

# **Investigating Barriers and Facilitators to Cervical Screening Uptake in the LGBT+ Community in Wolverhampton**

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## 1.0 Introduction

This report details the project carried out in Wolverhampton from February 2026 – April 2026 to investigate barriers and facilitators to cervical screening uptake in Wolverhampton's LGBT+ (lesbian, gay, bisexual, transgender, and other sexual orientations and gender identities) community. In the 2021 census, 91.9% of Wolverhampton residents who responded to the question of gender identity said that their gender is the same as that recorded at birth (compared to 93.5% for England), and 0.8% of respondents stated that their gender was different to that at birth (compared to 0.5% for England). The census also reported that 89.1% of residents identified as straight or heterosexual (compared to 89.4% for England), and 2.5% of people identified with an LGB+ orientation (compared to 3.2% for England).

All people with a cervix aged 25-64 in England are eligible to attend cervical screening, at least every 5 years. Cervical screening checks for the HPV virus in the cervix, which can in some cases cause cell changes which may lead to cervical cancer if untreated. Cervical screening uptake varies across the population, with factors such as deprivation, ethnicity, sexual orientation and gender identity influencing uptake. For instance, whilst all people with a cervix aged 25-64 are eligible for cervical screening, there is a lower likelihood of non-heterosexual women and transgender individuals participating in cervical cancer screening than heterosexual cisgender women<sup>1</sup>. Data on cervical screening uptake for LGBT+ individuals is limited and often dated, and it is important to bear these limitations in mind when assessing the data. However, existing data does suggest that LGBT+ individuals with a cervix are less likely to access cervical screening. In one study, 15% of lesbian and bisexual women over the age of 25 report never having had a smear test – compared to 7% of women in general. 20% of lesbian and bisexual women who have not attended a smear test had been previously told by a healthcare professional that they were not at risk, with 1 in 50 being refused cervical screening.<sup>2</sup> Another study found that trans male patients are less likely to access cervical screening than cisgender female patients.<sup>3</sup> Furthermore, 23% of LGBT people have reported witnessing at least one anti-LGBT remark by a healthcare staff member.<sup>4</sup>

The 2026 National Cancer Plan for England recognises that LGBT+ people are less likely to access cancer screening and commits to increasing screening uptake in underserved communities. Additionally, in 2025 City of Wolverhampton Council Public Health set

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<sup>1</sup> Heer, E., Peters, C., Knight, R., Yang, L., Heitman, S.J. 2023. Participation, barriers, and facilitators of cancer screening among LGBTQ+ populations: A review of the literature. Available at: <https://www.sciencedirect.com/science/article/abs/pii/S0091743523000580>

<sup>2</sup> Hunt, R. and Fish, J. 2008. Prescription for Change Lesbian and bisexual women's health check. Stonewall. Available at: [https://www.stonewall.org.uk/system/files/Prescription\\_for\\_Change\\_\\_2008\\_.pdf](https://www.stonewall.org.uk/system/files/Prescription_for_Change__2008_.pdf)

<sup>3</sup> Peitzmeier, S.M., Khullar, K., Reisner, S.L., Potter, J. 2014. Pap Test Use Is Lower Among Female-to-Male Patients than Non-Transgender Women

<sup>4</sup> Bachmann, C. and Gooch, B. 2018. LGBT in Britain. Health Report. Stonewall and YouGov. Available at: [https://www.stonewall.org.uk/system/files/lgbt\\_in\\_britain\\_health.pdf](https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf)

out its Top Ten Priorities, which include 'Cancer' and 'Access'. This project was proposed in line with these priorities and specifically focuses on access of the LGBT+ community to cervical screening.

## **2.0 Methodology**

### **2.1 Recruitment:**

Residents in Wolverhampton and the surrounding area were invited to take part in one of two focus groups if they met the eligibility criteria: aged 25-64, identify as LGBT+, have a cervix. The focus group was advertised through multiple routes including City of Wolverhampton Council internal communications, University of Wolverhampton, Wolverhampton Voluntary & Community Action, Black Country ICB, Wolverhampton LGBT, and community groups for LGBT+ parents and families. City of Wolverhampton Council's Rainbow Forum was consulted on the best routes to advertise. People could express interest either via a Microsoft Form, or via email. It was advertised that people could claim a £20 voucher upon taking part.

