

THE LOTU FACTOR Health Framework

Faith, Community and Wellbeing
in Aotearoa New Zealand

A culturally grounded framework
for healthier, more resilient
Pacific communities



**PEOPLE
AND RELATIONSHIPS**
STRONGER TOGETHER



FAITH AND CULTURE
MEANING AND PURPOSE



**HEALTHY
COMMUNITIES**
THRIVING TOGETHER



**PARTNERSHIPS
FOR CHANGE**
BRIGHTER FUTURES

HRC PACIFIC PROJECT 23/224

2026

FAITH
PEOPLE
RESILIENCE
TOGETHER

*Healthy People
Thriving Communities
Brighter Tomorrows*

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THE LOTU FACTOR FRAMEWORK

A Tongan Framework for Faith, Health and Wellbeing

Lotu Factor Project | HRC Pacific Project 23/224 | 2026

1. Purpose

The Lotu Factor Framework is a Tongan health and wellbeing framework for understanding how faith, spirituality and religious life interact with social, cultural, relational, institutional and structural conditions to influence health.

The framework recognises lotu as an important influence on Tongan wellbeing. Lotu encompasses faith and spirituality, scripture, prayer, worship, theological interpretation, church life, pastoral leadership, family and communal belonging, and moral understandings of illness, healing, care and responsibility.

The framework does not assume that religion is automatically protective or automatically harmful. Rather, the health effects of lotu depend on how faith is interpreted, communicated, practised and led, and how it interacts with relationships, professional healthcare, institutions and wider social conditions.

The core proposition is:

The influence of lotu on health and wellbeing depends not simply on the presence or strength of faith, but on how faith is interpreted, led, communicated, embodied and connected with the wider conditions of life.

The framework is designed to support:

- Tongan communities and kāinga;
- churches and faith leaders;
- health providers;
- community organisations;
- government and public agencies;
- researchers;
- educators; and
- digital-health and communication networks.

It is intended for reflection, planning, partnership, health promotion, accountability and evaluation. It is not a diagnostic instrument and must not be used to judge the spiritual worth of individuals or communities.

2. Evidence Base

The framework emerged from the Lotu Factor Project, a Tongan-led qualitative study involving 155 adult Tongan participants in Aotearoa New Zealand, including 17 individual interview participants and 138 group-tālanga participants.

Participants discussed experiences and understandings relating to:

