CENTER *for* REPRODUCTIVE RIGHTS

Intersecting Realities

Understanding Social and Legal Barriers to Abortion Access for LBT Individuals in South Asia

2025

About the Research

In May 2023, a three-day virtual training on sexual and reproductive health and rights in Asia was organized by the Center for Reproductive Rights (the Center) in collaboration with the South Asia Reproductive Justice and Accountability Initiative (SARJAI) to strengthen understanding of SRHR issues and challenges in the region amongst a new cohort of young legal practitioners and advocates. A specific vision for this initiative was to strengthen the capacities of a small group of young advocates to build newer advocacy initiatives which could provide direction to SARJAI's work in the future. Proposals were received from a group of the participants and through a careful process, this initiative/project has been developed, which aligns with the Center's strategic priorities, including its catalyze goal, as well as the Asia program's strategic priorities. The project seeks to address the evidence gap in relation to queer and trans persons' access to SRHR services, including to abortion services in the region, who continue to be excluded from abortion law and policy frameworks.

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Glossary

LBT	The term includes lesbian, bisexual, and queer women, transgender men, transmasculine, and all non-binary people on the gender spectrum who relate to an LBT identity. The term in this context of the study is used as the operational definition, we understand that labels are often inadequate or unwanted, language is limited, and gender exists on a continuum and varies with cultural context.
Transmasculine	Is used to refer to anyone whose gender identity does not exclusively align with the female sex they were assigned at birth.
Cisgender	A term that refers to a person who does not identify as trans.
Queerphobia/ Homophobia	Fear, unreasonable anger, intolerance or/and hatred directed towards homosexuality
Biphobhia	The fear, unreasonable anger, intolerance or/and hatred toward bisexuality and bisexual people.
Heteronormativity	refers to the set of beliefs and practices that consider gender to be an absolute, unquestionable binary, and therefore describe and reinforce heterosexuality as a norm.
Hormone Replacement Therapy (HRT)	It refers to hormone therapy that can be taken as part of transition-related medical care or intersex-specific healthcare.
Hijra	Refers to a distinct community in South Asia, particularly in India, Bangladesh, and Pakistan, comprising individuals who do not fit into traditional male or female gender categories. Hijras often include transgender, intersex, and gender-nonconforming individuals. It is important to note that not all trans people, especially trans women, are hijras or form a part of the hijra community. It is only when they seek out the community and the community accepts them that they become/are called a hijra.
Khwaja Sara	Similar to the Hijra, Khwaja Sara is the term for the ‘third gender’ community in Pakistan.

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1. Introduction

a. The Context

Globally, out of every ten pregnancies, as many as three end in induced abortion; six out of ten unintended pregnancies lead to the same outcome. When performed according to WHO-prescribed methods by skilled personnel, abortion is a safe medical procedure. However, approximately half (45%) of the 73 million abortions performed globally each year are unsafe, with 97% of these occurring in low- and middle-income countries (LMICs)[i]. The WHO guidelines consider an abortion a safe healthcare intervention when using medication or a simple outpatient surgical procedure carried out with a method appropriate to the gestational age of pregnancy and – in the case of a facility-based procedure – by a person with the necessary skills. It highlights the pivotal role of medical abortion in increasing access to safe abortion care worldwide, with evidence showing that medications for abortion can be safely self-administered outside clinical settings (e.g. at home). Individuals with a source of accurate information and access to a trained health worker (in case they need or want support at any stage of the process) can safely self-manage their abortion process in the first 12 weeks of gestation. Unsafe abortion is then defined under the guidelines as "the termination of an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimum medical standards or both."[ii] Unsafe abortions are associated with potentially life-threatening complications such as bleeding, infection, and trauma, and they remain a leading preventable cause of maternal mortality in LMICs. Additionally, unsafe abortions contribute to irreversible physical and mental health problems, including anxiety, depression, and post-traumatic stress disorders[iii].

Overall, in South Asia, abortion laws are restrictive and the stigma and cultural unacceptability of abortion are deeply rooted in the need to control female sexuality and body, perpetuated by unequal power structures. Reproductive health discourse predominantly centers on cisgender heterosexual (cis-het) women, often invisibilizing queer women, transgender men, and transmasculine people who also experience pregnancy, parenting, and abortion. Global research indicates that abortion is a common experience for queer and bisexual women, similar to their

cisgender-heterosexual counterparts[iv,v]. Queer women, particularly bisexual women, face a higher risk of intimate partner violence and 'corrective rape' due to biphobia[vi]. Transgender men and transmasculine people encounter significant barriers in accessing abortion services due to the uninformed perception that they cannot get pregnant, denial of service, and fear of discrimination from healthcare providers that lead them[vii] to resort to unsafe abortions. Forced parenthood is often used as a 'corrective' measure by natal families, partners, and healthcare providers to impose violence on trans men and transmasculine individuals[viii].

Lesbian, queer women, transmen, and transmasculine individuals (LBT) individuals face misogyny, homophobia, and heteronormativity, living in hostile contexts intersecting with gender, sexuality, caste, race, class, disability, and other identities.

> ***A 2023 Human Rights Watch report identified ten human rights abuses affecting LBT individuals, including barriers to accessing justice, unequal property rights, gender-based violence, workplace discrimination, unequal parental rights, forced marriage, movement restrictions, asylum-seeking challenges, and healthcare barriers[ix]. A 2016 Human Dignity Trust report found that, among 78 jurisdictions criminalizing consensual same-sex conduct, at least 44 explicitly criminalize consensual same-sex conduct between women.***

Mainstream LGBTIQ activism often focuses on decriminalizing homosexuality, legalizing same-sex marriage, and nondiscrimination policies. Still, these efforts do not sufficiently address the specific human rights violations, such as denial of access to their reproductive rights, impacting LBT individuals.

b. International Human Rights Standards

States are obligated under international human rights law to promote and protect the human rights of all persons without discrimination. Over the decades, United Nations treaty monitoring bodies (UNTMBs), special procedures of the United Nations Human Rights Council such as the Special Rapporteurs and Independent Experts, and the UN High Commissioner on Human Rights have expressed concerns about discrimination against and rights violations of LGBTIQ+

persons and highlighted core legal obligations of States to protect, prevent, and safeguard their human rights[x].[xi] The Independent Expert on sexual orientation and gender identity (IE SOGI) was created in 2016 and since then, this mandate has specifically examined the stigma, discrimination, and human rights violations against LGBTQI+ persons across different spheres, and reiterated that *having the autonomy to determine their own fate without undue policing of their bodies is a pre-requisite to living a life with dignity*[xii].

The Committee on Economic, Social and Cultural Rights (CESCR) has affirmed that the non-discrimination guarantee of the Covenant includes sexual orientation and gender identity and intersex status, including in relation to the right to sexual and reproductive health.[1][xiii] The Committee on Rights of the Child (CRC) has similarly called upon States to make particular efforts to overcome the violence, discrimination, stigma in both law and practice experienced by LGBTQI+ adolescents in accessing commodities, information and counselling on sexual and reproductive health and rights.[xiv] The IE SOGI has emphasized that the global targets regarding sexual and reproductive health decision-making must account for the rights and realities of lesbian, bisexual and trans persons,[xv] as well as acknowledge and protect all decisions concerning pregnancy and sexual and reproductive health of trans men.[xvi] These human rights mechanisms have drawn attention to discriminatory gender norms and stigma, laws criminalizing consensual sexual activity amongst adults or expressing one's gender identity, lack of access to information and counseling as key barriers for recognition of the right to sexual and reproductive health (Annexure 3 for details).

In this background, the study aims to understand how LBT individuals navigate access to abortion in South Asia, specifically in Bangladesh, India, Maldives, Nepal, Pakistan, and Sri Lanka. It is also imperative to note that restrictive abortion and 'homosexuality' laws in countries like India, Pakistan, Sri Lanka, Maldives, and Bangladesh are rooted in British colonial laws, while Nepal, despite not having a colonial history, mirrors this framework to some extent.

[1] Recognizing that they are more likely to experience discrimination, it noted that legal barriers to accessing sexual and reproductive health services such as criminalizing consensual sexual activities between adults violate the obligation to respect while failure to take effective steps to prevent third party discrimination violates the obligation to protect. Committee on Economic, Social and Cultural Rights, *General comment No. 22 (2016) Article 12: The right to sexual and reproductive health* E/C.12/GC/22

The study tries to bring in the queer-trans perspective to understand gaps in health systems, policies, and social settings to improve abortion accessibility for the LBT community.

2. Methodology

a. Approach and Methods

16 in-depth interviews (IDIs) were conducted with organisational representatives who work closely with queer people in South Asian countries providing support for SRHR information and services. A semi-structured questionnaire (annex A)was designed for the IDIs focusing on:legal country context, barriers to accessing healthcare and abortion services, social support sought by LBT individuals, and specific recommendations for law and policy reform sought by the interviewees. The IDIs were conducted from February to April 2024 virtually over Zoom. Participants for the interview were reached out through Asia-wide queer and SRHR networks within identified countries of South Asia. The IDIs were audio-recorded, transcribed, and translated to English simultaneously, with utmost care to preserve the cultural nuances of the conversations. Table 1 (annex B) shares the characteristics of the study respondents.

b. Limitations of the Study

This study serves as a preliminary attempt to understand the realities faced by queer and transgender individuals in accessing safe abortion in the South Asian region. Due to the small dataset and limited timeframe, the research does not claim to represent the diverse experiences and challenges within this community comprehensively. The interviews were conducted in English, Hindi, and Malayalam—the languages known to the researcher. Consequently, the findings provide an initial insight but should not be seen as encompassing the full spectrum of queer and trans realities in the region.

3. Country Contexts: Legal contexts on abortion and queer rights

a. Bangladesh

i) Legal Framework and Abortion Access

In Bangladesh, abortion is criminalized under Sections 312-316 of the Penal Code of 1860, with the only exception being when the procedure is necessary to save a woman's life[i]. However, since 1979, Menstrual Regulation (MR) has been permitted as part of the national family planning policy, allowing manual vacuum aspiration (MVA) for up to 12 weeks and menstrual regulation with medication (MRM) for up to 10 weeks and mandating its availability in all government and private healthcare facilities[ii]. MR is integrated into healthcare and birth control policies, facilitating abortion services for up to 12 weeks without conflicting with abortion laws. Trained paramedics can provide MR services for gestations up to ten weeks, while registered medical practitioners (RMPs) are required for cases between 10-12 weeks[iii]. Significantly, MR and post-abortion care (PAC) is designated as essential healthcare services, maintaining their availability even when non-urgent or elective services are suspended[iv].

