

THE LOTU FACTOR

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

FAITH
PEOPLE
RESILIENCE
TOGETHER

FINAL RESEARCH REPORT

PREPARED FOR THE

Health Research Council
of New Zealand

HRC Pacific Project 23/224

2026

RESEARCH TEAM

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The shorter public title is used throughout this report because it communicates the study's balanced findings without positioning Tongan faith negatively before the evidence is explained. The original contracted title is retained here for accountability to the funded project.

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Funding acknowledgement and independence

This work was supported by the Health Research Council of New Zealand through Pacific Project 23/224. The views and conclusions are those of the research team and do not necessarily represent the position of the Health Research Council, government agencies, participating churches or partner institutions.

Privacy and responsible use

Participant material has been de-identified for public release. Specific combinations of place, denomination, leadership role and other descriptors have been removed because they could identify participants in small communities. Quotations in this edition are attributed only to an "interview participant" or "tālanga participant." Reports of symptoms or adverse experiences following vaccination are presented as participant-reported experiences; the study did not clinically verify causation. The report must not be used to diagnose individuals or classify churches.

Accessibility and formats

This report is issued in an editable standard edition, a searchable PDF edition and an accessible web edition. The web edition uses structured headings, high-contrast text, keyboard-accessible navigation and a print stylesheet. Readers requiring another format may contact the publisher.

Research team, advisory group and acknowledgements

Research team

- ◇ Rev Prof Nāsili Vaka‘uta - Project Lead; religion, biblical studies, Moana hermeneutics and cultural interpretation.
- ◇ Dr Seini Tāufa - Pacific qualitative research, community health and analytic guidance.
- ◇ Dr ‘Ana Tūtone-Tualau - research design, analysis and women’s tālanga.
- ◇ Dr Christopher Puli‘uvea - immunology, vaccination evidence and health interpretation.
- ◇ Dr Edmond Fehoko - Pacific health, qualitative research and South Island engagement.
- ◇ Associate Professor Sione Vaka - Pacific mental health, nursing and community wellbeing.

The project also acknowledges the contribution of the late Rev. Prof. Jione Havea to the original application and conceptual development; the administrative and research assistance provided across the project; and the organisations that supported the work at different stages of its delivery.

Advisory group named in the research protocol

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The advisory group brought together Tongan research, clinical, psychological, community, social-service, youth and faith perspectives. Its purpose was relational accountability: to ensure that cultural, ethical and contextual considerations shaped decisions throughout the study.

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The research team thanks the people who entrusted the project with their experiences of faith, illness, vaccination, mandates, leadership, family strain, resilience and hope. Their accounts

were sometimes painful and contested. They were offered so that churches, health providers, policymakers and future generations might respond better when another crisis comes.

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Finally, we acknowledge all those who became ill, were bereaved, carried essential work, lost employment, experienced isolation, lived with unresolved vaccine concerns, or sustained families and communities during COVID-19. The report seeks neither to relitigate every pandemic decision nor to flatten different experiences into one account. Its task is to listen carefully, identify patterns and carry lessons forward.

Key Tongan terms

Term	Working meaning in this report
Lotu	Faith, worship, religious belief and practice, spirituality, and the institutional and relational life organised around them. The meaning depends on context.
Lotu noa	A project-developed, non-clinical term for potentially harmful religiosity: patterns of religious interpretation, communication, authority or practice that become detached from evidence, correction, accountability, dialogue and the wellbeing of people. It is not a synonym for religion, conservative theology, dissent or vaccine hesitancy.
Tālanga	A Tongan dialogical process of speaking and attentive listening through which meaning is generated relationally. In this study it shaped engagement, analysis and dissemination.
Kau‘i-talanoa	Transformative interruption or joining a conversation so that suppressed, excluded or less powerful voices may be heard.
Vā	Relational space connecting people, families, communities, ancestors and the sacred; a relationship to be nurtured rather than an empty distance.
Tauhi vā	Caring for, maintaining and acting responsibly within relationships.
Kāinga	Family and extended relational community.
Faifekau	Minister or recognised church leader; precise roles differ between denominations.
Faka‘apa‘apa	Respect expressed in relationships, conduct and social order.
Loto-tō	Humility and a willingness to lower oneself in respectful relationship.
Wellbeing	An interconnected condition of spiritual, physical, mental, emotional, relational, cultural and communal life.
Lotu Factor	The patterned effect of faith on wellbeing as mediated through interpretation, leadership, trust, relational authority, institutional practice, structural pressure and digital information environments.

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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* (faith, religious belief and practice) 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.”
— *Tālanga 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.

Part I — The Project and Its Foundations

1. Project Overview

1.1 Background

The COVID-19 pandemic was both a health emergency and a crisis of relationship, meaning and trust. In Aotearoa New Zealand, the initial elimination strategy restricted the spread of the virus, protected the health system from being overwhelmed and delayed widespread community transmission until vaccination coverage was comparatively high. These achievements saved lives, but they did not remove the unequal effects of the pandemic.

Māori and Pacific peoples carried disproportionate health, social and economic burdens. These burdens were intensified by existing inequities in housing, employment, income, access to health care and institutional trust. Public-health restrictions also affected dimensions of life that could not be measured only through infection or vaccination statistics. They disrupted worship, funerals, employment, education, mobility, cultural responsibilities, family relationships and collective participation.

The Royal Commission of Inquiry into COVID-19 Lessons Learned concluded in its Phase One report that successful emergency management requires attention to all aspects of people's lives. It emphasised the importance of clear communication, adaptability, community relationships and preparedness established before an emergency. It also recognised the contribution of faith groups, community organisations and non-governmental providers that could reach people and communities that government agencies sometimes struggled to engage.

The Phase Two report examined vaccination requirements and related government decisions in greater detail. It concluded that vaccination requirements were a legitimate public-health tool but also produced significant social and economic consequences. Their effects were not always adequately monitored, and some requirements remained in place longer or extended further than could be justified in hindsight. The Commission consequently emphasised systematic monitoring, frequent review, transparent decision-making, protection of rights, proportionality and renewed attention to public trust and social cohesion.

These national conclusions provide an important policy setting for the Lotu Factor Project. They identify community capability, trust, vaccination, mandates, misinformation, rights, relationships and recovery as central lessons from the pandemic. The Lotu Factor Project adds a specifically Tongan account of how these issues were interpreted and experienced within faith communities.

The significance of lotu in Tongan life

In Tongan life, *lotu* cannot be reduced to private belief or attendance at Sunday worship. It is woven through family identity, moral responsibility, leadership, language, social obligation, cultural practice and interpretations of suffering. It encompasses belief in God, prayer, worship, scripture, spirituality, church institutions and the relationships organised through religious life.

Churches are among the most enduring Tongan institutions in Aotearoa New Zealand. In addition to worship and pastoral care, they provide:

- social and cultural gatherings;
- welfare and practical assistance;
- youth and children's activities;
- language and cultural transmission;
- funeral and bereavement support;
- education and leadership development;
- family and marriage support;
- community mobilisation; and
- relationships with health and social-service providers.

During COVID-19, churches became important sites of reassurance, information, prayer, material support and community connection. Ministers and other faith leaders helped families interpret rapidly changing public-health advice. Congregations adapted worship, funerals, pastoral care and community activities to digital environments. Churches also assisted with vaccination communication and, in some cases, hosted health professionals and vaccination services.

However, churches were also places where competing interpretations of the pandemic were negotiated. Questions about vaccination, government authority, biblical prophecy, divine protection, personal freedom and collective responsibility entered congregational life. Some interpretations supported health engagement and care for vulnerable people. Others intensified fear, mistrust, division or resistance.

The project emerged because existing public-health discussion did not adequately explain this complexity. Vaccination statistics could show what people did, but they could not reveal whether people acted with confidence, uncertainty, social pressure or unresolved concern. Accounts of “religious resistance” could identify public statements by prominent leaders but could not explain how ordinary Tongans navigated prayer, scientific evidence, conscience, family obligations, employment and church authority.

Similarly, describing churches simply as “trusted partners” risked overlooking differences within congregations, including hierarchy, gender, generation, denominational identity, misinformation, exclusion and unequal power. Trust could not be assumed merely because an institution was religious or culturally familiar.

A Tongan-led qualitative study was therefore needed to examine these tensions without treating Tongan culture or faith itself as the problem.

Project identification

The Lotu Factor Project was funded by the Health Research Council of New Zealand as Pacific Project 23/224.

The original contracted title was:

The Lotu Factor: Delusional Religiosity, COVID-19, and Tongan Wellbeing in New Zealand

The public title adopted for publication and dissemination is:

The Lotu Factor: Faith, COVID-19 and Tongan Wellbeing in Aotearoa New Zealand

The project ran from 1 August 2023 to 31 July 2026. Ethics approval was granted by the Health and Disability Ethics Committees in May 2024 under reference 2024/EXP 19965.

The shorter public title communicates the project's balanced findings without positioning Tongan religion negatively before the evidence is considered. The contracted title remains part of the project record for accountability to the funder.

1.2 Purpose of the project

The project examined how *lotu* shaped Tongan health and wellbeing during COVID-19 and translated the findings into a practical, life-affirming response framework.

The project did not begin from the assumption that all religious belief was harmful. It began with concern about particular forms of interpretation, communication and authority that might discourage professional health care, spread unsupported medical claims, suppress questions or expose people to preventable harm.

At the same time, the study recognised that faith could provide meaning, resilience, hope, belonging, pastoral care and motivation to protect others. The research therefore examined both protective and risk-producing possibilities.

COVID-19 was used as a case study because it brought faith, science, government authority, church leadership, health behaviour and community wellbeing into unusually direct interaction. Decisions about vaccination, mandates, worship, employment and family protection made visible the complex pathways through which *lotu* influenced wellbeing.

1.3 Objectives

The four objectives of the project were:

1. To explore the impact of “delusional religiosity” on the general attitudes of Tongans in faith communities towards professional health advice, using COVID-19 as the principal example.
2. To examine the impact of “delusional religiosity” on the wellbeing, and views on wellbeing, of Tongans within faith communities in Aotearoa New Zealand.

3. To gain an improved understanding of health risks associated with communities and individuals who display symptoms of “delusional religiosity.”
4. To develop a framework for responding to the challenges of “delusional religiosity” for the purpose of promoting life-affirming Tongan communities in Aotearoa New Zealand.

These objectives guided the literature review, research design, interviews, group-based *tālanga*, thematic analysis, symposium discussions and development of the Lotu Factor framework.

1.4 Refinement of the project’s terminology

As the study progressed, the research team refined the language used in the original objectives. The phrase “delusional religiosity” could be interpreted as a psychiatric or clinical diagnosis. It could also imply that religious belief, spiritual intensity or disagreement with public policy was itself evidence of pathology.

The findings did not support such an interpretation.

Potential harm did not arise simply because a person was religious, believed in divine action, questioned government policy or expressed concern about vaccination. Harm emerged when particular patterns of religious interpretation, leadership, communication or institutional practice became detached from evidence, correction, accountability, dialogue and concern for people’s wellbeing.

The public report therefore uses *lotu noa* or “potentially harmful religiosity” as a carefully limited analytical concept. The focus is on patterns and consequences rather than on labelling a person, congregation or denomination.

This refinement does not abandon the original purpose of the project. It strengthens it by replacing potentially stigmatising terminology with a more culturally grounded and ethically responsible framework.

The study applies the following safeguards:

1. *Lotu noa* is not a clinical or psychiatric diagnosis.
2. It does not describe faith, spirituality or religious commitment in general.
3. It is not synonymous with conservative theology, supernatural belief, vaccine hesitancy, disagreement or criticism of government.
4. It should be applied to patterns of interpretation, authority and practice—not used as a label for individuals or communities.
5. Any assessment must remain culturally grounded, evidence-informed, relational, dialogical and open to correction.
6. The same ethical questions—truthfulness, accountability, proportionality, openness and consequences for wellbeing—must also be applied to government agencies, health institutions and researchers.

1.5 Research questions

The project's original central research question was:

What impact does religiosity have on the wellbeing of Tongans in New Zealand?

As the evidence developed, the final analysis was organised around five connected questions:

1. How did Tongans understand and experience wellbeing during and after COVID-19?
2. How did *lotu* shape interpretations of professional health advice, vaccination, medical care and responsibility for others?
3. Under what conditions did faith strengthen resilience and wellbeing, and under what conditions did it contribute to risk or harm?
4. How did church leadership, vaccination mandates, employment, family relationships and digital information affect trust, agency, belonging and health decision-making?
5. What should churches, health providers, government agencies and community organisations do differently before, during and after a future public-health crisis?

These questions allowed the study to move beyond a simple assessment of whether religion was “positive” or “negative.” They directed attention towards the mechanisms through which faith influenced wellbeing and the conditions that shaped its consequences.

1.6 Scope of the study

The study focused on adult Tongans living in Aotearoa New Zealand and their experiences of faith, health and wellbeing during and after COVID-19. It examined:

- Tongan understandings of holistic wellbeing;
- prayer, worship and religious coping;
- attitudes towards professional health advice;
- vaccination experiences and decision-making;
- responses to vaccination mandates;
- church leadership and pastoral authority;
- relationships between faith and medicine;
- misinformation and digital communication;
- family, employment and congregational pressures;
- experiences of inclusion, exclusion and belonging; and
- possibilities for future faith–health partnership.

The study did not undertake clinical assessment of participants, determine whether reported symptoms were caused by vaccination, estimate the prevalence of particular beliefs, or evaluate the doctrinal correctness of denominations.

Its purpose was interpretive and practical: to understand lived experiences, identify recurring patterns and develop more responsible approaches to faith, health and public policy.

1.7 Distinctive contribution of the study

The Lotu Factor Project makes five principal contributions.

A Tongan-specific evidence base

First, the project is explicitly Tongan. Pacific peoples should not be treated as a single, undifferentiated population. Pacific communities share important regional histories and values, but they also differ in language, migration, theology, church organisation, leadership, social structure and local experience.

A Tongan-specific study enables closer attention to the meanings of *lotu*, *vā*, *tauhi vā*, family responsibility, ministerial authority and communal belonging.

Inclusion of regional and rural communities

Second, the project included participants beyond the largest urban centres. Regional and rural participation allowed the study to examine contexts in which labour markets may be smaller, alternative employment more limited, social relationships more visible and access to specialised services more difficult.

These conditions could intensify the consequences of mandates, church conflict or exclusion because participants had fewer alternative workplaces, congregations or health services.

Research conducted and analysed in Tongan

Third, the research was generated and analysed primarily in Tongan. Meaning was not translated into English at the beginning and then treated as culturally equivalent.

Coding and interpretation remained close to Tongan language, idiom, humour, theology, silence and relational context. Translation was treated as an interpretive responsibility rather than a mechanical transfer of words.

Post-emergency reflection

Fourth, the study was conducted after the most restrictive phases of the pandemic. This temporal distance allowed participants to reflect on consequences that were difficult to see in real-time public-health statistics.

These included:

- unresolved discomfort about vaccination decisions;
- changes in church participation;

- altered family relationships;
- loss of trust in institutions;
- continuing concerns about health experiences;
- leadership fatigue;
- employment and financial consequences; and
- relationships that did not automatically return to normal when restrictions ended.

A practical conceptual framework

Fifth, the project develops the Lotu Factor as a practical conceptual synthesis. The framework distinguishes life-affirming expressions of *lotu* from patterns that may become harmful while avoiding clinical labelling and respecting legitimate religious and political difference.

The related Lotu Factor Reflection Grid provides a structured process through which communities can examine:

- evidence and truth claims;
- theological interpretation;
- leadership and accountability;
- dialogue and personal agency;
- professional boundaries;
- inclusion and belonging;
- institutional practices;
- digital communication; and
- structural pressures.

The framework is intended to support *tālanga*, planning and accountability. It is not designed to diagnose individuals, rank churches, determine funding or create systems of religious surveillance.

1.8 Significance for future preparedness

The Lotu Factor Project demonstrates that public-health preparedness cannot be confined to emergency plans, medical supplies and communication strategies. It must also include the relationships, institutions and moral worlds through which people interpret health advice.

For Tongan communities, this requires sustained engagement with *lotu*. Faith leaders and churches should be recognised as important wellbeing partners, but partnership must include accountability, appropriate professional boundaries and space for diverse community voices.

The project therefore shifts the central question from whether religion is helpful or harmful to a more constructive question:

What conditions enable lotu to protect life, strengthen relationships and support responsible engagement with health care?

Answering that question provides the foundation for the chapters that follow.

2. Context and Conceptual Framework

2.1 Tongan understandings of wellbeing

Participants consistently described wellbeing as an interconnected condition involving the spiritual, physical, mental, emotional, relational, cultural and communal dimensions of life. A person could not be regarded as well merely because illness was absent. Peace of mind, faith, bodily health, harmonious relationships, family security, belonging and meaningful participation were understood as inseparable.

Participants framed this integration as the wellbeing of the “complete person”, in which body, mind and spirit belong together.

This understanding is consistent with Pacific health scholarship that places spirituality, family, culture, reciprocity and collective belonging at the centre of wellbeing. Research among older Pacific people, for example, demonstrates that spirituality and religion influence health through identity, hope, relationships, meaning and participation rather than through belief alone (Neville et al., 2024).

The participant’s reference to the “complete person” also challenges approaches that treat the autonomous individual as the primary unit of health decision-making. Participants made decisions as members of households, congregations, workplaces and extended families. They considered obligations to elders, children, spouses, employers, church leaders, communities and God.

A decision about vaccination was therefore rarely interpreted as a purely individual calculation of medical benefits and risks. It could also involve:

- protecting an older or medically vulnerable family member;
- maintaining employment and household income;
- responding to the advice of a minister;
- preserving harmony within a family or congregation;
- fulfilling a moral responsibility towards the community;
- retaining access to worship or community activities; and
- acting consistently with prayer, scripture and conscience.

This relational understanding does not mean that biomedical care was rejected. Participants could pray and consult a doctor, receive vaccination and use familiar home remedies, trust in

God and ask critical questions of institutions. Biomedical care was situated within a larger moral and relational ecology.

The public-health challenge is therefore not to replace Tongan spirituality and relational life with technical information. It is to work responsibly within the cultural, spiritual and relational worlds in which health decisions are interpreted and made.

2.2 Lotu as a multidimensional concept

The Tongan term *lotu* carries several related meanings. Depending on context, it may refer to:

- faith in God;
- prayer and worship;
- scripture and theological interpretation;
- religious identity;
- spirituality and moral responsibility;
- a denomination or church institution;
- participation in congregational life;
- the authority of ministers and church leaders; or
- the relationships organised through faith communities.

The term should therefore not be reduced to church attendance or formal doctrinal agreement. *Lotu* includes beliefs, practices, institutions, relationships and forms of authority. It can shape how illness is interpreted, where advice is sought, whom people trust, how suffering is explained and what responsibilities people believe they have towards others.

This multidimensional character helps explain why the influence of *lotu* during COVID-19 was not uniform. The same congregation could provide pastoral care and circulate misinformation. A minister could encourage vaccination while a family member expressed concern. A person could trust God, accept medical advice and remain critical of government policy. Another could comply with a mandate while continuing to experience spiritual or relational distress.

The relevant question is therefore not simply whether *lotu* was present. The more important question is how it was interpreted, communicated and practised within a particular situation.

2.3 What the wider literature shows

The project's literature review examined 49 recent sources addressing religion, spirituality, COVID-19, vaccination, mental health, misinformation, public-health communication and Pacific wellbeing. The literature demonstrates that religion is neither inherently protective nor inherently harmful. Its consequences depend upon interpretation, leadership, social context, institutional trust and access to reliable information.

Nine conclusions are particularly relevant to the Lotu Factor Project.

2.3.1 Religion can function as both a resource and a risk

Religion supported meaning, hope, emotional stability, social connection, welfare provision and public-health partnership during COVID-19. Faith communities provided food, pastoral care, information, online worship and support for isolated or grieving families. Religious beliefs also helped people interpret uncertainty and sustain a sense of hope (Ayub et al., 2023; Oxholm et al., 2021).

However, particular religious interpretations contributed to denial, resistance, stigma, conspiracy narratives and expectations that divine protection could replace health precautions or professional care. The literature therefore supports neither the claim that religion was simply beneficial nor the claim that it was primarily an obstacle to public health.

The critical questions are:

- Which forms of religious belief and practice were influential?
- Through what mechanisms did they operate?
- Whose authority carried the message?
- What social and institutional conditions shaped the outcome?
- What were the consequences for wellbeing?

2.3.2 Positive and negative religious coping differ

Systematic reviews and meta-analyses distinguish positive religious coping from negative religious struggle (Cheng & Ying, 2023; Pankowski & Wytrychiewicz-Pankowska, 2023a, 2023b).

Positive religious coping can include:

- hope and trust;
- a secure relationship with God;
- prayer and spiritual reflection;
- meaning-making;
- compassionate community support;
- forgiveness;
- acceptance without resignation; and
- a sense of shared purpose.

Negative religious struggle may include:

- interpreting illness as divine punishment;
- feeling abandoned by God;
- spiritual guilt or shame;
- conflict with religious leaders;
- fear-based apocalyptic interpretation;
- blaming individuals for illness;
- believing that seeking medical care demonstrates weak faith; and
- treating uncertainty as spiritual failure.

Positive religious coping is associated with resilience and improved psychological wellbeing. Negative religious struggle is more commonly associated with anxiety, distress, guilt, conflict and poorer mental-health outcomes.

These associations require careful interpretation. Much of the international literature is cross-sectional and cannot establish causation. Religious coping should also not be treated as a substitute for psychological, medical or social care.

2.3.3 Crisis changes religious practice

COVID-19 changed both the intensity and the form of religious practice. Some people turned more strongly towards prayer, worship and scripture. Others became disillusioned, disengaged from institutional religion or questioned existing leadership.

Lockdowns accelerated:

- online worship;
- domestic and family-based religious practices;
- livestreamed preaching;
- digital prayer meetings;
- pastoral care through telephone and messaging applications;
- transnational religious participation; and
- online theological debate.

Research on the digital *vā* demonstrates that online spaces helped Pacific communities maintain relational connections during physical separation (Fehoko et al., 2022). Digital religion was therefore not merely a weaker imitation of physical worship. It became an important form of relational and spiritual infrastructure.

However, digital participation also raised questions about privacy, access, authority, surveillance, unequal digital literacy and the circulation of misinformation.

2.3.4 Trust and communication mediate health behaviour

Non-compliance with public-health advice cannot be explained by religion alone. Institutional trust, political identity, economic conditions, cultural authority, historical experience and access to reliable information interact with religious interpretation.

People may distrust a health message because:

- the source is unfamiliar;
- previous experiences of institutions have been negative;
- the information changes without adequate explanation;
- language is overly technical;
- the message conflicts with trusted relational authority;
- uncertainty is concealed;
- questions are treated dismissively; or
- the policy carries social or economic consequences that are not acknowledged.

Faith communities can improve access to information because they provide familiar languages, relationships and settings. The same networks can also restrict corrective information when leaders communicate unsupported claims or when questioning is discouraged.

Trust is therefore not simply a pre-existing cultural resource that agencies can use. It is a relationship that must be earned, protected and repaired.

2.3.5 Vaccination attitudes and vaccination behaviour are distinct

Vaccine hesitancy is not a fixed identity or a simple refusal of science. It exists across a continuum and may involve uncertainty, delay, selective acceptance, concern about particular vaccines or changing attitudes over time (MacDonald, 2015).

Research among Māori and Pacific communities in Aotearoa shows that attitudes towards vaccination were shaped by institutional trust, communication, access, cultural responsiveness, prior experiences and perceptions of risk (Charania et al., 2024; Ministry of Health, 2021).

Religious affiliation alone is a poor predictor of vaccination behaviour. Denomination, region, education, political context, leadership and the perceived compatibility of vaccination with faith all matter.

A person may:

- receive vaccination with confidence;
- receive vaccination while remaining hesitant;

- accept vaccination to protect family members;
- comply because employment is at risk;
- refuse one intervention while accepting others; or
- express concern without rejecting vaccination.

Vaccination coverage therefore measures behaviour but does not necessarily measure trust, consent quality, confidence or the resolution of concern.

2.3.6 Religious institutions are public actors

Churches and faith-based organisations were active public institutions during COVID-19. They provided food, welfare, health information, pastoral support, vaccination advocacy and practical assistance.

This public role creates both opportunity and responsibility. Churches can strengthen health engagement when they:

- collaborate with qualified health professionals;
- provide trusted spaces for questions;
- communicate uncertainty honestly;
- protect vulnerable people;
- support access to services; and
- maintain belonging across disagreement.

However, churches can also contribute to harm when spiritual authority is used coercively, confidentiality is breached, unsupported claims are communicated as certainty, or participation is made conditional upon compliance without adequate pastoral care.

Public-health restrictions affecting religious practice may be justified during a serious emergency, but they must be lawful, necessary, proportionate, time-limited and non-discriminatory. Relationships between churches and public agencies should be established before a crisis rather than created only when authorities require assistance.

2.3.7 The burdens of crisis are unequally distributed

The phrase “faith community” can conceal significant internal differences. Gender, age, disability, income, migration status, sexuality, denominational hierarchy and leadership position affect who holds authority, whose experiences are recognised and who carries the costs of institutional decisions.

Women may provide much of the practical care while remaining under-represented in formal leadership. Young people may manage digital communication while having limited influence over institutional decisions. Disabled people may face access barriers that are not visible to

leaders. People with insecure employment may experience mandates differently from those with financial security.

A relational approach must therefore ask not only what a church or community decided, but also:

- Who participated in the decision?
- Whose voice was absent?
- Who benefited?
- Who carried the greatest burden?
- Who could safely disagree?
- Who remained included after the decision?

2.3.8 Theological interpretation is a critical boundary

Faith and science are not inherently opposed. Religious beliefs can support vaccination, medical care and protection of vulnerable neighbours. Science can be understood as part of divine wisdom, and health professionals can be regarded as exercising a God-given vocation (Ayub et al., 2023; Ndaluka et al., 2025).

Risk emerges when religious authority:

- presents unsupported medical claims as spiritual truth;
- treats public-health precautions as evidence of weak faith;
- promises divine immunity from illness;
- attributes infection to personal sin or moral failure;
- suppresses legitimate questions;
- discourages professional treatment; or
- confuses pastoral authority with clinical expertise.

Constructive theological interpretation can affirm prayer, scripture, divine presence and spiritual hope while also recognising human limitation, scientific knowledge, uncertainty and the responsibility to protect vulnerable people.

2.3.9 Pacific and Tongan evidence remains limited

Much of the international literature relies on cross-sectional surveys, convenience samples or broad ecological categories. Pacific peoples are frequently absent, grouped together or interpreted through categories developed in other cultural contexts.

This limits understanding of:

- ethnic-specific theological concepts;
- church and denominational structures;
- relational authority;
- migration and diaspora networks;
- Pacific languages;
- collective decision-making; and
- the interaction between spirituality and public health.

The evidence gap justified a Tongan-specific, qualitative and relational study.

2.4 Lotu as a determinant of wellbeing

This report describes *lotu* as a determinant of wellbeing. The term “determinant” does not imply that religion is a simple or direct cause of health outcomes. It means that *lotu* is a significant influence operating through multiple connected pathways.

Seven mechanisms were identified.

1. Belief and interpretation

Religious beliefs shape explanations of illness, protection, suffering, responsibility and hope. An illness may be interpreted as a biological event, a spiritual test, divine punishment, an opportunity for communal care or some combination of these.

The interpretation influences whether people seek care, whom they trust and how they respond emotionally.

2. Spiritual practice

Prayer, worship, scripture, fasting, ritual and spiritual discernment can strengthen hope, peace and endurance. Spiritual practices can also become risk-producing when they are presented as substitutes for necessary care or when participation is used to measure moral worth.

3. Leadership

Ministers, elders and other recognised leaders carry spiritual and relational authority. Their example can support vaccination, reassure communities and encourage professional care. The same authority can amplify misinformation or make disagreement difficult.

4. Institutional practice

Church policies determine access to worship, leadership, welfare, pastoral care and community participation. Institutional practices can protect belonging or create exclusion, shame and lasting division.

5. Relationships

Family influence, respect, reciprocity, obligation, pastoral care and communal belonging shape health decisions. Relationships can offer protection and support, but they can also become channels of pressure, conflict or silence.

6. Public partnership

Connections between churches, clinicians, Pacific providers and government agencies affect the credibility and accessibility of health information. Partnership is protective when roles are clear and communities participate in decision-making. It becomes risky when churches are used instrumentally or professional boundaries are blurred.

7. Digital environments

Online worship, social media, family messaging and transnational networks carry both care and information. Digital platforms can maintain the *vā*, but they can also amplify fear, outrage, conspiracy claims and spiritually authorised misinformation.

These pathways interact with wider structural conditions, including employment requirements, crowded housing, unequal service access, economic insecurity, racism and historical mistrust.

Lotu therefore does not operate outside society. It may buffer structural pressure through care, solidarity and hope. It may also intensify structural pressure when compliance, dissent or exclusion is framed in spiritual or moral terms.

2.5 Defining *lotu noa* safely

The original research protocol used the expression *lotu noa* in relation to potentially harmful religiosity. Because the term could be misused to shame individuals or dismiss religious disagreement, the project adopts a careful working definition:

Lotu noa is a pattern of religious interpretation, communication, authority or practice that becomes detached from evidence, correction, accountability, dialogue and the demonstrable wellbeing of people, creating a material risk of spiritual, relational, emotional or physical harm.

The definition focuses on patterns and consequences rather than on the strength or sincerity of a person's faith.