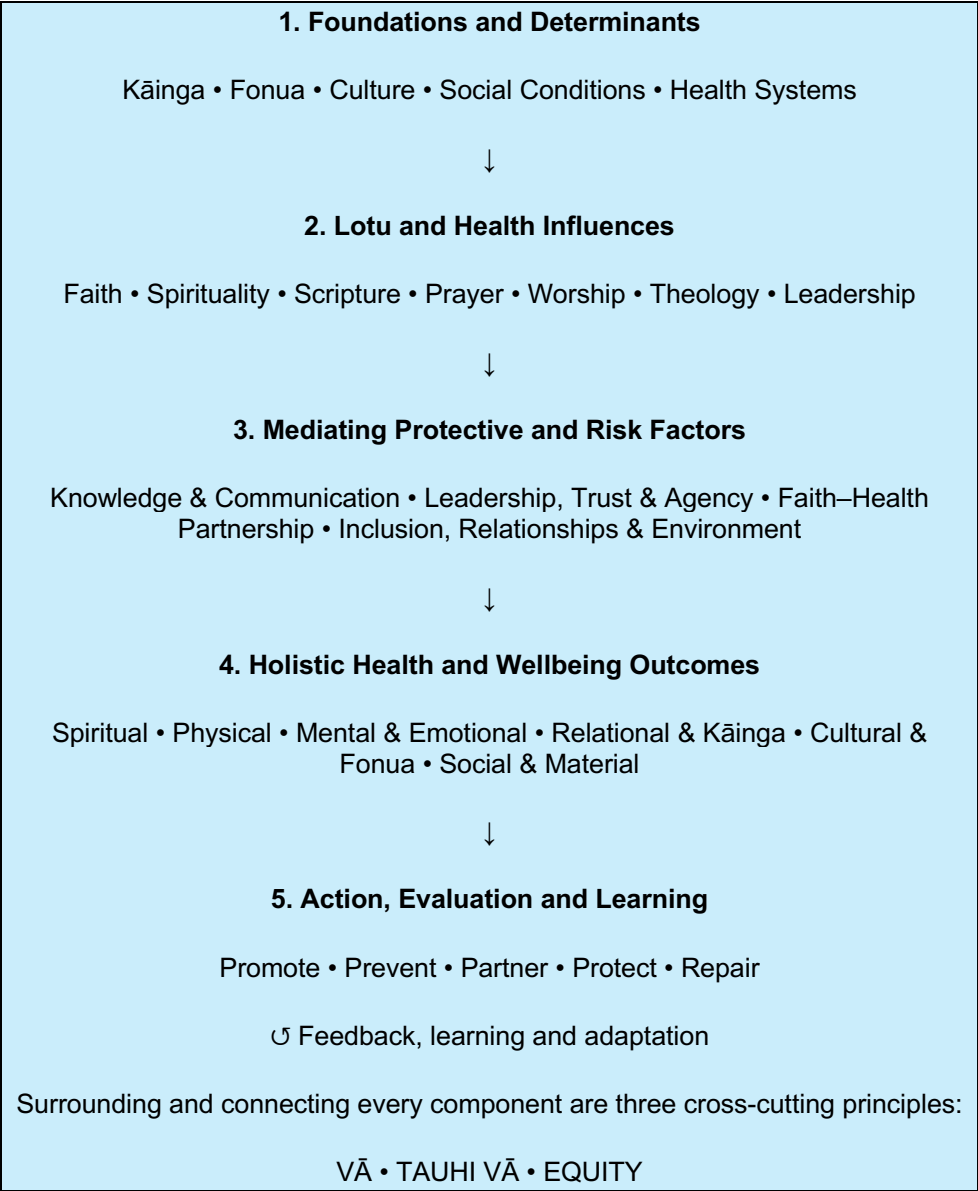
- holistic wellbeing;
- faith and spirituality;
- prayer and scripture;
- professional healthcare;
- COVID-19 vaccination;
- mandates and restrictions;
- church leadership;
- trust;
- misinformation;
- digital communication;
- family and employment pressures; and
- relational recovery.

The original project defines the Lotu Factor as the influence of faith on wellbeing operating through interpretation, leadership, trust, relationships, professional boundaries and social conditions.

The framework identifies processes, relationships and patterns arising from the qualitative findings. It does not estimate the prevalence of particular beliefs or practices in the wider Tongan population.

3. The Framework at a Glance

The Lotu Factor Framework consists of five interconnected components:



4. Foundational Tongan Concepts

Lotu

Lotu encompasses faith, spirituality, worship, scripture, prayer, theological interpretation, church life, pastoral authority and the relationships organised around religious practice.

Lotu may provide:

- meaning during uncertainty;
- hope;
- spiritual resilience;
- social connection;
- pastoral care;
- practical assistance;
- moral motivation;
- cultural continuity; and
- collective solidarity.

Lotu may also contribute to risk when religious authority, interpretation or communication becomes disconnected from evidence, accountability, dialogue, professional boundaries or demonstrable wellbeing.

The concern of the framework is therefore not whether people have "too much" or "too little" faith, but how lotu operates in relation to health and wellbeing.

Vā

Vā refers to the relational space connecting people, kāinga, communities, institutions, health professionals, the fonua and the sacred.

Vā is not an empty distance between individuals. It is a living relational space requiring attention, responsibility and care.

Health therefore involves more than individual biological functioning. It also concerns the quality of the relationships through which people experience:

- dignity;
- belonging;
- trust;
- authority;
- support;
- decision-making; and
- care.

Tauhi Vā

Tauhi vā is the active nurturing, protection, maintenance and repair of relationships.

In the context of health, tauhi vā involves:

- truthfulness;
- respect;
- reciprocity;
- accountability;
- listening;
- compassion;
- responsibility;
- confidentiality;
- reconciliation; and
- continued relationship across disagreement.

A central proposition of the framework is:

The health impact of lotu is mediated through the quality of the vā.

Kāinga

Kāinga refers to family and extended networks of belonging, identity, obligation, responsibility and mutual care.

Kāinga can function as a major protective health resource through:

- caregiving;
- emotional support;
- material assistance;

- collective decision-making;
- intergenerational knowledge; and
- cultural continuity.

Kāinga relationships may also create pressure where authority, obligation or unequal power restrict individual agency.