Advocates note that following Bangladesh's independence in 1971, there was a significant need for abortion services due to numerous victims of sexual assault. This led to the establishment of MR regulations in the late 1970s. The term "abortion" is seldom used in Bangladesh, minimizing backlash. However, increasing religiosity and polarization over the past decade have made it challenging for women and transmasculine individuals, with rising early marriage rates and attacks on feminist movements exacerbating the situation[v].

ii) Status of Queer and Transgender Rights

Queer and transgender persons encounter heightened vulnerabilities because of the prevalent legal framework that criminalizes same-sex relationships[vi], and although a 2014 government

Gazette allowed Hijras to self-identify as "male," "female," or "other" on their identity cards, not only does its implementation vary by region[vii] but it also excluded transgender men and non-binary individuals. Advocacy efforts have pushed for a more inclusive "Transgender Protection Bill". However, during the IDIs, queer rights advocates noted that recent targeted physical and digital attacks as well as misconceptions about Hijras and transgender people have led to reconsiderations by the Ministry of Social Welfare[viii, ix]. This backlash may result in a "Hijra Protection Bill" instead[2].

The National Adolescent Health Strategy (2017-2030) includes a provision against discrimination based on sexual orientation and gender identity, making it one of the few documents to mention sexual orientation explicitly[x]. However, due to fears of discrimination, many LBT individuals do not disclose their sexual orientation when accessing healthcare services[xi]. The Anti-Discrimination Bill, introduced in 2022[3], is a significant step towards addressing discrimination on various grounds in Bangladesh. However, the term "third gender" in the bill is often understood to refer specifically to Hijras, excluding other transgender identities such as trans men, trans women, and non-binary people[xii]. This exclusion highlights ongoing challenges in achieving comprehensive legal recognition and protection for all transgender individuals[xiii]. Respondents in the IDIs noted that the Hijra movement focuses primarily on economic empowerment rather than health, despite its origins in HIV prevention.

[2]Islamic hardliners, including the National Fatwa Board, have launched a campaign opposing transgender rights in Bangladesh. Their efforts involve distributing literature and leaflets with anti-transgender rhetoric, alongside organizing seminars and press conferences. The campaign argues that laws protecting transgender people are being used to promote homosexuality and introduce "immoral" Western values, which they claim are incompatible with the teachings of the Quran.

[3] The bill continues to be under review and has not yet been enacted into law. The bill was sent to the parliamentary committee for scrutiny, but significant changes are needed before it can be passed. Civil society organizations and legal experts have called for more inclusive provisions and stronger protections to ensure the law effectively combats discrimination across various sectors of society

b. India

i) Legal Framework and Abortion Access

With its shared colonial history, abortion in India too is criminalized under sections 312 to 318 of the Indian Penal Code (IPC)[i] . The Medical Termination of Pregnancy (MTP) Act of 1971[ii] is an exception to the penal provisions and lays down the legal framework for abortion access in India. Under the MTP Act, abortion is permitted up to 20 weeks of gestation with the approval of one Registered Medical Practitioner (RMP) and from 20 to 24 weeks with the approval of two RMPs under specific conditions[iii]. For pregnancies beyond 24 weeks, abortion is still permissible if a Medical Board diagnoses the foetus with a substantial abnormality[iv].

A landmark Supreme Court judgement in the case of *X v The Principal Secretary, Health & Family Welfare Department, Govt of NCT* (2022) expanded the interpretation of 'woman' to include persons other than cisgender women who may require abortion services[v]. However, transgender rights activists have critiqued this ruling, arguing that merely expanding the category of 'women' is insufficient for true inclusivity. They contend that this approach perpetuates the dangerous assumption that transgender men, masculine persons, and non-binary individuals are merely variations of 'women,' rather than recognizing their distinct identities[vi]. In recent times, intersex rights movements have also suggested that the classification of 'foetal abnormalities' as a sole condition upon which abortion is legally granted post 24-weeks also affects intersex communities, as the natural occurrence of foetuses with intersex diversities is also seen as undesirable and abnormal, and magnifies discrimination[vii].

ii) Status of Queer and Transgender Rights

India has witnessed several progressive legal reforms over the past decade, beginning with a historic 2014 decision[viii], in which the Supreme Court of India affirmed equal rights for transgender persons including affirming their right to self-identify gender without requiring medical or surgical interventions and importantly, recognized transgender persons as marginalized, extending reservations to them in public education and employment. Consensual same-sex relationships were decriminalized in India with the reading down of Section 377 in 2018[ix]. This was followed by the enactment of The Transgender Persons (Protection of Rights)

Act, 2019, which prohibits discrimination against transgender individuals in education, employment, and healthcare, and allows them to self-identify their gender[x]. However, the Act has been critiqued for its bureaucratic processes and lack of effective anti-discrimination enforcement[xi].

Despite the *NALSA* judgment and subsequent reforms, the law and policy framework continue to highlight transgender women, often neglecting transmasculine, transgender men, and non-binary individuals. Government social welfare policies remain binary, requiring individuals to fit specific categories to access these entitlements, for instance, targeted initiatives like Garima Greh[xii] primarily focus on transgender women while livelihood training programs tend to mirror those provided to cis women, such as tailoring and beautician courses.

The recent 'marriage equality' case before the Supreme Court[xiii] seeking legal rights for same-sex couples to marry[xiv] led to mixed results[xv]. While the court refused to read the right to marry into the fundamental rights, public conversation and visibility increased.[4]. However, queer rights advocates during the IDIs noted that the petition and advocacy on the issue have also led to negative repercussions, such as landlords evicting queer tenants who were previously discreet about their identities. Queer and transgender people continue to face violence in their private life, as well as in their public life and on social media, often resulting in forced conversion therapy, physical abuse, corrective rape, or spiritual interventions.

[4] Two significant petitions, Amburi Roy v. Union of India[xvi] and Rituparna Borah v. Union of India[xvii], challenge the state's failure to grant legal recognition to queer live-in couples, regardless of the stability or duration of their relationship. This lack of recognition severely limits a queer person's right to adopt, even as an individual. Both petitions highlight how non-recognition of non-conjugal and non-biological relationships leads to systemic exclusion, particularly in critical areas like healthcare, housing, inheritance, and socio-economic rights. Rituparna Borah v Union oh India argue for the acknowledgment of "chosen families" rather than solely "next of kin" under various laws, framing it as a fundamental aspect of the right to a dignified life under Article 21 of the Indian Constitution, which protects life and personal liberty.

c. Maldives

i) Legal Framework and Abortion Access

Located in the Indian Ocean, Maldives, the smallest Asian country, is an archipelago of 1,190 coral islands. Abortion in the Maldives is regulated under Section 416 of the Maldives Penal Code (2014), which permits the procedure only to save a woman's life or if the pregnancy is a result of rape or incest. The National Reproductive Health Strategy (2014-2018) by the Ministry of Health[i] acknowledged the impact of unsafe abortions and led to the Fiqh Academy of Maldives[5] issuing a Fatwa in 2013[ii]. This Fatwa allows abortion under specific conditions, such as rape or for social and financial reasons up to 120 days of gestation, and at any gestational age to save the woman's life. The procedure, however, requires spousal authorization, and if one's spouse is unavailable, from paternal father or guardian.[ii] Medical abortion pills like misoprostol are available in hospitals for managing 'miscarriages', but the full medical abortion kit is not available[iii].

Abortion and reproductive health services are only provided to married individuals, reflecting the broader socio-legal context where adultery and sex outside marriage are prohibited under Sharia Law, and children born out of wedlock are stigmatized. For unmarried women and queer individuals, access to reproductive health services, including birth control and abortion, is highly restricted unless they visit specific clinics that offer discretionary services[iv]. Wealthier individuals often travel abroad for abortions, highlighting economic disparities in access[v]. Respondents shared organizations offer referral services for abortion, typically discreetly, as many prefer not to use government hospitals[vi]. Before the 2000s, the Maldives' healthcare system faced considerable challenges, particularly in addressing maternal and child health. In 1984, the government launched its official family planning program to tackle these issues. Between 1984 and 1989, efforts to reduce infant, child, and maternal mortality showed some progress. During this period, the Maldives government collaborated with international organizations like UNFPA, UNDP, and WHO to implement child-spacing programs aimed at improving maternal and child

[5] Maldives Government's Council of Religious Scholars

health by increasing intervals between births. Assistance from countries like India also played a crucial role in enhancing healthcare infrastructure, leading to significant improvements in health outcomes[vii]. Since then, the healthcare system has modernized considerably, providing free healthcare under the social welfare mechanism 'Aasandha'[viii].

ii) Status of Queer and Transgender Rights

Homosexuality in the Maldives is criminalized under both the Penal Code (2014)[ix] and Sharia Law (as applied in the legal framework), reflecting the country's strict adherence to conservative Islamic principles. These laws, influenced by colonial-era legislation introduced in the 1830s, prohibit same-sex relations and impose severe penalties, including imprisonment and corporal punishment.

