Preventive screening in women who have sex with women

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Case description

A 30-year-old woman who is new to your practice presents for a periodic health assessment. While taking the sexual history, she indicates that she has only been in relationships with other women. She questions the need for cervical cancer screening based on the advice that she had been given by other women and her previous physician. During this discussion, you indicate that the Canadian Task Force on Preventive Health Care guideline recommends women consider starting cervical cancer screening with a Papanicolaou test at age 25, but that there is no specific recommendation for women who have sex with women (WSW). The patient asks for additional evidence and advice on the need for screening her for cervical cancer. You agree to provide additional information on the risks and benefits of cervical cancer screening in WSW at a follow-up visit.

Women who have sex with women are part of the larger group of LGBTQ+ (lesbian, gay, bisexual, trans, queer or questioning, and members of related communities) populations. While the makeup and characteristics of individuals within LGBTQ+ communities may share some similarities, there is substantial diversity,[1] including physical, linguistic, sexual, and cultural distinctions, making it critical for physicians to be aware of these differences. Even though critical health information for some LGBTQ+ members has been available for several years,[2,3] the overall community is much more diverse than originally perceived and their risks are not as well evaluated. Building upon Chronopoulos' presentation,[4] **Table 1** defines some of the terms associated with LGBTQ+ communities and shows the complexity by outlining important distinctions.

In recent years, societal norms have shifted considerably regarding LGBTQ+ communities, and family physicians are discovering their role in addressing their distinctive health issues. Research on members of this diverse community and guidelines for their care are slowly being recognized as important, but for preventive screening, no specific guidelines are yet available. This article will focus attention on screening guidelines for WSW. **Table 2** summarizes the current preventive care data available[5-25]; note that evaluations are based on the GRADE (Grading of Recommendations Assessment, Development and Evaluation) system from the Canadian Task Force on Preventive Health Care.

Participation in preventive screening

The LGBTQ+ communities comprise about 3.5% of the American adult population.[1] Gates notes that approximately 19 million Americans, or 8.2%, indicate same-sex behaviour.[1] When including those who report some same-sex attraction, the number rises to 25 million.[1] Canadian proportions are likely to be similar to these estimates.[26] According to a recent study on medical care, sexual minorities continue to encounter barriers to care, even though they are historically at greater risk of obesity, tobacco use, substance use, mental health issues, intimate partner violence, sexually transmitted infections, and cancer.[27] Negative experiences with health care professionals generally promote indifferent attitudes toward preventive care. Similar to other marginalized groups, WSW patients may not disclose their sexual orientation to their physicians.[28,29] Patients will, consciously or not, assess the safety of self-disclosure, and it is not unusual for considerable time to pass before patients speak openly about their sexuality and specific sexual

Key points

- Women who have sex with women (WSW) have low levels of participation in preventive screening and could have higher risk levels in specific health areas as a result. Preventive care guidelines have gaps in specifying what to do for WSW, often because of limited evidence.
- All women who do not participate in cervical cancer screening are at higher risk; however, there is a common misperception among physicians and WSW that they do not need to participate in regular screening.
- Communication with WSW patients is often poor because of previous negative experiences and discrimination, anticipation of hostility, and ongoing physician bias, leading to physician avoidance. Perceptions by WSW about cultural attitudes of physicians may result in refusal of screening protocols or a general reluctance to participate in medical care. The most effective practice strategies are to provide a welcoming environment and be sensitive regarding communication about preventive care.

Table 1. Sexual diversity definitions for the purposes of health care: *There may be geographic and cultural variation in acceptability of definitions. Across Canada, there are variations in interpretation.*

