

THE LOTU FACTOR Policy Brief

Engaging Faith Communities During Public Health Emergencies

Faith, health and stronger communities
in Aotearoa New Zealand



**PEOPLE
TOGETHER**
STRONGER COMMUNITIES



FAITH IN ACTION
HEALTHIER LIVES



**TRUSTED
PARTNERSHIPS**
BRIGHTER FUTURES



**RESILIENT
PACIFIC COMMUNITIES**
TOGETHER WE THRIVE

Based on the Lotu Factor Project

Centre for Advocacy, Research and Empowerment
in partnership with
Health Research Council of New Zealand

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FAITH
PEOPLE
RESILIENCE
TOGETHER

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Trinity Theological College

POLICY BRIEF

Faith, Trust and Tongan Wellbeing

Policy priorities for equitable health communication, preparedness and recovery

Executive Summary

COVID-19 showed that churches, families, health workers and community networks are central to Tongan wellbeing in Aotearoa New Zealand. These relationships supported prayer, pastoral care, cultural continuity, welfare, communication and social connection. They also became key pathways through which public-health information and interventions were understood, questioned and acted upon.

The Lotu Factor Project found that faith and medicine were not inherently in conflict. Many participants understood prayer, clinical care and vaccination as complementary. However, faith did not lead to one uniform health outcome. Its influence depended on leadership, theological interpretation, trust, opportunity for dialogue, professional boundaries, institutional practice, structural pressure and the digital information environment.

CENTRAL POLICY MESSAGE

Treat Tongan faith communities as long-term partners in wellbeing—not as temporary communication channels during emergencies.

Five Priorities

- Establish permanent, funded and representative Tongan faith-health partnerships.
- Co-design bilingual health communication through tālanga and trusted Tongan leadership.
- Build health and crisis literacy among faith leaders, with clear ethical and professional boundaries.
- Measure trust, understanding, agency and belonging alongside uptake and service use.
- Embed safeguards, accessible follow-up and relational recovery in restrictive or high-pressure interventions.

Why This Matters

Health uptake is not the same as trust or informed consent. People may comply while remaining uncertain, fearful, pressured or disconnected. A policy may therefore achieve a numerical target while weakening the relationships needed for future health programmes.

The central question is not whether health agencies should engage faith communities, but how that engagement should be structured, supported, governed and evaluated so that it strengthens health, trust, dignity and community wellbeing.

About the Research

The Lotu Factor Project was a Tongan-led qualitative study of faith, COVID-19 and Tongan wellbeing in Aotearoa New Zealand.

Participants	155 Tongan adults: 17 individual interview participants and 138 participants in group tālanga.
Language	Most data were generated in the Tongan language.
Topics	Faith, spirituality, wellbeing, professional healthcare, vaccination, mandates, church leadership, trust, misinformation, digital communication and recovery.
Digital inquiry	A supplementary inquiry examined social media, digital religion, diaspora networks and misinformation.

Interpretive limit: As a qualitative study, the project identifies experiences, meanings and relational mechanisms. It does not estimate how common those experiences are across the entire Tongan population.

What the Evidence Tells Us

1. Faith is part of health and wellbeing

Participants described wellbeing as spiritual, physical, mental, emotional, relational and communal. Prayer, worship, family, medicine, relationships and belonging were interconnected. Policies focused only on individual behaviour or biomedical information therefore engage only part of the world in which Tongan health decisions are made.

Policy implication: Recognise faith as a legitimate dimension of culturally responsive Pacific health policy and service design.

2. Faith and professional healthcare can work together

Many participants did not see prayer and medicine as opposites. Medical expertise could be understood as a gift from God, an expression of stewardship or an answer to prayer. One participant summarised this view: “We see the importance of health and faith working hand in hand.”

Policy implication: Frame credible health information within culturally and theologically meaningful dialogue; do not assume an automatic conflict between religion and science.

3. Faith leaders are influential health partners

Faith leaders often hold spiritual, cultural and relational authority. During COVID-19 they reduced isolation, supported families, shared information, encouraged engagement with healthcare and strengthened resilience. The same authority can make questioning difficult or amplify unsupported claims.

Policy implication: Support faith leaders with reliable information, continuing education, referral pathways, confidentiality requirements and clear professional boundaries.

4. Compliance is not the same as trust

Vaccination uptake did not necessarily mean that participants felt confident, informed or at peace with their decision. As one participant said: “I went and got vaccinated ... but I didn’t feel at peace with it.” Unresolved concerns can persist beneath apparently successful uptake.

Policy implication: Evaluate understanding, confidence, freedom to ask questions, perceived pressure, follow-up, trust and willingness to participate again—not uptake alone.

5. Mandates were experienced relationally

Mandates operated not only as government rules but through workplaces, churches, families and communities. Decisions were connected with employment, financial security, church participation, moral authority, family expectations and belonging. Their effects may outlast the formal policy.

Policy implication: Assess social, economic, cultural, equity and relational consequences alongside the intended public-health benefit.

6. Digital spaces carry care and risk

Livestreamed worship, messaging, prayer networks and social media maintained connection across the diaspora and sustained the digital vā. The same networks enabled rapid circulation of misinformation, conspiracy narratives and spiritually framed health claims.

Policy implication: Invest in Tongan-language capacity, theological literacy, trusted digital participation, privacy safeguards and rapid, proportionate responses to harmful misinformation.

Policy Recommendations

1. Establish permanent Tongan faith-health partnerships

Government and health agencies should fund regional partnership groups that operate before, during and after health crises.