Queer rights advocate during the IDIs shared that there has been a cultural-historical acceptance of intersex individuals, known as *Khunsa,* however, this has diminished due to a recent surge in conservative ideologies. They further shared, despite this, Maldivian society is known for its sexual promiscuity, with men and women often having multiple partners, highlighting a cultural paradox where heterosexual promiscuity is 'tolerated', but homosexuality is harshly condemned[x]. A queer rights advocate shared that public scandals in recent times have intensified the scrutiny and harassment of LGBTQ+ individuals and exemplified the stigma and persecution faced by the queer community. Nevertheless, there is a growing, albeit silent, movement among the younger generation advocating for LGBTQ+ rights, although it remains largely underground due to severe legal and societal repercussions for being openly queer[xi].

d. Nepal

Nepal has made significant strides in legal reforms and progressive policies to improve the rights and inclusion of queer individuals and enhance access to safe abortion services. However, despite these advancements, persistent challenges continue to hinder true equality and access to necessary services for the queer community.

i) Legal Framework and Abortion Access

Of the countries analysed, Nepal has one of the most liberal legal regimes regulating access to safe abortions. Abortion in Nepal is legal under specific conditions[i]:

- Up to 12 weeks' gestation on any ground with the woman's consent[ii].
- Up to 28 weeks' gestation in cases of rape or incest[iii].
- At any gestation if the pregnancy poses a danger to the woman's life, physical health, or mental health, or if there is a fetal anomaly.[iv]

The 2009 decision of the Supreme Court of Nepal in *Lakshmi Dikhta v. Government of Nepal* elevated the right to abortion to a constitutionally protected fundamental right[v]. In 2018, the Right to Safe Motherhood and Reproductive Health Rights Act (SMRHR Act) expanded access further. In 2018 and 2021, the Government accepted recommendations to decriminalize abortion and to protect sexual and reproductive rights respectively from the UN CEDAW Committee[vi], and from the Human Rights Council[vii]. Despite these commitments, a parallel criminal law framework continues to exist, making women criminally liable and vulnerable to prosecution for seeking abortion beyond prescribed legal conditions[viii]. Besides continued criminalization under the penal law framework, practical implementation continues to remain a challenge, particularly in rural areas where stigma, lack of awareness, and inadequate healthcare infrastructure impede access to safe abortion services[ix].

ii) Status of Queer and Trans Rights

In a landmark decision on June 27 2023, Nepal's Supreme Court legalized same-sex marriage in response to a writ petition[x]. The court's interim order directed the government to make arrangements to "temporarily register" the marriages of "sexual minorities and non-traditional couples." This order made Nepal the first South Asian nation—and only the second in Asia after Taiwan—to institutionalize marriage equality[xi].

> ***"it is (same-sex marriage) only accessible to privileged people in terms of class/ caste, and educational background, if they are closer to someone who is in power, but for people who come from a Dalit community, if they have disability, this is less accessible. The stigma is still very high even though there is recognition through legislation, but***

people implementing it are still not aware of the laws. For example, if someone goes to the district office and discloses their identity they would be subjected to mockery and humiliation."

Researcher, SRHR advocate, IDI[xii]

Citizenship under desired gender is recognised only if an individual has undergone sex-change surgery, which is not easily accessible in-country and can be financially burdensome .

A transwoman shared that her bottom surgery (genital reconstruction surgery) in Delhi, India, cost 9 lakh Nepali Rupees, and with accommodation costs, the total exceeded 9 lakh.

Transwoman, queer rights advocate IDI[xiii]

*L*aws relating to reproductive health and safe motherhood exclusively use the term "women", excluding LBT individuals from crucial SRHR services. Although Nepal officially recognized queer trans people under the term "gender and sexual minorities" in its constitutional and legal framework[xiv], government officials have limited understanding about who qualifies as gender and sexual minorities.[xv] This further marginalizes the LBT community and impedes their access to necessary services and legal recognition.

e. Pakistan

i) Legal Framework and Abortion Access

Abortion in Pakistan is regulated by the Pakistan Penal Code (PPC), which too has its origins in British colonial law, but witnessed significant amendments in the 1990s leading to the current legal framework[i]. The law permits abortion "before the organs of the fetus are formed" to save the woman's life or for "necessary treatment done in good faith" although these terms are not clearly defined[ii], and after the organs of the fetus are formed, only to save the woman's

life[iii].According to Islamic legal scholars, abortion is permissible up to 120 days of pregnancy to save the woman's life or provide necessary treatment. After 120 days, it is only allowed to save the woman's life[iv]. The National Standards & Guidelines (S&Gs) reference these legal conditions in the introduction, but the specific gestational age of 120 days is not noted in the standards themselves[v]. Despite these provisions, abortion remains highly restricted and stigmatized, with provincial guidelines offering some, albeit limited, direction[vi].

Medical practices in Pakistan reflect these legal complexities. Advocates during the IDIs shared that the development sector has played a crucial role in promoting manual vacuum aspiration (MVA) by working with the government to supply equipment and train healthcare providers. Post-abortion care constitutes a significant part of the workload in clinics, both private and governmental, as women often seek help when they are already in critical condition.
Abortion care in Pakistan, as in other countries in South Asia, is often accompanied by stigma and discrimination. Healthcare providers regardless of marital status shame pregnant people seeking abortions. Abortion is highly restrictive in Pakistan due to societal stigma, and equating abortion as a sin[vii]. The law does not recognize the gender-diverse pregnant individuals, further complicating access to safe abortion services for all who need them.

ii) Status of Queer and Trans Rights

In Pakistan, queer and transgender rights face significant challenges, rooted in colonial-era laws and exacerbated by contemporary societal attitudes[viii]. The LGBTQIA+ movement in Pakistan is primarily driven by the Khwaja Sara community, with the women's movement highlighting issues faced by gender non-binary and transgender communities[ix]. Despite this, lesbianism remains largely invisible in public discourse, as shared by the respondents, due to fear of severe backlash in a societywhere transphobic, misogynistic, and Islamist voices are powerful. Under the tag of ‘gender’ rights, issues about sexuality are addressed, as shared by the queer rights advocates during the IDIs , to minimize backlash from anti-rights and religious groups. Queer women and transmen, however, actively participate in movements like the ‘Aurat March’ or the Sindh Moorat March, seeking to advance their rights through allied causes that encompass ‘gender issues’. Respondents of the IDIs noted the challenges of coming out because of violence

against the queer trans community, especially trans women, who are the most visible queer identities in society[x].

The Transgender Protection of Rights Act, passed in 2018, initially provided for self-determination of gender identity[xi]. This law was ambiguous about the number of genders recognized, allowing transitions from male to female (MtF) or female to male (FtM) on CNICs. However, religious and political backlash led to the law being challenged before the federal Shariat Court, resulting in the 2020 Transgender Personal Rule, which limited self-determination to the third gender, marked as "X" on CNICs[xii]. In 2023, the Federal Shariat Court of Islamabad ruled against the 2018 Act, removing the definition of gender and the right to self-determination[xiii]. This ruling has been challenged in the Supreme Court of Pakistan, where it remains on hold pending a final decision[xi]. The global anti-gender movement's influence, with its significant Islamist tilt in Pakistan, mirrors similar movements in India.

f. Sri Lanka

i) Legal Framework and Abortion Access

In Sri Lanka, abortion is illegal except when the pregnancy endangers the life of the woman, as stipulated in Sections 303-307 of the Sri Lankan Penal Code of 1883[i]. Efforts to reform these colonial-era laws have been ongoing since the late 1990s. In 2011, the issue resurfaced in Government discussions and the National Action Plan for Human Rights 2011 also included a goal to decriminalize abortion in cases of rape and severe foetal anomalies[ii]. Proposals to amend the law to permit abortion in cases of rape, incest, and significant fetal anomalies were made in 2013[iii] and in 2017[iv] but strong opposition from religious groups stalled their progress[v]. , permitting, Currently, both the doctor and the pregnant person can face imprisonment if an abortion is performed for reasons other than saving the woman's life. Pregnant persons often seek clandestine, unhygienic procedures from untrained providers or purchase abortion pills illegally at exorbitant prices.

> ***"Women go to these clinics or buy pills from pharmacies which is illegal, and they sell them in exorbitant amounts from 2000 to 15000 Sri Lankan Rupees."***

Lawyer, Social Justice Advocate, IDI[vi]

This has contributed to high maternal mortality rates (33 per 1000 live births)[vii].Overall, the restrictive abortion laws in Sri Lanka have led to significant health risks for pregnant people, with ongoing debates and advocacy efforts aimed at law reform.

ii) Status of Queer and Transgender Rights

Same-sex relationships are criminalized under the Penal Code of 1885[viii] and arrests under Section 365A are common. Police frequently raid hotels and private spaces, often on the mere suspicion of same-sex activity.Non-governmental organizations, like iProbono, provide legal support to the queer community in such cases[ix]. An attempt to decriminalize sex between men was initially reversed to include criminalizing sex between women[x]. However, a recent progressive Supreme Court judgement declared that there is nothing in the constitution that opposes decriminalizing same-sex relationships[xi]. This judgement has set the stage for a potential legislative change, with advocacy efforts underway. While transgender individuals gained some legal recognition in 2016 through regulations allowing for Gender Recognition Certificates (GRC), the process is stringent and binary-focused[xii]. Transgender persons must be evaluated by a psychiatrist for at least six months and undergo transition surgery to receive a GRC and update their legal identity[xiii].

Respondents shared, the queer movement in Sri Lanka is primarily led by gay men, with limited representation of lesbian, bisexual, and transmasculine and non-binary individuals[xiv]. Societal acceptance varies, with two women living together generally facing less scrutiny than two men. Harassment and discrimination are prevalent, but data on these incidents is lacking[xv]. The ability to be openly queer often depends on one's social and economic status, with many unable to express their identities due to fear of repercussions[xvi]. Some transgender men have joined the police force post-transition, reflecting a degree of acceptance within certain professional spheres[xvii].

4. Barriers to seeking SRHR and abortion services

a. Restrictive Laws on abortion & SRHR and other access barriers.

Studies have highlighted how restrictive abortion laws do not significantly lower abortion rates but instead lead to unsafe abortion practices[i]. However, even where abortion is broadly legal, inadequate provision of affordable services can limit access to safe services. In addition, persistent stigma can affect the willingness of providers to offer abortions and can lead pregnant people to prioritize secrecy over safety[ii]. This was reflected in the responses and how it gets heightened in specific ways for queer individuals' access to safe abortion & other SRHR info & services.

i) Abortion Stigma and Spousal Consent Requirements

In Nepal and India, where abortion laws are relatively progressive, respondents highlighted that spousal consent is often sought despite the law stating that only the consent of the seeker is required for an adult[iii]. Societal constructs lead doctors to ask for spousal or parental consent, which they may use to deny services and shame pregnant individuals for engaging in sexual acts outside of marriage. For instance, a queer advocate from Pakistan highlighted the impact of stringent abortion laws on everyone[iv]. Abortion providers often refuse services to anyone, including heterosexual, married women with multiple children. The profile of the average abortion seeker in Pakistan typically includes women who have multiple children and do not want more. Unmarried individuals seeking abortions face additional barriers due to the stigma of premarital sex and relationships outside of marriage.

Survivors of rape or incest also encounter harsh treatment and judgment. The stigma is compounded for queer individuals, who may lie about their marital status to seek services, which are often, again, denied. In this context, the queer-trans activist explained queerness as

“"not inherent, it’s not that LGBTQ is the only queer. Queer is exclusion by design. Whoever is 'otherized' and excluded from a hetero-patriarchy and hetero-sexist medical industry is queer."

