

RESEARCH ARTICLE

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"I feel like I am surviving the health care system": understanding LGBTQ health in Nova Scotia, Canada

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Abstract

Background: Currently, there is a dearth of baseline data on the health of lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations in the province of Nova Scotia, Canada. Historically, LGBTQ health research has tended to focus on individual-level health risks associated with poor health outcomes among these populations, which has served to obscure the ways in which they maintain their own health and wellness across the life course. As such, there is an urgent need to shift the focus of LGBTQ health research towards strengths-based perspectives that explore the complex and resilient ways in which LGBTQ populations promote their health.

Methods: This paper discusses the findings of our recent scoping review as well as the qualitative data to emerge from community consultations aimed at developing strengths-based approaches to understanding and advancing LGBTQ pathways to health across Nova Scotia.

Results: Our scoping review findings demonstrated the lack of strengths-based research on LGBTQ health in Nova Scotia. Specifically, the studies examined in our scoping review identified a number of health-promoting factors and a wide variety of measurement tools, some of which may prove useful for future strengths-based health research with LGBTQ populations. In addition, our community consultations revealed that many participants had negative experiences with health care systems and services in Nova Scotia. However, participants also shared a number of factors that contribute to LGBTQ health and suggestions for how LGBTQ pathways to health in Nova Scotia can be improved.

Conclusions: There is an urgent need to conduct research on the health needs, lived experiences, and outcomes of LGBTQ populations in Nova Scotia to address gaps in our knowledge of their unique health needs. In moving forward, it is important that future health research take an intersectional, strengths-based perspective in an effort to highlight the factors that promote LGBTQ health and wellness across the life course, while taking into account the social determinants of health.

Keywords: LGBTQ, Health, Canada, Health promotion, Health research, Health measurement

Background

Currently, there is an absence of baseline data on the health of lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations in the province of Nova Scotia, Canada. Studies from other regions of Canada (Ontario, British Columbia, and Quebec), as well as the United States and the United Kingdom suggest that the health

of LGBTQ populations is worse than that of their heterosexual, cisgender age-matched peers [1, 2]. Given that Atlantic Canada, including Nova Scotia, tends to have worse health outcomes than other regions in Canada [3], the dearth of data specific to LGBTQ health in Nova Scotia is of particular concern. For example, in comparison with the national average, Statistics Canada data indicate that Nova Scotia has higher overall rates of obesity (60 % versus 52 %), arthritis (26 % versus 15 %), diabetes (8 % versus 6 %), high blood pressure (21 % versus 17 %), chronic obstructive pulmonary disease

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(COPD) (6 % versus 4 %), colon cancer (60 % versus 50 %), heavy drinking (20 % versus 17 %), lung cancer (54 % versus 45 %), and a lower rate of functional health (77 % versus 81 %) [4]. Although these data are important in advancing our understanding of the overall health conditions impacting the health of Nova Scotians, they do not specifically refer to the health of LGBTQ populations in Nova Scotia.

Conducting LGBTQ health research in Nova Scotia is critically important given that LGBTQ health needs have historically been understood through a heteronormative, gender-binary lens, which assumes that the health needs of LGBTQ populations are similar to those of their heterosexual, cisgender age-matched peers [2, 5, 6]. This heteronormative and gender-binary approach to LGBTQ health has effectively rendered the health needs and experiences of these populations invisible within mainstream health care systems, health data, and health policies [6, 7]. The invisibility or erasure [7] of LGBTQ populations and their specific health needs and lived experiences hinders the provision of evidence-based, culturally competent health care for these populations. Previous health research from projects conducted outside of Nova Scotia demonstrates that LGBTQ populations experience significant discrimination and stigma within health care systems based on the heteronormative and gender-binary framing of health [8, 9]. For example, Goins and Pye [9] found that the heteronormative and gender-binary language and structure of medical intake forms have the consequence of alienating LGBTQ populations. While the full impact of this form of invisibility or erasure on the health of LGBTQ populations in Nova Scotia is not well understood, a previous study on the experiences of queer and trans women in Nova Scotia found that participants experienced significant discomfort in their interactions with healthcare providers and expressed fear that they would be denied adequate health care based on their sexual orientation or gender identities [10].

The way in which health and wellness are defined has important implications for how research evidence is understood and reported. The Public Health Agency of Canada (PHAC) borrows its definition of health from the World Health Organization (WHO), which has long defined health as “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” [11]. The PHAC also recognizes that the health of individuals and populations is influenced by a variety of intersecting and overlapping determinants at both the individual and structural levels, including income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child

development, biology and genetic endowment, health services, gender, and culture [12]. Despite this recognition, public health policy and practice in Canada have traditionally focused on individual health and on interventions that target individual behaviour [6, 13]. The emphasis on individual-level health outcomes further obscures the ways in which structural determinants of health such as heteronormative health care systems and policies in Canada can negatively impact on health care access and uptake among LGBTQ populations [6].

