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Bridging The Gap

faith, fertility and inclusive healthcare in Aotearoa New Zealand

Abstract

In this article we examine the structural discrimination and noticeable absence of religious-based and faith-based support within the healthcare system in Aotearoa New Zealand. Between 2019 and 2021, we conducted interviews with 18 Asian migrants who identified as Sunni Muslims. Their accounts highlighted a significant lack of religious guidance and faith-sensitive support and counselling available at fertility clinics. To address these gaps, we put forward recommendations for policymakers, healthcare providers, government agencies, and ethnic community organisations and leaders. Our aim is to promote more inclusive policies and reduce inequities across the national healthcare system.

Keywords IVF, Asian Muslim migrants, compromised fertility, inclusive healthcare, faith-based counselling

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Declaration: generative AI tools were used in a limited capacity and only to improve the clarity and expression of the writing.

This article builds on a growing body of literature showing that migrant communities face multiple barriers to accessing assisted reproductive techonology (ART). These barriers include limited access to specialist care, language and literacy challenges, unfamiliarity with available subsidies, and difficulties navigating complex health systems (Harerimana, Pillay and Mchunu, 2025; Jawad, Hegarty and Al-Khersheh, 2024; Klein and von dem Knesebeck, 2018; Ngondwe and Tefera, 2023). Such barriers are often compounded for minority faith communities, including Muslim immigrants. Research highlights that cultural, religious and normative factors such as preferences for same-gender providers, beliefs about illness and reproduction, and the role of family or community further shape health service access (Afsah and Kaneko, 2023; Inhorn, 2016). The literature on ART in particular underscores the complex interplay of structural, ethical and religious barriers. While studies in Muslim-majority contexts document issues of acceptability and bioethical constraints (Ahmadi and

Bamdad, 2017; Inhorn, 2006; Murad, Daud and Abu Bakar, 2014), there remains a notable gap concerning Muslim immigrants navigating ART in Western settings (Hammond and Hamidi, 2024; Martin-Anatias, 2025; Martin-Anatias and Davies, 2023). Our research contributes to addressing this gap.

Our article expands on the empirical evidence noted above, demonstrating that minority and migrant groups encounter additional barriers to ART access, including high costs, long waiting times, and a lack of culturally sensitive information and support (Harris et al., 2016; Martin-Anatias, 2025; Shaw and Fehoko, 2023). Gendered norms further shape engagement with ART, as women often experience disproportionate stigma surrounding infertility, while men navigate complex social and religious expectations (Hammond and Hamidi, 2024; Martin-Anatias and Davies, 2022, 2023). Taken together, this literature underscores the need to investigate how Muslim migrant couples experience access to ART in Western health systems, how structural and cultural-religious factors intersect to shape their experiences, and how fertility services can be made more equitable, culturally responsive, and sensitive to the specific needs of multiply marginalised populations.

In response to these gaps, this article has three main purposes. First, it aims to explore ART access barriers faced by migrant Muslim women and couples experiencing fertility issues in their new home, Aotearoa New Zealand. Second, it seeks to highlight the structural gaps within fertility clinics and the healthcare system regarding the accommodation of religious and spiritual needs of minority groups. Third, it makes several recommendations for fertility clinics, healthcare providers and government agencies to adopt culturally and religiously inclusive approaches within clinic settings.

Several urgent issues contextualise this work. Since 2010, Aotearoa New Zealand has seen a declining fertility rate, currently at 1.56 births per woman, which represents a drop of about 20% (Statistics New Zealand, 2024). At the same time, the country is becoming increasingly ethnically and religiously diverse. Muslims comprise about 1% of the total population, and this number is expected to grow. Broader demographic projections indicate that by 2043, 30% of the population will be of Asian and Middle Eastern, Latin American and African (MELAA) backgrounds (Statistics New Zealand, 2023). These demographic shifts underline the importance of culturally responsive healthcare across the country. This need has already been recognised at the policy level, as reflected in the Pae Ora (Healthy Futures) Act 2022, which mandates the provision of more inclusive and equitable health services.

