RESEARCH ARTICLE

HUMANistic Caring: An approach for meeting the care needs of Filipino gay and lesbian older persons

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Abstract

Quality care is a basic human right and a core foundation for a patient's health, recovery, and well-being. In the current Philippine context, gay and lesbian older persons face gender-care disparities in the caring dynamism. Until now, their care needs are not articulated in the country's basic nursing curriculum. Consequently, the care approach is incongruent, biased, and risky. In response to this gender-care disparity, participatory action research (PAR) was used to identify this cohort's care needs and their meaning by developing a nursing care hub called the 'Gay Care Center' for older gays and lesbians. This paper focuses on describing: (a) the current situation of nursing care among the gay and lesbian older persons; (b) the meaning of care needs from their perspective; and (c) the Gay Care Center's tailored approach and services to meet their care needs. Multiple sources were utilized to collect data: focus group discussions, in-depth interviews, and observations. Data were then analyzed using Mayring's qualitative content analysis. Findings revealed that caring practices for older gays and lesbians could only be effective, satisfying, and holistic when the meaning of their individual needs are sensitively listened to, understood, and met. This led to the coined term HUMANistic caring, a new approach that emerged as their preferred mode of care. It is recommended that extensive gender-care training be conducted among gerontological nurses, and this be incorporated in the nursing curriculum to ensure that the provision of care is safe, respectful, humane, and just.

Keywords: *Humanistic caring, gay-friendly care hub, gerontology nursing, gender-care disparity, care approach, PAR*

Introduction

The annual increase of aging individuals worldwide denotes an emergent demand for fundamental preparation and new health challenges (Badana and Andel, 2018). Regardless of age, socioeconomic status, ethnicity, gender orientation, or religion, every person deserves health care. As the WHO acknowledged, this may seem ambitious, but it is worthwhile pursuing and must be realized to create "a healthier and more equitable world" (WHO, 2019).

One reality in the context of caring is the older gays and lesbians' (G.L.s) invisibility that can lead to adverse health outcomes (Fenge and Hicks, 2011; Cohen et al. 2018). Their unique care needs are still unknown, placing vague and confusing responsibilities on nurses expected to provide appropriate care approaches (Eliason, Dibble, and DeJoseph, 2010). Practitioners treat this elderly group as homogenous and hetero-stereotypical, thus, hampering the formulation of accurate, caring strategies to meet their actual needs (Cohen et al., 2018). The care provided is incongruent, biased, and risky (Cohen et al., 2018; Pearlberg, 2004). This substandard care and treatment jeopardize the older gays and lesbians' goals to achieve healing, causing significant stress and potential health risks (Kuan, 2015).

On the broader concept of care needs, these G.L.s are often overlooked, misunderstood, or ignored. Consequently, the unique concerns and realities of this under-reported minority within the aging population, the elderly G.L.s are not mentioned in the curriculum of basic nursing education. This raises legitimate concerns about whether the care provided to this aging cohort is holistic and equitable.

Despite the available record of the 5 million Filipino senior citizens (POPCOM, 2019), G.L.s are not statistically represented. In Republic Act 9994, also known as the Expanded Senior Citizen Act of 2010, their specific needs are not

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mentioned. With the existing law's failure to recognize their rights and protection, they might be denied health services and face harassment from service providers or other elders. The 2017 curriculum memorandum order (CMO) for nurses lacks teaching-learning strategies for gender-care sensitivity.

There is a dearth of local nursing literature that explores the care needs of this cohort (Guevara, 2016). Instead, researchers focus on young LGBTIQ+ and HIV/AIDS care experiences. This underscores that this aged G.L.s is an underserved population with disparities in healthcare. Compared to their younger counterparts who actively express their health rights, many senior G.L.s remain quiet and either avoid or delay accessing healthcare services out of fear of being stigmatized, mistreated, disrespected, and emotionally harmed by healthcare providers (Stanton, 2013). These may be rooted in their exclusion in the healthcare agenda and historical experience of discrimination (Eliason et al., 2010; Nadal and Corpus, 2012). This has created mistrust in the care offered for their needs (Eliason et al. 2010; Hillman, 2016) and they continue to suffer various forms of injustice (Stanton, 2013), which have implications in the caring system.

The senior Filipino G.L.s, just like those from other countries, are deprived of a safe space in the healthcare setting. Even though the Philippine Health Agenda (2017-2022) has the goal of improving geriatric health, policymakers excluded the older gays and lesbians in the mainstream, further marginalizing them. Their specific needs and experiences of care turned out to be silenced. Thus, a nursing care hub model, called 'Gay Care Center,' the first for gay and lesbian older persons in the country, was developed and piloted.

