Correlates of clinical breast examination among lesbian, gay, bisexual, and queer women

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ABSTRACT

OBJECTIVES: Lesbian, gay, bisexual, and queer (LGBQ) women have increased risk of breast cancer yet lower use of early detection screening than heterosexual women. This lower use may be due in part to sexual stigma. The study purpose was to explore correlates of past two-year clinical breast examination (CBE) among LGBQ women to better understand screening disparities, particularly among gender non-conforming LGBQ women.

METHODS: A cross-sectional Internet-based survey was conducted with LGBQ women in 2011–2012. We conducted multivariate logistic regression to assess the associations between individual, social/structural and health care factors and past two-year CBE among LGBQ women ($n = 414$), including a subsample of gender non-conforming LGBQ women ($n = 148$).

RESULTS: In multivariate analyses, significant correlates of past two-year CBE among the full sample included sexually transmitted infection knowledge (OR: 1.12, 95% CI: 1.05, 1.19), sexual risk practices (OR: 0.92, 95% CI: 0.87, 0.98), past two-year Papanicolaou test (OR: 8.36, 95% CI: 4.24, 16.45), having a regular source of health care (OR: 4.84, 95% CI: 2.60, 9.01), and health care provider knowing one's sexual orientation (OR: 3.60, 95% CI: 2.29, 5.81). Among gender non-conforming LGBQ women, perceived gender non-conformity stigma (OR: 0.85, 95% CI: 0.74, 0.99) and belief that one's health care provider is uncomfortable with one's sexual orientation (OR: 0.33, 95% CI: 0.11, 1.00) were also associated with lower screening.

CONCLUSION: These findings enhance understanding of individual, social/structural, and health care factors correlated with CBE among LGBQ women. More research is needed to understand the complex interplay of these factors to inform multi-level interventions to address screening disparities for diverse LGBQ women.

KEY WORDS: Lesbian; bisexual; cancer screening; breast cancer; masculinity; social stigma

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

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Breast cancer is the most common cancer among Canadian women, with an estimated 25,700 new cases and 4,900 deaths to occur in 2016.¹ Lesbian, gay, bisexual, and queer (LGBQ) women – who represent a diverse community of women attracted to other women, men, transgender, and gender-fluid persons – experience both increased rates of breast cancer and higher breast cancer mortality.² This disparity is attributed to biological and behavioural risk factors for breast cancer that are higher in LGBQ women compared to heterosexual women, including decreased use of oral contraceptives, and higher rates of nulliparity, alcohol consumption, smoking and obesity.³ These behavioural risk factors are associated with the social stress of pervasive stigma and discrimination experienced by LGBQ women.⁴

Studies show that despite their increased risk of breast cancer, LGBQ women access early detection screening, including mammography and clinical breast examination (CBE), less than heterosexual women.^{5,6} While controversies exist regarding optimal breast cancer screening modalities, age at which to start screening, and screening frequencies,⁷ it is generally believed that breast cancer screening improves early detection and treatment, ultimately reducing breast cancer mortality.⁸ Thus, improving accessing of screening among LGBQ women is an important public health priority.

Most studies that focus on LGBQ women and breast cancer have described differences in disease prevalence^{2,3} or use of mammography or CBE among LGBQ women compared to heterosexual women.^{5,6} Social ecological models (e.g., Andersen's Model⁹) suggest that multi-level (individual, social, structural) factors influence health care utilization. Yet studies that have examined correlates of LGBQ women's use of mammography or CBE are often limited to socio-demographic factors and overlook social/structural (e.g., stigma) and health care (e.g., having a regular source of health care) factors.

