Statewide Contraceptive Access Initiatives: Summary of Listening Session Findings

June 2024

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INTRODUCTION

Since the early 2000s, more than 30 Statewide Contraceptive Access Initiatives (SCAI) have been implemented in the U.S. The Coalition to Expand Contraceptive Access (CECA), in collaboration with the Center for Reproductive Health Research in the Southeast (RISE) at Emory University, led a collaborative effort to document and share lessons learned across SCAI and help ensure ongoing and future SCAI efforts can be shaped by previous project activities, challenges, and successes.

As an initial step in this process, CECA convened "listening sessions" with 38 representatives from nine SCAI to gather insights on promising practices, challenges, and opportunities. Six 90-minute structured small group discussions ("listening sessions") were conducted from October to December 2023 with SCAI leaders, staff, and funders of completed, ongoing, and newly funded projects to gather insights on promising practices, challenges, and opportunities related to the initiatives. The listening sessions focused on implementation, evaluation, and Sexual and Reproductive Health Equity (SRHE) in SCAI.

FINDINGS

Six key findings emerged from the listening sessions related to SCAI planning and initiation, implementation, evaluation, and dissemination. Illustrated below, these findings demonstrate the shared approaches, challenges, and future opportunities across the various initiatives, while also highlighting how SCAI consider and adapt to their unique contexts.

SCAI Listening Sessions: Overview of Key Findings	
1. **Centering Equity**	Despite an initial focus on expanding access to long-acting reversible contraceptives (LARCs) and/or unintended pregnancy, many SCAI have either shifted to or started from equity-informed approaches.
2. **Planning Yet Being Flexible**	When possible, SCAI benefit from having dedicated planning time built into the project approach and recognize the need to remain flexible as the project is underway.
3. **Implementing Activities**	SCAI implement a range of activities to expand contraceptive access based on local priorities, needs, and context, yet resource and capacity challenges can constrain implementation efforts.
4. **Evaluating Process and Outcomes**	Most SCAI include evaluations of the initiative's processes and outcomes, yet resource and capacity challenges can constrain evaluation efforts.
5. **Identifying Measures**	SCAI often use common measures to assess various components of the initiative and continue to explore approaches to assess broader impact.
6. **Disseminating Learnings**	SCAI aim to share key findings about the initiative with a broad range of stakeholders and carefully consider when and how to disseminate learnings.

1. Centering Equity

Despite an initial focus on expanding access to long-acting reversible contraceptives (LARCs) and/or unintended pregnancy, many SCAI have either shifted to or started from equity-informed approaches.

SCAI representatives shared that interest among key stakeholders (e.g., public and private funders, national sexual and reproductive health (SRH) organizations, governor's offices, and other state agencies) often helped to launch the SCAI and generate early funding opportunities. This interest was often initially tied to an explicit focus on reducing unique barriers (e.g., costs, logistical challenges) to expand access to long-acting reversible contraceptives (LARCs) and/or measuring outcomes, such as public cost savings associated with preventing unintended pregnancy. Many SCAI representatives shared that the scope of their initiatives broadened over time as the field shifted to approach contraceptive access differently. This expansion reflected the increased adoption of reproductive justice and person-centered care frameworks, advocacy by reproductive justice leaders, and creativity on the part of SCAI leaders and implementers.

Centering and advancing equitable contraceptive access. Many SCAI turned these shifts into an opportunity to adopt new language, framing, and goals that better centered equitable access to services and person-centeredness in care delivery. Reported strategies included:

- **Prioritizing facilitating access to the full range of contraceptive methods** for all people regardless of their ability to pay, particularly those who are uninsured, underinsured, have limited resources, or may face broader challenges to accessing care otherwise.

- **Purchasing or supplying the full range of contraceptive methods** for clinical and community partners, even when partners may have limited interest in stocking less commonly used methods, along with training on person-centered counseling and provision of all methods.

- **Offering trainings to internal staff and clinical and community partners** on cultural humility, racial equity, justice, and the history of coercion in SRH care as well as trainings for healthcare providers on removal of LARC methods and person-centered counseling around removals.

- **Engaging and supporting policy, advocacy, and implementation efforts** to expand contraceptive access (e.g., contraceptive coverage and enrollment).

- **Expanding contraceptive access for people living in rural areas**, areas with limited contraceptive access, and maternity care deserts, for example, by supporting expansion of telehealth offerings.