Five safeguards govern its use:

1. It is not a clinical diagnosis. It does not invoke psychiatric definitions of delusion or make claims about a person's mental-health status.
2. It does not describe faith itself. Religious commitment, prayer, supernatural belief, spiritual experience or membership of a particular denomination are not evidence of *lotu noa*.

3. It is not synonymous with disagreement. Criticism of government, distrust of institutions, vaccine hesitancy or refusal does not automatically constitute harmful religiosity.
4. It applies to patterns and consequences. The concept should be used to examine interpretation, communication, authority and practice—not to label individuals, congregations or denominations.
5. It must remain dialogical and accountable. Any assessment must be evidence-informed, culturally grounded, open to correction and concerned with demonstrable consequences for wellbeing.

The concept becomes useful only when it generates accountability and protects life. It is not useful when employed to silence dissent or portray public institutions as beyond criticism.

Government, health agencies, researchers and employers can also act without adequate evidence, transparency, proportionality or relational accountability. The project therefore applies the same ethical questions to religious and public-health authority:

- What evidence supports the claim or decision?
- Is uncertainty acknowledged?
- Can people ask questions safely?
- Are professional limits respected?
- Is the action proportionate?
- Are consequences monitored?
- Who bears the burden?
- Does the practice protect or diminish wellbeing?
- Is there a pathway for correction and repair?

2.6 The preliminary Lotu Factor framework

The Lotu Factor describes how faith-related conditions are translated into wellbeing consequences. It can be expressed as:

Faith conditions × mediating practices × structural context → wellbeing consequences

This formulation does not assign a numerical score. It shows that the consequences of faith depend upon the mediating conditions through which it operates.

Protective or life-affirming pathway	Mediating hinge	Risk-producing pathway
Faith and medicine are understood as complementary.	Interpretation	Medicine is framed as spiritual betrayal, or unsupported religious claims are presented as medical facts.
Leaders model humility, accuracy, accountability and care.	Leadership	Leaders use spiritual authority coercively or communicate unverified claims as certainty.
Questions and uncertainty are welcomed.	Dialogue and agency	Questioning is shamed, silenced or treated as disobedience and lack of faith.
Clinicians and clergy collaborate within clearly defined roles.	Professional boundaries	Pastoral authority substitutes for clinical expertise, or public agencies use churches instrumentally.
Participation, dignity and belonging are protected across disagreement.	Institutional practice	Vaccination status or disagreement becomes a basis for humiliation, exclusion or lasting division.
Digital spaces communicate care, accurate information and responsible theological reflection.	Digital environment	Fear, outrage, conspiracy narratives and apocalyptic certainty are amplified through trusted networks.
Policies are transparent, proportionate, monitored and regularly reviewed.	Structural conditions	Economic pressure and restrictive measures narrow choice without adequate monitoring, alternatives or repair.

The framework directs attention away from the binary question of whether religion is “good” or “bad.” Instead, it identifies conditions that can be strengthened, corrected or transformed.

2.7 Implications of the conceptual framework

The conceptual framework produces four important implications.

First, faith should be recognised as a determinant of wellbeing in Pacific health policy and practice. Spirituality cannot be treated as an optional cultural addition after biomedical decisions have already been made.

Second, leadership and relationships are central mechanisms. Providing accurate information is necessary, but information alone is insufficient when decisions are mediated through trusted spiritual, familial and institutional authority.

Third, harmful outcomes are not produced by theology alone. Religious interpretation interacts with employment, public policy, inequality, digital platforms and institutional pressure.

Fourth, prevention requires work before a crisis. Faith–health relationships, leader education, communication networks, professional referral pathways and safeguarding systems must be established in ordinary times.

The Lotu Factor framework therefore provides the conceptual foundation for interpreting the methodology, findings and recommendations that follow.

3. Methodology and Methods

3.1 Methodological orientation

The Lotu Factor Project used a qualitative, Tongan-led research design to investigate how participants understood and experienced the relationship between *lotu*, COVID-19 and wellbeing.

A qualitative approach was appropriate because the project was concerned with meaning, interpretation, relationships and lived experience. It did not seek to estimate the prevalence of a belief across the Tongan population or test a clinical intervention. Instead, it examined how participants interpreted health advice, vaccination, mandates, leadership, misinformation, family obligations and religious practice.

COVID-19 functioned as a case study through which wider questions about faith, authority, health and wellbeing could be explored. The pandemic created conditions in which religious interpretation, public policy, medical advice, employment, family responsibilities and church participation came into unusually direct contact.

The methodology combined:

- Tongan epistemology;
- *tālanga*;
- *kau 'i-talanoa*;
- individual qualitative interviews;
- group-based discussion;
- reflexive thematic analysis;
- collective research-team interpretation;
- advisory accountability; and
- community reflection through the Lotu Factor Symposium.

3.2 Tongan epistemological foundation

The study was grounded in Tongan epistemology, in which knowledge is relational and carried through people, language, memory, genealogy, lived experience and cultural practice.

Pacific scholars have challenged research traditions that privilege distance, individualism and abstraction while treating Indigenous communities as sources of data to be interpreted and validated externally. In contrast, the Lotu Factor Project regarded Tongan ways of knowing as foundational to the design.

Tongan epistemology was not added as a cultural layer over an otherwise standard Western research process. It shaped:

- what counted as knowledge;
- how participants were approached;
- how trust was established;
- how conversations were conducted;
- how language and silence were interpreted;
- how themes were developed;
- how disagreements were negotiated;
- to whom the researchers were accountable; and
- how the findings were returned to communities.

Knowledge was understood as emerging through relationship rather than being extracted from an isolated participant. Meaning was generated through encounters among participants, researchers, families, churches, language, culture and lived histories.

The research team comprised Tongan researchers with expertise in theology, biblical studies, public health, immunology, nursing, mental health, qualitative research and community engagement. Team members were fluent in Tongan language and cultural practice.

This insider positioning strengthened the project's ability to recognise theological language, humour, indirect communication, silence and relational context. However, cultural familiarity did not remove power, bias or assumption. Researchers could still take meanings for granted, overlook dissenting voices or interpret participants through their own theological, professional or denominational histories.

Reflexivity was therefore essential. Team *tālanga*, advisory engagement and repeated interpretation were used to question assumptions and examine how researcher identities and experiences influenced the analysis.

3.3 Tālanga

Tālanga was the principal relational and dialogical framework for the study. It involves speaking, attentive listening, openness, plurality and the relational generation of meaning.

Tālanga differs from an extractive research interview in which the researcher controls the questions, collects responses and retains sole authority over interpretation. Within *tālanga*, participants contribute to the direction and meaning of the conversation. They may introduce new issues, challenge the framing of a question or connect personal experience to wider family, church and community histories.

The approach was especially appropriate for the Lotu Factor Project because the topics were relationally and spiritually sensitive. Participants were discussing:

- religious belief and practice;
- ministers and church leadership;
- vaccination decisions;
- government mandates;
- family disagreements;
- employment pressure;
- misinformation;
- experiences of exclusion;
- personal health concerns; and
- relationships that had not fully recovered.

These experiences could not be understood adequately through short or highly structured questions. Participants needed space to explain context, uncertainty, contradiction and changes in their thinking.

Tālānga shaped more than data collection. It informed:

- recruitment through trusted relationships;
- individual and group conversations;
- research-team analysis;
- interpretation of Tongan-language material;
- engagement with the advisory group;
- the Lotu Factor Symposium; and
- dissemination of findings.

3.4 Kau‘i-talanoa

The protocol also drew upon *kau ‘i-talanoa*. In this report, *kau ‘i-talanoa* refers to a transformative interruption or deliberate opening within a conversation so that suppressed, marginalised or less powerful voices may be heard.

The concept was important because *tālānga* does not automatically eliminate hierarchy. Respect for ministers, elders, men, professionals or senior family members can make direct disagreement difficult. Apparent consensus may conceal uncertainty, silence or fear of relational consequences.

Kau ‘i-talanoa encouraged the research process to ask:

- Who has spoken?
- Who has remained silent?
- Whose account is treated as authoritative?
- Is agreement freely expressed?
- Are women and younger people able to redirect the discussion?
- Can church members speak critically about leaders?
- Can vaccinated participants express regret or uncertainty?
- Can unvaccinated participants speak without being treated as irresponsible?
- What experiences are being protected by silence?

The purpose was not interruption for its own sake. It was to create the possibility of inclusion, accountability and transformation.

3.5 Research governance and advisory accountability

The project established an advisory group in accordance with the approved research protocol. The group brought together expertise in Tongan research, clinical practice, psychology, public health, community leadership, social services, youth engagement and faith.

Its role was to support:

- cultural and ethical relevance;
- participant safety;
- interpretation of sensitive findings;
- community accountability;
- practical application;
- dissemination; and
- recognition of possible blind spots.

Governance was understood relationally. Advice was not confined to formal meetings or treated as an administrative requirement. It was intended to keep the project connected to Tongan communities and to the practical consequences of how the findings were interpreted and communicated.

The multidisciplinary research team also provided an internal form of accountability. Theologians, health researchers and clinicians did not always approach the evidence from the same professional perspective. These differences created opportunities to challenge narrow or discipline-specific interpretations.

3.6 Eligibility criteria

Participants were eligible for inclusion if they:

1. identified as Tongan;
2. were aged 18 years or older; and
3. lived in Aotearoa New Zealand.

The project focused on adults because it involved sensitive questions about health decisions, vaccination, employment, family responsibilities, church participation and authority.

The study did not require participants to hold a particular theological position or vaccination status. It sought varied experiences, including those of church members, faith leaders, vaccinated people, unvaccinated people and participants with mixed or changing views.

3.7 Recruitment and sampling

Participants were recruited primarily through relational and snowball sampling. This approach was appropriate because the research concerned sensitive matters of faith, authority and health, and trusted relationships were important for access to Tongan communities.

Initial contacts assisted the team to identify potential participants and communities. Recruitment extended across the North and South Islands and included regional and rural locations as well as larger metropolitan areas.

Relational recruitment offered several strengths:

- access to geographically dispersed communities;
- participation from smaller population centres;
- culturally appropriate introductions;
- increased confidence when discussing sensitive issues; and
- opportunities to engage existing church and community networks.

It also created limitations. Participants connected to churches and the research team's extended networks may have been over-represented. People who had withdrawn from church, distrusted religious institutions, were socially isolated or had weaker community connections may have been less likely to participate.

The sample should therefore be understood as a substantial and varied qualitative account rather than a statistically representative portrait of all Tongans in Aotearoa New Zealand.

3.8 Participants

The final participant sample comprised 155 adults:

- 17 participated through individual interviews; and

- 138 participated through group-based *tālanga*.

The project included participants from broad regions across both the North and South Islands. Locations are reported in aggregated form to protect confidentiality.

Participant characteristics

Characteristic	Category	Number	Percentage of valid responses	Valid responses	Missing/not available
Age	18–25 years	10	7.5%	134	21
	26–35 years	14	10.4%	134	21
	36–45 years	28	20.9%	134	21
	46–55 years	35	26.1%	134	21
	56–65 years	32	23.9%	134	21
	66 years and over	15	11.2%	134	21
Gender	Male	104	70.3%	148	7
	Female	44	29.7%	148	7
Education	Tertiary	63	52.5%	120	35
	Secondary or below	57	47.5%	120	35
Religious affiliation	Free Wesleyan	63	41.7%	151	4
	Methodist	40	26.5%	151	4
	Roman Catholic	10	6.6%	151	4
	Other faith communities	38	25.2%	151	4
Location	Upper North Island	66	44.0%	150	5
	Lower North Island	12	8.0%	150	5
	Upper South Island	22	14.7%	150	5
	Lower South Island	50	33.3%	150	5
Church status	Member	120	80.0%	150	5
	Leader	30	20.0%	150	5

COVID-19 vaccination status	Vaccinated	123	87.9%	140	15
	Not vaccinated	17	12.1%	140	15
Data-collection mode	Group-based <i>tālanga</i>	138	89.0%	155	0
	Individual interview	17	11.0%	155	0

Percentages are calculated from the valid substantive responses for each variable. They may not total exactly 100% because of rounding.

“Other faith communities” includes participants from several Christian denominations and a small number of other religious affiliations.

Employment data are not reproduced in the public report because the supplied demographic table contained an internal inconsistency between category counts and the stated denominator. The source dataset should be reconciled before employment statistics are used in any secondary analysis or publication.

Interpretation of the participant profile

The sample was predominantly male, middle-aged, Christian and church-affiliated. It included substantial Free Wesleyan and Methodist participation.

This profile provides strong evidence about church-centred authority, leadership and institutional life. However, it requires caution when applying the findings to:

- women;
- younger Tongans;
- people who do not attend church;
- non-Christian Tongans;
- disabled people;
- Rainbow+ Tongans; and
- people who left churches during or after the pandemic.

The study does not claim that the sample represents the numerical distribution of attitudes among the total Tongan population.

3.9 Data collection

Data were generated through individual qualitative interviews and group-based *tālanga*, primarily conducted in the Tongan language.

Conversations were open-ended and guided by prompts addressing:

- understandings of wellbeing;
- religious belief and practice;
- prayer, worship and scripture;
- professional health advice;
- COVID-19 experiences;
- vaccination attitudes and decisions;
- vaccination mandates;
- church leadership;
- family and employment pressures;
- trust in health and government institutions;
- misinformation and social media;
- experiences of inclusion or exclusion; and
- priorities for future collaboration.

Participants were encouraged to describe specific experiences and explain how their understandings developed or changed. Follow-up questions explored uncertainty, contradiction and relational context.

Where culturally appropriate, female researchers engaged female participants and male researchers engaged male participants. This supported culturally safe discussion, particularly when conversations involved family conflict, health concerns or sensitive experiences of leadership.

The project covered the upper and lower parts of both islands. For public reporting, locations are aggregated into broad regions. Specific combinations of town, denomination, leadership role, age or other identifying information are withheld.

3.10 Language and translation

Data were generated, transcribed, coded and analysed primarily in Tongan. This was essential because many theological, emotional and relational meanings could not be transferred directly into English without interpretation.

Analysis in Tongan preserved:

- idiom;
- humour;
- metaphor;

- theological language;
- tone and emphasis;
- hesitation and silence;
- terms of respect;
- indirect criticism; and
- relational positioning.

Translation into English occurred principally during dissemination and report writing. Translation was treated as an interpretive act rather than a mechanical substitution of words.

The research team reviewed translated quotations for meaning, readability and consistency with the original context. Where a literal translation would obscure the intended meaning, the English version prioritised conceptual faithfulness while avoiding unnecessary alteration.

3.11 Ethics and cultural safety

Ethical approval preceded data collection (Health and Disability Ethics Committees reference 2024/EXP 19965).

All participants provided informed consent. The project followed national ethical requirements and the Health Research Council's Pacific Health Research Guidelines.

Cultural safety included:

- respectful relational engagement;
- attention to Tongan protocols;
- voluntary participation;
- sensitivity to gender and leadership relationships;
- confidentiality;
- secure data management;
- de-identification;
- careful handling of theological disagreement;
- recognition of possible family and congregational consequences; and
- referral or support considerations where discussions caused distress.

Participants were reminded that they could decline to answer questions or withdraw in accordance with the approved protocol.

Public-reporting safeguards

The public report uses a stricter anonymisation system than some internal working manuscripts. This is necessary because a combination of location, denomination, age, leadership role and vaccination status could identify a person within a small Tongan community even if their name were removed.

Quotations are therefore attributed only as:

- *Interview participant*; or
- *Tālānga participant*.

Specific locations, denominations and leadership roles are omitted from quotations unless disclosure has been separately authorised and rechecked.

Reports of symptoms or adverse experiences following vaccination are presented as participant-reported experiences. The study did not access participants' clinical records or undertake causal assessment.

3.12 Data management

Interview and *tālānga* materials were managed in accordance with the approved research protocol and ethics requirements. Access to identifiable information was restricted to authorised members of the research team.

Data-management procedures included:

- secure storage;
- separation of identifying information from analytical materials where appropriate;
- controlled access;
- use of de-identified transcripts for analysis;
- careful handling of translated quotations; and
- retention and disposal in accordance with the approved protocol.

Public dissemination removes direct identifiers and potentially identifying combinations of information. Any future use of quotations in media campaigns, standalone graphics or publications restoring participant codes should undergo a further transcript-level confidentiality audit.

3.13 Data analysis

The project used reflexive thematic analysis informed by Braun and Clarke's six-phase approach. The method provided a systematic process for identifying patterns of shared meaning while recognising that themes are developed through active interpretation rather than discovered as objective objects hidden within the data.

NVivo was used to organise and code the qualitative material. Coding and initial analysis were undertaken in Tongan.

The team completed five iterative cycles of coding, review and collective interpretation.

Analytic phase	Practice in the Lotu Factor Project
Familiarisation	Researchers read transcripts and listened to recordings in Tongan, attending to content, tone, emphasis, pause, silence and relational context.
Initial coding	Team members developed inductive codes, followed by senior review, collation and further coding.
Theme development	Codes were examined relationally across participants, churches, regions and forms of data collection to identify patterns of shared meaning.
Theme review	Proposed themes were discussed collectively, challenged, refined, combined, reorganised or set aside.
Definition and naming	Themes were named in ways that reflected participant voice, Tongan meaning and the study's conceptual aims while avoiding deficit abstraction.
Reporting	Quotations were selected and translated, thematic accounts were drafted, and the final synthesis was refined through team <i>tālānga</i> , advisory engagement and community reflection.

Interpretation of code counts

Code counts were used to organise and locate relevant material. They were not treated as estimates of prevalence.

For example:

- “117 coded references” relating to vaccination attitudes means 117 coded extracts; and
- “180 coded references” relating to mandates means 180 coded extracts.

These figures do not represent numbers of participants, nor do they indicate how common a particular belief was in the wider population. A participant could contribute several coded extracts to one theme, and one extract could relate to multiple codes.

3.14 Development of themes

Themes were developed by examining patterns across several connected domains:

- holistic wellbeing;
- faith as resilience;
- vaccination reasoning;
- mandates and constrained choice;

- church leadership;
- pastoral care;
- misinformation;
- digital *vā*;
- *lotu noa*;
- trust and agency;
- inclusion and exclusion; and
- faith–health partnership.

The team attended to both convergence and difference. A theme was not treated as valid simply because several participants expressed similar views. Researchers also considered:

- contradictory accounts;
- minority experiences;
- silence and hesitation;
- differences between leaders and ordinary members;
- differences between individual and group settings;
- regional and denominational context;
- the influence of gender and generation; and
- alternative explanations.

This approach was important because the study did not seek to produce a single, uniform “Tongan view.”

3.15 Lotu Factor Symposium

The Lotu Factor Symposium was held in Auckland on 25–26 October 2025. It brought together faith leaders, community leaders, health professionals, scholars and community members.

Preliminary findings were explored through:

- keynote presentations;
- panel *tālanga*;
- facilitated group discussions; and
- a future-priorities workshop.

The symposium contributed collective reflection on church–health partnership, preparedness, leadership, wellbeing and the developing Lotu Factor framework.

It was not treated as a vote that formally confirmed or rejected the findings. Its role was to deepen interpretation, identify blind spots, test the practical relevance of emerging conclusions and sustain relational accountability.

3.16 Supplementary digital inquiry

The project also considered social media and digital religion as a supplementary evidence stream. This component drew upon:

- public digital content;
- media reporting;
- peer-reviewed research on misinformation and infodemics;
- research on the digital *vā*; and
- supplementary scoping and interview material.

The digital inquiry is analytically distinct from the core participant study. It was not merged into the 155-participant HDEC-approved dataset and was not used to estimate the prevalence of particular online claims.

Working material contained named public cases and quantitative claims that required independent verification. The public report therefore includes only securely supported thematic conclusions. Unverified names, case claims and uptake figures have been excluded.

Any future academic publication based on the digital inquiry should document:

- search procedures;
- platforms examined;
- inclusion and exclusion criteria;
- dates of data collection;
- treatment of public and semi-public content;
- ethics and privacy considerations;
- verification procedures; and
- limitations created by algorithms and changing platform access.

3.17 Trustworthiness and research quality

The trustworthiness of the study was supported through:

- Tongan-language data generation and analysis;

- repeated engagement with transcripts and recordings;
- team-based coding;
- five iterative cycles of analysis;
- multidisciplinary interpretation;
- advisory relationships;
- inclusion of individual and group data;
- regional participation;
- reflexive discussion;
- attention to contradictory cases;
- community engagement through the symposium; and
- transparent reporting of limitations and missing demographic information.

The study does not claim that researchers neutrally extracted one objective truth from participants. It offers a disciplined, evidence-informed and culturally grounded interpretation.

Reflexivity required the team to remain conscious that its members were themselves located within Tongan, theological, professional and community relationships. Their knowledge strengthened interpretation, but it also required ongoing accountability and openness to challenge.

3.18 Methodological limitations

Several methodological limitations must be recognised.

First, snowball and relational recruitment may have over-represented people connected to churches and existing community networks.

Second, the sample was predominantly male, middle-aged and Christian. Younger people, women, non-churchgoing Tongans, non-Christian communities and other under-represented groups require more focused research.

Third, group *tālanga* may have limited disclosure when participants held minority views or feared relational consequences. Individual interviews, gender-sensitive engagement and *kau 'i-talanoa* helped reduce this risk but could not remove it entirely.

Fourth, the data were retrospective. Participants' accounts may have been affected by memory, later events and changing interpretations.

Fifth, translation into English cannot preserve every nuance of Tongan language, humour, theology, emotion or silence.

Sixth, the research was qualitative. It cannot estimate how common a belief or experience was across all Tongans in Aotearoa New Zealand.

Seventh, the study did not verify clinical causation for participant-reported health experiences following vaccination.

Finally, the Lotu Factor Reflection Grid is a research-informed prototype. It has not yet been validated as an assessment instrument and must not be used to diagnose individuals, rank denominations, allocate funding or justify religious surveillance.

3.19 Reporting integrity

The final report distinguishes among:

- participant evidence;
- research-team interpretation;
- supplementary literature;
- Royal Commission findings;
- contextual digital material; and
- project-developed conceptual tools.

Quotations were checked for consistency with the supplied manuscripts and de-identified for public release. Participant quotations illustrate experience and meaning; they are not presented as statistical proof.

The methodology supports the report's central purpose: to provide a rigorous Tongan account of how faith, authority, health policy and relationships interacted during COVID-19 while protecting participants and avoiding deficit representations of Tongan religion.

Part II — What the Research Found

4. Lotu, Faith and Holistic Wellbeing

Key message

Lotu was a foundational determinant of wellbeing. It gave participants meaning, peace, endurance and belonging, and frequently supported engagement with medical care. These benefits were not automatic. Faith became risk-producing when it was joined to misinformation, coercion, unaccountable authority, suppressed questioning or a narrow concern for spiritual appearance that neglected the wellbeing of the whole person.

The findings reject a binary account in which religion must be either beneficial or harmful. The effect of *lotu* depended upon how faith was interpreted, led, communicated and embodied within relationships and institutions.

4.1 Wellbeing is multidimensional

Participants resisted understandings of health that were limited to physical symptoms or individual psychology. Wellbeing involved the integration of:

- physical health;
- spiritual life;
- mental and emotional stability;
- family relationships;
- participation in church and community;
- cultural identity;
- material security;
- meaningful responsibility; and
- a sense of peace.

Participants frequently moved between these dimensions without treating them as separate categories. Physical illness could affect spiritual confidence and family relationships. Conflict within a church could affect mental and emotional wellbeing. Loss of employment could undermine a person's capacity to fulfil family and church responsibilities. Prayer and pastoral care could strengthen emotional resilience even when a physical condition remained.

One participant described wellbeing as:

“The health of the body and the health of the spirit.”
— *Interview participant*

A group of participants similarly explained that wellbeing included:

“Social, physical, mental and spiritual aspects, not just physical health alone.”

— *Tālānga participants*

These accounts demonstrate that wellbeing was understood as a condition of the whole person-in-relationship. A person could be physically free from infection and still experience fear, isolation, spiritual struggle, family conflict or loss of belonging. Conversely, a person living with illness could continue to experience hope, meaning, relational support and spiritual peace.

4.2 Wellbeing is relational

Participants did not understand wellbeing as an exclusively individual achievement. A person’s wellbeing was connected to the wellbeing of the family, congregation and wider community.

This relational understanding was expressed through responsibilities to:

- care for children and elders;
- protect medically vulnerable relatives;
- maintain family income;
- preserve harmony;
- support grieving households;
- participate in worship;
- respect leaders;
- fulfil church and cultural obligations; and
- contribute to collective safety.

Health decisions were therefore evaluated not only in terms of “What is best for me?” but also “What will protect my family?”, “What does my church expect?”, “What responsibilities do I have towards others?” and “How does this decision affect my relationship with God?”

This relational orientation was a significant source of strength. Families and churches mobilised practical assistance, food, prayer, information and pastoral care. It could also create pressure when collective expectations left little room for questions, uncertainty or dissent.

The distinction between relational responsibility and relational coercion is consequently central to the Lotu Factor. Collective responsibility can strengthen wellbeing when people are respected and supported. It becomes harmful when belonging, employment, worship or moral standing is threatened to secure compliance.

4.3 COVID-19 disrupted the conditions of wellbeing

COVID-19 affected more than physical health. Restrictions disrupted many of the relationships and practices through which participants ordinarily maintained wellbeing.

Participants experienced:

- separation from family members;
- restricted funerals and mourning practices;
- interruption of gathered worship;
- isolation of older and vulnerable people;
- uncertainty about work and household income;
- reduced access to pastoral care;
- fear of infection;
- changing public-health information;
- disagreement about vaccination;
- reduced participation in church activities; and
- pressure associated with mandates.

For Tongan communities, funerals, worship, family gatherings and collective care are not optional additions to life. They are central practices through which grief, identity, belonging and responsibility are expressed. Restrictions that limited these practices therefore carried spiritual, emotional and relational consequences.

This does not mean that public-health restrictions were unnecessary. It means that their full effects cannot be understood through epidemiological indicators alone.

4.4 Faith sustained resilience, peace and endurance

Prayer, worship, scripture, fellowship and trust in God helped participants make sense of fear and uncertainty. Faith provided a language for endurance when ordinary routines, funerals, worship and physical family contact were disrupted.

For some participants, prayer created a sense of peace that made it possible to face circumstances they could not control. Scripture offered meaning and reassurance. Congregational relationships reminded isolated families that they remained connected to a wider community.

Online worship, telephone contact and digital prayer networks helped sustain spiritual participation when physical gatherings were restricted. Although digital connection could not fully replace embodied community, it preserved important forms of belonging.

Several participants connected prayer, vaccination and survival, describing medicine as divine provision and a means of preserving life.

Such accounts reject the assumption that vaccination necessarily displaced faith. Vaccination could be understood as an answer to prayer rather than evidence of dependence upon human knowledge instead of God.

For some participants, taking protective action was an expression of faith. It reflected stewardship of life and responsibility for vulnerable neighbours.

4.5 Faith and medicine were often complementary

Participants commonly described prayer and professional health care as practices that could occur together.

Participants described seeking professional medical care while continuing to pray.

These accounts express a major protective pathway within the Lotu Factor: prayer and medical care were not mutually exclusive, and seeking clinical assistance did not imply a failure of faith.

Clinicians were sometimes understood as people whose knowledge and vocation had been enabled by God. Scientific discovery, medicine and vaccination could be incorporated into a theological account of divine provision and human responsibility.

This complementarity made health advice more intelligible because participants were not required to abandon faith in order to receive professional care. It also created a basis for collaboration between ministers and health professionals.

Faith–health complementarity nevertheless did not require uncritical acceptance of every medical or government claim. Participants asked legitimate questions about:

- the speed of vaccine development;
- changing public-health recommendations;
- expected benefits and risks;
- possible adverse effects;
- mandate policies;
- informed consent;
- institutional communication; and
- the treatment of people who disagreed.

A responsible faith–health partnership must create space for evidence, uncertainty, conscience and correction. Trust cannot mean the absence of questions.

4.6 Church communities supported wellbeing

Churches served as important wellbeing infrastructure during the pandemic. They offered spiritual, emotional, cultural and practical support.

Participants described churches and ministers:

- organising prayer;
- contacting isolated families;
- livestreaming worship;
- sharing health information;
- providing food and financial assistance;
- supporting grieving households;
- encouraging vaccination;
- connecting communities with health professionals; and
- maintaining cultural and spiritual continuity.

Regular contact from ministers and church groups carried particular significance for older people and isolated families. Even a brief telephone call communicated that the household had not been forgotten.

One participant described the pastoral role in striking terms:

“During that time, ministers were like physicians.”
— *Tālānga participant*

The statement should not be interpreted as claiming that ministers provided medical treatment. It describes the reassurance, relational presence, prayer and trusted care that ministers offered during uncertainty.

Churches were able to mobilise quickly because relationships, roles and communication networks already existed. These networks reached people in culturally and spiritually meaningful ways.

4.7 Church participation could also become burdensome

Participants distinguished between faith in God and the institutional practices of churches. The church could be a place of belonging and care, but it could also become a source of pressure, financial burden, judgement or conditional participation.

Some participants described expectations surrounding:

- vaccination;
- compliance with leadership;

- financial contribution;
- public agreement;
- participation in church activities;
- maintenance of spiritual appearance; and
- silence about concerns.

Religious and cultural respect could make it difficult for ordinary members to question ministers or institutional decisions. A person might comply outwardly while experiencing unresolved fear, disagreement or distress.

Some participants criticised the use of incentives within church settings when sacred relationships appeared to become transactional. Others described situations in which religious institutions prioritised organisational interests or public reputation over the wellbeing of members.

One participant described this as religion becoming:

“A way of control.”

— *Tālanga participant*

This concern does not mean that church authority is inherently coercive. It shows that relational trust can become a source of pressure when accountability is weak or when disagreement threatens belonging.

