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Implementation Evaluation of Re:MIX in Travis County, Texas

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IMPLEMENTATION EVALUATION ABSTRACT: THE EVALUATION OF RE:MIX IN TRAVIS COUNTY, TEXAS

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Intervention Name

Re:MIX

Intervention Description

Re:MIX is a comprehensive, in-school health curriculum and teen pregnancy prevention (TPP) program for adolescents. It covers a broad range of topics related to sexual health and youth development including healthy relationships, communication, gender, consent, reproductive anatomy, disease prevention, contraception, sexual decision making, clinics, parenthood, and life planning. Re:MIX also aims to connect students and peer educators with community resources and links to services. The Re:MIX curriculum teaches mixed-gender groups of students in grades 8 to 10 to delay sex and use contraception if they are sexually active. A co-facilitation team of peer educators (who are young parents), alongside professional health educators, delivers the information using non-traditional approaches, such as game-based tools, technology, and storytelling. Youth receive just over nine hours of the program over one semester (55 minutes per week for 10 weeks, during regular school hours).

Comparison Condition

Healthy Youth, Healthy You or standard program

Comparison Condition Description

In the control classes, schools could choose to implement an alternative program, Healthy Youth, Healthy You, in part or in full, or their standard program. Control classes did not include sexual health topics. Healthy Youth, Healthy You comprises approximately 10 hours of classroom-based curriculum, delivered through 10 sessions that are approximately 55 minutes each.

Developed for grades 8 to 12, it focuses on health topics that include nutrition, mental health, and fitness. EngenderHealth staff provided the Healthy Youth, Healthy You curriculum and delivered a brief training for teachers from each partner school, so that they could lead the sessions in their comparison-condition classes.

Sample and Setting

This evaluation took place in three public charter schools in Travis County, Texas. The evaluation team recruited students in select classrooms in grades 8 through 10 of the three study schools. To be eligible for the study, participants had to be in 8th, 9th, or 10th grade; have parental consent; and provide assent. The evaluation enrolled 626 youth across 57 classes in five semester cohorts across two years.

Research Design

The research design was a cluster-level randomized controlled trial. In total, the evaluation team randomly selected 57 classrooms across three schools over five semesters to participate in the Re:MIX intervention group or comparison group. At the beginning of each semester or before the semester began, the evaluation team sent home consent and assent forms to all students in the selected classrooms. The study team had checks in place to ensure that no student participated in the study more than once. Students who provided parental consent and student assent received a baseline survey. After baseline surveys were complete, the evaluation team randomized classes within each grade level and school and provided the schools with the randomization results. Students who did not consent to participate in the evaluation could still participate in the program and stayed in the classroom during implementation. Parents could choose to opt their child out from the program; these students left class when program staff delivered the program. Youth in both the intervention and control groups received a three-month immediate post-intervention survey (posttest survey) and a 12- to 18-month long-term follow-up survey. The evaluation team conducted in-person online surveys at all survey points. In-person surveys were administered by either graduate student partners at the University of Texas at Austin or EngenderHealth staff. Staff scheduled survey administration dates at each school and back-up survey days to catch any students who were absent. If youth were not in school for the follow-up surveys, the evaluation team contacted them via phone, email, and text message to complete the online survey. However, the evaluation team reached out to very few youth for remote survey administration because in-person data collection was so successful.

Implementation Research Questions

Implementation research questions included: How many youth and classes were recruited and served? How many sessions were delivered? How often did youth attend sessions? Were sessions implemented with strong fidelity and high quality? And, what kind of programming did control youth receive? The body of the report includes more detailed research questions.

Key Implementation Findings

The study team found that Re:MIX was successful in recruiting classes and youth from the target population and continued program delivery and study activities across five semesters at three partner schools. The study team experienced some challenging with overcoming high study opt out rates but found that sending home informational flyers about Re:MIX with students was effective in improving opt out rates. Youth consistently attended program sessions and Re:MIX facilitators delivered all 10 program sessions to each treatment-condition class. Trained observers—as well as facilitators, school staff, and students—gave high ratings to the Re:MIX program and the facilitators. At the time of the posttest survey, youth who received the Re:MIX program were more likely than youth in the control group to report having received information on sexual and reproductive health (SRH) at school. The study team is unaware of any contamination effects from the treatment group, however, given the design of the study this was difficult to monitor. Overall, the unique co-facilitation component of Re:MIX, which paired young parent peer educators with trained health educators to deliver program content, was well-executed and well-received. However, the study team did encounter challenges with this model, such as how to address the unique and sensitive needs of peer educators, how to retain them, and how to balance the roles of peer and health educators to ensure effective co-facilitation.

IMPLEMENTATION EVALUATION OF RE:MIX IN TRAVIS COUNTY, TEXAS: FINDINGS FROM AN INNOVATIVE TEEN PREGNANCY PREVENTION PROGRAM

I. Introduction

This report presents findings from the implementation evaluation of Re:MIX, a sexual health education program aimed at reducing rates of unplanned pregnancy and sexually transmitted infections (STIs). Re:MIX was implemented in Travis County, Texas (which includes the city of Austin) with a population of mostly Latino students in grades 8–10. The implementation evaluation was conducted as part of cluster-level randomized controlled trial of Re:MIX performed under a grant from the Office of Population Affairs (OPA) (formerly the Office of Adolescent Health) in the U.S. Department of Health and Human Services (HHS). This report includes information on the Re:MIX intervention, the comparison condition, and the contextual factors that affected the way Re:MIX was delivered to participants. The report also addresses research questions relate to the population served; program adherence, dosage, and quality; and information on the counterfactual and context.

EngenderHealth developed the Re:MIX curriculum for a population at high risk for teen pregnancy: Texas teenagers. In 2014, Texas had one of the highest rates of teen births in the U.S., and rates for Travis County exceeded national averages for both younger (age 10-14) and older teens (ages 15-19).¹ Nationally, Texas had the fifth-highest statewide birth rate among teenagers, the fourth-highest in teenage pregnancies, and the highest rate of repeat births among teenagers ages 15 to 19.²

Re:MIX was implemented in three K-12 charter schools located in the zip codes associated with the highest number of teen pregnancies in Travis County. Two of the three study schools were also considered higher risk schools. These schools were 88 and 84 percent Hispanic, respectively (much higher than the 58 percent average for the school district), and 99 and 89 percent economically disadvantaged, respectively, compared with 53 percent for the school district overall.³ As a whole, the area served by the study schools was historically underserved in terms of social and public services.

Re:MIX provides age-appropriate, medically accurate, and factual information on a broad set of topics related to human development, healthy relationships, gender, decision making, contraception, and the prevention of sexually transmitted infections (STIs). It pairs peer educators who are young parents with professional health educators to co-facilitate the curriculum.

EngenderHealth designed Re:MIX specifically to address needs and gaps identified in existing adolescent sexual health programming. In 2014, researchers from the Child and Family Research Institute at the University of Texas at Austin collaborated with EngenderHealth to complete a comprehensive teen pregnancy prevention (TPP) needs assessment in order to increase understanding of the supports and barriers related to preventing teen pregnancy in Travis County. The following recommendations emerged from that assessment:

- Create a gender-transformative approach to address unhealthy gender norms and relationship dynamics.
- Provide more information about, and greater access to, educational and occupational opportunities as pathways to adulthood.
- Provide more youth-driven programs, especially with teen parents serving as peer educators.

Re:MIX responds to these identified needs and recommendations. Youth were engaged throughout the development of the Re:MIX curriculum, which was paramount to ensuring the program was relevant, meaningful, and inclusive for all of the target population. This included specific engagement of LGBTQ and parenting youth early in the development and editing processes before implementation began. Feedback was also solicited from a medical-accuracy review panel around autonomy over decision-making and was significant to the final curriculum content.

Formative research also confirmed that peer educators sharing their experiences could heighten adolescents' receptiveness to curriculum content, messages, and skill-building activities (see Appendix A). Focus groups, participant surveys, and in-depth interviews with adolescents and teen parents confirmed that youth felt they would learn more if young parents were included as facilitators. A task force of key stakeholders and youth representative of the intended population led the development of a logic model, the design of program implementation and core components, and the direction of the evaluation plan. More information on the curriculum design process is included in section II.A.

II. Intervention and Comparison Condition Description

A. Description of Intervention as Intended

Re:MIX Description

Re:MIX employs a new approach to TPP, engaging and empowering youth through activities that are fun and relevant. Educators use role play, and movement methodologies to encourage students to tap into their creative, expressive, and collaborative selves and build knowledge and critical thinking in all aspects of their lives, including their sexual lives. The program's goal is to empower and educate in-school adolescents and young parents with opportunities to learn and practice the crucial skills teens need to make informed, healthy, and safe life decisions in order to lead healthy lives. Re:MIX has three components: a curriculum, a professional development and leadership program for the peer educators, and a community health services linkage system that connects youth and peer educators with local resources and services through a mobile app.

Intervention

Re:MIX supports youth to “Maximize their strengths, Imagine a healthy future, and eXplore their identities.” The Re:MIX curriculum was developed by EngenderHealth based on formative

research and social influence approaches, including Social Cognitive Theory and Social Learning Theory (see Appendix A). The theories highlight how peers may influence attitudes and behaviors through modeling observed and learned behaviors. Re:MIX was also developed with a focus on positive youth development and empowerment strategies for engaging young people in their own health care. The Re:MIX curriculum consists of ten 55-minute-long sessions taught by a professional health educator, partnered with a young parent educator (aged 18-27). Young parent and health educators were generally representative of the populations served by the program, most of whom were Hispanic. The educators participate in a 40-hour training program and the co-facilitation team delivers information using game-based tools, technology, and role play techniques, in addition to storytelling. Young parent educators share stories about their experiences as parents and encourage youth to share their current experiences and knowledge, along with what they are learning and experiencing in the program. The program covers a range of educational topics: 1) healthy relationships, 2) positive communication strategies and consent, 3) the importance of delaying sexual activity, 4) reproductive anatomy, safe and effective contraceptive methods, and how to prevent STIs and unwanted pregnancies, 5) enhancing more equitable gender norms, and 6) teen friendly health services and resources available in the community.

See Table II.1 for additional details.

