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The Legal Relationship Between India's ART Act and Surrogacy Act: Regulatory Overlap, Normative Inconsistency and a Framework for Reform

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Abstract

The Assisted Reproductive Technology (Regulation) Act 2021 (ART Act) and the Surrogacy (Regulation) Act 2021 (Surrogacy Act) are companion bills for the new laws, but there is no coherence, either substantive or procedural, of the institutions involved in the practice. This article looks at the relationship between the enactments, from a doctrinal/statutory perspective, as well as a constitutional perspective and by way of a focused comparison with the United Kingdom and South Africa. It implies the statutes are a coherent and less than full co-regulatory system. The general clinical, laboratory, gamete and embryo elements of surrogacy are covered by the ART Act, the special elements of gestational, eligibility and parentage are covered by the Surrogacy Act. But the definitions and institutions are mutually incorporated, as are the divergent eligibility requirements, rules of genetic-connection, consent structures, requirements for registration, record retention periods and criminal classifications. The 2023 and 2024 amendments on donor gametes are examples of multiple substantive changes to access of surrogacy being made via delegated legislation. The implications of the transitional uncertainty and consent and lack of traceability of embryos have been further illustrated by the recent decisions of the Supreme Court in Vijaya Kumari S v Union of India (2025 INSC 1209) and Smt Usha Singh v State of Chhattisgarh (19 January 2026). The article suggests an express general – special relationship clause, harmonised definitions, modular single window licensing, integrated consent and audit protocols, data governance, harmonised data and proportional penalties and transitional provisions. In the longer term, it calls for the consolidation through a Reproductive Assistance and Surrogacy Code that safeguards the reproductive autonomy, the welfare of the surrogate and the interests of the child and guarantees clinical integrity.

Keywords: Assisted reproductive technology; surrogacy; reproductive autonomy; donor gametes; statutory interpretation; reproductive justice; infertility law; India

1. Introduction

Assisted reproduction gives an idea of the scope of legal categories which are determined by the marital family and the act of sexual conception and gestation. In vitro fertilisation is the disconnection of fertilisation from intercourse; gamete donation is the disconnection of the genetic contribution from the intention of the parent and gestational surrogacy is the disconnection of pregnancy and birth from the legal intention of the parent. Consequently, there needs to be regulations to ensure the clinical safety of the child, consent, parentage, data protection and professional accountability and prevention of exploitation of the child. In India, two laws were enacted in just one week; the Assisted Reproductive Technology (Regulation) Act 2021 and the Surrogacy (Regulation) Act 2021 to coordinate this. They both entered into force on 25 January 2022. They are nearly simultaneous and have much the same institutional framework, and therefore much the same regulatory effort, but use two parallel legislative texts, two series of rules and changing administrative forms.

The main part of the ART Act focuses on regulation and supervision of ART clinics, safe and ethical provision of reproductive services, management of gametes and embryos and children born as a result of ART. The Surrogacy Act, however, sets rules for the surrogacy arrangement, such as medical indications for surrogacy, insurance and certification, banning commercial surrogacy, and eligibility. The outcomes are always linked to the function, that is, creating and transferring embryos to a surrogate mother involves ART, and most ART procedures don't involve a surrogate mother. Hence, a clinic which participates in a surrogacy could be subject to the provisions of the rules with respect to the laboratory procedure, the surrogacy and the child.

The primary legal problem is not only that there are two pieces of legislation that have overlapping topics. If there are various risks that need a particular response, then parallel legislation may be desirable. What's happening is that there's a considerable institutional convergence and a normative divergence in the statues of India. They co-share the National and State Assisted Reproductive Technology and Surrogacy Boards, appropriate authorities and National Registry. All the ideas of the Acts are taken from one another. However, they have varied access categories, age cut-offs, reproductive-status definitions and definitions of crime. They also split up consent provisions, recordkeeping provisions, and genetic-parenthood provisions in acts without an explicit conflict clause. The resulting system is one of uncoherence, and frequently has to be assembled by clinics, district medical boards and relevant authorities and courts.

The scholarship already developed on exclusionary family model, ban on commercial surrogacy, protection of the surrogate mother and defects of the individual statutes (Gola, 2021; Kashyap and Tripathi, 2023, 2024; Tank et al. 2023). Empirical and socio-legal studies have also demonstrated that the

dichotomy of altruism vs. commerce cannot capture the complexity of Indian surrogacy (Pande, 2009, 2011; Jaiswal, 2012; Rudrappa and Collins, 2015; Tanderup et al., 2015; Hibino, 2023). Not much effort has been made to explain the precise relationship between the ART and Surrogacy Acts. An apparently reasonable provision in one statute may be ambiguous or prejudicial in the context of the two statutes.
This article does the rest. It poses 4 questions. Let's start with the question of what the legal relationship of the ART Act is to the Surrogacy Act? Secondly, in which places do enactments make legitimate specialisations and in which places do they make duplications, contradictions or silence? Third, how do recent constitutional and legal developments in relation to these matters interpret them? Lastly, what changes might result in a coherent, rights-responsiveness without any loss of protection from exploitation and unsafe practice? The notion is that the Acts are 'co-regulatory regime, which is functionally integrated, but normatively incomplete'. The Surrogacy Act should be a lex specialis to the gestational and eligibility/parentage components of surrogacy and the ART Act should be a general law in respect of clinical procedures and laboratories, gametes, embryos and professional standards. However, that relationship should be declared by Parliament and backed up with common definitions, integrated procedures and calibrated enforcement—rather than being deducted on a case-by-case basis.

The article is a contribution of three parts. From the doctrinal point of view, it sees the inter-statutory problems as being of a direct contradiction, of overlapping jurisdiction, of procedural duplication, of definitional mismatch, of normative disparity or of regulatory silence. The constitutional links reproductive access to equality, privacy, dignity and decisional autonomy, and doesn't make the broad statement as does Article 21 that there is an unlimited positive right to all reproductive services. Institutional-wise, it proposes two stages of amendments: first, the harmonisation of the amendments, and then, a consolidated Reproductive Assistance and Surrogacy Code. The law is stated as of 1 August 2026.

2. Legislative and Regulatory Context

This current system has grown out of a lengthy process of statutory transition from non-statutory medical advice to statutory regulation. The Indian Council of Medical Research's National Guidelines for Accreditation, Supervision and Regulation of ART Clinics (2005) was an attempt to portray uniformity in clinical practice, record keeping, consent and parentage, however it did not have any enforcement or legislative powers. The Law Commission of India's Report No. 228 (2009) called for legalisation of altruistic surrogacy and stressed upon consent, insurance and certainty of parentage. Later, the Parliamentary exams raised some concerns about commercial brokerage, abandonment, sex selection, exploitation, and the lack of reliable national statistics. The eventual legislative response was not an "assisted-reproduction code," but two separate codes, connected together with two different rules and regulations.

