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Surrogacy and Reproductive Autonomy: Legal Challenges of Gamete Preservation and Marital Breakdown in India

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ABSTRACT

Assisted reproductive technologies have changed how people make reproductive decisions and have prompted difficult legal and bioethical questions about autonomy, consent and the supervision of medical practice. The Surrogacy (Regulation) Act, 2021 and the Assisted Reproductive Technology (Regulation) Act, 2021 are India's careful, control-oriented answer to the clinical and ethical problems that surrogacy and gamete storage create. This paper treats reproductive autonomy as a facet of the liberty guaranteed by Article 21 of the Constitution of India and concentrates on surrogacy, the freezing of eggs and sperm, and reproductive decisions made after separation or divorce. It examines the legal standing of stored gametes, the questions of consent, ownership and withdrawal that follow, and the statutes' silence on choices made after a marriage ends. It also observes that the Surrogacy Act, although open to a widowed or divorced "intending woman", does not say how gametes preserved during a marriage may be used once it has ended. The paper asks whether current medical law protects women's reproductive autonomy while giving due weight to ethical concerns and the welfare of the child. Using doctrinal analysis, constitutional case law and selected comparative material, it finds significant gaps in the regulation of assisted reproduction. It argues for a rights-based, gender-sensitive framework built on continuing informed consent, ethical governance and reproductive choice that does not depend on the survival of a marriage.

Keywords: *Reproductive Autonomy, Surrogacy, Gamete Preservation, Assisted Reproductive Technology, Marital Breakdown*

I. INTRODUCTION

Assisted reproductive technologies (ARTs) have reshaped both medicine and law around human reproduction, and with them settled ideas of family and parenthood. In vitro fertilisation, gamete cryopreservation and surrogacy let people have children at times, and in circumstances, that biology and convention once ruled out. The same advances raise hard questions about bodily autonomy, informed consent, control over reproductive material and the proper reach of medical

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regulation. In India, where reproductive choices are closely bound up with social expectations and marital status, those questions carry added weight.

Surrogacy sits at a particularly contested point in medical law, where reproductive autonomy meets worries about exploitation, clinical responsibility and the welfare of the child. India's response has been to rein in what was seen as the excess of commercial reproduction while keeping medical practice under ethical supervision. With the Surrogacy (Regulation) Act, 2021 and the Assisted Reproductive Technology (Regulation) Act, 2021, the state has taken charge of reproductive medicine through eligibility conditions, institutional approvals and consent requirements. The statutes aim to prevent misuse and protect vulnerable parties, but they also leave open how much individual autonomy survives in such a tightly regulated field.

Indian courts have read reproductive autonomy into the protection of life and personal liberty under Article 21, treating the decision to have a child, or not to, as part of decisional privacy and bodily integrity.[1] That constitutional position has not yet been squared with the statutory regime for assisted reproduction, particularly where reproductive decisions are taken outside an ongoing marriage. Cryopreservation sharpens the difficulty. Frozen eggs and sperm allow reproduction to take place long after, and in a different relationship from, the one in which consent was first given.

One of the least examined questions in Indian law is what happens to reproductive decisions when a marriage ends. Gametes are often frozen during marriage as part of fertility treatment, and the law has little to say when the relationship later breaks down. May a woman use stored gametes through surrogacy after separation? Does the consent given at the time of storage outlast the marriage, or can one partner withdraw it alone? Are stored gametes property, bodily material, or something deserving a category of their own? The statutes answer these questions only in part, despite their medical, ethical and emotional gravity.

For clinics, practitioners and regulators the gaps are uncomfortable. ART clinics must obtain informed consent, observe ethical norms and meet statutory conditions, yet they have no clear rule for disputes over stored gametes or for surrogacy after separation. Without express provisions on the effect of withdrawal after a marriage has ended, on ownership and on decision-making authority, clinical practice is likely to vary and both patients and doctors are exposed to legal risk. The burden also falls unevenly: limits on post-separation reproductive choice weigh most heavily on women.

[1] *Suchita Srivastava v. Chandigarh Administration*, (2009) 9 SCC 1, ¶ 22 (India).

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This paper places these concerns within medical law and constitutional rights. It treats reproductive autonomy as a legally protected interest, reviews the regulatory structure for surrogacy and assisted reproduction, and studies the legal status of preserved gametes when a marriage breaks down. Drawing on constitutional case law, statutory analysis and selected comparative material, it identifies where India's reproductive governance is incomplete or unclear. Its argument is that the present framework does not meet changing reproductive realities and does not align medical regulation with the Constitution's commitment to decisional autonomy. The paper concludes by proposing a rights-based, gender-sensitive framework that recognises reproductive autonomy beyond the life of a marriage while protecting informed consent, ethical governance and the welfare of the child.

II. Reproductive autonomy, consent and medical law: A conceptual framework

Reproductive autonomy is central to modern medical law because it expresses the ethical duty to honour a person's choices about her body, health and reproduction. At its core is the liberty to decide if, when and by what means to become a parent, free from coercion and unjustified interference. Where ARTs are involved, that liberty is exercised through medical intervention, institutional regulation and statutory oversight, so that a personal choice becomes a regulated clinical decision. The interplay between patient autonomy and medical governance is what reproductive regulation is fundamentally about.