Table II.1. Table of Program Components

Program Component	Format of Service	Hours of Component Provided (Dosage)	Content Delivered
Curriculum	Group sessions in classrooms	9 hours 10 minutes	<ul style="list-style-type: none"> • Exploring gender and values • Relationships, communication, and consent • The ABCs of prevention • Planning for the future
Professional development and leadership program for peer educators	Group sessions, independent projects, individual mentoring	240 hours	<ul style="list-style-type: none"> • Personal motivation • Accountability • Communication • Leadership
Community health services linkage	Youth guide, mobile app	N/A	<ul style="list-style-type: none"> • Sexual reproductive health (SRH) services • Mental health services • Housing and shelter services • Parenting resources

The Re:MIX Curriculum

The Re:MIX curriculum includes 10 sessions that are each 55 minutes, grouped into four units:

Unit 1: Exploring Gender and Values introduces the storytelling thread and explains the gender lens, which strongly influences sexual and reproductive health (SRH) decision making, choices, attitudes, and behaviors. Unit 1 includes two sessions.

Unit 2: Relationships, Communication, and Consent explores characteristics of healthy and unhealthy relationships and connects these to SRH by building communication skills and awareness related to how to ask for and give consent. Unit 2 includes three sessions.

Unit 3: The ABCs of Prevention introduces the basics of puberty, anatomy, and STIs. It explores the options for preventing pregnancy and STIs, including abstinence, birth control, and condoms, and takes participants through a hypothetical health clinic and a decision-making process. Unit 3 includes three sessions.

Unit 4: Planning for the Future returns to the goal-setting themes explored in Session 1, as youth take stock of their current and future lives while exploring how an early, unplanned pregnancy could affect those goals. Unit 4 includes two sessions.

For more detailed information regarding the Re:MIX framework, please see this [fact sheet](#).

Professional Development and Leadership Program

Re:MIX peer educators participate in a Professional Development and Leadership Program (PD&LP), which aims to improve professional development and workforce skills through a range of activities, coupled with teaching Re:MIX in the partner schools.

EngenderHealth developed the PD&LP component in response to the high needs of and lack of support for young parents in Travis County, where many young parents find themselves in low-paying, entry-level jobs that do not offer schedule flexibility or the opportunity for advancement.³ The PD&LP aims to provide young parents with skills to identify and reach their professional goals through a series of trainings focused on professional development, parenting skills, active community engagement, and special projects—all in addition to facilitating the Re:MIX curriculum.

The program focused on four major competency domains: personal motivation, communication, accountability, and leadership. These domains encompass critical hard and soft skills needed to be successful in postsecondary education, the workforce, and society.

The intended outcomes for the PD&LP include:

- Increased knowledge and experience in four professional development competencies
- Established short- and long-term career goals and a plan for achieving them
- Increased financial management skills
- Increased social-emotional connectedness to mentors, staff, other peer educators, and the community
- Increased knowledge of community resources and services
- Increased attainment of postsecondary education and job training

Find out more about the [peer educator model](#).

Community Health Services Linkage System

Re:MIX aims to connect all program participants to youth-friendly health services in the community. As a supplement to curriculum activities, Re:MIX provides each classroom

participant and peer educator with a youth-friendly resource guide focused on services in their local area. The project initially provided this guide in print, and then later in app form, to maintain its relevancy and usability with teens. The goal is to provide youth with the tools and resources necessary to make confident decisions and to help them access the services that are best for their health. The guide empowers them to visit community-based providers who exemplify accessible, relevant, and inclusive supports and services for youth. The app has been available in app stores for Austin-area youth since year 3 of the project, and will be removed from the app store upon closure of the Re:MIX project in June 2020.

The print and app guides received a robust vetting process in the pilot year, engaging diverse youth from the community and the peer educators. Additionally, Re:MIX trained all health and peer educators on how to use the guide in the classroom and for making referrals to services.

Special Requirements of Staff

A review of all Re:MIX content and components identified some features essential to ensure a high-quality staff, including the following:

- Peer educators should be parents themselves and come from similar backgrounds as the students
- Health educators should have a demonstrated proficiency in adolescent health generally, preferably with knowledge of basic sexual reproductive health, as well as basic experience in facilitating youth groups
- Core project staff (managers and coordinators) should have demonstrated experience and knowledge in adolescent development, youth health, and parenting youth
- A demonstrated understanding of inclusive practices and Spanish-speaking capabilities to best connect with program participants

B. Description of Comparison Condition

Teachers in control classes could implement either their standard program or part or all of a curriculum developed by EngenderHealth called Healthy Youth, Healthy You. Like Re:MIX, the Healthy Youth, Healthy You curriculum was designed to be delivered in 10 once per week sessions for 55 minutes each. The curriculum included health-related information and lessons on the benefits of sleep and exercise, hygiene, drugs and alcohol prevention, stress and mental health, bullying, and positive influencers. The alternative curriculum did not include any sexual health topics. Each comparison-condition teacher reported how they chose to teach their class to the study team at the end of the semester. Whichever option the comparison-condition teachers chose, they were instructed not to teach health topics covered in Re:MIX, in order to prevent contamination across study groups. The control classes did not receive the mobile app and peer facilitators did not participate in comparison classes.

III. Implementation Evaluation

In this section, we present the research questions, data sources, and methods for the implementation evaluation.

A. Implementation Research Questions

The evaluation posited several key implementation research questions, described in Table 3.1.

Table III.1. Table of Program Components

Domain	Research Question
Study Sample	<ol style="list-style-type: none"> 1. How many classes were recruited for the study? 2. How many youth received services? 3. How many youth participated in the study? 4. What were the baseline characteristics of the youth in the treatment and control groups? 5. Did the program reach the target population?
Adherence	<ol style="list-style-type: none"> 1. How many young parent and health educators were planned to be hired to deliver the curriculum and how many were actually hired? 2. How many young parent and health educators who delivered the curriculum were trained as planned? 3. How many sessions were delivered across all classes? 4. How many activities were completed across all sessions and all classes? 5. What kinds of adaptations were made to sessions?
Dosage	<ol style="list-style-type: none"> 1. How many sessions did youth attend? 2. How many students attended at least one session? 3. How many youth were retained throughout the semester? 4. What additional professional development/mentoring did peer facilitators receive?
Quality	<ol style="list-style-type: none"> 1. How many sessions were observed by an outside observer? 2. Were sessions of high quality, according to observers? 3. Did youth actively participate in sessions? 4. Were facilitators clear in their explanations? 5. Did students feel the curriculum was high quality, that they learned something, and that they liked the facilitators? 6. Did school staff feel that the program was implemented with high quality? 7. Did facilitators feel that the program was implemented with high quality?
Counterfactual and Context	<ol style="list-style-type: none"> 1. What programming did youth in the control group receive? 2. What information on SRH topics did both groups receive? Where did they receive this information? 3. What other SRH programming was available to students at the school or in the community? 4. What other factors, outside of the evaluation, may have impacted the study?

B. Implementation Evaluation Data Sources and Methods

The evaluation team collected implementation data throughout the study using multiple sources. Adherence, dosage, and quality data were analyzed for the treatment group only; contextual factors were examined for both the treatment and control groups. For each implementation component, the evaluation team identified specific implementation elements, data types, and analytic approaches to address.

Adherence

Staffing and training. EngenderHealth tracked staff hiring and training using several key methods. They tracked:

- Recruitment and hiring using internal logs, such as interview notes and selection tools
- Training through attendance logs and monthly training reports
- Training comprehension and quality through pre/post-knowledge surveys, post-training evaluations, and monthly project team meetings

PD&LP activities. EngenderHealth tracked PD&LP activities in attendance logs, timesheets, and monthly program variance reports.

Content. Fidelity logs were the primary data sources for adherence to the curriculum content. Fidelity logs were completed by facilitators and observers after each session. Measures assessed the number of sessions taught, activities completed, and adaptations made.

Dosage

Facilitators reported attendance data in logs. Re:MIX collected and calculated attendance data for all youth in a treatment classroom, regardless of whether they consented to participate in the evaluation study. Measures of dosage included the percent of sessions attended and how many youth participated in at least one session and how many participated in the majority of sessions. Measures of retention included how many study students who participated in the baseline surveys also completed the posttest.

Quality

Observation logs and feedback from individuals via surveys, interviews, and focus groups were the primary data sources for quality assessment.

Observation logs. Observation logs were completed by trained observers and were conducted in 29 percent of sessions. Measures included ratings from observers on overall quality, participation, and clarity.

Student survey data. 594 posttest surveys were completed. Measures from youth included their perception of how much they learned and their rating of the program's overall quality and facilitation.

Focus groups with participants. In spring 2017, two focus groups were conducted, one with three female students and one with seven male students. In spring 2019, two focus groups were conducted, one with five 12th graders and one with nine 8th graders. Students were asked about their impressions of the Re:MIX content and its relevance, what they liked and disliked about Re:MIX, what they hoped to learn from Re:MIX compared to what they actually learned, and what they thought about having a young parent teach the class.

Interviews and focus groups with school and Re:MIX staff. In spring 2017, three interviews were conducted with school staff and one focus group was conducted with two school teachers. In spring 2018, four interviews were conducted with Re:MIX staff. Interviews were one to one

and a half hours long. Staff were asked about their involvement in Re:MIX, impressions of Re:MIX content and its relevance to their students, challenges of having Re:MIX implemented in their school, and suggestions on how to improve the program.

Focus groups and interviews with facilitators. In spring 2017, one focus group was conducted with four young parent educators and one focus group was conducted with three health educators. In spring 2018, one focus group was conducted with four peer educators and two interviews were conducted with health educators. In spring 2019, two interviews were conducted with peer educators and one interview was conducted with a health educator. Interviews and focus groups were one to one and a half hours long. Facilitators were asked about their experiences as facilitators, impressions of Re:MIX content and its relevance to the students, and impressions on the dynamics between peer and professional health educators.

See Appendix B for detailed tables showing data source(s) for each research question.

IV. Implementation Results

This section details the findings related to study sample; program adherence, dosage, and quality; counterfactual; and additional context. Re:MIX met or nearly met all goals related to these different domains: the sample was of sufficient size, the facilitation team was appropriately staffed and trained, and the program was administered as intended and with high quality.