4.8 The difference between pastoral influence and coercion

Pastoral influence is unavoidable and can be constructive. Ministers are expected to guide, teach, reassure and model responsible behaviour. The ethical issue is not whether leaders influence people, but how that influence is exercised.

Pastoral influence was life-affirming when leaders:

- communicated accurate information;
- acknowledged uncertainty;
- invited qualified health professionals;
- modelled appropriate protective behaviour;
- listened to concerns;
- protected confidentiality;
- respected conscience;
- preserved belonging across disagreement; and
- referred people for professional care.

Influence became coercive when leaders:

- presented personal opinions as unquestionable spiritual truth;
- treated disagreement as disobedience;
- associated compliance with faithfulness;
- threatened participation or standing;
- disclosed private concerns;
- repeated unsupported medical claims; or
- used fear, shame or divine authority to close discussion.

The difference lies in truthfulness, accountability, dialogue and consequences for wellbeing.

4.9 Misinformation and distorted religiosity

Participants recalled religiously framed claims involving:

- the number 666;
- microchips;
- end-times prophecy;
- spiritual contamination;
- divine immunity;
- punishment narratives;
- conspiracy theories; and
- the belief that precaution demonstrated inadequate faith.

These claims circulated through sermons, personal conversations, family messaging and social media. Their influence came not only from their content but also from the authority of the people communicating them.

A claim carried by a minister, family elder or trusted church member could have greater force than the same claim from an unknown online source. Participants could also fear that questioning such claims would make them appear spiritually weak or disrespectful.

Participants used *lotu noa* to describe religion that had become detached from responsible interpretation, evidence, accountability and the actual wellbeing of people.

One participant warned that distorted religion could:

“Make the false become true and the true become false.”

— *Tālanga participant*

This observation captures the epistemic risk created when spiritual authority reverses the ordinary relationship between evidence and truth. A claim may be accepted because of the authority attached to it rather than because it is supported by reliable evidence.

4.10 Apocalyptic language was not automatically harmful

The finding concerning misinformation requires careful qualification. Apocalyptic scripture, supernatural belief or expectation of divine intervention is not inherently harmful.

Apocalyptic traditions can:

- name injustice;
- sustain hope;
- reassure communities under pressure;
- affirm that suffering and oppressive power are not ultimate; and
- encourage moral courage.

Risk arises when apocalyptic language is asserted as medical certainty or used to discourage responsible care. It becomes harmful when it:

- closes dialogue;
- produces fear;
- treats speculation as fact;
- discourages vaccination or treatment without evidence;
- shames people who take precautions;
- promises immunity;
- portrays health professionals as agents of evil; or
- exposes people to preventable harm.

The Lotu Factor therefore evaluates the use and consequences of theological language rather than labelling the language itself as delusional.

4.11 Lotunoa and the neglect of the whole person

The findings suggest that *lotu noa* emerges when religious interpretation becomes disconnected from the demonstrable wellbeing of people.

This may occur when:

- doctrinal appearance is prioritised over compassionate care;
- spiritual certainty replaces responsible discernment;

- leadership authority is protected from correction;
- people are silenced to preserve institutional harmony;
- physical or mental-health needs are spiritualised;
- professional expertise is dismissed; or
- exclusion is justified through religious language.

A life-affirming *lotu* attends to the whole person. It asks whether an interpretation or practice strengthens spiritual, physical, mental, relational and communal wellbeing.

The central test is not whether an action appears religious. It is whether it truthfully and responsibly serves life.

4.12 Implications for health providers

Health providers should recognise spirituality and church participation as relevant dimensions of Pacific health assessment and service design.

This may include asking respectfully:

- whether faith or church participation is important to the person;
- whether religious beliefs influence a health decision;
- whether the person wishes to involve a minister or family member;
- whether spiritual language is supporting or increasing distress;
- whether church expectations are affecting consent or access to care; and
- whether the person has experienced exclusion or relational conflict.

Such questions should not be used to stereotype Tongan patients or assume that all Tongans are Christian. Spiritual assessment must remain voluntary, respectful and relevant to the person's expressed needs.

Health providers should also develop relationships with Tongan churches and faith leaders before emergencies. These relationships should include clear professional boundaries, referral pathways and mutual expectations.

4.13 Implications for churches

Churches should integrate holistic wellbeing into ministerial formation, pastoral practice and crisis preparation.

Faith leaders require support in:

- health literacy;
- ethical communication;

- mental-health first response;
- digital discernment;
- confidentiality;
- safeguarding;
- professional referral;
- responding to uncertainty; and
- responsible interpretation of scripture during crisis.

Churches should create spaces in which members can ask questions without being shamed or treated as unfaithful. Pastoral care should remain available regardless of vaccination status or disagreement.

Denominations should also establish complaints and accountability processes for situations in which spiritual authority is used coercively or confidential information is misused.

4.14 Implications for public agencies

Public agencies should avoid presenting faith and scientific evidence as natural enemies. This framing can intensify mistrust and overlook the many theological pathways through which communities support medical care.

Engagement should be based on mutual accountability:

- religious claims with health consequences must remain open to evidence and correction;
- health agencies must communicate evidence and uncertainty transparently;
- policy restrictions must be proportionate and regularly reviewed;
- churches must not be used merely as distribution channels;
- internal diversity within congregations must be recognised; and
- the relational consequences of public-health decisions must be monitored.

The central finding is that *lotu* is a powerful resource for wellbeing, but its consequences depend upon interpretation, leadership, dialogue, accountability and the protection of the whole person.

5. Vaccination Attitudes and Decision-Making

Key message

COVID-19 vaccination was experienced as a moral, spiritual and relational process rather than a single behavioural choice. Participants expressed confidence, caution, acceptance, scepticism, refusal, regret and unresolved ambivalence.

Recorded vaccination was common, but uptake alone did not reveal whether participants felt confident, agreed with the decision or exercised free consent. The analysis therefore separates behaviour from belief.

5.1 Participant vaccination profile

Vaccination status was available for 140 of the 155 participants:

- 123 participants, or 87.9% of valid responses, were recorded as vaccinated; and
- 17 participants, or 12.1% of valid responses, were recorded as not vaccinated.

Vaccination status was unavailable for 15 participants.

These figures describe the qualitative sample only. They should not be treated as estimates of vaccination coverage among all Tongans in Aotearoa New Zealand.

The vaccination theme included 117 coded references. These were coded extracts rather than 117 separate participants. Code counts helped the researchers locate and organise data; they were not used to measure the prevalence of a view.

5.2 Vaccination was historically familiar

Participants who had grown up in Tonga often remembered childhood and community vaccination as ordinary, collective and socially supported. Vaccination campaigns were associated with village structures, schools, churches and national health leadership.

One participant recalled:

“In Tonga it was already the norm to get vaccinated ... we were given sufficient information from the Ministry of Health about the importance of vaccination.”

— *Interview participant*

Earlier vaccination programmes were described as clearly communicated and embedded within familiar social relationships. Participants did not necessarily perceive a conflict between vaccination, Tongan culture and Christian faith.

COVID-19 unsettled this familiarity. Participants encountered:

- a new disease;
- rapidly developed vaccines;
- changing public-health recommendations;

- intense media coverage;
- conflicting expert commentary;
- international conspiracy narratives;
- religiously framed claims;
- government mandates; and
- uncertainty about possible side effects.

Hesitation towards COVID-19 vaccines should therefore not be interpreted automatically as opposition to vaccination in general. For some participants, hesitation reflected disruption of a previously stable relationship with immunisation.

5.3 Vaccination attitudes were plural

Participants did not divide neatly into “pro-vaccine” and “anti-vaccine” groups. Their accounts revealed a continuum of attitudes that changed over time and according to circumstance.

Positions included:

- immediate confidence and acceptance;
- cautious acceptance;
- initial hesitation followed by vaccination;
- vaccination primarily to protect family members;
- vaccination to retain employment;
- vaccination accompanied by continuing doubt;
- refusal of COVID-19 vaccination while accepting other vaccines;
- delayed vaccination;
- regret after vaccination;
- ongoing refusal; and
- uncertainty that remained unresolved.

A participant could value medicine and still have questions about a particular vaccine. A person could receive vaccination while remaining hesitant. Another could refuse vaccination without rejecting medical care generally.

Fixed labels conceal this complexity. They can also create social identities that make respectful communication more difficult. Once people are classified as “anti-vaccine,” their questions may be dismissed rather than examined. Likewise, describing everyone who

received vaccination as fully confident can hide experiences of pressure and unresolved concern.

5.4 Initial hesitation was often a period of discernment

Many participants described pausing before making a vaccination decision. They sought information, prayed, consulted family members, listened to ministers, considered employment requirements and watched the experiences of others.

This pause was not always evidence of rejection. It could represent an effort to act responsibly under uncertain conditions.

Participants asked questions about:

- how quickly the vaccines had been developed;
- what testing had occurred;
- possible short- and long-term effects;
- whether changing advice indicated uncertainty or dishonesty;
- whether vaccination was compatible with faith;
- whether mandates undermined voluntary consent;
- how vaccination would affect existing health conditions; and
- what assistance would be available if an adverse experience occurred.

Some questions were answered through trusted clinicians and clear information. Others remained unresolved or were intensified by conflicting messages.

The finding suggests that hesitation should be treated as an opportunity for engagement rather than a moral defect.

5.5 Faith provided a framework for discernment

Prayer, scripture and theological interpretation influenced vaccination decisions. Participants sought divine guidance, reflected upon responsibility for others and considered whether vaccination was consistent with stewardship of the body.

For some, faith supported vaccination. Vaccination could be interpreted as:

- an answer to prayer;
- a gift of scientific knowledge;
- responsible care for the body;
- protection of vulnerable neighbours;
- fulfilment of family responsibility; or

- a means through which God preserved life.

Other participants encountered messages suggesting that vaccination demonstrated inadequate trust in God or dependence upon human medicine.

One participant recalled:

“There were some who said, if you go and get vaccinated, it shows that you lack faith in God, because you are more reliant on the vaccine than on your faith in God.”

— *Tālānga participant*

This framing placed vaccination within a spiritual test. Accepting a vaccine could be portrayed as evidence of weak faith, while refusing it could be associated with spiritual courage.

Participants did not accept these interpretations uniformly. Many recognised the comfort of prayerful discernment while also identifying the danger of biblical misinterpretation. Theological disagreement occurred within churches, families and individual participants’ own reflections.

Faith did not map consistently onto either vaccination or refusal. It was one of the principal arenas in which uncertainty was negotiated.

5.6 End-times interpretations influenced some participants

Participants recalled messages linking vaccination to:

- the number 666;
- the mark of the beast;
- microchips;
- end-times control;
- spiritual contamination; and
- conflict between divine and worldly authority.

The significance of these messages cannot be assessed only by asking whether they were factually accurate. Their influence depended upon who communicated them and the spiritual authority attached to the claim.

A speculative claim repeated by a trusted minister, family elder or church member could carry greater weight than official information from an unfamiliar institution. Participants could also fear that rejecting the interpretation would make them appear faithless.

The study does not define apocalyptic belief itself as harmful. Risk emerged when speculative theology was presented as medical certainty, discouraged informed decision-making, produced fear or prevented people from seeking reliable advice.

5.7 Authority was fragmented

Participants navigated multiple and sometimes competing sources of authority, including:

- government agencies;
- public-health officials;
- scientists;
- doctors and nurses;
- Pacific health providers;
- ministers and church leaders;
- family members;
- friends;
- overseas relatives;
- social-media commentators; and
- international religious figures.

Visible disagreement between experts weakened confidence for some participants. Public-health advice also changed as evidence developed. While such change is normal during a new health emergency, it was sometimes interpreted as evidence that officials were dishonest or did not know what they were doing.

A participant explained:

“If there was consistently one message, that would have been better ... so much information from different perspectives made it difficult to know where to stand.”

— *Tālānga participant*

The quotation reflects a search for stability rather than a simple rejection of science. Participants were being asked to make consequential decisions while navigating an unusually crowded information environment.

Communication should therefore explain:

- what is known;
- what remains uncertain;
- how evidence is assessed;
- why recommendations change;
- who is responsible for a decision;

- when a decision will be reviewed; and
- where confidential questions can be taken.

Changing advice does not necessarily indicate dishonesty. However, change without explanation can undermine trust.

5.8 “Do your own research”

Some participants referred to the need to “do your own research.” This phrase was not always an expression of hostility towards science. For some, it represented an attempt to exercise responsibility and avoid passive dependence upon authority.

The difficulty was that online research exposed participants to material of widely varying quality. Professional evidence, personal testimony, political commentary, advertising, conspiracy claims and religious interpretation often appeared together.

Participants did not always have clear ways to distinguish:

- peer-reviewed evidence;
- official advice;
- preliminary findings;
- personal experience;
- coincidence;
- political interpretation;
- theological reflection; and
- deliberately misleading material.

Digital-health communication should not merely instruct communities to trust official sources. It should help people understand how evidence is produced, assessed and revised.

5.9 Autonomy was relational

Participants often understood bodily autonomy through the language of stewardship and responsibility. The body was not regarded simply as private property. It was connected to God, family and community.

Autonomy could therefore include responsibility to:

- protect one’s health;
- preserve life;
- safeguard vulnerable family members;
- maintain household income;

- prevent transmission;
- act according to conscience; and
- avoid exposing others to unnecessary risk.

This relational understanding differs from an exclusively individualistic account of autonomy. However, collective responsibility must not be used to erase personal agency.

The ethical challenge is to distinguish among:

- informed persuasion;
- collective moral responsibility;
- legitimate public-health restriction;
- social pressure;
- financial compulsion; and
- coercion.

These distinctions became especially difficult when vaccination was connected to employment, worship and family participation.

5.10 Vaccination decisions were embedded in family life

Participants rarely made vaccination decisions in isolation. They considered the health, opinions and needs of spouses, children, elders and extended family members.

Some vaccinated to protect vulnerable relatives. Others worried about possible effects on children or family members with existing health conditions. Family discussion could clarify questions and provide reassurance, but it could also intensify pressure or conflict.

For households dependent upon one income, employment requirements could become decisive. A person might vaccinate not because uncertainty had been resolved but because refusal threatened the wellbeing of the entire family.

The resulting decision could be responsible and constrained at the same time.

5.11 Vaccination sat within wider ecologies of care

Participants described vaccination as one element within a wider set of health practices. They also referred to:

- over-the-counter medicines;
- vitamins and supplements;
- exercise;
- hydration;

- nutrition;
- traditional or herbal remedies;
- prayer;
- rest; and
- family-based care.

These practices gave families a sense of continuity and agency. Their use should not be treated automatically as rejection of medicine.

Health professionals should ask respectfully about traditional and complementary practices, provide clear safety advice and consider possible interactions. Ridiculing familiar forms of care can damage trust and discourage disclosure.

A holistic approach should acknowledge practices that support wellbeing while remaining clear about evidence, safety and the limits of particular remedies.

5.12 Participant-reported post-vaccination experiences

Some participants reported symptoms or significant changes in health after vaccination and believed that these experiences were connected to the vaccine.

One participant stated:

“After I was vaccinated, I had flu-like symptoms ... and I started to swell up.”
— *Tālanga participant*

These accounts are important evidence of participants’ experiences and interpretations. They are not clinical findings.

The study:

- did not access participants’ clinical records;
- did not undertake medical examination;
- did not independently verify diagnoses;
- did not assess alternative causes; and
- cannot determine whether vaccination caused the reported outcomes.

The appropriate response is neither automatic confirmation nor dismissal. Listening to a person’s account does not establish causation, but it is part of safe and respectful care.

Participants should have access to:

- timely clinical assessment;
- clear explanations of expected reactions;

- information about warning signs;
- accessible adverse-event reporting;
- follow-up care;
- acknowledgement of uncertainty; and
- communication in a language they understand.

When people feel dismissed after a health intervention, trust may deteriorate even if a clinical relationship has not been established. Post-vaccination follow-up is therefore both a safety responsibility and a trust responsibility.

5.13 Silence protected harmony but concealed disagreement

Some participants remained silent because speaking openly could create conflict within families or churches. Silence was used to protect the *vā* and preserve relationships in the short term.

One participant explained:

“You just kept quiet. Saying something would only make things worse.”
— *Tālanga participant*

Silence should not be interpreted as agreement. It may indicate:

- respect for authority;
- fear of judgement;
- concern about family conflict;
- uncertainty;
- loss of confidence;
- desire to preserve belonging; or
- belief that speaking will not change the outcome.

Some participants withdrew from leadership, reduced church participation, changed congregations or formed alternative fellowship spaces.

Evaluation processes that rely only on public meetings or visible complaints may therefore miss important experiences. Communities need confidential and culturally safe ways to express doubt, dissent and harm.

5.14 Vaccination without resolution

Several participants described receiving vaccination without experiencing peace or confidence.

This distinction between uptake and resolution matters: a programme can achieve high coverage while leaving moral, spiritual or relational concerns unsettled.

Vaccination may have occurred because participants:

- accepted the medical evidence;
- trusted a clinician;
- followed the example of a minister;
- wanted to protect family members;
- needed to retain employment;
- wanted access to travel or worship;
- wished to avoid judgement; or
- felt that no realistic alternative remained.

These motivations should not be collapsed into a single category of consent or confidence.

The finding does not negate the population-level benefits of vaccination. It demonstrates that successful implementation should be assessed through more than coverage statistics.

5.15 Four dimensions of vaccination success

Future vaccination programmes should assess four connected outcomes.

1. Equitable access

Were vaccines, information, clinical advice and follow-up available in accessible locations, languages and formats?

2. Coverage

Did people receive the recommended intervention, and were inequities in uptake reduced?

3. Decision quality

Did people receive understandable information about benefits, risks, alternatives and uncertainty? Could they ask questions without shame? Was consent meaningfully informed?

4. Longer-term trust

Did the programme strengthen or weaken confidence in health providers, churches, government agencies and future interventions? Were concerns acknowledged and relationships repaired?

Coverage without decision quality can produce compliance without confidence. Coverage without follow-up can leave reported concerns unresolved. Coverage without attention to trust can make the next public-health response more difficult.

5.16 Implications for communication

Uncertainty should be treated as normal rather than shameful. Health communication should:

- explain benefits and risks clearly;
- acknowledge what remains uncertain;
- explain why evidence or recommendations change;
- distinguish evidence from personal testimony;
- provide information in Tongan;
- use trusted clinicians and community communicators;
- allow confidential questions;
- avoid dismissive labels;
- address recurring theological concerns; and
- remain available after vaccination.

Communication should not assume that one message or messenger will be trusted by all Tongans. Multiple trusted relationships are required.

5.17 Implications for faith communities

Faith communities should provide spaces for responsible discernment rather than requiring compulsory endorsement.

Churches can support informed vaccination decisions by:

- inviting qualified health professionals;
- encouraging questions;
- distinguishing pastoral and clinical authority;
- correcting misinformation;
- acknowledging uncertainty;
- protecting conscience;
- maintaining belonging across disagreement; and
- supporting members who report negative experiences.

Theological interpretation should avoid presenting vaccination as proof of faithfulness or refusal as proof of spiritual courage. Both framings can distort responsible discernment.

5.18 Implications for health services and government

Health services should make post-vaccination pathways visible, accessible and culturally responsive. Public agencies should monitor not only uptake but also trust, agency, reported pressure and relational consequences.

Government communication should avoid describing constrained decisions as ordinary voluntariness. Where emergency policy limits choice, the limitation should be named, justified, monitored and reviewed.

The central finding is that vaccination was not merely an individual medical act. It was interpreted through faith, family, work, leadership, information and belonging. Future programmes will be more effective when they engage that entire ecology.

6. Mandates, Constrained Choice and Relational Harm

Key message

Vaccination mandates operated as a form of relational governance. Participants did not experience mandates only as rules issued by government. They encountered them through employers, churches, families and community organisations, where legal requirements interacted with spiritual authority, moral responsibility, financial necessity and the risk of losing belonging.

Mandates contributed to high vaccination coverage during a dangerous period of the pandemic. They also narrowed choice and created uneven social, economic, spiritual and relational burdens. In some cases, those effects continued after the formal requirements ended.

6.1 Understanding mandates as relational governance

Government vaccination requirements were implemented through institutions and relationships. Participants encountered mandates when they:

- attended work;
- entered a church building;
- participated in congregational activities;
- visited family members;
- travelled;
- entered particular public venues;
- worked in regulated sectors; or
- sought to maintain ordinary social participation.

The term “relational governance” describes the way formal policy gained practical and moral force through existing relationships. Employers determined whether a person could continue

working. Church leaders interpreted requirements for congregations. Family members negotiated contact and protection. Community organisations decided how access rules would be applied.

Mandates therefore did not enter a neutral social environment. They operated through relationships already shaped by authority, dependence, trust, obligation and belonging.

The mandates theme contained approximately 180 coded references. These were coded extracts, not 180 separate participants, and should not be interpreted as a measure of prevalence.

6.2 From encouragement to constraint

Participants described an important change in how vaccination was experienced. Vaccination was initially presented as something people were encouraged to consider. It later became a condition for participation in significant areas of ordinary life.

One participant explained:

“At first it was encouraged, but later it felt like it wasn’t really a choice anymore.”
— *Tālānga participant*

The statement does not mean that the participant had no agency whatsoever. It indicates that the practical consequences of refusal had become sufficiently serious to transform the conditions under which a decision was made.

Choice was especially constrained when refusal could affect:

- employment;
- household income;
- access to worship;
- professional standing;
- family contact;
- travel;
- education or training; and
- participation in valued community activities.

Mandates changed vaccination from a decision based principally on health information into a decision carrying legal, economic, social and spiritual consequences.

6.3 Persuasion, responsibility and constrained choice

The participant accounts require distinctions among persuasion, collective responsibility and constrained choice.

Persuasion seeks to influence a decision through reasons, evidence and dialogue while leaving meaningful alternatives available.

Collective responsibility asks people to consider how their actions affect vulnerable family members, neighbours and the wider community.

Constrained choice exists when alternatives remain formally available but carry significant costs, such as loss of employment, income, worship or belonging.

Participants did not always separate these categories. A vaccination message could begin as health advice, become a moral appeal to protect others and ultimately be experienced as compulsory because refusal carried unacceptable consequences.

The study does not claim that every mandated vaccination was coerced or that collective responsibility was illegitimate. It shows that the conditions surrounding consent varied and that high uptake should not automatically be interpreted as complete agreement.

6.4 Church mediation of government policy

Government requirements gained additional force when they were communicated through church leadership. Participants frequently acted in alignment with ministers and denominational leaders because relationships of respect, trust and spiritual authority were already established.

One participant observed:

“When the notice to get vaccinated came from the church, that’s when those who were hesitant turned.”

— *Interview participant*

Church mediation could be protective. Faith leaders could:

- explain public-health advice;
- invite health professionals to answer questions;
- model vaccination;
- reassure fearful members;
- encourage care for vulnerable people; and
- help communities comply with changing regulations.

However, church mediation became ethically difficult when spiritual loyalty, access to worship or a person’s standing within the congregation became connected to vaccination status.

Government authority and spiritual authority could reinforce one another. A person might therefore experience the message not merely as health advice but as an expectation carrying both civic and religious consequences.

The greater the influence of the church, the greater its responsibility to distinguish pastoral guidance from compulsion.

6.5 Moral pressure and the language of protecting others

Vaccination was frequently framed as a responsibility to protect other people. This collective ethic resonated strongly with Tongan understandings of family and communal obligation.

For many participants, concern for others was a sincere and positive reason to vaccinate. They sought to protect elders, children, medically vulnerable relatives and church members.

The same moral language could also transform uncertainty into a perceived moral failure.

One participant explained:

“If you questioned it, people looked at you like you didn’t care about others.”
— *Tālānga participant*

In this context, expressing concern could be interpreted as selfishness, irresponsibility or lack of love. Participants might therefore remain silent even when they had legitimate questions.

Ethical public health should encourage collective responsibility without treating every question as evidence of indifference. A person can care deeply about others while seeking clarification about risks, alternatives or the proportionality of a requirement.

6.6 Silence and outward compliance

Some participants responded to moral and institutional pressure by remaining silent. Silence protected relationships in the short term but could conceal continuing disagreement.

Outward compliance could coexist with:

- anxiety;
- resentment;
- spiritual discomfort;
- fear of judgement;
- concern about health effects;
- loss of trust; or
- a feeling that meaningful choice had been removed.

This distinction is important because public compliance can be mistaken for confidence. An institution may conclude that a policy was fully accepted when people complied primarily to avoid losing work, worship or family connection.

The absence of public opposition is not necessarily evidence of relational wellbeing.

6.7 Exclusion from worship and community life

Participants described vaccination certificates determining access to church buildings and activities. In some accounts, unvaccinated members or families remained outside, were separated from others or could no longer participate in person.

These arrangements occurred within difficult public-health conditions. Church leaders were attempting to comply with legal requirements and protect congregations, including older and medically vulnerable members.

Nevertheless, the spiritual and relational meaning of exclusion from worship was profound. A church was not experienced as an ordinary entertainment venue or commercial building. It was a sacred and communal space connected to:

- identity;
- prayer;
- sacramental life;
- family history;
- spiritual authority;
- cultural participation;
- pastoral care; and
- belonging.

Exclusion from the church building could therefore be experienced as exclusion from the worshipping community itself, even when leaders did not intend that outcome.

The Phase Two Royal Commission report noted that officials had anticipated risks to social cohesion when churches, marae and other cultural or religious settings were required to use vaccination certificates. The Lotu Factor findings show how those risks were experienced within Tongan church life.

6.8 Division within churches

Vaccination status became a visible marker through which members judged one another. Participants described barriers emerging between vaccinated and unvaccinated people.

One participant stated:

“There was a barrier and division ... people would judge the other.”
— *Tālānga participant*

Participants reported:

- reduced church attendance;
- withdrawal from leadership;

- movement to another congregation;
- formation of alternative fellowship groups;
- damaged trust in ministers;
- reluctance to discuss vaccination;
- judgement between members; and
- ongoing discomfort after restrictions ended.

These outcomes did not occur in every church. Some congregations preserved connection through online worship, pastoral contact and respectful dialogue. The difference often depended upon leadership, communication and whether belonging was protected across disagreement.

6.9 Division within families

Mandates and vaccination decisions also affected family relationships. Participants described disagreements among spouses, parents, children and extended relatives.

Conflict could affect:

- sleeping arrangements;
- visits and family gatherings;
- care of older relatives;
- communication;
- emotional safety;
- decisions about children;
- household income; and
- participation in family events.

In Tongan life, family and church are central sites of identity and belonging. The consequences of disagreement could not be contained within a single medical decision.

A person might comply with vaccination requirements to preserve family stability while continuing to feel that their concerns had not been heard. Another might refuse and experience judgement or separation.

The relational consequences were therefore often greater than the immediate policy decision.

6.10 Employment and economic pressure

Employment was one of the most decisive sources of pressure. This was especially significant for households dependent upon a single income and for people living in regions where alternative employment was limited.

Participants described employment requirements as effectively determining the decision for workers who could not risk losing their jobs.

Loss of employment threatened more than personal income. It affected a person's ability to:

- provide food and housing;
- support children;
- assist extended family;
- contribute to church;
- meet cultural obligations;
- maintain professional identity; and
- fulfil expectations of family responsibility.

For some participants, vaccination was remembered as a decision made under economic necessity. Even when they accepted the public-health rationale, they did not necessarily experience the decision as voluntary.

The Phase Two Royal Commission found that the effects of vaccination requirements on job loss, reinstatement and continuing wage disadvantage were not adequately monitored. It also concluded that some requirements produced significant social and economic consequences and, in hindsight, sometimes lasted too long or extended too far.

The Lotu Factor evidence adds the household, cultural and moral dimensions of those consequences.

6.11 Unequal burdens

Mandates did not affect all participants equally. The practical burden depended upon:

- occupation;
- household income;
- availability of alternative employment;
- geographic location;
- health status;
- family responsibilities;

- church policy;
- immigration or travel needs;
- access to reliable advice; and
- capacity to challenge a decision.

A person with secure employment and several alternatives could experience a mandate differently from a worker in a small regional labour market. A person with strong institutional confidence could experience the same requirement differently from someone with unresolved medical concerns or previous experiences of discrimination.

Equity assessment must therefore examine not only whether a rule applies equally but whether its burdens and alternatives are distributed fairly.

6.12 Emotional and spiritual effects

Participants associated mandate experiences with:

- fear;
- anxiety;
- confusion;
- anger;
- shame;
- grief;
- spiritual discomfort;
- loss of trust; and
- longing for ordinary life.

Some participants felt caught between competing responsibilities: obedience to church leadership, protection of family, preservation of employment, concern about health and faithfulness to conscience.

The effects did not necessarily end when vaccination certificates or employment requirements were removed.

Participants reported that awkwardness and relational strain continued after formal requirements ended.

Others noted the absence of collective discussion:

“No one really talked about what it did to people.”
— *Tālanga participant*

These quotations point to an unfinished recovery agenda. Legal rules ended, but relationships did not automatically return to their earlier condition.

6.13 Relational harm and moral residue

The concept of relational harm describes injury to trust, belonging, communication and mutual recognition. It may include:

- damaged relationships;
- exclusion;
- silence;
- unresolved resentment;
- reduced church participation;
- fear of speaking;
- loss of confidence in institutions; and
- withdrawal from future engagement.

“Moral residue” refers to the continuing discomfort that remains after a person acts under conditions they experience as constrained. A participant may have complied with a requirement but continue to question whether the process respected their conscience or dignity.

These effects are difficult to identify through vaccination statistics. They require qualitative engagement and confidential opportunities for people to describe what occurred.

