BestCare 4LGBTQI+

Co-funded by the European Union

TRAINING FOR MORE INCLUSIVE SERVICES

HANDBOOK

PROJECT N° 2021-1-FR01-KA220-ADU-000035303

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Introduction

BestCare4LGBTQI+ is a European project funded under the Erasmus+ programme.

The mission of the BestCare4LGBTQI+ project is to support the development of LGBTQI+-friendly elder care services, providing tools, awareness-raising materials and learning resources to home care and residential care services managers and staff to ensure better adapted, more respectful, and inclusive care for LGBTQI+ older people living in care facilities.

Objectives of the project:

- Raise awareness on specific older LGBTQI+ needs among care home and services managers and staff as well as in the general audience
- Support care services to assess their inclusiveness and to implement an action plan to become more LGBTQI+ friendly
- Equip home care and residential care managers and staff with tools and skills for better integration of older LGBTQI+ people
- Ensure better care for LGBTQI+ older people in residential care facilities and home care services, especially when living with dementia

In Project Result 1, the partners' qualitative research shows how crucial is training for the professionals working in these care services. More specifically, the results of the research show the lack of expertise and training regarding LGBTQI+ issues. Many professionals of the focus groups that were interviewed acknowledge their lack of knowledge of LGBTQI+, gender and sexuality-related issues. Only some of them were familiarised with the clear meaning of the term LGBTQI+. Many of them were doubtful regarding the meaning of the acronym especially when it comes to issues related to transgenderism and intersexuality. "That part of IQ+, honestly no. I only knew LGBTI and I don't remember what the "I" was about anymore", stated a professional from Portugal. [The difference between sexual orientation and gender identity] "I think it's pretty clear to me, as I did a bit of research a while ago, anyway, it started from a discussion with some friends. But I can't say I have a very good grasp of it". (Romania)

For this reason, this training is developed by the partners in order to provide healthcare professionals with knowledge and experience.

The training is expected to have a positive impact on attitudes, beliefs, and behaviours towards LGBTQI+ people, as well as provoke a willingness in management to clearly take on an inclusive stance of their institution that can be concretized for example through the adoption of an inclusive policy or statement, or of the Excellence Badge (see PR4). The training and tools will be evaluated and adjusted according to

the feedback from the pilot participants (trainers and trainees). This PR is innovative because it starts from the narratives of the relevant actors for training (older people, professionals, and managers- PR1) and addresses the various instances of care services. Furthermore, it is linked, prepares, and enables institutions to build foundations for the requirements needed to be recognized with the Excellence Badge (PR4). In fact, this characteristic is a good indicator of its replicability potential. This resource can be easily replicable in other institutions, either by the trainers participating in the project or by the dissemination of Train the Trainers (PR3).

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MODULE 1

THE NEEDS OF OLDER LGBTQI+ AND SEXUALITY IN OLD AGE

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MODULE I

The needs of older LGBTQI+ and sexuality in old age

The mission of the BestCare4LGBTQI+ project is to support the development of LGBTQI+ friendly older care services, providing tools, awareness-raising materials and learning resources to home care and residential care services managers and staff to ensure a better adapted and more respectful and inclusive care for LGBTQI+ older people living in care facilities.

There is evidence that older LGBTQI+ suffer from difficulties in receiving a different service treatment in this kind of services and health professionals lack the knowledge on the needs of older LGBTQI+ (AGE Platform and ILGA Europe, 2012). This course is expected to have a positive impact on the attitudes, beliefs, and behaviours towards LGBTQI+ people and motivate care managers to take an inclusive stance in their institution by promoting diversity management, which is needed for services to change and not be compromised by ageism, homophobia and heterosexism, which affect the delivery of care.

In this module you will learn about the challenges and difficulties of growing old as an LGBTQI+ person, what are some specific needs and difficulties of this group, about sexuality in old age and some practical activities on care practices.

On the medical, emotional, and social needs of older adults

Everyone gets old, this is a given, from the moment we are born we start to get old. Getting old involves not only physical changes in the body, but also emotional, psychological, social. As people age, their needs and preferences change, and society must adapt to support them. Older people may require more assistance with daily activities, healthcare, and socialization. They may also face financial insecurity, housing challenges, and ageism.

Ageism can lead to social isolation, reduced access to healthcare, employment discrimination, and negative mental and physical health outcomes. Moreover, it perpetuates harmful myths and stereotypes that older people are less capable, less valuable, and less deserving of respect and care.

The World Health Organization defines ageism as "the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) directed towards people on the basis of their age"[1]. Ageism can be found in multiple levels of society, from the laws, policies or social norms of institutions that disadvantage people because of their age to interpersonal or self-directed ageism (when it is internalized and turned against oneself). Ageism is associated with a myriad of health-related issues ranging from physical to mental health to social well-being; it is associated with a shorter lifespan, it has been shown to accelerate cognitive impairment, reduce the quality of life, increase social isolation, loneliness, depression; it also restricts the ability to express sexuality. The risk of abuse against older people is also increased, so ageism has consequences not only for people's health and well-being, but also in terms of basic human rights[2].

[1] Global report on ageism (2021). World Health Organization, Geneva.
[2] Global report on ageism (2021). World Health Organization, Geneva.

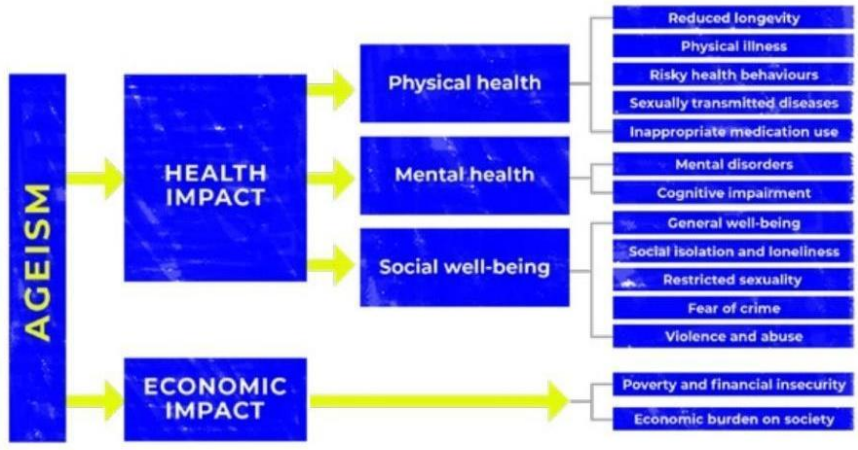

Figure 1. The impact on Ageism on older people (from Global Report on Ageism, 2021, p. 49)[3]

As the population of Europe is on an ageing trend, it is projected that by 2050 the number of people over the age of 65 to increase to almost 130 million from 90.5 million (in 2019-2020)[4]. The demand for social care, which includes long-term care (home or residential) has risen[5] and is expected to continue to rise in response to this ageing population and this is why there is a need for more research and more awareness on how to combat ageism in long-term care. There aren't many research studies on this particular subject currently.

However, the existing ones[6] showcase that most seniors in residential care find that the caregivers have an ageist attitude towards them, objectifying them, neglecting basic needs or they have a patronising behaviour and communication style. It is therefore essential to tackle ageism as best we can by educating the general public and care professionals on its negative impacts on the emotional, psychological, physical and social needs of the elderly.

Getting older as LGBTQI+

While on a EU level, the social acceptance of LGBTQI+ people seems to be on the rising, with 76% (in 2109) of Europeans agreeing that LGBTQI+ people should have the same rights as heterosexual people[7], it is best to mention that percentages vary widely by member states.

Generally speaking, Western and Northern European countries tend to be more accepting of LGBTQ+ individuals and have made more progress in terms of LGBTQ+ rights and protections. For example, several Western and Northern European countries have legalized same-sex marriage and adoption and have laws protecting individuals from discrimination based on sexual orientation and gender identity.

In contrast, many Eastern European countries have been slower to adopt these protections and continue to be more conservative in their attitudes towards LGBTQ+ individuals. For example, some Eastern European countries have laws prohibiting "propaganda of homosexuality" or promoting traditional gender roles, which can be used to discriminate against LGBTQ+ individuals. Moreover, many LGBTQ+

[3] Ibidem, p.49.
[4] Ageing Europe – Looking at the lives of older people in the EU (2020), Eurostat.
[5] Global report on ageism (2021). World Health Organization, Geneva.
[6] Idem.
[7] Special Eurobarometer 493: Discrimination in the European Union (2019).

individuals in Eastern Europe still face significant discrimination and violence and may not have access to support and resources that are available in other parts of Europe.

A 2014 report by FRA (EU Agency for Fundamental Rights)[8], pointed out that most members of the LGBTQI+ community felt that they have been personally discriminated against or harassed because of their sexual orientation. What is interesting to notice in this data is that most people who have felt discriminated against or harassed were young people between 18 – 39, while those over 55 were the ones who felt the least discriminated against. A potential explanation for these findings could be related to the smaller sample of people over 55, compared to the other age groups.

Older LGBTQI+ may be generally difficult to identify, for reasons that pertain to:

- Historical discrimination: Many LGBT older people have experienced discrimination throughout their lives, which may have led to underreporting of their sexual orientation or gender identity in previous generations.
- Fear of discrimination: LGBT older people may still fear discrimination, harassment, or mistreatment in healthcare and social services settings, which may make them less likely to seek out those services or participate in studies. If this is the case, it might be because people feel safer being in the closet, as there is no actual legal framework to truly protect them: *"If you remain in the closet, I don't think there will be a concrete risk of being discriminated against or assaulted or harassed, even if you act a little effeminate" (Italy, gay, 25)*[9].
- Greater isolation: LGBT older people may be more likely to live alone, have smaller social networks, or have lost connections with family and friends due to stigma or rejection, which may make it more difficult to recruit them for research studies[10].
- Health disparities: LGBT older people are more likely to experience health disparities, such as higher rates of depression, substance abuse, and HIV/AIDS, which may make it more difficult to recruit them for studies[11].

While getting older as an LGBTQI+ person poses mainly the same problems as everyone else getting older, there are some fundamental needs that this group requires for an appropriate service either in home or residential care. Being part of a sexual minority group brings additional challenges and burdens[12]. Most problems associated with members of this community include increased risk factors and health disorders in older lesbian and gay people and especially in transgender elders, who are at risk for chronic conditions due to the negative effects of hormone treatments. Mental health issues and substance abuse disorders are also higher in the older LGBTQI+ community, not to mention the additional stressors of homophobia within eldercare services (either home or residential care)[13].

As already stated, Europe has a growing ageing population, which in turn means that there will also be more LGBT older adults in the future, and they will also need health and social support in the future. This widespread discrimination against the LGBTQI+ population should raise concerns among authorities and community services / NGOs related to the quality of health and social services that will be available to the

[8] EU LGBT survey, Main results Report. European Union Agency for Fundamental Rights. Luxembourg: Publications Office of the European Union, 2014
[9] Idem.
[10] Fredriksen-Goldsen, K. I., et al. (2014). "Physical and mental health of transgender older adults: An at-risk and underserved population." The Gerontologist, 54(3), 488-497.
[11] Fredriksen-Goldsen, K. I., et al. (2013). "The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults." Institute for Multigenerational Health, University of Washington.
[12] Hughes, A. K., Harold, R. D., & Boyer, J. M. (2011). Awareness of LGBT aging issues among aging services network providers. Journal of Gerontological Social Work, 54(7), 659-677.
[13] Idem.

LGBTQI+ community of an older age[14]. So again, it needs to be stressed that culturally sensitive training and increased education for health care and social service professionals is much needed to provide support for this community. Their training could help reduce some of the fears of many elders when seeking professional help in their older years and also to reduce the heteronormativity within the health / care systems[15],[16].

Dementia and LGBTQI+

Dementia is a disorder that is feared by many people when thinking about old age, because the illness transforms the self, and negatively affects a person's ability to do even the most basic everyday activities, as it involves progressive impairments in memory, thinking, behaviour, it *"collapses the foundations of identity"*[17].

What makes this illness even more feared among the LGBTQI+ population is the collapse of the personal identity, which of course includes their sexual or gender identity, something which is feared even more so than loss of physical capacity (even in the late stages). Therefore, older adults in need of care may be reluctant to disclose their sexual orientation, due to the fear of being discriminated once their mind starts to become progressively impaired[18]. Dementia brings out another fear, and that would be the forced disclosure of sexual identity or gender identity, once progressive cognitive dysfunction begins, either by the patient (because of the cognitive impairment and the loss of impulse control) or by the caregivers. This fear is associated with the loss of certain coping mechanisms" that *compensate for other oppressed social identities and render affected persons more vulnerable to discrimination as a result of disclosure"*[19].

Specific needs of older LGBTQI+

We've already discussed the extremely special needs of older LGBTQI+ individuals in terms of home or residential care, which include not feeling prejudiced, insulted, or judged by the carers. While this is a universal desire, to be treated with respect even in old age, in LGBTQI+ people this is even more important because of them being a sexual minority. They need service providers that can create a safe environment where they can feel safe to disclose and express their sexual orientation: *"The importance of openly acknowledging and supporting LGBT relationships and being out about one's sexuality are often cited by older LGBT adults as central to their satisfaction and safety within older adult-care system"*[20].

[14] Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2020). Provider and LGBT individuals' perspectives on LGBT issues in long-term care: A systematic review. The Gerontologist, 60(3), e169-e183.
[15] Choi, S. K., & Meyer, I. H. (2016). LGBT aging: A review of research findings, needs, and policy implications. eScholarship, University of California.
[16] Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2020). Provider and LGBT individuals' perspectives on LGBT issues in long-term care: A systematic review. The Gerontologist, 60(3), e169-e183.
[17] McGovern, J. (2014). The forgotten: Dementia and the aging LGBT community. Journal of Gerontological Social Work, 57(8), 845-857.
[18] Idem.
[19] Idem.
[20] Hughes, A. K., Harold, R. D., & Boyer, J. M. (2011). Awareness of LGBT aging issues among aging services network providers. Journal of Gerontological Social Work, 54(7), 659-677.

One study[21] shows that elderly members of the LGBTQI+ community fear the treatment they would receive not only from care workers, but also from other residents (if living in residential care). They consider that such care centres are *"heteronormative environments that promote the invisibility of LGBT older adults"*[22]. This invisibility is mentioned not only by the LGBT seniors, but also by the care workers providing senior care, LGBT issues are either avoided or ignored.[23]

Another study[24] shows that the majority of LGBT elders would hide their sexual orientation if placed in a care centre for fear of hostility and isolation from staff / other residents. The same study revealed that some of the care workers that would make negative comments about residents, just suspected them of being LGBT. The situation is even more dire for transgender elders who have reported that *"they would choose suicide rather than experience discrimination in long term care"*.

Another thing worth mentioning is that even though most LGBT elders mainly face the same challenges, and studies usually talk about them generally as a group, there are varying degrees and impacts of these challenges for specific sexual/gender minorities.

The most underrepresented category of the LGBTQI+ umbrella would be the elder transgender population, because they require some specific type of support or expertise, generally associated with transition related medical care, and with the isolation and loneliness that comes with transitioning. One of the few studies[25] regarding the older transgender population has found that this group is at a higher risk of poor physical and mental health compared even with other LGB people. Some of the negative health outcomes involve "internalised *stigma, victimisation and lack of social support...obesity for physical health and disability, identity concealment for perceived stress"*[26]. While studies on the LGBTQI+ older population are still few, information on the transgender population specifically is even more scarce, but much needed.

Difficulties experienced by older LGBTQI+

There is a plethora of difficulties experienced by LGBTQI+ elders[27] and most of them stem from the fear of discrimination due to their sexual or gender identity:

- **Problems with receiving health / social support** – because of the fear of discrimination, older LGBTQI+ delay or even completely avoid health care, or, if they do solicit such services, they prefer to conceal their sexual identity. As a result of concealing their sexual orientation from their medical providers, aggravated depression or medical problems are mostly to be expected. LGB seniors who were open with their providers about them being a sexual minority reported better perceived health and lower depression.

[21] Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2020). Provider and LGBT individuals' perspectives on LGBT issues in long-term care: A systematic review. The Gerontologist, 60(3), e169-e183.
[22] Idem.
[23] Knochel, K. A., Croghan, C. F., Moone, R. P., & Quam, J. K. (2010). Ready to serve? The aging network and LGB and T older adults. Washington, DC: National Association of Area Agencies on Aging.
[24] Hillman, J. (2017). The sexuality and sexual health of LGBT elders. Annual review of gerontology and geriatrics, 37(1), 13-26.
[25] Fredriksen-Goldsen, K. I., Kim, H. J., Shiu, C., Goldsen, J., & Emlet, C. A. (2015). Successful aging among LGBT older adults: Physical and mental health-related quality of life by age group. The Gerontologist, 55(1), 154-168.
[26] Idem.
[27] Choi, S. K., & Meyer, I. H. (2016). LGBT aging: A review of research findings, needs, and policy implications. eScholarship, University of California.