A. Study Sample

This section describes implementation research questions one through four related to classes and students recruited for the study and the characteristics of participants. The project team adjusted study sample projections over time to reflect an updated understanding of the classes and students available at each school. This resulted in five cohorts of data collection with 57 classes. The team randomized classes (and the students within the classes) within each school and grade into the intervention or comparison groups each semester.

Goal

Re:MIX set projections for recruitment at the school, class, and student levels for the evaluation study sample. The goals at each level included:

- Three K-12 public charter schools in Travis County, Texas, serving primarily Latinx students
- A total of 55 classes serving students in grades eight to 10, including 28 treatment classes and 27 control classes (the project team planned to recruit the classes in five semester-based cohorts)
- Enrolling 633 students in the evaluation, half in the treatment classrooms and half in the control classrooms

The target population for the study was students in grades eight to 10.

Recruitment and Enrollment

EngenderHealth recruited charter schools to participate in the Re:MIX study. Each school identified classrooms to participate. All students in these classrooms participated in either Re:MIX or the comparison group. At the beginning of each semester, each school instructed teachers of classrooms that were assigned to participate in the evaluation to distribute information about the Re:MIX program and study to students to give to their parents. This information described the Re:MIX curriculum and indicated that students were enrolled in a classroom that would be randomized to receive Re:MIX or some other program. Schools also included a permission form (part of the program materials; not the evaluation materials) that gave parents the option to opt out of receiving Re:MIX programming. Schools reassigned students who opted out to non-participating classrooms.

The study team distributed evaluation consent packets to students in all participating classrooms. All materials were double-sided, with English-language materials on one side and Spanish-language materials on the other. The study team called and texted students and parents to ensure the receipt of study packets and to remind them to turn in the forms. If the school allowed, Re:MIX held pizza parties for classes when a minimum of approximately 90 percent of students returned their forms.

If students turned in parent consent and student assent forms that indicated they agreed to participate in the study, they were considered “consented” to the study. Students were not considered “consented” if they did not return both forms or if they returned a form that stated they or their parents did not want the youth to participate in the study. These students still remained in the classroom and received Re:MIX or the control condition depending on the outcome of randomization, but did not participate in evaluation activities.

Once the consent period was over, the project team administered in-person baseline surveys to consented students. After completing the baseline surveys, the team randomized each class within schools and grades to receive either Re:MIX or the comparison condition. Students that participated in the baseline and were randomized were included in the study sample. Conducting baseline administration before randomization eliminated attrition at baseline.

Sites and Youth Enrolled

Two of the three partner schools remained in the study across the five semesters of recruitment. One partner school left the study after four semesters of recruitment. As shown in Table IV.1, the study enrolled and randomized 57 classes, exceeding the overall goal of 55 classes. The team projected that 27 classes would be randomized to the control condition and 28 to the treatment condition, but Re:MIX randomized 30 classes to the treatment group and 27 to the control group during the study.

Overall, 626 youth were enrolled in the study; nearly meeting the goal of 633 youth. Enrollment in the treatment condition (347) exceeded the goal of 322, but enrollment in the control condition (279) fell short of the goal of 311. More students were in the treatment group than the control group because the treatment group had three more classes assigned to it than the control group, based on school needs. Overall 66 percent of students in participating classes enrolling in the study (Table IV.2). One key reason for success was that consent form return rates were high—

only 12 percent of students did not return forms or were excluded for other reasons. Students who did not enroll in the study fell into three categories:

- 1) Did not return consent forms (12 percent)
- 2) Alternate: Declined to participate in the evaluation, or excluded for other administrative reasons, but allowed to receive Re:MIX (12 percent)
- 3) Opted out of the program and therefore excluded from the study (11 percent)

For additional information on our recruitment strategy and enrollment rates, please see the following [research brief](#).

Table IV.1 Projected vs. Actual Number of Enrolled Classes and Students

Group	Treatment-Projected	Treatment-Actual	Control-Projected	Control-Actual	Total Sample-Projected	Total Sample-Actual
Classes	28	30	27	27	55	57
Students	322	347	311	279	633	626

Table IV.2 Youth Recruitment

	% Enrolled in Study	% Did not return forms	% Alternate ¹	% Opted Out
Total	66%	12%	12%	11%

Notes: ¹ Includes youth who declined to participate in the evaluation, youth whose parents declined allowing their youth to participate, youth who were absent at baseline administration, or youth who for other administrative reasons were not included in the enrolled sample.

Table IV.3 Enrolled Classes by Semester

Semester	Treatment	Control	Total
Fall 2016	6	5	11
Spring 2017	9	9	18
Fall 2017	3	2	5
Spring 2018	8	8	16
Fall 2018	4	3	7
Total	30	27	57

As shown in Table IV.4, all students enrolled at baseline were in grades eight to 10, with more than half (62 percent) enrolled in eighth grade. Thus, all students served were within the target population. The average age of youth was 13.9 at baseline. Approximately half of youth identified as male, half as female, and two percent self-identified as “transgender,” “unsure/unknown” or “other.” About three in four youth indicated that they were heterosexual (by indicating they were only attracted to the opposite sex). The majority of the sample was youth of color with 71 percent identifying as Hispanic, 8 percent black, and 7 percent other/mixed race. The remaining 15 percent were white. Eight percent of youth had ever had sex at baseline. Though not shown below, Re:MIX tested whether the treatment-control group differences in baseline means were statistically significant using ordinary least squares regression models controlling for classroom clustering and found no significant differences in key baseline demographics and behaviors (thus, achieving baseline equivalence).

Table IV.4 Characteristics of the Enrolled Sample at Baseline

Variable	Treatment Group- Prevalence Rate or Mean	Control Group- Prevalence Rate or Mean	Total Sample- Prevalence Rate or Mean
Gender identity			
Male	45.8%	50.7%	48.0%
Female	51.3%	48.2%	49.9%
Transgender/Unknown/Other ¹	2.9%	1.1%	2.1%
Sexuality			
Heterosexual	76.1%	76.1%	76.1%
Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ)	23.9%	23.9%	23.9%
Age	13.9	13.9	13.9
Grade level²			
8 th	60.1%	63.7%	61.7%
9 th	28.9%	22.7%	26.1%
10 th	11.1%	13.7%	12.2%
Race/ethnicity			
Hispanic (any race)	74.6%	65.8%	70.7%
White, non-Hispanic	12.9%	18.2%	15.2%
Black or African American, non-Hispanic	5.3%	10.2%	7.5%
Other/mixed race, ³ non-Hispanic	7.3%	5.8%	6.6%
Ever had sex	7.1%	9.5%	8.2%
Sample size	343	278	621

Notes: ¹ Student self-selected that they were “unsure/unknown” or “other.” ² Grade based on administrative data. ³ Includes Asian, Native American, Native Hawaiian or Pacific Islander.

Recruitment Challenges and Solutions

Re:MIX faced three primary recruitment challenges during the study: high opt-out rates, challenges obtaining returned consent forms, and mandatory reporting requirements. All of these issues potentially reduced the sample size that could be used for evaluation analyses or the willingness of participants to respond to critical survey questions.

Opt-out forms. The state of Texas mandates that all youth/parents be allowed to opt out of sexual health education delivered in schools. During some semesters, a high percentage of youth returned opt-out forms. During the first semester of the study, the team provided a simple form for parents/guardians to complete and return if they wanted to exclude their youth from the program. Based on the experience of receiving a high number of opt-out forms in the first semester (16%), the study team revised the forms. During the second semester, the team gave youth an informational flyer that provided more background about the program and highlighted its key components; the opt-out rate was much lower this semester (5%). However, due to an administrative error during the fourth semester of recruitment, the team distributed the original version of these forms to classes at two schools. With the help of school partners, the team restarted the opt-out process at one of the schools, which resulted in lower opt-out rates. Unfortunately, the team was not able to restart the process at the second school and opt-out rates remained high. Overall, the study reduced the opt out rate to 11 percent.

Consent form return rates. During the first semester, the team struggled with receiving consent forms in a timely fashion from all students. The team increased the return rate by calling and texting participants and their parents to remind them to return forms, offering incentives for returning forms (pizza), and emailing the teachers to remind them to ask students to return forms. The buy-in from teachers affected return rates. The team met with teachers in advance to provide information on the program and study. Some of the teachers decided to make returning the forms part of the students' homework grades or gave them additional incentives, such as a free period if all students returned the forms. These collective actions resulted in higher return rates.

Mandatory reporting. Texas requires the reporting of any child who has had sexual intercourse before the age of 14 to the Texas Department of Family and Protective Services (DFPS). The evaluation required the asking of all youth about their sexual experience, in order to conduct a rigorous impact analysis of the program. Because Re:MIX was implemented in many eighth-grade classrooms, the project team recognized that many youth would be age 13 at baseline. As a result, the evaluation team developed consent/assent forms and survey protocols to let students know that team members are mandated to report information about child abuse and neglect, and to also encourage accurate responses to study questions. Prior to survey administration, the team reminded youth that responses are kept confidential, but that facilitators are mandated reporters. The team used the Texas DFPS online reporting system to report any youth under 14 who said they had ever had sex. Texas DFPS replied that no report appeared to involve a substantial risk of abuse or neglect for which they had the authority to investigate.

Funding delays. The original funding for this project was truncated from five years to three years in early 2018. However, funding was reinstated in September 2018. The initial funding cut, and subsequent delay in reinstated funding, resulted in the loss of our largest partner school. When we informed them of the study closure, they found an alternate sexual education program to implement in Fall 2018. Additionally, the delay in reinstated funding resulted in a condensed timeline for our consent process in Fall 2018 that reduced our consent rates (54% consented to the study that semester compared to 66% overall) and caused delays in administering the 12-month follow up surveys for the Spring 2017 cohort. Due to the delay, the Spring 2017 cohort received an 18-month follow up survey.

B. Adherence

Understanding adherence to the curriculum is crucial to understanding the implementation of Re:MIX and to interpreting the findings of the study. High-quality implementation requires administering the curriculum as designed, with a sufficient number of adequately trained staff. Measures of adherence assess whether the project team hired and trained sufficient numbers of staff as well as how closely program delivery followed the curriculum. This section describes implementation research questions five through nine, related to how many staff were hired and trained, what curriculum content was offered to classes, how many sessions and activities were completed, and what kinds of adaptations or changes were made.