The two focus groups were held on different days, with one taking place in the afternoon and one in the early evening. This was to maximise the likelihood of people being able to attend one of the dates and try to ensure that working people were not excluded. After people had expressed interest in participating, they were invited via email to an individual follow up call on Microsoft Teams. This call provided an opportunity to discuss how to fill out the consent form and go through the supporting documents. It also provided an opportunity for the participants to ask questions without being in front of the whole group. Following the call, participants were sent the consent form, an information sheet and a support guide.

One key challenge associated with recruitment was that there were a lot of expressions of interest via the Microsoft Form – but not everyone responded to the follow up emails. This could be due to a range of reasons such as people changing their minds about participating or people not receiving the emails. In the future, alternative methods of communication could be considered, such as phone calls, to address the latter reason.

### **2.2 Delivery:**

The focus groups were originally planned to take place in person, at two locations in Central Wolverhampton. However, in the expression of interest forms, several participants requested that the focus group be delivered online for accessibility reasons. Hence, the decision was made to hold both groups on Microsoft Teams. The focus groups were scheduled to last for 90 minutes – allowing 60 minutes for discussion and 30 minutes to cover the introduction, conclusion and a scheduled break.

Participants were reminded that they could take a break at any point, as well as a scheduled break being planned for approximately halfway through each session.

There were 14 participants in attendance over the course of the sessions. In attendance alongside the participants were the two focus group co-facilitators (one leading the session and one providing support/acting as a Mental Health First Aider) and one university student (observing the focus group ahead of supporting with the transcript analysis). The sessions were recorded and transcribed using Microsoft Teams (audio only). The transcripts were checked for accuracy and anonymised following the sessions.

Note that some technical difficulties were encountered on the day of the first focus group, which meant that some participants struggled to join the meeting. A decision was made to continue the focus group with the one participant who had managed to join, and in the meantime a new link was sent out to the remaining participants to take place in a new focus group shortly afterwards. As a result, two shorter focus groups were conducted within the 90-minute time frame, which will be referred to as focus groups 1a and 1b. The transcripts from 1a and 1b will be considered together in the analysis, to ensure anonymity for the single participant who took part in 1a.

### 2.3 Analysis:

Two MPH students from the University of Wolverhampton were recruited to support with the transcript analysis.

The transcripts were produced by Microsoft Teams, but these were checked for accuracy and anonymised ahead of the analysis. The transcripts and comments given in the Microsoft Teams chat were analysed in turn using Thematic Content Analysis techniques, based on Braun and Clarke's methodology<sup>5</sup>. The transcripts from the shorter focus groups were analysed together by one student, and the second student analysed the transcript from the other focus group separately. The Project Lead met with the students at intervals to discuss their progress, answer any queries and provide guidance on the analysis. As discussed, the transcripts from the 1a and 1b focus groups were analysed together to avoid identifiable information coming through in the analysis. These were analysed separately to the transcript from focus group 2.

## 3.0 Findings

3.1 Due to the small number of participants, exact demographic figures will not be reported, to maintain anonymity for participants. Instead, the demographic groups

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<sup>5</sup> Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>

represented by focus group participants can be reported. Participants represented the age groups of 25-29 and 30-34, and they identified as female and trans male. In terms of sexual orientation, participants identified as lesbian, gay, bisexual and asexual. Participants' ethnicities were English, Welsh, Scottish, Northern Irish or British; African; White and Black Asian; White and Black Caribbean; Any other Black, Black British or Caribbean background.

### 3.2 Focus Group 1 Findings (Consisting of the two shorter transcripts)

Five key themes regarding barriers and facilitators to cervical screening uptake were identified from the transcripts:

#### 3.2.1 Theme 1: Knowledge Gaps and Inadequate Information

Participants reported being misinformed about cervical screening and receiving incorrect clinical advice. For instance, one participant recalled being told, "you don't need to worry about" getting screened due to identifying as LGBT+, and this resulted in them delaying attending screening for several years. Participants noted that it was difficult to find information about screening for LGBT+ individuals and reported a, "lack of information...for LGBT women", as well as a lack of understanding about the screening process itself. This included limited information on the available adjustments for the screening process: "they don't tell you stuff like you can request a smaller speculum...they just kind of expect you to come in and just lie there and it'll be over." This suggests that patients are put in a position where they lack complete agency over decisions regarding the screening process.

#### 3.2.2 Theme 2: Emotional and Psychological Barriers

Participants reported a range of emotional and psychological barriers to attending cervical screening. This includes, "anxiety about the test and also in terms of social stigma", Concerns about stigma create, "a fear of being maybe judged or shame, or in terms of maybe some taboo about discussing...reproductive health". There is also anxiety based on, "the past and traumatic experience(s)", and negative experiences led some participants to avoid in-person healthcare: "because of some of the experience that we had...I personally use telehealth with my doctor to communicate on [the] phone". This illustrates the downstream cycle of how negative experiences can lead to avoidance, which results in reduced uptake.

