
FROM AUTONOMY TO REGULATION: THE LEGAL COMPLEXITIES OF REPRODUCTIVE RIGHTS

Ms. Aayushi, P.G Student, LL.M., M.J.P. Rohilkhand University, Bareilly (U.P.)

ABSTRACT

Artificial Reproduction Technologies (ART) have revolutionized reproductive healthcare, offering new possibilities for individuals and couples struggling with infertility. However, these advancements have raised significant legal, ethical, and social challenges. The lack of a uniform legal framework globally has led to disputes over parental rights, embryo ownership, and access to ART for LGBTQ+ individuals. Gender discrimination remains a pressing issue, as women bear the physical and emotional burden of ART procedures while often facing societal stigma and lack of legal protection. Additionally, the growing demand for “cosmetic children” through genetic modifications has sparked ethical concerns over designer babies, eugenics, and genetic inequality.

Furthermore, the psychological and mental health challenges faced by women undergoing ART are often overlooked, with insufficient legal and medical support structures to address post-procedure trauma, anxiety, and depression. The lack of comprehensive mental health policies exacerbates the vulnerability of women in ART procedures.

This research paper explores the legal challenges in ART, examining key international and national legal frameworks, landmark case studies, and human rights concerns. It also highlights the urgent need for legal reforms to ensure gender equity, ethical genetic research, and psychological well-being of ART patients. A balanced legal approach is required to protect the rights of all stakeholders while promoting ethical scientific advancements in reproductive medicine.

Keywords: Artificial Reproduction Technologies (ART), Gender Discrimination, Genetic Modification, Cosmetic Child, Mental Health, Parental Rights, Human Rights, Legal Reforms.

1. Introduction

Reproductive rights, long rooted in the principles of bodily autonomy, privacy, and dignity, occupy a vital space in contemporary legal and human rights discourse. These include access to contraception, legal and safe abortion, assisted reproductive technology (ART), and maternal health. At their core, reproductive rights assert an individual's freedom to make decisions about their own body, sexuality, and reproduction without coercion, discrimination, or violence. However, the shift from a purely autonomy-driven framework to a highly regulated legal regime reveals a complex tension between individual liberty and state interest, especially concerning moral, religious, and public health considerations.

In many jurisdictions, the right to reproductive autonomy is framed as a subset of the constitutional right to privacy or liberty. For instance, in *Suchita Srivastava v. Chandigarh Administration*, the Supreme Court of India affirmed that reproductive rights are a dimension of Article 21's guarantee of personal liberty and bodily integrity.¹ Likewise, In the United States, *Roe v. Wade* (1973) had long established a constitutional protection for abortion access; however, this precedent was overturned by *Dobbs v. Jackson Women's Health Organization* (2022), leading to a major reorientation of reproductive rights doctrine.² The world legal landscape is now characterized by a wide range of models, ranging from liberal, autonomy-based models to increasingly restrictive legal frameworks—underscoring the importance of a nuanced and jurisdiction-specific legal analysis.

This paper explores the transformation from autonomy to regulation in the context of reproductive rights. It critically examines how domestic laws, constitutional principles, and international human rights norms interact and, at times, conflict in defining the boundaries of reproductive freedom. The paper adopts a doctrinal and comparative legal methodology, focusing on India, the United States, and selected European and Latin American jurisdictions. It also considers relevant international legal instruments, such as the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and evolving jurisprudence from bodies like the UN Human Rights Committee and the European Court of Human Rights.

¹ *Suchita Srivastava v. Chandigarh Admin.*, (2009) 9 SCC 1 (India).

² *Dobbs v. Jackson Women's Health Org.*, 597 U.S.(2022).

2. Reproductive Autonomy as a Fundamental Right

Reproductive autonomy is widely recognized as an essential component of personal liberty and human dignity. At its core, it encompasses the right of individuals to make informed and independent decisions about their reproductive lives—including whether and when to have children, access to contraceptives and abortion, and freedom from coercive reproductive practices. As a matter of law, reproductive autonomy is premised on the larger body of civil and political rights, particularly the rights to privacy, bodily integrity, and equality.