- **Fewer options for informal care** – most LGBTQI+ elders live alone, are less likely to have children and as opposed to their cisgender counterparts (who can rely on their immediate family), their only options for help, before looking for a retirement home are friends or community support (if available)
- **Financial instability and legal issues** are another concern, because most legal or social programs and opportunities established for supporting older adults are not tailored for LGBTQI+ needs
- **Difficulty in finding LGBTQI+ friendly retirement homes,** because of differential treatment (higher prices, no availability)
- **Worse mental and physical health** compared to cisgender older adults, associated with lifetime experiences of victimisation, discrimination, stigma. Transgender elders face an even higher risk than LGB older adults. Because of these issues there is a **higher prevalence for substance abuse or risky behaviour** (excessive smoking, excessive alcohol consumption, risky sexual behaviour etc.). In addition, because of the additional stressor, LGBT elders who are HIV-positive experience poorer conditions than LGBT elders who are HIV-negative.

Sexuality and security in long term care

The topic of older people's sexuality still remains a taboo, as they are often portrayed as asexual beings and while the medical perspective assumes a decline as well in sexual function with age progression. This may be the result of a *"too narrow a definition of sexual function (e.g. excluding solo, non-penetrative and same-sex sexual activity) and too great a focus on biological determinants of sexual function (e.g. declining levels of testosterone) to the exclusion of psychological and social determinants (e.g. depression, presence or absence of partners and characteristics of the relationship with a partner)"*[28], [29].

Even though sexuality is an essential aspect to express even in old age, ageist attitudes and portrayals of sexuality in older age in society and in the media put older people at a greater risk of STDs. They are also less likely to seek a diagnostic or treatment *"because there is limited information about STDs, a lack of sexual health services for older people and a fear of encountering ageist attitudes towards their sexuality"*[30]. Most people internalise these ageist stereotypes regarding sexuality at later stages in life and in turn are hesitant to discuss sexual issues with their medical providers out of fear of being judged.

On top of this general taboo around sexuality in later stages of life, health / social providers are not trained and educated adequately on how to deal with this issue. In residential care, knowledge on this topic is also lacking or ignored so the privacy needed for sexual expression in care centres is also lacking[31].

Keeping in mind the ageist attitudes around sexuality in old age, we can understand the added difficulties older LGBTQI+ people experience when it comes to expressing or even talking about their sexuality. As we have already covered in the other chapters, it is important to understand that LGBTQI+ represent different populations, varying in terms of sexual and gender identity, so each of these groups have specific needs when it comes to health.

As most older adults are reluctant to talk with their medical providers about sex, the risk of STDs for this population is higher, so it is important for care professionals to be aware of this issue, including some of

[28] Global report on ageism (2021). World Health Organization, Geneva.
[29] Hillman, J. (2017). The sexuality and sexual health of LGBT elders. Annual review of gerontology and geriatrics, 37(1), 13-26.
[30] Idem.
[31] Idem.

the most common diseases for each type of LGBT group, so they can better deal with their medical needs. According to one study[32], older LGBT people who are open to sharing their struggles and their negative treatment within a heteronormative health system, would appreciate a primary care physician that is either part of the LGBT community or a strong ally of the community, so they don't feel left out or discriminated against. This is especially the case for HIV positive people or transgender people, being the groups most stigmatised.

Each LGB group deals with some specific STDs or sexual health issues, so it is important to mention them for a better understanding, while also keeping in mind that the data we have is based on a limited number of research studies. When it comes to the lesbian population, the most common STD is HPV (human papillomavirus, the primary cause of cervical cancer) and this is because of the myth that lesbians are not at risk for STDs, so they generally don't do routine testing.

When it comes to gay people, the most common STD contracted is HIV. The bisexual population has not been clearly studied and this is because generally bisexuals identify as either lesbian / gay depending on their current partner, but we can infer from the data available that bisexuals have the same problems as their LG peers.

Transgender people face significant sexual health challenges, depending on their sexual orientation they can contract the same STDs as their LGB peers and on top of this they can have several other problems related to hormone use (eg. increased risk for diabetes or heart disease) or sex reassignment surgery (which is usually done later in life for various reasons, affordability, disclosure etc.)[33].

The multiple dimensions of discrimination

Recognizing and addressing intersectionality is crucial when discussing the needs and situation of older LGBTQI+ persons in residential care centres. Intersectionality refers to the interconnected nature of social identities such as age, sexual orientation, gender identity, race, ethnicity, religion, disability, and other forms of identity and oppression.

LGBTQI+ older adults may face unique challenges and experiences based on the combination of these multiple identities. For example, LGBTQI+ older adults who also belong to marginalised communities based on race, religion, or disability may face compounded discrimination and prejudice.

The European Network Against Racism and Center for Intersectional Justice published a report in 2020, on the "Intersectional discrimination in Europe: relevance, challenges and ways forward", explaining the individual, structural, institutional, and historical dimensions of discrimination. It could be a good starting point for understanding how intersectionality is visible and affects quality of life.

[32] Wilson, K., Kortes-Miller, K., & Stinchcombe, A. (2018). Staying out of the closet: LGBT older adults' hopes and fears in considering end-of-life. Canadian Journal on Aging/La Revue canadienne du vieillissement, 37(1), 22-31.
[33] Hillman, J. (2017). The sexuality and sexual health of LGBT elders. Annual review of gerontology and geriatrics, 37(1), 13-26.

Practical activities: reflection on care practices / case studies

Practical activity 1.1

Name of the activity	Working with labels
Number of participants	At least 10
Objectives	This activity will provide participants to practise how their idea or judgement of a person might be created and changed depending on what they know/see/perceive about the persons surrounding them.
Step-by-step description	First of all, the facilitator needs to create a safe space and tell everyone in the group this is not a place for judgement and that everyone is free to share their own opinions and ideas without any fear. Handout the cards and ask the participants to write answers to the following questions. Make sure that they **do not share** their responses with others until later. ● What wouldn't we know by just looking at you? ● What goal are you working towards? (personal, professional) ● What is an experience that you feel defines you? ● What personal experiences do you have, if any, with discrimination? If not, please write why you think that is. Collect the cards, shuffle them, and pass them around randomly between participants, making sure that no one has their own card. Ask the participants to find the owner of the card based on the answers. The answers should lead to a discussion, supported by the following questions: ● How accurate were the assumptions you made about people you don't know very well? What can you infer from your assumptions?

	• Why did you choose that specific person, what made you think it's their card? • How did you feel when you received a card that is not yours and doesn't represent you? • Did you learn anything that surprised you? Why?
Comments/hints for facilitators	The facilitator should always be aware that there might be sensitive subjects being discussed by the participants. Avoid taking sides and remain neutral and objective.
Resources	Cards / paper / markers

Practical activity 1.2

Name of the activity	Working with scenarios
Number of participants	At least 10
Objectives	This activity aims to provide residential care professionals with an opportunity to experience simulated scenarios that highlight the unique challenges and experiences faced by LGBTQI+ older people
Step-by-step description	The facilitator introduces the training activity by explaining the objective. Then, the participants should be divided into small groups of 3-4 individuals each and receive handouts with descriptions of scenarios. Each group should receive one scenario. Instruct participants to read and familiarise themselves with their assigned scenario silently. Ask participants to role-play their assigned scenarios within their small groups. After the activity, gather the small groups back together for a debriefing session. Use open-ended questions to encourage participants to reflect on their experience, such as: • What emotions did you experience during the activity?

	• What thoughts or insights did you gain from playing out the scenario? • How did the activity make you feel about the challenges faced by LGBTQI+ older people in residential care settings? • What did you learn about the importance of inclusivity and sensitivity towards LGBTQI+ older people in your role as a residential care professional? Conclude the activity with a discussion on strategies and best practices for creating a more inclusive and affirming environment for LGBTQI+ older people in residential care settings.
Comments/hints for facilitators	Encourage participants to immerse themselves in the scenario and reflect on the emotions, thoughts, and reactions they experience as they play out the scenario.
Resources	Handouts with descriptions of simulated scenarios (e.g., discriminatory treatment, isolation, lack of inclusivity, but may be adapted or changed by the trainer) **Scenario 1: Discriminatory Treatment** You are a residential care professional assigned to care for an older LGBTQI+ resident who has expressed their gender identity and sexual orientation openly. However, you overhear another staff member making derogatory remarks about LGBTQI+ individuals and using offensive language. You are faced with the challenge of addressing this discriminatory behaviour and ensuring a safe and inclusive environment for the resident. **Scenario 2: Isolation** You have been given the responsibility of providing residential care for an elderly LGBTQI+ resident who is suffering from social isolation as a result of their sexual orientation or gender identity. Due to their discomfort admitting their LGBTQI+ status to other residents or staff, the resident has expressed how this makes them feel alienated and lonely. You have to think of strategies to promote the resident's social inclusion and lessen their sense of social isolation. **Scenario 3: Lack of Inclusivity** You are a residential care professional assigned to care for an older transgender resident who is facing challenges related to

	lack of inclusivity. The resident has expressed discomfort with being misgendered, having their preferred name ignored, and not being provided with appropriate gender-affirming care. You need to find ways to ensure that the resident's gender identity is respected, and their care is inclusive and affirming. **Scenario 4: Family Rejection** You are assigned to care for an elderly LGBTQI+ person whose family has rejected them because of their sexual orientation or gender identity. The individual has stated a need for family assistance as he struggles with thoughts of abandonment. You have to balance giving the resident emotional support with figuring out how to meet their unmet familial requirements.

Additional resources

National level resources (Romania)

- This is a short informative material developed by CRJ for combating hate speech. It deals with the most common misconceptions and stereotypes people have about the LGBTQI+ community
  - 1.-Material-informativ-LGBTQ.pdf (crj.ro)
- Reports (not only in Romanian) that deal with diversity management in different settings, for different marginalized groups (not just LGBTQI+)
  - https://www.cartadiversitatii.ro/resurse

International resources

- The book *The Lover's Dictionary by David Levithan* is a short, witty book, written in dictionary style about the love story between two people. The gender and sexual orientation of the two characters are left ambiguous for the entirety of the book so it inclusive for all genders and sexual orientations, the story told can be about everyone, since no pronouns are used.
- An article about four gay friends that became an internet sensation thanks to their TikTok account (@oldgays). They make videos about their life, their experiences, their coming out, their first love etc. in a friendly and relatable manner which shows everyone that getting old is a part of life and you can still enjoy it fully.
  - The 'Old Gays' are getting their own docuseries (nbcnews.com)
- Professor Kathleen McInnis-Dittrich from the Boston College School of Social Work talks about ageism in care systems and across society and advocates for the full participation of older adults in society for a more inclusive society that promotes human dignity.
  - Living with Dignity: Social Justice for Older Adults - Boston College School of Social Work - YouTube

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BestCare 4LGBTQI+

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MODULE 2

HUMAN RIGHTS

PROJECT N° 2021-1-FR01-KA220-ADU-000035303

MODULE II
Human Rights

Introduction and learning goals of the module

This module explores human rights, discrimination and other legally-related issues which can emerge in relation to the care of older LGBTQI+ issue.

More specifically, the training material addresses the risks of human rights violations, abuse and discrimination to which older LGBTQI+ persons are exposed; the issues that might raise in case of loss of cognitive capacity as well as challenges related to believes and values of care professionals which might be in contrast with being LGBTQI+. Finally, the module also highlights the obligations of care workers, both in terms of quality of services to be provided as well as their protection duties towards clients.

At the end of this module we expect learns to:

- Know more about human rights and discrimination
- Be more aware to the risk of health inequalities affecting older LGBTQI+
- Know how older LGBTQI+ clients can be supported in exercising their legal rights and be protected from discrimination and abuse
- Be more capable to exercise self-reflection in recognizing own bias and understand how to deal with them in order to provide quality care to their clients.

Legal issues regarding Human Rights violations that LGBTQI+ face

What are the human rights?

According to the United Nations definition[34], human rights are rights that are not granted by any state. We have them simply because we exist as human beings. These universal rights are inherent to us all, regardless of nationality, sex, national or ethnic origin, color, religion, language, or any other status. They range from the most fundamental - the right to life - to those that make life worth living, such as the rights to food, education, work, health, and liberty.

Human rights are:

- Universal: This means that we are all equally entitled to our human rights.
- Inalienable: They should not be taken away, except in specific situations and according to due process. For example, the right to liberty may be restricted if a person is found guilty of a crime by a court of law.
- Indivisible and interdependent: this means that one set of rights cannot be enjoyed fully without the other and that there are no human rights more important than others.

[34] https://www.ohchr.org/en/what-are-human-rights

Legal references

The first and still today more important legal documents in the relation to human rights is the Universal Declaration of Human Rights (UDHR), adopted by the UN General Assembly in 1948.

At European level, human rights are recognized and protected by the

- European Convention on Human Rights (ECHR), that protects the human rights of people in countries that belong to the Council of Europe[35]. The rights and guarantees set out in the European Convention on Human Rights are protected by the European Court of Human Rights.
- Treaty on European Union (TEU) that makes reference to human rights in various articles. The most important of which is article 2 on EU values, stating that the EU's founding values are 'human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities'
- The Charter of Fundamental Rights of the European Union, that brings together the most important personal freedoms and rights enjoyed by citizens of the EU into one legally binding document.

Human rights

The human rights, as stated in the UDHR, are 30 – as you can explore here.

The Charter of Fundamental rights of the European Union lists 50 legally binding articles related to political, social, and economic rights.

However, those we can consider more relevant in relation to older LGBTIQ+ persons are the following:

- Right to life
- Freedom from torture
- Freedom of movement
- Right to autonomy
- Right to participation and social inclusion
- Right to privacy
- Freedom of expression
- Equality and non-discrimination
- Right to dignity
- Right to equality before the law
- Freedom from arbitrary detention

[35] Note that the Council of Europe is completely separate from the European Union and much larger, with 47 members compared to the EU's 28.

Indeed, when it comes to LGBTIQ+ related human rights, the United Nations highlights[36] that the core legal obligations of States with respect to protecting the human rights of LGBT people include obligations to:

- Protect individuals from homophobic and transphobic violence
- Prevent torture and cruel, inhuman and degrading treatment
- Repeal laws criminalizing same sex relations and transgender people
- Prohibit discrimination based on sexual orientation and gender identity
- Safeguard freedoms of expression, association and peaceful assembly for LGBTI people

On the other hand, this intersects with specific concerns in relation to the respect of human rights of older persons in need of long-term care. As emerged from the ENHRI[37] research project, while generally speaking care professionals uses a person-centred approach to inform their work, valuing older care users as individuals and respecting their dignity and independence several practices identified in relation to the full protection of the human rights of older persons in care homes raised concerns, particularly in

- upholding dignity
- the right to privacy, autonomy and participation
- access to justice.

Discrimination, equality, inclusion, abuse

Discrimination and equality

Discrimination occurs when a person is unable to enjoy his or her human rights or other legal rights on an equal basis with others because of an unjustified distinction made in policy, law or treatment.[38]

Article 1 of the UDHR states: "All human beings are born free and equal in dignity and rights." Freedom from discrimination, set out in Article 2, is what ensures this equality".

Non-discrimination cuts across all international human rights law, we can find it

- in the Preamble of the Charter Of Fundamental Rights Of The European Union ("the Union is founded on the indivisible, universal values of human dignity, freedom, equality and solidarity")
- as well as in article 14 ("Prohibition of discrimination") of the European Convention on Human Rights.

Unfortunately, these principles are far from being a reality for older LGBTQI+ persons, since they are often exposed to the risk of discrimination because of their age, sexual orientation and gender identity. The main fields of discrimination relevant for our topic are:

[36] https://www.ohchr.org/en/sexual-orientation-and-gender-identity/about-lgbti-people-and-human-rights
[37] http://ennhri.org/wp-content/uploads/2019/10/ennhri_hr_op_web.pdf
[38] https://www.amnesty.org/en/what-we-do/discrimination/

- **Health:** Healthcare services, including nursing and older people's care services, have been accused of mirroring the heteronormative and ageist assumptions of society by failing to recognise LGBT identities and, more specifically, the needs of older LGBT people. [39]
  Although it is difficult to retrieve in research solid data about occurred LGBTQI+ discriminatory practices in health care service access and provisions at European level, there is large consensus among researchers that anticipated fear of discrimination may lead to mistrust and the poor uptake of healthcare services and thus impact upon the quality of life of older LGB people**.** This is especially worrying in the light of the fact that recent research has shown relatively high levels of poor health among LGB older adults, including diabetes and depression, as well as high incidence of mental health issues for older LGBT people[40].
  According to research[41] it also important to acknowledge that non-conscious stereotyping of LGBT older adults (and other marginalized groups) persists in the health care delivery system and that these biases contribute to health disparities. Medical professionals' diagnoses and treatment of their patients can also be influenced by nonconscious bias, itself an important contributor to health disparities.
  When it comes to trans people specifically, since many of them do not fit easily within binary sex-segregated categories of health services targeted at cisgender women and men, there is evidence that they might be prevented access to the health care services they would need. For example, trans women may require prostate examinations and trans men may require cervical smears. Trans people have died after being denied access to such services. [42]
  On the other hand, it is easier to find evidence-based data in relation to age-based discrimination in health care services. In particular[43] when it comes to indirect discrimination, i.e. when 'practitioners' or 'organisations' ageist attitudes and assumptions inform decision-making and service provision, as when older people are seen as having lower priority than younger people and are therefore less likely to receive the care they need. For example, according to WHO[44] a systematic review in 2020 showed that in 85% (127) of 149 studies, age determined who received certain medical procedures or treatments.

