

# THE LOTU FACTOR PROJECT

## EXECUTIVE SUMMARY

Faith, COVID-19 and Tongan Wellbeing in Aotearoa New Zealand



FUNDED BY

**hrcnz**  
Health Research Council  
of New Zealand  
Te Kaunihera Rangahau Hauora o Aotearoa

PUBLISHED BY



CENTRE FOR ADVOCACY,  
RESEARCH &  
EMPOWERMENT  
OLA MELIE CONSULTANCY

ORIGINAL PROJECT HOST



Trinity Theological College



# Executive Summary

## Purpose of the project

COVID-19 exposed both the strengths and the fractures of life in Aotearoa New Zealand. Pacific communities carried disproportionate health, economic and social burdens while also mobilising extensive networks of family care, churches, community providers and cultural leadership. Within Tongan communities, *lotu* was central to this response. It shaped meaning, prayer, hope, pastoral care, interpretations of illness, confidence in medicine, attitudes towards vaccination, responses to mandates and the circulation of information.

Public discussion often reduced religion to one of two opposing narratives. In the first, faith was presented as a source of resilience and an effective channel for public-health communication. In the second, religion was portrayed as a barrier to vaccination, scientific evidence and professional health advice. Neither account adequately reflected the complexity of Tongan experiences. Faith could sustain life and strengthen engagement with health care, but it could also carry fear, misinformation, coercion or exclusion.

The Lotu Factor Project therefore asked a more precise question: under what conditions does *lotu* strengthen Tongan wellbeing, and under what conditions can religious interpretation, authority and practice contribute to preventable harm?

Funded by the Health Research Council of New Zealand through Pacific Project 23/224, the study examined the relationship between *lotu*, COVID-19 and the wellbeing of Tongans living in Aotearoa New Zealand. Its objectives were to:

1. explore the influence of potentially harmful religiosity on attitudes towards professional health advice;
2. examine its impact on Tongan understandings and experiences of wellbeing;
3. identify associated spiritual, physical, mental, relational and social risks; and

4. develop a culturally and theologically grounded framework for life-affirming engagement between faith communities and health systems.

## Study approach

The project used a qualitative, Tongan-led research design grounded in Tongan epistemology, *tālānga* and *kau 'i-talanoa*. These approaches recognised knowledge as relational and created space for participants to explain their experiences in their own cultural, spiritual and linguistic terms.

A total of 155 adults participated in the study:

- 17 participated through individual interviews; and
- 138 participated through group-based *tālānga*.

Participants came from communities across the North and South Islands, including regional and rural locations. Data were generated primarily in Tongan, coded in Tongan using NVivo and interpreted through five iterative cycles of reflexive thematic analysis and collective research-team *tālānga*. Translation into English occurred principally during the dissemination and publication stages.

The sample was predominantly male, middle-aged, Christian and connected to a church. These characteristics provided substantial insight into the role of authority, leadership and institutional church life. They also limited the extent to which the findings represented younger people, women, non-churchgoing Tongans, non-Christian communities, disabled people and Rainbow+ Tongans.

This was a qualitative study. Its findings identify patterns of experience, interpretation and meaning; they do not estimate population prevalence or establish clinical causation.

## Central finding: the meaning of the Lotu Factor

The Lotu Factor is not simply the presence or absence of religion. It describes the way faith is interpreted, led, communicated and embodied

within particular relational, institutional, structural and digital environments.

When *lotu* was joined to truthful leadership, responsible interpretation, compassionate pastoral care, open dialogue, appropriate clinical expertise and inclusive relationships, it strengthened resilience, belonging and engagement with health care.

When *lotu* was joined to absolute claims, spiritually authorised misinformation, coercive leadership, suppressed questioning, blurred professional boundaries or exclusion, it contributed to fear, mistrust, relational damage and possible health risks.

Faith was therefore neither automatically protective nor automatically harmful. Its effects were mediated by leadership, interpretation, trust, institutional practices, social pressures, digital communication and the quality of relationships.

This conclusion challenges both romantic and deficit accounts of Pacific religion. It rejects the assumption that Tongan faith communities are inherently resistant to science. It also rejects the assumption that religious authority is always protective or beyond critical examination.