In constitutional democracies, courts have often relied on privacy-based reasoning to interpret reproductive rights. In the landmark decision of *Roe v. Wade*, the United States Supreme Court held that the right to privacy, although not explicitly mentioned in the Constitution, was “broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”³ This reasoning was derived from the Due Process Clause of the Fourteenth Amendment. However, in *Dobbs v. Jackson Women’s Health Organization*, the Court overruled *Roe*, holding that the Constitution does not confer a right to abortion, and that such regulatory authority rests with the states.⁴ This reversal has intensified the debate between judicial protection of reproductive autonomy and majoritarian regulation.

In India, reproductive autonomy has been upheld through expansive interpretations of Article 21 of the Constitution, which guarantees the right to life and personal liberty. In *Suchita Srivastava v. Chandigarh Administration*, the Supreme Court affirmed that the right to make reproductive choices is intrinsic to women’s personal liberty, privacy, and bodily integrity.⁵ The Court emphasized that the reproductive choices of a woman must be respected, especially in the context of unwanted pregnancies and access to abortion services.

International human rights law also affirms reproductive autonomy as a subset of the right to health and non-discrimination. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obligates states to ensure that women have access to appropriate services in connection with pregnancy and childbirth, including family planning.⁶ Likewise, the International Covenant on Civil and Political Rights (ICCPR) and the

³ *Roe v. Wade*, 410 U.S. 113, 153 (1973).

⁴ *Dobbs v. Jackson Women’s Health Org.*, 597 U.S. (2022).

⁵ *Suchita Srivastava v. Chandigarh Admin.*, (2009) 9 S.C.C. 1 (India).

⁶ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13.

International Covenant on Economic, Social and Cultural Rights (ICESCR) acknowledge reproductive health as part of the right to life, dignity, and the highest possible level of health.

Regional human rights jurisprudence has further strengthened this interpretation. In *A, B and C v. Ireland*, the European Court of Human Rights had held that Ireland's restrictive abortion law was in violation of Article 8 of the European Convention on Human Rights, which guarantees the right to respect for private and family life.⁷ The Court concluded that a failure to provide access to lawful abortion created a chilling effect and legal uncertainty, thus infringing on personal autonomy.

The jurisprudential consensus, therefore, across domestic and international forums, supports the view that reproductive autonomy is not a peripheral right but a central tenet of individual freedom. However, the extent and manner of its protection vary significantly, influenced by cultural, religious, and political factors. These variations highlight the inherent tension between universal human rights principles and state sovereignty in regulating reproduction.

3. Regulation of Reproductive Rights:

National and Comparative Legal Trends:

While reproductive autonomy has found legal validation in many jurisdictions, it does not exist in an unregulated vacuum. States often assert a legitimate interest in protecting fetal life, ensuring medical safety, and maintaining social order. This has led to varied legislative approaches across jurisdictions, ranging from liberal access models to heavily regulated frameworks, particularly in areas of abortion, assisted reproductive technologies (ART), and surrogacy. Such regulation raises pressing concerns about equality, accessibility, and the justifiability of state intervention.

India:

In India, the Medical Termination of Pregnancy Act, 1971 (amended in 2021), permits abortion up to 20 weeks for certain categories and up to 24 weeks in exceptional cases, such as rape or incest survivors.⁸ While the 2021 amendment expanded the gestational limits and introduced

⁷ *A, B and C v. Ireland*, App. No. 25579/05, Eur. Ct. H.R. (2010).

⁸ Medical Termination of Pregnancy Act, No. 34 of 1971, § 3, amended by Act No. 8 of 2021 (India).

more inclusive language like “any woman,” the law remains deeply medicalized. The requirement of approval from one or more registered medical practitioners places the decision-making power in the hands of healthcare providers rather than the pregnant individual.⁹

Furthermore, the Assisted Reproductive Technology (Regulation) Act, 2021, and the Surrogacy (Regulation) Act, 2021 reflect a strong regulatory stance by the Indian state.¹⁰ These Acts ban commercial surrogacy and restrict ART services to married heterosexual couples and single women, thereby excluding LGBTQ+ individuals and live-in partners.¹¹ While the intention is to prevent exploitation and unethical practices, critics argue that the laws enforce patriarchal and moralistic norms, compromising individual choice and inclusivity.