- **Recognition of relationships:** Around half of all Member States allow same-sex couples to marry. Others offer alternative forms of civil registration. Six Member States do not provide a legal status for same-sex couples. However, even in countries where marriage or civil registrations are in place, the laws are relatively recent and they might not have had an impact on older citizens who represent a generation who lived through times when same-sex relationships were criminalized and pathologized.

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[39] Sharek, D. B., McCann, E., Sheerin, F., Glacken, M., & Higgins, A. (2015). Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland. International journal of older people nursing, 10(3), 230-240.

[40] Sharek D.B. et al, 2015, cit.

[41] Foglia MB, Fredriksen-Goldsen KI. Health Disparities among LGBT Older Adults and the Role of Nonconscious Bias. Hastings Cent Rep. 2014 Sep;44 Suppl 4(0 4):S40-4. doi: 10.1002/hast.369. PMID: 25231786; PMCID: PMC4365932.

[42] UNPD, Discussion Paper Transgender Health and Human Rights December 2013

[43] Clark A., Ageism and age discrimination in primary and community health care in the United Kingdom A review from the literature, Centre for Policy on Ageing December 2009

[44] Global report on ageism. Geneva: World Health Organization; 2021.

The lack of recognition of same-sex couples has an impact on several aspects of life, including decision making and care, access to social protection and financial security. This becomes particularly worrying when people get older and cannot ensure that their (dependent) partner will have access to their pensions and assets or when they will have to take end-of-life care decisions.
Same-sex couples may lack inheritance rights, even after a lifetime of sharing and acquiring property. Having no legal recognition as next-of-kin means that a person may not be entitled to a survivor's pension, to a living partner's health insurance or to continue living in the home of a deceased partner. If someone is hospitalised after a serious accident and not in a position to explain one's personal relationship, the person's partner may be denied visitation rights or access to the medical file.[45]

INCLUSION

When we talk about inclusion of LGBTQI+ older persons, we refer to a broader concept compared to discrimination. Indeed, these two terms are often confused but while social exclusion might be a consequence of discriminatory practices, in itself it might not be a discrimination, as legally defined. Of course, this doesn't mean that it doesn't have an impact on the well-being of older LGBTQI+ and that it shouldn't be addressed as a phenomenon compromising the quality of care provided.

LGBTQI+ older persons can be socially excluded as a result of socioeconomic factors (such as low income; lack of social network, health, and housing conditions) and as a result of discrimination based on their sexual orientation which affects their ability to realise their autonomy and their citizenship rights.

Generally speaking, research involving older people indicates that regardless of sexual orientation or gender identity, many experience loneliness and isolation and fear isolation as they age. However, for older LGBTQI+ the risk is higher as they usually have significantly less traditional forms of support when compared to the heterosexual older population. They are more likely to live alone, be non-partnered, not have children and lack a family member to call on in a time of need. In view of this, professionals need to be conscious of the potential for isolation and loneliness among this group and make every effort to assist the person to build networks with the community, including the LGBT community. [46]

Despite some progress on LGBTI rights achieved by many countries during last decades, older LGBTQI+ persons globally have spent significant parts of their life in the climate of hatred, criminalization, pathologization, violence and discrimination. Because of this, LGBTI older persons' current socio-economic situations are worse than that of their non-LGBTI counterpart, they experience internalized homophobia and transphobia and generally do not trust state institutions.[47]

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[45] https://www.coe.int/en/web/commissioner/-/access-to-registered-same-sex-partnerships-it-s-a-question-of-equality

[46] Sharek D.B. et al, 2015, cit.

[47] International Lesbian, Gay, Bisexual, Trans and Intersex Association, Intersections of ageism and age discrimination with cisheteronormativity, homophobia and transphobia, and discrimination based on sexual orientation, gender identity and gender expression, Submission to the Independent Expert on the

Many older LGBTQI+ report negative experiences when dealing with staff in health and LTC services, for example insensitivity and heteronormative assumptions by professionals, or perception of being treated with embarrassment, rejection, hostility, suspicion, pity or condescension.[48]

ABUSE:

The abuse of older people, also known as elder abuse, is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect. Data on the extent of the problem in institutions such as hospitals, nursing homes and other long-term care facilities are scarce. However, a review of recent studies on abuse of older people in institutional settings indicates that 64.2% of staff reported perpetrating some form of abuse in the past year.[49]

Therefore, while being in need of care and being a resident of a care facilities can both be considered as risk factors for abuse, being LGBTQI+ seems to further increase this risk. Older LGBT people, particularly current cohorts, have had lifelong experiences of discriminatory abuse associated with their sexualities/sexual identities and/or their gender identities. In older age, they are both more vulnerable to such abuse, in that they may be less able to avoid/negotiate it, and in that, due to older age-related care needs, they may also be in care contexts when they are more likely to be exposed to it. In this way, older LGBT people are both at risk of "elder abuse" as are all older people and at risk of LGBT-specific abuse in older age.[50]

Discrimination laws

EU legal framework

At the EU level, several law provisions ban discrimination against LGBTQI+ people, even though the legal framework is scattered in different pieces of legislation and does not cover sexual orientation and gender identity in the same way. Therefore, one has to jointly read the "patchwork" of legislation in order to gain a full understanding of the overall picture.

As far as primary law is concerned, the legal basis of the principle of non-discrimination based on sexual orientation can be found in four fundamental Articles:

enjoyment of all human rights by older persons, To inform forthcoming report to the 48th session of the Human Rights Council, April 2021

[48] Sharek D.B. et al, 2015, cit.

[49] https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people

[50] Sue Westwood (2019) Abuse and older lesbian, gay bisexual, and trans (LGBT) people: a commentary and research agenda, Journal of Elder Abuse & Neglect, 31:2, 97-114, DOI: 10.1080/08946566.2018.1543624

I. Art. 21 of the EU Charter of Fundamental Rights (EU Charter) – which has become a binding document since the entry into force of the so called "Lisbon Treaty" on 1 December 2009 – and explicitly bans discrimination based on sexual orientation;
II. Art 2 of the Treaty on European Union (TEU) state that non discrimination is one of the founding values of The European Union
III. Art 3 of the Treaty on European Union (TEU) enshrines EU "shall combat social exclusion and discrimination"
IV. Art. 19 of the Treaty on the Functioning of the EU (TFEU) has to be mentioned since it allows for tackling this kind of discrimination through secondary legislation.

According to these principles, in 2000 two directives were adopted:

- the Employment Equality Directive (2000/78/EC)21 prohibited discrimination on the basis of sexual orientation, religion or belief, age and disability, in the area of employment;
- the Racial Equality Directive (2000/43/EC)22: prohibition of discrimination on the basis of race or ethnicity in the context of employment, but also in accessing the welfare system and social security, as well as goods and services. Note that this Directive lacks to cover the scope of this text but it is useful cause it stipulates the Discrimination categories

Basically, discrimination does not allow all individuals an equal and fair prospect to access opportunities available in a society. Individuals who are in similar situations should receive similar treatment and not be treated less favorably simply because of a particular 'protected' characteristic that they possess, nonetheless in some situations treatment based on a seemingly neutral rule can also amount to discrimination, if it disadvantages a person or a group of persons as a result of their particular characteristic.

These two situations define two types of discrimination: Direct discrimination and Indirect Discrimination:

- **Direct Discrimination** shall be taken to occur where one person is treated less favorably than another is, has been or would be treated in a comparable situation, on any of the grounds [recognized by the law as protected characteristics][51]
- **Indirect Discrimination** shall be taken to occur where an apparently neutral provision, criterion or practice would put persons having a particular protected characteristic at a particular disadvantage compared with other persons unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary[52]

Beside these two types of behaviors, others around discrimination are taken into account such as: Harassment, instruction to discriminate, discrimination by association:

- **Harassment**, that shall be deemed to be a form of discrimination, when unwanted conduct related to any of the grounds referred to a protected characteristic takes place with the

[51] Article 2, § 2, lett. (a), Employment Equality Directive (2000/78/EC)21
[52] Article 2, § 2, lett. (b), Employment Equality Directive (2000/78/EC)21

purpose or effect of violating the dignity of a person and of creating an intimidating, hostile, degrading, humiliating or offensive environment.[53]

- An **instruction to discriminate** against persons on any of the grounds referred to a protected characteristic shall be deemed to be discrimination
- **Discrimination by Association**[54], where the victim of the discrimination is not themselves the person with the protected characteristic, but he/she end to be discriminate because he/she is associated, linked, to a person with a protected characteristic or to a situation related to a protected situation, such as a person fired because of his/her taking part in an equality parade, despite his sexual orientation which is the protected characteristic[55]

The Council of Europe, legal framework

Besides the EU institutions and sources of law, it is worth remembering the Council of Europe (CoE), which is an intergovernmental organization that originally came together after the Second World War to promote, among other things, the rule of law, democracy, human rights and social development (see Preamble and Article 1 of the Statute of the Council of Europe).

In 1950, CoE member states adopted the Convention for the Protection of Human Rights and Fundamental, better known as the European Convention on Human Rights (ECHR). That Convention was opened for signature in Rome on 4 November 1950 and came into force on 3 September 1953. It was the first instrument to give effect to certain of the rights stated in the Universal Declaration of Human Rights and make them binding.

The ECHR sets out a legally binding obligation for its members to guarantee a list of human rights to everyone within their jurisdiction, not just citizens. The implementation of the ECHR is reviewed by the European court of human rights (ECtHR), which hears cases brought against member states by everyone who has his or her rights under the ECHR infringed o breached. For what is relevant here, the ECHR articles which concerns LGBQTI+ discrimination are the following

- Art. 8 ECHR: States that everyone has the right to respect for their privacy and family life. The Court has held that the concept of "private life" is a broad term, It embraces aspects of an individual's physical and social identity (*Y.Y v. Turkey*, 2015, § 56), so elements such as gender identification, name and sexual orientation and sexual life fall within the personal sphere protected by Article 8 (*Sousa Goucha v. Portugal, 2016, § 27; B. v. France, 1992, § 63; Dudgeon v. the United Kingdom, 1981, § 41; Beizaras and Levickas v. Lithuania*, 2020, § 109; *Smith and Grady v. the United Kingdom*, 1999, § 71). Article 8 also protects the right to

[53] Article 2, § 3, Employment Equality Directive (2000/78/EC)21

[54] This category has been for the first time stated by the European Court of Justice (CJEU, C-303/06, S. Coleman v. Attridge Law and Steve Law [GC], 17 July 2008) judging on a case where a mother claimed that she was treated unfavourably at work because her son was disabled. In that case CJEU held that this amounted to discrimination and harassment on the grounds of the disability of her child, so not because she has that characteristic but because of a characteristic of a person to whom she is linked and to whom has been associated.

[55] Poland, District Court in Warsaw (court of the second instance), V Ca 3611/14, 18 November 2015

personal development and the right to establish and develop relationships with other human beings and the outside world (*Schlumpf v. Switzerland*, 2009, § 77)

- Art. 14 ECHR: contains a prohibition of discrimination on various grounds.Even if this article does not list explicitly sex, age, sexual orientation and gender identity, these categories are included in the expression "*other status*". The scope of this article, however, is the ban of discriminations in the enjoinment of the Convention rights, so – in order to broaden his ambit, the covenant has been implemented with a Protocol (the n. 12), whose art. 1 state that "All persons must be able to exercise their rights without being discriminated against for reasons such as gender, skin color, political or religious beliefs, or origins"[56]

The categories of discrimination seen above, play here a very important role, because -out of the scope and the purpose of EU jurisdiction- in its case law, the European Court of Human Rights (ECtHR) refer to EU legislation and the CJEU case law[57]

Decision making capacity

Ageing is sometimes correlated with diseases and conditions impairing the cognitive abilities of the older persons and therefore challenging their capacities to self-determinate and to make autonomous decisions. While this situation is worrying and complex for any older persons, it might be more difficult for LGBTQI+ older persons and this for two main reasons:

Self-determination

A first issue with regard to support, treatment and care is that of self-determination.

Self-determination is often described in terms of people's ability to make choices and manage their lives. It is more than just a matter of making decisions. It is about how decisions about oneself (i.e. about personal identity and self-expression) are acknowledged and accepted by other people. Being LGBTQI+ is a central part of identity, which older persons with cognitive impairment are afraid they would forget. Because of stereotyping and the persistence of a biomedical approach to dementia, the disease often becomes a person's chief defining characteristic, providing less attention to the things that made them unique, such as their gender and sexual identity. Having dementia may gradually make it more difficult for LGBTQI+ people to manage their gender and sexual identity in everyday life in different contexts.

The management of gender identities means attending to a lot of different cues and expectations in the context of interpersonal interactions, including practices, clothing, mannerisms, pitch of voice, make-up, bodily hair and communication styles, to name but a few. Impairments linked to memory, concentration, attention and planning may interfere with the effective management of

[56] Italy, even if it signed this protocol, did not ratificate it so it stems that for Italy, this protocol did not entry into force.

[57] European Union Agency for Fundamental Rights and Council of Europe, *Handbook on European non-discrimination lawI,* pag. 19 and for an example, ,see ECtHR, Biao v. Denmark, No. 38590/10 [GC], 24 May 2016

gender/ sexual identity, and there may be little support or understanding outside of the LGBTQI+ community.[58]

From the perspective of care professionals, this means that it is important to provide support for LGBTQI+ people with dementia to exercise their self-determination to the maximum possible extent, for example to respect the gender identity they are seeking to communicate so that the person is not only recognised by other people as what he, she or they are, but also continues to feel that they are what they are, and has what they need for this to be the case.

Proxy decision-making

Dementia impacts on the legal capacity of the patient and at some point, it becomes necessary to appoint someone who is recognized as a legal representative of the person with dementia, in order to take decisions related for example with health, care or finances. While this is true for any person living with dementia, the fact that it is more common for LGBTQI+ persons to relay on alternative support networks and preferences for support, compared to traditional family bonds, makes it even more relevant for this group. In fact, even if from a strictly legal point of view family members do not have any right to decide on behalf of the person with dementia if not appointed by a judge, it is true that they are often recognized some privileges and at least consulted by health and social care professionals.

On the other hand, caregivers who are not legal or biological family members often have limited legal power to be involved in the issues of consent and decision-making that arise in the context of worsening cognitive decline if they are not designated as a health care proxy.[59] For example, members of the LGBTQI+ community without a legal appointment, found their partners were unable to make medical decisions. Partners and fictive kin also may be denied entrance into critical care units or may be excluded from conversations with medical staff.[60] Also, in end of life care, those involved in non-traditional relationships may be excluded in a number of ways, for example, not being able to have an active role in the care of the dying or by not having their grief acknowledged.[61] In fact, none of the default rules to privilege next of kin will apply, because every potential beneficiary or fiduciary is a legal stranger, with the exception of legally recognized partners.[62]

From the perspective of care professionals, this means on one hand not to neglect and recognise the role of intimate partners, but also of friends and informal social networks and to give the opportunity to users to express their will in terms of elective families. On the other hand, it means

[58] Alzheimer Europe, Sex, gender and sexuality in the context of dementia: a discussion paper, 2021
[59] Fredriksen-Goldsen, K. I., Jen, S., Bryan, A. E., & Goldsen, J. (2018). Cognitive impairment, Alzheimer's disease, and other dementias in the lives of lesbian, gay, bisexual and transgender (LGBT) older adults and their caregivers: Needs and competencies. Journal of Applied Gerontology, 37(5), 545-569.
[60] Buckey, J. W., & Browning, C. N. (2013). Factors affecting the LGBT population when choosing a surrogate decision maker. Journal of social service research, 39(2), 233-252.
[61] Fredriksen-Goldsen, K. I., Jen, S., Bryan, A. E., & Goldsen, J. (2018), cit.
[62] de Vries, B., Gutman, G., Soheilipour, S., Gahagan, J., Humble, Á., Mock, S., & Chamberland, L. (2022). Advance care planning among older LGBT Canadians: Heteronormative influences. Sexualities, 25(1-2), 79-98.

providing information and sign-posting to organizations that can support older LGBTQI+ with legal aspects, in order to deal with wills, living wills and power of attorney for health care decisions.

