

LGBTQ+ Knowledge, Attitudes and Practice Among Medical Students in India: A Comprehensive Review

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ABSTRACT

The lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) community in India has historically faced deep-seated discrimination, stigma, and marginalization. This prejudice has led to significant disparities in health outcomes for LGBTQIA+ individuals, manifesting in numerous ways. These include limited access to healthcare services, poorer mental and physical health compared to the general population, and an increased vulnerability to violence and harassment. Despite recent progress in legal and social spheres, such as the decriminalization of homosexuality and the recognition of transgender rights, significant challenges persist. LGBTQIA+ individuals still encounter discrimination and a lack of understanding from healthcare providers, creating barriers to accessing appropriate and sensitive care. This negatively impacts their ability to seek help for health issues and can lead to delayed diagnoses, inadequate treatment, and overall poorer health outcomes. Medical education plays a crucial role in shaping the attitudes and knowledge of future healthcare providers. However, studies reveal a critical gap in medical curriculum in India. Training often lacks comprehensive information on LGBTQIA+ health issues, including the specific physical and mental health needs of this community, culturally sensitive communication strategies, and an understanding of the social determinants of health that uniquely affect LGBTQIA+ individuals. This gap in education perpetuates stigma and discrimination within the healthcare system, further hindering the provision of quality, equitable healthcare to LGBTQIA+ individuals. This review article aims to thoroughly examine the current state of knowledge and attitudes regarding the LGBTQIA+ community among medical students in India. It will analyse the findings of various studies to assess existing knowledge levels and prevalent attitudes, both positive and negative. Additionally, it will evaluate the impact of education and sensitization programs on medical students, identifying effective strategies for promoting inclusivity. Finally, the article will propose concrete recommendations for enhancing LGBTQIA+ awareness and sensitivity within medical education to foster a more inclusive and competent healthcare environment for all.

Introduction

The LGBTQIA+ community in India encompasses individuals with diverse sexual orientations, gender identities, and expressions. This historically marginalized community has faced systemic discrimination, stigma, and social exclusion, leading to significant health disparities. These disparities include limited access to healthcare, poorer mental and physical health outcomes, and increased vulnerability to violence and harassment. Hungarian Journalist Karoly Maria Benkert (K.M. Kertbeny) coined the term “Homosexual; Heterosexual; Monosexual; Heterogenit” in 1868(1). Before 19060s the term gay was used to denote carefree attitude but later the term “gay” became popular instead of the medically associated term “homosexual”. Around 1969 “Stonewall generation” (the term arrived from Stonewall Inn, a bar in New York city where LGBT liberation riots happened) dint see being gay as shameful and its the beginning of gay rights movement in history(2). The term “lesbian” originated from Greek island of lesbos(3). Though “gay” has been the umbrella term, the birth of bisexual, transgender and queer movements lead to LGBTQIA+ as years pass by. In Indian context there has been numerous ancient scriptures that has recognised LGBT but many historians have disagreements over these. In 1860 British declared sexual activities against order of nature including homosexual activities illegal under section 377 IPC. In 1977 Shakuntala Devi through her book called for “full and complete acceptance and not tolerance and sympathy” towards homosexuality. Though in Indian context the use of term “gay” started in 1960s with people who travelled to western countries the term become popular only after setting up of Bombay dost, first LGBT magazine in India by Ashok Row Kavi, a LGBT rights activist(4). In 1994 transgenders were legally granted voting rights in India but issuing voters id caught up in