In bioethics, reproductive autonomy tracks the principle of respect for autonomy, under which people may take informed and voluntary decisions about treatment and reproduction.[2] Informed consent is the means by which that principle operates in practice, above all in ART procedures that involve invasive interventions, third-party participation and long-term effects. Consent in reproductive medicine is more than a formality: it touches bodily integrity, decisional privacy and future parental status. This matters most for cryopreservation, where material is stored for later use, by which time the parties' lives may look very different.

Reproductive choice has long been read into Article 21 as part of the protection of life and personal liberty. In *Suchita Srivastava v. Chandigarh Administration*,[3] the Supreme Court held that a woman's right to make reproductive choices is an aspect of personal liberty, covering both the right to procreate and the right to abstain from procreating. The Court built on this when it recognised decisional privacy in *Justice K.S. Puttaswamy (Retd.) v. Union of India*,[4]

[2] Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics (7th ed. 2013).
[3] *Suchita Srivastava*, *supra* note 1, ¶ 22.
[4] *Justice K.S. Puttaswamy (Retd.) v. Union of India*, (2017) 10 SCC 1, ¶¶ 248, 298 (Chandrachud, J.) (India).

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which protects autonomy over intimate and personal choices, reproductive decisions among them. Together, the decisions place reproductive autonomy within a wider set of values: bodily integrity, dignity and self-determination.

Translating constitutional autonomy into medical law is, however, neither automatic nor absolute. Medical regulation brings permissible limits grounded in ethical concern, public interest and clinical accountability. The state may regulate medical practice to prevent exploitation, protect patient safety and uphold professional standards, and in assisted reproduction it does so through eligibility criteria, institutional approvals and restrictions on certain arrangements. Such measures can be legitimate, but they must be weighed against the individual's constitutional claim to reproductive choice.

Consent is unusually complicated in assisted reproduction, where several actors, delayed reproduction and stored biological material are involved. Unlike consent to ordinary treatment, consent to ART often has to hold over long periods and through events that cannot be foreseen. Freezing eggs and sperm illustrates the problem: what a person agreed to when the gametes were stored may not reflect her wishes when they are eventually used. As the next part shows, the ART Act lets either member of a commissioning couple withdraw consent before transfer to the uterus, but Indian law has not settled how that power operates once the couple are no longer married. That gap matters greatly for autonomy, especially once the relationship that gave rise to the consent has ended.

Marital status complicates matters further. Indian reproductive regulation has traditionally treated a continuing marriage as the normal setting for reproductive decisions. This shows most plainly in the Surrogacy Act, which ties access to marriage or to its ending through widowhood or divorce, and in the ART Act's category of the "commissioning couple", although that Act also admits a "woman" seeking services on her own. These conditions are commonly defended as protection against misuse and exploitation, but they may import moral views of the family into what is a constitutional guarantee of autonomy. Making marital continuity a precondition for reproductive choice invites the question whether autonomy is being made to give way to social conformity.

The gender dimension is clear. Women carry the physical burden of reproductive procedures, including hormonal stimulation, egg retrieval, pregnancy and childbirth, yet control over reproductive material and decisions is often routed through spousal consent and institutional approval. The imbalance is sharpest after separation, when a woman's intentions may differ from those of her former partner. With no clear standards on withdrawal of consent after a

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marriage has ended and on control of preserved gametes, her autonomy depends on legal uncertainty and institutional discretion.

Medical law must therefore balance respect for reproductive autonomy against the ethical governance of reproductive technologies. If the principles of consent, autonomy and control remain unarticulated, patient rights and clinical certainty both suffer. As technology allows reproduction to proceed independently of marriage and of biological immediacy, the law has to adapt. Treating reproductive autonomy as a continuing, context-sensitive right, rather than a consent fixed at a single moment, is necessary for bringing medical regulation into line with constitutional values.

This framework supports the analysis that follows of India's regulatory response to surrogacy and assisted reproduction. The next parts ask whether the existing statutory machinery accommodates changing reproductive choices, particularly in relation to gamete preservation and decisions after separation.

III. Regulatory framework governing surrogacy and assisted reproductive technologies in India

India's approach to assisted reproduction changed significantly with the Surrogacy (Regulation) Act, 2021 and the Assisted Reproductive Technology (Regulation) Act, 2021. Together they form the country's first comprehensive legislative effort to regulate reproductive medicine, fertility clinics and third-party reproductive arrangements. They replace judicially shaped permissibility and executive guidelines with a codified regime built on ethical oversight, institutional accountability and controlled access to reproductive technology.

A. Evolution of surrogacy regulation

Before legislation, surrogacy in India operated largely in a legal vacuum, governed by private contracts and professional practice standards, and the courts shaped the early law. *Baby Manji Yamada v. Union of India*[5] concerned the custody and travel of a child born through surrogacy to foreign commissioning parents. The Supreme Court's handling of the case showed how little legislative guidance existed on parentage and nationality. It revealed gaps in how children born of surrogacy are to be classified in law, and in what commissioning parents and surrogate mothers owe each other.

[5] *Baby Manji Yamada v. Union of India*, (2008) 13 SCC 518 (India).

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Concerns about exploitation, the commercialisation of reproduction and ethical lapses in fertility clinics then pushed the state toward restrictive regulation.[6] The Surrogacy (Regulation) Act, 2021 prohibits commercial surrogacy and permits only altruistic surrogacy on narrowly defined conditions. Access is limited to intending couples who are legally married and meet prescribed age and medical criteria, and to an "intending woman", defined as a widow or divorcee aged between 35 and 45, in each case subject to approval by designated authorities.[7] This model rests on a moralised conception of family and reproduction that favours marital continuity and biological parenthood over individual reproductive autonomy.

