Letter in Response to Previous Publication

Gender identity and sexual orientation: Need for using correct terminologies

Dear Editor,

This is with reference to the brief report titled 'Dermatologic care of the lesbian, gay, bisexual and transgender community of India' in the latest issue of the journal.[1] We read the article with great interest as it explored the often-neglected issue of the dermatological health concerns of the Indian transgender population. The article exhaustively talks about their skin problems and their health-seeking behaviour.

The title of the article mentions lesbian, gay, bisexual and transgender (LGBT) but we were surprised to discover that the study sample only included the transgender. Several times the authors have used the blanket term 'lesbian, gay, bisexual and transgender' very casually and inaccurately. The study is only carried out on transgender subjects and does not include any lesbian, gay or bisexual.

The article, in the very beginning, says that the LGBTQ community is commonly referred to as the third gender or transgender. This, however, is very incorrect. LGBTQIA+ is the umbrella term for sexual and gender minority (SGM) and includes Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Ally/Asexual.[2] Each term carries a unique meaning and it would be inappropriate to collectively call all of them transgender in today's times.

Transgender is an individual whose sex assigned at birth based on physical anatomy differs from their internal sense of gender (gender identity). It is antonymous to cisgender, which is an individual whose sex assigned at birth based on genital anatomy corresponds to their internal sense of gender.[2]

This is in contrast to sexual orientation, which is defined as a persistent pattern of physical and emotional attraction and includes heterosexuality, homosexuality [gay or men having sex with men (MSM) and lesbian], bisexuality and asexuality.[2]

Very contradicting data on the Indian transgender population is presented in the study. In the background, it says that their population is expected to exceed 1 million by 2030. Subsequently, in the summary, it is mentioned that they form over 2.5 million of the population of India. The methodology describes that the study sample size calculation was done based on the population of transgenders in India. This brings into question the accuracy of the sample size calculation, which could have been discussed in more detail. National AIDS Control Organisation (NACO) reports the population size of Hijras/Transgenders in India to be 70, 000.[3]

Only 2 out of the 51 study subjects (3.9%) were commercial sex workers. This is in contrast to the national data, as we know that the majority of the Indian transgenders rely on prostitution for livelihood. According to NACO, 32.9% of the transgenders are involved in sex work as their main occupation, reaching up to 86% in Mumbai.[3]

A significant proportion of the study sample (25%) were on anti-retroviral therapy (ART). The study fails to mention the cutaneous manifestations of HIV in the study subjects and also the cutaneous adverse effects of ART.

The study has also used phrases like 'incidence of transgender population' and 'incidence of trans men', which are scientifically incorrect. Incidence is defined as the number of new cases of an illness, disorder or behavioural phenomenon that occurs in a population during a specified period of time.[4] The term prevalence should have been better used at these places.

India has come a long way in promoting transgender health by decriminalising Section 377 of the Indian Penal Code and amending the Transgender Persons (Protection of Rights) Bill. We, the dermatologists and the venereologists, are the primary point of contact of the LGBTQIA+ people presenting to the STI (sexually transmitted infections) clinic. We must be aware of the different terminologies used for our sexually and gender-diverse population, which is essential in providing respectful and affirming care.

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Authors' reply

Sir,

This is with reference to the letter to the Editor published as 'Gender identity and sexual orientation-Need for using correct terminologies',[1] based on our article 'Dermatological concerns of the Lesbian, Gay, Bisexual and Transgender community of India'.[2] We thank the readers for their interest shown in our article and for highlighting certain points. We humbly submit our justifications as per the queries raised.

The readers have commented that the authors have been casual and inaccurate in using terminologies in the article and referred transgenders as 'third gender'. We beg to differ in that it is not the authors but it was the Supreme Court of India, which declared transgender people as the 'third gender', in their landmark judgement in 2014.[3–6] This judgement affirmed that the fundamental rights granted under the Constitution of India will be equally applicable to them, and gave them the right to self-identification of their gender as male, female or third gender.[3] The authors have immense respect for the LGBT community and quoted this term to highlight their past terminology in the background.

The title of the article initially was dermatological concerns of the transgender community of India. However, according to the GLAAD (Gay & Lesbian Alliance Against Defamation) organisation, the terms 'transgender' and 'transexual' is obsolete with LGBTQ being a more politically approved term.[7] In 2016, GLAAD's media reference guide clearly stated that LGBTQ is the preferred initialism. In order to avoid offending any member of the community, we suggested a modification of the title to make it all-inclusive.[7–9] In recent times, newer terminologies like LGBTIQA+ which stands for 'lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual' and many other terms (such as non-binary and pansexual) were introduced.[10]

As to why the title was used despite not having any gay, lesbian or bisexual people in the study, we affirm that this study is a questionnaire-based one with the primary objective to identify the dermatological problems presented by the self-declared members of the LGBT community. The sexual orientation of these participants was not questioned. Sexual history, like the number and sex of their partners or their practices, was not asked either as it was out of the scope of our study. As the aforementioned community is a minority and frequently neglected, we avoided asking such sensitive questions to make them comfortable during the study.

The readers have suggested using prevalence instead of incidence in our study. We thank the readers for pointing this out and we stand corrected.

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