RECOVERING FROM AN EPIDEMIC OF TEEN PREGNANCY: THE ROLE OF RURAL FAITH LEADERS IN BUILDING COMMUNITY RESILIENCE

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A couple of statements have guided my desire to look out for others:

"The King will reply, 'Truly I tell you, whatever you did for the least of these brothers and sisters of mine, you did for me.'"
"Religion that God our Father accepts as pure and faultless is this: to look after orphans and widows in their distress and to keep oneself from being polluted by the world."

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Abstract:

Oklahoma has the 3rd highest teen birth rate in the nation. High rates of teen pregnancy within a community represent a burden that mirrors a disaster. A community's level of vulnerability, resilience, and adaptive capacity determines whether the community is able to respond and recover and return to a state of pre-event functioning according to Disaster Resilience of Place (DROP) model. Faith leaders are uniquely qualified to address the juxtaposition between faith and health, thereby increasing community resilience in rural communities.

This study utilized a qualitative research design of faith-leaders residing in two rural communities. In-depth interviews used a deductive approach with a semi-structured interview guide to explore the role of faith-leaders and congregations in teen pregnancy prevention.

A grounded theory approach was used for analysis of interview transcripts.

Sixteen faith leaders from Evangelical and Non-Evangelical Christian faiths, and Judaism were interviewed in two rural communities matched on size. The names of these towns have been altered for confidentiality. Interviews from Tonka suggest that it is less resilient and more vulnerable. Predictors of community resilience include partnerships across denominational lines, and theological interpretations that prioritize body, which tend to be held by Non-Evangelical faith leaders.

Tonka has among the highest teen pregnancy rate in Oklahoma and far exceeds the teen pregnancy rate of Tolula. The stronger partnerships across denominational lines to meet community needs in Tolula makes Tolula a more resilient community than Tonka. Population health will be improved and teen pregnancy rates reduced when faith-based organizations—despite theological differences—partner and utilize its resources in a way that benefits the community at large.

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INTRODUCTION

Statement of the Problem

Oklahoma consistently has poor health outcomes compared to other states. Oklahoma has the 4th highest rate of death from all causes in the nation—23% higher than the national rate ("State of the State's Health," 2014). Oklahoma has the 3rd highest rate of death due to heart disease in the nation, the highest rate of death due to chronic lower respiratory disease in the nation, and the 4th highest rate of death due to diabetes in the nation ("State of the State's Health," 2014). Behavioral risk factors contribute to the overwhelmingly high rates of death and disease. Half of Oklahoma adults do not eat fruit daily, only 28% of Oklahomans reported exercising in the past 30 days, and more than 1 in 5 Oklahoma adults smoke cigarettes ("TSET," 2015).

The World Health Organization (WHO) defines health "as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" ("WHO," 1948). Health includes more than just nutrition and physical activity, as it is more holistic and multi-faceted. In addition to the behavioral risk factors mentioned above, Oklahoma has the 3rd highest teen birth rate in the nation among 15-19 year olds and the 2nd highest in the nation for

the teen birth rate among 18 and 19 year olds ("State of the State's Health," 2014). Teen pregnancy is not an isolated event, but rather serves as an indicator of numerous poor health outcomes present in a community. From low education attainment, single-parent households, and high poverty rates, teen pregnancy mirrors a disaster when present at high rates in a community.

Purpose of the Study

A dichotomy of faith and health persists in Oklahoma, evidence by extremely poor health outcomes and consistently high rates of religiosity. According to Pew Research Center, 79% of Oklahomans identify as Christian with 47% of those Oklahomans classified as Evangelical Protestants ("Religious Landscape," 2014). Furthermore, Oklahoma is located in the Bible Belt—an informal term describing a region in the South Central and South Eastern United States that has strong ties between widespread church attendance, socially and politically conservative ideals, and a high prevalence of Evangelical Protestantism. The high numbers of adults identifying as Christians, more specifically Evangelical Protestants, and consistently leading the nation in poor health outcomes, makes for a strong contradiction between belief and health in Oklahoma.

Oklahoma is less educated when compared with other states—considering that only 23.5% of Oklahomans have a bachelor's degree or higher compared to the national average of 28.8% ("US Census," 2014). Educational attainment is a factor known to improve health outcomes and is confounded by religiosity in Oklahoma. The Pew Research Center found that only 21% of Evangelicals have a college degree ("Religious Landscape," 2014).

Significance

In literature addressing natural disasters, frameworks are developed to assess existing resources and the community's ability to respond and recover from the event. Drawing from the

Disaster Resilience of Place (DROP) model and the model of Stress Resistance and Resilience over Time, three key factors emerge: vulnerability, resilience, and adaptive capacity (Cutter et al., 2008; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008). A community's level of vulnerability, factors of resilience, and adaptive capacity determines whether the community is able to respond and recover from a disaster and return to a state of post-event functioning as opposed to persistent dysfunction (Norris et al., 2008). As seen in the continuous poor health outcomes of Oklahoma, teen pregnancy brings a host of social problems to a community. The precursors to teen pregnancy include low education attainment, single-parent households, and high poverty rates leaving a community much the same way a disaster would when striking a specific area. The effects of poor health in a community, with a specific focus on teen pregnancy, mirrors the effects of a natural disaster. Using an adapted framework addressing a community's vulnerability, resilience, and adaptive capacity, this study assesses Oklahoma's ability to respond and successfully recover from its perpetual poor health outcomes, including teen pregnancy.

Vulnerability in a community is the pre-event, inherent characteristics or qualities of a social system that create the potential for harm (Cutter et al., 2008). Many frameworks have been developed to assess vulnerability, and despite many differences, two common elements persist. First, vulnerability must be addressed from a social-ecological perspective (Cutter et al., 2008). The socio-ecological perspective looks at the interaction between different levels, such as individual, organizational, community, and environment. Vulnerability at an individual level does not determine a community's level of vulnerability. Similarly with resilience, it is often noted that the "whole is more than the sum of its parts," meaning that a single vulnerable individual does not guarantee a vulnerable community nor vice versa (Norris et al., 2008). It must be a multi-leveled approach in order to best address vulnerability at all levels of a

community. Second, vulnerability must be conceptualized as a human rights or equity issue (Cutter et al., 2008). As with other poor health outcomes, an inequity exists in the teen pregnancy data affecting racial and ethnic minorities and those from a lower socioeconomic status. A look at the vulnerability within each community necessitates an answer to the question, "How did we get here?" What are the conditions within the community that created the disaster of perpetual poor health outcomes?

Resilience is the ability of a social system or community to respond and recover from disasters and includes those inherent conditions that allow the system to absorb impact and cope with an event as well as adaptive processes that facilitate the ability of the social system to re-organize, change, and learn in response to a threat (Cutter et al., 2008). In other words, it is a community's ability to absorb disturbance and re-organize into a fully functioning system. A community's resilience takes into consideration its inherent characteristics and adaptive abilities. Resources including social, economic, and community competence variables serve as indicators of a community's resilience. Social dimensions include inherent characteristics such as demographics, social capital, and faith-based organizations (Cutter et al., 2008). The economic dimension includes poverty levels, education attainment, and employment opportunities (Cutter et al., 2008). Lastly, community competence is another indicator of community resilience that promotes population wellness, quality of life, and emotional health (Cutter et al., 2008). Social justice necessitates social capital, which potentially leads to a community's resilience and ability to adapt to a disaster.

Adaptive capacity is defined as the ability of the system or community to adjust to change, moderate the effects, and cope with a disturbance (Cutter et al., 2008). It includes not only the ability of the community to return to the state before the disaster, but to advance the

community through learning and adaptation. Adaptive capacity answers the question, "What are we doing with our current situation?" All three components—vulnerability, resilience, and adaptive capacity—are nested together to asses a community's ability to respond and recover to a disaster such as teen pregnancy and persistent poor health outcomes.

Teenage pregnancy is not just a reproductive health issue, but a health problem that is significantly correlated to a host of other social issues that affect Oklahomans. In order to better the health of individuals, families, and the community, reducing teen pregnancies must be at the forefront of public health. Another social construct in Oklahoma is the high rate of religiosity—people identifying with Evangelical Protestantism. The juxtaposition between faith and health necessitates exploring in order to properly assess Oklahoma's potential for community resilience.

Conceptual questions

1. Do non-Evangelical churches perceive poor health outcomes as a threat to their congregations more than Evangelical churches?
2. Does competition between churches increase a community's vulnerability to high teen pregnancy rates?
3. Does community resilience serve as a protective factor against high teen pregnancy rates?

Delimitations

Delimitations for this study include geographic location, recruitment location, and religious identification. The two populations chosen for this study are Tonka and Tolula (not actual names). The responses may not generalize well to other locations in Oklahoma. Some recruitment took place with faith leaders found in health coalitions in both locations. The faith leaders involved in health coalitions already have some expressed interest in the health of their

community. Religious denominational categories cannot always be generalized across the board. One Evangelical individual cannot speak authoritatively for every Evangelical.

Limitations

Limitations include self-report by each faith leader interviewed. Self-report can potentially be flawed in details and accuracy. Since probability sampling was not employed, the extent to which the sample is representative of the overall faith leader population is 9% (16/173; n=173; approximate number of churches in Tonka and Tolula) ("Healthy Living Program County Profile," 2015).

CHAPTER II

REVIEW OF LITERATURE

Religious History

The South Central to the South Eastern states are traditionally considered the Bible Belt. These states have the highest teen birth rates throughout the United States. These states also have the highest smoking prevalence, obesity, and lowest education attainment. The correlation between religiosity—high rates of adult identification with Evangelical Protestantism—and poor health outcomes is alarming and puzzling. Given the dominance of Evangelical Protestantism in this geographic area ("Religious Landscape," 2014), the religious ideologies and theological rationales consistent with Evangelical Protestantism may be a social determinant of poor health.