Legal duty of professionals to protect their clients in case of abuse and discrimination

Social and health care professionals have a general duty to protect their clients from risks to which they can be exposed. Even though this issue might be disciplined more specifically in national legislations, there are international reference documents which can provide us some guiding principles.

Taking a look into the code of ethic of one of the most significant among the care professionals, the International Council of nurses **Code Of Ethics For Nurses** (CEN) states that "nurses[63] take appropriate actions to safeguard individuals, families, communities and populations when their health is endangered by a co-worker, any other person, policy, practice or misuse of technology"[64]

From this norm, it is possible to infer that nurses have a duty of care to those they care for.

The duty of care is translated into two sub-obligations:

- The obligation to protect, which pertains to the protection of the client from all sources of danger.
- The obligation to control, which pertains to the control of certain sources of danger toward all patients who may be cared for.

In the caring professions, the figure of the patient may simultaneously be both an object of protection and a source of danger. As far as it still detects here, older client could be discriminated but nevertheless they could also discriminate against.

Focusing on the topic of our concern,

- the article 1.2 of CEN stipulates that "nurses promote an environment in which the human rights, values, customs, religious and spiritual beliefs of the individual, families and communities are acknowledged and respected by everyone."
- The Article 1.4, "Nurses hold in confidence personal information and respect the privacy, confidentiality and interests of patients in the lawful collection, use, access, transmission, storage and disclosure of personal information." This is a very sensitive subject, since many older LGBQTI+ may not have come out or may not want to come out
- The article 1.8," Nurses demonstrate professional values such as respect, justice, responsiveness, caring, compassion, empathy, trustworthiness and integrity. They support and respect the dignity and universal rights of all people, including patients, colleagues and families.";

[63] Of course they don't cover all the care professions but, as they are recognized as relevant, they are embodied in public entity, they are extensively regulated so they could be considered as paradigmatic of care professional

[64] Art. 2.9 of The International Council of Nurses, Code Of Ethics For Nurses, revised 2021

- the article 1.10 "Nurses provide evidence-informed, person-centred care, recognising and using the values and principles of primary health care and health promotion across the lifespan."
- And last but not least, The CEN -providing its own guide lines of application- says that in "applying the Elements of the Code #1, "nurses, nurse leaders and nurse managers provide people focused, culturally appropriate, care that respects human rights and is sensitive to the values, customs and beliefs of people without prejudice or unjust discrimination."[65]

Moving the focus to social workers, according to the International Federation Of Social Workers social work is "a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and/or regional levels."[66]

In this regard, the **Global Social Work Statement Of Ethical Principles** stipulates:

- at Principle 2, "Promoting Human Rights" that Social workers embrace and promote the fundamental and inalienable rights of all human beings, as reflected in human rights instruments and conventions and that Social workers respect and defend the human rights principle of indivisibility, and promote all civil, political, economic, social, cultural and environmental rights. Recognizing that culture sometimes serves as a disguise to violate human rights, social workers serve as cultural mediators to enable consensus building, find an appropriate balance between competing human rights, and to advocate for the rights of marginalized, stigmatized, excluded, exploited and oppressed individuals and groups of persons. Also, it states that social workers recognize that human rights need to coexist alongside collective responsibility, understanding that individual human rights can only be realized on a day-to-day basis if people take responsibility for each other and the environment, and if they work towards creating reciprocal relationships within communities. Finally, it states that social workers provide people with information regarding their rights, and support people's efforts to access their rights."

- at Principle 3.1, "Challenging Discrimination and Institutional Oppression" the code mentions that Social workers challenge discrimination on any ground. That they recognize how ideology, laws, policies, regulations, customs, or practices may create inequalities and prevent members of certain groups from equitable treatment and that they should work against institutionalized discrimination and oppression in all its forms."

While the abovementioned principles are clearly set on the protection side, other principle as much clearly underline the duality of duty of care as protection and control in working with social worker clients. For example:

- Principle 3.2. stipulate that Social workers work towards strengthening inclusive communities that respect the ethnic and cultural diversity of societies, taking account of individual, family, group and community differences but that they recognize that respect for, and acceptance of diversity must not be used to stretch the boundaries of moral relativism, to the point where the rights of some groups of persons, including the right to

[65] The International Council of Nurses, Code Of Ethics For Nurses, revised 2021, p. 7
[66] https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/ visited on the 02.03.2023

life (e.g. of women and sexual, ethnic, and religious minorities) are violated. Social workers problematize and challenge those cultural practices that limit the full enjoyment of human rights."

- Moreover if in Principle 4, (Promoting the Right to Self-determination) it is stated that Social workers recognize people as capable and self-determining (4.1), at the same time it is stipulated that Social workers respect and promote people's rights to make their own choices and decisions, provided this does not threaten the rights and legitimate interests of others (4.2).

Impact of spiritual and religious feeling of staff on their job concerning LGTBQI+ people and how "conflict of identities" between LGTBQI+ guests and staff whose religion/values affects (e.g. considering "sin") sexual matters or homosexuality can be managed

Research done on the United States typically points to religion as one of the strongest predictors of attitudes about homosexuality. But, because research has primarily been conducted in Christian nations, it is not clear how non-Judeo-Christian faiths shape public opinion about homosexuality. Additionally, work in cultural sociology suggests that economic development and political stability may play a major role in shaping public opinion towards non-normative groups and behaviors, like homosexuality. While studies conducted in United States and Europe have tended to focus on the influence of personal religious beliefs and affiliation for understanding attitudes about homosexuality, the religious culture of a nation may also shape attitudes. Research on religious contexts has in fact suggested that even people who are not personally religious may be influenced by the religious culture in which they live.[67]

Tensions between religion and LGBTQI+ rights play out in terms of competing claims under the ECHR, namely articles 8 (private and family life), 9 (freedom of thought, conscience and religion), 10 (freedom of expression), and 14 (prohibits discrimination in the interference of other ECHR rights).

In fact, while not all branches of religion nor all religious individuals are intolerant of LGBTQ people, some of whom are religious themselves[68], there might be an issue on whether some religious views are compatible with adequate care provision. According to research, upholding values contrary to their religious beliefs is likely to create stressful 'identity incongruence' for some care workers and an inauthentic experience for service recipients.[69]

Prejudice is an important, though not the only, determinant of whether or not individuals engage in discrimination or identity-based harassment or violence towards a person or group of people. However, regardless of its form and intention, prejudice always has the potential to cause harm

[67] Adamczyk, A., & Pitt, C. (2009). Shaping attitudes about homosexuality: The role of religion and cultural context. *Social Science Research*, *38*(2), 338-351.
[68] Westwood, S. (2022). Can religious social workers practice affirmatively with LGBTQ service recipients? An exploration within the regulatory context. Journal of Social Welfare and Family Law, 1-21.
[69] Westwood, S. (2022), op. cit.

because it reduces the value, status or importance attached to people from 'the other group', that's why it should be recognized and addressed.[70]

Based on available research, it is not clear whether and to which extent having prejudices against LGBTQI+ affects the quality of services provided by nursing staff to clients. Indeed, according to a recent study, a person whose attitude is not as affirming toward the LGBTQI+ community is still able to provide services in line with best practices, but the less affirming one's attitude is, the less likely they will provide best practices. In another study conducted with psychiatric nurses in South Taiwan a positive correlation was determined between their homophobic attitudes and willingness to give care to lesbian and gay patients. For example, this research found that psychiatric nurses with negative attitudes toward homosexual people were more likely to have less intention to provide care to them[71].

So, to overcome that bias and avoid limiting effects of that perspective, care workers need additional training that focuses on being vigilant against the judgment-distorting effects of prejudice, stereotype, and prejudgment and should take ample opportunities to self-reflect. Without acknowledgment of one's own thoughts, feelings, experiences, and motivations, care workers may impose their own intentions on to their clients. Awareness of these perspectives allow them to gain insights for future practice implications, yet properly separate biases. [72] Professionals need to be aware of their own values toward sexual orientation, and integrate those with their personal and professional values in order to enhance their practice skills.

This can be found for ex. also in the Global Social Work Statement Of Ethical Principles where it is highlighted that "Social workers appreciate that the need for such differentiation elucidated in 1.2 calls for critically reflexive practice. As social workers we (as do the people whom we engage with) bring to the working relationship our histories, pains and joys, values, and our religious, spiritual and cultural orientations. Critical reflection on how the personal influences the professional and vice versa must be the foundation of everyday ethical practice."[73]

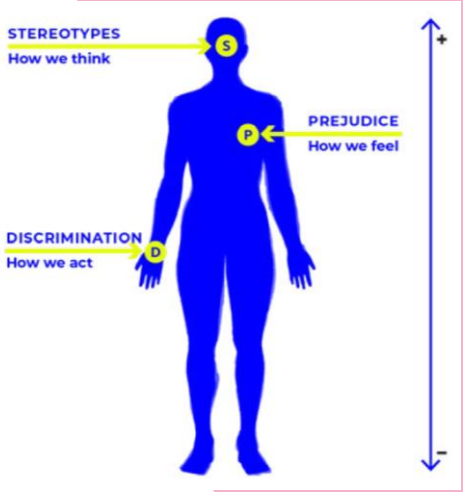
Even though professionals may not agree with patients' lifestyles, religious beliefs, or cultural upbringings, every client deserves to receive the most competent and compassionate care that can be provided. In this sense, more education on the topic of non-judgmental care relating to lesbian, gay and bisexual patients can be helpful.

Moreover, the experience of dealing with LGBTQI+ individuals is an important factor in changing homophobic attitudes in favour of these people. Relevant studies show that having social relationships with LGBTQI+ individuals and having LGBTQI+ acquaintances are related to positive attitudes and beliefs towards these individuals and may contribute to changes in negative

[70] Swift, H. J., Mahmood, L., & Abrams, D. (2016). Prejudice and unlawful behaviour: Exploring levers for change.
[71] Hou, S. Y., Pan, S. M., Ko, N. Y., Liu, H. C., Wu, S. J., Yang, W. C., ... & Yen, C. F. (2006). Correlates of attitudes toward homosexuality and intention to care for homosexual people among psychiatric nurses in southern Taiwan. The Kaohsiung journal of medical sciences, 22(8), 390-397.
[72] Mecklenburg, C. A. (2020). Attitudes and Practices of Social Workers Toward the LGBTQ Community (Doctoral dissertation, Olivet Nazarene University, Bourbonnais, Illinois).
[73] The International Association of Schools of Social Work (IASSW), Global Social Work Statement Of Ethical Principles, principle 1.3

attitudes.[74] Therefore, as theorized by Allport, social contact is also a strategy that can be put in place to decrease homophobic attitudes in care staff.

Practical activity 2.1

Name of the activity	**Prejudice, stereotype and discrimination towards older LGBTQI+ (Duration: 1h and 30 min)**
Number of participants	Minimum 3
Objectives	Aim of this activity is to guide participants on reflecting about the differences and the correlations between prejudice, stereotype and discrimination towards older LGBTQI+ in care settings and how good quality of care can be provided to all residents.
Step-by-step description	1. Divide participants into groups of 3 to 6 people 2. Provide to each group a poster representing this image[75]  3. Invite each group to discuss (allow +/- 20 min) and then to write down next to each heading examples of stereotypes, prejudices and discriminations related with care of older LGBTQI+. Clarify that they don't have to write their personal thoughts but they can refer to discussions they have heard, or situations they have experienced. 4. Get back in plenary and share the examples found by each group. Then open a discussion: how stereotypes, prejudices

[74] Aynur, T., Gamze, A. K., & Cennet, U. S. (2020). Attitudes of nurses to lesbian, gay, bisexual and trans (LGBT) individuals in Turkey. Int. J. Caring Sci, 13, 1914-1922.

[75] Source of the image: World Health Organization, Global report on ageism, 2021

	and discriminations are interconnected? Why it is important that we are aware of our own biases and how they can influence our practice? (+/- 30 min.) 5. Now provide to each participant a sheet with the same image and ask them to write down his/her own stereotypes and prejudices towards group of clients (not necessarily LGBTQI+ as they might not have direct experience) and, in case, any situation in which they recognise they have not provided the same quality of care to members of these groups. Clarify that this is for self-reflection and that they will not be requested to share. Allow +/- 10 min. 6. Open a discussion (+/- 20 min): How we can make sure that our practice keeps high standards for any clients, in spite of our personal values and ideas? Is that possible? Yes, no, why?
Comments/hints for facilitators	This exercise aims to elicit opportunities for self-reflection in relation to the fact that we can all have bias or be required to work in situations which challenge our personal values, but that as professionals we have to find ways to avoid this having a negative impact on our practice. It is important to guide the discussion in a way which is not judgmental but rather that tries to elicit strategies and approaches to support professionals in challenging their own work in a constructive way.
Resources	- Posters with copies of the image above (one per group) - A4 sheets with copies of the image above (one per participant) - Markers

Practical activity 2.2

Name of the activity	**Conflict of value/way to conciliation (Duration: 1 hour 30 min)**
Number of participants	All the audience
Objectives	Find and understand the reasons subtended to crushing position based on personal values and needs. Find a solution to conciliate them.
Step-by-step description	The audience will be divided into two groups. Each group will be provided with a description of a case (excerpt from a real case law) in which personal religious value conflict with LGBTQI+ condition in

	a situation in which the holder of religious value has to deliver service to LGBTQI+ client. One group will support and advocate for the holder of religious value social worker, one group will support and advocate for LGBTQI+ person as a potential social work client. After each exposition, everyone of different group, could move to the other group if, because of the discussion heard, has changed his/her mind After the switch, each group will discuss a way to conciliate the conflicting position
Comments/hints for facilitators	The aim is to give space to each position and, at the same time, to discuss on how the provider can make sure that his/her value did not became a prejudice and a discrimination in delivering the service and the client doesn't force the provider's to change his/her thoughts and values
Resources	A copy of the description of the case for each participant

CASE SCENARIO TO BE DISTRIBUTED

Tom is a social worker and a devout Christian for whom the Bible is the authoritative word of God. Tom posted a series of comments on his Facebook account about a prominent news story on a news website. The story related to the imprisonment of an employment of a public registrar for contempt of the order of a Court which resulted from her refusal to issue marriage license to same-sex couples because of her Christian religious beliefs about same-sex marriage. Tom contributed around twenty posts to the news Facebook website in response to comments by others. Tom's comments included statements and observations expressing views on same sex marriage and homosexuality:

"… Same sex marriage is a sin whether we accept it or not"

"… Homosexuality is a sin, no matter how you want to dress it up"

"… [Homosexuality] is a wicked act and God hates the act"

"… God hates sin and not man"

"… One day God will do away with all diseases and all suffering. He will also get rid of the devil who is the author of all wickedness. That day will surely come. But remember that He will also Judge all those who indulged in all forms of wicked acts such as homosexuality".

He also included a number of Biblical quotations:

"… If a man lies with a male as with a woman both of them have committed an abomination. Leviticus 18:22"

"…Just as Sodom and Gomorrah and the surrounding cities which likewise indulged in sexual immorality and pursued sexual desire, serve as an example by undergoing a punishment of eternal fire. Jude 1."

"…For this reason, God gave them to dishonourable passions. For their women exchanged natural relations for those that are contrary to nature; and the men likewise gave up natural relations with women and were consumed with passion for one another; men committing shameless acts with men and receiving in themselves the due penalty for their error: Romans 1:26-28."

Those posts were brought anonymously to the attention of the Health and Care Professions Council (HCPC). The Council found that Tom was in breach of two professional requirements stated by the HCPC code of conduct:

(a) to keep high standards of professional conduct and

(b) to make sure that his behaviour does not damage public confidence in the profession.

As a consequence, Tom was banned from the Health and Care Professional order.

Group A should take the position of Tom, supporting the idea that in spite of his personal believes he can still practicing the profession of social worker without them having an impact on their clients.

Group B should that the position of the Health and Care Professions Council, supporting the idea that Tom cannot perform the profession of social worker and should be banned.

Then the two groups should discuss whether an acceptable mediation can be found between the two position and how.

