Surrogacy: types and gestational carrier process

What surrogacy means in reproductive medicine

Surrogacy is an arrangement in which one person carries a pregnancy for another individual or couple, called the intended parent or intended parents. The person carrying the pregnancy may be called a surrogate or gestational carrier, depending on whether they are genetically related to the embryo.

From a medical perspective, surrogacy is usually part of assisted reproductive technology. It often involves IVF, embryo culture, and embryo transfer, with ongoing care coordinated among a fertility clinic, obstetric team, mental health professionals, legal counsel, and sometimes a surrogacy agency. Although the medical steps may resemble other IVF pathways, the presence of a separate carrier adds additional screening, consent, communication, and legal requirements.

People may consider surrogacy for many reasons. These can include absence of a uterus due to congenital differences or hysterectomy, uterine conditions that make pregnancy unsafe or unlikely, serious medical conditions that make pregnancy high risk, repeated pregnancy loss, repeated unsuccessful embryo transfer, or family building by male same-sex couples and some single intended parents. The decision is rarely purely clinical; it often carries grief, hope,

uncertainty, financial stress, and profound emotional meaning.

Types of surrogacy: gestational and traditional

The two main types are gestational surrogacy and traditional surrogacy.

Gestational surrogacy means the carrier becomes pregnant through transfer of an embryo created with IVF. The embryo may be made from eggs and sperm from the intended parents, donor eggs, donor sperm, or donor embryos. The key point is that the gestational carrier's own egg is not used, so the carrier is not the biological or genetic parent of the baby.

Traditional surrogacy means the surrogate's own egg is used. Conception may occur through insemination with sperm from an intended parent or donor. Because the surrogate contributes the egg, they are genetically related to the child. This type is less common in many fertility settings and can involve more complicated legal, ethical, and emotional issues.

Most medical organizations and fertility clinics that provide surrogacy-related care emphasize gestational carrier arrangements because they separate the role of pregnancy carrier from genetic parentage. Even so, laws vary widely by country, state, and region, so legal advice should be obtained before any medical cycle begins.

Who may need or choose a gestational carrier

A gestational carrier may be considered when pregnancy is medically impossible, unsafe, or unlikely to be successful for the intended parent. Examples can include congenital absence of the uterus, prior hysterectomy, severe uterine scarring, some uterine anomalies, or medical conditions in which pregnancy could pose serious risk to the intended parent, such as certain cardiac, renal, or pulmonary diseases. It may also be considered after recurrent implantation failure or recurrent pregnancy loss when evaluation suggests that carrying a pregnancy may not be feasible or safe.

Surrogacy may also be part of family building for intended parents who do not have eggs, sperm, or a uterus in the combination needed to conceive and carry a pregnancy. Embryos may be created using donor gametes. For example, donor eggs

may be used when an intended parent cannot provide eggs, and donor sperm may be used when sperm from an intended parent is not available or not medically appropriate.

Before moving forward, intended parents usually meet with a reproductive endocrinologist to review prior fertility history, medical conditions, embryo options, expected success rates, and alternatives. It can also be helpful to review a broader fertility treatments overview, especially if there are several possible pathways, such as IVF with self-carry, donor gametes, embryo donation, adoption, or remaining child-free.

Choosing and screening a gestational carrier

A gestational carrier may be known to the intended parents, such as a friend or relative, or may be matched through an agency or fertility program. Regardless of how the match occurs, screening is a central safety step. Clinics typically evaluate whether the carrier is medically able to undergo embryo transfer, carry a pregnancy, and deliver with acceptable risk.

Screening commonly includes a detailed medical and obstetric history, review of prior pregnancies and deliveries, physical examination, infectious disease testing, uterine evaluation, medication review, and assessment of lifestyle factors that could affect pregnancy. Many programs prefer carriers who have previously had at least one uncomplicated pregnancy and birth, because this provides information about how their body responds to pregnancy.

Psychological evaluation is also essential. Surrogacy involves boundaries, expectations, attachment, communication, potential pregnancy complications, and decisions around prenatal testing or pregnancy management. A mental health professional can help assess readiness and support both the carrier and intended parents in discussing sensitive issues before treatment begins.

Legal agreements should be completed before medications or embryo transfer. These agreements usually address parentage, compensation or reimbursement where legally permitted, medical decision-making, confidentiality, insurance, prenatal testing, delivery plans, and what happens if complications occur. Because surrogacy law varies substantially, each party should have independent legal counsel experienced in reproductive law.

The gestational carrier medical process step by step

The gestational carrier process is individualized, but it often follows a structured sequence.