Given these national trends, ensuring culturally responsive fertility care is not only relevant for Muslim communities but also an essential priority for the wider population. As fertility declines and diversity grows, gaps in current services risk becoming systemic barriers that disproportionately affect minority groups (Statistics New Zealand, 2024). When religious expectations discourage individuals from seeking help, and when secular healthcare settings do not acknowledge or accommodate spiritual and cultural needs, trust in the health system weakens. Preparing for a diverse and heterogeneous population therefore requires proactive transformation in fertility care. This article contributes to that effort by presenting insights from our research examining the barriers faced by Muslim participants seeking ART interventions to address their experiences of childlessness.

We faced challenges when recruiting Muslim participants due to their cultural interpretations and religious beliefs relating to childlessness and [assisted reproductive techonology].

Research project and overview

This article draws on our research with 18 Sunni Muslim migrants living in Aotearoa New Zealand, ranging in age from late 20 to 50 years old. Our Sunni Muslim participants held a relatively traditional interpretation of Islamic rulings, particularly regarding ART, including in vitro fertilisation (IVF). This perspective contrasts with that of Shia Muslims, who often adopt more progressive views on ART and IVF (Inhorn, 2006, 2010).

Our participants are migrants who moved to Aotearoa New Zealand for various reasons, but primarily in search of a better life. Most are either permanent residents or citizens, and this legal status has enabled them to access government-funded ART services. All of them are experiencing either primary or secondary fertility issues and have sought medical intervention at fertility clinics due to difficulties conceiving or compromised fertility. We conducted our research interviews from 2019 to 2021 after securing ethics approval from the Auckland University of Technology ethics committee and Victoria University of Wellington. Our research was funded through a Marsden Fund grant.

We faced challenges when recruiting Muslim participants due to their cultural interpretations and religious beliefs relating to childlessness and ART. The onset of the Covid-19 pandemic in early 2020 further complicated our data collection efforts, leading some potential participants to withdraw due to concerns about participating in digital or online interviews. Despite these challenges, we successfully engaged 18 Muslim participants, which is commendable given the sensitivity of the topic and the impacts of the pandemic. Most interviews were conducted in person, with some facilitated via Zoom. All participants provided both verbal and written consent and were informed of their rights within the study.

The interviews were semi-structured, and the data was transcribed and thematically analysed. The researchers, who

come from diverse ethnic and cultural backgrounds, met regularly between 2019 and 2021 to discuss and enrich our understanding of the findings, thus enhancing our data analysis and perspectives.

Research findings

Limited access to information on government public funding

Participants experienced multiple barriers to understanding fertility services and public funding pathways. Many reported feeling lost due to the difficulty in finding information about government-funded fertility support. This struggle highlights a significant communication gap within the health system at a broader level. For migrants unfamiliar with Aotearoa New Zealand's health policies, the absence of clear public guidance creates considerable barriers to accessing the support they need.

Although some participants encountered supportive general practitioners who provided clear guidance, many relied on informal networks, such as friends, ethnic community members, or healthcare workers from similar backgrounds, to access basic information. One participant explained:

> The first big issue was lacking information. We do not know how to find the information or where to find the information. If you are not familiar with the health system in New Zealand, then you get lost, especially if you are a foreigner. Even locals would not know how to get the information and how to do the IVF and the public funding.

The consequences were significant. Several participants learned about public funding only after surpassing the age eligibility threshold, which meant they could no longer access subsidised treatment. Because age is a key criterion for eligibility, this lack of timely information resulted in irreversible outcomes.

Lack of religious guidance and care for Muslim participants in fertility clinics

At the meso level, participants felt unsupported within clinical settings. Many could not access clear, faith-sensitive guidance about the Islamic permissibility (halal status) of IVF, which is a crucial component of fertility decision making among Sunni Muslim patients. The absence of such guidance left women and couples to navigate spiritually and emotionally complex questions alone.