For medical practice, the Act embeds reproductive decision-making in an approval-based administrative framework. Doctors must act as gatekeepers as well as clinicians: no procedure may begin unless the director or in-charge of the clinic and the qualified person are satisfied, for reasons recorded in writing, that the statutory certificates and conditions are in place, and the surrogate mother's written informed consent must be obtained.[8] These duties help prevent exploitation and unethical practice, but they also narrow patient autonomy by making treatment depend on statutory approval and not on clinical indication alone.

B. The Assisted Reproductive Technology (Regulation) Act, 2021

The ART Act complements the surrogacy statute by regulating fertility clinics, gamete banks and procedures such as IVF and gamete preservation. It requires registration of ART clinics and banks, prescribes standards of practice and places them under the supervision of the national and state boards constituted under the Surrogacy Act.[9] Informed consent, record-keeping and ethical governance are at its centre.

The Act expressly accepts gamete cryopreservation as legitimate practice and permits the storage of eggs and sperm for later use. Its procedural safeguards, however, are not matched by provisions on ownership, control and decisions after storage. Written consent, with instructions for death or incapacity, is required before storage, and a member of a commissioning couple may withdraw consent before transfer, but the Act does not say how that power operates once

[6] Amrita Pande, *Commercial Surrogacy in India: Manufacturing a Perfect Mother-Worker*, 35 SIGNS 969 (2010), https://doi.org/10.1086/651043.

[7] The Surrogacy (Regulation) Act, 2021, No. 47, Acts of Parliament, 2021, §§ 2(1)(h), 2(1)(r), 2(1)(s), 3(ii), 4 (India) [hereinafter Surrogacy Act].

[8] Surrogacy Act, *supra* note 7, §§ 4(iii), 6(1), 46(1); The Surrogacy (Regulation) Rules, 2022, G.S.R. 460(E), Gazette of India, Extraordinary, pt. II, § 3(i) (June 21, 2022), Form 2, ¶ 1(d) (India). *See generally* EMILY JACKSON, MEDICAL LAW: TEXT, CASES AND MATERIALS (4th ed. 2016).

[9] The Assisted Reproductive Technology (Regulation) Act, 2021, No. 42, Acts of Parliament, 2021, §§ 3–8, 12–20, 28(1) (India) [hereinafter ART Act]; The Assisted Reproductive Technology (Regulation) Rules, 2022 (India) [hereinafter ART Rules].

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the couple has divorced. The gap is most troubling where the relationship behind the consent, such as a marriage, later changes.

The Act also places heavy responsibility on clinics for consent documentation and compliance. Without clear standards for disputes over stored gametes, clinics must resolve hard ethical and legal questions unaided. That uncertainty exposes practitioners to liability and inconsistent decisions, and defeats the certainty that regulation is supposed to supply.

C. Consent, autonomy and regulatory silences

Both statutes treat consent as a foundational principle, but largely as a procedural step and not as a continuing expression of autonomy. The Surrogacy Act gives the surrogate mother an option to withdraw her consent before implantation, and the ART Act allows any member of a commissioning couple to withdraw consent before the embryos or gametes are transferred to the woman's uterus.[10] Neither says whether consent to use stored gametes outlasts a separation, or whether a former spouse, once no longer married, keeps the power to withdraw it. The silence is striking given how irreversible reproductive decisions are and how much reproductive intent matters ethically.

Courts have repeatedly stressed informed consent in medical settings. *Devika Biswas v. Union of India*,[11] a challenge arising from sterilisation camps, insisted on safeguards for informed consent in reproductive healthcare. The statutory framework for assisted reproduction has not carried that emphasis into clear rules on withdrawal of consent after a marriage has ended and on post-separation decision-making. Constitutional principles of autonomy and decisional privacy therefore remain only partly integrated into medical law.

D. Gendered implications of regulatory design

India's regulatory design has gendered effects. Although framed in neutral terms, limits on access to surrogacy and ART fall more heavily on women, especially those who seek reproductive choice outside a continuing marriage. Because women carry the physical burden of these procedures, spousal consent requirements, eligibility rules and administrative approvals bear most directly on their autonomy.[12]

The position of a divorced or separated woman illustrates the tension between reproductive autonomy and regulatory paternalism. A divorced woman may qualify as an intending woman, yet the framework does not say whether she may use her own eggs stored during the marriage,

[10] Surrogacy Act, *supra* note 7, § 6(2); ART Act, *supra* note 9, §§ 2(1)(e), 22(4).
[11] *Devika Biswas v. Union of India*, (2016) 10 SCC 726, ¶ 111 (India).
[12] ART Act, *supra* note 9, §§ 21(a), 22(1); Surrogacy Act, *supra* note 7, § 4(iii)(a), (c).

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and its rule on gametes leaves no evident room for embryos created with her former husband. Where eligibility is tied to marital status, the law reinforces assumptions about family and reproduction that may conflict with constitutional guarantees of equality and personal liberty. In medical-law terms, such limits risk subordinating patient autonomy to moralised regulatory goals and weaken the ethical foundations of reproductive healthcare.