United States:

In the United States, the legal landscape of reproductive rights has drastically shifted following the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, which overturned *Roe v. Wade*.¹² This decision delegated authority over abortion regulation to individual states, resulting in a patchwork of laws. Some states, such as California and New York, protect abortion access and reproductive healthcare through state constitutions or legislation.¹³ In contrast, others like Texas, Alabama, and Mississippi have imposed near-total bans with limited exceptions.¹⁴

The state-level divergence has triggered widespread concerns about reproductive migration, wherein individuals are forced to travel across state lines for basic reproductive care.¹⁵ Moreover, criminal penalties against providers and those assisting abortions raise questions of legal overreach and potential chilling effects on reproductive services.

⁹ Medical Termination of Pregnancy (Amendment) Act, No. 8 of 2021, section 3, Gazette of India, Extraordinary, Part II, section 1 (Mar. 25, 2021); see also section 3(2)(a)–(b) (requiring approval from one or more registered medical practitioners depending on gestational age).

¹⁰ Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021 (India); Surrogacy (Regulation) Act, No. 47 of 2021 (India).

¹¹ Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021, sec 2(1)(s), 4(ii) (India); Surrogacy (Regulation) Act, No. 47 of 2021, sec 2(1)(zg), 4(ii) (India).

¹² *Dobbs v. Jackson Women's Health Org.*, 597 U.S. (2022).

¹³ See CAL. CONST. art. I, sec 1.1 (2022); N.Y. Pub. Health Law sec 2599-aa (McKinney 2019).

¹⁴ TEX. HEALTH & SAFETY CODE ANN. 170A.002 (West 2022); ALA. CODE 26-23H-4 (2022).

¹⁵ Rachel Rebouché, Abortion Pills and Interstate Travel, 53 COLUM. HUM. RTS. L. REV. 1, 4–7 (2022).

Europe and Latin America:

In Europe, reproductive rights vary significantly. The Netherlands offers broad access to abortion, ART, and surrogacy, regulated under healthcare frameworks that prioritize individual choice.¹⁶ In contrast, Poland enforces one of the most restrictive abortion laws in Europe, banning the procedure in almost all cases, including fetal abnormality.¹⁷ This has drawn sharp criticism from human rights bodies and led to mass protests across the country.¹⁸

Latin America, long conservative, has recently seen tremendous liberalization. Argentina legalized abortion up to 14 weeks of pregnancy in 2020, marking a landmark victory for reproductive rights activists.¹⁹ Colombia followed in 2022, decriminalizing abortion up to 24 weeks.²⁰ These reforms were catalyzed by feminist movements, constitutional litigation, and regional jurisprudence recognizing reproductive rights as essential to dignity and equality.

Analysis

The comparative legal trends demonstrate that while some jurisdictions are progressing toward inclusive, rights-based reproductive policies, others are regressing due to political, religious, or cultural shifts. Even within liberal frameworks, regulation often reflects gatekeeping tendencies—through medical paternalism, moral policing, or socio-economic barriers—that dilute the practical realization of autonomy.

Thus, the central question is not whether regulation is permissible, but whether it is reasonable, proportionate, and rights-respecting. Laws must balance state interests with constitutional and human rights mandates, ensuring that legal safeguards do not morph into barriers for those most vulnerable.

4. Ethical and Socio-Legal Dilemmas in Regulation:

The regulation of reproductive rights inevitably raises profound ethical and socio-legal dilemmas, particularly where legislation intersects with moral norms, cultural values, and

¹⁶ Dutch Termination of Pregnancy Act 1984, amended 2003.

¹⁷ Polish Constitutional Tribunal, Case No. K 1/20 (Oct. 22, 2020).

¹⁸ Eur. Parl. Res. 2021/2925(RSP), section 2 (Nov. 11, 2021).

¹⁹ Law No. 27.610, Legal Interruption of Pregnancy Act (Arg.), Jan. 2021.

