

Article

# Patient Perspectives on Factors Influencing Initiation of Gynecologic Care

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**Abstract:** Addressing adolescent and sexual reproductive healthcare is essential to providing young patients with the resources they need to navigate and empower themselves with. However, there is limited data about how often this occurs. Several studies have previously indicated that there is a large gap in accessing this gap in low-income neighborhoods. Our study aims to identify the establishment of gynecologic care among adolescent cisgender women and elucidate potential reasons for seeking or not seeking out care. We approached women in the pediatric emergency room that matched the inclusion criteria set out. Qualitative surveys were conducted until thematic saturation was reached and a cross-section study design was employed. Interviews were analyzed through modified ground theory. The study was conducted at the pediatric emergency department at University Hospital located in Newark, NJ. In 2018 estimates, the Newark population consists of 47.0% Black and 39.2% Hispanic or Latinos. Semi-structured interviews were conducted with 27 cisgendered, English-speaking females between ages 18 to 25 presenting to the pediatric emergency room who may or may not have previously established primary care with a gynecologist. Transcriptions were analyzed using modified grounded theory and themes were identified using inductive coding of patient interviews.

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## 1. Introduction

Sexual and reproductive health should be addressed by all providers coming in primary contact with adolescents. Based on the guidelines provided by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the Society of Adolescent Health and Medicine, providers are encouraged to discuss puberty, sexuality, and sex with adolescents regardless of their socioeconomic status, race, ethnicity, gender, or sex [1-3]. By 19 years old, 85% of female adolescents report some type of sexual activity (vaginal, oral, anal, same-sex) [4]. Forty eight percent of sexually transmitted infections occur in people age 15-24, further indicating the need to discuss safe-sex practices and appropriate methods of STI prevention and contraception [5]. Importantly, these duties of addressing sexual and reproductive health are shared by pediatricians, family medicine physicians, and gynecologists. It is important to have these conversations prior to sexual debut [6]. One study demonstrated that less than half of the sexually active adolescents in an urban setting had initiated gynecologic care, with an average delay between sexual debut and pelvic exam of 13 months [7].

Understanding that fair amounts of contraceptive and STI-related questions can be answered by pediatricians or family medicine physicians, there is no published data identifying the average age of first gynecology visit among adolescents and young adults. For those who do establish care with a gynecologist as adolescents, little is known about the factors that influence this decision and if any barriers prevent an initial visit during the recommended age range. Our study aims to identify and characterize reasons why adolescent women seek gynecologic care and evaluate the presence of potential barriers to an initial gynecologist visit. We conducted surveys of adolescent females presenting to the emergency department for gynecologic complaints to inquire about their access to and experiences with gynecologic care. These findings can help pediatricians and gynecologists recognize patient factors and prompt counseling for an initial gynecologist visit.

## 2. Materials and Methods

This is a qualitative study using data from cisgender women between 18 and 25 who were present in the Pediatric Emergency Department at University Hospital in Newark, New Jersey between April 2021 to September 2021. Due to the pandemic, the age criteria for patients entering the pediatric emergency department was raised to 25 years old. All patients younger than 25 years old were automatically sent to the pediatric emergency department without question. Eligibility was determined by research staff using electronic medical records (EMR) of patients present in the emergency department at the time of recruitment. Inclusion criteria for the study included English-speaking women between the age of 18 and 26 presenting for gynecologic concerns. Patients outside of these criteria were excluded from the study. A trained research assistant approached eligible women to discuss the study during their emergency department visit. Participants provided written informed consent. The Rutgers University Institutional Review Board approved this study. Participants were asked to fill out a demographic questionnaire at the time of the interview, which consisted of 10 questions regarding education, sexuality, insurance status, employment, and sexual history. The data from these questionnaires was not linked to interview responses but used to determine the demographics of the participant population.