Although PHAC does not recognize LGBTQ identity as a key social determinant of health [12], it is important to consider how sexual orientation and gender identity intersect with other determinants to shape the health of LGBTQ individuals. The concept of intersectionality is key to understanding health outcomes among LGBTQ populations in that health is determined by the complex interactions of LGBTQ identity with other factors such as race, socioeconomic status, age, social exclusion, employment, etc. [14, 15]. For example, previous research has demonstrated that LGBTQ populations experience higher rates of homelessness, social exclusion, poverty, and other negative determinants of health compared to their heterosexual, cisgender, age-matched peers [16–19]. Bowleg, Huang, Brooks, Black, and Burkholder contend, for example, that the health of black lesbians is affected by the ‘triple threat’ of racism, sexism, and heterosexism [20]. Further, social stigma, discrimination, and victimization have been found to not only have negative effects on physical and mental health [21], but also to affect rates of access to and uptake of preventative health screening programs and health care services among LGBTQ populations [6, 22–24]. According to the findings of an earlier study on lesbian and bisexual women’s experiences with family physicians in Nova Scotia, more than two-thirds of the 98 women interviewed reported encountering heterosexist assumptions and many women reported avoiding routine or preventative health care due to health care providers’ heteronormative assumptions [25]. As such, the overemphasis on individual-level health factors contributes to the invisibility or erasure of the health needs and experiences of LGBTQ populations by obscuring the unique social, structural, and systemic determinants that impact the health outcomes of these populations [26, 27].

The lack of health data on, and the resultant invisibility of, LGBTQ health needs and experiences in Nova Scotia highlights the importance of conducting research focused specifically on these topics. The long history of health research approaches that have tended to psychopathologize differences between LGBTQ populations and heterosexual and cisgender populations [6, 28, 29] has reinforced the framing of LGBTQ health as the inability to maintain health at

160 the level of the individual. Based on this framing of
161 LGBTQ health, much health research has tended to
162 focus on risks for poor health outcomes among
163 LGBTQ populations, particularly rates of STI and
164 HIV infection, smoking, obesity, depression, and
165 suicidal ideation [30–32]. Although early health
166 research played an important role in identifying,
167 mitigating, and treating poor health outcomes among
168 LGBTQ populations as something more than an
169 individual deficit, it also served to create negative
170 perceptions of LGBTQ health and obscured the ways
171 in which these populations maintain their health. As
172 such, it is necessary to shift away from deficit-
173 focused health research toward strengths-based
174 perspectives that take a more holistic approach to
175 understanding LGBTQ health across the life course
176 [33–36]. Strengths-based perspectives do not ignore
177 health risks and challenges but rather focus on the
178 positive resources available to address these risks
179 and challenges [37]. Improving cultural competence
180 within health care systems, policies, and services in
181 Nova Scotia requires acknowledging, rendering
182 visible, and appropriately measuring the determi-
183 nants of LGBTQ health and wellness across the life
184 course [38, 39].

185 Purpose

186 The purpose of this paper is to offer an overview of the
187 findings of a scoping review and community consulta-
188 tions aimed at developing strengths-based approaches to
189 understanding LGBTQ pathways to health in Nova
190 Scotia. The scoping review and community consultations
191 are nested within a larger program of research aimed at
192 rendering visible the health needs, outcomes, and lived
193 experiences of LGBTQ populations in Nova Scotia in an
194 effort to improve access to, and the provision of,
195 evidence-based, culturally competent health care for
196 these populations.

197 Methods

198 The research described in this paper is informed by the
199 central tenets of community-based participatory
200 research. Community-based participatory research
201 involves “individuals and communities affected by the
202 research in all aspects of the research process, reciprocal
203 learning from the expertise of the members, shared
204 decision-making, and mutual ownership of the processes
205 and products of the research” (Van Wagenen et al., [40],
206 p. 4). In this regard, we sought to include LGBTQ popu-
207 lations and other stakeholders, such as health care
208 providers, health researchers, and policy makers, in
209 every stage of this research.

210 In an effort to gain a clearer understanding of the
211 existing health-focused LGBTQ literature, we conducted

a scoping review using the methodology proposed by 212
Arksey and O'Malley [41]. The purpose of our scoping 213
review was to explore the academic, peer-reviewed 214
health research literature specifically for strengths-based 215
approaches to understanding LGBTQ health. In accord- 216
ance with community-based participatory research 217
methodology, we consulted with a community advisory 218
committee comprised of LGBTQ community members, 219
representatives from LGBTQ organizations, LGBTQ 220
health researchers, and a health reference librarian to 221
determine the search terms for our scoping review (see 222
Appendix 1). We then conducted a search of five key 223
databases containing academic, peer-reviewed journals 224
using these search terms. Our initial search yielded a 225
total of 1855 de-duplicated results, of which 105 articles 226
met the inclusion criteria. Given that the health sector 227
tends to draw on peer-reviewed evidence to inform best 228
practice for clinical care and related health practice 229
guidelines, only articles published in peer-reviewed 230
academic journals that discussed research from 231
strengths-based or health promotion perspectives were 232
eligible for inclusion (see Appendix 2). As such, studies 233
that relied primarily on a health deficit model or risk 234
assessment approach to studying LGBTQ health were 235
excluded. We also included studies that presented 236
alternative analytical and methodological frameworks 237
such as needs assessments, which can help challenge 238
heteronormative and cisnormative approaches to 239
LGBTQ health by allowing LGBTQ populations to iden- 240
tify their own health needs. To ensure that the included 241
studies are relevant to the context of Nova Scotia and to 242
the Canadian health care system, only studies published 243
in English and conducted in Canada, the United States, 244
the United Kingdom, Australia, or New Zealand were 245
considered for inclusion. The scoping review was con- 246
ducted in October 2014 and only papers published by 247
that time were considered. We did not, however, limit 248
our findings to a particular start date. To ensure rigour, 249
an inter-rater reliability approach was used in the inclu- 250
sion process whereby both the research assistant and 251
principal investigator reviewed all articles flagged for 252
possible inclusion. Articles selected for inclusion were 253
read and thematically mapped by research question and 254
methodological approach for consideration for health 255
research and promoting LGBTQ health and wellness in 256
the context of Nova Scotia. 257