IDI with Queer-trans activist, Pakistan (2024)[v]

ii) Specific Barriers faced by LBT people

Queer individuals face numerous intersecting challenges when accessing abortion services due to restrictive laws, societal stigma, and intersecting legal frameworks. For instance, queer trans advocates from Pakistan shared how those trapped in forced heterosexual and abusive marriages often encounter severe complications if they decide to elope while pregnant in patriarchal societies[vi]. The Muslim Family Law Ordinance of 1962 imposes specific custodial duties, complicating matters of paternity and child custody[vii]. A pregnant woman running away with her lesbian partner or a transman could face accusations of child abduction, particularly if the child is a son. An instance of a lesbian married woman in a relationship with a transman was shared, where the pregnant lesbian woman and transman eloped and sought asylum in Nepal to be protected from the husband filing charges and seeking protection while they sought safe abortion services[viiii]. Advocates from countries such as Maldives, and Pakistan with restrictive abortion laws shared how many abortion seekers fly to neighbouring countries of India and Nepal to access safe services.

Additionally, finding safe shelter is a significant challenge, especially for queer individuals with children. Shelter homes often have restrictive policies regarding the age and gender of the children they accommodate, forcing many queer individuals to either stay in abusive situations or

leave their children behind, causing emotional turmoil and denying them the right to live freely. A queer advocate from India shared:

> ***"Sometimes, we get crisis calls from transmen who wish to leave their house and husband, and they already would be having a kid. However, shelter homes don't host children who are older than six years of age if they are of the same gender, so that is another challenge. So for example, if there is a self-identifying transman, who has a male child, then only they can avail of a male shelter home. But if it's a transman who has not undergone surgeries, and can pass off as a cis-woman, but the child is a girl child, then they both can seek refuge in a women's shelter home, however, would experience dysphoria. They are unable to find a safe place, so they are not able to leave their family, or they go through emotional turmoil and leave the child and the family. This is one of the major crises in the community. No matter in what situation the child was conceived, they are unable to lead a life they want and keep the child, they don't have that basic right."*** [ix]

This sentiment is echoed by advocates from various regions, who highlight the pervasive barriers for queer-trans individuals to accessing safe abortion services.

b. Criminalisation and/or full legal recognition of queer identities

The Committee on Economic, Social and Cultural Rights emphasizes that non-discrimination in sexual and reproductive health includes the full respect of sexual orientation, gender identity, and intersex status for all individuals. Criminalizing consensual same-sex relationships or gender expression, and treating LGBTI individuals as mentally ill or subjecting them to "curative" treatments, is a clear violation of their right to sexual and reproductive health[i]. Furthermore the Committee highlights, criminalization of consensual sexual activities between adults creates legal barriers that hinder access to sexual and reproductive health services, violating the State's obligation to respect these rights[ii, 6]. However, LBT individuals in South Asia face significant

[6] Please refer to the annexure for a detailed compilation of International Human Rights Standards specifically addressing the protection and realization of LGBTI+ rights. This section includes key conventions, treaties, and recommendations from authoritative bodies like the United Nations Human Rights Council and the Committee on

challenges accessing healthcare due to the lack of legal recognition of their identities. Existing laws often operate within a cis-heteropatriarchal framework, leaving little room for lesbian, bisexual, transmasculine, and non-binary individuals to assert their rights without fear or shame. Abortion and SRHR laws, for instance, typically refer to "women" rather than "pregnant people," excluding many queer individuals. In the Maldives, a queer respondent noted that couples must present their marriage certificates to access SRHR services, effectively erasing the existence and realities of queer and trans people[iii]. Despite advocacy efforts leading to slow changes, cultural and religious systems heavily influence access.

In countries where queer identities are criminalized, queer and trans individuals face significant abuse. In Sri Lanka, laws against impersonation and the Vagrancy Ordinance allow police to arrest individuals perceived to be dressed in the opposite sex or loitering[iv]. These laws disproportionately affect transgender individuals and sex workers, restricting their access to safe spaces and services, including safe abortion[v].

Violence from the family of origin is another critical barrier that queer couple faces. In Pakistan, after the Transgender Protection of Rights Act, of 2018, a transman who married his longtime girlfriend faced severe backlashvi. Despite having a male CNIC, the woman's parents filed a police case against him for "abducting" their child, leading to a media outcry. The subsequent passing of the 2020 Act, which restricted gender identification to an "X" marker, a designation many transmen reject.

The Committee on the Elimination of Discrimination against Women underscores the state's responsibility to ensure that healthcare services are not only of high quality but also accessible, affordable, and culturally sensitive for Indigenous women and girls, including those who are lesbian, bisexual, transgender, and intersex[vii]. These services must be free from discrimination to

Economic, Social and Cultural Rights,Committee on the Elimination of Discrimination against Women, and Committee on the Rights of Children, which emphasize the right to equality, non-discrimination, and access to healthcare, housing, and protection from violence for individuals regardless of their sexual orientation, gender identity, or intersex status. The annexure also covers significant regional human rights frameworks and guidelines aimed at safeguarding the rights of LGBTI+ individuals globally.

meet the needs of these marginalized groups. However, across South Asia, many queer individuals are compelled to conceal their sexual orientation or gender identity when accessing healthcare, driven by the fear of stigma and discrimination, which significantly limits their access to appropriate and respectful care. In Nepal, a study conducted by the respondent shared how queer individuals would rather avoid hospitals[viii]. They shared with the respondents, ‘‘I would rather die than go to a hospital” due to humiliating experiences that breach their privacy and dignity. A queer advocate from Pakistan shared an instance where a lesbian friend could only vaguely admit to being sexually active, and shared ‘fingering’ as a sexual act, fearing the repercussions of revealing her true identity[ix].

The outdated medical curriculum also exacerbates these issues. A queer advocate from Bangladesh noted how medical students are taught to perceive queer individuals as "abnormal."[x] A non-binary Dalit advocate shared their traumatic abortion experience, emphasizing the binary and stigmatizing nature of the process. They described the profound internal conflict and external stigma they faced:

> ***“I had an abortion when I was 19 years old. I was also coming to terms with my queerness…but the world around me was so cis-het, I did not know how to be queer around that space. I was trying to reform my ideas and perspective and undo the conditioning and internalization of norms. At that point, this happened to me, and it was also a result of abuse. I didn’t know what to do. I know as a female-bodied person, as a ‘woman’, I know of the right to go and access abortion. But I found it so difficult to come out of that space; as a 19-year-old, I did not have a lot of options. The good thing was that I was an adult, and I did not have to involve my parents. But what was happening internally– it is very difficult to put into words. If I identify as non-binary, I don’t want to be identified as a woman. The entire process will be done in binary, as it is going to assert that ‘I am a woman, and nothing more than that,’ Pregnancy when you are not married, or in a relationship that is not acceptable is scary. And even if you cross all the hurdles and reach the hospital, people look at you with so much disrespect, their eyes propel shame. I could not look at myself with pride even years after that. Those few days of going to the doctor and to the clinic still live within me.”xi***

c. Awareness and perception of abortion and SRHR needs

Respondents across countries highlighted the limited access to rights-based information on safe abortion for queer and transgender individuals. Awareness programs and policies often prioritize HIV, neglecting SRHR needs among the LBT communities. Awareness of SRHR and safe abortion within these communities is low, with many relying on social media, peer groups, or trusted NGOs for information. The lack of queer and trans perspectives in creating information further exacerbates this issue. An SRHR advocate from Nepal noted that when Queer rights advocates engage in the discourse, they often face unwelcoming questions, such as why a lesbian would need to talk about abortion[i]. Heteronormative assumptions prevail, such as believing that transmen would only be attracted to women and not considering the possibility of trans people being gay or bisexual. This misconception is echoed by a queer respondent from India who recounted a conversation with a trans person who was surprised that a transman could need an abortion, revealing underlying biases against trans-lesbianism and gay relationships within the community[ii].

The lack of trust in the healthcare system further discourages queer individuals from seeking information from public health institutions. A queer advocate from Pakistan shared an instance where a lesbian woman was humiliated by a gynecologist who advised her to get married before seeking SRHR information[iii]. Organizations are working to create information for queer and transgender individuals, but much of it is not available in regional languages, and there is a significant gap in local research. The data referenced often comes from Global North countries, posing additional challenges. NGOs have developed apps to debunk SRHR and abortion misconceptions, but these apps are not well-known, leading many to rely on potentially unreliable or misleading information found through internet searches[iv].

Limited recognition and availability of comprehensive sexuality education (CSE) within the public education system contributes to the lack of understanding of bodily autonomy and sexual identity among the queer community. A respondent from Sri Lanka shared a case where a woman in an unhappy marriage with children did not have the articulation to describe same-sex sexual desires, highlighting the need for better sexual education.