Priority actions

- Include Tongan clinicians and providers, church and denominational leaders, community organisations, women, young people, disabled people, community navigators, non-churchgoing Tongans, and communication and evaluation specialists.
- Give the groups defined roles in service design, preparedness, communication, referral, crisis response and evaluation.
- Provide transparent governance, accountability and appropriate payment for community expertise and relational labour.

Safeguard: No single minister, denomination or organisation should be treated as representing all Tongan people.

2. Make health communication Tongan-led and dialogue-based

Engagement should begin with Tongan communities—not after an English-language message has already been finalised.

Priority actions

- Co-design messages in Tongan and English and make them available in accessible, low-data formats.
- State the source and date, what is known and uncertain, why advice changes, and where further help is available.
- Distinguish clinical evidence from public policy, theology and personal testimony.
- Create safe and confidential opportunities for questions through tālanga, trusted navigators and clinical referral.

3. Invest in health and crisis literacy for faith leaders

Faith leaders need enough health literacy to communicate responsibly and refer safely, without being expected to act as clinicians.

Priority actions

- Provide continuing development in public-health fundamentals, evidence interpretation, uncertainty, ethical communication and misinformation recognition.
- Include mental-health referral, safeguarding, confidentiality, professional boundaries and leader wellbeing.
- Maintain rapid access to credible Tongan clinicians and current, plain-language guidance during crises.

Safeguard: Training must clarify the limits of pastoral authority and clinical expertise.

4. Measure trust, agency and belonging alongside health outcomes

Performance measures should capture the quality and durability of engagement, not only coverage, attendance, views, service use or compliance.

Priority actions

- Measure understanding of benefits, risks and uncertainty; confidence in information; ability to ask questions; and experience of pressure or exclusion.
- Assess access to follow-up, trust in health and faith institutions, effects on family and church belonging, and willingness to engage in future programmes.
- Report findings back to communities and identify what changed because of their feedback.

5. Embed safeguards, follow-up and relational recovery

Restrictive or high-pressure interventions require transparent justification, practical protections and a plan to repair damaged relationships.

Priority actions

- State the public-health objective, evidence threshold, less restrictive alternatives, workable exemptions, review and appeal processes, exit criteria, and monitoring of unintended harm.
- Provide visible follow-up on expected reactions, when to seek care, assessment pathways, adverse-event reporting and available support.
- Hear participant-reported experiences respectfully and assess them clinically without ridicule or premature claims about causation.
- Where relationships remain damaged, offer facilitated community tālanga, pastoral support, counselling, acknowledgement of harmful experiences, review of exclusionary practices and pathways for reintegration.

Implementation Roadmap

Timing	Priority actions	Expected result
First 6 months	Appoint accountable leads; establish partnerships; map churches, providers, community and digital networks; select priority health issues; agree governance, privacy and accountability arrangements.	A representative, funded and accountable foundation.
Months 6–12	Pilot faith-leader development, bilingual communication, community tālanga, clinical referral, post-intervention follow-up, trust measures and misinformation response.	Tested models with documented learning and community feedback.
Year 2	Integrate partnerships into preparedness plans; establish a standing Tongan digital-health network; expand effective communication and referral approaches; conduct annual privacy and safeguarding reviews.	Routine capability rather than crisis-only engagement.
Year 3	Evaluate trust, service engagement, referral outcomes, communication, relational wellbeing, participation and emergency readiness; embed effective approaches in Pacific health practice.	Evidence of impact, sustainability and readiness.

Accountability and Senior Oversight

Senior leaders should receive a concise, regular dashboard that combines delivery measures with evidence about the quality of engagement.

Domain	Minimum reporting content
Partnership and participation	Active regional groups; diversity of Tongan contributors; attendance and decision-making roles; payment for community expertise.
Capability and communication	Faith and health leaders trained; bilingual resources produced; confidential questions answered; referral success; response time to significant misinformation.
Trust and safeguards	Understanding and trust; reports of pressure or exclusion; privacy and safeguarding issues; availability of follow-up; effects on belonging.
Learning and change	Community feedback received; changes made and communicated; preparedness and willingness to engage in future programmes.

OVERSIGHT QUESTION

Did engagement strengthen understanding, trust, agency, dignity and belonging—not simply reach more people?

Essential Policy Safeguards

Implementation must protect pluralism, privacy, professional integrity and genuine community decision-making. It should not:

- turn churches into government communication contractors or ministers into uncritical endorsers of policy;
- assume theological uniformity or treat dissent and vaccine hesitation automatically as religious pathology;
- monitor private digital groups without lawful authority and consent, or establish watchlists of individuals, ministers or churches;
- present personal testimony as proof of clinical causation, blur pastoral and clinical roles, or collect unnecessary personal information;
- substitute one-off consultation for shared decision-making or rely on unpaid cultural and relational labour.

Call to Action

The Lotu Factor Project calls for a shift from episodic engagement to permanent relational infrastructure. Tongan communities should not become important to the health system only during a pandemic, vaccination campaign or emergency. The trust and capability required in a crisis must be built beforehand and sustained afterwards.

The policy goal is a health system in which Tongan people can understand, question and act on health information while retaining dignity, faith, agency and belonging.

Suggested Citation

Vaka'uta, N., Tāufa, S., Tūtone-Tualau, 'A., Puli'uvea, C., Fehoko, E., & Vaka, S. (2026). Faith, Trust and Tongan Wellbeing: Policy Priorities for Equitable Health Communication, Preparedness and Recovery. Centre for Advocacy, Research & Empowerment.

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