- **Exploring opportunities to expand access to broader SRH and related services to meet people's needs**, for example, by working in partnership with primary care and STD services.

- **Collaborating with new partners in adjacent areas** (e.g., transportation, early childhood education) to further expand opportunities to access contraceptive education and services outside of traditional health delivery setting and help create a culture of reproductive wellbeing.

- **Integrating equity-informed approaches into evaluation plans** by prioritizing assessing individuals' experience with quality of care, person-centered counseling, and access, through focus groups, in-depth interviews, and surveys with patients and other community members, to elevate lived experiences and community voice.

"Whenever we talk about our program, we talk about our pillars of our program. It is all encompassed around reproductive justice. Everything we do is with this mindset. We offer transportation, referrals to primary care, we have a patient liaison. Whenever we talk about new things coming to our program, we ask about how we bring equity to that work."

Taking accountability and building trust. SCAI representatives reflected on existing mistrust in the community around healthcare, especially related to contraception and SRH, as a key challenge. Participants discussed the importance of SCAI leaders and staff having awareness of the larger historical context around SRH when implementing their projects, and specifically their distinct state contexts. SCAI leaders who previously implemented LARC-focused projects shared the importance of taking accountability and striving to demonstrate the initiative's commitment to principles of equity and reproductive justice, including prioritizing slow and meaningful relationship-building and re-gaining trust and support with partners and community members.

Aligning funder, partner, and program priorities. SCAI representatives shared that consistent and flexible funding allowed initiatives to respond rapidly to evolving project needs and local community needs. Public funding was considered to demonstrate support and broader public buy-in for the initiative from the state and favorable for ongoing sustainability of the initiative but was, generally, less flexible compared to private funding. Philanthropic investment was often described as pivotal to the initiative's initiation, particularly in states where dedicated public funding for a SCAI would be unlikely due to the political context.

Yet, at times, SCAI representatives reported that misalignment of priorities between SCAI leaders and external stakeholders hampered progress and fostered harmful and inequitable practices. Advocates have noted the practice of focusing on expanding access to LARC (rather than promoting access to the full range of contraceptive methods a person may choose) and/or preventing unintended pregnancy reinforces "harmful agendas on whose reproduction should be prioritized."[1] In some SCAI, this focus led to limitations on how initiatives could use their funding, which required SCAI leaders to be clear about the benefits of focusing on equitable access to all methods. In some states with restrictive SRH policy, talking about equity could be a "conversation-ender" with state government and other partners, which required SCAI leaders to align access to contraception with other state priorities, like infant and maternal mortality.

> *"Our funding restricted what methods we could purchase by brand. We were restricted to only purchasing LARCs because we were told the Title X network could cover other methods. We couldn't push back against the funder. As time went on and the funder evolved in their thinking, we were permitted to expand to purchase any brand of any method. If any funder wields power that inhibits the purchase of particular contraceptive brands or methods, it's a huge problem."*
>
> *"We live in a state where you have to talk about contraception in terms of infant and maternal mortality. There's a lot of emphasis on LARC in our state. We have to walk that line a little bit and say, 'We do provide LARC, but also all of these methods' in order to make sure that every patient is given what they want. We talk about this as an equity issue based on infant mortality, just to get our foot in the door."*

2. Planning Yet Being Flexible

When possible, SCAI benefit from having dedicated planning time built into the project approach and recognize the need to remain flexible as the project is underway.

Planning. Several SCAI representatives discussed the value of building dedicated planning time, generally one year, into their project timelines and funding to prepare for project implementation and evaluation.

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[1] Dehlendorf, C., & Perritt, J. (2022). Statewide contraceptive access initiatives: a critical perspective. *American Journal of Public Health*, *112*(S5), S490-S493.

Those without built-in planning time mentioned that, in hindsight, the dedicated planning time would have been helpful before launching the initiative. When available, SCAI maximized planning time by:

- **Mapping out the project vision, frameworks, and implementation and evaluation approaches**, and using these tools to guide value-aligned decision-making.
- **Understanding the landscape** by conducting needs assessments, scans, and partner site visits.
- **Identifying and managing relationships** with potential partners and champions across the state and across sectors whose buy-in, support, and/or participation can help advance the effort.
- **Learning from organizations doing similar work**, especially leaders of other statewide initiatives.
- **Connecting with key stakeholders**, including funders, clinical and administrative partners, community members, and others, to understand needs and challenges that need to be addressed, and receive feedback on implementation and evaluation plans.
- **Grounding all conversations, approaches, and practices in shared values** and building trust and relationships around those values to build buy-in across multiple levels of stakeholders (e.g., public, healthcare providers, and community partners).

