



**WHAT
IS
SRA?**

What is Sexual Risk Avoidance (SRA) Education?

SRA is a sex education approach based on a recognized and often used public health model known as “risk avoidance” or “primary prevention.”

It differs from a “risk reduction” model in that it seeks to help individuals eliminate all risk as opposed to simply reducing risk. Sexual Risk Reduction (SRR), often called Teen Pregnancy Prevention or “Comprehensive” sex education is primarily focused on increasing contraceptive use among teens. SRR approach normalizes teen sex and is considered a “secondary prevention” strategy.

How does SRA education differ from Sexual Risk Reduction (SRR) or so-called “comprehensive sex education” (CSE)?

There are vast differences between SRA education and SRR comprehensive sex education. The major distinction is how each approach regards teens. SRA education believes teens can avoid sex and CDC trend data shows, in increasing numbers, they are doing so. Discussions empower teens to make the healthy decision to wait for sex regardless of their previous sexual experience. By contrast, SRR assumes that teens can't or won't avoid sexual experimentation; so the majority of their time is spent talking about sex - using condoms and other forms of contraception with a view to simply reduce, rather than eliminate, sexual risk among teens.

Is there evidence that SRA programs are effective?

Yes. There are currently 25 peer-reviewed studies showing that students in SRA classes are: a) more likely to delay sexual initiation, and b) if sexually active, more likely to discontinue or decrease sexual activity and no less likely to use a condom. In addition, the latest CDC research on youth and sex shows that most teens have not had sex - and that percent has improved 28% in the past 20 years.

Why is SRA education a superior approach that all youth deserve to receive?

Sexual Risk Avoidance education is science-based and focused on helping youth achieve optimal health outcomes. In an increasingly sexualized culture ALL youth, regardless of orientation or past sexual experience, need and deserve the information and skills that can help them make choices that can eliminate risk. Those who promote programs that normalize teen sex as an expected adolescent behavior sell our youth short to the soft bigotry of low expectations. In addition, a recent Barna survey revealed that about 40% of teens say that sex education makes them feel pressured to have sex, contradicting the claim by “comprehensive” sex education advocates that they prioritize “waiting.”

Is SRA education relevant to gay teens?

Absolutely. Encouraging young people, irrespective of their sexual orientation, to delay sex promotes equality in health for all. SRA programs share universally transferable principles from which all students can benefit

including:

- Sexual delay
 - Fewer lifetime partners
 - Developing healthy relationships
 - Setting boundaries
- Reserving sex for a lifetime, faithful, monogamous and uninfected partner are protective factors that help all teens avoid risk

In addition, the holistic nature of SRA programs address broader, generalized topics regarding adolescent development relevant to all teens.

Is the SRA message relevant to sexually active teens?

Sexually experienced teens receive the skills and positive empowerment to make healthier choices in the future as a result of SRA education. A published study demonstrated that those enrolled in an SRA program were much more likely to choose to abstain than their sexually experienced peers who did not receive SRA education. And further, about one half of sexually active 18- and 19-year olds wish they had waited longer before becoming sexually active. The SRA message is important to all teens regardless of orientation or sexual experience. Every teen deserves to receive the knowledge and skills needed to achieve optimal health

To do otherwise exhibits an unacceptable form of “advantage discrimination” to those at greatest risk.

Why are SRA programs important to helping teens become successful adults?

SRA programs focus on the whole person by sharing the importance of healthy decision-making to future life outcomes. Programs teach the skills of the success sequence, which dramatically reduce the chance that youth will live in poverty as adults, if they implement, in sequence, these things: finish school, get a job, and then have children after marriage. If teens adopt these behaviors, they risk only a 2% chance of living in poverty as adults. In addition, SRA programs discuss the components of healthy relationships, future family formation, and the impact that waiting for sex can have on academic success. Research shows that teens who wait to have sex increase their chances for a happier marriage, healthier future family, a life of personal responsibility, and productive citizenship. The research also reveals that when teens have sex, besides the risk of pregnancy and STDs, the following negative life outcomes are more likely to occur, often persisting into adulthood:

- Less academic achievement (not necessarily linked to pregnancy)
- Decreased general physical and psychological health, including depression
- More involvement in other risky behaviors such as smoking, drinking, and drugs
- More likely to participate in anti-social behavior or delinquent behavior
- Less financial net worth and more likely to live in poverty

Conclusion: In light of the overwhelming evidence supporting the benefits of the SRA message to the health and well-being of teens, The Bridge is committed to championing SRA education as the best approach to help teens thrive now and enter adulthood prepared to achieve optimal health and life success.