BestCare 4LGBTQI+

Co-funded by the European Union

MODULE 3

GUIDE FOR INCLUSIVE LANGUAGE AND DEVELOPMENT OF „GLOSSARY”

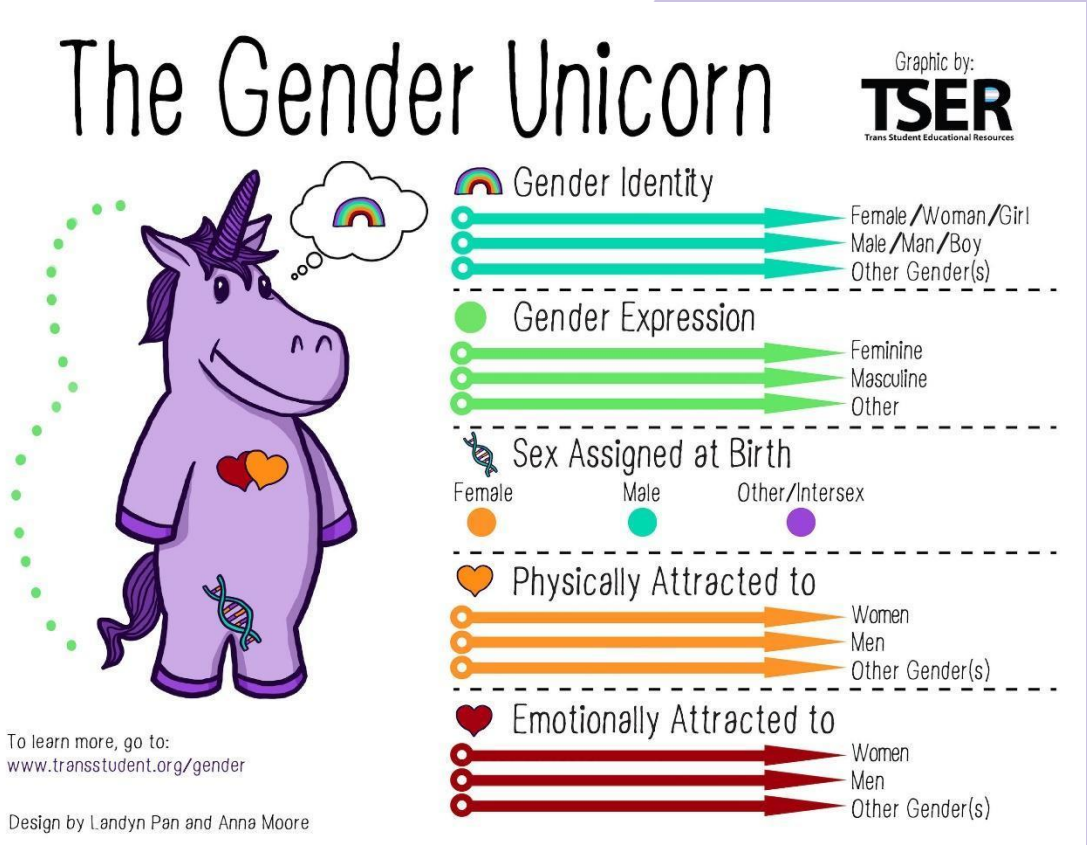
PROJECT N° 2021-1-FR01-KA220-ADU-000035303

MODULE III

Guide for inclusive language and development of "Glossary"

The specific module is part of the training for healthcare professionals regarding gender, sexuality and LGBTQI+ - related issues. It is the third module of the whole training curriculum and its topic is inclusive language, pronouns and terms. Using inclusive language is a key part of creating a welcoming and trusting environment where everyone feels included. Hence, this module contains definitions, explanations, and suggestions. As mentioned above, the target group is the healthcare professionals that work with older people and indirectly the LGBTQI+ older people who receive care services.

Gender identity, sex and sexual orientation: What's the difference?



https://transstudent.org/gender/

GENDER

Generally, we consider that there are only two poles of gender (male and female) because our society thinks of gender in a binary way. However, many gender possibilities fall between the two poles "female-male", or outside the "male-female" spectrum.

GENDER EXPRESSION

These are the different ways people express their gender identity (appearance) and perform it socially. It can be fairly feminine, more masculine, more androgynous... We are talking about ways to dress, walk and move, to wear or not makeup, talk, wear this or that physical attribute (such as hairstyle, body hair, etc.).

GENDER IDENTITY

Gender identity refers to how someone defines oneself, it is the gender with which a person identifies. When gender identity corresponds to the gender assigned at birth, we call them cisgender people. But it can be different, as is the case for transgender people.

SEX

A set of biological characteristics (genetic, epigenetic, endocrine, skeletal, ...) used to divide human beings into two strict categories: "male" and "female".

SEXUAL ASSIGNMENT

The sexual assignment is the decision made by the doctor at the birth of the child, after observation of the baby's genitals, to tick the box M (male) or F (female) on the birth certificate.

SEXUAL ORIENTATION

It is the sexual attraction or the absence of sexual attraction towards another person (man, woman, or a person of another gender). You can be heterosexual, homosexual, bisexual, asexual, etc.

Inclusive language

What is inclusive language?

Language is one of the main categories that contribute to the changes that promote diversity and inclusion. Using positive words that acknowledge the diversity of people and demonstrate dignity and respect for how they describe their own bodies, genders, and relationships. An inclusive language is a form of communication free from disparagement, prejudice, discrimination and stereotypes. It is a way of speaking and writing that recognises and values diversity and promotes equality. It involves avoiding language that is insensitive, derogatory, or offensive to certain groups of people, such as those based on their race, gender, sexuality, ability, or any other aspect of their identity. Although many people do not use offensive language, there are many instances where seemingly innocent everyday language can make people feel uncomfortable or/and excluded. Inclusive language helps create a welcoming and respectful environment for all people, regardless of their background. It also helps break down barriers and promotes understanding and

acceptance of differences. By using inclusive language, we can foster a more inclusive and equitable society.

Pronouns

The use of pronouns is one way people refer to each other and themselves. A person can be a man, woman, neither or both while using a set of pronouns that may or may not align with the social expectations associated with that gender identity. We should use the correct pronouns in order to validate and respect every person's gender identity. If we are unsure what someone's pronouns are, we can ask them respectfully: "What pronouns do you use?". Otherwise, we can use the pronoun "they/them".

How to use an inclusive language

Here are some tips:

- We should understand and respect the difference between sexual orientation and gender identity.
- We should not assume an individual's gender. We should not misuse or assume an individual's pronouns.
- We should not mention a person's gender, sexuality, etc. unless it is relevant.
- We should be gender-neutral whenever we aren't speaking about a specific individual. Use they/them instead of she/her or he/him.
- We should be inclusive of non-binary identities by using phrases like regardless of gender, all genders or different gender rather than men and women, both genders or opposite gender.
- When we talk about an individual, we should use the language they use to refer to themself. We should accept and respect how people define their gender and sexuality. When we aren't sure, we should ask.
- We should not assume that everyone is heterosexual or straight. For example, we should avoid using "wife" or "husband" because these words assume that all relationships are heterosexual. We can use partner/spouse instead.
- We should avoid asking people what they "prefer". Being LGBTQI+ is not a preference or a choice.

- We should avoid creating invisibility. LGBTQI+ people are often rendered invisible in conversation, in public discourse and in cultural and media representation.
- We should avoid stereotyping LGBTQ+ people. Placing limitations or expectations on individuals because they belong to a certain group is damaging, hurtful and discriminatory. Challenging queerphobic jokes and derogatory comments by speaking up and naming them as such contributes toward creating an environment inclusive of gender and sexual diversity.
- We should avoid expressions that disparage or trivialise the diverse sexual experiences and desires of LGBTQ+ people.
- We should avoid microaggressions. Microaggressions refer to intentional and unintentional day-to-day behaviours or interactions that can come across as insulting or hostile and some people believe that they are harmless.
- We should use person-centred language and avoid de-personalising people by referring to them categorically. Instead of lesbians, gays, bisexuals, and transgenders, we should use lesbian, gay, bisexual, transgender people, and LGBTQ+ people.
- We should avoid terms that presume a person of a particular gender holds a job position. Instead of cleaning ladies, policeman we should use cleaning staff or police officers.
- We should avoid using patronising terms or expressions that may cause offence or perpetuate stereotypes. Avoid phrases such as “that’s so gay”, and “and they’re experimenting”.

What if I make a mistake?

People may worry that they will offend or be embarrassed if they use the wrong word, name or pronoun, particularly trans and gender-diverse people. The important thing is to try to use respectful language and if you make a mistake, promptly apologise and continue the conversation. It’s ok to make a mistake. Practice makes perfect, so keep trying – it is perfectly normal to make mistakes and even members of the LGBTQ+ communities do not always use the correct terms. If you make a mistake, simply apologise and continue the conversation or amend your work, where this is applicable. But repeated mistakes show a lack of respect and can be very distressing. If it continues or is deliberate, it could constitute bullying or discrimination which is unlawful.

BestCare 4LGBTQI+

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Glossary

Meaning of LGBTQI+

The LGBTQI+ acronym is an umbrella abbreviation to embrace diverse sexualities, genders, and sex characteristics.

LGBTQI+

Acronym for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex. The "+" refers to all identities, orientations, and expressions not represented in the acronym. In short, to all other realities.

Being LGBTQI+ is never a choice, it is a natural condition and impossible to change, just like being heterosexual or cisgender. LGBTQI+ people are distributed evenly across the world and over time, but not all citizens have the same opportunity to experience it or express it. It is considered that between 5% and 15% of human beings can be defined or self-defined as LGBTQI+. LGBTQI+ people come together under this acronym because they are victims of somewhat similar systems of oppression and invisibility, but all these letters also represent different realities of life.

The first three letters of the acronym, LGB, are sexual orientations:

LESBIAN

An adjective used to speak of a homosexual woman, that is to say, a woman who is romantically and/or sexually attracted to women.

GAY

An adjective used to speak of a homosexual man, that is to say, a man who is romantically and/or sexually attracted to men.

Attention! "Homosexual" often connotes a medical diagnosis or discomfort with gay/lesbian people. "We want to do a better job of being inclusive of our gay employees."

BISEXUAL

Physical, sexual, emotional or romantic attraction to two or more genders.

TRANSGENDER, TRANS

Said of a person whose gender identity differs from that assigned to him at birth according to sex (biological). The abbreviation is ‘trans”.

Transgender citizens can decide to make different forms of transitions, physical or not, to reach their point of comfort, that is to say, the expression, the way of living that most correspond to their gender identity.

People whose gender identity agrees with the gender to which they have been assigned at birth, according to their biological sex, are said to be "cisgender."

/!\To abolish: "transexual." The term "transexual" is an outdated term dating from the 19th century, ideological, pathologizing, and discriminating. Please use the term transgender instead. It is to be used as an adjective, like “gay”, “lesbian”, etc: e.g. “a trans man” instead of “a trans”.

QUEER

Is a person whose sex, gender, sexual orientation, gender identity and/or gender expression differs from society's expectations, or is considered to be "non-compliant, non-traditional, out of the category." This term, therefore, defines all the letters of the acronym LGBTQI+.

INTERSEX

Intersex persons are born with sexual characteristics (such as chromosomes, genital organs or hormonal structures) that do not entirely correspond to the male or female category but belong to both at the same time. In many countries, intersex children whose reproductive system is considered "not conforming" to either male or female are still mutilated at birth to "normalize" them according to heteronormative and cisnormative criteria.

The number of births with intersex characteristics is estimated to be between 1 and 2% worldwide.

/!\To abolish: "Hermaphrodite": Hermaphrodite is a stigmatising, inaccurate word with a negative medical history.

Extra useful terms:

CISGENDER / CIS

A person whose gender identity matches the gender assigned to them at birth

COMING OUT, OUTING

Coming out: coming out means revealing very personal and intimate information to someone, such as your sexual orientation or gender identity.

Outing: is to reveal the sexual orientation, gender identity, or sexual characteristics of an LGBTQI+ person without their explicit consent. Outing can expose these people to very embarrassing or even quite dangerous situations. Likewise, it is entirely inadequate to compel someone to come out. That is to say, encourage or even force someone to disclose their belonging to the LGBTQI + community when they do not wish to or do not don't feel ready for it.

DISCRIMINATION

Discrimination means interference in terms of rights and opportunities. It is about the unfair treatment of a person because of their gender, sexuality, age, weight, ethnicity, religion, disability, etc. Discrimination can take many different forms, from acts of personal hatred to an institutional denial of privileges normally granted to other groups of individuals.

LGBTQI+ FRIENDLY

We can use the expression "friendly" in the sense of "welcome" when speaking of a place, or a space, but it can also be used when talking about a person.

Example: "this cafe is gay-friendly, that is to say, that gays are welcome there", "This doctor is trans* friendly" means that they receive trans* people correctly.

HIV

Human immunodeficiency virus. HIV infection cannot currently be cured, but antiretroviral (ARV) drugs can keep the infection under control and avoid the appearance of its development disease, AIDS. People with HIV who are following an effective antiretroviral therapy and whose viral load is, therefore, undetectable will not transmit the virus during sex, even without protection.

A person who's infected with the HIV virus is called HIV positive.

HOMOPHOBIA

Homophobia groups all the negative attitudes that may lead to discrimination or persecution (harassment, rejection, violence, etc.) against a person or a group of people based on homo-bisexuality, actual, or perceived. Homophobia can be broken down into lesbophobia (rejection of lesbians), gayphobia (rejection of gays), or biphobia (rejection of bisexuals).

HORMONE THERAPY (HT)

Use or blockage of hormones such as testosterone, estrogen, or progesterone in a gender transition process. HT causes a series of body transformations, some reversible and others irreversible, to develop secondary male or female sexual characteristics.

INVISIBILITY

Direct or indirect discrimination by which needs, desires, rights, life choices, or the cultural and intellectual production of a minority are ignored, ridiculed, or made inaccessible. Invisibility affects, among other things, sexual and gender minorities.

LGBTQI-PHOBE

Relating to discrimination against LGBTQI+ people.

MISGENDERING

To misgender is to use, intentionally or not, a pronoun or a gender that does not correspond to a person's gender identity.

NON-BINARY

To be non-binary is to except oneself from the binary "masculine-feminine" gender scheme. It is an umbrella term that includes, among others, people who identify with both men and women, or with neither. These people often prefer to use neutral pronouns to address them.

NORMATIVITY: HETERONORMATIVITY, CISNORMATIVITY

Heteronormativity is the presumption that heterosexuality is the valid norm, and that heterosexual relationships are the standard for determining what is normal (valid) or not.

Cisnormativity is the presumption that being cisgender is the valid norm and that the framework of gender binarity must serve as a reference for the determination of what is normal (valid) or not.

OUTING/DISCLOSURE

The outing is to reveal the sexual orientation of an LGBTQI+ person, their gender identity, or their sexual characteristics. We must never out someone without their express consent, as this can expose them to very embarrassing or even quite dangerous situations. Likewise, it is entirely inappropriate to compel someone to come out, that is to say, encourage or even force a person to reveal their membership of the "LGBTQI+ community "when they do not wish or are not ready to do so.

PATHOLOGIZING

Regard or treat someone or something as pathological, that is to say, treating it as unhealthy, or abnormal.

TRANSITION

The period during which psycho-social and bodily transformations are most marked, in a person who has undertaken the change of their social role (for example, to live "as a woman") and/or modify their physical appearance (for example by waxing, taking hormones, or genital surgery).

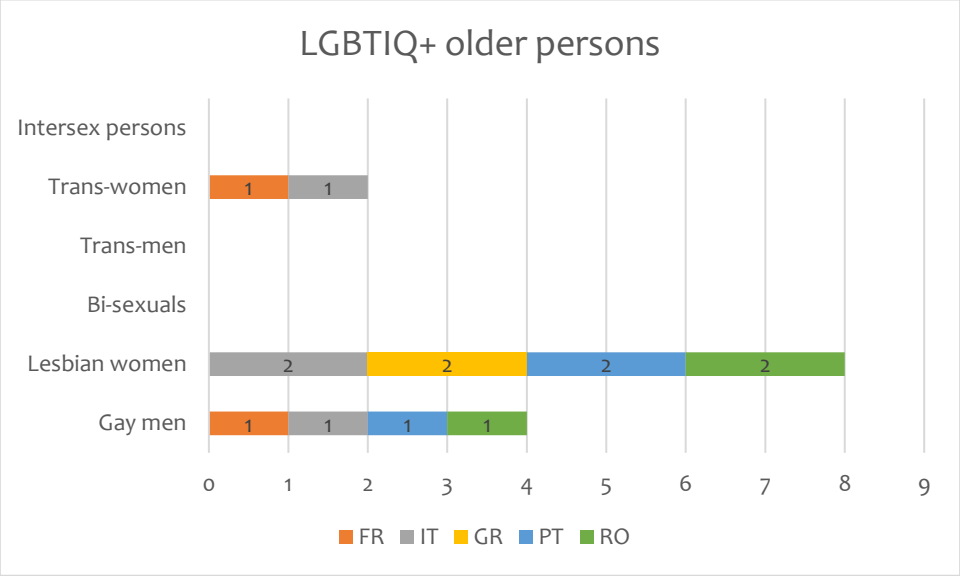
The transition occurs at three levels: social, medical, and legal. You can choose to take care of only one level, two, all three, or none. Everyone experiences their transition as they wish. Transition is not an obligation.