Remaining flexible. Even with dedicated planning time, SCAI representatives emphasized the importance of being flexible enough to respond to changes and unexpected events while the project is underway. SCAI representatives reflected on the various ways the initiative's planned approach shifted in response to changes in programming, policy, and social contexts, such as:

- **Revising the initiative's mission and approach** to center equity and justice and align with the field.
- **Becoming involved in local, state, and national efforts** to better understand and address shifting state policy landscapes around abortion and SRH access.
- **Enhancing telehealth opportunities and adapting training modalities** for clinical partners in response to the COVID-19 pandemic and its impact on service delivery systems and the workforce.
- **Developing high-quality educational materials** for a range of audiences to combat mis- and dis-information about contraception.

> *"We started with a LARC-focused process. We thought about equity as people being able to access highly effective methods and are now thinking about it as people being able to access everything. We evolved to look at the project in a different way. We needed to learn and would not design it the same way now."*

3. Implementing Activities

SCAI implement a range of activities to expand contraceptive access based on local priorities, needs, and context, yet resource and capacity challenges can constrain implementation efforts.

While several different models for SCAI exist, initiatives implement a set of similar activities, often with shared goals, to expand contraceptive access across the states. When asked about facilitators who successfully implemented project activities, SCAI representatives described strong, collaborative partnerships; open dialogue and consistent communication; and building project activities around stakeholders' needs and priorities, especially the people accessing care. SCAI representatives were also

asked to indicate which two activities were most critical for success, based on activities described in the conceptual framework for SCAI.[2]

Training healthcare providers and staff. Mentioned most often, provider and staff training for clinical partners was integrated into almost all the participating initiatives. SCAI representatives described a range of strategies, including:

- **Developing and offering highly tailored trainings on a range of topics**, such as routine screening for SRH services, person-centered contraceptive counseling, LARC insertion and removal, foundations of reproductive justice, bias and coercion in contraceptive care, and billing and logistics.
- **Employing diverse training approaches**, such as in-person trainings, e-learning modules, in-clinic simulation trainings, preceptorships, email blasts, and job aids, focused on reaching a wide range of providers and staff multiple times and in multiple ways.
- **Offering training for all staff in a variety of settings**, including medical assistants, front-desk staff, and others in primary care settings, nursing schools, and residency programs.
- **Offering incentives for healthcare providers and staff at clinical partner sites to complete training**, including continuing education credits and credit for state-mandated implicit bias trainings.
- **Regularly revisiting training curriculums** throughout the project to update topics and content.

SCAI representatives also reflected on the challenges associated with implementing training for healthcare providers and staff at clinical partner sites. Many reported spending significant staff time and energy creating and delivering trainings, often customizing trainings for the state context, different health delivery settings, and different types of providers and staff across training platforms and modalities. While some initiatives adopted or tailored training materials developed by other national and academic organizations, SCAI representatives emphasized the need for trainings customized to each state and local context to increase relevance of the training for providers and staff. SCAI representatives also reflected on the time commitment required of clinical partners completing trainings and the need to balance how much time providers and staff were asked to devote to trainings. They also noted that high turnover rates among clinical staff, especially during the COVID-19 pandemic, often resulted in knowledge loss and need for additional training of new staff.

> *"We had high turnover and high vacancy rates among our clinical partners. We offer ongoing training to compensate for all of the turnover that happens. But we can work with a health center for 18 months and then key personnel leaves and all of a sudden, that practice change is disintegrating."*
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> *"Our program doesn't do training on contraceptive care, and there's two reasons why. When we got our funding, our team of providers on-staff didn't have the bandwidth to be educators and deliver care. It is also really hard to change clinician behavior. Our model focuses on finding partners that are already champions who are interested in providing this care, and our training relies on introducing the program [which finances contraceptive methods for eligible clinical partners] and the billing and logistics."*

Financing and supplying no- or low-cost contraception. SCAI often used their funds to purchase contraceptive methods and supplies for clinic and community partners or reimburse partners for the costs of contraceptive methods for eligible patients. SCAI representatives discussed several challenges to this activity, including billing departments in partnering clinical sites that have limited bandwidth and interest in figuring out how to bill for contraceptive care. One SCAI reported being initially limited in the types and

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[2] Malcolm, N. M., Patterson, K. V., Pliska, E. S., Akbarali, S., Moskosky, S. B., & Hart, J. (2022). Scaling up evidence-based practices in contraceptive access initiatives. *American Journal of Public Health*, *112*(S5), S473-S477.

brands of contraception they could purchase and supply, based on restrictions in their grant funding. SCAI representatives also shared that the pricing variability of less commonly used short-acting contraceptive methods sometimes made maintaining a supply of all contraceptive methods a challenge and potentially unsustainable for the initiatives.

