IRR=10.68; adolescent-multiple: IRR=2.36) (partner single: IRR= 11.73; partner-multiple: IRR=10.80) or reporting penile-vaginal sex (adolescent-single: IRR=16.11; adolescent-multiple: IRR=22.93; partner-single: IRR= 9.17; partner-multiple: IRR=16.74) increased orgasm odds. Reporting anal sex doubled the likelihood of perceiving their partner had multiple orgasms (IRR=2.35) and tripled the adolescent's own orgasm uncertainty (IRR=2.97).

Conclusions: Enjoying sex – including orgasms – is key to healthy sexual development. Inquiring and about adolescents' perceptions of and experiences with pleasure and orgasm could serve as a good starting place for encouraging open sexual communication. Such dialogue scaffolds healthy sexual development by encouraging the learning and experimentation key for both young people's understanding of what is enjoyable in their own/partner's sexual lives, as well as what the circumstances are most conducive to positive sexual interactions.

Sources of Support: Church & Dwight, Inc.

213.

SEXUAL DESIRE IS NOT JUST A WOMEN'S ISSUE: AN EXPLORATORY STUDY ON SEXUAL DESIRE AMONG YOUNG ADULTS IN SWITZERLAND

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Purpose: Desire or libido issues are often discussed in a female perspective. The aim of this study was to assess the characteristics of both young males and females who reported poor sexual desire.

Methods: Data were drawn from the Swiss national survey on youth sexual behavior carried out in 2017. Out of 5175 participants (49.0% females; mean age 26.3) who completed the questionnaire, 5124 (99.0%; 48.9% females; mean age 26.3) answered a question about current sexual desire ("In the last 4 weeks, how would you rate your level of sexual desire or interest?"). Answers ranging from inexistent or very poor to very high were dichotomized into POOR (inexistent or very poor, poor) and NoPOOR (medium, high, very high). We compared both groups on sociodemographic status, education (tertiary/other), residence (urban/rural), social life and financial satisfaction, sexual orientation (heterosexual / non-heterosexual), current mental health (poor / good), partner-related and pornography experience variables. For the partner-related variables, we assessed the current relationship status (none / yes [casual or stable]) and current sexual life satisfaction (unsatisfied / other). We asked participants if they had ever watched pornography and we dichotomized the answers into yes (once, several times) and no (never). We first ran a bivariate analysis and all significant variables ($p<.05$) were included in a logistic regression using the NoPOOR group as the reference category. Results are presented as odds ratios (OR). We compared the groups separately by gender.

Results: Among males, 5.8% (n=151) reported poor sexual desire compared to 17.2% of females (n=431). At the bivariate level, for both gender, poor sexual desire was associated with poorer mental health (24.3% versus 14.2%), less social life (mean 7.0 versus 7.7 / 10) and sexual life satisfaction (30.0% unsatisfied versus 15.8%), no current relationship (43.3% versus 18.8%) and no pornography viewing (35.7% versus 18.1%). No associations were found for age, residence, education, sexual orientation and financial satisfaction. At the multivariate level, compared to the NoPOOR group, males in the POOR group were less likely to be satisfied with their social life (OR 0.89), to be in a current relationship (OR 0.26) and to have watched pornography (OR 0.24). Compared to females in the NoPOOR group, those in the POOR group were less likely to be satisfied with their social (OR 0.88) and sexual life (OR 0.48), to be in a current relationship (OR 0.39) and to have watched pornography (OR 0.68).

Conclusions: Even though sexual desire was rated as low by more females than males, still 6% of young males reported inexistent or poor sexual desire. Regarding gender stereotypes about sexuality, this rate is not negligible and highlights that sexual desire must be discussed independently of gender. It seems that these young adults might be in a context of greater dissatisfaction, especially in their social life. Further longitudinal studies are needed to determine the direction of causality between sexual desire, relationship status, psychological well-being and pornography use.

Sources of Support: The survey was financed by the Swiss National Science Foundation (grant #162538).

214.

CHARACTERISTICS OF YOUNG ADULT FEMALES WHO HAVE NEVER SEEN A GYNECOLOGIST

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Purpose: Swiss guidelines indicate that the first gynecological visit should take place when initiating sexual activity or, at the latest, at age 21 to perform a first pap smear. However, close to 5% of young adult females in our survey report never having seen a gynecologist by age 26. The aim of this study is to describe the characteristics of young adult females never having consulted a gynecologist.

Methods: Data were drawn from the Swiss national survey on youth sexual behavior carried out in 2017. Out of 5175 participants who answered all questions, 2534 (49%; mean age 26.3) were females and included in the study. They were distributed in two groups depending on whether they had ever seen a gynecologist (GYN group; 95.4%) or not (NOGYN group; 4.6%). Groups were compared on age, age at first sexual contact, having ever had oral, vaginal or anal sex, being a virgin, type of partner relationship they were in (none/other), and having a history of STI. We first ran a bivariate analysis and all significant variables ($p<.05$) were included in a logistic regression using the GYN group as the reference category. Results are expressed as odds ratios (OR) with [95% confidence intervals].

Results: At the bivariate level, NOGYN were older at first sexual contact (18.2 vs. 16.4 years), less likely to have ever had oral (88.5% vs. 97.4%) or vaginal sex (48.0% vs. 93.9%) or to have a history of STI (3.7% vs. 29.8%) and more likely to be a virgin (41.3% vs. 2.8%) and not being in a current relationship with a partner (52.5% vs. 16.1%). No difference was found for age or anal sex. At the multivariate level, NOGYN females were older at first sexual contact (1.19 [1.05:1.34]), less likely to have ever had vaginal sex (.07 [0.02:0.20]) and less likely to have a STI history (.53 [0.30:0.94]). We ran a second regression were we introduced being a virgin instead of oral or vaginal sex and NOGYN females were much more likely to be virgins (24.06 [15.91:36.38]).