the gender problem with most were refused id for the gender they preferred(5). The AIDS Bhedbhav Virodhi Andolan (ABVA) filed case against section 377 but was dismissed(6). In 2009 Delhi high court found section 377 is in direct violation of fundamental rights(7). In 2014 Supreme court of India granted third gender rights to transgender community(8). In the same year Indian Psychiatric society spoke against treating homosexuality as a disease(9) while its American counterpart removed homosexuality as a mental disorder from its Diagnostics and Statistical Manual (DSM) in 1973(10) even before World health organisation which removed homosexuality from International classification of diseases (ICD) only in 1990(11). In 2017 supreme court of India allowed safe expression of sexual orientation by LGBTQ but homosexual acts remained still criminalised(12). Finally in 2018 supreme court struck down the clause that made homosexual acts criminal. The then Chief Justice of India Dipak Misra on delivering the landmark judgement said , “The LGBTQ community has the same fundamental rights as citizens. The identity of a person is very important and we have to vanquish prejudice, embrace inclusion and ensure equal rights”(13). In 2019 “Transgender persons bill” was passed(14) and it prohibited discrimination against them in employment, education, healthcare, and other services but it was rejected by queer community as it requested each person to be recognized as transgender by a certificate issued by district magistrate after providing proof of sex reassignment(15). Also the law mainly deals with transwomen and left intersex, queer, transmen. In 2020 the bill was revised to include free surgeries for sex reassignment surgeries from state run hospitals and will also bear the cost of schooling and accommodation(16). However, these changes have not fully translated into improved healthcare experiences for LGBTQIA+ individuals. Many still face discrimination and lack of understanding from healthcare providers, hindering their ability to seek and receive appropriate care. Medical education plays a crucial role in shaping the attitudes and knowledge of future healthcare providers. However, studies have shown that medical curriculum in India often lack comprehensive information and training on LGBTQIA+ health issues. This gap in education can perpetuate stigma and discrimination, hindering the provision of quality healthcare to LGBTQIA+ individuals. The term "LGBTQIA+" is an evolving acronym that encompasses a wide range of sexual and gender minorities. It is crucial to recognize that this community is not a monolith and that individuals within it have diverse experiences and needs.

Basics of LGBTQIA+ and Gender

The lack of proper health care for LGBTQIA+ community stems from the lack of understanding the concepts of biological sex and social sex which later termed as gender. Psychiatry professor Robert J Stoller coined the term “Gender identity” in 1964(17). Gender identity is something a person wants to be identified with. Gender expression is a person’s behaviour mannerisms that is associated with socially constructed genders either masculinity or femininity. In a simple world a person’s sexual identity is same as biological sex which is assigned to an infant at the time of birth by examining the external genitalia or masculine or feminine mannerisms they express. But this may not be true always. While their gender expression point towards a particular gender role that may not reflect their gender identity. Psychologist John Money who popularised the term ‘gender identity’ believed that a person’s gender identity was determined by both biological factors and upbringing which is in stark contrast to the earlier belief that sexual identity of a person stems from only biological factors(18). Definitions of common terms used among LGBTQIA+ community:

Lesbian: A woman who endures physical or romantic or emotional attraction towards other woman.

Gay: People who endures physical or emotional attraction towards other people of same sex.

Bisexual: Individuals who experience attraction towards same gender and to those of other gender.

Transgender: Individuals whose gender identity is incongruent with their assigned sex at birth.

Queer: An umbrella term often used to describe individuals whose sexual orientation is not exclusively heterosexual. These people believe the terms gay, lesbian or bisexual are too limiting for them and it don’t apply to them.

Intersex: Individuals born with reproductive or sexual anatomy or chromosomal pattern that can’t be attributed to typical male or female. Though intersex people can also identify as transgenders, the two terms are separate and not to be confused with.

Asexual: Individuals who experience varying degrees of attraction towards different genders.

+: Signifies that the acronym is not exhaustive and includes other gender identities and sexual orientations. There are numerous other terms that keeps on expanding and it's not in the scope of this article to explain them(19).