TERM	DEFINITION
LGBTQ+	A large group of diverse communities with physical, racial, linguistic, sexual, and cultural distinctions. Women who have sex with women form a community within this larger group
Heterosexual	A person who is sexually and-or romantically attracted to people of the opposite sex
Lesbian	A woman who is sexually and-or romantically attracted to other women. Some women may find this term derogatory. Self-identity as lesbian does not necessarily exclude male sex partners
Bisexual	A person who is romantically and-or sexually attracted to people of the opposite gender as well as the same gender. This presupposes the binarity of the genders, by definition
2-spirit (Indigenous)	*2-spirit* is used exclusively by Indigenous peoples to describe their sexual, gender, and-or spiritual identity and refers to a person who identifies as having both a masculine and a feminine spirit. A person who is 2-spirit may identify as gay, lesbian, bisexual, transgender, nonbinary, and gender nonconforming, but the terms are not synonymous. This may vary within different First Nations communities, especially regarding the spiritual definition
Asexual	A person who has no sexual feelings or desires, or who is not sexually attracted to anyone
Pansexual	A person who is romantically and-or sexually attracted to a person, regardless of their self-identification in the gender spectrum
Women who have sex with women	This term focuses on behaviour and includes all women who have sex with women, regardless of how they self-identify. Women in this group may self-identify as any term in the sexual diversity
Queer	Historically, *queer* was a derogatory term, but it is currently transitioning to be reclaimed by the communities. For some members who identify as queer, it is a political identity and, therefore, feels empowering. It may be used as an inclusive umbrella term by members of the communities to reflect unique sexualities that are not reflected by words such as *gay, lesbian,* or *trans*
Trans	A person whose gender identity does not match the biological sex that was given at birth. *Trans male* is the transition from female to male, while *trans female* is the transition from male to female
Other	Some other terms used to describe members of the LGBTQ+ communities can include *nonbinary, agender* or *gender neutral, genderqueer, genderfluid, gender nonconforming,* and *demisexual*
Coming out	The process that LGBTQ+ individuals undergo as they work to individually accept their sexual orientation and sexual identity and then share that identity openly with other people. This can be associated with fear of prejudice, victimization, and disapproval by family, friends, employers, and health care professionals

LGBTQ+—lesbian, gay, bisexual, trans, queer or questioning, and members of related communities.
Adapted from Chronopoulos.[4]

practices. Physicians should be aware of this and how it may have a negative effect on screening willingness. Some physicians may also be unsure of the current recommendations for preventive screening in WSW, which makes patients question the effectiveness of screening.[30] It is also possible that participation rates may be affected by the gender of the physician.[31]

Gaps in preventive care guidelines

Evidence-based preventive screening for patients identifying as WSW remains elusive.[32,33] Effective guidance may be provided by the GRADE system, but systematic study of all categories of preventive care might not be imminent. At the same time, problem areas, such as stress analysis and mental health issues, are especially problematic for family physicians to adjudicate, given the current state of knowledge.

Considering cervical cancer screening as an example, note that the Canadian Cancer Society indicates that human papillomavirus (HPV) vaccines do not prevent all types of infection and, therefore, recommends regular testing.[33] In addition, information provided by WSW interest groups call for screenings similar to heterosexual women.[34] A study on cervical cancer testing in Sweden confirms the importance of the test for all female patients, but does not address sexual minority women.[35] The most comprehensive list of screening issues for WSW related to cancer screening is found in Fish's study,[6] which included bisexual women, and notes that HPV may be transmitted by a partner who has had sex with a man or from an early sexual encounter with a man. In this same study, HPV diagnosis ranged between 3.3% to 30%; for those with no heterosexual experience, the rate remained at 19%. Women who have sex with women tend to consider themselves at lower risk of cervical cancer than others because intercourse with men for them is regarded as the primary risk factor. The same study of WSW and bisexual women found that they were 10 times less likely to have had a Pap test in the past 3 years, which could mean additional risks.[6]