E. The need for coherent governance

The regime for surrogacy and assisted reproduction in India is cautious and control-oriented. The aims of preventing exploitation and ensuring ethical practice are legitimate, but the present law lacks coherence in dealing with the realities that technology now makes possible. Failure to state clear principles on consent, autonomy and control over reproductive material creates uncertainty for patients, practitioners and regulators alike.

This part shows that Indian reproductive regulation puts institutional oversight ahead of individual autonomy, especially after separation. Because no provision addresses the legal status of preserved gametes or their use after a marriage ends, the next part examines gamete preservation, consent and ownership as central problems of reproductive medical law.

IV. Gamete preservation, consent and the legal status of stored reproductive material

Freezing reproductive material has changed the timing and relational setting of reproduction. Eggs and sperm can be stored so that decisions are postponed, split up and detached from the circumstances in which consent was first given. Although cryopreservation is accepted clinical practice, its legal consequences, above all for consent, ownership and use after separation, are barely addressed in Indian medical law.

A. Cryopreservation as medical and legal practice

Gametes are frozen for many medical and social reasons: to preserve fertility before treatment, to postpone childbearing, and to support assisted reproduction within marriage. The ART Act treats gamete preservation as lawful and requires clinics and banks to follow prescribed standards, consent requirements and record-keeping duties.[13] But it mainly regulates the process of preservation, not the legal consequences of storing reproductive material.

As a matter of medical law, stored gametes are in an ambiguous position. They are neither ordinary property nor tissue to be discarded after treatment; they carry reproductive potential and personal, genetic and emotional meaning. That ambiguity clouds questions of control,

[13] ART Act, *supra* note 9, §§ 2(1)(b), 22(2), 23, 28.

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especially when people who jointly consented to storage later separate. Because stored gametes have no settled legal category, clinics lack authoritative guidance for disputes over their use.

B. Consent and its temporal limits

Consent is central to medical ethics and to the regulation of reproductive technology. Informed consent to ART normally requires disclosure of risks, procedures and future contingencies, including the duration of storage and the conditions for disposal. Yet consent given at the time of freezing tends to be treated as fixed, even though reproductive intent changes over time.

Written consent from all the parties is mandatory under the ART Act, and section 22(4) allows any member of a commissioning couple to withdraw consent under section 22(1) at any time before the embryos or gametes are transferred to the woman's uterus.[14] Section 22(3) separately forbids a clinic to use reproductive material to create an embryo, or to use an in-vitro embryo, without the specific written consent of all the concerned persons. Section 22(4) is limited, however. It speaks only of a commissioning couple, which the Act defines as an infertile married couple, and it says nothing about consent after that marriage has ended, about a surrogacy arrangement, or about what becomes of the stored material once consent is withdrawn. Wishes can shift, particularly after events such as separation or divorce. Treating consent as immutable in those cases binds people to decisions taken in materially different circumstances and so weakens autonomy.

Suchita Srivastava treated reproductive choice as part of a person's liberty and control over her body.[15] Applied to cryopreservation, the principle suggests that permission to use stored gametes ought to be re-confirmed rather than assumed from the time of storage. Indian statutes have not written this into explicit rules on reconfirmation.

C. Ownership and control over stored gametes

A central unresolved question is whether stored gametes can be "owned" and, if so, by whom. No Indian statute classifies gametes as property or offers another scheme for deciding control. The silence is most acute for jointly preserved gametes, where rival claims may arise after marital breakdown.

Comparative law sheds light on the problem. In *Evans v. United Kingdom*, the Grand Chamber of the European Court of Human Rights upheld a UK statute requiring the continuing consent of both gamete providers for the use of stored embryos, accepting that the decision not to

[14] ART Act, *supra* note 9, §§ 2(1)(e), 2(1)(u), 21–22; ART Rules, *supra* note 9, rr. 13(1)(f)(i), (iv), 16, Form 6, ¶ 5, Forms 9–10; *see Saswati Mohury v. Union of India*, WPA 1592 of 2023 (Cal. HC Mar. 24, 2023).
[15] *Suchita Srivastava*, *supra* note 1, ¶ 22.

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become a parent is protected alongside the decision to become one, since otherwise the man would be forced to become a father.[16] In *R v. Human Fertilisation and Embryology Authority, ex parte Blood*,[17] the English Court of Appeal held that, without the man's written consent, the statute barred both the storage of his sperm and treatment in the United Kingdom, although it held that the Authority's refusal to allow export for treatment abroad could not stand. Both decisions show the weight courts give to clear consent, even where the other party's reproductive interests suffer.

No Indian court appears to have ruled directly on a dispute between former spouses over stored gametes. The nearest decisions concern death, not divorce. In *Gurvinder Singh v. Government of NCT of Delhi*, the Delhi High Court, relying on the consent given by an unmarried man before his death, treated his frozen sperm as property and ordered its release to his parents.[18] Constitutional protection for decisional privacy and autonomy suggests that compelled reproduction would be incompatible with Article 21. In *Puttaswamy*,[19] the Court recognised autonomy over intimate personal choices as a core constitutional value. Applied to cryopreservation, this implies that neither party should be forced into genetic parenthood against their will. Yet the lack of clear statutory guidance leaves open whether a woman may proceed with surrogacy using stored gametes when her former partner withdraws consent after separation.

