

Sexually transmitted infection testing among heterosexual Maritime Canadian university students engaging in different levels of sexual risk taking

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ABSTRACT

OBJECTIVES: Individuals aged 15–29 years have the highest rates of diagnosed sexually transmitted infection (STI), and in Canada routine STI testing is recommended for sexually active individuals under 25 years of age. Despite its being readily available to most Canadian university students, testing is not accessed by all sexually active students. This study examines correlates of STI testing among sexually active heterosexual university students. Specifically, we sought to determine: i) the lifetime incidence of STI testing overall and stratified by biological sex; ii) whether those most at risk of STI are being tested; and iii) which other characteristics are associated with ever having been tested for STI.

METHODS: A cross-sectional survey of undergraduate students at eight universities in Maritime Canada was carried out in 2012, gathering information on student demographic characteristics, sexual behaviours and use of sexual health services. We conducted a sex-stratified descriptive analysis of each covariate and of STI testing at three levels of STI risk. We then performed multiple logistic regressions to determine the factors associated with lifetime STI testing.

RESULTS: Only 34% of the study population and 51% of those at higher risk of STI acquisition had ever been tested for STI. Individuals at moderate or higher risk of STI were more likely to be tested than those at lower risk. In both sexes, older students, those who reported experiencing non-consensual sex while enrolled at university and those with more sexual health knowledge were more likely to be tested. Higher perceived risk was associated with STI testing only among females.

CONCLUSIONS: Individuals at higher risk of STI acquisition are more likely to be tested; however, STI testing rates are low in this sample. Health promotion with campaigns designed to increase general sexual health knowledge may be more effective in increasing testing when targeting younger students.

KEY WORDS: Student health services; sexually transmitted diseases, bacterial; reproductive health; health knowledge, attitudes, practice; heterosexuality

La traduction du résumé se trouve à la fin de l'article.

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In Canada, university-aged individuals have the highest rates of diagnosed bacterial sexually transmitted infection (STI).¹ Reported rates of STI among Canadians are likely underestimated because of the asymptomatic nature of STI.² Women with untreated STI are at risk of pelvic inflammatory disease (PID) and its sequelae,³ and both men and women with STI are at increased risk of HIV infection.⁴ Chlamydia control programs have been shown to reduce rates of PID and its sequelae.⁵ For these reasons, annual STI testing is recommended for all sexually active individuals under age 25 in Canada and the US.^{3,6}

Core group theory suggests that a small subgroup of infected individuals within the general population disproportionately perpetuates STI infection, because their condition goes undiagnosed for long periods of time and they have many sexual partners without protection.⁷ This theory suggests that diagnosis and treatment of higher risk individuals would contribute significantly to STI prevention efforts. Little is known about the relationship between risky sexual behaviours and bacterial STI testing in Canadian university student populations, since most previous studies involving college students have investigated HIV testing but not bacterial STI testing.^{8–12} Two studies investigating bacterial STI testing have been conducted among post-secondary

students. One of these, involving four US college campuses, found an unadjusted association between condom non-use and lifetime STI testing among females, but the study did not adjust for confounders.¹³ The other, which involved Dutch vocational college students, adjusted for potential confounders but examined psychosocial and not behavioural correlates of intention to be tested for STI, not actual testing.¹⁴

Factors generally associated with STI testing or testing intention include age,^{14–16} biological sex,^{14,16} ethnicity,¹⁴ perceived peer norms toward sexual health,^{14,15} perceived STI risk,^{14,16} community of residence^{15,17} and religiosity.¹⁴ A Canadian qualitative study indicated that attitude toward testing was most affected by peer norms and knowledge of testing procedures.¹⁷ STI testing is also correlated with HIV testing⁹ and other previous health services use.^{14,16} Variables generally correlated with HIV

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testing are year of university study,¹² having experienced non-consensual sex⁸ and living arrangement.¹⁰ Factors generally associated with lack of health services use include depression risk¹⁸ and attitudinal barriers to help-seeking.¹⁹

Objectives

On the basis of core theory and the literature available, we hypothesized that many university students engaging in higher-risk sexual behaviours are not being tested for STI. We aimed to determine whether recommendations for STI testing are being met among Canadian students and to characterize those not being tested. Using a sample of heterosexual Maritime Canadian university students, this study sought to determine: i) the lifetime incidence of STI testing overall and stratified by biological sex; ii) whether those most at risk of STI are being tested; and iii) which other characteristics are associated with ever having been tested for STI.