The early church in the New Testament grew in number without any sort of organized worship gathering taking place in buildings. Emperor Nero and Emperor Domitian both ruled during the time of the New Testament authors and persecuted this new sect harshly. Emperor Nero blamed early Christians for the burning of Rome in 64 CE and would burn many of them alive as punishment (Ferngren, 2011). Emperor Domitian narcissistically desired the praise of his subjects, and when Christians and Jews refused to bow down to him, he tortured and killed them (Ferngren, 2011). The early Church—occupied by survival in the midst of severe persecution—

did not have a systematic approach to health, but they found refuge in one another and took care of people. Diaconal (deacon-led) care served as the informal infrastructure to meeting the needs of others and was often palliative, since it was administered by people with little or no medical training or experience (Ferngren, 2011). A tradition of the "seven works of corporal mercy" arose in the early church and was eventually systematized by medieval theologians (Ferngren, 2011). The works of mercy were: feed the hungry, give drink to the thirsty, clothe the naked, bury the dead, shelter the traveler, comfort the sick, and free the imprisoned—all based on the parable of the sheep and the goats in Matthew 25 (Ferngren, 2011). Another New Testament writing that indoctrinated the early Christians was written by James, the brother of Jesus (James 1:27) in which James defines "religion that is pure and undefiled before God" in part as caring for "orphans and widows"—biblical shorthand for all those in need and without protectors (Ferngren, 2011). This mantra served as the catalyst for practical morality that eventually laid the foundation for Christian philanthropy.

The early church forged on for a few centuries, often in hiding, until the conversion of Emperor Constantine in 313 CE—the first Roman emperor to align himself with Christianity. Christianity quickly changed from a persecuted religion to the favored religion of Rome, pioneering the way for Christianity to be the official, established religion of the Roman Empire (Wright, 1990). As the favored religion, Christianity changed from a diaconal care form of leadership—looking out for the needy among them—to a leadership intertwined with the government that was interested in conquering, converting, and controlling.

Similar to the 4th century CE, Christianity is still among the favored religions in America. Many philanthropies and charities exist to meet the needs of people and continue the seven works of corporal mercy, but most of it is done through parachurches—Christian-faith based

organizations independent of church oversight—and not as much in the local church. These transitions were mirrored by changes in the face of public health. As the leading causes of death have changed dramatically over the past few centuries—from communicable diseases like the plague, Ebola, measles, and tuberculosis, to chronic diseases like obesity, cancer, heart disease, and diabetes—many that are preventable and caused by lifestyle choices. In a strange juxtaposition, it seems, based on the health outcomes of the Bible Belt region, that many churches still support the "seven works of corporal mercy" through partnering with parachurch ministries but suffer from the same chronic diseases that public health initiatives are battling to prevent. If the modern church acted congruously with the original heart of the early church—taking care of those in need and without protectors—then these religious communities would be the champions of health and advocates for high risk communities, helping the disadvantaged to break the cycles of poor health outcomes.

However, religiosity throughout time has promoted spirit over body—influenced by an early church heresy called Gnosticism. Gnostics believed that the material world was evil and prevented spiritual ones from achieving perfection (Bingham, 2007). Although Gnosticism was, and still is, viewed as heretical from orthodox Christianity, traces of the heretical thought has seeped into Protestant theology. Christian author and blogger, Dianna Anderson (2014) wrote about the danger of this separation of flesh and spirit:

> But the pathologizing of everyday human interaction with their own bodies and their own sexuality is a further example of purity culture and the evangelical fear of our own bodies. Because sexuality is so scary and so fleshy and so much a part of our physicality, the conservative theological reading must reject any part of bodily experience as something pathologically wrong. Our very bodies, our very

> sexual experiences become fraught with fear of addiction, of sin, of destruction. When we pathologize certain behaviors while simultaneously misunderstanding what that pathology actually means, we create a world of fear, a world of shame. We make it impossible for people to differentiate between normal sexual expression and experience and the dangerous, life-altering effects of sexual addiction. And that, of course, is the goal—evangelicalism thrives on the fear of our own bodies, so keeping us in the dark about potential addictions prevents us from actually confronting the idea that we might be sexual beings altogether.

The shame of sexuality and sexual experiences has a foothold on Evangelical Protestantism and has resulted in a highly religious region of the United States having worse poor health outcomes than other states.

Overall Health in Oklahoma

The Oklahoman dichotomy of faith and health is not easily remedied. Research recognizes the importance of religion in individual-level mortality risk and health, highlighting factors such as positive lifestyle choices, enhanced social support, a stronger capacity to cope with adversity, and outlets for social participation and role diversity as protective factors (Blanchard, Bartkowski, Matthews, & Kerley, 2008). However, a much richer study is necessary to explain the missing link between religiosity and population health in America—more specifically for the purposes of this study, Oklahoma. Oklahoma routinely ranks among the unhealthiest states.

Compared to the 179.1 rate of death per 100,000 for adults in the United States, Oklahoma has a rate of 235.2 ("State of the State's Health," 2014). The leading causes of death in Oklahoma that outpace other states include: chronic lower respiratory disease—rate of 67.4;

unintentional injury—rate of 60.5; diabetes—rate of 26.9; and suicide—rate of 16.5 ("State of the State's Health," 2014). Oklahomans have a diabetes prevalence of 11.5% compared to a prevalence of 9.7% in the United States ("State of the State's Health," 2014). High risk factors and poor behaviors are what lead to many preventable diseases and deaths.

The prevalence of obesity in Oklahoma is just one indicator of the poor health status of the state. Over half of Oklahomans do not eat at least one piece of fruit daily, over one-fourth of Oklahomans do not eat the minimal vegetable suggestion, and 28.3% of Oklahomans do not regularly exercise ("State of the State's Health," 2014). Oklahoma is the 6th most obese state in the United States ("The State of Obesity in Oklahoma," 2015). Nearly one-third, or 27.6% of Americans are obese ("Adult Obesity Facts," 2015) compared to 33.0% of Oklahomans ("The State of Obesity in Oklahoma," 2015). Heart disease and type 2 diabetes are among the leading causes of preventable death and are obesity-related conditions ("Adult Obesity Facts," 2015). A recent trend in the United States indicates that women with college degrees are less likely to be obese in comparison with less educated women ("Adult Obesity Facts," 2015).

The high poverty rates in Oklahoma is a determinant of poor health. Compared to the United States' rate of 15.9%, 17.2% of Oklahomans live in poverty ("State of the State's Health," 2014).

Sexual Health

Teen pregnancy is an indicator of overall health ("Tulsa Campaign to Prevent Teen Pregnancy," 2015). Reproduction and sexual health morbidity in the United States far exceeds that of other developed nations (E. Coleman, 2015). The sexual health outcomes in the United States are bleak: 50,000 new HIV cases, 20 million STIs, 3 million unintended pregnancies, and 1 million rapes annually with a substantial economic cost associated with each poor outcome (E.

Coleman, 2015). Adolescents account for nearly half of the 18.9 million cases of STIs in the United States each year, although they make up only one-quarter of the sexually active population (Grose, Grabe, & Kohfeldt, 2014). The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental and social well-being related to sexuality and not merely the absence of disease, dysfunction or infirmity ("WHO," 1948). Moving the conversation of sex from a shameful one to an informed and honest one will help decrease the adverse sexual health outcomes. Research has linked sexual guilt to lower levels of contraceptive use, especially condom use, among young people (Higgins, Mullinax, Trussell, Davidson Sr, & Moore, 2011). Open discussion and conversation about sexual health in the United States would serve as a helpful starting point in minimizing the effects of poor sexual health. Former Surgeon General Jocelyn Elders asserted, “knowledge and open discussion are paths to societal change that lead us away from viewing sexuality primarily in negative terms and towards viewing sexuality as a part of life that is wholesome and pleasurable” (Elders, 2010). The best contraceptive in the world is a good education (Elders, 2010).

The male condom is one of the oldest methods of contraception and offers significant advantages: not made with hormones, available without a prescription, can be used directly by men, widely available in the United States and other parts of the world, and its use can be visibly validated by both sex partners (Reece et al., 2010). The condom continues to be the only current contraceptive method other than abstinence that effectively prevents HIV transmission, unintended pregnancy, and the reduction of risk for most STIs (Reece et al., 2010). The results of the National Survey of Sexual Health and Behavior (NSSHB) showed that condom use rates were highest among adolescents compared to other life stages in adulthood.

The sexual behavior of adolescents, aged 14-17, are of particular interest. Adolescents' sexual behavior is important because it is deeply rooted in social, cultural, and religious prescriptions for appropriate sexual behavior (Fortenberry et al., 2010). The sexual attitudes and behaviors for the current generation of adolescents have been substantially affected by the evolution of a variety of social media sources, making exposure to sexuality, to sexual information, and to sexual images readily available (Fortenberry et al., 2010). The current generation of adolescents entered adolescence during a period of relative political and social conservatism, with a national emphasis on abstinence-until-marriage as a foundational philosophy of sexual education (Fortenberry et al., 2010). Many (40%) of 17-year-old males reported penile-vaginal intercourse in the past year, but only 27% reported penile-vaginal intercourse in the past 90 days (Fortenberry et al., 2010). However, condom use appears to be a normative behavior for many adolescents (Fortenberry et al., 2010).

Teen Pregnancy

One-half of all pregnancies in the United States are unintended (Fenton, 2010). The teen pregnancy rate in the United States is among the highest for an industrialized nation—more than twice as high as Canada and Sweden (Grose et al., 2014). Teen pregnancy continues to be a major health problem that plagues Oklahoma and contributes to the cycle of unhealthy living. Despite a recent national decline in teen pregnancies, Oklahoma continues to have one of the highest teen birth rates in the country (Kohler, Manhart, & Lafferty, 2008). Teen pregnancies cost the United States an estimated $11 billion each year (E. Coleman, 2015). Teen pregnancy reflects, in part, the broader problem of youth's lack of access to psychological, social, and material resources that support well-informed, empowered choices about reproduction and sexual health (Grose et al., 2014).

Many factors contribute to making the health problem of teen pregnancy a priority in public health. Teen pregnancy is linked to several other risk factors and social issues. Teen mothers are more susceptible to high school dropout; furthermore, there is a higher risk that the baby will have poor health and social outcomes. Consistent factors for the teen mother are poverty, having parents of low levels of education, growing up in a single-parent household, and having poor performance in school ("Reproductive Health: Teen Pregnancy," 2015). Poverty and a lack of education are consistent indicators in poor health, making teen pregnancy a contributing factor and indicator of a high susceptibility to poor health outcomes. Teenage pregnancy is not just a reproductive health issue, but a health problem that is significantly correlated to a host of other social issues that affect children in the United States. In order to better the health of individuals, families, and the community, reducing teen pregnancies must be at the forefront of public health.

The teen birth rate has continued to decrease nationally to current (2013) levels of 27 births per 1,000 teen girls (15-19 years old) ("Reproductive Health: Teen Pregnancy," 2015). However, socially “conservative” states in the South and Bible Belt tend to have the highest rates of teenage pregnancy. Approximately half of the population in Oklahoma resides in rural communities, necessitating that programs and interventions address unique needs of rural and urban environments. Oklahoma ranked 48th in the teen birth rate in the United States with a rate of 42.9 births per 1,000 girls and 5,310 teen births in Oklahoma in 2013 ("The National Campaign," 2015). Every day in Oklahoma, an average of 15 teenage girls aged 15-19 give birth ("State of the State's Health," 2014).