²⁰ Constitutional Court of Colombia, Ruling C-055/22, Feb. 21, 2022.

healthcare delivery systems. Although state intervention is often justified under the premise of protecting vulnerable populations or upholding public morality, such regulations frequently result in the erosion of individual autonomy, disproportionately affecting marginalized groups. These dilemmas become especially pronounced in the context of abortion, assisted reproductive technologies (ART), and surrogacy.

Informed Consent and Medical Gatekeeping One of the central ethical challenges concerns the erosion of informed consent through regulatory overreach. In India, the Medical Termination of Pregnancy Act, while permitting abortion under defined conditions, vests decision-making power with registered medical practitioners, often requiring multiple approvals for pregnancies nearing the legal limit.²¹ This medical paternalism undermines the agency of pregnant individuals and creates a bureaucratic bottleneck, especially in rural areas where access to trained providers is scarce.

Similarly, under the Assisted Reproductive Technology (Regulation) Act, 2021, Indian law requires not only the consent of the woman undergoing ART but also that of her spouse, assuming a heterosexual, marital relationship.²² This not only reflects patriarchal assumptions but also excludes non-traditional families, single parents, and LGBTQ+ individuals from access to reproductive technologies. In jurisdictions where spousal consent is legally mandated, autonomy is subordinated to familial or gender hierarchies, raising serious concerns about bodily integrity and equality.

Commercial Surrogacy and Moral Policing:

The legal prohibition of commercial surrogacy in India under the Surrogacy (Regulation) Act, 2021, is often justified on the grounds of preventing exploitation.²³ However, the blanket ban ignores the economic agency of women who may choose surrogacy as a form of employment. Instead of regulating contracts to ensure ethical and transparent practices, the law drives surrogacy into informal sectors, increasing the risk of exploitation and reducing legal protections for all parties involved.²⁴

²¹ Medical Termination of Pregnancy Act, No. 34 of 1971, Section 3, amended by Act No. 8 of 2021 (India).

²² Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021, section 7(1)(a) (India).

²³ Surrogacy (Regulation) Act, No. 47 of 2021, section 4(ii) (India).

²⁴ See Smriti Singh, Ethical Concerns in Indian Surrogacy Law, 13 NUJS L. REV. 321, 328–30 (2021).

In contrast, jurisdictions like Ukraine and certain U.S. states have established legal frameworks that allow commercial surrogacy under tightly regulated conditions, offering safeguards for surrogates and intended parents alike.²⁵ The Indian model reflects moral paternalism that stigmatizes reproductive labor and fails to consider the nuanced realities of women's choices in socio-economically constrained contexts.

Barriers for Adolescents and LGBTQ+ Individuals:

Socio-legal barriers are particularly burdensome for adolescents and LGBTQ+ communities. In many U.S. states, parental involvement laws mandate that minors seeking abortions must obtain parental consent or undergo judicial bypass procedures.²⁶ These requirements, while intended to promote parental guidance, often result in delayed care or forced continuation of pregnancy, especially in cases involving abusive or unsupportive families.

In India, neither ART nor surrogacy laws explicitly permit access to same-sex couples or transgender persons.²⁷ This exclusion is in tension with the spirit of the Navtej Singh Johar judgment, where the Supreme Court decriminalized same-sex relations and affirmed the equal dignity of LGBTQ+ individuals.²⁸ Such legal contradictions highlight the failure of reproductive regulation to keep pace with broader constitutional developments.

Commodification and Reproductive Labor:

A significant ethical dilemma centers on the commercialization of reproductive labor, wherein economic disparities may lead to the exploitation of vulnerable individuals under the guise of choice. While ART and surrogacy can empower individuals seeking parenthood, they also create market dynamics where the bodies of economically disadvantaged women may become sites of exploitation. Without robust safeguards, the reproductive labor of these women risks being undervalued or manipulated for commercial gain. The challenge lies not in banning such services outright but in crafting legal structures that ensure dignity, transparency, and equitable compensation.

²⁵ See U.S. State Laws on Surrogacy, Ctr. for Reprod. Rights, <https://reproductiverights.org> (last visited June 2025).