Stigma is a fundamental cause of population health inequities,¹⁰ and may contribute to reduced access to early detection through mammography and CBE.^{5,11} LGBQ women experience sexual stigma, including perceived and enacted stigma, which present barriers to health care access.¹² Enacted sexual stigma includes acts of subtle or overt forms of discrimination resulting in unequal treatment, whereas perceived sexual stigma includes concerns of rejection and negative treatment by others because of actual or

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perceived LGBQ identity.¹³ Enacted sexual stigma documented in health care settings includes health care provider lack of knowledge and comfort regarding LGBQ women's health issues.¹⁴ Jacobs et al.'s¹⁵ study of 3,258 US women found that reported discrimination owing to "other" reasons (including gender, income, sexual orientation) was associated with reduced receipt of CBE, though these data were not disaggregated by sexual orientation. With regards to perceived sexual stigma, DeHart's¹² cross-sectional survey assessing correlates of breast self-examination among 173 lesbian and bisexual women found that perceived sexual stigma was associated with reduced use of breast self-exam (BSE) and overall accessing of primary health care.¹²

Few studies have explicitly explored the role of different forms of stigma, beyond sexual stigma, in breast cancer screening among LGBQ women. Gender non-conformity (GNC) is defined as gender expression or physical appearance that does not follow traditional gender roles, for example, women who appear androgynous and women who appear to have masculine characteristics or appearance (e.g., dress).¹⁶ Gender non-conforming LGBQ women represent a visible subpopulation of LGBQ women who may experience perceived and/or enacted GNC stigma in relation to their masculine/masculine-of-centre gender presentation.¹⁶ Transgender and gender nonconforming people experience pervasive stigma and discrimination across multiple life domains, and in particular in health care.¹⁷ Moreover, GNC has been found to be associated with increased mental distress among gay men¹⁸ and GNC stigma has been found to be associated with reduced psychological well-being among LGBQ women.¹⁹ The role of GNC stigma in impacting access to breast cancer screening is unexplored.

The aim of our study was to contribute to an understanding of LGBQ women's access to breast cancer screening. We examined factors associated with past two-year CBE among LGBQ women, including gender non-conforming women, in Toronto, Ontario.

METHODS

Study design and sample

We conducted a structured cross-sectional Internet-based survey with LGBQ women in Toronto, ON between December 2011 and January 2012. Women aged 18 years and over, capable of providing online informed consent, who self-identified as LGBQ or other women who have sex with women and were living in the Greater Toronto Area were included. We recruited participants online through 10 peer research assistants (PRAs) who self-identified as LGBQ women and were representative of diverse ages and ethnicities. Each PRA aimed to recruit a minimum of 25 participants using a combination of strategies (in-person, Internet, study flyers), with actual recruitment reaching approximately 45 participants each. Convenience sampling techniques, including sending e-mails to LGBTQ-specific, community health, HIV/STI, and ethno-cultural agencies serving LGBTQ women, were also utilized. Research ethics approval was granted from the University of Toronto.

Data collection

The online survey, designed to collect information on socio-demographics, health outcomes, individual, social/structural and health care factors, was pilot-tested with a focus group of LGBQ

community representatives ($n = 12$) to assess clarity and content validity.²⁰ The 60-minute survey was self-administered by participants online in a location of their choice. Participants who included their e-mail address received a \$20 honorarium for survey completion.

Measures were chosen based on established reliability and validity in the North American context, and where possible among LGBQ persons. Cronbach's alpha is presented from the full sample with complete outcome data ($n = 414$). The outcome measure of self-reported past two-year CBE was dichotomized for logistic regression analysis. A two-year interval ensured an adequate timeframe within which women were likely to attend a routine health care visit. We collected the following socio-demographic information: age, annual income, sexual orientation, ethnicity, highest level of education, relationship status, and born in Canada. Participants who responded *somewhat yes* or *definitely yes* to the question: *Do people consider you masculine by looking at you, your mannerisms, and your appearance? (e.g., a butch, stud)* were categorized as gender non-conforming.