Many SCAI representatives found that being able to provide low- or no-cost birth control was particularly important in states that were not Medicaid expansion states and did not have a strong Title X network. Conversely, one SCAI in a state with more comprehensive contraceptive coverage used funds to build capacity around billing and reimbursement and used the findings about costs savings of each contraceptive visit to recruit new clinical partners.

"A lot of hospitals felt it wasn't worth the time to figure out how to bill for inpatient contraception. Hospitals were sometimes going to eat the cost of LARC devices, but it wasn't sustainable. People also told us figuring out billing for contraception is not a priority, and there are other things that are causing hospitals to lose money. Unless someone in power can give different direction, it just doesn't happen. Reproductive health never gets the same respect that other things do."

"We are in a different scenario because our state has expanded Medicaid and people have fairly decent contraceptive coverage. We have never as an initiative served as a payor or reimbursed for the cost of contraceptive methods. We focus on providing technical assistance on reimbursement to our clinical partners and capturing data around the cost for each contraceptive encounter. The cost per encounter was decreasing the more providers routinely screening their patients. That data was very important when we were recruiting new partners, without the incentive of providing some sort of financial support to partners for participating in the project."

4. Evaluating Process and Outcomes

Most SCAI include evaluations of the initiative's processes and outcomes, yet resource and capacity challenges can constrain evaluation efforts.

During the listening sessions, SCAI representatives shared that SCAI evaluations range from small- to large-scale data collection and analysis efforts, from collecting informal feedback from project staff and clinical and community partners to conducting robust, longitudinal evaluations. Participants described the various evaluation models across SCAI. For example, some initiatives have an internal evaluation managed by or conducted closely with the project team, based on in-house evaluation expertise and capacity, funder requests, or budget constraints. Other initiatives include an independent external evaluation largely performed separate of implementation. The types of evaluation data, and for which outcomes, SCAI collect and analyze also varies.

Not all SCAI included formal evaluation as part of their project; SCAI representatives cited reasons such as the desire to alleviate the burden of data collection on clinical and community partners and limiting potential coercion from clinical practice and care delivery. For example, representatives noted the potential risk of clinical partners promoting LARC use over other contraceptive methods, based on data from contraceptive method provision rates and rates of unintended pregnancy.

Designing effective evaluations. All SCAI representatives recognized the benefits of evaluation and found it important to adequately plan and budget upfront for what might be required of SCAI evaluation, no matter the scale. SCAI representatives reported the need to consider a range of issues, including:

- What questions about the initiative should be answered and what measures can help answer them.

- How measures are specifically defined for different contexts and what data elements are available.

- How to integrate community voice into the evaluation.

- How to collaborate with partners for evaluation support and ensure alignment with key stakeholders, including funders, implementation teams, and clinical partners.

- What resources are needed, such as personnel, relationships, and tools.

- How the evaluation aligns with and might be able to respond to changes in implementation, including evolution of implementation strategies and extensions in implementation periods.

- Evaluation periods of interest and how to differentiate data collection, analysis, and reporting for process and quality improvement versus outcome evaluation.

Experiencing and addressing evaluation challenges. SCAI representatives reported that evaluations can be costly, in large part because they are time-consuming, labor-intensive, and logistically challenging. Participants reflected on a range of challenges they encountered as evaluation efforts were underway:

- While high-quality, unbiased data is essential for drawing meaningful conclusions and assessing the difference that these initiatives are making, data collection proved to be more challenging and resource-intensive than expected.

- Poor data quality and other data collection difficulties for both qualitative and quantitative data often required SCAI to deviate from their initial evaluation plan.

- Other barriers included clinician and staff capacity, survey burden on patients and community members, logistics of on-site data collection, inconsistent (or nonexistent) electronic health record (EHR) and claims data, and the need to heavily rely on health center systems and processes.