## Principal findings

### 1. Lotu is a significant determinant of Tongan wellbeing

Participants did not separate physical health from spiritual, mental, emotional, relational, cultural and communal wellbeing. Prayer, worship, family, church, belonging and peace were integral to what it meant to be well.

One participant explained:

“We are body, mind and spirit. When these three come together properly, that is wellbeing; that is the complete person.”  
— *Tālānga participant*

Health interventions directed only towards individual behaviour or biomedical information therefore engage only part of the world in which Tongan health decisions are made. Effective Pacific health policy must

recognise spirituality, family relationships, church participation and cultural belonging as determinants of wellbeing.

## 2. Faith can strengthen both resilience and engagement with health care

Prayer, scripture, fellowship and trust in God helped many participants endure isolation, grief, uncertainty and disruption. Faith provided language for hope and helped participants interpret suffering without surrendering to it.

Faith and medicine were not necessarily understood as opposing systems. Doctors, nurses, vaccines and scientific knowledge could be regarded as gifts provided through divine wisdom and human vocation.

As one participant stated:

“If I am sick, I will go and see the doctor. I can still pray, but it is important that I go to the doctor.”

— *Interview participant*

Another interpreted vaccination through prayer:

“The knocking we did in prayer during lockdown, I believe this was God’s answer: the medicine was brought so that we could be vaccinated and live.”

— *Interview participant*

These accounts demonstrate that the conventional framing of “faith versus science” is inadequate. Within a life-affirming theological framework, prayer, medicine, vaccination and professional care can be understood as complementary.

## 3. Leadership is the hinge between faith as care and faith as harm

Faith leaders carried spiritual, cultural, institutional and relational authority. Their visible example influenced vaccination decisions, their pastoral contact reduced isolation, and their collaboration with health professionals helped translate complex information into trusted settings.

Participants nevertheless recognised that the same authority could amplify unsupported claims, discourage questioning or make disagreement difficult. A message carried through spiritual authority could become more influential than the evidence supporting it.

Legitimate faith leadership was therefore associated with:

- humility and willingness to listen;
- truthful and evidence-informed communication;
- confidentiality and ethical pastoral conduct;
- recognition of professional limits;
- collaboration with qualified health practitioners;
- openness to questions and correction; and
- accountability to the wellbeing of the community.

Leadership was not simply another theme in the findings. It was a decisive mediator between protective and risk-producing expressions of *lotu*.

#### 4. Vaccination uptake did not necessarily mean confidence or freely resolved consent

Most participants whose vaccination status was recorded had received a COVID-19 vaccination. Their accounts, however, included confidence, doubt, prayerful discernment, acceptance, concern, compliance, regret and unresolved ambivalence.

Some participants vaccinated to protect vulnerable family members. Others did so to retain employment, maintain income, travel, participate in church life or avoid social judgement. Behaviour and belief were therefore distinct. A person could be vaccinated while remaining uncertain or distressed.

One participant reflected:

“I went and got vaccinated, but I didn’t feel at peace with it.”  
— *Tālānga participant*

Vaccination coverage alone cannot measure trust, informed decision-making or the quality of people’s experiences. Future programmes should assess confidence, agency, understanding, access to follow-up, relational consequences and willingness to engage with future health interventions.

Participants also reported symptoms or changes in health that they associated with vaccination. These accounts must be heard respectfully and clinically assessed where appropriate. The study did not access clinical records or establish whether vaccination caused the reported experiences.

## 5. Mandates were experienced through employment, church, family and belonging

Participants did not experience vaccination mandates only as government policy. Employers translated mandates into conditions of work and income. Churches mediated them through spiritual authority and access to worship. Families negotiated them through responsibilities for care, housing and economic security.

Participants described constrained choice, silence, judgement, exclusion and continuing relational discomfort. For some, the consequences extended beyond vaccination itself.

One participant stated:

“Workplaces called the shot. If you didn’t get vaccinated, there was no job.”  
— *Interview participant*

Another reflected on the continuing relational effects:

“Things didn’t just go back to normal. It felt awkward after everything that happened.”  
— *Tālānga participant*

The findings do not claim that mandates lacked public-health justification. They show that restrictive policies entered communities

through existing relationships and structures of authority. Future emergency measures must therefore include equity assessment, least-restrictive alternatives, transparent justification, systematic monitoring, frequent review and plans for relational repair.