"She was not happy in the marriage, and she was attracted to women, and then she wrote about it– beautifully about her attraction, and through that only I understood that she is attracted to women. Then she slowly opened up and then accepted that yes, she is attracted to women. She was sharing about her experience of sex with her husband. It is really sad- he hates using protection, and she was telling me that she was standing upside down and jumping so that the sperm would come out. Must be from some movie that she would have picked up, but also this shows how important sexual education is. She can't also get out of this marriage, who will accept her with 3 children?"[v]

Many LBT individuals with children conceived through rape or violence face difficulties owning their queer or trans identities due to societal stigma. As a result, conversations around abortion are scarce within the LBT community. A queer advocate from India shared that the community doesn't typically consider abortion:

> ***"because it is not in their imagination itself that they can safely access it. The more you are oppressed, your accessibility to information and services also reduces"***[vi]

They recounted a case where a transman, married to a cisman and enduring abuse, stayed in the marriage to ensure the child's well-being before planning to leave. This scenario reflects the harsh realities faced by many lesbians, bisexuals, and transmen.

d. Barriers within the healthcare system, including conscientious objection and discrimination

Respondents across countries highlighted significant barriers queer and trans individuals face in healthcare settings. Hospitals operate on a binary understanding of gender and are ill-equipped to address the specific needs of queer and trans people. This often forces individuals to hide their sexual identities or face discrimination and humiliation. For instance, lesbian and bisexual women might pass as cis-heterosexual women, but transmasculine people face distinct challenges, especially those who have undergone hormone therapy and changed voices, and

beards. Insensitive and unaware doctors ask inappropriate and invasive questions. A trans rights advocate from Nepal shared a harrowing example:

> ***"When you go to a gynaecologist, you have to complete administrative processes, buy a ticket, pay fees – the discrimination starts here. A transman once shared that he was denied services because the staff said, 'You are a man, why do you need these services?' He had to explain his identity publicly before being allowed to see the doctor. This kind of humiliation deters many from seeking necessary healthcare."*** [i]

Healthcare professionals often lack awareness about trans issues such as trans pregnancy and menstruation. They may neglect medical conditions, treating patients more as curiosities or study subjects than individuals needing care. A respondent from India shared:

> ***"Trans people avoid ultrasounds for fear that their identity will be disclosed. A Transman was scared to go through an ultrasound and didn't want the hospital staff and doctors to know that he was trans. We then advised them to write a letter to the people conducting the ultrasound that this information was to be kept confidential, and to share the report directly with the doctor, not to anyone else. Sometimes, if they get to know this is a trans person, then the report is passed on and people start to look at the report like it is a 'freak', imagine how scary this situation could be?."*** [ii]

So the majority of them try to avoid going to government hospitals. They would either crowdfund or take loans and consult private hospitals to get that safety. Which is an added financial burden that queer trans individuals harbour. Since many queer trans individuals escape their family of origin, they experience financial distress, and accessing healthcare becomes challenging, and is rather a luxury.

In Sri Lanka, there are no specific laws protecting queer individuals from discrimination in hospitals, leading to dangerous situations. A cleaning staff member sexually harassed a transwoman admitted to a male ward because her appearance did not align with the binary expectations of the hospital staff[iii]. Such incidents highlight the urgent need for trans-friendly healthcare environments where they can avail services with dignity and safety.
The issue of conscientious objection extends beyond queer identities to the paradigm of anyone outside the framework of marriage accessing SRHR. A Pakistani transgender activist explained:

> ***"The marital bias defines access to SRHR. We haven't gotten into the realm of discrimination specifically because of queer identity, because queer women seeking healthcare = unmarried women/ unaccompanied without a husband. That is the definition of queer women seeking healthcare. Denial is based on marital appeal, and that is how queerness is defined. "***[iv]

This heteronormative expectation in the healthcare settings was echoed in all other South Asian countries where spousal and parental consent was sought even if the law didn't demand it. In Maldives, they are asked to present marriage certificates to access SRHR and contraceptive services[v].

Even in countries where abortions are legal, respondents univocally shared how transgender individuals often opt for clandestine procedures to avoid discrimination and humiliation in healthcare settings. This contributes to significant mental health and emotional distress. An SRHR advocate from Nepal recounted,

> ***""A queer person was abused during a pre-surgery check-up under the guise of 'verification.' They were forced to undress and were subjected to invasive examination to 'confirm' their gender. This kind of obstetric violence is pervasive and extremely disturbing."***[vi]

An Indian Dalit non-binary respondent shared a heartbreaking experience:

> ***"A transmasculine friend went to a government hospital for a cheaper abortion but felt so small and humiliated that they attempted suicide afterward. The lack of consideration and sensitivity in healthcare settings is a bigger problem than legal barriers."*** [vii]

All of such discriminatory scenarios push queer and transgender individuals to rely on unsafe abortion methods. Respondents also highlighted how the community relies on an informal referral system to seek 'safer' clinics to seek abortion. All respondents highlighted how the community would rely on Medical Abortion pills since it is discrete and exempt from the harrowing experience of visiting doctors, and also since surgical abortion would induce dysphoria in transmasculine and transgender men.

e. Lack of Social acceptance and support

In South Asia, abortion is widely regarded as a sin and lacks social acceptability, which is compounded for queer and transgender individuals who face additional stigma due to their sexuality. Many queer individuals cannot rely on their family of origin for support, as these families are often sources of violence and discrimination. Instead, they depend on their chosen families and friends for both financial and emotional support.

A Dalit non-binary activist from India emphasized the importance of viewing access through an intersectional lens since queer identities do not exist in silos:

> ***"If you are a Dalit person, your social capital and mobility are limited. Add queerness to that, and these factors compound. Accessing 'safe' services becomes more expensive and thus less accessible. For a queer-***

trans person with a disability, the barriers are even higher, as few doctors are trained to handle intersecting identities." [i]

A queer advocate from Pakistan shared a poignant example: *"A lesbian victim of sexual violence didn't inform her family, fearing victim-blaming and restrictions on her mobility. She took a friend to the gynecologist instead, but the experience was still traumatic due to the doctor's intrusive questions about her condition, chlamydia, contracted from the rape.*[ii]*"*

Navigating a healthcare system entrenched in heteronormative structures is particularly challenging for LBT individuals, who often face requirements for parental or spousal presence for procedures like abortion. This is further compounded by the lack of family/societal acceptance. The Dalit non-binary activist from India further explained,
"When I had an abortion, my chosen family, not my family of origin, was there. We have redefined what family and home can be. This lack of recognition affects mental health. For instance, during hospitalization, my caretaker had to sign in as a friend, despite the deep familial bonds we share." [iii]

A transgender healthcare professional and queer rights advocate from Pakistan highlighted the critical role of queer kinship:
"Queer kinship and allies are essential for navigating these systems. I often get requests for help because I am seen as 'Mataji' (Mother) who can get things done. It's through this network that we manage to access necessary services."[iv]

These narratives underscore the profound need for intersectional approaches and systemic changes in healthcare to support queer and trans individuals. By recognizing and validating chosen families and training healthcare providers to understand and respect diverse identities, the system can begin to offer the inclusive, dignified care that all individuals deserve.

5. Conclusion and Recommendations

Addressing social and legal barriers to abortion access for LBT individuals in South Asia requires laws, policies, and protocols that explicitly protect the rights of LBT people as well as address existing ones that explicitly or otherwise discriminate against them. This includes overhauling patriarchal systems that limit women's rights, such as male guardianship laws and discriminatory property and inheritance laws. Additionally, removing barriers to women's autonomy, freedom of movement, and personal liberty is critical. These legal reforms are necessary to ensure LBT individuals have access to fundamental LGBT rights and to promote broader equality.

a. Recommendations relating to law and policy

Organisational representatives across South Asia consistently stress the critical need for robust legal protections and rights for queer and transgender individuals, especially LBT individuals, to ensure they can safely access reproductive health services. In countries like Pakistan, Maldives, Sri Lanka, and Bangladesh, where homosexuality remains criminalized and abortion laws are stringent, LBT individuals are particularly vulnerable and often resort to unsafe abortion practices. Advocacy in Nepal and India highlights the need for protection against violence targeting queer and transgender individuals. For instance, India's Transgender Persons (Protection of Rights) Act, 2019, prohibits discrimination against transgender people in areas such as education, employment, healthcare, public services, housing, and property rights[i].

The current laws and policies governing the lives of LBT persons lack an accurate and compassionate understanding of their lived realities. To address this, policies related to transgender persons and other marginalized communities must be developed through a bottom-up approach. This involves in-depth involvement of affected communities and multiple consultations with activists and experts on transgender issues. Lawmaking bodies, such as parliaments, should enact affirmative action policies, including reservations, to ensure equitable representation of transgender persons in decision-making spaces. This inclusion allows them to have a say in the formulation of new laws and policies.

Advocacy for self-managed abortion is also crucial. Studies highlight that queer individuals, especially transmasculine and transgender men, prefer self-managed abortions due to formidable barriers to facility-based abortion care and a strong desire for privacy and autonomy. Efforts are needed to connect LBT people with information on safe and effective self-managed abortion methods and to dismantle barriers to clinical abortion care, allowing them to choose a safe and effective abortion setting freely[ii].

Combating stigma around abortion and related SRH topics requires targeted efforts. One effective approach is institutionalizing CSE in schools. CSE can normalize discussions on gender and sexuality-related topics for young people from an early age, introducing them to issues of reproductive healthcare and marginalized gender identities. This education is crucial for fostering understanding and acceptance in society.

b. Recommendations relating to service delivery

Upgrading medical curricula to include comprehensive training on Sexual Orientation, Gender Identity, and Expression (SOGIE) issues, as well as the specific needs of LBT patients, is essential. Healthcare professionals must undergo these training in partnership with LBT organizations and collectives to ensure sensitivity and competence. In countries with relatively progressive abortion laws, like Nepal and India, many medical practitioners and other service providers continue to remain unaware of the legalities of the law. Despite robust advocacy efforts, the practical implementation of these laws remains a significant challenge. Even if an abortion seeker overcomes barriers such as mobility, affordability, referrals, frontline workers' support, societal stigma, and legal awareness, the final decision-maker—the medical practitioner—holds significant power in providing dignified services.

Conscientious objection by doctors, which allows them to refuse and deny services based on religious or conscience-based convictions[i], also provides room to practice queer and transphobia. This discourages lesbian, bisexual, non-binary, transmasculine persons, and transgender men from accessing abortion services and creates distrust among marginalized communities in formal healthcare systems. Consequently, these individuals are pushed to choose unreliable and unsafe methods that can lead to severe health complications or even death.

Advocates in restrictive abortion settings emphasize the need for more community experts with technical expertise. The community, historically at the receiving end of healthcare discrimination, relies on trusted referrals for their reproductive needs.

"We only have one activist with a public health degree, and that is me. We are such a minority community. Health is a feminist issue. Health is also a technical issue. Roll out, and democratize technical issues to the grassroots, or else we are failing,"[ii] says an organizational representative from Pakistan.

Advocacy is needed to broaden the range of practitioners qualified to perform abortions to include nursing assistants, nurses, midwives, and non-clinical doctors, as recommended by the World Health Organization, to increase access to LBT-affirming medical professionals.

c. Recommendations for CBO and Abortion rights movements

"Everything is so much in binary again. When we say 'abortion for all,' what do we mean? When we look at the conversations taking place, how many queer trans people are on the panel, leading discussions? How many people are taking these spaces are all the questions we need to ask. Who is leading this space, and how are they making this experience inclusive? Also, people who have dual marginalisation—are we talking about all of these aspects? Are there enough conversations on them?"[i]

This perspective shared by an Indian Dalit non-binary organizational representative resonates with queer activists throughout the South Asian region.