The division is based on a policy that is understandable. Many aspects of infertility treatment, cryopreservation, donation and manipulation in the laboratories are covered in the ART Act. The Surrogacy Act covers the additional risks of a third party becoming pregnant and having a baby for the intended parents. Pressure, injury to the surrogate during the pregnancy, disagreement over termination, abandonment of the surrogate and parentage disputes and payment disputes are all potential issues. This makes it justifiable to have specialised regulations. Nevertheless, it was crucial to set out the allocation and conflict rules to follow for the parallel legislation method. Rather, Parliament used the cross-reference strategy; that is, it merged the provisions of the ART Act with the Surrogacy Act and vice versa. There is no complete integration, and the statutes are not autonomous.

The significance of delegated legislation has increased. The Surrogacy Rules 2022 include rules regarding medical boards, insurance, clinic staffing, consent forms and medical indications. 36 months general health insurance for surrogate mothers, Rule 5 (same for 7). The technical standards for ART clinics and banks will be incorporated into the ART Regulations 2023. With the change in the law concerning donor gametes, there has been a radical change in Form 2. The Surrogacy (Regulation) Amendment Rules 2023 also stated that both the intended parents must use their own gametes in the surrogacy procedure and for the surrogacy procedure to be conducted using single widowed or divorced woman's own gamete, she must provide her own oocyte and the donor gamete will be from a donor. Medical exception for an intending couple: Where the District Medical Board certifies that party to the marriage to conceive a child has a medical condition that relies upon the use of a donor gamete the use of such gamete shall be permitted where the child has had at least one gamete from the intending couple (as amended in 2024). The "single intending woman" requirement regarding own oocyte was not removed.

This sequence is important for two reasons: First, it proves that access to surrogacy has been based not just on the parent Act, but also the terms of a prescribed consent form. Secondly, the relaxation of 2024 wasn't just about who would be allowed to pursue surrogacy and the type of genetic connection the law demanded, but also about the process itself. This is a classic delegated legislation question – is a rule a correct interpretation of the procedural detail or does it impose a substantive condition which is not specifically empowered by the Act? They're also not very consistent in their regulation design. Couples can invest in evaluation, embryo creation and storage which might change in the event of changes in eligibility requirements and cultivate reliance interests and transition disputes which are litigated later by the Supreme Court.

3. Methodology and Analytical Framework

The article will be based on a doctrinal method which focuses on the text, structure and purpose of the two Acts, their rules and regulations, and judicial decisions handed down from 2000 to 2026. It has a relational reading of provisions. The analysis questions what the different stages of the same treatment pathway in

clinics are, banks, medical boards, appropriate authorities and the Registry. It also utilizes the constitutional principles to attack classifications and restrictions, and a partial functional analysis of the United Kingdom and South Africa. Comparative investigation is not a transplant procedure! It refers to the institutional approaches that may address specific Indian challenges like central licensing, specific consent governments and pre-conception legal review.

Here are three rules of interpretation. The first of these is harmony in construction: If several related acts are performed, they, insofar as possible, should be read together. There are two conditions: i) generalia specialibus non derogant means that a more specific rule will take precedence over a more general rule, where both rules are applicable to the same area; and ii) derogation, when there is a specific rule and there is a general rule, the specific one will take priority. Surrogacy is a specialised type of ART, and the arrangement should typically be governed by the Surrogacy Act. The third is the consistency with the constitution: Where there may be a reasonable possibility of more than one interpretation, courts should favour the one that does not arbitrarily exclude a choice, and which does not serve as a disincentive to informed consent, privacy and interests of the child. The principles cannot, however, take precedence over the plain language of the statute. There are contradictions which persist and need to be amended.

There are six types of legal friction which are distinguished for analytical accuracy. Where there is simultaneous incompatibility, there is a direct contradiction. There may be a risk of overlapping jurisdiction where two or more regulators/licences are issued for the same activity. When information / approval is requested more than once, this is called procedural duplication. A definitional mismatch occurs when associated legislation gives different definitions to associated terms. Normative disparity is the treatment of similar behavior or the similar individuals in a material way without any reason. Regulatory silence: A problem in which there is no appropriate rule in Act, e.g. origin information for donor conceived children. This classification excludes any difference as being an inconsistency because some differences are risk-based specialisation which are proper and acceptable.

4. The Legal Architecture Connecting the Acts

Functional scope is the starting point. Assisted reproductive technology is defined in the ART Act in a broad sense to include techniques which involve handling sperm or oocytes outside the human body and transferring a gamete or embryo into the reproductive system of a woman in order to obtain pregnancy. It regulates clinics and banks, counselling, consent, donation, storage, research and the status of children. It is an Act that regulates the practice of a woman who becomes pregnant for an intending couple or intending woman and gives the child to the intending couple or intending woman when the child is born. Usually there is a transfer of embryos in gestational surrogacy, so the Surrogacy Act is part of the clinical scope of the ART Act, albeit with its own social and legal aspect. The overlap is not contiguous but overlap nested.

Such is the case because of the language of the statute. Section 3 of ART Act introduces the National Assisted Reproductive Technology and Surrogacy Board under the Surrogacy Act, sections 6 and 7 introduce the same State Boards. A National ART and Surrogacy Registry is created by section 9. Words used in the ART Act which are not defined in that Act have the same meaning as defined in the Surrogacy Act. In contrast, part 15 and 16 of the Surrogacy Act do create and regulate the common Registry with reference to the ART Act. It is not only a matter of coordinating administrators, each of these pieces of legislation in part is dependent upon the other for the institutional and definitional functioning.

The advantages of the common architecture. One registry can prevent data scattering and ensure the monitoring of clinics and prevent double donation or banned activities. There can be uniform standards in the reproductive sector from Common Boards. One of the relevant bodies, with knowledge and understanding of both pieces of legislation, can consider the entire treatment journey and not the lab and the pregnancy as separate events. Shared institutions also lessen the dangers of a clinic characterising an activity strategically to steer clear of the more stringent statute. In principle, it is an asset, therefore, that institutional convergence took place.

However, the Acts don't specify how conflicts are to be handled. The Surrogacy Act has specific provisions but also restates many of the provisions contained in the ART Act such as provisions on registration, consent, record keeping and offences. There is no sweeping precedence clause to either of the two enactments. The ordinary lex specialis might be invoked in the case where the question is part of the surrogacy – such as, can the intending parents be considered the parents of the child? does a medical indication exist? insurance in case of a surrogate birth etc. As long as the ART Act does not expressly provide for a more protective requirement, the ART Act takes precedence with respect to the requirements for competence of staff in the laboratory, the sourcing and storage of the gametes, handling of the embryos, screening of the donors and standards for the clinics.