Fonua

Fonua expresses the interconnected life of:

- people;
- bodies;
- land;
- place;
- environment;
- sustenance;
- ancestry;
- identity; and
- community.

Fonua prevents health from being understood only as an individual or clinical condition. It locates wellbeing within broader cultural, ecological, social and historical relationships.

5. Component One: Foundations and Determinants of Health

The Lotu Factor does not operate independently of the conditions in which people live.

Health choices are shaped by relationships, resources, institutions and structural conditions. The framework therefore begins with the determinants surrounding individuals and communities.

A. Kāinga and Community

Relevant factors include:

- family relationships;

- caregiving responsibilities;
- intergenerational authority;
- church and community relationships;
- social support;
- collective expectations; and
- community participation.

B. Cultural and Fonua Context

Relevant factors include:

- language;
- cultural identity;
- migration and diaspora;
- ancestral connection;
- cultural authority;
- collective values; and
- relationships with place and environment.

C. Social and Structural Conditions

Relevant conditions include:

- housing;
- employment;
- income;
- financial pressure;
- education;
- transport;
- disability;
- access to healthcare;
- racism and discrimination;
- public policy;
- mandates and restrictions;
- emergencies and pandemics; and
- previous experiences of institutional harm.

D. Institutional and Information Environment

Relevant environments include:

- churches;
- health services;
- community organisations;
- government agencies;
- workplaces;
- education institutions;
- mainstream media;
- social media; and
- digital communication networks.

These conditions influence the choices available to people and can either strengthen or constrain health and wellbeing.

6. Component Two: Lotu and Health Influences

Lotu may influence health through several interconnected pathways.

Meaning

Lotu shapes understandings of:

- illness;
- suffering;
- healing;
- death;
- hope;
- divine protection;
- moral responsibility; and
- care for vulnerable people.

Motivation

Faith may encourage:

- care for others;
- prevention;
- service;
- sacrifice;
- responsibility;

- perseverance; and
- collective protection.

Behaviour

Religious beliefs and relationships may influence decisions about:

- seeking treatment;
- accepting professional advice;
- prevention;
- vaccination;
- medication;
- prayer;
- pastoral care; and
- participation in health programmes.

Relationships

Faith communities can provide:

- belonging;
- emotional support;
- pastoral care;
- practical help;
- social connection; and
- relational repair.

Authority

Ministers, church leaders, parents, elders, clinicians and public institutions possess different forms of authority.

Their influence can become health-promoting when authority is accountable and appropriately exercised, or risk-producing where it becomes coercive or unchallengeable.

Resilience

Lotu may provide resources for:

- coping with uncertainty;
- grief;
- illness;
- isolation;
- loss;
- social disruption; and
- recovery.

7. Component Three: Mediating Protective and Risk Factors

The health effects of lotu are mediated through four interconnected domains.

These domains determine whether a particular practice, message, policy or leadership approach moves predominantly towards protection, emerging concern or risk.

Domain 1: Knowledge and Communication

This domain examines how religious and health knowledge is interpreted, communicated and related to evidence.

Protective characteristics

- information sources can be identified;
- evidence is distinguished from personal opinion;
- uncertainty is acknowledged;
- health information is current and culturally meaningful;
- scripture is interpreted responsibly;
- corrections can be made;
- questions are welcomed; and
- misinformation is addressed.

Emerging concerns

- sources are unclear;
- evidence and testimony are mixed together;
- changing health advice is poorly explained;
- conflicting interpretations remain unresolved; or
- reliable and unreliable digital information circulate together.

Risk characteristics

- unsupported claims are presented as fact;
- speculation is presented as divine certainty;
- fear-based misinformation is amplified;
- correction is rejected;
- spiritual claims are presented as medical evidence; or
- scripture is used to shame appropriate care-seeking.

Domain 2: Leadership, Trust and Agency

This domain examines how authority is exercised and whether people are able to participate in decisions affecting their health.

Protective characteristics

- leaders are accountable;
- limits of expertise are acknowledged;
- questions are welcomed;
- informed choice is respected;
- conscience is protected;
- less powerful voices are heard;
- decision-making is transparent; and
- mistakes can be acknowledged and corrected.

Emerging concerns

- accountability depends primarily on individual personalities;
- people may ask questions privately but not publicly;
- some voices dominate decision-making; or
- silence is treated as agreement.