Traditional rights-based and justice movements as well as public health frameworks movements often overlook LBT issues and fail to include them in sexual and reproductive health & rights discussions. This omission indicates a lack of understanding that abortion concerns LBT individuals as well. For instance, mainstream feminist movements and queer spaces seldom align, leaving the issues of trans men, lesbians, and bisexuals at the bottom of the hierarchy, overshadowed by the focus on gay men and transgender women. Queer organizations also tend to deprioritize abortion, with the majority of global funding focused on HIV and STI prevention, thereby invisibilizing the issues of LBT individuals. Additionally, some organizations restrict conversations to HIV and safe sex, further highlighting how funders control movement spaces. Researchers, activists, and civil society organizations working on reproductive access and queer rights must collaborate to build cross-movement solidarity and inform perspectives across movements. This collaboration would enable the development of robust and intersectional strategies addressing multiple issues from a rights-affirming lens. It is crucial to work closely and consistently with historically marginalized communities to understand their distrust of government systems and navigate a way forward where legal frameworks for access exist but remain underutilized by marginalized groups.

The lack of inclusive, accessible, and localized information on SRHR and abortion for queer and transgender individuals underscores the need for more targeted efforts to bridge these gaps and address the unique challenges these communities face. Trans-national solidarity and knowledge exchange in the region can also help build and sustain movements. An advocate in Sri Lanka highlighted the challenges of publishing materials on sex education, which could be deemed obscene and lead to arrest. As a result, the queer community relies heavily on social media to understand their identities and connect with others. For example, Tamil-speaking queer communities in Sri Lanka connect with their counterparts in India through social media, which serves as a platform for obtaining information on safe sex and other issues[ii]. Community-based organizations (CBOs) and feminist movements must establish trans-national networks to foster solidarity, facilitate cross-sharing, and create learning spaces. These efforts are essential for advancing advocacy initiatives aimed at decriminalizing abortion and sustaining queer and

transgender rights movements. Such networks will ensure increased accessibility to safe abortion services for LBT individuals and enhance the overall support for their reproductive rights.

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XI. Shamayeta Bhattacharya, et al., *Transgender Persons (Protection of Rights) Act' of India: An Analysis of Substantive Access to Rights of a Transgender Community*. 14(2) JOURNAL OF HUMAN RIGHTS PRACTICE, at 676–697 (2022). https://doi.org/10.1093/jhuman/huac004

XII. A component of the Ministry of Social Justice & Empowerment's scheme Support for Marginalised Individuals for Livelihood & Enterprise (SMILE), Garima Greh aims to provide shelter and basic amenities to destitute and abandoned transgender persons and is aligned to Section 8(4) of the TG Act 2019. https://transgender.dosje.gov.in/GarimaGreh/About

XIII. Supriyo @ Supriya Chakraborty & Anr. v. Union of India 2023 INSC 920

XIV. The petitions filed by queer couples, and activists emphasized the need for marriage equality from the perspective of any two people, regardless of gender identity, and stressed the need for protection from natal family violence. See Diksha Saniyal, *Going Beyond Marriage: A Case For Relational Equality,* SUPREME COURT OBSERVER, Mar. 10, 2023, https://www.scobserver.in/journal/going-beyond-marriage-a-case-for-relational-equality/#:~:text=The%20Rituparna%20Borah%20petition%20was,by%20marriage%2C%20birth%20or%20adoption.

XV. Saumya Kaliya, *Supreme Court's Verdict on Same-Sex Marriage: Explained,* THE HINDU, Oct 22, 2023, https://www.thehindu.com/news/national/supreme-courts-verdict-on-same-sex-marriages-explained/article67429494.ece#:~:text=Beyond%20recognising%20natal%20family%20violence,entitlements%20for%20same%2Dsex%20couples.

XVI. Amburi Roy v. Union of India, https://www.scobserver.in/wp-content/uploads/2023/01/Amburi-Roy-RedactedCompressed.pdf

XVII. Rituparna Borah v. Union of India, https://www.scobserver.in/wp-content/uploads/2023/01/Rituparna-Borah-and-Ors.-v.-UoI_Redacted.pdf

C. Maldives

I. National Reproductive Health Strategy (2014-2018). Ministry of Health. http://www.health.gov.mv/Uploads/Downloads//Informations/Informations(47).pdf

II. World Health Organisation, *Factsheet*: *Abortion Policy Landscape Maldives,* https://iris.who.int/bitstream/handle/10665/338768/factsheet-maldives-eng.pdf?sequence=7&isAllowed=y

III. As shared by the medical student and SRHR advocate (cis-woman) from Maldives during IDI

IV. Interview with the medical student, SRHR advocate (cis-woman), and non-binary SRHR advocate from Maldives.

V. Interview with the non-binary SRHR advocate from Maldives, however, this has not been independently verified by us.
VI. Ibid., IV
VII. Bhanu Bhakta Niraula. *The Status of Family Planning and Reproductive Health in the Republic of Maldives, 2010.* Pages- 155-168, Family Planning in Asia and The Pacific: Addressing the Challenges. International Council on Management of Population Programmes (ICOMP), 2012: https://tinyurl.com/49nxp89f
VIII. See Government of Maldives, Aasandha Scheme: https://aasandha.mv/en/scheme/aasandha-scheme/overview
IX. Section 411(a)(2)& 412(c), Penal Code of Maldives, No. 6/2014 (2014). Republic of Maldives
X. Interview with the non-binary queer rights and SRHR advocate from Maldives
XI. The non-binary queer rights advocate further shared that societal attitudes towards intersex, transgender, and nonbinary individuals are relatively lenient if they pass as a particular gender. However, openly homosexual individuals as opposed to those assuming face significant demonization and harsh repercussions, making access to SRHR and abortion even more challenging for the LBT community.

D. Nepal

I. Safe Motherhood and Reproductive Health Rights Act, 2075 (2018), Preamble (Nepal) [hereinafter SMRHR Act].
II. SMRHR Act, supra note 3, at part 4, sec. 15(a)
III. Id., at part 4, sec. 15(c) and (d).
IV. Id., at part 4, sec. 15(b) and (e).
V. Lakshmi Dhikta v. Government of Nepal, Writ No. 0757, Jestha, 2066 (2009) (Nepal)
VI. CEDAW, Concluding Observations on its Sixth Periodic Report, November 2018: https://documents.un.org/doc/undoc/gen/n18/378/89/pdf/n1837889.pdf
VII. Center for Reproductive Rights, *Nepal Agrees to Decriminalize Abortion and Protect SRHR,* Apr 8, 2021: https://reproductiverights.org/nepal-abortion-decriminalization-un-upr/
VIII. Center for Reproductive Rights and FWLD, *Decriminalization of Abortion in Nepal: Imperative to Uphold Women's Rights* (2021), https://reproductiverights.org/wp-content/uploads/2021/06/Decriminalization-of-Abortion-in-Nepal_02June021_-Final-Version-1.pdf
IX. Interview with the researcher on SRHR, cis-woman working in a non-profit organisation based out of Kathmandu, Nepal
X. Sanjeeb Gurung aka Pinky Gurung, et al. Versus Government of Nepal, June 27, 2023: https://www.hrw.org/sites/default/files/media_2023/12/SC%20interim%20order%20-%20Pinky%20Gurung%20v.%20OPMCM.pdf
XI. The Indian Express, *Nepal's First Official Same-Sex Marriage : A Beacon of Change for South Asia,* Dec 2, 2023, https://indianexpress.com/article/opinion/editorials/nepals-first-official-same-sex-marriage-a-beacon-of-change-for-south-asia-9050639/
XII. Interview with the researcher and SRHR advocate (cis-woman), working in a non-profit organisation based out of Kathmandu, Nepal
XIII. Interview with a transwoman working in a queer organisation in Nepal
XIV. The term was formalized through landmark rulings such as the Sunil Babu Pant v. Nepal Government case in 2007, which led to the recognition of LGBTQI+ rights. The 2015 Constitution includes provisions for the rights of transgender individuals under Article 12, which allows self-identification on citizenship documents, and Article 18, which provides protections against discrimination. Additionally, Article 42 guarantees the right to social justice for sexual and gender minorities, making it one of the most progressive frameworks in South Asia for LGBTQI+ rights See South Asian Translaw Database, *The Constitution of Nepal, 2015,* https://translaw.clpr.org.in/legislation/the-constitution-of-nepal-2015-constitution-nepal/

XV. As shared in the interview by the researcher, SRHR advocate, and transwoman and queer rights advocate from Nepal

E. Pakistan

I. Sections 338A to 338C, Pakistan Penal Code (Act XLV of 1860), Chapter XVI, Section 338(A)-(C).
II. Section 338A, Pakistan Penal Code, 1860.
III. Section 338B, Pakistan Penal Code 1860
IV. See Center for Reproductive Rights, *Provisions of Abortion in Pakistan* https://reproductiverights.org/maps/provision/pakistans-abortion-provisions/ . In the interview with the queer cis-woman and SRHR advocate, it was shared that while Islamic teachings make a distinction between Isqat-i-Hamal (termination of pregnancy) and Isqat-i-Janin (termination of life after 120 days), both are conditionally permitted, though there is no consensus among scholars.
V. Aahung & Center for Reproductive Rights, U*nsafe and Unjust: Legal and Social Barriers that Deny Women and Girls Their Right to Safe Abortion Services in Sindh, Pakistan*. 2023: https://reproductiverights.org/wp-content/uploads/2024/03/Unsafe-and-Unjust-report-Pakistan-3-27-24.pdf
VI. Interview with the queer cis-woman and SRHR advocate working in non-profit organisation in Pakistan
VII. Ibid., V.
VIII. The colonial penal code inherited from the British criminalizes "homosexuality," specifically mentioning sodomy under Section 377. However, enforcement is rare, and there are no known cases of imprisonment or conviction under this law. Section 377, Pakistan Penal Code 1860: http://www.pljlawsite.com/html/ppc377.htm
IX. As shared by queer cis-woman and SRHR advocate and Transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation during IDIs, the facts have not been verified by us.
X. Ibid, IX. Ashfaq Yusufzai, *Transgender People Face Growing Violence, Discrimination in Pakistan.* INTER PRESS SERVICE, July 24, 2023. https://www.ipsnews.net/2023/07/transgender-people-face-growing-violence-discrimination-in-pakistan/
XI. Transgender Persons (Protection of Rights) Act, 2018 (Pakistan)
XII. As shared during an interview with an SRHR advocate and Transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation, this fact has not been independently verified by us.
XIII. Amnesty International, *Pakistan: Revocation of rights of transgender and gender-diverse people must be stopped,* May 19, 2023, https://www.amnesty.org/en/latest/news/2023/05/pakistan-revocation-of-rights-of-transgender-and-gender-diverse-people-must-be-stopped/
XIV. Tanmay Durani & Harsh Bansal, T*he Battle for Inclusion: Pakistan's Transgender Community Faces Setbacks with Shariat Court Verdict*, JURIST – Student Commentary, June 26, 2023, https://www.jurist.org/commentary/2023/06/durani-bansal-pakistan-transgender-shariat-court/