One-on-one interviews were conducted and recorded in the emergency department by a member of the research team based on a scripted interview guide. All interviews were conducted by two members of the study team (NJ and DS) through a convenience sample. Interviews were conducted until thematic saturation was achieved. The participants of the study were not contacted after interview for protection of privacy. Recordings were deidentified and transcribed by study personnel. Deidentified transcripts were imported into qualitative data analysis software QRS International's NVivo version 11.0 for analysis.

Data analysis was performed using modified grounded theory, a useful qualitative method when little is known about a phenomenon and needs to be explored from the participant's point of view [8]. Following modified grounded theory, an initial code dictionary was developed with consultation of the study team. Three of the researchers (KB, NJ, and RM) independently coded multiple interviews and code directory was further edited based on comparisons. Discrepancies in coding were addressed until inter-rater reliability of Kappa score of  $\geq 0.7$  was reached. The first author coded the rest of the interviews based on the code directory using NVivo (Version 11.0). The study team identified recurrent themes with emphasis on understanding participants' perspectives and reasoning for making the transition to gynecologic care. Given the qualitative nature of the study, we determined that thematic saturation was achieved when we were able to successfully identify distinct themes to understand initiation of gynecologic care and did not focus on numeric prevalence of these themes.

### 3. Results

Participant demographics are summarized in [Table 1](#). Of the total 27 participants in the study, 26 answered the demographics survey completely. Average age of participants was 21.38 years (range 18-25). As seen in [Table 1](#), the majority of participants were Black or Hispanic (92%). This demographic composition reflects the patient population where the study was conducted. Out of twenty-seven participants reporting insurance status, a majority (81.5%) were insured, either under their own plan or their parents' plan. Most participants (58%) completed high school or some equivalent. Sixteen (61.5%) participants reported seeing a gynecologist at least once before, while 10 (38.5%) participants reported no prior visits to a gynecologist. Participants provided information on past gynecologic history, with 21 (78%) of participants endorsing history of previous sexual intercourse. Fifty-four percent of patients reported history of previous pregnancy. Average age at onset of sexual activity was 16.6 years.

Analysis revealed five central themes regarding the decision to see a gynecologist for the first time: (1) sexual activity as an indicator for transition; (2) screening and preventative health as a goal of gynecologic care; (3) autonomy in decision-making; (4) circumstances that necessitated transition to a gynecologist; and (5) barriers to accessing gynecologic care.

**Table 1. Characteristics of study participants**

Demographics	
Average age ( $\pm$ SD)	21.4 $\pm$ 1.94
<b>Previously seen a gynecologist in the past?</b>	<b>n (%)</b>
Yes	16 (61.5%)
No	10 (38%)
<b>Race</b>	<b>n (%)</b>
White	1 (4%)
Black	19 (70%)
Hispanic/Latino	6 (22%)
Other	1 (4%)
<b>Ethnicity</b>	<b>n (%)</b>
Hispanic/Latino	7 (28%)
Not Hispanic/Latino	17 (65%)
<b>Sexuality</b>	<b>n (%)</b>
Heterosexual/straight	22 (81%)
Lesbian	3 (11%)
Bisexual	1 (4%)
Other	1 (4%)
<b>Country of Origin</b>	<b>n (%)</b>
USA	18 (67%)
Other	5 (19%)
<b>Highest level of education</b>	<b>n (%)</b>
< High school	3 (11%)

High school or some equivalent	15 (58%)
Some college or trade school	7 (27%)
College graduate	0 (0%)
Other	1 (4%)
<b>Occupation</b>	<b>n (%)</b>
Student	5 (19%)
Full-time	15 (58%)
Part-time	3 (12%)
Retired	1 (4%)
Unemployed	1 (4%)
Disabled	1 (4%)
<b>Insurance status</b>	<b>n (%)</b>
Yes, my own	17 (63%)
Yes, under my parents	5 (19%)
I do not have insurance	5 (19%)
<b>History of previous pregnancy</b>	<b>n (%)</b>
Yes	14 (54%)
No	12 (46%)
<b>History of previous sexual intercourse</b>	<b>n (%)</b>
Yes	21 (78%)
No	6 (22%)
Average age at first sexual intercourse	16.6 years