In this division do not visualize the material as a hierarchy of one thing being better than another, one being better than the other; one above the other. This is an assignment class for the content area. Both statutes can be applicable concurrently: embryo creation under ART Act, eligibility and relationship between intending parents and surrogate under Surrogacy Act. So the need is for a conflict resolution process that can distribute issues, and for a process that can obtain approvals without duplication. The ART Act would be extended to all clinical and laboratory needs and embryo-related issues of surrogacy and the Surrogacy Act would be extended to the criteria for being a surrogacy mother, the surrogacy agreement, the protection of embryo, the pregnancy determination, parentage and post-birth obligations. If different provisions stipulate different safety standards, the safer one that can be adhered to applies, if neither can be followed, the individual surrogacy provision applies.

The best description of this is therefore a "functionally integrated but normatively incomplete co-regulatory regime". It is integrated with the sharing of institutions, data systems and treatment processes. Both statutes are co-regulatory, that is, neither of them applies to the entire pathway. It is normatively incomplete since their values and categories are not in complete harmony. Part of the ART Act acknowledges access by the individual woman and regulates donation as a regular part of assisted reproduction. The Surrogacy Act is more strictly based on the idea of the family and emphasises genetic link. Who can act on behalf of the parents and which sense of legitimacy of parenthood will prevail should be decided by the system.

5. Areas of Regulatory Overlap

The first level of overlapping occurs at the institutional level. The Government, as recommended by the National and State Boards, monitors the application of the Acts, establishes standards and supervises the sector. Clinics are registered, inspected, investigated and suspended as needed by the appropriate authorities. The Registry is for the documentation of clinics, banks and treatment. This architecture will ensure that there is a linkage between the information that is generated at the ART stage (donor identity, gamete source, information related to creation and storage of the embryos) and information that is generated during the Surrogacy stage will be maintained. It also sets a parallel duty to comply with certain data minimisation and role-based access rules and to ensure the data is secure in the Registry since it contains highly sensitive reproductive, genetic and medical data.

The second is the clinical, material one. A surrogacy clinic can monitor and/or carry out the procedure of ovarian stimulation, where eggs and sperm are harvested from the mother, the process of fertilisation, the culture of the embryo in the laboratory, and the transfer of the embryo to the mother's uterus. These activities are regarded as core ART services if the purpose of the activities is a surrogate pregnancy. ART banks can provide donor gametes and embryologists and gynaecologists can collaborate between the two categories of licensing. Both laws prohibit sex selection, commercial use of embryos/gametes and exploitation. So their protection objectives are to ensure the integrity of the reproductive material, and to avoid market abuse.

The procedural layer is the third layer. Both pieces of legislation mandate registration, counselling, written consent, medical assessment, confidentiality and records. However, the risks and people vary. ART consent is given to the couple or woman who is commissioning, and to the donors and the clinic. The consent regarding surrogacy should also protect the rights of the surrogate prior to and during her pregnancy. Overlapping procedures do not necessarily mean that it is wrong; separate consent must be obtained for separate interventions. It is present if there are inconsistencies among forms, duplication of

information, at the same time forms are not connected, or if one form does not give one an understanding of how its consent plays into the other.

The fourth layer has to do with kids. According to Section 31 of the ART Act, if a child is conceived using ART, such child is presumed to be the biological child of the ART commissioning couple and the donor has no parental rights. The surrogate child in section 8 of the Surrogacy Act is considered the biological child of the intending couple or the intending woman. Both stipulations amount to certainty and to the prevention of abandonment as well as later claims by the donors or the surrogates. They, however, are not particularly cooperative with the law of deeming, and have an interest in intended parenthood. The emphasis in the law is on "legal parenthood" and not on the genetic contribution, but the law is not satisfying the future needs of the child for medical information relating to the mother and father's genes.

Table 1. Inter-statutory overlap and allocation of function

Regulatory matter	ART Act	Surrogacy Act	Recommended allocation
Boards and authorities	Uses common National/State Boards and appropriate authority	Constitutes or adopts common institutions	Joint institutional governance
Registry	Establishes common National Registry	Applies ART Registry provisions	Single data architecture with role-based access
Clinics	ART clinics and banks	Surrogacy clinics	One core licence with modular endorsements
Gametes and embryos	Donation, sourcing, handling and storage	Permitted use within surrogacy	ART Act as general technical law
Surrogate and pregnancy	Limited indirect application	Consent, insurance, abortion and welfare	Surrogacy Act as specialised law
Child status	Legal status of ART child	Legal status of surrogate child	Unified parentage and origin-information rules

6. Inconsistencies, Conflicts and Regulatory Gaps

6.1 Definitional mismatch and access categories

The ART Act distinguishes between a “commissioning couple” which is defined as an infertile married couple and a “woman” defined as “any woman over the age of twenty-one who approaches an ART clinic or bank”. It provides service to a woman who is less than 50 years old and a man who is less than 55 years old, but not under 21. On the other hand, the Surrogacy Act 2002 includes the definition of “intending couple” as a couple whose child had medical indications for the gestational surrogacy, and “intending woman” as a widow or divorcee woman in India between the age of 35 years and 45 years. It is a general

definition of "couple" that of a legally wed couple; and Age range of eligibility varies for wife and husband. These categories create at least three uncertainties. There is no correlation between 'infertility' and 'medical indication' under the ART Act (that is, a person may not be recognised as an ART recipient if they are not recognised as a medical indicator under the Surrogacy Act), and an individual woman recognised under the ART Act may not be recognised as a medical indicator under the Surrogacy Act if the Act has a narrower age range.

Some of the differences may be accounted for by the increased risk of surrogacy, and possibly by the justification for being treated more carefully. Marital status, sex and age are proxies but consistently associated to such risks. A married couple of opposite sexes is eligible for surrogacy while an unmarried couple, same sex couple, a single man or never married single woman are not eligible – all these marriages are in a similar clinical situation, and they can provide a stable home for the child. It is also not consistent with the Constitution's assumptions in Navtej Singh Johar v Union of India and Deepika Singh v Central Administrative Tribunal, which strike down the assumption of the Constitution and place the dignity and family life in a single, narrowly constructed form. It would not be those cases that would ever give rise to the "right to surrogacy" but would require the State to rely on more than a moralistic argument to exclude the surrogate.

