

“He went back into the closet”

Older LGBTI people´s interactions with health and social care in the Nordic countries

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Summary

The situation for LGBTI people in the Nordic countries has changed radically in recent decades. This has led to increased access to social and legal rights, strengthened protection against discrimination, increased visibility and more opportunities to create organisations, groups and meeting spaces. Despite this, studies show that a gender identity or sexual orientation that does not conform to conventional norms still significantly increases the risk of ill-health. In particular, bisexual and transgender people experience a higher degree of vulnerability and poorer mental and physical health compared to the majority population throughout their lives. How do these conditions affect older LGBTI persons' prospects as they age, and what happens in their contacts with healthcare and social care?

The Nordic Council of Ministers has initiated a project that aims to increase knowledge about the living conditions and quality of life of older LGBTI people, especially in relation to their encounters with the healthcare system and social care. The Nordic Council of Ministers co-operation body *Nordic Information on Gender* (NIKK), located at the Swedish Secretariat for Gender Research at the University of Gothenburg has carried out the project. The report is a result of the project. The report is based on publications consisting of quantitative as well as qualitative studies published as scholarly articles, dissertations, anthology chapters, reports and books.

The report has two parts:

- a research overview that describes the research on the living conditions of older LGBTI people and their encounters with health and social care in the Nordic countries; and
- a knowledge inventory that describes how the LGBTI perspective is taken into account in courses and study programmes for professions that encounter the target group.

Part 1 Research overview of the living conditions and experiences of older LGBTI people

The overall aim of the first part of the report is to contribute to increased knowledge about the living conditions and quality of life of older LGBTI people in the Nordic countries, in particular in their encounters with healthcare and social care; and to provide a historical background to the situation we find ourselves in today. There are both similarities and differences between the Nordic countries when it comes to LGBTI people's history, rights and living conditions. Some general

features are that during the 1950s and 1960s, public sentiment was strongly anti-homosexual and there were few places where LGBTI people could meet. During the 1960s and 1970s, a more public LGBTI culture emerged in parallel with a more open gay movement. In the 1980s, all Nordic countries decriminalised homosexuality, but the outbreak of HIV and AIDS created new stigmas around homosexuality and the gay environment suffered many backlashes.

Several of the Nordic countries were some of the first to introduce legislation that permitted a legal change of sex and access to trans care after an investigation and diagnosis. But the legislation was also coloured by narrow gender norms. Today, the LGBTI environment is important for those who are older, and several Nordic countries have organisations that offer social and political meeting places specifically for older LGBTI people. These countries have also often been a driving force in getting the specific living conditions for older LGBTI people on the political agenda.

Health

The results of studies show that LGBTI people, especially older bisexual and transgender people, feel more vulnerable and experience poorer mental and physical health throughout life, although there is some improvement with age. These factors can often be explained by minority stress, which means that people who are in a minority position can be subject to higher levels of psychosocial stress, which in turn affects their health.

When it comes to sexual health, this report highlights that the research on LGBTI-people often tends to focus on gay men, their sexual practices and other aspects such as norms around sex, consent, changes in sexual function due to diseases such as prostate cancer, and what it is like to age with HIV are investigated less. Qualitative studies can provide a deeper understanding of how these aspects affect the lives and well-being of older LGBTI people.

When it comes to older people who are ageing with HIV, from the research it emerges that these individuals often have very strong memories and experienced great losses in connection with the HIV epidemic in the 1980s. Although medical treatment has improved and HIV is now seen as a chronic disease in the Nordic countries, new challenges arise when ageing with HIV. People living with HIV express concern about how their health and healthcare will be managed as they get older and emphasise the importance of the healthcare system being well informed about HIV and related specific needs.

Encounters with healthcare and social care

Generally speaking, older LGBTI people often find it difficult to feel trust in healthcare and social care and social services. This can be traced back to historical stigmatisation and pathologisation within the healthcare system. Trans people in particular have a special relationship with the healthcare system, as they need to go through an arduous process to access trans care. This process can be marked by binary gender norms and geographical limitations, which can affect their access to this care. For older trans people, this may also mean that they encounter ageist ideas during the trans care investigation. Multiple studies show that previous experiences of homophobia and/or transphobia in their contacts with the healthcare system and elder care lead to some older LGBTI people refraining from seeking the care they need. It is known that in some instances, some couples in same-sex relationships choose to avoid accompanying their partner to healthcare appointments to avoid discrimination.

Being open is often considered an important strategy in encounters with healthcare and elder care. However, there is individual variance in how open one is, and trust in the healthcare professionals they encounter is crucial to dare to come out. Older LGBTI people feel that healthcare and social care are often marked by heteronormative and cis-normative assumptions that render them invisible and result in perceived discrimination. A lack of knowledge about LGBTI identities and the right language to use in the healthcare system reinforces this invisibility.

Regarding elder care, there are concerns about the lack of knowledge about LGBTI issues, as well as fears to be poorly treated due to their sexuality or gender identity, both by staff and other residents. Among those who have experience of elder care, the research shows that discussions about sexuality and gender identity are rare and that responsibility for raising LGBTI perspectives in this encounter rests largely with the social care recipients themselves. Older LGBTI people are also worried about the lack of privacy in elder care, where staff often knock on the door and enter without waiting for an answer, limiting the possibility of engaging in intimacy and sexual activity.

Relationships, networks and LGBTI contexts

Older LGBTI people's relationships and networks greatly affect their well-being and health. International quantitative research has shown that LGBTI people with social support and a sense of belonging in their communities have better health and lower levels of depression and stress. Studies show that older LGBTI people in Denmark and Sweden often have less contact with their families and friends compared to heterosexual people of the same age. They also feel lonelier and lack emotional support to a greater extent. Many older LGBTI people stress the importance of

'chosen families', meaning those they have created in the form of important and meaningful relationships outside of their biological families. Friends often play a key role in these chosen families. Their chosen families provide social and practical support in everyday life.

Legal aspects are important, especially when older LGBTI people do not have legally recognised partnerships or marriages. This may mean that their chosen family lacks legal rights, and biological families can become involved in important decisions regarding their healthcare and estates. Wills and documents that set out LGBTI people's wishes are therefore important.

For older trans people, there have been challenges linked to how these contexts have developed and often excluded them or set limits on how they were permitted to identify themselves. Differences between contexts that targeted homosexuals and those that targeted trans people have also affected older individuals' experiences of belonging and community. The contexts that LGBTI people have found important during their lives often remain significant as they get older, and these relationships can serve to form chosen families that go beyond traditional family ties.

Part 2 Knowledge inventory of healthcare, social care and social sciences study programmes and professions

The purpose of the knowledge inventory in Part 2 is to look at what knowledge and skills concerning LGBTI people's living conditions and gender and sexuality norms are found in healthcare and social sciences study programmes, and among active professionals in healthcare and social care in the Nordic countries.

The knowledge inventory is based primarily on relevant research from the literature searches conducted for this study, as well as relevant reports and other grey material from supplementary searches. The analysis has been supplemented with contextualising material: policy documents that regulate national intended learning outcomes for relevant professional study programmes at university level, as well as interviews and e-mail interviews with university employees and continuing professional development (CPD) providers. CPD courses are the channel through which many professionals without formal education gain knowledge, for example in the home care service and elder care.

Norms and knowledge perspectives in healthcare and social sciences study programmes in the Nordic countries

There is relatively little research on what knowledge and knowledge perspectives concerning gender, sexuality, LGBTI people's living conditions and ageing are

available in different study programmes in the Nordic countries. The amount of research also varies greatly between the Nordic countries and the Faroe Islands, Greenland and Åland. The biggest lack is in studies that specifically investigate older people and ageing, and the studies included here therefore focus mainly on gender and sexuality perspectives.

Despite the fact that there are few studies of how knowledge about gender, sexuality and LGBTI people's living conditions has been implemented in professional study programmes, there is a clear pattern in the material, regardless of the profession or country concerned: Whether students acquire such knowledge in their study programmes varies greatly and is often dependent on individuals. This is despite the introduction of new common guidelines for healthcare and social sciences study programmes with the aim of ensuring learning exchanges linked to equality in healthcare and social care services, and gender identity, gender expression and sexual orientation, for example.

Teaching materials in Scandinavian languages about sexuality are also important for this area to be included in the teaching according to many of the interviewed teachers. If you search for key publications concerning older LGBTI people's living conditions, you find that they are included as course literature for some professional study programmes, which indicates a positive development.

Professional practitioners' experiences in encounters with patients and users

In general, a majority of the studies show that professional practitioners are positive to LGBTI people being treated equally and with respect, and that knowledge is key to making this possible. On the other hand, there are large knowledge gaps in the field, where heteronormative thinking dominates, along with an equality rhetoric where everyone should be 'treated equally' with reference to the legislation and guidelines governing the specific service.

Healthcare and social care services are regulated by various laws, central government directives and municipal guidelines, in addition to professional practice guidelines for different professions. In general, today's welfare policy discourses tend to emphasise that social services should facilitate greater user participation, empowerment and a focus on individual needs. Healthcare and social care services are dominated by person-centred care as a philosophical framework, where an empathetic perspective is to form the basis for meeting the patient's basic psychological needs in the care of the person. There also seems to be a trend towards gender identity, gender expression and sexual orientation being included more often in government agencies' policy documents that concern equal access to good health and equal healthcare, and in strategies for older people in certain Nordic countries.

All the included studies of professionals in healthcare, social care and social sciences professions highlight a significant lack of knowledge regarding gender, sexuality and LGBTI perspectives. These perspectives have been absent in their study programmes, particularly in compulsory courses. This leads to uncertainty when it comes to raising questions about sexuality and gender identity on one's own initiative.

CPD for healthcare, social care and social sciences professions

Higher education institutions offer some CPD courses and elective courses for professionals working in healthcare, social care and social sciences occupations that include knowledge about gender, sexuality and LGBTI perspectives. These focus in particular on occupational groups that encounter children and young people. CPD initiatives are also important because many in the elder care sector do not have higher education, or received their education some time ago, or did not acquire LGBTI perspectives from their study programmes.

CPD is currently provided primarily by civil society organisations, in particular LGBTI organisations and other organisations working with issues related to sexual and reproductive health rights (SRHR). In Sweden and Norway, the national LGBTI organisations have their own education units, and courses are offered in all the Nordic countries and in Åland to a greater or lesser extent. These education activities are mainly financed by state and municipal funding in most of these countries, while the Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights (RFSL) offers courses as a limited company, where LGBTI certification comprises a considerable part of its contract education, largely for public sector activities. However, there is a limited qualitative knowledge base concerning how CPD initiatives actually impact healthcare activities.

Demand for courses and certifications has increased over the past five years according to the trainers interviewed for this study. This is a result of stricter anti-discrimination laws as well as explicit policy to increase competence in this area, and that the knowledge provided in professional study programmes is inadequate. This leads to a significant gap elder care service between nursing home for older people or requirements to work to prevent discrimination and being able to do so in practice. Civil society organisations that provide courses with central government or municipal funding talk about the pressures in this context, both in terms of the amount of funding provided and the possibility of continuity.

A positive trend is that LGBTI perspectives appear to be more often integrated into CPD courses or existing knowledge resources for healthcare and social care professionals who encounter older people. However, despite positive developments in integrating knowledge of LGBTI perspectives, gender and sexuality into central government and municipal resources for healthcare and social care staff, it is inadequate in relation to the knowledge needed by those working in these fields.

Recommendations

Based on the results and conclusions of the studies, this report compiles recommendations for policy and practice. A recurring need expressed in the studies, seen to the results, is for increased LGBTI competence in healthcare and social care. The recommendations are divided up to address different levels and concern everything from improving the language used and communication with the individual patient in the everyday encounter to improving trans care at a structural level. Based on the knowledge inventory in Part 2, the recommendations emphasise that a norm-critical inventory of existing study resources should be carried out; and that knowledge about the LGBTI perspective, life course, healthcare and social care should be included in professional qualification study programmes and CPD.

The Recommendation section ends with the conclusion that more quantitative and qualitative knowledge about older LGBTI people is needed. More longitudinal studies would also facilitate analyses of causal effects for the group of older LGBTI people and what effects cohort and generation have in relation to this. Based on the research overview, it is possible to conclude that knowledge from some countries – primarily Finland and Iceland, as well as the Faroe Islands, Greenland and Åland – is inadequate, and that from these contexts we need more knowledge about older LGBTI people. In view of the range of experiences in this group, in particular there is very little knowledge about older intersex people, where knowledge is currently virtually non-existent.

Sammanfattning

Situationen för LGBTI-personer i de nordiska länderna har förändrats radikalt de senaste årtiondena. Detta har medfört ökad tillgång till rättigheter på det sociala och juridiska området, förstärkt skydd mot diskriminering, ökad synlighet och fler möjligheter till gemenskap. Trots detta framgår det i studier att en könsidentitet eller sexuell läggning som inte följer den konventionella normen fortfarande signifikant ökar risken för ohälsa. Särskilt bisexuella och transpersoner inom LGBTI-gemenskapen upplever högre utsatthet och sämre psykisk och fysisk hälsa jämfört med majoritetsbefolkningen under hela livet. Hur påverkar dessa villkor förutsättningar för äldre LGBTI-personers möjligheter i åldrandet och vad som sker i kontakten med vård och omsorg?

Nordiska ministerrådet har tagit initiativ till ett projekt som ska bidra till ökad kunskap om äldre LGBTI-personers levnadsvillkor och livskvalitet, särskilt i mötet med hälso- och omsorgsvård. Nordiska ministerrådets samarbetsorgan Nordisk information för kunskap om kön, NIKK, placerat vid Nationella sekretariatet för genusforskning i Sverige, har utfört projektet som bland annat resulterat i denna rapport. Rapporten baseras på 38 publikationer som utgörs av kvantitativa såväl som kvalitativa studier publicerade som vetenskapliga artiklar, avhandlingar, antologikapitel, rapporter samt böcker.

Rapporten består av två delar:

- En kunskapsöversikt som beskriver forskningsläget om äldre LGBTI-personers livsvillkor och möte med vård och omsorg i de nordiska länderna, och
- En kunskapsinventering som beskriver hur LGBTI-perspektivet beaktas i utbildningar för yrken som möter målgruppen

Del 1. Kunskapsöversikt om äldre LGBTI-personers livsvillkor och erfarenheter

Det övergripande syftet med den första delen i rapporten är att bidra med ökad kunskap om äldre LGBTI-personers livsvillkor och livskvalitet, särskilt i mötet med vård och omsorg, i de nordiska länderna och ge en historisk bakgrund till den situation vi befinner oss i idag. Det finns både likheter och skillnader mellan de nordiska länderna när det gäller LGBTI-personers historia, rättigheter och livsvillkor. Några generella drag är att det under 1950- och 60-talen fanns starka antihomosexuella stämningar i samhället och få mötesställen. Under 1960- och 70-talen växte en mer offentlig homokultur fram parallellt med en mer öppen

homorörelse. På 1980-talet hade alla nordiska länder avkriminaliserat homosexualitet, men utbrottet av hiv och aids skapade nya stigmat kring homosexualitet och homomiljön drabbades av många förluster.

Flera av de nordiska länderna var tidiga med lagstiftning som möjliggjorde juridisk ändring av kön samt tillgång till transvård efter utredning och diagnostisering, men lagstiftningen har samtidigt präglats av snäva normer kring kön. Idag är LGBTI-miljön viktig för de som är äldre, och flera nordiska länder har organisationer som erbjuder sociala och politiska träffpunkter som riktar sig specifikt till äldre LGBTI-personer. Dessa har också ofta varit drivande i att sätta äldre LGBTI-personers specifika livsvillkor på den politiska agendan.

Hälsa

Resultaten från studier visar att LGBTI-personer, särskilt äldre bisexuella och transpersoner, upplever ökad utsatthet och sämre psykisk och fysisk hälsa genom livet, även om det finns en viss förbättring med stigande ålder. Förekomsten kan ofta förklaras genom minoritetsstress, vilket innebär att personer som befinner sig i minoritetspositioner kan utsättas för högre psykosociala stressnivåer, vilket i sin tur påverkar deras hälsa.

När det gäller sexuell hälsa belyser texten att forskning ofta har en benägenhet att fokusera på homosexuella män och deras sexuella praktiker, medan andra aspekter som normer kring sex, samtycke, förändringar i sexuell funktion till följd av sjukdomar som prostatacancer och hur det är att åldras med hiv undersöks. Genom kvalitativa studier kan man få en djupare förståelse för hur dessa aspekter påverkar äldre LGBTI-personers liv och välbefinnande.

När det kommer till äldre som åldras med hiv, framkommer att dessa individer ofta haft mycket starka minnen och förluster kopplade till hiv-epidemin på 1980-talet. Även om medicinsk behandling har förbättrats och hiv nu betraktas som en kronisk sjukdom i de nordiska länderna, uppstår nya utmaningar när det gäller åldrande och hiv. Människor som lever med hiv uttrycker oro för hur deras hälsa och vård kommer att hanteras när de blir äldre, och det betonas vikten av att vården är välinformerad om hiv och dess specifika behov.

Möte med vård och omsorg

Sammantaget har äldre LGBTI-personer ofta svårt att känna förtroende för hälso- och sjukvård och socialtjänst, vilket kan spåras till historiska stigmatiseringar och patologisering inom vårdsystemet. I synnerhet transpersoner upplever en särskild relation till vården, eftersom de behöver genomgå en krävande process för att få tillgång till transvård. Denna process kan präglas av binära könsnormer och geografiska begränsningar, vilket kan påverka möjligheten till vården. För äldre transpersoner kan detta även innebära att de möter ålderistiska föreställningar

under transvårdsutredningen. Flera studier visar att tidigare erfarenheter av homo- och/eller transfobi i kontakter med vården och äldreomsorgen leder till att vissa äldre LGBTI-personer avstår från att söka den vård de behöver. Det är känt att vissa par i samkönade relationer, i vissa fall, väljer att undvika att följa med sin partner till vården för att undvika diskriminering.

Öppenhet anses ofta vara en viktig strategi i möten med vård och äldreomsorg. Emellertid varierar graden av öppenhet bland individer, och förtroende för vårdpersonalen är avgörande för att de ska våga komma ut. Äldre LGBTI-personer upplever att vård och omsorg ofta är präglad av hetero- och cis-normativa antaganden, vilket skapar osynliggörande och upplevd diskriminering. Bristen på språk och kunskap om LGBTI-identiteter inom vården förstärker detta osynliggörande.

När det gäller äldreomsorgen finns en oro över bristande kunskap om LGBTI-frågor, samt farhågor om att bli dåligt bemött på grund av sexualitet eller könsidentitet, både av personal och andra boende. Bland de som har erfarenhet av äldreomsorg framkommer att diskussion om sexualitet och könsidentitet är sällsynt och att ansvaret att lyfta LGBTI-perspektiv i stort vilar på omsorgstagarna själva. Äldre LGBTI-personer oroas också över bristande integritet i äldreomsorgen, där personalen ofta knackar på dörren utan att invänta svar, vilket begränsar möjligheten till intimitet och sexuell aktivitet.

Relationer, nätverk och LGBTI-sammanhang

Äldre LGBTI-personers relationer och nätverk påverkar i hög grad deras välmående och hälsa. Internationell kvantitativ forskning har visat att äldre LGBTI-personer med socialt stöd och tillhörighet i sina gemenskaper har bättre hälsa och lägre nivåer av depression och stress. Studier visar att äldre LGBTI-personer i Danmark och Sverige ofta har mindre kontakt med sina familjer och vänner jämfört med heterosexuella personer i samma ålder. De känner sig också mer ensamma och saknar emotionellt stöd i högre utsträckning. Många äldre LGBTI-personer betonar vikten av "valda familjer", vilket innebär att de har skapat viktiga och meningsfulla relationer utanför sina biologiska familjer. Vänner spelar ofta en central roll i dessa valda familjer. Dessa valda familjer ger socialt och praktiskt stöd i vardagen.

Juridiska aspekter är viktiga, särskilt när äldre LGBTI-personer inte har juridiskt erkända partnerskap eller äktenskap. Det kan innebära att deras valda familj saknar juridiska rättigheter, och biologiska familjer kan bli inkopplade vid viktiga beslut som gäller vård och arv. Testamenten och dokument som beskriver önskemål är därför betydelsefulla.

För äldre transpersoner har det funnits utmaningar kopplade till hur dessa sammanhang har utvecklats och ofta exkluderat dem eller satt begränsningar för hur de fick identifiera sig. Skillnader i sammanhangen som riktade sig mot homo-

sexuella och de som riktade sig mot transpersoner har också påverkat de äldre individernas upplevelser av sammanhållning och gemenskap. Sammanhållningen som LGBTI-personer har funnit viktiga under sina liv förblir ofta betydelsefulla när de blir äldre, och dessa relationer kan fungera som valda familjer som går bortom de traditionella familjebanden.

Del 2. Kunskapsinventering av vård- omsorgs- och socialvetenskapliga utbildningar och yrken

Syftet med kunskapsinventeringen i del 2 är att se på vilken kunskap och kompetens om LGBTI-personers livsvillkor och normer för kön och sexualitet som finns i såväl vård- och socialvetenskapliga utbildningar som bland yrkesutövande vård- och omsorgspersonal i de nordiska länderna.

Kunskapsinventeringen bygger framför allt på relevant forskning från de litteratursökningar som gjorts i denna studie, samt relevanta rapporter och annat "grått material" från kompletterande sökningar. Analysen har kompletterats med kontextualiserande material; policydokument som reglerar nationella lärandemål för relevanta professionsutbildningar på högskolenivå, samt intervjuer och e-postintervjuer med universitetsanställda och fortbildningsaktörer. Fortbildningskurser är den kanal som många yrkesverksamma utan formell utbildning får kunskap genom, inom exempelvis hemtjänst och äldreomsorg.

Normer och kunskapsperspektiv i vård- och socialvetenskapliga utbildningar i de nordiska länderna

Det finns relativt lite forskning om vilken kunskap och vilka kunskapsperspektiv om kön, sexualitet, LGBTI-personers livsvillkor och åldrande som finns inom olika utbildningar i de nordiska länderna. Förekomsten varierar också stort mellan de nordiska länderna och Färöarna, Grönland och Åland. Störst brist är det på studier som specifikt undersöker äldre och åldrande, och de inkluderade studierna fokuserar därför i huvudsak på kön- och sexualitetsperspektiv.

Trots att antalet studier av hur kunskap om kön, sexualitet och LGBTI implementerats i olika professionsutbildningar är få, finns ett tydligt mönster i materialet, oberoende av profession och land: Huruvida studenter får kunskap i sina utbildningar varierar starkt och är ofta personberoende. Detta trots att nya gemensamma riktlinjer för vård- och socialvetenskapliga utbildningar införts med syfte att säkerställa lärandeutbyte, bland annat kopplad till likvärdiga vård- och omsorgstjänster och könsidentitet, könsuttryck och sexuell läggning.

Läromedel på skandinaviska språk om sexualitet är också viktiga för att det ska tas in i undervisningen, berättar flera av de intervjuade lärarna. Om man söker på

centrala utgivningar som rör äldre LGBTI-personers livsvillkor finns de med som kurslitteratur på enskilda professionsutbildningar, något som tyder på en positiv utveckling.

Professionsutövares erfarenheter i möte med patienter och brukare

Generellt sett visar en majoritet av studierna att professionsutövare har ett positivt förhållningssätt till att LGBTI-personer bör behandlas likvärdigt, med respekt och att kunskap är centralt för att detta ska möjliggöras. Å andra sidan finns det stora kunskapsluckor inom fältet, där ett heteronormativt tankesätt är dominerande- och en likabehandlingsretorik där alla ska "behandlas lika" med referens till lagar och riktlinjer för den specifika tjänsten.

Vård- och omsorgstjänster är reglerade av olika lagar, statliga direktiv och kommunala riktlinjer, i tillägg till yrkesprofessionella riktlinjer för olika professioner. Generellt sett finns en utveckling av välfärdspolitiska diskurser där socialtjänsterna ska lägga till rätta för större brukarmedverkan, inflytande och fokus på individuella behov. Vård- och omsorgstjänsterna domineras av personcentrerad omvårdnad som vårdfilosofiskt ramverk, där ett empatiskt perspektiv ska ligga till grund för att möta patientens grundläggande psykologiska behov i människovårdandet. Det verkar också finnas en tendens till att könsidentitet, könsuttryck och sexuell läggning i ökande grad tas in i myndigheters policydokument om lika tillgång till god hälsa och jämlik vård och i äldrepolitiska strategier i vissa nordiska länder.

Alla inkluderade studier om yrkesverksamma inom vård- omsorgs- och socialvetenskapliga professioner lyfter fram en betydlig kunskapsbrist när det gäller kön, sexualitet och LGBTI-perspektiv. Dessa perspektiv har varit frånvarande i utbildningen, i synnerhet i den obligatoriska utbildningen. Detta leder till osäkerhet när det gäller att på eget initiativ lyfta frågor kring sexualitet och könsidentitet.

Rekommendationer

Baserat på studiernas resultat och slutsatser har rekommendationer sammanställts för policy och praktik. Det är återkommande i studierna, baserat på resultaten, att det behövs ökad LGBTI-kompetens inom vård och omsorg. Rekommendationerna är uppdelade på olika nivåer och berör alltifrån att i det vardagliga mötet förbättra språk och kommunikation med den enskilde vårdtagaren till att på strukturell nivå förbättra transvården. Utifrån kunskapsinventeringen i avsnitt 2 lyfts exempelvis att normkritisk inventering av existerande läromedel bör genomföras och att kunskap om LGBTI-perspektiv, livslopp, vård och omsorg bör ingå inom ramen för professionsutbildning och fortbildning.

Rekommendationsavsnittet avslutas med att konstatera att det behövs mer kvantitativ såväl som kvalitativ kunskap om äldre LGBTI-personer. Fler

longitudinella studier kan även underlätta analyser om kausala effekter för gruppen äldre LGBTI-personer och vilka effekter som kohort respektive generation har i relation till detta. Utifrån kunskapsöversikten går det att konstatera att kunskapen från vissa länder, som Finland och Island, samt Färöarna, Grönland och Åland är bristfällig, från dessa kontexter behöver vi mer kunskap om äldre LGBTI-personer. Sett till gruppens olika erfarenheter saknas även kunskap om äldre intersexpersoner, där kunskapen idag är i princip obefintlig.

Introduction

In recent decades the situation for LGBTI people has changed radically in large parts of the world, including the Nordic countries. This has meant increased access to social and legal rights, stronger protections against discrimination, greater visibility and more places to gather. Despite this, public health surveys illustrate how a gender identity or sexuality that does not conform to conventional norms still matters. LGBTI people, especially bisexual and transgender people, experience a greater degree of vulnerability and impaired mental and physical health than the majority population over the life cycle (Nordic Council of Ministers, 2021, Eggebø, Stubberud & Andersen 2020, FHI 2015; Johansen Laursen & Juel, 2015).

Older LGBTI people are a heterogeneous group with different conditions when it comes to ageing, but they also have two things in common.

- They have grown up in a society where the view of their norm-breaking gender identities and/or sexualities has been heavily stigmatised, in some periods even criminalised and pathologised, and without access to fundamental rights and protection against discrimination.
- In many ways, they are ageing in a heteronormative culture, where public social care, healthcare and social services have little knowledge about their living conditions, experiences and close relationships.

How do these conditions affect older LGBTI persons' prospects as they age and what happens in their contacts with health and social care?

The research on older LGBTI people comes mainly from an English-speaking context. The patterns in these studies show that the life experiences in close relationships of older lesbians, gays, bisexuals, trans and intersex people strongly affect their living conditions, health, and healthcare and social care needs in various ways (Kneale et al., 2021). The majority are living good lives and report to be in good health. But the studies also indicate that older LGBTI people are at significantly higher risk of impaired mental health than their peers, have an increased risk of social isolation, and retain a palpable concern about being treated negatively and with ignorance when they need healthcare and social care (Fredriksen Goldsen et al., 2011). This is especially true of older adults with trans experiences, and older gay and bisexual men with HIV (ibid). Fredriksen Goldsen, Jen, och Muraco (2019) conclude in their latest literature review of key international publications on LGBTI ageing and life course perspectives between 2009 and 2016 that this field of research has grown rapidly. They also identify greater breadth in the methodologies used as well as a stronger theoretical foundation. But there is also a lack of intersectional perspectives and a greater focus on differences within

the LGBTI group. Few studies address the very oldest bisexual or non-binary people, people with intersex variations, older racialised individuals, and LGBTI people with low income.

International studies also show that people working in elder care service providers have little knowledge and competence about LGBTI people's life experiences and special needs, although attitudes are more positive than before (Leyerzapf, Visse & Abma, 2018; Hafford-Letchfield, Simpson, Willis and Almack, 2018; Willis 2013). Thus, there is also good reason for their low expectations and their concerns about not being responded to with knowledge and understanding. The ultimate consequence is that older LGBTI people, like other marginalised groups, simply do not seek help when needed. Another consequence is that it does not feel safe to be open about one's gender identity or sexual orientation in contacts with the healthcare system, or prior to moving into a nursing home for older people or short-term housing – despite having been open earlier in life (Leyerzapf et al., 2018; Pijpers, 2022; Siverskog, 2021a; Rainbow Project and Age Northern Ireland, 2011). On the one hand, not being open about one's gender identity or sexual orientation can protect the person from discrimination, but on the other hand, make it impossible to access understanding and positive affirmation of one's identity, life experiences and relationships.

Living conditions and prospects for ageing are strongly associated with the local context, and the legislation and welfare structure that feature there. In order to create better ageing conditions for older LGBTI people in the Nordic countries, as well as the Faroe Islands, Greenland and Åland, a knowledge base of the situation from this geographical area is needed. This report therefore brings together knowledge about older LGBTI people's prospects for, as well as experiences of, healthcare and social care in the Nordic countries from two points of departure: older LGBTI people's living conditions and experiences from encounters with healthcare and social care; and knowledge and the need for knowledge concerning gender, sexuality, norms and older LGBTI people in professional qualification study programmes and CPD initiatives after graduation.

About the report

In January 2020, Nordic co-operation within the Nordic Council of Ministers was extended to include work for equal rights, treatment and opportunities for LGBTI people in the Nordic countries. One of the strategic policy areas for Nordic co-operation concerns quality of life and living conditions and has the aim of reducing the significant differences in both physical and mental health between LGBTI people and the rest of the population. In particular, it emphasises the importance of knowledge about the situations of older LGBTI people as the basis for promoting fair and just health and medical care services.

The Norwegian Presidency of the Nordic Council of Ministers in 2022 therefore initiated a project that aims to increase knowledge about the living conditions and quality of life of older LGBTI people, especially in relation to their interactions with healthcare and social care. The Nordic Council of Ministers co-operation body *Nordic Information on Gender* (NIKK), located at the Swedish Secretariat for Gender Research at the University of Gothenburg has carried out the project, which has resulted in this report among other things.

The report has two parts:

- A research overview that describes the state of the research on the living conditions of older LGBTI people and their interactions with health and social care in the Nordic countries, and
- A research inventory that describes how the LGBTI perspective is taken into account in courses and study programmes for professions that interact with the target group.

The research overview has been written by Anna Siverskog, PhD, project researcher at the School of Culture and Education, Södertörn University, and senior lecturer at the School of Health and Welfare, Jönköping University. The knowledge inventory was written by Janne Bromseth, PhD, researcher at Eastern Norway Research Institute, Innland Norway University of Applied Sciences and is translated from Swedish to English by Katherine Stuart.

Terms and definitions

LGBTI

LGBTI is an abbreviation for Lesbian, Gay, Bisexual, Transgender and Intersex. After a decision by the Nordic Ministers for Gender Equality, this term is now used in official Nordic cooperation so as to correspond to the term used by other international organisations. The collective term is used throughout this report, except when referencing studies where other terms are used. It may be that parts of this group are studied, such as LGBT, LGBTQ or LBTTQ. LGBT is an abbreviation for lesbian, gay, bisexual and transgender people. The Q refers to those who identify as queer, and the L is sometimes used to make lesbians visible. Although LGBTI is used consistently, it is with an awareness that there is no equilibrium in the groups encompassed by this acronym; for example, intersex is rarely highlighted in the research.

Transperson

An umbrella term for individuals who experience that their gender identity does not match the legal gender assigned to them at birth.

Non-binary

A person who feels themselves to be neither woman nor man, but instead as both, midway between, floating, or completely beyond gender categories.

Intersex variations

Intersex variation, which may also be called variation in sex characteristics, is a collective term for describing many different conditions where a person is born with an internal or external anatomy that does not correspond to what a typical female or typical male body is expected to be. An intersex variation can be a difference in external anatomy, but may also be a hormonal or genetic difference that is not expressed in an obvious anatomical difference. There is a wide range of intersex variations, some of which are treated medically and others not. Some intersex variations are detected during pregnancy or birth, while others become noticeable during puberty, when trying to become pregnant, or are detected randomly.

Queer

Queer can have multiple meanings. It can be used as an identity in which case it represents a desire to avoid identifying with something and a desire to question gender and/or sexuality norms. Queer is also a concept that can describe a critical approach to norms in which case it relates to both gender and sexual orientation.

Cis person

A person who identifies with the legal gender assigned to them at birth. Cisnormativity is a term for identifying the norms that assume that there are only

two genders, and that everyone is a cis person. These norms give cis persons privileges and benefits that trans people may lack.

Heteronormativity

Norms based on the assumption that there are two separate genders woman and man, which are understood to be opposite to each other, and are based on an expectation concerning these sexes should demand of each other.

Heteronormativity involves the assumption that everyone is heterosexual and creates notions of heterosexuality, and a certain type of heterosexual life, as natural, self-evident and given.

Legal gender or legal gender assignment

The gender assigned to a person in the population registers in the Nordic countries. Legal gender is assigned in the absolute majority of all cases based on the appearance of the external genitals of the newborn baby.

Gender identity

A person's self-perceived gender, that is, the gender with which the person identifies. Gender identity is sometimes also called psychological or mental gender.

Gender-affirming care and treatment

A collective term for different ways of changing the body so that it more closely matches the individual's gender identity.

Background: LGBTI policy and history in the Nordic countries

LGBTI history in the Nordic countries

There are both similarities and differences between the Nordic countries when it comes to LGBTI people's history, rights and living conditions (Bromseth & Siverskog, 2013). Homosexuality was previously banned by law in all the Nordic countries and was decriminalised in the 20th century in the following order: Denmark 1933, Iceland 1940, Sweden 1944, Finland 1971 and Norway 1972. Some general features are that during the 1950s and 1960s public sentiment was strongly anti-homosexual and there were few places where LGBTI people could meet, which could also be difficult to access. During the 1960s and 1970s, a more public homoculture emerged in parallel with a more openly homosexual movement. In the 1980s, all Nordic countries had decriminalised homosexuality, but the outbreak of HIV and AIDS created new stigmas around homosexuality and the homo environment suffered many backlashes (Bromseth & Siverskog, 2013). Many of the Nordic countries were early to introduce legislation that permitted a legal change of sex and access to trans care after examination and diagnosis. However the legislation was also coloured by narrow gender norms.

The largest LGBTI organisations in the Nordic countries were established in the 1940s, for example in Denmark in 1948, Norway in 1949 and Sweden in 1948. In Finland, the first organisation with homosexuals as the target group was established in 1969, in Iceland in 1978, in Åland in the early 1990s, and in Greenland in the early 2020s. The early organisations targeted bisexual lesbian and gay individuals, and separate trans groups were formed in the 1960s in several Nordic countries. It was not until the 21st century that transgender people were officially included in the umbrella organisations, and in recent years, intersex has also been included under the LGBTI umbrella. Lesbian women have also often built up their own feminist contexts and organised themselves outside the national LGBTI organisations. These divisions still characterise those who are now older and have been part of those environments. (Bromseth & Siverskog, 2013).