D. Marital breakdown and post-separation reproductive choice

Gamete preservation and marital breakdown together expose the weakness of existing regulation. Where eggs or sperm were stored during marriage with mutual consent, dissolution of the marriage leaves it unclear whether consent survives and whether post-separation reproductive choice can be justified. Indian surrogacy regulation assumes a continuing marriage as the setting for reproductive arrangements, and so overlooks cases where reproductive intent outlasts it.

Women bear the heavier cost, especially those who have gone through egg retrieval and freezing. Denying post-separation use of stored gametes cancels the medical investment women

[16] *Evans v. United Kingdom*, (2008) 46 EHRR 34, App. No. 6339/05, ¶¶ 71, 73, 89–90, 92 (Grand Chamber).
[17] *R v. Human Fertilisation and Embryology Authority, ex parte Blood*, [1997] 2 All ER 687, 703–04 (CA) (Eng.).
[18] *Gurvinder Singh v. Government of NCT of Delhi*, W.P.(C) 15159/2021, ¶¶ 143–45 (Del. HC Oct. 4, 2024) (India), *notice issued on appeal by the Union of India* (Del. HC Jan. 29, 2026), *as reported in Centre Moves Delhi HC Against Order Permitting Posthumous Reproduction*, MILLENNIUM POST (Feb. 1, 2026), https://www.millenniumpost.in/big-stories/centre-moves-delhi-hc-against-order-permitting-posthumous-reproduction-646426; *see also Priya Sreeraj v. Union of India*, W.P.(C) No. 22457 of 2025, 2026:KER:66664 (Ker. HC Sept. 1, 2026) (India) (widow permitted to use embryos cryopreserved during her husband's lifetime).
[19] *Puttaswamy*, *supra* note 4, ¶¶ 248, 298.

have already made and lets a spouse's consent operate as a veto over later choice. This risks entrenching gendered power imbalances and undermines the constitutional commitment to reproductive autonomy.

For clinics, the absence of rules on post-separation use is untenable. They must weigh duties to respect patient autonomy, avoid liability and meet regulatory obligations with no clear statutory rule. The predictable response is caution: refusing services instead of reasoned adjudication of competing interests.

E. Ethical and legal implications

The unsettled status of preserved gametes raises wider ethical concerns about bodily integrity, reproductive intent and the avoidance of forced parenthood. The principles that underpin medical law, in particular respect for autonomy and non-maleficence, require reproductive decisions to be voluntary and sensitive to context. Compelling or forbidding the use of preserved gametes without clear legal justification risks serious psychological and moral harm.

Regulatory silence also undermines predictability and consistency in reproductive healthcare. Without express legislative standards on withdrawal of consent after a marriage has ended, ownership and post-separation use, governance stays fragmented and open to discretionary decisions. The gap shows the need for a coherent legal framework that recognises the distinct status of preserved gametes and accommodates changing reproductive realities.

F. Towards a principled legal framework

A principled approach to regulating gamete preservation must reconcile reproductive autonomy with ethical governance and clinical certainty. It requires treating consent as a continuing process instead of a single event, setting clear standards for withdrawal, and acknowledging the gendered effects of reproductive regulation. Legislative clarity on these points would protect individual autonomy and give practitioners and regulators the guidance they now lack.

The analysis shows that the legal status of preserved gametes is among the most pressing unresolved issues in Indian medical law. The next part considers how these uncertainties appear most sharply in cases of marital separation and surrogacy, and whether existing law can accommodate post-separation reproductive decision-making.

V. MARITAL BREAKDOWN, SURROGACY AND POST-SEPARATION REPRODUCTIVE RIGHTS

Indian surrogacy law presumes a stable marriage and shared reproductive intent. The Surrogacy Act permits surrogacy for intending couples who are legally married and meet the prescribed

criteria, and for an intending woman who is a widow or divorcee within a defined age band.[20] Marriage, or its ending through widowhood or divorce, is thus the gateway to lawful surrogacy. The framework aims to prevent commercial exploitation and protect children, but it does not address cases where reproductive intent outlives a marriage and the gametes or embryos at issue were created within it. The omission is most significant for women's reproductive autonomy.

A. Statutory silence and marriage as the organising premise

Although a divorced woman may qualify as an intending woman, neither the Act nor the Rules addresses her use of material preserved during the marriage. The Rules now require a single woman, meaning a widow or divorcee, to use her own eggs and donor sperm,[21] which leaves little room for embryos or sperm stored jointly with a former spouse and provides no rule on that spouse's consent. Marital status thus influences who may use surrogacy and also whose gametes may be used. The Act also forbids storing a human embryo or gamete for the purpose of surrogacy, saving only storage for other legal purposes such as sperm banks, IVF and medical research.[22] This overlooks the fact that reproductive decisions, including storage, are frequently taken during marriage in the expectation of future parenthood, whatever becomes of the marriage.

From a medical-law perspective, the silence is a problem. Assisted reproduction is regulated as a clinical intervention grounded in consent, autonomy and patient welfare. Yet when surrogacy is sought after a marriage has broken down, the legitimacy of the procedure is judged by marital norms rather than by informed consent and reproductive choice. Equating marital status with reproductive entitlement risks denying medical services on grounds unrelated to health, ethics or clinical suitability.

B. Reproductive autonomy beyond marital continuity

Constitutional case law has steadily recognised reproductive choice as part of personal liberty. *Suchita Srivastava* held that a woman's reproductive decisions fall within her bodily autonomy under Article 21.[23] *Puttaswamy* later treated decisional autonomy over intimate matters as inseparable from dignity and privacy.[24] These decisions suggest that reproductive autonomy belongs to the individual and does not depend on marriage.

