

THE LOTU FACTOR Reflection Grid

A practical framework for reflecting on faith, health and community wellbeing in Aotearoa New Zealand

A guided tool for discernment, dialogue, planning and action for churches, leaders and communities.



GUIDED REFLECTION

pausing, listening and discerning



COMMUNITY INSIGHT

reading people, context and wellbeing



FAITH AND PRACTICE

integrating belief, care and action



PLANNING FOR RESPONSE

moving from reflection to next steps

Based on the Lotu Factor Project

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

HRC PACIFIC PROJECT 23/224

2026

FAITH
REFLECTION
DISCERNMENT
TOGETHER

*Thoughtful Reflection
Strong Communities
Hopeful Futures*

The Lotu Factor
Reflection Grid

SEE What is happening?	DISCERN What might God be saying?	PLAN What can we do?	ACT Who will take this forward?

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THE LOTU FACTOR REFLECTION GRID

A Religiosity Assessment Grid Framework for Faith,
Community and Health Partnerships

A practical reflection and improvement tool for churches, community organisations, health services, government agencies and partnership networks.

About this Grid

Purpose

The Lotu Factor Reflection Grid is a practical tool that helps churches, community organisations, health services and government partners reflect on how faith-related leadership, relationships, teaching and practices influence individual, family and community wellbeing.

The grid recognises that lotu can be a powerful source of hope, meaning, belonging, resilience and practical support. It also encourages honest reflection on situations where religious messages, leadership decisions or community practices may unintentionally create fear, exclusion, misinformation, stigma or barriers to accessing health care and other essential services.

It is designed to support:

- Crisis preparedness and response — identifying strengths, risks and responsibilities before, during and after a crisis.
- Church and health-sector planning — helping faith communities and health providers develop coordinated, culturally appropriate and faith-sensitive responses.
- Leadership reflection — enabling leaders to consider how their decisions, communication and conduct affect trust, safety and wellbeing.
- Community tālanga — creating a respectful space for communities to share experiences, concerns and insights.
- Programme evaluation — assessing whether activities are strengthening wellbeing, inclusion, collaboration and access to support.
- Post-crisis learning — identifying lessons, good practices and areas requiring improvement after an emergency or significant community event.

The grid may be used by a leadership team, congregation, community group, health provider, government agency or partnership network. It can be completed individually or collectively and may be adapted to different cultural, denominational and organisational settings.

The Reflection Grid is an improvement and learning tool. It is **not** an audit, compliance exercise, ranking system or measure of religious faithfulness. Its

purpose is not to judge churches, leaders or communities, but to encourage constructive dialogue, shared responsibility and practical action. Responses should therefore be approached with honesty, humility, respect and a commitment to strengthening the wellbeing of all people.

Understanding the Lotu Factor

The **Lotu Factor** describes the many ways that faith, spirituality, church leadership, religious teaching, institutional practices and relationships influence health and wellbeing. It recognises that lotu is not limited to personal belief or worship. It is also expressed through sermons, prayer, pastoral care, family relationships, church policies, leadership decisions, community expectations and responses to illness or crisis.

For many Pacific people, lotu is closely connected to identity, culture, family, belonging and everyday life. It can shape how people understand illness, suffering, healing, death, responsibility and hope. It can also influence whether people trust health information, seek professional care, accept treatment, support others or participate in collective action.

The Lotu Factor can be:

- • Protective — when faith strengthens hope, trust, belonging, compassion and resilience; supports informed decision-making; encourages timely access to health care; and mobilises practical assistance for individuals, families and communities.
- • Mixed — when meaningful spiritual and practical support is available, but messages, leadership approaches or institutional practices are inconsistent. For example, a church may encourage prayer and professional care while some members circulate misinformation or create uncertainty about treatment.
- • Risk-producing — when religious authority, fear, misinformation, exclusion, stigma or spiritual pressure undermine wellbeing. This may occur when people are discouraged from seeking care, blamed for illness, pressured to reject treatment, silenced from asking questions or excluded because of their identity, condition or circumstances.

These categories are not fixed labels. The same church, leader or practice may be protective in one situation and mixed or risk-producing in another. The purpose of the framework is therefore to examine the effects of particular messages, decisions, relationships and practices—not to judge the sincerity or value of anyone's faith.

Understanding lotu noa

The term **lotu noa** may be used to describe an approach in which lotu is applied in isolation from evidence, context, responsibility or appropriate professional care. It may include relying on prayer or spiritual claims alone when medical treatment, accurate information, safeguarding or practical intervention is also required.