As a result of the COVID-19 pandemic, many SCAI representatives mentioned having to rethink particular data elements, data collection strategies, planning timelines, and data analysis plans given the toll on health system staff, lack of focus on national surveys, changes in SRH service use, and fundamental changes in how initiative activities were implemented. Many are questioning the utility of their data at the height of the pandemic and the feasibility and appropriateness of comparing initiative data across years that span the pandemic. Additionally, SCAI leaders from several initiatives that started just before the COVID-19 pandemic did not consider the initiative to have true baseline data and are exploring options for longitudinal analysis.

SCAI representatives described evaluation as complex and evolving, due to programmatic, social, and political shifts and the need to remain flexible and adaptable to unplanned factors. They continue to explore ways to help improve data quality and alleviate the burden of evaluation. Strategies included building leadership support among key partners and staff to enhance data collection and improve the quality of data as well as tailoring the approach when working with different clinics and health organizations to ease on-site processes and facilitate the collection of consistent and comparable data.

"Longitudinal evaluations are insightful, but process evaluation and rapid-cycle quality improvement (QI) are also helpful. We are not just interested in what the results of the SCAI are, but how things are working. Stronger process evaluations/QI can identify outcomes, like potential coercion, and allow implementation teams to address it sooner."

"We found discordance between health center administrative data and provider data and conducted key informant interviews to learn more. Getting qualitative input from various staff helped us understand the nuance that exists. What is happening within health centers is so nuanced – for example, patient decision making, patient interaction, billing/coding. Trying to understand the truth about what is going on takes a lot of data and relies on having established relationships."

5. Identifying Measures

SCAI often use common measures of interest and continue to explore approaches to assess the broader impact of the initiative.

Whether working with available measures or developing new tools to collect more meaningful data, SCAI representatives discussed their approaches to evaluating processes and outcomes across different levels of the initiatives. During the listening sessions, those levels were framed as: 1) healthcare providers and health centers, 2) clients and potential clients/community members, 3) public policy, and 4) health and social outcomes.

Healthcare providers and health centers. SCAI representatives reported that evaluations often assess the delivery of provider training and technical assistance and its effects on knowledge, skills, changes in service delivery, and delivery of person-centered care. Additional measures of interest include changes in clinic workflow, contraceptive care encounters, method mix provision/stocking and same-day access, and provider experience and perceptions.

Clients and potential clients. Initiatives primarily assessed client satisfaction and experience care using patient-reported outcome measures, like the Person-Centered Contraceptive Counseling (PCCC) Measure; enrollment and service utilization; and contraceptive use, continuation/switching, and decision-making. SCAI representatives mentioned shifting away from solely monitoring use/provision of highly effective methods and moving toward evaluating people's experiences of care and ability to access the method of their choice. Within the community, few evaluators mentioned assessing barriers to care and preferences for individuals who were not service users.

Initiatives use a variety of methods (e.g., paper questionnaires, phone interviews, digital surveys) to assess individual-level factors. Some SCAI used digital surveys to empower respondents to answer more truthfully about sensitive topics, such as individual demographics and whether they felt pressure to choose a certain contraceptive method. SCAI representatives were enthusiastic about the value of qualitative data to provide context and enrich findings around both patient and provider perspectives. SCAI representatives discussed continuing efforts to improve response rates, diversify survey methods, and build relationships with health center staff and other partners to support patient-reported data collection. Some also described future opportunities to leverage centralized data reporting and analytics tools to help simplify evaluation efforts.

"We conceptualized equity in terms of quality of care, PCCC, and access, given the context in our state and priority populations of the initiative. We designed studies and data collection instruments to examine intrapersonal quality with individual experiences, as well as the different dimensions of access at the clinic and system level."

Public policy. Some SCAI representatives mentioned integrating assessments of changes in and effects of public policy into their evaluation plans. These participants described a multi-pronged approach, including tracking policy objectives and developments; conducting key informant interviews with stakeholders to understand shifts in the policy environment; tracking enrollment and utilization for family planning services under Medicaid; and using narrative perspectives to understand the effects of changing policy landscapes. Some SCAI also reported monitoring population-level behavioral risk factors surveillance systems to look at broader state-level contraceptive use data.