Table 2. Screening recommendations for WSW

HEALTH CONDITION	SCREENING RECOMMENDATION*	COMMENTS
Mental health	• For adults at average or increased risk of depression, it is recommended to not routinely screen (weak recommendation; very low-quality evidence)[5] • Clinicians should be aware of the possibility of depression, especially in patients with characteristics that may increase the risk of depression[5]	• WSW may have concerns about confidentiality and disclosure, discrimination and treatment, and the limited understanding of health risks by health care practitioners[6-12] • Lesbian and bisexual women are more likely to experience depression, anxiety, suicidality, and substance abuse than heterosexual women.[6-13] Bisexual women may have poorer mental health outcomes than either heterosexual or lesbian women[7-12] • Lesbian women are more likely to have received treatment for depression than heterosexual and bisexual women[7-12] • During adolescence, youth who self-identify as WSW may be at higher risk of depression, suicide, and substance abuse; they may benefit from counseling[9]
Cervical cancer	**Screening using Pap test** Women < 20 y • Recommend not routinely screening for cervical cancer (strong recommendation; high-quality evidence)[14] Women 20-29 y *Women 20-24 y* • Recommend not routinely screening for cervical cancer (weak recommendation; moderate- to high-quality evidence)[14] *Women 25-29 y* • Recommend routine screening for cervical cancer every 3 y (weak recommendation; moderate-quality evidence)[14] Women 30-69 y • Recommend routine screening for cervical cancer every 3 y (strong recommendation; high-quality evidence)[14] Women ≥ 70 y • Women with adequate screening (3 successive negative Pap test results in past 10 y) may stop. Other women should continue screening until 3 negative Pap test results (weak recommendation; low-quality evidence)[14]	• Lesbian and bisexual women may contact HPV via previous sexual behaviour with men or via a female partner who has had previous heterosexual contact[6,13] • Many WSW do not screen for cervical cancer at recommended intervals[6,13] • Potential exposure to HPV puts WSW at risk of cervical cancer; WSW should be regularly screened with Pap tests[6] • HPV prevalence among lesbian and bisexual women ranges from 3.3% to 30%[6] • HPV prevalence among women with no history of heterosexual contact is 19%[6]
Breast cancer	**Screening using mammography** Women 40-49 y • Recommend not screening with mammography (conditional recommendation; low certainty of evidence)[15] Women 50-69 y • Recommend screening with mammography every 2 to 3 y (conditional recommendation; very low certainty of evidence)[15]	• WSW should follow screening recommendations for breast cancer based on their age group[15] • There is no physiologic or genetic difference between lesbian and heterosexual women[16] • There is a belief that lesbian women may be at increased risk of breast cancer because of a "cluster of risks" as a result of behaviour that results from the stress and stigma of living with homophobia and discrimination[17] • There is insufficient evidence to determine if lesbian women may be at increased risk of breast cancer[17] • Because of low certainty of evidence for benefits and harms of screening with mammography, decisions with women should be made through shared decision making and knowledge translation tools[15]
Domestic abuse	The CTFPHC does not recommend routinely screening Canadian residents for intimate partner violence or abuse of elderly and vulnerable populations[18]	• Domestic abuse in lesbian couples may be comparable or higher than in heterosexual couples[19] • Partner or domestic violence can include physical, sexual, and psychological abuse[20] • Physicians need to be aware that domestic abuse may be a potential issue[9]

Table 2 *continued on page 833*

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HEALTH CONDITION	SCREENING RECOMMENDATION*	COMMENTS
Diabetes, hypertension, lung cancer, and colon cancer	• See the CTFPHC for specific recommendations on each of these conditions[21] • See Diabetes Canada for information on screening for diabetes in adults[22]	• WSW should follow screening recommendations for each of these conditions based on their age[21] • WSW have higher prevalence rates of obesity, tobacco use, and alcohol use,[9,23] and increased risk of type 2 diabetes, lung cancer, and cardiovascular disease[9,23-25]

CTFPHC—Canadian Task Force on Preventive Health Care, HPV—human papillomavirus, WSW—women who have sex with women.
*Recommendations are graded according to the GRADE (Grading of Recommendations Assessment, Development and Evaluation) system.

Given this situation, WSW should follow the recommendations on screening for cervical cancer with Pap tests from the Canadian Task Force on Preventive Health Care.[14] A collaborative assistance model may help alleviate some patient concerns.

Common misinformation and misconceptions

Social environments and what is identified as implicit culture[36] also impact willingness to participate in screening. Even so, it is difficult to quantify risks across a spectrum of women because of diversity in age, socioeconomic status, and ethnic identity. However, there seems to be little doubt that public perception of WSW can be very misleading, with resulting discriminatory attitudes. It becomes the case that, in the delicate balance of personal respect required between these patients and their physicians, preventive care is, to some extent, dependent upon intangibles like expressed personal values,[29,37] some of which can be construed as antagonistic to members of this community.