Given the importance of engaging with LGBTQ 258
populations, community consultations were undertaken 259
following the completion of our scoping review to 260
discuss the findings and their relevance in the context of 261
Nova Scotia. We conducted two community consulta- 262
tions with LGBTQ populations and health service 263
providers in Truro and in Halifax. Participants were re- 264
cruited through word of mouth and through existing 265

266 community networks in both urban and rural Nova Scotia.
267 In total, there were twenty participants, six of whom
268 attended the rural consultation in Truro and fourteen of
269 whom attended the urban consultation in Halifax. Participants
270 ranged in age from mid-20s to late 60s and the
271 majority identified as white. Prior to data collection, ethics
272 approval was provided by the Dalhousie University
273 research ethics board (REB #2014-3291) and informed
274 consent was obtained from all participants. All data were
275 audio recorded with permission, transcribed verbatim,
276 and analyzed for key emergent themes. In addition to
277 sharing the findings of the scoping review, the overarching
278 purpose of these consultations was to discuss strategies
279 for conducting strengths-based research on
280 LGBTQ health needs, outcomes, and experiences in
281 Nova Scotia. The community consultation transcripts
282 were analyzed and coded for emergent themes.

283 Results

284 Scoping review findings

285 Overall, the findings of our scoping review confirmed
286 that the majority of LGBTQ health research conducted
287 to date has largely remained focused on risks and deficits,
288 underscoring the need to shift towards strengths-based
289 approaches. It is also noteworthy that very few of
290 the studies that met our inclusion criteria were conducted
291 in Canada ($n = 16$) or were conducted in multiple
292 countries but included populations in Canada ($n = 3$)
293 (see Appendix 3) and only one study specifically included
294 LGBTQ populations in Nova Scotia. This finding
295 further illustrates the need for strengths-based research
296 focused on the health needs and experiences of LGBTQ
297 populations in Nova Scotia. The included studies also
298 featured a range of study populations and terminology
299 (see Appendix 4). While some studies focused on
300 LGBTQ populations in general, others focused on specific
301 subpopulations. Notable subpopulations included
302 youth ($n = 26$), older adults ($n = 14$), and people of
303 colour ($n = 14$). Although we did not limit our studies to
304 a particular start date, the findings demonstrate that
305 strengths-based research on LGBTQ health is becoming
306 increasingly prevalent. Of the included studies, none
307 were published prior to 1990, six were published between
308 1990 and 1999, 36 were published between 2000
309 and 2009, and 68 were published between 2010 and
310 2014 (See Appendix 5).

311 The articles included in our scoping review explored a
312 wide range of protective or health promoting factors
313 with the potential to contribute to LGBTQ health, including,
314 for example, social support, coping skills, and positive
315 school and/or work environments [33, 42–44].
316 Further, these studies used diverse tools to measure
317 positive health factors. However, we also noted that
318 many of the measures used were not specific to LGBTQ

319 populations, and, as such, their appropriateness and utility
320 as tools to measure LGBTQ health in Nova Scotia may be
321 limited. Although the included studies employed a wide
322 variety of different qualitative, quantitative, and mixed
323 methods approaches, the use of online surveys was
324 relatively common ($n = 28$). This finding is significant
325 in that online surveys may provide participants with a
326 greater degree of anonymity and have therefore been
327 identified as an effective and appropriate way of reaching
328 'hidden populations,' including LGBTQ populations, for
329 research [29, 45–50]. The use of focus groups and
330 interviews was also common and may be an important
331 means of allowing LGBTQ populations to identify and
332 discuss their own health needs and experiences.

333 Many of the studies included in the scoping review
334 also featured an element of community involvement.
335 While some involved a community advisory committee
336 [51–54], others conducted their research in partnership
337 with community-based organizations or service providers
338 with the goal of informing the development or
339 improvement of programs and services for LGBTQ
340 populations [55–59]. These approaches are in keeping
341 with the principles of community-based participatory
342 research [40].

343 The concept of resilience, referring to the ability to
344 overcome or positively adapt in the face of significant
345 adversity, emerged as a commonly cited framework or
346 theme but there is debate about whether this concept
347 is inclusive of LGBTQ lived experiences [36, 43, 44].
348 While many of the included studies suggested that
349 LGBTQ populations are in fact resilient [20, 34, 43,
350 60–63], resilience was not consistently defined or
351 measured across these studies. In addition, there was
352 no clear consensus on the factors that contribute to
353 resilience among LGBTQ populations. Like health
354 care systems and policies, resilience has historically
355 been focused on individual level determinants of
356 health, which has led some to characterize resilience
357 as a set of inherent personal traits or skills [64–66].
358 This is particularly concerning given the ways in
359 which the overemphasis on individual-level factors
360 associated with health has contributed to the invisibility
361 of LGBTQ health needs, outcomes, and experiences.
362 As with the remainder of the measures used in the
363 studies included in our scoping review, the majority
364 of tools used to measure resilience were not LGBTQ-
365 specific. There is also a need to approach resilience
366 from an intersectional lens as it has historically
367 been defined and framed from a Western perspective
368 [65]. Overall, there is some uncertainty regarding
369 the appropriateness and utility of the concept of
370 resilience for LGBTQ health research in Nova Scotia
371 and this knowledge gap warrants further exploration.
372