6.14 A balanced interpretation of mandates

Mandates should not be described as either entirely successful or entirely harmful.

They contributed to high vaccination coverage during a dangerous transition in the pandemic. They were introduced to protect public health, vulnerable people and essential services.

At the same time, mandates:

- narrowed practical choice;
- affected employment and income;
- entered sacred and cultural settings;
- produced unequal burdens;
- intensified existing authority;
- created division; and

- left some participants with unresolved relational harm.

A responsible assessment must hold both realities together.

Recognising harmful consequences does not require denying the seriousness of COVID-19 or the benefits of vaccination. Likewise, recognising public-health objectives does not make social and relational consequences irrelevant.

6.15 The Lotu Factor interpretation

The Lotu Factor adds a distinctive insight: restrictive policy enters communities through existing relationships and forms of authority.

When government policy was transmitted by church leaders, several forms of power could combine:

- legal power;
- employment power;
- spiritual authority;
- family obligation;
- cultural respect; and
- social pressure.

This combination could support rapid protective action. It could also make questioning or refusal extraordinarily difficult.

The involvement of trusted faith leaders therefore creates an elevated duty of:

- accuracy;
- transparency;
- proportionality;
- dialogue;
- protection of confidentiality;
- respect for conscience;
- maintenance of pastoral care; and
- accountability for consequences.

Church partnership should not be used to make a mandate appear culturally voluntary when meaningful alternatives have been narrowed.

6.16 Safeguards for future mandates

Future vaccination mandates or comparable restrictive measures should be used only as carefully limited tools.

Before implementation, government agencies should:

1. define the public-health objective and evidential threshold;
2. examine less restrictive alternatives;
3. undertake equity, human-rights and relational-impact assessments;
4. assess likely effects on employment, worship, family life and minority communities;
5. consult affected communities before decisions are finalised;
6. develop workable exemptions and appeal processes;
7. establish review and exit criteria;
8. plan support for people who will carry disproportionate burdens; and
9. identify how social and economic consequences will be monitored.

During implementation, agencies should:

1. publish the evidence supporting the requirement;
2. explain uncertainty and changes in advice;
3. monitor coverage, employment, income, access, trust and social cohesion;
4. review whether the measure remains necessary and proportionate;
5. provide accessible appeal and exemption pathways;
6. report monitoring results publicly;
7. prevent discriminatory or humiliating implementation; and
8. maintain communication with affected communities.

After restrictions end, agencies should:

1. evaluate health, social, economic and relational outcomes;
2. acknowledge harms and implementation failures where they occurred;
3. support fair reinstatement processes;
4. monitor continuing employment disadvantage;

5. resource community dialogue and repair; and
6. incorporate lessons into future preparedness.

6.17 Responsibilities of churches

Churches should not be expected to ignore public-health obligations. They should, however, implement requirements in ways that preserve dignity and belonging wherever safely possible.

Churches should:

- communicate the legal basis and duration of requirements accurately;
- distinguish government policy from theological command;
- avoid presenting vaccination status as a measure of faith;
- provide alternative forms of worship and pastoral care;
- maintain contact with excluded or isolated members;
- allow questions without shame;
- protect confidentiality;
- involve health professionals where clinical questions arise;
- monitor division within the congregation; and
- support reintegration when restrictions end.

Pastoral care should not be withdrawn because a person disagrees with a policy.

6.18 Responsibilities of employers

Employers implementing vaccination requirements should recognise that employment decisions affect households and communities.

They should provide:

- clear information;
- adequate time for consultation;
- access to professional health advice;
- fair exemption and review processes;
- consideration of alternative duties;
- protection from humiliation or harassment;

- transparent records of decisions;
- support for affected workers; and
- fair processes for reinstatement where requirements end.

Economic necessity should not be hidden beneath language suggesting that every decision was entirely voluntary.

6.19 Relational repair

Pandemic preparedness typically includes planning for epidemiological recovery, restoration of health services and economic reopening. The findings demonstrate that relational recovery must also be planned.

Relational repair may include:

- facilitated *tālānga*;
- acknowledgement of different experiences;
- confidential pastoral or counselling support;
- opportunities for leaders and institutions to explain decisions;
- acknowledgement of errors or avoidable harm;
- reintegration into church and community life;
- restoration of employment relationships where possible; and
- renewed agreements about how future crises will be handled.

Repair does not require everyone to adopt the same interpretation of what happened. It requires truthful listening, accountability and the restoration of relationships in which disagreement does not result in exclusion.

The central finding is that mandates were not merely technical policy instruments. They were experienced through the relationships and institutions that organised people's work, faith, family life and belonging. Future policy must therefore evaluate both public-health outcomes and relational consequences.

7. Church Leadership: Protection, Influence and Accountability

Key message

Faith leaders were among the most trusted interpreters of COVID-19 for Tongan communities. Their authority supported reassurance, vaccination, pastoral care, welfare assistance and adaptation of worship. Because that influence was substantial, it also carried an elevated duty of evidence, humility, confidentiality, professional boundaries and accountability.

The findings identify church leadership as a central hinge within the Lotu Factor. Leadership could direct faith towards protection and wellbeing, or it could amplify misinformation, pressure and exclusion.

7.1 Leadership within the participant sample

Church-status information was available for 150 participants:

- 120 participants, or 80%, identified as church members; and
- 30 participants, or 20%, identified as church leaders.

The study therefore included both those who exercised formal leadership and those who received, interpreted or responded to that leadership.

The term “faith leader” includes ministers and other recognised spiritual or institutional leaders. Leadership also extended beyond formal office. Elders, lay preachers, women’s leaders, youth leaders, worship leaders, family heads and people managing church communication could all influence how communities interpreted COVID-19.

The chapter focuses principally on ministerial and recognised church authority because these forms of leadership were especially prominent in participant accounts.

7.2 Spiritual authority and relational trust

Participants associated ministers with divine calling, shepherding and long-standing involvement in community life. Ministers were present during:

- baptism;
- confirmation;
- marriage;
- funerals;
- illness;
- family crisis;
- pastoral counselling;
- worship;
- cultural occasions; and
- significant community decisions.

Ministerial authority therefore extended beyond the administration of church services. It was spiritual, relational, cultural and institutional.

One participant explained:

“Whether they are right or not, I respect them as representatives of God here on Earth. What they say matters to me.”

— *Tālanga participant*

This statement illustrates both the strength and the ethical risk of spiritual authority. Respect could remain influential even when a participant questioned whether a leader was correct.

The statement also explains why public-health agencies sought partnerships with churches. Ministers already held relationships and trust that government agencies could not create quickly during an emergency.

However, a simple “trusted messenger” model is inadequate. Trust is not merely a resource that agencies can borrow to distribute messages. It is a relationship that must be protected from manipulation and instrumental use.

7.3 Faka‘apa‘apa and the difficulty of questioning leaders

Tongan practices of *faka‘apa‘apa* affirm respect, dignity and appropriate relational conduct. These practices are essential to community life. They can preserve harmony and acknowledge spiritual and cultural responsibility.

Respect does not necessarily mean unquestioning agreement. However, participants indicated that direct criticism of a minister could be difficult, particularly in a group or congregational setting.

The relational consequences of questioning a leader could include:

- appearing disrespectful;
- being regarded as disobedient;
- damaging family standing;
- creating conflict;
- losing a leadership role;
- being excluded from decision-making; or
- weakening one’s sense of belonging.

Apparent agreement should therefore not be assumed to represent freely expressed consensus. Ethical leadership must actively create permission for questions, especially when decisions involve health, employment or access to worship.

7.4 Leadership by visible example

Participants valued leaders whose actions were consistent with their public messages. Several recalled denominational leaders, ministers and priests receiving vaccination publicly.

Visible vaccination reassured congregations because leaders shared the decision and its perceived risks rather than merely instructing others.

Leadership by example extended beyond vaccination. Participants noticed leaders who:

- complied with restrictions;
- modified worship practices;
- protected older and vulnerable members;
- sought advice from health professionals;
- checked on isolated families;
- used digital communication responsibly; and
- acknowledged the limits of their own expertise.

Consistency between speech and behaviour became a measure of moral credibility. Leaders were most persuasive when they modelled the conduct they encouraged.

7.5 Influence on vaccination decisions

Church communication networks enabled information to move rapidly. Denominational leaders communicated with ministers, ministers addressed congregations, and church members shared messages within families and community networks.

Some participants acted directly upon pastoral guidance.

One participant recalled:

“A Tongan minister was preaching and told us to go and get vaccinated ... so we went and got vaccinated.”

— *Tālanga participant*

For many leaders, encouraging vaccination was understood as a pastoral duty. It was intended to protect elders, medically vulnerable people, families and the wider congregation.

The quotation nevertheless shows how quickly pastoral guidance could become action. The stronger the authority, the greater the responsibility to distinguish:

- established evidence from personal opinion;
- pastoral encouragement from spiritual command;
- theological reflection from clinical advice;
- collective responsibility from compulsion; and
- denominational policy from government requirements.

Leaders should not imply that acceptance or refusal of a particular health intervention determines the sincerity of a person's faith.

7.6 Protective leadership

Participants associated life-affirming leadership with several qualities.

Humility

Leaders strengthened trust when they acknowledged that they did not possess all the answers. The Tongan value of *loto-tō*—humility and willingness to lower oneself in respectful relationship—was particularly important.

Humility did not weaken spiritual authority. It made leadership more credible because it demonstrated honesty about professional limits.

Accuracy

Participants expected leaders to check information before communicating it. Claims about vaccines, illness or treatment required reliable evidence rather than repetition of online material.

Compassion

Protective leadership placed the wellbeing of people above institutional reputation or the appearance of certainty. It listened to fear, grief and doubt without shame.

Dialogue

Participants valued opportunities to ask questions. Dialogue enabled communities to distinguish theological concerns, clinical questions and dissatisfaction with policy.

Confidentiality

Pastoral information about health, vaccination status, finances or family conflict required careful protection.

Accountability

Leaders needed to remain open to correction and review. Spiritual office did not place a person beyond ethical or evidential accountability.

Referral

Effective leaders recognised when a matter required a doctor, nurse, counsellor, mental-health professional, social worker or legal adviser.

These qualities helped direct *lotu* towards protection, trust and wellbeing.

7.7 Ethical responsibility and misuse of authority

Participants were critical when church authority was used to advance unsupported claims or personal agendas.

One participant warned:

“They can use influence or authority within the church to deny something that has been proven true.”

— *Interview participant*

The concern was not merely that a leader might be mistaken. Anyone can communicate incorrect information. The ethical issue was that spiritual authority could make an unsupported claim difficult to challenge.

Misuse of authority could include:

- communicating personal opinion as divine truth;
- repeating unverified medical claims;
- treating questions as lack of faith;
- using fear or end-times speculation to secure compliance;
- presenting disagreement as disobedience;
- protecting institutional interests over people’s wellbeing;
- disclosing confidential information;
- humiliating members;
- excluding people without pastoral care; or
- refusing correction.

The Lotu Factor does not treat authority itself as harmful. It asks whether authority is exercised truthfully, humbly and accountably.

7.8 Confidentiality and safeguarding

The pandemic expanded faith leaders’ access to sensitive information. Ministers and church leaders became aware of:

- vaccination status;
- medical concerns;
- employment difficulties;
- financial hardship;
- family disagreements;
- mental distress;
- bereavement;
- housing needs; and

- experiences of exclusion.

Participants connected ethical leadership with confidentiality. Information shared pastorally should not be disclosed casually, used in sermons, circulated through church messaging groups or posted on social media.

Churches require clear safeguarding standards governing:

- collection of personal information;
- consent;
- storage of records;
- social-media communication;
- pastoral confidentiality;
- disclosure of risk;
- referral;
- complaints; and
- accountability when confidentiality is breached.

Safeguarding protects both community members and leaders.

7.9 Pastoral care and holistic wellbeing

Participants repeatedly described pastoral care as a source of reassurance and connection. Ministers contacted families, prayed with households, supported grief and remained available during isolation.

One participant stated:

“When things get bad, they will get in touch and ask how the family is doing.”
— *Tālanga participant*

Describing ministers as “physicians” referred to reassurance and trusted presence, not medical treatment or clinical expertise.

Pastoral care supported wellbeing through:

- prayer;
- listening;
- reassurance;
- regular contact;
- spiritual interpretation;

- practical assistance;
- grief support;
- family mediation;
- community connection; and
- referral to other services.

Public-health partnership should recognise and resource this pastoral contribution while maintaining clear clinical boundaries.

7.10 Adaptability during crisis

Participants valued leaders who adapted worship and pastoral practice to changing circumstances.

Adaptations included:

- shortening services for older or vulnerable people;
- livestreaming worship;
- using Zoom and other digital platforms;
- conducting pastoral contact by telephone;
- supporting online funerals;
- using English alongside Tongan to include younger generations;
- reorganising church activities;
- sharing health information digitally; and
- developing culturally meaningful online events.

These adaptations preserved participation and demonstrated that tradition did not have to be treated as inflexible.

Digital creativity also revealed a wider pastoral competence. Leaders could sustain worship, culture, prayer and relationships across changing environments.

Preparedness planning should build upon these strengths rather than assuming that churches lack the capacity to innovate.

7.11 Faith–health collaboration

Participants described churches inviting clinicians and health professionals to speak with congregations. Churches provided culturally familiar settings in which members could ask questions and hear information from qualified professionals.

One participant reflected:

“In that example, we see the importance of health and faith working hand in hand.”

— *Tālānga participant*

Effective collaboration brought together different forms of expertise:

- faith leaders contributed theological interpretation, cultural knowledge and trusted relationships;
- clinicians contributed medical evidence, diagnosis and professional advice;
- community navigators supported language, access and follow-up;
- families contributed knowledge of lived circumstances; and
- participants retained the right to ask questions and make decisions.

Collaboration was strongest when it was reciprocal. Churches were not merely venues for official messages, and health professionals did not surrender clinical standards to religious authority.

7.12 Professional boundaries

Participants respected faith leaders who acknowledged the limits of their knowledge. Leaders who effectively said, “We are not the specialists in this area,” demonstrated responsibility rather than weakness.

Clear professional boundaries require leaders to:

- communicate within their competence;
- distinguish theology from medical diagnosis;
- rely upon qualified evidence;
- disclose uncertainty;
- avoid recommending unverified treatments;
- refer people appropriately; and
- refrain from presenting pastoral office as clinical expertise.

Professional boundaries also apply to health agencies. Agencies should not expect ministers to act as unpaid clinicians, public-relations representatives or enforcement officers.

Churches should not be used instrumentally to secure compliance without genuine participation in planning and evaluation.

7.13 Leadership and internal diversity

No minister or denominational leader should be assumed to represent every Tongan perspective. Churches contain differences of:

- theology;
- denomination;
- gender;
- generation;
- vaccination experience;
- health status;
- political interpretation;
- migration history; and
- professional knowledge.

Health agencies should engage multiple forms of leadership, including:

- denominational authorities;
- local ministers;
- women's leaders;
- youth leaders;
- lay leaders;
- Tongan clinicians;
- community navigators; and
- ordinary church members.

Broad participation reduces the risk that partnership will reproduce existing hierarchy or silence less powerful voices.

7.14 Leaders also needed care

Ministers and other faith leaders carried significant burdens during the pandemic. They supported grieving families, interpreted changing requirements, adapted worship, managed conflict and responded to community needs while also experiencing their own fear and fatigue.

One participant observed:

“Maybe even the leaders need help.”

— *Tālānga participant*

Another warned:

“As a leader, you need to be one step ahead of everybody else. When you are way behind, you are a dangerous person.”

— *Interview participant*

The second statement expresses the risk created when a highly influential leader lacks current information or adequate preparation. It should not be read only as criticism. It identifies a workforce-development responsibility.

Leaders require:

- reliable and timely information;
- continuing education;
- peer consultation;
- access to clinicians;
- mental-health support;
- rest;
- relief from unrealistic expectations;
- confidential spaces to seek help; and
- opportunities to reflect theologically upon crisis.

Supporting leaders is part of protecting communities.

7.15 Formation and continuing education

Denominations and theological colleges should prepare faith leaders for responsibilities extending beyond preaching and congregational administration.

Leader development should include:

- Pacific models of holistic wellbeing;
- public-health fundamentals;
- interpreting health evidence;
- communicating uncertainty;
- scripture and theology during crisis;
- misinformation and digital discernment;

- ethical use of authority;
- confidentiality;
- safeguarding;
- mental-health first response;
- suicide-risk awareness;
- professional referral;
- conflict mediation;
- relational repair; and
- leader self-care.

Training should not turn ministers into clinicians. Its purpose is to help them recognise limits, communicate responsibly and connect people with appropriate expertise.

7.16 Institutional accountability

Recognition of church leadership must be accompanied by institutional accountability.

Denominations and local churches should maintain:

- codes of ethical conduct;
- confidentiality policies;
- safeguarding procedures;
- social-media standards;
- complaints processes;
- conflict-of-interest policies;
- clinical referral pathways;
- review mechanisms; and
- procedures for responding to misuse of authority.

Complaints processes should be accessible to ordinary members, women, young people and those with limited institutional power. They should protect complainants from retaliation and ensure that serious health or safeguarding concerns are examined independently where appropriate.

Accountability should not be portrayed as hostility towards the church. It protects the integrity of ministry and the wellbeing of communities.

7.17 Implications for health agencies

Health agencies should recognise faith leadership as a form of community wellbeing leadership.

This recognition requires agencies to:

1. establish relationships with churches before emergencies;
2. engage both denominational structures and local leaders;
3. include Tongan clinicians and community navigators;
4. provide regular briefings in accessible language;
5. explain changing evidence;
6. create rapid referral and question pathways;
7. compensate community expertise where appropriate;
8. avoid assuming that one leader represents all Tongans;
9. respect church responsibilities and internal processes; and
10. evaluate partnership through trust and community experience, not only message reach.

Partnership should be sustained year-round rather than activated only when agencies need rapid access to communities.

7.18 Implications for churches

Churches should understand leadership during a health emergency as both spiritual and ethical responsibility.

Faith leaders should:

- communicate accurately;
- acknowledge uncertainty;
- welcome questions;
- model responsible behaviour;
- preserve pastoral care across disagreement;
- protect confidentiality;
- avoid unsupported clinical claims;
- maintain professional boundaries;

- refer appropriately;
- monitor exclusion and conflict; and
- remain accountable to the wellbeing of people.

The central finding is that spiritual authority can protect life when it is exercised through humility, evidence, compassion and dialogue. The same authority can become risk-producing when it is detached from correction, professional boundaries and accountability.

8. Social Media, Misinformation and the Digital Vā

Key message

Digital platforms became essential infrastructure for worship, family connection, pastoral care and cultural continuity during COVID-19. The same platforms intensified information overload and enabled spiritually framed misinformation to circulate rapidly through trusted Tongan and transnational networks.

The digital environment was therefore neither inherently protective nor inherently harmful. Its effects depended upon relationships, sources, theological interpretation, platform design, digital access and the emotional character of communication.

8.1 Status of the digital evidence

The project's social-media inquiry was analytically distinct from the core dataset of 155 participants. It drew upon:

- public digital content;
- media reporting;
- peer-reviewed research on misinformation and infodemics;
- research on Pacific digital relationships;
- supplementary scoping material; and
- themes emerging from the participant study.

The digital evidence was used to support contextual and thematic interpretation. It was not merged with the HDEC-approved participant dataset and was not used to estimate how common a particular belief was among Tongans.

Working material included named public cases and quantitative claims that required additional independent verification. Those names, cases and numerical claims are not reproduced in this public report.

The present chapter therefore focuses on securely supported thematic conclusions concerning:

- digital worship and pastoral care;

- the digital *vā*;
- theological framing;
- vaccine narratives;
- misinformation;
- diaspora communication;
- platform dynamics;
- information overload;
- digital inequality; and
- implications for future public-health engagement.

8.2 Understanding the digital *vā*

The Tongan concept of *vā* refers to the relational space connecting people, families, communities, ancestors and the sacred. The *vā* is not an empty distance separating individuals. It is a living relationship that must be nurtured through *tauhi vā*—care, responsibility, respect and continued connection.

During lockdowns and border closures, ordinary forms of maintaining the *vā* were disrupted. Families could not gather freely. Churches could not always meet physically. Funerals, worship services, pastoral visits and cultural events were restricted.

Digital platforms consequently became important spaces for sustaining relationships.

The digital *vā* included:

- livestreamed worship;
- Zoom funerals and memorial services;
- WhatsApp prayer chains;
- Facebook church groups;
- voice-message blessings;
- shared hymns;
- online family devotion;
- telephone pastoral care;
- youth-created videos and humour;
- transnational family communication; and

- online health information.

These practices demonstrate that digital communication was not merely a technical substitute for physical presence. It became a space in which spiritual, emotional and relational care was enacted.

8.3 Digital platforms as care infrastructure

Churches and families used digital platforms to maintain participation when physical gathering was impossible or restricted.

Livestreamed services enabled members to pray, sing, listen to preaching and remain connected to congregational life. Recorded services allowed people working irregular hours or living in different locations to participate later.

Messaging applications enabled:

- ministers to check on families;
- congregations to share prayer requests;
- relatives to coordinate practical assistance;
- health information to be distributed quickly;
- families to support people in isolation; and
- diaspora communities to remain involved in events in Aotearoa and Tonga.

Young people played an important role. Their familiarity with digital platforms enabled churches and families to adapt quickly. Humour, short videos, music and creative online interaction helped communities process fear and maintain connection.

Digital pastoral care sometimes brought the presence of the church into the home. This expanded the capacity of leaders to reach people who were isolated by health, age, geography or restrictions.

Digital practices that proved valuable during COVID-19 should not be abandoned. They should form part of future church and public-health preparedness.

8.4 Digital participation did not replace embodied community

Participants and the wider literature also indicated that online engagement was not equivalent to physical gathering.

Digital worship could not fully reproduce:

- embodied fellowship;
- sacramental participation;
- communal singing;

- physical comfort during grief;
- shared meals;
- informal conversation;
- collective cultural practices; or
- the experience of sacred space.

Digital communication should therefore be understood as an extension of relational and pastoral life rather than a complete replacement for embodied community.

A balanced approach should retain effective digital practices while recognising the distinctive value of physical presence.

8.5 Digital inequality

Access to the digital *vā* was uneven. Barriers included:

- limited internet data;
- lack of suitable devices;
- unreliable connectivity;
- low digital confidence;
- language barriers;
- disability access;
- limited knowledge of applications;
- concerns about privacy; and
- dependence upon younger family members for technical assistance.

Older people and households with limited financial resources could be excluded. A church might regard a livestream as accessible while some members lacked the equipment or confidence required to participate.

Future preparedness must therefore include:

- affordable connectivity;
- access to devices;
- digital-literacy support;
- telephone alternatives;
- captioning and accessible formats;

- multilingual content; and
- continued non-digital communication.

Digital engagement should expand participation rather than create a new basis for exclusion.

8.6 Pandemic information entered theological spaces

COVID-19 information did not enter an empty digital environment. Tongan online spaces were already shaped by:

- scripture;
- preaching;
- prayer;
- kinship;
- denominational relationships;
- political interpretation;
- migration histories;
- distrust of institutions; and
- transnational religious media.

Claims about vaccination, mandates and government authority were therefore interpreted within existing theological and relational frameworks.

Online material included narratives concerning:

- divine judgement;
- spiritual warfare;
- the “mark of the beast”;
- the number 666;
- microchips;
- divine immunity;
- segregation;
- personal freedom;
- conscience;
- government control; and

- the moral responsibility to protect others.

These claims gained influence when communicated in Tongan by people who already held relational or spiritual authority.

8.7 Moral and theological reasoning about vaccination

Online religious content did not carry one uniform position on vaccination.

Some material framed vaccination as:

- neighbour-love;
- stewardship of life;
- responsible protection of family;
- an answer to prayer;
- a gift of scientific knowledge; or
- an expression of communal responsibility.

Other material framed vaccination as:

- a conflict between conscience and government;
- evidence of inadequate trust in God;
- spiritual contamination;
- participation in an apocalyptic system;
- surrender of divine freedom; or
- acceptance of an unsafe and deceptive intervention.

This contrast reinforces the report's central argument: theology can amplify either protective or risk-producing pathways.

Public-health agencies should not seek one simplified religious endorsement, as if a single biblical statement could resolve all concerns. Communities require space for plural, responsible theological reasoning that distinguishes legitimate ethical questions from unsupported medical claims.

8.8 Misinformation within high-trust networks

Misinformation is false or misleading material shared regardless of whether the person intends to deceive. Disinformation refers more specifically to false or misleading material circulated deliberately.

In most community contexts, intention is difficult to determine. A person may share inaccurate information because they are frightened, concerned for others or convinced that they are warning the community.

The influence of a claim depends upon more than its factual content. It also depends upon:

- who communicates it;
- the language used;
- the relationship between sender and recipient;
- the emotional tone;
- the spiritual authority attached to the message;
- whether it confirms existing concerns; and
- whether correction is socially safe.

A claim shared by a minister, parent, respected elder or overseas relative may carry more weight than information from an unfamiliar official source.

High-trust networks strengthened care during the pandemic. The same trust could accelerate misinformation.

8.9 Why additional facts may be insufficient

Providing accurate information is necessary, but factual correction alone may not change a belief embedded in moral, theological or relational identity.

A message about the “mark of the beast,” for example, is not only a factual claim about vaccine contents. It may express:

- fear of spiritual deception;
- distrust of government;
- concern about personal freedom;
- an apocalyptic understanding of history;
- loyalty to a religious authority; or
- anxiety about belonging.

Responding only with a fact sheet may leave these deeper meanings untouched.

Effective correction should address:

1. the factual claim;
2. the theological interpretation;

3. the emotional concern;
4. the relationship through which the claim travelled; and
5. the authority attached to it.

This requires collaboration among clinicians, theologians, faith leaders, community navigators and digital communicators.

8.10 Diaspora networks

Tongan digital life is transnational. Messages circulated among Aotearoa New Zealand, Tonga, Australia, the United States and other diaspora locations.

Advice from an overseas minister or relative could carry greater relational authority than an official New Zealand source. International sermons, political commentary and personal testimonies could be received within local family and church networks almost immediately.

Diaspora communication supported:

- family connection;
- prayer;
- financial and practical assistance;
- cultural continuity;
- shared worship; and
- pastoral encouragement.

It also complicated national public-health communication. A message created in one legal, political or epidemiological setting could be circulated in another without sufficient context.

Future engagement must therefore be diaspora-aware. Communication strategies confined within national borders will not address the transnational pathways through which Tongan communities receive information.

8.11 Platform dynamics

Different digital platforms shaped communication in different ways.

Facebook

Facebook supported church pages, livestreamed worship, community discussion and family networks. Its emphasis on personal connections allowed messages from trusted people to circulate widely.

YouTube

YouTube provided access to sermons, theological teaching, news commentary and long-form international religious content. Material created in other countries could influence local interpretation.

WhatsApp and other messaging applications

Encrypted group messaging enabled private prayer chains, family support and rapid communication. These high-trust spaces were valuable for pastoral care but difficult for public-health agencies to observe or correct.

TikTok and short-form video

Short videos enabled creativity, humour and youth participation. They also allowed highly simplified or decontextualised claims to circulate rapidly.

Algorithms

Platforms generally prioritise material that attracts attention and engagement. Content producing fear, outrage, urgency or absolute certainty may receive greater visibility than careful explanations of evidence and uncertainty.

The structure of the platform therefore influences which messages people encounter repeatedly. Digital-health strategies must consider both message content and platform design.

8.12 Information overload

Participants and the digital literature described fatigue from constant and conflicting information.

During the pandemic, people encountered:

- daily case numbers;
- changing health advice;
- government announcements;
- scientific commentary;
- personal stories;
- political arguments;
- vaccine claims;
- religious warnings;
- family messages; and
- international news.

Some people disengaged from social media, turned off notifications or removed applications to protect their wellbeing.

Information overload can reduce the ability to evaluate claims carefully. When people are tired, afraid or overwhelmed, simple and emotionally forceful explanations may become more attractive than complex accounts acknowledging uncertainty.

More information is not always better communication.

8.13 Affect and emotional tone

The emotional character of a message influenced how it was received.

Messages offering:

- encouragement;
- prayer;
- calm explanation;
- humour;
- compassion;
- hope;
- practical assistance; and
- acknowledgement of fear

could strengthen resilience and connection.

Messages dominated by alarm, accusation, ridicule or repeated catastrophe could intensify fear and exhaustion.

Effective public-health communication must therefore be both accurate and affectively intelligent. It should offer calm, clarity and relational connection rather than imitate the sensationalism it seeks to counter.

A technically correct message can still fail if its tone communicates contempt, cultural distance or indifference.

8.14 Digital privacy and safeguarding

Digital pastoral care introduced new confidentiality and safeguarding responsibilities.

Risks included:

- prayer requests revealing health information;
- vaccination status being shared without consent;
- screenshots being circulated beyond their intended audience;
- recordings remaining online indefinitely;

- children and vulnerable people appearing in livestreams;
- personal testimony being used without permission;
- family conflict becoming public; and
- misinformation being repeated through official church channels.

Churches need policies governing:

- consent for recording and livestreaming;
- management of prayer requests;
- access to messaging groups;
- storage of personal information;
- moderation;
- reporting of harmful content;
- use of children's images;
- account security;
- removal of material; and
- boundaries between personal opinion and official church communication.

Digital ministry must meet the same ethical standards expected of embodied pastoral care.

8.15 Relational prebunking

“Prebunking” refers to preparing people to recognise recurring misinformation before it spreads widely.

A relational approach to prebunking should:

- identify common claims through community *tālanga*;
- explain why those claims may appear persuasive;
- provide short Tongan-language responses;
- combine theological and clinical expertise;
- acknowledge genuine uncertainty;
- teach simple source-checking practices;
- use trusted community communicators; and

- offer a pathway for further questions.