### *Theme 1: Sexual Activity*

Engaging in sexual activity was cited commonly as a reason for wanting to see a gynecologist for the first time. Most participants believed that the first visit to the gynecologist should correlate to first sexual encounter. The type of sexual activity ranged from any first sexual experience to specifically unprotected intercourse as a reason to see the gynecologist. Participants who expressed they wished they had been older to have their first sexual encounter also noted that they would have preferred to delay gynecologic care. Although not stated, this emphasizes that even if the decision to see a gynecologist is delayed, it would continue to correlate with the onset of sexual activity. Consequently, lack of sexual activity was also mentioned as a reason for not yet having seen a gynecologist. One participant stated, "I don't think I needed one because I was not having sexual activities" (P23). One participant described: "So if we felt like it was an issue with sex, we would go, not just because like 'oh we need to get a pap smear', not like that. Just when something was wrong or a discharge or something that's when we would go" (P07).

Seeking gynecologic care as a result of sexual activity represented a transition to adulthood for many patients. One patient stated, "It was like stepping into adulthood basically. It was just like another step... if you're going to do this [sexual activity], then you gotta deal with what comes after it too" (P02). Similarly, three participants mentioned

initiation of contraception as their inciting reason for visiting the gynecologist for the first time. One participant indicated that the conversation she had with her gynecologist dealt with counseling around safe sexual practices, “They talked about... contraception, protection. Using protection, such as condoms... They went over STDs and risk of having unprotected sex, including pregnancy (P08).

Initial visits were often scheduled to undergo screening for sexually transmitted infections. One participant noted that “after I had my sexual encounter, you know, that was the right time to see to make sure everything was ok as far as health and everything” (P01). Another participant stated “... the first person [I had sex with] was much older than me so I let him have sex with me without a condom but then when I started to see the way he was carrying himself I got afraid” indicating and verbalizing fear of sexually transmitted infections, a common source of concern among participants seeking gynecologic care (P07). Participants noted increased frequency of gynecologic care depending on sexual activity as well, with one participating stating “when I was maybe a little bit more rowdy I would go and get an [sexually transmitted disease] test in the middle of that annual” (P05).

Sexual activity was further linked to sexual education provided in schools. One participant stated they were taught to seek out gynecologic care “before you engage in sexual activity, but if not, as soon as you do engage in sexual activity” (P01). Many participants remembered having a sexual education course in school but could not recall what they were told. One participant explained her regrets with sex education as “I wish I would’ve had a lot more knowledge on sexually transmitted diseases and stuff like that. Thank god I never encountered any of them, but just to have known that, I would’ve took a lot more precautions than I did” (P14).

### *Theme 2: Screening and preventative health*

Some participants that had seen already seen a gynecologist expressed understanding of screening and preventative health as a reason to seek an initial visit. While some participants wanted “just a regular checkup” (P21) during their first visit, others cited screening as a reason to continue seeing their gynecologist after the first visit. This includes participants that first presented to the gynecologist with an acute clinical condition. Screening or well-visits often went in conjunction with milestones such as onset of menses or new and continued sexual activity. One participant expressed she went to the gynecologist “like every couple of months or in between new partners, just to make sure that everything’s okay with myself” (P08). Another participant stated “After your period you can maybe get advice. You go in at that transitional age and you go to a gynecologist, you get advice on how to properly care for your vagina and they tell you certain things, so you don’t feel like it’s only you that’s happening to” (P24). Some women that had not seen a gynecologist yet stated that they knew they should go for a check-up to prevent complications downstream. One participant said: “I feel like I probably should’ve gone around 13, when I first received my menstrual, you know just to check in and make sure everything was regular”. Witnessing gynecologic complications encouraged participants to seek gynecologic care. One participant explained she visited a gynecologist because “I had a friend that passed away from ovarian cancer, she was very young. So, I scheduled an appointment to go check and everything so I would say her death got me to check on my well-being down there” (P24). Some participants that had not seen a gynecologist expressed understanding of the gynecologic well-visit, they did not feel the need to seek care if asymptomatic. One participant stated: “I mean, I know it should be a regular thing for women and that we can be affected easily but I feel like there’s no point if I’m not feeling anything” (P03).