373 **Community consultations**

374 The following section offers an overview of the key con- 427
375 cerns raised about LGBTQ health in Nova Scotia from 428
376 our community consultations. Our semi-structured 429
377 focus group guide centred around core issues to emerge 430
378 from our scoping review, including experiences with 431
379 health care systems and services, factors seen to contrib- 432
380 ute to LGBTQ health and wellness, LGBTQ resilience, 433
381 improving the cultural competence of health care sys- 434
382 tems and services, and finally, suggestions for future 435
383 LGBTQ health research in Nova Scotia. 436

384 **Negative experiences with health care systems and services**

385 Following the scoping review, the community consult- 437
386 ation discussions offered a rich overview of LGBTQ ex- 438
387 periences with health care systems and services, factors 439
388 that contribute to LGBTQ health and wellness, and how 440
389 LGBTQ pathways to health in Nova Scotia can be im- 441
390 proved. Unsurprisingly, many of the LGBTQ participants 442
391 attending the consultations reported negative experi- 443
392 ences with health care services in Nova Scotia. Several 444
393 participants described having negative first impressions 445
394 of health care settings based on their interactions with 446
395 medical office assistants and heteronormative, gender- 447
396 binary language on medical intake forms. In other 448
397 words, intake forms and salutations required patients to 449
398 select gender-congruent ‘male’ or ‘female’ categories and 450
399 to select corresponding terms such as ‘Mr.’ and ‘Mrs’. As 451
400 one participant explained, “I shouldn’t have to go into a 452
401 doctor’s office and be like I’m probably going to get mis- 453
402 gendered and I need to prepare myself for that and put 454
403 on my armour. That shouldn’t even be happening in the 455
404 first place. But it does happen and it’s my reality, and I 456
405 have to deal with it”. Similarly, participants expressed 457
406 concern about the challenges of communicating with 458
407 health service providers and being open with them re- 459
408 garding their LGBTQ identity—both in terms of sexual 460
409 orientation and gender identity. One participant charac- 461
410 terized this experience as “explaining yourself over and 462
411 over” when interacting with health service providers. 463

412 Participants suggested that these negative encounters 464
413 serve to discourage LGBTQ populations from accessing 465
414 regular check-ups and preventative care, and instead, 466
415 waiting until they are ill before seeking health care ser- 467
416 vices. Participants also expressed concern regarding 468
417 health service providers’ lack of knowledge on LGBTQ 469
418 health issues, which may lead to inappropriate advice. 470
419 One participant shared the story of a friend in a rural 471
420 setting whose doctor threatened to involuntarily commit 472
421 them for psychiatric care based on their non-binary gen- 473
422 der identification. This experience is supported by the 474
423 findings of a previous study on lesbian and bisexual 475
424 women in Nova Scotia wherein several women reported 476
425 being told by a physician that their sexuality was 477

478 pathological and referred to psychiatric services [25]. 479
Another participant felt that health care providers in 480
Nova Scotia may have lower expectations for their 481
health outcomes and that this may lead to a lower stand- 482
ard of care in comparison with other provinces. These 483
experiences were summarized by a participant who 484
stated “I feel like I am surviving the health care system”. 485
Thus, while the focus of the consultations was on advan- 486
cing strengths-based research on LGBTQ pathways to 487
health, it is important to acknowledge these negative ex- 488
periences as they reinforce the importance of under- 489
standing and reconciling these tensions in access to and 490
uptake of health care services and programs. 491

492 **Factors contributing to LGBTQ health and wellness in Nova Scotia**

493 One of the central discussion questions during the com- 494
495 munity consultations focused on the factors that are 496
497 regarded as keeping LGBTQ populations in Nova Scotia 498
499 well and promoting their health across the life course. 500
Participants reflected on many different factors, ranging 501
492 from the individual level to broader social and structural 502
493 levels. Although some of these factors may also be deter- 503
494 minants of health for the broader population, others are 504
495 specific to LGBTQ populations. Participants listed 505
496 widely recognized social determinants of health includ- 506
497 ing socioeconomic status, access to housing, education, 507
498 social isolation, and food security as key to promoting 508
499 health. While these factors may be considered determi- 509
500 nants of health for all populations, it is important to 510
501 recognize how these factors intersect with LGBTQ iden- 511
502 tities. For example, as previously mentioned, LGBTQ 512
503 populations face higher rates of homelessness and 513
504 poverty than their heterosexual, cisgender age-matched 514
505 peers [16–18]. These factors are also interconnected; as 515
506 one participant pointed out, poverty among older 516
507 LGBTQ populations may, for example, prevent individ- 517
508 uals from engaging in social activities, thereby contrib- 518
509 uting to social isolation. 519

520 Participants identified health literacy and knowledge of 521
522 one’s own health issues as important individual-level 523
524 factors. Participants suggested that the ability to read 525
526 and process health information has a significant impact 527
528 on individuals’ awareness of their own health and 529
530 wellness. While the issue of health literacy may not be 531
532 unique to LGBTQ populations, they experience particu- 533
534 lar challenges in accessing appropriate and meaningful 535
536 health information that speaks to their LGBTQ identities 537
538 and lived experiences. Participants argued, for example, 539
540 that sex education currently tends to be framed through 541
542 a heteronormative and gender-binary lens, thereby limit- 543
544 ing its utility for LGBTQ youth. Self-acceptance and 545
546 levels or degrees of ‘outness’ to health service providers 547
548 were also described as important health promoting 549

479 factors. As one participant noted, “it took me a long
480 time to get to that point to be able to talk openly about
481 my own body [and] my own sex life”. Most participants
482 reasoned that while not being ‘out’ to a health service
483 provider can potentially have negative implications for
484 health, it is also a necessary part of the process of acces-
485 sing health care in order to negotiate personal safety in
486 instances where there is uncertainty or lack of trust with
487 a health care provider. Similarly, not being ‘out’ was seen
488 as a factor preventing LGBTQ populations from acces-
489 sing certain community organizations and services for
490 fear of being identified as LGBTQ. In addition, cognitive,
491 behavioural, and emotional personal coping strategies
492 and self-care were viewed as key individual-level factors
493 contributing to the health and wellness of LGBTQ popu-
494 lations in Nova Scotia.