While research on elderly WSW is lacking in the literature, Blair observed relatively low rates of screening in a sample of 201 women 60 years of age and older[38]; this could mean that physicians incorrectly assume that WSW have traditional monogamous relationships, failing to appreciate the heterogeneity of this population. Age-based preventive screening may seem unclear for WSW, but there is no actionable documented difference in the approach. Despite this, some misconceptions persist among both patients and physicians alike: patients are still sceptical of physicians, information about the reliability and negative aspects of screening are not always conveyed by physicians,[39] and there is public confusion about the regularity and effectiveness of some tests, such as cancer screening tests.[40] The lay population has highly variable views on the value of such testing, implying a need for open discussion and shared decision making on critical issues.[41]

Physician responses

There is some evidence that the sex of the health care provider affects assessment participation: female physicians appear to have higher female testing rates,[31] suggesting that lack of physician comfort with a procedure may also be a constraining factor.[42] It is crucial that other preventive recommendations about health habits and other forms of screening be consistently applied to all WSW. It would appear, therefore, that physician response is a factor in these statistics.

Women who have sex with women do experience fear and often report negative experiences in their encounters with health care providers.[13] Physicians may be unaware of the specific problem areas of WSW health, such as the range of health challenges affecting the community.[43] For example, in a US study, the percentage of young lesbian and gay women meeting the criteria for major depression (18%) and posttraumatic stress disorder (11.3%) in a 12-month period was much higher than the national averages of 8.3% and 3.9%, respectively.[44] These women also appear to be at greater risk of partner violence and social rejection.[19,20] Adult WSW also have an increased prevalence of depression and anxiety; Suarez et al point out that "many known risk factors for cancer, such as tobacco, alcohol, nulliparity, and obesity, have higher prevalence among LGBTQ+ persons compared with heterosexual peers," which leads the researchers to suspect higher rates of breast and cervical cancer in LGBTQ+ populations than in heterosexual populations, and express doubt regarding the accuracy of reported data.[45]

Communication issues

It has been reported that some physicians have difficulty taking a respectful and inclusive sexual history.[46] Women who have sex with women report that sexual histories are almost inevitably based on heterosexual models that emphasize reproductive health. Consequently, some WSW and their physicians may continue to believe that general health messages for women (eg, folic acid supplementation if contemplating pregnancy, Pap tests, screening for sexually transmitted infections) do not apply to WSW, despite the fact that sexual activity (eg, skin-to-skin contact, use of sex toys, digital insertion) is important to consider in any global sexual health care program. Research also indicates that disparity in preventive care is largely based on sexual assumptions.[47] Thus, it is assumed that health requirements for WSW are different than for heterosexual women. This may, in fact, not be the case. For example, with cervical cancer screening, it is widely believed that WSW are not at risk

of cervical cancer because they do not have sex with men.[48] Even if some women identify as WSW, it does not mean that they do not have, or have not had, sex with men. Even if they are exclusively sexually active with women, they may still be at risk through genital skin-to-skin contact, etc. The screening discrepancy can be substantial, with fewer than two-thirds of WSW reporting a Pap test within the previous 3 years in 2008, compared with three-quarters of heterosexual women.[14] More recent data show that there is a persistent statistically significant difference in the rate of cervical cancer screening between WSW and heterosexual women (85.7% of heterosexual women, and 78.9% and 80.1% of bisexual and WSW women, respectively, received timely tests).[27] This is in contrast to mammography screening in women older than 50 years of age, where there is no disparity between these 2 groups.[47] Since cervical cancer screening appears to be foundational in today's preventive recommendations, it is important to determine the proper recommendations for WSW, as there is a weak distinction from a medical standpoint between screening WSW and heterosexual women.[14] Evidence within the LGBTQ+ community indicates that screening preferences are a factor in participation rates.[49]

Sensitive communication for WSW

Health care providers need to realize that WSW face a legacy of antipathy or worse from Canadian institutions and that they often arrive expecting some form of hostility from physicians.[13,14,29-50] There is also some evidence that WSW patients, such as those within certain religious groups, have especially difficult medical experiences,[51] with risks of loss of confidentiality, concern about disclosure, and fear of discrimination predominating.[52] Awareness of the cultural and social context of WSW is critical when the goal is to provide appropriate preventive care, since addressing the sensitive topic of sexual activity can be very detrimental within some communities. Family physicians are at the front line of issues around sensitive communication.