METHODS

Study design

We used data collected by the online Maritime Undergraduate Sexual Health Services Survey designed by two of the authors (DL and AS), which was administered in the fall of 2012. This is a cross-sectional online survey of undergraduate students from eight Maritime universities.

Survey administration

Using a modified Dillman approach,²⁰ we contacted all undergraduate students at the participating universities through their university registrar's e-mail listserv and provided a link to the survey. Responses were collected using OPINIO software, a secure online service hosted at Dalhousie University. Students were prevented from using the same computer to complete the survey more than once. The survey design and data collection were both approved by the Research Ethics Board at each university.

Study population

All 50,790 undergraduate students attending eight universities in Canada's Maritime provinces (Nova Scotia, New Brunswick and Prince Edward Island) were eligible to participate in the survey; 10,361 students (20.4%) participated. We limited the population to males and females who self-identified as completely heterosexual, had ever had heterosexual vaginal intercourse, were aged between 17 and 29, answered a survey item about having ever been tested for STI and who provided complete information on STI risk behaviours. Of the 10,361 participants, 2,289 were not sexually active, 2,440 were not completely heterosexual, 302 were over 29 years old, and 811 had missing information for at least one required variable. Thus 4,519 individuals were included.

Dependent variable

- *Ever tested for STI:* Using one survey item measuring lifetime incidence of STI testing, we created a binary outcome variable: Ever Tested for STI versus Never Tested.

Independent variables

Survey items associated with STI testing,^{14–17} HIV testing^{8,10,12} or university students' use of health services^{18,19} were included as covariates in all multiple variable regression models and were defined as follows:

- *Age:* Age (in years) coded as a continuous variable.
- *Ethnicity:* We used one non-mutually exclusive categorical survey item to create a binary ethnicity variable: Non-Caucasian Descent and the referent category, Any Caucasian Descent.
- *Personal Importance of Religion:* Using an item measuring personal importance of religion with four response options, we created a binary variable: Religion Less/Not Important (not important at all/not very important) and the referent category, Religion Important (fairly important/very important).
- *Perceived Risk of STI Acquisition:* Using an item measuring self-reported perception of risk of STI acquisition with four response options, we created a binary variable: Higher Self-Perceived Risk of STI Acquisition (greatly at risk/quite a lot at risk) and the referent category, Lower Perceived Risk (not very much at risk/not at all at risk).
- *Level of STI Risk Behaviour:* We defined STI risk level using a combination of two risky sexual behaviours: no condom at last vaginal intercourse and >1 partner for vaginal intercourse in the last year. Those with both behaviours were classified as being at higher risk; those with one were classified as at moderate risk and those with neither as lower risk.
- *Perceived Peer Sexual Risk-Taking Score:* We measured perceived peer sexual risk taking using an established scale (9 items, score range 9–45), with a higher score indicating perception of more sexual risk taking by friends (Cronbach's $\alpha = 0.79$).²¹
- *Sexual Health Knowledge Score:* Sexual health knowledge was measured using a true/false/don't know test, summing correct responses to create a continuous variable (12 items, score range 0–12); a higher score indicated greater sexual health knowledge (Cronbach's $\alpha = 0.67$). This test covered a range of topics: contraception methods' effectiveness/use, STI prevention/symptoms/reinfection and the menstrual cycle.²²
- *Non-Consensual Sex:* An item measuring whether the study participant had been forced to have sex of any type against his or her will while enrolled at university was used to create a binary variable coded Yes and No (the referent category).
- *Year of Study:* Year of post-secondary study in the fall of 2012 was used to categorize participants into one of five categories: 1st to 4th Year by year, and Other. First year students served as the referent category.
- *Living Arrangements:* Participants' current living arrangements consisted of five categories: Student Residence, Alone, Roommate(s) (off campus with only non-sexual or non-romantic partner[s]), Romantic Partner (off campus with a romantic or sexual partner) and the referent category, Parent(s).
- *Risk of Depression:* Risk of depression was measured using a 12-item version of the Center for Epidemiological Studies of