This paper describes the process through which the care hub was developed and the emergence of a tailored caring approach evolved based on the gay and lesbian older persons' identification and meaning of needs. It can be a guideline for future program development efforts. It would shed light on the underlying phenomenon of care dynamism among older gay and lesbian persons, hence, the goal of 'Healthy Aging for All' is realized to assist G.L.s in growing old with security, dignity, and live meaningful lives.

Methodology

Pilot Study

The study was conducted in the 'Gay Care Center', developed using a participatory action research (PAR) methodology. PAR is the collection, reflection, and analysis of data involving people who will act and bring about social change (MacDonald, 2012). This method allows concerned individuals with knowledge and experience to decide and take responsibility for the contents and the delivery of the actions to be performed (Blair & Minkler, 2009). The pilot care hub project also followed the key steps of the nursing process – assessment, planning, implementation, and evaluative analysis, done continuously to determine the effectiveness of the planned activities. Evaluating the entire pilot implementation was executed through in-depth interviews and focus group discussions (FGDs). These were then used as analytical support to revise activities and remodel training modules.

Selection of participants

The study used passive snowballing technique to recruit participants. In this method, the researchers did not obtain identities/contact information of potential participants. Instead, the researchers tapped the City Social Welfare of Bislig City to recruit the potential participants within their network using the research's recruitment inclusion guidelines. The potential participants then directly contacted the researchers for more information if they were interested. The reason for this is to protect the potential participant's identity/confidentiality.

With this strategy, ten non-institutionalized GL (five gays and five lesbians, predominantly 'who came out') ages 60 and above, and ten heterosexual geriatric nurses (five males and five females) volunteered. Nurses were selected because of their particular experience caring for an elderly G.L. and identified self as exclusively heterosexual). All participants were based in Bislig City in the province of Surigao del Sur, Philippines.

Table 1. *Profile of Participants*

	Sexual Orientation	Age	Occupation
P1	Lesbian	63	Driver
P2	Lesbian	64	Laborer
P3	Lesbian	62	Part-time Teacher
P4	Gay	65	Beautician
P5	Lesbian	64	Pensioner
P6	Gay	67	Retired Teacher
P7	Lesbian	63	Vendor
P8	Gay	61	Government Employee
P9	Gay	65	Unemployed
P10	Gay	62	Retired Banker

	Sexual Orientation	Age	Length of Experience
N1	Male	30	2 years
N2	Male	29	5 years
N3	Female	44	8 years
N4	Female	30	4 years
N5	Male	27	3 years
N6	Male	45	8 years
N7	Female	26	2 years
N8	Male	32	3 years
N9	Female	33	4 years
N10	Female	32	5 years

Legend: P – G.L. participant(s); N – Nurse participant(s)

Data Collection

This study used two phases to collect data.

Phase one: Development of hub's activities and training module

Data were gathered through a plenary FGD. It was a critical first step in developing the care hub since there was no Philippine-based literature to serve as a model for starting it. It enabled the G.L. participants to define their current situation and its meaning as they and the nurses shared experiences and reflected on past incidences in healthcare as patients and care providers, respectively. All activities and the program's name were extracted from the initial assessment when asked about their expectations of a gay-friendly care hub.

Consultative meetings were conducted before finalizing the pilot program's activities and training module. The first author developed the initial set of activities based on what appeared to be significant and consistent aspects during the FGD and supported by published literature. Once drafted, the training module was made. The module involved various instruments, including brochures, slides, videos, booklets, posters, and questionnaires. The research team reviewed and pre-tested these, which comprised three academicians, four clinicians, four advocates, a researcher, a social welfare specialist, and two local government officials. Finally, a care specialist in gerontology was hired to validate and scrutinize the final draft of the model pilot project.

Phase two: Implementation of the hub and its module

After the model pilot project was finalized, the care hub was organized. This was intended as a shelter for the older G.L.s and served as a training facility for professional nurses. Moreover, this was conceptualized to improve the caring strategies parallel to the care needs for this specific age group. This was piloted for 32 days in the Barangay Mangagoy Senior Citizens Shelter.

Random in-depth interviews and day-to-day observations followed by weekly FGDs were utilized. Reports were done before, during, and after every post-conference in the implementation phase of the study. Audio and video materials, minutes of meetings, respondents' feedback on activities, and recorded dialogues supplemented the reports and added details and substance to the data collected. The technical working group conducted regular post conferences to discuss and reflect on their observations, and the participants' comments were shared with the hired care specialist. This expert also acted as the project supervisor and process evaluator.