TRANSPHOBIA

Irrational fear/rejection that an individual may feel towards a trans person. Transphobia can manifest itself in discrimination and intolerance (discrimination in hiring, housing...), physical violence (assaults, rapes, murders, ...), verbal (insults), psychological, and the refusal to consider a person in the genre that corresponds to their comfort zone.

It is important to note that everyone's experience of their gender and sexuality is unique and valid. It is important to listen to and respect each individual's self-identification and use language that is appropriate and respectful to them.

Diversity charts



Practical activities

Practical activity 3.1

Name of the activity	**Inclusive Language Scenario Role-Play**
Number of participants	**Group or pairs**
Objectives	**To practice using inclusive language in real-life situations and to raise awareness about the impact of language on individuals and communities.**
Step-by-step description	**1. Divide the participants into small groups or pairs.** **2. Give each group a scenario related to using inclusive language. Here are some examples:** **a) A friend introduces you to their partner who uses they/them pronouns. You are not sure how to address them and want to make sure you are using the correct pronoun.**

	b) You are at a wedding and the couple getting married are both women. You are not sure how to refer to them in conversation and want to make sure you are using language that is respectful and inclusive. c) A friend tells you that they are gender non-binary. You are not familiar with the term and want to make sure you are using the correct language when referring to them. d) You are in a public place and overhear someone using offensive language to refer to someone who is LGBTQIA+. You want to intervene but are not sure how to do so in a way that is safe and effective. 3. Have each group act out the scenario, with one person taking on the role of the speaker and the others taking on the role of the listener(s). 4. After the scenario is acted out, ask the listeners to give feedback to the speaker on their use of language. This can include positive feedback on the use of inclusive language, as well as suggestions for using more inclusive language in the future. 5. After each group has completed their scenario, have each group share their experience with the larger group and discuss the importance of using inclusive language in real-life situations.
Comments/hints for facilitators	Encourage participants to think about ways they can use inclusive language in their daily lives and to continue to educate themselves about different communities and identities. Ask them to reflect on the following questions:

	○ What was challenging about using inclusive language in the scenario? ○ What strategies did you use to ensure that you were using inclusive language? ○ How do you think the use of inclusive language can impact individuals and communities?
Resources	https://www.hrc.org/resources/glossary-of-terms

Practical activity 3.2

Name of the activity	"Glossary Jumble"
Number of participants	To help participants understand basic definitions of terms in the LGBTQIA+ glossary and to encourage them to think about the importance of using inclusive language.
Materials	A set of cards with terms from the LGBTQIA+ glossary, scissors, pens and paper.
Objectives	To help participants understand basic definitions of terms in the LGBTQIA+ glossary and to encourage them to think about the importance of using inclusive language.
Step-by-step description	1. Cut the terms from the LGBTQIA+ glossary into separate cards, making sure that each card has only one term on it. 2. Randomly distribute the cards to the participants. 3. Ask the participants to take a few minutes to look at the term on their cards and write down its definition. Emphasize that they should not

	look up the definition online or ask others for help. 4. After a set amount of time (such as 5 minutes), invite the participants to stand up and find a partner. 5. Have the participants stand back-to-back with their partners and share their definitions of the term on their cards. 6. After both participants have shared their definitions, have them compare their answers and discuss any similarities or differences. 7. Repeat the process with a new partner, until all participants have had a chance to compare their definitions with several other participants. 8. Conclude the activity by inviting the participants to share any insights or observations about the importance of using inclusive language, and how understanding the definitions of terms in the LGBTQIA+ glossary can help.
Comments/hints for facilitators	Before starting the activity, make sure to set the tone for a respectful and inclusive environment, where all participants feel comfortable to share their thoughts and experiences. Some participants may have a lot of experience and knowledge related to the terms in the LGBTQIA+ glossary, while others may have limited exposure. Be prepared to support and guide participants with different levels of knowledge and understanding.
Resources	https://www.hrc.org/resources/glossary-of-terms

References

Equality, Diversity & Inclusion Inclusive Language Guide, City of Glasgow College

(2018) LGBTIQ Inclusive Language Guide, Victorian Government(2019)

Gender-inclusive language guidelines (English): Promoting gender equality through the use of language, UN Women

Inclusive language guidelines, Chartered Insurance Institute (2018)

Inclusive Language Guidelines, Faculty for Social Wellbeing, University of Malta

(2018) NHS guidelines, https://service-manual.nhs.uk/content/inclusive-language

https://www.theequalityproject.org.au/blog/lgbtiqa-inclusive-language-guide

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https://www.glaad.org/

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MODULE 4

PERSON-CENTRED CARE

PROJECT N° 2021-1-FR01-KA220-ADU-000035303

MODULE IV

Person-centred care

Introduction and learning goals of the module

In person-centred care, health and social care professionals work collaboratively with people who use services, seeking to ensure that they develop the knowledge, skills and confidence they need to manage their own health more effectively and make informed decisions about their own health and that care is tailored to the needs of the individual, seeking to ensure that people are always treated with dignity, compassion and respect.

Person-centred care is not common practice, often being delivered "to" or "for" people rather than "with" them, and there seems to be difficulty in including people in decisions, with their goals being addressed only in terms of specific clinical outcomes.[76]

This approach is gaining more popularity as it grows and develops, and has many fundamental principles that are beneficial to rehabilitation and recovery.

This module explores person-centred care. More specifically, it will explore and analyse the importance of person-centred care in institutions caring for the elderly and, in particular, LGBTQI+ people, and how it can be developed. By the end of this module, we hope to learn how to:

- know more about person-centred care approach, definition and principles
- be more aware of the importance of person-centred care, benefits and the challenges of implementing it
- realise the importance of empathy and understanding for residents in general and LGBTQI+ residents in particular, to implement person-centred care.

Person-centered approach

Definition of Person-Centred Values in Health & Social Care

There is no consensus on how to define "person-centred care" and it is associated with many different principles and activities. This is partly because person-centred care depends on the needs, circumstances and preferences of the individual receiving care and is still an emerging and evolving area.

In the early 1960s, psychologist Carl Rogers was the first to use the term "person-centred" in relation to psychotherapy (and had already used "client-centred" in the 1950s). Although different in many ways from the current meaning of 'person-centred care', a key element that both

[76] https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf

approaches share is empathy - the willingness of the professional to suspend judgment and appreciate the perspective of the service user. Rogers called this 'unconditional positive regard'.

In the late 1970s, American psychiatrist George Engel promoted the shift from a medical model to a biopsychosocial model of health - a model that is now used to explain the change needed to provide person-centred care and is aligned with the Chronic Care Model developed in the US in the 1990s to address perceived shortcomings in the way people with long-term illnesses were supported. In 2001, the Institute of Medicine included "patient-centeredness" as one of its six quality of care goals.[77] During the following decade, ideas of personal centeredness began to emerge with increasing regularity in Europe, especially in health care models.

Person centred care is a concept that affects the thought process, and the way everyday responsibilities are performed by health/social staff and carers.

The Health Foundation has identified a framework that comprises four principles of person-centred care[78]:

1. Affording people dignity, compassion, and respect.

2. Offering coordinated care, support, or treatment.

3. Offering personalised care, support, or treatment.

4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

Most definitions of person-centred care have several common elements that affect how health care systems are designed, managed, and delivered:

- The mission, vision, values, leadership, and quality improvement factors of the health care system are aligned with person-centred goals.

- Care is collaborative and accessible. The right care is delivered at the right time and in the right place.

- Care focuses on physical comfort and emotional well-being.

- The preferences, values, cultural traditions, and socioeconomic conditions of the person and family are respected, and they are considered part of the team, playing a role in patient- and system-level decisions. To this end, information is shared in a complete and timely manner so that patients and their families can make informed decisions.

[77] Committee on Quality of HealthCare in America, Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press, 2001.
[78] Dr Alf Collins' thought paper for the Health Foundation, measuring what really matters. Available from: www.health.org.uk/publications/measuring-what-really-matters

Figure 1 - Patient-centred care: patient at the centre of the care continuum. Patient's goals and values are top priority. Family involved at all stages.

This concept is designed to create a plan of care that is tailored to each individual and is delivered in a way that he or she feels completely at ease, whereby there is a combination of the health professionals' knowledge and the patient's own personal knowledge of the body, values, feelings, and abilities.

Principles of Person-Centered Care

Although different organisations may write their principles in slightly different ways, they all share the same values.

Here is a breakdown of these valuable principles[79]:

Respecting the individual

It is important to get to know the patient as a person and recognise their unique qualities. They have their own personal values, beliefs, boundaries, and perspectives. It is vital to not only understand these aspects of the person but to also respect them and incorporate them into the care plan.

[79] https://ajcasemanagement.com/person-centred-care-principles-definitions-examples/

Treating people with dignity

This involves communicating with the patient in a respectful way, listening to what they have to say and taking on board their input. It also means maintaining their dignity and avoiding embarrassment or shaming.

Understanding their experiences and goals

To create a successful long-term care plan it is important to know the patient's life experience, their present state and their goals for the future. This will help you gain a deeper understanding of the individual and allow you to further tailor the care.

Maintaining Confidentiality

It is critical to ensure the confidentiality of the person, not only for their well-being, but also to build trust and create a productive relationship. This principle can be addressed by establishing with the individual what information they wish to share with friends, family, or other professionals.

Giving responsibility

A person-centred care approach helps the patient to perform as many everyday activities by themselves as they can. This is important for encouraging the development of the patient's skills and creating more confidence in the journey to recovery. Although in this approach the persons boundaries must be recognised and not pushed too far.

Coordinating care

For recovery to be adequate, there must be coordination and cooperation in the care provided to the person, minimizing the possibility of causing confusion, stress, anxiety, or a setback in recovery.

Peerson-centred practices

Person-centred practices are used in teams and organizations to ensure that attention is focused on what is important to the people receiving support and their families.

Person-centred practices can be seen as a "toolbox" or a variety of ways to listen and gather information with people. Like any other tool, they are only effective if the user has developed the skills to use them and continues to improve them through practice and feedback with others. Working in this way ensures that people are truly listened to and are at the centre of all decisions. To ensure that plans are implemented and that the person continues to be supported in ways that make sense for them, person-centred practices must be integrated into daily practice at all levels of organizations.[80]

[80] NDP Factsheet What is a person-centred approach? file:///C:/Users/CCOMP/Desktop/bestModulo4/2016-10-person-centred-approach.pdf

The relationship between empathy and person-centred care

Empathy, or the ability to imagine what another person may be feeling or thinking, is a central component and is often present in definitions of person-centred care.[81]

The connection between person-centred care and empathy also seems logical, because without interpersonal understanding, it is difficult to focus a care plan around the patient. But there are aspects of person-centred care that go beyond empathy, for example, related to the continuum of teamwork and the coordination of that care.[82]

Why it is important and the benefits of person-centered care

The primary goal and benefit of patient-centred care is to improve individual health outcomes, not just population health outcomes, although population outcomes may also improve. Not only do patients benefit, but providers and health care systems benefit as well, through[83]:

- Improved satisfaction scores among patients and their families.
- Enhanced reputation of providers among health care consumers.
- Better morale and productivity among clinicians and ancillary staff.
- Improved resource allocation.
- Reduced expenses and increased financial margins throughout the continuum of care.

Person centred care has many benefits for both patients and professionals. The benefits to the person receiving care are[3]:

- They will feel more responsible, motivated and independent when they follow a plan that they have participated in and that is tailored to their specific needs (medical, emotional, personal and social).
- The patient will feel more comfortable and positive about the service they are receiving, which creates a much better environment for both the individual and the professional.
- The quality of care is improved, which can speed recovery.

There are also many benefits for the care giver. Namely, the positive environment is more accessible when care is focused on people's needs, and patients are more likely to be more committed to their care and medication plans. In the long term, patients' interest in their health

[81] Scholl I, Zill JM, Härter M, et al. An integrative model of patient-centeredness – A systematic review and concept analysis. PLOS ONE 2014;9(9): e107828. doi: 10.1371/journal.pone.0107828
[82] https://eprints.soton.ac.uk/433982/1/Therapeutic_empathy_and_person_centred_care_Accepted_Manuscript.pdf
[83] https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

may increase if they are involved in decision making in the recovery process, and all these benefits create more cost- and time-efficient services.

There is a lot of evidence that shows that actively involving the person in their healthcare can improve a number of factors, including patient experience, quality of care, and health outcomes. Examples include the following:

- Helping patients with long-term illness manage their health and care can improve clinical outcomes.[84] When people play a more collaborative role in managing their health and care, they are less likely to use emergency hospital services.[85] They are also more likely to stick to their treatment plans[86] and take their medicine correctly.[87]

• Patients who have the opportunity and support to make decisions about their care and treatment in partnership with health professionals are more satisfied with their care[88] are more likely to choose treatments based on their values and preferences rather than those of their clinician,[89] and tend to choose less invasive and costly treatments.[90]

• Individuals who have more knowledge, skills and confidence to manage their health and health care are more likely to engage in positive health behaviours and to have better health outcomes.[91]

• Person-centred care is good for health care professionals too. As patient engagement increases, staff performance and morale see a corresponding increase.[92]

[84] De Silva D. Helping people help themselves. London: The Health Foundation, May 2011, p6. www.health.org.uk/publications/evidence-helping-people-help-themselves
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[90] De Silva D. Helping people share decision making, The Health Foundation, June 2012, p.12. www.health.org.uk/publications/evidence-helping-people-help-themselves. See also evidence emerging in the US suggesting that use of patient decision aids, a tool used in shared-decision making, can reduce costs: Arterburn D, et al. Introducing decision aids at group health was linked to sharply lower hip and knee surgery rates and costs. Health Affairs, 8 Feb. 2013.
[91] Hibbard J, Gilburt H. Supporting people to manage their health: An introduction to patient activation. The King's Fund, 2014
[92] The King's Fund. Leadership and engagement for improvement in the NHS: Together we can. London: The King's Fund, 2012.

What are the barriers and enablers of person-centred care?

There are many factors, at all levels of the health system, that can act as barriers or enablers to developing and embedding person-centred care in mainstream health care.

At a national level there are a number of levers, such as payment systems, that may support or hinder person-centred care in practice. Within health services, organisational processes and systems can also affect attempts to implement person-centred care.

More fundamentally, organisational culture can have a big influence on whether teams and individuals feel motivated and able to work in a person-centred way. Support and buy-in from senior leaders, acting as champions for change, can have a powerful effect. Encouraging and empowering staff to change services locally, rather than imposing solutions, and bringing together a core team to drive change can also really help.

In addition, individuals' personal characteristics can affect the extent to which they want or are able to engage in their health and care. These characteristics include their social and cultural background, their health status or condition and their beliefs and preferences. It is important to take into account these factors when designing interventions and approaches.

Ultimately, all levels of the health system, including local and national policy, organisational leadership and management, and individual health professionals, patients and service users, have a role to play in creating the right conditions and circumstances for person-centred care to flourish.

How can we tell if care is person centred?

It is not easy to assess whether care is person-centred, since it comprises a combination of activities that depend on the patient and the situation in question, and therefore varies from person to person.

A person-centred approach means focusing on the elements of care, support and treatment that are most meaningful to the patient, his family and professionals. So before even thinking about measurement, the priority is to identify what is most important to them, without making assumptions.

The starting point is to consider an experience of care (e.g., an outpatient visits or an inpatient stay for surgery) in terms of the principles described above and assess the extent to which care demonstrates each of the principles.

Person-Centred Care for LGBTQI+ Older Adults

"We are never too old to experience healing— physical, spiritual, emotional, or psychosocial" (p.4).[93]

LGBTQI+ older adults face barriers in access to care, impacting their ability to receive person-centred care in old age, which is central to the prevention and management of frailty, disability and disease. Health policies, service design and delivery all impact on the ability of the health system to meet the needs of LGBT+ older adults across all levels and types of care.[94]

LGBTQI+ older adults have been a population greatly affected with health disparities across all levels of healthcare, leading many LGBTQI+ older adults to avoid and postpone healthcare for fear of being mistreated, disrespected, and even harmed.

Person-centred care emphasizes one's humanity, recognizing that each individual is multidimensional and that health and well-being derive from the interconnectedness of these different dimensions throughout our lives. Although sexual orientation and gender identity are central to individual identity and life experiences, health care providers have very little knowledge and training to care for LGBTQI+ individuals, leading to person-centred care not being optimal and appropriate.[18]

Respect, openness, decency and kindness are essential to person-centred care in LGBTQI+ seniors, and there should be no labels or acts of discrimination. In this way, this care can catalyse and cultivate healing and create healthier, happier environments and organizations that benefit everyone.