One participant described being advised by her fertility specialist to consider egg or sperm donation, an option she believed was prohibited in her faith tradition. As she explained: 'He knew I was a Muslim but he still suggested I do an egg donation, which is an offense to my faith.' From the clinician's perspective, this recommendation may have reflected a standard practice of outlining all medically viable pathways for addressing infertility. However, for this participant, the suggestion conflicted directly with her religious beliefs and left her feeling that her faith commitments were not understood or respected in the clinical encounter. She further noted that 'the clinic did not have the religious information about the halalness (religious permissibility) of assisted reproductive technologies', underscoring a broader absence of faith-based guidance within fertility services.

> Participants perceived that these religious leaders lacked adequate knowledge of [assisted reproductive techonology], which prevented meaningful engagement with their concerns.

Participants expressed deep concerns about whether their prescribed assisted reproductive technologies aligned with Islamic beliefs, especially because the procedure involves intimate bodily intervention. Some viewed IVF as potentially conflicting with understandings of destiny, while others were aware of ongoing debates within Islamic scholarship, including differences between Sunni and Shia perspectives (Inhorn, 2006, 2010). Many joined this research in the hope that their experiences would encourage clinics to provide clearer religious guidance in the future.

These gaps became particularly salient during intimate procedures. One Indonesian Muslim woman who wears a hijab described her uncertainty during egg retrieval:

> For a Muslim woman wearing a hijab, how do we approach it? Is it okay to open the intimate part? Sometimes I take off my hijab during examinations, but I feel uncomfortable because they can see my private area. I keep thinking, how should I approach this issue?

Her account highlights the tension between religious obligations and clinical requirements. This issue affects many Muslim women, and its impact is often intensified for women who wear the hijab. For many Muslim women, the hijab symbolises modesty and religious identity (Ash, Tuffin and Kahu, 2019; Siraj, 2011; Soltani, Johnston and Longhurst, 2021). The lack of integrated religious guidance meant participants were left to reconcile these competing concerns without support.

This issue is also compounded by the lack of female doctors who are deemed religiously acceptable to treat female Muslim patients. This highlights the structural need for faith-sensitive guidance and care.

Lack of religious guidance and support for Muslim participants in their communities

In the absence of clinical support, participants turned to local imams. However, gendered norms often limited women's ability to speak directly with male religious leaders, reflecting broader patterns in Muslim communities where

interpretive authority is predominantly male and women's access to such authority is constrained (Mahmood, 2005; Mir-Hosseini, 1999). One female participant shared: 'It's hard for the Muslim women to access the imams (here), as the imams are male dominated, so we cannot approach them directly.'

Even when male participants sought guidance from local imams, several of their inquiries were dismissed. Participants perceived that these religious leaders lacked adequate knowledge of ART, which prevented meaningful engagement with their concerns. A male participant shared:

> The local imams may have the religious knowledge, but they don't have the social knowledge, that's what I know, so when asked about IVF, they will straight away say, 'No, that's not allowed' because they don't have the knowledge to, uhm, because they're scared that they may say the wrong thing, so when they don't know something, they'll just say, don't do [it]. That is why I would say they should be educated through an Islamic scholar who knows about this subject.

Other inquiries were dismissed because the topic was deemed 'too sensitive or controversial', according to the participants. This narrative is consistent with findings that infertility remains shrouded in cultural silence and stigma in many Muslim societies (Inhorn, 1996, 2012, 2016; Martin-Anatias and Davies, 2022). These responses reinforced the pronatalist pressures participants already faced in communities where childbearing soon after marriage is central to women's social legitimacy (Clarke, 2009; Inhorn, 2012; Luo et al., 2024).