Open-ended questions followed by probing questions were used in both in-depth interviews and FGDs. Both guide questions were discussed between the research team and a hired care specialist before being performed. Expectations, contents, and types of activities, competency assessment, policies, experiences, and feedbacks were parts of the core context of the discussions. The interviews with older G.L.s and the focus groups among trained nurses were audio-recorded and transcribed verbatim. The duration of the data gathering sessions lasted not over 60 minutes.

Observations were done allowing the researcher to monitor the nurses and the nursed older G.L.s' interactions as these could not be captured from interviews and FGDs. The participants were keenly observed on their individual responses, gestures, and overall behaviors. This happened during the project meetings and prior or actual nurse-client care hub activity sessions.

Data Analysis

Analysis was accomplished alongside data collection and through an iterative process. Textual data were coded, categorized, and synthesized manually using Mayring's Qualitative Content Analysis (QCA). In this analytic approach, the central tool is its system of categories, where every unit of the analysis must be coded and allocated to a system of categories. Content coding techniques were based on meaningful segments and patterns (Mayring, 2014). These were divided into macro-categories and subcategories following a tree-chart or matrix. The macro-categories referred to the main themes that were included in the interview guide. The subcategories were the direct results from the interviewees' thoughts.

Data analysis was carried out by the first author and audited by the hired gerontology specialist, who was also the project supervisor. For each interview, the author carried out the steps of content analysis by Mayring, followed by cross-case analysis, while developing the emerging themes was done separately. The thematic analysis began with open coding of the transcripts, and the overarching thematic codes were discussed. The participants' accounts were meticulously observed to ensure that the analysis was grounded on actual collected data. Summaries that contained brief descriptions were attached to substantiate the codes.

Identified parts of the interviews with emerging themes and meaningful patterns, as agreed by the researchers, were included. The authors also added unique phrases from the interviewees enhancing the richness of thematic coding. At first, both authors independently created macro-category themes based on the individual thematic coding for each case. This was followed by a series of meetings to discuss and reflect on the codes and macro-categories throughout the analysis process, thereby, increasing the level of trustworthiness. The macro-category themes identified by researchers were then combined. These became the bases of the search for cross-case, sub-category themes.

Before coding was finalized, two independent referees were hired to ensure congruence and concreteness of the overall data management process. It included cross-checking between macro-category themes, sub-category themes, and the transcripts. To further enhance the rigor of the analysis, other members of the research team conducted an audit trail of the initial findings. Last, a linguist was consulted when complexities requiring immediate language intervention occurred.

Limitation of the Study

The participating older G.L.s in this study identified themselves as such based on sexual orientation as gay or lesbian. Given the limited representatives, experiences and issues in nursing care faced by senior bisexuals and transgender people were excluded from the current study's analysis. The G.L.s were identified through contact with key informants from the local offices of the senior citizens' association. Demographic data, other than age, occupation, and sexual orientation among these older persons, were not collected since the study tried to understand their respective meanings of care and inclusivity care, which will then be used to develop the care hub.

Ethical Consideration

The protocols for this study were reviewed and approved by the City Social Welfare Development Office of Bislig City before the pilot project started. The principles set by the National Ethical Guidelines for Health Research of the Philippines (2011) were followed. Before data collection, invitation letters were sent to each participant enclosed with research consent reemphasizing their rights as respondents of the study. Questions from the participants were answered and clarified, and the settings for the interview were selected per participants' preferences and convenience. Pseudonyms and special coding were assigned to de-identify the respondents for confidentiality and avoid potential risk.

Findings

This section summarizes the descriptions of the current nursing care situation for senior gays and lesbians, the meaning of their care needs, and the center's tailored approaches and services to meet their care needs.

The Situation: Knowledge Gaps in the Philippine Nursing Curriculum

The Philippine nursing curriculum has specific knowledge gaps in caring for senior G.L.s. A review of the old and the new CMOs showed that both did not have structured teaching-learning strategies of gender-care sensitivity. In the absence of these critical guidelines, providers based their care on personal childhood experiences (N1, N3, N7, N8) and exposures (N2, N5). Their attitudes in caring for older gays and lesbians may have been based on either gender-orientation preference where male nurses showed negative attitudes for gays, or female nurses had the same negative attitudes for lesbians (N1, N4, N6, P3, P4). Another attitude may have been based on relatedness, wherein nurses showed a positive attitude when the patient was related to or known (N1, N3, P2, P7, P8).