#### 3.2.3 Theme 3: Discrimination, Cultural Barriers and Lack of Inclusive Practice

Participants described their experiences of racial and cultural discrimination, including in healthcare settings: "we face a lot of discrimination every day. In school, work, everywhere, hospital." Participants also reported being, "faced with language barrier(s)" and expressed wishes for, "medical workers from different backgrounds with different languages...[to] break the language barrier." Whilst language barriers are not exclusively

an issue for the LGBT+ community, participants confirmed that the intersection of identifying as LGBT+ and experiencing language barriers make accessing screening even more difficult. It would be reasonable to assume that intersectionality is also a key factor in making accessing screening more challenging for LGBT+ people from ethnic minorities. There was also a case where a participant reported being asked personal questions by a receptionist: “I was just trying to like explain myself that I have an appointment. And instead she was just maybe questioning me and asking me some personal questions that were not meant to be shared.” Here, a participant experiencing a breach of dignity at the pre-appointment stage acts as a barrier to access, and a similar experience was reported by another participant.

### 3.2.4 Theme 4: Gender Exclusion and Lack of LGBT+ Inclusive Practice

Participants reported experiences of cervical screening being presented as an issue for cisgender, heterosexual women. This excludes LGBT+ people with a cervix – “there is not enough support for LGBT+ individual(s) with a cervix to access cervical screening” – and, in particular, trans men and non-binary individuals – “I think it’s very much pigeonholed as...this is a woman’s problem which then of course leaves out everyone who doesn’t necessarily classify themselves as a woman.” This issue is reflected in the language used in materials and appointments, with participants expressing a wish for, “campaigns and appointment invitation(s)...[using] gender neutral language”, and, “clear and inclusive information that explicitly states that screening is for anyone with a cervix, regardless of gender identity or sexual orientation.” This lack of inclusive practice also extends to one participant reporting feeling uncomfortable about disclosing their asexual identity to a healthcare professional, due to anticipated misunderstanding: “I haven’t quite been able to summon the confidence to tell her I’m ace because I don’t want to have to explain that. There’s a lot of misunderstanding about it.”

### 3.2.5 Theme 5: Facilitators and Recommendations

Participants reported several different recommendations for improving cervical screening uptake. These include having supportive healthcare staff with whom trusted relationships can be built – who ask patients what their concerns are and follow up in a compassionate way: “I think showing more interest in general, like kind of is there a particular reason you don’t want your smear? Rather than just, oh you don’t want it.” Participants also highlighted the importance of support systems in, “encouraging” them to attend a screening appointment. Discussing cervical screening takes, “courage”, which is why a supportive response is so important. Participants also noted they would find it helpful if they could get support from LGBT+ healthcare providers, which would make them feel, “safer” and less worried about being, “discriminate[d]” against. Similarly, one participant expressed a wish for, “referring LGBT individuals that are suffering from cancer to all the LGBT individuals that are recovering from it”. What these points highlight are the role that engaging with other LGBT+ individuals (whether

patients or professionals) can have in supporting LGBT+ individuals to attend cervical screening.

Participants also recommend increased staff training and knowledge regarding LGBT+ inclusive care to, “create a welcoming environment”. This is summarised by one participant who notes, “healthcare professionals should receive training on trans and non-binary health needs, trauma-informed care, gender sensitivity, and sometimes correct pronouns use.” This links to the recommendation that inclusive language and communication are used in healthcare. For example, healthcare professionals asking, “do you have a partner?” rather than assuming sexual orientation. Communication should also be sensitive, to protect patient privacy – “because especially if someone’s come in with a parent or someone that they may not be out to, they might not want to answer that question [regarding sexual orientation]”. It should be noted that one participant did report an improvement in awareness and recognition of people with cervixes more broadly – “many healthcare system[s] and clinic[s] are now trying to recognise all group[s] of people with [a] cervix, irrespective of who they are.” This was one of the few explicitly positive observations about the current system – and so further training and improved communication can hopefully progress this more.

Participants also reported structural and environmental improvements that can help improve accessibility. For example, email and app-based booking – “that is so much easier, especially if you’ve got a little bit of kind of social anxiety or whatever, than having to sit on the phone and wait.” Participants also noted that flexible appointment times in the evenings and weekends help to improve access.