Strategies

Physicians need to provide screening information in 2 forms: risk information and test effectiveness. The ability of professionals to delineate the risks and make those risks concrete enough to be understood and acted upon is paramount.[34] Physicians need to recognize the diversity in WSW women and be able to give appropriate advice. Preventive care of the WSW population is complex; it requires a joint commitment to health betterment by both patients and physicians. **Table 3** provides some tools to make encounters more friendly toward WSW.[9,53]

Case resolution

At the follow-up appointment, using gender-neutral language, you acknowledge the patient's reluctance and provide reassurance, first, that sexual orientation is not an issue under discussion, and second, that preventive

Table 3. Practice strategies for WSW

PRACTICE STRATEGY	SUGGESTIONS
Inclusive communication style	• Focus on respect for the individual and ensure all staff adopt an inclusive communication style • Ask how the person prefers to be addressed (avoid using Miss or Mister at first encounter; simply use their full name) • Do not assume sexual orientation and gender identity based on their sex assigned at birth • Do not presume sexual practices: ask open-ended and clear questions • Be aware of questions that assume heterosexuality (eg, are you married?). Instead ask, "Who are the important people in your life?"
Safe environment promotion	• Recognize that patients may choose not to divulge sensitive information until they have built trust in you • Indicate awareness of the diversity in LGBTQ+ communities. This helps enhance patient safety and promotes trust. Have a LGBTQ+ flag, a posted nondiscrimination policy, or a safe-zone sign • If you have images in the waiting room, ensure they represent diversity of couples and families • Provide a unisex bathroom • Ensure registration forms are inclusive and obtain specific information (eg, do you have a domestic partner?)
Sexual history	• Inquire about sexual orientation using nondiscriminatory language • Be aware that some terms may trigger negative responses. Advocacy groups recommend refraining from the use of terms like *gay* and some WSW object to the term *lesbian* • Use reflective language, as the term they themselves use is likely most appropriate
Preventive care decisions	• Use shared decision making or information tools like you would with any other individual • Be transparent when specific data are missing for a particular population • Information and knowledge translation tools can be obtained from the CTFPHC website[53]
Resource for patients and families	• Familiarize yourself with local resources and consider referral to a LGBTQ+ organization or website to offer support

CTFPHC—Canadian Task Force on Preventive Health Care; LGBTQ+—lesbian, gay, bisexual, trans, queer or questioning, and members of related communities; WSW—women who have sex with women.
Adapted from the ACOG Committee on Health Care for Underserved Women.[9]

screening decisions will be made together (shared decision making). You also indicate that there is no evidence to screen WSW differently (ie, the current cervical cancer screening recommendations apply to WSW) and you give her some references for more information about this. You also communicate that trust is an essential element in the doctor-patient relationship and convey the sentiment that you hope to provide her with good-quality care going forward.

Conclusion

Since preventive care is conditional on determining health risks, and not on immediate or imminent debilitation, physicians cannot always point to clinically validated guidelines as grounds for assessments. The grounds for proper health care depend on a shared commitment between patients and physicians built on trust, in which physicians must recognize the difficulties with access to care that WSW face.