> *'Nothing special, what should we expect. Never was it taught. Remember, we don't have nursing books that specify an approach for them.' (N6, male nurse)*

> *'I felt that the female nurses were afraid of me. There were instances when they were uneasy or even unfriendly with me.' (P2, lesbian patient)*

Several nurses believed that care provided for older G.L.s must be heteronormative or *gender-care blinded*, where care needs between them and their heterosexual counterparts do not differ and gender-orientation should not be the primary focus (N1, N2, N5, N8). Three nurses assumed (assumptive or *gender-care tampering*) that senior gays should be provided with a feminine-care-type and masculine-care approach for lesbians (N1, N4, N7). One nurse said that caring should be selective *(gender-care swing)*, quality care is appropriate for influential or wealthy (N6). One out of the ten nurses verbalized that a carer must sensitively acknowledge gender differences *(gender-care sensible)* (N3).

> *'It depends on the nurse's discretion. To be safe, I usually provide female-type care to a gay patient, and male-type care to a lesbian. (N1, male nurse)*

Nurse participants have difficulty in providing essential care for these elderly patients because of limited knowledge (N5, N6, N8). First, the fitting care: the concept of sensitivity in nursing is broad and not clearly defined (N1, N2, N4, N5, N7). The nurses emphasized that no literature guides prioritizing the older G.L.s' needs (N2, N4). Second, the fitting approach: the prefixes that can be used in addressing them as nurses initiate the nurse-patient interaction (N2, N5, N8). Last, the fitting communication: language competency in 'gay-lingo' (N6).

> *'Why do male nurses treat us as males, when we are still females?' (P2, lesbian patient)*

> *'It is really difficult to provide essential care for these patients when in fact I really don't understand their real needs, their "gay – lingo", and the right approach for them.' (N6, male nurse)*

The absence of specific guidelines in caring for older G.L.s threatens the care outcomes for both the care providers and the cared for. This can lead to psychological distress (P3, P4) care

mistrust (P2, P3), and care dissatisfaction (P6, P8) on the patients causing immediate care termination or going home against medical advice.

> *'I need comfort but I felt belittled. I was emotionally disturbed. With no second thoughts, I left the hospital even against medical advice.' (P4, gay patient)*

> *'I believe that social and personal status matter. Some nurses are just good to those they know.' (P3, lesbian patient)*

Nurses, too, can be affected, leading to psychological distress (N2, N3) and trauma (N1, N5) when they hear sarcastic and demeaning statements, especially from aggressive patients dissatisfied with the care they received.

> *'I am hesitant in caring for them because they say harsh words that insult me.' (N1, male nurse)*

Unspoken Meaning of Care Needs of Filipino Gay and Lesbian Older Persons

The identified needs of the older G.L.s are similar to the general population, but their unique definition of every need must be sensitively heard, understood, and met. Their identified needs are as follows: health needs, financial needs, support needs, legal and protection needs, recreational needs, spiritual needs, and trust needs.

Health Needs

Among the elderly respondents, gays were more health-conscious in seeking preventive care than lesbians (P2, P3, P6). The older lesbians said that they were diagnosed as having cardiovascular diseases (P7, P8), diabetes mellitus (P6, P9), osteoporosis (P8), and breast/cervical cancers (P1, P3), while the gays verbalized that they were diagnosed with hypertension (P2, P3), HIV+ (P9), and anal/prostate cancers (P4, P5).

Almost half of the older G.L.s in this study were active smokers (P1, P6, P7, P8) and occasional drinkers (P2, P3, P7). These lifestyle practices contribute to their overall poor health outcomes compared to the rest of the aged population.

> *'Been an alcoholic since I left home at age 15. And, I was diagnosed with HIV+ in my late 50s.' (P9, gay patient)*

Financial Needs

Three of the gay respondents were forced to quit their jobs when they were younger to care for their sickly aging parents (P1, P3, P9) or young nieces/nephews (P6, P8). Meanwhile, two financially supported their younger siblings in school (P2, P7). In turn, five of them could not build up their savings. Three of the gays were financially stable compared to the lesbian participants. Two gay respondents were college teachers (P1, P3), and another owned a beauty salon (P4). In contrast, a lesbian respondent was forced to retire as a security guard because of her age and had to work as a low-paid laborer in a market (P7). One of the lesbian participants verbalized her difficulty in finding a job as work opportunities for aged lesbians is lower compared to senior gays (P2). Additionally, their single status exacerbated their poverty as they did not have children to support them in their old age; thus, they rely on charity for their necessities, including drug maintenance (P1, P2, P7, P10).