495 As one participant cautioned, it is imperative that
496 individual-level factors are not overemphasized:

497 when we take the emphasis off the system and put it
498 on the individual, I worry a little bit about victim
499 blaming...[if] I go to get care, there’s a 50 per cent
500 chance that I’m going to leave worse than when I
501 went in and that’s not my fault...We should also
502 recognize that in acquiring those [personal coping]
503 tools that there’s an injustice happening.

504 Consistent with our scoping review findings, social
505 support was one of the most prominent determinants
506 seen as contributing to LGBTQ health and wellness. Po-
507 tential sources of social support include biological family
508 or family of origin, family of choice, friends, and other
509 LGBTQ community members. Community connected-
510 ness was also seen as a source of strength among partici-
511 pants. Participants defined community connectedness
512 quite broadly, referencing involvement in gay-straight
513 alliances, LGBTQ communities, sports leagues, commu-
514 nity activities such as Pride Week, and accessing
515 community services as potential connections. Similarly,
516 participants suggested that for LGBTQ populations for
517 whom religion or spirituality are important, belonging to
518 an affirming religious or spiritual community could play
519 a critical role in maintaining health and wellness. As one
520 participant explained,

521 a lot of people who are [LGBTQ]... don’t feel
522 right in the eyes of God. So they really kind of
523 have to feel connected to a faith to actually feel
524 that they are okay. And so we have a church that’s
525 all affirming and we have a gay couple, one is the
526 minister, and the whole church is just so
527 supportive. They have rainbow stickers
528 everywhere. So it’s that opportunity to start to feel
529 a little bit more healthy within yourself, a little bit

more whole within yourself, if that’s what you 530
want to do. 531

Participants viewed the issue of pride in LGBTQ 532
history as another important factor contributing to the 533
health and wellness of LGBTQ populations in Nova 534
Scotia. One participant shared stories of LGBTQ indi- 535
viduals who faced significant adversity but overcame 536
them, demonstrating their strength and resilience. The 537
participant argued that “we need more pride in our 538
history. We need more pride in our people... and not 539
just the ones that stood in front of the camera and 540
became movie stars; the people that lived ordinary lives 541
in rural communities, that lived, loved, and maybe died. 542
But they lived together”. The same participant argued 543
that sharing these stories and histories can be an import- 544
ant source of strength for LGBTQ populations. Similarly, 545
participants suggested that having positive LGBTQ role 546
models is a key factor contributing to their sense of 547
wellness and social connectedness. Other factors 548
included having safe and supportive work and/or school 549
environments. In this regard, participants argued that 550
acceptance within the community and in other environ- 551
ments is an important contributor to health. For 552
example, one participant suggested that an individual’s 553
social status within the community (in terms of recogni- 554
tion and respect) might impact acceptance within the 555
community, which, in turn, might affect the likelihood 556
that the individual will feel comfortable seeking health 557
care services. 558

LGBTQ resilience 559

We also asked participants in the community consulta- 560
tions whether they felt that the concept of resilience was 561
relevant to understanding the health needs, outcomes, 562
and experiences of LGBTQ populations in Nova Scotia. 563
Consistent with the lack of clarity on this concept in our 564
scoping review results, participants spoke of the need for 565
clarification on how resilience is defined. While partici- 566
pants generally felt that LGBTQ populations in Nova 567
Scotia are resilient, the utility of this concept for LGBTQ 568
health research remained unclear as participants strug- 569
gled to define it, identify the factors that comprise it, 570
and determine how it should be measured. This led one 571
participant to suggest that future research should ask 572
LGBTQ populations how they perceive their own resili- 573
ence and how they would compare it to the resilience of 574
others. Participants also discussed the need to consider 575
measuring whether and how resilience changes over 576
time, depending on the complex interactions of 577
determinants of health. In terms of the determinants 578
contributing to resilience among LGBTQ populations, 579
participants repeated many of the same modifiable and 580
non-modifiable determinants discussed above, including 581

582 social support, pride, self-acceptance, community con-
583 nectedness, and personal coping skills.

584 ***Improving the cultural competence of health care systems***
585 ***and services in Nova Scotia***

586 In addition to determinants that contribute to promot-
587 ing the health and wellness of LGBTQ populations in
588 Nova Scotia, participants also discussed ways in which
589 the cultural competence of health care systems and ser-
590 vices in Nova Scotia could be improved. One of the key
591 areas of improvement noted was making health care en-
592 vironments safer and more inclusive and welcoming for
593 LGBTQ populations. Participants argued that making
594 small changes within health and social systems such as
595 removing heteronormative and gender-binary language
596 from intake forms and posting visible symbols like a
597 pride flag or an LGBTQ ally card would contribute to
598 improving pathways to health for LGBTQ populations.
599 As one participant explained:

600 if you change spaces then you could change who
601 accesses the spaces...If I walk into a space where I see
602 a poster on the wall where my identity is reflected,
603 and I see a tick box on a form and know that that
604 healthcare provider expects me in the room, then I'm
605 more likely to access those services again.