Health and social outcomes. SCAI representatives grappled with measuring outcomes that can demonstrate the impact of the project while also being aligned to the initiative's values. Participants discussed decisions to either exclude changes in unintended pregnancy as an outcome of interest in the evaluations or shift away from a focus on unintended pregnancy as the primary health and social outcome reported (and instead toward, for example, measures of interpregnancy intervals or impact on systems change), based on aligning the evaluation with principles of equity and justice. Several participants shared that the data currently available on the initiatives do not demonstrate an impact on broader health. They also reflected on the ongoing, changing, and dynamic nature of contraceptive use in people's lives, further complicating initiatives' ability to measure the impact on health and social outcomes accurately and meaningfully.

Many representatives discussed the limitations of the existing measures and the need to develop new measures and approaches to:

- Advance equity, justice, and person-centeredness.
- Better indicate if and how SCAI should adjust their implementation approach to advance equity.
- Demonstrate the impact on the broader health and wellbeing of people and communities.
- Provide a more reliable and complete story of the contraceptive access landscape in their states.

"The measures we do have have limitations. What we have is inequitable and very difficult to use and it is difficult to measure access to contraceptive care. The actual assessment tools that are nationally available are not good for equity. People want to stick with what we have but we need to look for new ways."

6. Disseminating Learnings

SCAI aim to share key findings about the initiative with a broad range of stakeholders and carefully consider when and how to disseminate learnings.

Several SCAI representatives found that sharing meaningful findings about the initiatives, when done in a way that resonates with specific audiences, can bring prioritize SRH care and demonstrate the importance of contraceptive access to overall health and wellbeing. Participants reported sharing project findings with clinical and community partners and with the public in various ways and for various reasons. Examples include:

- Annual and semi-annual reports available online and/or shared with implementation teams, funders, and other stakeholders.
- Brief and easy-to-digest one-pagers.
- Peer-reviewed publications.
- Presentations at professional conferences.
- Social media posts.

SCAI representatives shared that timing of dissemination can be as important as the approach, as stakeholders sometimes draw inaccurate conclusions based on when teams share project findings. This was described for several audiences, including funders, some of whom want regular feedback loops and touch points to hear stories, findings, and perspectives from the project team and other key partners.

SCAI representatives discussed a range of strategies they felt could bring power and clarity to the narrative that SCAI findings provide, including:

- **Being strategic and judicious** about what findings are shared, when, and with whom.
- **Tailoring the method or product** for the specific audience and having conversations with them to demonstrate the value of the work and increase alignment around shared values.
- **Providing context**, like sharing that data can fluctuate over time and for various reasons.
- **Educating audiences about how to interpret the data**, especially when sharing early or incomplete data.
- **Sharing findings with actionable recommendations** to potentially gain greater interest in the data, for example by sharing patient experience data with considerations for person-centered approaches.

> *"We had to educate our partners that not seeing shifts in contraceptive method use does not mean that implementation is not working. Small or no changes in LARC uptick is okay if people are accessing the contraception method of their choice. Changes in LARC method use may be the result of improved patient awareness and decision-making."*

CONCLUSION

SCAI seek to expand access to contraception by bringing together key partners committed to advancing access, increasing health center capacity to provide services, and removing structural barriers to contraceptive access, such as cost. The listening sessions and growing body of evidence indicate that SCAI can advance the provision of person-centered care, expand contraceptive access, and improve health outcomes.

Summarizing the Key Findings

As some of the legacy SCAI end and a new generation of SCAI emerge, the listening sessions underscored the critical need to expand the potential of these initiatives, with an eye toward advancing SRHE across all phases of project implementation and evaluation. The report outlines six key findings for consideration.

1. Centering Equity

In response to changes in the field and advocacy from reproductive justice leaders, SCAI representatives reported they centered equity by, for example, prioritizing facilitating access to the full range of contraceptive methods, expanding access to broader SRH and other services, and demonstrating a commitment to principles of equity and reproductive justice to build trust and support in communities. Yet, SCAI representatives shared that the historical primary interest on expanding access to LARC methods (rather than promoting access to the full range of contraceptive methods that a person may choose) and reducing unintended and teen pregnancy was not consistent with an equity-focused approach. This misalignment of priorities at times limited how initiatives could use their funding and hindered potential partnerships and community relationships.

2. Planning Yet Being Flexible

SCAI representatives reported using dedicated planning time to map out the project vision and approach, engage partners and champions, and gather diverse stakeholder feedback about needs and challenges to refine project activities. SCAI representatives also stressed the need to remain flexible, while the project is underway, to respond to changes and unexpected events. SCAI engaged and aligned with the broader SRH field to better understand and address shifting SRH policy landscapes and revise their vision and approach to center equity and justice. They also adapted training and service delivery models in response to the COVID-19 pandemic and developed educational materials to combat mis- and dis-information about contraception among healthcare providers and the public.