### 3.3 Focus Group 2 Findings

Four key themes regarding barriers and facilitators to cervical screening uptake were identified from the transcript:

#### 3.3.1 Theme 1: Misinformation and Fear

Participants’ first encounters with cervical screening information were inaccurate, stigmatising, or fear-inducing, often originating from peer or social media sources rather than health services – “the very first information I got about cervical cancer was online. It was probably made to shame the LGBTQ community because I heard that those in the LGBTQ [community] could not have cancer, that they’re at risk and probably they could die trying to have an operation. Initially I was scared...” The internet was consistently a first point of call for accessing information but was recognised as unreliable. Some participants found reputable and professional information online – “I have seen information online, particularly on the NHS website, which explains who is eligible and why screening is important.” Others sought privacy online that they lacked in clinical

settings – “searching online felt more private and convenient, especially if I had questions I didn’t feel comfortable asking in person.” GP consultations/enquiry from healthcare professionals served as the primary site of accurate information – “everything was carefully explained to me”. The GP experience was broadly positive once accessed – “the doctor is always very okay”.

### 3.3.2 Theme 2: Structural and Logistical Barriers

Structural and logistical barriers included scheduling appointments around limited availability and irregular or demanding work/family schedules – “most times my appointments clash [with] my work schedule”. The cost of travel also acted as a genuine deterrent, particularly for those on limited incomes or with distant clinics – “one of the barriers I face is transportation cost”. Some participants adopted telehealth as a workaround for appointments; however, consultations were sometimes disrupted by technical failures. Cervical screening also cannot be conducted via telehealth.

### 3.3.3 Theme 3: Discrimination and Identity-Based Hostility

Front-of-house staff (not GPs) were the most commonly cited source of discrimination, through intrusive questioning, inappropriate gatekeeping, and hostile body language – “sometimes I don’t feel comfortable with the way the receptionist look at me”. Several participants identified as Black and LGBT+, and their accounts revealed discrimination operating on both axes simultaneously. For example, one participant noted that they, “face discriminations in [their] neighbourhood as a member of [the] LGBTQ [community]” and also that, “sometimes [the receptionists] make us feel less of humans, especially, you know, we are black”. This produces experiences of dehumanisation not reducible to either dimension alone. Fear of discrimination was also sufficient to delay or prevent booking, even without a current discriminatory encounter, and this fear of discrimination and abuse also drove preference for telehealth – “one of the reasons that most of the LGBTQ+ members used to adapt to telehealth communication with their GP is because sometimes on the bus they got abused, even in the clinic they got abused. So, they feel they should stay at the comfort of their home.”

### 3.3.4 Theme 4: Calls for Systemic Change and Community Support

Participants noted several changes to improve cervical screening uptake in the LGBT+ community, including that NHS record and invitation systems should be reformed to be anatomy-based rather than gender-marker-based – so that, “[eligible] people registered as male or non-binary...receive automatic reminder(s) within the NHS screening programme”. Furthermore, screening communications should be redesigned to explicitly include LGBT+ people as, “public health messaging often assumes a gender narrative, like strictly for women should be screened, so sometimes the transgender feel they are not being covered”. There was also a call for mandatory, comprehensive

training for all staff (both clinical and administrative) on LGBT+ health needs, inclusive language, and trans/non-binary identities.

Participants also recommended community peer groups where LGBT+ people can, “feel safe and comfortable to share their feelings”, as well as welcoming clinical environments. This is particularly important in cases where family or peer support is absent (a barrier for some LGBT+ individuals). Participants also expressed a wish for greater, “flexibility [of] screening options” as an alternative to the GP surgery – for instance, community settings, LGBT+ sexual health clinics, and HPV self-sampling. Community outreach through LGBT+ networks is recommended.

#### **4.0 Limitations**

The limitations of the project should be considered before recommendations are made. Firstly, there were 14 participants in total who took part in the focus groups and these small numbers entail caution about extrapolation of the findings. Furthermore, all participants were in the age brackets of 25-29 and 30-34 and there were no non-binary participants, so the findings may not fully reflect the experiences of those in other age brackets nor of non-binary people.