Support Needs

Despite sacrifices for their respective biological family, the G.L.s had little support, and two were rejected by their siblings/parents (P3, P7). Filipino society is still largely conservative. Acceptance of a G.L. family member remains difficult because of the perception that this may bring shame to the family. Some of them either lived alone and were unsure who would care for them (P2, P3), stayed with friends/other older persons in a sibling-like relationship (P1, P8, P9), or depended on the help of strangers (P10).

> *'Acceptance should start at home… our homophobic family must understand this.' (P4, gay patient)*

Older G.L.s in this study have a limited social circle, unlike the younger LGBTQI+. They dissociate themselves from the existing community-based elderly association (P7). For them, invisibility and silence were their only options of protection from homophobic victimization and discrimination (P4, P7).

> *'Our world [older G.L.s] and their world [heterosexual counterparts] are like water and oil. We never mix.' (P7, lesbian patient)*

The question of same-sex marriage yielded varied viewpoints. Half of them have not considered it due to trauma from past abusive relationships (P1, P8), age reasons (P9), the choice to be single (P7), and financial instability (P10). The other half was in a relationship with live-in partners for more than-five years. For them, the legalization of same-sex marriage would provide the opportunity to be officially recognized as a couple (P2, P4), express intimacy (P5), and become eligible for social security benefits (P6).

Legal and Protection Needs

The problem of same-sex partnership abuse exists in this cohort, particularly in relationships between older G.L.s and younger partners who financially exploited, blackmailed, and physically/verbally abused them (P1, P8). Aside from this, the older G.L.s also experienced poly-victimization from their family's

non-acceptance (P3, P7), sibling rivalry (P4), discrimination (P2), and poor standards of healthcare (P2, P8, P9). One of the older G.L.s said he did not know where to go (P10).

'In my bruises and deep wounds, who will protect me? Nobody cares. I don't know where to go. We have no space in the Office of the Senior Citizens Association of the city.' (P1, lesbian patient)

Recreational Needs

Besides the rejection from their families, the internalized homophobia and limited funds contributed to their preference to spend most of their time at their abode (P3, P9). Two of the G.L. respondents expressed their need for a fun recreational program that considers their current condition (P3, P4). Despite leisure activities planned by local offices for the general elderly population, none was tailored fit for the G.L.s (P5).

Spiritual Needs

In a predominantly Roman Catholic country like the Philippines, homosexuality is taboo. Participants believed that churches should stop 'homosexual-church-phobia' (P8) and stop giving homonegative sermons (P6). Instead, it should start to be spiritually welcoming as they too have spiritual needs (P3, P4) and are also searching for hope in the remaining years of their lives (P9).

'We're created by God, and churches cannot deny that.' (P9, gay patient)

Trust Needs

Trust is a vital component of the nurse-patient relationship, and two G.L.s expected their caregivers to provide them with emotional support, yet they verbalized their anxiety over possible discriminatory care (P3, P4). One was anxious about the care providers' naiveté in meeting their care needs or possibly harboring hidden gender biases (P5).

Caring Approach Needs

When older G.L.s were asked about the type of care they needed, they verbalized that they were looking for a care type that is comfortably welcoming and trusting from the beginning to the end. More important to them than alleviating physical complaints is a caring strategy with a human touch.

The care can be summarized in the acronym *HUMAN.* First, (*H*) humanely accepting and welcoming, where they can be themselves, freely and safely express their sexuality as an individual/couple, and where nurses are non-judgmental, non-malicious, respectful, do not discriminate and say colored jokes, and use gender-neutral language (P1, P2, P3, P4). Second, (*U*) understand the meaning of inclusivity, gender-care needs, and quality care (P1, P5, P7, P8). Third, (*M*) maintain privacy/preserve dignity: create a trusting environment that can protect their being, physicality, and intimacy (P3, P6). Fourth, (*A*) attentively and sensitively listen to understand their unique needs/feelings as an individual, provide quality person-centered nursing and involve them in the care planning (P2, P4, P7). Last, (*N*) nurturing their inner being and offer a positive interfaith building that is accepting and affirming of their sexuality (P2, P9).

'All I need is-care that does not discriminate, sincere, can understand and respect me for who and what I am. I am also human, created by God with equal rights and similar needs for care, love and sensitivity.' (P2, lesbian patient).

Five out of the ten respondents said they do not want to be cared for by LGBTIQ+ nurses. In their experience, the LGBTIQ+ nurses, especially the younger ones, are more homophobic than the heterosexual nurses (P2, P3, P5, P7, P9). The senior lesbians want to be cared for by female nurses as they have feminine needs (P2, P3); while gender preference was not an issue for the gay participants (P4, P6).

