areas. As such, it reduces the rural/metropolitan disparity in teen birth rates, rather than adding to it. This is reflected as a negative entry in Figure 2.

Figure 2. What Accounts for the Difference Between Rural and Metropolitan Teen Birth Rates?



* State fixed effects capture unmeasured factors that are unique to each state. Their contribution can be thought of as the percentage of the disparity that is not explained by the other factors measured in our analysis. See the full report and Technical Appendix, both of which are available online at <http://TheNationalCampaign.org/resource/sex-non-city>, for details on methodology and definitions of factors.

IMPLICATIONS FOR TEEN PREGNANCY PREVENTION

The challenges faced by many rural communities are not easily addressed, yet teen childbearing has been declining everywhere, including in rural communities. Our results, in combination with insights offered in the literature, have a number of implications for preventing teen pregnancy in rural areas, highlighted here and discussed more completely in the full report (available online at <http://TheNationalCampaign.org/resource/sex-non-city>).

Our analysis shows that poverty and low college enrollment are major drivers of the rural/metropolitan disparity in teen birth rates, and the literature suggests these are often embedded within a broader dynamic of shrinking labor markets and the migration of young, educated workers toward more urban areas.³ This set of issues is complicated and important, and also beyond the scope of our report.

By contrast, improving access to clinical services that help teens plan and postpone childbearing may offer the most concrete, actionable opportunities for reducing teen

pregnancy, and doing a local assessment of the health care landscape can be a good place to start. This could include mapping the location of family planning services and tracking how enactment of the Affordable Care Act is affecting access to those services, as well as assessing local providers' attitudes and knowledge regarding contraception. This information could, in turn, inform strategies aimed at achieving the following broad goals:

- Protecting the public health care safety net. This is important everywhere, but especially so in rural areas where our analysis shows a greater share of the population lacked health insurance (at least as of 2010), and a greater share of teens relied on publicly funded clinics for reproductive health care.
- Improving access to the full range of contraceptive methods, including the most effective methods—long-acting, reversible contraception (or LARC). These methods may be especially beneficial in rural areas because they are nearly 100% effective and require very little effort on the part of the user for long periods of time.
- Ensuring that health care providers have adequate training regarding teen reproductive health and all methods of contraception. This may be especially important in rural communities, where, according to some studies, providers are, on average, less comfortable discussing contraception with teens and less familiar with LARC.⁴
- Including family doctors and advanced practice nurses in outreach efforts. Our analysis indicates that, on average, they make up a larger share of providers in rural settings.
- Ensuring that clinics are teen friendly, particularly when it comes to hours and confidentiality. This could play a pivotal role in rural communities where reaching a clinic can be difficult, patients are more likely to mention restricted hours as a barrier, and where everybody knows everybody.⁵
- Consider whether applying for designation as a HPSA might support changes that help strengthen the local network of providers.

Changing availability, access, and standards of care regarding teen contraceptive services in rural areas won't happen overnight, but much can be learned in this regard from working with Title X funded clinics. Studies show that clinics receiving Title X funding lead the way in terms of stocking and providing the most effective methods of contraception, and they are also required to ensure confidentiality when serving minors, which is particularly important to rural teens.⁶ At the same time, research suggests that rural Title X clinics face many of the same challenges as other rural clinics, and lag behind urban Title X clinics in their provision of the most effective methods of contraception.⁷ Ideally, best practices and improvements in care at rural clinics receiving Title X funds could be replicated at other publicly funded clinics and then in rural health care systems more broadly. In addition, it is important to promote collaboration among these systems to ensure high quality contraceptive care for teens.

Engaging school-based health centers might also be valuable in efforts to reduce teen pregnancy. Although only a small share of these clinics provide contraceptive services and many are restricted from doing so,⁸ it is worth exploring any role these clinics can play given the transportation barriers that many rural teens face reaching other clinics. In cases when these clinics are unable to provide contraceptive services, they may still be able to help with clinic referrals.

Though not a focus of our analyses, teen pregnancy prevention programs and community outreach can also play important roles. In particular consider:

- Using programs that have been proven effective in reducing teen pregnancy. Many programs are available, including some shown to reduce pregnancy among rural teens and including youth development interventions that address multiple risk factors such as educational attainment.⁹
- Surveying the community to document support for teen pregnancy prevention efforts, inform strategies, and form a basis for partnership. Parents, religious institutions, businesses, economic development leaders, and others can all be constructive allies and may not be as opposed to addressing topics related to teen sex and contraception as conventional wisdom suggests.