Lack of faith-based counselling for Muslim participants in fertility clinics

The IVF journey presents significant physical, mental and emotional challenges for our Muslim participants. Coming from a pronatalist culture where having children after heterosexual marriage is considered a rite of passage, these individuals often face stigma from their ethnic communities due to issues with fertility or childlessness (Luo et al., 2024; Martin-Anatias and Davies, 2022). Furthermore, many have reported that their experience with IVF has been difficult. This sentiment was expressed by a Malay Muslim woman in her early 40s, who shared her struggles throughout the process.

> We were indeed experiencing some mental breakdown at that time. It was really bad. It was one difficult journey and if the baby didn't happen, and you have put all your hopes [in that journey]. And you were probably thinking by the time they put the embryo inside you, as a baby, as an embryo, [you had some hope]. But then, they told me in other news that [technology] didn't have the glue to put it in [our womb], [for] the embryo [to stay].

The fragility of the IVF journey was openly shared by a Malay-Singaporean Muslim participant. She candidly admitted to experiencing a mental breakdown, emphasising the intense emotional toll that IVF can take, especially when the outcomes are uncertain or unsuccessful. This highlights the cumulative emotional exhaustion associated with the process. IVF is not just a biomedical intervention; it is deeply emotional, involving cycles of hope, grief and vulnerability (Hu et al., 2025). This narrative illustrates the delicate balance between hope and heartbreak in assisted reproduction.

Another participant recounted her heartbreaking experiences after multiple failed IVF cycles and miscarriages. The emotional burden was significant, and while the healthcare system acknowledged this by offering free counselling sessions, she found the services too secular and disconnected from her faith. Unfortunately, the faith-based counselling she needed was simply unavailable.

> The secular counselling was not asking important religious questions. [They] just asked, 'How do you feel?' And, 'how do you manage?' and, 'tell me about …'. Basically, it was to stimulate our emotions so we could pour our feelings out. Yeah, obviously, [because I] was asked intensively, in that very moment, of course [I] became emotional and let it out. I mean, I poured [my emotion] out. Because it was a very frustrating journey, you know? But then they didn't really give me that spiritual side because they didn't have any faith, right? The counselling itself was not spiritually based, right? So, they didn't really give us any kind of motivation, or something along the line, no.

She was not alone in her feelings. Other Muslim women in our study voiced similar concerns. Consequently, many opted not to use the (secular) counselling services available to them. Instead, they faced the psychological and emotional burden on their own or relied only on their spouses for support. Ideally, this burden should have been addressed by a trained and culturally sensitive mental health professional.

This narrative highlights a significant structural gap in fertility clinics. While secular counselling is available, there is a noticeable absence of faith-based counselling. Our Muslim participants expressed a strong desire for fertility clinics that can provide a counselling space where

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their religious beliefs are acknowledged, respected and meaningfully accommodated. We have learned that there is a sense of isolation following failed treatments, which fertility clinics often do not address or accommodate. When IVF treatment does not result in pregnancy, the impact can be multifaceted, involving emotional distress, medical disappointment, and feelings of being left alone without adequate support (Hu et al., 2025).

This experience reveals more than just personal pain; it underscores a systemic gap in psychosocial follow-up care. There is an urgent need for post-treatment care that is not only psychologically supportive but also sensitive to patients' faith, culture and values, regardless of the treatment's success. This type of care is essential for emotional recovery and for helping patients make informed decisions about their next steps.

Support systems – clinical, community and religious – must recognise this fragility and offer integrated care that includes mental health support and culturally sensitive dialogue. Clinics need to go beyond merely delivering clinical outcomes; they must communicate results in clear, compassionate and culturally appropriate ways, especially for patients from diverse religious, linguistic and cultural backgrounds.

Resilience and self-advocacy in navigating fertility challenges

Despite these barriers, participants demonstrated significant resilience, self-advocacy and resourcefulness. In the absence of accessible clinical or community-based guidance, they sought information independently by consulting online Islamic rulings, joining WhatsApp groups, searching YouTube lectures, and engaging with transnational religious networks (Bunt, 2000, 2018; Campbell, 2013; Mandaville, 1999, 2001). As one participant explained:

> I also asked my Indonesian friend via WhatsApp, who has been through the IVF programme in Indonesia and is a Muslim as well, to receive a similar answer. Being legally married should be the first condition that needs to be met.