In this type of care, knowing the person's life story can help assess, plan, and implement care. It is important for this to happen by creating channels of communication with older adults so that they feel safe to openly communicate their individual needs, concerns, and feelings to professionals. Older adults can derive health benefits from their own reminiscence. Reminiscence can help reduce depression, loneliness, and isolation.[18]

Heteronormativity and discrimination must be eliminated throughout the health care system to achieve the health policy objective of supporting all older persons to enjoy health and well-being. Heteronormativity within health systems can be seen in service assessment forms, which fail to collect information on sexual orientation and gender identity. Knowing this information could influence care plans and prompt staff to involve 'chosen family'; use preferred pronouns; include same-sex partners; assist appropriate room placement in nursing home care; and ensure LGBTQI+ older adults are cared for in a way they would have chosen at the end of life.[19]

As a conclusion, there is evidence to show that the supportive and health needs of LGBTQI+ elders are not always adequately addressed by health care systems. Without adequate training, those may not be prepared to work with LGBTQI+ elders. More research is therefore called for on the capacity of health services to provide adequate healthcare for LGBTQI+ people and the creation of associated education and training opportunities.

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[93] Steelman RE, Chaplain S. Person-Centered Care for LGBT Older Adults. JOURNAL OF GERONTOLOGICAL NURSING 2018; 44(2). doi:10.3928/00989134-20180110-01

[94] Roe L, Galvin M. Providing inclusive, person-centred care for LGBT+ older adults: A discussion on health and social care design and delivery. J Nurs Manag. 2021;29: 104–108. DOI: 10.1111/jonm.13178

Practical activity 4.1

Name of the activity	What are my care, support and treatment needs?
Number of participants	Minimum 4
Objectives	The objective of this activity is to guide participants in thinking about what their care, support, and treatment needs might be and could be addressed in their care plan.
Step-by-step description	1. explain the objective and what the exercise is about 2. Provide each person with an A4 sheet of paper, in case they want to write down their reflection 3. Invite each person to reflect, trying to identify what aspects and needs should be addressed in their care plan, in partnership with the caregivers. 4. Return to the plenary and share each person's reflections. 5. Open a discussion: Is there difficulty in identifying and communicating our care needs? What do you think is important to include in care plans? What should be prioritized by professionals and informal caregivers? How would you like to be treated/cared for?
Comments/hints for facilitators	This exercise is intended to encourage opportunities for self-reflection and group reflection on the self-identification of care, support and treatment needs, highlighting the importance of communicating these needs and the person's active participation in defining their care plan. It is important to guide the discussion in such a way as to reflect on the importance of person-centred care in an empathetic way, supporting professionals to constructively challenge their own work.
Resources	- A4 sheets of paper (one for each person)

Practical activity 4.2

Name of the activity	Person-centred approach**:** from theory into practice
Number of participants	Minimum 4
Objectives	The objective of this activity is to guide participants in reflecting on how the person-centred care approach can be transposed into the care practice of their workplaces.
Step-by-step description	1. explain the objective and purpose of the exercise 2. Hand each person a sheet of A4 paper, in case they want to write down their reflection. 3. Invite each person to reflect, trying to identify if a person-centred approach is used in their workplace, in the provision of care? If so, what measures and principles are applied? If not, what are the barriers/difficulties identified for its application? 4. Return to the plenary and share each person's reflections. 5. Open a discussion on the topic, seeking to understand in what ways institutions in care delivery apply or can apply the person-centred approach. Identify the benefits and barriers of person-centred care in practical care settings.
Comments/hints for facilitators	This exercise is intended to encourage opportunities for self-reflection and group reflection on how the person-centred care approach can be applied in practical care settings. It is important to guide the discussion to reflect on the importance of person-centred care and its transposition to their workplaces, supporting practitioners to constructively challenge their own work.
Resources	- A4 sheets of paper (one for each person)

Practical activity 4.3

Name of the activity	Scenarios inspired by real-life cases to be familiarized with the needs and difficulties LGBTQI+ people face
Number of participants	Minimum 4
Objectives	The objective of this activity is to guide participants in reflecting on different scenarios inspired by real cases to become familiar with the needs and difficulties that LGBTQI+ people face.
Step-by-step description	1. Divide the participants into groups of 3 to 6 people 2. Provide each group with a case study 3. Invite each group to discuss the case studies, trying to identify whether the needs of the older people were met and whether the care followed a person-centred approach? If there were scenarios of incidence of discrimination, violation and isolation of the LGBTQI+ community? 4. Return to the plenary and share the reflections found by each group. 5. Open up a discussion: How can we develop our care practice centred on the needs of people, especially LGBTQI+ older adults?
Comments/hints for facilitators	This exercise aims to elicit opportunities for self-reflection and group reflection on case studies in which the needs of older people, particularly the LGBTQI+ older adults, are identified and the care approach used is analysed. It is important to guide the discussion in a way that reflects on the importance of person-centred care and in a way that is not judgmental, but tries to elicit strategies and approaches to support professionals to challenge their own work in a constructive way.
Resources	- A4 sheets with a case study (one per group)

STUDY CASE 1

"Two friends of mine, Vera and Zayda, had been together for 58 years. When Vera's Alzheimer's became too much, Zayda moved her to an assisted living facility.

Zayda could barely trust family or neighbours with the truth, let alone strangers, so she and Vera became "sisters." Much later, after Vera's death, Zayda needed to move into an assisted living facility herself. She had many, many photos of the love of her life, but dared not display them in her new home. The other residents would talk about husbands, children and

grandchildren, but she felt too vulnerable to tell the truth. Zayda was in hiding and terribly isolated."

STUDY CASE 2

A gay couple, Pedro and António, who were together over 30 years, were afraid to tell their children and the rest of their family their truth, sharing their story only with a few close friends. When Pedro developed dementia symptoms, it was very challenging because, although António had power of attorney, Pedro's daughter wanted to control decisions because she was family. Eventually, they decided to institutionalize Pedro, as the symptoms of dementia began to be more evident, although Pedro would still recognize António as his partner. António continued spending his days with Pedro in the nursing home, but without revealing about the nature of their relationship, which limited their privacy. Eventually one of the nurses saw the tenderness between these two men and asked the question, "Are you partners?" António was able to answer, "Yes, this is true." The nurse encouraged them to make a commitment to one another before the partner with dementia get to severely ill or passed. The nurse witnessed the private ceremony and they were able to openly express their feelings and symbolically "formalize" their relationship. From that day on, the nurse helped them to have some privacy in the nursing home, respecting their will of not revealing their relationship.

STUDY CASE 3

"Iris Young is an 88-year-old cisgender female (assigned female gender at birth) diagnosed with moderate dementia. She was admitted to a long-term care dementia unit six months ago. She is married to Rob and they celebrated their 65th wedding anniversary in 2018.

Iris makes friends easily and developed a closer relationship with another female resident, Raven, on the unit. Raven is an 82-year-old female of Indigenous heritage who identifies as two-spirit. Over the last few months, Iris and Raven have been known to spend a few hours each day sitting together and often hug each other when they say goodbye.

Rob is happy that Iris has a friend. More recently, Iris and Raven have been holding hands and kissing. Rob came in today to visit Iris and found her and Raven cuddling in Iris's bed."

BestCare 4LGBTQI+

Co-funded by the European Union

MODULE 5

SAFE AND INCLUSIVE ENVIRONMENT IN THE CARE OF LGBTQI+ ELDERLY PEOPLE

PROJECT N° 2021-1-FR01-KA220-ADU-000035303

MODULE V

Safe and inclusive environment in the care of LGBTQI+ elderly people

Learning Objectives

Throughout this module we will approach:

- Inclusive practices in care facilities to promote inclusive care
- How to adopt an active anti-discrimination stance
- Good professional postures to be adopted
- 2 dynamic activities to discuss the topics of the module

Inclusive practices in care facilities

This chapter is aimed to show the challenges we need to overcome to make healthcare facilities and nursing homes more LGBTQI+ friendly.

Before we trying to develop a more inclusive health care ecosystem, we should take a look through a specific problematic that stereotypically surrounds elderly people: sexuality, or more specifically: "non-sexuality".

Sexuality in nursing homes and healthcare facilities: the limits we have to overcome

Several surveys on sexuality in old age point to old age as a determining factor in the decline of sexual activity, a finding that is found in several national contexts.

Not only sexuality is a very taboo topic within this population and its carers but it is globally assumed that elderly people do not have intimate relationships. This statement is even more declared for elderly people who do not live alone and are accompanied by a facility in the long run. The guesses are: there are more priority difficulties that they face daily, especially health issues, and their sexuality is not a big concern for both their families and their carers. This is even more observed when the person, regardless of gender or sexual orientation, has lost his or her partner. Not only it is difficult to assume they want to have another relationship (platonic or intimate) but even more if sexual matters are involved.

In addition to this, since birth control is at that age not really a problem when elderly people have low reproductive capacities, there are even less prevention sexuality-wise and awareness raising on sexually transmitted diseases.

Our research has shown that elderly people isolate themselves when and because they can't express themselves sexuality-wise in the nursing home they live. The stigma comes from both the residents and the professionals. To prevent this kind of isolation, it is advised to work on the topic of sexuality to make the environment a safe place so that people can talk more freely about

sexuality, feeling comfortable and without judgement. This environment is the first step to freeing the word, without immediately addressing sexual orientation or gender.

What can we do to create this environment?

- Establish a climate of trust with the elderly so that they can confide in the professionals about sexuality in general if they wish, but also more specifically about sexuality and relationships in the nursing home.
- Talk with them about visits from outsiders and privacy and how to make the rooms at the nursing home more private so that the residents feel comfortable receiving people.
- Make sure to communicate (with posters, healthcare intervention in the common room, during a health checkup) about sexually transmitted diseases and the different ways to prevent them.
- Establish a climate of trust between residents

How do we do it?

- Respect their privacy: if a resident is sexually active and doesn't want to speak about it, or doesn't have medical issues related to it to discuss with healthcare, there is no need to address it. On the other hand, make it apparent that the professionals can be open to speak about it if needed: it is possible to make posters promoting dialogue with healthcare professionals. This applies also to the residents who are not active and do not want to speak about it.
- Make condoms and lubricant available in a vending machine, or freely in the healthcare facility, so they don't need to ask someone to get them if they are uncomfortable.
- Do not speak about sexual matters in presence of the family. In fact, do not ask or speak about it to a resident in front of any other person. Some family members have trouble accepting their parent can have a relationship in a facility or can't fathom them with another significant other, especially if the previous partner has died.
- Normalize sex outside of relationships. This topic can be difficult to introduce when some elderly people have only had one relationship or only one significant other, not outside of marriage. Normalizing the existence of not-marital sex and sex outside any kind of exclusive relationship without judgment can help free the word and create a safe environment for those who would like to speak.
- If couples are both resident in the nursing home and feel confident speaking about their relationship, make sure they know a sex therapist can intervene and
- Communicate and promote consent in the facility. This can be done with posters or awareness days to stress the existence of danger and violence, without forgetting to mention of marital rape. Again, these acts of preventions work regardless of the sexual orientation or gender.

Time management in nursing homes and healthcare facilities: the limits we need to overcome

A difficulty we cannot exclude before diving in our problematic is the increasing of the population taken care of in healthcare facilities and the overload of the professionals. Indeed, the care is more difficult in support daily activities (as nursing, feeding, animation etc.) but also in the support for resident with physical or mental disabilities. Sadly, it has become more and more difficult for our

professionals to dedicate the time they would like to all residents, especially those with special needs. With this overload, the care provided is lacking of relational activities and the turnover of these professionals is very high.

Another difficulty that our professional may face that is independent of gender and sexual orientation of our elderly: how they manage time in these facilities.

It is needless to say we are short of manpower in this type of facilities. Time is precious and healthcare professional are already running daily to meet our elderly's needs. This is a variable we need to take in consideration when working towards more inclusivity in our systems.

In addition to this, some nursing homes are designed like hospitals, as a place to receive healthcare and it is difficult to integrate that they are indeed the home of the elderly and not just a place to receive treatments. Since it has to be considered as a home, their privacy should be respected, and their sexuality as it follows.

Heteronormativity is an obstacle to good healthcare, regardless of age, but can be even more problematic with elderly people.

What can we do:

- Work around professionals
- Work around residents
- Work around the elderly LGBTQI+ community

How do we do it:

- Plan awareness sessions for the staff of the facility: this Includes every person working or involved with the residents. This session can few hours to a day. You can choose who to intervene and it doesn't have to bring all the employers together at once. But can be schedule in a way that everyone has attended once. These sessions need to be scheduled to speak about diversity and inclusion in general weather is about sexuality, gender, ethnicity, politics etc.. Others sessions can be scheduled only around the LGBTQI+ stigma. It is advised to make these sessions dynamic and funny and make sure to give a briefing on the specific vocabulary that revolves around the community.
- Plan ahead days of awareness in the nursing home or facilities: making an external speaker intervene in the facility can help make the discussion easier because the residents knows they may not see this person again, and opening up can be easier.
- Train a professional in particular to be the LGBTQI+ referent. It can be a psychologist, a sex therapist or any other healthcare workers that works full time in the facility: this means that the resident who asks to speak to them won't be stigmatize because this referent is competent on other matters. This person must be aware of the difficulties of "going back to the closet", hormonal treatments that transgender people can go through, and others issues the community faces daily.
- Make the LBGTQI+ flag apparent. You can put it as stickers in the elevator, have a little flag next to your national flag at the entrance, have your staff wear pins on their clothing during the pride month. You don't need to over-display it: just make it exist, so that residents and visitors can become aware of its existence within the institution and understand that this is a welcoming and safe facility.

- If a resident or a visitor asks about thee meaning of the flag: offer a kind and benevolent definition. Do not be judgmental against people who do not know. They can be good learners or they can just struggle to put a name on it.
- Do not force someone out of the closet.

Institutional rules and LGBTQI+ protection

This chapter is aimed to go through the institutional work done at an international level and point out the right interlocutor to go to when facing discrimination. We will also see what can be done to ensure a benevolent and inclusive care in the long. This curriculum is specifically aimed at nursing home and healthcare professionals but training must be available outside the healthcare facilities as well. Gender and sexual orientation issues need to be addressed in school for the future professionals and not only within the facility. The point is to change the visions and to raise awareness on advanced and expert professionals who didn't get this type of training in school. It is not a one-time training but a long run awareness raising.

The right to sexuality, sexual health and sexual education

The right to sexuality is part of the Human Rights: it is a continuity of fundamental rights that is applicated to sexuality. This means they parts of the personality rights, the right to privacy and the right to dignity.

<u>The work of the OHCHR</u>

The OHCHR (Office of the Unites Nations High Commissioner for Human Rights) is a department of the United Nation Human Rights Office. It works to promote and protect human rights that are guaranteed under international law and stipulated in the Universal Declaration of Human rights of 1948. The OHCHR is committed to fight against all sort of discrimination and stresses that people from the LGBTQI+ community who are already discriminated against, face additional discriminations linked to ethnicity, age, disabilities, socioeconomical status…

Indeed, the OHCHR is committed to working with different stakeholders, States, national human rights institutions civil society towards inclusion.

- First of all, in the UN entity itself: the OHCHR is committed to guarantee gender equality within the organization.
- The OHCHR is committed to work with the states with the aim of reforming discriminatory law and policies that promote gender discrimination to bring them in line with the international human right law.
- It works to transform discriminatory social norms and harmful gender stereotypes to make way for more equitable social structures and power relations for all genders; and helps facilitate equal participation of women, men and people of diverse gender identities in civil, political, economic, social and cultural life.
- Last but not least, the OHCHR operates towards the elimination of gender-based violence and the ensure of the enjoyment of sexual and reproductive health rights for all.

<u>The accessibility of sexual health and sexual education</u>

Sexual health is fundamental to the well-being of individuals, couples, family and the overall development of communities and countries.

In fact, according to the World Health Organization, the ability of individuals to achieve sexual health and well-being depends on several things:

- Their access to good quality information about sex and sexuality
- Their knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity;
- Their access to sexual care;
- Them living in an environment that affirms and promotes sexual health.

Sexual health includes issues related to sexual orientation, gender identity, sexual expression, relationships and pleasure. It is important to mention as well the conditions and negative consequences that are included in sexual health such as:

- infections with HIV (human immunodeficiency virus), (STIs) sexually transmitted infections and their possible outcomes: cancer, infertility etc.
- unintended pregnancy and abortion
- sexual dysfunction
- endometriosis
- sexual violence
- and finally: harmful practices such a female genital mutilation

That is why a more inclusive and safer environment is required in nursing homes and healthcare facilities: the resident can feel confident enough to reach out for help and knowledgeable healthcare professionals can detect patient's difficulties and respond and intervene more quickly and effectively.