'My nurse was also gay, but he had no empathy for me.' (P9, gay patient)

Addressing Care Needs for Filipino Senior Gays and Lesbians

'HUMAN-istic care' as a caring approach was the overarching concept generated from the assessment phase of the study. Participants believed that the coined term encompasses the concept of inclusive elder care. They wanted to capitalize on the importance of the 'HUMAN' concept in contrast to the traditional gerontological nursing because they believed it was the missing element that was also often misunderstood, causing gender care disparities. Moreover, they also verbalized that if this element will be incorporated into the future care hub, the hub will be transformed into a *'healing nest'* (P3, P4). In this place, holistic needs, not only the basics, are addressed, and nurse-patient interaction is meaningful (P2).

'More than the basic needs that anyone can imagine, we are also persons who need care as a patient and as human beings with rights.' (P2, lesbian patient)

This new caring approach was the basis for developing the training module of the pilot project. The primary authors for the service structure in the training module were the care recipients and the care providers.

The care hub was intentionally crafted with four mechanisms, namely (1) Rescue, (2) Support, (3) Refer, and (4) Care. These mechanisms were integrated from the G.L.s identified

interrelated care requisites and directed the formulation of a clear service pathway.

The first mechanism, *rescue,* provided temporary shelter for elderly G.L.s abused in their homes. A 24/7 hotline was activated to respond to emergencies like first aid or transportation to a hospital. A trauma care package was prepared that included materials for wound care, counseling, legal support, and post-trauma rehabilitation.

The second mechanism, the *support,* provided extensive training courses for nurses and caregiver volunteers in handling older gays and lesbians. The module used was generated from the assessment of participants and refined by a multi-professional workgroup in consultative meetings that considered findings retrieved from the literature review. A gender care nursing strategy was also developed and integrated with the training module. Family members or guardians were included in the hub's activities, a hallmark and salient project component. This enhanced their participation, bolstered awareness and understanding of their ethical and caring responsibilities toward older gays and lesbians in the family. This created a positive attitude in the older G.L.s' concept of aging gracefully when they saw family members participating in selected hub activities.

> *'Seeing my nephew actively join the hub's sessions made me happy and gave me hope for the future.' (P10, gay patient)*

Refer, the third mechanism of the hub was included to create a potential network and possible funding sources from diverse agencies, ensuring that the needs of this specific elderly group were supported and addressed. This was managed by a volunteer social worker who assessed their financial, psychological, legal, and spiritual needs. The G.L.s were referred to appropriate agencies and local government offices. The hub was also working closely with an HIV treatment clinic where identified HIV+ older G.L.s were referred for treatment and monitoring.

Care, the fourth mechanism, provided care services in either center-based or homecare settings. Nursing services were implemented according to how they defined the care. To ensure sensitivity, some approaches were added in operation like (a) gender-neutral approach; patients were called according to "their name of choice" without prefixes (unless requested); (b) special sections were added to the information sheet: sexuality (gender stratification) and types of relationship (living with others); and (c) care provision according to age cohort (young-old to oldest-old).

At first, the older G.L.s, volunteer care providers, and nurses expressed discomfort and varied 'what ifs' prior to the project's implementation at first. For the elderly G.L.s, their historical experience of discrimination in life made them hyper-vigilant and hesitant to speak out during the nurse-patient interactions. On the other hand, the nurses verbalized their doubts, the by-product of their lack of knowledge and understanding of the term 'sensitivity' which is vaguely defined in nursing. As a result, defensiveness and distancing were shared between the carers and the cared during the initial implementation phase. A reorientation/open forum was purposely conducted to neutralize the tension. This was followed by setting boundaries specifying the role of the nurse, defining the nurse-patient relationship, and clarification of daily expected outcome.

In depth-interviews and FGDs were conducted during post-conferences. In a separate interview, both the senior G.L.s and trained nurses were asked to describe their experiences in the hub. Their inputs were incorporated updating and revising the module based on daily lessons learned. Self-reflections and daily informal dialogues were also used as elements in the evaluation process. Some participants reported that the training inside the hub was more than an experience and affected their lives (N1, N3, N6). The project turned out to be an eye-opener for the trained professionals and student nurses, helping them reshape caring practices and become advocates for the provision of equitable gender-sensitive care equitable. Applying the new knowledge care approach yielded high patient satisfaction and overwhelming positive appreciation from the nurses reported during the evaluation phase. To ensure sustainability, ongoing monitoring and evaluation of the project were conducted to confirm that the needs of the G.L.s were heard, understood, and met. Analyses of the implemented project became the basis for further internal and external consultations, and plans were discussed for possible replication in the nearby municipalities.