A male participant similarly described turning to online religious authorities:

> As we did not really get the answers on IVF from the local imams, we then used YouTube of the ustad we knew from Indonesia. From him, he explained that IVF is halal as long as the egg and the sperm are from the married couple.

These digital practices reflect not only participants' determination to make informed decisions but also the inequitable burden placed on Muslim patients to source critical medical and religious information on their own.

Religious concerns, such as whether to remove a hijab during intimate procedures, were often kept private because participants felt unable to discuss them openly with religious leaders, family or community members.

Participants also relied heavily on spouses, diaspora communities, and emotional ties to family abroad facilitated by social media. These networks often substituted for the lack of faith-sensitive counselling and local community understanding. However, this resilience carried emotional costs. One Malay Muslim participant described experiencing a mental breakdown after repeated IVF failures and miscarriages, while others declined secular counselling because it did not address their spiritual concerns. This left them to manage distress privately.

The persistent shortage of female doctors further shaped participants' strategies. Many preferred to be examined by women, particularly during intimate procedures, and repeatedly requested female clinicians when possible. Their efforts to negotiate clinical encounters illustrate how cultural, religious and medical needs intersect in a system that was not designed with Muslim patients in mind.

Considering these issues, we argue that the resilience shown by Muslim participants is not simply an individual trait but a response to structural gaps in the healthcare system. Their experiences point to the urgent need for culturally and religiously responsive fertility care in Aotearoa New Zealand.

Discussion

The experiences of our migrant participants navigating involuntary childlessness in Aotearoa New Zealand cannot be understood from a single perspective only, given their multi-layered identities (Crenshaw, 1989, 1991). For our participants, being migrant, Muslim and involuntarily childless did not produce separate challenges. Instead, these identities interacted to shape their access to information, their encounters with fertility clinics, and the stigma they faced within their communities. Their newcomer status made the health system unfamiliar; their Muslim identity created a need for faith-sensitive guidance that was rarely available; and their childless status exposed them to cultural and gendered expectations within their diasporic networks.

These narratives reveal that information barriers and gaps in faith-based guidance were not simply administrative oversights but structural issues that disproportionately affected those situated at the intersection of migration, religion, gender and reproductive status (Crenshaw, 1991). Although Aotearoa New Zealand offers advanced medical care, many participants felt that fertility services did not address their core religious question: 'Is this

treatment aligned with my beliefs?' As a result, Muslim women and couples were left to navigate the ethical, spiritual and emotional complexities of assisted reproduction on their own. At this point, reproductive rights are not well met by the ostensibly fair and equitable systems (Ross and Solinger, 2017).

These structural gaps were further compounded by cultural taboos within their communities. Religious concerns, such as whether to remove a hijab during intimate procedures, were often kept private because participants felt unable to discuss them openly with religious leaders, family or community members. While counselling was available after IVF failure or miscarriage, it was predominantly secular and did not acknowledge their spiritual grief. This created the impression that the system viewed them solely as patients, disregarding their identities as believers, migrants, community members or residents of Aotearoa New Zealand (Martin-Anatias, 2025), and thereby failing to recognise their intersectionality of identities (Crenshaw, 1989, 1991).

The narratives illustrate how Muslim participants negotiate multiple, overlapping identities that remain largely invisible within the health system. The lack of faith-sensitive guidance, together with cultural silences surrounding infertility, produces forms of marginalisation that are both structural and relational. Addressing these gaps requires fertility care that recognises and supports Muslim women's, and couples', embodied, emotional and spiritual needs. It is imperative for the government and policymakers to address these gaps.