The current situation

Today, the LGBTI environment continues to be important for those who are older, and several Nordic countries have organisations that offer social and political gathering spaces specifically for older LGBTI people. These countries have also often been a driving force in getting the specific living conditions of older LGBTI people on the political agenda. In Finland, *Gummedalen* for lesbian and bisexual women and *Fin-Bears* for gay and bisexual men were established in the 1990s as places to meet socially, which also pushed for the first survey of older LGBTI people's conditions in Finland. Since 2021, there is also *Sateenkaariseniorit – Regnbågsseniorer* (rainbow seniors), which also include trans and intersex people. The association is run voluntarily as a place to meet socially in Helsinki and also provides courses for those working in the healthcare system. In Norway in 2006, FRI Oslo Akershus initiated a project on queer ageing, primarily driven by older activists in the organisation. A number of social groups were established specifically targeting older people, and these exist today, in addition to their own Rainbow meeting place for seniors in Oslo. Multiple senior centres for older people also started their own rainbow meetings in 2022. In Sweden there are several social groups that were established in the late 1990s and early 2000s in several major cities: *Gayseniorerna* (the Gay seniors) and Golden ladies in Stockholm, *HBT-seniorerna* (the LGBT seniors) in Gothenburg, and since several years there are local senior groups within RFSL in Gävle, Malmö, Västerås and Örebro. Since 2018, RFSL has prioritised issues related to older people at national level. There are also intergenerational projects, *Regnbågsseniorer* (Rainbow seniors) in Gothenburg and *Generation hbtqi* (Generation LGBTI) in Stockholm, which aim to facilitate contacts between people of different ages. FPES, an association for trans people, does not specifically target older people but many older people are among its members. In Denmark, there are several groups that do not necessarily profile themselves as targeting older people, but have members who are 50+. These groups share specific interests, identities or history. In Denmark, there is no specific meeting place for older LGBTI people, but a project will be launched in autumn 2023.

The Faroe Islands, Greenland and Åland have no social meeting places of their own for older LGBTI people, but do have active LGBTI organisations. *Regnbågsfyren* (the Rainbow Lighthouse) is a member organisation under the Finnish organisation SETA, and was founded in 2005. *LGBT+ Føroyar* (Faroes) was started in 2012 but has few older participants in its activities. *Lgbtq+ Greenland* has only recently started, but has no active older members.

Legislation and legal protections

The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) maps the status of LGBTI people's rights in Europe annually with a focus on seven thematic areas: equality and non-discrimination; family; hate crime and hate speech; legal gender recognition; intersex bodily integrity; civil society space; and asylum. In its latest Rainbow Europe Map, all Nordic countries rank high: Denmark (3), Iceland (5), Finland (6), Sweden (8) and Norway (9) among the 49 countries in the ranking (ILGA Europe, 2023). The Faroe Islands, Greenland and Åland are not included in the Map. In the most recent Map, ILGA notes that a general trend can be seen of an increase in hate speech, especially targeting trans people. Denmark, Finland, Iceland and Sweden are all mentioned as countries where politicians and representatives of the state have made public statements expressing hatred of LGBTI people. They also see a trend of increased violence against LGBTI people, where two people were murdered and twenty injured in an attack outside an LGBTI bar in Oslo in 2022 (ILGA Europe, 2023).

All Nordic countries currently have anti-discrimination laws that cover sexual orientation and gender identity. The nature of the protection and the sectors of society covered vary. In all countries, there are protections in place for the workplace. From an international perspective, the Nordic countries have also come a long way in terms of opportunities for LGBTI people to start a family. In all Nordic countries, same-sex couples have the right to marry, and they are covered by the same law that covers heterosexual relationships. (Nordic Council of Ministers, 2020).

The possibilities for changing one's legal gender also vary between the Nordic countries. In Denmark, Sweden and Finland, the age limit for changing one's legal gender is 18 years and in Norway it is 6 years old (over 16 without the consent of a parent or custodian or county governor). In Iceland there is no age limit but children younger than 15 years must have their guardian's consent or get a consent from an expert committee. In Norway, Denmark, Finland and Iceland, the process is currently based on self-determination, so the consent of a third party (a doctor or a judge) is not required to change one's legal gender. In Sweden, a gender dysphoria investigation and a diagnosis (of gender dysphoria) are required in order to change one's legal gender. In the Faroe Islands and Greenland, it is not possible to change one's legal gender.

In Iceland, legislation prohibits interventions that alter the sex characteristics of newborns with an intersex variation, until they themselves attain the age of consent. This type of legislation is lacking in the other Nordic countries. In an international comparison, several of the Nordic countries are lagging behind when it comes to legislation covering recognition of legal gender and bodily integrity for people with intersex variations. However, all the Nordic countries are planning initiatives or new laws in the area (ILGA Europe, 2023; Nordic Council of Ministers, 2020).

Method

A more detailed explanation of the approach to the literature searches is given in Appendix 1. A search strategy based on the method used for a systematic literature review has been conducted. Four key terms – older people, LGBTI, Nordic and healthcare/social care – were used to create search strings with synonyms and related terms. The searches were separated into two different search queries. Search query 1 aimed to find literature on the living conditions of older LGBTI people in the Nordic countries. Search query 2 aimed to find literature on the competence of healthcare and social care staff in their interactions with LGBTI people, or knowledge about the situation of LGBTI people in healthcare and social care study programmes, in the Nordic region. Supplementary interviews with academic staff at higher education institutions as well as providers of CPD were also conducted to supplement the literature search in sub-study 2.

The searches were limited to literature published between the years 2012 and 2022, and were conducted in the databases Scopus, PubMed, Gender Studies Database, and PsycINFO for search query 1; and supplemented with searches in Education Research Complete and ERIC for search query 2. The time span was chosen in light of how there have been relatively large societal changes regarding LGBTI rights that affect living and ageing conditions in all the Nordic countries, as well as in certain autonomous regions from 2010 onwards. It is worth noting that there have been changes during this period of time, and that the time span is for publications, not collected material. This means that the included studies may have empirical data older than from 2012. The time span also means that studies that are currently ongoing are not included. For example, the Swedish National Board of Health and Welfare and the Public Health Agency of Sweden have been working on mappings of older LGBTI people and knowledge about LGBTI issues within elder care in the context of Sweden during 2022–2023. Their final reports will be published in autumn 2023.

Due to the geographical limits on the subject, searches in each of the languages were also carried out in the search services of the various Nordic countries for scholarly publications. The search resulted in a total of 1671 hits. The hits were reviewed at title and abstract level by the authors of this report in the screening program *Rayyan* in blind mode, followed by a second stage in which the full texts were read. Finnish and Icelandic language hits was reviewed by external reviewers. The inclusion criteria meant, among other things, that the included studies were to be empirical and focus on LGBTI people who were 65+ years old, and that the studies were conducted in one or more of the Nordic countries. Finally, a total of 25 scholarly publications were included for Part 1 and 22 publications for Part 2.

In addition to the database searches, targeted searches for so called grey material were also made on the websites of relevant public authorities and organisations. For each Nordic country, two self-programmed search engines were created. The full texts were selected and reviewed from the first 50 hits of the searches. In total, the searches for grey material resulted in 8 included publications for Part 1 and 9 publications for Part 2. In addition, 5 publications were included on recommendations from the reference group and others. A total of 38 + 31 publications were included as the basis for the report.

A thematic coding was developed in collaboration between the researchers during the process of close reading of the abstracts, which further contributed to clarifying the inclusion and exclusion criteria and the limits for these. This was also further developed in the process of reading the full texts. The next step in the thematic analysis was taken after close reading of the included full texts and discussion of the proposals for thematic categories in the literature selection in each sub-study (Braun & Clarke, 2006, 2019).

For search query 2, a contextualising mapping was done of the documents regulating the knowledge and skills requirements for relevant health and social sciences professional qualification study programmes in different Nordic countries. Nineteen in-person and online interviews and e-mail interviews were also conducted with academic staff who teach in the health and social sciences professional qualification study programmes included in the study; and with people who provide CPD courses on gender, sexuality, norms and LGBTI ageing for professionals working in municipalities or civil society actors, in particular in Finland and Iceland where few or no publications were found in the literature searches.

A photograph of two individuals in an indoor setting. On the left, a person with short dark hair and glasses stands behind a wooden podium. They are wearing a black jacket over a vibrant, multi-colored striped t-shirt. On the right, an older person with short grey hair and glasses sits in a chair, looking towards the camera. They are wearing a dark blue and black plaid shirt. The background is a plain, light-colored wall. The text 'Part 1 Research overview of the living conditions and experiences of older LGBTI people' is overlaid in white on the lower-left portion of the image.

**Part 1 Research overview
of the living conditions
and experiences of older
LGBTI people**

Introduction

The overall aim of the first part of this report is to contribute greater knowledge about the living conditions and quality of life of older LGBTI people, in particular in their interactions with health and social care, in the Nordic countries. The research overview has been based on the following questions: What knowledge is available about older LGBTI people's interactions with healthcare and social care services in the Nordic countries, and what does this knowledge tell us? Since the studies that specifically investigate older LGBTI people's interactions with and experiences of healthcare and social care are very limited in a Nordic context, the focus was broadened to research concerning older LGBTI people's life experiences and living conditions in a broader perspective. This was also done because factors such as previous experiences of discrimination, openness about their sexuality/gender identity, health status and relationships affect how interactions with healthcare and social care are experienced.

In this part of the report, the research and knowledge that highlights older LGBTI people's own experiences are the focus. One criterion for inclusion of the texts in this part was that they should contain LGBTI people's own experiences in the form of their participation in, for example, survey studies or through interviews. In the full text reading stage, we found several publications that included LGBTI people between 60 and 65 years of age, which meant that we decided to include these as well. The overview thus contains texts with empirical data from the Nordic countries that included LGBTI people aged 60 years or older, and which were presented in a way that makes it possible to deduce something about that group's experiences. There were both quantitative and qualitative studies where the results were not reported in a way that it was possible to deduce something about the specific group, for example where people of all ages were included, but where the results were reported as general and it was therefore not possible to specifically identify older people as a group. This also occurred in qualitative studies where, for example, LGBTI people of all ages were included, but where age was not specified when quotes or empirical data were presented. These studies were excluded in light of the fact that the research shows that there are often big differences between age groups among LGBTI people (2016, 2022; Zeluf et al., 2016).

An additional purpose of the research overview is that it should result in concrete recommendations that can improve the quality of life for older LGBTI people, primarily in their interactions with public healthcare systems and social care. This first part ends with a list of recommendations that are highlighted in the studies.

Age, generation and life course

Since the research overview concerns older LGBTI people, we want to briefly discuss the importance of age, generation and life course – all of which are key concepts for an understanding of the lives of older LGBTI people. Age becomes relevant in multiple ways here, where ageing and being in the latter part of life constitute a particular experience and position in one's life course, but also because of having experience from a life lived at a certain time in history and characterised by the social and cultural discourses that have surrounded it.

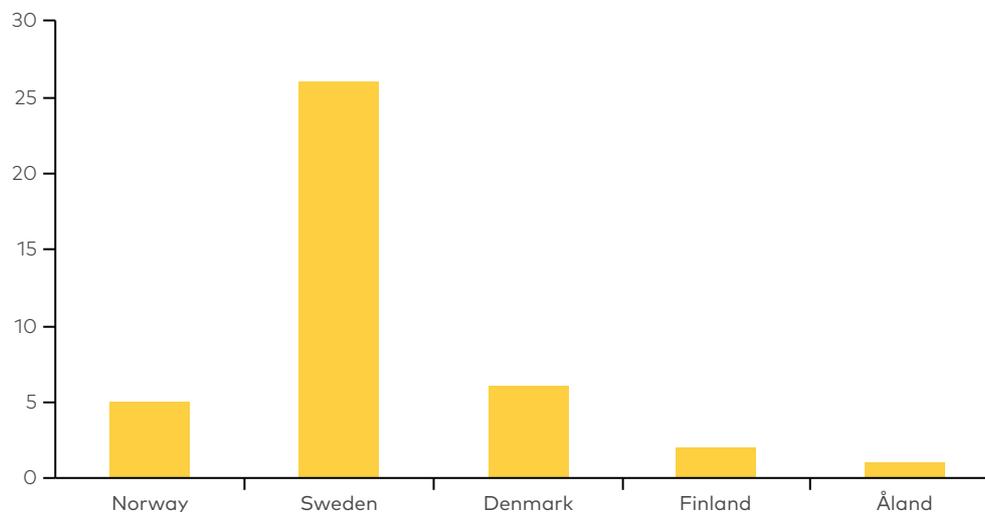
Usually, we understand age as chronological age, a way of measuring life, but age is also a basis in the social order. Structurally, this can be seen in how different age groups are rewarded, prioritised and given different power in the society. In everyday encounters, age often plays a role in how people are treated and what assumptions are made about them. Ageing occurs throughout life, where the body is constantly changing from the time we are born to the time we die. In other words, age and ageing are at once physiological and social processes (Andersson, 2008; Närvänen, 2009; Siverskog, 2016). Norms for ageing and ideas about what it means to be older also change over time. In pace with demographic changes, where more and more people are living longer, we can see how the post-retirement period is expected to be an active time, with a focus on self-actualisation and the consumption of experiences and products. These ideals bear traces of the focus on 'active and successful ageing' that has dominated gerontology, but are also characterised by capitalist interests that have established a new clientèle to which products to avoid ageing can be marketed. This period – the time after retirement for as long as you can manage yourself without help in everyday life – is sometimes referred to as the third age, while the fourth age represents a period of illness, where you become dependent on others for help (Andersson, 2009; Gilleard & Higgs, 2000). We live our lives in specific historical periods, where the historical context marks the time in which we live and where important things in our lives can mean different things depending on when in history they occur (Elder, 1994). Being a young LGBTI person today in the Nordic countries means something different compared to being a young LGBTI person in the 1930s. Society also changes over a person's lifetime, which is particularly evident in the case of those who belong to the oldest generations of LGBTI people today. The social and legal situation, as well as the conditions for living as an LGBTI person, have changed radically during their lives in the context of living in a Nordic country. For example, different historical times have meant different conditions for living openly as LGBTI. Multiple factors play a role concerning the question of living openly, where the individual's experiences are marked by when they came out during the course of their life – and possibly also when they came into LGBTI contexts. Different times have been marked by different norms, where discretion in relation to the outside world was long seen as self-evident for LGBTI people. It was not until the 1970s and 1980s that new ideals of openness emerged, especially in the context of (homo)sexual politics.

Decriminalisation, depathologisation, more places to meet, greater visibility, increased rights and a shift in the discourse around LGBTI have also created different conditions for openness over time (Lindholm & Nilsson, 2005; Siverskog & Bromseth, 2019). This is indicative of the fact that there are differences based on age within the group of older LGBTI people, where the very oldest have lived in a different context than those who have recently retired from working life. In addition to chronological age, it has a bearing on the point in life when the person came out, and whether or not this was into an LGBTI context. Those who are older today carry experiences from different times, which often affects how they relate to the healthcare system and social care and life after retirement for example, where age, generation and life course all play a role.

Description of the state of the research

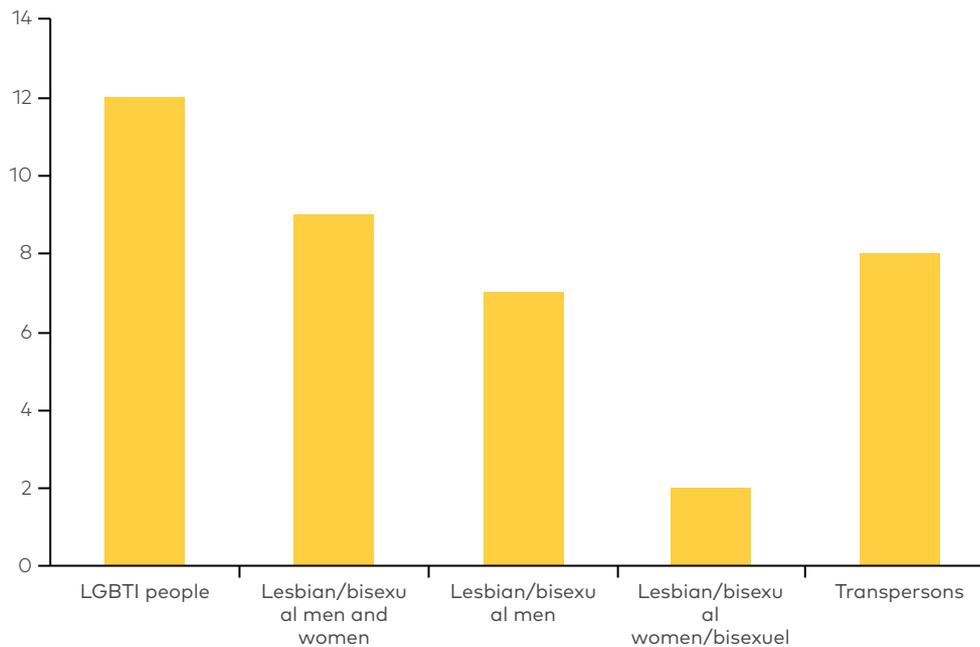
The research overview is based on 38 publications which include quantitative as well as qualitative studies published as scholarly journal articles, dissertations, anthology chapters, reports and books (described in more detail in terms of selection, method and focus in the overview in Appendix 2). Publications from Sweden dominate in number. Norway and Denmark are also well represented while there are only two publications from Finland, one from Åland. No publications from Iceland, The Faroe Islands or Greenland are included in the review (see the table below). However, if we look at other research areas, such as Nordic research on the health and well-being of young LGBTI people, we can see that results from some of the Nordic countries are often relevant in other Nordic countries' contexts, as the countries have seen similar historical developments and have similar welfare systems (Nordic Council of Ministers, 2021).

Publications in their respective contexts



Some studies are based on national public health data where several hundred older LGBTI people are sometimes included in the sample. But the vast majority of studies consist of qualitative interview studies that include a smaller number of people. The majority of the studies focus on lesbian, gay and bisexual people, but there are some studies that also include transgender people or focus solely on transgender people (see table below, which concerns the number of publications not the number of studies, and where many of the publications are often based on the same studies).

Focus/selection among the studies



However, research concerning older people with an intersex variation has proven to be non-existent. There are also few studies internationally on older people with intersex conditions, which may have to do with the fact that intersex conditions are often brought to light at birth or in adolescence, and that research on experiences of living with intersex conditions is generally inadequate. This is despite the fact that these people often have experiences of surgical interventions and hormone therapy without consent, which then has consequences for the rest of their lives, but is rarely followed up (Berry & Monro, 2022). As Latham & Barrett (2015) point out, older people with intersex variations may have been on hormone therapy for many years, have traumatic experiences from the healthcare system, and have concerns about future care needs, especially for intimate care when the body is exposed (Latham & Barrett, 2015).

Experience of discrimination during their lifetime

This introductory section deals with experiences of discrimination during LGBTI peoples lifetime, and includes both current and past experiences. As mentioned earlier, the historical context in which older LGBTI people lived their lives entailed different conditions than those that we see today. Previous experiences of discrimination can also mark a person's life when they reach old age and affect how they relate to the healthcare system and social services.

In large public health surveys, when it comes to discrimination, compared to heterosexual men and women, a greater proportion of lesbian and bisexual women and men in the age group 64–84 years state that they *have been treated or responded to in such a way that they felt insulted during the last three months*. In the same age group, more than twice as many lesbian and bisexual women and men compared to heterosexuals reported that they *had been subjected to violence* in the past year (Public Health Agency of Sweden, 2014:108–109). No differences in the proportion who were *afraid to go out alone* were found between lesbian and bisexual women and heterosexual women in any age group. Among men, on the other hand, the proportion was greater among gays and bisexuals consistently across all ages (Public Health Agency of Sweden, 2014). There were slightly more lesbian and bisexual women (34%) compared to heterosexual women (32%) in the age group 64–84 who *had refrained from going out alone for fear of assault, robbery or other harassment*. For men, almost twice as many (16%) say that they had refrain from going out alone due to such fears compared to heterosexual men (8.8%) (2014:135). Among trans people aged 65–94, just over 20% sometimes refrained from going out for these reasons (2015:35). No women in the 64–84 age group stated that they had been *subjected to violence in public places*, while 0.5% of gay men reported this compared to 0.1% of heterosexuals. 17% of the age group 65–94 have been subjected to violence at some point *because of their trans experience* (Public Health Agency of Sweden, 2015:32).

The qualitative studies reveal experiences of being discriminated against in life on the basis of gender identity or sexuality in schools, workplaces, religious communities, voluntary associations and in public places. This can include anonymous notes in pigeonholes for mail at work, losing one's job because of coming out, encountering and needing to respond to homophobic or transphobic sentiments at work, or being subjected to physical violence or threats of violence in public places because of one's gender identity or sexuality. The historical context plays a role here, where criminalisation, pathologisation and times when different norms concerning gender and sexuality have influenced what a person can be and

say during different periods in history (Eggebø et al., 2019; Robertsson, 2013; Siverskog, 2016; Synnes & Malterud, 2019; Vesterlund, 2013).

Another difficult experience recognised in many studies is that people who have previously been close to the person cut off contact with them when that person comes out (Bromseth, 2013; Eggebø et al., 2019; Meggers Matthiesen, 2019; Siverskog, 2016). Below is an example where Viktor's sexuality influenced his relationship with his son, and had consequences for his relationship with his grandson:

My now 40-year-old son, he is homophobic, he is. And fully contemptuous of homosexuals. And my grandchild will soon be 12 years old, and we could spend time together, and I don't know if I can. I guess it's because... If I am going to spend time with his son, he absolutely must not know that I am gay. Then he would move heaven and earth, wouldn't he? Having to send your own son down here to a grandfather who is gay... (Viktor, 74-year-old gay man, in Meggers Mathiessen, 2019:39)

Here, Viktor's relationship with his grandchild has been made conditional on Viktor not being open about who he is. Another example is Lena, who lives in a rural area and who previously had good relations with her neighbours, often meeting them for coffee. After she was involuntarily outed as a trans person by her former partner, she was no longer invited home to her neighbours:

It gets kind of lonely, because "normal" people, they don't invite Lena to their homes . . . for coffee, because what would the neighbors think? Then that norm comes into play again; it can sort of be contagious in a way. (...) Yeah, but I think people feel that way, we can't invite Lena over for coffee, what would the neighbours say and think. (Lena, 65 years old, identified as trans, in Siverskog, 2016:138)

As in the examples, it can be children or neighbours who cut off contact, but it can also be partners, one's family of origin, grandchildren, friends and acquaintances. Another thing that emerged for many participants is that they have lost their rights to their children. This can include both losing custody of their child where the other parent used their sexuality as grounds for them not seeing their child, or having been a co-parent with a same-sex partner at a time when there was no legal right to continue having a relationship with the child in the event of a separation (Meggers Matthiesen, 2019:40; Siverskog, 2016:93).

Thus, there is a link between experiences of discrimination and openness, where openness involves risk-taking: a risk of harassment and being treated badly, and where previous experiences of discrimination can make it difficult to dare to be open (Meggers Matthiesen, 2019). Multiple factors play a role concerning the question of living openly, where the individual's experiences are marked by when

they came out during the course of their life and possibly also when they came into LGBTI contexts. As mentioned earlier, different times have been marked by different norms, where discretion in relation to the outside world was long seen as self-evident in the context of being lesbian, gay or trans, only later being replaced by ideals of openness. Among these individuals, it is common to have alternated between openness and discretion in different contexts and some were still doing so at the time of the interviews (Eggebo et al., 2019; Lindholm, 2013; Møllerop, 2013; Robertsson, 2013; Siverskog, 2016; Siverskog & Bromseth, 2019; Vesterlund, 2013; Alasuutari, 2020). Hiding one's gender identity or sexuality from the outside world is often associated with stress and anxiety. A gay man who hid the existence of his partner for twenty years tells of how terrible this was, to deny the most important person in his life and with it also his own life story (Törmä et al., 2014). There is more about openness in the section on interactions with the healthcare and social care systems.

In the qualitative studies, it is common for lesbian, gay and bisexual people to state that they were aware of their sexuality as a young person, but that it was seen as an impossible life choice because of the spirit of the times, to live as lesbian, gay or bisexual. Therefore, many entered into heterosexual marriages in order to live up to the expectations of the environment, to just pass as 'normal', or because it was seen as the only possibility of having children (Meggers Matthiesen, 2019; Robertsson, 2013; Siverskog, 2016).

In several studies, it was particularly common for trans people to have come out late in life, often after retirement (Löf & Olaison, 2020:261; Siverskog, 2016). At the same time, in the Public Health Agency of Sweden's quantitative study, it was most common among older age groups to have hidden their trans experience (2015:31). Coming out late in life is explained, for example, by the fact that they had seen it as unthinkable during their working lives, and there is more freedom in the period after working life to choose the contexts you want to be in, but also because society and views about being trans have changed over time. For some, it has meant decades of hiding their trans identity, including stories of hiding clothes, burning clothes, being secretive in relation to partners and children (Siverskog, 2016). For those who have undergone gender-affirming treatment, the doctors in the investigation have previously encouraged people to move to a new place and start over, and not tell anyone about their background. One such example is a man who underwent gender-affirming treatment in the 1970s and moved to a new place where he had only come out to a few people since the move. His doctor told him that he was "an expert at concealment", to which he replied: "I know, I have been practising all my life" (Siverskog, 2016:135). But it requires constantly explaining things away and making excuses, and he also states that he sometimes dreams of going to Pride or being part of an LGBTI context.

Experiences of discrimination, as well as opportunities to be open, affect a person's everyday life and well-being, which leads into the health of older LGBTI people.

Health

Mental and physical health among older LGBTI people is of course relevant to the need for contact with the healthcare system, social care and social services. In quantitative studies, we can acquire knowledge about major trends what sexuality and gender identity means for health and well-being among older age groups. When it comes to sexual health and experiences of living with HIV among older LGBTI people, this knowledge is also based on qualitative research and provides perspectives on their experiences as well as norms concerning gender, age and sexuality.

Mental and physical well-being: general patterns

The roles that sexuality and age play in mental and physical well-being have been investigated in data from national public health studies in Denmark and Sweden. When it comes to assessing one's own *general health*, there are no major differences among LGB people compared to heterosexual people in Sweden, where 57–59% of all people in the age groups 65–84 stated that they have good general health. A slightly higher proportion of lesbian and bisexual women (9.7%) in the age group report *poor general health* compared to heterosexual women (7%) (Public Health Agency of Sweden, 2014). Among trans people, 72% rated their health as good (Zeluf et al., 2016). In Denmark, it is more common among heterosexual and bisexual people (82–83%) to rate their health as good or excellent compared to lesbians and gays (74%) aged 60 years and older. This is also a lower proportion compared to younger age groups (Bindesbøl Holm Johansen et al., 2015:30).

Regarding *physical health*, the Danish study shows how there is a link between age and physical ill-health, where health becomes worse with age and worst at older ages, where 19% of lesbians/gays report poor physical health compared to 18% of bisexuals and 16% of heterosexuals in the same age group (Bindesbøl Holm Johansen et al., 2015). The Swedish survey shows how older lesbian and bisexual women are the group that report more often that they have *sedentary leisure time* compared to all groups of women. Older gay men also have a more sedentary leisure time compared to heterosexual men of the same age (2014:140).

When it comes to *mental health*, one can see how LGB people generally report poorer mental health compared to heterosexuals in the same age groups, but at the same time it is possible to see a correlation with age, where mental health improves with age even if these differences persist among older age groups (Bindesbøl Holm Johansen et al., 2015; Public Health Agency of Sweden, 2014; Gustafsson et al., 2017). In the Swedish study, in the age groups 65–84 there were

about twice as many LGB people who reported that they suffer from *severe anxiety, worry or anxiety and sleep problems* compared to heterosexuals (Public Health Agency of Sweden, 2014:146 et seq.). In the Danish study, 9% of lesbians and gays in the older age groups report *poor mental health* compared to 4% among bisexuals and 6% among heterosexuals in the same age groups (Bindesbøl Holm Johansen et al., 2015:32). Bränström et al. (2016, 2022) analysed how differences in mental health between heterosexuals and sexual minorities differ in different age groups based on Swedish national public health data. They show that the risks for anxiety and depression are higher among lesbians, gays and bisexuals throughout the life course, but that differences based on sexuality are simultaneously reduced as people age (Bränström et al., 2016, 2022). Also Zeluf et al. (2016) notes that when it comes to the health of trans people, the proportion of people reporting good health and quality of life increases with age (Zeluf et al., 2016:46).

The Swedish study shows how the proportion of lesbian, gay and bisexual men and women who have had suicidal thoughts at some point in the last 12 months decreases with age, but on the other hand is almost twice as large compared with the proportion of heterosexuals in the age group 65–84 (Public Health Agency of Sweden, 2014:150). One study based on register data in Denmark and Sweden explored completed suicide and the significance of living in a same-sex or heterosexual marriage (Erlangsen et al., 2020). Their results show that there was a higher rate of suicide among same-sex couples in all age groups, and for those who were 65 years and older, the risk was 2.5 times higher among same-sex couples. When looking at same-sex marriage in all age groups, those older than 65 had a higher rate of suicide compared to younger people (Erlangsen et al., 2020:79). Among trans people aged 65–94, 17% tried to take their own lives at some point and 11% seriously considered taking their own lives in the last 12 months. This had a clear correlation with age, where the risk of suicide dropped in the older age groups (Zeluf et al., 2018). 72% of trans people (of all ages) who have attempted to take their own lives responded that it was due to some part of the trans experience (Public Health Agency of Sweden, 2015).

The differences in health based on sexuality and gender identity are often explained by the theory of minority stress, i.e. the increased risk of psychosocial stress factors that being in a minority position can mean (Bränström et al., 2016, 2022). Gustafsson et al. (2017) also show how an unequal distribution of material resources (such as finances, position in the labour market and access to healthcare) were equivalent contributory psychosocial stress factors that explained differences in health based on sexuality. They argue that it is not just about exposure to stress factors, but also about social inequality which is related to the unfair distribution of resources such as money, social capital and power which may influence health factors (Gustafsson et al., 2017).

Sexual health

When it comes to sexual practices, sexual desire and sexual health, research on older LGBTI people tends to be largely based on gay men. The research focuses on different aspects ranging from norms and beliefs about sex and masculinity, consent, and changes due to prostate cancer to experiences of ageing with HIV.

In Hans Wiggo Kristiansen's qualitative study with fieldwork and life stories from 23 gay or bisexual men aged 60–85 in Norway, he investigated men's attitudes to sexual desire and sexual relationships. In the interviews, he found two mutually contradictory attitudes. On the one hand, some expressed resignation, that sexuality was something they left behind in line with 'ageing with dignity'. On the other hand, other men, often with pride, pointed out that they were still sexually active, and that they met younger men (Kristiansen, 2013).

In the case of experiences of sex without consent, this was explored among people aged 60–75 in Norway through a survey study. The results show how it was about five times more common among gay and bisexual men to have experiences of sex without consent during their lives. The study also illustrates correlations between experiences of sex without consent and anxiety and depression, decreased well-being and increased feelings of loneliness (Træen et al., 2020).

A Swedish interview study investigated older gay men's experiences of sexual changes after prostate cancer treatment in relation to their physical bodies, identity and relationships (Danemalm Jägervall et al., 2019). Physical changes as a result of the treatment were changed orgasms, inability to ejaculate and erection problems. In general, the stories are similar to other studies where heterosexual men were the focus. What differed, however, was the importance given to ejaculation in the studies, where the men talk about this as an important aspect of sexual pleasure, as a material manifestation of masculine sexual performance. Ageing was central to these stories, and understanding one's body and illness in relation to what was expected due to ageing. How the interviewees' sex life changed was also influenced by the relationships the men had. For those who had partners, there were stories about how practices such as physical closeness and emotional intimacy could be strengthened, while for those who sought temporary sexual contacts, impotence was an obvious problem (Danemalm Jägervall et al., 2019). In a Danish study in which 32 lesbian, gay and bisexual people aged 63–95 were interviewed, Paul, 73, tells how he felt invisible as a gay man after undergoing prostate cancer treatment. After the operation, he searched for information material that would give him answers about whether it was possible to have anal sex after the surgery, but the material he found was based only on heterosexual couples (Meggers Matthiesen, 2019:91-92).

Irene, a 70-year-old lesbian woman, says her sexual desire is just as strong now that she is older:

But I also masturbate and that keeps it alive. I think every woman should do this actually, keep it alive. (...) You get something, it's such a life-affirming feeling. (...) No, so I masturbate and Ingrid and I work with and re-evaluate our sex life as well and make something better out of it. So when we make love, those of us who are a bit older, then maybe the positions that we thought were good a while back are no longer good because, you might not be as flexible in bed so or maybe you should have another bed, maybe a somewhat firmer bed. So that's what we're doing. But you have to take responsibility for your own sexuality and keep it alive and I think masturbation is very good and now you can go to the pharmacy and buy machines, so it's fantastic if you can't manage it yourself in a different way. But it should be kept alive. (Irene, in Siverskog, 2016:209)

Here, responsibility for one's own sexuality is repeated, which reflects a contemporary discourse in which older people are increasingly being made responsible for maintaining an active sexuality, where this is made into a personal responsibility. The body is mentioned here, as in other interviews, as something that may limit the possibilities of certain sexual practices. The quote also mentions equipment beyond the body relevant to enabling sex, such as a firmer bed and vibrators.

Among the trans people in the same study, a frustration surrounding seeking sexual partners online is frequently expressed, and both needing to explain their (trans)identity along with an impending risk of not being seen as who they are. Sexual situations involve exposing the body which also poses a risk of being rejected. In these stories, it becomes clear how gender identity, sexual desire and sexuality are intertwined, where what and who you desire is also dependent on what and who you are allowed to be and become in those situations (Siverskog, 2016:213-215).

Ageing with HIV

Many of those who are ageing today and who were in lesbian, gay and bisexual communities during the 1980s have strong memories from this time and suffered major losses when HIV broke out (Åberg, 2018; Meggers Matthiesen, 2019; Siverskog, 2016; Vesterlund, 2013; Alasuutari, 2020). Thanks to the development of antiretroviral drugs, HIV is now a chronic disease and people age with HIV. In addition, more and more older people are diagnosed with HIV, which in turn means that more and more older people living with HIV interacted with the healthcare system and elder care (Åberg, 2018). Between 3% and 4% of men who have sex with men (MSM) are living with HIV in Sweden, compared to 0.06% in the general

population. Other sexually transmitted diseases (STD) such as syphilis and gonorrhoea are also more common in the MSM group. A Swedish survey of 656 MSM who had travelled abroad investigated their experiences of HIV/STD prevention (Qvarnström & Oscarsson, 2015). Few had encountered prevention campaigns in Sweden (5%) and abroad (23%), and a majority (58%) of the participants felt that there should be more prevention initiatives. Free access to condoms and lubricants was the initiative preferred by most the men. The oldest (60–75 years) participants (together with the youngest) were those who had the least experience of prevention initiatives (Qvarnström & Oscarsson, 2015).