Sexual education must be available at all age: this not only includes anatomy explanation and prevention but also needs to stress the following subjects:

- respect, safety and absence of discrimination or violence
- sexual diversity and forms of sexual expression
- the importance of deconstructing the gender norm, roles, expectations and power dynamics that influence it.

How the law and civil society protects the LGBTQI+ community

This paragraph also aims to explicit who to turn to when you are discriminated against. Even if the countries make specific laws, there is work to do to make the mentality change with the civil society.

Who to reach out to if you are discriminated against:

This chapter applies if you are discriminated against but also if you are a testimony of discrimination and the victim accept your help with this matter.

If this happens within the establishment and is an attack from another resident:

Reaching out the healthcare professional during personal time. This privileged alone time with a professional can be a moment of exchange, listening and support.

For more support reach out to your local LGBTQI+ associations lots of them are competent with different matters:

- Having an anonymous listening and support hotline
- Online chat service
- Online testimonial form
- Service of legal support

These tools that are mainly available online can be difficult to use to elderly persons: that is why an additional support from the healthcare professional can be needed. Make these tools visible and accessible to the public, especially if the victim doesn't want to speak to a known professional directly.

if you witness discriminatory behavior or language from a fellow healthcare professional: this is the competence of the Human Resources of the establishment. It needs to be addressed and the sanction will come from there.

If this doesn't make things better: you need to reach out to your local public service. The law specifically punishes insults, defamation, violence and discrimination based on the victim's real or supposed sexual orientation. This is known as LGBTIQ+ abuse, defamation, violence and discrimination. If you are a victim or a witness of these acts, you can alert the emergency services and report the facts. If you are a victim, you can file a complaint.

The international day against homophobia, transphobia and biphobia

The international day against homophobia, transphobia and biphobia takes place the 17th of May and is a Worldwide celebration of Sexual and Gender diversities. It was launched in 2004 and is celebrated in over 130 countries including 37 countries where same-sex acts are illegal. This event was created to draw attention to the violence and discrimination experienced by the LGBT community. This event gathers millions of people (record of 200 million people reached in 2014) around the globe. To show visibility and support, the nursing home or healthcare facility can host a micro-event related on the topic to raise awareness while enjoying a festive and convivial moment.

Professional postures to be adopted: Do's and Don't

To make changes we need to implement more inclusive and benevolent care or adapt some practices. Some establishment are already very involved to ensure a safe and inclusive environment, others are indeed involved in the fight against discrimination but are lacking some specific accompaniment and support for the LGBTQI+ people that need it. In fact, creating services destined to the LGBTQI+ community to respond to their special needs is an interesting idea, but make them feel at home and enable them to feel comfortable in already existing institution is better!

Here are the do's and don'ts for supporting the elderly LGBTQI+ community the best we can:

Do's:

- Make sure the nursing home or facility is aa place to live in and less an hospital. The residents that are institutionalized, have, for most of them, left their home to live there. In addition to this: keep in mind that they are living in the facility for the rest of their lives. It is crucial to understand that these facilities are not only a place to receive daily care, but also their new home. Make sure they can have personal place and enjoy their privacy when needed. (not only for sexual matters)
- Do consider sexuality and affective life as a human need. In fact, aging is as universal as love. It is important to take into consideration that the residents are not only elderly and sick people. They are human and have the same needs as any other person regarding sexual life and affection. Having a relationship at an old age is as valid as another younger age.
- Make sure to raise awareness about consent. Both in sexual matters but also in affectionate and medical matters. This means: if doing a medical exam or procedure, make sure to ask for consent when you need to be touching the patient and explain why they need to be touched in certain areas. This works as well for undressing.
- Make sure to explain a medical exam or procedure before going through with it. A resident can not feel confident to do it or to speak about their transition even if it can be relevant for the exam. Give the person time, especially if the medical exam is not urgent.
- If a resident comes out to you, you can ask about their partners if they are feeling confident to speak about it. This means: have the same conversation you would have with a straight cisgender person. Some people feel uncomfortable with asking question on the personal life of a LGBTQI+ person: don't. The worst thing you can do is ignore it like an elephant in the room. Do not whisper: use normal voice or else it will seem that talking about "gay stuff" is bad or taboo. Of course, do not be too noisy.
- Do not talk only about their sexuality and gender. There are lots of topics to discuss, and only speaking about that reduces them to their orientation or sexuality: they are way more than that as a person.
- Do educate yourself a make some research. The LGBTQI+ person you know may explain to you some things, but don't expect them to be your personal educator. Moreover, do not assume that is someone is LGBTQI+, they know everything about the LGBTQI+ community.
- Try to make an effort with pronouns and inclusive writing. Don't be scared to ask if you're not sure what pronouns someone uses. Don't hesitate to communicate to your coworkers which pronouns a person goes by. If you here someone misgender a person in your presence, call them out (if the person is out to them).

- If the budget allows: provide medical beds that can accommodate two people.

Don'ts:

- Don't make assumptions. Do not assume somebody 'sexuality orientation nor gender. You can't tell if someone is part of thee LBTQI+ community by only looking at them.
- Do not force or put the pression on someone on to coming out. If the person feels confident to tell you about it, keep it for you and don't speak about it to anybody else. Even if it is not explicitly a secret, it doesn't mean it should be disclosed. Some resident can come out for the other nursing home residents and professionals and talk freely about their orientation and gender but don't want to come out yet to their family. We should respect this decision.
- When and if speaking about sex: do not limit the sexual intercourse to only penetrative sex. In fact, sex can be seen and done in many ways and penetrative sex is usually a heteronormative preconception. Lots of heterosexual and LGBTQI+ people include other ways in the sexual intercourse that are usually seen as part of foreplay. Take into consideration that there are as many ways to have sex as humans on earth.
- When and if speaking about sex: do not be judgmental about a specific sexual practice. Pleasure is particular to each individual and as long as the participants consent to it, there is nothing wrong with it.
- Do not let LGBTQI+-phobic jokes slide. If you hear someone tell a LGBTQI+-phobic joke: call them out: this is how things change.

Specific situations to be considered

1. Concerns about dementia and consent

An important and rather tricky questions is asked when the residents suffer from any type of dementia. This is an issue that concerns both healthcare professionals and families and raises the questions of how to be sure that consent is given or understood by a person with dementia in the context of sexual relationships.

Just because a resident has Alzheimer's doesn't mean that you don't need caresses, physical contact etc.. Rather the contrary! Studies have proven that physical contacts, display of affection can be rather beneficial.

How to be sure that no incident had occurred between two residents? It is advised to keep an eye on these specific residents and try to detect any change in behavior. Professionals are becoming better trained and know their residents well. They can ensure as much as possible of the person's consent, and spot a worrying change in behavior.

2. Knowing how to react to problematic behavior

When it exists, sex life in the nursing homes of other facilities is not just about couples holding hands, or even about residents having sex in their rooms, not always with the same person. Sometimes, situations of physical or verbal exhibition do occur and can put professionals in a difficult position. As respect goes in both ways, some attitudes have no place in such a public and visited area. It is advised to keep calm but be firm on the prohibition of problematic behaviors by reminding in an educational way the rules of the establishment and of community life.

Practical activity 5.1

Name of the activity	Live/moving debate "What is your position?" (Duration of the activity: 1 hour)
Number of participants	From 4 to 15 max
Objectives	A moving debate consists of putting a proposal before a group, and then asking participants to physically take a position for or against it, going to one side of the room or the other, corresponding to the affirmation or negation. After allowing time for reflection to develop arguments, the debate is launched with the following rule: formulate arguments to explain one's position and change "sides" if the other side's arguments are convincing. The moving debate thus allows participants to elaborate and justify their opinion by constructing arguments. Their physical position indicates their theoretical position and involves them in reflection ("why am I here?") as much as in listening to the arguments, while their movement concretely reflects their intellectual activity. This activity aims to understand the stereotypes attached to elderly people sexuality and. At the end of the activity a discussion will help deconstruct these stereotypes permitting each participant to give an input.
Step-by-step description	I. This activity is a live/moving debate that take place in an empty room. The aim of the activity is to move around the room in accordance with the answer we give to the questions asked. II. The moderator tells the affirmations (which you will find below). The room is divided in two: the left part signifies "strongly disagree" and the right side signifies "strongly agree", this makes the middle "neutral". III. After each affirmation, the participants will elaborate their answer and justify their physical position in the room. When everyone has specified their opinion, the moderator explains the answer. IV. The affirmations that the moderator has to give are the following: - <u>After the menopause, a woman has less and less sexual desire</u> Solution: False! The menopause does not mean the end of a woman's sex life. It is true that she no longer has menstrual cycles, no longer ovulates, and her fertility stops. While her desire may change, it persists throughout her life. If a menopausal woman's desire decreases, it is often because she has been in a relationship for a very long time and routine may have set in. Studies have shown that a menopausal woman who meets a new partner has as much desire as a 30-year-old woman... - <u>Older people are no longer interested in sex</u>

	Solution: False! Emotions, fantasies, erotic imagination have no age; they exist throughout life and until our death. Sexuality is an integral part of life and as long as life is present, sexuality is also present. - With age, in couples, tenderness ends up replacing sexuality Solution: False! Tenderness exists in couples at all ages and is both part of sexuality and complementary to the sexual drive. Since many people cannot imagine the sexual life of very old people, they imagine them tenderly holding hands without wanting to believe that sexual life exists after 70. - As they get older, they are no longer desirable enough to have sex Solution: False! In sexuality, it is of course important to desire each other. It is true that a person who grows older and no longer feels desirable may find their sexual desire blocked. But if they take care of themselves and continue to love their body and the pleasure it can bring them, if they know how to appreciate the intimacy of bodies, desire persists at 80 and over. The problem is that in our society, where youthism predominates, it takes a lot of character to be convinced that you are desirable despite your advanced age. - As we get older, we have less and less sex. Solution: Not quite true. It is true that at the age of 50 for women and 55 for men, the frequency of sexual relations decreases. It drops from an average of 8 sexual encounters per month to 5 per month. This rate is maintained at least until the age of 69, which is the age at which studies stop. And it is likely that this rate continues much later, but this is not studied. - One day, sexuality completely stops with advancing age Solution: False, stopping sexual relations is linked to problems, not to age. Sexuality never stops since erotic imagination and sexual thoughts are part of sexuality. When sexual relations stop with age, it is because of the absence of a partner, particularly because of widowhood or separation. Otherwise, in a healthy couple, active sexuality can continue for life. In other words, erection and vaginal lubrication continue to function. And in couples who get along well sexually, a serious erectile dysfunction or impotence does not prevent them from continuing to have an active sexual life, because penetration is not the only way to have sex... - The evolution of sexuality over the years depends on the character

	True. A person who is very narcissistic (I am the most beautiful, the best, I admire myself, I want to dazzle) often feels that the changes in their body due to ageing are unbearable. They therefore find it more difficult to integrate these changes while maintaining an active sexual life. They will find it difficult to accept the sexual changes imposed by age. Similarly, people who are perfectionists seek efficiency and performance. If their sexuality does not keep up with their perfectionism, they tend to lose interest. Other very anxious people, known as avoiders, lacking in self-esteem, will very quickly feel anxious about changes in the functioning of their sexual body. As a result, they tend to avoid sexual relations as they age.
Comments/hints for facilitators	Make sure to make this activity judgement free. Some participants may not have the knowledge to respond.
Resources	V. A room where the participants can move around VI. The lists of the questions

Practical activity 5.2

Name of the activity	Quiz on gender stereotype
Number of participants	Minimum 2
Objectives	A gender stereotype is a generalized view or preconception about attributes or characteristics that are ought to be possessed by, or the roles that are or should be performed by, men and women: it is a BELIEF. This quiz aims at make the participants reflect on the stereotypes linked to the LGBTQI+ community.
Step-by-step description	I. The moderator has a list of questions where the participants can respond true or false or choose from different options. II. After each question is asked the participants show the answer they have written on their white board. III. A discussion follows with the explanation of the right answer. IV. The questions the moderator has to ask are the following: 1) <u>What is the symbol of the LGBTQI+ community?</u> A) A 6 pointed star

	B) A rainbow flag C) A colorful rose Solution: Answer B 2) What does the T in LGBT stands for? A) Transgender B) Transformer C) Telepathic Solution: Answer A 3) For most of the 20th century, many researchers often associated homosexuality with what? A) Religion B) Psychology C) Genetics D) Upbringing Solution: Answer D 4) Homosexuality is a disease and it can be treated True/False Solution: False 5) Bi-sexual individuals are more likely to cheat on their partners True/False Solution: False 6) The members of the LGBTQI+ community are known for having multiple partners and having a higher libido than straight cisgender people True/False Solution: False 7) If a woman finds another woman pretty she might be a lesbian True/false Solution: False 8) A person can't define themselves as transgender if they haven't surgically changed their anatomical sex True/false Solution: False 9) Transgender people are all gay True/False

	Solution: False 10) Transgender people are just "confused' about their gender True/False Solutions: False 11) Gay people often prefer very young partners True/False Solution: False 12) All drag queens are gay True/False Solution: False 13) Intersexual and transgender is the same True/False Solution: False
Comments/hints for facilitators	Make sure to make this activity judgement free. Some participants may not have the knowledge to respond.
Resources	- One small white board per participants and white board markers - It is possible to put the questions into a Kahoot to make it 100% digital.

Additional activity

You will find 3 LGBTQI+ movies to watch with a short description:

Blue is the warmest color (2013): The film follows Adèle, a teenager who falls in love with an older student named Emma who is an aspiring painter. The protagonist, who is an introverted 15-year-old high school student who dates a boy from school: Thomas. As she passes by a blue-haired woman, to whom she is instantly attracted, she has vivid fantasies about her and start experiencing kissing with one of her female friends. Emma and Adèle end up seeing each other and Adèle's school friends start to ostracize her when suspecting of her being a lesbian. She discovers throughout the movie, desire, freedom and is troubled about her sexuality.

Love, Simon (2018): Simon Spier, 17, is a teenager who hides his homosexuality8 . He attends Creekwood High School in suburban Atlanta with his three best friends. One day, Simon learns that another gay teenager at his school has just come out anonymously on the internet, under

the pseudonym "Blue". Also anonymously, Simon begins to communicate with this boy. The two teenagers soon confide in each other and form a real bond. But when the messages he exchanges with "Blue" fall into the wrong hands, Simon's life begins to change.

Crush (2022): An aspiring artist is forced to join her high school track team, using the opportunity to pursue the girl she has long had a crush on. Later, however, she falls in love with an unexpected teammate and discovers what true love is.

Conclusion

To conclude this module, we can say that before addressing the difficulties the elderly LGBTQI+ community can face in nursing homes and healthcare facilities, we need to go over the stereotypes on sexuality of elderly people in general. In fact, admitting that elderly people can have a sexuality it is a big step towards more inclusion of the LGBTQI+ community. In fact, freeing the word on sexuality in general, makes it easier to explain that heterosexuality is not the only sexuality existing. A work on raising awareness and opening minds is crucial to make these institutions more LGBTQI+ friendly and permit this community to feel at home, just like any other individual.

In addition to this, we could share some ideas and suggestions to make the nursing home more LGBTQI+ friendly. These suggestions can help build trust and benefit all residents regardless of their sexual orientation and gender identity.

Moreover, we could approach which international law are aimed to protect the LGBTQI+ community and what services to reach when we are facing discrimination. This can vary between countries depending on what actions are taken against these discriminations. In addition to this, more professional advice were listed to help the residents feel more at home and some vigilances were addressed for specific problematic behaviour.

Finally two dynamic activities were presented to go with this curriculum and get over the stereotypes we can have on elderly sexuality and the LGBTQI+ community.

What we need to remember: If the nursing home or healthcare facility is related to a place of life and care, it is also the reflection of our society in which it appears to be still the norm of sexual orientation: that of being straight. So, bear in mind that the deconstruction of heteronormativity in the nursing home is a continuity of what our overall society needs to work on.

Resources

CASTANET Victor, "L'homosexualité, interdite de séjour en Ehpad". *Le Monde, Mars 2019*

Une maison de retraite LGBT: https://youtu.be/goJVAVf9mvk

Podcast: "Les seniors LGBT+", par Hors Case

About gender equality and the human rights of women and LGBTI persons, OHCHR and Women's human rights and gender equality: OHCHR and women's human rights and gender equality | OHCHR

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United Nations Human Rights (Office of the High Commissioner) "Gender Stereotyping and the judiciary: a workshop guide": Gender Stereotyping and the Judiciary: A Workshop Guide | OHCHR

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SOS Homophobie, Intervention et formation pour Adultes: Nous contacter | SOS homophobie (sos-homophobie.org)

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La mutuelle Générale, "7 idées reçues sur la sexualité des personnes âgées", 20 Octobre 2017: 7 idées reçues sur la sexualité des personnes âgées | La Mutuelle Générale (lamutuellegenerale.fr)

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