6.2 Infertility, disease and medical indication

An inability to conceive following 1 year of unprotected coitus or any other medically diagnosed cause of inability to conceive is considered an infertility. The medical indication required for a gestational surrogacy is the core of the Surrogacy Act, which is expanded upon by Rule 14 of the 2022 Rules. But, in some instances administrative forms have muddied the waters around pregnancy inability and infertility. The law should be based on the inability or serious contraindication to gestation based on clinical evidence and not on the ability to provide gametes by both the intending parents. Reproductive capacity is not a switch on/off switch, and a genetic connection should never be used in place of a judgement regarding the need for gestation.

6.3 Donor gametes and genetic connection

The first obvious difference is that of the giving of the gift. The ART Act provides recognition of and regulation over Sperm and Oocyte donation, sets out screening requirements and limitations on source of donation and removes donor parental rights. Donation is thus being seen as a valid path to parenthood in the clinic. The Act does not state that the primary requirement for surrogacy is that there are two intending spouses that will provide the gametes. The amendment in Form 2 for the year 2023, however, stipulated that the embryo be made by the gametes of the intending couple and prohibited the use of donor gametes only one intending woman could use her own oocyte. This rule set up a substantive genetic-eligibility gate, using a consent form.

The intent of the amendment of 2024 was to remove the requirement that one donor gamete should be used for intending couples (when this would clearly have been considered medical necessity by a District Medical Board), but not without the proviso that any donor gamete should be used in conjunction with at least one gamete of the intending couple. It didn't make a similar exception for a woman who has lost her husband or been divorced without ability to produce viable oocytes. This leads to normative heterogenicity and possibly ultra vires regulation. The married couple will not be legally allowed to use the donor gamete, but a statutorily eligible single woman will not be allowed to use a donor egg even if she is using a donor in a gestational surrogacy arrangement and it is medically impossible for her to be pregnant. This unequal treatment seems to give some degree of connection, but not an equal one and it is not clear to me why that is not sufficient for one woman to be the mother of one child.

It is the subject matter of an order passed by Karnataka High Court in Smt XXXX versus Union of India dated 8th February 2024. The Court did not address the question of whether the notification is valid for 2023 or not, but pointed out that in a medically compelling situation, the notification was not applicable and remanded the case for the authorities to not require reliance on donor gametes if they satisfy the other statutory requirements. The 2024 amendment then paved the way to the medical side of this type of case the next year. The concept of the episode is that substantive eligibility and genetic link should not be included in the main bill but should be recorded on a consent form following debate in Parliament. Delegated legislation may be used to set out evidence and procedure but should not be used to extend or limit the universe of people to whom Parliament has made the legislation applicable.

6.4 Registration and administrative duplication

Under the ART Act, ART clinics must be registered whilst surrogacy clinics must be registered separately under the Surrogacy Act. Multiple registration, disclosure, inspection and renewal processes may be required for a fertility clinic that is involved in a programme of production, storage and transfer of embryos. It is appropriate that there are separate endorsements since the ART bank and surrogacy clinic serve different functions. That same establishment needs to have the same infrastructure, ownership and personnel data turned in to the same appropriate authority, but does not improve safety. The right answer is one institutional licence with the modular endorsement for ART clinic and ART bank and surrogacy services. The core information would be provided once and each module would have its own specific staffing and safety needs.

6.5 Consent, withdrawal and pregnancy decisions

The written informed consent is required by ART Act 22 and can be withdrawn by either of the commissioning couple before the gamete or embryo is transferred. Section 6 of the Surrogacy Act requires the surrogate to provide her with informed written consent and to have the opportunity to withdraw her

consent before the implantation. The rules are available at the level of the pre-transfer and can be used at the same time but are not given as a single decision map in the framework. A clinic should know who needs to be informed of the need for gamete retrieval, fertilisation, storage, embryo transfer, donor material and even surrogacy, what the consequences of pulling out are and what needs to be destroyed or stored.

There's a change of interests after the implanting. Where the patient is pregnant the patient has a constitutional and statutory interest in bodily integrity, medical decision making and about her privacy. Since abortion relates to the written consent of the surrogate, the authorisation of an appropriate authority, in addition to the Medical Termination of Pregnancy Act as provided in Section 10 of the Surrogacy Act, a connection is established between abortion and the written consent of the surrogate. The intending parents are involved in the pregnancy but aren't entitled to demand treatment and continuation. It is therefore necessary to establish the definition of consent for a publication quality consent regime which is different from consent to the treatment of the pregnant body and consent to the reproductive project. Independent counselling and legal advice is particularly important as the surrogate may be a relative or economically dependent person in a supposedly altruistic arrangement.

Another consent issue that has been brought into the fore by the 2026 case of Usha Singh vs State of Chhattisgarh is that of authenticity and traceability. The DNA profiling technique failed to establish the non-congruence in the genetic make-up of the first child who was born to the female partner of the men and the second child, who was born by IVF, about the genetic make-up of the male partner of the female partner. The clinic had claimed that it had utilized donor eggs and donor sperm with the consent of the husband and the external sperm and egg donor, while the appellants had claimed that there was manipulation of the consent form and that donor sperm and egg was not allowed to be used more than once in a treatment cycle in accordance with section 24(c) of the ART Act. Supreme Court had made an order for the registration of an FIR and without finding the guilt of the accused, asked for investigation. In this case, it was established that a signed form is insufficient without having established a chain of custody that shows the gamete, embryo, consent and transfer were not tampered with. When it comes to auditable identity controls, then consent governance is no different from any other type.

6.6 Donor and surrogate protection

There are multiple players that are protected by the Acts. The ART Act mandates insurance coverage for 12 months and donor screening and frequency of donations. The Surrogacy Rules stipulate that medical insurance be given to the surrogate mother for thirty-six months. The various stages are defensible as pregnancy and childbirth are a much more complex and longer risk than gamete retrieval. The degree of uniformity is therefore not always sought after. The real question is whether each regime considers the actual injury, loss of income, psychological damage, needs of care and treatment after the procedure. The

under-compensation situation doesn't have to be a problem as long as the insurance policy is nominal, but the exclusion, claim procedure and the amount of insurance are not clear.

The commercial surrogacy ban was to prevent the trade in pregnancy and children. However, an altruistic only model can be misleading and can have no removing of economic pressure. Wages are not a substitute for the non-monetary costs of withholding wages (travel, accommodation, nutritional support, childcare, loss of work or long-term health effects). However, the socio-legal research cautions that the rhetoric of altruism can lead to internalisation of reproductive labour within the family, and to make negotiations more difficult (Rudrappa and Collins, 2015; Hibino, 2023). Reform should include the prohibition on brokerage, sale and coercive profit, and a professional, transparent and regulated reimbursement of expenses and income lost. It is not about regularizing the labour, it's about not getting exploited.