There is a growing concentration of adverse sexual and reproductive health outcomes among the economically disadvantaged and socially marginalized (Fenton, 2010). According to

the Centers for Disease Control and Prevention, non-Hispanic black youth, Hispanic/Latino youth, American Indian/Alaska Native youth, and socioeconomically disadvantaged youth of any race or ethnicity experience the highest rates of teen pregnancy and childbirth. In addition, teen mothers are twice as likely to forgo prenatal care in the first trimester, which may contribute to poorer health outcomes for the mother and baby ("The National Campaign," 2015). This disparity of socioeconomically disadvantaged youth having high rates of teen pregnancy and birth confirms the argument that teen pregnancy promotes and is a result of a cycle of poverty, low education attainment, and single-family households. In 2010, Oklahoma spent $169 million on teen childbearing ("The National Campaign," 2015). Just 38% of mothers who have a child before the age of 18 receive a high school diploma; resulting in uneducated parents and potentially a low education attainment of the child. Likewise, daughters of teen moms are three times more likely to become teen mothers themselves, continuing the cycle.

The factors that contribute to teen pregnancy are often exacerbated by teen childbearing, therefore, placing the children of teen pregnancy at heightened risk of repeating the behavior. Children of teenage mothers have lower school achievement, higher rates of high school dropout, and are more likely to experience health problems, adolescent incarceration, teen childbearing, and unemployment as a young adult ("Reproductive Health: Teen Pregnancy," 2015). Similarly, growing up in poverty, having parents with low levels of education, growing up in a single-parent household, and having poor performance in school are factors that increase a teenager's risk of pregnancy. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, by preventing teen and unplanned pregnancy, serious social problems—including poverty, child abuse and neglect, father-absence, low birth weight, school dropout, and poor job attainment—can significantly improve ("The National Campaign," 2015).

Formal sex education—curriculum based programs both inside school and out—is a key strategy for promoting safer sexual behaviors for adolescents and young adults (Lindberg & Maddow-Zimet, 2012). However, the appropriate type of sex education to be taught in U.S. public schools continues to be a major topic of debate. The U.S. government promotes abstinence-only initiatives. The current federal definition of what constitutes a fundable sex education program reflects social and religious ideals ensuring abstinence education programs are implemented almost exclusively by ultraconservative groups (Boonstra, 2008). The central message of these programs is to delay sexual activity until marriage, and under the federal funding regulations, most of these programs cannot include information about contraception or safer-sex practices (Stanger-Hall & Hall, 2011). Currently, two types of federal funding programs are available, and legislators of individual states have the opportunity to decide which type of sex education to choose for their state to minimize teen pregnancy. Some argue that sex education that covers safe sexual practices, such as condom use, sends a mixed message to students and potentially promotes sexual activity (Kohler et al., 2008). This view has been supported by the U.S. government, which promotes abstinence-only initiatives. Based on a national analysis of all available state data, the results clearly show that abstinence-only education does not reduce and likely increases teen pregnancy rates (Stanger-Hall & Hall, 2011).

Comprehensive sexual health education that includes abstinence as a desired behavior was correlated with the lowest teen pregnancy rates across states (Stanger-Hall & Hall, 2011). Unfortunately, in terms of sex education, most schools only offer “disaster prevention” and not a holistic and honest picture of sexuality (Haffner, 2011). Oklahoma is a state that promotes abstinence-only sex education that stresses abstinence until marriage. A recent study found that higher teen birth rates in poorer states were also correlated with a higher degree of religiosity at

the state level, which led to the finding that the more strongly abstinence is emphasized in state laws and policies, the higher the average teen pregnancy and birth rate (Stanger-Hall & Hall, 2011). Oklahoma, and seemingly the majority of states making up the Bible Belt, were significantly less successful in preventing teen pregnancy compared to other states. Based on the teen pregnancy data in Oklahoma and surrounding Bible Belt states, the religious ideologies and theological rationales consistent with Evangelical Protestantism may be a social determinant of poor health.

Sexual Health and Religion

According to the National Study of Youth and Religion, religion plays an important role in the lives of many American teens (Boonstra, 2008). Eight-four percent of adolescents identify as having a religious affiliation. Six in ten say they attend a religious service at least once a month, and half say that religion is extremely or very important in shaping how they live their daily lives (Boonstra, 2008). Faith-based organizations are instrumental in connecting with teens and can serve as vital resources for adolescent socialization and development. According to a study of more than 2,000 clergy conducted by the Christian Community, only 14% of congregations offered a "reasonably comprehensive" sex education program, about half offered a limited amount of sex education, and 37% close to nothing (Boonstra, 2008). However, when the Christian Community surveyed teens in the same year, they reported that the sex education was even less comprehensive and salient than what clergy reported. The large majority of teens stated that they did not receive the information they needed and wanted from their faith communities (Boonstra, 2008). Nine in ten teens felt the information on sexual decision making they had received from their congregation was inadequate, and fewer than 14% indicated they had

received any significant information on contraception, prevention of STIs, rape and homosexuality (Boonstra, 2008).

Religiosity serves as a protective factor as it delays the onset of sexual behavior (Boonstra, 2008). However, there is a negative association between family religiosity and teen contraceptive use, confirming the suspicion that religious teens have a reduced contraceptive use rate from non-religious teens (Manlove, Terry-Humen, Ikramullah, & Moore, 2006). This may suggest that the first sexual encounter was unplanned with religious teens. Furthermore, one could conclude that there is a greater perceived barrier associated with obtaining contraception in more religious families and communities, thereby making it more difficult for teens in religious families to seek contraception after the first encounter (Manlove et al., 2006). Moreover, men and women who hold traditional perspectives on gender and sexual roles report lower sexual autonomy and higher risk for contracting HIV/AIDS than those with less traditional beliefs (Grose et al., 2014).

Because faith communities play a major role as a rich resource for adolescent growth and maturation, the absence of comprehensive sexual health education may cause more harm than good in the sexual health of its congregations. Religious messages about sex have the potential of harming people, installing fear, shame, and guilt about their sexuality (Haffner, 2011). Only about one in ten people say that the congregations from their youth taught them that their sexuality was a blessing, a gift from God; consequently, shame, fear, and guilt ensued in the other nine (Haffner, 2011). Half of pregnancies in the United States do not need to be unintended, and it serves as evidence that congregations, schools, government, and families have failed in their approach to sexual health and sexuality.

Community Resilience

Faith-based communities and faith leaders can potentially serve as rich resources in assisting people in experiencing health: a true state of complete physical, mental, and social well-being. A framework that conceptualizes how faith-based communities can aid in population health is community resilience. Community resilience is a conceptual framework found in disaster readiness and emergency preparedness literature. Resilience is essentially a metaphor—originally used to describe the capacity of a material or system to return to equilibrium after a displacement (Norris et al., 2008). Resilient materials bend and bounce back; they adapt to disruption. The concept of community resilience can be understood in much the same way, except within the context of a community—environments that influence one another in complex ways (Norris et al., 2008). It is important to note that when it comes to community resilience, the whole community must be the focus, not the individual parts; thereby, a collection of resilient individuals does not guarantee a resilient community (Norris et al., 2008). Community resilience is often discussed in context of a disaster. In this case, the disaster being poor health outcomes—more specifically, high rates of teen pregnancy. In discussions of community resilience, resilience is better conceptualized as a process rather than an outcome. In addition, community resilience is better conceptualized as protean adaptability rather than as stability (Norris et al., 2008).

Drawing from the Disaster Resilience of Place (DROP) model and the model of Stress Resistance and Resilience over Time, three key factors emerge: vulnerability, resilience, and adaptive capacity (Cutter et al., 2008; Norris et al., 2008). A community's level of vulnerability, factors of resilience, and adaptive capacity determines whether the community is able to respond and recover from a disaster and return to a state of post-event functioning as opposed to

persistent dysfunction (Norris et al., 2008). As seen in the continuous poor health outcomes of Oklahoma, teen pregnancy brings a host of social problems to individuals, families, and communities as a whole. The effects of poor health in a community, with a specific focus on teen pregnancy, mirrors the effects of a natural disaster. Using an adapted framework addressing a community's vulnerability, resilience, and adaptive capacity, this study assesses Oklahoma's ability to respond and successfully recover from its perpetual poor health outcomes, including teen pregnancy.

Vulnerability is the pre-event, inherent characteristics or qualities of social systems that create the potential for harm and assesses the degree to which people and places are susceptible to a disaster (Cutter et al., 2008). The social-ecological model is necessary in addressing vulnerability as individuals, families, and communities are each uniquely susceptible to poor health outcomes. The socio-ecological model looks at the interaction between different levels of society, such as individual, organizational, community, and environment. In addition, as seen in the disparity in health outcomes among the socioeconomic status spectrum, vulnerability is best conceptualized as an equity or human rights issue (Cutter et al., 2008). The religious ideologies and theological rationales consistent with Evangelical Protestantism seem to inherently leave communities vulnerable to disaster and poor health outcomes.

Resilience is the ability of a social system or community to respond and recover from disasters and includes those inherent conditions that allow the system to absorb impacts and cope with an event as well as adaptive processes that facilitate the ability of the social system to re-organize, change, and learn in response to a threat (Cutter et al., 2008). In other words, it is a community's ability to absorb disturbance and re-organize into a fully functioning system. A community's resilience takes into consideration its inherent characteristics and adaptive abilities.

Resources including social, economic, and community competence variables serve as indicators of a community's resilience. Social dimensions include inherent characteristics such as demographics, social capital, and faith-based organizations (Cutter et al., 2008). Churches can build social capital and can potentially serve as a protective factor against poor health outcomes. Social capital has been defined as not a single entity, but a variety of different entities claiming two characteristics in common: they all consist of some aspect of social structure, and they facilitate certain actions of individuals who are within the structure (Dawson, 2012). Social capital is not stagnant; it is productive, making possible certain ends that would not be attainable in its absence (Dawson, 2012). Social capital makes up a collective to which the individual belongs. It is a public good, and it is a byproduct of social relationships (Dawson, 2012). The economic dimension includes poverty levels, education attainment, and employment opportunities (Cutter et al., 2008). Lastly, community competence is another indicator of community resilience that promotes population wellness, quality of life, and emotional health (Cutter et al., 2008). The need for social justice necessitates social capital, which potentially leads to a community's resilience and ability to adapt to a disaster.