### ***Theme 3: Circumstances prompting initial gynecologist visit***

Participants noted acute clinical conditions as a reason to establish gynecologic care. These circumstances include contraceptive care, pregnancy, and medical conditions that prompted primary care providers to refer them to a gynecologist. In provision of contraceptive counseling, a participant said “I graduated high school and my mom wanted to put me on the pill starting college” (P05), explaining how a change in her external environment led to birth control as a preventative measure. However, a few participants noted that discussion of birth control was handled by their primary care physician at the time. One participant endorsed having an intrauterine device placed by their primary care physician.

Three of the fourteen participants with history of previous pregnancy mentioned pregnancy as the initiating reason for seeking gynecologic care. Participants who described first going for obstetric visits, stated that “[seeing the gynecologist] had just [become] normal routine” after the pregnancy (P08). One participant stated that she presented initially to the gynecologist for routine prenatal and postpartum visits for her first child but stopped shortly after; she then expressed “The only reason I went back is because I had a TOP [termination of pregnancy]. So the very last time I went was in October to have a TOP done but after that no more” (P04).

All participants that appointed pregnancy as their primary reason had experienced the pregnancy during teenage years and explained some of their concerns regarding their age and associations with the gynecologist. One participant stated: “I would have really been a little more happier if I had went around 18 because I didn’t expect to go so early at that age... the only reason I went to the OB/GYN was because I was pregnant but I wouldn’t really want to change that because I’m very happy with my child” (P04). Another participant endorsed more distaste around the care received, “I remember that they told my parents to get out of the room and everything and asked me if I wanted to keep the baby or not. In my opinion, I didn’t like that because I was underage and what if I was an unstable girl... and just ruined [my] life by making this one decision by [myself]” (P10).

Participants referenced several different health conditions that led their primary care provider to encourage them to see a gynecologist, including polycystic ovarian syndrome (PCOS) and pelvic inflammatory disease (PID). One participant who had not seen a gynecologist yet shared that while her chronic condition was managed by her primary care physician, she was still recommended to see a gynecologist “just because diabetics get yeast infections” (P03). The patient had not visited the gynecologist, however, because she was waiting for the onset of symptoms to do so.

### ***Theme 4: Autonomy in decision-making***

Participants indicated that seeking gynecologic care was a personal decision. Despite influencing factors, participants expressed their autonomy in determining the appropriate age for them to see a gynecologist for the first time. Many participants stated that they would have preferred to see a gynecologist earlier than they did. However, participants were cognizant that this was an individual decision and should not be universalized to a particular age. “No, I feel like you should do what is necessary for yourself, even if you are young, you should do it” (P23). When asked about the influence of family, friends, or culture, many denied any influence and exerted personal autonomy in decision-making. Autonomy was often discussed in conjunction with individuals transitioning to adulthood and making the decision to see a gynecologist “as me being a grown woman, an adult” (P04). All participants that mentioned adulthood or growing up had seen a gynecologist in the past.

A few participants shared that family members played a role in encouraging an initial visit, notably their mother or sister. No participants identified friends as a source of

influence, but one participant mentioned “Just because my friends were saying... they see them at that age but that’s because they were sexually active so I was just like oh well, maybe I should too” (P01). Many participants noted that they did not discuss going to the gynecologist with their friends. Three participants noted an initial hesitation in reference to their cultural norm “I feel in Nigeria, because I come from Nigeria, we don’t really see gynecologists, so I guess that played a role in me not wanting to see one. But I also look forward to seeing one. Changed my mind” (P15). Another participant shared this hesitation with doctors in general, which led her to feel she waited too long to see a gynecologist.