Staffing and Training

Goal

At the start of the project, EngenderHealth set benchmarks to meet quality staffing and training standards. The goals at each level (after the shortened project period) included the following:

- Hire and train between five and eight peer educators as a unique cohort for each implementation year
- Hire and train two to three health educators for the grant period
- Ensure all peer and health educators actively participate in and complete the facilitators training, designed to be a minimum of 30 hours throughout the implementation year, with approximately 20 of those hours happening before the facilitation started each school year
- Ensure that all other core project implementation staff are also proficient in the training of facilitators curriculum and are able to support and provide back-up assistance, when needed

These numbers were intended to be sufficient to implement the program with quality and fidelity in all treatment classes at the schools and to ensure that there would still be sufficient staff if a staff member resigned or was out sick or on leave.

Results

Peer educators in the program were young mothers and one father (ages 18–27) at entrance into the program. While EngenderHealth tried to recruit male peer educators (young fathers), all educators except one were females. The majority of peer educators were Latinx and and/or black (10 of the 13 peer educators who taught any Re:MIX classes) and four spoke Spanish. Peer educators were screened for prior leadership or training experience and their interest in sharing their stories with others. Peer educators were typically recruited through their school, a counselor, a social worker, a caseworker, an internship specialist, or online through the Indeed job search site. Peer educators were employed 15 hours per week.

EngenderHealth hired, trained, and retained the necessary number of peer educators for the majority of program implementation. During the pilot, EngenderHealth hired and trained three peer educators. At the start of Year 2 of the project, for the first two semesters of the evaluation, EngenderHealth retrained the three peer educators from the pilot and hired two new peer educators. At the start of Year 3 of the project, the third semester, there was initially a new cohort of five peer educators on staff, two left mid-way through the first semester, and one left at the end of the first semester. This was a smaller semester overall (fewer classes) so the loss of peer educators was not as detrimental as it would have been during other semesters. Prior to the start of the fourth semester, EngenderHealth hired two new peer educators to replace the two that had left. This means that at the end of Year 3, there were four peer educators. At the start of Year 4 of the project, the fifth and last semester, EngenderHealth rehired a peer educator from the third semester and a new peer educator.

EngenderHealth initially contracted external partners to provide three health educators who met the desired skills and experience requirements for the position. Initially, the team hoped to

receive three health educators from one community organization, but due to availability, the team had to contract a second partner. Using health educators from external organizations had its benefits and challenges, but after re-evaluating priorities and needs, EngenderHealth decided to hire internally, starting in the third semester. During the third semester, EngenderHealth promoted a peer educator into the health educator position in the fall, while preparing to hire one more for the spring. This person left after the completion of fall semester and EngenderHealth hired two new health educators prior to the fourth semester, though one had to leave the program four weeks early. At the start of the fifth semester, EngenderHealth retained one of the health educators from the previous semester.

Over the course of the project, there were also planned and unplanned transitions in many project team positions including: program manager, senior project coordinator, program assistant, and youth engagement coordinator. This also included the addition of two new evaluation positions after the pilot year.

All peer educators and health educators completed 40 hours of implementation training, with 20 hours of core training before beginning facilitation.

Challenges and Solutions

Recruitment of young fathers. Recruiting young fathers as peer educators proved challenging. The fathers were often older, not in the picture, or looking for full-time work as opposed to part-time. One solution was to engage a male youth engagement coordinator and a male health educator. While not intentional, having male teachers from the partner schools in the classrooms was helpful for including positive male role models and voice.

Retention rates. Peer educators often had needs that program staff did not always anticipate when hiring them, such as child care, mental health counseling, or housing. Without supports, these young parents were often unable to perform their jobs as peer educators. Some peer educators ultimately left their positions early due to the demands of parenting or in order to meet other basic needs related to providing for their families. To address this, EngenderHealth developed partnerships with various organizations and provided peer educators with referrals to these services.

A few peer educators also left earlier than planned for postsecondary or workforce development programs and for full-time employment to more quickly meet personal and professional goals. Once EngenderHealth made the health educator role an internal position, a few of the health educators left for full-time work and academic programs. To address this, the team focused on ensuring there were strategic back-up plans for additional staffing and support when needed. Some core staff required more time to recruit and hire than expected in order to find the best candidate, and some transitioned during uncertain funding times. The team regularly updated its recruitment and retention approaches to ensure new hires and hiring teams assessed candidates for fit and to create incentives that were meaningful and relevant to the individuals in each position.

Peer educator late arrivals and absences. Peer educators were often late or absent to Re:MIX trainings and classes, due to a variety of influencing factors that parenting youth face, ranging from competing family needs to personal well-being and health. This required frequent

rescheduling and restructuring of training plans, which left the project vulnerable to fidelity and quality issues with training and facilitation. In order to combat these issues proactively, EngenderHealth created detailed processes for substitute facilitator and re-teaching training modules. Peer educators who joined after the initial training of facilitators training for the implementation year, missed opportunities to train with the larger group and often had to onboard individually with their supervisors. In Year 2, the team employed some additional creative strategies, such as designing recorded trainings and bringing in alumni to support, as needed.

Peer and health educator relationships. During the first year of implementation, Re:MIX experienced a disconnect between the peer and health educators due to the nature of their employment—peer educators were supervised by the internal team and health educators were contracted by external agencies and supervised by their company’s management. The Re:MIX team addressed this issue by directly hiring and supervising health educators in the second year of implementation. Differences in availability, cultural upbringings, and professional experience further influenced power dynamics and norms in these relationships, which continued even after shifting the management of the health educator role.

Training time. Training often felt rushed for staff, due to limited time between when the facilitators were hired to when program implementation was scheduled to start. This often impacted facilitation quality for educators for the early sessions, as they familiarized themselves with the Re:MIX content and model. A few strategies that proved successful were re-arranging the recruitment and hiring calendar to allow for an earlier onboarding of educators, the inclusion of weekly demos and practice sessions, and a refresher training in early spring based on the fall’s classroom observation data for quality and fidelity. Additionally, upon training completion, Re:MIX assigned numbers and types of facilitation assignments to peer educators based on their demonstrated knowledge and skill. All peer educators received assignments and additional opportunities to serve as observers and assistants in other classrooms, which proved helpful for enhancing their knowledge and ensuring there were back-ups who were familiar with classrooms and campuses and could help maintain the quality of facilitation.

As part of continuous quality improvement efforts, EngenderHealth also enhanced the training program and structure in Year 2 in order to better meet the needs of new Re:MIX facilitators, including spacing the trainings over key periods in the year to increase comprehension and incorporating more frequent refresher trainings based on training comprehension surveys and classroom observation data.

Content

Goal

The Re:MIX team sought to deliver the curriculum as originally designed to all treatment classes. As stated above, Re:MIX intended to cover overarching topics of sexual health and youth development including: healthy relationships, communication, gender, consent, reproductive anatomy, contraception, sexual decision making, clinics, parenthood, and life planning. Therefore, the goal in delivering Re:MIX was for the majority of classes to receive all 10 sessions of the curriculum, in order to ensure they received all content. EngenderHealth did not set specific goals for exactly how many activities, on average, the project should complete

across all sessions and all classes. The answers to the implementation research questions provide additional context on how well EngenderHealth implemented the program, without assessing whether the project achieved a specific quantified goal.

Results

As shown in Table IV.5, overall, Re:MIX delivered the curriculum as intended. The project delivered all 10 sessions to all classes. The educators were usually able to complete the majority of intended activities in each session, with an average 90 percent of activities completed. The most common adaptations were time reductions for individual activities, as described next in the challenges section.

Table IV.5 Content Adherence

Measure	Total
Average number of sessions delivered	10
Average percentage of activities completed across all sessions ¹	90%

Note: ¹ Does not include the final semester

Challenges and Solutions

Classroom times. EngenderHealth designed the Re:MIX curriculum to be delivered over the course of 10 sessions lasting 55 minutes; however, these sessions were packed full of content. The sessions did not always factor in some of the realities of transition times at schools (e.g., arriving in the room and setting up for the session). Additionally, one of the schools only had 50-minute periods available, so the team had to adapt the curriculum accordingly; this school implemented 12 of the 26 treatment classes. Because of these timing issues, health and peer educators consistently dropped the closing activity from the sessions. The closing activity was the one where students could ask final questions, reflect upon and write about what they learned, and do a group Re:MIX chant. Educators who ran out of time often omitted this activity, because it did not cover any health content.

Realities of school activities. While the implementation team worked hard with school liaisons to plan and prepare implementation calendars, there were still regular unforeseen circumstances and changes due to school testing, inclement weather, emergency drills and events, and other school events. As the project learned about school variables, trends, and culture, it developed and employed strategies that were user-friendly and would still allow teams to complete activities. A few examples include negotiating implementation periods that include extra time at the beginning and end of each semester, creating an online form for the school to communicate anticipated school events each semester, and negotiating and pre-planning make-up days with school liaisons and teachers.

Cultural and language barriers. There were large numbers of Spanish speakers across study schools but, due to constraints related to team capacity and resources, Spanish translations of the Re:MIX curriculum were not available to students. One strategy Re:MIX employed to address this included hiring and placing Spanish-speaking educators in classrooms with a high need for language support.

C. Dosage

This section describes implementation research questions related to youth attendance, youth retention, and professional development/mentoring opportunities for peer facilitators.

Youth Attendance

Goal

Re:MIX was implemented in schools during the school day and schools held youth to the same attendance expectations as they did for any other class (e.g., history or math). Therefore, the study team assumed that the majority of youth would attend at least 75 percent of sessions offered. Additionally, the study team assumed that at least 80 percent of participating youth would remain engaged for the posttest.

Results

As shown in Table IV.6, 399 youth attended at least one Re:MIX session. This number is larger than the number who were enrolled in the study in treatment classes (347) because it includes youth who did not consent to the evaluation but did participate in classes. On average, students attended 92 percent of sessions and similarly, 92 percent of students attended at least 75 percent of sessions. Overall, Re:MIX was very well attended, as the study team anticipated.

Table IV.6 Youth Dosage

Measures	Total
Total number of students participating in at least one session	399
Average percentage of sessions attended	92%
Percentage of students attending at least 75 percent of sessions	92%

As shown in Table IV.7, retention across the study was also high, with 95 percent of students completing the posttest. Re:MIX retained all classes throughout the duration of each semester.