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Competing interests

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References

1. Gates GJ. *How many people are lesbian, gay, bisexual, and transgender?* Los Angeles, CA: UCLA The Williams Institute; 2011. Available from: **https://williamsinstitute.law.ucla.edu/publications/how-many-people-lgbt/**. Accessed 2021 Oct 1.
2. Lim FA, Brown DV Jr, Justin Kim SM. Addressing health care disparities in the lesbian, gay, bisexual, and transgender population: a review of best practices. *Am J Nurs* 2014;114(6):24-45.
3. Knight DA, Jarrett D. Preventive health care for men who have sex with men. *Am Fam Physician* 2015;91(12):844-51. Erratum in: *Am Fam Physician* 2016;94(2):84.
4. Chronopoulos J. *Making space: guide to queer friendly practice*. Presented at: Family Medicine Summit; 2020 Mar 6-8; Banff, AB.
5. Joffres M, Jaramillo A, Dickinson J, Lewin G, Pottie K, Shaw E, et al. Recommendations on screening for depression in adults. *CMAJ* 2013;185(9):775-82. Epub 2013 May 13. Erratum in: *CMAJ* 2013;185(12):1067.
6. Fish J. *Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods*. Leicester, UK: De Montfort University; 2009. Available from: **https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.539.4206&rep=rep1&type=pdf**. Accessed 2021 Oct 1.
7. Gilmour H. *Health reports: sexual orientation and complete mental health*. Ottawa, ON: Statistics Canada; 2019. Available from: **https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2019011/article/00001-eng.pdf?st=vEFYOJrm**. Accessed 2021 Oct 1.
8. Koh AS, Ross LK. Mental health issues: a comparison of lesbian, bisexual and heterosexual women. *J Homosex* 2006;51(1):33-57.
9. ACOG Committee on Health Care for Underserved Women. ACOG Committee Opinion No. 525: health care for lesbians and bisexual women. *Obstet Gynecol* 2012;119(5):1077-80.
10. Pompili M, Lester D, Forte A, Seretti ME, Erbuto D, Lamis DA, et al. Bisexuality and suicide: a systematic review of the current literature. *J Sex Med* 2014;11(8):1903-13. Epub 2014 May 20.
11. Meads C, Hunt R, Martin A, Varney J. A systematic review of sexual minority women's experiences of health care in the UK. *Int J Environ Res Public Health* 2019;16(17):3032.
12. Kerr DL, Santurri L, Peters P. A comparison of lesbian, bisexual, and heterosexual college undergraduate women on selected mental health issues. *J Am Coll Health* 2013;61(4):185-94.
13. Tracy JK, Lydecker AD, Ireland L. Barriers to cervical cancer screening among lesbians. *J Womens Health* (Larchmt) 2010;19(2):229-37.
14. Dickinson J, Tsakonas E, Conner Gorber S, Lewin G, Shaw E, Singh H, et al. Recommendations on screening for cervical cancer. *CMAJ* 2013;185(1):35-45. Epub 2013 Jan 7.
15. Klarenbach S, Sims-Jones N, Lewin G, Singh H, Thériault G, Tonelli M, et al. Recommendations on screening for breast cancer in women aged 40-74 years who are not at increased risk for breast cancer. *CMAJ* 2018;190(49):E1441-51.
16. Meads C, Moore D. Breast cancer in lesbians and bisexual women: systematic review of incidence, prevalence and risk studies. *BMC Public Health* 2013;13:1127.
17. Margolies L. *LGBT cancer information: lesbians and breast cancer risk*. Providence, RI: National LGBT Cancer Network; 2021. Available from: **https://cancer-network.org/cancer-information/lesbians-and-cancer/lesbians-and-breast-cancer-risk/**. Accessed 2021 Oct 1.
18. *Domestic abuse 2013 critical appraisal report*. Montreal, QC: Canadian Task Force on Preventive Health Care; 2013. Available from: **https://canadiantaskforce.ca/wp-content/uploads/2016/05/2013-domestic-abuse-en.pdf**. Accessed 2021 Oct 1.
19. Rollè L, Giardina G, Caldarera AM, Gerino E, Brustia P. When intimate partner violence meets same sex couples: a review of same sex intimate partner violence. *Front Psychol* 2018;9:1506. Erratum in: *Front Psychol* 2019;10:1706.
20. Waldner-Haugrud LK, Gratch LV. Sexual coercion in gay/lesbian relationships: descriptives and gender differences. *Violence Vict* 1997;12(1):87-98.
21. *Published guidelines*. Montreal, QC: Canadian Task Force on Preventive Health Care. Available from: **https://canadiantaskforce.ca/guidelines/published-guidelines/**. Accessed 2021 Oct 1.
22. Diabetes Canada Clinical Practice Guidelines Expert Committee; Ekoe JM, Goldenberg R, Katz P. Screening for diabetes in adults. *Can J Diabetes* 2018;42(Suppl 1):S16-9.