Individual Factors

STI knowledge was measured using the Sexually Transmitted Disease Knowledge Questionnaire (STD-KQ)²¹ (Cronbach's $\alpha = 0.76$). The two-item Patient Health Questionnaire-2 was used to assess depression symptoms²² (Cronbach's $\alpha = 0.90$). Sexual risk practices was measured using the Safer Sexual Practices among Lesbian Women scale,²³ (Cronbach's $\alpha = 0.70$), renamed to *sexual risk practices* rather than *safer sex practices* for ease of comprehension given that a lower score on the scale indicates decreased sexual risk practices²³ and increased safer sex.

Social/Structural Factors

Social support was measured using the total score of the Multi-dimensional Scale of Perceived Social Support,²⁴ (Cronbach's $\alpha = 0.91$). Sexual stigma was assessed using the Homophobia Scale,²⁵ adapted and validated for LGBQ women.²⁶ Sexual stigma subscales had acceptable reliability: perceived sexual stigma (Cronbach's $\alpha = 0.70$) and enacted sexual stigma (Cronbach's $\alpha = 0.73$). GNC stigma was measured similarly using an adapted version of the Homophobia Scale and was administered only to participants who considered themselves gender non-conforming ($n = 148$).²⁵ GNC stigma subscales had acceptable reliability: perceived GNC stigma (Cronbach's $\alpha = 0.66$) and enacted GNC stigma (Cronbach's $\alpha = 0.73$). We asked participants if they had ever experienced forced sex in their lifetime.

Health Care Factors

Participants were asked whether they had had a Papanicolaou test in the past two years, whether they have a regular source of health care (family physician or community health centre vs. walk-in clinic, no regular source of health care, no health coverage or other), and whether their sexual orientation is known to their health care provider. Participants were also asked whether they believed their health care provider was uncomfortable with the participant's sexual orientation.

Data analysis

We conducted descriptive analyses to calculate frequencies, means and standard deviations for each variable. We conducted

multivariate logistic regression analyses to examine multi-level correlates of self-reported past two-year CBE. We first conducted unadjusted logistic regression analyses, followed by analyses that controlled for significant socio-demographic variables (age, education, and gender non-conformity). Following these analyses among the full sample, we conducted unadjusted logistic regression analyses followed by analyses that controlled for significant socio-demographic variables (age, education) among gender non-conforming women. For all analyses, we present the results as odds ratios (OR) with statistical significance reported at the standard level ($p = 0.05$). Analyses were conducted on non-missing responses using IBM SPSS 22.

RESULTS

Study population

Socio-demographic and health characteristics of participants are described in Table 1. Of 466 women who completed the survey, 414 had complete data on the outcome variable and were included in the full analysis. The majority of participants were aged 25–34 years (58.1%), mean: 31.2 (SD 7.9), range 18–70. Most participants (47.3%) identified as queer, followed by lesbian (29.9%), bisexual (15.7%), and gay or other sexual orientation (7.1%). The majority of participants identified as white (67.5%), and had completed a college diploma or university degree (74.1%). Most participants were dating (living together or not living together) (51.4%) and were born in Canada (75.1%). Over half of participants (52.9%) reported having had a CBE in the past two years.

Among the subsample of 160 gender non-conforming participants, 148 had complete data on the outcome variable and

were included in analyses. Gender non-conforming participants had similar socio-demographics to the full sample. Almost half of participants (44.6%) reported having had a CBE in the past two years.

Correlates of self-reported past two-year CBE

Univariate and multivariate logistic regression analyses are presented in Table 2. Among the full sample univariate analyses, several socio-demographic factors (age, education, and gender non-conformity) were associated with past two-year CBE. Specifically, gender non-conformity was associated with more than a 40% decrease in the odds of having had a CBE in the past two years (OR: 0.59, 95% CI: 0.39, 0.89). *Individual* level (STI knowledge, sexual risk practices score) and *health care* level (having a regular source of health care, past two-year Papanicolaou test, health care provider [HCP] knowing one's sexual orientation) factors were also correlated with past two-year CBE. In multivariate analyses controlling for age, education, and gender non-conformity, all variables remained statistically significant. At an individual level, increased STI knowledge was associated with higher odds of past two-year CBE and higher sexual risk practices were associated with lower odds of past two-year CBE. At a health care level, having had a Papanicolaou test in the past two years, having a regular source of health care and HCP knowing one's sexual orientation were associated with substantially higher odds of past two-year CBE.