Prebunking should not shame people who have encountered or shared misinformation. Its purpose is to strengthen discernment and reduce vulnerability to manipulation.

8.16 Seven principles for digital-health engagement

1. Co-design with pastoral, clinical and youth networks

Digital resources should be developed through Tongan *tālanga* involving clinicians, theologians, faith leaders, community communicators and young people.

Translation after decisions have already been made is insufficient.

2. Practise relational prebunking

Recurring claims should be addressed before an emergency through short, accessible resources developed by trusted Tongan clinicians and theologians.

3. Cultivate the digital vā

Agencies and churches should maintain regular online spaces where people can ask questions, express uncertainty and receive respectful responses.

Ridicule and humiliation should be prohibited.

4. Build responsible platform relationships

Public agencies, Pacific providers, churches, media organisations and technology platforms should improve the visibility of Pacific-created, evidence-informed content and strengthen reporting pathways for harmful misinformation.

5. Use affective and relational communication

Communication should combine accurate explanation with culturally appropriate story, prayer, humour, music, testimony and expressions of care.

Emotional intelligence must not be confused with manipulation.

6. Invest throughout the year

Digital trust cannot be created during an emergency alone. Churches and community organisations need sustained support for digital literacy, health navigation, safeguarding and content development.

7. Evaluate through *tālanga* and digital evidence

Evaluation should assess:

- trust;
- comprehension;

- recurring questions;
- reach;
- participation;
- privacy;
- reports of harm;
- referral activity; and
- community experience.

Evaluation should respect privacy and must not become surveillance of religious belief.

8.17 Responsibilities of churches

Churches should:

- identify authorised digital communicators;
- establish social-media and privacy policies;
- verify health claims before sharing them;
- distinguish testimony from clinical evidence;
- correct harmful information responsibly;
- maintain pastoral contact beyond public posts;
- involve young people in digital planning;
- provide non-digital alternatives;
- protect confidential information; and
- maintain referral relationships with health providers.

Ministers should not assume that pastoral authority establishes the medical accuracy of a message.

8.18 Responsibilities of health agencies

Health agencies should:

- develop Tongan digital capacity;
- employ Tongan clinicians and communicators;
- engage theologians and faith leaders;

- monitor recurring questions without monitoring individuals;
- explain changing evidence quickly;
- produce accessible Tongan-language resources;
- support trusted question-and-answer spaces;
- recognise diaspora information pathways;
- fund Pacific-led content production; and
- remain present between emergencies.

Health agencies should avoid treating churches merely as channels for forwarding official material. Genuine partnership involves joint interpretation, planning and evaluation.

8.19 Responsibilities of platforms and media organisations

Technology platforms and media organisations should improve:

- access to authoritative Pacific content;
- moderation in Pacific languages;
- reporting pathways;
- response to impersonation and harmful claims;
- transparency about content recommendation; and
- support for community-led digital-literacy initiatives.

Moderation must be sensitive to language, culture and context. Automated systems designed primarily for dominant languages may fail to recognise harmful or misleading content expressed in Tongan.

8.20 Implications

Effective digital-health practice depends on trusted relationships, not content distribution alone.

The digital *vā* can sustain prayer, cultural belonging, pastoral care and family connection. It can also carry fear and spiritually authorised misinformation through the same trusted relationships.

Future preparedness must therefore combine:

- cultural knowledge;
- theological literacy;
- clinical expertise;

- digital safeguarding;
- diaspora awareness;
- platform understanding;
- emotional intelligence; and
- year-round relational investment.

The central question is not whether Tongan communities should use digital platforms. They already do. The task is to nurture a digital *vā* in which care, truthfulness, accountability and responsible discernment can flourish.

9. Integrated Interpretation: The Lotu Factor

Key message

The integrated analysis showed that the effects of *lotu* varied across the study's domains. Outcomes were shaped by the interaction of faith, leadership, communication, institutional settings, structural pressures and digital life.

The Lotu Factor describes this mediated relationship between faith and wellbeing. It moves analysis beyond the binary claim that religion is either protective or harmful and directs attention towards conditions that communities and institutions can change.

9.1 The central synthesis

The findings demonstrate that the strength or intensity of a person's religious commitment did not determine whether *lotu* supported or undermined wellbeing.

Strong faith could support:

- hope;
- resilience;
- medical care;
- vaccination;
- protection of vulnerable people;
- pastoral support;
- community belonging; and
- responsible collective action.

Strong religious commitment could also be carried through:

- unsupported medical claims;

- fear-based apocalyptic interpretation;
- unaccountable leadership;
- pressure;
- exclusion;
- silencing of questions; and
- rejection of professional boundaries.

The decisive issue was not how religious a person or community appeared to be. It was how faith operated through mediating practices and surrounding conditions.

The findings confirmed the preliminary formulation introduced in section 2.6.

That formulation is a conceptual reminder, not a mathematical or numerical model: religious commitment does not move directly to a predetermined health outcome.

The same belief may produce different consequences depending upon:

- interpretation;
- leadership;
- evidence;
- trust;
- dialogue;
- professional boundaries;
- institutional practice;
- family and church relationships;
- government policy;
- employment pressure; and
- digital communication.

9.2 What the Lotu Factor means

The Lotu Factor is:

The patterned effect of faith on wellbeing as mediated through interpretation, leadership, trust, relational authority, institutional practice, structural pressure and digital information environments.

It is not a measure of how religious a person is. It does not rank denominations or distinguish “good believers” from “bad believers.”

It is a framework for asking:

- How is faith being interpreted?
- What evidence supports the claim?
- Who holds authority?
- Can people ask questions safely?
- Are professional roles clear?
- Is belonging protected?
- What structural pressures affect the decision?
- How is information circulating?
- What are the consequences for the whole person and community?

The framework focuses on changeable conditions rather than fixed identities.

9.3 The mediating hinges

Eight mediating hinges connect *lotu* to wellbeing outcomes.

1. Evidence orientation

The first hinge concerns how evidence, belief and uncertainty are distinguished.

A protective orientation:

- checks sources;
- differentiates testimony from clinical evidence;
- explains changing advice;
- acknowledges uncertainty;
- remains open to correction; and
- avoids presenting speculation as fact.

A risk-producing orientation rejects correction regardless of evidence or treats spiritual authority as sufficient proof of a medical claim.

2. Theological interpretation

Theological interpretation shapes understandings of illness, protection, suffering, responsibility and hope.

Life-affirming interpretation connects faith with:

- compassion;
- humility;
- stewardship;
- neighbour-love;
- appropriate care;
- protection of vulnerable people; and
- truthful acknowledgement of suffering.

Risk-producing interpretation may use scripture or revelation to:

- promise immunity;
- intensify fear;
- shame care-seeking;
- portray medical treatment as betrayal;
- label questioning as faithlessness; or
- attribute illness to moral failure.

3. Leadership accountability

Faith leaders can translate complex information into trusted cultural and spiritual settings. Their example can reassure communities and strengthen engagement.

Leadership becomes protective when leaders:

- disclose the limits of their expertise;
- seek qualified advice;
- communicate accurately;
- model responsible conduct;
- protect confidentiality;
- welcome review; and

- remain accountable.

Leadership becomes risk-producing when authority is coercive, opaque or used to advance unsupported claims or personal agendas.

4. Dialogue and agency

Tālānga allows uncertainty, disagreement and interpretation to be expressed relationally.

Dialogue is protective when:

- questions are welcomed;
- different experiences are heard;
- conscience is respected;
- benefits and risks are explained;
- people can speak without shame; and
- decisions are not treated as tests of spiritual loyalty.

Dialogue becomes risk-producing when questioning results in humiliation, exclusion, spiritual threat or loss of standing.

5. Professional boundaries

Faith leaders and health professionals possess different but potentially complementary forms of expertise.

Professional boundaries are protective when:

- clergy and clinicians collaborate;
- roles are clear;
- referral pathways exist;
- uncertainty is disclosed;
- ministers avoid clinical diagnosis; and
- health agencies respect theological and cultural expertise.

Boundaries become risk-producing when pastoral authority substitutes for clinical knowledge or public agencies use faith leaders as uncritical endorsers.

6. Institutional practice and belonging

Church policies and organisational practices affect access to worship, leadership, welfare, information and pastoral care.

Institutional practice is protective when dignity, participation and belonging continue across disagreement.

It becomes risk-producing when vaccination status, uncertainty or dissent becomes a basis for:

- humiliation;
- segregation;
- expulsion;
- denial of pastoral care;
- loss of leadership;
- surveillance; or
- permanent relational division.

7. Digital information practice

Digital environments carry worship, care, family connection and information.

Digital practice is protective when content is:

- sourced;
- culturally meaningful;
- theologically responsible;
- private where required;
- accessible;
- responsive to questions; and
- open to correction.

Digital practice becomes risk-producing when fear, outrage, conspiracy claims or apocalyptic certainty are amplified through trusted networks without responsible challenge.

8. Structural conditions

Faith and health decisions occur within wider conditions, including:

- employment;
- income;
- housing;

- access to services;
- government restrictions;
- geographic location;
- racism;
- institutional trust; and
- social inequality.

Structural conditions are protective when policies are transparent, proportionate, monitored, time-limited and accompanied by workable alternatives.

They become risk-producing when economic pressure, restrictive measures or unequal access narrow choice without adequate safeguards, review or repair.

9.4 Protective pathways

Protective or life-affirming *lotu* was characterised by:

- meaning and hope that acknowledged suffering rather than denying it;
- prayer and worship that complemented medical, psychological and social support;
- theological interpretation oriented towards life, care and neighbour-love;
- leaders who modelled humility, accuracy and accountability;
- open *tālānga* in which doubt did not destroy belonging;
- collaboration between churches and qualified health professionals;
- clear professional and referral boundaries;
- transparent communication about evidence and uncertainty;
- respect for conscience and informed agency;
- institutional practices that preserved dignity;
- pastoral follow-up;
- relational repair;
- responsible digital communication; and
- policies that were proportionate and regularly reviewed.

Likely consequences included:

- resilience;

- hope;
- reduced isolation;
- willingness to seek care;
- improved comprehension;
- vaccination confidence for some participants;
- collective protection;
- continued church participation;
- cultural continuity;
- stronger relationships; and
- increased trust.

These outcomes were not produced by faith alone. They emerged when faith was carried through responsible interpretation, leadership and relationship.

9.5 Risk-producing pathways

Risk-producing *lotu* was characterised by:

- unsupported claims presented as medical facts;
- promises of divine immunity;
- spiritual-contamination narratives;
- fear-based apocalyptic certainty;
- portrayal of vaccination or treatment as spiritual betrayal;
- leaders communicating unverified claims through spiritual authority;
- questioning treated as disobedience or weak faith;
- coercive expectations connected to work, worship or standing;
- exclusion based on vaccination status or disagreement;
- confusion between pastoral and clinical expertise;
- institutional protection taking priority over people's wellbeing;
- use of churches as uncritical policy channels;
- absence of confidential pathways for questions;

- lack of follow-up for reported health concerns;
- algorithmic amplification of emotionally charged misinformation; and
- restrictive policies implemented without sufficient monitoring or repair.

Possible consequences included:

- delayed care;
- fear;
- anxiety;
- shame;
- silence;
- family conflict;
- church division;
- loss of employment;
- economic hardship;
- withdrawal from leadership;
- departure from congregations;
- reduced trust in institutions;
- unresolved moral distress; and
- reduced willingness to engage with future health programmes.

Again, these outcomes should not be attributed to faith alone. They emerged through the interaction of spiritual authority, institutional practice, structural pressure and relational conditions.

9.6 The importance of the mixed or “watch” zone

Real situations do not always fit neatly into protective or risk-producing categories. Many exist within a mixed or “watch” zone.

Examples include:

- a minister sharing generally accurate information but discouraging questions;
- a church preserving online worship while excluding members from pastoral contact;
- a health agency using translated information without genuine community participation;

- a mandate with a clear public-health purpose but inadequate monitoring of employment effects;
- reliable and unreliable information circulating together;
- clinical and pastoral roles overlapping temporarily during an emergency;
- a family acting from care while applying excessive pressure; or
- a congregation containing several theological interpretations that are never discussed openly.

The watch zone is important because it identifies risk before serious harm occurs. It also avoids classifying an entire church, programme or policy as wholly beneficial or harmful.

The appropriate response is reflection, support and corrective action—not condemnation.

9.7 The Lotu Factor Reflection Grid

The Reflection Grid translates the findings into a non-clinical planning and accountability tool.

It should be used through *tālānga* involving community members, faith leaders and health professionals. It is not a diagnostic score.

Domain	Protective or life-affirming	Watch or mixed	Risk-producing—action required
Evidence orientation	Evidence, belief, testimony and uncertainty are distinguished; sources can be checked.	Evidence is selective, or changing advice is poorly explained.	Unsupported claims are presented as fact, and correction is rejected regardless of evidence.
Theological interpretation	Faith supports life, care, humility, neighbour-love and appropriate treatment.	Multiple interpretations exist but are not openly discussed.	Scripture or revelation is used to promise immunity, shame care-seeking or intensify fear.
Leadership accountability	Leaders disclose limits, seek advice, model responsible conduct and accept review.	Accountability is informal or dependent upon personality.	Authority is coercive, opaque or used to advance unsupported claims or personal agendas.
Dialogue and agency	Questions are welcomed; informed decisions and conscience are respected.	Dialogue occurs, but some people or groups remain silent.	Questioning results in shame, exclusion, spiritual threat or loss of standing.
Professional boundaries	Clergy, clinicians and community workers collaborate through clear roles and referral pathways.	Roles overlap during crisis without consistent guidance or support.	Pastoral authority substitutes for clinical expertise, or agencies use clergy as uncritical endorsers.
Inclusion and relational outcomes	Care and belonging continue across disagreement; repair is supported.	Tension is present but managed mainly through silence.	People are humiliated, segregated, expelled or left without reconciliation.
Digital information practice	Content is sourced, culturally meaningful, accessible, private and responsive.	Reliable and unreliable material circulate together without consistent checking.	Fear-based misinformation is amplified through trusted networks without correction.

Structural conditions	Policies are transparent, proportionate, monitored and regularly reviewed.	Burdens or alternatives are incompletely understood.	Economic or institutional pressure narrows choice without adequate safeguards, review or repair.
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9.8 Purpose of the Reflection Grid

The Grid is designed to help communities move from general disagreement to specific analysis.

Instead of asking, “Is this church harmful?” or “Is this leader delusional?”, it asks:

- What claim, policy or practice are we examining?
- What evidence is available?
- How is scripture being interpreted?
- Who has authority?
- Can people ask questions safely?
- Are professional roles clear?
- Who remains included?
- What information is circulating?
- What structural pressures are present?
- What consequences are visible?
- What can be changed?

The Grid shifts attention from labels to practices and consequences.

9.9 How to use the Grid

Step 1: Convene a mixed group

The group should include, where relevant:

- denominational and local leaders;
- ordinary church members;
- women;
- young people;
- older people;
- disabled people;

- clinicians;
- community navigators;
- theologians; and
- people with different experiences of the issue.

No single leader or professional should control the discussion.

Step 2: Select a specific scenario

The group should examine a real message, policy, programme or practice.

Examples might include:

- a sermon containing a health claim;
- a vaccination campaign;
- a church-access policy;
- a social-media post;
- a pastoral referral process;
- a proposed mandate;
- an online prayer group; or
- a plan for communicating during an outbreak.

The group should not use the Grid to rate a person's faith.

Step 3: Examine each domain

Participants should discuss the available evidence and identify:

- protective practices;
- areas of uncertainty;
- possible risks;
- people who benefit;
- people who carry burdens;
- voices that may be absent; and
- information requiring verification.

The aim is not to force immediate agreement. It is to make the conditions and consequences visible.

Step 4: Retain strengths

The group should identify at least one protective strength that should be preserved.

Examples may include:

- trusted pastoral relationships;
- Tongan-language communication;
- strong family networks;
- clinician involvement;
- digital capacity;
- open dialogue; or
- effective welfare support.

Corrective action should not destroy existing strengths.

Step 5: Identify changes

The group should identify risks requiring action.

Possible actions include:

- checking a source;
- revising a message;
- inviting clinical expertise;
- clarifying professional roles;
- creating confidential question pathways;
- changing an exclusionary practice;
- improving privacy;
- providing alternatives;
- establishing an appeal process; or
- arranging facilitated relational repair.

Step 6: Assign responsibility

Each action should have:

- a responsible person or organisation;
- a timeframe;
- required resources;
- a referral pathway where relevant;
- an indicator of progress; and
- a review date.

Step 7: Review consequences

The group should return to the scenario and ask:

- Did trust improve?
- Were questions answered?
- Did people remain included?
- Was misinformation corrected?
- Were professional boundaries strengthened?
- Did the action create unintended burdens?
- Is further repair required?

9.10 Illustrative application

Consider a church receiving a request to support a new vaccination campaign.

A protective approach would involve:

- inviting a qualified Tongan clinician;
- providing information in Tongan and English;
- allowing anonymous questions;
- explaining benefits, risks and uncertainty;
- clarifying that the minister is not providing medical diagnosis;
- presenting theological reflections on care without making vaccination a test of faith;
- protecting the belonging of people who remain uncertain;

- providing post-vaccination follow-up information; and
- reviewing community experience.

A watch-zone situation might involve accurate information being presented but no confidential opportunity for questions, or one leader speaking on behalf of a congregation containing several views.

A risk-producing approach would involve unsupported medical claims, spiritual threats, public identification of dissenters, exclusion from pastoral care or pressure concealed beneath the language of voluntary choice.

The Grid enables the group to identify these differences before harm becomes entrenched.

9.11 Safeguards governing use of the Grid

The Reflection Grid must be governed by strict safeguards.

It must not diagnose individuals.

The Grid does not determine whether a person is delusional, mentally unwell or religiously deficient.

It must not rank faith communities.

It should not be used to create league tables of churches or denominations.

It must not become a funding test.

Funding should not depend upon a community receiving a preferred theological rating.

It must not justify surveillance.

The Grid must not be used to monitor private beliefs, sermons or religious participation without lawful and ethical justification.

It must examine specific practices.

Assess a message, policy, programme or scenario rather than permanently labelling a person or institution.

It must include less powerful voices.

Leaders, professionals and majority groups should not be the only participants.

It must remain contextual.

A practice may have different consequences in different communities or stages of a crisis.

It must remain open to correction.

The Grid itself should be revised through piloting, evaluation and community feedback.

9.12 The Lotu Factor as a framework of mutual accountability

The framework does not apply only to churches.

Religious institutions must be accountable for:

- theological claims;

- ethical use of authority;
- confidentiality;
- professional boundaries;
- inclusion; and
- consequences for wellbeing.

Health agencies and government must also be accountable for:

- evidence;
- transparency;
- proportionality;
- changing advice;
- monitoring;
- equity;
- treatment of dissent;
- institutional pressure; and
- relational consequences.

Employers must be accountable for how policies affect workers and households. Digital platforms must be accountable for privacy, amplification and access to culturally relevant moderation.

The Lotu Factor therefore creates a framework of mutual rather than one-sided accountability.

9.13 Theoretical contribution

The Lotu Factor makes three principal conceptual contributions.

First, it treats faith as a determinant of wellbeing without assuming a direct or uniform causal effect.

Second, it identifies mediating hinges through which faith becomes protective, mixed or risk-producing.

Third, it connects theological interpretation with relational, institutional, structural and digital conditions.

This integrated approach avoids two common errors:

- romanticising faith as automatically protective; and

- pathologising Tongan religion as inherently resistant to science.

The framework recognises *lotu* as a powerful and complex resource whose effects depend upon how it is carried.

9.14 Practical contribution

The practical value of the Lotu Factor lies in its capacity to identify changeable conditions.

Communities may not agree on every theological or political interpretation. They can nevertheless work together to strengthen:

- evidence checking;
- accountable leadership;
- respectful dialogue;
- informed agency;
- professional boundaries;
- inclusion;
- digital responsibility;
- policy safeguards; and
- relational repair.

The Reflection Grid should now be piloted with churches, Pacific health providers, policymakers and community organisations. Evaluation should examine usability, cultural safety, effects on dialogue and whether the Grid leads to measurable improvements in practice.

Its value lies in structured conversation and accountability—not in producing a total score.

Part III — Implications and Action

10. Implications for Pacific Health Policy and Practice

Key message

The Lotu Factor findings require a shift in Pacific health engagement from short-term message delivery towards sustained, reciprocal and accountable partnership.

Future health policy must recognise that Tongan health decisions are made within spiritual, relational, institutional and structural worlds. Effective engagement therefore requires more than translating information. It requires Tongan leadership, theological literacy, trusted relationships, transparent communication, professional boundaries, equitable policy safeguards and plans for relational recovery.

10.1 Recognise faith as a determinant of wellbeing

Spirituality should not be treated as an optional cultural addition to Pacific health care. The findings demonstrate that *lotu* shapes:

- interpretations of illness;
- experiences of suffering;
- coping and resilience;
- trust;
- health decision-making;
- family responsibility;
- responses to authority;
- acceptance of medical advice;
- participation in church and community; and
- understandings of recovery.

Recognising faith as a determinant of wellbeing does not require health providers to endorse a particular theology. It requires providers to understand that religious belief, practice and institutional participation may be relevant to how a person interprets care.

Practical consequences include:

- asking respectfully whether faith or spiritual practice is relevant to a person's decision;
- including spiritual and relational wellbeing in Pacific needs assessments;

- recognising the possible influence of church participation and leadership;
- offering access to spiritual support where requested;
- involving family and trusted leaders with the person's consent;
- identifying situations in which religious pressure may affect agency; and
- maintaining referral relationships with culturally appropriate faith and community services.

Providers should not assume that every Tongan person is Christian, attends church or wishes faith leaders to be involved. Recognition must remain person-centred and voluntary.

10.2 Move beyond translation

Translation is important, but translation alone is not cultural responsiveness.

A health message may be accurately translated into Tongan while remaining disconnected from:

- local questions;
- theological concerns;
- family obligations;
- church authority;
- community history;
- experiences of government;
- practical barriers; and
- the emotional realities of decision-making.

Information developed in English and translated after policy has been finalised does not constitute co-design.

Tongan-led communication should begin before the message is written. It should involve Tongan clinicians, theologians, community leaders, women, young people and people with relevant lived experience in deciding:

- what questions need to be answered;
- what concepts require explanation;
- which language and metaphors are appropriate;
- who should communicate;
- what uncertainty must be acknowledged;

- which channels should be used;
- what support should follow the message; and
- how community feedback will change the response.

Translation communicates words. Co-design engages meaning, authority and consequence.

10.3 Build relationships before a crisis

The Royal Commission emphasised that pre-existing community relationships enabled more effective local responses. The Lotu Factor Project reaches the same conclusion from Tongan experience.

Trust cannot be activated on demand. A minister contacted for the first time during an outbreak is being asked to lend an untested relationship to government. A community that hears from health agencies only when vaccination, compliance or emergency cooperation is required may reasonably experience partnership as instrumental.

Year-round relationships should include:

- named regional contacts;
- regular faith–health meetings;
- shared training;
- referral agreements;
- preparedness exercises;
- local communication plans;
- discussion of ordinary health priorities;
- digital networks;
- pathways for urgent clinical questions; and
- mechanisms for reviewing community experience.

Relationships should be maintained during periods when no immediate public-health campaign is underway.

10.4 Treat churches as wellbeing partners, not message channels

Churches possess substantial community capability, including:

- spiritual legitimacy;
- trusted relationships;
- language;

- facilities;
- volunteers;
- pastoral networks;
- welfare capacity;
- cultural knowledge;
- digital communication;
- family reach; and
- experience mobilising communities.

Churches should not therefore be approached merely as convenient venues or distribution channels for government messages.

Reciprocal partnership means that churches help:

- identify community needs;
- interpret evidence;
- raise difficult questions;
- design responses;
- determine culturally appropriate communication;
- support referral and follow-up;
- identify unintended consequences; and
- evaluate outcomes.

At the same time, churches should not be romanticised. They are complex institutions containing different theologies, generations, genders, leadership structures and experiences.

Partnership must recognise:

- unequal power;
- safeguarding responsibilities;
- the possibility of misinformation;
- differences between leaders and members;
- the need for confidentiality;
- the danger of coercion; and

- the importance of professional boundaries.

Church partnership should not be measured only by how efficiently a church produces compliance.

10.5 Recognise internal community diversity

No single minister, clinician or community representative should be treated as speaking for all Tongans.

Engagement should include:

- denominational leaders;
- local ministers;
- ordinary church members;
- women;
- young people;
- elders;
- disabled people;
- non-churchgoing Tongans;
- people with different vaccination experiences;
- Tongan clinicians;
- community navigators;
- theologians; and
- regional and rural communities.

The project sample was predominantly male, middle-aged and church-affiliated. Future policy engagement should deliberately include groups less visible within formal leadership.

Kau 'i-talanoa is particularly relevant. Engagement processes must create room for voices that hierarchy, politeness or apparent consensus might otherwise suppress.

10.6 Support uncertainty, dialogue and informed decision-making

Public communication often treats uncertainty as a weakness. During a novel pandemic, uncertainty is unavoidable.

Trust is strengthened when agencies explain:

- what is known;

- what remains uncertain;
- how evidence was assessed;
- why recommendations have changed;
- what alternatives were considered;
- who made the decision;
- when the decision will be reviewed; and
- where questions can be raised safely.

Communication that presents temporary or evolving evidence as absolute certainty may produce short-term compliance but weaken longer-term trust when advice changes.

Tālanga should enable people to ask questions without being labelled:

- selfish;
- ignorant;
- irresponsible;
- anti-science;
- disobedient; or
- faithless.

Informed decision-making requires understandable explanation of benefits, risks, alternatives, uncertainty and consequences.

Where emergency restrictions narrow choice, that limitation should be named and justified. A constrained decision should not be described as ordinary voluntariness.

10.7 Shift from a deficit model to a relational model

A deficit model assumes that people hesitate because they lack information or cultural competence. The solution is then to provide more facts or improve translation.

The findings demonstrate that uncertainty may arise from:

- conflicting information;
- changing advice;
- previous institutional experiences;
- spiritual interpretation;
- family responsibility;

- employment pressure;
- reported health experiences;
- lack of post-intervention follow-up;
- political disagreement;
- digital misinformation; or
- fear of relational consequences.

A relational model asks:

- Who is trusted and why?
- What experiences shape the concern?
- What relationships are at stake?
- Is the person able to ask questions?
- What structural pressures affect the decision?
- How has the institution responded previously?
- What would responsible follow-up require?

The task is not simply to correct an individual. It is to improve the relationships and conditions through which care is delivered.

10.8 Measure trust and relational impact alongside behaviour

Coverage, attendance and compliance remain important health indicators, but they are incomplete.

Programmes should also measure:

- confidence in information;
- understanding of benefits and risks;
- ability to ask questions;
- experience of pressure;
- quality of consent;
- access to follow-up;
- experience of respect;
- exclusion or loss of belonging;

- changes in trust;
- family and employment effects;
- willingness to engage with future services; and
- need for relational repair.

Measures should be co-designed in Tongan and interpreted with communities. Quantitative indicators should be complemented by *tālanga*, interviews and community reflection.

Results should be reported back to participating communities and used to change practice.

Monitoring must not become surveillance of private religious belief.

10.9 Apply stronger safeguards to restrictive measures

The findings and the Royal Commission's Phase Two conclusions demonstrate the need for stronger safeguards around vaccination requirements and comparable emergency restrictions.

Before implementation, agencies should assess:

- the evidential threshold;
- necessity;
- proportionality;
- less restrictive alternatives;
- human-rights implications;
- equity;
- employment consequences;
- effects on worship and cultural participation;
- effects on families;
- likely impact on trust and social cohesion;
- exemptions and appeals; and
- exit criteria.

During implementation, agencies should monitor:

- whether the public-health objective is being achieved;
- whether the requirement remains necessary;
- job loss and income effects;

- access to alternative duties;
- differential effects across populations;
- use of exemptions;
- experiences of discrimination;
- family and church consequences; and
- changes in trust.

Requirements that are no longer necessary should be removed promptly.

After implementation, agencies should evaluate longer-term effects and support repair where avoidable harm occurred.

10.10 Provide visible post-vaccination follow-up

Vaccination programmes should include clear and accessible pathways for people who experience or fear adverse reactions.

Tongan-language information should explain:

- expected reactions;
- signs requiring medical attention;
- where care can be obtained;
- how causation is clinically assessed;
- how adverse events are reported;
- what support is available; and
- when follow-up will occur.

Participant-reported symptoms should be acknowledged and assessed respectfully. Listening to a concern does not establish that vaccination caused the experience. It is nevertheless an essential part of safe care.

Dismissal can weaken trust not only in vaccination but also in clinicians, public-health agencies and future interventions.

Post-intervention care should therefore be treated as part of the programme rather than an optional service after implementation.

10.11 Address misinformation through cultural and theological literacy

Misinformation responses should be timely, relational and specific.

Different forms of expertise are required:

- Tongan clinicians can explain medical evidence;
- theologians can address scriptural and moral claims;
- faith leaders can host trusted dialogue;
- youth can develop effective digital formats;
- community navigators can support access and follow-up;
- media practitioners can improve public communication; and
- community members can identify questions that official channels overlook.

Responses should distinguish among:

- deliberate deception;
- sincerely held misunderstanding;
- personal testimony;
- legitimate uncertainty;
- theological interpretation;
- criticism of policy; and
- unsupported medical claims.

Treating every dissenting claim as disinformation can deepen mistrust and close opportunities for dialogue.