Depression (CES-D) scale (12 items, score range 0–36, with a higher score indicating greater risk of depression) (Cronbach's $\alpha=0.85$).²³ Two categories were created using an established cut-off value,²³ those at higher risk of depression (score >11) and the referent category, those at lower risk (score ≤ 11).

- *Barriers to Help-Seeking Score:* Attitudinal barriers to help-seeking were measured using an eight item scale (score range 0–32), with a higher score indicating more barriers to help seeking (Cronbach's $\alpha=0.79$).¹⁹

Statistical analysis

The data were statistically adjusted using population weights specific to the age and sex distributions at each of the universities. Missing responses were estimated using multiple imputation. Since males and females use health services at different frequencies and often for different reasons,²⁴ we stratified the study population by biological sex.

We first calculated the weighted prevalence of STI testing in the overall study population and by sex and then described the characteristics of the male and female subgroups using weighted means/proportions with 95% confidence intervals. All descriptive analyses were carried out without adjustment for the university attended.

Next, we cross-tabulated STI testing incidence against level of STI risk, stratified by biological sex, to determine the proportion in each group that had ever been tested for STI. We ran simple logistic regressions to determine the weighted, univariable association between each independent variable and the outcome of interest

separately for males and females. Last, we investigated STI testing incidence using multivariable logistic regression models for each biological sex. Measures with univariable p values <0.2 in either males or females were used as covariates in all multivariable logistic analyses to allow for direct comparisons between the findings for males and females. All regressions were adjusted for intraclass correlation by university attended. Statistical analyses were performed using SAS OnlineDoc[®] 9.3 software.

RESULTS

Table 1 shows participants' characteristics overall and by sex. Overall, 33.9% of the 4,519 sexually active heterosexual students had ever been tested for STI. Significantly more females than males reported having been tested. Compared with female respondents, males were significantly more likely to be older, perceive their peers as having liberal attitudes towards sex, live with a roommate and have more attitudinal barriers to help-seeking. Females were more likely to have higher sexual health knowledge scores, consider religion important, be at risk of depression, live with a romantic partner, be Caucasian and indicate having experienced non-consensual sex while at university.

Table 2 presents the results of an unadjusted cross-tabulation of the proportion of individuals at each STI risk level who had ever been tested for STI, stratified by sex. For both sexes individuals categorized as being at higher or moderate risk of STI acquisition were more likely to report ever having been tested than those at lower risk. Comparing 95% confidence limits, higher-risk students were also more likely to have undergone STI testing than moderate risk students.

Table 1. Characteristics of the study population ($N=4519$), overall and stratified by student sex