A participant in a Norwegian study talks about how he lost his entire circle of friends and his partner because of his HIV diagnosis. He could not be open about his sexuality with his family because they had not accepted that he was gay. However, he received support and help through a support group organised by the Norwegian Directorate of Health (Eggebo et al., 2019:80). Another aspect is contact with doctors and primary care, where it may be necessary to be open about your sexual practices to get tested regularly. In a Danish study focusing on experiences from the healthcare system, a 70-year-old gay man talks about having anonymous sex and therefore wants to be tested for HIV annually. He talks about being well received by his doctor:

And he agrees, and says 'we'll do that, we'll do a test every year, and that's a good idea, and we'll protect you that way'. I think ... it is ideal ... that you don't think: 'God, I wonder what he's going to say' or you sit and package it all up and make up some kind of story, without being able to honestly say: 'this is how it is'. (Egede et al., 2019:57)

The study also includes examples of people who have seen other doctors or attended specific testing clinics in order to remain anonymous in relation to their regular doctors (Egede et al., 2019:92). In a Finnish study, there was an example where a bisexual man sought medical care for physical problems which led to a long process of investigations. He had a female partner at the time and was afraid to tell about his previous relationships with men for fear of discrimination. This meant that doctors missed testing him for HIV until late in that process. Geography also comes into play here, where people from smaller towns state that they are afraid of HIV testing because of fear of the local community's reactions and that the results from the test would not be confidential (Törmä et al., 2014). These fears, combined with the fact that prevention campaigns rarely target older people, increase the risk that older people with HIV do not detect it until a later stage in the disease when it has had time to progress. In addition, this also increases the risk of infecting others with HIV.

Although knowledge has improved over time, the stigma surrounding the disease persists in some instances. A gay man who received notification that he had HIV a few years earlier in connection with a heart attack says:

A person who has HIV should not have to feel dirty. I have cared for people who have AIDS myself. They suffered a lot before they could end their lives. They were alone too. It was a shameful disease. They were treated like rubbish and put into black sacks. (Åberg, 2018:143)

Even if those who are open about their HIV status identify this openness as an important political strategy, most are only open about it with those closest to them and otherwise hide it. Communities that include others living with HIV can be important for sharing experiences (Backer Grønningsæter & Skog Hansen, 2018). It is common for the disease to cause serious health problems, especially for those who were diagnosed before the more advanced drugs became available and for those who have been ill but have been diagnosed at a late stage in the disease. Among the participants in a Norwegian study on ageing with HIV, it was common to have experienced loneliness, anxiety and worry about one's own health, with several referring to themselves as 'long-term survivors' (Backer Grønningsæter & Skog Hansen, 2018).

When people living with HIV were asked what they think about ageing and how they saw the future, several of the participants expressed concerns (Åberg, 2018; Backer Grønningsæter & Skog Hansen, 2018). One said that he was "terrified" and because he himself had worked in elder care, he knew that medications were sometimes forgotten, something he was worried about because his HIV medication was so crucial. Another gay man who learned that he had HIV in 1991 said:

I am terrified of what is going to happen in the healthcare system and elder care. I'm very pessimistic. We cannot close our eyes to the facts. There are, of course, rays of hope here and there. If I need to go into a nursing home, I want to be able to talk openly about my life and my HIV" (Åberg, 2018:51).

Here, both life as a LGBTI person as well as his HIV status has become something he wants to be able to live openly with. The participants also agree that the healthcare system and social care system must have knowledge about HIV (Åberg, 2018). They also have in common that they often have extensive experience of contacts with healthcare and social care. This leads into the next section, which deals more specifically with past experiences with these systems as well as thoughts concerning future contacts with healthcare and social care.

Encounters with healthcare and social care

This section focuses on the studies that deal with encounters with social services, healthcare and social care – both earlier in life as well as at the time of participation in the studies. Firstly, previous care experiences that the people had during their lives are discussed, and followed by discussion about experiences of elder care or apprehensions about going into elder care. In this section, qualitative studies dominate. In the Swedish public health survey, fewer lesbians aged 65–84 (14%) reported *low trust in the healthcare system* compared to heterosexual women (19%), and this figure was 22% for gay men compared to 18% for heterosexual men. When it comes to *low trust in social services* (within which elder care falls), the proportion of lesbians (32%) was slightly higher than that of heterosexuals (27%), while 44% of gay men reported low trust, compared with 34% of heterosexual men (Public Health Agency of Sweden, 2014:117-122).

Previous experiences of healthcare: (Hetero)normativity and ignorance

The previous experiences you have had in your life from interactions with healthcare and social care can play into your expectations and fears concerning what your future interactions with healthcare and social care as you age will be like. Historically, LGBTI people have often had a poor relationship with the healthcare system as well as psychiatry, where medical theory and practice have actively created notions of social normality and deviation – what is healthy and sick (Møllerop, 2013). This has been particularly apparent through pathologisation, i.e. how psychiatry has classified homosexuality as well as trans expressions as forms of mental illness (Törmä et al., 2014).

When it comes to trans people, they often have a specific relationship with the healthcare system since needing trans care have often required a need to undergo an investigation and get a diagnosis for the right to care. This process is very often described as difficult to navigate, characterised by binary gender norms and demanding for the right to what one wants (Egede et al., 2019; Linander, 2018; Siverskog, 2014, 2015, 2016; Törmä et al., 2014). Geography also comes into play here, where proximity to trans care is important. In Åland, for example, trans care is often provided elsewhere, with people being referred to Helsinki, Tampere or Stockholm, where it takes a long time to get a referral. It can be difficult to get support in Åland during this process for mental health care for example (Government of Åland, 2019).

Undergoing a transition as older may mean special experiences. While it is common among older trans women to have come out after retirement, many who wish to undergo surgery have been forced to realise that their health puts a stop to the interventions they would like. This can include heart problems making the narcosis required to undergo the surgery you want impossible (Siverskog, 2016:115–116; Törmä et al., 2014). But it can also include encountering ageist notions during the trans investigation where the necessity to undergo a transition is questioned because the person 'does not have that long to live' (Siverskog, 2016; Linander, 2018).

In a Danish study, several participants recall a time when homosexuality was categorised as a mental illness, how they encountered notions of homosexuality as a nervous disorder, symptoms of psychosis and uncertainty about their gender identity. (Vesterlund, 2013). The fact that it was classed as a diagnosis also affected whether people sought counselling for how to relate to their sexuality. One participant tells about how he needed support, but did not want to be registered based on his sexuality and therefore avoided seeing a psychiatrist despite mental health issues (Vesterlund, 2013:124–125). In a Norwegian study, an older lesbian woman remembers that this diagnosis limited how possible it felt to be open about one's sexuality. That being declared an illness meant that lesbianism was not associated with pride but rather with a category that one did not want to belong to. For gay men in a Norwegian context, it also meant criminalisation, which all in all contributed to the ideal of discretion discussed in previous sections (Eggebo et al., 2019:79).

Homophobia or transphobia may also have been encountered earlier in life in contacts with healthcare and social care, which participants in several qualitative studies describe. In the worst case, this has consequences in the form of people not seeking the care they actually need (Meggers Matthiesen, 2019; Møllerop, 2013; Siverskog, 2016; Törmä et al., 2014). Examples of this are in the Törmäs et al. study (2014) where a couple with one of the partners having dementia had refrained from seeking care because they were afraid of how they would be treated. The study also shows how relatives in same-sex relationships sometimes refrained from attending healthcare appointments with their relative as support to avoid the risk of discrimination (Törmä et al., 2014).

Openness is often highlighted as an important strategy in encounters with healthcare and social care (Siverskog, 2021; (Meggers Matthiesen, 2019). However, to what extent people are open varies / (Siverskog 2021; Löf & Olaison, 2020). Some stress that you need to trust the staff if you are going to come out to them. A lesbian woman talks about feeling out the atmosphere first and trying to sense if she thinks the person will take it well (Löf & Olaison, 2020: 257). Older LGBTI people experience that social services and the healthcare system are characterised by heteronormative and gender normative thinking. This is expressed in the

assumption that everyone is a heterosexual cis-person, which in turn renders LGBTI people invisible. Examples of this are forms that need to be filled in with only two gender options, and where there was no option to fill in civil partnerships even before marriage was possible for same-sex couples. The participants also feel that appropriate language and knowledge about LGBTI identities is lacking, which renders them invisible and creates a silence that in itself is perceived as discrimination (Törmä et al., 2014).

In coming out, there is also a tension between invisibility and hypervisibility. Coming out can entail a feeling of security – being seen for who you are – but at the same time there is resistance to being stereotyped and reduced to one's LGBTI identity (Eggebo et al., 2019:36). One trans person describes what this can look like in practice: their experience is that as soon as they have told the healthcare staff about their trans identity, confusion often ensues and they have difficulty completing what they are doing; their trans identity suddenly takes all the focus and what the care visit is about ends up in the periphery (Törmä et al., 2014).

In qualitative studies, especially among older trans people, it is common that they express frustration and weariness at having to educate the healthcare staff they encounter (Bindesbøl Holm Johansen et al., 2015:83 ff.; Löf & Olaison, 2018; Siverskog, 2014, 2016; Törmä et al., 2014):

We're so tired of instructing people who are going to take care of us (...)
We don't come from another planet. We're normal people and just
happen to have this little extra thing. (Löf & Olaison, 2020:259)

Some participants describe having the habit of bringing information leaflets about transgender to head off ignorance and avoid repeating themselves again and again. Even during the trans investigation, some had encountered people with poor knowledge, such as speech therapists and counsellors (Siverskog, 2014, 2016). Several participants say they have been referred to by the wrong name, gender and pronoun. In some cases, trans people have experienced a direct unwillingness from the healthcare system to help them because of their trans identity, having experienced that doctors did not want to examine or treat them. Medical centres have also refused to take blood tests related to the trans process. For some trans people, this has led to them seeking out private clinics and many trans people get private health insurance to be able to choose clinics and doctors that they know have trans competence (Törmä et al., 2014). It is repeatedly emphasised in the studies how important it is that there is LGBTI competence in health and social care.

The equal treatment perspective, which has been strong in healthcare and social care, is problematised in several studies because it risks leading to excluding LGBTI people in rendering them invisible. The idea that everyone is equal often contains assumptions about heteronormativity (Löf & Olaison, 2020:258; Siverskog, 2021).

Apprehensions about and experiences of elder care

The time after retirement can mean increased opportunities to choose for yourself which contexts you want to be in and which people you want to have around you, which in turn can lead to greater opportunities for openness. But a greater need for social care can instead mean that these opportunities decrease and that one's home also becomes someone else's workplace (Siverskog, 2021a). At the time of their interviews, the vast majority of the participants in the qualitative studies were not in need of elder care, but some studies (Löf & Olaison, 2018; Meggers Matthiesen, 2019) include people receiving elder care interventions, and one study focuses in particular on LGBTI people with elder care interventions (Siverskog, 2021a, 2021b).

Among those who do not yet need social care, many express apprehensions about what it will be like when that time comes when they will need social care from others. While all older people can be worried about illness, dependence, impairments in their capacities, and needing to move to an institution, there are additional worries that are specific to the LGBTI group. These worries are linked to fears of a lack of knowledge about LGBTI in elder care, and of being poorly treated due to their gender identity or sexuality by other residents or staff. This can include fears of being discriminated against by healthcare staff, not getting help with what is important for them in relation to their gender identity, being rejected as a care recipient, getting dementia and losing the capacity to tell the staff what is important to them, worry about what will happen with their hormone therapy, worry about not having their relationships recognised or being able to be open and maybe even having to 'go back into the closet' again (Lindholm, 2013; Meggers Matthiesen, 2019; Siverskog, 2014, 2016). Lindholm understood this worry as being based on how elder care, and in particular residential aged care, being seen as a heteronormative institution and their opposition to moving to such an institution can be understood as resisting conforming to its heteronormativity (Lindholm, 2013). In addition to a general concern about the quality of elder care, Meggers Matthiesen interprets this worry as being about encountering homophobia, i.e. negative attitudes or behaviours towards lesbian, gay or bisexual people, while finding it difficult to defend themselves or fend off these behaviours (Meggers Matthiesen, 2019).

Those who do have experience of elder care describe a general silence around gender identity and sexuality in their care, which can be understood from different aspects. On the one hand, this is about the fact that elder care has been subjected to cuts and efficiencies for many years, which has put pressure on working conditions in the sector, which in turn leaves little room for conversation in everyday life between staff and care recipients. It is also about norms, about care as a desexualised place where sex is not something that is talked about. This silence, along with heteronormativity, leaves the entire responsibility for coming out or

highlighting LGBTI perspectives on the care recipients (Siverskog, 2021a, 2021b). For those who receive the home care service, this can be trying because so many different individuals visit your home. Among those who are open about their LGBTI identity, this is highlighted as important. It can be about coming out verbally, but also manifesting one's LGBTI identity through art, books, photos and images (Meggers Matthiesen, 2019; Siverskog, 2021a). Openness is emphasised as a strategy, a way of taking over interpretation of the situation and forestalling it. However, this often involves being always ready to act in response to being treated poorly. Several participants said that if they were to encounter homophobia, they would object and emphasise that this is their home, and homophobes are not welcome there (Meggers Matthiesen, 2019; Siverskog, 2021a).

However, not everyone is open about their sexuality or gender identity in elder care. There are several examples of people being open about it earlier in life but not being open in the context of social care. One example is Helle, a lesbian woman aged 78 who had lived in a nursing home for four years at the time of her interview. She said that she wonders regularly about why she has not dared to come out of the closet in that context and feels that she is "a bit cowardly" (Siverskog, 2021a:106). In a Norwegian study, one of the participants describes how;

One of the founders and pioneers of the Norwegian LGBTI struggle died in an institution, old and lonely. None of the staff nor the other residents knew that he was one of the many activists who were behind and established the entire LGB movement in Norway. He went back into the closet. It's sad and disgraceful. (A woman in Møllerop, 2013:292).

The issue of special LGBTI nursing homes comes up in several studies and throughout, the participants' feelings and thoughts about this are mixed. While some see this option as welcome and something that guarantees freedom from homophobia and transphobia, as well as being able to share experiences with other residents, others are more hesitant, or not interested (Löf & Olaison, 2018; Meggers Matthiesen, 2019; Siverskog, 2016; Vesterlund, 2013).

Another thing that emerges from the interviews is how elder care contexts, and in particular nursing homes, mean reduced privacy and dissolved boundaries between the private and the public something that can be of great importance for older LGBTI people in light of how their own home has often been a haven in a heteronormative world. This is mainly about staff knocking but not waiting for an answer before entering, which means that perceived opportunities for intimacy and sexual practice are limited (Siverskog, 2021a, 108 et seq.). Access to participation in LGBTI contexts can also be more difficult due to older people's care needs. This is exemplified by not having access to the internet in connection with moving to a nursing home, which caused one participant in Siverskog's study to lose all contact

with their LGBTI community. Or that because the home help service rarely arrives on time, other activities, such as participation in a senior LGBTI group, sometimes need to be cancelled (Siverskog, 2021a). This leads into the importance of relationships, social networks and LGBTI communities.

Relationships, networks and LGBTI contexts

From international quantitative research, we know that older LGBTI people who feel they have social support and feel a sense of belonging in the LGBTI community have better health, as well as lower levels of depressive symptoms and perceived stress (Fredriksen-Goldsen et al., 2013). Studies concerning young LGBTI people also demonstrate the connection between having good relationships and well-being (Alanko & Lund, 2020; Thorsteinsson et al., 2017). Relationships and networks are not least important when it comes to having social and practical support in everyday life – as informal carers, and as support in relation to contacts with healthcare and social care. In this section, firstly quantitative studies of relationships and networks are highlighted, followed by a focus on families and close relationships, and finally a discussion of LGBTI contexts.

LGBTI relationships: General patterns

A couple of quantitative studies indicate some general patterns in older LGBTI people's relationships and networks. In the Danish national public health study, a larger proportion of LGBTI people over the age of 60 report that they *rarely or never have contact with family they do not live with* compared to heterosexuals of the same age, where the figures are 6% for heterosexuals, 10% for lesbians and gays, and 25% for bisexuals. For the item *rarely or never have contact with friends*, the proportions for heterosexuals and bisexuals are similar, with a slightly higher proportion among lesbians and gays. Even when it comes to those who experience *involuntarily loneliness* at times, a slightly higher proportion of gays and lesbians report this compared to heterosexuals and bisexuals. In the Swedish public health survey, the results show how lesbian women aged 64–84 are the group where the most people (33%) reported *low social engagement* compared to heterosexuals of the same age and women of all ages. Even gay men in the same age group more often reported low social engagement compared to heterosexual men of the same age and younger men. (Public Health Agency of Sweden, 2014:116). When it comes to *trust in most people*, the numbers are slightly higher among lesbians and gays compared to heterosexual women and heterosexual men (2014:117).

When it comes to *the possibility of receiving practical support and help in case of illness*, fewer gays and lesbians *do not* expect to receive help, compared to bisexuals and heterosexuals. When asked if they *never or almost never have anyone to talk to*, 4% of heterosexual responded in the affirmative, with this figure being 5% among lesbians and gays, and 9% of bisexuals (Bindesbøl Holm Johansen et al., 2015). In a Swedish context, a much higher proportion (11%) of lesbian women reported that they *lack practical support* compared to 3.7% of heterosexual women. Among men, the figures are more similar, being 5.7% for gay men compared to 5.2% for heterosexual men (Public Health Agency of Sweden, 2014).

When it comes to emotional support, almost half of the trans people surveyed between the ages of 65 and 94 said they lack support. Among gay men in the age group 65–84 years, the corresponding figure was 16%, which can be compared with 9–11% for lesbian women and heterosexuals in the same age group (Public Health Agency of Sweden, 2014, 2015:34). Bränström et al. (2022), who based their study on the 2018 Swedish public health survey, showed that the differences between homosexuals and bisexuals compared to heterosexuals in terms of *social isolation* were particularly great among older age groups. The proportion of lesbian, gay and bisexual people in their 70s who reported being socially isolated was three times higher compared to heterosexuals of the same age (Bränström et al., 2022).

In other words, the quantitative studies that exist indicate that older lesbian, gay and bisexual people are less likely to have contact with family and friends, and that they lack emotional support to a greater extent compared to the rest of the population in a Danish and Swedish context. A much higher proportion of older trans people in Sweden lacks emotional support. In the qualitative research, relationships, family and community in LGBTI contexts are often central themes.

Chosen (and non-chosen) families

In the qualitative studies where relationships with original families are discussed, experiences often differ among the participants. Some have been accepted and have good relationships with their original family, while others have struggled to be acknowledged and understood in those relationships. As discussed in the previous section, it is a common experience that family, relatives and friends have distanced themselves from you when you come out about your sexuality or gender identity. Sometimes it is the individuals themselves who have finally broken off contact as a strategy to avoid encountering homophobia or transphobia (Bromseth, 2013; Meggers Matthiesen, 2019; Siverskog, 2016). Relationships with one's family of origin are often conditioned by heteronormative premises and interpretative frameworks for what counts as acceptable and valuable relationships (Bromseth, 2013).

Some participants in the qualitative studies have children from previous relationships. Among these, relationships with their children have been unproblematic for some, while others have had difficult relationships. As previously discussed, some have lost custody of their children because of their sexuality or the children may have broken off contact with them over the course of their life (Meggers Mathiessen, 2019:40; Siverskog 2016:93). Others maintain relationships with their children, but these relationships are sometimes conditional on not being able to be fully open.

Then things calmed down with the children, but when they married more problems arose, and the grandchildren – we can't tell the grandchildren, it has been kept secret that I am... now and we are... now 'we just live together', I live with a (short laugh) female friend. (Eila, 77, in Bromseth, 2013:63)

As Bromseth writes, heteronormativity is part of the picture and influences how the person navigates everyday life and shapes their close relationships (2013:63).

Something that is frequently highlighted in the research on older LGBTI people is how chosen families are commonly seen as significant and important. This entails a notion of family that goes beyond blood ties and kinship. Often, friends are given an important role in this context. An example is Irene, a 70-year-old lesbian woman who says "my family is my circle of friends". She also points out that blood relations can be important, but one "cannot always find kindred spirits among them" (Irene, in Siverskog, 2016:186). Vigdis, 68 years, expresses the same views:

And we usually say, Hillevi and I, that we have our own family. We have no children, and not very many relatives left, but we have a lot of acquaintances and some good friends. They are the ones who are our family. And we think that feels very good. (...) They have also been chosen by us to some extent. You don't choose your relatives. (Vigdis, 68 years, in Bromseth 2013:53)

What Vigdis stresses, that one doesn't choose your family of origin, becomes important to understand in light of what was discussed in the section on discrimination and openness, since many older LGBTI people have experienced that their family of origin (and others) distance themselves from the person when they came out. This is seen again in more studies:

Sometimes I think that maybe, even though I don't have any children myself, we are in some ways more privileged because we have had to choose our lives, we have had to choose our... well, a kind of chosen family. Whether it has been through the LGBT organisation or through a mixture of all these [communities]. (Gitte, 71 years old, in Meggers Mathiessen, 2019:34)

These relationships can of course also include the person's biological family, but as the quotes show, they are often constituted by relationships with partners and friends who provide social and practical support in everyday life. What is different here is that friends, and not infrequently ex-partners, are often reported as playing an important role and are highlighted as people that the person can count on for support and help in everyday life. Birgit, aged 69, explains that her ex-partners often remain in her life as close friends because the lesbian contexts in the 1970s were so small that it would have been too socially awkward to not get along well even if the love relationship ended (Meggers Mathiessen, 2019:33). Partners are often important of course, and sometimes these romantic relationships have been going on for several decades. Here, there can be differences between cis people in same-sex relationships and trans people, where for the people in same sex relationships, it means a shared experience of deviation from heteronormativity, where they can renegotiate norms together and share experiences and work out strategies (Siverskog, 2016:92; Bromseth, 2013:62; Eggebø et al., 2019:61et seq.). However, a person who identifies as transgender who has or has had romantic relationships with cis people cannot share experiences of being trans and deviating from cis norms (Siverskog, 2016:92).

Having a same-sex partner has not necessarily meant being acknowledged and confirmed by the environment surrounding the person. The studies show how heteronormativity creates different conditions for those who do not have relationships that conform to heteronormativity. One participant in the Norwegian study talks about how she was not seen by employers and her surroundings in her lesbian relationship: "Being treated like someone who was alone was the hardest thing. They deducted pay on the day I was going to attend my partner's funeral" (Møllerop, 2013:287).

Even for those who have had close, supportive relationships, ageing can mean that many of them pass away (Eggebø et al., 2019; Siverskog, 2016)). Sture, a non-binary transperson aged 76, says: "You have to realise that the older you get, the more alone you are" (Sture, 76, in Siverskog, 2016:237). Another participant says:

A lot of people have died (...) And I have lost... most of my close friends. (...) Precisely those you might have talked to a lot and had a lot of contact with and been able to discuss things with that you can't talk about with anyone else. That's what you miss the most. (Maj, 68 years, in Siverskog 2016:237)

As Maj says, shared experiences, memories and relationships are lost when those who have previously been close pass away. As mentioned earlier, many of those who are older today were also part of the LGBTI community during the time of the HIV and AIDS epidemic that impacted gay men in particular, many of whom experienced the loss of loved ones. Aksel, 65 years, says: "Jeg kan navngive i hvert fald 30, der er forsvundet på den konto... det tror jeg også følger en, fordi det som egentlig skulle have været netværk, de er jo væk." (Meggers Mathiessen, 2019:55).

That period in time is marked by personal loss, fear and an intensified homophobia in the wider community. But it was also a time when fellowship in the LGBTI community collectively dealt with crises and losses through mutual support (Siverskog, 2016:180). These experiences can re-emerge in connection with needing social care and in relation to the end stage of life. One participant who is in a hospice talks about how the same people with whom he previously shared losses and political struggle are there for him now:

We lived a very social life with those who were in the fight, they are the ones who have come to see me now that I am in here. That's been really great. Then you can also say that there are many older people who have been sick and died from AIDS and had, we have friendships that have been with them and taken care of them right to the end. So that has well, you have to say that, before it is too late, you have to get yourself social contacts, social contacts, social contacts, social contacts, social contacts, social contacts. That's been my mantra to everyone. Then, then, then you will have a good old age. (Inge, 88 years, in Siverskog, 2016:88)

But even though many older LGBTI people are part of what they refer to as chosen families and have strong networks and relationships, far from everyone has stories of being alone, voluntarily as well as involuntarily, are present in the studies.

Many people complain that they are alone, and that they can be alone even with their partners and in all sorts of contexts. Yes, I tell them, I know that but when I get home on Friday afternoon it feels empty until Monday morning, unless I go out by myself. I mean I don't have anyone, I don't like that kind of thing, but just that kind of thing like going to a flea market, going to the theatre, well you know, you name it, how much fun it is when you go with someone. Just a friend. I can miss that. (Klas, 64 years, in Siverskog, 2016:200)

I don't think I'm alone in that way. I can feel lonely sometimes, but it's more because, as soon as there's a holiday, everyone is suddenly away. Then they choose family and friends and children. And I am left alone. I have nowhere to go during the summer holidays, Easter holidays, Christmas holidays... and then I feel lonely. It is such a sad realisation to come to. But I know it's true, it's in those situations that I'm lonely. (Søren. 65 years old, in Meggers Mathiessen, 2019:55)

The feeling of loneliness can be especially acute during family-oriented holidays and celebrations. Some people have large networks, but few supportive relationships of a more personal nature. Thus it is important to look at the quality of relationships. Other factors also play a role in the nature of relationships and networks: social, cultural and financial resources; whether a person lives in an urban or rural area; and proximity to communities (Siverskog, 2016; Bromseth, 2013). Many of those

with strong networks and chosen families have previously been involved in political movements, which in turn are often marked by middle-class experiences (Siverskog, 2016). Heteronormative language can also confuse and create uncertainty, for example in healthcare situations. In a Danish study, Søren explains how he would fill in a contact person in a healthcare context:

Even when it says 'next of kin' (banging the table anxiously) - and I can use none of them for that. And then I asked if I could write a friend there instead. It doesn't matter - there just needs to be a phone number they can call if something happens. But yes, I thought it was a bit strange. I sat and thought, that's how lonely people are. (Søren, 65 years old, in Meggers Mathiessen, p. 91)

Establishing new relationships in older age, finding new friends, can be perceived as more difficult (Siverskog, 2016:237). In the studies, those who live without a partner sometimes express a desire to meet someone, to share experiences and everyday life with as well as closeness and intimacy (Meggers Mathiessen, 2019:56 et seq.; Siverskog 2016:). There are also clear gender differences, where gay men are often confronted with ideals of youth in the dating world, where one's own old age causes one to decline in hierarchy and status (Kristiansen, 2013; Meggers Mathiessen, 2019; Siverskog, 2016; Vesterlund, 2013). This is not as present among women. Although accounts of ageism in lesbian contexts do occur, the lesbian movement has often been closely linked to a feminist movement where bodily ideals are often actively problematised (Siverskog, 2016:209 et seq.). In trans people's accounts of dating as an older person, as mentioned earlier, it is central that they should be seen as they want and wish to be seen, where previous experiences of transphobia are often a factor. Often they need to explain their trans experience and what it means (Siverskog, 2016:213 et seq.).

In legal terms, there is an additional important aspect here, as many older LGBTI people living in couples may not have entered into a registered partner or married due to past ideals of discretion, or because they got together in times where this was not legally possible. This in turn may mean that the person's chosen family have no legal rights if the person falls ill or dies. Instead, the person's biological family, with whom they may not have had contact for several decades, can become involved in important decisions regarding matters such as estates, care and funeral. This points to the importance of wills and other documents that set out a person's wishes (Alasuutari, 2020; Møllerop, 2013:291). In a Finnish study of LGBTI people's experiences of dying, grief and rituals, one of the older participants, Reino, describes how his ex-partner passed away. Although Reino was the heir to his ex-partner's estate, neither he nor his ex-partner's new partner were allowed to participate in the planning of the funeral. The biological family located the funeral in the small village where they lived, instead of in the city where this man had lived his life. During the funeral, Reino and the man's new partner were only allowed to

place their flowers last of all, in the hierarchical order that reflects an imagined importance of the mourners and recognises some and not others (Alasuutari, 2020:132 et seq.).

A participant in a Norwegian life-course study talked about when her partner passed away. The interviewer asked her if she was seen at the funeral as the chief mourner, whereupon she replied that she sat far back among the friends because the family saw her as nothing but a friend, and they also distanced themselves from her after her partner passed away (Eggebo et al., 2019:53). This rendered their relationship invisible, as well as her importance as a partner and their sexuality.

LGBTI contexts and community

Given the historical context, where LGBTI identities have been criminalised, pathologised and very often not socially accepted during the lives of older LGBTI people, LGBTI contexts have often been very important for LGBTI people. These can include political groups, bar and club environments and Internet spaces – places where gender identity and/or sexuality are a common denominator for the context. They have constituted places and contexts where LGBTI people have been able to find energy, strength and community, and have been experienced as havens away from heteronormativity, as well as places for political struggle. Often these contexts have been places where one could meet friends, lovers and partners, who have sometimes become lifelong relationships (Meggers Matthiesen, 2019; Siverskog, 2016; Siverskog & Bromseth, 2019). These contexts do not cease to be important to older people. On the contrary, older LGBTI people tell us that senior contexts (without an LGBTI focus) can often be experienced as 'hetero spaces' where they easily feel that they are rendered invisible, and feel excluded or isolated (Meggers Mathiessen, 2019; Møllerop, 2013).

Older LGBTI people have come out during different periods – and into LGBTI contexts in different periods. For those who came out in the 1950s and 1960s, the places where one could meet others were sometimes hard to get to and sometimes required proof of identity and/or being recommended by someone who was already a member. There are stories about LGBT clubs with closed curtains, advertisements with code words in newspapers where you could apply to be contacted. But once inside these environments, there were often very important contexts that felt freeing and sometimes quite life-changing:

I just felt that ALL the doors were opened at the Femø camps. I have never experienced anything so warm. And I met real people. The people I used to socialise with, part of my family - they treated me like an object. And down there I was treated like a real human being. (Herdis, 72 years old, in Meggers Mathiessen, 2019:63)

It was like being on fire - a cultural fire. It was a feeling of happiness that I have never experienced since. When we had a pride parade, and you suddenly find yourself in the middle of all these people in the same situation. We know each other, we can say hello to each other and we can kiss each other just because we are having so much fun. (Regitze, 85 years old, in Meggers Mathiessen, 2019:63)

For many lesbians, the women's movement has been an important context and the metaphor of finding context as synonymous with 'coming home' occurs in several different studies (Siverskog, 2016:173; Meggers Mathiessen, 2019:63). Metaphors that allude to family are also not uncommon. In Synnes' and Malterud's (2019) study of queer narratives from Norway, a 71-year-old male participant says:

One of the greatest joys I now have in life is to go to Pride weeks in Scandinavia's capitals. What joy to see people of all ages in the parade – people who eventually become aware that underneath all this joy and fun packed antics, is a deep and serious truth about oppression and injustice – both in today's society, and whose roots go far back in our history. These events are wonderful – heterosexuals and LGBTI friends, transgender people and others hold each other's hands and dancing down the streets. People from all corners of the world in perfect harmony! I stand there, always with a tear in my eye. It mirrors my hard past, but also reflects the joy in what I am now experiencing ... How many good and wonderful sisters and brothers I have, from all over the world! (Paul, 71 years, in Synnes & Malterud, 2019:109)

Paul refers to brothers and sisters from all over the world, and it is not uncommon to allude to family terms which in turn challenge nuclear families and kinship. here queer generations become instead a term spanning generations, where struggle and community intertwine them (cf. Siverskog, 2016:266). Many who have found friends and networks through LGBTI contexts have retained these over decades, and for many they constitute important supportive relationships in older age (Siverskog, 2016; Meggers Mathiessen, 2019:63-64). Lisa Blackman (2011) argues that the concept of the queer family allows us to imagine the bonds and connections that bind us intergenerationally and which therefore identify contexts that circulate through time and place. These connections are not always expressed or easy to articulate. But they are embodied in complex ways, creating lines that intersect generations to reveal how affect, trauma and shame are communicated intergenerationally (Blackman, 2011). Freeman (2010:64-65) has also written about how the concept of generation does not need to be based on family, but can, for example, be associated with political work that produce shared subjectivities and experiences that go beyond family.

As Meggers Mathiessen (2019:68) points out, meeting places for LGBTI people are often commercial bar and club environments in big cities, which are not necessarily

perceived as easily accessible places for an older target group. Some participants in the studies say that it can be more difficult to become part of a context when you have come out later in life, in particular for men because of the ideals of youth that often characterise those contexts (Vesterlund, 2013:133; Eggebø et al., 2019:83-84). But even women say that it can be difficult feel comfortable and at home in these contexts:

They ARE simply too young. No, I've been in and looked twice, but I don't really feel comfortable. It is too much of a bar environment (Pia, 63 years old, in Meggers Mathiessen, 2019:68)

I haven't been at the Mermaid Pride in many years, I think last time was in Copenhagen. And then I just felt "What am I doing here?" I walked there with two other ladies with grey hair and we looked at each other and then there was a lot of gay guys in spandex around us, I mean I felt I had more in common with the cops who walked there. (Kari, 65 years, in Siverskog, 2016: 211-212)

While in the first quote Pia has come out as an older person and has difficulty getting 'in', Kari in the second quote has been engaged in lesbian groups earlier in life, but the context that was previously important and felt like home suddenly does not feel that way anymore because of markers of age. Others feel that the contexts in which they once felt at home change over time, for example, there may have been a community around things that one fought for together – rights that are now self-evident. It can also be a feeling that the youth-dominated contexts are academic and that this in turn makes it difficult to be able to participate:

It gets lost, that class analysis, somehow. Because the feminist movement is driven by young academic women. But it is so academic! And you need to have studied gender studies for five years to participate. I mean, I've tried to read Judith Butler, but I can't get through it. I don't understand what she is saying. And I can read a page three times and not understand half of it. (Issa, 76 years, in Meggers Mathiessen, 2019:72)

Class, norms concerning age along with other structures intersect in LGBTI contexts and affect who can gain access, be seen and heard, and feel comfortable and at home. Even an ageing body and impairments can limit opportunities to participate in an LGBTI community, for example through impairments that make people abstain from rather than participate in contexts and thus make them feel isolated (Meggers Mathiessen, 2019:67). At the same time, there are accounts from older lesbian feminists about how they can feel appreciation from younger lesbians, because they have 'forged the way' and fought for liveable lesbian lives. Here old age becomes an asset and source of admiration, but reserved for those who have political capital (Siverskog, 2016:211).

While the research in the Nordic countries focuses primarily on gay and bisexual communities historically as well as now, there is less empirical research on older transgender people's experiences of organising themselves and their contexts. In Sweden, the first trans associations were formed in the 1960s and there were strict demands for anonymity:

You know when they started this association, at that time they couldn't say that they were trans. They could never show themselves, they would never go out, it was like a closed Rotary club sort of. It was a closed group. No one could get in, the doors were locked and then they sat inside talking and drinking coffee or drinking beer and so on. But today it's different, fortunately. (Lena, 65 years, in Siverskog, 2016:164)

You should know this association, when it started in 1965, we can say then, around that time, back then it was secret and then it was hush-hush and then it was all kinds of things. And yes, it was like that, so you thought what kind of sect is this, is it the Ku Klux Klan or what is it about? It was secret addresses and secret names and so on and it was. But then we've seen how things have developed today, that today it's actually... the goal is really then to dismantle this association the day when society becomes so tolerant that it does not matter what you're like, but that takes a long time. (Lily, in Siverskog, 2016:165)

Lily talks about how the context that existed was not really in line with how she identified herself. While she perceived herself to be a woman, there were strict norms in these trans groups for identifying yourself as a man, cross-dressing occasionally, and preferably living heterosexual life outwards. Nevertheless, these contexts, and the opportunity to meet others and be seen as you want to be seen, is experienced as very important, strengthening and significant (Fabbre & Siverskog, 2019; Siverskog, 2016:165). During the 1970s and 1980s, there was a trend within LGBTI contexts as well as trans contexts to separate trans(sexuality) from (homo)sexuality (Siverskog, 2016:168). In 2001, the Swedish umbrella organisation RFSL included transgender people as part of its target group, something that was not entirely unproblematic. The older transgender people in Siverskog's study say that they felt like they were being stared at by a lesbian, gay and bisexual audience, and that they often had to push for trans issues to be covered in their local RFSL groups. A non-binary participant says that they are careful to tell that they are heterosexual because there are "many members who believe that the lowest common denominator is homosexuality and it really isn't any longer. The lowest common denominator today is this that you are breaking what RFSL calls the heteronorm" (Kjell, 65 years, in Siverskog, 2016:170).