Adaptive capacity is defined as the ability of a system to adjust to change, moderate the effects, and move beyond the disturbance (Cutter et al., 2008). A resilient community has the ability to reach adaptive capacity and move beyond the disaster to a system that has adapted to an altered environment. Resilience is necessary in order for a community to adapt and move beyond the disaster to a healthier functioning system.

Regional Health—Bray County and Leek County

Sixty-nine of Oklahoma's 77 counties have a teen birth rate higher than the national average, giving Oklahoma among the highest rates of teen birth in the nation ("State of the

State's Health," 2014). According to the 2014 State of the State's Health Report, Oklahoma had a teen birth rate of 22.9 per 1,000 births compared to the United States' rate of 15.4. Two cities will serve as the samples for this research. The communities have been assigned code names to maintain confidentiality of faith leaders. Tonka is located in Bray County, and Tolula is located in Leek County. One of the reasons Tonka and Tolula were chosen was because of their similar population size: Tonka has a population of approximately 25,000 and Tolula has a population of approximately 20,000 ("US Census," 2014). Tonka is located in Bray County, a county with a teen birth rate that exceeds by more than 18 pregnancies per 1,000 live births. Bray County is among the 4th highest teen birth rate in the state, and is 168% higher than the national rate ("State of the State's Health," 2014). Tolula is located in Leek County, a county with a teen birth rate approximately the same as the state rate, but higher than the national teen birth rate ("State of the State's Health," 2014). Comparing two cities of similar size, but with teen birth rates that either mirror the state rate or far exceed it, will allow for a fruitful investigation into the protective factors that contribute to community resilience and the ability to respond and adapt to a disaster.

Despite differences in the teen birth rate in Bray County and Leek County, both counties suffer from poor health outcomes. The leading causes of death in both Bray County and Leek County are heart disease, cancer, and chronic lower respiratory disease ("State of the State's Health," 2014). See Table 1 and Table 2 to compare and contrast Bray County and Leek County.

Table 1: County Profile for Bray County and Leek County

	Bray County	**Leek County**
Poverty Rate:	1 in 6 people	1 in 6 people
Demographics:		
White	81.3%	80%
American Indians	10.4%	10.4%
Bachelor's degree or higher	19.5%	15.3%
Median household income	$41,012	$43,026
Risk Factors:		
% of people that did not meet minimal fruit consumption	55%	51.3%
% of people that did not meet minimal vegetable consumption	30%	21.0%
Obesity prevalence	25.1%	39%
Physical inactivity prevalence	31.5%	36.1%
Smoking prevalence	21.9%	35.5%

("Healthy Living Program County Profile," 2015).

Table 2: Religious Landscape of Bray County and Leek County

	Bray County	**Leek County**
Evangelical Protestant	34.2% (67 congregations)	39.7% (104 congregations)
Mainline Protestant	18.3% (24 congregations)	5.3% (18 congregations)
Catholic	6.4% (5 congregations)	1% (3 congregations)
Other	1.7% (5 congregations)	1.5% (5 congregations)
Black Protestant	0.4% (1 congregation)	0.8% (4 congregations)
None	38.9%	51.7%

("U.S. Religion Census: Religious Congregations and Membership Study," 2012).

CHAPTER III

METHODOLOGY

Study Design

This thesis study utilized a qualitative research design in which faith-leaders residing in Bray County and Leek County were recruited for in-depth interviews. Interviews utilized a deductive approach, following a theoretical framework to explore the role of faith-leaders and congregations in teen pregnancy and overall health. Prior to the initiation of the study, procedures were approved by the Institutional Review Board (IRB) at Oklahoma State University.

Participants and Recruitment

The initial phase of this study utilized the concept of purposeful, voluntary sampling to identify participants for recruitment into the study (J. Corbin & Strauss, 2014). Eligibility involves two criteria: 1) recognized as a faith-leader in the community; and 2) resided in either Tonka or Tolula. Sampling data collection occurred until the level of data "saturation" was reached (J. Corbin & Strauss, 2014). Saturation is reached when no significant new codes or themes are emerging from collected data (J. Corbin & Strauss, 2014). Qualitative research focuses in on the setting or group that is likely to provide the strongest, most relevant

information about the research problem (Daly et al., 2007). Therefore, sampling is not a matter of numbers or of convenience but is strategically focused to collect the most appropriate, "rich" data (Daly et al., 2007). Recruitment occurred by asking contacts (e.g., Tonka Healthy Community Coalition, Ministerial Alliance, and Leek County Healthy Living Coalition) that would yield the highest proportion of participants. Once a few participants were identified, snowballing occurred as faith-leaders provide names of their peers who might be interested in participating in the study as well.

Potential participants were contacted using telephone or electronic mail conversations to establish rapport and address any concerns the participant had about the study. During this time, participants were screened for eligibility based on the two criteria via phone. A review of the literature using qualitative research within a conceptual framework focuses on yielding a sample size that will allow for the development of an overall account of the views of participants (Daly et al., 2007). Therefore, I estimated that approximately 15 participants were needed before data saturation was reached.

Procedures

If the participant met the two eligibility requirements and agreed to participate in the study, an in-person interview was scheduled in his or her community at a mutually agreed upon location. The study involved an in-depth interview using a semi-structured interview guide (see Appendix I) developed by the principal investigator and reviewed by a team of experts from Oklahoma State University. Interviews were no longer than 60 minutes and were conducted by the principal investigator. In each interview, a male was present with me to avoid any discomfort a male faith leader may have when discussing topics such as sexual health and teen pregnancy

with a female investigator. At the initiation of the interview, participants were given an informed consent document (see Appendix II) to sign in order to participate in the research study. This consent document includes confidentiality practices, an outline of the interview process, and an explanation for how data will be utilized by the investigator. In order to ensure confidentiality, the names of the cities, counties, and specific churches have been renamed in this study.

During the course of a single interview, narratives were prompted from each participant. Questions such as: What are the historical conditions that may contribute to current health outcomes? And does the church have a role in sexual education and if not, should it? These questions and more are designed to elicit rich data from participants on health, social capital, community resilience, vulnerability, and teen pregnancy. Interviews were digitally audio-recorded and fully transcribed. The principal investigator took interview notes during the course of the interview to record key aspects of discussions, observations, and impressions of participants. Hand-written notes recorded by the principal investigator were transcribed as well.

Measures

Interview Guide

This qualitative research utilized interviews because it is the most common method in health research (Daly et al., 2007). A semi-structured interview guide (see Appendix I) was developed to elicit narratives from participants. Due to the fact that this study utilized a semi-structured interview guide, questions and probes were moved around as deemed appropriate to encourage additional elaboration if necessary. Narratives were prompted from participants on various topics. Main topics included: 1) Community resilience; 2) Social capital; 3) Perception of health; and 4) Exploration of theology that pertains to a church's role in health.

In both Tolula and Tonka, community resilience was assessed to see if it serves as a protective factor against high teen pregnancy rates. A semi-structured interview guide was used to interview faith leaders in a variety of churches—both Evangelical and non-Evangelical. A question of interest was used to see if competition between churches increases a community's vulnerability to high teen pregnancy rates. The absence of competition would address the presence of social capital. Churches can build social capital and it can potentially serve as a protective factor against poor health outcomes. In addition to social capital indicating a lessened vulnerability in a community, interviews with faith-leaders compared non-Evangelicals and Evangelicals perceptions of poor health.

Poor health contributes to a high burden of cost, which is evidenced in a diminished quality of life, inability to serve in the church, and more frequent visits made by faith leaders to injured or sick congregants. A faith-leader's perception of poor health will also determine if they view it as a "spiritual" problem. A faith-leaders theology could potentially limit their action in contributing to its prevention. For example, is a faith-leader's role in obesity prevention to encourage congregants to eat better and move more; or is their role to encourage more prayer, service, and faithfulness. Their perception can also lead to a determination whether Evangelical or non-evangelical theology in fact fosters poor health outcomes.

Data Analysis

Interview Guide Analysis

A grounded theory approach was used for analysis of interview transcripts. Grounded theory integrates a set of concepts in order to provide a thorough theoretical explanation of the social phenomena under study (J. M. Corbin & Strauss, 1990). Although there is flexibility within limits in grounded theory, there are specific procedures for data collection and analysis (J.

M. Corbin & Strauss, 1990). Data collection and analysis occur simultaneously. Analysis must occur from the start because it can direct the next interview and set of observations (J. M. Corbin & Strauss, 1990). Also within grounded theory, concepts are the basic units of analysis (J. M. Corbin & Strauss, 1990). Actual data, or "raw" data, is not used as much as conceptualizations of data, which allows for analyzing themes. Next, concepts are categorized into themes through the use of coding.

Each interview was transcribed and included multiple read-throughs. Once transcribed, concepts were coded into categories eventually producing consistent themes. The simultaneous practice of data collection and analysis took place until saturation occurs, which I predicted would be around the fifteenth interview.

CHAPTER IV

RESULTS

Demographics

The simultaneous process of data collection and analysis reached saturation after the sixteenth faith leader was interviewed. Ultimately, 9 faith leaders in Tonka were interviewed and 7 faith leaders in Tolula. The faith leaders represented a wide range of denominational backgrounds (see Table 3). Faith leader perceptions of his or her congregation as evangelical or non-evangelical are included in Table 3. Each faith leader answered yes or no to the question, "Would you consider your congregation evangelical or non-evangelical?" Some faith leaders answered this easily, others qualified their no with a reason why. There was a wide variety of understandings of what that meant to the faith leader. Therefore, faith leader perceptions should not be considered representative of all other congregations in that particular denomination. In order to protect the anonymity of each faith leader, the denomination—or religion if outside the Christian spectrum—is named, but not the actual congregation. Out of the 9 faith leaders interviewed in Tonka, 6 were male, 2 were female, and one was a husband and wife team. Eight of the faith leaders held the role of Senior Pastor or leader, and one was an Associate Pastor. In Tolula, 6 of the faith leaders were male and one was female (see Table 4). Five of the faith leaders were the Senior Pastor, one was the leader/pastor of a recovery ranch, and one was the church secretary and non-profit organization executive director.