Policy recommendations

Based on our key findings, we recommend the following actions. First, there is a need for improved access to information. Migrant Muslim communities have faced inconsistent and unclear access to both medical and public funding information. It is essential to establish standardised dissemination practices and foster community partnerships. General practitioners and the related health institutions need to work with the Ministry of Ethnic Communities for the dissemination of the information. Second, the shortage of female doctors has raised discomfort during intimate procedures, which can hinder patients' ability to fulfil modesty obligations. Addressing this shortage is a necessary structural change. Lastly, it is crucial to provide counselling and religious guidance within clinics. The lack of faith-sensitive support has left patients feeling spiritually isolated, often leading them to seek help from online networks and sources of varying reliability and credibility. Clinics should integrate culturally and spiritually informed care. Implementing these actions will help create a fertility care system that is inclusive, equitable, and aligned with the reproductive rights and lived experiences of Muslim communities in Aotearoa New Zealand.

> To build a more inclusive society in Aotearoa New Zealand, it is important to thoughtfully address the pressing needs of minority groups.

Why act now?

It is crucial that we act now to ensure equity in health. First, this policy aligns with the Pae Ora (Healthy Futures) Act 2022, which establishes a clear mandate to 'protect, promote, and improve the health of all New Zealanders' and to 'achieve equity in health outcomes' and healthcare accessibility across all groups, no matter who or where they are, especially for Māori communities. We believe that taking action now will help ensure that ethnic and faith-based communities are not left behind. These recommendations directly support the government's commitment to health equity and will foster a fairer, more inclusive healthcare system.

Second, social cohesion helps reduce stigma within ethnic communities. Mental health stigma remains a significant barrier in many ethnic groups. The report of the Government Inquiry into Mental Health and Addiction, *He Ara Oranga* (2018), reported that migrants and refugees faced significant challenges when it comes to access to mental health and addiction services. A 2025 Asian Family Services and Trace Research report revealed that the mental health and well-being of Asians is declining, with life satisfaction dropping from 86.5% in 2021 to 75.1% in 2025. This highlights a concerning trend within Asian communities, as over half of the 1,016 respondents in this survey are at risk of depression. Additionally, Asians often internalise the stigma associated with mental health and depression (Asian Family Services and Trace Research, 2025). This stigma makes it more challenging to seek help and feel included. Therefore, the Ministry for Ethnic Communities should support initiatives aimed at reducing stigma by funding community projects that promote belonging, inclusion and trust. Building social cohesion means ensuring that everyone feels seen, heard and supported.

Third, from an economic perspective, an inclusive policy can reduce long-term mental health costs. The economic burden of mental illness in Aotearoa New Zealand is substantial. The *He Ara Oranga* report estimated the total cost at $12 billion per year, which is about 5% of GDP. Similarly, a report by the Royal Australian and New Zealand College of Psychiatrists identified $3.1 billion annually in indirect costs from premature deaths linked to serious mental illness (Sweeney and Shui, 2016). These figures suggest that preventable long-term costs in this context may amount to approximately $12,000 per couple per year, highlighting the importance of early intervention, access and support for underserved communities. An inclusive policy that recognises and treats individuals as whole beings is not only essential; it is imperative. It embodies the core practice of dignity and inclusion that must be upheld.

Conclusion: moving forward to build an inclusive future

Stories of migrants and Muslims highlight systemic gaps as well as the resilience of the individuals. Their trust in this country deserves culturally responsive care. Aotearoa New Zealand must work towards a future where no one is forced to choose between their faith and their family. We owe it to these communities to create a system that not only addresses their medical needs but embraces their entire identity, including their religious beliefs. It is essential to initiate conversations where policymakers drive these reforms with clear mandates and sustained funding. Healthcare professionals should adopt holistic, identity-aware models of care, while faith leaders can provide accessible and up-to-date spiritual guidance. Lastly, community organisations should lead safe and inclusive dialogues surrounding reproductive health. To build a more inclusive society in Aotearoa New Zealand, it is important to thoughtfully address the pressing needs of minority groups. By committing to these efforts, the country can advance its policies aimed at reducing inequities and foster a sense of pride in its diversity and inclusiveness.

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