Among the subsample of gender non-conforming LGBTQ women, in multivariate analyses controlling for age and education, *individual* level factors (increased STI knowledge scores) were associated with increased odds of past two-year CBE. At a *social/structural* level, increased perceived GNC stigma was associated

Table 1. Participant socio-demographic characteristics

Variables	Full sample LGBQ women (N = 414)			Gender non-conforming LGBQ women (N = 148)		
	n	(%)	Mean (SD)	n	(%)	Mean (SD)
Age, years (n = 370; n = 130)			31.2 (7.9)			31.0 (8.0)
18–24	61	16.5		29	22.3	
25–34	215	58.1		72	55.4	
≥35	94	25.4		29	22.3	
Annual income, CAD (n = 102; n = 39)			\$32,373 (28,219)			\$29,885 (24,438)
Sexual orientation (n = 408; n = 145)						
Lesbian	122	29.9		48	32.4	
Bisexual	64	15.7		6	4.1	
Queer	193	47.3		80	54.1	
Gay/other sexual orientation	29	7.1		11	7.4	
Ethnoracial identity (n = 385; n = 136)						
White	260	67.5		89	65.5	
Person of colour	125	32.5		47	34.5	
Education (n = 413)						
College diploma, bachelor degree, graduate degree	306	74.1		100	67.6	
Less than diploma/degree or other	107	25.9		48	32.4	
Relationship status						
Living together (not married)	128	30.9		42	28.4	
Dating (not living together)	85	20.5		38	25.7	
No current partners	50	12.1		16	10.8	
Polyamorous/multiple partners	44	10.6		18	12.2	
Married	42	10.1		20	13.5	
Casual dating	39	9.4		10	6.8	
Other	26	6.3		4	2.7	
Born in Canada (% yes)	311	75.1		113	76.4	
Gender non-conforming (% yes)	148	35.7				
Past two-year CBE* (% yes)	219	52.9		66	44.6	

* CBE refers to self-reported clinical breast exam.