606 Additionally, education and training for health care
607 providers on how to provide culturally competent health
608 care services for LGBTQ populations was seen as a
609 major area for improvement. A nurse attending one of
610 the consultations stated that, in her experience, nurses
611 are not taught "how to make an equitable presentation
612 for an experience in health care whatsoever. It's just not
613 there. We might be given one session one afternoon in
614 our undergrad, and that's it. And this was 2 years ago
615 when I graduated". This feeling echoes the views of
616 physicians interviewed in a previous study on queer and
617 trans women's health care in Nova Scotia who felt that
618 they lacked knowledge, particularly with regards to
619 providing care for trans populations [10]. Another
620 participant felt that the only way to ensure positive expe-
621 riences of 'coming out' to health service providers is
622 through additional education and training. This finding
623 is supported by the conclusions of a previous study that
624 found that nurses in Nova Scotia "take a 'don't ask, don't
625 tell' approach, trusting that quality care can be provided
626 without acknowledging LGBTQ identities and that the
627 ways in which marginalization and oppression may
628 shape LGBTQ patients' health and health care" (Beagan
629 et al. p.60 [67]). Beyond improving communication
630 between health service providers and LGBTQ
631 populations, educating health service providers on
632 LGBTQ-specific health needs and issues was also seen

as critically important. Overall, participants felt that
education related to culturally competent care is
essential for all individuals working in health care
services, including medical office administrators, who
are often the first people that patients interact with. One
participant suggested that efforts could be made to
increase the number of LGBTQ individuals interested in
undertaking training to become health care providers in
Nova Scotia and to offer them support for their training.

Participants argued that advocacy plays a significant
role in improving pathways to health for LGBTQ popu-
lations in Nova Scotia. One participant stated that
knowing their rights as a patient, such as the right to
bring a friend along to an appointment, to record
appointments, and to pursue formal resolution if some-
thing goes wrong, would have made them less likely to
experience discrimination. Further, participants argued
that having LGBTQ patient advocates who could assist
LGBTQ populations in navigating health care systems is
an important means of improving LGBTQ pathways to
health in Nova Scotia.

Participants also shared their views on the norms that
should be central in health care services and systems in
Nova Scotia. For example, one participant argued that
"continuity of care, meaning that you have access to a
healthcare provider that you know and [that] care is per-
sonalized" is critical. Participants discussed the notion of
informed consent in health care and the importance of
making sure that patients have all of the necessary infor-
mation to make informed decisions regarding their own
health and wellness. Finally, participants viewed the no-
tion that patients' decisions will be supported by their
health service providers as being critical in improving
health care services and systems for LGBTQ populations
in Nova Scotia.

Suggestions for future LGBTQ health research in Nova
Scotia

Participants in the community consultations also identi-
fied a number of key questions for future strengths-
based, health promotion research on understanding
LGBTQ health in Nova Scotia. Several research ques-
tions centred on health care experiences and access.
These questions included "have you ever had a positive
[or inclusive] interaction with a health care provider?",
"what did that look like?", and "how did that make a dif-
ference?". Other participants noted that having access to
a doctor in Nova Scotia can be a challenge and as such,
it is important to ask whether LGBTQ populations have
access to a doctor and whether they have a choice of
doctors. Participants suggested that LGBTQ populations
might seek health care services from providers other
than their doctor, such as community nurses and teen
health nurses, and that research should explore which

686 health care provider they choose to see first and why.
687 Participants also felt that it is important to ask LGBTQ
688 populations whether they feel that their health service
689 providers are LGBTQ-friendly and knowledgeable of
690 LGBTQ health issues.

691 Based on the factors discussed above, participants
692 suggested a number of key issues related to how LGBTQ
693 populations in Nova Scotia maintain and improve their
694 own health and wellness across the life course. For ex-
695 ample, participants felt that it was important to ask
696 whether LGBTQ populations are 'out' at work and/or
697 school, whether these are positive environments, and if
698 so, what factors contribute to making these environ-
699 ments positive. With respect to personal coping skills,
700 participants argued that it is imperative to ascertain not
701 only whether an individual possesses coping skills, but
702 also how effective they are, how diverse their coping
703 toolkit is, and whether they have the ability to develop
704 new coping skills. Participants suggested that it is im-
705 portant to determine the number of support people that
706 an LGBTQ individual has, as well as the role that those
707 people play, and how social support affects their health
708 and wellness.

709 When asked to identify who should be included in fu-
710 ture health research focused on LGBTQ health, in
711 addition to LGBTQ populations, participants suggested
712 a wide range of health service providers, including emer-
713 gency departments, medical office administrators,
714 nurses, physical therapists, occupational therapists, teen
715 health nurses, long-term care providers, telemedicine
716 providers, public health policy makers, midwives, and
717 continuing care assistants. In keeping with the emphasis
718 on improving culturally competent responses among
719 health service providers, participants felt that it was also
720 important to include those responsible for educating
721 health service providers, as well as students training to
722 become health service providers. Finally, participants
723 suggested including non-profit organizations that pro-
724 vide services for LGBTQ populations, such as shelters.