> *'I have never been to a place like this before where I feel loved and respected despite my gender orientation.' (P9, gay patient)*
>
> *'This is the start of a meaningful nurse-patient relationship where we can work together in resolving this unspoken gender care disparity among our older gay and lesbian constituents.' (N1, male nurse)*

The interactive sharing of experiences between the care recipients, the care providers, and the research team helped to understand better the concept of care appropriate for the older G.L.s' needs. The new caring knowledge, HUMAN, helped correct the nursing strategy mismatch in gerontology nursing.

Discussion

The findings of the study highlight the dearth of knowledge on the needs of older G.L.s' in nursing education and literature not only in the Philippines. Other studies revealed that nurses lack specific knowledge, skills, and values in identifying and caring for

the needs of older G.L.s as this was not included in their education (Eliason, Dibble, and DeJoseph, 2010; Fenge and Hicks, 2011; Frediksen-Goldsen et al., 2014). There is uncertainty in the care providers' approach towards gays and lesbians (Fenge & Hicks, 2011; Mitchel, 2016). There is also difficulty implementing gender-based care because of limitations in their nursing education and personal biases (Fenge and Hicks, 2011; Frediksen-Goldsen et al., 2014). This situation is compounded by the scarcity of researches addressing the needs and concerns of older gays and lesbians that could guide practitioners in meaningfully caring for this cohort (Montilla, 2008; Badana and Andel 2018).

Lim and Berstein (2012) pointed out that nurses' beliefs about older G.L.s' care needs reflect their societal attitudes. This belief influenced by their societal attitude causes a struggle to reconcile their reservations with professional responsibilities in providing quality care (Kentlyn, 2011; Lim and Pace, 2013). Their non-recognition of the older G.L.s' sexuality in their nursing care planning often leads to inappropriate care service deliveries and, worse, discriminative gender care (Fenge and Hicks, 2011). All these have contributed to this cohort's discomfort and negative experiences in the healthcare milieu, raising serious bioethical concerns that contribute to the erosion of a sense of safety and trust in the healthcare system (Harbin, Beagan, and Goldberg, 2012). As Nadal and Corpus (2012) disclosed, they have developed distrust towards healthcare providers having experienced discrimination in the past. Their lack of trust in caregivers results in negative consequences in the caring flow (Frediksen-Goldsen, 2015), affecting their ability to cooperate in the caring process (Choi & Meyer, 2016).

In several general population-based aging studies, older G.L.s had an overall higher risk of poor physical health, alcoholism, smoking substance abuse, nutrition deficiency, poor mental health such as depression, anxiety, and suicide (Brotman et al., 2007, Guevera, 2016; Frediksen-Goldsen et al. 2014; Cohen & Cribbs, 2017; Cannon, et al., 2017). This may be due to their mistrust in the current healthcare system (Cannon et al., 2017). The rate of STDs, including HIV/AIDS is now increasing among older G.L.s due to having had multiple partners in the past (Frediksen-Goldsen et al., 2015). Despite this, there is still a lack of sexual and reproductive health support programs particularly on HIV/AIDS for senior LGBTIQ+ (Choi & Meyer, 2016).

Another concern of the older Filipino gays and lesbians is their financial needs. Usually, they could not invest at their younger age because of the career and self-sacrifices for their families (Guevara 2016). Since same-sex marriage is illegal in the country, they could not access benefits from life insurances from their deceased live-in partners (Choi & Meyer, 2016).

As Tan (2012) pointed out, older G.L.s are voiceless regarding their rights. They are victimized by ageism and by homophobia, and various forms of abuse (Frediksen-Goldsen et al., 2014). They are not safe in their own houses because they also experience domestic violence in the form of battery, verbal abuse, and worse, being thrown out from home (Nadal and Corpus, 2012; Guevara, 2016). Older gays and lesbians are forced to have limited social circles and dissociate themselves from others, even from elderly community groups. (Martos, Wilson and Meyer, 2017). Many of them are victims of sexual orientation attacks but chose not to report nor seek legal help (Guevara, 2016; Choi & Meyer, 2016; Westwood, 2018), believing that there are no laws related to their protection (Tan, 2012; Guevara, 2016). This caused their further distancing from other people (Choi & Meyer, 2016) without recognizing that the more they disengage themselves from others, the higher the risk of becoming socially isolated, lonely, depressed, and developing mental problems (Hughes, 2009; Frediksen-Goldsen et al., 2014; Guevara, 2016).