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[20] Surrogacy Act, *supra* note 7, §§ 2(1)(h), 2(1)(r), 2(1)(s), 4.
[21] The Surrogacy (Regulation) Rules, *supra* note 8, Form 2, ¶ 1(d)(ii), *as substituted by* The Surrogacy (Regulation) Amendment Rules, 2024, G.S.R. 119(E), Gazette of India, Extraordinary, pt. II, § 3(i), r. 2 (Feb. 21, 2024) (India).
[22] Surrogacy Act, *supra* note 7, § 3(vii).
[23] *Suchita Srivastava*, *supra* note 1, ¶ 22.
[24] *Puttaswamy*, *supra* note 4, ¶¶ 248, 298.

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Surrogacy regulation nevertheless remains tied to marital norms. Preventing a woman from using surrogacy because her marriage has broken down, even though she holds preserved gametes and is ready to take sole parental responsibility, makes her choice depend on a former spouse's consent or continued association. A woman who is separated but not divorced is in a sharper difficulty, because she is not yet an intending woman at all. This invites weighty constitutional objections on grounds of equality, dignity and decisional privacy.

C. Consent conflicts and forced parenthood

Surrogacy after separation also complicates consent, particularly where stored gametes or embryos were created jointly. Two interests collide: freedom from unwanted genetic parenthood and the freedom to have a child. Beyond the requirement in section 22(3) of the ART Act of specific written consent from all the concerned persons, Indian law gives no express guidance on resolving the conflict, leaving clinics and courts without a principled framework.

Comparative authority is wary of compelled genetic parenthood. In *Evans*, the European Court held that a law allowing either party to withhold consent to the use of embryos struck a fair balance, and it declined to give the right to become a genetic parent greater weight than the right not to become one, even though the outcome ended the applicant's only chance of a genetically related child.[25] In *A.Z. v. B.Z.*, the Supreme Judicial Court of Massachusetts declined to enforce an agreement allowing a former wife to use frozen embryos after divorce, holding that a court will not compel a person to become a parent over his or her present objection.[26] Both cases show a preference for contemporaneous consent and caution about enforcing earlier agreements that no longer reflect present wishes.

Indian courts do not yet appear to have decided comparable disputes, but constitutional principle suggests that forced parenthood would conflict with Article 21. At the same time, a blanket bar on post-separation surrogacy disadvantages women who have undergone invasive egg retrieval or who face age-related fertility limits. Without nuanced standards the result is all-or-nothing, and competing rights are poorly balanced.

D. Gendered impact of post-separation restrictions

Restrictive surrogacy regulation is not gender-neutral. For the reasons already given, refusing access to surrogacy after marital breakdown falls hardest on women and reinforces patriarchal control over reproductive outcomes. This is especially troubling given *Navtej Singh Johar v.*

[25] *Evans*, *supra* note 16, ¶¶ 72, 90, 92.
[26] *A.Z. v. B.Z.*, 431 Mass. 150, 725 N.E.2d 1051 (2000).

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Union of India,[27] where the Supreme Court held that constitutional morality, not societal morality, must guide the Court when personal autonomy is at stake.

By privileging marital status over individual consent, the law also sustains a heteronormative and relational model of reproduction that marginalises women whose choices fall outside conventional family structures. In medical-law terms, such exclusion undermines ethical commitments to patient autonomy and non-discrimination in access to healthcare.

E. Clinical uncertainty and regulatory risk

Uncertainty in the law on post-separation surrogacy leaves ART clinics and surrogacy practitioners exposed. Clinics risk liability if they proceed without clear statutory authority, while refusing services may infringe patients' constitutional rights. This encourages conservative practice that puts avoidance of legal risk ahead of patient-centred care and ultimately narrows access to lawful medical services. A coherent framework must address post-separation scenarios expressly; without that, reproductive governance stays fragmented, inconsistent and open to arbitrary decisions, harming both patient trust and clinical ethics.

F. Reimagining surrogacy regulation

A rights-based approach requires decoupling reproductive autonomy from marital continuity. Legal recognition of post-separation surrogacy, subject to robust consent safeguards and child-welfare checks, would bring medical law closer to constitutional values. It would acknowledge that reproductive intent can persist independently of a marriage and that a woman's autonomy should not hang indefinitely on spousal consent.

This part has shown that excluding post-separation reproductive choice is a serious limitation of India's surrogacy framework. The next part considers the ethical, constitutional and policy reforms needed to reconcile reproductive autonomy with responsible medical regulation.

VI. Ethical tensions, child welfare and constitutional balancing in assisted reproduction

Assisted reproductive technologies, particularly surrogacy and gamete preservation, create ethical tensions that go beyond individual choice to touch child welfare, medical responsibility and the interests of society. Indian surrogacy regulation tries to balance these considerations, but its use of marital status as a regulatory proxy risks oversimplifying complex ethical and constitutional questions. A principled approach balances reproductive autonomy against ethical governance and child welfare instead of subordinating autonomy to formal marital categories.

[27] *Navtej Singh Johar v. Union of India*, (2018) 10 SCC 1 (India), slip op. ¶¶ 116, 119 (Misra, C.J.).