Table IV.7 Youth Retention

Time	Treatment Condition	Control Condition	Total Sample
Baseline	347	279	626
Posttest	327 (94%)	267 (96%)	594 (95%)
12-month follow up	293 (84%)	240 (86%)	533 (85%)

Challenges and Solutions

Staff scheduled survey administration dates at each school and back-up survey days to catch any students who were absent. However, there were some youth who were unable to be surveyed at the school either because they were absent or were no longer a student at the school. To address this, the survey team created an online version of the survey that could be sent to students. If a student was absent during both in-person survey administration dates, the study team contacted them via phone, email, and text message to complete the online survey.

Professional Development and Leadership Program (PD&LP)

Goal

The overall goal of the PD&LP is to develop, enhance, and expand the professional skills and leadership potentials of our peer educators. The program aimed to help develop positive attitudes and behaviors that will prepare them for success in postsecondary education and the workforce. The program comprises a blend of activities designed to teach, practice, and reinforce proficiencies and skills in four core competency areas (accountability, communication, leadership, and personal motivation).

Informally, EngenderHealth set goals for peer educators to receive at least 240 hours of training, special projects, skills practice, and mentoring activities for cohorts in years 1-3. EngenderHealth further developed benchmarks with the peer educators for the number and kinds of professional development activities within these hours.

In Year 4, project staff had to relaunch the program later and more expediently than normal. Since the PD&LP was implemented on a shortened timeline and with a smaller group of classroom participants and peer educators, the program was adapted to be a six-month-long [special project](#) that touched on all four PD&LP competencies.

Results

Based on the results of post-program self-assessments, peer educators in years 2-3 reported the most growth within the personal motivation competency area, particularly in the goal-oriented and coachability sub-competencies. These findings were confirmed through interviews and focus groups with project staff and health educators, who worked closely with the peer educators throughout the program.

Project staff reviewed progress toward goals and benchmarks monthly and made adjustments to ensure successful completion of objectives.

In years 2-3, nine of the 11 peer educators received 240 hours as intended. Two only served a semester in the program and received only 120 hours, and one left after two months with a total of 32 hours.

In Year 4, a returning peer educator and a new peer educator participated in approximately 30 hours of professional development in the form of their [special project](#).

Challenges and Solutions

As stated in the staffing and training section, there was higher turnover than expected for peer educators. This corresponded with more barriers to peer educators' ability to participate in PD&LP activities. Barriers observed by project leadership and communicated in supervision check-ins frequently included intensive parenting demands with younger children and substantial social support needs. EngenderHealth responsively created a youth engagement coordinator role, who was responsible for developing new processes for addressing peer educator barriers. Some of the solutions that the coordinator developed were creating an attendance incentive (created with peer educator input) and hosting a retreat (also with their input) to allow peer educators an

opportunity to reconnect and openly discuss the semester’s successes and challenges, participate in teambuilding activities, and hosting guest speakers from across the health spectrum.

In Year 4, project staff had to quickly relaunch the program and were unable to recruit a full new cohort of peer educators. Due to these challenges, staff offered the job to a former peer educator who completed the program in Year 3. Staff also enlisted a second peer educator, who was a young father. Since two peer educators were teaching a full roster of classes normally split by a larger team, staff modified the PD&LP and reduced the number of professional development hours required.

For additional information and findings regarding the peer education model and approach, please see the following [research brief](#) and [Appendix C](#).

D. Quality

Measuring whether Re:MIX was delivered with high quality required a diverse set of data sources. Therefore, the team examined quality through observation logs, student feedback, school staff feedback, and facilitator feedback.

Goal

The Re:MIX team sought to deliver the curriculum with high quality to all treatment classes. Though the project did not set specific quantifiable benchmarks to assess quality, observers examined: the facilitators’ clarity of explanation of activities; the facilitators’ ability to keep track of time; participants’ understanding of material and their active participation; facilitators’ knowledge, enthusiasm, poise, and rapport; and whether facilitators addressed participants’ questions and concerns. The evaluation team aimed to observe at least 10 percent of sessions to report on these items in order to ensure that all individuals who contributed to the program (facilitators, students, and school staff) felt that the Re:MIX team implemented the program with high quality.

Results

The study team exceeded its goal, observing nearly three in 10 sessions (29 percent). As shown in Table IV.8, observers rated 73 percent of sessions as high quality, rated 63 percent as having active participation by youth, and 93 percent of sessions as having clear explanations.

Table IV.8 Quality as Assessed by Observers

Measure	Percentage
Percentage of sessions observed	29%
Percentage of high-quality sessions	73%
Percentage of sessions with active participation	63%
Percentage of sessions with clear explanations	93%

Youth also reported positive experiences with Re:MIX; 84 percent of youth felt that overall Re:MIX was of good quality. Approximately nine in 10 youth reported that they liked their peer

educator (90 percent), liked the professional health educator (89 percent), and that they learned “some” or “a lot” from Re:MIX (87 percent). Approximately eight in 10 youth reported they probably or definitely would recommend Re:MIX to a friend (78 percent), reported that they trust health educators (84 percent) and peer educators (80 percent), and felt that the health educators and peer educators motivated students to talk (78 percent and 76 percent, respectively). See Table IV.9.

Table IV.9 Quality by Participants

Measures	Percentage
Percentage of students rating Re:MIX as good quality	84%
Percentage of students reporting they probably or definitely would recommend Re:MIX to a friend	78%
Percentage of students reporting they learned “some” or “a lot” from Re:MIX	87%
Percentage of students reporting they liked health educators	89%
Percentage of students reporting they liked peer educators	90%
Percentage of students reporting they trusted health educators	84%
Percentage of students reporting they trusted peer educators	80%
Percentage of students reporting they felt health educators motivated students to talk	78%
Percentage of students reporting they felt peer educators motivated students to talk	76%

In spring 2017 and spring 2018, the team also conducted focus groups with participants, interviews with school staff, and interviews with facilitators to assess program quality. These provided information about Re:MIX’s appropriateness for youth, the perceived need for Re:MIX services, and the program’s strengths and weaknesses.

Participant perspectives on Re:MIX. Participants generally felt that Re:MIX taught them valuable information that they would use when they are older. They appreciated the interactive nature of the curriculum and sessions where they played games or had group discussions. Students saw great value in having a peer educator but wished more male peer educators had been available. One female student said she wished she could “understand what the male has to go through [when they have a baby as a teen]” and similarly a male student said, “guys couldn’t relate” to the female facilitators and that “sometimes it would be better if a male was there.” Some youth felt the sessions were rushed, with too much material to cover. They felt the discussions were too educator-led and wanted more time to discuss among themselves, ask questions, and share their own opinions.

School staff perspectives on Re:MIX. School staff valued, saw the need for, and were grateful to have Re:MIX in their schools. They felt the program was appropriate for the intended age group and appreciated the unique resources that it offered youth. They particularly valued the peer educators and felt that they related well to youth. School staff emphasized that it would be beneficial if program staff understood the culture of the school (e.g., classroom teaching and management styles) before implementing the program. For example, one staff member said, “We

spend a lot of time here at school developing relationships [with students]. I think especially when [you cover] challenging topics... our kids always get the opportunity to not speak if they are not ready to and I don't think they had that chance in some of the sessions." Teachers across two of the schools felt that requesting students to participate goes against the school culture of restorative, trauma-informed approaches.

Facilitator perspectives on Re:MIX. Both the professional health educators and peer educators noted that Re:MIX met a need in the community and felt that some of the content was particularly needed by the youth and would not have been received any other way. They also felt that the youth were gaining knowledge and skills from the curriculum and that the co-facilitating relationship was critical to the success of the curriculum, as well as to their own personal development. Health educators said that they learned a lot from peer educators and appreciated hearing their stories and voices. Peer educators noted that they learned a lot from the health educators and appreciated the mentoring they received. However, the facilitators overall felt that the roles for each type of facilitator needed to be better defined to ensure that the program was implemented with high quality. One health educator said that it needs to be clear "what is the territory of the health educator and what is the territory of the peer educators; I don't think it needs to be super rigid, but we need to talk about that." Both peer and health educators also had ideas for curriculum improvements; these included: incorporating more movement, changing the way participants discussed lesson messages, adding energizing activities, and rearranging some activities and lessons to help address issues related to running out of time in each session.

Challenges and Solutions

In addition to challenges and solutions described above, we identified one additional challenge and solution related to defining quality.

Defining quality. While observation tools predefined high-quality facilitation, evaluators were often inconsistent in their methods and reasoning for ratings. While this initially arose as a measurement issue, it influenced perceptions of quality and led to differences among project staff in what they regarded as appropriate levels of quality. With the expansion of the internal evaluation team, these staff members assumed leadership roles in observing classrooms, and were often "tougher" than previous evaluators were. However, these changes also provided important opportunities for the team to reflect upon and address quality more comprehensively, including setting revised benchmarks for internal quality, holding quarterly data-for-decision-making meetings, and hosting conversations and meetings with educators on the topic of quality.

E. Counterfactual

The study team measured the receipt of services by control-group students by examining the programming the youth received, the information on SRH topics they reported receiving at posttest, and any other SRH programming that was available to them at their school or in their community.

Each semester, the study team tracked whether the classroom teachers overseeing the comparison condition classes used the alternative curriculum. The project did not set expectations for whether classes would use the alternative curriculum. Each teacher could decide to use the alternative curriculum in full, use it in part, or not use it all (and just proceed with the

standard program). As shown in Table IV.10, no classes received the full alternative curriculum. Teachers for 41 percent of control classes decided to use parts of the alternative curriculum. The remaining 59 percent of classes proceeded with their standard program.