23. Caceres BA, Brody A, Luscombe RE, Primiano JE, Marusca P, Sitts EM, et al. A systematic review of cardiovascular disease in sexual minorities. *Am J Public Health* 2017;107(4):e13-21. Epub 2017 Feb 16.
24. Corliss HL, VanKim NA, Jun HJ, Austin SB, Hong B, Wang M, et al. Risk of type 2 diabetes among lesbian, bisexual, and heterosexual women: findings from the nurses' health study II. *Diabetes Care* 2018;41(7):1448-54. Epub 2018 May 2.
25. Boehmer U, Miao X, Maxwell NI, Ozonoff A. Sexual minority population density and incidence of lung, colorectal and female breast cancer in California. *BMJ Open* 2014;4(3):e004461.
26. *Socioeconomic profile of the lesbian, gay and bisexual population, 2015 to 2018*. Ottawa, ON: Statistics Canada; 2021. Available from: **https://www150.statcan.gc.ca/n1/daily-quotidien/210326/dq210326a-eng.htm**. Accessed 2021 Oct 21.
27. Solazzo AL, Gorman BK, Denney JT. Cancer screening utilization among U.S. women: how mammogram and pap test use varies among heterosexual, lesbian, and bisexual women. *Popul Res Policy Rev* 2017:36(3):357-77.
28. Roberts MC, Ferrer RA, Rendle KA, Kobrin SC, Taplin SH, Hesse BW, et al. Lay beliefs about the accuracy and value of cancer screening. *Am J Prev Med* 2018;54(5):699-703. Epub 2018 Mar 16.
29. Lee R. Health care problems of lesbian, gay, bisexual, and transgender patients. *West J Med* 2000;172(6):403-8.
30. Shimizu T, Bouchard M, Mavriplis C. Update on age-appropriate preventive measures and screening for Canadian primary care providers. *Can Fam Physician* 2016;62:131-8 (Eng), e64-72 (Fr).
31. Lurie N, Margolis KL, McGovern PG, Mink PJ, Slater JS. Why do patients of female physicians have higher rates of breast and cervical cancer screening? *J Gen Intern Med* 1997;12(1):34-43.
32. Moran N. Lesbian health care needs. *Can Fam Physician* 1996;42:879-84.
33. *Lesbian, bisexual and queer women and cervical cancer screening*. Toronto, ON: Canadian Cancer Society; 2021. Available from: **https://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/lesbian-bisexual-and-queer-women-and-cervical-cancer/?region=bc**. Accessed 2021 Sep 8.
34. *Guidelines for care of lesbian, gay, bisexual, and transgender patients*. San Francisco, CA: Gay and Lesbian Medical Association. Available from: **http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf**. Accessed 2021 Aug 16.
35. Lei J, Ploner A, Elfström KM, Wang J, Roth A, Fang F, et al. HPV vaccination and the risk of invasive cervical cancer. *N Engl J Med* 2020;383(14):1340-8.
36. Shangani S, Gamarel KE, Ogunbajo A, Cai J, Operario D. Intersectional minority stress disparities among sexual minority adults in the USA: the role of race/ethnicity and socioeconomic status. *Cult Health Sex* 2020;22(4):398-412. Epub 2019 May 30.
37. Hirsch O, Löltgen K, Becker A. Lesbian womens' access to healthcare, experiences with and expectations towards GPs in German primary care. *BMC Fam Pract* 2016;17(1):162.
38. Blair KA. Cancer screening of older women: a primary care issue. *Cancer Pract* 1998;6(4):217-22.
39. Stott DB. The training needs of general practitioners in the exploration of sexual health matters and providing sexual healthcare to lesbian, gay and bisexual patients. *Med Teach* 2013;35(9):752-9. Epub 2013 Jun 28.
40. Agénor M, Bailey Z, Krieger N, Austin SB, Gottlieb BR. Exploring the cervical cancer screening experiences of Black lesbian, bisexual, and queer women: the role of patient-provider communication. *Women Health* 2015;55(6):717-36. Epub 2015 Apr 24.
41. Floyd SR, Pierce DM, Geraci SA. Preventive and primary care for lesbian, gay and bisexual patients. *Am J Med Sci* 2016;352(6):637-43. Epub 2016 May 17.
42. Reissman SE. Comparison of two Papanicolaou smear techniques in a family practice setting. *J Fam Pract* 1988;26(5):525-9.
43. *Achieving health equity in preventive services: systematic evidence review*. Rockville, MD: Agency for Healthcare Research and Quality; 2018. Available from: **https://effectivehealthcare.ahrq.gov/products/health-equity-preventive/protocol**. Accessed 2021 Aug 18.
44. Russell ST, Fish JN. Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annu Rev Clin Psychol* 2016;12:465-87. Epub 2016 Jan 14.
45. Suarez S, Lupez E, Siegel J, Streed C Jr. The annual examination for lesbian, gay, and bisexual patients. *Prim Care* 2021;48(2):191-212. Epub 2021 Apr 22.