6.7 Records, privacy and genetic identity

Clinics and banks must keep records for a minimum of ten years and report to the central database when they close before the time limit. There is a Surrogates Act which mandates that surrogates' records be saved for 25 years. The long period may be related to the length of parentage records and birth records, but there is no association between the two. An incomplete 25-year Surrogacy file, due to the destruction of laboratory and donor records after 10 years. A consolidated retention schedule should only be used to retain essential information for clinical accountability, identification and the child's health, for a specified retention period, and should remove unnecessary identifiable information.

Privacy rights should not just be expressed in the "rules of confidentiality" phrases. Reproductive files contain information about diagnosis of infertility, marital status, sexual information, genetic information, donor information and the circumstances of child's birth. Therefore, the general Registry should be limited in scope; have access levels; be encrypted; have reporting requirements for any violations of security; have audit logs; and have disclosure requirements to courts, investigators and parties. There is no legal certainty in the Acts about the right to receive non-identifying medical information or even identifying origin information by a donor-conceived person. There is an increasing trend towards disassociating the donor's mindset from the potential child's interest in origins. There should be a counselling supported access mechanism in India, not ad hoc litigation which will fail to cater to the needs of the "little one" whose maturity is not in tune with the law. The problem should not be left to ad hoc litigation, but an age-appropriate counselling-based access mechanism should be put in place in India.

6.8 Child status and parentage

Both pieces of legislation contain deeming provisions that will ensure intended parents can not give away a child, for reasons of disability, plurality, sex or genetic unexpectedness as is appropriate. The donor and the surrogate are, in turn, protected from any liability that is not desired. But parentage should not just be

determined by a post facto birth certificate. If a parentage declaration/certified surrogacy order is granted before the procedure, the intended parents and their consent may be specified and their responsibilities in the event of separation, death or cancellation of consent before delivery may be set out. This can be particularly important in the case of using donor material or one parent of a couple passing away during treatment. But pre-pregnancy uncertainty is just as important as remedial litigation following birth, as it is in the best interest of the child.

6.9 Offences and enforcement

The crimes are cognizable and bailable as per section 36 of ART Act. Offences are cognisable, non-bailable and non-compoundable under section 43 of the Surrogacy Act. Some behaviour may have more than one statute to which it can be attributed, e.g. commercial dealing in embryos, exploitation, unregistered clinical activity or prohibited transfer. The fact that a charging choice is made can consequently lead to very different arrest and bail outcomes for the same factual transaction. While it could be argued that this tougher definition would apply to trafficking or to commercial surrogacy in which the surrogate mother is coerced, it cannot be assumed that any violation of the law is trafficking. In a consolidated offence schedule, there should be a distinction between administrative non-compliance, professional misconduct, reckless endangerment, fraud, and coercion and trafficking. Penalties should be stepped up according to culpability and harm and there should be no rule of double jeopardy.

These problems will all have a common theme. The best organisation (most coherent) of the Acts is where their functions are different, e.g. the protection in the context of pregnancy under the Surrogacy Act, compared to the protection under the ART Act. They are least coherent when a social judgement of a legitimate family formation in some way exists subliminally in clinical rules, or when a parallel procedure exists to document the activity, then to punish it. Inconsistencies in the risk-based specialisation should generally be avoided by harmonising it, but inconsistencies based on status and form should be avoided at all costs.

Table 2. Classification of principal inconsistencies

Issue	Type of friction	Practical consequence	Priority reform
Commissioning couple / intending couple / woman	Definitional mismatch	Different access routes and uncertain cross-reference	Common definitions schedule
Infertility / medical indication	Normative disparity	ART eligibility does not establish surrogacy eligibility	Separate gestational-necessity test
Donor gametes and genetic link	Rule-based inconsistency	Eligibility changed through Form 2 and differs for single women	Primary-legislation rule applied consistently

Clinic registration	Jurisdictional overlap and duplication	Multiple applications and inspections	Modular single-window licence
Consent and withdrawal	Procedural fragmentation	Unclear decision map and weak authenticity controls	Integrated, auditable consent pathway
Records: 10 and 25 years	Temporal inconsistency	Linked files may become incomplete	Harmonised core retention period
Bailable / non-bailable offences	Direct normative disparity	Charging choice changes liberty consequences	Graduated consolidated offence schedule

7. Constitutional and Judicial Evaluation

7.1 Equality and reproductive autonomy

The analysis of the constitution starts from Article 14. All classifications based on marital status, age, sex, sexual orientation, widowhood, divorce, genetic relationship and existing children should have an intelligible basis that should be related to the statutory objective. The goals of the coerced, medical risk and child abandonment are valid goals. Not all of the family units are at those risks, and not all of the married couples are at the risks. The State have to prove why they are not a categorical exclusion and rely on individual assessment, counselling and enforceable parentage obligations. If it is a rule only in delegated legislation, the requirement for rational connection would be stronger and the executive should not be allowed to "facilitate" an executive rule that has not been very clearly made by Parliament.

Article 21 is the right to privacy, dignity and decisional autonomy. Reproductive choice was seen as being part of personal liberty in Suchita Srivastava v Chandigarh Administration, intimate and family decisions were considered to be part of privacy in K.S. Puttaswamy v Union of India while marriage was seen to not be relevant in the context of denying reproductive decision-making in X v Principal Secretary, Health and Family Welfare Department. There is a zone of reproductive control, but not a positive right to surrogacy services, say these authorities. The regulation of institutions in the public sphere, the well being of an unborn child, other people's bodies in surrogacy. Restrictions may be necessary, if they are legitimate, if they are based on evidence, if they are proportionate, and if they are respectful of the surrogate's independence.

A proportionality analysis should examine whether or not there is a legitimate purpose for the restriction, whether the restriction is rationally related to the legitimate purpose, whether there is a list of less restrictive alternatives available, and whether the restriction is balanced. An absolute prohibition on commercial brokerage would be more likely to respond to this question than, for example, a prohibition on never-married people. Pregnancy or parenting may also be the reason for the age restriction but this can be a difficult reason to justify if the embryos are lawfully created prior to the introduction of the age restriction or if the age is connected to the intended parent who is not a parent. Some parentage disputes

will be excluded from the genetic-link requirement, and, in some cases of consent parentage orders and donor records, there are less exclusionary options.

7.2 Surrogate autonomy

The surrogate, however, is not a "vessel" whose consent to be used is presumed to be waived at the time of the making of the contract. In the case of Devika Biswas v Union of India, informed consent and reproductive dignity was emphasised as a core component of the State's reproductive-health programmes. The most important decision is the decision of the patient (surrogate) when a patient is pregnant and regulated by general law. They, that is the intending parents, can be given agreed information, they can attend counselling, but they cannot have coercive power over their movements, treatment, diet and termination. Contractual provisions to waive bodily autonomy should be banned by law and allow for access to independent clinicians and advisers in a confidential manner.