Table 3: Demographics of Faith Leaders Interviewed

Tonka	**Denomination**	**Evangelical/Non-Evangelical**
	Judaism	Non-Evangelical
	Independent Baptist	Evangelical
	Episcopal	Non-Evangelical
	Southern Baptist	Evangelical
	Nazarene	Evangelical
	United Methodist 1	Non-Evangelical
	United Methodist 2	Non-Evangelical
	First Christian	Non-Evangelical
	Foursquare	Non-Evangelical
Tolula	**Denomination**	**Evangelical/Non-Evangelical**
	Assemblies of God	Evangelical
	Southern Baptist 1	Evangelical
	United Methodist	Non-Evangelical
	Southern Baptist 2	Evangelical
	Recovery Ministry	Non-Evangelical
	Presbyterian	Non-Evangelical
	Non-denominational	Evangelical

Table 4: Gender of Faith Leaders Interviewed

	Male	**Female**	**Total Interviews**
Tonka	7	3	9
Tolula	6	1	7

The interviews took a mean of 58 minutes from start to finish and consisted of a productive conversation guided by the Interview Guide. Using an adapted framework addressing a community's vulnerability, resilience, and adaptive capacity, consistent themes were found within each factor assessing rural community response recovery from poor health outcomes, including teen pregnancy. The process of comparing two communities of similar size, but with distinct differences in the teen birth rates, allowed for a fruitful investigation into the protective factors that contribute to community resilience and the ability of each community to respond and adapt to a disaster.

Vulnerability

Historical Conditions

The vulnerability of a particular community—the historical conditions, lack of social capital across congregations, and disparities found among teen mothers—increases a community's susceptibility to the lasting effects of a disaster. A community's level of resilience determines its ability to respond and recover from disasters. Tonka showed less community resilience than Tolula because of its vulnerability, lack of perceived partnerships across denominational lines, and theological interpretations that separate and prioritize soul and spirit over the body. According to the interviews in Tonka and Tolula, Tonka is a more vulnerable community than Tolula—Tonka also has much higher teen pregnancy rates. Tonka's inherent conditions left the community vulnerable and unable to absorb impact and cope with teen

pregnancy, consequently limiting its ability to re-organize into a fully functioning system. Several questions in the Interview Guide assessed the vulnerability of each community by looking at elements that create the potential for harm and leave a greater susceptibility to poor health. More than half (55.6%; n=5) of the faith leaders in Tonka pointed to a single historical condition that contributed to the current health climate—a large company that employed the majority of the city left the community. The distinct historical event of the big company leaving the community and the perception of little to no partnerships amongst faith leaders stands in stark contradiction to Tolula.

> "[When the company] left [Tonka] making a primarily white-collar town to a now blue-collar town. The low income community is getting larger. The zip code is different for the poor community."
>
> –Non-Evangelical Faith Leader in Tonka

> "[The big company] moved out of town. Now mostly blue-collar jobs exist. This led to an increase in poverty and racial tension."
>
> –Non-Evangelical Faith Leader in Tonka

> "[The big company] left. The excellent teachers were married to the educated men that worked at [the big company]. The quality of teachers went down when [the big company] left. We need a good education system to draw good doctors with their families. It is a cycle."
>
> –Non-Evangelical Faith Leader in Tonka

> "Poverty became more noticeable when [the big company] left. Jobs changed to mostly blue-collar. Anyone with the ability to move, moves. Oklahoma has a history of people moving out when things get hard. Look at the Dustbowl. Fast forward to the present: the

bright kids leave to places with more opportunity. [Tonka] is now left with that mindset and attitude."

-Non-Evangelical Faith Leader in Tonka

In contrast, Tolula did not have the same consistency when noting historical conditions that contribute to the current health outcomes. Faith leaders varied in their observations. Less than a third (28.6%; n=2) of the faith leaders pointed back to a factory that closed in the 70's. Tolula faith leaders did not have as strong of a theme when identifying a historical event that led to current health outcomes and mostly expressed an ease at partnering with other faith leaders in the community.

"[Tolula] used to have [factories]. They closed in the 70's. It closing left behind a community that produces problems. People move out to bigger and better things and it leaves holes."

-Evangelical Faith Leader in Tolula

This thought was confirmed by a Non-Evangelical faith leader who carried along a consistent theme that many people with potential leave Tolula for a nearby large city.

"Historically [Tolula] was a blue-collar town with [factories]. Only one is in operation now. There are less blue-collar jobs available today. All the wealthy people that live here work in [the big city]."

-Non-Evangelical faith leader in Tolula

Perception of Partnerships

Lack of partnerships increase a community's vulnerability and increases its susceptibility to poor health. When asking Tonka faith leaders about other churches and if other churches could

be considered a threat to their faith community, the vast majority expressed a lack of partnerships among faith leaders.

> "Not for us—we are the larger church. I am not interested in church hopping or transfers. We are focused on preaching the gospel, baptizing, and training. We hold a literal interpretation of the Bible. We are friends with other churches, but big on separation."
>
> -Evangelical faith leader in Tonka

> "There are not a lot of partnerships. It is hard to connect with peer faith leaders. There are mostly evangelical churches in [Tonka] and they are not open to connecting with churches that appear 'Catholic'."
>
> -Non-Evangelical faith leader in Tonka

> "Other people see us as a threat. We do not see churches as a threat. We are able to offer more events because we have more money. We used to be the 'country club' church, but not anymore because [the big company] left. Smaller churches are more reluctant to join and collaborate. It is a struggle to be more inclusive."
>
> -Evangelical faith leader in Tonka

> "We have very little to do with other churches. The fear of competition is huge in small towns."
>
> -Non-Evangelical faith leader in Tonka

> "Other churches should be potential partners. But in [Tonka], churches do not work together. Many churches see it as a threat."
>
> -Non-Evangelical faith leader in Tonka

> "Partnerships are not natural, but more tied to events."

-Non-Evangelical faith leader in Tonka

As in the previous dimension of vulnerability, a contrasting theme arose among faith leaders in Tolula when addressing their perception of partnerships amongst other faith leaders.

> "There is a sense of competition at times, but there are no churches that are intentionally trying to proselytize others. There is mostly a cooperative mentality."
>
> -Non-Evangelical faith leader in Tolula
>
> "There is a good partnership amongst pastors with a good representation from all denominations."
>
> -Non-Evangelical faith leader in Tolula
>
> "There are always turf issues, but less here than other places. There is a strong Ministerial Alliance in [Tolula]. Most pastors who are a part of the alliance are not about attracting members, but serving the community."
>
> -Non-Evangelical faith leader in Tolula

The glaring opposing perception of partnerships in Tolula came from an Evangelical faith leader. A contrasting theme between Evangelical and Non-Evangelical faith leaders arose in the area of partnerships. In both Tonka and Tolula, the Evangelical faith leaders were not considered by others as partners, nor did they express the desire to partner with other churches. The Evangelical churches in both communities had the largest congregations.

> "There are no partnerships among pastors here and the community knows it. There is a Ministerial Alliance but the only thing they do is a Thanksgiving meal. There is a 'Me, Myself, and I' mentality among pastors. Pastors do not partner because of shallow reasons."
>
> -Evangelical faith leader in Tolula

Disparities found in Teen Pregnancy

Regardless of community, faith leaders pointed to income as the primary driver in teen pregnancy. Poverty and a lack of education are consistent indicators in poor health—making teen pregnancy a contributing factor and indicator of a high susceptibility to poor health outcomes.

"It primarily affects low-income, which comes from choices."

-Evangelical faith leader in Tonka

"It seems to be poverty driven."

-Non-Evangelical faith leader in Tonka

"Generally speaking, it can be separated by income because it usually affects lower income people."

-Non-Evangelical faith leader in Tonka

"It affects people that are financially struggling."

-Non-Evangelical faith leader in Tolula

"There are huge disparities. It mostly affects low income populations."

-Non-Evangelical faith leader in Tolula

Resilience
Population Wellness

Contrasting themes arose between Tonka and Tolula, but a greater distinction was found between Evangelical and Non-Evangelical churches—independent of the community in which they were located. Social factors, economic factors and community competence serve as resources contributing to a community's resilience. Evangelicals did not contribute to these resources in either community. The correlation between religiosity—high rates of adult identification with Evangelical Protestantism—and poor health outcomes is alarming and puzzling. Given the dominance of Evangelical Protestantism in Tonka and Tolula, the religious

ideologies and theological rationales consistent with Evangelical Protestantism appears to be a social determinant of poor health. Faith leaders were probed in interviews to think about this dichotomy when asked if they thought the church should have a role in health.

> "A minor one. Health is not the primary purpose of the church. I won't put resources toward it. I will speak to it if it appears in the text. The church's priority is the Great Commission. Don't miss the priority purposes of the church—spirit and soul. Body is only secondary. The church should be neutral on health."
>
> -Evangelical faith leader in Tonka

> "It ought to have a role in health by members being active and sharing their resources."
>
> -Evangelical faith leader in Tonka

This particular faith leader's response was not as blatant at the other Evangelical faith leader's response, but seemed disconnected from the health of Tonka as a whole. A disconnect from the health of the community has the same result as the faith leader who speaks blatantly against it. Both contribute to the congregation's decreased involvement in the community, diminished partnerships across denominational lines, and increased prioritization of the spirit and soul over anything with the body. The Non-Evangelical faith leaders in both Tonka and Tolula displayed a greater passion and purpose when discussing the church's role in health connecting it to a theological rational of the whole body.

> "Absolutely. We should serve as advocates for clinics, grant funding, etc. The role of the church is to advocate for the community. Our job is to be good neighbors. Christ calls us to save all of someone—not just a part. The body, mind, and spirit are all important."

-Non-Evangelical faith leader in Tonka

"Absolutely. When Jesus transforms someone, he transforms the whole body—the whole being. Spirituality has to be doable and practical, that is why we focus on health."

-Non-Evangelical faith leader in Tonka

"The church needs to focus on all three parts of the body—the body, spirit, and soul—the whole person."

-Non-Evangelical faith leader in Tolula

"Absolutely. There is tension between 'social justice and action' and 'evangelism and preaching the gospel.' There should not be tension between the two. It should be both/and. The church has a role in exposing gaps and providing answers."

-Non-Evangelical faith leader in Tolula

Faith leaders found themselves on a spectrum of the church having a little role to a primary role in the health of the community, and it was consistent with their identification as an Evangelical or Non-Evangelical church.