²⁶ Guttmacher Inst., Parental Involvement in Minors' Abortions (Apr. 2025), <https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortion>.

²⁷ See generally, ART Act, 2021; Surrogacy Act, 2021.

²⁸ Navtej Singh Johar v. Union of India, (2018) 10 S.C.C. 1 (India).

5. Intersectionality and Reproductive Inequality:

While reproductive rights are often framed as universal entitlements, their practical realization is deeply affected by intersecting forms of discrimination—based on gender, class, caste, race, disability, and geography. Intersectionality, as a conceptual framework coined by Kimberlé Crenshaw,²⁹ reveals how individuals experience layered inequalities in accessing reproductive healthcare, making it essential to evaluate how legal regulation may exacerbate or alleviate such disparities.

Caste, Class, and Geographic Exclusion in India:

In the Indian context, caste and socio-economic status are crucial determinants of reproductive access and agency. Historical evidence points to coercive sterilization campaigns disproportionately targeting Dalit and Adivasi women under family planning policies, often without adequate consent.³⁰ Though framed as population control, these practices reflected caste-based power structures and undermined reproductive autonomy.

Access to ART and abortion services remains concentrated in urban centers and private institutions, rendering them inaccessible to large segments of rural and low-income populations.³¹ The cost of in-vitro fertilization (IVF) cycles and the centralization of accredited clinics mean that reproductive technologies are effectively a privilege of the urban elite. Even when state policies offer subsidized services, social stigma and institutional discrimination discourage marginalized groups from seeking care.

Racial and Economic Disparities in the U.S.:

In the United States, intersectionality plays a central role in reproductive justice movements, which critique mainstream reproductive rights discourse for ignoring the systemic barriers faced by women of color. Black, Indigenous, and Latina women experience significantly higher maternal mortality rates, reduced access to prenatal care, and higher rates of coercive birth

²⁹ Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex*, 1989 U. CHI. LEGAL F. 139, 140–42 (1989).

³⁰ Kalpana Wilson, *Reproductive Rights, Gender and Class in India*, 15 FEMINIST REV. 91, 95–98 (2011).

³¹ Vinita Pandey, *Economic Barriers to ART in India: A Socio-Legal Perspective*, 12 NAT'L L. SCH. J. 88, 91–94 (2020).

control practices.³² These outcomes stem not only from socio-economic inequality but also from implicit bias and systemic racism within healthcare and legal systems.

Moreover, punitive laws in several U.S. states disproportionately impact marginalized communities. Low-income individuals, undocumented immigrants, and racial minorities face greater legal, financial, and logistical hurdles in accessing abortion and contraception.³³ Travel restrictions, enforced waiting periods, and burdensome regulations targeting abortion providers disproportionately affect already marginalized populations, compounding existing barriers to access.

LGBTQ+ Discrimination and Legal Erasure:

Legal frameworks governing reproduction often presume a cisgender, heterosexual norm, resulting in the exclusion of LGBTQ+ individuals from full reproductive participation. Indian ART and surrogacy laws restrict access to married heterosexual couples or single women, effectively denying services to same-sex couples and transgender persons.³⁴ This contradicts constitutional protections afforded in *Navtej Singh Johar v. Union of India* and *NALSA v. Union of India*, which recognize sexual orientation and gender identity as protected categories under Articles 14, 15, and 21.³⁵

In several countries, adoption laws and fertility clinic policies similarly exclude LGBTQ+ individuals, reinforcing family structures that are limited to traditional gender and marital norms. These exclusions not only restrict access but also contribute to the legal invisibility of queer families.

6. International Human Rights Standards and Domestic Reproductive Law:

The intersection of international human rights norms and domestic legal frameworks plays a pivotal role in shaping reproductive rights. While international treaties and declarations provide foundational principles supporting bodily autonomy, non-discrimination, and access

³² U.S. Dep't of Health & Human Servs., Office of Minority Health, Maternal and Infant Health Disparities, (2023), <https://minorityhealth.hhs.gov>.

³³ Guttmacher Inst., Addressing Abortion Access Barriers for Marginalized Populations (2024), <https://www.guttmacher.org>.