Table IV.10 Comparison Class Services

Semester	Full Alternate Curriculum	Partial Alternate Curriculum	Standard Program
Fall 2016	0	5	0
Spring 2017	0	3	6
Fall 2017	0	1	1
Spring 2018	0	1	7
Fall 2018	0	1	2
Total	0 (0%)	11 (41%)	16 (59%)

At posttest, all study participants were asked what information they received on SRH in the past three months. If they reported receiving information on these topics, they were asked where they received this information. As shown in Tables IV.11 and IV.12, students in the treatment group were much more likely than students in the control group to report receiving information on SRH topics in the past three months (93 percent for treatment, 71 percent for control). More students in the treatment than control group reported receiving information on all categories of SRH, including relationships, dating, or marriage; abstinence from sex; birth control methods; and STIs. Students in both treatment and control groups reported receiving this information primarily from school classes, but students in the treatment group were 38 percentage points more likely than students in the control group to report receiving this information in school. Interestingly, students in the control group were 10 percentage points more likely than students in the treatment group to report receiving SRH information from parents, family, or group homes in the past three months. Similar percentages of youth across treatment and control groups reported receiving SRH information from alternative sources, including friends (28 and 25 percent, respectively), internet (22 percent for both conditions), doctor (18 and 16 percent, respectively), community (5 and 3 percent, respectively), and other sources (7 and 2 percent, respectively).

Table IV.11 Receipt of SRH Information in the Past Three Months at Posttest

Topic	Treatment	Control	Total Sample
Received any information on the SRH topics below	93%	71%	83%
Relationships, dating, or marriage	88%	63%	77%
Abstinence from sex	87%	49%	70%
Methods of birth control	90%	54%	74%
Sexually transmitted diseases or infections	88%	54%	72%

Table IV.12 Receipt of SRH Information from Different Sources in the Past Three Months at Posttest

Source	Treatment	Control	Total Sample
School class	78%	40%	61%
Community center, after-school activity, or religious class	5%	3%	4%
Doctor, nurse, or clinic	18%	16%	17%
Friends	28%	25%	26%
Parents, family, or group home	34%	43%	38%

Source	Treatment	Control	Total Sample
Internet or social media	22%	22%	22%
Other	7%	2%	5%

In the first year of the project, the study team reached out to other known TPP programs in Texas to confirm that they were not providing services in Travis County. The team concluded that there was no known risk of contamination with other organizations serving the same area. Throughout the duration of the study, the local team did not learn of any additional services being offered to youth in the community. No teachers reported that students were receiving information on SRH in any other classes.

F. Additional Context

A few additional factors influenced program delivery and/or the evaluation and were not described above. In particular, information about organizational features, funding, school partners, and unique community partners provide additional context about the Re:MIX study.

Organizational features

EngenderHealth had conducted a previous project funded by the Office of Adolescent Health, which proved beneficial in understanding the basic processes and standards for federally funded programs. Additionally, EngenderHealth headquarters provided critical support in human resources, communications, evaluation, and financial management. The organization offered institutional knowledge and preexisting operating procedures and policies that provided critical standards and expectations and thus a strong foundation for operational efficiencies and program success.

School partners

In general, partnerships with the three schools went well and were mutually beneficial. Each school established a “school liaison” to serve as the intermediary between the study team and the teachers/students. In two schools, these liaisons were the school social workers and in the other the assistant principal served as the liaison. Additionally, EngenderHealth conducted Re:MIX orientations each semester with any new school teachers supporting the program and study to clearly describe the program and roles. These relationships were significant in developing strategic and comprehensive support mechanisms for participants and ensuring successful completion of all study activities. After the pilot year, the Re:MIX team recognized that the logistics of implementing a study on campuses could be overwhelming for school staff, so in subsequent years, the team streamlined communication, created tools for proactive and shared planning, and identified unique ways to share program information and appreciation for school staff. Re:MIX offered high-level pre- and post-semester check-in meetings. These meetings quickly evolved to include: presentations of insightful quantitative and qualitative data, shared digital media, personalized thank you notes from the Re:MIX team, and open dialogue for ongoing partnership improvements. After the first year, Re:MIX also enhanced school partnerships by tailoring training and approaches to each individual school culture and further developing relationships between the treatment teachers and educators by conducting pre-semester campus visits, observations, and meet-and-greets. The team also expanded facilitator training to incorporate ongoing discussions of each school’s unique culture and classroom

management approaches. Due to these various strategies, EngenderHealth noted increased support from campus partners, which positively impacted consent return rates, classroom management, referrals, and participant engagement and satisfaction with Re:MIX. Unfortunately, because of a gap in funding between Year 3 and Year 4, one of the partner schools had to leave the study.

A few highlights of particularly special moments at each school include:

- At one school, the Re:MIX team was invited to attend sessions of the campus's teacher training before the school year began to not only participate as learners but to present on Re:MIX to the entire staff. This proved incredibly helpful in sharing knowledge and making personal connections that served both parties throughout implementation.
- After the devastating loss of a student during the Austin bombings in 2018, the licensed social workers on staff at Re:MIX offered support through free counseling sessions with students and teachers at a partner campus.
- After observing the project's success and the student reaction to the Re:MIX approach, one school decided to make condoms publicly available on their secondary school campus.

A few key challenges of working with the schools that arose during the study:

- As previously mentioned, there were many cancellations and rescheduling requests, particularly in the pilot year. Coordinating the logistics for the program and the study often proved overwhelming for school partners and required continual problem-solving efforts to meet everyone's priorities and needs. In subsequent years, the Re:MIX team offered and implemented creative solutions to make scheduling as manageable, streamlined, and flexible as possible.
- During one semester, a classroom teacher's teaching style negatively impacted the learning environment between the Re:MIX educators and the participants. Typically, classroom teachers would stay in the class to help with behavior management. To address the negative environment, the team worked closely with the school liaison to provide ongoing feedback and request additional support in working through this issue with the classroom teacher. The team identified opportunities to help teachers create a safe and supportive space for youth inside and outside of this classroom. Similarly, during another semester, the school classroom teachers were not always supportive and sometimes negatively impacted the learning environment. As with the other instance, the team worked with the school liaison to resolve the issue. To provide more support, the school liaison agreed to attend sessions or to send their social work intern.

Unique community partnerships

There were also particularly special and beneficial community partnerships that enhanced program deliverables and outcomes:

- Most peer educators were enrolled in local colleges or workforce development programs during their time with Re:MIX. This provided an opportunity for their supervisors to coordinate with leaders at these organizations to create additional pathways for communication, mentorship, and support.
- EngenderHealth partnered with a national storytelling organization in the first implementation year to integrate storytelling into the Re:MIX curriculum and training. In

the second year, the team engaged local storytellers in the community to offer diverse perspectives and to show how to use storytelling as a tool for facilitation, networking/partnerships, and sustainability. Former peer educators later became community partners in the program; they returned to train or to be a guest speaker for later cohorts of educators.

V. Unplanned Program Adaptations

No unplanned program adaptations occurred during the course of the study.

VI. Conclusions and Lessons Learned

In summary, there are several key conclusions, lessons learned, and recommendations for future research stemming from this implementation evaluation of Re:MIX.

A. Conclusions

The development of the Re:MIX curriculum and engagement of youth in the process was paramount to ensuring the program was relevant, meaningful, and inclusive for all of the target population. These intentionally inclusive and engaging processes with key stakeholders and experts produced a highly youth-centered curriculum.

The co-facilitation model brought diverse insight, experience, and support into classrooms and brought rich connections and learning that influenced both participants and facilitators. The model also allowed for additional support and ease of classroom management, which was important in larger classes. Additionally, the power of storytelling was a cornerstone of Re:MIX. Not only did the peer educators bring in their experiences, but the participants were encouraged to share theirs as well. This two-way interaction created richer learning and facilitated greater comprehension of the subject matter. Students rated the peer educators and health educators highly—nine of 10 participants reported that they liked the peer educators and their health educators.

There were high levels of community support and enthusiasm for the program. The team gained and maintained tremendous buy-in from school partners. Schools were willing to participate in a long-term study for the benefit of research and to help create more innovative and evidence-based curriculum for their communities. This was also demonstrated at the participant-level through high consent, attendance, completion, and satisfaction rates across all classes and schools. Response rates for follow-ups showed personal commitment by students and partners. Specifically, nearly nine in 10 students (88%) returned completed consent forms and 66 percent consented to participate in the evaluation, despite the ability for parents or students to opt out of any sex education class in the community. Within treatment classes, students attended 92 percent of sessions, on average, and nine in 10 students (92%) attended at least 75 percent of sessions (demonstrating high attendance rates). Students also gave positive ratings of the Re:MIX program, with 84 percent rating Re:MIX as overall good quality. All classes were retained from baseline to posttest and 95 percent of enrolled students completed the posttest survey.

High fidelity ratings give further credibility to the project’s positive outcomes, show effectiveness in the training approach, and demonstrate the team’s commitment to the curriculum and pedagogical approaches. Despite the scheduling challenges described throughout the report, the Re:MIX team delivered all 10 program sessions to all 30 treatment classes. Within these sessions, the team completed 90 percent of activities and observers rated 73 percent of sessions as high quality.

The cluster-level, randomized control design at the class-level was successful at creating equivalent treatment and control groups with no significant differences in key demographics and outcomes. Additionally, the team randomized classes after baseline assessment, which ensured no classes and minimal youth were lost due to attrition.

Local data collectors were essential for data collection. Re:MIX was successful at recruiting and retaining youth for the study because it had local staff from the University of Texas at Austin and EngenderHealth who could collect data in-person at each school. Staff were very successful at collecting in-person data and minimal out of school follow up was needed. These efforts resulted in high retention rates at both posttest (95%) and 12-month follow up (85%).

B. Lessons Learned

Recruiting young fathers as peer educators proved challenging. Programs for young fathers in the community are sparse—even though EngenderHealth identified fatherhood programs during the grant proposal period, those programs eventually dissolved and it became even more challenging to recruit young fathers as peer educators. One solution was to engage men through other roles, such as having male teachers from partner schools in the classrooms and recruiting male health educators. Including positive male role models and voice in the classroom is essential.

Programs in classroom settings face the challenge of adequate time and schedule coordination. Future programs need to factor in a variety of influencing factors related to scheduling and allow for adequate time to address any transition time and unique classroom management needs outside of the allotted 55 minutes.

Adapting to a particular school’s culture and partners is important in supporting participants. Projects must acknowledge needs and priorities on both sides in building relationships. For example, the team expanded facilitator training to incorporate ongoing discussions of each school’s unique culture and classroom management approaches, which proved beneficial for improving working relationships with partners and enriching interactions with participants.