Perception of Teen Pregnancy

Each interview progressed from discussing general health to teen pregnancy. Faith leaders had definite opinions on teen pregnancies and the church's role in sex education as a means of preventing further teen pregnancies. Stances on general health seemed to be guided by facts and natural consequences, whereas teen pregnancy and sex education stances were guided by moral principles. A faith leader's perception of teen pregnancy and his or her moral stance on

the issue contributes to the resilience of a community. The resilience of a community necessitates community competence which is determined by population wellness and a perceived high quality of life. Teen pregnancy includes a host of social problems that afflict a community. When faith leaders were asked about their concerns with teen pregnancy in their community, they were either indifferent or knowledgeable about the issue. However, when the same faith leaders were asked about their views on sex education, each one had a thought out answer expressed with conviction. The Evangelical faith leaders in both communities provided the indifferent answers on teen pregnancy in a community as well as the harshest responses.

> "We don't see any teen pregnancy problems, but I am sure it is a problem."
>
> -Evangelical faith leader in Tolula

> "It is an issue, but teen moms are not active with our student ministry. A [Tonka] teen mom program used to be housed at our church, but now it is at the school."
>
> -Evangelical faith leader in Tonka

Some of the Evangelical faith leader responses from Tonka and Tolula were a bit harsher than indifferent.

> "Teen pregnancy leads to poverty, little peace and happiness, welfare, and others needing to offer support. It affects families and the future of kids. It leads to more bad choices and dysfunctional families."
>
> -Evangelical faith leader in Tonka

> "It is a generational thing. The community's problems can be solved if we build 'big men.' True answers to healthy families is having healthy fathers."

-Evangelical faith leader in Tonka

A Non-Evangelical faith leader provided an answer that demonstrated his knowledge of teen pregnancy and its disastrous effects on a community.

> "We have made some gains in this area, but it is still a problem. Teen pregnancy feeds into other health issues. Teen parents can't get an education and good jobs."

-Non-Evangelical faith leader in Tolula

Role of the church in Sexual Education

Some faith leaders may have been indifferent when discussing teen pregnancy itself, but each one held a strong conviction on the role of sex education in the church. Evangelical churches seemed to hold more conservative views on the role of sex education—abstinence only with no discussion of contraceptives for safety.

> "Yes, the church has a role. It could have alternates to prom since most girls lose their purity at prom. Youth directors can talk about it. Parents need to be involved. I am 100% against teaching alternatives to abstinence—curiosity leads to a sin nature."

-Evangelical faith leader in Tonka

> "First and foremost needs to be the parents, but parents are not as involved. True Love Waits (an abstinence only education curriculum) has been taught at our church. It needs to be communicated more."

-Evangelical faith leader in Tonka

> "As a spiritual leader, I don't feel comfortable giving people a way out from biblical truth. Church should be a place of absolutes. Abstinence is a biblical truth. Like I said, if you get the 'head [man]' screwed on right, everything else falls into place."
>
> -Evangelical faith leader in Tolula

> "We teach abstinence; we teach the destruction of what sex does; we teach porn education to men. Teaching abstinence but with contraceptive information does no good—it is just giving them a reason not to be holy or pure and giving them the ability to have sex recreationally. Only non-medicinal contraceptives are non-abortive; the non-abortive types of contraception are okay, but only in a marriage setting. All contraceptives lead to recreational sex."
>
> -Evangelical faith leader in Tolula

In contrast, Non-Evangelical faith leaders held different opinions on sex education than their Evangelical counterparts. Some faith leaders interviewed understood the tenacious cycle of teen pregnancy and its effects on a community, and this understanding led to a conviction that an abstinence only education, although preferred, may not be best. Evangelical and Non-Evangelical faith leaders differed by some viewing the prevention of teen pregnancy from a social good perspective and others viewing it from a moral perspective.

> "[We do] not have the same concept of 'living in sin' as Protestants. 2000 years ago, the marriage contract was meant to protect women. Cohabitation equaled marriage to these communities, not stigmatized as sins. Commitment should be the focus."
>
> -Non-Evangelical faith leader in Tonka

"Churches may do more harm than good. When we come across to strong it does harm. Sex is a gift. Church may not be involved with this topic from the pulpit, but should be involved in the classrooms and pregnancy centers."

-Non-Evangelical faith leader in Tonka

"Abstinence is promoted, but the church should also talk about contraceptives—it is just tricky at the church."

-Non-Evangelical faith leader in Tonka

"The church needs to be cautious. Maybe teach through a youth group session. There is a dilemma because abstinence is the best and healthiest. Unprotected sex is dangerous, but I am not sure what I think about making contraceptives accessible at church or in schools. I would advocate for abstinence until marriage in a growing secular culture in terms of morality."

-Non-Evangelical faith leader in Tolula

"The church needs to have a role in it. Educators need to be proficient in the topic because education can be miseducation. Misunderstanding can be a problem and lead to miseducation. I prefer abstinence, but I know people are not abstinent. We must be aware of that and teach how to protect."

-Non-Evangelical faith leader in Tonka

"When we throw everything behind abstinence only, we do a disservice to our young people."

-Non-Evangelical faith leader in Tonka

"Those who prohibit have the highest rates. Abstinence is desired, but might not work. Guilt and shame come along with abstinence only education."

-Non-Evangelical faith leader in Tonka

"Yes, but people are afraid to talk about it. It should be discussed out loud in the house and in the church. Abstinence only is the best, but if you have to—offer contraceptives."

-Non-Evangelical faith leader in Tolula

"I sat on a committee at the school about sex education. Kids need to be exposed to answers, and this has been effective. Kids should properly understand risk, but not change God's expectation while communicating this. I can lament this or I can deal with reality and work with it, bringing grace and becoming a part of the solution."

-Non-Evangelical faith leader in Tolula

Social Capital through Partnerships

Some faith leaders pointed to building social capital as an answer to teen pregnancy in their community. The Non-Evangelical faith leader in Tolula who served on a school's sex education committee contributed to Tolula's social capital. Another way to build social capital in a community is when churches work together to solve social problems. A key indicator of resilience in a community is social capital found in partnerships. When meeting a community need, faith based organizations have the potential to be highly effective when partnering together. Evangelical faith leaders overall were less likely to partner with other faith leaders to meet a community need. Additionally, Tonka faith leaders perceived less partnerships among all

faith leaders than the faith leaders in Tolula. Faith leaders in Tonka and Tolula were asked if there are faith groups that they partner with on a regular basis to help meet community needs. In addition to whether or not faith based organizations partnered to meet needs, it was interesting to see what the faith leader qualified as a community need.

> "Minimal. We do things with like faith groups. We do some benevolence in house."
>
> -Evangelical faith leader in Tonka

Besides the Evangelical faith leader's response, most faith leaders in Tonka pointed to two events as a community-wide partnership to meet needs. One is the Great Day of Service, which is hosted by an Evangelical church. The faith leader of that particular Evangelical church described it as a, "day in which ten churches partner to do service projects around town." It is a one-time annual event that coordinates different churches to help with projects for the elderly, poor, or sick. One Non-Evangelical faith leader in Tonka reference the Great Day of Service, but did not see that as a continuing effort for churches to partner on a regular basis.

> "Churches are not really partnering. Some pastors partner with each other, but it is not common. We do the Great Day of Service with [Evangelical] church. We host blood drives, but no other churches partner with us. We have a community garden, but no one else helps with it."
>
> -Evangelical faith leader in Tonka

The other continued partnership that was a common theme amongst Tonka faith leaders is the Friendship Feast, which is hosted by a Non-Evangelical church. The faith leader of that particular church described it this way:

"Friendship Feast started here 25 years ago. We provide dinners Monday through Thursday to the community. Churches volunteer at the Friendship Feast to be greeters, servers, and cooks. An [Evangelical] church in town cooks once a month. They make a very good meal—meatloaf. People look forward to it. But, you have to listen to them share the gospel first. [Our] investment in the community is not to make others like us, but to serve—with no strings attached."

-Non-Evangelical faith leader in Tonka

"We are passionate for outreach within our community. We participate in Friendship Feast with other groups. Mostly mainline [Non-Evangelical] churches are involved."

-Non-Evangelical faith leader in Tonka

"Community projects we partner with are the Friendship Feast, Crop Walk, and a community breakfast feeding mostly children. The [Non-Evangelical churches] work together well. Evangelical churches do not partner."

-Non-Evangelical faith leader in Tonka

Tolula faith leaders perceived a greater partnership amongst churches than the faith leaders in Tonka, despite the fact that Tonka faith leaders all referenced one of two outreach programs. Many faith leaders referenced the cooperative program in Tolula that was designed to bring hope to disaster survivors in Oklahoma by responding to the needs of the impoverished. However, Non-Evangelical and Evangelical faith leaders described the event differently.

> "The Ministerial Alliance often does cooperative programs…. It was a summer program that had health screenings, haircuts, job interviews, etc. Churches in [Tolula] know they can call one another to ask for financial assistance for certain families."
>
> -Non-Evangelical faith leader in Tolula

> "[The cooperative program] took place for two summers in a row at the fairgrounds. It had a health fair, offered school supplies, haircuts, etc. Not everyone was reached that needed to be. Only the needy, greedy, and entitled came. Help shouldn't paralyze people."
>
> -Evangelical faith leader in Tolula

Non-Evangelical faith leaders were optimistic about the culture of partnerships in Tolula.

> "Churches in [Tolula] have a long history of working together. We have a soup kitchen at church. We hope to offer free health services for those that fall through the gaps in accessing health care. We helped with Convoy of Hope. 'Love [Tolula]' is a twice-a-year event that takes place on Sunday mornings where we do community projects. Other churches help with that. Our calling is to extend the kingdom of God—his grace, love, and hope—in this place. Our events and activities are intended for us to get to know our neighbors better, not to get people to our church."
>
> -Non-Evangelical faith leader in Tolula

> "All denominations help us. Smaller churches help more. Several churches help the ranch financially. Other pastors teach Bible studies and lead prayer groups. The denomination really doesn't matter, as long as we are building the body of Christ together."

-Non-Evangelical faith leader in Tolula

The one negative response about church partnerships in Tolula came from an Evangelical faith leader:

"Churches in [Tolula] do not partner. Most groups meet just to meet."

-Evangelical faith leader in Tolula

Adaptive Capacity
Church Involvement in the Community

Adaptive Capacity is an important measure in the Community Resilience framework. It is the ability of the community not only to return to the state before the disaster, but to advance the community through learning and adaptation. Community resilience is displayed through active partnerships across denominational lines creating the collective capacity to sustain and renew the community. Bray County—the county which houses Tonka—has among one of the highest teen pregnancy rates in the state—far exceeding the teen pregnancy rate of Tolula. The interviews with faith-leaders in the two communities gave a glimpse into the resiliency of each community and strategies that could be employed to become more resilient, thus preventing further teen pregnancy and a host of other poor health outcomes that mirror a disaster when present in a community. Faith leaders in Tonka and Tolula were asked if they believe the local church should or should not be active in the community. A small minority conveyed that the role of the church was only for ministry and the gospel.