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A. Reproductive autonomy and medical ethics

Reproductive autonomy rests on the basic principles of medical ethics, notably respect for autonomy and informed consent. These principles require that people keep meaningful control over decisions about their bodies and reproductive futures. Where surrogacy and gamete storage are concerned, autonomy means more than initial consent: it includes the capacity to reassess reproductive intent given changed personal circumstances.

The Supreme Court has returned often to the ethical centrality of bodily autonomy. In *Suchita Srivastava*, it tied reproductive choice to decisional autonomy and dignity.[28] In *Common Cause (A Registered Society) v. Union of India*,[29] which concerned advance medical directives and the withdrawal of life-sustaining treatment, the Court affirmed a patient's right to decide about medical treatment as an aspect of dignity and self-determination. The principle, though stated in another setting, applies by analogy to assisted reproduction: ethical medical practice must accommodate consent that evolves and cannot be tied inflexibly to marital continuity.

B. Child welfare as a ground for regulation

Child welfare is often cited to justify limits on who may use surrogacy. The Surrogacy (Regulation) Act, 2021 is driven by worries about exploitation, the status of the child and the child's best interests. These concerns are legitimate, but using them as a blanket ground for exclusion raises constitutional and ethical difficulties.

Indian family law has made clear that the "best interests of the child" is a context-specific standard and not a formula. In *Gaurav Nagpal v. Sumedha Nagpal*,[30] the Court said that a court faced with conflicting parental claims must look beyond the legalistic and decide each time by reference to the child's welfare, taken in its widest sense. Applied to surrogacy, this undermines the assumption that children born after separation are inherently disadvantaged. It is submitted that a child's welfare is shaped by the quality of caregiving and social support rather than by marital status alone.

From a medical-law perspective, denying reproductive services on speculative welfare grounds risks confusing moral discomfort with clinical or ethical harm. Ethical governance calls for evidence-based regulation, not categorical assumptions about family structure.

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[28] *Suchita Srivastava*, *supra* note 1, ¶ 22; *see also* LAW AND BIOETHICS (Michael Freeman ed., 2008).

[29] *Common Cause (A Registered Society) v. Union of India*, (2018) 5 SCC 1 (India), slip op. ¶¶ 161–63 (Misra, C.J.).

[30] *Gaurav Nagpal v. Sumedha Nagpal*, (2009) 1 SCC 42, ¶¶ 50–51 (India); *see also* ANDREW BAINHAM, CHILDREN: THE MODERN LAW (3d ed. 2005); Eric Blyth & Lucy Frith, *Donor-Conceived People's Access to Genetic and Biographical History: An Analysis of Provisions in Different Jurisdictions Permitting Disclosure of Donor Identity*, 23 INT'L J.L. POL'Y & FAM. 174 (2009), https://doi.org/10.1093/lawfam/ebp002.

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C. Avoiding forced parenthood and ethical harm

One of the hardest ethical dilemmas in assisted reproduction is the prevention of forced parenthood. Compelling a person to become a genetic parent against her or his will raises serious objections, affecting personal autonomy, psychological well-being and moral agency. Comparative case law has tended to give priority to freedom from procreation when disputes over stored reproductive material arise.

In *Evans v. United Kingdom*, the European Court acknowledged that the interests at stake include both the wish to become a genetic parent and the wish not to become one, and found that the law protecting the latter struck a fair balance.[31] Ethical practice has to respect both sides of autonomy: autonomy covers choosing parenthood as well as declining it. Indian constitutional law, particularly *Puttaswamy*, likewise recognises freedom in deeply personal choices without coercion.[32]

Ethical analysis must also account for gendered asymmetry in reproductive burden. Women's reproductive timelines, medical risks and social expectations make a purely symmetrical consent framework inadequate. Governance must therefore balance the prevention of forced parenthood against the avoidance of disproportionate harm to women who have invested physically and medically in fertility preservation.

D. Constitutional balancing under Article 21

Under Article 21, any curb on personal liberty must pass a test of fairness and reasonableness, so limits on reproductive autonomy must satisfy proportionality. In *Modern Dental College & Research Centre v. State of Madhya Pradesh*,[33] the Supreme Court set out a stepwise proportionality analysis for limits on fundamental rights. Applied to surrogacy regulation, the test raises the question whether excluding post-separation reproductive choice is a proportionate means of achieving ethical or welfare objectives.

Gentler options, for example enhanced consent protocols, judicial oversight and child-welfare assessments, could serve the regulatory goals without absolute prohibitions. A proportionality-based approach would allow reproductive autonomy to be balanced against ethical concerns in a context-sensitive way, rather than being closed off by rigid statutory categories.

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[31] *Evans*, *supra* note 16, ¶¶ 71, 90, 92; *see also* JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES (1994).
[32] *Puttaswamy*, *supra* note 4, ¶¶ 248, 298.
[33] *Modern Dental College & Research Centre v. State of Madhya Pradesh*, (2016) 7 SCC 353, ¶ 60 (Sikri, J.) (India).

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E. Towards ethical and constitutional coherence

The ethical and constitutional tensions around assisted reproduction expose the limits of India's current approach. By privileging marital status over autonomy, consent and welfare assessment, the law risks harming both ethical medical practice and constitutional guarantees. A coherent framework must bring together ethical principles, constitutional norms and medical realities, recognising that reproductive autonomy and child welfare are not inherently opposed.