The concern is not with prayer, faith or spiritual practice themselves. Prayer and professional care can work together. The concern arises when lotu is used as a substitute for responsible action, as a reason to ignore evidence, or as pressure that prevents people from making informed and safe decisions.

Lotu noa must never be used to label, shame or dismiss a person, congregation, denomination or expression of faith. It should describe a specific approach or practice and its consequences, not define the identity or faithfulness of those involved. Any use of the term should be respectful, evidence-informed and directed toward learning, dialogue and improvement.

1. RAG Rating Scale

Rating	Meaning	Response
Green — Established	Protective practices are consistently demonstrated and supported by evidence or community experience.	Maintain, strengthen and share effective practice.
Amber — Developing	Positive practices exist but are incomplete, inconsistent or dependent on particular individuals.	Identify gaps and agree on practical improvements.
Red — Priority concern	Protective systems are absent, or current practices may create harm, exclusion, confusion or delay in care.	Take prompt corrective action and seek appropriate support.
Not assessed	There is insufficient evidence or the domain has not yet been discussed.	Gather information before assigning a rating.

Ratings should be agreed through facilitated tālanga. Differences of opinion should be recorded rather than forced into artificial consensus.

2. Lotu Factor Reflection Grid

Domain 1: Health Evidence and Public Information

Core question: *Are faith-related messages informed by credible health evidence and communicated honestly?*

Green	Amber	Red
Leaders consult appropriate health professionals and trusted sources.	Leaders sometimes use credible information but verification is inconsistent.	Unverified or misleading health claims are promoted.
Faith and professional care are presented as complementary.	Messages about faith and healthcare differ between leaders.	Prayer or spiritual practice is presented as a replacement for necessary care.
Uncertainty is acknowledged and explained clearly.	Complex information is passed on without sufficient explanation.	Certainty is claimed where evidence is limited or contested.
Incorrect information is corrected promptly.	Corrections occur slowly or informally.	Harmful claims remain uncorrected or are repeatedly circulated.

Reflection prompts

- Who verifies health information before it is shared?
- Can leaders explain uncertainty without creating fear?
- Are qualified Tongan and Pacific health professionals involved?
- Are corrections communicated as widely as the original message?

Priority action if red: Stop circulating the disputed claim, obtain professional advice and issue a clear correction.

Domain 2: Theological and Scriptural Interpretation

Core question: *Does the use of Scripture and theology protect life, dignity, hope and responsible action?*

Green	Amber	Red
Scripture is interpreted in its literary, historical and pastoral context.	Context is considered by some leaders but not consistently.	Isolated verses are used to justify predetermined claims.
Teaching supports care, compassion, lament and practical responsibility.	Messages offer hope but provide limited practical guidance.	Crisis is presented mainly as punishment, conspiracy or proof of another person's lack of faith.
Different interpretations can be discussed respectfully.	Questions are permitted but may be discouraged.	Questioning an interpretation is treated as spiritual disobedience.
Apocalyptic texts are handled carefully.	Sensational language occasionally appears.	Biblical imagery is used to spread fear or oppose evidence-based care without sound interpretation.

Reflection prompts

- Does the interpretation protect life and human dignity?
- Is it faithful to the wider message of Scripture?
- Does it produce responsible action rather than fear or passivity?
- Can people ask theological questions safely?

Priority action if red: Review the teaching with suitably qualified theological and pastoral advisers before it is repeated.

Domain 3: Leadership and Accountability

Core question: *Is religious authority exercised transparently, consistently and accountably?*

Green	Amber	Red
Decisions are made through accountable and inclusive processes.	Consultation occurs but final decisions remain concentrated.	Decisions depend on one person without review or accountability.
Leaders distinguish pastoral, theological and clinical roles.	Role boundaries are understood informally.	Spiritual authority is used to make unsupported clinical claims.
Leaders acknowledge mistakes and correct them publicly.	Errors are corrected privately or inconsistently.	Leaders refuse correction or silence legitimate concerns.
Women, youth, health professionals and community representatives contribute.	Participation is present but limited.	Important groups are excluded from decision-making.

Reflection prompts

- Who can question or review a leader's decision?
- Are conflicts of interest declared?
- Are messages consistent across church leadership?
- Are responsibilities shared beyond ordained leaders?

Priority action if red: Establish an accountable response group and obtain independent pastoral, theological or professional advice.