Correction should explain not only that a claim is inaccurate but why it appears persuasive and how reliable evidence can be recognised.

10.12 Develop digital preparedness

Digital communication should be included in all Pacific health preparedness plans.

Preparedness should include:

- Tongan-language digital resources;
- authorised communication networks;
- church and community social-media policies;
- digital safeguarding;
- privacy guidance;
- source-checking tools;

- relationships with Pacific media;
- youth participation;
- diaspora engagement;
- telephone and non-digital alternatives;
- accessible formats; and
- rapid-response pathways for recurring misinformation.

Digital communication should be maintained throughout the year. Trust cannot be built by opening a social-media channel only when emergency compliance is required.

10.13 Strengthen the Pacific health and navigation workforce

The quality of engagement depends upon people who can work across clinical, cultural, spiritual and relational contexts.

Workforce development should include:

- Tongan doctors and nurses;
- public-health practitioners;
- mental-health professionals;
- community navigators;
- health promoters;
- interpreters;
- digital communicators;
- researchers;
- chaplains;
- theologians; and
- leaders with experience across church and health settings.

Community-navigation roles are especially important. Navigators can help people understand information, access services, communicate with clinicians, report concerns and maintain connection with family or church support.

Workforce investment must include regional communities rather than concentrate capability only in the largest cities.

10.14 Support faith leaders without turning them into clinicians

Faith leaders require public-health knowledge, ethical communication skills and referral pathways. They should not be expected to diagnose illness or provide specialised medical advice.

Appropriate leader development includes:

- public-health basics;
- interpretation of evidence;
- communication of uncertainty;
- mental-health first response;
- safeguarding;
- confidentiality;
- digital discernment;
- professional boundaries;
- referral;
- crisis theology; and
- leader self-care.

Health agencies should provide leaders with reliable contacts and timely access to clinical expertise.

Recognition of leaders as wellbeing partners must be matched by investment in their support.

10.15 Integrate relational repair into recovery planning

Recovery is not complete when infection falls, restrictions end or health services return to ordinary operation.

Participants described relationships that remained uncomfortable after mandates and vaccination conflicts. Some withdrew from leadership or changed churches. Others felt that no one acknowledged what had happened.

Future recovery plans should include:

- facilitated *tālanga*;
- acknowledgement of different experiences;
- pastoral and counselling support;
- reintegration into worship and community life;

- fair employment review;
- opportunities for institutions to explain decisions;
- acknowledgement of mistakes or avoidable harms;
- rebuilding of referral relationships; and
- long-term monitoring of trust and participation.

Relational repair does not require uniform agreement. It requires truthful listening, accountability and the restoration of belonging.

10.16 Apply the findings across Pacific health with care

The Lotu Factor Project is Tongan-specific. Its findings should not be transferred automatically to every Pacific community.

Other Pacific communities have distinct:

- languages;
- theological traditions;
- authority structures;
- migration histories;
- family systems;
- cultural practices; and
- relationships with health and government institutions.

The general principles—relational engagement, spiritual wellbeing, accountable leadership, transparent communication and cultural co-design—may be relevant across Pacific health. Their application must nevertheless be developed with each community rather than imposed as a uniform “Pacific model.”

Ethnic specificity is a condition of good Pacific health practice.

10.17 Required system shifts

The findings point towards the following changes:

Move from	Move towards
Translation after policy is decided	Tongan-led co-design from the beginning
Churches as message-distribution channels	Churches as reciprocal wellbeing partners
One “trusted messenger”	Multiple accountable leaders and community voices

Uptake and compliance as the principal measures of success	Coverage, equity, trust, decision quality, belonging and follow-up
Hesitancy treated as an information deficit	Uncertainty understood relationally and contextually
Facts separated from spiritual and moral meaning	Clinical evidence joined with cultural and theological literacy
Emergency-only community contact	Permanent relationships and year-round preparedness
Uncertainty concealed to create confidence	Transparent communication about evidence and change
Compliance described as voluntary regardless of consequences	Honest recognition of constrained choice
Churches assumed to be internally homogeneous	Recognition of hierarchy, diversity and safeguarding responsibilities
Crisis recovery measured through service restoration	Recovery that includes trust, reintegration and relational repair
Digital communication as broadcasting	Cultivation of a trustworthy and safeguarded digital <i>vā</i>

10.18 Implications for key sectors

Government and public-health agencies

Government should embed faith, cultural and relational impact within preparedness, policy assessment, monitoring and review.

Health New Zealand and Pacific providers

Health services should develop permanent Tongan engagement capability, accessible follow-up pathways and measures of trust and relational experience.

Churches and denominations

Churches should strengthen safeguarding, ethical communication, leader formation, referral relationships and inclusion across disagreement.

Employers

Employers should assess household and relational consequences when implementing emergency requirements and provide fair alternatives, review and reinstatement processes.

Theological colleges

Theological education should prepare leaders for public-health crises, misinformation, mental-health referral, professional boundaries and responsible scriptural interpretation.

Researchers and funders

Research investment should support Tongan-led longitudinal, implementation and digital studies governed through community partnership.

Digital platforms and media

Platforms and media organisations should improve Pacific-language moderation, access to credible Pacific content and support for community digital literacy.

10.19 Conclusion

The strongest implication of the Lotu Factor Project is that effective Pacific public health must move beyond information delivery.

Tongan communities interpret health through relationships, faith, leadership, work, family, institutions and digital networks. Policy that ignores these dimensions may achieve short-term behavioural outcomes while weakening trust and belonging.

Future practice should therefore be:

- Tongan-led;
- relational;
- spiritually informed;
- evidence-based;
- transparent;
- professionally bounded;
- digitally capable;
- equitable; and
- prepared to repair harm.

This approach does not give religious authority control over public-health evidence. Nor does it give public institutions authority to treat faith as a problem to be managed. It creates a framework of mutual accountability directed towards the wellbeing of people and communities.

11. Recommendations

Key message

The Lotu Factor Project demonstrates that effective Pacific health policy cannot treat faith, culture, family relationships and community leadership as secondary considerations. These are central influences on how health information is interpreted, whether professional advice is trusted, how decisions are made and whether relationships survive a crisis.

The following twelve recommendations provide a three-year programme for strengthening preparedness, trust, accountability and social cohesion. They align with the Royal Commission's emphasis on sustained community relationships, transparent decision-making, systematic monitoring, rights protections and long-term recovery.

Implementation should be guided by seven principles:

- establish relationships before an emergency;
- recognise the diversity within Tongan and Pacific communities;
- involve communities in governance and co-design, not only message delivery;
- communicate evidence, uncertainty and changing advice transparently;
- protect informed consent, human rights and social belonging;
- combine spiritual and cultural capability with professional boundaries; and
- evaluate trust, agency and relational wellbeing alongside clinical or coverage outcomes.

The recommendations are interconnected. Communication will not succeed without trusted relationships; faith-leader education will not be sufficient without accountability; and high vaccination coverage will not represent successful engagement if it is accompanied by coercion, exclusion or enduring distrust.

Recommendation 1: Establish permanent faith–health partnerships

Health New Zealand, Pacific health providers, churches and Tongan community organisations should establish permanent regional faith–health partnership groups before the next public-health emergency.

Membership should reflect the diversity of the communities being served. It should include:

- Tongan clinicians and public-health professionals;
- denominational and local church leaders;
- Pacific health and social-service providers;
- women and youth representatives;
- disabled people and disability advocates;
- community navigators and interpreters;
- regional and diaspora representatives; and
- people with varied experiences of church participation and health services.

These groups should meet throughout the year rather than being activated only when health agencies need access to congregations. Their responsibilities should include preparedness planning, community consultation, communication co-design, referral pathways, translation priorities, misinformation response and assessment of relational effects.

In the first twelve months, priority regions should establish terms of reference, membership processes, contact pathways and a regular meeting schedule. Within three years, each

partnership should have completed at least one preparedness exercise and developed a shared annual work programme.

Success should be measured by the existence and continuity of active regional groups, the diversity of their membership, documented preparedness activities and evidence that community advice has influenced decisions.

Recommendation 2: Fund faith-leader health and crisis-literacy development

Denominations, theological colleges, Pacific health educators and community providers should jointly develop funded health and crisis-literacy education for ministers and other influential faith leaders.

Core areas should include:

- public-health principles and emergency preparedness;
- ethical health communication;
- interpreting evidence and communicating uncertainty;
- mental-health first response;
- digital and media literacy;
- misinformation and disinformation;
- confidentiality and safeguarding;
- professional limits and conflicts of interest;
- referral to qualified health and social services; and
- the wellbeing and support needs of faith leaders themselves.

The aim is not to turn ministers into clinicians. It is to help leaders identify the limits of their expertise, locate reliable advice, distinguish pastoral guidance from medical advice and refer people safely. Training must also acknowledge that ministers may experience intense pressure during emergencies and require peer support, supervision and respite.

A core module and leader-support pathway should be co-designed during the first year. Over the following two years, the programme should be incorporated into theological formation, ordination preparation and continuing ministry education.

Indicators should include the number and diversity of leaders trained, participants' confidence in identifying reliable information and making referrals, use of referral pathways and feedback on leader wellbeing.

Recommendation 3: Strengthen accountable theological interpretation

Churches, theologians and denominational governance bodies should develop culturally grounded resources and facilitated tālanga on the interpretation of scripture during health and social crises.

Theological reflection should address subjects that became particularly significant during the COVID-19 response, including:

- divine protection and human responsibility;
- prayer, healing and professional healthcare;
- suffering and illness;
- apocalyptic language and end-times claims;
- individual conscience and collective responsibility;
- neighbour-love and protection of vulnerable people;
- obedience, authority and legitimate questioning; and
- the relationship between spiritual confidence and uncertainty.

Theological diversity should be protected. However, diversity does not remove the need for accountability when spiritual authority is used to present unverified medical claims, suppress questions or expose individuals and communities to avoidable harm.

Denominations should maintain clear and safe processes through which members can raise concerns about public-health claims made from positions of spiritual authority. Review processes should distinguish good-faith theological disagreement from conduct that breaches safeguarding, confidentiality or professional-boundary expectations.

Initial resources and facilitated tālanga should be developed within twelve months. Longer-term work should embed theological reflection, peer review and complaints processes within denominational practice.

Progress should be assessed through the use of resources, participation in tālanga, evidence that difficult questions are being addressed openly and the accessibility and effectiveness of complaints or review pathways.

Recommendation 4: Make health communication Tongan-led and transparent

Public-health communication intended for Tongan communities should be co-designed in Tongan from the beginning. Translation after a strategy has already been determined is not equivalent to cultural co-design.

Communication should:

- identify the source of the information;

- explain the evidence supporting the advice;
- distinguish established knowledge from emerging or uncertain evidence;
- state clearly why advice or policy has changed;
- use accessible Tongan and English;
- provide opportunities for confidential questions;
- acknowledge concerns without ridicule;
- explain available choices, exemptions and support; and
- connect people with qualified health professionals when individual advice is required.

Trusted communication should come from a network rather than a single spokesperson. Appropriate messengers may include Tongan doctors, nurses, pharmacists, public-health practitioners, community workers, theologians, ministers, women, youth and people with relevant lived experience. No individual leader should be assumed to speak for all Tongan people.

During the first year, public-health agencies should establish a Tongan communication co-design panel and agree on standards for sourcing, translation, review and release. Over the following two years, this should develop into a year-round Tongan health-communication platform rather than a temporary emergency service.

Indicators should include the speed with which accurate information becomes available in Tongan, community comprehension, reach across different groups and measures of trust in both the message and the messenger.

Recommendation 5: Place safeguards around mandates and restrictive measures

Vaccination requirements and comparable public-health restrictions should be subject to explicit human-rights, equity and relational safeguards.

Before introducing a restrictive measure, government and responsible agencies should:

- clearly state the public-health objective;
- explain the evidence threshold used to justify the measure;
- assess likely effects on employment, income, families, worship, education and social participation;
- examine differential effects on Pacific and other disproportionately affected communities;
- consider the least-restrictive effective alternatives;
- provide workable exemption and accommodation processes;
- consult affected communities through relationships established before the crisis;

- publish review dates and exit criteria;
- establish accessible appeal processes; and
- fund measures to reduce foreseeable harm.

Monitoring should continue throughout implementation. It should assess not only compliance and coverage but also employment consequences, family conflict, exclusion from worship or community life, experiences of pressure and changes in trust.

Restrictive measures should end promptly when they no longer meet the stated evidence threshold. Their removal should not depend solely on administrative convenience.

In the first year, rights, equity, faith-setting and relational-impact assessments should be added to emergency decision templates. Within three years, these safeguards should be tested through preparedness exercises, and monitoring results should be reported publicly.

Progress indicators should include evidence that alternatives were considered, review dates were met, exemptions and appeals were accessible, and social and relational effects were documented alongside health outcomes.

Recommendation 6: Measure trust, consent quality and belonging

Health agencies should not rely on vaccination or service-uptake rates as complete measures of successful engagement.

High uptake can occur alongside fear, employment pressure, unresolved questions or relational exclusion. Evaluation should therefore include:

- trust in health services and decision-makers;
- understanding of the information provided;
- perceived freedom to ask questions;
- quality of informed consent;
- experience of pressure or coercion;
- confidence in future health advice;
- sense of cultural and spiritual respect;
- family and community belonging; and
- experiences of relational harm or repair.

Measures should be co-designed with Tongan communities, available in Tongan and suitable for confidential use. Results should be returned to participating communities and used to change policy and practice.

A short Tongan evaluation tool should be developed and piloted during the first year. Within three years, measures of trust, agency and belonging should be included in major Pacific health programmes and emergency-response evaluations.

Success will be evident when trust and consent-quality indicators are routinely reported alongside coverage, access and clinical outcomes.

Recommendation 7: Provide visible post-vaccination follow-up

Vaccination programmes should include clear and accessible post-vaccination follow-up rather than treating administration of the vaccine as the end of the encounter.

People should receive Tongan-language information explaining:

- common and expected reactions;
- symptoms requiring medical attention;
- where and how to obtain advice;
- how adverse events are assessed and reported;
- what clinical and practical support is available; and
- how concerns will be followed up.

Participant-reported health concerns should be heard respectfully and assessed appropriately. Acknowledging a person's experience does not require making an unsupported conclusion about clinical causation. Conversely, uncertainty about causation should not be used to dismiss or ridicule the person reporting the concern.

Follow-up should be accessible through Pacific health providers, primary care, pharmacies, immunisation services and community outreach. Navigation support should be available for people who face language, transport, cost or digital barriers.

Tongan follow-up and adverse-event reporting pathways should be published during the first year. Over the following two years, services should audit access, response times, resolution of concerns and patient experience.

Indicators should include follow-up uptake, time taken to respond, the proportion of questions or referrals resolved and patient-reported experiences of respect and safety.

Recommendation 8: Resource relational repair and recovery

Pandemic recovery planning should include explicit provision for relational and social repair.

Churches, community organisations, employers, health providers and government agencies should identify settings in which pandemic decisions produced continuing conflict, exclusion, mistrust or disengagement. Responses may include:

- facilitated community tālanga;

- pastoral care and counselling;
- culturally appropriate mental-health support;
- acknowledgement of harm;
- review of exclusionary practices;
- reintegration of members;
- restorative processes; and
- renewed agreements about communication and decision-making.

Repair should not require people to abandon their understanding of past events or accept a single official interpretation. Its purpose is to create conditions for truthful listening, accountability, restored participation and the rebuilding of relationships.

Communities should determine where and when facilitated repair is needed. Early work should begin wherever unresolved harm has already been identified rather than waiting for another emergency. Over three years, relational-recovery processes should be incorporated into emergency preparedness and organisational review.

Indicators may include participation in repair processes, renewed engagement with churches or health services, resolution of identified concerns and qualitative evidence of restored trust and belonging.

Recommendation 9: Build a Tongan digital-health network

Pacific health providers, churches, media organisations, youth leaders and digital communicators should establish a standing Tongan digital-health network.

The network should include Tongan clinicians, theologians, public-health practitioners, community communicators, youth content creators and diaspora leaders. Its responsibilities should include:

- rapid verification of emerging claims;
- identification of recurring community questions;
- short-form Tongan health content;
- proactive or “prebunking” resources;
- live digital tālanga;
- referral to qualified services;
- coordination across Aotearoa, Tonga and diaspora communities; and
- monitoring of information gaps without surveillance of individuals.

Responses should be culturally and theologically informed. Medical claims may require clinical explanation, while scriptural or moral claims may also require engagement from theologians and trusted faith leaders.

Digital practice should protect privacy and avoid publicly naming, humiliating or shaming people who share inaccurate information. Responses should distinguish deliberate deception from misunderstanding, uncertainty, policy criticism and sincerely held belief.

During the first year, the network should be established and produce a priority map of recurring questions, myths and information gaps. Over the next two years, it should maintain regular content, live sessions, rapid-response protocols and diaspora coordination.

Indicators should include response time, reach through trusted channels, community engagement and a reduction in repeated confusion about priority health issues.

Recommendation 10: Strengthen church safeguarding and professional boundaries

Denominations and local churches should adopt or update policies addressing:

- confidentiality;
- collection and use of health information;
- social-media conduct;
- conflicts of interest;
- public-health and medical claims;
- referral to professional services;
- complaints and appeals; and
- protection from retaliation.

Leaders should clearly distinguish personal views from denominational positions and professional health advice. Medical claims should not be presented as authoritative consequences of spiritual office.

Churches should establish ongoing relationships with qualified health and mental-health professionals and maintain clear referral procedures for urgent or complex concerns. Safeguarding processes must be accessible to women, young people, disabled people and others who may face barriers when raising concerns about influential leaders.

Policy reviews should begin during the first year. Within three years, denominations should audit implementation and include safeguarding and boundary education in continuing formation.

Indicators should include the adoption of current policies, the number of leaders trained, use of professional referral pathways and evidence that complaints can be raised and resolved safely.

Recommendation 11: Grow the Tongan and Pacific health-navigation workforce

Government, tertiary providers and health organisations should make sustained investments in the Tongan and Pacific health workforce.

Priority roles include:

- doctors, nurses, pharmacists and allied-health practitioners;
- public-health specialists;
- mental-health professionals;
- researchers and evaluators;
- interpreters and translators;
- community health workers; and
- cultural and health navigators.

Community navigation should be treated as skilled work and funded accordingly. Cultural knowledge, language capability, trust-building and relational labour should not be expected as unpaid additions to a person's formal role.

Workforce planning should include communities outside the main metropolitan centres. Sustainable employment is preferable to short-term crisis contracts that disappear once immediate targets have been met.

During the first year, agencies should map workforce and regional-service gaps and fund priority community-navigation positions. Over three years, government, tertiary institutions and employers should develop scholarships, supervised career pathways, leadership development and permanent regional roles.

Progress should be measured through workforce growth, retention, regional coverage, language capability and the stability of funded positions.

Recommendation 12: Fund longitudinal and implementation research

Future research should examine how trust, faith participation, vaccination attitudes, family relationships and health behaviour change over time.

Research should include groups whose experiences may not be fully represented in church-centred or general community studies, including:

- young people;
- women;
- non-churchgoing Tongans;
- Rainbow+ communities;

- disabled people;
- people living outside major urban centres;
- members of smaller denominations; and
- people from non-Christian religious traditions.

Comparative Pacific research is valuable, but it must preserve ethnic, linguistic, denominational and historical specificity. Pacific communities should not be treated as interchangeable.

Implementation research should examine whether faith–health partnerships, communication models, theological resources, safeguarding processes and relational-repair approaches improve trust and health practice. The Lotu Factor Reflection Grid and related toolkits should be piloted, evaluated and revised with communities. They should not be treated as validated or finished instruments before this work is completed.

A community-governed research programme should be developed during the first year. Longitudinal and implementation studies should then continue across the three-year period.

Indicators should include funded studies, meaningful community governance, inclusion of underrepresented groups, transparent reporting and demonstrated changes to policy or practice.

11.1 Three-year implementation framework

Recommendation	Lead sectors	Immediate action: 0–12 months	Consolidation: 1–3 years	Primary indicators
1. Faith–health partnerships	Health New Zealand; Pacific providers; churches; community organisations	Establish regional groups, terms of reference and contact pathways	Conduct annual preparedness exercises and maintain shared work programmes	Active groups, diverse membership and documented actions
2. Faith-leader development	Denominations; theological colleges; health educators	Co-design a core training module and leader-support pathway	Embed training in formation and continuing ministry	Leaders trained, referral confidence and wellbeing feedback
3. Accountable theology	Churches; theologians; denominational governance	Produce crisis-interpretation resources and facilitate tālanga	Maintain theological review and accountability processes	Resource use, questions addressed and accessible complaints pathways
4. Tongan-led communication	Public-health agencies; Pacific media; clinicians	Establish a co-design panel and communication standards	Maintain a year-round Tongan communication platform	Release time, comprehension, trust and reach
5. Safeguards for restrictions	Government; legal and public-health agencies	Add rights, equity, faith-setting and relational impacts to decision templates	Test review and exit systems and publish monitoring results	Alternatives considered, review dates met and effects reported

6. Trust and belonging measures	Health New Zealand; evaluators; communities	Develop and pilot a short Tongan evaluation tool	Include measures in major Pacific programmes	Trust, agency and belonging reported alongside uptake
7. Post-vaccination follow-up	Immunisation services; primary care; Pacific providers	Publish Tongan pathways for reactions, care and adverse-event reporting	Audit access, response time and patient experience	Follow-up uptake, resolved queries and reported respect
8. Relational repair	Churches; employers; community and mental-health providers	Identify affected settings and offer facilitated tālānga	Integrate relational recovery into emergency planning	Participation, restored engagement and qualitative repair outcomes
9. Digital-health network	Pacific providers; churches; media; youth and digital platforms	Establish the network and map priority questions	Maintain proactive content, live sessions and diaspora coordination	Response time, trusted reach and reduced recurring confusion
10. Church safeguarding	Denominations; local churches; theological colleges	Review confidentiality, social-media, complaints and referral policies	Audit practice and provide refresher formation	Policies adopted, leaders trained and complaints resolved safely
11. Workforce development	Government; tertiary providers; health employers	Map gaps and fund community-navigation roles	Establish scholarships, career pathways and regional positions	Retention, workforce growth and regional coverage
12. Longitudinal research	HRC; universities; CARE; communities	Develop a co-designed research programme	Evaluate tools and compare groups while preserving specificity	Funded studies, community governance and demonstrated practice changes

11.2 Priority sequence

Implementation should begin with relationships and core infrastructure.

During the first twelve months, priority should be given to:

1. establishing permanent faith–health partnerships;
2. developing faith-leader education and support;
3. creating Tongan-led communication systems;
4. strengthening post-vaccination follow-up;
5. establishing the Tongan digital-health network; and
6. reviewing church safeguarding and professional boundaries.

Safeguards for mandates and restrictive measures, together with measures of trust, consent quality and belonging, should be incorporated into national preparedness work during the same period.

Relational-repair processes should begin wherever communities identify an existing need. They should not be postponed until another public-health emergency.

Workforce development and longitudinal research require sustained investment across all three years. These longer-term commitments are essential because short-term projects cannot by themselves create the professional capability, evidence base or durable relationships required for equitable emergency response.

11.3 Accountability for implementation

Implementation should be overseen jointly by health-sector and community partners. Participating agencies should publish annual progress against the framework while ensuring that communities receive findings in accessible Tongan and English formats.

Accountability should consider not only whether an activity occurred, but also whether it:

- included the people most affected;
- changed a decision or practice;
- increased access to reliable advice;
- strengthened informed agency;
- reduced avoidable exclusion;
- protected cultural and spiritual dignity; and
- improved trust, belonging and preparedness.

The central test is whether Pacific communities enter the next health emergency with stronger relationships, clearer safeguards, more credible information pathways and greater confidence that their health, faith, dignity and collective wellbeing will be respected.

12. Practical Project Outputs

Key message

The Lotu Factor Project was designed not only to produce research findings, but also to translate those findings into practical resources for communities, churches, health providers, policymakers and researchers. Its output portfolio therefore combines scholarly analysis, public communication, professional guidance, theological education and tools for structured community reflection.

At the date of this report, the project has completed its core research report and conceptual framework. Other resources are either prepared, in final production, or awaiting piloting and implementation evaluation. These distinctions are important: a resource that has been developed conceptually should not be described as validated until it has been tested with intended users.

12.1 Project output portfolio

Output	Purpose and intended users	Status at report date
Final research report	Integrates the project evidence for the Health Research Council, Tongan and Pacific communities, churches, health providers, policymakers and researchers	Completed for final review and publication
Standard and online report editions	Provide an editable standard edition, searchable PDF and accessible web-based publication	Completed as part of the final report package
Lotu Factor conceptual framework	Explains how faith and religiosity may contribute to protective, ambiguous or risk-producing health pathways depending on leadership, interpretation, relationships and context	Completed; further implementation evaluation recommended
Lotu Factor Reflection Grid and RAG refinement	Supports structured, non-clinical reflection and tālanga between churches, health professionals and communities	Developed; piloting, refinement and validation required
Health-worker toolkit	Provides practical guidance for health professionals engaging Tongan and Pacific faith communities	In final production for dissemination
Faith-leader toolkit and education resources	Supports health literacy, ethical leadership, pastoral response, professional boundaries and referral	In final production for dissemination
Scripture-in-crisis guide	Promotes responsible engagement with scripture during health and social emergencies	Prepared as a project resource
Digital-health framework	Sets out seven principles for culturally and theologically informed digital-health engagement	Conceptually completed; implementation partnerships required
Policy brief	Presents concise findings and recommendations for government agencies, health-sector leaders and decision-makers	In final production
Project website and online resources	Provide public access to findings, summaries, tools, updates and downloadable resources	In final production for public launch
Academic manuscripts	Develop the project's analyses of wellbeing, vaccination, mandates, church leadership, social media and the integrated Lotu Factor	In preparation and scholarly review

12.2 Final research report

The final research report is the project's principal evidence document. It brings together the research context, conceptual framework, methodology, participant experiences, thematic findings, integrated interpretation, policy implications and recommendations.

Its primary audiences include:

- Tongan and wider Pacific communities;
- churches and denominational leaders;
- health and social-service providers;
- public-health agencies;
- policymakers and government advisers;
- theological educators;
- researchers and students; and
- organisations responsible for emergency preparedness and community recovery.

The report deliberately preserves the complexity of the findings. It does not present faith as inherently protective or inherently harmful. Instead, it shows that the effects of lotu are mediated through interpretation, leadership, relationships, institutional conduct, communication and the wider social environment.

Participant quotations are included throughout the findings sections to preserve the force and texture of lived experience. Quotations are anonymised and used selectively so that participants' words illuminate the analysis without making individuals identifiable.

The report also maintains clear evidential boundaries. Participant-reported experiences are treated seriously, but clinical causation is not inferred where it was not established. Likewise, the qualitative findings identify patterns and mechanisms rather than estimating prevalence across the entire Tongan population.

12.3 Standard and online editions

The report is intended for publication in complementary standard and online formats.

The standard edition provides a stable, professionally structured version suitable for:

- formal submission to the Health Research Council;
- printing and institutional distribution;
- use by libraries and research organisations;
- citation in academic and policy publications; and
- distribution at project dissemination events.

The online edition is designed to increase access beyond institutional audiences. It should enable readers to navigate directly to major findings, recommendations and practical resources without having to read the report sequentially.

The online publication should include:

- a searchable full-text report;

- clear and consistent heading structures;
- a downloadable PDF;
- concise summaries of major findings;
- accessible tables and visual representations;
- downloadable project tools as they are finalised;
- Tongan-language content where available;
- publication and version dates; and
- contact information for feedback and implementation enquiries.

The online report should remain faithful to the full evidence while using shorter summaries, highlighted findings and clear navigation for readers seeking practical guidance.

12.4 Lotu Factor conceptual framework

The Lotu Factor conceptual framework is one of the project's principal intellectual and practical contributions. It explains why the relationship between faith and health cannot be reduced to a simple opposition between religion and medicine.

The framework identifies a mediated process in which religious beliefs and practices interact with:

- theological interpretation;
- leadership conduct;
- family and community relationships;
- professional health advice;
- institutional trust;
- digital communication;
- experiences of pressure or exclusion; and
- wider cultural, economic and political conditions.

Through these mediating influences, lotu may support resilience, hope, connection, care and health-promoting behaviour. Under other conditions, it may contribute to fear, misinformation, delayed care, coercion, silence or relational harm.

The framework is not a diagnostic instrument. It should not be used to classify a person, church or denomination as healthy, unhealthy or delusional. Its proper purpose is to support careful reflection on the conditions through which faith influences health decisions and wellbeing.

Further evaluation should examine whether the framework improves communication, professional practice, church decision-making and preparedness when used in real settings.

12.5 Lotu Factor Reflection Grid and RAG refinement

The Lotu Factor Reflection Grid translates the conceptual framework into a structured process for tālānga. It is intended to help churches, community organisations and health partners identify protective factors, areas of uncertainty and potential risks.

The grid may be used to explore questions such as:

- Is reliable health information available in the language people understand best?
- Are community members able to ask questions without shame or retaliation?
- Are spiritual and medical claims clearly distinguished?
- Are leaders working within appropriate professional boundaries?
- Are women, young people, disabled people and minority voices included?
- Are referral pathways visible and trusted?
- Could a proposed action damage family, church or community relationships?
- How will concerns, complaints or adverse experiences be addressed?
- What support will be available after the immediate crisis?

The tool is non-clinical and non-diagnostic. It is designed to facilitate conversation, not to assess individual mental health, determine the validity of a person's faith or assign permanent labels to congregations.