F. Sri Lanka

I. Sri Lankan Penal Code, Act No. 2 of 1883, Section 303-307
II. Center for Reproductive Rights, *Factsheet: Sri Lanka Abortion Laws. Policies, and Practices,* https://reproductiverights.org/sri-lanka-abortion-laws-policies-fact-sheet/
III. The Law Commission in consultation with the Ministry of Child Development and Women's Affairs and the Ministries of Health and Justice, see Dharmasena A. Abortion debate open. *Lakbima News*. February 26, 2012
IV. In 2017, Justice Aluvihare recommended amendments to allow abortions for rape, incest, serious fetal anomalies, and pregnancies in girls under 16. Although the cabinet approved a draft bill, strong opposition from religious groups stalled its progress. See, Melani Manel Perera, *Sri Lankan Bishops Oppose the*

Legalisation of Abortion, PIME ASIA NEWS, Aug 29, 2017, https://www.asianews.it/news-en/Sri-Lankan-bishops-oppose-the-legalisation-of-abortion-41636.html

V. Ibid., II

VI. Interview with Lawyer (cis-woman) from Sri Lanka who works on advocacy and legal reform focusing on issues of marginalized women, girls, children, Dalit, and queer community

VII. Family Health Bureau, Ministry of Health, 2022, https://fhb.health.gov.lk/statistics/

VIII. Article 365 & 365A(Cap.19), Sri Lanka Penal Code (1885), https://database.ilga.org/api/downloader/download/1/LK%20-%20LEG%20-%20Penal%20Code%20(1995)%20-%20OR(en).pdf

IX. As shared by SRHR advocate (cis-woman) from Sri Lanka in the interview. See, Shihara Mudhuwage, *Arrest and Harassment of LGBTIQ Persons,* GROUNDVIEWS, Oct 22, 2022, https://database.ilga.org/api/downloader/download/1/LK%20-%20LEG%20-%20Penal%20Code%20(1995)%20-%20OR(en).pdf

X. Meera Srinivas, *Sri Lanka Supreme Court Clears Way to Decriminalise Homosexuality ,* THE HINDU, May 14, 2023, https://www.thehindu.com/news/international/sri-lanka-supreme-court-clears-way-for-bill-to-decriminalise-homosexuality/article66830862.ece

XI. News Cutter, *Landmark Ruling By Supreme Court Declares Parliament's Simple Majority Sufficient to Overturn Discriminatory Laws against LGBTQ+ Community,*May 9, 2023, https://www.newscutter.lk/sri-lanka-news/top-stories/lgbtq-community-sri-lanka-supreme-court-ruling-09052023-60902/

XII. As shared by SRHR advocate (cis-woman) from Sri Lanka in the interview. See, the Ministry of Health, Sri Lanka issued Circular on the Issuance of the Gender Recognition Certificate (GRC) (Circular No. 01-34) (2016) , https://database.ilga.org/api/downloader/download/1/LK%20-%20EXE%20-%20Circular%2001-34%20(2016)%20-%20OR.OFF(en).pdf

XIII. As shared by Lawyer (cis-woman) from Sri Lanka during interview, Ibid, GRC Circular, XII

XIV. As shared by Lawyer (cis-woman) and SRHR advocate (cis-woman) from Sri Lanka during interview, this has not been independently verified by us.

XV. Ibid, IX

XVI. Ibid, XIV

XVII. Ibid, XIV

Section 4

A. Restrictive Laws on abortion & SRHR and other access barriers.

II. World Heath Organisation, *Factsheet: Abortion,* May 17, 2024, https://www.who.int/news-room/fact-sheets/detail/abortion

III. Susheela Singh, et al., *Abortion Worldide 2017: Uneven Progress and Unequal Access,* GUTTMACHER INSTITUTE, 2018, https://www.guttmacher.org/report/abortion-worldwide-2017

IV. All respondents from Nepal and India

V. As shared by queer cis-woman and SRHR advocate from Pakistan during interview

VI. Shared by Transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation during interview

VII. Ibid., V

VIII. Shared by Transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation during interview , however, this has not been verified by us independently

IX. Ibid., V

X. Interview with lesbian cis-woman working in LBT organisation in India

B. Criminalisation and/or full legal recognition of queer identities

I. Committee on Economic, Social and Cultural Rights, General Comment No. 22 , para 23 (2016) Article 12: The right to sexual and reproductive health E/C.12/GC/22
II. Ibid., para 56
III. Interview with non-binarry SRHR advocate from Maldives
IV. Ajita Banerjie & Nadine Hassan, *Sri Lanka: Amendment in Police Guidelines as a necessary first step towards ensuring access to justice for LGBTIQ persons,* ILGA ASIA, Nov 29, 2023, https://www.ilgaasia.org/news/2023/11/29/sri-lanka-amendment-in-police-guidelines-as-a-necessary-first-step-towards-ensuring-access-to-justice-for-lgbtiq-persons
V. Interview with Lawyer (cis-woman) and SRHR advocate (cis-woman) from Sri Lanka
VI. Interview with a transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation from Pakistan
VII. Committee on the Elimination of Discrimination against Women, General recommendation No. 39 (2020) on the rights of Indigenous women and girls CEDAW/C/GC/39, para. 52 (a)
VIII. Interview with the researcher on SRHR, cis-woman working in a non-profit organisation based out of Kathmandu, Nepal
IX. Interview with the queer cis-woman and SRHR advocate working in non-profit organisation in Pakistan
X. Interview with queer cis-woman working in an LGBTI+ organisation in Bangladesh
XI. Interview with a Dalit non-binary person working in an SRHR organisation in India

C. Awareness and perception of abortion and SRHR needs

I. Interview with a transman working in an SRHR organisation in Nepal
II. Interview with non-binary queer rights advocate from India
III. Interview with the queer cis-woman and SRHR advocate working in non-profit organisation in Pakistan
IV. Interview with a transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation from Pakistan
V. Interview with Lawyer (cis-woman) from Sri Lanka who works on advocacy and legal reform focusing on issues of marginalized women, girls, children, Dalit, and queer community
VI. Interview with a lesbian cis-woman working in LBT organisation in India

D. Barriers within the healthcare system, including conscientious objection and discrimination

I. Interview with transwoman working in LGBTIQ+ organisation in Nepal
II. Interview with two queer women working in LBT organisation in India
III. Interview with Lawyer (cis-woman) from Sri Lanka who works on advocacy and legal reform focusing on issues of marginalized women, girls, children, Dalit, and queer community
IV. Interview with a transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation from Pakistan
V. Interview with the non-binary SRHR advocate from Maldives, however, this has not been independently verified by us.
VI. Interview with SRHR advocate (cis-woman) working in non-profit organisation in Nepal
VII. Interview with a Dalit non-binary person working in an SRHR organisation in India

E. Lack of Social acceptance and support

I. Interview with a Dalit non-binary person working in an SRHR organisation in India
II. Interview with the queer cis-woman and SRHR advocate working in non-profit organisation in Pakistan
III. Ibid., I

IV. Interview with a transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation from Pakistan

Section 5

A. Recommendations at the law and policy level

II. The Transgender Person (Protection of Rights) Act 2019 (India)

III. Heidi Moseson, et al. *Abortion attempts without clinical supervision among transgender, nonbinary and gender-expansive people in the United States*. 48(e1) BMJ SEXUAL & REPRO. HEALTH, e22–e30,(2022). https://srh.bmj.com/content/48/e1/e22

B. Recommendations at the service delivery level

I. Himani Bhakuni & Lucas Miotto. *Conscientious objection to abortion in the developing world: The correspondence argument*. 21(2), DEVELOPING WORLD BIOETHICS, 90–95, (2020). https://doi.org/10.1111/dewb.12302

II. Interview with a transwoman who is a healthcare professional and Director of trans-specific (Khwaja Sara) organisation from Pakistan

C. Recommendations for CBO and Abortion rights movements

I. Interview with a Dalit non-binary person working in an SRHR organisation in India

II. Interview with Lawyer (cis-woman) from Sri Lanka who works on advocacy and legal reform focusing on issues of marginalized women, girls, children, Dalit, and queer community

7. Annexures

a. Interview Questionnaire

UNDERSTANDING COUNTRY CONTEXT

1. Are LGBTQ+ identities legally recognized in your country?
2. What is the current status of laws in terms of self-determination for transgender people, and recognition of same-sex relationships? If there are laws currently in place, how accessible are these laws to the queer individuals?
3. Is homosexuality a criminal offense in your country?
4. Are there any laws affecting healthcare access for members of the LBT community? If yes, how accessible are they, please highlight any exclusionary provisions, that create specific barriers.
5. Is abortion legal in your country? Under what gestational period can one access it? Is there any provision that criminalizes abortion (or restricts medical abortion)? How accessible are abortion and post-abortion services?
6. How does it impact access to lesbian, bisexual, transgender, non-binary, and gender non-conforming[GNC] people?

UNDERSTANDING BARRIERS TO SRH

7. Where do people usually get information about SRH for Queer-trans/GNC people? (sources)
8. How often do you think LBT people visit obstetrics and gynaecology clinics? Are they comfortable in visiting clinics or any other healthcare provider for their SRH needs whenever they feel the need?
9. Do you think members of LBT community are comfortable discussing issues concerning SRH/reproductive histories/pregnancy goals with a healthcare provider?
10. [If answers to Q. 7, 8&9 is no] What are the reasons in your opinion/in your experience?