46. Merrill JM, Laux LF, Thornby JI. Why doctors have difficulty with sex histories. *South Med J* 1990;83(6):613-7.
47. Baptiste-Roberts K, Oranuba E, Werts N, Edwards LV. Addressing health care disparities among sexual minorities. *Obstet Gynecol Clin North Am* 2017;44(1):71-80.
48. Tjepkema M. *Health care use among gay, lesbian and bisexual Canadians*. Ottawa, ON: Statistics Canada; 2008. Available from: **https://www150.statcan.gc.ca/n1/en/catalogue/82-003-X200800110532**. Accessed 2021 Aug 13.
49. McDowell M, Pardee DJ, Peitzmeier S, Reisner SL, Agénor M, Alizaga N, et al. Cervical cancer screening preferences among trans-masculine individuals: patient-collected human papillomavirus vaginal swabs versus provider-administered Pap tests. *LGBT Health* 2017;4(4):252-9. Epub 2017 Jun 30.
50. Aaron DJ, Markovic N, Danielson ME, Honnold JA, Janosky JE, Schmidt NJ. Behavioral risk factors for disease and preventive health practices among lesbians. *Am J Public Health* 2001;91(6):972-5.
51. Hasnain M, Connell KJ, Menon U, Tranmer PA. Patient-centered care for Muslim women: provider and patient perspectives. *J Womens Health* (Larchmt) 2011;20(1):73-83. Epub 2010 Dec 29.
52. Dearing RL, Hequembourg AL. Culturally (in)competent? Dismantling health care barriers for sexual minority women. *Soc Work Health Care* 2014;53(8):739-61.
53. *Canadian Task Force on Preventive Health Care* [website]. Ottawa, ON: Canadian Task Force on Preventive Health Care; 2019. Available from: **https://canadiantaskforce.ca/**. Accessed 2021 Sep 28.

Can Fam Physician 2021;67:830-6. DOI: 10.46747/cfp.6711830

Suggested reading

Haviland KS, Swette S, Kelechi T, Mueller M. Barriers and facilitators to cancer screening among LGBTQ individuals with cancer. *Oncol Nurs Forum* 2020;47(1):44-55.

Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender (LGBT) community: a field guide. Oak Brook, IL: The Joint Comission; 2011. Available from: **https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=FD725DC02CFE6E4F21A35EBD839BBE97&hash=FD725DC02CFE6E4F21A35EBD839BBE97**. Accessed 2021 Sep 8.

Resource library: LGBTTQ+. Ottawa, ON: The Society of Obstetricians and Gynaecologists of Canada; 2021. Available from: **https://www.sexandu.ca/resources/resource-library/#tc3**. Accessed 2021 Sep 8.