725 **Discussion: advancing LGBTQ health research in** 726 **Nova Scotia**

727 Based on the findings of our scoping review and com-
728 munity consultations, we argue that the determinants of
729 LGBTQ health must be understood through a model
730 that considers both individual and structural factors. For
731 example, a lens of intersectionality acknowledges that
732 health outcomes among LGBTQ populations are a result
733 of the intersections of their LGBTQ identities with other
734 determinants of health, including race, socioeconomic
735 status, social exclusion, employment, etc. (see [65] for
736 example). Further, the relationship between these factors
737 and health outcomes is complex. For instance, while al-
738cohol use may potentially contribute to negative health

739 outcomes, it may also mitigate social isolation by allow- 739
740 ing individuals to overcome social anxiety. Perhaps most 740
741 importantly, rather than focusing on individual-level fac- 741
742 tors such as individual behaviour, it is important to con- 742
743 sider how structural factors shape and influence 743
744 individual risks for negative health outcomes. Similarly, 744
745 rather than focusing on developing personal coping 745
746 skills, there is a need to address social and structural fac- 746
747 tors such as homophobic and transphobic stigma and 747
748 discrimination, particularly within health care systems, 748
749 that may necessitate the use of personal coping skills. 749

750 **Implications for LGBTQ health research**

751 Efforts to better understand the complex pathways to 751
752 health among LGBTQ populations in Nova Scotia 752
753 should include collecting additional data on the health 753
754 needs, outcomes, and lived experiences of LGBTQ pop- 754
755 ulations in Nova Scotia. The purpose of our scoping re- 755
756 view and the community consultations described in this 756
757 paper was to help inform future LGBTQ health research 757
758 by exploring knowledge gaps in relation to how to 758
759 understand LGBTQ health in Nova Scotia from a 759
760 strengths-based perspective. Although capturing data on 760
761 negative health outcomes and experiences of LGBTQ 761
762 populations plays an important role in identifying, miti- 762
763 gating, and treating health issues, future health promo- 763
764 tion research on LGBTQ health in Nova Scotia should 764
765 also capture the ways in which LGBTQ populations 765
766 maintain and improve their own health and wellness 766
767 across the life course. 767

768 The strengths-based studies in our scoping review and 768
769 the community consultations data provide important in- 769
770 sights into the factors that potentially promote the 770
771 health of LGBTQ populations in Nova Scotia. These 771
772 strength-based determinants range from the individual 772
773 level to the structural and social levels. In particular, the 773
774 importance of personal coping skills, social support net- 774
775 works, and community connectedness were frequently 775
776 cited in the scoping review and consultations as impor- 776
777 tant determinants of LGBTQ health. Future health pro- 777
778 motion research on LGBTQ populations in Nova Scotia 778
779 should investigate the presence and significance of these 779
780 factors and the potential for health promotion interven- 780
781 tions to build on these strengths. At the structural level, 781
782 supportive work and school environments, accepting 782
783 communities, and safe, inclusive, and welcoming health 783
784 care spaces were considered to have a major impact on 784
785 LGBTQ pathways to health. Additional research on 785
786 these structural factors in the context of Nova Scotia 786
787 could contribute to policy changes that could have posi- 787
788 tive impacts on LGBTQ health outcomes. The utility of 788
789 resilience as a strengths-based conceptual framework for 789
790 understanding and measuring LGBTQ health in Nova 790
791 Scotia also warrants further exploration. Finally, given 791

792 that we were only able to conduct community consulta-
793 tions in two regions, there is a need for additional
794 research on LGBTQ health in Nova Scotia that captures
795 the perspectives of LGBTQ populations across the
796 province.

797 Limitations

798 Although our scoping review and the community con-
799 sultations provide important information for conducting
800 strengths-based LGBTQ health research, there are sev-
801 eral limitations to note. The scoping review only in-
802 cluded peer-reviewed, academic articles published in
803 English and in academic journals and, as such, may not
804 reflect the perspectives of non-peer reviewed or grey lit-
805 erature. Further, given the diversity of identities and
806 terms related to LGBTQ populations (see Appendix 4),
807 there may be identities or populations that were not ad-
808 equately captured by the search terms, such as men who
809 have sex with men (MSM) but do not identify as gay or
810 bisexual, for example. While scoping reviews are a useful
811 approach to retrieving literature related to a specific
812 topic of interest and identifying gaps in the existing lit-
813 erature, they do not assess the quality of the evidence or
814 synthesize the findings presented in the retrieved litera-
815 ture in the way that systematic reviews do [41]. As such,
816 future research on this topic should consider including
817 systematic reviews which provide a more rigorous meth-
818 odology. In addition, the community consultations were
819 limited by time and budgetary constraints which only
820 allowed for two consultations, one in rural and one in
821 urban Nova Scotia. Moreover, although we sought to
822 make the consultations safe, inclusive, and respectful
823 spaces, we invited both LGBTQ populations and health
824 service providers to attend. This may have deterred
825 LGBTQ individuals who have had negative health care
826 experiences from attending. While we have highlighted
827 the importance of intersectionality in LGBTQ health re-
828 search, the majority of our community consultation par-
829 ticipants identified as white and, as such, do not
830 necessarily represent the diversity of LGBTQ popula-
831 tions in Nova Scotia. Future research should consider
832 using alternative recruitment strategies that may result
833 in greater diversity among participants.