As discussed in the full report, there are a number of programmatic innovations that may offer particular promise in rural areas that face a shortage of providers or clinics and have limited transportation options for reaching them. For example, there is a growing list of digital resources containing medically accurate and age-appropriate information related to sexual education including our own StayTeen.org (for teens age 13–17) and Bedsider.org (for young people age 18–29). Also, there is an expanding role for “telehealth” in supplementing traditional clinical services.¹⁰

Finally, we note that the health care landscape is changing rapidly, due not only to changes following enactment of the Affordable Care Act, but other changes as well, such as the expanding role played by some pharmacies. While these developments offer many opportunities to improve access to health care, early assessments of what they imply for rural areas paint a picture that is complex and still emerging.

Broadly speaking, the reasons why teen pregnancy and childbearing are higher in some communities than others are more nuanced and complex than an analysis such as ours can fully explore. And, while further research is always helpful, the most important insights related to teen childbearing in rural areas are likely to come from the communities themselves. Therefore, the primary goal of this report is to spark conversations among community leaders, practitioners and experts in the field that can pick up where research leaves off—discussions that identify challenges and potential solutions unique to each community.

For a broader discussion of the data, methods, results, and conclusions summarized here, please see the full report available for download at <http://TheNationalCampaign.org/resource/sex-non-city>.