	Male	Female	Overall
	Weighted mean or proportion (95% CI) ($n=1480$)	Weighted mean or proportion (95% CI) ($n=3039$)	Weighted mean or proportion (95% CI) ($N=4519$)
Age, years*	21.4 (21.2–21.5)	20.9 (20.8–21.0)	21.1 (21.0–21.2)
Year of study			
First	23.4% (21.2–25.7)	23.3% (21.7–24.9)	23.4% (22.0–24.8)
Second	20.6% (18.3–22.8)	22.9% (21.3–24.6)	21.8% (20.5–23.2)
Third	21.3% (19.0–23.6)	22.4% (20.8–24.0)	21.9% (20.5–23.2)
Fourth	24.4% (22.0–26.9)	23.2% (21.5–24.8)	23.8% (22.3–25.2)
Other*	10.3% (8.4–12.3)	8.2% (7.0–9.3)	9.2% (8.1–10.3)
Non-Caucasian descent*	11.0% (9.3–12.8)	7.2% (6.1–8.2)	9.0% (8.0–10.0)
Religion less/not important*	77.5% (75.1–79.9)	68.9% (67.1–70.7)	73.0% (71.5–74.5)
Living arrangements			
Alone*	7.4% (5.9–9.0)	5.7% (4.7–6.6)	6.5% (5.6–7.4)
Roommate(s)*	38.0% (35.3–40.8)	32.1% (30.3–33.9)	34.9% (33.3–36.5)
Romantic partner*	12.0% (10.2–13.8)	16.1% (14.6–17.5)	14.1% (13.0–15.3)
Parent(s)	20.8% (18.5–23.1)	23.6% (22.0–25.3)	22.3% (20.9–23.7)
Student residence	21.7% (19.5–23.9)	22.6% (21.0–24.1)	22.2% (20.8–23.5)
Experienced non-consensual sex*	1.5% (0.8–2.2)	5.4% (4.5–6.3)	3.6% (3.0–4.2)
Higher self-perceived STI risk	6.0% (4.7–7.3)	5.5% (4.6–6.3)	5.7% (5.0–6.5)
Level of STI risk behaviour			
Higher	16.3% (14.2–18.3)	14.3% (13.0–15.6)	15.2% (14.1–16.4)
Moderate	46.8% (44.0–49.7)	49.0% (47.0–50.9)	47.9% (46.3–49.6)
Lower	36.9% (34.2–39.6)	36.7% (34.9–38.6)	36.8% (35.2–38.4)
Perceived peer sexual risk-taking score (out of 45)*	22.9 (22.6–23.3)	19.6 (19.4–19.8)	21.2 (21.0–21.4)
Sexual health knowledge score (out of 12)*	6.9 (6.8–7.1)	8.6 (8.6–8.7)	7.8 (7.8–7.9)
Barriers to help-seeking score (out of 32)*	23.9 (23.5–24.2)	22.2 (22.0–22.5)	23.0 (22.8–23.2)
Higher risk of depression*	25.3% (22.8–27.8)	32.2% (30.5–34.0)	29.0% (27.4–30.5)
Ever tested for STI*	26.2% (23.7–28.7)	40.8% (38.9–42.7)	33.9% (32.3–35.5)

* Significant difference ($p < 0.05$) between males and females. CI, confidence interval; STI, sexually transmitted infection.

Table 2. Weighted proportion of the study population ($N=4519$) ever tested for STI stratified by biological sex and level of STI risk behaviour and the unadjusted association between ever tested for STI and level of STI risk behaviour

Level of STI risk behaviour	Males ($n = 1480$)			Females ($n = 3039$)		
	Weighted proportion (95% CI)	Unadjusted OR (95% CI)*	<i>p</i> value	Weighted proportion (95% CI)	Unadjusted OR (95% CI)*	<i>p</i> value
Higher ($n = 694$)	46.7 (39.8–53.6)	5.00 (3.24–7.70)	<0.0001	55.3 (50.4–60.2)	2.85 (2.40–3.37)	<0.0001
Moderate ($n = 2162$)	28.0 (24.2–31.8)	2.22 (1.96–2.52)	<0.0001	44.5 (41.7–47.2)	1.84 (1.43–2.37)	<0.0001
Lower ($n = 1663$)	14.9 (11.5–18.3)	1.00	–	30.3 (27.3–33.3)	1.00	–

* Intraclass correlation at the university level accounted for statistically without including university in the model. STI, sexually transmitted infection; CI, confidence interval; OR, odds ratio.

Unadjusted analyses revealed that all variables except two were associated with STI testing at $p < 0.20$ in either males or females; the two variables, ethnicity and risk of depression (data not shown), were excluded from the multivariable analyses.