Risk characteristics

- spiritual authority is unchallengeable;
- questioning produces shame;
- people experience spiritual threats;
- pressure replaces informed choice;
- dissent leads to exclusion;
- confidentiality is breached; or

- leaders use their authority to advance unsupported health claims.

Trust is both an input and an outcome. Existing trust affects how health messages are received, while people's experience of those messages influences future trust.

8. Domain 3: Faith–Health Partnership

This domain examines relationships between spiritual care and professional healthcare.

Faith and clinical care need not compete.

Prayer, pastoral support and professional treatment may operate together while retaining distinct roles and responsibilities.

Protective characteristics

- faith leaders and health professionals collaborate;
- professional boundaries are understood;
- clinical advice is provided by appropriately qualified people;
- faith concerns are taken seriously by clinicians;
- referral pathways are available;
- urgent care is not delayed; and
- pastoral care continues alongside treatment.

Emerging concerns

- professional roles overlap without clear guidance;
- referral pathways are informal;
- clinicians have limited understanding of spiritual concerns; or
- faith leaders lack access to trusted health expertise.

Risk characteristics

- pastoral authority substitutes for clinical expertise;
- treatment is discouraged;
- referral is delayed;
- spiritual explanations override urgent clinical needs;
- clinicians dismiss or ridicule faith; or

- theological and medical claims are presented as interchangeable.

9. Domain 4: Inclusion, Relationships and Environment

This domain examines whether institutions and communities protect dignity, belonging and the relational conditions required for wellbeing.

Protective characteristics

- confidentiality is respected;
- safeguarding is active;
- vulnerable voices are included;
- cultural safety is supported;
- disagreement does not remove belonging;
- practical barriers to care are recognised;
- relational repair is available; and
- communication protects the vā.

Emerging concerns

- conflict is managed mainly through silence;
- participation is uneven;
- privacy practices are inconsistent;
- some groups are poorly represented; or
- access barriers are recognised but not adequately addressed.

Risk characteristics

- people are humiliated;
- individuals or families are excluded;
- health information is disclosed without consent;
- stigma prevents care-seeking;
- cultural authority suppresses questioning;
- structural inequalities are ignored; or
- relationships are damaged without opportunities for repair.

10. The Protective–Risk Continuum

The framework does not classify churches, leaders or communities as either "healthy" or "unhealthy".

Instead, particular practices are located along a continuum.

PROTECTIVE

Practices strengthen health and wellbeing through:

- trustworthy information;
- responsible theology;
- accountable leadership;
- informed agency;
- appropriate health partnerships;
- inclusion;
- care; and
- tauhi vā.

EMERGING CONCERN

Protective and risk-producing elements coexist.

These situations require:

- further dialogue;
- clarification;
- support;
- additional information;
- strengthening of safeguards; and
- review.

They should not automatically be treated as harmful.

RISK / HARM

Practices may contribute to poorer wellbeing where:

- fear overrides evidence;
- authority cannot be questioned;
- people are shamed or coerced;
- clinical care is delayed;
- misinformation is amplified;
- belonging becomes conditional;

- confidentiality is breached; or
- structural pressures are given inappropriate spiritual force.

11. Component Four: Holistic Health and Wellbeing Outcomes

The Lotu Factor Framework understands wellbeing holistically.

A programme should not be considered successful solely because it produces a desired health behaviour if the process also causes spiritual, relational, cultural or psychological harm.

Six domains of wellbeing are therefore considered.

Wellbeing Domain	Protective Outcomes	Risk-Producing Outcomes
Spiritual	Meaning, hope, humility, sustaining faith, peace	Fear, shame, spiritual threat, false certainty
Physical	Prevention, appropriate treatment, timely care, follow-up and protection	Delayed treatment, inappropriate advice, neglected follow-up
Mental & Emotional	Resilience, reassurance, confidence, reduced isolation	Anxiety, confusion, distress, unresolved trauma
Relational & Kāinga	Belonging, dialogue, mutual care, shared responsibility and repair	Silence, coercion, conflict, exclusion and unequal burden
Cultural & Fonua	Identity, cultural continuity, collective responsibility and connection	Cultural alienation or use of cultural authority to suppress or shame
Social & Material	Access, participation, practical support, institutional trust and equity	Financial hardship, barriers to care, mistrust, withdrawal and inequity

12. Cross-Cutting Principle: Equity

Equity must be considered across every component of the framework.