Table 2. Correlates of past two-year CBE among LGBQ women

Variables	Full sample LGBQ women (N = 414)		Gender non-conforming LGBQ women (N = 148)	
	Unadjusted univariate logistic regression analyses, OR (95% CI)	Adjusted multivariate logistic regression analyses, [†] OR (95% CI)	Unadjusted univariate logistic regression analyses, OR (95% CI)	Adjusted multivariate logistic regression analyses, [‡] OR (95% CI)
<i>Socio-demographic factors</i>				
Age, years				
18–24 (ref)				
25–34	2.20 (1.22, 3.96)*		2.78 (1.09, 7.08)*	
≥35	3.43 (1.75, 6.74)**		3.72 (1.24, 11.17)*	
Income	1.00 (1.00, 1.00)		1.00 (1.00, 1.00)	
Sexual orientation				
Gay/other sexual orientation (ref)				
Lesbian	0.84 (0.37, 1.89)		0.60 (0.16, 2.22)	
Bisexual	1.55 (0.63, 3.80)		4.17 (0.36, 48.44)	
Queer	0.80 (0.37, 1.76)		0.59 (0.17, 2.10)	
Ethnicity (person of colour vs. white)	0.72 (0.47, 1.10)		1.17 (0.58, 2.38)	
Education (less than diploma/degree or other vs. college diploma/bachelor degree/graduate degree)	0.48 (0.31, 0.75)**		0.38 (0.18, 0.79)**	
Relationship status				
Polyamorous/multiple partners (ref)				
Living together (not married)	0.94 (0.46, 1.87)		0.62 (0.20, 1.88)	
Dating (not living together)	0.89 (0.43, 1.85)		0.52 (0.17, 1.63)	
No current partners	0.84 (0.38, 1.90)		0.78 (0.20, 3.01)	
Married	2.28 (0.93, 5.58)		2.33 (0.62, 8.82)	
Casual dating	1.18 (0.50, 2.81)		1.50 (0.31, 7.19)	
Other	0.91 (0.35, 2.41)		0.33 (0.03, 3.84)	
Born in Canada (no vs. yes)	0.88 (0.56, 1.37)		0.78 (0.36, 1.69)	
Gender non-conforming (yes vs. no)	0.59 (0.39, 0.89)*		–	–
<i>Individual factors</i>				
Sexually transmitted infection knowledge	1.12 (1.06, 1.19)***	1.12 (1.05, 1.19)***	1.20 (1.07, 1.34)**	1.22 (1.08, 1.38)**
Depression score	0.97 (0.87, 1.10)	1.01 (0.89, 1.15)	0.96 (0.80, 1.16)	0.98 (0.79, 1.21)
Sexual risk practices score	0.94 (0.89, 0.99)*	0.92 (0.87, 0.98)**	0.91 (0.83, 0.99)*	0.91 (0.82, 1.00)
<i>Social/structural factors</i>				
Total social support	1.01 (0.99, 1.03)	1.00 (0.97, 1.02)	0.98 (0.95, 1.02)	0.98 (0.94, 1.02)
Perceived gender non-conformity stigma	–	–	0.83 (0.72, 0.95)**	0.85 (0.74, 0.99)*
Enacted gender non-conformity stigma	–	–	0.53 (0.26, 1.09)	0.52 (0.23, 1.14)
Perceived sexual stigma	1.24 (0.95, 1.62)	1.12 (0.84, 1.50)	1.37 (0.89, 2.12)	1.30 (0.81, 2.10)
Enacted sexual stigma	1.03 (0.67, 1.58)	0.95 (0.59, 1.55)	0.61 (0.29, 1.31)	0.57 (0.23, 1.37)
History of forced sex	1.23 (0.82, 1.82)	1.22 (0.79, 1.88)	1.39 (0.71, 2.73)	1.66 (0.74, 3.71)
<i>Health care factors</i>				
Past two-year Papanicolaou test	8.68 (4.61, 16.34)***	8.36 (4.24, 16.45)***	14.14 (4.10, 48.85)***	15.06 (4.07, 55.75)***
Regular source of health care	5.08 (2.88, 8.98)***	4.84 (2.60, 9.01)***	6.67 (2.41, 18.47)***	6.18 (2.13, 17.93)***
HCP knows sexual orientation	3.72 (2.39, 5.78)***	3.60 (2.29, 5.81)***	4.11 (1.89, 8.97)***	4.01 (1.71, 9.41)***
Belief that HCP is uncomfortable with sexual orientation	0.75 (0.44, 1.28)	0.76 (0.42, 1.36)	0.31 (0.12, 0.83)*	0.33 (0.11, 1.00)*

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

† Adjusted for age, education, and gender non-conformity.

‡ Adjusted for age and education.

with slightly decreased odds of self-reported past two-year CBE. At a *health care* level, having a regular source of health care, having had a Papanicolaou test in the past two years and HCP knowing one's sexual orientation were associated with substantially higher odds of past two-year CBE, while the belief that one's HCP is uncomfortable with one's sexual orientation was associated with slightly lower odds of past two-year CBE.

DISCUSSION

This study aimed to understand correlates of CBE among LGBQ women. Our findings highlight individual (STI knowledge, sexual practices), social/structural (GNC stigma) and health care (past two-year Papanicolaou test, having a regular source of health care, HCP knowledge and comfort with one's sexual orientation) factors associated with past two-year CBE among LGBQ women. While CBE is currently not recommended by the Canadian Task Force on Preventive Health Care, given the strong relationship between CBE and receipt of a Papanicolaou test, CBE may be a proxy for

women's participation in preventive health care.²⁷ Our findings may be applied to understand multi-level factors associated with LGBQ women's uptake of other types of preventive screening (e.g., mammography).