7.3 Transitional rights and the Supreme Court's 2025 judgment

The most recent interpretation is in the case of Vijaya Kumari S v Union of India (2025 INSC 1209), and Arun Muthuvel v Union of India (2025 INSC 1209). The couple intending to marry had initiated the process before the Surrogacy Act came into effect, had created and frozen embryos but when they tried to be certified, they were too old to be under the Age limits stipulated in the Surrogacy Act. If so, it had no impact on the past, said the Supreme Court, referring to section 4(iii)(c)(I). The making and the freezing of embryos made the process more apparent and constituted the decision to participate in surrogacy, to which the age limits could not be used to oppose, the interests of Article 21 of the right to become a parent. The subject of the age limits was not addressed by the Court.

It is not a judgment that is restricted to the age. It recognises that the assisted reproduction is a multi-step legal process and that rights, reliance and medical issues arise in this process. There is no vested claim from consultation alone but there is with the creation and freezing of embryos which is a bodily act, cost and irreversible planning. The legislation should therefore include significant transition dates, and cover how this new law will impact on stored gametes and embryos, current insurance and upcoming certifications/approvals. The use in general presumptions of these questions with respect to retrospectivity results in inconsistent decisions and thus in unnecessary constitutional litigation.

7.4 Divergent High Court responses

High Courts have addressed the issue of reliance of gametes by the donor, age restrictions and transition, thus offering fact sensitive relief. The crystallised surrogacy process was found to be relevant in the case of Mrs D v Union of India (Delhi HC, 10 October 2023) as the steps taken towards the making of the embryos were also found to be relevant. In 2024, Karnataka High Court refused to impose the ban on gamete donors on the petitioners whose cases came up for hearing were of "medical compulsion" and the

general validity of the notification was left unchallenged. In Nemai Roy v State of West Bengal (10 September 2025) however, the Calcutta High Court found section 21(g) of the ART Act constitutional. An example of the decisions that not all age/eligibility limits are without transition and relational provisions and that that rules are expensive without transition and relational provisions.

7.5 Consent, provenance and criminal investigation in 2026

Usha Singh will be ushering in dawn of enforcement regime under ART Act. Usha Singh is ushering the new era of enforcement under ART Act. It's unclear if the Supreme Court learned that a kid was traded or the clinic obtained parental consent for this. It had determined that the allegations of DNA mismatch, the use of the donors and section 24(c) called for a criminal investigation. Order is important as it converts what can be a technical condition into a protection to evidential. Accurate donor records, one cycle source restriction, verified consent and embryo identification ensure Child identity and legal protection of the parents, as well as regulatory compliance. Interoperable electronic log should be required and be dual witnessed in a future code and logs should be independently audited after a serious mismatch or complaint in a future code.

The Court's findings record are consistent with a limited finding. Retrospective unfairness can be prevented by these courts, and in medically exceptional cases can grant relief and require investigation. They can't create a regulatory structure via petition, one case at a time. The repetition of litigation, referencing age, donor material and forms is indicative of a design fault. Primary legislation should contain clear and specific guarantees of procedure but should contain specifications of who will be included and when and how they will be included; Constitutional interpretation should have protective functions.

Table 3. Selected judicial developments, 2008–2026

Authority	Legal issue	Relevance to the present framework
Baby Manji Yamada v Union of India (2008) 13 SCC 518	Cross-border surrogacy and custody	Demonstrated parentage and nationality uncertainty before legislation
Suchita Srivastava v Chandigarh Administration (2009) 9 SCC 1	Reproductive choice and consent	Foundation for Article 21 reproductive autonomy

Jan Balaz v Anand Municipality, AIR 2010 Guj 21	Citizenship and legal parentage	Showed consequences of transnational surrogacy without clear status rules
K.S. Puttaswamy v Union of India (2017) 10 SCC 1	Privacy and decisional autonomy	Protects intimate reproductive and family decisions
Navtej Singh Johar v Union of India (2018) 10 SCC 1	Sexual orientation, dignity and equality	Challenges family-law exclusions based on heteronormativity
X v Principal Secretary, Health (2022) 10 SCC 1	Reproductive autonomy beyond marriage	Rejects marital-status stereotypes in reproductive health
Smt XXXX v Union of India (Karnataka HC, 8 Feb 2024)	Donor gamete prohibition	Granted case-specific relief and exposed delegated-legislation tension
Nemai Roy v State of West Bengal (Calcutta HC, 10 Sep 2025)	ART Act age limits	Upheld section 21(g), showing limits of constitutional challenge
Vijaya Kumari S v Union of India, 2025 INSC 1209	Retrospective operation of surrogacy age limits	Embryo creation and freezing crystallised pre-Act process
Usha Singh v State of Chhattisgarh (SC, 19 Jan 2026)	Disputed consent, DNA mismatch and embryo provenance	Directed FIR and investigation; underscores traceability

8. Comparative Regulatory Lessons

The United Kingdom offers an instructive contrast between the two kinds of fertility-treatment regulation and the broader ‘surrogacy relationship'. The Human Fertilisation and Embryology Act 2008 provides for a licence for clinics, regulation of storage, consent and keeps treatment and donor information under the control of the Human Fertilisation and Embryology Authority. Parents' rights in surrogacy is dealt with by another legal procedure. The Law Commission of England and Wales, and Scottish Law Commission, recommended a new process in the 2023 report in which intended parents would become legal parents from the moment the embryo is created, but the surrogate would have the right to withdraw at a certain time deadline, prior to conception. The lesson to be learned by India is that the clinical licensing process should not be blindly copied, there should be no link between clinical licensing and parentage, and India should be linked to it by a sound pre-conception pathway, with only reliable data driving the process.

Artificial fertilisation will require the agreement of a surrogate mother in addition to being certified by a High Court, as required by the Children's Act 38 of 2005 in South Africa. This model includes the principles of consent, suitability, costs and children's interests in examining the pre-conception examination in law. It also illustrates the potential "genetic-link rules" issue. In AB v Minister of Social Development [2016] ZACC 43, the Constitutional Court has decided on the requirement of the statute that at least one of the commissioning parents must give a gamete. The challenge ultimately failed in the Constitutional Court, but the litigation did bring to light differing notions of dignity, infertility and intended parenthood. In India, the features that contribute to value are advance validation and parentage

certainty but be warned not to come with a hefty price tag or one that requires a highly limited biological understanding of parentage.

The following four comparisons can be made: (1) An independent advisor to monitor clinical skill and information about the surrogate; (2) Establish origin parentage through a pre-conception or pre-birth process; (3) Allow surrogate to control their own body; (4) Regulate information about origin differently from other aspects of parentage. These can be done in India by establishing special tribunals or special courts or using digital filing and time limits to process cases instead of forcing costly and time-consuming high court cases in each instance.