Holding the focus groups online also poses several potential limitations. Participants had the option to have their cameras on or off, and all chose to keep their cameras off. Discussion at the start of the focus groups took a while to warm up, and it was more difficult to engage people without being able to see their faces. This could indicate that holding the focus groups online could have limited discussion. However, holding the groups online and having the option to keep cameras off could also have facilitated more participants attending the sessions – due to easier accessibility and being able to maintain some level of anonymity. Participants also had the opportunity to contribute via the Teams chat, which may have enabled some participants to share things they would not have felt comfortable contributing verbally. Holding the focus groups online also led to technical difficulties for the first focus group, as discussed, which led to the focus group being split into 1a and 1b. These technical difficulties could have led to fewer participants being able to attend the focus group, however quick email communication with participants was able to resolve the issue and ensured that all participants could still participate.

The focus group was advertised as being for members of the LGBT+ community with a cervix in Wolverhampton, and the eligibility criteria was clearly displayed in the recruitment poster and expression of interest form. The eligibility criteria were covered again during individual calls with the participants, and participants also had to sign a consent form saying that they met the eligibility criteria. However, one of the participants in focus group 1b primarily discussed the experiences of their wife, giving

the impression that they may not have a cervix themselves. Whilst no participants reported feeling uncomfortable, this does not mean that they were not uncomfortable and there is the potential that this could have affected how much other participants were willing to share during the focus group. To try and mitigate this issue in focus group 2, it was re-emphasised that the focus of the discussion should be on participants' own experiences of accessing cervical screening.

Participants discussed several barriers to accessing cervical screening that were not barriers exclusive to the LGBT+ community, but were applicable more generally – for example, scheduling appointments around other commitments and accessing transport for appointments. Whilst some of these barriers are more generally applicable, and so should not inform recommendations specifically regarding LGBT+ barriers to uptake, it is important to consider when intersectionality may affect the impact of these barriers in a way that is specific to LGBT+ people. 'Intersectionality' refers to how the interaction of different factors (e.g., sexuality, race, gender) can result in unique experiences of oppression and discrimination. For example, participants' experiences of racism and language barriers may have interacted with their experiences of identifying as LGBT+, to result in unique barriers to access. This is particularly important to consider for Wolverhampton's population, with 45% of its residents being Ethnic Minority.

## **5.0 Recommendations**

### **5.1 Development of an LGBT+ Cervical Screening Toolkit as a Resource for Training and Education**

Misinformation, gaps in knowledge and lack of awareness regarding cervical screening for LGBT+ individuals was highlighted as an issue for both patients and healthcare professionals – for instance, screening eligibility, importance of screening and making screening more accessible for LGBT+ individuals. Patients struggle to find useful and trustworthy sources of information, whilst professionals have often not received sufficient training in this area. To address this, it is recommended that an LGBT+ Cervical Screening Toolkit is developed as an educational resource that serves a dual purpose of educating both patients and professionals.

The toolkit should include: clear, non-gendered explanations of eligibility for cervical screening (i.e., individuals who have a cervix); information on the screening process, including available adjustments (e.g., smaller speculum, double appointments); trauma-informed guidance and reassurance about consent and stopping the procedure at any time; use of inclusive language; signposting to LGBT+ services and support; and translated information to address language barriers.

## 5.2 Training for Primary Care Staff (Non-Clinical and Clinical) on LGBT+ Inclusive Care

Participants reported discrimination and exclusionary behaviour, particularly from reception and administrative staff, and mixed messages about the need for screening. These experiences acted as direct deterrents to booking or attending screening.

Training should be delivered, potentially utilising the toolkit recommended above, on topics including LGBT+ identities, inclusive language, confidentiality and dignity, intersectionality, and trauma-informed care.

## 5.3 Advocate for Anatomy-Based, Non-Gendered Screening Invitations

Campaigns and invitation letters that use gendered language can pose a barrier to booking cervical screening appointments, whilst some trans male and non-binary individuals may not receive a screening invitation.

Communications should explicitly state that cervical screening is for all people with a cervix – including trans men and non-binary individuals, and GP surgeries should ensure that eligible individuals are not excluded from invitation lists.

## 5.4 Increase Promotion of Existing Accessibility Initiatives

Participants demonstrated a lack of awareness of existing accessibility initiatives such as the free transport scheme and LGBT+ sexual health clinics (offers cervical screening), which suggests that these need to be promoted more effectively to relevant groups. These initiatives can help to address barriers such as affordability of transport, and people not feeling like they are in an inclusive and safe environment for their screening appointment.

## 6.0 Conclusion

This report outlines the methodology and findings of a project investigating barriers and facilitators to cervical screening uptake in the LGBT+ community in Wolverhampton. These have been translated into a series of four recommendations for action, which have the aim of addressing barriers to uptake and improving access in this community.