The requirements of a research study are challenging. School staff tend to have an ethical desire to bring programming to all students on campus, thereby ensuring that “control” groups also have access to educational and informational activities. This issue was exacerbated when the project period was reduced to three years (instead of five), as teachers and school faculty were concerned that Re:MIX might be unable to provide any programming in the future. Indeed, one of the schools decided to end any future partnerships with Re:MIX in order to find a program that could provide content to all students, instead of only to those classes that were assigned to the treatment group.

The co-facilitation model requires strategic training, management, and regular evaluation. While Re:MIX employed many best practices in co-facilitation and regular coaching and support, there

are many nuances that factor into the success of these working relationships, ranging from cultural backgrounds to working conditions. Streamlining the management of peer and health educators should be a strong consideration for replication.

It is critical to be properly equipped to meet the unique needs of parenting peer educators and to provide incentives for retention. Successful participation in this program requires that their basic needs be met (i.e., food and housing), that they have reliable transportation to the office and the schools, and that they have a current support system to rely on for various needs, such as emotional support and childcare. Furthermore, peer educators must have a desire to achieve postsecondary education or job training. Without this personal drive and having basic needs met, they are unlikely to stay engaged in the program or in their job as a classroom facilitator. However, each participant requires different levels of support and it is important to consider an organization's capacity and limitations so that these can be thoughtfully integrated into recruitment, hiring, and onboarding processes. One recommendation is to create a trial period for new peer educators that would allow for each party to test out the fit within a reasonable period of time. Additionally, it would be beneficial to hire or contract with a case manager or social worker who is specifically available to provide support for the peer educators beyond the scope of what project staff and their immediate supervisors can reasonably provide with their credentials and skill set.

Implementers need solutions for training when new educators are engaged after the main components of the training of facilitators trainings occur. Training staff who join on timelines outside of the standard periods creates added stress to ensuring adequate and high-quality training before these educators begin facilitation. These educators miss critical group bonding opportunities and must internalize material rapidly. As mentioned in earlier sections, Re:MIX employed a few strategies to mitigate these issues, but also gained many insights into the importance of a revised training program that is more flexible and adaptable to potential situations like these.

One final consideration is the need to assess language or cultural barriers that could prohibit full engagement or intended outcomes. In Texas, there are large numbers of Spanish speakers, but the Re:MIX content is not currently offered in Spanish, due to constraints related to team capacity and resources. Spanish-speaking staff and partners were important for translating and creating new documents for parents about the program and evaluation. With more time and resources, EngenderHealth would use a similar approach to adapt Re:MIX for Spanish speakers. EngenderHealth is creating some Spanish adaptation tools that can be used while implementing the Re:MIX curriculum. These tools will be available with the full implementation package.

C. Additional Research Opportunities

In order to better understand additional components within Re:MIX, EngenderHealth recommends the following areas for additional research: a closer examination of the effectiveness of the co-facilitation model, additional qualitative and quantitative data on the peer education and professional development models, and culturally appropriate adaptations of the content.

VII. References

¹ Texas Department of State Health Services (2014). Austin, TX: Center for Health Statistics.

² Office of Adolescent Health. (2014). Texas Adolescent Reproductive Health Facts. Retrieved from <http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/fact-sheets/state.html?s=texas#footnote-3>

³ The Texas Tribune (n.d.) Public Schools Explorer. Retrieved from <https://schools.texastribune.org/districts/>

⁴ Smith, Christensen, and Cumpton (2015). An Evaluation of Local Investments in Workforce Development. Retrieved from <https://repositories.lib.utexas.edu/bitstream/handle/2152/30304/An%20Evaluation%20of%20Local%20Investments%20in%20Workforce%20Development.pdf?sequence=3&isAllowed=y>

Appendix A: Formative Work and Theoretical Base of Re:MIX

EngenderHealth designed Re:MIX—previously called Our Stories, Your Choices—to make content that is as relevant to adolescents as possible, without sacrificing the knowledge and objectivity that professional health educators also provide. Re:MIX incorporates a peer education approach, which resonates with youth more than comprehensive sex education delivered by adults only, because it connects more to youth culture and is informed by youth insights.

Re:MIX draws upon formative research with youth, as well as existing evidence-informed curricula, including Gender Matters (developed by EngenderHealth) and No Kidding: Straight Talk from Teen Parents (a public/private collaboration sponsored by the Texas Attorney General’s Child Support Division and developed by YouthLaunch). Gender Matters, funded by the OAH from 2010-2016, was an innovative, science-based, gender-transformative TPP curriculum that incorporated current research on gender-based attitudes and behaviors. Gender Matters was recognized by the Healthy Teen Network as the most innovative program of 2013. No Kidding, funded by HHS, Administration for Children, Youth, and Families Fatherhood Initiative (2005 – 2010), received the same award in 2006. No Kidding similarly engaged young parents as peer educators to deliver a curriculum focused on healthy relationships and responsible parenting.

Several key theories and approaches guided the development of Re:MIX.

- 1. Social Cognitive Theory and Theory of Reasoned Action.** Cognitively, Re:MIX engages peer educators to model and teach a range of concepts in a variety of formats to aid in the uptake of knowledge and skills. Behaviorally, youth have the opportunity to practice the new skills themselves, with support from peer educators, in order to gain confidence and self-efficacy in particular health behaviors. Environmentally, the curriculum provides the literal and figurative space for youth to try out new identities and explore different approaches to arriving at the best decisions for their lives.
- 2. Cognitive Dissonance Theory.** While the primary goal of Re:MIX is to improve knowledge and behavioral outcomes of youth who complete the curriculum, it also served as an opportunity for the peer educators to improve a set of skills for themselves. The peer educators may not have previously practiced healthy behaviors, but by taking a peer-teaching role, they may experience positive changes in their behaviors and beliefs. The curriculum links youth and peer educators through the common threads of youth development.
- 3. Theory of Possible Selves.** By engaging youth in various goal-setting activities and supporting peer educators in mentorship and career planning, both groups have the opportunity to plan for their futures by aligning their current health behaviors to their goals. In doing so, they are able to explore their identities in expansive ways.
- 4. Fuzzy Trace Theory.** Re:MIX emphasizes how youth weigh costs and benefits when making calculated decisions, and the curriculum was designed to help youth determine the best decision based on which is better than an alternative one. The program aims to leave youth with gist traces (i.e., memories of bottom-line meanings) of desirable choices that they can access cognitively when making important decisions about relationships and sex in the future. This is achieved through final key messages stated in each activity and in the closing session when participants mix the key messages to restate what they have internalized. Finally, Re:MIX uses a reflective approach (ReMIX Code) consistently and

frequently throughout the curriculum to synthesize the curriculum objectives and key messages.

5. **Sociological Imagination.** Re:MIX asks participants to connect what they think about their gender identities to the broader communities in which they live. Participants consider socially defined gender norms and messages placed on men and women and how these norms and messages affect their own beliefs and behaviors regarding gender and relationships. Throughout the curriculum, storytelling segments give participants the opportunity to hear stories from their peers as well as to share their own stories that have shaped who they are and what they think and believe. Group discussions provide a space for youth to share their perspectives while listening and thinking about how others may have experienced similar situations and how this relates to the world around them.
6. **Additional approaches.** Re:MIX also incorporates aspects of positive youth development, gender-transformative approach, inclusivity, and peer education.

In addition to the formative research discussed in the report's Introduction, the study team gathered formative feedback during the program's planning and development stages.

1. Following a session titled, "Am I Ready to be a Parent?" a sample of Gender Matters participants completed a survey about their perceptions of the session, their thoughts and feelings about teen parenting, and their reflections on facilitation and activities. Nearly all of the 25 respondents (92 percent) reported that they probably or definitely would have learned more if teen parents had facilitated the session. When asked to explain, two main concepts emerged: 57 percent mentioned that teen parent facilitators have credibility and direct experience that makes their presence valuable and 52 percent identified that teen parent facilitators could provide concrete details about the emotional and social impacts and realities of teen parenting.
2. The evaluation team conducted in-depth interviews with 12 former No Kidding peer educators, who were also parenting teens. These interviews provided insights about how they perceived their risk for pregnancy, relationships, personal growth, future education and employment prospects, and access to health resources—as a result of participating in the No Kidding peer education program. Re:Mix incorporated these views into its content and activities, including a particular emphasis on the role of peer educators and their personal contributions through storytelling.

Drawing on this research and experience, EngenderHealth determined that a rigorous evaluation of the program would add to the scientific evidence about aspects of this intervention that have not been studied extensively to date: the relative strength and influence of peer health education in TPP approaches, the effectiveness of gender-transformative interventions, adolescents' acceptance of and access to other health services (including long-acting reversible contraceptives), and the program's impact on repeat unplanned pregnancies.