There is thus a difference in the early groups for trans people compared to those for gays and lesbians. The former often assumed that deviation from heteronormativity occurred temporarily in locked rooms, and the participants were

otherwise expected to live relatively heteronormative lives, while homosexual communities were based on a community characterised by metaphors of 'finding their way home' and 'family'. This created different entry points to contexts and communities that are often present as people age, where stories of chosen families and strong networks are not present in the same way in the accounts of older trans people (Siverskog, 2016).

In summary, this section has shown how older lesbian, gay and bisexual people are less likely to have contact with family and friends and more often lack emotional support compared to heterosexuals of the same age. Among transgender people, there is a much higher proportion of people who say they lack emotional support compared to cis gender people of the same age. This section has also shown how heteronorms have accompanied and stipulated the conditions for LGBTI people's relationships earlier in life as well as in older age, but how close relationships, chosen families and LGBTI contexts are highlighted as important havens from heteronormativity.

The final part of the report contains a summary of this first part and the recommendations that the studies resulted in. We summarise the knowledge gaps we have identified based on this report's results.

A photograph of two elderly men walking outdoors, holding hands. The man on the left is wearing a blue t-shirt and a brown cardigan. The man on the right is wearing a grey sweater, a white cap, and blue pants. The background is a blurred natural setting with trees and a path. The text is overlaid in the center of the image.

**Part 2 Knowledge
inventory of healthcare,
social care and social
sciences study programmes
and professions**

Introduction

The results in Part 1 conclude that the experiences of older LGBTI people point to serious shortcomings when it comes to being treated with knowledge and respect in the healthcare system. This leads to rights violations, invisibility, the wrong treatment and, in the worst case, to their refraining from seeking help. The purpose of the knowledge inventory in Part 2 is to investigate these experiences by looking at the knowledge and competence about LGBTI people's living conditions and gender and sexuality norms that exist in both health and social sciences study programmes and among healthcare and social care staff in the Nordic countries. In this part, we will look at:

- The central policy documents in the Nordic countries; above all, the formal knowledge requirements in *health and social sciences* study programmes in the Nordic countries. Is equal access to good health and healthcare included in the intended learning outcomes of central professional qualification study programmes, and are LGBTI people's needs included as part of these?
- How do knowledge and skills requirements manifest themselves in practice, in general syllabuses and in course syllabuses?
- What experiences do healthcare and social care professionals have of interacting with patients and users and what knowledge do they have of LGBTI, gender, sexuality and norms?
- What CPD courses and additional knowledge about LGBTI, gender, sexuality and norms are available?

The knowledge inventory is based primarily on relevant research from the literature searches made in this study, and relevant reports and other grey material from supplementary searches. The reports that we learned about during the process of compiling and writing this report have also been included. All publications included are listed in Appendix 2. For this sub-study, we searched for scholarly works that analysed *health and social sciences professional qualification* study programmes, and professional practice and CPD in relation to gender, sexuality, norms and above all LGBTI perspectives on ageing. The searches showed that very few studies have been carried out in which older LGBTI people are included in relation to professional qualification study programmes or professional practice. A majority of the studies focused on 'all', on children/young people, or on adult LGBTI people in their interactions with the healthcare system in relation to reproduction and family building. We have also included studies that are not age-specific in addition to those that specifically focus on interactions with older adult LGBTI people.

The analysis has been supplemented with contextualising material; policy documents that regulate national intended learning outcomes for relevant professional qualification study programmes at university level, and interviews and e-mail interviews with university employees and CPD actors (see Appendix 4). CPD courses are the channel through which many staff without formal education gain knowledge, for example in the home care service and elder care. CPD courses on LGBTI-related themes are essential for professionals who have completed higher education because of the large knowledge deficit in this area.

Since a majority of the research comes from Sweden and Norway, interviews have mainly been conducted with relevant individuals in Iceland, Denmark and Finland, as well as the Faroe Islands, Greenland and Åland. The primary aim of the interviews was to gain a deeper understanding of patterns that emerged in the literature study, and to provide a picture of the situation in the countries in which no literature was found. The informants were sought using the snowball method, via the researcher's contact networks and via the LGBTI organisations in each country.

Policies and frameworks for healthcare and social sciences study programmes

Anti-discrimination laws and older people in LGBTI action plans

The knowledge base and discourses on gender and sexuality on which healthcare and social sciences study programmes in the Nordic countries are based are closely interwoven with the position of LGBTI people in society. As described above, during the 21st century there have been major changes in LGBTI people's access to rights and protections against discrimination in the Nordic countries (NIKK, 2020, see Introduction). Several countries have LGBTI action plans at national level, and in parallel with this LGBTI perspectives have been implemented in other policy documents and in national strategies related to human rights, living conditions and health, as well as sexual health and public health (Areskoug-Josefsson, 2023). LGBTI policy usually lies within the area of gender equality. Generally, older adults are rarely the focus of policies for social justice (Debesay, Langhammer & Nortvedt, 2021), and gender equality policy is often both heteronormative and age normative (NIKK, 2017). In surveys of differing conditions for older adults' access to good health and equality in healthcare and social care services, gender identity and sexual orientation are also rarely included as a power dimension (National Board of Health and Welfare, 2017).

Older LGBTI people have also been a relatively invisible group in national action plans for LGBTI people, but have been highlighted in the latest Swedish, Danish, Norwegian and Icelandic action plans. Concrete measures to boost knowledge about the group's living conditions, and strategies for more inclusive healthcare and social care services, have been the main themes of these action plans. In a previous Danish plan, there was a measure to increase competence in the healthcare and social care sector via an online course for working healthcare and social care staff. In the current LGBTI action plan for 2022–2025, increased knowledge in professional qualification study programmes is highlighted as one of several measures to improve LGBTI people's health and well-being, and it is the only plan in the Nordic region that links low competence in health-related professional practice to the knowledge healthcare and social care professionals are taught in their study programmes: 'Drøftelse med lederne af professionsuddannelserne på velfærdsområdet om LGBT+ viden i uddannelserne' (Discussion with managers of professional qualification study programmes in the welfare area about LGBT+ knowledge in the programmes) (p. 21, 2022).

The Swedish action plan prioritises the living conditions of older LGBTI people and their access to healthcare and social care in a separate chapter (p. 18, 2022). Older trans people are highlighted as a particularly vulnerable group, supported by the commission of inquiry into trans people's living conditions (2017). The plan highlights the need for increased competence in municipal services, and how this will be achieved through state-funded competence-enhancing initiatives, to be implemented regionally. The Icelandic plan (2022–2025) aims to investigate the situation and needs of older LGBTI people. The Norwegian action plan refers to knowledge enhancement through this Nordic mapping, but has few measures specifically targeted at older LGBTI people as a target group, saying that all measures must include all life phases and ages (2022–2026).

Gender, sexuality, LGBTI and norms in education policies

Higher education in Europe is characterised by certain common features in its development, with the state as the organiser (responsible authority) and public governance having been affected by market mechanisms and greater autonomy for individual higher education institutions (Huisman and Lyby, 2020, p. 1). Higher education is shaped by common European standards according to the Bologna Process, but is regulated by national guidelines on form and content to assure the quality of education in the Nordic countries. The content of the various professional qualification study programmes is regulated via overarching intended learning outcomes, with the objectives for knowledge and skills being determined by an academic committee under the countries' councils for higher education and regularly revised. In Finland, the intended learning outcomes are determined by the universities. How these knowledge and skills objectives are then achieved is up to the individual educational institution via the design of study programmes and course syllabuses. When the institutions are then evaluated, it is in relation to whether the national intended learning outcomes of the individual study programme have been achieved. It is therefore of interest to look at whether and how knowledge about gender and sexuality norms and LGBTI people's living conditions is included in governing guidelines.^[1]

In Norway, all health and social sciences professional qualification study programmes since 2019 have both common guidelines and framework plans (RETHOS), and framework plans and regulations for specific study programmes: '[...] for å styrke kvaliteten og relevansen i de helse- og sosialfaglige utdanningene og en konklusjon om behov for bedre styring på nasjonalt nivå, der REHTOS er en del av dette systemet.' (to enhance the quality and relevance of health and social sciences study programmes and a conclusion on the need for better governance at

1. Compared to other professional qualification study programmes, there has generally been a bigger change in intended learning outcomes in teacher education programmes over the past 10 years, with knowledge about sexuality, relationships and gender identity having been included in the learning outcomes.

national level, in which REHTOS is part of this system) (Ministry of Education and Research, 2017).

Education institutions should prepare local plans based on both the regulations of the common framework for healthcare and social care study programmes and the guidelines for the chosen programme. The plans should include academic content, teaching methods, organisation and assessment methods and a description of the practical studies (Ministry of Education and Research, 2019)." (Areskoug-Josefsson & Solberg, 2023, p. 5)

The work to implement the guidelines is taking place during the period 2017–2024 and is cross-sectoral. The implementation of the new guidelines in the study programmes is being continuously evaluated until the end of the period. One of the new common objectives is closely tied to the Norwegian anti-discrimination legislation, linking intended learning outcomes and competence and skills to the capacity to offer equivalent services regardless of gender identity, gender expression and sexual orientation:

The candidate has knowledge about inclusion, gender equality and non-discrimination, based on gender, ethnicity, religion and belief, disability, sexual orientation, gender identity, gender expression and age, so that the candidate contributes to ensuring equivalent services for all groups in society. (Lovdata, 2017)

In the intended learning outcomes for Swedish professional qualification study programmes in the field of health and social sciences, the wordings in Sweden's Higher Education Act's rules governing the intended learning outcomes of the study programmes vary. They are decided by different academic committees at regular intervals.

[...]demonstrate knowledge of social circumstances that affect the health of children, women and men, - demonstrate knowledge of men's violence towards women and violence in close relationships. (Intended learning outcomes for the Degree of Bachelor of Science in Nursing, Higher Education Ordinance, Appendix 2)

In this quotation from the intended learning outcomes, and generally in healthcare and social sciences professional qualification study programmes, human rights are used as a framework for knowledge and understanding, and competence and skills outcomes. Men's, women's and children's health is named in these learning outcomes, and men's violence against women is named as a specific challenge. There is the hint of a heteronormative understanding of gender and sexuality here, with the heterosexual nuclear family as the basis for prioritised groups, while other

marginalised groups remain invisible and are lumped together as 'various groups' that need to be taken into account (cf. Reimers, 2008). A revision of the qualitative targets in the nursing and midwifery programmes was proposed in 2022, with person-centred care being included as examined learning outcome. However, the reason for this is stated to be increased user and patient participation rather than differing conditions for access to equal care (Ministry of Education and Research, 2022, p. 136). Inserting knowledge about the living conditions of LGBTI people and intersex people in caring profession study programmes through the revision of qualitative targets in caring profession qualifications was one of the final recommendations in the Swedish commission of inquiry into trans people's living conditions, but this has not yet been implemented (Westerlund, SOU 2017).^[2]

In the Danish intended learning outcomes for professional qualification study programmes in the health and social care field, democracy and human rights are primarily used to support consideration of the conditions of different groups. However, gender or sexuality is not specifically highlighted, while religion and social and cultural conditions are mentioned, as in this text for the nursing programme:

3) has knowledge about and can reflect on the knowledge about how individual, social, cultural, religious, international and ethical factors influence people's experiences of and reactions to health challenges and disease contexts. (Executive Order no. 2672 of 28/12/2021)

In Finland, competence and skills and intended learning outcomes are defined in professional qualification study programmes by the faculty responsible at each higher education institution, and they consequently vary (Lähteinen, Raitakari, Hänninen, Kaittä, Kekoni, Krok, Skaffari, 2017):^[3]

As Finnish universities are autonomous institutions with regard to defining the content of the programmes they offer, the mechanisms steering their work allow for considerable flexibility. The most important guidelines for what is taught are the competency objectives for the degrees and courses offered; these aims are approved by the university faculties (ibid).

Competence and skills outcomes for social work are characterised by general wordings for different conditions and social structures according to Sosnet, the Finnish National University Network for Social Work:

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2. "We therefore propose that changes be made to the system of qualifications so that knowledge about LGBTI people's living conditions must be included in relevant professional qualifications, as well as a stronger emphasis on the importance of equal, competent and respectful treatment regardless of sexual orientation, gender identity, gender expression and gender characteristics" (2017, p. 25).
 3. Only the form and content are regulated by the Government in the 'Government Decree on University Degrees and Professional Specialisation Programmes': <https://www.finlex.fi/en/laki/kaannokset/2004/en20040794.pdf>

[...] is familiar with and understands inequality, the problems people encounter in different life situations and phases as well as the structural nature of and underlying reasons for these. (Lähteinen, Raitakari, Hänninen, Kaittila, Kekoni, Krok, Skaffari 2017)

In Iceland, gender identity and sexual orientation are explicitly highlighted in relation to intended learning outcomes for teacher education programmes, but not in relation to the health and social sciences professional qualification study programmes.^[4]

In addition to intended learning outcomes for the study programmes, different professional associations have their own governing ethical guidelines for professional practice, nationally and internationally. They are relevant to the requirements made of the members of the associations, and guidelines for professional education are often included (Giertsen, 2019; Lundberg, Malmqvist & Wurm, 2017; Areskoug Josefsson & Solberg, 2023). However, they do not govern the study programme itself, which is subject to the statutory national or institutional intended knowledge and skills outcomes, only the members of the professional association.

The examples above show how knowledge and skills intended learning outcomes are regulated differently in the Nordic countries – from national governance in Norway to full autonomy at the higher education institution/faculty level in Finland. This results in different conditions for how knowledge content and intended learning outcomes in the study programme may be influenced, changed and evaluated, and the requirements that may be imposed on the study programme through policy regulation.

From policy to practice: LGBTI perspectives and ageing in general and course syllabuses in Norway and Sweden

What is the significance of the national intended learning outcomes for the knowledge and understanding requirements in relation to gender, sexuality and ageing in concrete programme syllabuses at higher education institutions, and in general syllabuses and course syllabuses? Two comparable surveys conducted in Norway and Sweden investigate the existence of indicators related to sexual and reproductive health and rights (SRHR) in central government regulations, and in general syllabuses and course syllabuses for caring profession study programmes, which are relevant to this mapping (Schindele et al., 2017; Areskoug-Josefsson & Solberg, 2023).

4. Interview with AuðurMagndís Auðardóttir, School of Education, University of Iceland

The study programmes covered by the survey also include health and social sciences professions that interact with older adults: social work, ergonomics, physiotherapy, medicine, protective care, psychology and nursing. The Swedish survey, commissioned by the Public Health Agency of Sweden, included 31 indicators of which, among others, LGBTI, sexuality throughout life and heteronormativity occurred rarely throughout:

The results show that HIV prevention and SRHR are rarely represented in descriptions of professions, programme syllabuses and course syllabuses for the study programmes that were investigated. This may result in students not acquiring relevant knowledge. There are particularly few indicators for SRHR in professional qualification study programmes at higher education institutions for nurses, social workers, lawyers, police officers, psychologists, occupational therapists and physiotherapists. [...] Ultimately, this may lead to a lack of competence in the area of sexuality and its importance for health. It may also make it difficult to understand the needs and rights of clients and patients. Higher education institutions should see the results as a basis for further development of professional qualification study programmes. Students need to be given the opportunity, in their future professional roles, to support all people's right to achieve sexual and reproductive health and other rights, regardless of gender, age, sexual orientation, gender identity, disability, socioeconomic position, ethnicity, cultural background and legal status (2017, p. 31).

The Norwegian study investigated the prevalence of 68 indicators for SRHR-related themes,^[5] but only 11 of these were included in plans at different levels, despite tightened requirements in the new common guidelines in the *National Curriculum Regulations for Norwegian Health and Welfare Education* (RETHOS).^[6]

The results are disheartening and show that SRHR are rarely included in study plans. The only programme in which all the study sites surveyed have SRHR included in the course syllabus is the pre-school teacher training programme. This means that SRHR indicators included in regulations are not automatically transferred to the study plans. (2023, p. 14)

Looking at how the indicators were implemented in concrete programme syllabuses at the higher education institutions included in the Norwegian study, the incidence varied widely both between professional qualification study programmes and

5. Compared to the Swedish mapping, the Norwegian mapping contains a larger number of indicators that are relevant to LGBTI people's living conditions and ageing: trans health, gender incongruence, gender-affirming treatment, older people and sexuality, sexuality in institutions, sexuality and disease, adverse effects of medicines, and sexuality, physical health and sexuality.

6. The Norwegian study investigated roughly one third of all study programmes relating to a professional qualification. The Swedish study covered profession descriptions, programme syllabuses and course syllabuses for 93 study programmes at all 27 higher education institutions in Sweden.

within study programmes at the same or different educational institutions. The vast majority of programme syllabuses that included sexual health indicators included the indicators gender, gender identity, gender expression and sexual orientation. They thus reflect the requirements of RETHOS' section 16, which relates directly to Norway's Equality and Anti-Discrimination Act. In some study programmes, there are also more indicators in the programme syllabuses than in individual course syllabuses, such as in medicine, where trans health and gender incongruence are included in only a few syllabuses; or sexuality as a social construct in the course syllabus for psychology. Social work included few indicators, but was the only profession to have an elective subject in which sexuality throughout life was included. Graduates' competence in sexual health therefore seems highly random.

Despite the fact that gender identity, gender expression and sexual orientation were common indicators in the syllabuses, the question remains about *how* they are included, which needs to be investigated in more detail in further studies. Areskoug Josefsson and Solberg give examples of how these indicators were used in several cases in a superficial and legalistic manner, for example in formulations such as: "good access to treatment, regardless of gender, gender identity, sexual orientation".

The 68 indicators investigated in the Norwegian study included far more indicators that are relevant to LGBTI people overall, but also a relatively high number of indicators that are particularly relevant to older LGBTI people: *sexuality and older people, sexuality in institutions, sexuality and disease, effects/adverse effects of medicines and sexuality, physical health and sexuality, sexuality and disability and sexuality across the life course*. There are no or few hits for these indicators in the programme syllabuses and course syllabuses. This suggests that there are very limited requirements for knowledge about older adults in general or older LGBTI people's living conditions and needs more specifically, but this age dimension is not particularly highlighted in the report's analysis.

Another key indicator that is rarely included is *heteronormativity*. This may indicate a perspective on knowledge where norms for gender and sexuality are rendered invisible, and norm-breaking gender identities and sexual orientation are highlighted and problematised on the basis of normative conditions. This is something that is confirmed in several of the reviewed studies of norms and the knowledge perspectives in the programme syllabuses and course syllabuses of professional qualification study programmes that we will look at in the next section (Tengelin, 2019; Giertsen, 2019; Areskoug Josefsson and Gard, 2015).

Norms and knowledge perspectives in healthcare and social sciences study programmes in the Nordic countries

How are knowledge and understanding, and competence and skills, requirements made manifest in practice and in healthcare and social sciences study programmes? There is relatively little research into the knowledge and knowledge perspectives on gender, sexuality, LGBTI people's living conditions and ageing in different study programmes in the Nordic countries. Their prevalence also varies widely between countries. The greatest lack is in studies that specifically look at older people and ageing, and the studies included therefore focus mainly on gender and sexuality perspectives (see Appendix 3).

The majority of the material is qualitative studies that investigate study programmes in the caring sciences/nursing, social work, psychology, physiotherapy and medicine. The focus is primarily on general syllabuses and subject syllabuses, course literature and students' experiences of the presence of knowledge about gender, sexuality and LGBTI perspectives. The qualitative analyses carried out in different professional qualification study programmes are seen in relation to patterns in the Norwegian and Swedish indicator mappings referred to in the previous section, since they provide a broad context in which to interpret the results (Schindele et al., 2017; Areskoug-Josefsson & Solberg, 2023). Supplementary interviews and e-mail interviews with people working in the *healthcare and social work field* at higher education institutions are used in addition to the literature found in the searches. The interviewees were mainly from Finland and Iceland, since no literature has been found there.

Heteronormative general and course syllabuses and study resources

Programme syllabuses are an important link between society and education, as they are grounded in specific values and knowledge, and represent the consensus product of ideological struggles in terms of expectations and objectives for learning, write Tengelin et al. (2019) in their study of general syllabuses and course syllabuses for nursing education. Understanding how norms shape professional interaction and help to challenge or maintain social difference in access to healthcare is

key.^[7] All studies included in this knowledge inventory (Schindele et al., 2017; Giertsen, 2019; Tengelin et al., 2019; Areskoug Josefsson & Solberg, 2023) show that programme syllabuses and course syllabuses have a heteronormative knowledge base. In a study of the national intended learning outcomes in nursing study programmes in Sweden, Tengelin et al. (2019) analysed programme syllabuses and 17 course syllabuses for the nursing programmes at a higher education institution, and the compulsory readings specified in the course syllabuses, focusing on the dominant perspectives represented in the texts from a norm-critical perspective.

The authors investigated how national intended learning outcomes are filled out with content and made concrete in programme syllabuses and course syllabuses in relation to the two intended learning outcomes that focus on the word 'society'. The first – "social circumstances that affect the health of children, women and men" – is reproduced without further concretisation in the programme syllabus, and is not included in the course syllabuses at all, with the exception of one, in which the students are required to "describe societal power structures related to gender, class, culture, and age". Terms such as LGBTI were not included in any course syllabus, and the course literature conveyed a conventional view of sexuality which equated sexuality with reproduction. One textbook in psychiatry that was course literature included homosexuality and transsexualism in a chapter entitled 'Sexuality and Disturbed Gender Identities', a chapter that began by comparing human gender roles with those of animals (ibid, 29). Social justice is not a priority perspective in the socialisation of future nurses, the authors conclude. On the contrary, the study programme's strong focus on a professional role in which a nurse is encouraged to use self-reflection and empathy as important tools supports the re-creation of a normative knowledge base. Here, the Other (who does not conform to norms) is rendered invisible or presented as deviant and different, as in 'other cultures' and 'queer sexuality', where the solution is that an increased understanding of the Other should lead to increased tolerance.

Despite a degree of promotion of societal awareness, the socialization of nursing students into advocates of social justice may be discouraged by these dominant perspectives. This leads us to conclude that the politically correct rhetoric that occasionally occurs is little more than rhetoric" (ibid, p. 31).

This is a rhetoric in which everyone's equal value is used in combination with a norm-reproducing knowledge base. A division into 'us and them' is common, where the intended learning outcomes of the study programme and the dominant knowledge perspectives are at odds with each other.

7. However, norm-critical perspectives are used as a theoretical framework and methodology tool in several studies included in this reading list to investigate the relationship between explicit knowledge outcomes related primarily to gender, sexuality, class, ethnicity, disability and age in guidelines, programme syllabuses and course syllabuses; and the knowledge perspective on which they seem to be based in terms of norms and power relationships. Norm-critical perspectives are based on feminist, queer and post-structuralist theory. They were introduced in Sweden in the early 21st century and have primarily focused on norms, power and learning within different learning contexts and to a lesser extent health and social sciences professional qualification study programmes (Bjorkman & Bromseth 2019).

There is also a similar pattern in the nursing study programme in Finland according to Minna Laiti, Senior Lecturer in Nursing at the University of Turku, although it is perhaps rendered even less visible. LGBTI perspectives in research and education are almost non-existent in the fields of health and social sciences in Finland, perhaps because LGBTI policy has long been more restrictive than in the other Nordic countries, thinks Laiti:

I have looked at the nursing education curricula (curricula are published online so that anyone can look at them from the universities' websites) from universities of applied sciences that educate public health nurses, and the topics of sexual and gender diversity, lgbtq+ people's lives, norms, intersectionality etc. are very rarely described in the official curricula documents. My assumption is, that it is quite much up to the nursing educator what specific topics they cover in their courses, that deal with sexual health for example. (Minna Laiti, interview)

A similar pattern appears to exist for social work. Merethe Giertsen (2017) analysed course literature for 2013–2014 in the Bachelor's programme in social work at 11 institutions in Norway. This was before the introduction of the new national guidelines for *health and welfare* professional qualification study programmes. In the previous national guidelines for social work, sexuality was only included under social medicine. Despite profession-based guidelines to the effect that social work should actively combat discrimination and marginalisation on the grounds of sexual orientation (International Federation of Social Workers and the Norwegian Union of Social Educators and Social Workers), social work as a field of science is still rooted in a heteronormative base, which highlights lesbians, gays and bisexuals, but rarely heterosexuality, writes Giertsen:

"[...]is a direct reflection of heterosexuality being taken for granted: "The rationale for addressing minority sexuality is the belief that social work involves working "with those who are disadvantaged in society" (Fish, 2012, p. 15)." (Giertsen 2019, p. 3)

Giertsen's analysis of the course literature confirms this pattern. Above all, sexuality as a theme is very absent, and is addressed in only 0.08% of the literature (90 pages) in six articles used for the foundation course in five out of eleven study programmes. However, one of these articles, of 15 pages, is used by three study programmes and thus accounts for 45 of these pages. When sexuality is addressed, it is primarily by sexuality researchers from other professional fields. Five out of six have a queer theory approach, while only one highlights LGBTI people's problems about deviating from the norms without questioning the heteronormative basis that creates them. Sexuality is generally invisible in most of the core literature in the study programmes for social work.

If we look at Areskoug Josefsson & Solberg's survey of SRHR indicators in *health and welfare* professional qualification study programmes in Norway, only four out of eight general syllabuses in study programmes in social work have indicators for gender identity, gender expression and sexual orientation (Areskoug Josefsson & Solberg, 2023). However, the course syllabuses for social work lack detailed descriptions of how they are included. A similar pattern also seems to characterise social work in the context of Finland. The research group in the ongoing project *Queering social work* write on the project's website that, despite positive development with an increased focus on LGBTI, gender, sexuality and norms in the field internationally, and professional guidelines nationally, essentialist understandings of sexual identity and gender in relation to healthcare and social care services and needs dominate.

However, there is still a need for social work education curriculum development and evaluation to be implemented at the intersection of sexual identity, gender identity and expression and oppressive practices. In Finland, social work is framed as an occupation promoting human rights, but there is a deep silence in social work education curricula, research and official guidelines when it comes to sexual and gender diversity and discrimination. (*Queering social work*, website)

The project has not published anything yet, but one of the project participants, Inka Söderström, who teaches social work, says that there are no compulsory courses or any Finnish course literature that addresses LGBTI themes: "This is unfortunate but true. The courses in social work might talk about diversity and intersectionality in a general level, but not specifically about LGBTQ+ identities".^[8]

The LGBTI perspective seems to be somewhat better represented in the social work programmes at first-cycle level, which are offered mainly available at universities. Sandra Hagman of Diaconia University of Applied Sciences is a queer researcher and teaches in the Bachelor's programme:

At the moment, three of my students plan to make their bachelor thesis about queer elder care in cooperation with Helsinki city and with the queer seniors' association. This is a very topical issue especially in Helsinki city. (E-mail interview with Sandra Hagman)

There is thus interest in the theme, but whether and how norms, gender, sexuality and LGBTI perspectives are included in the study programmes seems to be consistently person-dependent, even when this is explicitly established in national guidelines for intended learning outcomes.

In Iceland, there seems to be a similar pattern, according to interviews with key individuals. Guðbjörg Ottósdóttir, a senior lecturer in social work, says that gender

8. E-mail interview with Inka Söderström 23 February 2023.

identity and sexual orientation are mentioned in professional guidelines, but are not included in the course literature or as intended learning outcomes in the general Bachelor's programme in social work:

Gender and sexual minorities are part of an elective course in cultural competence that I teach, but otherwise it is up to the individual teacher. However, the students request this knowledge, and the teachers are aware of that. Everyone agrees that it is important, but most people do not have the competence, so it is essential to teach the teaching staff this. (Guðbjörg Ottósdóttir, interview)

Students therefore want more knowledge about gender, sexuality and LGBTI perspectives, but do not get enough in their study programmes – a pattern that is repeated in several studies of different health and social sciences study programmes.

In a Swedish study of physiotherapy students' experiences of SRHR perspectives in their study programmes, it appears that both LGBTI and sexuality perspectives are almost completely absent. The students think that it would be particularly difficult to talk about sexual health with patient groups that break with expectations of gender and sexuality (Areskoug Josefsson and Gard, 2015). Students express that they are positive about working with sexual health, write Areskoug Josefsson & Gard (2015), and that sexual health is an important part of life and therefore should also be part of the physiotherapy study programme. The study also shows that students lack knowledge about LGBTI perspectives, sexual health and sensitive themes:

Sexual health needs to be more addressed in the physiotherapy education. Students lack knowledge of lesbian, gay, bisexual, transgender and queer, sexual health, and communication about sensitive issues. (Areskoug Josefsson & Gard, 2015, p. 530)

Increased knowledge in the study programme would probably make it easier to work with sexual health, especially when combined with working in a case-oriented way when training communication skills to deal with sensitive themes. But this also needs to be explored empirically (ibid).

Students' attitudes to studying sexual health are generally positive in health and social sciences study programmes in Norway, Sweden and Denmark. This is shown in several studies in which researchers have jointly developed national context-sensitive tools to map students' attitudes and knowledge (Areskoug-Josefsson et al., 2016; Gerbild et al., 2017; Lunde et al., 2022). This is particularly true when it comes to sexual orientation, according to a Norwegian study (Lunde et al., 2022). The studies asked about the students' attitudes to asking patients about sexual health in relation to age, sexual orientation, gender, gender identity, disabilities, etc. but not directly about older age.

The physiotherapy, social work and nursing programmes were among the professional qualification study programmes in which there were very few SRHR indicators in programme syllabuses and course syllabuses in both the Swedish and Norwegian surveys. The programmes for lawyers, police officers, doctors, psychologists and occupational therapists also had few indicators (Schindele et al., 2017; Areskoug-Josefsson & Solberg, 2023). There are only a few Nordic studies of how gender, sexuality and LGBTI people's living conditions are included in these professional qualification study programmes, and none about older LGBTI people.

Knowledge perspectives in medicine and psychology

Which knowledge perspectives characterise medicine and psychology in relation to gender, sexuality, ageing and LGBTI people's life experiences? Only one out of five course syllabuses in medicine programmes in Norway has the indicators relevant to this knowledge inventory: sexual orientation, gender incongruence and trans health (Areskoug Josefsson & Solberg, 2023). However, there are a higher number of indicators in the medicine programme syllabuses than course syllabuses, several of which are important for this survey:

The survey of medicine study programmes found several SRHR indicators in the course syllabuses: SRHR (as an overarching concept), abortion, andrology, fertility, family planning, gynaecology, gender, gender incongruence, women's health, men's health, obstetrics, contraception, puberty, sexual history, sexuality, sexuality throughout life, sexuality in connection with illness, sex education, sexual health, sexual orientation, sexual violence, abuse and trauma, sexual problems, sexual rights, sexually transmitted diseases, trans health, urology (Appendix 1, Figure F). The SRHR indicators included in the regulations are also found in the course syllabuses, but not as clearly in the study plans." (Areskoug-Josefsson & Solberg 2023, p. 11).

However, ageing and sexual health and LGBTI are not represented in either the programme syllabuses or the course syllabuses. In the comparable Swedish mapping, two out of seven professional descriptions in the country's medicine programmes included a part about HIV prevention and SRHR, but the indicator HBTQ^[9] was only included in four course syllabuses (Schindele et al., 2017). However, several key indicators included in the Norwegian mapping were not included in the Swedish mapping that was conducted seven years earlier, such as gender identities, gender expression, gender incongruence, trans health (which have become more established terms in the meantime).

9. This is the Swedish term used in the study referred to here. It stands for homosexual, bisexual, trans and queer.

Gender identity and heteronormativity are not included in the course syllabuses of medicine programmes in either the Swedish or Norwegian mapping of SRHR indicators (Schindele et al., 2017; Areskoug Josefsson & Solberg, 2023). This may indicate that the focus is more clinically oriented in relation to trans health, and based on a gender-binary mindset (Linander et al., 2021). Identities, bodies and behaviours that have been considered to break with social and cultural expectations of gender and sexuality have been pathologised in social medicine and psychiatry since the mid-19th century via diagnoses in which the 'abnormal' has been regarded as pathologically deviant from the normal (Foucault, 1976; Kveim Lie & Slagstad, 2018). Transsexualism was removed as a psychiatric diagnosis from the WHO ICD-11 diagnostic standard only in 2018 and was replaced with various diagnoses for gender incongruence. This means, above all, that gender identity is regarded as fluid, in contrast to a binary 'born in the wrong body' understanding, with the new diagnosis regarding gender incongruence as:

Incongruence between gender identity and primary or secondary gender characteristics, accompanied by a strong desire to remove or change some or all of these. The diagnosis paves the way for more people with different gender identities to access gender-affirming treatment. (Kveim Lie & Slagstad, 2018).

For example, non-binary people will more easily get access to healthcare within this understanding. Although understandings of norm-breaking gender expression and gender identities have changed significantly over the past ten years, pathologising understandings still live on in current guidelines for trans health (Linander et al., 2021). The article *Two steps forward, one step back. A policy analysis of Swedish guidelines for trans-specific healthcare* analyses which understandings form the basis for the new guidelines for trans-specific healthcare/gender-affirming treatment.

Sweden has only had established guidelines for trans-specific healthcare/gender-affirming treatment for people with trans experience since 2015, despite this treatment having been available since the 1970s. The results show that, despite ambitions to depathologise trans experiences, psycho-medical understandings of gender incongruence still characterise the guidelines for entitlement to treatment. The emphasis remains on a linear understanding between gender identity and social gender expression to be able to access treatment, show Linander (et al., 2021). This means a mindset in which the experiences of binary trans persons are more easily valued as credible than those of non-binary trans persons, in which gender identity and desired gender expression are linear and conform to normative conventions.