834 Conclusion

835 As the findings from our scoping review and commu-
836 nity consultations demonstrate, there is an urgent
837 need to conduct health research on the unique health
838 needs, lived experiences, and outcomes of LGBTQ
839 populations in Nova Scotia to ensure that current
840 health policies, programs and services are responsive
841 to these populations. Given the historical emphasis on
842 negative health outcomes among LGBTQ populations,
843 it is important that future health research be

conducted from an intersectional, strength-based per- 844
spective in an effort to highlight not only the health 845
risks and challenges experienced by LGBTQ popula- 846
tions, but also positive approaches to addressing these 847
issues. Specifically, additional health promotion re- 848
search that takes into account the social, systemic, 849
and structural determinants of LGBTQ health is 850
warranted. 851

Appendix 1

Table 1 Search terms used in scoping review

Concept 1: LGBTQ identity	Concept 2: health	Concept 3: measurement	
Two spirit	Resilienc*	Data collection	t1.4
Lgb*	Protective factor*	Survey*	t1.5
Gender minorit*	Health promot*	Model*	t1.6
Sexual minorit*	Health protect*	Framework*	t1.7
Trans sexual*	Life course*	Measure*	t1.8
Trans gender*	Harm reduction	Tool*	t1.9
Gender identit*	Health predict*	Assess*	t1.10
Gender varian*	Social determinants of health	Epidemiology	t1.11
Genderqueer*	Health disparities	Module	t1.12
Queer*	Health status	Evaluat*	t1.13
Gay*			t1.14
Lesbian*			t1.15
Bisexual*			t1.16
Transgender*			t1.17
Transsexual*			t1.18
Homosexual*			t1.19
Intersex*			t1.20

Appendix 2

Table 2 Inclusion/Exclusion criteria for scoping review

Inclusion	Exclusion	
Published in English	Published in language other than English	t2.3
Peer-reviewed	Non peer-reviewed	t2.4
Academic journal article	Book, dissertation, conference abstract, etc.	t2.5
Primary study	Not a primary study	t2.6
Study conducted in US, UK, Australia, New Zealand or Canada	Study conducted in country other than US, UK, Australia, New Zealand or Canada	t2.7 t2.8
Approaches LGBTQ health from a strengths-based or health promotion perspective	Approaches LGBTQ health from a deficit-based or risk-focused perspective	t2.9 t2.10 t2.11

Time Frame: The scoping review was conducted in October 2014. All included results were published before then. We did not limit our search using a start year

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856 **Appendix 3**

t3.1	Table 3 Study locations	
t3.2	Country	# of studies
t3.3	United States	70
t3.4	United Kingdom	3
t3.5	Canada	16
t3.6	New Zealand	5
t3.7	Australia	6
t3.8	Multiple countries	5

857

858 **Appendix 4**

t4.1	Table 4 Study populations	
t4.2	Study population	# of studies
t4.3	Gay men	16
t4.4	Gay and bisexual men or men who have sex with men (MSM)	12
t4.5		
t4.6	Bisexual individuals	2
t4.7	Lesbian women	10
t4.8	Lesbian and bisexual women	2
t4.9	Transgender individuals	16
t4.10	Gay and lesbian individuals	4
t4.11	Lesbian, gay, and bisexual individuals (LGB)	9
t4.12	Lesbian, gay, bisexual, and transgender individuals (LGBT)	15
t4.13	Lesbian, gay, bisexual, transgender, and queer individuals	7
t4.14	(LGBTQ)	
t4.15	Sexual minority individuals	5
t4.16	Transgender, queer, and questioning individuals (TQQ)	1
t4.17	Gay, lesbian, bisexual, transgender, and intersex individuals (GLBTI)	2
t4.18		
t4.19	Gay and bisexual men and male-to-female (MTF) transgender individuals	1
t4.20		
t4.21	Lesbian, gay, bisexual, and queer individuals	2
t4.22	LGBTQ women	1

859

860 **Appendix 5**

t5.1	Table 5 Historical trends in included studies	
t5.2	Date of publication	Number of studies
t5.3	Before 1990	0
t5.4	1990–1999	6
t5.5	2000–2009	31
t5.6	2010–2014	68

862 **Abbreviations**

863 COPD: Chronic obstructive pulmonary disease; HIV: Human
864 immunodeficiency virus; LGBTQ: Lesbian, gay, bisexual, transgender and

queer/questioning; PHAC: Public Health Agency of Canada; STI: Sexually transmitted infection; WHO: World Health Organization 865
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Acknowledgements

We wish to thank PrideHealth and the (former) Capital District Health Authority for providing funding for this research. We also wish to thank Cybelle Rieber for her review of the earlier version of this manuscript. 867
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Funding

PrideHealth and the (former) Capital District Health Authority provided funding for the scoping review and community consultations. They also provided funding for EC to draft this manuscript. 871
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Availability of data and materials

The datasets generated during and/or analysed during the current study available from the corresponding author on reasonable request. 875
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Authors' contributions

EC participated in the study design, participated in conducting the scoping review, analyzed the scoping review data, co-facilitated the community consultations, analyzed the consultations data, and drafted and revised the manuscript. JG conceived the study, participated in the study design and conducting the scoping review, co-facilitated the community consultations, and revised the manuscript. Both authors read and approved the final manuscript. 878
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Competing interests

The authors declare that they have no competing interests. 886
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Consent for publication

Not applicable. 888
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Ethics approval and consent to participate

Prior to data collection, this study received ethics approval from the Dalhousie University Research Ethics Board (REB #2014-3291). Informed consent to collect, record and report the data was obtained from all community consultations participants. 890
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Received: 22 July 2015 Accepted: 16 September 2016 895

Published online: 22 September 2016 896

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