9. A Framework for Legislative Reform

9.1 An express relationship and interpretation clause

The first step towards making the inter-statutory design clear is to be made by Parliament. In a surrogacy procedure the provisions of the Assisted Reproductive Technology (Regulation) Act 2021 shall apply to clinical, laboratory, gamete, embryo, donor and storage matters; the provisions of the Surrogacy (Regulation) Act 2021 shall apply to eligibility; the provisions of the Surrogacy Act 2021 shall apply to the surrogacy arrangement; the provisions of the Surrogacy Act 2021 shall apply to protection of the surrogate mother; the provisions of the Surrogacy Act 2021 shall apply to pregnancy-related decisions, parentage, and post-birth obligations; to the extent of any inconsistency, the provisions of the Surrogacy Act 2021 shall prevail. A companion clause should maintain a higher safety standard which is compatible, and should not allow double punishment.

9.2 Common definitions and rights-based eligibility

The following should be included in a common definitions schedule in the Acts: intending parent, commissioning person, couple, woman, infertility, medical indication, donor, clinic, bank, embryo and parentage. Medical need, informed capacity, no forced surrogacy or enforceable responsibility for the child should be the considerations for eligibility to be a surrogate. Parliament must rethink the exclusion of categories of people – for example, on the basis of marital status, sex or sexual orientation – and consider the reasons, with evidence, for those which are still excluded. Requirements based on donor-gamete and minimum genetic-link must be specified in the Act, and should be equally applied to couples and individual intending parents.

9.3 Single-window modular licensing

A basic digital application should generate a basic licence and separate endorsements for ART clinic services, ART bank services and surrogacy services. When established, the establishment would submit information on ownership, premises and the primary staff and any extra special needs for each endorsement. Inspection should be coordinated, planned on a risk basis and based on serious findings

across modules. This would entail less duplication, but not provide a clinic with a robust skill set of IVF services with the ability to provide surrogacy or banking services as well.

9.4 Integrated consent and traceability

There should be a minimum period of twenty-five years for which the retained core data in the linked ART and surrogacy record should be kept, or a minimum period of parentage and genetic-health information, if relevant and appropriate. The Registry must be role based, secure, and have non-delectable audit logs and ensure breach notification. Right of donor conceived adult to receive non-identifying medical information in an identifiable form and identifiable information in a form prescribed by Parliament with prospective rules, following counselling. The anonymous donor and donor non-parenthood should not be confused as two different legal issues.

9.5 Data governance and origin information

There should be a minimum period of twenty-five years for which the retained core data in the linked ART and surrogacy record should be kept, or a minimum period of parentage and genetic-health information, if relevant and appropriate. The Registry must be role based, secure, and have non-delectable audit logs and ensure breach notification. Right of donor conceived adult to receive non-identifying medical information in an identifiable form and identifiable information in a form prescribed by Parliament with prospective rules, following counselling. The anonymous donor and donor non-parenthood should not be confused as two different legal issues.

9.6 Surrogate welfare and lawful reimbursement

There should be minimum cover limits, cashless treatment of pregnancy complications, cover for actual injury, reasonable loss of income/expenditure and post-partum mental health cover together with the 36 months insurance. Reports need to go to the authority, any payments made through an ‘account monitored' account without being hidden from the authority (covert brokerage) should not be reported, but any material burden should be recognised. No organisation should restrict anyone's freedom of movement, communication or access to care or make decisions about birth termination on their behalf.

9.7 Consolidation

The present system can be made feasible by a simple amendment, but a Reproductive Assistance and Surrogacy Code would be a long-term solution. It should cover separate sections on access and eligibility; clinic/ bank licensing; donation; creation and testing of embryos; storage of embryos; surrogacy arrangements; consent and counselling; pregnancy and surrogate rights; parentage and child interests; information governance; research; offences; and transition. There would be no end to differences which would need to be made. It would put them in one hierarchy, one definitions chapter, and one rights framework, rendering the law easier to comprehend before litigation, than after.

Table 4. Two-stage reform matrix

Problem	Immediate amendment	Long-term code solution
Unclear statutory priority	Express subject-matter and conflict clause	Single hierarchy within consolidated Code
Conflicting concepts	Common definitions schedule	Unified definitions and interpretation part
Duplicate registration	Single-window modular licence	Unified reproductive regulator
Donor-gamete uncertainty	Eligibility in primary legislation	Consolidated access and donation chapters
Fragmented consent	Treatment-stage consent and audit trail	Integrated consent, counselling and traceability part
Record and privacy gaps	Core 25-year retention and security rules	Central reproductive-data governance regime
Uneven sanctions	Graded offence and bail classification	Consolidated enforcement chapter
Reliance and pending treatment	Express transition and savings provisions	Permanent amendment-transition protocol

10. Conclusion

The Laws of India namely, ART and Surrogacy are closely linked by the law. They cannot be read independently as they are contained within the same Boards, authorities and Registry, and share the same definitions and common treatment pathway. The general clinical and laboratory rules are provided by the ART Act, the rules of eligibility, gestation and protection of the surrogate and rules of parentage are provided by the Surrogacy Act. This functional relationship, although rational, is still not expressed in legislation.

The main drawbacks are not necessarily the same. Others are clear deficiencies and discrepancies, such as multiple definitions for the same crime. Others include definitional discrepancies between infertility and medical indication, different registrations (procedural duplication), different norms (normative) and silence on information regarding origin and traceability (digital). These are not theoretical weaknesses: The 2025 Supreme Court decision on transitional age limits, and the 2026 decision on embryo provenance and consent show this. They affect access, law enforcement and the security of the families and the identity of children.

The principles of the Constitution, and harmonious construction, can be used by the courts, but cannot be used to create exceptions to the scheme. Parliament should be clear about the general – special relationship among the enactments, make definitions clear and coherent, include substantive eligibility conditions in the primary legislation, include features of licensing and consent, protect reproductive data, and include

penalties, and include transition clauses. Lastly, a future Reproductive Assistance and Surrogacy Code should be streamlined and not combine the risks. The next phase of the reform of India should not be the attempt to control the clinics and ban on trading but to have a clear policy that will ensure reproductive autonomy, surrogate welfare, the clinical integrity and the interest of the children without creating any contradictory path for parenthood.