3. Implementing Activities

SCAI participants shared that strong, collaborative partnerships; consistent communication; and project activities built around stakeholders' needs and priorities are key factors for successful implementation. Provider and staff training was highlighted as the most critical activity for success, and SCAI representatives reported providing trainings on a range of topics and through a variety of modalities and settings. Reported challenges included high staff turnover rates at clinical and community partner sites and time commitments of partners. Financing and supplying no- or low-cost contraception was also prioritized by SCAI representatives, particularly for states that are not a Medicaid expansion state and do not have a strong Title X network. Reported challenges included lack of interest in or capacity for billing for contraceptive care among clinical partners, funding restrictions, and stocking issues.

4. Evaluating Process and Outcomes

SCAI implement evaluations range from small- to large- scale data collection and analysis efforts, from collecting informal feedback from project staff and clinical and community partners to conducting robust, longitudinal evaluations. SCAI representatives described evaluation as complex, expensive, and evolving, due to programmatic, social, and political shifts and unplanned factors, such as the COVID-19 pandemic. To address these factors, SCAI reported rethinking specific data elements, data collection strategies, planning timelines, and data analysis plans; building leadership support among key partners and staff to enhance data collection; and using tailored approaches when working with multiple clinical partners to ease on-site processes and facilitate the collection of comparable data.

5. Identifying Measures

SCAI representatives reported using a range of shared measures to assess various components of the initiative (see below). Yet, many participants discussed the limitations of the existing measures and the need to develop new measures and approaches to advance equity and person-centeredness, demonstrate impact, and provide a more complete story of the contraceptive access landscape in specific states.

Examples of Evaluation Measures Highlighted During Listening Sessions

- ***Healthcare providers and health centers*** *– To assess delivery of provider training and technical assistance and their effects on knowledge, skills, and delivery of person-centered care.*

- ***Clients and potential clients*** *– To assess client satisfaction and experience with care using patient-reported outcome measures; enrollment and service utilization; and contraceptive use, continuation/switching, and decision-making.*

- ***Public policy*** *– To track policy objectives and developments; conduct key informant interviews with stakeholders; track enrollment and utilization for family planning services under Medicaid; and share narrative perspectives to understand the effects of changing policy landscapes.*

- ***Health and social outcomes*** *– Potentially to shift away from a focus on unintended pregnancy completely or as the primary health and social outcome and better align the evaluation with principles of equity and justice.*

6. Disseminating Learnings

SCAI representatives reported sharing project findings with clinical and community partners and with the public through, for example, annual and semi-annual reports, one-pagers, peer-reviewed publications, conference presentations, and social media posts. Strategies for sharing meaningful findings and fostering action included being strategic about when and with whom findings are shared, tailoring the method or product for the specific audience, educating the audience about how to interpret the data, and sharing findings with actionable recommendations.

Sustaining SCAI Efforts and Impacts

Sustainability was explored briefly during the listening sessions and will be a primary discussion topic during the Summit convenings with SCAI leaders in Winter 2024. During the listening sessions, initiatives shared that sustainability, particularly as project funding ends, presents a challenge for many SCAI. As a potential promising practice to support sustainability, SCAI representatives reported that sharing project "wins" in user-friendly reports with key stakeholders can help SCAI leaders advocate for funding, contributing to the preservation of the project. SCAI leaders continue to explore approaches to meaningful sustainment of project activities, impact, and progress toward broader contraceptive access goals.

Continuing the Conversation

Several SCAI representatives reported during the listening sessions that they value opportunities to cross-share experiences and approaches. Teams appreciated hearing what other initiatives are doing, as they navigate continuous learning, improvement, scaling, evolution, and sustainment efforts. The Summit convenings in Winter 2024 will serve as an opportunity for SCAI representatives to exchange information and explore what national SRH organizations, like CECA, ASTHO, Power to Decide, and the broader field, can do to maximize their support to existing and future SCAI teams.

"There's so much opportunity and impact at the state level. For organizations that are looking at statewide work, there is so much need and opportunity. I find that to be incredibly motivating."

"At the end of the day, if someone can access care with dignity, quality, and non-coercion, it makes it all worth it!"