Health Disparities Faced by the LGBTQIA+ Community:

Though various laws have transformed the legal playground of LGBTQIA+ the health care needs of the community has been unmet due to social stigma and lack of training among medical professionals. In India religion and cultural practices plays a major role. The stigma created by these factors not only acts as a barrier for accessing the health care needs but also prevents further research into this field. In social context members of this community faces physical and sexual abuse, improper care. For many revealing their identity to a health care provider has been a problem as they are either discriminated or their identity has been neglected. People who are visibly queer faces disparagement from their own family members and society. This makes them to hide their identity which in turn prevents them from accessing health care tailored for their needs. This whole scenario push them into a depressed mental state followed by anxiety, substance abuse, suicidal thoughts. Even if some health care providers are eager to change the overall approach towards LGBTQIA+ health care, they are rendered helpless because of lack of knowledge. Longna et al. (2024) explored the perceived stress and coping strategies among the homosexual and bisexual community in northeast India and found that this population is likely to experience higher levels of stress, highlighting the need for more research in this field(20). Mishra (2022) conducted a psychological exploration of the LGBT community and found that discrimination, acceptance, violence, mental health issues, and substance abuse are significant challenges faced by this community(21). Manaktala (2021) further explored the causes of depression and anxiety in the LGBTQIA+ community, emphasizing the need for greater understanding and support for this marginalized group(22). Kitts RL study had shown that most doctors wont associate suicidal thoughts and LGBTQ. Doctors also agreed that they believe they don't have enough knowledge on this subject in order to elicit proper sexual history that includes sexual orientation or gender identity from their sexually active adolescent patients(23). In 2022 Arora et al set out to study about discrimination against LGBTQIA+ community in hospital setting using human rights perspective. The study glaring revealed the policies followed in both government and trust hospitals regarding LGBTQ is either non-existent in case of government or inadequate in private setting. The study also found that hospitals run under religious trust avoided policies pertaining to LGBTQIA+(24).

Methodology:

Extensive research was carried out to find literatures related to the topic. Given the nature of the topic the availability of literature is limited. Articles from Journals based primarily on LGBTQ and original studies done in India and published in Scopus, PubMed, web of science Indexed journals were selected for review purposes. To have a complete understanding other literatures in notable journals, websites, literatures from other countries were also taken into account to broaden the view. Efforts were made to not dilute the source material with unscientific literatures. LGBT, LGBTQ, LGBTQIA, LGBTQIA+, homosexuality were used as search terms in finding the literatures. A manual verification of the articles were done. The articles were then screened with inclusion and exclusion criteria. Articles that involve medical students and LGBTQIA were included. Literatures that involve other health care workers were excluded. A standardised data collection form was used to extract data from these literatures. Accuracy of the data extracted were cross checked.

Knowledge and Attitude and Practice of Medical Students on LGBTQIA+:

Lack of knowledge among doctors in India can be attributed to the medical education in India which is not inclusive and rather treats all sexual orientation against order of nature as a disease which got recently struck down by Madras high court on whose direction National Medical Commission directed collages and authors to remove derogatory remarks on LGBTQIA+ from syllabus(25,26). The entire undergraduate curriculum is devoid of even basic concepts of gender. These medical students who are not properly trained how to address the problems faced by this community either neglects the problem or mistreat it. Several studies have investigated the knowledge and attitudes of medical students towards the LGBTQIA+ community in India. A study by Banwari et al. (2015) found that medical students and interns had inadequate knowledge about homosexuality, although they endorsed a neutral stance in their attitudes towards homosexuals(27). Mediboina et al. (2024) conducted a study with a larger sample size and found that medical students had satisfactory knowledge and a positive attitude towards the LGBTQ+ community . However, there were still misconceptions and areas where knowledge was lacking(28). Kar A et al study done in West Bengal revealed that even though more than 50% students said that homosexuality is an illness, more than 70% believed talking about homosexuality didn't embarrass them which is on the positive side(29). Nerli et al study showed that students knowledge about LGBT is adequate but that doesn't translate in attitudes towards them(30). Study done by Dr Mano Ranjitha revealed that female students are comfortable in communicating with LGBT persons than their

male counterparts(31–33). This result is further reinforced by a study done in Kerala by Fenn et al which also revealed that medical students have less prejudice towards LGBTQ community than Practicing doctors(34). Contrastingly among the teaching faculties in a medical college in southern India male faculties showed more favourable beliefs than female counterparts according to a study done by Gururaj et al(35). Study by Madhu Vamsi et al have shown that medical students have prejudice towards LGBTQIA+ community that stems from their socioeconomic background. Interestingly the students felt they need more awareness programmes and curriculum that is inclusive(36). A study done in Australia revealed that the prejudice increases with the person being religious(37). These studies highlight the variability in knowledge and attitudes among medical students in India. While almost all studies have shown positive attitudes and satisfactory knowledge some have indicated a lack of understanding and potential prejudice.

