

# Improving the uptake of cervical screening among sexual minority women

How health professionals can help

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Current public health guidance recommends that everyone who has a cervix, is aged 25–69 and is sexually active undergo cervical screening. International research consistently indicates that the uptake of cervical screening among sexual minority women (e.g. lesbians, wahine takatāpui, bisexual women) is considerably lower than for heterosexual women.

While many sexual minority women do regularly engage in cervical screening, a sizeable minority have either never been for a cervical smear, or if they have been in the past, they have not routinely participated. In a recently published research article (Ellis, 2024) fewer than half of the 206 sexual minority women who participated had regularly engaged in cervical screening. This is comparable to the reported participation rate of Māori and Pasifika women, indicating that sexual minority women may potentially be an ‘at risk’ group for cervical cancer.

## The study’s findings

In this study, reasons for not engaging in screening regularly (or at all) were varied. One of the most reported reasons for not engaging in cervical screening was having never had sex with men. Regardless of cervical screening status, those who participated in the study indicated that a perception that women who have sex with women are not at risk of cervical cancer is prevalent, with many having been told by a health professional at some point that as a lesbian they did not need to have a smear. This points to a historical legacy of misinformation in which sexual minority women have been given the impression – or in some cases, directly told – that they do not need to engage in cervical screening. However, even where sexual minority women have taken on current guidance around cervical screening (i.e. that if you have a cervix, you need to engage in screening), heteronormativity in both health care generally and this process specifically means that many sexual minority women are reticent to engage. For example, it was common for participants to recount instances in which health care professionals had interacted with them as if they were heterosexual (e.g. assumed their partner was male; asked about birth control) during the appointment.



In addition, for sexual minority women who had never engaged in penetrative sex (the group least likely to engage in cervical screening) and/or have not engaged in routine gynaecological processes (e.g. pregnancy and childbirth), the screening process itself may feel particularly invasive. Any combination of these reasons might put sexual minority women off engaging in such an intimate process as cervical screening.

In this study, participants were also asked what things could be done to improve levels of engagement in cervical screening among sexual minority women. The analysis of participants' responses suggests three main considerations:

- 1. Ensure that interactions with patients are inclusive** – don't automatically assume that the person in front of you has a male partner, that penetrative sex is invariably penile or that sexual relationships inevitably involve penetration. Avoid referring to contraception unless you are sure that the person is in a heterosexual relationship or has a medical reason to use it. Be aware that some people who have a cervix will not identify as women and use best practice of referring to patients by name or asking for their preferred pronouns rather than automatically using 'she' or 'her'.
- 2. Ensure that information offers clarity to all** – provide clear evidence of the risk of HPV and cervical cancer for those who have never engaged in penetrative sex to enable informed decision-making around engagement in cervical screening. Provide a clear indication of the incidence of cervical abnormalities in sexual minority women specifically.
- 3. Provide targeted health information/promotion** – use posters that indicate to sexual minority women that they are welcome in health spaces. Ensure that women who are diverse in gender and/or sexuality are visible in advertising and the promotion of cervical screening. Produce health campaigns that speak to the interests or lived realities of sexual minority women. As one participant wrote:

"I am yet to see a public health campaign about it that includes anyone with dykey or butch or trans masculine vibes about them. And representation can help! A lot of ads in my lifetime have had more of a 'you are a mum, you are an aunty' kinda angle, which doesn't feel super inclusive of my queer life." (Lesbian, 35–44).

To find out more about the study and the ways in which sexual minority women feel marginalised in cervical screening, you can access the following open access research articles listed in the sidebar of this article.

#### Additional reading:

[Ellis SJ. Improving cervical screening rates among sexual minorities: Insights from Aotearoa New Zealand. Health Promot J Austr. 2025 Jan;36\(1\):e904. doi: 10.1002/hpja.904. Epub 2024 Jul 22.](#)

[Ellis SJ. Are women-who-have-sex-with-women an 'at-risk' group for cervical cancer? An exploratory study of women in Aotearoa New Zealand. Sex Health. 2024 Feb;21\(1\):NULL. doi: 10.1071/SH23145.](#)

Although there were some trans and non-binary (TNB) participants in the study, these papers do not focus on that group specifically. For information about the uptake and experiences of cervical screening among TNB people in Aotearoa New Zealand, you can read the following article: [Carroll R, Tan KKH, Ker A, Byrne JL, Veale JF. Uptake, experiences and barriers to cervical screening for trans and non-binary people in Aotearoa New Zealand. Aust N Z J Obstet Gynaecol. 2023 Jun;63\(3\):448-453. doi: 10.1111/ajo.13674. Epub 2023 Apr 2](#)

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