Table 3 presents the results of the adjusted logistic regression models. Among males, there were significant associations between older age, having experienced non-consensual sex, higher sexual health knowledge and having engaged in moderate or higher STI risk sexual behaviours and increased odds of ever having been tested for STI. Among females, engaging in moderate or higher STI risk sexual behaviours, older age, having fewer attitudinal barriers to help seeking and having higher sexual health knowledge were most strongly associated with having ever been tested for STI; being a third or fourth year student rather than a first year student, having experienced non-consensual sex while at university, having higher perceived risk of STI acquisition, perceiving peers as having more liberal attitudes towards sex, considering religion less or not important and living alone rather than with a parent were also associated with higher odds of ever having been tested. When

university was included in the models, the results were essentially the same.

DISCUSSION

We found that more than half (66%) of sexually active heterosexual Maritime undergraduate students aged 17–29 had never been tested for STI; more males (74%) than females (59%) reported never having been tested. These rates are lower than those observed in a study of Dutch vocational college students, which showed that 89% of males and 80% of females had never been tested; however, the populations may not be comparable, as the Dutch participants were, on average, five years younger than those in this study and European STI screening guidelines are risk-based rather than universal.^{14,25} Overall, 49% of 694 higher STI risk, 63% of 2,162 moderate STI risk and 77% of 1,663 lower STI risk heterosexual students reported never having been tested for STI. These findings indicate that the Public Health Agency of Canada (PHAC) recommendation for routine STI testing in all sexually active individuals under age 25 is not being achieved in this population.³

Table 3. Adjusted logistic regression of ever being tested for STI among heterosexual males ($n = 1463$) and heterosexual females ($n = 3013$) on demographic, behavioural and psychosocial correlates

Covariate of interest	Males		Females	
	Adjusted odds ratio (95% CI)*	<i>p</i> value	Adjusted odds ratio (95% CI)*	<i>p</i> value
Age	1.15 (1.07–1.23)	0.0002	1.23 (1.17–1.29)	<0.0001
Year of study				
First	1.0		1.0	
Second	1.40 (0.81–2.44)	0.2309	1.10 (0.82–1.47)	0.5461
Third	1.42 (0.65–3.14)	0.3796	1.28 (1.00–1.63)	0.0500
Fourth	1.63 (0.95–2.82)	0.0787	1.38 (1.04–1.83)	0.0235
Other	1.29 (0.78–2.14)	0.3250	1.17 (0.72–1.89)	0.5324
Religion less/not important	0.84 (0.62–1.13)	0.2432	1.24 (1.00–1.55)	0.0498
Living arrangements				
Alone	1.46 (0.80–2.65)	0.2162	1.60 (1.09–2.36)	0.0162
Romantic partner	0.97 (0.51–1.85)	0.9365	0.90 (0.60–1.35)	0.6047
Student residence	1.10 (0.72–1.67)	0.6575	0.83 (0.67–1.04)	0.0997
Roommate(s)	1.40 (0.95–2.07)	0.0884	1.08 (0.82–1.43)	0.5972
Parent(s)	1.0		1.0	
Experienced non-consensual sex	3.61 (1.58–8.27)	0.0024	1.83 (1.27–2.63)	0.0011
Higher self-perceived risk	1.33 (0.85–2.08)	0.2109	1.53 (1.09–2.15)	0.0129
Perceived peer sexual risk taking score	1.02 (1.00–1.03)	0.0503	1.02 (1.00–1.05)	0.0407
Sexual health knowledge score	1.11 (1.06–1.17)	<0.0001	1.19 (1.15–1.24)	<0.0001
Barriers to help seeking score	0.99 (0.96–1.02)	0.4253	0.97 (0.96–0.99)	0.0002
Level of STI risk behaviour				
Higher	3.70 (2.16–6.35)	<0.0001	2.68 (2.21–3.26)	<0.0001
Moderate	1.96 (1.72–2.23)	<0.0001	1.66 (1.27–2.15)	0.0002
Lower	1.0		1.0	

* Intraclass correlation at the university level accounted for statistically without including university in the model. CI, confidence interval; STI, sexually transmitted infection.