³⁴ Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021, § 2(1)(s) (India); Surrogacy (Regulation) Act, No. 47 of 2021, Section 4(ii) (India).

³⁵ *Navtej Singh Johar v. Union of India*, (2018) 10 S.C.C. 1 (India); *NALSA v. Union of India*, (2014) 5 S.C.C. 438 (India).

to healthcare, their domestic enforcement is often uneven, mediated by local politics, cultural values, and legal traditions. This tension between global human rights obligations and sovereign regulatory practices results in fragmented protection of reproductive rights across jurisdictions.

International Legal Standards:

Reproductive rights are implicitly and explicitly protected under various international human rights instruments. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) affirms the right of every individual to enjoy the highest attainable standard of physical and mental health, encompassing access to reproductive healthcare services such as family planning and maternal care.³⁶ Similarly, CEDAW mandates that states eliminate discrimination against women in the field of healthcare and ensure access to services related to reproduction.³⁷ The Maputo Protocol, applicable in several African nations, explicitly guarantees access to abortion in cases of rape, incest, or danger to the mother's life or health.³⁸

UN treaty-monitoring bodies have consistently interpreted these provisions to include the right to abortion, contraception, and non-coerced reproductive decisions. In General Comment No. 22, the Committee on Economic, Social and Cultural Rights underlined that the right to health includes a fundamental element consisting of access to sexual and reproductive health services, as it demands availability, accessibility, acceptability, and quality in healthcare provision..³⁹ Similarly, the Human Rights Committee has critiqued overly restrictive abortion laws as integral to the right to life and the protection against cruel, inhuman, or degrading treatment under international human rights law..⁴⁰

Domestic Resistance and Selective Incorporation:

Despite these normative frameworks, states often resist or selectively incorporate international reproductive rights standards into domestic law. For example, while India is a party to both

³⁶ International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

³⁷ Convention on the Elimination of All Forms of Discrimination Against Women, arts. 10–12, Dec. 18, 1979, 1249 U.N.T.S. 13.

³⁸ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), art. 14(2)(c), July 11, 2003.

³⁹ U.N. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 22, page 14–17, U.N. Doc. E/C.12/GC/22 (May 2, 2016).

⁴⁰ Human Rights Comm., General Comment No. 36, page 8, 19, U.N. Doc. CCPR/C/GC/36 (Oct. 30, 2018).

CEDAW and the ICESCR, its ART and surrogacy laws reflect moralistic and heteronormative biases that limit access to services for unmarried and LGBTQ+ individuals.⁴¹ The Indian Supreme Court has referred to international conventions in cases like *Vishaka v. State of Rajasthan* to fill legislative gaps,⁴² but it has not consistently done so in reproductive rights jurisprudence.

In the United States, the withdrawal from the Global Gag Rule by the Biden administration reinstated funding for international NGOs providing abortion services, aligning with international health norms.⁴³ However, domestically, the overturning of *Roe v. Wade* illustrates how federalism and political polarization can thwart compliance with international human rights standards.⁴⁴ The U.S. has also not ratified CEDAW, limiting its formal obligations under global reproductive rights frameworks.

Judicial Engagement and Transnational Dialogue:

Domestic courts have increasingly drawn on international human rights jurisprudence in shaping reproductive rights. The Inter-American Court of Human Rights, for instance, in *Artavia Murillo v. Costa Rica*, held that a blanket ban on in-vitro fertilization violated the right to private life and family.⁴⁵ In contrast, courts in more conservative jurisdictions may reject international law when perceived to conflict with domestic values or religious principles.

Nevertheless, the trend toward judicial transnationalism—where courts cite each other’s judgments and UN treaty interpretations—offers a pathway to harmonize reproductive rights protection. This is especially relevant in the global south, where constitutional courts are more willing to interpret rights expansively in light of international norms, even when legislative reforms lag behind.

7. Conclusion and Recommendations

The evolving legal landscape of reproductive rights reveals a complex interplay between individual autonomy, state regulation, and international human rights frameworks. While

⁴¹ Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021, section 2(1)(s), 4(ii) (India).