#### ***Theme 5: Barriers to care***

Of the participants that had not seen a gynecologist, some referred to the lack of health insurance and/or financial stability as a barrier to accessing care. These participants also did not have access to a primary care physician to whom they could bring gynecologic issues to. One participant waited to see a gynecologist but was unable to once she was older because “by the time I turned 21, I did not have insurance of my own” (P19). Of the participants citing lack of health insurance/money as a barrier, most expressed desire to see a gynecologist. Three participants of ten who previously had no gynecologic care stated lack of time was an additional barrier to care. One stated, “I am actually looking forward to seeing one, but I have not had time to go” (P15).

#### **4. Discussion**

In this qualitative study, we identified 5 factors that influence young female decision-making regarding the transition to beginning gynecologic care: sexual activity, screening, autonomy, acute situations, and barriers to accessing care. There was no consensus on an optimum age to establish gynecologic care among the participants. Instead, there was a sentiment regarding goal-directed care, whether it be for initiation of sexual activity, contraception, pregnancy, screening for sexually transmitted infections, or for maintenance of gynecologic pathologies including PCOS or PID. Participants encouraged autonomy in decision-making and recognized that initiation of care was dependent on the individual and their circumstances. The most common barrier to receiving care was lack of health insurance.

Sexual activity arose as a major milestone for patients to establish gynecologic care, enforcing that the transition between pediatric to gynecologic care was not age-dependent but rather experience-dependent. Current ACOG guidelines suggest an age range of 13-15 years and topics to be discussed at an initial visit but many women seek care outside of this time period and may miss these discussions [1]. Initiation of sexual activity or discussion of initiation at pediatrician appointments could be an opportunity to recommend scheduling an initial visit with the gynecologist, a sentiment which is shared by practicing OB/GYNs [9]. A qualitative study showed that women regretted not being informed about the indications and time to establish care with a gynecologist [10]. Primary care physicians and pediatricians should screen for initiation of sexual activity and initiate conversations regarding contraception and sexually transmitted infections. If these providers do not feel comfortable managing these conversations themselves, they should initiate discussion about visiting a gynecologist. This allows the process to be individualized to the patient and conveys the information from a trusted provider. Women associate having both an OB/GYN and a generalist with greater access to clinical preventative services [11]. Studies have shown safe-sex intervention and education is effective in preventing pregnancy and sexually transmitted infections, especially with sexually experienced adolescents [12]. At the time sexual education is discussed in school, it may not be applicable to all individuals of that age range. Participants in our study echoed that they did not remember if their sexual education courses encouraged visiting

a gynecologist, further indicating a need for individualized introduction to gynecologic care.

ACOG and the American Medical Association (AMA) have recommended that regardless of sexual experience, adolescents should receive counseling regarding sexual behavior, including topics of contraception and STI screening [9, 13]. As participants discussed, the milestone of sexual activity provides a reason to begin screening for STIs. A majority of adolescents experience sexual intercourse most commonly between 15 and 17 years [14, 15]. As per the Youth Risk Behavior Surveillance (YRBS) Report, approximately half of sexually active students reported no use of condoms at last sexual encounter, and many reported multiple sexual partners, exhibiting high-risk sexual practices [16, 17]. Among female adolescents, STIs are often acquired soon after initiating sexual activity [18]. It is imperative for all providers to reinforce the importance of screening as well as safe-sex practices. For hesitancy of seeking care while asymptomatic, addressing screening as a purpose of the initial visit may aid in earlier initiation of gynecologic visit before acute clinical conditions arise.

Contraceptive care was not as commonly cited by participants despite the consensus that sexual activity was correlated with gynecologist visits. Only three participants mentioned visits to the gynecologist for contraception care. However, neither the interview nor questionnaire explicitly asked about current contraceptive methods or where contraceptive care was received. A few participants reported that their pediatrician or family medicine provider was providing them with contraception, including intrauterine devices (IUDs), indicating that contraceptive care is not limited to the gynecological visit and is accessible through other routes. A recent database study showed that 32.4% of pediatricians prescribed contraception, and the most frequent contraception providers were family medicine physicians and advanced practice nurses. These providers were less likely to provide longer-acting forms of contraception and opted for oral contraceptive pills. New Jersey, the location where our study was completed, had the lowest rate of primary care providers providing contraception [19]. The results of this study in conjunction with ours indicate that adolescents have access to contraception outside of the gynecologist's office.