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1 Ascend (2016) SRA Works. Washington, DC

2 US Department of Health and Human Services & the Administration for Children and Families (2007, May). Review of Comprehensive Sex Education Curricula.

3 CDC (2016) Youth Online: 2015 YRBS Survey Results. Atlanta: Author.

4 Institute for Youth Development (2011). A consultation report on sexual risk avoidance programs and contraceptive information. Washington D.C.: IYD. Page 3.

5 National Center for Health Statistics. (2015, Nov) Key statistics from the National Survey of Family Growth – T Listing. National Survey of Family Growth.

6 CDC (2016) Youth Online: 2015 YRBS Survey Results. Atlanta: Author.

7 Barna Group (2015). Teens Speak Out. Ventura: Author

8 Tobacco Control Programs. (2014, February 10). Retrieved June 22, 2015, from http://www.cdc.gov/tobacco/stateandcommunity/tobacco_control_programs/index.htm

9 Sandfort, T. G., Orr, M., Hirsch, J. S., & Santelli, J. (2008). Long term health correlates of timing of sexual debut: Results from a national US study. *American Journal of Public Health, 98*(1), 155–161.

10 Sandfort, T. G., Orr, M., Hirsch, J. S., & Santelli, J. (2008). Long term health correlates of timing of sexual debut: Results from a national US study. *American Journal of Public Health, 98*(1), 155–161.

11 Centers for Disease Control. (2016) HIV Basics/Prevention Retrieved June 17, 2016 at <http://www.cdc.gov/hiv/basics/prevention.html>

12 Centers for Disease Control (2016). Sexual Violence: Risk & Protective Factors Atlanta: CDC. Retrieved on June 17, 2016 at <http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.htm> Rape, Abuse & Incest National Network (RAINN). (n.d.) Ways to reduce your risk of sexual assault.

13 Centers for Disease Control and Prevention (2013) Condoms and STDs: Fact sheet for public health personnel. Accessed on June 17, 2016 at <http://www.cdc.gov/condomeffectiveness/latex.html>

14 Borawski, Trapl, Lovegreen, et al. (2005). Effectiveness of abstinence-only intervention in middle school teens. *American Journal Health Behavior*

15 Barna Group. (2015). Teens Speak Out survey. Ventura: Author. Albert, B. (2012). With One Voice 2012. Washington, DC: the National Campaign to Prevent Teen Pregnancy. Retrieved March 18, 2015 at

https://thenationalcampaign.org/sites/default/files/resourceprimary-download/wov_2012.pdf This older survey shows that among younger teens, the regret is even more pronounced.

16 Mosack, M. (2007). Well Said: Using Language that Leads - An Abstinence Educators Guide to Effective Communication. HHS Technical Assistance Module, Washington, D. C.: Administration for Children and Families, Pal-Tech Contract, p. 15.

17 Barna Group. (2015). Teens Speak Out survey. Ventura: Author.

18 Magnusson, B., Nield, J. Lapane, K., (2015, Feb 7). Age at first intercourse and subsequent sexual partnering among adult women in the US, a cross sectional study. *BMC Public Health. 15*:98.

19 Kagesten, A., Blum, R (2015, April) Characteristics of youth who report early sexual experiences in Sweden. *Archives of Sexual Behavior. 44*:679-694

20 Sandfort, T., Orr, M., Hirsch, J., Santelli, J. (2008) Long-Term Health Correlates of Timing of Sexual Debut: Results From a National US Study *American Journal of Public Health. 98*:155-161

21 Kastborn, A., Sydsjo, G., Bladh, M., Preibe, G., Svedin, C. (2015, May 4). Sexual debut before the age of 14 leads to poorer psychosocial health and risky behavior in later life. *Acta Paediatrica 104*: 91-100.

22 Armour, S., Haynie, D. (2007) Adolescent Sexual Debut and Later Delinquency. *J Youth Adolescence 36*:141–152

23 Kastborn, A., Sydsjo, G., Bladh, M., Preibe, G., Svedin, C. (2015, May 4). Sexual debut before the age of 14 leads to poorer psychosocial health and risky behavior in later life. *Acta Paediatrica 104*: 91-100.

24 Scott, M., Wildsmith, E., Welti, K., Ryan, S., Schelar, E., Steward-Streng, N. (2011). Risky Adolescent Sexual Behaviors and Reproductive Health in Young Adulthood. *Perspectives on Sexual and Reproductive Health. 43*(2):110–118,