Domain 4: Trust, Dialogue and Personal Agency

Core question: *Can people ask questions and make informed decisions without shame, pressure or exclusion?*

Green	Amber	Red
Tālanga provides a safe space for questions and disagreement.	Discussion occurs, but some people remain hesitant to speak.	People stay silent because they fear conflict, shame or spiritual consequences.
Decisions are supported through clear information and voluntary consent.	Information is available but pressure may still be experienced.	Religious or family authority is used to coerce decisions.
Dissent does not lead to exclusion from worship or community support.	Relationships become strained when views differ.	People are shamed, isolated or treated as spiritually deficient.
Leaders listen before responding.	Listening depends on the leader or setting.	Questions are dismissed or interpreted as disloyalty.

Reflection prompts

- Who feels safest speaking, and who remains silent?
- Can a person disagree while retaining dignity and belonging?
- Is apparent agreement being mistaken for trust?
- Are people given sufficient time and information to decide?

Priority action if red: Create a confidential, independently facilitated tālanga and establish explicit protections against coercion and retaliation.

Domain 5: Professional Boundaries, Referral and Safeguarding

Core question: *Are people referred to appropriate services while continuing to receive spiritual and relational support?*

Green	Amber	Red
Leaders know when and how to refer people to health, mental-health or social services.	Referral happens but relies on personal contacts.	Serious needs are handled only through prayer or informal pastoral support.
Emergency and safeguarding procedures are documented.	Procedures exist but are not widely understood.	There is no clear response to emergencies, abuse or serious psychological distress.

Green	Amber	Red
Confidentiality and informed consent are respected.	Expectations about confidentiality are unclear.	Personal information is shared without permission or used to shame someone.
Pastoral care continues alongside professional treatment.	Pastoral and professional support are poorly coordinated.	People are encouraged to stop treatment or avoid professional care.

Reflection prompts

- Do leaders recognise medical and mental-health warning signs?
- Are referral contacts current and accessible?
- Does pastoral support complement professional care?
- Are children and vulnerable adults adequately protected?

Priority action if red: Address immediate safety needs, contact the appropriate professional service and activate safeguarding procedures.

Domain 6: Inclusion, Belonging and Practical Care

Core question: Does the faith community strengthen belonging and respond to the whole person and kāinga?

Green	Amber	Red
Support addresses spiritual, physical, emotional, relational and material needs.	Support is strong in some areas but limited in others.	Care is reduced to spiritual advice while practical hardship is overlooked.
Women, youth, older people, disabled people and marginalised groups participate meaningfully.	Inclusion is encouraged but barriers remain.	Some groups are ignored, excluded or spoken for.
Assistance is provided fairly and confidentially.	Assistance is informal and may not reach everyone.	Support depends on status, loyalty or ability to contribute financially.
Diaspora and locally based kāinga are connected appropriately.	Connections exist but are irregular.	Distance, technology or migration-related needs are disregarded.

Reflection prompts

- Who is not currently reached by church support?
- Are material needs identified without causing shame?

- Are activities physically, linguistically and digitally accessible?
- Does support strengthen the vā within families and communities?

Priority action if red: Identify excluded groups, remove immediate access barriers and appoint responsible people to coordinate practical support.

Domain 7: Digital Information and Digital Vā

Core question: *Do digital practices protect relationships, privacy and access to trustworthy information?*

Green	Amber	Red
Digital messages are checked before publication or forwarding.	Verification occurs inconsistently.	Sensational or unverified content is routinely shared.
Online communication is respectful, accessible and culturally appropriate.	Communication reaches many people but excludes some groups.	Online discussion becomes hostile, shaming or divisive.
Privacy and consent are respected.	Privacy expectations are informal.	Health, prayer or family information is published without permission.
Online channels connect people to reliable services and pastoral support.	Information is shared without clear pathways to assistance.	Digital content discourages care or directs people to unsafe sources.

Reflection prompts

- Who approves official digital content?
- How are misinformation and harmful comments managed?
- Are messages available in suitable languages and formats?
- Can people access support privately rather than only through public groups?

Priority action if red: Remove harmful content where possible, correct the information and review digital moderation and privacy procedures.

3. Context Review

Before assigning ratings, record the conditions affecting the organisation or community:

- Current health or social crisis
- Government policies and public-health requirements
- Previous experiences of institutions or health services
- Economic and housing pressures
- Language and health-literacy needs
- Denominational structures
- Migration and diaspora relationships
- Digital access and platform use
- Existing conflicts, inequalities or historical harms

Context helps explain a rating, but it does not excuse practices that create preventable harm.