References

Primary legal materials

1. Assisted Reproductive Technology (Regulation) Act 2021, Act No. 42 of 2021 (India). Official text
2. Assisted Reproductive Technology Regulations 2023, Gazette of India, 5 April 2023. Official text
3. Baby Manji Yamada v Union of India (2008) 13 SCC 518 (Supreme Court of India). Judgment
4. Deepika Singh v Central Administrative Tribunal (2022) 7 SCC 1 (Supreme Court of India). Judgment
5. Devika Biswas v Union of India (2016) 10 SCC 726 (Supreme Court of India). Judgment
6. Human Fertilisation and Embryology Act 2008 (United Kingdom). Official text
7. Jan Balaz v Anand Municipality, AIR 2010 Guj 21 (Gujarat High Court). Judgment
8. K.S. Puttaswamy v Union of India (2017) 10 SCC 1 (Supreme Court of India). Judgment
9. Medical Termination of Pregnancy Act 1971, as amended by the Medical Termination of Pregnancy (Amendment) Act 2021 (India). Official text
10. National Legal Services Authority v Union of India (2014) 5 SCC 438 (Supreme Court of India). Judgment
11. Navtej Singh Johar v Union of India (2018) 10 SCC 1 (Supreme Court of India). Judgment
12. Nemai Roy and Another v State of West Bengal and Others (Calcutta High Court, 10 September 2025). Judgment
13. Smt XXXX v Union of India (Karnataka High Court, 8 February 2024), NC: 2024:KHC:5312. Judgment
14. South Africa, Children's Act 38 of 2005, Chapter 19. Official text
15. Suchita Srivastava v Chandigarh Administration (2009) 9 SCC 1 (Supreme Court of India). Judgment
16. Surrogacy (Regulation) Act 2021, Act No. 47 of 2021 (India). Official text
17. Surrogacy (Regulation) Rules 2022, G.S.R. 460(E), 21 June 2022 (India). Official text
18. Surrogacy (Regulation) Amendment Rules 2023, G.S.R. 179(E), 14 March 2023 (India). Official text
19. Surrogacy (Regulation) Amendment Rules 2024, G.S.R. 119(E), 21 February 2024 (India). Official text
20. Usha Singh and Another v State of Chhattisgarh and Others, Criminal Appeal arising from SLP (Crl.) No. 13950/2025, order dated 19 January 2026 (Supreme Court of India). Judgment

21. Vijaya Kumari S and Another v Union of India, with connected matters, 2025 INSC 1209 (Supreme Court of India). Judgment
22. X v Principal Secretary, Health and Family Welfare Department, Government of NCT of Delhi (2022) 10 SCC 1 (Supreme Court of India). Judgment

Secondary literature and policy materials

23. Arathi, P.M. (2019). Silent voices: A critical analysis of surrogacy's legal journey in India. Social Change, 49(2). https://doi.org/10.1177/0049085719844097
24. Gola, S. (2021). One step forward or one step back? Autonomy, agency and surrogates in the Indian Surrogacy (Regulation) Bill 2019. International Journal of Law in Context, 17(1), 58–74. https://doi.org/10.1017/S174455232100001X
25. Gowda, M., Deepthi, B., and Nichanahalli, K.S. (2024). The Assisted Reproductive Technology Act 2021—provisions and implications. Indian Pediatrics, 61, 675–681. https://doi.org/10.1007/s13312-024-3235-8
26. Hibino, Y. (2023). The advantages and disadvantages of altruistic and commercial surrogacy in India. Philosophy, Ethics, and Humanities in Medicine, 18, 8. https://doi.org/10.1186/s13010-023-00130-y
27. Indian Council of Medical Research (2005). National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India. New Delhi: ICMR. Report / guidance
28. Jaiswal, S. (2012). Commercial surrogacy in India: An ethical assessment of existing legal scenario from the perspective of women's autonomy and reproductive rights. Gender, Technology and Development, 16(1), 1–28. https://doi.org/10.1177/097185241101600101
29. Jaswal, P.S. and Kaur, J. (2021). Surrogate motherhood in India: An analysis of the Surrogacy (Regulation) Act, 2021. Shimla Law Review, 4, 257–280. https://doi.org/10.70556/hpnlu-slr-v4-I1-2021-13
30. Kashyap, S. and Tripathi, P. (2023). The Surrogacy (Regulation) Act, 2021: A critique. Asian Bioethics Review, 15, 5–18. https://doi.org/10.1007/s41649-022-00222-5
31. Kashyap, S. and Tripathi, P. (2024). Assisted Reproductive Technology (Regulation) Act 2021: Critique and contestations. Asian Bioethics Review, 16, 149–164. https://doi.org/10.1007/s41649-023-00253-6
32. Law Commission of England and Wales and Scottish Law Commission (2023). Building Families through Surrogacy: A New Law, Law Com No. 411 / Scot Law Com No. 262. Report / guidance
33. Law Commission of India (2009). Report No. 228: Need for Legislation to Regulate Assisted Reproductive Technology Clinics as well as Rights and Obligations of Parties to a Surrogacy. New Delhi. Report / guidance

34. Mishra, R. and Thakral, S. (2024). Legal subtleties of the Indian Assisted Reproductive Technology Act of 2021. National Medical Journal of India, 37(5), 272–274. https://doi.org/10.25259/NMJI_785_2023
35. Pande, A. (2009). 'It may be her eggs but it's my blood': Surrogates and everyday forms of kinship in India. Qualitative Sociology, 32(4), 379–397. https://doi.org/10.1007/s11133-009-9138-0
36. Pande, A. (2011). Transnational commercial surrogacy in India: Gifts for global sisters? Reproductive BioMedicine Online, 23(5), 618–625. https://doi.org/10.1016/j.rbmo.2011.07.007
37. Parry, B. and Ghoshal, R. (2018). Regulation of surrogacy in India: Whenceforth now? BMJ Global Health, 3, e000986. https://doi.org/10.1136/bmjgh-2018-000986
38. Rudrappa, S. and Collins, C. (2015). Altruistic agencies and compassionate consumers: Moral framing of transnational surrogacy. Gender & Society, 29(6), 937–959. https://doi.org/10.1177/0891243215602922
39. Tanderup, M., Reddy, S., Patel, T. and Nielsen, B.B. (2015). Reproductive ethics in commercial surrogacy: Decision-making in IVF clinics in New Delhi, India. Journal of Bioethical Inquiry, 12(3), 491–501. https://doi.org/10.1007/s11673-015-9642-8
40. Tank, J., Kotiswaran, P., Tank, P. et al. (2023). Voices from health care providers: Understanding the challenges in the implementation of the Assisted Reproductive Technology and Surrogacy Acts. Journal of Obstetrics and Gynaecology of India, 73, 301–308. https://doi.org/10.1007/s13224-023-01815-2
41. Tripathi, P. (2023). Reproductive justice discourse vis-à-vis abortion law in India. Space and Culture, India, 10(4), 6–17. https://doi.org/10.20896/saci.v10i4.1301