⁴² *Vishaka v. State of Rajasthan*, (1997) 6 S.C.C. 241 (India).

⁴³ White House, Memorandum on Protecting Women’s Health at Home and Abroad, Jan. 28, 2021.

⁴⁴ *Dobbs v. Jackson Women’s Health Org.*, 597 U.S.(2022).

⁴⁵ *Artavia Murillo et al. v. Costa Rica*, Inter-Am. Ct. H.R. (ser. C) No. 257 (Nov. 28, 2012).

reproductive autonomy is increasingly acknowledged as an essential facet of personal liberty, privacy, and equality, its implementation remains uneven and contested across jurisdictions. Legal systems often grapple with competing interests—ranging from public health and medical ethics to religious values and political ideologies—when formulating policies governing abortion, ART, surrogacy, and related services.

This paper has examined how the recognition of reproductive autonomy as a fundamental right is both affirmed and constrained by domestic laws. Jurisdictions like India and the United States illustrate the push and pull between judicial recognition of reproductive freedom and legislative efforts to regulate or restrict access. The Indian legal framework, despite its progressive judgments under Article 21, imposes gatekeeping mechanisms through the ART and Surrogacy Acts, limiting reproductive choices based on marital status, gender, and sexual orientation.⁴⁶ Similarly, post-Dobbs, the United States has witnessed a significant rollback in abortion access, devolving regulatory authority to states and amplifying disparities among marginalized populations.⁴⁷

International human rights instruments, including the ICESCR, CEDAW, and General Comments by treaty bodies, have provided robust normative guidance affirming reproductive rights as integral to the right to health, non-discrimination, and human dignity.⁴⁸ However, the incorporation of these standards into domestic law remains voluntary and politically contingent. Courts have played a crucial role in interpreting constitutional rights in light of international norms, but judicial activism alone cannot substitute for structural reforms and inclusive policymaking.

Recommendations

To address the legal and ethical complexities discussed throughout this paper, a multidimensional approach is necessary:

- Legal Reform with an Intersectional Lens: Legal barriers rooted in marital status,

⁴⁶ Assisted Reproductive Technology (Regulation) Act, No. 42 of 2021, section 2(1)(s), 4(ii) (India); Surrogacy (Regulation) Act, No. 47 of 2021 (India).

⁴⁷ Dobbs v. Jackson Women's Health Org., 597 U.S. (2022).

⁴⁸ See International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3; Convention on the Elimination of All Forms of Discrimination Against Women, arts. 10–12, Dec. 18, 1979, 1249 U.N.T.S. 13; U.N. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 22, U.N. Doc. E/C.12/GC/22 (May 2, 2016).

gender identity, or sexual orientation should be dismantled to ensure full realization of constitutional principles of equality and dignity. Policy reforms must also be sensitive to the specific reproductive healthcare needs of adolescents, LGBTQ+ individuals, and those from socio-economically disadvantaged backgrounds.

- **De-medicalization and Autonomy-Centered Access:** Abortion and ART laws should prioritize the individual's decision-making over medical paternalism. While medical guidance remains essential, it should not override the autonomous choices of informed individuals. Mechanisms for grievance redressal and safeguards against coercion must also be strengthened.
- **Harmonization with International Human Rights Norms:** Domestic legislation should align with international treaties to which the state is a party. Even in dualist legal systems, international human rights jurisprudence can inform constitutional interpretation and policy development.
- **Ethical Regulation, Not Moral Policing:** Laws should be framed to prevent exploitation—especially in surrogacy and ART—without criminalizing or stigmatizing reproductive labor. Ethical contracts, financial transparency, and consent protocols are preferable to blanket bans that force the practice underground.
- **Judicial Dialogue and Transnational Learning:** Courts and lawmakers must engage in transnational dialogue, learning from progressive jurisprudence across jurisdictions to build a coherent, rights-based reproductive law framework.

In conclusion, a rights-based approach to reproductive regulation requires balancing state interests with individual freedoms through proportional, inclusive, and ethically sound laws. The global momentum toward recognizing reproductive justice must be matched by domestic efforts that translate legal principles into accessible realities.