## 6. Churches were essential wellbeing infrastructure

Churches provided worship, prayer, information, welfare, emotional support, cultural continuity and practical connection. Ministers and church groups contacted families, supported grieving households, shared information and adapted services to maintain participation during restrictions.

Some participants described ministers as being “like physicians.” This language referred to reassurance, prayer, relational presence and pastoral care; it did not mean that ministers provided clinical treatment.

Churches should therefore be engaged as long-term wellbeing partners rather than used only as convenient channels for distributing government messages. Partnership must recognise both the strengths of churches and their internal differences, power structures, safeguarding responsibilities and need for professional referral pathways.

## 7. Digital platforms sustained care and amplified risk

Livestreamed worship, online prayer meetings, family messaging and youth creativity helped maintain the *vā* during lockdown. Digital platforms allowed families, congregations and diaspora communities to remain connected across physical and national borders.

The same networks also circulated apocalyptic claims, accounts of divine immunity, conspiracy narratives and emotionally charged misinformation. Digital trust frequently followed kinship, pastoral authority and transnational relationships rather than official institutional sources.

Future digital-health engagement must therefore include:

- Tongan-language resources;
- theological and cultural literacy;

- trusted clinicians and faith leaders;
- youth and diaspora participation;
- rapid responses to recurring questions;
- privacy and safeguarding practices; and
- relationships maintained before and after emergencies.

Digital public health is not simply the transmission of information. It is the cultivation of trustworthy relationships and spaces.

## 8. Future engagement must be Tongan-led, relational and theologically informed

Translation alone is not cultural responsiveness. Effective engagement must involve Tongan clinicians, theologians, faith leaders, community navigators, women, young people and people with diverse lived experiences from the beginning.

Communication must acknowledge uncertainty, explain why advice changes, support questions without shame and distinguish pastoral authority from clinical expertise. Relationships must be established before a crisis rather than improvised during an emergency.

The strongest policy implication is that public-health engagement must enter the spiritual, relational and moral worlds in which health decisions are made.

## Priority recommendations

The project recommends that churches, health providers, policymakers, researchers and community organisations:

1. establish permanent Tongan and Pacific faith–health partnerships before the next public-health crisis;
2. provide health literacy, crisis communication, safeguarding and theological interpretation education for faith leaders;

3. strengthen accountable and life-affirming theological engagement with health emergencies;
4. ensure that Tongan health communication is Tongan-led, transparent and co-designed;
5. place safeguards around mandates and restrictive measures, including equity analysis, least-restrictive alternatives, monitoring and rapid review;
6. measure trust, informed agency, belonging and relational harm alongside vaccination coverage and compliance;
7. provide accessible post-vaccination assessment, follow-up and adverse-event reporting pathways;
8. resource relational repair in families, churches and workplaces affected by coercion, exclusion or unresolved conflict;
9. establish a Tongan digital-health network involving clinicians, theologians, youth, media practitioners and diaspora communities;
10. strengthen church accountability, confidentiality, professional boundaries and referral pathways;
11. grow the Tongan and Pacific clinical, public-health and community-navigation workforce; and
12. fund longitudinal and implementation research on faith, trust, vaccination, church participation and post-pandemic recovery.

## Contribution of the project

The Lotu Factor Project contributes:

- a substantial Tongan-specific national qualitative study;
- inclusion of regional and rural Tongan voices;
- research generated and analysed primarily in Tongan;

- an integrated account of faith, leadership, vaccination, mandates, digital life and wellbeing;
- a culturally and theologically grounded interpretation of potentially harmful religiosity;
- practical recommendations for churches, health providers and government agencies; and
- the Lotu Factor Reflection Grid as a non-clinical framework for community reflection and planning.

The Reflection Grid helps communities examine evidence, interpretation, leadership, dialogue, professional boundaries, inclusion, institutional practice and digital communication. It is intended to support *tālanga*, accountability and preparedness. It is not a diagnostic instrument, surveillance mechanism or tool for ranking people, churches or denominations.

Accordingly, the project links public-health practice with the contexts in which Tongan communities discern responsibility, trust and care.

*Lotu* is a powerful resource for wellbeing, but its effects depend on truthful interpretation, accountable leadership, open dialogue, inclusive belonging and respectful partnership with health expertise.