The knowledge perspectives on which professional qualification study programmes in medicine and psychology are based, and the guidelines that regulate LGBTI people's access to medical and psychological treatment, are particularly important

for people with trans and intersex experiences, as access to government-funded treatment is diagnosis-related. Gender, gender identity and sexuality were integrated into Nordic ethical professional guidelines for psychology in 2013 (Lundberg, Nordlund and Narvola, 2017). In the article *Normkritiska perspektiv: nya möjligheter för psykologisk praktik* (Norm-critical perspectives: new opportunities for psychological practice), Lundberg, Nordlund and Narvola describe the guidelines as 'the most powerful guidelines so far in Sweden, in which it is claimed that psychologists should have knowledge in matters related to gender, gender identity and sexuality'. Although the guidelines are not directly linked to national intended learning outcomes for the study programme, they are also relevant in different parts of the programme.^[10]

Since the policy document does not provide guidance on how to take into account the sociocultural context in practice or the underlying perspectives on which the interaction should be based, this needs to be discussed and explored, write the authors. The article highlights the wordings in other countries' policy documents, examines the critical perspectives used in psychology in a historical context and aims to investigate how psychologists can apply a norm-critical perspective with a particular focus on gender and sexuality in their practice:

The science of psychology produces knowledge about humans and their behaviour, thoughts and feelings. By establishing facts about human functioning, moral and normative notions of right and wrong, normal and deviant are created. It is impossible to describe how humans are without pointing out how they should be (Brinkmann, 2011). Consequently, psychology researchers and practitioners are involved in a (re)production of norms. (Lundberg, Nordlund and Narvola, 2017, p. 6)

The article describes key elements of norm-critical pedagogy, and how they can be used to critically examine norms in both the psychology programme and in professional practice. Norm-critical perspectives are based on a feminist, intersectional and post-structuralist theoretical foundation with the focus on self reflexivity about the influence of power structures on one's own values and practice. Lundberg, Nordlund and Narvola conclude with concrete proposals for initiatives for working on norms and values in practice, both individually and in a shared workplace, which are later further developed in the anthology *HBTQ+. Psykologiske perspektiv på bemötande (LGBTI+)*. *Psychological perspectives on interaction* (in the chapter *Normkritiska metoder för psykologi* (Norm-critical methods for psychology) (Narvola & Nordlund, 2017) and the appendix *Riktlinjer (Guidelines)*, aimed at educators, researchers and practitioners (Wurm & Traczyk, 2017). The book is an extensive anthology focusing on LGBTI perspectives in psychology with a foundation in queer theory and norm-critical perspectives with students and professionals as the target group.

10. E-mail interview with Matilda Wurm, March 2023

How can therapists create a climate for conversation in which clients can feel safe? What knowledge about LGBTI+ people's living conditions is needed for a professional interaction? And why is empathy not enough? [...] Despite a positive trend in society, minority stress still leads to increased ill health among LGBTI+ people, and knowledge gaps are large in social and healthcare services. (Lundberg, Malmqvist & Wurm, 2017, p. 10).

The anthology includes 21 authors – all but one with a scientific background in the field of psychology (Lundberg, Malmqvist & Wurm, 2017). This may indicate that LGBTI perspectives and sexuality are integrated in their own professional field to some extent and do not just come from queer and sexuality research (cf. Giertsen, 2019). In the chapter *HBTQ+ och åldrande (LGBTI+ and ageing)*, Ingela Steij Stålbrand, whose background is in psychology, gerontology and sexology, provides valuable insights into both LGBTI perspectives on ageing and what older age means for sexuality, identity and life experiences, as well as implications for interactions with healthcare and social care institutions.

In the survey of SRHR indicators in Swedish professional studies in psychology, LGBTI is included in 7 out of 10 profession descriptions (Schindele et al., 2017). In 157 out of 251 course syllabuses, there are indicators for sexual health, among which gender, ethics and communication are some of the most common, while LGBTI and heteronormativity are marginally represented with three hits for each.

Person-dependent teaching

Despite the small number of studies of how knowledge about gender, sexuality and LGBTI has been implemented in different professional qualification study programmes, there is a clear pattern in the material, regardless of profession and country: whether students gain knowledge in their study programmes varies greatly, both between and within education providers, and is often person-dependent. Why are LGBTI perspectives and knowledge about sexuality taken into account to only a small extent in course syllabuses and teaching despite clear guidelines and requirements in current policy documents? Even in those countries with clear guidelines and policies, such as Norway, these perspectives are lacking. This is despite the introduction of new common guidelines for health and welfare study programmes with the aim of ensuring learning exchange, partly linked to equivalent healthcare and social care services and gender identity, gender expression and sexual orientation. Hilde Lunde, who taught health sciences at Oslo Met for many years, reflects on why:

How is it that the various healthcare and social sciences study programmes do not have an SRHR focus? It is really quite incomprehensible - it's their mandate in a way - so I don't know... is it a fear of not having enough expertise... that you think the area is so difficult... is it avoidance, that other things take up space all the time or...? Yes. I think there are so many different reasons why it is still person-dependent, why it is not a learning objective. And it has to be a learning objective, and it has to be in the course syllabus. Otherwise, neither students nor teachers will value it. So we just have to get it in there. (Hilde Lunde, senior lecturer in health sciences, Oslo Met, interview)

Despite the fact that the University of Iceland has been working on integrating gender equality and diversity policies in its activities for several years, with educational objectives for more inclusive teaching, there is no active work on knowledge perspectives that integrate LGBTI issues, says Guðbjörg Ottosdóttir, professor of social work: "But now policy has to become practice. It must become standard for diversity to be included as a compulsory part of study programmes in health and social sciences subjects as well." Instead, it seems to be students who are driving demand for LGBTI perspectives in teaching in general, and in relation to LGBTI ageing in particular, say academic staff in the professional qualification study programmes, who shared their experiences as part of the knowledge inventory. Students also discuss this in Bachelor's essays and Master's theses.^[11]

When a majority seems to be positive about including LGBTI perspectives, gender and sexuality in teaching, why is it not being done more? One of the problems of integrating gender, sexuality and norms in professional qualification study programmes is that there are too few lecturers who are qualified researchers and can research and write course literature in Norwegian, argues Hilde Lunde. She herself is engaged in extensive Nordic collaboration that has been central to the development of a Master's programme in sexual health at Oslo Met in Norway. A separate course on sexuality and ageing will also be included as one of seven courses there. Working in an interdisciplinary way and with a broad approach linked to sexual health may be a strategy that, in the long term, will also broaden the understanding of its relevance and further integration of the topic, she thinks:

But when we created these seven subjects, we were keen for each subject to have a reference group. And so we contacted a wide range of people. We had anthropologists, psychologists and sociologists. We were keen to have a wide range of expertise in sexual health and ageing, abuse, etc. We went a bit overboard and found people who were slightly interested in sexual health. So now we have 100 contacts with people who have backgrounds in different areas.

11. Since Master's theses are not included in this study, several relevant works were not included here.

Matilda Wurm, who has been teaching psychology since 2012, says that there are generally positive attitudes among her colleagues to having LGBTI perspectives as part of the teaching in professional qualification study programmes, and that it is increasingly included in course syllabuses at many higher education institutions. At the same time, it can easily be person-dependent. When she left her institution, there was no one who could take over the course in LGBTI perspectives in psychology:

The conclusion is probably that there is not a very clear or strong emphasis 'from above' on bringing LGBTI perspectives into study programmes. In practice, however, I have a feeling that many psychology programmes are in favour of raising these questions. In practice, however, it is highly dependent on the people who are there. For example, I moved from psychology to social work two years ago and the LGBTI course I had previously offered thus disappeared. (E-mail interview, Matilda Wurm)

Despite its absence from the compulsory teaching in professional qualification study programmes, there are elective subjects, individual courses and Master's programmes in which knowledge is available, but it is vulnerable because it depends on individuals and there are few lecturers who are qualified as researchers in the field.

The importance of course literature

Study resources in Scandinavian languages about sexuality are also important if it is to be included in the teaching, say several of the teachers interviewed. If you search for central publications concerning older LGBTI people's living conditions, they are included as course literature in individual professional study programmes, which indicates a positive development. Merete Giertsen highlights this point in her review of Hans Knutagård's textbook, *Sexualitet och socialt arbete (Sexuality and social work)*:

With regard to social work's discourse on sexuality, Hans Knutagård, senior lecturer in social work, makes three important points in his book *Sexualitet och socialt arbete (Sexuality and social work)*. One is that sexuality is thematised. The second is that sexuality is not treated primarily as a problem. The third is that Knutagård treats sexuality as a matter for all of us, and not just for sexual minorities. Using these approaches, Knutagård makes an important contribution to the fact that sexuality can be thematised in a wide range of courses in social work study programmes, and not only in courses that focus on sexuality or marginalisation and anti-discrimination. (Giertsen, 2017, p. 1).

This was also a driving force behind the anthology *HBTQ+ och psykologiska perspektiv (LGBTI+ and psychological perspectives)*; to contribute to the Swedish knowledge base for the professional field. Anna Siverskog, who is one of the few people to have published research into older LGBTI people's living conditions in the Nordic countries in Swedish, is also pleasantly surprised to see her own thesis (2016) being used as course literature in several different professional qualification study programmes:

Social work at the University of Gothenburg seems to have my thesis included on a course in elder care, *Queer äldreomsorg (Queer elder care)* is included in a course in elder care at Dalarna University, the thesis in the social work programme at Karlstad University, and in the social work programme at Stockholm University. It seems, however, that it is at least mentioned/represented through literature in more and more courses. (Anna Siverskog, Senior Lecturer at Södertörn University)

Here, knowledge perspectives play an important role in the literature, as several of the authors cited point out. If gender identity only applies to trans people and not to cis people, it is easily perceived as 'marginal' and a normative notion of a deviant minority is perpetuated. However, the majority of the literature cited here has a norm-critical approach. Representation in course literature should be followed up in further research, and also how it is used in teaching.

Furthermore, we will look at the knowledge that exists among professional practitioners about LGBTI people's life experiences and needs, and their experiences of interacting with older LGBTI people as patients and users.

Professional practitioners' experiences in their interactions with patients and users

Healthcare and social care services are regulated by various laws, central government directives and municipal guidelines, in addition to professional guidelines for different professions. We will not go through all of these here, as it would be too extensive for the limitations of this study, but we will look at how they are made relevant in studies of how professionals in practice talk about and relate to them. In Part 1, we saw that older LGBTI people's own experiences of healthcare and care interactions are mainly characterised by heteronormative and cisnormative assumptions and language, and lack of knowledge about the group's life experiences, identities and needs, which often results in invisibility and silence. What do these encounters look like from the perspective of healthcare and social care providers? What knowledge and experience do practitioners have of gender and sexuality norms and the living conditions and needs of older LGBTI people, and what are their attitudes to the importance of having such knowledge? The material in this part is based on studies of professional practitioners with a background in psychology, social work, health science and medicine.

In general, there is a trend in welfare policy discourses where social services are described as enabling greater user participation, influence and focus on individual needs (Askheim, 2017). Healthcare and social care services are dominated by person-centred care as the philosophical framework of care (Brooker, 2007), with an empathetic perspective forming the basis for meeting the patient's basic psychological needs in human care. There also seems to be a tendency for gender identity, gender expression and sexual orientation to be increasingly included in government agencies' policy documents on equal access to good health and equal care, and in strategies for older people in certain Nordic countries such as *Leve hele livet (A life lived to the full)*, a national reform package developed by the Norwegian Directorate of Health in 2017–2018.

Although this has not been systematically investigated as part of this report, one particular example is from the Swedish National Board of Health and Welfare, which carried out a survey on its own initiative in 2013.^[12] The survey included the municipalities' knowledge about and work with LGBTI perspectives, with administration managers responsible for healthcare and social care for older people

12. Following a request to do so, the association FRI/FRI Oslo Viken provided informants for focus group interviews as part of preparatory work for public health strategy for the City of Oslo, for example.

responding to an online survey: “[...] there are relatively few studies of older LGBTI people in healthcare and social care. This report aims to increase knowledge about how the LGBTI perspective is taken into account in municipal healthcare and social care for older people.” The results were disheartening and showed that few municipalities, only 16%, had taken an LGBTI perspective into account in their policy documents (which are not age-specific), that there were big differences between large and small municipalities (45% vs. 6%), and that there were few educational efforts. In 2023, the study was followed up by a new survey commissioned by the Swedish Government which showed a similar pattern but with some increase in efforts (National Board of Health and Welfare, 2023). On average, one-fifth of the municipalities report that they carry out CPD activities that include the needs of older LGBTI people: all the metropolitan municipalities of Stockholm, Gothenburg and Malmö, and half of the municipalities with more than 50,000 inhabitants (ibid). According to both reports, CPD activities in Swedish municipalities seem marginal in terms of the living conditions of older LGBTI people (see also the section on CPD). This is confirmed by RFSL’s education unit, which has been commissioned to carry out CPD in elder care activities.

Benevolent attitudes – normative practices

In general, a majority of the studies show that professional practitioners have a positive attitude to equal treatment of LGBTI people and that they are treated with respect and to the fact that knowledge is central to this being possible (Smolle & Espvall, 2021; Traczyk, Wurm & Ahonen, 2013; Sommarö, Baiocco et al.; Solberg, 2017).^[13] On the other hand, there are large knowledge gaps in the field, with a heteronormative mindset dominating and an equal treatment rhetoric in which everyone should be ‘treated equally’ with reference to laws and guidelines for the specific service (Norrman et al., 2013; Egede et al., 2019).

Treating everyone equally is interpreted as meaning that different situations and unequal conditions do not need to be taken into account in particular. What is considered important is generally a good response to people. However, this recreates a heteronormative foundation whereby everyone is treated as if they were heterosexual and identified with the gender they were assigned at birth. In Norrman et al.’s interview study with five unit managers of municipal nursing homes in Umeå in Sweden, knowledge about LGBTI people’s living conditions and ageing was not seen as relevant because ‘we treat everyone equally’ and ‘there are none here’ (Norrman et al., 2013): “The unit managers repeatedly restated the importance of equal treatment of older people who lived in their nursing homes and

13. This is most evident in those countries who were earliest to include gender expression, gender identity and sexual orientation in their anti-discrimination legislation, and is consistent with a trend in which attitudes to LGBTI people have generally become more positive in line with increased rights and protections against discrimination (Norrman, Eggebø & Stubberud, 2020).

that sexual orientation or identity would not affect how a person was treated" (ibid, 237). The managers referred to the social services' core values in the municipality, the Discrimination Act and the Social Services Act, but above all to the core values. As they focus on equal treatment, 'they do not provide staff with guidance on interacting with people who are outside the heteronorm or comment on how operations should handle bullying,' write the authors (p. 243). An equal treatment discourse also characterised doctors' and nurses' understandings of interactions with LGBTI patients in a Danish study (Egede et al., 2019):

This is most evident in those countries who were earliest to include gender expression, gender identity and sexual orientation in their anti-discrimination legislation, and is consistent with a trend in which attitudes to LGBTI people have generally become more positive in line with increased rights and protections against discrimination (Norrman, Eggebø & Stubberud, 2020).

The staff interviewed did not consider gender or sexual characteristics per se to be more important or interesting than other background factors, but they all stated that they obviously needed to understand the whole patient in order to understand their disease pathway and overall well-being. In general, they did not ask about sexual orientation or gender identity if what was to be discussed in the consultation was not related to gender, sex or cohabitation. (2019, p. 56)

In an interview study on working with LGBTI perspectives at two habilitation institutions in Sweden for people with learning disabilities, several of the 19 interviewees stated that they 'treated everyone equally', and that the workplace was good at doing this. At the same time, they described patients with learning disabilities and norm-breaking gender identities or sexuality as an invisible group at the habilitation centre. Few employees had met a patient who had openly identified as LGBTI, and confirmed the general pattern in which people with learning disabilities were desexualised (Löfgren Mortensson, 2009). The patient group was considered to break with norms in several ways, but other themes were prioritised and considered more important than gender and sexuality, which were rarely addressed compared to discussions concerning their capacities or ethnicity, about which there was also more knowledge. Sexuality was considered by many to be too private. However, the units that had undergone LGBTI training had more reflections on how their own prejudices and normative ideas affected interaction, and had also worked on, for example, examining the organisation's schedules and language use and gender-neutral signs in toilets.

Lack of knowledge – a negative spiral

All studies included on professionals in healthcare, social care and social science professions highlight a significant lack of knowledge regarding gender, sexuality and LGBTI perspectives. These perspectives were absent in their education, particularly in compulsory education (Stubberud, Pröitz & Hamidiasl, 2018; Solberg, 2018; Egede et al., 2019). This leads to uncertainty when it comes to raising issues of sexuality and gender identity on your own initiative (Träen & Schaller, 2018; Brekke & Vik, 2017; Egede et al., 2019). In Egede et al.'s interviews with five doctors and two nurses at general practice surgeries, it emerged that they felt a great deal of uncertainty about where to find relevant information about LGBTI people's specific needs for healthcare (2019, p. 65). In a survey of 1,064 psychologists, one fifth of them raised the topic of sexuality regularly with patients, but a majority of respondents did so from time to time (Träen & Schaller, 2018). Those who raised it most often had more sexology knowledge and felt more confident about raising issues on the topic. More than half of the respondents thought they had too little knowledge about sexuality to address it. The oldest respondents and those with the longest clinical experience felt more confident about talking about sexuality than the younger ones. Questions about negative and problematic sexuality were easier to raise than positive sexuality; sexual abuse, sexual problems, sexual orientation were the most common. In our Western culture, 'problematic sexuality' has a prominent place, and therefore it is no wonder that this is reflected by psychologists, write the authors.

Sexuality was more integrated in psychology education in the past, while today it has become a more specialised field, write Träen and Schaller (2018). 64% of psychologists said they did not have any knowledge of sexology. The result is often that the therapist does not feel confident about addressing sexuality, which affects the patient, and thus topics relating to sexuality may remain unspoken.

Lack of knowledge not only leads to avoidance of the topic. In a survey of healthcare staff, unit managers of four county services in Norway that offer psychiatric support, two of which to adults, were asked about employees' education and skills in relation to gender identity, gender expression and sexual orientation (Solberg et al., 2017). Few services, only 8.3%, had formal skills in the form of approved CPD:

Lack of prioritisation of the subject means that management will not pay for long-term skills development. In the long term, a basic understanding of the subject must therefore be prioritised in the training of healthcare professionals. In addition, more people must be given the opportunity for CPD in sexology, so that more people have in-depth expertise in sexual orientation, gender identity and gender expression in health care. (2018, p. 22)

In the services in which there were employees with competence and skills, the quality of the services was also better in relation to LGBTI perspectives and prioritisation of them as being thematically important in the services:

The common denominator is that unit managers who have employees with formal expertise in the area have better knowledge of external resources and use them to a greater extent than other respondents. Unit managers with formal expertise also report that they encourage their staff to enhance their expertise in the area to a greater extent than other managers.

The studies show that the gaps in knowledge are particularly large when it comes to gender identity and gender expression (Smolle and Espvall, 2021; Brekke & Vik; Sommarö, Anderson & Skagerström, 2020; Tikkinen et al., 2019; Egede et al., 2019). Sofia Smolle and Majen Espvall (2021) interviewed 16 social work professionals who interact with older adults in their work about their understanding and knowledge of older trans people's needs and norm-critical approaches and perspectives. Social workers usually play a key role in elder care, establishing the assistance required, cooperating with other healthcare and social care, and communicating with relatives. Older trans people have lower confidence in healthcare and social services but are also particularly vulnerable to social isolation and more dependent on healthcare and social services. The analysis focuses on three central topics: the strong dominance of heteronormativity and cisnormativity in the professional field, causes and consequences of invisibility and language and pronouns:

The majority of the interviewees deliberated about how heteronormative structures form the basis of preconceived opinions and views that social workers, more or less intentionally, let influence their work. (Smolle & Espvall, 2021, p. 527)

During the interviews, it also emerged that gender identity and sexual orientation were both presented as one and the same and confused, which may indicate a lack of understanding of the difference between them, write Smolle and Espvall (2021, p. 7). Although everyone expressed their willingness to interact with older trans people in an inclusive and affirmative way, most were unsure how to do so without giving offence or making someone uncomfortable by actively asking about pronouns or using gender-neutral language. The result instead was that they continued to maintain a heteronormative approach that caused invisibility by their choice of pronouns and by not addressing gender identity, which also contributed to more invisibility by creating a normative, insecure framework for the interaction:

Invisibility can be understood as a silence, from both parts – social workers as well as older trans adults. When needs are not expressed, they are not seen to exist, which underlines the importance of identifying silence and silencing within care settings. (Smolle & Espvall, 2021, p. 9).

Knowledge about trans people's specific history and living conditions is also essential to the ability to contribute to better treatment because you know what to look for and listen for, for example in relation to trans people who are not clearly trans or do not have a trans history but pass as the gender they identify with.

In sum, Swedish social workers have good intentions to promote social justice and human rights for older transgender adults. In addition to an increased reflective practice to grasp a trans person's specific experiences, needs and historical vulnerability beyond the topics of sexual orientation or stereotypical ideas, institutional and organizational conditions for increased knowledge are required. (Smolle & Espervall, 2021, p. 532)

Without recognising individual experience and history, equal treatment principles can help reproduce normative ideas and fail to recognise individuals who fall outside of a cisnormative and heteronormative culture.

In summary, lack of knowledge at different levels leads to several negative consequences: a re-creation of norms through rendering LGBTI people invisible and excluding them, which often stems from a lack of confidence about interacting with non-normative identities and life experiences. At a structural level, lack of knowledge in the management leads to LGBTI perspectives not being considered to be important priorities in staff CPD and they are thus not prioritised by employees either. However, the opposite also applies. The managers who know why it is important were more willing to prioritise giving employees opportunities for CPD in different ways (Solberg, 2018).

Healthcare professionals' understandings of gender identity, gender expression and gender characteristics in the treatment of trans and intersex people

Several studies show that cisnormative and heteronormative understandings of gender and sexuality dominate healthcare staff's practice in their interactions with people seeking gender-affirming care and treatment, with a dominant binary gender norm and an understanding of trans identities and experiences as psychopathology (Linander et al., 2020; Trazcyk, Wurm & Ahonen, 2013; Rosqvist, Nordlund & Kaiser, 2014). Sweden has offered state-funded gender-affirming treatment since 1972, which at the same time means that patients have had to fit into the pathological diagnostic criteria that existed, write Linander et al. (2020). The diagnosis criteria have changed gradually during the 21st century, and are no longer considered to be a psychiatric diagnosis based on a 'gender identity disorder'. The new WHO standards, ICD 11, were published in 2018 after years of advocacy by trans activists:

What Lysenko (2009) calls a trans-gender-positive discourse also includes arguments in which transgenderism is described as an expression of natural variation and in which the focus is on human rights. This argument sets transgenderism in a cultural rather than a pathological context. (Rosqvist et al., 2014)

That which is diagnosed and treated in the healthcare system is gender dysphoria, a state of severe discomfort in which a patient's perceived gender identity does not match their body and/or assigned legal gender. The treatment institutions' understandings of who falls within and outside the diagnostic criteria is particularly important in those countries in which access to changing one's legal gender still depends on a person having been diagnosed and treated for gender dysphoria (ibid). Although an attempt has been made to move away from a psychiatric diagnosis understanding, it persists. In an attitude survey of what healthcare professionals in Finland perceived to be 'mental illnesses', with 1,701 participants, 20–50% said that transsexualism is a mental illness, and roughly half of the doctors agreed in full or in part (Tikkinen et al., 2019). In psychology, a developmental psychology framework dominates rather than a medical understanding of illness (Rosqvist et al., 2014; Linander et al., 2020). This is based on identity development as stages:

[...] transgenderism as an identity crisis or a phase in a developmental process is based on the understanding that an individual's immaturity is connected to confusion and feelings of incompleteness. (Rosqvist et al., 2014, p. 34).

Treatment for gender dysphoria then involves achieving maturity and stability. However, a subject position that is 'perfect' and without crisis will be considered impossible within this framework of understanding, write the authors. In a study by the gender-affirming treatment investigation team, psychiatrists and psychologists in the team were interviewed about the understandings that characterised their evaluations of patients. Maturity and immaturity are often linked to authenticity, which is equated to age – where the meaning of being young is to be an identity seeker – and of being adult to be finished with identity formation. Thus, a young patient may risk being evaluated as not credible in their experience of their own gender identity and dysphoria because it 'could be something else' since a young person is not considered to be fully developed, while a middle-aged patient 'ought to have discovered their gender identity earlier in life':

Ps3: [...] this came up when he was forty-two or forty-five, and that seems to be a bit late for a debut as transsexual. (Interview quote, ibid, p. 34)

Being evaluated as credible as a person seeking care still depends on age-coded, ageist heteronormative, binary and essentialist understandings of gender and identity, as the quotation clearly shows. This is also evident from transgender people's own experiences in interactions with the healthcare system reported in Part 1, where several have experienced that they receive gender-affirming treatment 'too late' (Siverskog, 2016; Bremer, 2013). An interview study with five psychologists on their experiences of patients with trans identities also shows that understandings of gender as binary and heteronormative frameworks influence professional practice (Traczyk, Wurm & Ahonen, 2013):

The present study shows a lack of knowledge among psychologists about gender-affirming care as a phenomenon, which affects interactions with clients, especially when the client identifies outside the gender dichotomy. The respondents and their professional practice are clearly affected by heteronormative frames of understanding. (Traczyk, Wurm & Ahonen 2013, p. 85)

The psychologists were interviewed about their experiences with patients with 'gender-crossing behaviour'. They were not part of the investigation team for gender-affirming treatment; they were county council psychologists. However, they have a central role as gatekeeper in referring patients in the system when necessary for investigation for gender-affirming care. The material shows that the psychologists had not gained knowledge in their basic education, and when they had gained it, the focus was on psychopathology rather than on approach and treatment:

This suggests that the diagnostic manuals play a major role in psychology practice. They often seem to be followed even when psychologists personally do not think they really match the client's presentation. (Traczyk, Wurm & Ahonen 2013, p. 86)

It was always the patients themselves who addressed gender identity as the topic of conversation, and not something the psychologist initiated. Most demonstrated positive, supportive approaches, but often based on normative and binary understandings of gender, with experiences that broke with these understandings not being recognised.

Normative understandings of gender and sexuality are also created in the treatment of people with vaginal agenesis, a congenital intersex diagnosis in which the vagina and uterus do not develop, for which one treatment is vaginal reconstruction (Roen et al., 2018). In an interview study of 32 medical specialists and psychologists in cross-professional treatment teams in Sweden and England, it appears that the pressure of normality can lead to women being treated for vaginal agenesis minimising the time, effort, physical discomfort and emotional costs of vaginal reconstruction:

Under pressure, treatment might be presented to patients with insufficient attention to the potential psychological effect of the language used. Furthermore, the opportunity to question what is normal in sex is generally not taken up. It can be challenging to help the women to transcend their medicalized experiences to come to experiencing their bodies as sexual and enjoyable. (Roen et al., 2018)

Although psychological support is considered important by doctors and psychologists in treatment teams, social norms about how women's genitals should look and function were rarely questioned. Rather than lead patients (back) to treatment, the team should more explicitly question social norms and help patients do the same, thereby changing the definition of 'success' from anatomy to personal agency, and the clinical focus from treatment to the women themselves, write the authors.

CPD for healthcare, social care and social sciences professions

Who provides CPD?

Higher education institutions offer some supplementary courses and elective courses for professionals in healthcare, social care and social sciences, including knowledge about gender, sexuality and LGBTI perspectives, with a particular focus on professional groups that interact with children and young people (Solberg, 2017; Stubberud et al., 2018). In this section, we will look at short CPD initiatives that have been and still are important for how professionals in these professions acquire knowledge. The CPD initiatives are also important because many in the elder care sector do not have higher education, received their education some time ago, or did not acquire LGBTI perspectives from their education.

The material is based on studies of CPD and interviews with course providers in different countries conducted in connection with the knowledge inventory. The knowledge about the Norwegian context is mainly taken from the author herself, who has worked in CPD in elder care in Oslo in recent years.^[14] CPD is mainly provided by civil society organisations, especially LGBTI organisations and other organisations working with SRHR-related issues. In Sweden and Norway, the national LGBTI organisations have their own education units, and training is provided in all the Nordic countries and in Åland to a greater or lesser extent. These education activities are mainly financed by state and municipal funding in most of these countries, while the Swedish Federation for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Rights (RFSL) offers courses as a limited company, where LGBTI certification comprises a considerable part of its contract education, largely for public sector activities.

LGBTI certification has been offered in Sweden since the early part of the 21st century. These are longer, process-oriented training programmes with mandatory participation, and require an action plan for the period of validity of the certification. The certification results in a visible mark after the course has been completed if the organisation has met a number of requirements to be certified in relation to equivalent services and a gender-equal, non-discriminatory work environment. The certification model exists in different variants in several European countries, and has expanded as statutory protection against discrimination on the grounds of gender identity, gender expression and sexual orientation has been

14. Janne Bromseth worked as a training manager for FRI Oslo Viken's training programme *Skeiv kunnskap* (Queer knowledge) with special responsibility for the elder care field in 2017–2022.

instituted, along with stricter requirements for preventive efforts (Christophersen, 2021; Pijpers, 2022).

In Sweden, there are several different models due to organisations in municipalities and regions having developed their own model, LGBTI certification, which is often shorter and aimed at healthcare and social care staff^[15] (Linander & Nilsson, 2021). National funds to increase knowledge for more equal access to care for LGBTI people in the regions have also been allocated (Linander & Nilsson, 2021). In the Nordic countries, variants of certification of operations are also offered in Finland, Iceland, Norway and Åland. In Denmark, civil society organisations hold courses but do not offer certification. The Finnish LGBTI organisation SETA developed certification specifically for elder care activities in 2018, based on the Dutch Pink Passkey model which has been available to healthcare and social care institutions with older LGBTI people as target groups since 2008. The Pink Passkey model is based on older LGBTI people themselves being an active part of the training process, which the Swedish and Norwegian models do not do. The Norwegian *Regnbuefyrtårn* is based on the experiences of Swedish actors and was launched by FRI Oslo Viken in 2020. Reykjavik Municipality has an employee who holds courses for the municipality's employees in various activities. This employee has also developed a short certification process. The pedagogical approach in different models seems to have been developed based on other actors' experiences and approaches. Learning exchange has been documented in some cases, mainly on order from the responsible CPD coordinator (Ahlsdotter, 2017; Johansson Wilén & Lundsten, 2019; Tapper, 2016; Linander & Nilsson, 2021).

It is worth noting that a majority of these courses today are based on norm-critical perspectives, which are highlighted as a key starting point for change by several people in the studies referred to in Part 2 (Tengelin et al., 2019; Lundberg, Malmqvist & Wurm, 2018). But what results do they produce in practice?

The impact and results of CPD

There is a lack of qualitative knowledge data on how CPD initiatives affect healthcare activities, which Linander and Nilsson point out in their study of LGBTI certification from a patient perspective in Västerbotten County in Sweden^[16]:

LGBTI certification processes have been used as an intervention to improve access to healthcare for LGBTI people. However, whether LGBTI certification actually affects access to healthcare and, by extension, the health of the group, remains unknown. (Linander & Nilsson 2021, p. 5)

15. Västra Götaland Region's Närhälsan's LGBTI certification was established in 2009 and Region Stockholm's LGBTI certification for healthcare centres in 2015. The City of Stockholm also has its own LGBTI certification.

16. This study is mainly used to look at the structural and educational framework of the training, and not the patient perspective as it is based on patients between 20 and 40 and their experiences of certified healthcare activities in Region Västerbotten.

There are a few studies that look at the results of CPD initiatives among the staff who have been trained (see also Part 1). However, they do not specifically address elder care activities, but may have older adults as part of their target group. Several of the Swedish studies of professional practitioners' knowledge and practice in healthcare, social care and social sciences also include participants who have taken part in CPD initiatives even if the training itself is not the main focus (Sommarö et al., 2017; Smolle & Espvall, 2021; Johansson Wilén & Lundsten, 2019; Solberg, 2017). Johansson, Wilén and Lundsten (2019) investigated the *Kunskapscentrum för sexuell hälsa* (the knowledge centre for sexual health) process-oriented course on norm-conscious treatment on behalf of Västra Götaland Region (which funds the LGBTI certification). The study is based on both interviews with people identifying as LGBTI seeking care from certified activities about their experiences, and employees' experiences of the training and how it subsequently affected their activities. KSH has certified different types of healthcare activities: *Närhälsan* (primary care), hospital services, healthcare centres, administrative units in healthcare in the Västra Götaland region and all midwifery clinics and most youth clinics in the region.

Since its inception in 2009, the certification has undergone two major changes, gradually increasing its focus on norm-conscious interaction as a goal and process-oriented activity analysis as a pedagogical approach with fewer lectures, and this study was carried out just before the last revision. Employees who participated in the study worked in two different activities: a therapy clinic and a healthcare provider. Their experiences differed in several ways:

Employees describe how the certification has created awareness in the workplace and helped make it possible for LGBTI issues to be put on the agenda. How well an activity can continue working with norm-conscious interaction after the certification depends on the circumstances of the activity. Staff turnover and lack of time make it more difficult to maintain knowledge and keep following procedures. (Johansson Wilén & Lundsten, 2019)

While the therapy clinic was able to build on already established practice of reflecting on conversations and interactions in lunch breaks and the workplace community, with norm-conscious interaction and LGBTI perspectives becoming an extension of this, this was much more challenging in a healthcare practice with high staff turnover. At the therapy clinic, practice has changed in several ways in routine work according to an employee:

When asked how it is obvious that the clinic is LGBTI certified, 2A responded that they do not problematise matters that the patient does not want to problematise in conversations. Asking open-ended questions that are not based on any assumptions about the patient is important, said 2A. As an LGBTI-certified organisation, they should also have relevant knowledge about other healthcare units that may be particularly relevant to LGBTI people, according to 2A. These aspects of qualities that interviewee 2A highlights are consistent with what patients say they expect from an LGBTI-certified organisation. (Johansson Wilén & Lundsten, 2019, p. 25).

Routines concerning gender-neutral language and asking about pronouns are now an integral part of the clinic's practice. In the healthcare activity, there were similar positive experiences of integrating new knowledge into existing procedures come. At the same time, the healthcare activity faced major challenges related to high staff turnover, which also meant temporary workers from other departments who had not undergone certification, as well as a lack of time in the system to integrate the knowledge sufficiently.

Knowledge about LGBTI people often becomes the responsibility of employees who themselves identify as LGBTI. The need for patients to train healthcare staff is also a common experience among older LGBTI people, especially for trans people (see Part 1). Even in certified organisations, employees who identify as LGBTI feel that they have to take greater responsibility for implementing LGBTI perspectives than their colleagues, write Johansson Wilén & Lundsten (2019):

In the same way that there is a risk of patients having to train employees, there is a risk of LGBTI employees being assigned this role, which can lead to a strained work situation. We believe that the experiences of employees identifying as LGBTI show the importance of emphasising that the LGBTI perspective should not be borne by individuals. It should be live throughout the organisation. This would protect both patients and staff who identify as LGBTI, as the staff do not have to take greater responsibility and the patients do not have the risk of receiving a different quality of care depending on who in the workforce they encounter.

In Sommarö et al. (2017)'s study of gender, sexuality and LGBTI perspectives in two habilitation units for people with learning disabilities, all employees of two out of four teams had also undergone LGBTI certification:

The results also showed that the conditions for improved and more inclusive treatment at the workplaces existed. Positive results were described in the teams that had undergone LGBTQ training. Examples given were changes to paperwork, forms, questionnaires and other materials to ensure that these were inclusive and changes towards more gender-inclusive restroom signs, which may result in less discomfort for patients when not being forced to choose a men's or women's restroom (Transgender Law Center, 2005). (Sommarö et al., 2017)

The CPD led to important changes in the organisation: inclusive and gender-neutral language in schedules, gender-neutral toilets and increased awareness that they were affected by heteronormativity in their thoughts and working methods, and willingness to use this insight to continue a norm-conscious, self-reflexive approach in their work. Despite this, several people still found it difficult to discuss LGBTI-related topics in conversations with patients unless the patient initiated the conversation, and could feel uncertain about what to do, especially in connection with norm-breaking gender identities. There was also no clear integration of LGBTI perspectives into the provider's policies and guidelines that were visible to new employees and patients.

Lack of knowledge and uncertainty about gender identity and gender expression were also evident in Smolle and Espvall's interviews with social workers who interact with older people. Among their informants, about half had participated in CPD courses in the form of certification or similar (Smolle & Espvall, 2021). However, they could not see any major difference in how the informants talked about how knowledge about norms, gender identity, gender expression and life experiences and inclusive interaction with users and patients had influenced them, whether they had attended a course or not. However, evaluating the training process and its conditions was not their main focus and they wanted more research into the effects of training initiatives on knowledge about gender and trans experiences.