4. Wellbeing Outcome Check

After completing the grid, consider how current practices affect the following outcomes:

Wellbeing area	Reflection question
Physical	Are people able to access timely and appropriate healthcare?
Mental and emotional	Do messages reduce fear and support people experiencing distress?
Spiritual	Are faith, hope, meaning and dignity strengthened?
Relational	Are trust, family relationships and the vā protected?
Social	Do people retain belonging and community participation?
Material	Are food, housing, transport and financial pressures recognised?
Cultural	Are language, identity, collective responsibility and Tongan values respected?
Digital	Can people access trustworthy information without harassment or exclusion?

5. Recording Template

Domain	Rating	Evidence or example	Required action	Responsible person/group	Review date
Health evidence					
Theological interpretation					
Leadership and accountability					
Trust, dialogue and agency					
Boundaries and referral					
Inclusion and practical care					
Digital information and digital vā					

Do not calculate a single overall score. A total can conceal a serious red-rated concern behind several green ratings.

6. Action Rules

When a domain is **green**

- Document what is working.
- Maintain the people, relationships and resources supporting it.
- Share the practice where appropriate.
- Review it periodically.

When a domain is **amber**

- Identify the specific gap.
- Agree on one realistic improvement.
- Assign responsibility and a completion date.
- Review progress within three months.

When a domain is red

- Determine whether anyone faces immediate risk.
- Stop or contain the harmful practice where possible.
- Seek appropriate health, safeguarding, theological or legal advice.
- Develop a documented corrective action.
- Review progress within an agreed short timeframe.

Any red concern involving medical emergencies, abuse, self-harm, violence, serious misinformation or pressure to discontinue necessary treatment requires immediate referral through the appropriate professional pathway.

7. Recommended Reflection Process

The Reflection Grid is most effective when completed through an inclusive, evidence-informed and well-facilitated process. The aim is to create a safe space for honest reflection, shared learning and practical improvement. The process should avoid blame, protect confidentiality and ensure that people with different experiences can contribute meaningfully.

1. Form a balanced reflection group

Bring together people who represent different roles, perspectives and experiences. The group may include church leaders, health professionals, women, youth, older people, people with disabilities, Rainbow+ community members and other relevant community representatives.

Where possible, include people directly affected by the organisation, programme or crisis response. Attention should be given to power differences so that senior leaders do not dominate the discussion and participants feel safe to express concerns or disagreement. An independent facilitator may be helpful where relationships are sensitive.

2. Define the setting and scope

Clearly identify what is being assessed. This may be a particular church, organisation, programme, health initiative, crisis response, leadership period or community event.

Agree on:

- The purpose of the reflection.
- The period being reviewed.
- The people or communities involved.
- The domains to be considered.
- How the findings will be recorded and used.

A clearly defined scope keeps the discussion focused and prevents broad or unsupported judgements about an entire church, denomination, organisation or community.

3. Gather relevant evidence

Collect information that shows what occurred and how people were affected. Evidence may include:

- Organisational policies and guidelines.
- Sermons, Bible studies and pastoral messages.
- Social-media posts, livestreams and digital communications.
- Health information and public statements.
- Referral records and service-use information.
- Programme reports and meeting notes.
- Community feedback, complaints and evaluations.
- Tāles, testimonies and lived experiences.

Evidence should be gathered ethically and handled confidentially. Personal stories should not be shared beyond the agreed process without permission. Both positive and difficult experiences should be included to present a fair picture.

4. Hold a facilitated tālanga

Use a respectful and culturally appropriate tālanga process to discuss each domain of the grid. The facilitator should ensure that all participants have an

opportunity to contribute and that differences of opinion are acknowledged rather than silenced.

The discussion should explore:

- What worked well?
- What caused concern or harm?
- Whose voices were heard or overlooked?
- What evidence supports these conclusions?
- What could have been done differently?
- What should be strengthened or changed?

Record areas of agreement, disagreement and uncertainty. Lack of agreement should not be treated as failure; it may reveal experiences or issues requiring further attention.

5. Assign evidence-based ratings

Assign a rating to each domain using the agreed criteria. Ratings should be based on available evidence and actual effects rather than an organisation's reputation, a leader's intentions or assumptions about religious faithfulness.

Where evidence is incomplete or participants disagree, record the uncertainty and explain why. A lower rating should be understood as an invitation to improve, not as a judgement against the organisation or its people. Positive ratings should also identify the practices that need to be maintained.

6. Select priority areas

Review the ratings and identify the issues requiring action. Immediate **red** concerns should normally be addressed first, particularly where there is a risk to health, safety, dignity, access to care or community trust.

Important **amber** areas should then be prioritised to prevent risks from becoming more serious. **Green** areas should also be recognised so that effective practices can be maintained, strengthened and shared.