"The local church should be active in the sense of ministry. Everything must be done with a presentation of the gospel. Meeting the physical needs of a community is not the primary purpose of the church. The primary purpose is to preach the gospel."

-Evangelical faith leader in Tonka

Faith leaders in both communities shared similar responses when discussing if a local church is supposed to be involved in its community. Most of the other responses from faith leaders in Tonka were more inclusive of involvement within the community.

> "It is at the heart of what Christ calls us to do. There are a lot of vague things in faith, but we are directed to care for others."
>
> -Non-Evangelical faith leader in Tonka

> "Anything we can do to minister outside the walls of the church we should do."
>
> -Evangelical faith leader in Tonka

> "It is the main purpose of the church. We should be outside of the building just as much as inside. It is going to look like love in the little and the big things."
>
> -Evangelical faith leader in Tonka

> "Absolutely. Historically the church as the community center. If the church believes we should change the world, we should be part of the world."
>
> -Non-Evangelical faith leader in Tonka

> "Yes, the church should be all over the place. There would be less problems at football games if a church presence was there. Community events should be like Sunday morning."
>
> -Evangelical faith leader in Tolula

"We need to make a difference in the community. We need to be difference makers. We must be in the community for this to happen. If our church left today, the only thing [Tolula] would miss is a nice building. This needs to change."

-Evangelical faith leader in Tolula

"The love of God demands us to be active in the community. It is not optional."

-Non-Evangelical faith leader in Tolula

Utopic Communities

The last question of each interview required faith leaders to dream of utopia for their communities. They were each asked to imagine a utopic Tonka or Tolula. Less than a third (31%; n=5) of the faith leaders expressed their inability to even imagine a utopic community. According to one Evangelical faith leader, there is no purpose in even trying to move beyond the health disaster of teen pregnancy, because it is humanly impossible until after Jesus returns. A different Evangelical faith leader in Tonka described what it would look like, but was not hopeful in his answer.

"Jesus Christ reigning in Tonka after rapture. There are no pre-rapture utopic possibilities."

-Evangelical faith leader in Tonka

"The City and faith-based groups working hand in hand to meet needs. But our ideas of how to meet people's needs are different. We are unable to partner because of different purposes—we have two different perspectives."

-Evangelical faith leader in Tonka

However, most were inspiring and their answers hopeful for a community advanced through learning and adaptation.

> "No poverty, better education and access to community colleges; better job base preventing kids from moving away because of no jobs; strong cultural life; a good library."

-Non-Evangelical faith leader in Tonka

> "An equal sharing of resources—none of our children hungry."

-Non-Evangelical faith leader in Tonka

> "More community. Parks full of shared fruit trees. Farmers Markets full. Things are shared. It takes vulnerability because community requires it. It takes being real and falling in love with each other. We need to fall in love with each other because then you put their needs ahead of your own."

-Evangelical faith leader in Tonka

> "A place where people will realize their purpose and accomplish it, making them genuinely happy and full of joy."

-Non-Evangelical faith leader in Tonka

> "A [Tonka] that reflects the Kingdom of God and your zip code would not indicate anything. Poverty is resolved, people healed, equity exists."

-Non-Evangelical faith leader in Tonka

Similarly, a utopic Tolula was described in much of the same way, with an equal mixture of some with hope and others without.

> "Utopia is not the right goal, improvement is better. Churches doing their best to scramble and fill in the gaps. We can disagree, but focus on the best way to help people together."

-Non-Evangelical faith leader in Tolula

> "Utopia probably won't happen, but we are trying. The influence of the kingdom being propagated to the city. Families are put back together. There is brotherly love. We all have love and respect for one another and we can exist without any division. The number one thing the church can do to help with the health of the community is to focus on the head [man] of the family."

-Evangelical faith leader in Tolula

> "There are no prejudices, but people come together."

-Evangelical faith leader in Tolula

> "I have no idea. Never thought about that. A better version of our church would be one that looked like the community. Walmart looks more like the community than church. We do not even look like our immediate neighbors."

-Evangelical faith leader in Tolula

“A utopic [Tolula] would be a community where no one goes hungry. No one has a need unmet. A community that looks out for one another.”

-Non-Evangelical faith leader in Tolula

CHAPTER V

DISCUSSION

A community's vulnerability, resilience, and adaptive capacity determines whether a community can recover from a disaster and possibly adapt to a better functioning system than the pre-disaster environment. In a study written specifically on forest sustainability, community resilience was measured as a key construct in determining whether environments could thrive in contexts of constant change. The definition which emerged from that research was, "Community resilience is the existence, development, and engagement of community resources by community members to thrive in an environment characterized by change, uncertainty, unpredictability, and surprise. Members of resilient communities intentionally develop personal and collective capacity that they engage to respond to and influence change, to sustain and renew the community, and to develop new trajectories for the communities' future" (Magis, 2010). This definition of community resilience remains true when the context is teen pregnancy in rural communities. The church in rural communities has the ability to positively affect the teen pregnancy rates by contributing to the community's resilience. Community resilience is displayed through active partnerships across denominational lines creating the collective capacity to sustain and renew the community.

Bray County, the county which houses Tonka, has one of the highest teen pregnancy rates in Oklahoma, far exceeding the teen pregnancy rate of Tolula. The 16 interviews with faith-leaders

in the two communities gave a glimpse into the resiliency of each community and initiatives that could create more resilience, thus preventing further teen pregnancy and a host of other poor health outcomes that mirror a disaster when present in a community. Tonka showed less community resilience than Tolula because of its vulnerability, lack of perceived partnerships across denominational lines, and theological interpretations that prioritized soul and spirit over the body.

Vulnerability

According to the interviews in Tonka and Tolula, Tonka is a more vulnerable community than Tolula—as evidenced in their heightened teen pregnancy rates. Faith leaders in Tonka did not recognize ongoing partnerships across denominational lines. Some Non-Evangelicals perceived that Evangelical churches do not partner. At the same time, some of the self-identified Evangelical faith leaders did not see partnering as a priority or seemed indifferent about the subject. Tonka did not have an active Ministerial Alliance and relied on single events to work together. Tonka does have one ongoing community feeding program in which churches and civic organizations participate. The infrastructure for on-going partnerships among faith leaders exists through that program. Churches are uniquely positioned to facilitate participation of people from hard-to-reach populations (Goldmon & Roberson Jr, 2004). The feeding program has the potential for expansion wherein faith leaders address disparities in unison. Conversely in Tolula, the perception of partnerships across denominational lines is great among faith leaders. The only exceptions to this perception were two of the Evangelical faith leaders interviewed in Tolula. Faith leaders in Tolula viewed the Ministerial Alliance as a hub for partnerships. These partnerships increase community capacity to respond to social problems, including the precursors of teen pregnancy. The teen pregnancy rate in Tolula was similar to the state average. Ministerial Alliances may be utilized to

increase the resilience of a community and in order to become better equipped at facing the disaster-like outcomes of teen pregnancy, specifically rural communities that are underserved in regards to access to key resources.

The other distinct reason Tonka is more vulnerable to the disaster of teen pregnancy than Tolula is the historical conditions that led to the community's susceptibility to poor health. The prevailing sentiment among Tonka faith leaders was that the highest SES individuals regularly leave the community seeking opportunity elsewhere. The community is left with lower SES individuals who do not have the resources available to better themselves or those around them. Whether this actually happens or not in Tonka is second to the fact that the faith leaders perceive it happening. There is a victim mentality among faith leaders in Tonka causing them to settle with the status quo instead of empowering themselves to help with the change. Addressing this victim mentality may limit the consequences of vulnerability within a community. The church is uniquely positioned to influence perception, and faith leaders must take an active role in making their communities great, and consequently in creating a community for people to stay.

Theological Priorities

Theology guides practice in congregations. For most faith leaders, theology is formulated through a combination of four sources: the revelation of God, the faith experience of the believer, the Bible, and the church (Yarbrough, 2000). In states with high rates of Evangelical Protestantism, the prevailing conviction is scripture only. Meaning, a faith leader's interpretation of the Bible will be what guides the practice of the congregation. Therefore, it is difficult to shape the theology of a faith leader, particularly by a lay person outside of the denomination. If a faith leader holds the conviction and interprets the Bible in a way that makes spirit and soul

separate from and an exceedingly greater priority than the body, then naturally anything that emphasizes the health of the body will be secondary and not a priority. This theological rational, although not intended for ill among faith leaders, has disastrous consequences on the health of Oklahoma. The poor health outcomes and alarming teen pregnancy rates are an indirect result of the theological belief that the body is secondary and therefore not a priority. This theological interpretation was unique to the Evangelical faith leaders interviewed. Although not intentionally, it alienated them from partnering with other congregations on community health initiatives because it is not seen as something with eternal value. More than health behavior changes, changing a faith leader's interpretation of the Bible and influencing behavior based on that interpretation is challenging if not impossible.

Solution approaches in the short-term target the congregations and faith leaders whose theological interpretations of the Bible allow them to have a holistic and whole-body view of health and faith. These faith leaders can help change the fabric of rural communities in Oklahoma. They view social action as a natural and consequential practice of following Jesus. There is a powerful effect when someone believes their God-given purpose is to help others live better lives. This belief can be used for the prevention of teen pregnancy when faith leaders are shown a way to partner and address sexual health as a unified front.

Many Evangelicals are open to partnerships. However, it will take a knowledge of a community and individual relationships with Evangelical faith leaders. Behavior change models may be used across a long-term relationship with the faith leaders in order to gain their participation in health partnerships.

Resources

Resilience & Adaptive Capacity

Resources, including economic, social, or community competence, contribute to a community's resilience. In terms of social resources, Tonka and Tolula differed in social capital. Social capital is built upon mutual giving and reciprocation. "All social relations and social structures facilitate some forms of social capital; actors establish relations purposefully and continue them when they continue to provide benefits. Certain kinds of social structures, however, are especially important in facilitating some forms of social capital (J. S. Coleman, 1988). Faith based organizations have vast potential in facilitating forms of social capital that benefit the community as a whole. Tonka perceived little to no partnerships amongst pastors, specifically amongst Evangelical pastors. Whether a partnership was present or not, the mere perception of an absence of partnerships and therefore an absence of mutual reciprocation, lends to an absence of social capital among faith based organizations. Whereas the majority of faith leaders interviewed in Tolula perceived an effective partnership among pastors and congregations. This partnership led to social resources present in the community resulting in a great resilience to respond and recover from teen pregnancy. Tolula's strong Ministerial Alliance serves as a conduit for partnerships across denominational lines. Social capital is cultivated within churches in groups like the Ministerial Alliance and through ongoing partnerships like the Friendship Feast.