Health initiatives should ask:

- Who defines the health problem?
- Who participates in decisions?
- Who has access to information?
- Who holds authority?
- Who can ask questions?
- Who can refuse?
- Whose knowledge is recognised?
- Who benefits?
- Who carries the burden?
- Who may be excluded?
- Who bears the consequences when systems fail?

Special attention should be given to people whose voices may be less visible or less powerful, including:

- young people;
- women;
- disabled people;
- people experiencing financial hardship;
- people socially isolated from church or community networks; and
- others directly affected by the health issue being considered.

13. Component Five: Health Action

The practical purpose of the framework is to strengthen protective influences and reduce preventable harm.

Five areas of action are recommended.

1. Promote

Strengthen forms of lotu that support:

- resilience;
- hope;
- prevention;
- healthy behaviour;
- social connection;

- informed decision-making; and
- collective care.

2. Prevent

Identify and reduce:

- misinformation;
- coercion;
- stigma;
- exclusion;
- unsafe health advice;
- inappropriate use of authority; and
- delayed access to care.

3. Partner

Strengthen collaboration among:

- kāinga;
- faith communities;
- health professionals;
- community organisations;
- researchers; and
- public institutions.

Partnership should respect the different forms of expertise that each group contributes.

4. Protect

Ensure:

- informed choice;
- confidentiality;
- safeguarding;
- appropriate professional boundaries;
- culturally safe communication;
- inclusion; and
- protection of vulnerable people.

5. Repair

Where relationships or trust have been damaged:

- acknowledge what occurred;
- create opportunities for safe dialogue;
- address grievances;
- reconnect people with appropriate services;
- restore accountability; and
- rebuild the vā.

Repair is not separate from health. Relational recovery contributes to future resilience and preparedness.

14. Theory of Change

The Lotu Factor Framework proposes that:

If:

- Tongan communities participate meaningfully in health decision-making;
- faith and health expertise work collaboratively;
- health and religious claims remain open to evidence and correction;
- leaders exercise accountable authority;
- people can ask questions safely;
- informed choice and conscience are respected;
- professional boundaries and referral pathways are clear;
- institutions protect dignity, privacy and belonging;
- structural barriers to health are recognised;
- digital communication is trustworthy and culturally meaningful; and
- relationships are nurtured through tauhi vā;

Then:

- people will understand health information more clearly;
- uncertainty and concern can be discussed earlier;
- misinformation can be challenged;

- coercion can be reduced;
- appropriate care-seeking can increase;
- vulnerable people can be better protected;
- faith and professional healthcare can operate collaboratively;
- relational harm can be reduced; and
- trust can become more durable.

Contributing to:

- holistic wellbeing;
- equitable health engagement;
- resilient kāinga;
- accountable leadership;
- stronger faith-health partnerships;
- improved preparedness;
- healthier communities; and
- sustained trust between Tongan communities and health institutions.

15. Evaluation and Learning

Evaluation should examine more than service utilisation, attendance, compliance or single health behaviours.

The framework uses four levels of evaluation.

Process Indicators

These examine whether planned activities occurred.

Examples include:

- faith leaders trained;
- health-faith partnerships established;
- community tālanga undertaken;
- community representatives included;
- referral pathways established;
- culturally relevant health resources developed; and
- safeguarding processes implemented.

Output Indicators

These examine what was produced or delivered.

Examples include:

- health education activities delivered;
- referrals made and followed up;
- questions responded to;
- corrections to misinformation issued;
- participation across community groups;
- resources distributed; and
- communication channels established.

Outcome Indicators

These examine what changed.

Examples include:

- improved understanding;
- greater confidence in health information;
- stronger perceived agency;
- increased willingness to ask questions;
- earlier care-seeking;
- improved referral;
- stronger trust;
- reduced reported pressure or exclusion;
- improved faith-health collaboration; and
- greater continued belonging across disagreement.

Long-Term Impact

Longer-term impacts may include:

- improved holistic wellbeing;
- stronger health equity;
- increased community resilience;
- sustained institutional trust;
- stronger kāinga and community support;

- effective faith-health partnerships; and
- improved preparedness for future health emergencies.

No single indicator should be treated as sufficient evidence of success.

16. Feedback, Learning and Adaptation

Health experiences shape future behaviour.