Priorities should be selected according to:

- The seriousness and urgency of the issue.

- The number of people affected.
- The potential for harm or improvement.
- Available resources and authority.
- The feasibility of taking action.

7. Develop an action plan

Translate the findings into clear and achievable actions. For each priority, record:

- The issue to be addressed.
- The action required.
- The person or group responsible.
- The partners who need to be involved.
- The resources or training required.
- The expected outcome.
- The completion and review dates.
- How progress will be measured.

Actions may include revising policies, providing leadership training, strengthening referral pathways, correcting misinformation, improving communication, creating safer feedback processes or developing closer church–health partnerships.

8. Repeat and review the reflection

The Reflection Grid should be used as part of an ongoing cycle of learning and improvement. Repeat the process after a crisis, major programme, significant community event, leadership change or policy review. Where no major event occurs, the reflection should be undertaken at least annually.

Each review should examine whether agreed actions were completed, whether practices improved and whether new concerns have emerged. Progress should be communicated back to participants and affected communities. Repeating the

reflection allows organisations to monitor change, sustain protective practices and respond early to developing risks.

8. Ethical Safeguards

The Lotu Factor Reflection Grid must be used with care, fairness and respect for religious freedom, cultural dignity, privacy and community self-determination. Its purpose is to support reflection and improvement—not surveillance, judgement, punishment or control.

Participation should be voluntary wherever possible. People must be informed about the purpose of the reflection, how information will be used, who will have access to it and how findings will be reported. Particular care is required when participants have less institutional authority or may feel pressured to agree with church, community, health or government leaders.

The Reflection Grid must not be used to:

- Judge the sincerity or strength of a person's faith. The grid considers the effects of particular messages, decisions and practices; it does not measure personal spirituality or religious commitment.
- Label individuals or communities as “lotu noa.” The term should refer only to a specific approach in which lotu is separated from evidence, context, responsibility or appropriate care. It must never become a name for a person, congregation, denomination or community.
- Rank denominations or congregations. Ratings are intended to identify strengths, concerns and opportunities for improvement within a defined setting. They must not be used to create competitive tables or public comparisons.
- Punish disagreement or vaccine hesitancy. Questions, concerns and uncertainty should be met with respectful tālanga, accurate information and appropriate support. The grid must not be used to shame, discipline or exclude people because they hold different views.
- Monitor private religious beliefs. Personal beliefs, prayers and spiritual experiences should not be recorded or investigated unless participants freely choose to share them and they are directly relevant to the agreed purpose.
- Replace clinical, safeguarding or legal assessment. The grid is not a diagnostic, risk-assessment or investigative instrument. Concerns

involving health, abuse, neglect, discrimination, professional misconduct or legal obligations must be referred to appropriately qualified services or authorities.

- Present participant experiences as proof of medical causation. Lived experience provides important evidence about meaning, relationships and perceived effects, but it does not by itself establish that a religious practice caused a particular medical outcome.
- Collect identifiable information without informed consent. Names and other identifying details should be gathered only when necessary, with clear permission and appropriate protection. Wherever possible, findings should be anonymised or reported in a way that prevents identification.

Community ownership and interpretation

Findings should be owned, discussed and interpreted with the community concerned. Communities should have a meaningful opportunity to review the findings, correct misunderstandings, explain the context and participate in deciding what actions should follow.

External organisations, researchers or agencies should not remove findings from their cultural and relational setting or publish them without appropriate agreement. Community ownership does not, however, remove professional or legal responsibilities to respond when there is an immediate risk of serious harm.

Confidentiality and responsible reporting

Reporting must protect the privacy, dignity and safety of participants. Personal experiences should not be attributed to individuals without their explicit consent. Small details that could indirectly identify a person, family, church or community should also be removed where necessary.

Reports should clearly distinguish between:

- **Documented evidence** — information supported by policies, records, public statements or other verifiable sources.
- **Participant experience** — what individuals or groups report that they saw, heard, felt or experienced.
- **Professional interpretation** — conclusions or assessments offered by researchers, health professionals, facilitators or other specialists.

Limitations, uncertainties and areas of disagreement should be stated openly. Findings should be communicated in language that is accurate, respectful and focused on learning and improvement, avoiding sensational claims, stigma or unnecessary harm.

Final Reflection

The central question is not simply whether lotu is present. It is how is lotu operating in this setting, through whose authority, and with what consequences for life, dignity, trust, relationships and wellbeing?

A strong Lotu Factor is evident when faith, evidence, accountable leadership, safe dialogue, professional care and tauhi vā work together to protect and sustain life.