In light of their results, Johansson Wilén & Lundsten (2019) recommend specific frameworks and conditions for CPD initiatives that build on and learn from the experiences of the activities studied:

- Training in LGBTI issues needs to be adapted to the specific organisation and the needs of the employees. Follow-ups may be needed.
- In order for staff to be able to immerse themselves in new areas of knowledge during working hours, it is necessary for them to be given the opportunity and time to do so instead of it becoming an extra job to be squeezed into an already tight schedule.

- Employees who openly identify as within the LGBTI spectrum should not bear the responsibility for maintaining the level of knowledge on LGBTI issues.
- The work environment in relation to LGBTI perspectives is an important element in training about LGBTI issues, regardless of whether someone in the team is an openly LGBTI person or not.

The certification process studied underwent a major change after this evaluation, and today focuses mainly on organisation-based, process-oriented analysis and has fewer lectures, something that was requested in the study.

Since the effects of CPD initiatives will depend on its content and how it is taught, as well as structural and organisational frameworks for the activity (municipal/private, size, general working conditions, part of municipal strategy, etc.) and other contextual factors, the effects of CPD initiatives must be seen in the broader context of these factors.

Conditions for CPD initiatives

The demand for courses and certification has increased over the past five years, say trainers interviewed for this study. This is a result of both stricter anti-discrimination laws and explicit policy to increase competence and the fact that the knowledge provided in professional qualification study programmes is insufficient. This leads to a significant gap between requirements to work to prevent discrimination and being able to do so in practice. Svandis Anna Sigurdadottir has been employed by Reykjavik Municipality since 2017, and is its only employee to develop resources and hold courses in all of the municipality's activities on gender, sexuality and LGBTI. In 2019, she developed a short 4.5-hour certification course for these activities, with a requirement that each activity establish their own action plan and follow-up course after three years. Today, 90 activities are certified. But no elder care service has contacted her: "I have not received any trainings from departments providing elder care. This is an underdeveloped topic in Iceland, I experience." Over the years, positive changes in various municipal activities have clearly taken place, she thinks, which she has been able to follow from within over time:

A school celebrated non-binary day, kindergartens celebrating IDAHOBIT-day the 17th of May, amazing things are happening. The swimming pool where transpeople did not want to go swimming; 7 years ago it was 'no, no we cannot have mixed changing rooms because of genitals' – we have had to work really hard to get to where we are today, which is completely different. It is way better. (Interview, Svandis Anna Sigurdadottir)

Now there are 40 activities in the queue, but there are no more resources in the

form of employees, which has led to exhaustion and frustration. Especially when she sees positive results over time in the activities that have been trained. She says: "I've got really conflicted feelings because I've just been burnt out, because of work, and I can't see how it will change in the future because there is no funding and obviously the political will is mainly there around pride week, but they do not want to put real money into it.

"It is a political issue in itself," says Svandis, "that the municipality should take responsibility for the issue, and own the knowledge: Shouldn't we as an arena be responsible for these issues, shouldn't we build up the competence within the system, not always buy it from external parties who we do not have control over?"

The Icelandic LGBTI organisation *Samtökin 78* also provides training in Iceland, and among other things has held short training courses for healthcare staff, in schools, and in teacher education. There is a lot of good will, according to Daniel Arnarsson of *Samtökin 78*; the organisations want knowledge. However, *Samtökin 78* has not been involved in elder care organisations either:

We have been teaching teacher students at university, we made a contract with them - elementary school, kindergarten, upper school and universities. We are also doing a contract with the police, so we will also educate all the people who are becoming police officers. Of course it would be great if we had something like this when it comes to these issues [elder care], but there is nothing at the moment. (Interview with Daniel Arnarsson)

Civil society organisations engaged in education and training with central government or municipal support talk about stressful conditions, both in terms of the scope of support and the possibility of continuity (Nordic Council, 2021). SETA has been a driving force in creating better healthcare and social care for older LGBTI people since the early 21st century in Finland. In 2010, a knowledge base document was written for an older peoples initiative to create an 'elementary perception of the situation of older LGBTI people in Finland with a focus on healthcare needs' (Irni & Wickman, 2010, in Wickman, 2013). They received funding for two projects in which older LGBTI people were the main target group, with the development of training for healthcare and social care services as part of the project *Likställd ålderdom (Equal ageing)*, which was funded in 2012. After two years of development of materials and a separate model based on the Dutch Pink Paskey, two senior citizens' centres were certified. The funding then quickly ran out, says Touko Niinimäki, who was responsible for the training. SETA currently has no special support for training elder care services, says Outi Tjurin of SETA:

The Equal Aging project of SETA first run from 2012–2014 and after that we got funding for a continuation The Equal Aging project II 2015–2017. After that we got permanent funding (not as a project anymore, but one sector of SETA's work) for advancing the rights of LGBTI seniors, but the funding was cut in 2020. People can order trainings from SETA and we modify them to their needs. Mostly they are for people working or studying the social and health fields. Now we are not marketing any trainings for the elder care, because we don't have an allocated resource for it. We do, however, also have some video trainings that we sell. (E-mail interview with Outi Tjurin, SETA)

However, the material – a knowledge resource with interviews with older LGBTI people aimed at healthcare and social care staff, and a short film, *Jag skulle kunna berätta (I could tell you some things)* – remains. Tanja von Knorring, the head of *Sateenkaariseniorit – Regnbågsseniorer* (Rainbow Senior Citizens), says that the organisation's activists now provide training under the theme 'How to interact with older rainbow people in healthcare contexts' free of charge:

Formerly while these services were rendered by SETA, and enough of state financing was available, we had the possibility to maintain also a certification procedure for care units ('Regnbågsscertifikatet'). The financing for that ended unfortunately in the very beginning of reasons not known, and we could only certify two units in Helsinki (Kampens servicecentral, Helsingfors and Kinaborg servicecentral, Helsingfors). Now the organisation Regnbågsseniorer works completely with help of activists, and we are trying to get funds in the first place for short courses and on place training in the first mentioned topic, that is given as a two to three hours training. (E-mail interview with Tanja von Knorring, Vice Chair of SETA/Chair of Sateenkaariseniorit)

Regnbågsseniorer are also active in political advocacy work to improve LGBTI perspectives in professional qualification study programmes: "We are also active in policy work and are trying to influence on the education schemes of vocational and higher education institutes, thus that they would include enough teaching on rainbow related questions". In the Åland Islands, LGBTI certification was developed, but unfortunately there was no further funding after the project ended:

Knowledge about limiting norms is quite low in Åland as it is in many smaller places. Therefore, we consider it very important to increase the level of knowledge, and we had hoped for an extension of the project on LGBTI certification, as the project was very affected by the COVID-19 pandemic, but unfortunately it ended at the year-end. Within that project, older LGBTI people were a natural part. (Interview with Sofia Enros, Executive Director, Regnbågssfyren (Rainbow Lighthouse))

De säljer nu utbildningen, men hon tvivlar på om någon äldreomsorgsverksamhet har råd med att betala vad den kostar.

In Denmark, LGBT+ Danmark holds courses for employees in the LGBTI-profiled nursing home Slottet. There is also a three-year visiting friend project in connection with LGBT+ Danmark with support from the City of Copenhagen. After having tried to establish the project within the City's elder care services, it became clear how important it was to boost knowledge in the City's general work to counteract social isolation among older people. Project manager Kamille Hjuler Kofoed started to hold courses for employees in elder care but is unsure whether there will be further funding or whether the project will again have to be run on a non-profit basis in the future. Aids-Fondet (the AIDS Foundation) also trains healthcare staff in sexuality and SRHR-related issues, and constantly struggles to maintain funding, which is provided in the short term and is insufficient to meet the demand.^[17]

In Norway, Rosa kompetanse (Pink skills), the national training body of the association FRI, has received very few requests from elder care, and does not have any special funding for this. However, the local association FRI Oslo Viken has worked politically and socially with older LGBTI people's conditions in the ageing process for a long time (Møllerop, 2013). Since 2015, they have received annual funding from the municipality to train healthcare staff, with elder care as a priority area, and have their own training unit, Skeiv kunnskap (Queer knowledge), which primarily works in the City of Oslo. Since 2018, work has been intensified because directives to increase LGBTI competence were included in the sector's budget guidelines for two years, which was crucial since the activities then had to prioritise it. Elder care services currently represent a significant proportion of training activity's clientele, and the sector has its own action plan and works closely with Skeiv kunnskap on various CPD initiatives.^[18]

The Swedish company RFSL Utbildning, which is not run with central government or municipal support, has found that, despite a huge increase in demand for LGBTI certification, very few elder care services have been certified. This is what Åsa Wern of RFSL Utbildning has to say:

In particular, special housing – it seems that senior citizens' centres have more capacity. We have been inside the sector, but very few have been certified. It seems that there is a huge scarcity of resources in the sector, for both training and other purposes. I remember we once provided training for a whole day in a nursing home, where we got flowers but the staff didn't get a coffee break all day.

17. Of 158 people over 50 who tested for HIV and STI at AIDS-Fondet, only 30 say they would have taken a test at their own doctor's if they had not done so at the AIDS-Fondet test station (AIDS-Fondet, 2023).

18. Six senior citizens' centres became Regnbuefyrtårn in 2021–2022.

Elder care services are prioritised when this is a particular focus of projects or a political priority, as in Finland and Norway, but otherwise they seem to form a small part of the actors' training initiatives. The same is true for the regionally driven LGBTI certification schemes in Sweden (Johansson Wilén & Lundsten, 2019; Linander & Nilsson, 2021). It seems here that there is an unfortunate combination of invisibility in older age, scant resources for CPD on gender, sexuality, LGBTI perspectives and non-discriminatory practice, and scant resources generally in the elder care sector.

CPD initiatives and the integration of LGBTI perspectives into policies and practices in elder care

A positive trend is that LGBTI perspectives appear to be more often integrated into CPD courses or existing knowledge resources for healthcare and social care staff who interact with older people. An example is the City of Oslo in Norway, where funding for CPD in the elder care sector has been prioritised since 2016. This has also enhanced the sector's internal knowledge over time, which creates greater potential to integrate the knowledge into routine quality work. An easy-to-read CPD resource, *Veier til inkluderende eldreomsorg. Skeive perspektiv (Paths to inclusive elder care. Queer perspectives)* (Bromseth, 2019) was published in collaboration with the City of Oslo and a collaborative project on a documentary film, *Gammel og skeiv (Old and queer)*, (both of which were externally funded) and other learning resources for healthcare staff in elder care were developed in 2019–2021. These are based on norm-critical perspectives and, since 2021, they have also been included in *Eldreomsorgens ABC (An ABC of elder care)*, which is a regionally organised introductory course for everyone who works in elder care and has some 5,000 participants every year. The Norwegian Directorate of Health's national competence centre *Aldring og helse (Ageing and health)* is responsible for the training material for the courses.

In Denmark, there is a digital resource at the Danish Health Authority's competent centre *Videnscenter for værdig ældrepleje (Knowledge centre for dignified elder care)* on how services should work on norm-critical approaches to equivalent and LGBTI-inclusive elder care based on experiences from the City of Copenhagen's nursing home Slottet. Slottet gained an LGBTI profile in 2015, and one of the strategies for proactively creating a knowledge-based inclusive environment has been a close collaboration with LGBT+ Danmark, which holds workshops three times per year, at which all new employees receive a total of nine hours of skills enhancement; and continuously supervises employees when needed over the year. Simon Meggers Matthiesen's mapping is used as a teaching resource, and was funded by the Ensomme Gamles Værn (social inclusion of older adults) foundation (Meggers Matthiesen, 2019, see Part 1). The digital resource describes, among other things, the norm-critical working method used as the framework for the organisation:

At Slottet, all employees receive training and knowledge about LGBT+, which equips employees to adopt a norm-critical approach. Employees are made aware of societal and personal norms and how these affect their interactions with other people. When you are aware of norms, you can interact better with people who have lived in a different way from what the (societal) norm prescribes, in a more dignified way. (Danish Health Authority, 2023)

The municipality allocated DKK 350,000 to boost knowledge during the transition to a LGBTI-profiled nursing home, and the initiative received a lot of attention. Some of Slottet's experiences of the process, and central parts of the work on uniform skills-enhancement work, are described in the digital resource, along with films and concrete case studies.

In Sweden, the knowledge centre for sexual health in the region of Västra Götaland published a resource on dementia care and sexuality, *Sexualitet och demens* (*Sexuality and dementia*), in collaboration with Svenskt Demenscentrum (the Swedish Dementia Centre), with a norm-conscious approach in the knowledge base and focus in case studies and reflection tasks. In 2021, the research-based resource *Queer äldreomsorg* (*Queer elder care*), written by Anna Siverskog, was published by RFSL. It is based on interviews with older LGBTI people with experiences from elder care, with healthcare and social care staff working in elder care as the target group. A year later, the City of Stockholm, on its own initiative, used the resource as the basis for a digital course that is now offered to the City's employees.

A clear pattern is that local action plans are important for initiating and driving CPD initiatives. Long-term work on CPD in certain Swedish metropolitan municipalities and regions seems to have contributed to a greater integration of responsibility for and implementation of skills enhancement with what several refer to as 'norm-conscious working methods' (instead of LGBTI competence), in which municipalities and regions themselves are responsible for CPD (Johansson Wilén & Lundsten, 2019; Linander & Nilsson, 2021). The situation varies greatly, says Åsa Wern. Some municipalities have taken a long-term approach over several years, even a few smaller municipalities. Since RFSL's certification is also expensive, political support is also required here that also highlights the need in political forums such as municipal executive committees. There is often good will and an understanding that a knowledge boost is necessary, she thinks. But the opposite has also happened in recent years, that organisations want knowledge but not visible certification, especially in Skåne, where right-wing conservative forces have grown strong on municipal executive committees and actively opposed LGBTI CPD initiatives.

Taking responsibility for change

Despite positive developments in terms of integrating knowledge about LGBTI perspectives, gender and sexuality in government and municipal resources for healthcare and social care staff, it is insufficient in relation to the knowledge needs of the staff. This is the case in all Nordic countries, with the exception of Sweden, where CPD initiatives are highlighted at central government and regional policy levels in relation to work on equal access to healthcare, and with clearer integration where regions themselves carry out the CPD (see also Wickman, 2013). Insufficient resources easily lead to superficial box-ticking measures in which a short online lesson or a short lecture is intended to meet the need, and to knowledge being considered voluntary and not an integral part of the activity, say several of the trainers interviewed:

It is not considered basic knowledge, but something for those with a special interest. When we go there, we have always been invited by a key individual who thinks this is important. Or they have a specific case with a patient. There is nothing systematic about it. And if the queer person is responsible for it in the workplace, it becomes personal experience, not quality-assured knowledge. (Mikkel Enevoldsen, AIDS-fondet)

The person who often takes responsibility for ensuring that the training takes place is a key individual who has a special interest because they are LGBTI themselves or have a family member who is. The same person also takes responsibility for training healthcare staff when there is insufficient knowledge, which is also discussed by queer employees in Johansson Wilén & Lundsten's study of certified healthcare organisations (2019):

Besides the fact that she [an employee of the healthcare activity] herself feels that she is doing unpaid work, she also describes how a structure that relies on the knowledge of individuals risks becoming vulnerable if that person leaves. She also does not believe that the organisation would ensure that she was replaced if she chose to change her workplace: "I don't think anyone would do the same job if I were to quit today. They probably wouldn't have said that 'we have lost a nurse with intersectional skills, we need to appoint a new one'. It just happens to be lucky that I'm here. (Johansson Wilén & Lundsten, 2019)

It is largely the LGBTI organisations and people who identify as LGBTI who provide training with scant resources, with highly trained staff working on short, precarious contracts with project funding that may suddenly run out. These people feel the need for knowledge to exist for their own sakes, that of their friends, the LGBTI

community or the lives of rainbow families. Svandis Anna Sigurdadottir explains how she feels a great responsibility to continue to exert influence through her training activities in a small country in which few people have her skills. This is also linked to a clear concern about the political climate in which LGBTI rights and, in particular, trans rights have been actively opposed by anti-gender movements in recent years:

And on a totally selfish note, I have two kids – one is in preschool and the other is 7 and in primary school. And I have always been like, I wanna make sure that my kids get a good education, they've got queer parents and all of this- and then my 7-year-old is non-binary, so I have to stick at it... just a little longer. It's just this responsibility, making sure that its OK, because of your kids, you know. (Interview with Svandis Anna Sigurdadottir)

The level of knowledge is low and the organisations have a great responsibility to provide the knowledge that would have been part of the staff's basic training, says Kamille Hjuler Kofod of LGBT+ Danmark – and at the same time it is random who gets it:

It is not satisfying- it's not good enough! Because there's gonna be so many holes, and it's so random you know [...] If all caretakers should know about this, then it should be much more systematic and incorporated into the education from the beginning. I have met so many workers who said, "You know I have been working for 30 years and I have never met a homosexual" So they in general they think that "we treat everyone the same, we don't care about sexuality and gender identity. I feel that equality is a big part of their work ethics, but then you know there are so many blind spots, so I think it would help if it was part of their education from the beginning, at least a little bit. [...] The people I met who knew something already, they are queer themselves or have a relative but from a professional take they don't have anything. It is from scratch. (Interview with Kamille Hjuler Kofod)

There is no policy for training initiatives specifically for elder care services in Iceland, says Daniel Arnarsson, head of Samtökin 78. However, increased demands on schools to integrate knowledge about sexual orientation, gender identity and gender expression have led to the organisation giving teachers one lesson in year 3 of their training, but it is not enough to ensure change in practice:

If we had policies, we would tell them; like we have policy so you have to step up and do better. But we have seen that even if you have policy, they can ignore it. Like in elementary schools, there are a lot of elementary schools that never talk about sexual orientation and gender identity, sex characteristics, gender expression, never. And we tell them

that the ministry of education tells you to teach, you have to teach this they just don't. Sometimes having the policy is one thing and following it is another. (Interview with Daniel Arnarsson)

Here, too, it is the LGBTI organisation that goes in as a knowledge provider to fulfil a statutory requirement in teacher education, and at the same time concludes that it is not enough to change the teachers' competence to carry out their task in practice.

The material shows that there seems generally to be a significant gap between the policy and practice levels when it comes to integrating knowledge in healthcare and social care activities that interact with older people. Studies show that CPD initiatives have some effect, but who gets knowledge is random and vulnerable. LGBTI organisations carry out a large part of their CPD initiatives with scant resources and uncertain funding conditions, and feel a great responsibility to raise the level of knowledge. There are examples of strategic measures to integrate knowledge in the municipal sector, especially in Sweden, where municipalities or regions are responsible for training initiatives. However, the elder care sector is rarely represented among the organisations that are trained.

Concluding remarks

The purpose of this report was to contribute knowledge about the living conditions and quality of life of older LGBTI people, in particular in their interactions with healthcare and social care, in the Nordic countries; and to investigate what knowledge about and competence in LGBTI people's living conditions and gender and sexuality norms is provided in health professionals' study programmes and among healthcare and social care professionals working in the Nordic countries. In 2013, the authors of this report edited the anthology *LHBTQ-åldrande: Nordiska perspektiv (LGBTI ageing: Nordic perspectives)*, with the aim of compiling the knowledge about older LGBTI people that existed at that time in a Nordic context. This research overview has explored what has happened in the field since then, in the past decade, which we note is a great deal. Ten years ago there were a few qualitative studies, while we now have a much larger qualitative basis, as well as a quantitative basis from some of the Nordic countries. In this final section we provide a summary of the results of the research that forms the basis of the research overview. Then we highlight the implications and recommendations made in the studies, and discuss the knowledge gaps we have identified in the overview.

Summary of the results of the report

Part 1. The living conditions of LGBTI people in the Nordic countries

Since the studies that specifically focuses on older LGBTI people's interaction with and experiences of healthcare and social care are very limited in a Nordic context, the focus was broadened to research on the life experiences and living conditions of older LGBTI people from a broader perspective. This is also because factors such as previous experiences of discrimination, transparency, health status and relationships affect experiences of interaction with healthcare and social care. The research overview has focused on previous experiences of discrimination during a person's life; on health, including mental, physical and sexual health, and experiences of living with HIV; interaction with healthcare and social care earlier in life and experiences of and concerns about elder care; and on relationships, social networks, chosen and non-chosen families, and LGBTI contexts. Finally, the recommendations resulting from the studies have been summarised.

The research overview has shown how a gender identity or sexuality that goes beyond the heterosexual cis norm among older people is often of great importance for mental health and living conditions and that LGBTI people who are older today have been shaped by the experiences they have had during their lives, and the historical context in which they have lived their lives. Their LGBTI identity has shaped and influenced their lives in many areas and continues to do so even in older

age. When it comes to discrimination, a larger proportion of the LGBTI group than the rest of the population have been treated in ways that they find to be offensive, and subjected to violence. Experiences of having been discriminated against during their lives on the basis of gender identity or sexuality at school, in workplaces, in religious communities, in associations and in public places are presented in the studies. A recurring experience is that people who have previously been close break contact with a person when they come out. There is therefore a link between discrimination and transparency here, with transparency also involving risk-taking. LGBTI people in the older age groups report poorer mental health and higher rates of suicidal ideation than the rest of the population. The differences in health based on sexuality and gender identity are often explained by the theory of minority stress, i.e. the increased risk of psychosocial stress factors that being in a minority position may entail (Bränström et al., 2016, 2022). Gustafsson et al. (2017) also show how unequal distribution of material resources (such as finances, position in the labour market and access to healthcare) helped explain health differences as much as psychosocial stress factors. They argue that it is not just exposure to stress factors but also social inequality related to the unfair distribution of resources such as money, social capital and power that may influence health factors (Gustafsson et al., 2017). Many of those who are ageing today and who were in lesbian, gay and bisexual communities during the 1980s have strong memories from this time and suffered major losses when HIV broke out. Prevention campaigns often target younger people. Living with HIV often involves a fear of how you will be treated by elder care services.

Historically, LGBTI people have often had a poor relationship with the healthcare system as well as psychiatry, where medical theory and practice have actively created notions of social normality and deviation – what is healthy and sick (Møllerop, 2013). This has been particularly apparent through pathologisation, i.e. how psychiatry has viewed homosexuality as well as trans expressions as forms of mental illness. A number of participants have also encountered homophobia or transphobia in healthcare and social care, which may result in a person not seeking the care they need, or choosing not to be open about being LGBTI in their interactions with healthcare and social care. Cisnormative and heteronormative healthcare and social care create a tension about coming out, between invisibility and hypervisibility. Ignorance is described as being particularly high about trans people.

While the time after retirement may mean increased opportunities to choose for yourself which contexts you want to be in and which people you want to have around you, which in turn may lead to greater opportunities to be open, care needs may instead mean that these opportunities decrease and that your home also becomes someone else's workplace. Among the participants who do not yet have care needs, there is a recurring concern about what it will be like when they get to the point of being in need of care from others. While all older people can be worried about illness, dependence, impairments in their capacities, and needing to move to

an institution, there are additional worries that are specific to the LGBTI group. These worries are linked to fears of a lack of knowledge about LGBTI in elder care, and of being poorly treated due to their gender identity or sexuality by other residents or staff. It may involve fear of being discriminated against by healthcare staff, not getting help with what is important for you in relation to gender identity, being rejected as a care recipient, developing dementia and losing the ability to say what is important to you, concern about how hormone therapy, concern about not having your relationships recognised or not being able to be open, and maybe even having to 'go back into the closet'. Those who have received elder care talk about a general silence about gender identity and sexuality in care services, which may be understood on the basis of different factors. On the one hand, this is about elder care having been subject to cuts and rationalisations for many years, which has created pressurised working conditions, which in turn leaves little room for conversation between staff and care recipients. It is also about norms, about care as a desexualised place where sex is not something that is talked about. This silence, along with heteronormativity, leaves the entire responsibility for coming out or highlighting LGBTI perspectives on the care recipients.

In terms of relationships and networks, quantitative studies suggest that older lesbian, gay and bisexual people are less likely to have contact with family and friends, and that they lack emotional support to a greater extent than the rest of the population in a Danish and a Swedish context. A much higher proportion of older trans people lack emotional support.

In the qualitative studies where relationships with original families are discussed, experiences often differ among the participants. Some have been accepted and have good relationships with their original family, while others have struggled to be acknowledged and understood in those relationships. That family, relatives and friends having distanced themselves from the person when they came out regarding their sexuality or gender identity is a common experience. Sometimes it is the individuals themselves who have finally broken off contact as a strategy to avoid encountering homophobia or transphobia. Relationships with one's family of origin are often conditioned by heteronormative premises and interpretative frameworks for what counts as acceptable and valuable relationships. A recurring theme in the research is how chosen families are highlighted as significant and important among many older LGBTI people. This means an idea of family that goes beyond blood ties and kinship. But even though many older LGBTI people are part of what they call chosen families and have strong networks and relationships, far from everyone as these. Stories of being alone, voluntarily as well as involuntarily, are present in the studies. Given the historical context, where LGBTI identities have been criminalised, pathologised and very often not socially accepted during the lives of older LGBTI people, LGBTI contexts have often been very important for LGBTI people. These can include political groups, bar and club environments and Internet spaces places where gender identity and/or sexuality are a common denominator for the context. They have been places and contexts in which LGBTI people have

been able to find power, strength, community, friends and partners, and have been zones free of heteronormativity, and places for political struggle. These do not cease to be important for older people.

Part 2. Knowledge inventory of healthcare, social care and social sciences study programmes and professions

The purpose of the knowledge inventory in Part 2 was to investigate the knowledge and competence about LGBTI people's living conditions and norms for gender and sexuality in study programmes as well as among professional practitioners in healthcare, social care and social sciences professions in the Nordic countries, as well as the CPD and additional knowledge on LGBTI, gender, sexuality and norms that healthcare and social care staff receive. The inventory is based on literature studies, analyses of policy documents and supplementary interviews with employees of higher education institutions and key CPD actors. The literature search produced few studies, and analyses of the supplementary interviews and policy documents need to be understood in relation to their respective contexts. Although the inventory cannot provide comprehensive answers, it can help to highlight some trends in the material, and show the important knowledge gaps that need to be filled in future research.

An overarching pattern is a contradictory relationship in which knowledge and competence about LGBTI people's living conditions are highlighted and made visible as important for caring professions at policy level, but there is a lack of integration of these goals in practice (Areskoug-Josefsson & Solberg, 2023). Knowledge about LGBTI people's living conditions is prominent at policy level as part of university diversity strategies. There are also some positive tendencies to integrate LGBTI perspectives as knowledge requirements in guidelines for intended learning outcomes in professional education in health and social sciences subjects, as in Norway. However, this does not yet seem to have been systematically integrated into individual first-cycle study programmes according to several of the studies in the literature review (Areskoug-Josefsson & Solberg, 2023; Tengelin et al., 2019).^[19] There is an increase in Scandinavian language study resources in individual professional qualification study programmes, as well as relevant research relating to sexuality, gender, ageing and LGBTI perspectives, which makes it easier to integrate knowledge into the programmes (Giertsen, 2017). Both the literature and the interviews indicate that teachers at higher education institutions seem to be willing to integrate knowledge, but that there still seems to be a considerable gap between policy/guidelines and the implementation of knowledge in practice. This applies in particular to knowledge about the living conditions of older LGBTI people. However, whether and to what extent knowledge is integrated in first-cycle study

19. It is interesting here to look at how intended learning outcomes for men's violence against women and violence in close relationships were integrated into eight study programmes and followed up by study support programmes in Sweden to integrate them into the teaching (Carlsson, 2020).

programmes seems to be highly dependent on individuals, and there is a tendency for responsibility to be placed on students to ask for knowledge or on teachers who themselves have knowledge about queer theory and LGBTI perspectives on ageing. Consequently, the result is that who gains the knowledge is random and the structures for education on the topic are vulnerable.

The knowledge base in central professional qualification study programmes in health and social sciences subjects is mainly based on a heteronormative, gender-binary notion of sexuality. Older LGBTI people's stories about experiences of invisibility and lack of knowledge about their life experiences, health and needs are reflected in the inventory in the absence of and ad-hoc representation of knowledge in both study programmes and the professional practice of health professionals. The lack of knowledge is particularly great when it comes to norm-breaking gender identities and what trans and intersex experiences may mean for ageing in a life course perspective (Smolle & Espvall, 2021). Lack of knowledge also leads to insecurity and a negative spiral, with health professionals, in their interactions with patients and clients, continuing to avoid discussing gender identity, sexual orientation and sexuality in general. Lack of knowledge among leaders in healthcare and social care-related activities is also a contributing factor to the fact that resources are not spent on increasing knowledge through CPD (Solberg et al., 2017). Discussing sexuality appears to be generally challenging in interactions with older patients (Træen & Schaller, 2018).

CPD and knowledge-enhancing interventions are important to enhance the competence of staff in healthcare and social care professions. In some cases, this is offered in study programmes, but above all it is provided as short courses or LGBTI certification. In most countries, it is civil society, in most cases the national LGBTI organisations, that provide CPD with scant resources and precarious funding. The interviews show that the representatives of the LGBTI organisations feel a great responsibility to raise the level of knowledge and are concerned about the tendencies to restrict LGBTI people's rights that exist in society, especially those of trans people, and how this affects LGBTI people's conditions in different social arenas. There is low priority for CPD in elder care services. This seems to be linked to both age normativity at training providers, with it primarily being the person who orders courses who receives training, and a lack of resources for CPD in the elder care sector (which cannot order certification, for example, because it is challenging to implement with current resources). To date, there are no studies of the long-term effects of CPD in elder care services, and this needs to be investigated in more detail to know what has an effect and under what conditions. Since the challenge is that elder care services have structural challenges and too few staff in general to be able to provide good person-centred care, as other studies point out, this will be a crucial condition for CPD. This is also pointed out by evaluations of CPD for healthcare and social care services included in the literature search (Johansson Wilén & Lundsten, 2019; Linander & Nilsson, 2021; Sommarö et al., 2017).

Recommendations

In this section, the recommendations made for policy and practice, based on the results and conclusions of the studies, will be summarised. A recurring theme in the studies, based on the results, is that there is a need for LGBTI competence in healthcare and social care. A key element here is that those working in healthcare, social care and other professions in which they interact with older people should have LGBTI competence and that the target group itself should not be responsible for educating the professionals they encounter. Inclusion of such knowledge in healthcare and social care study programmes and CPD initiatives is thus repeatedly highlighted as important (Egede et al., 2019; Lof & Olaison, 2018; Meggers Matthiesen, 2019; Siverskog, 2014, 2021b; Zeluf et al., 2016).

In day-to-day interactions with healthcare and social care

- **Knowledge about (different experiences within) the LGBTI group:** The importance of there being basic knowledge among those who interact with older people through their profession about the special experiences and needs that LGBTI people may have is repeatedly highlighted. At the same time, it is important to see the LGBTI group as heterogeneous with different experiences; for example, trans people's experiences may differ from those of gay or bisexual people, and age, gender, sexuality, health, geography, socioeconomics, ethnicity and access to relationships and social networks also create different experiences and needs. This also means that there is no 'right way' to respond to an LGBTI person. Instead, norm-critical knowledge about gender and sexuality and knowledge about LGBTI history and LGBTI rights are highlighted as important (Johansson Wilèn & Lundsten, 2019; Giertsen, 2017). This also includes critical self-reflection through regular dialogue that makes it possible to reflect on the assumptions you make about people's gender, sexuality, life experiences and family status to highlight and counteract heteronormativity (Sommarö et al., 2017). In light of the paucity of knowledge about trans people, people with intersex variations and people living with HIV, this needs to be focused on in particular in competence-enhancement initiatives (Åberg, 2018; Bromseth, 2013; Egede et al., 2019; Meggers Matthiesen, 2019; Siverskog, 2014, 2021b).
- **Language and communication:** Another factor that is frequently highlighted in the studies is the importance of being treated in a respectful, unbiased manner so that people feel safe and welcome to be open about their identity and be affirmed in who they are. Recognition and respectful language are important here. A few more concrete factors that are emphasised are the use of gender-neutral language, i.e. language that does not reflect certain

assumptions. This may involve using words like 'partner' or 'life partner' instead of husband or wife, or making space for important close relationships beyond partners or family of origin by asking questions such as 'what relationships have been important to you?' This may also be a matter of being attentive and listening to the terms the person uses themselves and using these (Löf & Olaison, 2018:262; Meggers Matthiesen, 2019:94; Siverskog, 2021b:63 ff.). Several studies show that norm-critical, intersectional perspectives in CPD contribute to gender-neutral, inclusive healthcare interactions that provide greater scope for marginalised life experiences and needs (Sommarö et al., 2017; Johansson Wilén & Lundsten, 2019), for which reason this is also recommended by several researchers (Tengelin et al., 2019; Lundberg, Malmqvist & Wurm, 2017).

At organisational level

- **The physical environment:** The physical environment also influences and reproduces norms, conditions practices and may contribute to feelings of inclusion or exclusion. It can be important to see yourself represented, for example through pictures, newspapers or rainbow symbols. Gender-neutral toilets and forms that enable LGBTI identities are other examples. For those who live in nursing homes, it is important for their integrity and privacy to be respected, for example by the staff not only knocking but also waiting for a response before entering a room. These things can affect the perceived opportunities to be open and to feel safe, not least in light of how their own home has often been a haven free from heteronormativity for older LGBTI people. Another important factor is routines to deal with homophobia or transphobia if someone is abused by other residents or staff (Egede et al., 2019:97; Meggers Matthiesen, 2019; Siverskog, 2021b, 2021a).
- **Collaboration with LGBTI organisations:** Collaboration between healthcare and social care actors, and other actors working on initiatives to, for example, create efforts to counteract mental illness and social isolation among older people, and LGBTI organisations may be a way of offering competence-enhancement initiatives and implementing social activities with an LGBTI focus. It is also important to be up to date on the resources and meeting places available for LGBTI people locally and to be able to refer people to them. LGBTI organisations and mixed-age LGBTI contexts should both work against ageism and have an awareness of age norms (Meggers Matthiesen, 2019; Siverskog, 2021b).

- **Person-centred care:** Since the 'equal treatment perspective' risks being based on heteronormativity, several studies emphasise a person-centred approach instead. Life stories are often used within this approach, and these can also help understand the full context of people's lives, and contribute to an understanding of how past life experiences also affect their experiences as an older person. Here, however, silences need to be respected and it is necessary to understand and respect that some people do not want to talk about their background. While this approach aims to shift power to the patient in the care interaction, it must not mean that the responsibility to educate and inform falls on the patient (Meggers Matthiesen, 2019; Siverskog, 2014).

At structural level

- **Policy:** Older LGBTI people need to be represented in policy documents. This is particularly important in the area of social isolation, as interventions and initiatives are often aimed at young LGBTI people. It is important to continue effective anti-discrimination work in all areas of society to promote the health of older LGBTI people (Bränström et al., 2022:10; Public Health Agency of Sweden, 2015; Meggers Matthiesen, 2019).
- **Prevention work should include an older target group:** The group of older LGBTI people should be addressed in prevention work against HIV, sexually transmitted diseases and suicide. The older target group living with HIV should be represented in policy and there should be knowledge about HIV in the practice of elder care. Prevention work should be carried out respectfully, avoiding stigmatisation and discrimination in light of how men who have sex with men may have experienced this earlier in life. Rehabilitation programmes after prostate cancer should be designed based on the experiences and needs of gay and bisexual men and not presuppose heterosexuality. The profession should ask patients norm-critical questions about sexuality and sexual practice to be able to provide relevant advice, for example in connection with prostate cancer (Åberg, 2018; Backer Grønningsæter & Skog Hansen, 2018; Danemalm Jägervall et al., 2019; Erlangsen et al., 2020; Qvarnström & Oscarsson, 2015).
- **Improving trans care:** Several studies highlight how trans care needs to be more accessible and designed for users to a greater extent to promote trans people's health. There is a need for affirmative trans care, and suicide prevention and psychiatric services targeted specifically at trans people to reduce health inequalities. Trans care should also enhance its knowledge about older trans people and work to avoid ageist responses (Linander, 2018; Siverskog, 2014, 2015; Zeluf et al., 2016, 2018).