The framework therefore includes continuous feedback loops.

Protective Feedback Loop

Trustworthy communication

- positive experience
- stronger trust
- earlier questioning and care-seeking
- stronger partnership
- improved preparedness.

Harmful Feedback Loop

Pressure, misinformation or relational harm

- negative experience
- damaged vā
- reduced trust
- silence or withdrawal
- increased dependence on closed networks
- greater vulnerability during future health crises.

The framework therefore understands **post-crisis repair as part of future health preparedness.**

17. Applying the Framework

The framework can be applied to a:

- sermon;
- church health message;

- pastoral practice;
- health campaign;
- policy;
- community programme;
- leadership decision;
- digital message;
- emergency response; or
- community health experience.

Step 1: Define the Issue

Identify the specific health practice, message, intervention or experience being considered.

Step 2: Understand the Context

Identify:

- affected communities;
- health issue;
- social and structural determinants;
- cultural context;
- existing levels of trust;
- relevant institutions;
- forms of authority; and
- possible power differences.

Step 3: Convene the Appropriate Voices

Where relevant, include:

- community members;
- kāinga;
- faith leaders;
- clinicians;
- community health workers;
- young people;
- women;
- disabled people;
- cultural advisors; and

- people directly affected.

Step 4: Examine the Four Mediating Domains

Consider:

1. Knowledge and Communication;
2. Leadership, Trust and Agency;
3. Faith–Health Partnership; and
4. Inclusion, Relationships and Environment.

Identify protective features, emerging concerns and possible risks.

Step 5: Assess Wellbeing Consequences

Consider possible consequences for:

- spiritual wellbeing;
- physical health;
- mental and emotional wellbeing;
- relationships and kāinga;
- cultural and fonua wellbeing; and
- social and material wellbeing.

Step 6: Agree on Action

Identify:

- protective strengths to retain;
- risks requiring attention;
- actions required;
- responsible people or organisations;
- referral or safeguarding requirements; and
- a review date.

Step 7: Review and Learn

Assess:

- what changed;
- what worked;
- what caused difficulty;
- whose voices were heard;
- whether trust changed;
- whether relationships were strengthened or damaged; and
- what should be adapted next time.

18. Guiding Principles

Six principles guide all use of the Lotu Factor Framework.

1. Holistic Wellbeing

Health includes physical, spiritual, mental, emotional, relational, cultural, social and material dimensions.

2. Equity

Health resources, opportunities, risks and burdens should not be distributed unfairly.

3. Evidence

Health claims should remain open to appropriate evidence, uncertainty, review and correction.

4. Agency

People should be able to ask questions and make informed decisions without coercion, shame or spiritual threat.

5. Partnership

Faith communities, kāinga, communities and health professionals contribute complementary forms of knowledge and expertise.

6. Tauhi Vā

Health practice should protect dignity, relationships, trust, responsibility and continued belonging.

19. Safeguards

The Lotu Factor Framework assesses practices, relationships, messages and institutional processes.

It does **not** assess the spiritual worth of people.

The framework must not be used to:

- diagnose individuals;
- classify people according to the strength of their faith;
- classify churches as inherently healthy or unhealthy;
- monitor religious belief;
- create religious watchlists;
- label theological disagreement as pathology;
- treat silence as agreement;
- equate vaccine hesitation with deficient faith;
- assume compliance means informed consent;
- infer population prevalence from qualitative findings;
- treat participant-reported experiences as proof of clinical causation; or
- justify coercion in the name of health or wellbeing.

The unit of reflection should be a specific:

- message;
- interpretation;
- leadership practice;
- health intervention;
- policy;
- institutional process;
- relationship; or
- communication environment.

The framework requires humility and reflexivity.

It supports structured reflection and accountability but does not provide a final judgement on a person, congregation or community.