Only 6% of both males and females perceived themselves as being at risk of STI acquisition, whereas 15% overall (14.3% of females, 16.3% of males) were categorized as at higher risk according to their sexual behaviours. This suggests a gap in real versus perceived sexual risk, a finding also demonstrated by Wolfers et al. among vocational students in the Netherlands.²⁶ Diagnosis rates for STI are higher among females than males;¹ this is supported by our finding that females are more likely to have ever been tested for STI than males. Heterosexual males may go untested more often than their female counterparts because females are more likely to access sexual health services routinely for other testing (e.g., PAP testing).²⁴ Given the similarity of risk and its perception in both sexes, lack of contact with health care providers may be a factor in males not being tested.²⁷ STI risk perception was associated with STI testing only in females, indicating that such perception may play a greater role in females' choosing to be tested.

We identified several factors associated with STI testing within each biological sex. All the correlates of STI testing, HIV testing and health services use except for depression risk and ethnicity were associated with STI testing in males or females, including several variables that have not previously been linked to STI testing. These were student year of study, having experienced non-consensual sex, attitudinal barriers to help-seeking and living arrangement.

Older age, having experienced non-consensual sex while at university, more sexual health knowledge and engaging in moderate or higher STI risk sexual behaviour were consistently associated with testing in both sexes. The finding that younger individuals are less likely to be tested for STI would be expected, as this experience is a function of time, and it is possible that many individuals who have not been tested have only recently experienced sexual debut. However, considering that the average age at first intercourse in Canada is 16.5 years and the average age of the study population was 21.2 years, this does not likely contribute greatly to the low levels of testing observed.²⁸ Heterosexual students who engage in sexual risk behaviours putting them at higher risk of STI acquisition were more likely to have ever been tested for STI, implying that individuals more in need of STI testing services are more likely to access them. However, 51% of those engaging in higher risk sexual behaviours had never been tested, indicating that a core group of higher risk individuals remains untested.⁷ In addition, individuals who had experienced non-consensual sex of any kind while enrolled at university were more likely to have ever accessed STI testing services, indicating that these individuals may be appropriately accessing the post-abuse care available to them. Greater sexual health knowledge was also associated with increased STI testing in undergraduate students. Studies of European university students have shown that interventions designed to improve sexual health knowledge can improve uptake of STI testing at student health clinics, especially among females.^{26,29} McClean et al. demonstrated improved uptake of chlamydia testing services at a college in the UK during an education campaign in which trained peer volunteers provided information about chlamydia to students; testing rates declined after the information-giving ceased.²⁹ Wolfers et al. demonstrated that interventions aimed at improving STI testing rates among vocational college students were most effective when focused on two areas: sexual health education and STI testing

on school sites.²⁶ Wolfers et al. also found that sexual health knowledge was significantly associated with perceived risk of STI acquisition,³⁰ suggesting perhaps that interventions designed to improve sexual health knowledge could also be used to improve the accuracy of STI risk perception. Given the mean age of sexual debut in Canada, interventions designed to improve sexual health knowledge in high school students may also improve STI testing rates.

Limitations

Previous studies have shown that STI testing services must be accessible to users both physically and psychologically.¹⁷ In this study, we accounted for variation in both the physical and psychological accessibility of STI testing by controlling for university attended and attitudinal barriers to help-seeking. It is possible that additional factors (e.g., stigma), however, could have prevented students in this study population from accessing STI testing services. The potential relationship between patients' perceived stigma when disclosing sexual behaviour and STI testing is unclear; two previous studies have shown that anticipated stigma is associated with reduction in STI-related care seeking behaviour,^{16,31} whereas two more recent studies have shown no significant association between STI-related stigma and testing.^{14,15}

The study's response rate was low (20.4%), and it is unclear whether non-response was systematic or random; our estimates must thus be interpreted with caution. Because of regional differences across Canada, the results may not be generalizable to all Canadian university students. This study is also limited by its cross-sectional design. For example, it is possible that being tested might improve sexual health knowledge rather than sexual health knowledge increasing the odds of testing.