- **Improving working conditions in healthcare and social care:** To ensure good treatment and to be able to apply a norm-critical approach in day-to-day healthcare and social care, care needs to be organised in such a way that there are reasonable working conditions, with time for CPD and for conversations in day-to-day care. As elder care has been made more efficient and market-based over several decades, this has also led to tough working conditions for the employees. There should be continuity in healthcare, with those with the greatest need having the same staff where possible, and supportive, present leadership (Siverskog, 2021b; Åberg, 2019:286 ff.).

Professional qualification study programmes and CPD

- **Intended learning outcomes:** Implement life course perspectives on LGBTI people's living conditions, health and ageing as intended learning outcomes in health and social sciences professional qualification study programmes. Overarching guidelines for intended learning outcomes are important instruments for monitoring how the objectives are integrated in study programmes over time (Areskoug Josefsson & Solberg, 2023). Increased knowledge about older LGBTI people's conditions in the healthcare and social care sectors is highlighted as an important measure in several national LGBTI action plans. However, measures relating to changed intended learning outcomes and integration strategies in relation to health and social sciences professional qualification study programmes are given little focus in most Nordic countries. Intended learning outcomes (and professional ethical guidelines) send a message that teaching about a diversity of life course experiences and needs, not just norms, is considered *mandatory knowledge* not optional (cf. Giertsen, 2019; Lundberg et al., 2017). In addition, the implementation needs to be continuously reviewed and followed up.
- **Study support structures:** Implement study support structures for integrating knowledge about life course perspectives on LGBTI people's living conditions, health and ageing into professional qualification study programmes. Study support structures have been shown to facilitate the introduction of knowledge about, for example, domestic violence (Carlsson, 2020). This includes allocating resources for the establishment of systematic, long-term work to help teaching institutions translate the learning objective into integrated knowledge throughout the professional qualification study programme, from general syllabus and course syllabus to course literature, educational resources and examinations (cf. Areskoug-Josefsson & Solberg, 2023).

- **Study resources:** A norm-critical inventory of existing study resources and of how knowledge about LGBTI perspectives, life courses, healthcare and social care is included is needed. The knowledge inventory shows that course literature in certain health and social sciences subjects continues to have a heteronormative and cisnormative basis in the representation of identities, bodies and ways of living (Giertsen, 2017; Tengelin, et al. 2019). The representation and knowledge in study resources in different professional fields needs to be investigated in more detail based on norm-critical, intersectional perspectives. If LGBTI experiences are represented, which are represented and in what way? There is generally less knowledge about older people than about younger people, and less about the living conditions of trans and intersex people than about those of gay and bisexual people. To increase the representation of older LGBTI people in course literature, it is important to know what it looks like and to ensure that particularly vulnerable groups and marginalised experiences are also included.
- **Course literature in Nordic languages:** Resources are needed for the development of research-based course literature in the Nordic languages which includes knowledge about LGBTI perspectives, life courses, healthcare and social care. Both the articles reviewed and the interviews with higher education institution teachers on health and social sciences professional qualification study programmes highlight the importance of there being literature in their own language that can be used as course literature. This may be newly written study resources or translated literature.
- **Knowledge requirements in upper secondary education:** Knowledge requirements must also be included in the curriculum and followed up in upper secondary healthcare and social care study programmes. The knowledge inventory shows a tendency for life course perspectives on LGBTI people's living conditions, health and ageing among professional practitioners in healthcare and social care professions to be generally absent (Solberg, 2017; Sommarö et al., 2017; Smolle & Espevall, 2021). A large proportion of the staff working in the healthcare and social care professions have upper secondary education. This education must therefore also have learning outcomes that include LGBTI perspectives, life courses, healthcare and social care. The content of upper secondary education is outside this study, but in light of what we know about the conditions in higher education, we can assume that a similar situation exists at upper secondary level.
- **CPD for professionals:** Knowledge about marginalised life course experiences, ageing conditions and needs need to be included as an integral part of existing CPD for professionals who interact with older people in the healthcare and social care sectors – including LGBTI perspectives. Knowledge about trans experiences and intersex experiences must be particularly highlighted and prioritised.

- **The role of the civil society sector in CPD:** The civil society sector should be provided with long-term funding for its work to improve the living conditions of older LGBTI people through social and educational initiatives. It must be ensured that older LGBTI people do not disappear as target groups for interventions. The civil society sector should not, however, bear the ultimate responsibility and be the driver of the necessary knowledge being integrated into the social and education sectors. In light of this, CPD should be included as a more integral part of long-term municipal and regional strategic work in the healthcare and social care sectors in close dialogue and cooperation with civil society organisations.

Continued research

A number of studies also indicate what should be further explored in future research. There is a need for more quantitative and qualitative knowledge about older LGBTI people. As Bränström et al. (2022) indicate, it is important to include people of all ages in national public health studies, and to have questions about gender identity and sexuality to enable analyses of the impact of these factors. In light of the inclusion process for this report, we would like to emphasise that it is important to also present the results in such a way that all these factors are clear, so that it is possible to read something about this group. Bränström et al. (2022) also state, given how mental health is often better in older age groups than younger ones in quantitative studies with LGBTI people of all ages, that it is important to further investigate the causes of this. For example, it could be that during their lives they may have developed resilience to stress factors, but this is something that needs to be investigated further. Longitudinal studies may also facilitate analyses of causal effects and the effects of cohort and generation in relation to this (Bränström et al., 2022:10). Löf & Olaisson indicate that it is important to explore experiences of healthcare, social care and social services to a greater extent, and to translate research results into training initiatives for elder care (2018:261-262). The focus should be on how formal care and the general environment can contribute to reducing minority stress and instead strengthening mental health (Löf & Olaisson, 2018; Synnes & Malterud, 2019).

In terms of quantitative knowledge, we need better data, with a larger sample of older LGBTI people, from many parts of the Nordic region. Based on the research overview, it is possible to conclude that knowledge from some countries, such as Finland and Iceland, and the Faroe Islands, Greenland and Åland is inadequate. We need more knowledge about older LGBTI people from these contexts. In view of the group's different experiences, there is also a lack of knowledge about older intersex people, with knowledge today basically non-existent. Better quantitative data may provide greater knowledge about general patterns both in terms of the importance of gender identity and sexuality for health, well-being and ageing, to be able to point to differences within the group based on other structures/experiences, and to

be able to compare differences between the different Nordic contexts. There is a need for both more systematic inclusion of gender identity and sexual orientation in population studies related to public health and quality of life, and targeted studies, which often have higher response rates than the general ones.^[20]

There are also specific knowledge needs relating to different subgroups within the group of older LGBTI people; in particular the very oldest (80+), people with trans and intersex experiences, racialised LGBTI people, LGBTI people living with HIV, and LGBTI people who are at increased risk of social isolation. Studies have previously shown how, for example, LGBTI people's opportunities to participate in LGBTI communities depend on factors such as geography, class and health, and research needs to take these factors into account in the analysis. There is also a need to investigate how age-based arrangements and normativity structure LGBTI policies and social meeting places. Research into older LGBTI people should also aim to capture different experiences within the LGBTI community (Siverskog & Bromseth, 2019; Siverskog, 2016; Löf & Olaisson, 2018).

As can be seen from the knowledge inventory, there are large knowledge gaps in how LGBTI perspectives and ageing are included in education, professional practice and CPD. There is limited knowledge about the ways in which LGBTI people's living conditions and life course experiences are included as mandatory elements in education and study resources (Tengelin et al., 2021; Areskoug Josefsson & Solberg, 2023), and hardly any knowledge about how *older* LGBTI people's life course experiences and ageing conditions are included as mandatory elements in education and study resources. What are the knowledge and understanding requirements in intended learning outcomes, general syllabuses and course syllabuses in the Nordic countries, and how are they implemented in the form of course literature, compulsory modules and as part of the examination of the intended learning outcomes? Several studies and interviews show willingness to include knowledge, and that students seek more knowledge (Tengelin et al., 2021; Lunde et al., 2022) – but what are the reasons why this is *not* done by teaching staff? What are the structural changes that can support these processes? This needs to be investigated further.

Several studies have evaluated CPD initiatives such as LGBTI certification, but none of these was carried out in activities specifically aimed at older adults (Sommarö et al., 2019; Johansson Wilén & Lundsten, 2019). The studies suggest some effect of CPD in terms of norm-conscious treatment, but more inadequate knowledge about trans experiences. They also highlight the structural challenges of maintaining knowledge in organisations as a whole. Studies are needed that investigate the effects of CPD initiatives in activities that encounter *older adults*, including longitudinal studies that investigate the long-term effects of CPD and LGBTI certification.

20. For example, RFSL's targeted survey for older LGBTI people has a higher number of respondents than the Swedish Public Health Agency's public health survey.

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Appendix 1. Search strategy and method

Description of the search strategy

The strategy for the literature search for this research overview is based on the approach for systematic reviews. The aim of a systematic overview is to give an account of all the collected research on a specific research question. This method involves reporting in detail how the search and selection of literature has been conducted to ensure reproducibility and transparency, and to reduce bias during the process.

The search strategy was developed in consultation with the authors/researchers Anna Siverskog and Janne Bromseth, and librarians Elina Nybergh and Louise Preinitz Gärdinge. The librarians are responsible for the searches and referencing. The authors of the report are responsible for drawing up the selection criteria and for the selection. The searches were conducted in both international article databases and national search services covering the Nordic countries. All the references from the database searches were reviewed independently at the title and abstract level by the two researchers. The searches were mainly documented out by the librarians.

In addition to the database searches, the literature search was supplemented by searches for grey material – documents produced outside the academic sphere – to investigate what knowledge exists among practitioners, public authorities and other relevant actors for the topic. The results from the grey material searches were divided up between the authors of the report and were assessed in full-text directly. The reviews and selection of Finnish and Icelandic-language publications was carried out by external reviewers.

Search words

Since the two research questions differed in part, it was decided that two different searches should be carried out for the overview. Search query 1 aimed to find literature on the living conditions of older LGBTI people in the Nordic countries. Search query 2 aimed to find literature on the competence of healthcare and social care staff in their interactions with LGBTI people, or knowledge about the situation of LGBTI people in healthcare and social care study programmes, in the Nordic region.

Four key terms were developed for the searches:

1. Older people
2. LGBTI
3. Nordic countries
4. Healthcare/social care

Each term was expanded with synonyms and related terms with the support of subject matter experts and reviews of already known relevant literature, along with the databases' thesauruses where available, and other controlled vocabularies in the subject area. Thesauruses and controlled vocabularies are lists of subject words with descriptions and hierarchical classification of terms. The references in a database that has a thesaurus are assigned subject words based on their content, which facilitates re-finding the literature. A search block was formed using the Boolean operator OR for all the words within a term. The blocks were combined into a search string using the Boolean operator AND. For search query 1, terms 1 + 2 + 3 were used, and for search query 2, terms 2 + 3 + 4 were used. The search string for query 1 in English in the PubMed database was:

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((aged[TIAB] OR aged[MESH] OR Ageing[TIAB] OR ageis*[TIAB] OR aging[TIAB] OR elder*[TIAB] OR frail elderly[MESH] OR frail elder*[TIAB] OR geriatric*[TIAB] OR geriatrics[MESH] OR gerontol*[TIAB] OR "later life"[TIAB] OR older[TIAB] OR pension[TIAB] OR retiree*[TIAB] OR retired[TIAB] OR retirement[TIAB] OR senior*[TIAB]) AND (Denmark*[TIAB] OR danish[TIAB] OR Faroe Islands[TIAB] OR Faroese[TIAB] OR finnish[TIAB] OR Finland*[TIAB] OR Greenland*[TIAB] OR Iceland*[TIAB] OR nordic[TIAB] OR Norway*[TIAB] OR norwegian*[TIAB] OR scandinavia*[TIAB] OR "Scandinavian and Nordic Countries"[Mesh] OR Sweden[TIAB] OR swedes[TIAB] OR swedish[TIAB] OR Åland[TIAB])) AND (Bisexual*[TIAB] OR bisexuality[Mesh] OR butch[TIAB] OR crossgender[TIAB] OR femme*[TIAB] OR gay[TIAB] OR gays[TIAB] OR "gender change"[TIAB] OR "gender dysphoria"[TIAB] OR gender dysphoria[Mesh] OR "gender expression"[TIAB] OR "gender identit*" [TIAB] OR gender identity[Mesh] OR "gender minorit*" [TIAB] OR "gender nonbinary" [TIAB] OR "gender nonconfirming" [TIAB] OR "gender transformation" [TIAB] OR "gender transition" [TIAB] OR genderqueer*[TIAB] OR GLB[TIAB] OR GLBQ[TIAB] OR GLBT[TIAB] OR GLBTI[TIAB] OR GLBTQ[TIAB] OR GLBTQI[TIAB] OR GQNB[TIAB] OR heteronorm*[TIAB] OR heterosexis*[TIAB] OR homonegativ*[TIAB] OR homophob*[TIAB] OR homosexual*[TIAB] OR homosexuality, female[Mesh] OR homosexuality, male[Mesh] OR intergender*[TIAB] OR intersex*[TIAB] OR intersex persons[Mesh] OR lesbian*[TIAB] OR lesbigay*[TIAB] OR LGB[TIAB] OR LGBQ[TIAB] OR LGBT[TIAB] OR LGBTI[TIAB] OR LGBTQ[TIAB] OR LGBTQI[TIAB] OR "men loving men" [TIAB] OR MSM[TIAB] OR "men who have sex with men" [TIAB] OR "nonbinary gender" [TIAB] OR "non-heterosexual*" [TIAB] OR pansexual*[TIAB] OR Queer*[TIAB] OR "same sex couples*" [TIAB] OR "same sex relation*" [TIAB] OR sexual and gender minorities[Mesh] OR "sexual minorities" [TIAB] OR "sexual orientation" [TIAB] OR SOGI[TIAB] OR Transgender*[TIAB] OR transgender persons[Mesh] OR transnegativ*[TIAB] OR transphob*[TIAB] OR transsexual*[TIAB] OR transsexualism[Mesh] OR transvesti*[TIAB] OR "trans female*" [TIAB] OR "trans male*" [TIAB] OR "trans man" [TIAB] OR "trans men*" [TIAB] OR "trans woman" [TIAB] OR "trans women*" [TIAB] OR "trans people*" [TIAB] OR "trans person*" [TIAB] OR "women loving women" [TIAB] OR "women who have sex with women" [TIAB]) Filters: from 2012 – 2022
```

And for search query 2 in English in the PubMed database, the search string was:

```
((("Academic Medical Center"[Title/Abstract] OR "Academic Medical Centers"[Title/Abstract] OR
"Academic Medical Centers"[MeSH Terms] OR "community health service*"[Title/Abstract] OR
"community health services"[MeSH Terms] OR "Health Service"[Title/Abstract] OR "Health
Services"[Title/Abstract] OR "Health Services"[MeSH Terms] OR "Health services for the aged"
[MeSH Terms] OR "Health services for the aged"[Title/Abstract] OR "Homes for the aged"
[MeSH Terms] OR "Homes for the aged"[Title/Abstract] OR "Housing for the elderly"[MeSH
Terms] OR "Housing for the elderly"[Title/Abstract] OR "hospital"[Title/Abstract] OR "Hospitals"
[Title/Abstract] OR "Hospitals"[MeSH Terms] OR "Hospital unit"[Title/Abstract] OR "Hospital
units"[Title/Abstract] OR "Hospital units"[MeSH Terms] OR "Nursery"[Title/Abstract] OR
"Nurseries"[Title/Abstract] OR "nurseries, infant"[MeSH Terms] OR "Primary care"
[Title/Abstract] OR "Primary Health care"[Title/Abstract] OR "Primary Health care"[MeSH
Terms] OR "Primary Healthcare"[Title/Abstract] OR "Residential Facilities"[Title/Abstract] OR
"Residential Facilities"[MeSH Terms] OR "Residential Facility"[Title/Abstract] OR "University
Medical Center"[Title/Abstract] OR "University Medical Centers"[Title/Abstract] OR "caregiver*"
[Title/Abstract] OR "caregivers"[MeSH Terms] OR "care worker*"[Title/Abstract] OR "curator"
[Title/Abstract] OR "Geriatric nursing"[Title/Abstract] OR "Geriatric nursing"[MeSH Terms] OR
"HCS"[Title/Abstract] OR "health and social care professional*"[Title/Abstract] OR "health care
professional*"[Title/Abstract] OR "health personnel"[Title/Abstract] OR "health personnel"
[MeSH Terms] OR "health care provider*"[Title/Abstract] OR "healthcare worker*"
[Title/Abstract] OR "medical staff"[Title/Abstract] OR "medical staff"[MeSH Terms] OR
"nurse*"[Title/Abstract] OR "nursing staff"[Title/Abstract] OR "nursing staff"[MeSH Terms] OR
"paraprofessional personnel"[Title/Abstract] OR "physician*"[Title/Abstract] OR "physicians"
[MeSH Terms] OR "psychologist"[Title/Abstract] OR "psychiatrist"[Title/Abstract])) AND
("bisexual*"[Title/Abstract] OR "bisexuality"[MeSH Terms] OR "butch"[Title/Abstract] OR
"crossgender"[Title/Abstract] OR "femme*"[Title/Abstract] OR "gay"[Title/Abstract] OR "gays"
[Title/Abstract] OR "gender change"[Title/Abstract] OR "gender dysphoria"[Title/Abstract] OR
"gender dysphoria"[MeSH Terms] OR "gender identit*"[Title/Abstract] OR "gender identity"
[MeSH Terms] OR "gender minorit*"[Title/Abstract] OR "gender nonbinary"[Title/Abstract] OR
"gender nonconforming"[Title/Abstract] OR "gender transformation"[Title/Abstract] OR "gender
transition"[Title/Abstract] OR "genderqueer*"[Title/Abstract] OR "GLB"[Title/Abstract] OR
"GLBQ"[Title/Abstract] OR "GLBT"[Title/Abstract] OR "GLBTI"[Title/Abstract] OR "GLBTQ"
[Title/Abstract] OR "GQNB"[Title/Abstract] OR "heteronorm*"[Title/Abstract] OR
"homonegativ*"[Title/Abstract] OR "homophob*"[Title/Abstract] OR "homosexual*"
[Title/Abstract] OR "homosexuality, female"[MeSH Terms] OR "homosexuality, male"[MeSH
Terms] OR "intergender*"[Title/Abstract] OR "intersex*"[Title/Abstract] OR "intersex persons"
[MeSH Terms] OR "lesbian*"[Title/Abstract] OR "lesbigay*"[Title/Abstract] OR "LGB"
[Title/Abstract] OR "LGBQ"[Title/Abstract] OR "LGBT"[Title/Abstract] OR "LGBTI"
[Title/Abstract] OR "LGBTQ"[Title/Abstract] OR "LGBTQI"[Title/Abstract] OR "MSM"
[Title/Abstract] OR "men who have sex with men"[Title/Abstract] OR "nonbinary gender"
[Title/Abstract] OR "non heterosexual*"[Title/Abstract] OR "pansexual*"[Title/Abstract] OR
"queer*"[Title/Abstract] OR "same sex couples*"[Title/Abstract] OR "same sex relation*"
[Title/Abstract] OR "sexual and gender minorities"[MeSH Terms] OR "sexual minorities"
[Title/Abstract] OR "sexual orientation"[Title/Abstract] OR "SOGI"[Title/Abstract] OR
"transgender*"[Title/Abstract] OR "transgender persons"[MeSH Terms] OR "transnegativ*"
[Title/Abstract] OR "transphob*"[Title/Abstract] OR "transsexual*"[Title/Abstract] OR
"transsexualism"[MeSH Terms] OR "transvesti*"[Title/Abstract] OR "trans female*"
[Title/Abstract] OR "trans male*"[Title/Abstract] OR "trans man"[Title/Abstract] OR "trans
men"[Title/Abstract] OR "trans woman"[Title/Abstract] OR "trans women"[Title/Abstract] OR
"trans people*"[Title/Abstract] OR "trans person*"[Title/Abstract] OR "women loving women"
[Title/Abstract] OR "women who have sex with women"[Title/Abstract])) AND ("denmark*"
[Title/Abstract] OR "danish"[Title/Abstract] OR "faroe islands"[Title/Abstract] OR "Faroese"
[Title/Abstract] OR "finnish"[Title/Abstract] OR "finland*"[Title/Abstract] OR "greenland*"
[Title/Abstract] OR "iceland*"[Title/Abstract] OR "nordic"[Title/Abstract] OR "norway*"
[Title/Abstract] OR "norwegian*"[Title/Abstract] OR "scandinavia*"[Title/Abstract] OR
"Scandinavian and Nordic Countries"[MeSH Terms] OR "Sweden"[Title/Abstract] OR "swedes"
[Title/Abstract] OR "swedish"[Title/Abstract] OR "Aland"[Title/Abstract])) AND
(2012:2022[pdat])
```

For PubMed and PsycINFO which have thesauruses, the free text words in the search string were supplemented with the relevant subject words. The search words we have selected do not reflect the most contemporary use of language in the subject areas, especially given that these are fields where terms are under rapid development. Terms for the searches for both the older and LGBTI people can be perceived as outdated and even derogatory. We used the vocabulary that gave us the best prospects of capturing relevant literature, where we needed to relate to a ten-year-old vocabulary, vocabulary used in fields other than gender research and research about older people, and vocabulary used in databases where there is a certain lag in introducing new concepts or replacing old ones.

Limitations and databases

The searches were limited to include scholarly articles published from 2012 onwards because the research question aimed to compile a current knowledge base. Based on the nature of the topic, four international article databases were selected for the search: Gender Studies Database (GSD), PsycINFO, PubMed and Scopus.

Given the geographical limitation for the topic, searches were also carried out in databases from each of the Nordic countries. The selected databases were Det Kgl. Bibliotek (DK), Finna (FI), Opin Visindi (IS), Oria (NO) and SwePub (SWE). In these searches, the search block for the Nordic countries was not used. Material other than scholarly articles was also searched for, such as dissertations and chapters in anthologies. The searches were conducted in each Nordic language and in some cases together with English (see table below)

Description: Search query 1

| Database (+ search language) | Number of hits | Comments on search technique | Date |
|-----------------------------------|----------------|---|---------------|
| Finna (Finnish) | 67 | Free text response | 04 May 2022 |
| Gender Studies Database (English) | 20 | TI + AB + SU | 23 March 2022 |
| Royal Danish Library (Danish) | 68 | Title + subject | 04 May 2022 |
| Opin Visindi (Icelandic) | 16 | Free text response | 04 May 2022 |
| Oria (Norwegian, English) | 86 | Title + subject, academic libraries, + Nordic countries block | 04 May 2022 |
| PsycINFO (English) | 330 | TIAB + SU | 23 March 2022 |
| PubMed (English) | 149 | TIAB + MeSH | 23 March 2022 |
| Scopus (English) | 113 | TITLE-ABS-KEY | 23 March 2022 |
| SwePub (Swedish) | 326 | Free text response | 04 May 2022 |
| Total | 1138 | | |
| After removal of duplicates | 1013 | | |

Description: Search query 2

| Database (+ search language) | Number of hits | Comments on search technique | Date |
|--|----------------|---|---------------|
| Education Research Complete (English) | 25 | TI + AB + SU | 28 March 2022 |
| Education Resources Information Center (English) | 7 | TI + AB + SU | 28 March 2022 |
| Finna (Finnish) | 89 | Free text response | 06 May 2022 |
| Gender Studies Database (English) | 10 | TI + AB + SU | 28 March 2022 |
| Royal Danish Library (Danish) | 43 | Title + subject | 06 May 2022 |
| Opin Visindi (Icelandic) | 34 | Free text response | 06 May 2022 |
| Oria (Norwegian, English) | 51 | Title + subject, academic libraries, + Nordic countries block | 06 May 2022 |
| PsycINFO (English) | 61 | TIAB + SU | 28 March 2022 |
| PubMed (English) | 137 | TIAB + MeSH | 28 March 2022 |
| Scopus (English) | 161 | TITLE-ABS-KEY | 28 March 2022 |
| SwePub (Swedish) | 253 | Free text response | 06 May 2022 |
| Total | 871 | | |
| After removal of duplicates | 658 | | |

Selection

The searches were carried out in two stages and were delivered to the researchers in the screening program Rayyan. The total of 1671 references were reviewed by the two authors in *blind mode*, which means that the researchers could not see the other person's decisions but made decisions on each reference independently. This was to avoid being influenced by the other researcher's decision, and to base the selection on the selection criteria, thereby ensuring the scholarly quality of the report. After the references where the researchers made different assessments were discussed and decided on jointly, the following remained for question 1: 99 references (75 from Nordic databases + 24 from the second search), and for question 2: 126 references (106 from the Nordic databases and 20 from the second search), the full texts of which were then read. Since the research field is relatively small, the 'benefit of the doubt' principle was applied at this stage so as not to miss anything of relevance. The articles were selected based on the following inclusion and exclusion criteria:

Inclusion/exclusion criteria: Question 1

| | Inclusion | Exclusion |
|-----------------------|---|--|
| Participants | Studies including older people, 60+ (or where this group is studied together with other age groups but is presented in such a way that it is possible to distinguish data for this particular group) | Studies including participants of other ages. Studies that lack LGBTI people as a group. |
| Focus | Living conditions, healthcare and social care, the end stage of life | Strictly medical studies |
| Context | Studies that include demographics from one or more of <i>the Nordic countries and/or autonomous regions</i> , also where comparisons are made with populations from other countries if the results from the Nordic countries and autonomous regions are independently reported. | Studies that do not include demographics from any of <i>the Nordic countries and/or autonomous regions</i> . |
| Technical limitations | Publications from 2012 onwards Peer review-reviewed articles, dissertations, and other types of scholarly production Grey material | - |

Inclusion/exclusion criteria: Question 2

| | Inclusion | Exclusion |
|-----------------------|--|---|
| Participants | Studies of health and social sciences courses and study programmes with a focus on older age (65+) and ageing and LGBTI people | Studier av hälso- och socialvetenskaplig utbildning i andra åldrar. Studier som saknar fokus på LGBTI-personer i hälso- och socialvetenskaplig |
| Focus | Courses and study programmes concerning living conditions, healthcare and social care, the end stage of life | |
| Context | Studies that include health and social sciences courses and study programmes from one or more of <i>the Nordic countries and/or autonomous regions</i> , also where comparisons are made with populations from other countries if the results from the Nordic countries and autonomous regions are independently reported. | Studies that do not include courses and study programmes from any of <i>the Nordic countries and/or autonomous regions</i> . |
| Technical limitations | Publications from 2012 onwards Peer review-reviewed articles, dissertations, and other types of scholarly production Grey material | |

After the full text reading, further references were excluded. The reasons were for example that the reference was a conference abstract, that data was presented in in such a way that age was not reported with sexuality/gender identity, and where it was therefore not possible to deduce anything about the group in question. The number of articles included after full text reading for search query 1 was 25, and for search query 2, it was 19. The review of the hits from the searches in Icelandic and Finnish did not result in the inclusion of any publications.

Supplementary searches

Grey material

In order to supplement the gaps in the research and look for knowledge on the topic in literature beyond academic production, searches for grey material were also conducted. Reports and other publications published by actors with knowledge of the issue were of particular interest were, and to find this material, customised search engines were used in Google. This tool permits listings of websites where one can then search documents only on the selected websites. The search prefix *filetype:pdf* was used to only find publications in PDF format and exclude HTML sources. Together with the project's reference group, the authors identified relevant actors for all the Nordic countries, and also decided on which search words to use. The focus on these actors followed the initially identified focus of the search strategy, where search query 1 aimed to find literature on older LGBTI people's living conditions in the Nordic region. Search query 2 aimed to find literature on the competence of healthcare and social care professionals in their interactions with LGBTI people, or knowledge about the situation of LGBTI people in healthcare and social care study programmes, in the Nordic region. For each Nordic country, two search engines were created, one for search query 1 and one for search query 2.

It is difficult to export the combined search results because the PDF files lack meta data, which in turn is due to lack of bibliographic records. Therefore, the first screening was used to select publications at full-text level. For each search, the first 50 hits were reviewed and the same selection criteria as for the database searches were applied. External reviewers were engaged for searches and selection in Icelandic and Finnish. In total, the searches for grey material for question 1 resulted in a further eight publications, three of which were from Denmark, two from Sweden, one from Norway, one from Finland, and one from Åland. For question 2, it resulted in five more publications, three of which were from Sweden and two from Norway.

Through recommendations from the reference group, contacts and previously known publications, another 5 publications were included for Part 1 and 14 for Part 2. Finally, citation searches were conducted on a selection of publications in the Scopus and Google Scholar databases, and this search added two more articles for assessment.

A total of 38 + 37 publications formed the basis for the research overview.

Appendix 2. Included publications for the first part, research overview

| Publication | Context | Selection | Type | Focus |
|--|---------|---|--|---|
| Alasuutari, V. (2020). <i>Death at the End of the Rainbow. Rethinking Queer Kinship, Rituals of Remembrance and the Finnish Culture of Death</i> . University of Turku. | FI | 14 LGBTQ-personer 30–70 år varav två var i 60–70-årsåldern | Kvalitativ intervjustudie Avhandling | Döende, sorg, förlust Homo-, bisexuella, transpersoner samt queera |
| Backer Grønningsæter, A., & Skog Hansen, I. L. (2018). <i>Om å bli eldre med hiv</i> (2018:43; Fafo-rapport). Fafo. https://www.fafo.no/zoo-publikasjoner/fafo-rapporter/om-a-bli-eldre-med-hiv | NO | 20 personer 55–84 år varav nio var homosexuella män | Rapport | Att åldras med HIV Homosexuella män |
| Bindesbøl Holm Johansen, K., Laursen, B., & Juel, K. (2015). <i>LGBT-sundhed. Helbred og trivsel blandt lesbiska, bøsser, biseksuelle og transpersoner</i> . Statens Institut for Folkesundhed, Syddansk Universitet. | DK | 142 LGB-personer 60 år och äldre bland ett totalt urval på 14 625 personer. 8 transpersoner över 60 (redovisas inte separat) | Kvantitativ (folkhälsostudie) Rapport | Hälsa och välmående Homo- och bisexuella |
| Bromseth, J. (2013). "Som en riktig familj": Äldre lesbiska och bisexuella kvinnors berättelser om familj och nära relationer. I J. Bromseth & A. Siverskog (Red.), <i>LHBTQ-personer och åldrande (47–75)</i> . Studentlitteratur. | SV | 15 icke-heterosexuella kvinnor 60–94 år | Kvalitativ intervjustudie Antologikapitel | Relationer, familj Lesbiska och bisexuella kvinnor |
| Bränström, R., Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Sexual orientation disparities in physical health: Age and gender effects in a population-based study. <i>Social Psychiatry and Psychiatric Epidemiology</i> , 51(2), 289–301. | SV | 60 922 personer 18–64 år, varav 430 homosexuella och 757 bisexuella i alla åldrar. | Kvantitativ (folkhälsostudie) Artikel | Fysisk hälsa, betydelse av ålder och sexualitet Homo- och bisexuella |

| | | | | |
|--|--------|---|--|--|
| Bränström, R., Fellman, D., Pachankis, J. E. (2022) Age-varying Sexual Orientation Disparities in Mental Health, Treatment Utilization, and Social Stress: A population-Based Study. <i>Psychology of Sexual Orientation and Gender Diversity</i> . | SV | 5115 homo- och bisexuella personer, 103 526 heterosexuella i åldrarna 16–84 år | Kvantitativ folkhälsostudie Artikel | Psykisk hälsa, betydelser av ålder och sexualitet Homo- och bisexuella |
| Danemalm Jägervall, C., Brüggemann, J., & Johnson, E. (2019). Gay men's experiences of sexual changes after prostate cancer treatment-a qualitative study in Sweden. <i>Scandinavian Journal of Urology</i> , 53(1), 40–44. | SV | 11 homosexuella män 58–81 år som behandlats för prostatacancer | Kvalitativ intervjustudie Artikel | Erfarenheter av sexuella förändringar efter prostatacancer Homosexuella män |
| Egede, S. J., Fouchard, J., Frisch, M., & Graugaard, C. (2019). <i>Danske LGBT-personers møde med almen praksis: Udfordringer og muligheder</i> . Sundhedsstyrelsen; Sexologisk Forskningscenter, Klinisk Institut, Aalborg Universitet. | DK | 16 intervjuer med LGBT-personer varav 2 med personer 60–80 år | Kvalitativa djupintervjuer Rapport | Möte med vården Homo-, bisexuella samt transpersoner |
| Eggebo, H., Stubberud, E., & Anderssen, N. (2019). <i>Skeive livsløp. En kvalitativ studie av levkår og sammensatte identiteter blant lhbtis-personer i Norge</i> . (No. 6/2019). Nordlandsforskning. https://bufdir.no/Bibliotek/Dokumentside/?docId=BUF00005039 | NO | Intervjuer med 99 queera (skeive) mellan 16–87 år varav minst sex stycken var 70 år eller äldre | Kvalitativa intervjuer Rapport | Livsvillkor Homo-, bisexuella samt transpersoner |
| Erlangsen, A., Drefahl, S., Haas, A., Bjorkenstam, C., Nordentoft, M., & Andersson, G. (2020). Suicide among persons who entered same-sex and opposite-sex marriage in Denmark and Sweden, 1989-2016: A binational, register-based cohort study. <i>Journal of Epidemiology and Community Health</i> , 74(1), 78–83. | DK, SV | Alla kvinnor och män i Danmark och Sverige som ingick äktenskap 1989–2016 | Registerdatastudie Artikel | Jämförelse av suicid bland samkönade respektive heterosexuella äktenskap Homosexuella |

Fabbre, V. D., & Siverskog, A. (2019). Transgender Ageing: Community Resistance and Well-Being in the Life Course. In A. King, K. Almack, & R. Jones (Eds.), *Intersections of Ageing, Gender and Sexualities. Multidisciplinary international perspectives*. Policy Press.

SV

Empirisk data från USA samt Sverige där den svenska datan utgörs av sex transidentifierade personer 62–78 år, födda mellan 1933–1950.

Kvalitativa
livsberättelseintervjuer

Antologikapitel

Livsloppserfarenheter,
community, välmående

Transpersoner

| | | | | |
|--|----|---|--|---|
| Folkhälsomyndigheten. (2014). <i>Utvecklingen av hälsan och hälsans bestämningsfaktorer bland homo- och bisexuella personer. Resultat från nationella folkhälsoenkäten Hälsa på lika villkor</i> . Folkhälsomyndigheten. | SV | Enkätdata från nationella folkhälsoenkäten 2010–2012. I urvalet finns 334 lhb-personer 65–84 år (136 bisexuella män, 62 homosexuella män, 89 bisexuella kvinnor, 47 lesbiska kvinnor) | Enkätstudie Rapport | Hälsa Homo- och bisexuella |
| Folkhälsomyndigheten. (2015). <i>Hälsan och hälsans bestämningsfaktorer för transpersoner—En rapport om hälsoläget bland transpersoner i Sverige [Elektronisk resurs]</i> . Folkhälsomyndigheten. http://www.folkhalsomyndigheten.se/publicerat-material/publikationer/Halsan-och-halsans-bestamningsfaktorer-for-transpersoner---en-rapport-om-halsolaget-bland-transpersoner-i-Sverige | SV | 800 transpersoner varav 40 var 65–94 år | Enkätstudie Rapport | Hälsa Transpersoner |
| Gustafsson, P. E., Linander, I., & Mosquera, P. A. (2017). Embodying pervasive discrimination: A decomposition of sexual orientation inequalities in health in a population-based cross-sectional study in Northern Sweden. <i>International Journal for Equity in Health</i> , 16(1), 22. | SV | 248 LGBTQ-personer bland totalt 25 667 respondenter | Enkätstudie Artikel | Hälsa, sexualitet, ojämlikhet Homo-, bisexuella, transpersoner samt queera |
| Kristiansen, H. W. (2013). Sexualitet och värdighet bland äldre homosexuella män i Norge. I J. Bromseth & Siverskog, Anna (Red.), <i>LHBTQ-personer och åldrande: Nordiska perspektiv</i> (163–183). Studentlitteratur. | NO | 23 homo- och bisexuella män 60–85 år i Norge. | Kvalitativa livsberättelse-intervjuer samt fältarbete Antologikapitel | Sexuellt begär och relationer Homo- och bisexuella män |
| Linander, I. (2018). <i>"It was like I had to fit into a category" people with trans experiences navigating access to trans-specific healthcare and health</i> . Umeå Universitet. http://urn.kb.se/resolve?urn=urn:nbn:se:umu:diva-152817 | SV | Intervjustudie med tjugo transpersoner varav en var 69 år. | Intervjuer Avhandling | Transpersoners erfarenhet av hälsa och samt transvård Transpersoner |

| | | | | |
|--|----|--|--|---|
| Lindholm, M. (2013). "Jag vill dö med gräsklipparen i händerna!": En berättelse om lesbiskhet och åldrande. I J. Bromseth & A. Siverskog (Red.), <i>LHBTQ-personer och åldrande: Nordiska perspektiv</i> (77–104). Studentlitteratur. | SV | En lesbisk kvinna i 80-årsåldern i glesbygd | Intervju Bokkapitel | Lesbiskhet och åldrande; relationer; öppenhet. Lesbisk kvinna |
| Löf, J., & Olaison, A. (2020). 'I don't want to go back into the closet just because I need care': Recognition of older LGBTQ adults in relation to future care needs. <i>European Journal of Social Work</i> , 23(2), 253–264 | SV | 15 LGBTQ-identifierade personer 65 år eller äldre, födda mellan 1939 och 1950. | Kvalitativa semi-strukturerade intervjuer Artikel | Öppenhet, erkännande, tankar om framtida omsorgsbehov, HBTQ-boenden. Fraser som teori. Homo-, bisexuella, transpersoner och queera |
| Meggens Matthiesen, S. (2019). <i>Seksuel identitet sent i livet. Ældre homo- og biseksuelles sociale vilkår i Danmark</i> . Ensomme Gamles Værn. | DK | 32 homo- och bisexuella personer 63–95 år. | Intervjuer Rapport | Livsvillkor Homo- och bisexuella |
| Møllerop, C. A. (2013). Normen, identiteten, sexet och ålderdomen. I J. Bromseth & A. Siverskog (Red.), <i>LHBTQ-personer och åldrande: Nordiska perspektiv</i> (277–302). Studentlitteratur. | NO | 21 hbt-personer 59–82 år | Samtal Antologikapitel | Livsvillkor, åldrande, relationer, identitet, begravning Homo- och bisexuella |
| Qvarnström, A., & Oscarsson, M. G. (2015). Experiences of and attitudes towards HIV/STI prevention among holidaymaking men who have sex with men living in Sweden: A cross-sectional Internet survey. <i>Scandinavian Journal of Public Health</i> , 43(5), 490–496. | SV | 656 män som har sex med män 18–75 år | Enkätstudie Artikel | Sexuell hälsa/HIV-prevention bland män som har sex med män som reser |
| Robertsson, H. (2013) Äldre homo- och bisexuella mäns upplevelser av normbrytande. I <i>LHBTQ-personer och åldrande. Nordiska perspektiv</i> . | SV | Intervjuer med 21 homo- och bisexuella män födda 1922–1945. | Intervjuer Antologikapitel | Normbrytande Homo- och bisexuella män |

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| Siverskog, A. (2013). "För oss blir ju livet en enda stor teater": Äldre transpersoners erfarenheter av åldrande och könsidentitet. <i>LHBTQ-Personer Och Åldrande</i> . http://libris.kb.se/hitlist?d=libris&q=9789144077697&f=simp&spell=true&hist=true&p=1 | SV | Sex transidentifierade 62–78 år, födda mellan 1933 och 1950. | Kvalitativa intervjuer Antologikapitel | Livserfarenheter Transpersoner |
| Siverskog, A. (2014). "They just don't have a clue": Transgender aging and implications for social work. <i>Journal of Gerontological Social Work</i> , 57(2), 386–406. | SV | Sex transidentifierade 62–78 år, födda mellan 1933 och 1950. | Kvalitativa livsberättelseintervjuer Artikel | Transerfarenheter i relation till socialt arbete Transpersoner |
| Siverskog, A. (2015). Ageing Bodies that Matter: Age, Gender and Embodiment in Older Transgender People's Life Stories. <i>NORA</i> , 23(1), 4–19 | SV | Sex transidentifierade 62–78 år, födda mellan 1933 och 1950. | Kvalitativa intervjuer Artikel | Kroppslighet, materialitet Transpersoner |
| Siverskog, A., (2016). <i>Queera livslopp: Att leva och åldras som lhbtq-person i en heteronormativ värld</i> . Linköpings Universitet. http://liu.diva-portal.org/smash/get/diva2:1046379/FULLTEXT02.pdf | SV | Livsberättelseintervjuer med tjugo personer 64–88 år (födda 1922–1950) | Kvalitativa intervjuer Avhandling | Livserfarenheter Homo-, bisexuella, transpersoner och queera |
| Siverskog, A. (2017) "Att åldras som lhbtq-person". I Stina Johansson (red.) <i>Social omsorg i socialt arbete: grunder och fördjupningar</i> . Malmö: Gleerups | SV | Livsberättelseintervjuer med tjugo personer 64–88 år (födda 1922–1950) | Intervjuer Antologikapitel | Livslopp, åldrande Homo-, bisexuella och transpersoner |
| Siverskog, A., & Bromseth, J. (2019). Subcultural Spaces: LGBTQ Aging in a Swedish Context. <i>International Journal of Aging and Human Development</i> , 88(4), 325–340 | SV | 33 hbtq-identifierade 59–94 år | Kvalitativa intervjuer Artikel | Subkultur och community Homo-, bisexuella och transpersoner |

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| Siverskog A. (2021) <i>Queer äldreomsorg? Att möta äldre lhbtq-personer inom vård och omsorg</i> . Stockholm: RFSL Stockholm. | SV | Intervjuer med 11 hbtq-identifierade personer med äldreomsorgsinsatser, samt fokusgrupp med fyra äldre hbtq-personer utan äldreomsorgsinsatser | Kvalitativa intervjuer Utbildningsmaterial | Erfarenhet av äldreomsorg Homo- och bisexuella, transpersoner |
| Siverskog, A. (2022). Möjligheter och hinder att vara lhbtq-person inom äldreomsorgen: hur påverkar normer för kön och sexualitet? I Sandberg, L., Larsdotter, S. (red.) <i>Att främja äldres sexualitet och sexuella hälsa inom vård och omsorg</i> . Stockholm: Södertörns skriftserie. | SV | Intervjuer med sju hbtq-identifierade personer med äldreomsorgsinsatser, samt fokusgrupp med fyra äldre hbtq-personer utan äldreomsorgsinsatser. | Intervjuer Antologikapitel | Erfarenheter av äldreomsorg Homo- och bisexuella, transpersoner |
| Synnes, O., & Malterud, K. (2019). Queer narratives and minority stress: Stories from lesbian, gay and bisexual individuals in Norway. <i>Scandinavian Journal of Public Health</i> , 47(2), 105–114. | SV | Material med 65 berättelser av hbt-personer där de valt ut 3 varav 1 är en homosexuell man 71 år | Narrativ analys av personlig berättelse Artikel | Minoritetsstress, narrativ Homosexuell man |
| Træen, B., Kvalem, I. L., & Ohnstad, I. (2020). Experiences of Non-consensual Sex of Older Adult Men and Women in Norway, Denmark, Belgium and Portugal. <i>Sexuality and Culture</i> , 24(1), 113–139. | NO, DK | 1271 personer fr Norge och 1045 i Danmark 60–75 år varav 8–12 % var icke-heteros. | Enkätstudie Artikel | Erfarenheter av sex utan samtycke Homo- och bisexuella |
| Törmä S., Huotari, K., Tuokkola, K. & Pitkänen, S. (2014). <i>Ikäihmisten moninaisuus näkyväksi. Selvitys vähemmistöihin kuuluvien ikääntyneiden henkilöiden kokemasta syrjinnästä sosiaali- ja terveystalveluissa</i> . Sisäministeriön julkaisu 14/2014. | FI | Sex LGBTQ-personer 57–65 år från ett större urval | Kvalitativa intervjuer samt berättelser Rapport från Finska DO | Diskriminering i social – och hälsovårdstjänster Homo-, bisexuella samt transpersoner |

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| Vesterlund, J. (2013). Den som lever dolt lever gott?: Perspektiv från en dansk undersökning om äldre homo- och bisexuella. I J. Bromseth & A. Siverskog (Red.), <i>LHBTQ-personer och åldrande: Nordiska perspektiv</i> (105–138). Studentlitteratur | DK | 18 personer homo- och bisexuella män och kvinnor 60 år eller äldre. | Kvalitativa intervjuer Antologikapitel | Öppenhet; tankar kring vård och omsorg; diskriminering Homo- och bisexuella |
| Zeluf, G., Dhejne, C., Orre, C., Nilunger Mannheimer, L., Deogan, C., Höijer, J., & Ekéus Thorson, A. (2016). Health, disability and quality of life among trans people in Sweden—a web-based survey. <i>BMC Public Health</i> , 16(1), 903. | SV | 796 transidentifierade respondenter varav 39 personer var i åldrarna 55–94 år | Enkätstudie Artikel | Hälsa, funktionsnedsättningar och livskvalitet Transpersoner |
| Zeluf, G., Dhejne, C., Orre, C., Mannheimer, L. N., Deogan, C., Höijer, J., Winzer, R., & Thorson, A. E. (2018). Targeted victimization and suicidality among Trans people: A web-based survey. <i>LGBT Health</i> , 5(3), 180–190. | SV | 796 transidentifierade respondenter varav 39 personer var i åldrarna 55–94 år | Enkätstudie Artikel | Diskriminering och suicid Transpersoner |
| Ålands landskapsregering (2019) <i>Handlingsplan för hbtqia-personers lika villkor i det åländska samhället 2019–2025</i> . | Åland | Cirka 50 personer varav 5 % var över 60 år | Enkät samt diskussion Rapport/handlingsplan | Livsvillkor, möte med vård och omsorg Homo-, bisexuella, transpersoner |
| Åberg, Lars. <i>Leva Livet. Att åldras med hiv</i> . (2018) | SV | Äldre hivpositiva personer varav sju är homosexuella män, äldre än 60 år. | Kvalitativa intervjuer Bok | Erfarenheter av att åldras med hiv. Homosexuella män |

Appendix 3. Included publications for the second part, inventory of current knowledge

| Publication | Context | Selection | Type of study | Focus | Results |
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| Ahlsdotter, Maria, 2016. <i>Slutrapport projekt hbtq-diplomerering. Resultat och erfarenheter</i> . Stockholms läns landsting. LAFA Enheten för sexuell hälsa. | SE | 31 healthcare centres, 242 participants educated | Questionnaire | Replacement of pilot in LGBTI certification | A majority experienced learning exchanges. Access to CPD is a challenge in the healthcare system. |
| Areskoug Josefson, Kristina & Gard, Gunvor, 2015. <i>Sexual Health as a Part of Physiotherapy: The Voices of Physiotherapy Students. Sexuality and disability</i> , 2015. | SE | 31 students studying physiotherapy from two universities in Sweden | Focus group interviews | Is sexual health important knowledge for practising professionals and is there enough of this knowledge in study programmes? | There is not enough knowledge in study programmes but sexual health is considered to be very important for professional practice |
| Areskoug-Josefsson, K., Larsson, A., Gard, G. <i>et al.</i> (2016). Health Care Students' Attitudes Towards Working with Sexual Health in Their Professional Roles: Survey of Students at Nursing, Physiotherapy and Occupational Therapy Programmes. <i>Sex Disabil</i> 34, 289–302 (2016). https://doi.org/10.1007/s11195-016-9442-z | SE | 419 students in physiotherapy, occupational therapy and nursing programmes | Quantitative survey | Is sexual health important knowledge for practising professionals and is there enough of this knowledge in study programmes? | The students experienced that they had acquired too little knowledge in how to address sexual health related themes with patients. |

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| <p>Areskoug Josefsson, K. & Solberg, A. S. (2023). Kartlegging av SRHR i forskrift og lokale program-, studie- og emneplaner for utvalgte utdanningsløp i Norge – Rapport Desember 2022. 49 s. ODA Open Digital Archive.</p> | <p>NO</p> | <p>General, subject and course syllabuses were investigated in roughly one third of all study programmes for 8 health and social sciences professional qualifications.</p> | <p>Mapping of indicators</p> | <p>To what extent are SRHR indicators taken into consideration in the selected education pathways? What needs for improvement does the mapping show?</p> | <p>Many SRHR indicators are not included in the study programme documents, so the extent of the inclusion of SRHR in the study programmes from different perspectives cannot be established. The results indicate a need for a stronger foundation for working holistically with the SRHR indicators at all levels in the study programme documents to ensure high quality in their work for the practising professionals included in the mapping.</p> |
| <p>Baiocco, Roberto et al, 2021. LGBT+ Training Needs for Health and Social Care Professionals: A Cross-cultural Comparison Among Seven European Countries.</p> | <p>DK (included)</p> | <p>412 practising professionals in healthcare in seven European countries (Denmark, Cyprus, United Kingdom, Romania, Spain, Italy)</p> | <p>Quantitative survey</p> | <p>What are the needs for competence-enhancing efforts in LGBT+ perspectives among practising professionals in healthcare and social care occupations?</p> | <p>In the study, the participants expressed a need for competence-enhancing efforts and better inclusion of LGBT+ perspectives.</p> |
| <p>Christensen, M., 2019. Konkreta möten med hbtq-frågor: queerande ögonblick i vårdpraktiken. In Vårdvetenskap och postmodernitet, editors Salzmänn-Erikson, Eriksson, H. Christiansson, M., Holmgren, J. & Engström, A. Lund: Studentlitteratur</p> | <p>SE</p> | <p>Chapter in textbook for nursing students</p> | <p>The chapter describes how queer theory perspectives can be used in concrete interactions with patients, with a focus on gay men and older adults.</p> | <p>Medvetenhet kring kön- och sexualitetsnormer, samt äldre LGBTI-personers livloppserfarenheter är viktigt för mer inkluderande bemötande i vård- och omsorgspraktiker.</p> | |

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| Egede, S. J., Fouchard, J., Frisch, M., & Graugaard, C. (2019). <i>Danske LGBT-personers møde med almen praksis: Udfordringer og muligheder</i> . Sundhedsstyrelsen; Sexologisk Forskningscenter, Klinisk Institut, Aalborg Universitet. | DK | Interviews with five general practice physicians and three nurses | Interview | Encountering LGBTI patients and the need for competence and skills | Those interviewed generally had little LGBTI competence and felt uncertain about where they could find knowledge about special needs |
| Giertsen, Merete. Heteronormativity Prevails. A Study of Sexuality in Norwegian Social Work Programs. <i>Journal of Social work education</i> , 2017 | NO | Analysis of course literature in social work for the academic year 2013–2014 | Document analysis | How often is sexuality mentioned and in what ways? | Sexuality is mentioned on 90 pages, 0.08% of the course literature |
| Gerbild, H., Larsen, P.T., Junge, T. Schantz Laursen, B. & Areskoug-Josefsson, K. (2020). Danish Health Professional Students' Attitudes Toward Addressing Sexual Health: A Cross-Sectional Survey. <i>Sex Med</i> , 9:100323. | DK | 584 students from physiotherapy, occupational therapy and nursing study programmes | Quantitative survey | Is sexual health important knowledge for practising professionals and is there enough of this knowledge in study programmes? | The students had positive attitudes but their experience was that they had acquired too little knowledge in how to address sexual health related themes with patients in their education. |
| Knutagård, H. 2016. <i>Sexualitet och social arbete</i> . Lund: Studentlitteratur | SE | Textbook | | Sexualitet i socialt arbete som professionsfält | |
| Linander, Ida et al, 2020. Two Steps Forward, One Step Back: A Policy Analysis of the Swedish Guidelines for Trans-Specific Healthcare. <i>Sexuality Research and Social Policy</i> (2021) 18:309–320 | SE | Policy analysis of guidelines for assisting in the health of trans people in Sweden | Policy analysis | Which understandings of problem and solution are advocated in the guidelines | The guidelines have features in common with psycho medical understandings of gender dysphoria which dominate medical research and practice but also aim to depathologise trans experiences. |

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| Linander, Ida & Nilsson, Maria, 2021. "Det är fokus på rätt saker". <i>Hbtq-personers upplevelser av region Västerbottens hbtq-diplomering</i> . Institutionen för epidemiologi och global hälsa. Umeå universitet/ Folkhälsoenheten, Region Västerbotten | SE | Evaluation of Region Västerbotten's LGBTI certification: analysis of its structure, organisation and interviews with users of health services. | Qualitative | Effekter av hbtq-certifiering i Region Västerbotten, Sverige | Underlag för förbättring av hbtq-diplomeringen; det saknas kunskap om STI och sexuella praktiker för lesbiska och att alla på kliniken är fortbildade. |
| Lundberg, T., Nordlund, L., Narvola, J., 2017. Normkritiska perspektiv: nya möjligheter för svensk psykologisk praktik. <i>lambda nordica</i> , nr 4, 2017. | SE | National and international guidelines for practice in psychology | Qualitative | Psychology profession's guidelines for good treatment and norm-critical perspectives | New guidelines in psychology provide greater scope for working in a norm-critical way in professional practice. The knowledge perspectives used are however central. |
| Lundberg, T, Malmquist, A. och Wurm, M. (2017) <i>HBTQ+ Psykologiska perspektiv och bemötande</i> . Stockholm: Natur och kultur | SE | Textbook | Qualitative | Anthology with a focus on LGBTI perspectives in psychology grounded in queer theory and norm-critical perspectives with students and practising professionals as the target groups | LGBTI perspectives on psychology, living conditions and treatment, as well as guidelines which aim, based on the chapter in the book, to provide a brief overview of the skills and knowledge required by those who treat and encounter LGBTI people. |
| Lunde, Gerd Hilde, Blaaid, Laila, Gerbild, Helle & Areskoug-Josefsson, Kristina, 2022. Assessment of the Psychometrics of the Student's Attitudes Towards Addressing Sexual Health Extended (SA-SH-Ext) Questionnaire for Social Educator Students. <i>Sexual medicine</i> 10, Issue 3. | NO/SE/DK | 213 students studying social work | Survey | Develop a method for measuring knowledge about sexual health among students studying social work | The questionnaire can measure knowledge needs and attitudes towards taking up key topics in sexual health as future social workers. A majority were not comfortable with taking up sexual health in relation to age or sexual orientation |

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| Nielsen, B. F.R, 2018. Sygepleje til ældre lgbt-personer. <i>Nordisk sygeplejeforskning</i> , vol =, Issue 4, 302- 307 | DK | Review article | Qualitative | LGBTI+ and ageing challenges and knowledge needs for nurses in Denmark | There is little knowledge from Denmark about LGBTI ageing in Danish nursing study programme |
| Norrman, Lina, Nilsson, Emma och Törnblom, Johan, 2013. Den kommunala garderoben. I <i>LHBT-personer och åldrande</i> . Nordiska perspektiv, red Bromseth & Siverskog. | SE | Five unit managers of nursing homes in Umeå municipality | Interview study | Attitudes to knowledge about LGBTI people's experiences across the life course and needs in nursing homes for older people | An attitude that it is sufficient to 'treat everyone equally' dominates. |
| Prebble, K., Gerbild, H. N., & Abrahamsen, C. (2022). Content validity and reliability of The Danish version of Health Care Students Attitudes towards Addressing Sexual Health - A psychometric study. <i>Scandinavian Journal of Caring Sciences</i> , 36(2), 515-523. https://doi.org/10.1111/scs.13048 | DK | 111 students in health sciences, physiotherapy and occupational therapy | Questionnaire | Develop a method for measuring knowledge about sexual health among students studying social work | A majority were not comfortable with taking up sexual health in relation to age or sexual orientation |

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| <p>RFSL/SKL (2015). <i>RFSLs kommunundersökning 2015</i>. Stockholm: RFSL</p> | <p>SE</p> | <p>Survey responses from 246 municipalities about their work to measure the differences in conditions for their residents based on six different areas: municipal activities, schools, education efforts, LGBTI community's infrastructure, prevalence of hate crimes, and attitudes to LGBTI people</p> | <p>Survey</p> | <p>Survey of all the country's municipalities working with LGBTI perspectives in various areas. Also includes surveys conducted in collaboration with SALAR.</p> | <p>49 municipalities, 16.9%, get the pass rating of at least 3. Compared with when RFSL conducted its most recent municipal survey in 2006, this is an improvement. Then only nine municipalities got the pass rating of at least 3.</p> |
| <p>Roen, K., Creighton, S. M, Hegarty, P. and Liao, L.-M. 2018. Vaginal Construction and Treatment Providers' Experiences. <i>North American Society for Pedriativ and Adolescent Gynecology</i>.</p> | <p>SE/GB</p> | <p>Interview study with 32 specialist doctors in multidisciplinary investigation teams from 12 hospitals in Sweden and the UK</p> | <p>Qualitative</p> | <p>To investigate clinical specialists' experiences of treating vaginal reconstruction.</p> | <p>Specialist doctors were of the view that psychological support in discussions around vaginal reconstruction are important, but often reproduce normative expectations. The conversations ought to challenge social norms around the body and sexuality to a greater extent in order to create understanding and choice.</p> |
| <p>Rosqvist, H.B. Nordlund, L. och Kaiser, N., 2014. Developing an authentic sex: Deconstructing developmental–psychological discourses of transgenderism in a clinical setting. <i>Feminism & Psychology</i>, Vol. 24(1) 20–36</p> | <p>SE</p> | <p>Interviews with nine health professionals, observation of two clinical conferences and a focus group interview</p> | <p>Qualitative</p> | <p>To investigate the discursive understandings of transsexualism and identity that exist among psychologists in treatment teams</p> | <p>A developmental psychology discourse dominates with the emphasis on the development of authenticity and maturity in the development of gender identity. A more critical attitude to a developmental psychology discourse is essential to creating a more equal gender-affirming treatment</p> |

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| Schindele, A-C., Wallin, M. & Josefsson, A. K. 2017. Kartläggning av utbildning i hiv-prevention och SRHR. Östersund: FHI | SE | Document analysis of indicators for sexual health in general and course syllabuses in eight professional qualification study programmes | Mapping of indicators | Representation of indicators for sexual health in general and course syllabuses human care professional qualification study programmes in Sweden. | Few of the study programmes have indicators for gender identity, sexual orientation and older age. |
| Solberg, A., 2017. <i>Skeiv i helse-Norge</i> . Hamar: Likestillingssenteret | NO | Mapping of places to meet and healthcare services LGBTI people in the Innlandet region, as well as the competence and skills of healthcare staff concerning sexual orientation, gender identity, and gender expression. | Mapping and survey | Investigate the knowledge and knowledge needs concerning LGBTI perspectives in units working with mental health in Innlandet, Norway | The mapping shows that there are few units in Innlandet who have employees with formal competence and skills concerning sexual orientation, gender identity and gender expression, and that efforts to increase competence in these areas has a low priority. |
| Socialstyrelsen 2013. <i>Äldre hbt-personer och kommunernas vård och omsorg om äldre. En kartläggning.</i> | SE | Survey of Swedish municipalities' knowledge and competence enhancement efforts concerning older LGBTI people | Quantitative | Investigate Swedish municipalities' work with older LGBTI people and active measures for equality in healthcare and social care. | Only 17% of municipalities and suburbs of the major cities mention older LGBTI people in any current governing documents. |
| Socialstyrelsen 2023. <i>Äldre hbt-personer och kommunernas vård och omsorg om äldre. En kartläggning.</i> | SE | Mapping of Swedish municipalities' knowledge and competence-enhancement efforts concerning older LGBTI people and their experiences of healthcare and social care | Survey study and interviews | Investigate the experiences of older LGBTI people of healthcare and social care, and Swedish municipalities' active measures for older LGBTI people's access to equal healthcare and social care. | Less than one third (28%) specifically mention older LGBTI people in their governing documents for equal treatment. All in all, 1/5 of the country's municipalities are working with knowledge-enhancing activities that encompass older LGBTI people. |

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| <p>Sommarö, Susanna, Anderson, Agneta och Skagerström, Janna, 2020. A deviation too many? Healthcare professionals' knowledge and attitudes concerning patients with intellectual disability disrupting norms regarding sexual orientation and/or gender identity. <i>J Appl Res Intellect Disabil.</i> 2020;33:1199–1209</p> | SE | <p>Interviews with 19 healthcare staff with a variety of professional qualifications working at two habilitation centres for people with intellectual impairments. Twelve worked with children and seven with adults.</p> | Qualitative method | <p>Investigate healthcare and social care staff's knowledge about and attitudes to patients who do not conform to the norms for gender identity and sexual orientation.</p> | <p>The analysis identified three themes: 1) heteronormative treatment in the healthcare system, 2) barriers in work for inclusion, and 3) opportunities for inclusion.</p> |
| <p>Steij Stålbrand, I. 2017. HBTQ+ och äldre. In <i>HBTQ+ Psykologiska perspektiv och bemötande</i>, editors Lundberg, T, Malmquist, A. och Wurm, M. Stockholm: Natur och kultur</p> | SE | <p>Overview chapter, textbook Swedish and International research</p> | Qualitative literature review | <p>Ageing, sexuality, identity, norms LGBTIQ+ Implications for teaching in professional interactions</p> | <p>Knowledge about ageing, sexuality and LGBTI people's experiences is lacking in professional qualification study programmes. To increase knowledge is important for the capacity of psychologists and healthcare and social care staff LGBTI people to be treated with respect and understanding.</p> |
| <p>Stubberud, E., Prøitz, L. & Hamidiasl, H, (2018). <i>Den eneste skeive i bygda. Unge LHBT-personers bruk av kommunale helsetjenester</i>. KUN: Forlaget Nora</p> | NO | <p>Interview with 13 health workers in Norwegian municipalities</p> | Qualitative | <p>LGBTI perspective in practising their profession and competence needs</p> | <p>Almost no health workers had any knowledge about LGBTI perspectives included in their basic education. There are big differences between large and small municipalities when it comes to resources, funding and distance.</p> |

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| Tengelin, Elinor, Bulow, Pia H., Berndtsson, Ina, Dahlborg Lyckhage, Elisabeth, 2019. Norm-critical potential in Undergraduate Nursing education: A Document Analysis of curricula. | SE | Document analysis of programme syllabuses for nursing education at a Swedish university | Qualitative document analysis | The article analyses what dominant perspectives are represented in national intended learning outcomes, programme syllabuses and course literature, and looks at the degree to which norm-critical perspectives are represented. | Policy documents and course literature at times contain a politically correct rhetoric but lack any anchoring in core values of social justice |
| Tengelin, Elinor, 2019. <i>Becoming aware of blind spots – Norm-critical perspectives on healthcare education.</i> Dissertation, MIUN | SE | Analysis of policy documents, interviews with teaching staff and students in the nursing study programme at a university | Qualitative method and survey study | A compilation thesis investigating norm-critical perspectives in healthcare and social care related higher education by looking at normative perspectives in the study programme. | Tolerance as a slogan needs to be problematised in relation to norms, privileges and power at all levels. A tool for testing non-critical awareness was developed for students that can be used actively in teaching. |
| Tikkinen, Kari A O et al., 2019. Public, health professional and legislator perspectives on the concept of psychiatric disease: a population-based survey. <i>BMJ Open</i> , 2019. | FI | Survey involving 3,259 respondents, including 1,701 psychiatrists/doctors/nurses | Quantitative survey | The survey investigates what was classified as mental illness by health professionals, members of Parliament and laypeople in Finland. | 20–50% are of the opinion that transsexualism is a mental illness More than 75 % think that homosexuality is not a mental illness |

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| <p>Traczyk, M., Wurm, M., Ahonen, L, 2013. "Det är ju inget vi frågar efter som psykologer": psykologers upplevelse av klienter med könsöverskridande beteende. <i>Lambda nordica, Vol 18, nr 3-4, 77-99</i></p> | SE | <p>Interviews with five psychologists employed in Swedish county councils</p> | <p>Qualitative interview study</p> | <p>Experiences of interacting with patients with gender-crossing behaviours</p> <p>Knowledge about gender identity in education and in guidelines</p> | <p>The study shows a lack of knowledge among psychologists about gender-crossing behaviour is a phenomenon, which affects the interaction with the client, especially when the client identifies themselves as non-binary. The respondents and their professional practice were clearly influenced by heteronormative frames of understanding.</p> |
| <p>Træen, Bente & Schaller, Sidsel, 2013. Talking to patients about sexual issues: experiences of Norwegian psychologists, <i>Sexual and Relationship Therapy</i>, 28:3, 281-291, DOI: 10.1080/14681994.2013.768338 To link to this article: https://doi.org/10.1080/14681994.2013.768338</p> | NO | <p>1064 clinical psychologists at various workplaces in Norway recruited via the Norwegian Psychological Association (NPF)</p> | <p>Quantitative survey with 1064 responses</p> | <p>Investigated whether psychologists take up sexuality in therapy and if so, any differences related to age, gender and knowledge background</p> | <p>1 of 5 take up questions about sexuality with patients, with the majority asking now and then. 58% experienced that their knowledge was inadequate.</p> |
| <p>Wickman, Jan, 2013. Äldre lhbt-personers livsvillkor och möte med vården i Finland. In <i>LHBT-personer och åldrande. Nordiska perspektiv</i>, editors Bromseth, J. & Siverskog, A.</p> | FI | <p>Research overview concerning older LGBTI people's conditions in Finland based on policy and mappings in the competence needs of the healthcare and social care sector concerning ageing in LGBTI people</p> | <p>Mapping</p> | <p>Overview chapter concerning older LGBTI People's conditions in Finland and access to equal healthcare</p> | <p>LGBTI people's ageing and access to equal healthcare and social care is rendered entirely invisible in current policy and study programmes</p> |

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| <p>Wilén, Johansson, E. & Lundsten E, 2019. <i>HBTQ-personers upplevelser av bemötande inom HBTQ-diplomerade vårdverksamheter i Västra götalsregionen</i>. Göteborg: GU/Västra götalsregionen</p> | <p>SE</p> | <p>19 people, 20–60 year + employees working in healthcare activities and therapy activities in Västra Götaland region</p> | <p>Qualitative, interviews</p> | <p>How are LGBTI-certified activities experienced by LGBTI patients, and what does this training mean to healthcare staff?</p> | <p>The certification was experienced as positive by the majority of employees as well as patients. The employees described certification as having created an awareness in the workplace and help to get LGBTI issues on the agenda. Being able to continue to work on a norm-conscious interaction after the certification depends on the activity's circumstances. Some patients lacked general factual knowledge concerning LGBTI issues and support in navigating the healthcare system.</p> |
| <p>Wurm, Mathilda & Lundberg, Tove, 2016. "The formation of an LGBTQ network for psychologists in Sweden: A work in progress". <i>Psychology of Sexualities Review</i>, Vol 7, no 1.</p> | <p>SE</p> | <p>Historical review of the Swedish psychologists' association's work with LGBTI perspectives and the establishment of an LGBTI network in Sweden.</p> | <p>Mapping</p> | <p>Our professional associations and psychology in Sweden have worked with LGBTI perspectives, and how the establishment of a network affects work in the field</p> | <p>A network has positive effects in the form of starting conversations and exerting influence around the introduction of LGBTI and norm-critical perspectives in the field.</p> |

Appendix 4. Interviews

Since the literature search in sub-study 2 resulted in few or no studies of LGBTI perspectives and ageing in professional courses and study programmes and CPD initiatives, a number of contextualising interviews were conducted with professionals in higher education institutions offering health and social sciences courses and study programmes and CPD actors, mainly in Finland and Iceland, but also in Denmark, Sweden and Norway.

Method: Interviewees were recruited using the snowball method: initially via the researcher's contact network and via suggestions from the reference group, and subsequently through the tips that came from these people. These individuals contributed valuable information via e-mail or longer e-mail exchanges, or participated in short interviews (maximum one hour), most of them online. The interviews have been recorded and transcribed with a focus on their content.

Finland:

- Juhka Lehtonen, Senior Lecturer, Gender Studies, University of Helsinki. E-mail interview, 23 February 2021.
- Inka Soderström, doctoral student in Social Work, University of Helsinki. E-mail interview, 28 February 2023.
- Minna Laiti, senior lecturer and doctoral student in nursing science, University of Turku. E-mail interview, 6 April 2023 and online interview, 6 August 2023.
- Sandra Hagman, PhD, Senior Lecturer in Social Work at the Diaconia University of Applied Sciences. E-mail interview, 3 March 2023.
- Touko Niiinimäki, expert in equality and gender equality, Suomen nuorisoalan kattojärjestö Allianssi ry, formerly responsible to certification of elder care services. Online interview, 2 March 2023.
- Outi Jurin, SETA Secretariat, E-mail interview, 2-26 March 2023.
- Tanja von Knorring, Vice Chair of SETA and Chair of Rainbow Seniors, E-mail interview, 20 April 2023.

Iceland:

- Svandís Anna Sigurðardóttir, LGBTIQ+ and Gender Equality Advisor, City of Reykjavík Human Rights and Democracy Office, City Hall. Online interview, 23 March 2023.
- Auður Magnús Auðardóttir, Assistant Professor of Education Studies, University of Iceland. E-mail interview, 3-4 April 2023.

- Guðbjörg Ottósdóttir, Associate Professor, Social Work, University of Iceland. Online interview, 11 April 2023.
- Daniel Arnarsson, President, Samtökin 78. Online interview, 9 March 2023.

Denmark:

- Kamille Hjuler Kofoed, LGBT+ Denmark. Online interview, 9 May 2023.
- Susanne Branner Jespersen, LGBT+ Denmark. E-mail interview.
- Mikkel Enevoldsen, Aidsfonden. Online interview, 28 April 2023.

Norway:

- Gerd Hilde Lunde, Assistant Professor in Health, OsloMet. Interview in Oslo. 6 March 2023.

Sweden:

- Mathilda Wurm, Senior Lecturer in Social Work, Örebro. E-mail interview.
- Åsa Wern, RFSU Education. Digital interview, 21 April 2023.

About this publication

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Janne Bromseth and Anna Siverskog for NIKK, Nordisk information för kunskap om kön

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