20. Summary of the Framework

The Lotu Factor Framework proposes that:

- ◇ Lotu is an important influence on Tongan health and wellbeing.
- ◇ Its health effects are mediated rather than automatic.
- ◇ Kāinga, fonua, culture, social determinants and health systems shape the conditions within which lotu operates.
- ◇ Knowledge and communication, leadership and agency, faith-health partnership, and relational environments influence whether lotu becomes protective or risk-producing.
- ◇ Vā and tauhi vā are central mechanisms connecting faith, relationships, institutions and wellbeing.
- ◇ Protective and risk-producing characteristics may coexist within the same community or practice.
- ◇ Health outcomes must be assessed holistically across spiritual, physical, mental, emotional, relational, cultural, social and material dimensions.
- ◇ Equity must be considered across all levels of the framework.
- ◇ Health action should promote protective resources, prevent harm, strengthen partnership, protect vulnerable people and repair damaged relationships.
- ◇ Trust is both a determinant and an outcome of health engagement.
- ◇ Evaluation should examine processes, outputs, outcomes, equity, relationships and long-term impact rather than relying solely on behavioural compliance.

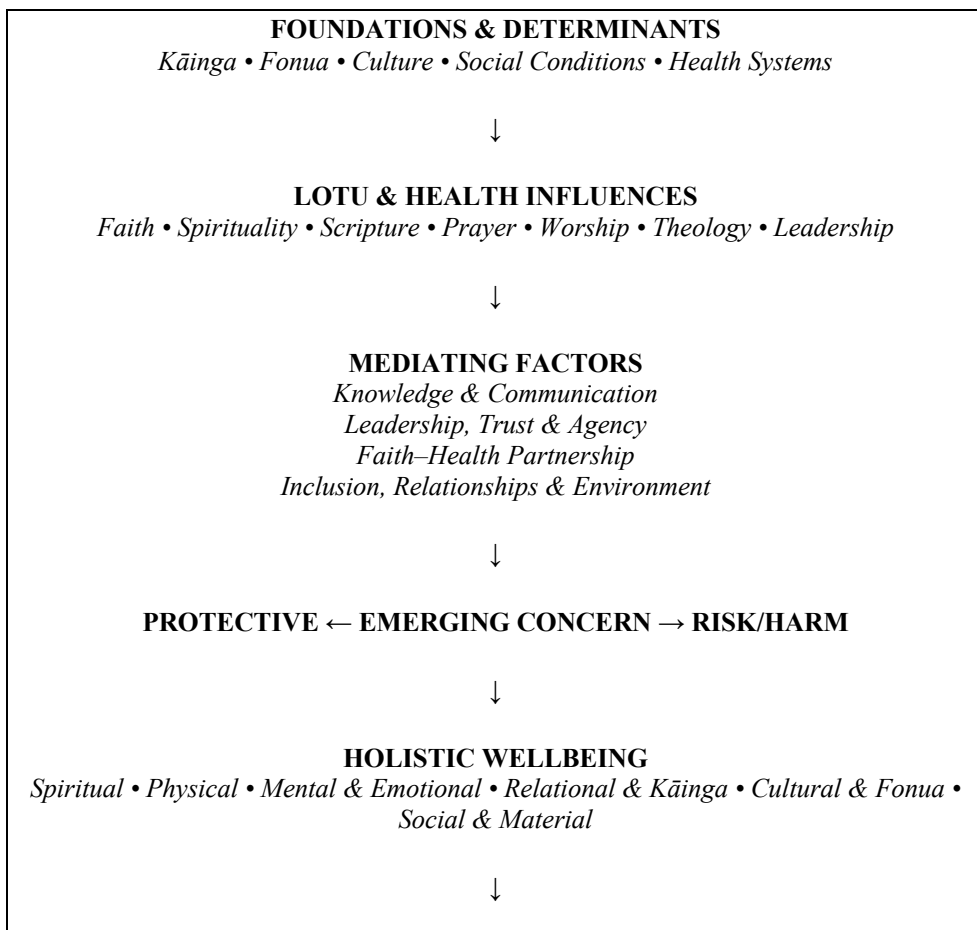
- ◇ Learning and relational repair contribute to future resilience and preparedness.

Final Proposition

Life-giving lotu strengthens health when faith is truthful, humble, relationally accountable, open to evidence, respectful of professional knowledge, protective of human agency and committed to tauhi vā.

The goal of the Lotu Factor Framework is therefore not to measure how religious people are, but to understand and strengthen the conditions through which lotu contributes to the flourishing of the whole person, the kāinga, the vā and the fonua.

THE LOTU FACTOR MODEL



HEALTH ACTION

Promote • Prevent • Partner • Protect • Repair



EVALUATION & LEARNING

Process → Outputs → Outcomes → Impact → Feedback

Surrounding and connecting the whole framework:

VĀ • TAUHI VĀ • EQUITY