Each unit increase in STI knowledge score resulted in a 12% and 22% increase in the odds of past two-year CBE among LGBQ women and gender non-conforming LGBQ women respectively. It is likely that women with higher STI knowledge may be more knowledgeable about reproductive health as a whole, including breast health. STI knowledge score may also be a proxy for engagement in health care. Several health care factors were correlated with past two-year CBE. Notably, having had a Papanicolaou test in the past two years was associated with substantially increased odds of having had a past two-year CBE, suggesting a potential opportunity to combine multiple screening practices during routine health visits. These findings are congruent with another Canadian study that linked initiation of mammography to having had a recent blood pressure check.²⁸

Future research should explore how even in a universally insured health care system such as Canada's, health care factors play a role in women's uptake of health screening. Given the strong association between having a regular source of health care and having had a CBE in the past two years, promoting engagement in primary care overall may enhance women's practices of breast cancer screening. Moreover, our finding that HCP knowing one's sexual orientation is associated with screening suggests that promoting health care provider assessment of sexual orientation and creating environments conducive to women's sexual orientation disclosure may enhance LGBTQ women's screening.

Interestingly, neither perceived nor enacted sexual stigma was correlated with women's uptake of past two-year CBE, nor did enacted GNC stigma significantly predict past two-year CBE among the gender non-conforming sample. In validating the sexual stigma scale assessing perceived and enacted sexual stigma among LGBTQ women, Logie and Earnshaw reported that most women had not experienced extreme forms of enacted stigma (e.g., being beaten up), while perceived stigma was more pervasive.²⁶ As perceived GNC stigma was associated with reduced odds of having had a CBE in the past two years, these findings suggest the need for interventions to address the subtle ways that social and health care environments may stigmatize women on the basis of gender presentation. Education of HCP about LGBTQ women's lived experiences and health care needs, and GNC stigma, can facilitate competent health care provision. Our findings also suggest the need for LGBTQ women's stigma measures to include gender presentation as a source of inequitable treatment and social norms.

Given that scant studies have looked at stigma as a correlate of breast cancer screening,¹² these findings suggest that future research could include stigma as a correlate of breast cancer and other types of preventive health screening among LGBTQ women. Our study also points to the need to examine multiple forms of stigma that may impact access to care for LGBTQ women, including GNC stigma.

Our findings also suggest a need to fully theorize the potential role of GNC stigma on LGBTQ women's health care access. Cruz²⁹ has theorized transgender and/or gender non-conformity stigma as a barrier to access of care. Specifically, not being seen as transgender or gender non-conforming, also known as "passing," may prevent outward experiences of discrimination. However, gender non-conforming LGBTQ women may not be aiming to "pass" as male through their gender expression and their gender non-conformity may serve as a "marker" of their sexual orientation. Future studies could qualitatively explore the experiences of gender non-conforming women in health care to inform stigma-reducing interventions.

Limitations

Our study is limited by the cross-sectional study design, which precludes the establishment of causality. As increased STI knowledge could be the result of having received a CBE that was part of a routine check-up and learning about STIs, further study is necessary to understand the role of increased STI knowledge on women's health care access. The small sample size of gender non-conforming LGBTQ women is a limitation to the power of our analysis and our ability to conduct robust analyses. A longitudinal

study design with a large sample allowing for mediation analyses would allow for a more thorough understanding of pathways to screening uptake for gender non-conforming LGBTQ women. Our sample included predominantly white and highly educated women and thus may not be generalizable to racially and socio-economically diverse women. Moreover, our sample included only cisgender women – whose sex labeled-at-birth corresponds to their gender identity – therefore, results may not be generalizable to transgender LGBTQ women who may also experience transgender stigma. The use of an Internet-based survey, subject to the barriers of the digital divide, may have limited the recruitment of socio-economically and racially diverse LGBTQ women. All data collected were self-reported, and therefore subject to recall bias and social desirability bias. However, the use of an Internet-based survey completed in the privacy of women's location of choice may have allowed them to be more open about their personal experiences.