Current Programs

A collaborative partnership is an alliance among people and organizations from multiple sectors, working together to achieve a common purpose (Roussos & Fawcett, 2000). Faith-based organizations should view themselves as necessary partners in public health. In public health,

collaborative partnerships attempt to improve conditions and outcomes related to the health and well-being of entire communities (Roussos & Fawcett, 2000). A great place to start for a collaborative partnership is the Ministerial Alliance. Faith leaders in rural communities need to begin seeing themselves as a key piece of the partnership puzzle that can attempt to improve the health outcomes in Oklahoma.

Faith leaders maintain a role in the health of their congregations in many communities, and in partnership with public health entities. “Religious leaders possess extraordinary credibility and influence in promoting healthy behaviors by virtue of their association with time-honored religious traditions and the status which this affords them—as well as their communication skills, powers of persuasion, a weekly captive audience, mastery over religious texts that espouse the virtues of healthy living, and the ability to anchor health-related actions and rituals in a person’s values and spirituality” (Anshel & Smith, 2014). In 2014, Oklahoma incorporated congregations to the list of organizations allowed to apply and receive recognition in the Certified Healthy Oklahoma program. Certified Healthy is a certification that showcases businesses, campuses, schools, communities, and more that are committed to supporting healthy choices through environmental and policy change ("Certified Healthy Oklahoma," 2015). A Certified Healthy Congregation recognizes faith traditions in Oklahoma that are working to improve the health of their congregations by providing wellness opportunities and adhering to policies and rules that lead to healthier lifestyles ("Certified Healthy Oklahoma," 2015).

Modeling the importance of health from the pulpit and changing the environment in congregations to support healthy living is a great step in changing behavior. However, current resources are limited to improving the health inside the walls of a congregation, and need to be implemented in conjunction with a resource focused outside the walls as well. In addition to

congregation specific resources, resources are needed to encourage partnerships that lead to community resilience and ultimately better health.

Conclusion

Congregations are in a unique position to address health issues. With more than 6,500 congregations in Oklahoma, the potential for a robust partnership between faith and health is great (Pew Research, 2013). Tonka has among the highest teen pregnancy rate in Oklahoma and far exceeds the teen pregnancy rate of Tolula. The stronger partnerships across denominational lines to meet community needs in Tolula makes Tolula a more resilient community than Tonka. Despite theological differences, population health will be improved when faith-based organizations partner and utilize resources in a way that benefits the community at large. The theological rationales of Evangelical Protestantism that have contributed to the high rates of teen pregnancy in Oklahoma can ultimately be reversed by resilient communities built upon strong partnerships among faith leaders. If the modern church acted congruously with the original heart of the early church—taking care of those in need and without protectors—then these religious communities would be the champions of health and advocates for high risk communities, helping the disadvantaged to break the cycles of poor health outcomes and ultimately building resilient communities.

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APPENDICES

APENDIX I

FAITH-BASED LEADERS AND HEALTH COMMUNITY STUDY INTERVIEW GUIDE

Topic Domain: A faith-based group's ability to contribute to the resilience of the community in which it resides and in doing so better the health outcomes and lower the rate of teen birth.

Covert Categories of Interest:

Health	Resilience	
Social Capital	Adaptive Capacity	
Teen Pregnancy	Population Health	
Vulnerability		

Introduction

Thank you for agreeing to be part of the study. My name is Becky and I will be asking you a few short questions this morning/afternoon/evening. Your comments and thoughts are valuable and important to this research project. This interview has been designed to be as informal as possible and is designed to give you the most opportunity to speak about your personal experience and beliefs.

Purpose

Today I would like to get your comments, thoughts, and experiences pertaining to your experience as a faith leader and your perceptions of health here in Sapulpa/Ponca City.

There are no wrong or right answers, so please feel free to say what comes to your mind first when a question is asked. Please feel that you can elaborate or speak for any length of time on a question. All of your ideas and comments are welcomed.

I am conducting this interview as a researcher at Oklahoma State University. The results of this interview will be used for learning and evaluation processes.

Procedure

During the course of your responses I will be taking notes and audio recording the interview to make sure I do not miss any important comments or ideas you may develop. Before I begin recording, I wanted to check in with you again to make sure it is okay that this interview is audio recorded.

(Check in. Upon completion, continue.)

The interview should last about 45-60 minutes. Everything said during the course of the interview is confidential. You are free to leave the interview at any time or not answer any questions that you choose not to.

Now, at this time I would like to go ahead and begin with the interview questions.

(If participant has previously approved, turn audio recording device on. Continue.)

Interview Guide

Lead Off Questions:

1. What is your role in your faith-community? Would your faith-community be considered Evangelical or Non-evangelical? Is there a label that best describes your church?

2. I am interested in the concept of community and a faith-community's role in health. Any health concerns in your community that jump out to you?

Follow-Up Questions:

1. From your perspective, what drives poor health outcomes in your community?

2. What are some historical conditions that may contribute to current health outcomes? *(Vulnerability—pre-disaster state)*

3. In what ways could other churches be considered a threat to your faith-community? On a scale of 1-10, 1 being no threat and ten being a great threat, how would you rate the perception of threat your faith-community has with other churches in Sapulpa/Ponca City? *(Vulnerability—competition between churches)*

4. Does the church have a role in health? If not, should it? *(Resilience—resources)*

5. Finish this sentence: Religiosity is beneficial to health because…

(Resilience—resources: population wellness/quality of life)

6. Finish this sentence: Religiosity might contribute to poor health because…

7. What are the concerns with teen pregnancy in your community?
   (Resilience—resources: education attainment/poverty levels)

8. Does the church have a role in sexual education? If so, how does the education look? If not, should it?

9. How does the church handle a teen pregnancy if it happens to one of its members?

10. Are there other faith groups that you partner with on a regular basis to help with community needs?
    (Resilience—Resources: social capital)

11. Can you share an experience where churches worked together to accomplish a community task?
    (Resilience—Resources: social capital/faith-based organizations)

12. What do you believe to be the greatest influencers in an adolescents' life?
    (Vulnerability—socio-ecological impact)

13. Do you see any disparities in poor health or in teen pregnancy?
    (Vulnerability—equity)

14. Finish this sentence: I believe the local church should (or should not) be active in the community because…
    (Adaptive Capacity—community advancement post-disaster)

15. What are the top three strengths/advantages for people being connected to a local church?

16. Can you share an experience of a success story within your church or community? Someone who struggled in an area of health and how the church intervened and helped?

17. Let's say a faith-leader friend from a different community wanted to be more involved in the community. What advice would you give him or her?

18. Imagine a utopic Sapulpa/Ponca City. What would it look like?
    (Adaptive Capacity—community advancement post-disaster)

I appreciate your willingness to discuss your experiences. At this time, this is all of the questions I have for you. Are there any questions you have for me? If not, thank you once again for your participation.

(If audio recording device is on, turn off. Continue.)

End of Interview

APENDIX II

INFORMED CONSENT

IRB STUDY #

OKLAHOMA STATE UNIVERSITY
ROLE OF FAITH LEADERS IN HEALTH STUDY

CONSENT FORM

You are invited to participate in a research study about the role of faith leaders in health because of your role as a faith leader and your residence in Ponca City or Sapulpa. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Becky Taylor, MDiv. Becky Taylor is pursuing a Master of Public Health at Oklahoma State University.

STUDY PURPOSE

The purpose of this study is to gain insight from faith leaders who reside in Ponca City or Sapulpa about their role in health within their communities.

PROCEDURES FOR THE STUDY:

If you agree to be in the study, you will do the following things:

You will be participating in an interview to discuss the health of your congregations and the health of Ponca City/Sapulpa. The interview is estimated to take between 45-60 minutes of your time.

RISKS OF PARTICIPATION

There are no risks that are anticipated from your participation in the study. Some of the questions may make you feel uncomfortable, but you are free to decline to answer any questions you do not wish to answer or stop participation in the study.

BENEFITS OF PARTICIPATION

The anticipated benefit of participation is the opportunity to discuss perceptions and concerns related to the health of your community from the perspective of a faith-leader.

CONFIDENTIALITY

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and her research associates, the Oklahoma State University Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP), etc., who may need to access your research records.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study, contact the researcher, Becky Taylor at becky.taylor@okstate.edu or Dr. Julie Croff (Faculty Advisor) at julie.croff@okstate.edu .

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IRB Office at 223 Scott Hall, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with Oklahoma State University.

CONSENT DOCUMENTATION:

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the benefits of my participation. I also understand the following statements:

I affirm that I am 18 years of age or older.

I have read and fully understand this consent form. I sign it freely and voluntarily. A copy of this form will be given to me. I hereby give permission for my participation in this study.

_____

_____ _____

Signature of Participant Date

I certify that I have personally explained this document before requesting that the participant sign it.

_____ _____

Signature of Researcher Date

VITA

Becky Taylor

Candidate for the Degree of

Master of Public Health

Thesis: RECOVERING FROM AN EPIDEMIC OF TEEN PREGNANCY: THE ROLE OF RURAL FAITH LEADERS IN BUILDING COMMUNITY RESILIENCE

Major Field: Public Health

Education:

Completed the requirements for the Master of Public Health in Rural and Underserved Communities at Oklahoma State University, Stillwater, Oklahoma in May, 2016.

Completed the requirements for the Master of Divinity at Golden Gate Baptist Theological Seminary, Mill Valley, California in May, 2008.

Completed the requirements for the Bachelor of Arts in Sociology at Oklahoma State University, Stillwater, Oklahoma in May, 2005.

Experience:

OSU Prevention Programs, Stillwater, Oklahoma
TSET Healthy Living Program Coordinator (November 2014 – Present)

- Coordinate the Payne County TSET Healthy Living Program grant.
- Wrote annual grant submissions—securing approximately $1 million in funding throughout my tenure.

OSU Prevention Programs, Stillwater, Oklahoma
Assistant Tobacco Prevention Coordinator (January 2013 – November 2014)

Portland Christian Schools, Portland, Oregon
8th and 11th Grade Teacher (August 2009 – June 2011)