Access to contraceptive care is important in the teenage population and should be discussed as part of adolescent visits to the physician for reduction of unintended pregnancies. Most pregnancies that occur in teen years are unintended [20]. Limited data exists on where adolescents primarily look to receive contraceptive care which is consistent with our data where few participants mentioned contraceptive care as a factor in seeking care. Studies have shown that visiting an OB/GYN for contraceptive care significantly increases likelihood of receiving reproductive health services than visiting the pediatrician or generalist [21]. Prior studies have shown contraceptive counseling is more likely to be offered to adolescents with history of pregnancy, abortion, or sexual debut [22, 23]. Further studies analyzing usage of direct-to-consumer applications, other physician referrals, and pharmacist prescriptions for contraception will allow us to determine why this is not a leading cause of adolescent visit to the gynecologist while initiation of sexual activity is.

Fourteen of the participants had history of prior pregnancy, with three participants mentioning pregnancy as their inciting reason for visiting the gynecologist. Adolescents, particularly of low socioeconomic status, that seek care in the ED have been shown to increase risk for unintended pregnancy [24]. As per the YRBS, only 9% of sexually active students utilized both condoms and a more effective contraceptive option to achieve optimal prevention against unintended pregnancy [16]. High risk sexual behaviors include unintended pregnancies, multiple partners, failure to use contraception, and acquiring a sexually transmitted infection [25]. These are all topics that we have previously discussed should be brought up at initial visits discussing intention to engage

in sexual activity. Participants in our study consistently highlighted initiation of sexual activity as the instrumental marker for beginning gynecologic care.

Interviews revealed friends and family did not appear to have as significant an influence on decision-making as compared to patient autonomy. Participants reported that they mostly visited the gynecologist because they felt it was time to go and no person influenced their decision. Pediatricians should continue to encourage the benefits of visiting the gynecologist while maintaining adolescent autonomy and allowing them to make the decision on their own when appropriate. Family that did discuss the initial visit with participants often relayed the importance of screening or provided knowledge on what the visit may entail. Most often, participants reported a close female, like their mother or sister, who prepared them for the visit and informed them why it was important. This may help decrease apprehension regarding the first visit as well as uncertainty around indications for going from a source other than a healthcare provider.

There are several limitations to this study. First, we recruited patients 18 years and older, affecting the generalizability of this study. Themes recognized by our study might not be applicable to younger adolescents today seeking gynecologic care. Due to the nature of the study location, most of the population was Black or Hispanic affecting generalizability in populations who do not see a diverse, underserved community. Furthermore, we were unable to include non-English speaking patients in our survey. There is a potential for selection bias, attracting participants who are more comfortable discussing topics relating to gynecologic care and sexual health. We acknowledge that our sample size is an extremely unique population, which introduces bias into the study. We believe that these studies should be replicated on a wider scale to answer important questions about the initiation of gynecologic care and identify that our results are only a start. Another significant limitation to the study was not asking patients about their current contraceptive practices, as this could have acted as a proxy indicator for their current reproductive health needs and provider status. Further studies should investigate and see what types of providers are fulfilling this role in adolescent patients.

Adolescent women had many reasons for transitioning from pediatric to gynecologic care, including sexual activity, pregnancy, and screening for sexually transmitted infections. Overall, autonomy should be prioritized as a decision-making factor with ample knowledge and education to explain benefits and indications of seeking gynecologic care. Surprisingly, contraceptive care was not a leading reason for care. This data can help inform better care of adolescents in gynecologic settings and address current healthcare disparities and gaps. Our study is limited in its generalizability, and future studies should replicate this work in larger populations to compare itself to an urban, underserved population. Larger studies will allow deeper understanding of adolescents' expectations when seeking gynecologic care to aid providers in initial appointments.

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