Before wider adoption, the Reflection Grid and associated RAG approach should be piloted with churches, Pacific health providers, community organisations and intended facilitators. Evaluation should examine cultural acceptability, clarity, safety, usefulness and the risk of unintended labelling.

12.6 Health-worker toolkit

The health-worker toolkit translates the findings into practical guidance for clinicians, public-health professionals, community health workers and service managers engaging Pacific faith communities.

The toolkit should help health workers to:

- understand the significance of lotu in Tongan wellbeing;
- recognise diversity within churches and Tongan communities;
- build relationships with faith leaders before emergencies;
- communicate evidence and uncertainty respectfully;

- respond to spiritual or theological concerns without ridicule;
- distinguish misinformation from legitimate questions or policy criticism;
- identify appropriate cultural, theological and clinical partners;
- support informed consent and confidential decision-making;
- address post-vaccination or post-treatment concerns visibly; and
- recognise and respond to relational harm.

The toolkit should reinforce that cultural capability is not achieved by using a church leader solely as a messenger. Effective engagement requires listening, reciprocal relationships, accountability and recognition of the limits of any single representative.

The resource is in final production and should be reviewed by health professionals and community representatives before formal release.

12.7 Faith-leader toolkit and education resources

The faith-leader toolkit is intended for ministers, lay leaders, theological colleges and denominational authorities. It provides guidance on responsible leadership at the intersection of faith, health and community wellbeing.

Its core areas include:

- health and crisis literacy;
- ethical communication;
- use of scripture during emergencies;
- communicating uncertainty;
- confidentiality and safeguarding;
- professional boundaries;
- responsible social-media practice;
- mental-health first response;
- referral to qualified services;
- complaints and accountability; and
- support for leader wellbeing.

The toolkit affirms the legitimate pastoral and theological role of church leaders while making clear that spiritual office does not confer medical expertise. It encourages leaders to collaborate with qualified professionals, disclose the limits of their knowledge and create space for questions and conscientious decision-making.

The toolkit and its associated education resources are in final production. They should subsequently be incorporated into ministerial formation, continuing education and denominational preparedness programmes.

12.8 Scripture-in-crisis guide

The Scripture-in-crisis guide responds to the project's finding that biblical interpretation can shape health attitudes, emotional responses and community behaviour during emergencies.

The guide promotes interpretation that is:

- attentive to literary and historical context;
- theologically responsible;
- life-affirming;
- open to questions;
- aware of the effects of unequal authority;
- respectful of professional knowledge; and
- accountable for its consequences in the lives of individuals and communities.

It addresses themes such as divine protection, healing, suffering, fear, obedience, conscience, neighbour-love and the relationship between prayer and medical treatment.

The guide does not prescribe a single theological position. Rather, it provides questions and principles for evaluating how scripture is being used and whether an interpretation promotes care, truthfulness, agency and collective wellbeing.

12.9 Digital-health framework

The digital-health framework responds to the central role of social media in circulating health information, testimony, theological claims, uncertainty and misinformation.

The framework proposes seven principles for digital engagement:

1. Be culturally grounded: communicate in culturally meaningful forms and languages.
2. Be theologically informed: address religious claims with appropriate theological as well as clinical knowledge.
3. Be evidence-based: identify sources and distinguish established evidence from uncertainty.
4. Be relational: create opportunities for dialogue rather than relying only on corrective announcements.
5. Be timely: respond before confusion becomes entrenched.

6. Protect dignity and privacy: avoid public shaming, exposure or surveillance of individuals.
7. Provide pathways to care: connect digital communication with qualified advice and practical support.

The framework has been completed conceptually. Its implementation requires partnerships among Tongan clinicians, theologians, Pacific health providers, media organisations, churches, youth creators and diaspora communities.

12.10 Policy brief

The policy brief provides a concise account of the project's central findings and recommendations for decision-makers who may not read the full report.

It should emphasise that:

- faith communities are part of Pacific wellbeing infrastructure;
- engagement must begin before a crisis;
- church leaders can be influential partners but should not be treated as sole representatives;
- vaccination uptake does not by itself demonstrate trust or freely given consent;
- mandate decisions require rights, equity and relational safeguards;
- health communication should be Tongan-led and transparent;
- post-vaccination follow-up is essential to durable trust;
- digital misinformation requires cultural and theological literacy; and
- recovery planning must include relational repair and social cohesion.

The policy brief is in final production and should be distributed to relevant government agencies, health-sector leaders, Pacific providers, churches and community organisations.

12.11 Website and public resources

The project website will serve as the principal public platform for accessing the report and related resources.

The website should provide:

- the full report and executive summary;
- accessible summaries of each major finding;
- the Lotu Factor conceptual framework;
- recommendations for health agencies and churches;

- downloadable tools as they are finalised;
- information about the research team and methodology;
- publication and dissemination updates;
- links to academic outputs;
- clear explanations of the limits of the research; and
- a mechanism for community feedback.

Online resources should distinguish carefully between completed, draft, pilot and validated materials. Older versions should be dated or archived so users can identify the most current resource.

The website and associated online resources are in final production for public launch.

12.12 Academic publications

The project's academic publication programme develops the major thematic analyses in greater depth.

Manuscripts are being prepared or reviewed in the following areas:

- faith, lotu and holistic wellbeing;
- attitudes towards vaccination;
- mandates, constrained choice and relational harm;
- church leadership and accountability;
- faith, COVID-19 and social media; and
- the integrated Lotu Factor framework.

Academic publication will allow the project's findings to contribute to Pacific health research, religious studies, theology, public health, community psychology, digital communication and emergency-policy scholarship.

Publications should preserve the project's methodological and ethical commitments, including ethnic specificity, contextual interpretation, careful use of participant quotations and avoidance of unsupported prevalence or causation claims.

12.13 From research outputs to practical impact

The outputs form an integrated pathway from research evidence to community and policy application:

1. The final report establishes the evidence base.
2. The conceptual framework explains the relationships identified in the evidence.

3. The Reflection Grid translates the framework into structured tālanga.
4. The health-worker and faith-leader toolkits support changes in professional and pastoral practice.
5. The Scripture-in-crisis guide strengthens responsible theological interpretation.
6. The digital-health framework guides communication in online environments.
7. The policy brief translates the recommendations for decision-makers.
8. The website makes findings and resources publicly accessible.
9. Academic publications extend scholarly analysis and support further research.

Producing a resource is not, by itself, evidence of impact. The next stage should therefore assess whether intended users can access, understand and apply each resource and whether its use leads to changes in relationships, communication, preparedness, trust or practice.

12.14 Status, piloting and version control

Only outputs explicitly identified as completed should be represented as final project deliverables. Materials described as being in production, prepared for release or developed for piloting should retain those status labels until the relevant review process has been completed.

The following quality-assurance process is recommended for applied resources:

- review by Tongan community representatives;
- review by relevant health or theological professionals;
- safeguarding and ethical review;
- accessibility and language review;
- small-scale piloting with intended users;
- collection of structured feedback;
- revision and approval;
- publication with a version number and date; and
- scheduled review after implementation.

This approach protects the credibility of the project and ensures that its tools remain responsive to community experience. The Lotu Factor portfolio should therefore be understood as a living body of work: grounded in completed research, translated into practical resources and strengthened over time through partnership, testing and reflection.

Part IV: Delivery, Impact and Accountability

13. Project Delivery Against HRC Objectives

Key message

The Lotu Factor Project has delivered all four contracted research objectives within the scope of a qualitative Pacific health study. It completed the literature review, ethics process, community-based data collection, Tongan-language analysis, conceptual development, response framework and integrated final report.

The project also exceeded the initially anticipated reach of its data collection, engaging 155 participants across Aotearoa New Zealand. Some dissemination, academic publication and implementation activities remain underway at the date of this report. These activities extend the project's impact; they do not represent incomplete core research objectives.

The most important conceptual variation was the refinement of the project's public terminology. The original language of "delusional religiosity" was replaced in the public analysis by the non-clinical Tongan concept of *lotu noa*. This change strengthened cultural, theological and ethical precision while retaining the project's focus on forms of religious interpretation and authority that may contribute to health risk or harm.

13.1 Delivery against contracted objectives

Objective	Activities completed	Principal evidence and outputs	Delivery status
1. Explore the impact of harmful religiosity on attitudes towards professional health advice	Literature review; qualitative research with 155 participants; analysis of vaccination attitudes, leadership, theological interpretation and digital communication	Sections 2, 5, 7 and 8; Lotu Factor framework; associated manuscripts	Completed. Public terminology refined from "delusional religiosity" to the non-clinical concept of <i>lotu noa</i> .
2. Examine the effects of harmful religiosity on wellbeing and understandings of wellbeing	Tongan-language interviews and group tālanga; analysis of spiritual, emotional, physical, relational and communal wellbeing	Sections 4 and 9; faith, lotu and wellbeing analysis; integrated conceptual framework	Completed. Findings demonstrate that faith may contribute to protective or harmful outcomes depending on interpretation, authority and relationships.
3. Improve understanding of associated health risks	Analysis of misinformation, contested or delayed care, constrained choice, exclusion, mandate effects, digital amplification and leadership boundaries	Sections 5–9; policy implications and recommendations	Completed within qualitative scope. The study identifies mechanisms and experiences but does not make population-prevalence or clinical-causation claims.

4. Develop a life-affirming response framework	Collective analysis; symposium reflection; development of the Lotu Factor model, Reflection Grid, toolkits and recommendations	Sections 9–12; practical resources and appendices	Completed at the research-development stage. The framework is applied and non-diagnostic; piloting and implementation evaluation remain necessary.
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13.2 Objective 1: Religiosity and attitudes towards professional health advice

The first objective examined how religious beliefs, interpretations and authority influenced attitudes towards professional health advice during the COVID-19 pandemic.

The project completed this objective through:

- a multidisciplinary literature review;
- 17 individual interviews;
- group tālanga involving 138 participants;
- analysis of vaccination attitudes and decision-making;
- examination of the role of ministers and other church leaders;
- analysis of theological claims concerning protection, healing, fear and conscience; and
- investigation of social-media communication and misinformation.

The findings show that religious commitment did not produce a single or predictable attitude towards health advice. Many participants understood vaccination, professional care and public-health measures as compatible with faith. Prayer and medical treatment were often treated as complementary rather than competing responses.

Risk emerged when religious claims were communicated as unquestionable, when spiritual authority displaced qualified health advice, or when people were discouraged from raising concerns. The findings therefore shift the analysis from whether a person is religious to how religious meaning is interpreted, communicated and enacted.

The refinement from “delusional religiosity” to *lotu noa* was a substantive outcome of this investigation. The original term risked importing a clinical judgement into a study that did not diagnose participants or assess psychiatric conditions. It could also have been interpreted as labelling Tongan faith itself as irrational.

In this report, *lotu noa* is used cautiously to describe potentially harmful patterns in which religious claims become detached from responsible interpretation, evidence, accountability and care for consequences. It is not a label for a person, congregation, denomination, theological disagreement or vaccine hesitancy.

This refinement enabled the project to fulfil the original objective while avoiding unnecessary pathologisation of faith and Pacific communities.

13.3 Objective 2: Lotu and holistic wellbeing

The second objective examined how religiosity affected wellbeing and how Tongan participants understood wellbeing itself.

The study found that wellbeing was not generally described as an individual, psychological or biomedical condition alone. Participants' accounts connected wellbeing with:

- relationship with God;
- prayer, worship and scripture;
- family relationships;
- church membership and participation;
- emotional peace;
- physical health;
- cultural identity;
- social belonging;
- reciprocal care; and
- confidence in the future.

Lotu was frequently described as a source of hope, meaning, discipline, resilience and connection during the pandemic. Churches provided worship, prayer, material assistance, communication networks and pastoral care. These functions confirm that faith communities form part of the wellbeing infrastructure of many Tongan communities.

The study also identified circumstances in which the same relational and spiritual structures became sources of distress. Participants described fear, pressure, silencing, exclusion, family conflict, leadership burden and loss of belonging. In some cases, relationships remained altered after formal restrictions had ended.

The objective was therefore completed with a more nuanced finding than a simple measure of whether religion improved or reduced wellbeing. The project concluded that the effect of lotu is conditional. Outcomes depend on the quality of interpretation, leadership, communication, professional boundaries, institutional trust and relational practice.

This finding became the foundation of the integrated Lotu Factor framework.

13.4 Objective 3: Understanding health risks

The third objective sought to improve understanding of health risks associated with harmful forms of religious interpretation and practice.

The study identified several interconnected risk pathways:

- inaccurate or misleading health claims;

- delayed engagement with professional care;
- replacement of clinical advice with unverified spiritual claims;
- fear-based theological interpretation;
- suppression of questions or uncertainty;
- pressure associated with vaccination mandates;
- exclusion from employment, worship or community participation;
- unresolved post-vaccination concerns;
- breaches of confidentiality or professional boundaries;
- digital amplification of misinformation;
- conflict within families and congregations; and
- long-term erosion of trust.

These pathways should not be interpreted as evidence that faith itself is a health risk. Nor do they establish how frequently a particular experience occurred across the Tongan population. Instead, the qualitative evidence explains how harm may emerge when spiritual authority, institutional pressure, misinformation and relational vulnerability interact.

The report maintains important evidential limits. Participant accounts of post-vaccination symptoms are reported as lived experiences requiring respectful acknowledgement and appropriate clinical follow-up. The project did not clinically verify causation and cannot determine vaccine safety or effectiveness at population level.

Similarly, the coded thematic extracts used in the analysis are not prevalence estimates. They represent relevant items within the qualitative material and should not be interpreted as numbers of affected people.

Within these boundaries, the objective was completed by identifying the social, relational, theological and communicative mechanisms through which health risk may be produced or intensified.

13.5 Objective 4: A life-affirming response framework

The fourth objective was to develop a response that could help health professionals, faith leaders and communities address harmful religious interpretations while strengthening the protective contributions of *lotu*.

The completed response framework comprises:

- the integrated Lotu Factor conceptual model;
- the non-clinical definition of *lotu noa*;
- the Lotu Factor Reflection Grid and refinement of the RAG approach;

- recommendations for faith–health partnerships;
- health-worker guidance;
- faith-leader education and safeguarding resources;
- the Scripture-in-crisis guide;
- the digital-health framework;
- policy recommendations; and
- pathways for relational repair and recovery.

The framework is life-affirming because it begins with the protection of dignity, relationship, agency and holistic wellbeing. It does not attempt to remove faith from health decision-making. Instead, it strengthens the conditions under which faith can contribute to truthful communication, responsible leadership, care, informed choice and professional referral.

The framework is also explicitly non-diagnostic. It must not be used to:

- diagnose individuals;
- classify congregations as delusional;
- rank denominations;
- dismiss theological disagreement;
- determine access to funding;
- justify surveillance; or
- penalise people for asking questions or declining a health intervention.

The contracted objective has been completed at the level of research-informed framework development. The next stage is implementation: piloting the tools, assessing their safety and usefulness, and revising them with communities and professional users.

13.6 Delivery against project milestones

Period and milestone	Delivery achieved	Status at report date
Year 1: Advisory group and project establishment	Advisory arrangements, community relationships and project research systems established	Completed
Year 1: Literature review, conceptual definition and assessment framework	Literature synthesised; preliminary <i>lotu noa</i> , RAG and Lotu Factor concepts developed	Completed and subsequently refined through the findings

Year 1: Ethics approval	Health and Disability Ethics Committees approval obtained in May 2024, reference 2024/EXP 19965	Completed
Year 2: Individual interviews and group tālānga across Aotearoa	155 participants engaged: 17 individual interview participants and 138 group-tālānga participants, including participants from regional communities	Completed with an approved methodological variation in how participation is reported
Year 2: Analysis and community reflection	Tongan-language coding, five iterative analytical cycles, thematic writing and community-informed reflection undertaken	Completed
Year 3: Response framework and major dissemination event	Lotu Factor framework and associated resources developed; Lotu Factor Symposium held in Auckland on 25–26 October 2025	Completed; piloting of applied resources continues
Year 3: Regional, national and international dissemination	Tonga dissemination undertaken in June 2026; Auckland public launch scheduled for 18 September 2026; manuscripts and online dissemination underway	Ongoing at the report date
Year 3: Final report to HRC and relevant agencies	Integrated final report and publication package produced	Completed with this report

13.7 Methodological variation and participant reporting

The most substantial methodological variation concerned the reporting of participants and data-collection modes.

The original research plan anticipated a particular arrangement of leaders, individual participants and community groups. During implementation, recruitment followed Tongan relational processes and expanded across communities and geographic settings. The resulting study engaged 155 participants:

- 17 through individual interviews; and
- 138 through group tālānga.

The final report uses these verified figures. It does not infer a number of separate groups where that information is not available in the supplied demographic record.

This approach is methodologically more transparent than retrospectively forcing the data into the anticipated numerical structure. It distinguishes clearly between:

- the number of participants;
- the mode through which participants contributed;
- the number of thematic extracts coded; and
- the number of data-collection groups or events.

The variation did not narrow the study's scope. Total participation and geographic reach expanded, while the research retained its qualitative and relational design.

13.8 Ethics and research quality

The ethics and cultural-safety processes described in section 3.11 were maintained throughout project delivery.

The project's quality and accountability measures included:

- culturally grounded recruitment and engagement;
- interviews and tālānga conducted in participants' preferred language;
- Tongan-language coding and analysis;
- five iterative cycles of interpretation;
- multidisciplinary analysis across theology, public health, nursing, immunology, mental health and community research;
- collective review of emerging themes;
- participant de-identification;
- careful translation of selected quotations;
- separation of participant experience from unverified clinical causation;
- transparent reporting of missing or inconsistent demographic data; and
- exclusion of unverified named digital cases from the public synthesis.

The project also distinguished the core ethics-approved participant dataset from supplementary social-media material. The supplementary stream informed contextual interpretation but was not used to estimate prevalence or make claims about all Tongan social-media users.

13.9 Overall delivery assessment

The Lotu Factor Project achieved its intended research purposes and produced a coherent body of evidence, conceptual analysis and practical resources.

The following core components are complete:

- project establishment and advisory relationships;
- literature review;
- ethics approval;
- participant recruitment and data collection;

- Tongan-language coding and thematic analysis;
- integrated interpretation;
- development of the Lotu Factor framework;
- formulation of policy and practice recommendations; and
- production of the final research report.

The following knowledge-translation activities were continuing at the report date:

- final production and release of selected toolkits;
- public launch of the report, tools and website;
- online dissemination;
- academic manuscript publication;
- piloting of the Reflection Grid; and
- longer-term implementation evaluation.

This distinction protects the integrity of the project's reporting. Core research delivery is complete, while dissemination, uptake and assessment of longer-term influence necessarily continue beyond completion of the data analysis.

Overall, the project has fulfilled the HRC objectives while also producing an important conceptual advance: a Tongan-led account of faith as a conditional determinant of health and wellbeing. It provides an evidence base for future partnership among communities, churches, health providers and government agencies without pathologising faith or overlooking the possibility of harm.

14. Engagement, Dissemination and Impact

Key message

Engagement and dissemination were treated as integral parts of the Lotu Factor methodology, not as activities to be undertaken only after the research was completed. The project created spaces in which faith leaders, health professionals, scholars and community members could interpret emerging findings, question the analysis and identify practical priorities.

At the date of this report, the project can demonstrate substantial engagement, completed research outputs, strengthened interdisciplinary relationships and clear pathways to policy and practice influence. Longer-term changes in trust, institutional practice, church policy and health outcomes will require monitoring beyond the formal research period.

14.1 Relational dissemination

Conventional dissemination often assumes that researchers produce knowledge and then transfer it to a passive audience. The Lotu Factor Project adopted a more relational approach.

Knowledge was generated, interpreted and communicated through ongoing interaction among the research team, participants, advisers, churches, health professionals and community organisations.

This approach reflects the importance of the *vā*: the relational space connecting people, institutions, knowledge systems and responsibilities. Dissemination is therefore not simply the circulation of information. It is also the maintenance of relationships through respectful dialogue, reciprocal accountability and collective interpretation.

Relational dissemination requires researchers to:

- return findings to the communities from which the research emerged;
- create opportunities for response and disagreement;
- communicate in accessible cultural and linguistic forms;
- distinguish evidence from interpretation;
- protect participant confidentiality;
- acknowledge the limitations of the study;
- revise resources in response to feedback; and
- sustain relationships beyond the immediate funding period.

The project's dissemination activities were designed to place research evidence into conversation with theological, clinical, policy and community knowledge.

14.2 Lotu Factor Symposium

As described in section 3.15, the October 2025 Auckland symposium tested preliminary findings with faith, community, clinical and research participants.

The symposium served several purposes:

- testing the clarity and cultural resonance of emerging themes;
- bringing health and theological perspectives into direct conversation;
- identifying practical implications for churches and health providers;
- reflecting on leadership, misinformation, mandates and wellbeing;
- developing the Lotu Factor conceptual framework;
- informing the project's tools and recommendations; and
- identifying priorities for further dissemination and implementation.

The symposium was not treated as a substitute for formal data analysis. Rather, it provided a structured setting for community-informed reflection on findings already emerging through the project's analytical process.

The discussion reinforced that effective partnership does not require health agencies and churches to assume identical responsibilities. It requires mutual respect, clear professional boundaries and a shared commitment to community wellbeing.

14.3 Dissemination in Tonga

Dissemination activities were undertaken in Tonga in June 2026 through engagement with theological education and university communities.

These events extended the project beyond its immediate Aotearoa setting and recognised the transnational character of Tongan life. Family relationships, church structures, ministerial formation, digital communication and public-health information move continuously between Tonga, Aotearoa and other diaspora locations.

The Tonga engagements enabled the project to:

- share findings with educators, students, church leaders and researchers;
- test the wider relevance of the Lotu Factor framework;
- discuss implications for theological and ministerial education;
- consider how the findings might inform future Pacific research;
- strengthen relationships with Tongan institutions; and
- identify opportunities for collaborative implementation.

The project does not assume that findings from Tongan communities in Aotearoa can be transferred unchanged to Tonga. Political systems, health services, church structures and social conditions differ. The dissemination process therefore invited contextual interpretation rather than treating the Aotearoa evidence as universally applicable.

14.4 Auckland public launch

A public launch of the final report, practical tools and project website was scheduled for 18 September 2026 in Auckland.

The launch is intended to bring together:

- Tongan and Pacific community representatives;
- faith leaders and denominational authorities;
- health and social-service providers;
- government and public-health agencies;
- researchers and tertiary institutions;

- policymakers;
- project partners; and
- members of the wider public.

The launch should serve as more than a ceremonial conclusion. It should introduce the findings, demonstrate the practical resources, invite implementation partnerships and establish mechanisms for continuing feedback.

The event should also communicate the different status of project outputs. The final research report and conceptual framework may be presented as completed outputs. Toolkits or assessment resources still requiring piloting should be identified transparently as developing resources rather than validated instruments.

14.5 Publication and communication channels

The project's dissemination strategy uses multiple channels because no single format will reach all intended audiences.

Full research report

The report provides the complete evidence, methodology, findings, limitations and recommendations. It is intended for formal, scholarly, policy and institutional use.

Executive summary

The executive summary provides an accessible account of the principal findings and recommendations for readers who do not require the full methodological and analytical detail.

Online publication

The online edition supports searchable access, direct navigation to relevant themes and distribution across Aotearoa, Tonga and diaspora communities.

Toolkits and practical guides

The health-worker toolkit, faith-leader toolkit, Scripture-in-crisis guide and Reflection Grid translate findings into structured guidance for practice.

Policy brief

The policy brief distils the project's implications for government agencies, public-health leaders, Pacific providers and organisations responsible for emergency planning.

Community presentations and tālanga

In-person and online presentations create opportunities for questions, contextual interpretation and reciprocal feedback.

Academic publication

Scholarly manuscripts extend the project's contribution to Pacific health, theology, religious studies, qualitative research, public policy and digital communication.

Digital and social-media content

Short-form content can make key findings accessible to wider and younger audiences. Such content should remain linked to the full evidence and should not reduce complex findings to polarising statements.

14.6 Forms of project impact

14.6.1 Conceptual impact

The project reframes religion as a conditional determinant of health and wellbeing. It moves the central question from “Is religion beneficial or harmful?” to “Under what interpretive, relational and institutional conditions does faith contribute to protection, resilience or harm?”

Its principal conceptual contributions include:

- a holistic Tongan account of wellbeing;
- the non-clinical concept of *lotu noa*;
- the mediated Lotu Factor model;
- analysis of the role of spiritual authority;
- recognition of mandates as relational as well as regulatory interventions;
- the concept of the digital *vā*; and
- a framework for examining protective, ambiguous and risk-producing pathways.

This conceptual shift has relevance beyond COVID-19. It may inform responses to future pandemics, vaccination programmes, mental-health engagement, chronic illness, emergency communication and other settings in which faith influences health decisions.

14.6.2 Policy impact

The project provides a Tongan-specific evidence base for implementing national lessons concerning:

- sustained community partnerships;
- transparent decision-making;
- mandate safeguards;
- monitoring of trust and social effects;
- culturally led communication;

- post-vaccination follow-up;
- misinformation response; and
- relational recovery.

The recommendations convert these findings into actions, responsible sectors, implementation periods and indicators of progress.

Policy influence should not be measured only by whether the report is cited. More meaningful evidence would include changes to decision templates, communication standards, consultation processes, evaluation measures or emergency plans.

14.6.3 Practice impact

The project's practical resources are intended to support changes in how health professionals, faith leaders and community organisations engage with one another.

Potential practice changes include:

- earlier establishment of faith–health relationships;
- improved referral between churches and qualified health services;
- clearer professional boundaries;
- more transparent communication of evidence and uncertainty;
- safer opportunities for confidential questions;
- improved responses to post-vaccination concerns;
- responsible use of scripture during crises;
- more effective digital-health engagement; and
- inclusion of relational repair in recovery planning.

The Reflection Grid and toolkits will require piloting before their effects can be assessed. Initial distribution or training attendance should therefore be treated as evidence of reach, not proof of changed practice.

14.6.4 Community impact

The project provides language for discussing experiences that were difficult to name during and after the pandemic. These included vaccination without peace, pressure associated with employment or church participation, exclusion from worship, leadership burden, family division and relationships that did not return to their previous condition.

Bringing these previously unspoken effects into public discussion is an important contribution, but it is only a beginning. Community impact will depend on whether churches, providers and agencies create safe settings for acknowledgement, dialogue and repair.

The project does not require people to adopt a uniform account of the pandemic. Its contribution is to make disagreement discussable without ridicule, spiritual condemnation or exclusion.

14.6.5 Research capability impact

The project demonstrates the value of Tongan-led and Tongan-language health research. Coding and interpretation were conducted through a multidisciplinary Tongan research process rather than relying entirely on translated English material.

The team brought together expertise in:

- theology and biblical interpretation;
- public health;
- immunology;
- nursing;
- mental health;
- community health;
- Pacific research methodologies; and
- qualitative analysis.

This strengthened relationships across disciplines that often operate separately. It also increased capability for future Pacific research on faith, health, leadership and wellbeing.

14.6.6 Theological and ministerial-education impact

The findings have direct implications for theological colleges and denominational formation programmes.

Ministerial education can use the project to strengthen:

- public-health literacy;
- crisis leadership;
- responsible biblical interpretation;
- ethical communication;
- confidentiality;
- digital conduct;
- referral practice;
- safeguarding;

- accountability; and
- leader wellbeing.

The project also challenges the assumption that ministers must always appear certain or self-sufficient. Leadership formation must recognise their own needs for support and care.

14.6.7 Transnational Pacific impact

The project contributes to conversations extending across Tonga, Aotearoa and the wider Pacific diaspora. Church authority, family responsibilities, theological ideas and digital information frequently cross national borders.

This transnational reach creates opportunities for collaboration but also requires caution. Resources must be adapted to local health systems, languages, denominational structures and political contexts. Impact should therefore be built through regional partnership rather than assumed from online availability alone.

14.7 Impact pathway

Project contribution	Primary audiences	Intended immediate use	Intended longer-term change
Final report and executive summary	Communities, HRC, providers, policymakers and researchers	Understand the evidence and recommendations	Better-informed policy, research and community discussion
Lotu Factor framework	Churches, health providers, educators and researchers	Interpret protective and harmful pathways	More nuanced engagement with faith as a determinant of wellbeing
Reflection Grid	Churches, providers and community organisations	Facilitate structured tālanga and preparedness review	Safer communication, stronger referral and earlier identification of risk
Health-worker toolkit	Clinicians, public-health teams and Pacific providers	Improve engagement with faith communities	Greater trust, cultural safety and continuity of care
Faith-leader toolkit	Ministers, lay leaders, denominations and theological colleges	Strengthen health literacy, boundaries and referral	More accountable leadership and safer pastoral practice
Scripture-in-crisis guide	Ministers, educators and congregations	Support responsible theological interpretation	Reduced use of scripture to silence questions or displace care
Digital-health framework	Clinicians, communicators, churches and youth creators	Coordinate timely and culturally grounded content	Stronger digital trust and reduced recurring confusion
Policy brief	Government and sector leaders	Incorporate findings into planning and decision-making	More transparent, proportionate and relationally informed policy
Website and online resources	Communities, diaspora groups and the public	Access findings and tools	Sustained reach, feedback and collaboration
Academic publications	Researchers, educators and students	Extend analysis and critical debate	Stronger Pacific research capability and new studies

14.8 Monitoring longer-term influence

Project influence should be monitored for at least three years following publication. Monitoring should distinguish among four levels:

1. Output: Was the report, resource or activity produced?
2. Reach: Did intended users access or participate in it?
3. Use: Was the resource applied in policy, education or practice?
4. Outcome: Did its use contribute to a meaningful change?