CONCLUSIONS

Despite the above limitations, this study fills a gap highlighted by Canadian scholars in addressing intersectionality in sexual minority women's health.³⁰ We provide a comprehensive understanding of factors that may influence LGBTQ women's uptake of breast cancer screening. Our findings support a growing body of literature around the need for multi-level interventions to address health disparities. Given the substantial stigma and discrimination faced by gender non-conforming people, the health care needs of this population are important to understand. Thus, this research underscores the importance of examining gender non-conformity – and its associated stigma – among LGBTQ women, rather than treating LGBTQ women as a homogenous group. Future research should explore individual, structural and health care factors that may influence other types of screening (e.g., mammography, Papanicolaou tests) among diverse LGBTQ women. Understanding the complex interplay of individual, social/structural and health care factors that shape access to, and uptake of, breast cancer screening can inform practice and interventions focused on reducing screening disparities among LGBTQ women.

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RÉSUMÉ

OBJECTIFS : Les femmes lesbiennes, gaies, bisexuelles et allosexuelles (LGBA) ont un risque accru de cancer du sein, mais elles ont moins recours au dépistage précoce que les femmes hétérosexuelles. Ce moindre recours pourrait s'expliquer en partie par la stigmatisation sexuelle. Le but de notre étude était d'explorer les corrélats de l'examen clinique des seins (ECS) au cours des deux années antérieures chez les femmes LGBA pour mieux comprendre les disparités dans le dépistage, en particulier chez les femmes LGBA au genre non conforme.

MÉTHODE : Nous avons mené une enquête transversale sur Internet auprès de femmes LGBA en 2011–2012. Au moyen d'une régression logistique multivariée, nous avons estimé les associations entre les facteurs individuels, sociaux/structurels et liés à l'accès aux soins de santé d'une part, et l'ECS d'autre part, au cours des deux années antérieures chez les femmes LGBA ($n = 414$), y compris dans un sous-échantillon de femmes LGBA au genre non conforme ($n = 148$).

RÉSULTATS : Dans les analyses multivariées, les corrélats significatifs de l'ECS au cours des deux années antérieures dans l'échantillon complet étaient les connaissances sur les infections transmissibles sexuellement (RC : 1,12, IC de 95 % : 1,05, 1,19), les pratiques sexuelles à risque (RC : 0,92, IC de 95 % : 0,87, 0,98), le fait d'avoir subi un test de Papanicolaou au cours des deux années antérieures (RC : 8,36, IC de 95 % : 4,24, 16,45), le fait d'avoir une source régulière de soins de santé (RC : 4,84, IC de 95 % : 2,60, 9,01) et le fait que le dispensateur de soins de santé connaisse l'orientation sexuelle de la répondante (RC : 3,60, IC de 95 % : 2,29, 5,81). Chez les femmes LGBA au genre non conforme, la perception d'une stigmatisation sociale liée au genre non conforme (RC : 0,85, IC de 95 % : 0,74, 0,99) et la croyance que le dispensateur de soins de santé n'était pas à l'aise avec l'orientation sexuelle de la répondante (RC : 0,33, IC de 95 % : 0,11, 1,00) étaient aussi associées au moindre recours au dépistage.

CONCLUSION : Ces constatations améliorent notre compréhension des facteurs individuels, sociaux/structurels et liés à l'accès aux soins de santé corrélés avec l'ECS chez les femmes LGBA. Il faudrait pousser la recherche pour comprendre l'action réciproque complexe de ces facteurs afin d'éclairer des interventions à niveaux multiples pour réduire les disparités entre les femmes LGBA sur le plan du dépistage.

MOTS CLÉS : homosexualité féminine; bisexualité; dépistage du cancer; tumeurs du sein; masculinité; isolement social