This part has shown that ethical governance of assisted reproduction needs nuanced balancing rather than categorical exclusion. The final part sets out legal and policy reforms to reconcile reproductive autonomy, ethical responsibility and constitutional values in India's medical law.

VII. Recommendations and Way Forward: Towards a Rights-Based Medical Law Framework

The analysis shows that India's regulatory framework for surrogacy and ART does not adequately address present reproductive realities, especially in relation to reproductive autonomy, withdrawal of consent and post-separation choice. To secure ethical governance and constitutional compliance, targeted legal and policy reform is needed. This part proposes a rights-based framework that reconciles reproductive autonomy with ethical safeguards and child welfare. Scholarly work on reproductive tourism identifies ethical challenges for surrogate mothers in low-income nations and would leave the regulation of these questions to national parliaments; it is submitted that this gives domestic standards added importance.[34]

A. Statutory recognition of continuing and withdrawable consent

Indian assisted reproduction law should recognise more fully that consent is a continuing and revocable process. Section 22(4) of the ART Act should be amended to state that the power of withdrawal continues after a marriage ends and covers consent given for storage, and to require that consent to the use of preserved gametes be reaffirmed when the gametes are to be used. Such a provision would bring statute in line with constitutional case law that treats autonomy as dynamic and context-sensitive.

Clear legislative standards on withdrawal would reduce uncertainty for clinics and limit disputes. Consent protocols should also include enhanced counselling, so that the parties

[34] Raywat Deonandan, Samantha Green & Amanda van Beinum, *Ethical Concerns for Maternal Surrogacy and Reproductive Tourism*, 38 J. Med. Ethics 742 (2012), https://doi.org/10.1136/medethics-2012-100551; Guido Pennings, *Legal Harmonization and Reproductive Tourism in Europe*, 19 Hum. Reprod. 2689 (2004), https://doi.org/10.1093/humrep/deh486.

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understand the legal and ethical consequences of cryopreservation, including what follows from separation or divorce.

B. Clarifying the legal status of preserved gametes

The lack of a defined legal status for preserved gametes lies behind many of the ambiguities discussed above. Rather than classifying gametes as property, Indian law should adopt a *sui generis* framework that recognises their distinct reproductive significance. This would allow principled decisions that give priority to autonomy, informed consent and prevention of forced parenthood without reducing reproductive material to a commodity.

Statutory guidance on control and decision-making authority over preserved gametes, particularly where they were preserved jointly, would give much-needed clarity to courts and practitioners.

C. Decoupling surrogacy eligibility from marital continuity

The Surrogacy Act's close link between reproductive entitlement and marital status needs reconsideration. A woman's reproductive autonomy should not lapse when her marriage is dissolved, particularly where she holds preserved gametes and wishes to take sole parental responsibility. The existing provision for widows and divorcees should be clarified so that it states whether, and on what conditions, gametes or embryos created during the marriage may be used.

A reformed framework should allow post-separation surrogacy with stringent safeguards: demonstrable informed consent, independent medical and psychological evaluation, and a child-welfare assessment. That would better reflect constitutional values while keeping ethical oversight.

D. Incorporating proportionality and judicial oversight

Restrictions on reproductive choice must meet the proportionality requirement under Article 21. Legislative amendments should therefore provide for case-by-case assessment instead of blanket prohibitions. Limited judicial or quasi-judicial oversight, similar to the authorisation mechanisms used elsewhere in medical law, such as the medical boards under the Medical Termination of Pregnancy Act, 1971 and the medical-board procedure with recourse to the High Court laid down in *Common Cause*,[35] could provide a balanced forum for disputes over

[35] The Medical Termination of Pregnancy Act, 1971, No. 34, Acts of Parliament, 1971, § 3(2C)–(2D) (India); *Common Cause*, *supra* note 29, slip op. ¶ 191.

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withdrawal of consent or competing reproductive interests. This would ensure that restrictions are justified, necessary and proportionate, not arbitrary or over-inclusive.

E. Strengthening ethical governance and clinical guidance

Beyond statutory reform, ethical governance should be reinforced by binding clinical guidelines from the appropriate regulatory authorities. The guidelines should cover consent renewal, dispute-resolution protocols, record-keeping and risk management for ART clinics handling post-separation requests. Such guidance would promote consistent clinical practice, protect medical professionals from liability and keep patient-centred ethics at the heart of assisted reproduction governance.

VIII. Conclusion

Assisted reproductive technologies have transformed the range of reproductive choice and challenged legal assumptions built on marital continuity and static consent. India's framework for surrogacy and gamete preservation represents an uneasy compromise between ethical concern and constitutional liberty, and it often resolves uncertainty by excluding rather than balancing.

This paper has argued that reproductive autonomy, rooted in Article 21, covers choices about gamete preservation and surrogacy, even after a marriage has broken down. The statutes' silence on post-separation reproductive choice, combined with rigid eligibility criteria, weakens women's autonomy, entrenches gendered disadvantage and leaves medical practitioners in ethical and legal uncertainty.

A rights-based medical law framework resting on continuing consent, proportionality, ethical governance and child welfare would be more coherent and more faithful to the Constitution. By recalibrating the regulation of assisted reproduction to current realities, Indian law can protect autonomy while preserving ethical responsibility. Such reform is necessary, not merely desirable, if reproductive governance is to stay responsive, just and consistent with constitutional values as medical technology advances.

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