Impact of Education and Sensitization Programs:

Studies have shown that education and sensitization programs can positively influence the attitudes and knowledge of medical students towards the LGBTQIA+ community. For instance, a study by Salkind et al. (2019) demonstrated that a brief educational program on LGBT+ terminology and health significantly improved medical students' understanding and confidence in providing care to LGBT+ patients(38). Study done by Wahlen et al showed that a single 1 hour lecture on LGBTQIA+ have increased the students' knowledge and attitude towards LGBT members(39).

Curriculum Recommendations:

To address the gap in medical education, several recommendations have been proposed. Incorporate comprehensive content on LGBTQIA+ health needs, including physical and mental health disparities, social determinants of health, and culturally sensitive communication strategies. Integrate LGBTQIA+ health topics across different medical disciplines, rather than limiting it to specific modules or lectures. This will ensure that students understand the intersectionality of LGBTQIA+ identities and health concerns. Incorporate experiential learning opportunities, such as interactions with LGBTQIA+ patients and community members, to enhance students' understanding and empathy. Provide faculty development programs on LGBTQIA+ health to ensure that educators are equipped to deliver culturally sensitive and competent instruction. Regularly evaluate the effectiveness of LGBTQIA+ education and sensitization programs and monitor students' attitudes and knowledge to identify areas for improvement.

Discussion:

The studies reviewed in this article highlight the need for greater awareness and understanding of LGBTQIA+ health issues among medical students in India. While there have been some positive findings, there is still a significant gap in knowledge and potential for prejudice. Education and sensitization programs have been shown to be effective in improving attitudes and knowledge. However, there is a need for more comprehensive and integrated approaches to LGBTQIA+ education within medical curriculum. Several factors contribute to the health disparities faced by the LGBTQIA+ community in India. The stigma and discrimination experienced by LGBTQIA+ individuals can lead to social isolation, mental health issues, and reluctance to seek healthcare. Lack of knowledge and awareness among healthcare providers about the specific health needs of LGBTQIA+ individuals can result in inadequate or inappropriate care. Legal and policy barriers, such as the lack of recognition of same-sex relationships, can create challenges for LGBTQIA+ individuals in accessing healthcare and other essential services. Social and cultural norms that reinforce heteronormativity and gender binary can marginalize LGBTQIA+ individuals and contribute to their health disparities. To address the challenges faced by the LGBTQIA+ community in India, a multi-pronged approach is needed. Implement comprehensive education and sensitization programs for medical students and healthcare providers to enhance their knowledge, attitudes, and skills in providing culturally competent care to LGBTQIA+ individuals. Reform medical curriculum to include comprehensive content on LGBTQIA+ health needs, integrated across different medical disciplines. Advocate for policy changes that address the legal and policy barriers faced by LGBTQIA+ individuals in accessing healthcare and other essential services. Engage with LGBTQIA+ community organizations and leaders to ensure that healthcare services are culturally sensitive and responsive to the needs of the community. Conduct research to better understand the health disparities faced by the LGBTQIA+ community in India and to evaluate the effectiveness of interventions aimed at improving their health outcomes.

Conclusion:

Improving LGBTQIA+ awareness among medical students in India is crucial for ensuring equitable and quality healthcare for all individuals, regardless of their sexual orientation or gender identity. By incorporating comprehensive education and training on LGBTQIA+ health issues into the medical curriculum, we can

promote greater understanding, reduce prejudice, and empower future healthcare providers to deliver culturally sensitive and competent care.

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