The discrimination older G.L.s' experience is also manifested in the spiritual realm. One study showed that some religious groups asked the G.L.s to leave the church (Beagan & Hattie, 2015). Conflicts between sexuality and religious teachings can significantly damage the psychological and emotional well-being of older gays and lesbians (Ibid, 2015), and condemnation from church members marginalizes LGBTIQ+ in faith communities (Frediksen-Goldsen et al., 2014).

As stated earlier, the needs that the older gay and lesbian respondents identified from health, financial, support, legal and protection, recreational, spiritual and trust are similar to their heterosexual counterparts and the general population. But, the pivotal difference lies within their unique and distinctive definition of care needs and how every need must be sensitively heard, understood and met.

There are avenues where G.L.s' needs can be incorporated into the current nursing curriculum. Describing and explaining the phenomenon in this participatory action research provides a clear although partial LGBT cultural competency for gerontology nurses. The Gay Care Center and its discovered care approach appear significant in the curriculum framework development of the pilot project implementation as a gender-care mismatch and silencing care-discrimination are recognized but remain largely neglected.

Its hub development went far beyond merely understanding the care needs and providing care for older gays and lesbians. The hub served both as a temporary service center and a home for the older G.L.s where they could safely and freely express their sexuality. It also revealed the mandatory element of a meaningful relationship of interconnectedness between the cared client(s), the nurse(s), and the care center. Nurses who were part of the project learned that they needed to understand this group's meaning and care needs as persons with HUMAN needs. As

carers, they should understand the importance of allowing the care recipients to speak out and decide for themselves. The incongruence of care occurred when they failed to listen with sensitivity or insisted on their heteronormative care strategy. Therefore, nurses must understand the importance of sensitivity and confidentiality and demonstrate these in their practice (Brotman, 2007; Barrett, et al., 2014). To deliver this, they must recognize their personal biases (Cannon, et al., 2017). The care recipients, older G.L.s must be assertive and express their caring needs to be heard. It is essential that both sides keenly listen to each other's viewpoints, mindful that each side's attitudes and behaviors are consistent with their definition of their respective role in the caring dynamism inside the hub.

The care recipients viewed the hub specifically as a *'healing nest'* where both they and the nurses could *HUMAN*-istically, safely, and meaningfully interact. Thus, the intention of addressing the care mismatch and ending the disparities within the caring circle of the nursed, the nurses, and the hub, equally important components, contributed to a meaningful flow of connectedness.

Conclusion

The richness of the method used does not discount the other care needs of G.L.s that must be explored and discovered. In HUMANistic caring, it is pivotal to understand the meaning of the concept of care as perceived by older G.L.s. When accomplished, culture care competency is enhanced. Despite the absence of guidelines and available resources for gender care, something of value can be done as initial steps to respond coherently and tactfully to the G.L.s caring needs as exemplified by the *'Gay Care Center'* when people are open and willing to change for the better.

Integrating and strengthening gender care strategies in the nursing curriculum can provide clear guidance and direction to nurses caring for this cohort. This will cause the quality of care provided to Filipino gay and lesbian older persons, one that is safe, respectful, humane, and just. Indeed, care practices can only be effective, satisfying, and holistic when the meaning of needs from the recipients' perspective is sensitively listened to, understood, and met.

Recommendation

With the growing number of Filipino LGBT, especially among older persons, nurses must recognize their expanding role as health equity advocates to appropriately respond to the unique needs of this population group. Many of them experience disparities and discrimination when accessing health care services. Perhaps, because of this, gay and lesbian older persons delay seeking care or, worst, avoid treatment. Hence, nurses should be prepared to provide settings and services that are culturally congruent, competent, safe, inclusive, and sensitive. Furthermore, nurses need to change their attitudes and biases to meet the caring demand holistically and respond to their calls for greater inclusivity. Therefore, including gender-care sensitivity content in the basic nursing curriculum is time to educate and raise nurses' competency in addressing the needs of one of the diverse population groups.

The newly identified care practice and needs of the Filipino gay and lesbian older persons, in this study, are only scratching the surface from among real macro-needs. It is crucial to conduct further studies on a bigger scale to meaningfully understand the holistic context of needs among this population. Nevertheless, the findings can be utilized in crafting evidence-based guidelines to address the shortage of materials for this specific aggregate in nursing education. In addition, much more still needs to be done to make the older gays and lesbians' needs visible. On top of the rigorous studies recommended to reinforce the findings of this pilot project, the challenge of harnessing this initiative to its optimum level and getting the policymakers' commitment to support and embrace it remains a priority.

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Declaration of Interest

The author declares no competing interest.