Appendix B: Data Sources

Table A.1. Implementation Element: Study Sample

Implementation Evaluation Research Question	Data Source(s)	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
How many classes were recruited for the study?	Enrollment tracker	N/A	N/A	Sum of classes
How many youth received services? How many youth participated in the study?	Enrollment tracker	N/A	N/A	Sum of youth
What were the baseline characteristics of the youth in the treatment and control groups? Did the program reach the target population?	Baseline data	Each youth complete baseline before the first treatment session was held	<ul style="list-style-type: none"> • Gender • Race/ethnicity • Age • Grade 	Percent male; percent Hispanic, white, black, other race/ethnicity; mean age; percent 8th, 9th, 10th grade

Table A.2. Implementation Element: Adherence

Implementation Evaluation Research Question	Data Source(s)	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
How many staff were planned to be hired to deliver the curriculum and how many were actually hired?	Administrative notes	N/A	N/A	Sum of staff
How many staff who delivered the curriculum were trained as planned?	Administrative notes, training attendance logs, training reports	N/A	N/A	N/A
How many sessions were delivered across all classes?	Facilitator fidelity logs	Facilitators were expected to complete a fidelity log after each session delivered	Average sessions delivered, out of 10 possible	Average sessions delivered calculated as the average number of the sessions delivered across the total number of classes
How many activities were completed across all sessions and all classes	Facilitator fidelity logs	Facilitators were expected to complete a fidelity log after each session delivered	Average activities completed per session	Average activities completed calculated as the average percent of activities completed in each of the 10 sessions, across all classes
What kinds of adaptations were made to sessions?	Facilitator fidelity logs, meeting notes	Facilitators were expected to complete a fidelity log after each session delivered; meeting notes were regularly taken	Count of most common adaptations	Review of meeting notes and count of common adaptations

Table A.3. Implementation Element: Dosage

Implementation Evaluation Question	Data Source(s)	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
How many sessions did youth attend?	Youth attendance logs	A tracking database was created for facilitators to take attendance at the start of each session	The number of sessions attended, out of 10 possible sessions	Average sessions attended calculated as the average number of the sessions attended across students in all classes
How many youth attended sessions?	Youth attendance logs	A tracking database was created for facilitators to take attendance at the start of each session	<ul style="list-style-type: none"> The number of students who attended at least one session The percent of students who attended at least 75% of sessions 	Students who attended at least 75% of sessions calculated as the number who attended at least 8 out of 10 sessions out of the number who attended at least one session
How many youth were retained throughout the semester?	Posttest response rates	N/A	The percent of students who completed both baseline and posttest surveys	Percent based on treatment or control status
What additional professional development/mentoring did peer facilitators receive?	Administrative notes, attendance logs, timesheets, monthly reports	N/A	N/A	Counts of additional supports used by peer facilitators

Table A.4. Implementation Element: Quality

Implementation Evaluation Question	Data Source	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
Were sessions of high quality according to observers?	Observations of the quality of classroom interactions	The research team developed a protocol to assess session quality during at least 10% of program sessions	Session quality was rated on a 5 point scale with 1 indicating low quality and 5 indicating high quality	Percentage of sessions that were high quality, calculated as the percent of observed sessions that the evaluator scored as a 4 or 5 for overall quality
Did youth actively participate in sessions?	Observations of the quality of classroom interactions	Evaluator-developed protocol	Active participation was rated on a 5 point scale with 1 indicating low participation and 5 indicating high participation	Percentage of sessions that were high participation, calculated as the percent of observed sessions that the evaluator scored as a 4 or 5 for participation quality
Were facilitators clear in their explanations?	Observations of interaction quality	Evaluator-developed protocol	Clear explanation was rated on a 5 point scale with 1 indicating low quality and 5 indicating high quality	Percentage of sessions where facilitators were clear, calculated as the percent of observed sessions that the evaluator scored as a 4 or 5 for explanation quality
Did students feel the curriculum was of good quality, that they learned something, and that they liked the facilitators?	Posttest feedback	<ul style="list-style-type: none"> Participants reported whether they felt Re:MIX was good quality overall, whether they learned from Re:MIX, whether they liked and trusted health and peer educators, and whether the 	<ul style="list-style-type: none"> Overall quality was rated on a 5 point scale with 1 indicating a low rating and 5 indicating a high rating (response options were poor, fair, good, very good, excellent) 	<p>Percentage of youth reporting good rating (a score of 3, 4, or 5)</p> <p>Percentage of youth reporting high ratings (a score of 4 or 5)</p>

Implementation Evaluation Question	Data Source	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
	Focus groups	<p>educators could motivate youth to talk</p> <ul style="list-style-type: none"> Focus groups of 7 youth were convened to discuss their perceptions of the program 	<ul style="list-style-type: none"> Remaining items were rated on a 4 point scale with 1 indicating low ratings and 4 indicating high ratings 	Qualitative analysis for common themes
Did school staff feel that the program was implemented with high quality?	Interviews	Interviews with school staff to discuss their perceptions of the program	N/A	Qualitative analysis for common themes
Did facilitators feel the program was implemented with high quality?	Interviews	Interviews with facilitators to discuss their perceptions of the program	N/A	Qualitative analysis for common themes

Table A.5. Implementation Element: Counterfactual and Context

Implementation Evaluation Question	Data Source(s)	Brief Description of Data Collection Methods	Constructs and Variables Included	Analysis Conducted
What programming did youth in the control group receive?	Control class log	The research team gathered information from teachers each semester on what they did with the control classes	Classes were categorized as “full alternative curriculum,” “partial alternative curriculum,” and “standard program”	Percentage of classes using each type of programming
What information on SRH did both groups receive?	Posttest responses	Participants reported whether they had received information on different SRH topics in the past 3 months, and where they got this information from if they had	Receiving information on SRH topics and source of this information in the past 3 months	Percentage of students in treatment vs. control groups reporting receiving information on SRH topics and reporting receiving these from school vs. other sources
What other SRH programming was available to students at the school or in the community?	Interviews with school staff, contamination report	Interviews with school staff discussing the need for Re:MIX; contamination report developed in Year 1 describing other TPP programming available in the region	N/A	N/A
What other factors may have influenced Re:MIX?	Meeting notes	N/A	N/A	N/A

Appendix C



Re:MIX — A pilot study using young parents as peer educators to deliver a comprehensive sexuality education curriculum



EngenderHealth
for a better life

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THE PEER EDUCATOR PROGRAM

The Re:MIX Project has two arms: a comprehensive sexuality education curriculum that provides age-appropriate, medically accurate sexual and reproductive health information, and the Peer Educator Program (PEP), a professional development (PD) program for young parents. The PEP combines a wide range of PD activities with employment as a peer educator (PE) in Re:MIX classes in three charter schools in Austin, Texas, USA. PEs co-teach Re:MIX classes with a health educator, providing the opportunity to master sexual and reproductive health (SRH) content, as well as facilitation and classroom management skills. PD activities include trainings, mentorship, and community engagement opportunities, all designed to teach, practice, and reinforce proficiency and skills in four core competency areas.



TABLE 1: FOUR CORE PROFESSIONAL DEVELOPMENT COMPETENCIES

LEADERSHIP	Role Model	Sharing Knowledge	Taking Responsibility
	Vision	Civic Engagement	Teamwork
COMMUNICATION	Professionalism	Facilitation	Presentation & Attitude
	Interaction	Language	Boundaries
	Public Speaking	Grammar & Spelling	
PERSONAL MOTIVATION	Growth	Coachability	Flexibility
	Goal-Oriented	Initiative	Ownership
ACCOUNTABILITY	Attendance	Reliability & Dependability	Effort
	Time Management		



PROGRAM CAPSTONE:
Closing plenary at the seventh annual Healthy Youth Partnership Conference, a regional conference for youth-serving professionals, in Austin, Texas.



TABLE 2: PORTFOLIO OF WORK TO DEMONSTRATE GROWTH OVER THE 10-MONTH PROGRAM

DELIVERABLE	DESCRIPTION
Resume, Cover Letter, & LinkedIn	Copy of sample resume, cover letter, and link to professional LinkedIn profile
Goals Tracking Forms	Tracking goal-setting forms from beginning and end of program
Record of Trainings	List of training sessions completed over the program period
Record of Facilitation	List of class/curriculum sessions facilitated over the program period
Record of Community Service	List of volunteer hours and/or council positions held over the program period
Storytelling Video	Hyperlink to online video
Formal Presentations	Slide decks from individual research project(s) and/or conference presentations
Independent Work Projects	Sample collection of written and visual work produced over the program period
Social Media Videos	Selection of SRH social media videos produced over the program period

"I have gained a lot of confidence in myself. I have learned to appreciate my own story and life more than I did before I started this program."
—Peer educator



"I have grown in realizing what I am capable of and that I can track progress without validation from others."
—Peer educator

THE PEER EDUCATOR PROGRAM EVALUATION

A process and ethnographic evaluation of a 10-month professional development program for Re:MIX PEs to increase their confidence and self-efficacy in professional competency areas and to reduce repeat unplanned pregnancies among the PEs.

Sample:
• N = 4 mothers
• Aged 19–27 years
• Age at first birth: 17–22 years old

Tools:
• Surveys & feedback forms
• Individual interviews & focus groups
• Classroom and training observations

RESEARCH QUESTIONS:

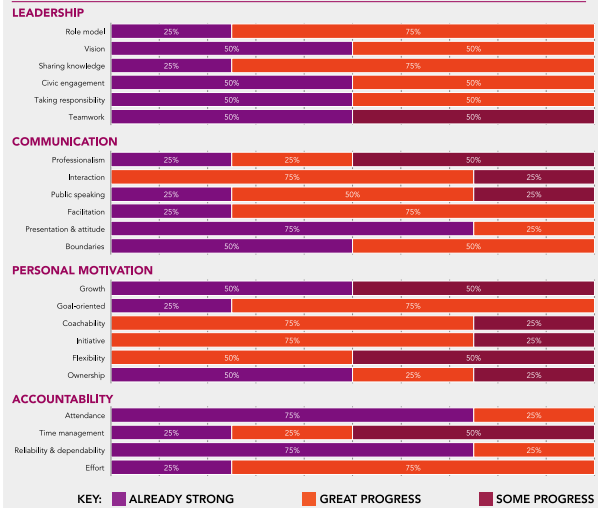
The individual-level research questions are:

1. Do PEs gain proficiency in the four competency areas over the course of the program?
2. If so, are those gains maintained 12 months after they have exited the program?

The programmatic/organizational-level research questions are:

1. What are the challenges and successes that Re:MIX staff experience during implementation of the PEP?
2. How can these challenges be minimized and successes maximized during replication and scale-up?

FIGURE 1: SELF-REPORTED GROWTH IN FOUR CORE PD COMPETENCIES



* Re:MIX staff and Health Educators interviews confirm growth in the competency areas.

CONCLUSION/NEXT STEPS

- A 360-degree rating component will be added to Year 2 for PEs, HEs, and full-time Re:MIX program staff to rate one another in the four competencies. Data will be collected each semester and used as data for decision making continuous quality improvement.
- Despite targeted recruitment efforts, Re:MIX program staff were not able to engage any young fathers in the PEP for the second year in a row; this continues to be an area for improvement for the team.
- Data collection for Year 2 is underway. The current cohort of PEs consists of four mothers aged 18–21.
- Re:MIX staff continue to keep previous PEs engaged in the program by providing leadership and mentoring opportunities to the current cohort.

"I have improved or gained skills on what assertive communication is and how to effectively utilize it in different scenarios. Also, to be direct yet sensitive to others when communicating."
—Peer educator



"The most important lesson I've learned is working with the different personalities... how to cofacilitate, do trainings and meetings together, and be a team."
—Peer educator