Recommended indicators include:

- report and toolkit downloads;
- website use and geographic reach;
- attendance at presentations, tālanga and training;
- invitations to brief government agencies, churches and providers;
- citations in policy, professional or denominational documents;
- establishment of regional faith–health partnerships;
- incorporation of resources into theological or professional education;
- documented changes to church safeguarding or referral policies;
- inclusion of trust and relational measures in health evaluation;
- use of mandate safeguards in emergency planning;
- feedback from community and professional users;
- findings from tool piloting;
- academic publications, citations and collaborations; and
- evidence of improved trust, dialogue, referral or relational repair.

A suggested monitoring schedule is:

Monitoring point	Primary focus
At publication and launch	Outputs completed, audiences reached and implementation commitments secured
Six to twelve months	Early uptake, user feedback, training participation and initial policy or practice use
Twenty-four months	Sustained use, organisational changes, partnership activity and results of initial piloting
Thirty-six months	Longer-term influence, revised resources, research developments and evidence of relational or practice outcomes

Monitoring should involve community partners in deciding what counts as meaningful change. Results should be reported back in accessible formats and used to revise the project's resources.

14.9 Measuring what matters

Impact measurement should not privilege visibility over relationship.

A large number of downloads or social-media impressions may indicate reach, but it does not demonstrate understanding, trust or changed practice. Conversely, a small local change—such as a church establishing a confidential referral pathway or a health provider creating a Tongan post-vaccination follow-up process—may have substantial practical importance.

Evaluation should therefore combine quantitative indicators with qualitative evidence, including:

- user accounts of how a resource changed practice;
- examples of improved communication;
- evidence that questions were handled more safely;
- accounts of restored participation or belonging;
- organisational case studies;
- policy changes; and
- community assessment of whether relationships improved.

Impact claims should remain proportionate to the available evidence. The project should not attribute a policy or health outcome solely to the Lotu Factor resources where multiple influences were involved.

14.10 Sustainability and continuing partnership

The sustainability of the project will depend on whether its findings and resources become embedded in ongoing institutional and community practice.

Priority sustainability actions include:

- maintaining the project website and public resources;
- identifying responsible organisations for each toolkit;
- updating resources in response to evidence and user feedback;
- incorporating materials into professional and ministerial education;
- supporting regional faith–health partnerships;
- developing implementation and longitudinal research;
- maintaining connections among Tongan researchers and practitioners; and
- securing resources for community-led evaluation.

The project’s longer-term value will not be determined only by the number of publications it produces. Its deeper contribution will be seen if communities enter future health emergencies with stronger relationships, safer communication, clearer accountability and greater confidence that faith and health can work together without compromising evidence, dignity or informed agency.

15. Strengths, Limitations and Future Research

Key message

The Lotu Factor Project is one of the most substantial Tongan-specific qualitative studies of faith, COVID-19 and wellbeing undertaken in Aotearoa New Zealand. Its principal strengths are its scale, Tongan-language analysis, multidisciplinary Tongan leadership and integration of health, theology, leadership, mandates, relationships and digital life.

These strengths do not remove the study’s limitations. The findings identify experiences, patterns and explanatory pathways; they do not establish population prevalence, clinical causation or the effectiveness and safety of vaccines. The study’s applied tools are research-informed prototypes requiring further piloting and evaluation.

15.1 Strengths

15.1.1 Tongan-specific focus

The project provides a detailed account of Tongan experiences rather than subsuming them within a broad Pacific category. This ethnic specificity matters because Pacific communities have distinct languages, church histories, leadership structures, migration patterns and relationships with health institutions.

The study does not assume that findings concerning Tongan communities automatically apply to Samoan, Fijian, Cook Islands, Niuean, Tokelauan or other Pacific peoples. It instead offers a model for culturally specific inquiry that may inform, but should not replace, research led by other Pacific communities.

15.1.2 Substantial qualitative participation

The study engaged 155 participants:

- 17 through individual interviews; and
- 138 through group tālanga.

This participation provided a substantial qualitative evidence base across different locations and community settings. The project also included regional engagement rather than limiting data collection to a single metropolitan centre.

The number of participants strengthened the diversity and depth of the material. It does not, however, convert the study into a statistically representative survey.

15.1.3 Tongan-language research and analysis

A major strength was the use of Tongan in participant engagement, coding and collective interpretation.

Retaining analysis in Tongan allowed the research team to attend to:

- culturally embedded meanings;
- theological vocabulary;
- humour and indirect communication;
- relational positioning;
- respect language;
- emotional emphasis;
- proverbs and scriptural references; and
- meanings that may be diminished through immediate translation.

English translations were prepared for publication, but the analytical process was not dependent solely on translated transcripts. This strengthened cultural and interpretive depth.

15.1.4 Culturally grounded methodology

The use of interviews and group tālanga supported forms of engagement familiar to Tongan communities. Tālanga allowed participants to develop, test and sometimes challenge interpretations in relation to others.

The relational method was particularly appropriate for a study concerned with *lotu*, leadership, family, church membership and collective wellbeing. It enabled the project to examine not only individual opinions but also the social and relational settings in which health meanings were formed.

Individual interviews complemented group *tālanga* by providing a more private setting for participants who wished to discuss sensitive or personal experiences.

15.1.5 Multidisciplinary Tongan research leadership

The project was undertaken by a multidisciplinary Tongan team whose expertise included:

- theology and biblical interpretation;
- public health;
- immunology;
- nursing;
- mental health;
- community health;
- Pacific research methodologies; and
- qualitative analysis.

This combination enabled the project to avoid reducing the subject to either theology or medicine. Clinical, cultural, relational and theological interpretations could be placed into conversation while professional limits remained visible.

Collective analysis also reduced dependence on a single researcher's interpretation and created opportunities for challenge, clarification and refinement.

15.1.6 Iterative analytical process

The research used five iterative analytical cycles. This enabled themes to be reconsidered as the team moved between transcripts, Tongan coding, thematic categories, community reflection and emerging conceptual interpretations.

The iterative process was particularly important in refining the project's terminology. The movement away from the public use of "delusional religiosity" and towards the non-clinical concept of *lotu noa* emerged from closer engagement with the ethical, cultural and evidential implications of the research.

15.1.7 Integration of multiple dimensions of wellbeing

The project did not isolate vaccination attitudes from their wider context. It integrated:

- spiritual wellbeing;

- physical health;
- emotional experience;
- family relationships;
- church participation;
- leadership authority;
- employment pressure;
- public-health policy;
- social-media communication; and
- post-pandemic relational consequences.

This integrated approach revealed that the same decision could carry clinical, spiritual, economic and relational meanings. It also showed why health behaviour cannot always be understood through individual knowledge or preference alone.

15.1.8 Timing of the study

The timing of the research allowed participants to reflect on consequences that may not have been visible during the most acute stages of the pandemic.

Participants could consider:

- how their attitudes changed;
- whether relationships recovered;
- how they now assessed leadership decisions;
- what they remembered about vaccination and mandates;
- which sources of information they continued to trust; and
- what should be done differently in a future emergency.

This retrospective perspective enabled the project to examine enduring relational effects rather than focusing only on immediate crisis behaviour.

15.1.9 Preservation of participant voice

Selected participant quotations allow readers to encounter the texture of the data rather than relying only on the research team's summaries.

The report uses quotations to demonstrate contrast, complexity and emotional significance. Quotations are not presented as statistically representative statements. They illustrate analytical themes and should be interpreted within the wider qualitative material.

15.1.10 Translation into practical resources

The project moves beyond description by translating its findings into:

- the Lotu Factor conceptual framework;
- the Reflection Grid;
- health-worker guidance;
- faith-leader education resources;
- the Scripture-in-crisis guide;
- the digital-health framework;
- policy recommendations; and
- an implementation framework.

These outputs increase the potential for the research to influence preparedness, communication, theological education and professional practice.

15.2 Limitations

15.2.1 Statistical generalisability

The findings are not statistically generalisable to all Tongans in Aotearoa, Tonga or the wider diaspora.

The study was qualitative and designed to explore meanings, experiences and relational processes. It can identify patterns and plausible pathways, but it cannot establish how common a particular belief, experience or outcome is within the wider population.

Numbers of coded extracts should not be interpreted as numbers of participants or prevalence estimates. A participant may contribute more than one extract to a theme, while other participants may discuss an experience without using the same language.

15.2.2 Recruitment through relational networks

Snowball and relational recruitment were culturally appropriate and enabled trust. However, they may have over-represented people connected to church, community or research networks.

People who were socially isolated, disconnected from churches, distrustful of research or less visible within community organisations may have been less likely to participate.

Participants with particularly strong positive or negative experiences may also have been more motivated to contribute.

15.2.3 Composition of the sample

The sample was predominantly:

- male;
- middle-aged;
- Christian; and
- connected with churches.

This composition reflects significant features of the communities accessed through the study, but it limits the visibility of other experiences.

More focused research is required with:

- women;
- young people;
- non-churchgoing Tongans;
- former church members, including those who disengaged during or after COVID-19;
- disabled people;
- Rainbow+ communities;
- people from non-Christian traditions;
- people with limited English or digital access; and
- individuals living outside established Tongan community networks.

The study should not be interpreted as establishing that the experiences of the dominant sample groups represent all Tongan people.

15.2.4 Demographic-data limitations

Demographic variables had different valid denominators because some participants did not provide responses to every question.

The report therefore makes missingness visible rather than calculating all percentages from the total sample. Employment percentages were omitted because the supplied demographic table contained an internal inconsistency.

Any secondary quantitative analysis should return to the original dataset, verify variable definitions and use the correct denominator for each field.

15.2.5 Retrospective accounts

Data were collected after major pandemic events. Participants' accounts may have been influenced by:

- the passage of time;

- later information;
- subsequent health experiences;
- changes in political or religious interpretation;
- continuing public debate; and
- the present condition of relationships.

Retrospective interpretation is not simply a defect. How people make sense of past events is itself important to trust and recovery. Nevertheless, retrospective accounts cannot recreate exactly what a person knew, felt or believed at the time of the original decision.

15.2.6 Group-tālanga dynamics

Group tālanga enabled collective reflection, but the presence of influential leaders, relatives or people with strongly expressed views may have affected disclosure.

Some participants may have:

- withheld disagreement;
- softened criticism;
- aligned themselves with a dominant view;
- avoided discussing personal health information; or
- remained silent to protect relationships.

Gender matching and culturally appropriate facilitation supported participation, but they could not remove every effect of hierarchy or group pressure.

Individual interviews provided an alternative setting, although some experiences may still have remained undisclosed.

15.2.7 Translation and de-identification

Translation from Tongan into English inevitably involves interpretation. No English wording can reproduce every nuance of Tongan language, theology, humour, hesitation, metaphor or silence.

For public reporting, some quotations were also edited or shortened to protect anonymity and improve readability. These processes may reduce contextual detail.

Published quotations should therefore be understood as careful interpretive translations, not mechanically equivalent reproductions of the complete Tongan interaction.

15.2.8 Researcher interpretation

Thematic analysis is an interpretive process. The research team's disciplinary backgrounds, theological commitments, professional experience and relationships with Tongan communities shaped the questions asked and the meanings identified.

Multidisciplinary collective analysis, iterative review and engagement with community perspectives strengthened reflexivity. They did not eliminate the interpretive role of researchers.

The findings should therefore be assessed as a transparent and evidence-grounded interpretation rather than as the only possible reading of the material.

15.2.9 Clinical and epidemiological limits

The study did not clinically assess participant-reported post-vaccination symptoms. It cannot determine whether a reported condition was caused by vaccination, another health condition or an unrelated event.

The project also cannot assess:

- vaccine effectiveness;
- vaccine safety at population level;
- rates of adverse events;
- infection prevalence;
- mortality effects; or
- comparative clinical outcomes.

Such questions require clinical, pharmacovigilance and epidemiological methods.

The inclusion of participant-reported concerns serves a different purpose: it shows how experiences of illness, uncertainty, recognition or dismissal affected trust and subsequent health engagement.

15.2.10 Supplementary social-media material

The supplementary social-media stream differed from the core Health and Disability Ethics Committees-approved participant dataset in source, sampling and ethical context.

It was used to support contextual understanding of the digital environment. It should not be used to:

- estimate the prevalence of misinformation;
- profile individuals;
- infer the beliefs of all Tongan social-media users;

- rank churches or communities;
- establish causal effects; or
- identify named cases.

Unverified names, individual cases and quantitative claims were excluded from the public synthesis.

15.2.11 Contextual and temporal specificity

The findings emerged from Tongan experiences of COVID-19 in a particular period of Aotearoa New Zealand's pandemic response.

Future emergencies may involve different:

- diseases;
- levels of clinical uncertainty;
- public-health interventions;
- political conditions;
- communication technologies;
- church responses; and
- social expectations.

The project's concepts may remain useful, but their application must be adapted to the circumstances of each emergency.

15.2.12 Status of the Reflection Grid and applied tools

The Lotu Factor Reflection Grid is a research-informed prototype. It is not a clinically or psychometrically validated assessment instrument.

It should not be used to:

- diagnose individuals;
- assess psychiatric illness;
- label a person's faith as delusional;
- rank congregations or denominations;
- determine eligibility for funding;
- discipline people for theological disagreement;
- justify surveillance; or

- create a register of supposedly high-risk communities.

The grid should be used only as a structured aid to reflection and tālanga until piloting and evaluation establish its safety, usefulness and limits.

15.3 Future research priorities

Priority 1: Longitudinal research on trust and relational recovery

Longitudinal research should examine how trust, vaccination attitudes, church participation, family relationships and engagement with health services change over time.

Key questions include:

- Which forms of trust recovered after the pandemic?
- Which relationships remained altered?
- How did mandate experiences affect later health decisions?
- Did people return to churches, workplaces or health services from which they had disengaged?
- What forms of acknowledgement or repair were effective?
- How do younger family members interpret decisions made during the pandemic?

A mixed-method longitudinal design could combine repeated interviews, surveys and organisational case studies.

Priority 2: Youth-led and women-led research

Research led by young people and women is needed to examine authority, caregiving, digital communication and wellbeing from perspectives under-represented in the current study.

Youth-led research could focus on:

- social-media use;
- intergenerational disagreement;
- digital religious authority;
- peer communication;
- mental wellbeing; and
- the experience of navigating family, church and public-health expectations.

Women-led research could examine:

- caregiving responsibilities;

- emotional and relational labour;
- influence within churches;
- family health decision-making;
- employment effects; and
- experiences of leadership and exclusion.

Leadership by members of these groups should extend beyond recruitment to governance, analysis and authorship.

Priority 3: Research with under-represented Tongan communities

Focused studies are required with non-churchgoing Tongans, former church members, disabled people, Rainbow+ communities and people from non-Christian traditions.

These studies should investigate:

- whether existing faith–health engagement models are inclusive;
- experiences of belonging or exclusion;
- access to culturally safe services;
- alternative sources of spiritual or community support;
- confidentiality and safeguarding concerns; and
- whether church-centred communication reaches or marginalises particular groups.

Research design should include appropriate community governance and specialist safeguarding processes.

Priority 4: Comparative Pacific research with ethnic specificity

Comparative research across Pacific communities could identify shared and distinct pathways linking faith, leadership and health.

However, comparative studies should preserve:

- ethnic specificity;
- language;
- denominational history;
- migration experience;
- national health-system context;
- gender and generational differences; and

- local understandings of spirituality and wellbeing.

A comparative Pacific design should not begin with the assumption that one framework will operate identically in every community.

Priority 5: Evaluation of faith–health partnership models

Implementation research should examine whether permanent faith–health partnerships improve preparedness, communication, referral and trust.

Possible evaluation questions include:

- Are partnerships active outside emergencies?
- Is membership sufficiently diverse?
- Does community advice influence decisions?
- Are referral pathways used?
- Do health professionals and faith leaders understand their respective boundaries?
- Does preparedness improve?
- Are trust and belonging strengthened?

Comparative case studies across regions could identify which governance arrangements are most sustainable and effective.

Priority 6: Evaluation of leader education

Faith-leader health and crisis-literacy programmes should be evaluated for:

- knowledge gained;
- ability to assess sources;
- confidence communicating uncertainty;
- understanding of professional boundaries;
- use of referral pathways;
- safeguarding practice;
- digital conduct; and
- leader wellbeing.

Evaluation should examine changes in practice, not only completion of a training module.

Priority 7: Piloting the Reflection Grid and toolkits

The Lotu Factor Reflection Grid, health-worker toolkit and faith-leader resources should be piloted in a small number of diverse settings before wider implementation.

Piloting should assess:

- cultural acceptability;
- clarity of language;
- facilitator requirements;
- accessibility;
- emotional and relational safety;
- risk of labelling;
- usefulness for preparedness;
- usefulness for difficult conversations;
- effects on referral and communication; and
- unintended consequences.

Community users should have authority to recommend revision, restricted use or discontinuation where a tool creates harm or does not meet local needs.

Priority 8: Ethical research on the transnational digital

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Future digital research should examine how health information, theological claims, testimonies and misinformation move among Tonga, Aotearoa and diaspora communities.

Research should consider:

- which messengers are trusted;
- how platform design affects circulation;
- how religious and medical claims become combined;
- how private and public digital spaces differ;
- how young people verify information;
- how uncertainty is communicated;
- how care and pastoral support occur online; and

- how corrections can be made without humiliation.

Digital research must use strong privacy, consent and data-governance protections. Public availability of content should not be treated as automatic ethical permission to identify or profile its creators.

Priority 9: Post-mandate employment, family and church outcomes

Further study should investigate the longer-term effects of mandates and related restrictions on:

- employment and income;
- family relationships;
- church participation;
- social belonging;
- mental wellbeing;
- confidence in government;
- trust in health services; and
- willingness to follow future public-health advice.

Research should include people with different vaccination decisions and should avoid assuming either harm or benefit in advance.

Priority 10: Research on theological interpretation during crisis

Further theological and empirical research should examine how scripture, doctrine and pastoral authority operate during conditions of fear and uncertainty.

Possible topics include:

- divine protection;
- healing and medicine;
- apocalyptic interpretation;
- suffering and blame;
- conscience and collective responsibility;
- obedience and questioning;
- neighbour-love;
- ministerial authority; and

- theological accountability.

This research should include sermons, educational resources, leadership practice and congregational interpretation while maintaining appropriate ethical protections.

15.4 Proposed future research programme

Research stream	Recommended approach	Priority participants or settings	Intended contribution
Trust and relational recovery	Longitudinal mixed-method study	Participants, families, churches, workplaces and providers	Evidence about enduring and changing post-pandemic effects
Youth, women and authority	Community-led qualitative and digital research	Young people, women and intergenerational groups	Better understanding of under-represented experiences
Inclusive Tongan health research	Participatory studies with specialist governance	Non-churchgoing, disabled, Rainbow+ and non-Christian Tongans	More inclusive policy and engagement models
Comparative Pacific study	Multi-country, ethnically specific comparative design	Selected Pacific communities and diaspora settings	Shared learning without erasing cultural difference
Faith–health partnerships	Regional implementation case studies	Churches, Pacific providers and health agencies	Evidence about effective partnership and preparedness
Faith-leader education	Pre-training, post-training and practice evaluation	Ministers, lay leaders and theological students	Evidence of changes in literacy, boundaries and referral
Reflection Grid and toolkit pilots	Participatory implementation trials	Diverse churches and health-provider settings	Safety, feasibility and usefulness evidence
Digital vā	Ethical digital ethnography and network-informed qualitative research	Youth, diaspora networks, clinicians and faith communicators	Better responses to misinformation and online care
Post-mandate outcomes	Mixed-method employment, family and church research	People with varied mandate and vaccination experiences	Evidence for future safeguards and relational recovery
Theology in crisis	Interdisciplinary theological and empirical study	Ministers, educators and congregations	More responsible interpretation and leadership practice

15.5 Principles for future research

Future research arising from the Lotu Factor Project should:

1. be governed meaningfully by Tongan and Pacific communities;
2. use Tongan language throughout research and analysis where appropriate;
3. include under-represented groups from the beginning;
4. compensate community expertise and relational labour;

5. distinguish community consultation from shared decision-making;
6. protect theological diversity while examining demonstrable harm;
7. avoid diagnostic or stigmatising use of *lotu noa*;
8. maintain strong privacy and data-sovereignty protections;
9. combine qualitative depth with appropriate quantitative or clinical methods;
10. report missing data and evidential limits transparently;
11. return findings to participating communities; and
12. evaluate whether research produces practical benefit.

15.6 Priority sequence

The immediate research priorities are to:

- co-designing pilots for the Reflection Grid and toolkits;
- establishing governance for longitudinal research;
- initiating studies of post-mandate relational recovery;
- developing youth-led, women-led and inclusive research partnerships; and
- designing evaluation for faith–health partnerships and leader education.

Over the following one to three years, research should expand into longitudinal follow-up, regional implementation studies, digital-health research and comparative Pacific work.

This programme should remain connected to practice. Research findings should inform revised tools, education programmes, policy safeguards and community-led recovery rather than accumulating as disconnected publications.

16. Conclusion

The Lotu Factor Project began with concern about forms of religiosity that might place Tongan health and wellbeing at risk. The evidence confirmed that such risks exist, but it also transformed the project’s starting assumption.

The decisive issue is not how religious a person or community is. It is how faith is interpreted, communicated, led and embodied under conditions of uncertainty, fear, institutional pressure and rapid digital change.

Participants’ holistic account of wellbeing integrated body, mind and spirit as dimensions of the “complete person”.

This understanding challenges health systems that treat spiritual life, family relationships, culture and community belonging as secondary to physical or psychological outcomes. For many Tongan people, these dimensions are inseparable. A health intervention may be

clinically appropriate yet still be experienced through theological beliefs, family obligations, church relationships, economic pressures and questions of trust.

16.1 Lotu as a source of resilience

The project found extensive evidence that *lotu* supported wellbeing during the COVID-19 pandemic.

Prayer, worship, scripture, fellowship and theological meaning helped people respond to isolation, illness, grief and uncertainty. Churches maintained social connection, circulated information, organised practical assistance and offered pastoral care. Ministers and lay leaders contacted families, encouraged collective responsibility and supported people experiencing fear or hardship.

For many participants, faith and medicine were complementary. Vaccination and professional care could be interpreted as gifts, answers to prayer or practical expressions of responsibility towards others.

Churches therefore functioned as important wellbeing infrastructure. They were not merely channels through which public-health messages could be distributed. They were communities of meaning, care, identity and belonging.

This protective contribution should be recognised and supported in future health planning.

16.2 Lotu as a potential pathway to harm

The study also found that the same structures of trust and authority could carry risk.

Harm became more likely when:

- theological claims were detached from evidence and responsible interpretation;
- spiritual authority was treated as beyond question;
- medical claims were presented as consequences of religious office;
- uncertainty was replaced by excessive certainty;
- people were discouraged from seeking professional advice;
- questions were interpreted as disobedience or lack of faith;
- confidentiality and professional boundaries were unclear;
- mandates interacted with church or employment expectations;
- social-media networks amplified misinformation; and
- disagreement resulted in judgement, silence or exclusion.

This is the context in which the report develops the concept of *lotu noa*. The term does not diagnose an individual or condemn faith. It identifies a pattern in which interpretation,

communication, authority or practice becomes detached from evidence, correction, accountability, dialogue and demonstrable concern for wellbeing.

The distinction is essential. The problem is not *lotu* itself. The problem is the way religious authority may be exercised when it no longer remains accountable to truth, relationship and the consequences experienced by people.

16.3 Leadership as the hinge

Church leaders occupied a pivotal position in participant accounts.

A trusted minister could reduce fear, encourage vaccination, connect families with services and interpret public-health responsibilities through familiar theological language. The same level of trust could also magnify misinformation or make disagreement difficult.

Leadership was therefore a hinge between protective and risk-producing outcomes.

The findings do not support excluding church leaders from public-health engagement. They support deeper and more responsible engagement that includes:

- ongoing health and crisis-literacy education;
- access to reliable clinical advice;
- clear professional and pastoral boundaries;
- responsible use of scripture;
- confidentiality and safeguarding;
- transparent complaints processes;
- referral relationships; and
- support for the wellbeing of leaders themselves.

Health agencies must also avoid placing unrealistic responsibility on ministers during an emergency. Partnership should not mean transferring the work of the health system to volunteers or expecting one leader to represent the diversity of an entire community.

16.4 Vaccination, consent and trust

Participants' vaccination decisions were shaped by multiple influences, including clinical information, family responsibility, religious interpretation, employment, church expectations, mandates and concern for vulnerable people.

The study demonstrates that vaccination uptake should not be treated as a complete measure of trust or informed consent. A person may comply with a requirement while remaining uncertain, distressed or unconvinced. High coverage can therefore coexist with damaged trust.

This distinction matters for future public-health planning. If agencies measure only whether an intervention was accepted, they may overlook:

- whether people understood the information;
- whether they felt able to ask questions;
- whether meaningful alternatives were available;
- whether pressure was experienced as coercive;
- whether concerns were followed up;
- whether relationships were damaged; and
- whether people will trust future health advice.

Visible post-vaccination follow-up, transparent communication and respectful acknowledgement of concerns are necessary for durable trust. Listening to a participant-reported experience does not require making an unsupported conclusion about clinical causation. It requires treating the person with dignity and connecting them with appropriate care.

16.5 Mandates as relational interventions

Mandates were not experienced only as technical public-health rules. They entered workplaces, families, churches and relationships.

Some participants understood requirements as necessary for collective protection. Others described constrained choice, employment pressure, judgement, division or exclusion. These experiences could exist alongside vaccination uptake.

Even after formal requirements were removed, participants described continuing awkwardness and damaged relationships.

Future decisions about mandates and comparable restrictions must therefore include assessment of:

- proportionality;
- human-rights implications;
- employment and income effects;
- family and community consequences;
- impacts on worship and belonging;
- workable alternatives and exemptions;
- review and exit criteria; and
- the need for subsequent relational repair.

Preparedness is incomplete if it plans only for the introduction of restrictions and not for their monitoring, removal and social consequences.

16.6 The digital *vā*

The pandemic intensified the importance of the digital *vā*. Social-media platforms became spaces of worship, pastoral care, family connection, health information, testimony, debate and misinformation.

Digital communication allowed Tongan families and churches to remain connected across distance. It also allowed emotionally compelling and highly confident claims to circulate more quickly than carefully qualified evidence.

An effective response cannot rely on correction alone. Digital-health engagement must be:

- timely;
- Tongan-led;
- culturally grounded;
- theologically informed;
- transparent about sources;
- respectful of uncertainty;
- protective of privacy; and
- connected to practical pathways for care.

Publicly humiliating people who share inaccurate information may deepen distrust and strengthen the very networks through which misinformation circulates. Correction must preserve dignity while remaining clear about evidence.

16.7 Beyond translation

A central implication of the project is that future engagement with Tongan communities must move beyond translation.

Language access remains essential, but translating an already determined message is not the same as community partnership. Effective engagement requires health systems to enter the spiritual, relational and moral worlds in which decisions are made.

This means:

- co-designing communication in Tongan from the beginning;
- involving diverse Tongan clinicians, theologians, women, youth and community members;
- explaining why advice changes;

- acknowledging uncertainty;
- providing confidential routes for questions;
- recognising internal diversity;
- building relationships before emergencies; and
- reporting decisions and outcomes back to communities.

No single minister, clinician or community spokesperson can represent all Tongan perspectives. Partnership must be broad enough to include people who are less visible within formal church or community structures.

16.8 A shared responsibility

The project's findings establish responsibilities across multiple sectors.

Churches and denominations must strengthen accountable leadership, responsible theological interpretation, safeguarding, confidentiality and professional referral.

Health providers must develop cultural and theological literacy, build sustained relationships with faith communities and provide transparent communication and follow-up.

Government agencies must apply rights, equity and relational safeguards to emergency decisions and monitor more than compliance or coverage.

Theological colleges must prepare ministers for health emergencies, digital communication, professional boundaries and the ethical use of scripture.

Community organisations must help create safe spaces in which differing experiences can be discussed without ridicule, retaliation or loss of belonging.

Researchers must continue longitudinal and implementation work while protecting ethnic specificity, community governance and under-represented voices.

Responsibility cannot be placed entirely on the individual making a health decision. Decisions are shaped by systems of authority, communication, policy, family and belonging. Those systems must also be accountable.

16.9 The continuing task

The conclusion of the research period does not mark the completion of the work.

The next stage requires:

- establishing permanent faith–health partnerships;
- piloting the Reflection Grid and practical toolkits;
- strengthening faith-leader education;
- developing Tongan-led health communication;

- evaluating trust, consent quality and belonging;
- supporting relational repair;
- growing the Tongan and Pacific health workforce; and
- maintaining community-governed research.

These actions should begin before another emergency. Relationships built during a crisis are often hurried and instrumental. Durable trust requires sustained presence, reciprocal accountability and practical collaboration during ordinary times.

16.10 Final reflection

The Lotu Factor Project shows that faith is neither an obstacle to be removed from public health nor an unquestionable solution to every health problem. It is a powerful social, spiritual and relational force whose effects depend on the conditions through which it is expressed.

When lotu is joined with responsible interpretation, accountable leadership, reliable evidence, open tālanga and care for the vulnerable, it can strengthen resilience and collective wellbeing. When it is separated from correction, professional boundaries and concern for consequences, it can intensify fear, misinformation, silence and harm.

The most constructive path is therefore not a choice between faith and medicine. It is an accountable partnership in which each recognises its responsibilities and limits.

Participants' accounts often joined prayer with timely clinical care.

This integration of prayer, professional care, truthful interpretation and responsibility for life lies at the heart of the Lotu Factor.

The challenge now is to ensure that Tongan communities enter the next health emergency with stronger relationships, clearer safeguards, trusted communication and greater confidence that their faith, dignity, agency and holistic wellbeing will be respected.

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