Initial consultation and planning. Intended parents meet with a fertility specialist to review medical history, whether eggs and sperm will come from intended parents or donors, whether embryos already exist, and whether genetic testing of embryos is being considered.
Embryo creation through IVF. If embryos are not already available, eggs are retrieved from an intended parent or egg donor and fertilized with sperm from an intended parent or sperm donor. Embryos are cultured in the laboratory. Some embryos may be cryopreserved for later use.
Carrier screening and legal clearance. The gestational carrier completes medical and psychological screening, and legal contracts are finalized before embryo transfer preparation.
Uterine preparation. The carrier's endometrium is prepared to be receptive to an embryo. In many cycles, this is done with estrogen and progesterone medications; in some cases, a natural or modified natural frozen embryo transfer approach may be used if clinically appropriate.
Embryo transfer. A clinician places the embryo into the carrier's uterus using a thin catheter, typically under ultrasound guidance. The procedure is usually brief and does not require surgery.
Pregnancy testing and early monitoring. Blood testing for human chorionic gonadotropin, often called hCG, is performed after transfer. If positive, early ultrasound monitoring confirms location, viability, and number of gestations.
Obstetric care and delivery. Once early pregnancy is stable, care transitions to an obstetric clinician. Delivery planning includes the carrier's medical needs, the intended parents' presence if desired and permitted, hospital policies, and legal parentage documentation.

The embryo transfer portion may resemble a frozen embryo transfer cycle, particularly when embryos were previously cryopreserved. Decisions about single versus multiple embryo transfer are medically important because multiple gestation increases risks such as preterm birth, hypertensive disorders, gestational diabetes, fetal growth complications, and cesarean delivery.

Benefits, risks, and medical considerations

For intended parents, gestational surrogacy may allow a child to be born when carrying a pregnancy is not possible or safe. It may also allow one or both intended parents to have a genetic connection to the baby, depending on the egg and sperm sources. For some families, this pathway offers a medically structured alternative after years of infertility treatment or pregnancy loss.

For the gestational carrier, pregnancy can be emotionally meaningful, especially when helping someone else build a family. However, it is still a real pregnancy with real medical risk. Potential risks include nausea and vomiting, anemia, gestational diabetes, hypertensive disorders of pregnancy, placenta-related complications, cesarean delivery, hemorrhage, infection, thromboembolic events, and mental health strain. These risks vary based on personal health history, obstetric history, age, body mass index, number of embryos transferred, and whether the pregnancy is singleton or multiple.

IVF-related steps also carry considerations. The intended parent or egg donor undergoing ovarian stimulation and egg retrieval may face medication side effects, ovarian hyperstimulation syndrome, bleeding, infection, or anesthesia-related risks. Embryo transfer can fail, result in miscarriage, or rarely result in ectopic pregnancy. No surrogacy arrangement can guarantee pregnancy or live birth.

Because these issues are nuanced, decisions about embryo transfer, medication protocols, prenatal testing, and delivery planning should be individualized by qualified clinicians. Surrogacy is safest when everyone involved has clear information, realistic expectations, and access to appropriate medical care.

Emotional, ethical, and communication issues

Surrogacy is not only a medical pathway; it is a relationship. Intended parents may be coping with infertility, prior loss, cancer treatment, chronic disease, or the pain of not being able to carry a pregnancy. Carriers may be motivated by compassion, personal values, financial considerations where permitted, or a combination of reasons. Both sides deserve respect, autonomy, and support.

Clear communication before pregnancy helps reduce distress later. Topics to

discuss include frequency of updates, attendance at appointments, prenatal testing preferences, views on pregnancy complications, delivery room expectations, postpartum contact, and how children in each family will be included in age-appropriate ways. These conversations can be emotionally delicate, and many teams recommend counseling or facilitated meetings.

Ethically sound surrogacy requires informed consent, protection from coercion, fair treatment of the carrier, appropriate medical care, and legal clarity for the child and intended parents. When donor eggs, donor sperm, or donor embryos are used, families may also want guidance on disclosure, genetic origins, and future contact with donors if relevant.

Questions to ask before starting

Before beginning a gestational carrier journey, consider bringing a written list of questions to the fertility clinic, attorney, and mental health professional.

What medical criteria does the clinic use for gestational carriers?
Will embryos be created from intended-parent gametes, donor eggs, donor sperm, or donor embryos?
How many embryos does the clinic recommend transferring, and why?
What screening is required for the carrier and intended parents?
What are the estimated chances of implantation, miscarriage, and live birth in this specific situation?
How will prenatal testing, pregnancy complications, or multifetal pregnancy be handled?
What insurance coverage applies to fertility treatment, pregnancy care, delivery, and complications?
What does local law require to establish parentage?

These questions do not remove uncertainty, but they can make the pathway more transparent and help everyone enter the arrangement with shared expectations.