Sources

- 1 Martin, J.A., Hamilton, B.E., Osterman, M.J., Curtin, S.C., & Matthews, T.J. (2015). Births: Final data for 2013. *National Vital Statistics Reports*, 64(1), 1-68; Kost, K., & Henshaw, S. (2015). *U.S. teenage pregnancies, births and abortions, 2010: National and state trends by age, race and ethnicity*. New York, NY: Guttmacher Institute. Retrieved from <http://www.guttmacher.org/pubs/USTPtrends10.pdf>.
- 2 Ng, A.S., & Kaye, K. (2013). *Science Says 47: Teen childbearing in rural America*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from https://thenationalcampaign.org/sites/default/files/resource-primary-download/ss47_teenchildbearinginruralamerica.pdf.
- 3 Burton, L.M., Lichter, D.T., Baker, R.S., & Eason, J.M. (2013). Inequality, family processes, and health in the “new” rural America. *American Behavioral Scientist*, 57(8), 1128-1151; Kusmin, L., Gibbs, R., & Parker, T. (2008). Education's role in the metro-nonmetro earnings divide. *Amber Waves*, 6(1), 30-35. Retrieved from the U.S. Department of Agriculture, Economic Research Service website <http://www.ers.usda.gov/amber-waves/2008-february/educations-role-in-the-metro-nonmetro-earnings-divide.aspx#.VKb8gCtzRy4>.
- 4 Chuang, C.H., Hwang, S.W., McCall-Hosenfeld, J.S., Rosenwasser, L., Hillemeier, M.M., & Weisman, C.S. (2012). Primary care physicians' perceptions of barriers to preventive reproductive health care in rural communities. *Perspectives on Sexual and Reproductive Health*, 44(2), 78-83; Figueroa, E., Kolasa, K.M., Horner, R.E., Murphy, M., Dent, M.F., Ausherman, J.A., & Irons, T.G. (1991). Attitudes, knowledge, and training of medical residents regarding adolescent health issues. *Journal of Adolescent Health*, 12(6), 443-449; Lunde, B., Smith, P., Grewal, M., Kumaraswami, T., Cowett, A., & Harwood, B. (2014). Long acting contraception provision by rural primary care physicians. *Journal of Womens Health*, 23(6), 519-524; Vaaler, M.L., Kalanges L.K., Fonseca, V.P., & Castrucci, B.C. (2012). Urban-rural differences in attitudes and practices toward long-acting reversible contraceptives among family planning providers in Texas. *Womens Health Issues*, 22(2), e157-162.
- 5 Martins, S., Damm, K., Hellerstedt, W., & Gilliam, M. (2014). *Rural/Urban differences in family planning service provision: A survey of Title X clinics in Great Plains and Midwestern United States*. Paper presented at the Population Association of America (PAA) Annual Meeting, Boston, MA. Retrieved from <http://paa2014.princeton.edu/papers/143033>; Elliott, B.A., & Larson, J.T. (2004). Adolescents in mid-sized and rural communities: Foregone care, perceived barriers, and risk factors. *Journal of Adolescent Health*, 35(4), 303-309.
- 6 Park, H.Y., Rodriguez, M.I., Hulett, D., Darney, P.D., & Thiel de Bocanegra, H. (2012). Long-acting reversible contraception method use among Title X providers and non-Title X providers in California. *Contraception*, 86(5), 557-561; Elliott & Larson, 2004; Rosenbaum, S., Wood, S., Cunningham, M., Beeson, T., & Shin, P. (2014). *Implications of the 2014 quality family planning services guidelines issued by the CDC and the Office of Population Affairs*. Retrieved from the Milken Institute School of Public Health at George Washington University website <http://publichealth.gwu.edu/pdf/hp/health-centers-family-planning-update.pdf>; Office of Population Affairs (OPA). (2014). *Program Requirements for Title X Funded Family Planning Projects*. Washington, DC: U.S. Department of Health and Human Services (HHS). Retrieved from <http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf>.
- 7 Martins et al., 2014; Vaaler et al., 2012.
- 8 Lofink, H., Kuebler, J., Juszczak, L., Schlitt, J., Even, M., Rosenberg, J., & White, I. (2013). *2010-2011 census report of school-based health centers*. Washington, DC: School-Based Health Alliance. Retrieved from <http://www.sbh4all.org/atf/cf/%7B241D183-DA6F-443F-9588-3230D027D8DB%7D/2010-11%20Census%20Report%20Final.pdf>; Santelli, J.S., Nystrom, R.J., Brindis, C., Juszczak, L., Klein, J.D., Bearss, N., ...Schlitt, J. (2003). Reproductive health in school-based health centers: Findings from the 1998-99 census of school-based health centers. *Journal of Adolescent Health*, 32(6), 443-451.
- 9 Cronin, J., Heflin, C., & Price, A. (2014). Teaching teens about sex: A fidelity assessment model for Making Proud Choices. *Evaluation and Program Planning*, 46, 94-102; Stanton, B., Guo, J., Cottrell, L., Galbraith, J., Li, X., Gibson, C., . . . Harris, C. (2005). The complex business of adapting effective interventions to new populations: An urban to rural transfer. *Journal of Adolescent Health*, 37(2), 163.e117-163.e126; Hubbard, B.M., Giese, M.F., & Rainey, J. (1998). A replication study of Reducing the Risk, a theory-based sexuality curriculum for adolescents. *Journal of School Health*, 68(6), 243-247; Allen, J.P., Philliber, S., Herrling, S., & Kuperminc, G.P. (1997). Preventing teen pregnancy and academic failure: Experimental evaluation of a developmentally based approach. *Child Development*, 68(4), 729-742.
- 10 Health and Resources Service Administration (HRSA). (2014). *Telehealth*. Retrieved from <http://www.hrsa.gov/ruralhealth/about/telehealth/>; Lustig, T. (2012). *The role of telehealth in an evolving health care environment: Workshop summary*. Washington, DC: The National Academies Press. Retrieved from <http://www.ic4n.org/wp-content/uploads/2014/06/1oM-Telehealth-2012-Workshop-Summary.pdf>; Vestal, C. (2014, March 7). Expanding telemedicine beyond state borders. *USA Today*. Retrieved from <http://www.usatoday.com/story/news/nation/2014/03/07/stateline-telemedicine-expansion/6159775/>; Planned Parenthood. (2014). *Video Visit [Application]*. Retrieved from <http://www.plannedparenthood.org/get-care/online/video-visit>.



Mission

Our mission is to improve the lives and future prospects of children and families and, in particular, to help ensure that children are born into stable, two-parent families who are committed to and ready for the demanding task of raising the next generation.

Our strategy is to prevent teen pregnancy and unplanned pregnancy, especially among single, young adults. We support a combination of responsible behavior by both men and women and responsible policies in both the public and private sectors.

When we are successful, child and family wellbeing will improve. There will be less poverty, more opportunities for young men and women to complete their education or achieve other life goals, fewer abortions, and a stronger nation.

www.TheNationalCampaign.org

www.Bedsider.org

www.StayTeen.org