Future studies that define STI risk based on all forms of sexual intercourse (vaginal, oral and anal sex) would be better able to demonstrate potential differences in STI testing rates among university students of different sexual orientations and gender identities.

CONCLUSIONS

We were able to determine that STI testing rates in this sample of heterosexual university students were not meeting the routine screening targets recommended by the PHAC.³ By investigating a wide variety of variables known to be associated with STI testing, HIV testing and health care utilization, this study has identified new potential covariates that should be included in future analyses of STI testing rates in university populations, including student year, living arrangements, non-consensual sex and attitudinal barriers to help-seeking. This study also found that the students most at risk of STI are more likely to have been tested for STI. Finally, we were able to determine that health promotion with campaigns designed to increase general sexual health knowledge may be most effective at increasing lifetime STI testing when targeting younger students.

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RÉSUMÉ

OBJECTIFS : Les 15 à 29 ans ont les plus hauts taux d'infections transmissibles sexuellement (ITS) diagnostiquées, et au Canada, le dépistage systématique des ITS est recommandé aux personnes sexuellement actives de moins de 25 ans. Bien que le dépistage soit aisément accessible à la plupart des étudiants d'université canadiens, tous les étudiants sexuellement actifs ne s'en prévalent pas. Notre étude porte sur les corrélats du dépistage des ITS chez les étudiants d'université hétérosexuels sexuellement actifs. Nous avons cherché à déterminer : i) l'incidence (globale et stratifiée selon le sexe biologique) du dépistage des ITS au cours de la vie; ii) si les sujets les plus à risque de contracter des ITS se font dépister; et iii) quelles sont les autres caractéristiques associées au fait d'avoir subi un test de dépistage des ITS.

MÉTHODE : Nous avons mené en 2012 une enquête transversale auprès des étudiants de premier cycle de huit universités des provinces maritimes du Canada afin de réunir de l'information sur leur profil démographique, leurs comportements sexuels et leur recours aux services de santé sexuelle. Nous avons effectué une analyse descriptive stratifiée par sexe pour chaque covariable et pour le dépistage des ITS selon trois niveaux de risque d'ITS. Nous avons ensuite effectué plusieurs analyses de régression logistique pour déterminer les facteurs associés au dépistage des ITS au cours de la vie.

RÉSULTATS : Seulement 34 % de la population étudiée et 51 % des sujets plus à risque de contracter des ITS avaient subi un test de dépistage des ITS. Les sujets à risque modéré ou élevé de contracter des ITS étaient plus susceptibles d'avoir subi un dépistage que les sujets à faible risque. Chez les deux sexes, les étudiants plus âgés, ceux qui ont dit avoir eu des relations sexuelles non consenties pendant qu'ils étaient inscrits à l'université et ceux dont les connaissances en matière de santé sexuelle étaient supérieures étaient plus susceptibles d'avoir subi un dépistage. Un risque perçu plus élevé n'était associé au dépistage des ITS que chez les femmes.

CONCLUSIONS : Les personnes dont le risque de contracter des ITS est plus élevé sont aussi plus susceptibles de se faire dépister; néanmoins, les taux de dépistage des ITS sont faibles dans l'échantillon de l'étude. Les efforts de promotion de la santé, avec des campagnes conçues pour accroître les connaissances générales sur la santé sexuelle, pourraient être plus efficaces pour accroître le dépistage lorsqu'ils ciblent les étudiants les plus jeunes.

MOTS CLÉS : services de santé pour étudiants; maladies sexuellement transmissibles bactériennes; santé de la reproduction; connaissances, attitudes, pratiques en santé; hétérosexualité