- Important for understanding the barriers to SRH/factors that deter them from seeking care [Potential hypervigilance when interacting with the healthcare system. Laws/legal

provisions criminalizing LBT persons or criminalizing certain procedures can also contribute to hypervigilance other than the social stigmatisation of sexuality and gender]

Insight from literature: (i) In one study (MacDonald et al, 2), transmasculine individuals universally noted feeling unable to ask their mastectomy surgeon about the potential implications of future pregnancy on their top surgery outcome and lactation - they described feeling that they had to stick to a narrative of "trapped in the wrong body" to avoid jeopardising their ability to get surgery.

(ii) the systematic use of cis-normative language may deter gender-diverse people from seeking needed care - fear of being misgendered - the gendered environment and language can be dysphoric (Stroumsa, 2018).

(iii) Fear of discrimination, refusal to care, verbal harassment, physical violence. Pelvic exams particularly tend to trigger dysphoria.

(iv) denial/ discrimination of queer- trans individual by health system using HIV 'preventive' lens as an excuse*

11. If yes, how has the experience been?

- was there the use of inclusive language about their gender identity and sexual orientation? [or if cis-normative assumptions were made]
- were they asked about their preferred terminology for anatomy?
- manner in which they were about their sexual activity [partner's sex assigned at birth, if the nature of sexual activity could potentially cause pregnancy]
- Any other that you would like to share

12. Are there instances where services are denied based on natal and spousal consent?
13. Any negative experiences you have come across in healthcare directly related to queer/gender identity?
14. Does the LBT community experience additional stress (in addition to the gender minority stress) in accessing healthcare due to intersectional identities (of caste, class, ethnicity, disability, economic)?

HETERONORMATIVE EXPECTATIONS OF BIOLOGICAL PARENTHOOD AND FAMILY FORMATION - IT'S IMPLICATIONS ON RECEIVING BIRTH CONTROL, ABORTION CARE

15. In your understanding do queer women use birth control - and are the primary purposes for which they use it? -?

    Stark et. al (2019) highlight the use of birth control is to a large extent mainly for protection against STD when engaging in penetrative sex or hormonal birth control pill could be for menstrual regulation.

16. Have they faced any difficulties in accessing birth control of their choice due to their identity?

    Findings from an administrative data form the US suggest transmasculine people are less likely to be prescribed oral contraceptive pills or long-acting reversible contraception, than cisgender women.

17. Have they felt any kind of pressure from healthcare providers due to heteronormative expectations of biological parenthood? Does that, in any way, affect the quality of SRH they receive?

ABORTION HISTORY AND PREFERENCES

18. Has anyone in the community you work with ever sought abortion care?
19. Were they aware of different abortion methods - were these methods available and accessible to them;
    a. Is there a preferred choice of method that queer women and transmasculine people opt for? What were the reasons for their choice [could be related to method privacy, level of invasiveness, cost, accessibility, pain, familiarity etc.] – different factors (social, religious and legal) influencing the prefered methods for abortion
    b. Were they able to discuss their need for abortion care and methods available with i) medical provider; ii) any other (community member/service provider/family)?
20. If you have supported someone in their abortion journey, would they feel comfortable sharing anything about the experience?

[if there is a gap between the preferred Abortion method and obtained abortion method]

21. In your experience or knowledge has any LBT member ever sought legal support/advice while accessing SRH services and care, or if you have ever made such referrals specifically concerning SRH services, including for safe abortion
22. What gender-related recommendations would you make to improve the abortion experience?

SOCIAL SUPPORT

23. Do queer women and trans individuals rely on biological family/parents - if they involve them in concerns about their SRH including abortion care (for medical visits, etc)

24. Follow-up question - Do they have a support structure outside of biological kinship who have accompanied them for hospital visits?
25. Has the absence of biological kins/parents/partner been a factor for being denied SRH? *The support structure for queer and trans people may look different from that of cisgender individuals. Scholarly work expands on how queer kinship allows for sexual and gender minorities to lean on each other for care illness and health, for hospital visits, etc.*

CONCLUDING QUESTION

26. What changes do they wish for/suggest for creating a structurally affirming sexual and reproductive healthcare environment?
27. Recommendations for policymakers, CBOs, and feminist abortion rights movements to bridge the gap?

b. Participant List and Profile

Sl.No.	Identity	Profession
Bangladesh		
1	Queer Cis-woman	Works in LGBTQI+ organisation
2	Cis-woman	SRHR advocate working at the South Asia level
India		
1	Queer non-binary person	SRHR advocate
2	Dalit Non-binary person	Works in an SRHR organisation
3	Two Queer women	Works in an LBT organisation
4	Lesbian Cis- woman	Works in an LBT organisation
Maldives		
1	Queer non-binary (AMAB) person	SRHR advocate
2	Cis-woman	Medical Student, SRHR advocate
Nepal		
1	Cis-woman	Working in a non-profit organisation focusing on young people's SRHR
2	Cis-woman	SRHR researcher working in a non-profit organisation
3	Transwoman	Works in LGBTQI+ organisation
4	Transman	Works in an LBT organisation
Pakistan		
1	Queer Cis-woman	SRHR Researcher working in non-profit organisation
2	Transwoman	Healthcare professional, Director of trans-specific (Khwaja Sara) organisation
Sri Lanka		
1	Cis-Woman	Lawyer; works on advocacy and legal reform focusing on issues of marginalized women, girls, children, Dalit, and queer community
2	Cis-Woman	Works on safe abortion advocacy, leadership building for the deaf community, young people with intellectual disability,

c. Compilation of General Recommendation of United Nations Treaty Bodies

Treaty Body	General Comment/General Recommendation	SRHR/Health Care Content
Committee on Economic, Social and Cultural Rights	General comment No. 22 (2016) Article 12: The right to sexual and reproductive health E/C.12/GC/22	Lesbian, gay, bisexual, transgender and intersex persons experience multiple and intersecting discrimination that exacerbates exclusion in both law and practice, and further restricts the full enjoyment of their right to sexual and reproductive health (para. 2).
		Evidence-based information on all aspects of sexual and reproductive health must be provided in a manner consistent with the needs of the individual and the community, taking into consideration sexual orientation, gender identity and intersex status (paras. 18 and 19).
		Non-discrimination, in the context of the right to sexual and reproductive health, encompasses the right of all persons, including lesbian, gay, bisexual, transgender and intersex persons, to be fully respected for their sexual orientation, gender identity and intersex status; criminalization of sex between consenting adults of the same gender or the expression of one's gender identity is a clear violation of human rights; regulations requiring that lesbian, gay, bisexual transgender and intersex persons be treated as mental or psychiatric patients, or requiring that they be "cured" by so-called "treatment", are a clear violation of their right to sexual and reproductive health; State duty to combat homophobia and transphobia, which lead to discrimination, including violation of the right to sexual and reproductive health (para 23).
		Lesbian, gay, bisexual, transgender and intersex persons are more likely to experience multiple discrimination; measures to guarantee nondiscrimination and substantive equality should be cognizant of and seek to overcome the often-exacerbated impact that intersectional discrimination has on the realization of the right to sexual and reproductive health (para 30)
		State duty to reform laws that impede the exercise of the right to sexual and reproductive health, such as laws criminalizing consensual sexual activities between adults and transgender identity or expression (para 40).
		Criminalization of consensual sexual activity between adults creates legal barriers impeding access by individuals to sexual and reproductive health services, and thus violates the State's obligation to respect (para 57).

		State obligation to protect is violated by failure to take effective steps to prevent third parties from undermining the enjoyment of the right to sexual and reproductive health – including failure to prohibit and take measures to prevent violence targeting lesbian, gay, bisexual, transgender and intersex persons, and medically unnecessary, irreversible and involuntary surgery and treatment performed on intersex infants or children (para. 59).
Committee on the Elimination of Discrimination against Women	General recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change CEDAW/C/GC/37	State duty to explicitly included in health-care policies and standards relating to situations of disaster specific measures to ensure the promotion and protection of the rights of lesbian, bisexual and transgender women and girls and intersex persons (para. 68 (f)).
Committee on the Elimination of Discrimination against Women	General recommendation No. 39 (2020) on the rights of Indigenous women and girls CEDAW/C/GC/39	State duty to ensure that quality health services and facilities are available, accessible, affordable, culturally appropriate and acceptable for Indigenous women and girls, including lesbian, bisexual, transgender and intersex women and girls (para. 52 (a).
Committee on the Rights of the Child	General comment No. 3 (2003): HIV/AIDS and the rights of the child CRC/GC/2003/3	Discrimination, including based on sexual orientation, is responsible for heightening the vulnerability of children to HIV and AIDS, as well as seriously impacting the lives of children who are affected by HIV/AIDS, or are themselves HIV infected (paras. 7 and 8).
Committee on the Rights of the Child	General comment No. 4 (2003): Adolescent health and development in the context of the CRC Convention CRC/GC/2003/4	State duty to ensure that all human beings below 18 enjoy all the rights in the Convention on the Rights of the Child without discrimination, including based on adolescents' sexual orientation and health status (including HIV/AIDS and mental health) (para. 6)
Committee on the Rights of the Child	General comment No. 20 (2016) on the implementation of the rights of the	Lesbian, gay, bisexual and transgender adolescents commonly face persecution, including abuse and violence, stigmatization, discrimination, bullying, exclusion from education and training, lack of family and social support, or access to sexual and reproductive health services and information; in extreme cases, sexual assault, rape and even death; these experiences have been linked to low self-esteem, higher rates of depression, suicide and homelessness (para. 33)
		All adolescents have the right to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy; the imposition of so-called "treatments" to try to change sexual orientation and forced surgeries or treatments on intersex adolescents are condemned by the Committee on the Rights

	child during adolescence CRC/C/GC/20	of the Child; State duty to eliminate such practices, repeal all laws criminalizing or otherwise discriminating against individuals on the basis of their sexual orientation, gender identity or intersex status and adopt laws prohibiting discrimination on those grounds, and to take effective action to protect all lesbian, gay, bisexual, transgender and intersex adolescents from violence, discrimination or bullying by raising public awareness and implementing safety and support measures (para. 34).
		State duty to make particular efforts to overcome barriers of stigma and fear experienced by lesbian, gay, bisexual, transgender and intersex adolescents in gaining access to commodities, information and counselling on sexual and reproductive health and rights (para. 60).
		Comprehensive and inclusive sexual and reproductive health education, with attention to sexual diversity, should be part of the mandatory school curriculum and reach out-of-school adolescents (para. 61).