Conclusions: The vast majority of our sample had seen a gynecologist at least once. However, one woman in twenty has never seen a gynecologist by age 26 despite recommendations. They seem to be women who may think not needing such a consultation because they do not have a partner or have a less intense sexual life or no sexual life at all. There is a need to better explain the importance for women

to consult a gynecologist for prevention purposes, independently of their sexual behavior.

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215.

VIRGINS AT AGE 26: WHO ARE THEY?

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Purpose: Swiss data indicate that the average age at first intercourse is just below age 17. However, by age 26 there is a minority of young adults who is still virgin in Switzerland. Our aim was to describe the characteristics of this specific group of young adults.

Methods: Data were drawn from the Swiss national survey on youth sexual behavior carried out in 2017. Out of 5175 participants (49% females; mean age 26) who answered all questions, 275 (5.3%) were virgins and were compared to the rest of the sample. We defined virgins as those never having had any sexual contact. We compared both groups on socioeconomic, familial, academic, social and health-related variables. We also compared them regarding substance use, online sexual behaviors, and life satisfaction. We first ran a bivariate analysis and all significant variables ($p<.05$) were included in a logistic regression using non-virgins as the reference category. Finally, we asked them the main reasons for remaining virgin.

Results: At the bivariate level, virgins were mainly males (58%), still living with their parents, in poorer physical and mental health, and obese. They reported a better financial situation but a poorer social one. They were significantly less likely to have ever smoked, been drunk, or used cannabis or other illegal drugs. They were also significantly less likely to adopt online sexual behaviors. At the multivariate level, they were more likely to be males (OR: 2.10), in poor physical health (1.52) and obese (1.33), and to consider their financial situation as better (1.15). However, they were less likely to live on their own (.24) or to be satisfied with their social life (.77). Overall they were also less likely to have ever smoked (.39), been drunk (.25) or used cannabis (.38). They were also less likely to encounter persons met on Internet (.52) or to have erotic conversations over the Internet with people they had never met face-to-face (.26). No difference was found for visiting pornographic websites. The main reason for not having had sex for females was I have not found the right person (46%) followed by I want to wait to be married (19%) and for males I have not had the occasion (47%) and I have not found the right person (19%), respectively.

Conclusions: About one young adult in 20 is a virgin by age 26. Young adults who are virgins seem to be overall less socially driven individuals who do not seem to have gone through the usual experimentations of adolescence. Interestingly, the main reason reported to explain virginity reveals gender-stereotyping responses. Their poorer health and the fact that they are more likely to be obese (and maybe feel less attractive) may also play a role and needs to be further explored.

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216.

WHAT'S A COACH TO DO?: FINDINGS FROM A 6-MONTH HEALTH COACHING INTERVENTION DESIGNED TO INCREASE CONTRACEPTIVE CONTINUATION AMONG ADOLESCENT AND YOUNG ADULT WOMEN

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Purpose: Adolescent women have high rates of contraceptive discontinuation and inconsistent method adherence, which are key factors driving the persistently high rates of unintended teen pregnancies. Although several evidence-based interventions to reduce contraceptive discontinuation targeting young women exist, none are tailored to meet adolescents' unique developmental needs. The Health Coaching for Contraceptive Continuation (HC3) intervention was designed as a developmentally-tailored program to help young women correctly and consistently use contraception. We examined the approaches health coaches used to support young women during the first 6-months after initiating a new contraceptive method.

Methods: This is a secondary analysis of data from the single-arm feasibility pilot of the HC3 intervention, which was conducted March-December 2017. Participants were recruited from 3 urban clinics affiliated with a large pediatric health system. Eligible women were ages 14-22 years, sexually active with a male in the prior year, not desiring pregnancy in the next 12-months, English-speaking, and had started a new contraceptive the prior 30 days. At baseline, participants completed a sociodemographic questionnaire, and contraceptive needs assessment interview. They then completed up to 5 monthly coaching sessions over the next 6 months. The baseline interview and coaching sessions were audio-recorded and transcribed verbatim. The qualitative codebook was created and adapted based on a previously validated adolescent sexual health framework. Two coders performed content analysis to identify strategies coaches used to support participants with contraceptive continuation. The study was approved by the Institutional Review Board at the Children's Hospital of Philadelphia.

Results: Among the 33 participants, the mean age was 18.1+0.4 years. Most were non-Hispanic Black (72.7%), had less than a high school education (69.7%), and were privately insured (60.6%). Fourteen (50.0%) had used contraception prior to enrolling. We identified 5 approaches coaches used to support young women with contraceptive adherence including helping participants using short acting methods to overcome difficulties with dosing regimens, providing strategies for managing side effects, addressing concerns about the safety of the method being used, helping to identify alternative methods that might better meet a participants' needs, and building participants general reproductive health knowledge. Coaches used different approaches for women who experiencing at least one barrier to method adherence (21, 75.0%) compared to those who reported no barriers. Barriers included difficulty adhering to dosing schedules, experiencing undesirable side effects, and having concern about the safety or effectiveness of their method. Of the 21 participants who experienced barriers, 2 (9.5%) switched methods, and only 1 (4.8%) discontinued their method over the course of the study.