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

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215.

VIRGINS AT AGE 26: WHO ARE THEY?

Joan-Carles Suris, MD, MPH, PhD, Diane Auderset, MA, Christina Akre, PhD, Yara Barrense-Dias, PhD

Center for Primary Care and Public Health (Unisanté).

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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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

Gabrielle DiFiore, MPH, Ava Skolnik, MPH, Margaret Kelly, BA, C. Alix Timko, PhD, Aletha Akers, MD, MPH, FACOG

Children's Hospital of Philadelphia.

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.