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ORIGINAL PAPER

Filling the Gaps: The Role of Faith-Based Organizations in Addressing the Health Needs of Today's Latino Communities

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Abstract

Research on the acceptability of faith-based health promotion programs by Latino communities in the Bible Belt is limited. This study examined the needs, barriers, and facilitators related to such programs in Memphis, TN. Thirty Latino community members and ten faith leaders participated in focus groups and in-depth interviews, respectively. Health needs identified included diet, dental care, and screenings, while barriers included cost, education, lack of prevention-seeking behaviors, and need for Spanish language services. Faith leaders were aware of more health resources than community members. Despite being receptive and acknowledging the need for faith-based programs aimed at prevention and filling healthcare gaps, concerns regarding the influence of religious doctrine on health interventions were expressed by members of both groups. Faith leaders, practitioners, and community members must work together to overcome barriers related to trust and health behavior norms.

Keywords Hispanic · Denomination · Health promotion · Disease prevention · Qualitative research

Introduction

Over 56 million people in the USA identify as Hispanic or Latino, making them the largest and fastest growing minority population in the country (United States Census Bureau 2017). The Latino population in the USA is diverse and varies by

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age, education, country of origin, and geographic location (Pew Research Center Religion & Public Life 2015). As the Latino population and the diversity within this population increase, the need for health services is also expected to increase. Nationally, almost 36% of Latinos have been diagnosed with diabetes (Centers for Disease Control and Prevention 2018). While cardiovascular disease is low among Latinos compared to other ethnic groups, growing rates of obesity may put many at risk for future disease (Kaplan et al. 2014). Currently, Latinos in the USA have a high prevalence of both overweight and obesity with Latinas more likely than Latinos to have a higher body mass index (Kaplan et al. 2014; Ogden et al. 2015). With increasing weight, chronic health issues and doctor visits become more common (Hubert et al. 2005).

Some health professionals are targeting low rates of physical activity among Latinos to reduce obesity and chronic disease rates (Bopp et al. 2011; Larsen et al. 2014). Within this heterogeneous population, however, dietary behaviors have been harder to address due to cultural and regional food preferences (Perez-Escamilla 2011; Siega-Riz et al. 2014). Other health promotion efforts, such as improving health screening and knowledge, are scattered, with many programs focusing on subsets of the population (e.g., migrant workers, women) (DeHaven et al. 2004; Lopez-Cevallos et al. 2013; Spencer et al. 2011). Some Latinos also may choose not to seek health services from traditional providers due to barriers such as health insurance, money, language, health system knowledge, and documentation (Derose et al. 2007).

Since barriers may exist between Latino communities and healthcare organizations, working with nontraditional organizations provides a possible solution for health outreach. Faith-based organizations, which are community-embedded and -trusted resources, may be particularly advantageous partners (Campbell et al. 2007). Most faith-based health promotion programs target improved knowledge and behaviors related to the prevention of chronic diseases (DeHaven et al. 2004). To date, the majority of these programs have focused on African American churches and communities (Campbell et al. 2007; DeHaven et al. 2004), but there is growing interest in using faith-based strategies to reach Latino communities with chronic disease prevention and other health promotion programs (Bopp et al. 2011; Gutierrez et al. 2014; Lopez-Cevallos et al. 2013).

Catholicism is the dominant religious affiliation among Latinos attending church in the USA, with 55% of Latinos identifying as Catholic (Pew Research Center Religion & Public Life 2014a), and historically health promotion programs have been implemented with Catholic churches in Latino communities (Allen et al. 2014; Bopp et al. 2011; Krukowski et al. 2010). A growing number of Latinos (22%), however, are moving toward Protestant denominations (Pew Research Center Religion & Public Life 2014a). This shift in religious affiliation and its impact on historical faith-based health promotion methods are important for researchers to understand. Other shifts in Latino populations are also occurring, which impact research on faith-based health promotion efforts with Latino communities.

Historically, research conducted with Latino communities has taken place in states and cities with a large Latino population (Campbell et al. 2007; Hubert et al. 2005; Lopez-Cevallos et al. 2013; Martinez et al. 2012; Siega-Riz et al. 2014).

While the majority of Latino populations remain concentrated in six states, several states (South Dakota, Tennessee, South Carolina, Alabama, Kentucky) have seen high rates of growth since 2000 (Castaneda and Cayuela 2017). Tennessee is second in the nation, with its Latino population growing by almost 176% between 2000 and 2014 (Castaneda and Cayuela 2017). Interestingly, Tennessee and three other states where Latino populations are growing are part of the "Bible Belt," where Protestant religious affiliation outnumbers Catholic affiliation by a larger margin than anywhere in the USA (Pew Research Center Religion & Public Life 2014b). However, the appropriateness of faith-based health promotion initiatives among Latino communities in this area of the USA is unknown.

The current study addresses gaps in the literature regarding the appropriateness of faith-based health promotion programs for Latino communities that have become increasingly diverse in their health needs, religious affiliations, diversity in countries of origin, and locations of residence. Using qualitative methods, this study explored faith leaders' and community members' perspectives on the needs, barriers, and facilitators related to providing faith-based health promotion programs to Latino communities in Memphis, TN: a metropolitan statistical region with a highly diverse Latino population possessing a complex set of religious affiliations.

Methods

Theoretical Framework and Participants

The reality of faith-based health promotion programs in Memphis is socially constructed; therefore, this study used the constructionism framework (Patton 2002). Researchers using this framework believe our culture and lived experience within that culture shape our worldview (Patton 2002). As such, no one individual, or group of individuals, sees the world in the same way, each group's perception of the world being shaped by their culture and unique lived experience. A constructionist framework also holds each group's reality is valid, with none being more right or true or real, and it is only understanding these multiple perspectives of a phenomenon that gets us closer to universal "Truth" (Patton 2002). Given this framework, perspectives of both faith leaders and Latino community members were sought to capture the knowledge and experiences of both faith-based program providers and potential participants, respectively.

Adults (over 18 years of age) living in the greater Memphis area self-identifying as Latino/a and faith leaders serving Latino communities were recruited between January and March 2016. We purposively sampled community members with and without religious affiliation to reflect the potential heterogeneity in individuals using faith-based resources (e.g., clothes closets, food pantries, health clinics, childcare services). It is well documented that many faith-based organizations play a larger role in communities beyond offering spiritual guidance (Campbell et al. 2007; Mamiya 2006; Marquardt 2006). The church becomes a safe gathering place and trusted resource for both congregants and the wider community, especially among Latino communities in the USA (Marquardt 2006). Gathering viewpoints from a

diverse cross section of Latino community members helps shed light on whether faith-based health promotion programs will attract only members of a congregation or will be more widely accepted within a community.

Community members participated in approximately 1-h-long focus groups, while faith leaders participated in 1-h-long in-depth interviews. Each participant was compensated with a $20 gift card. Community members were recruited through connections with local churches, football (soccer) clubs, and promotion by local Latino organizations. Recruitment strategies aimed to gain a broad perspective from individuals who may be interested in community-based health promotion programs. Therefore, individuals with various religious affiliations, including no religious affiliation, were recruited. A total of 35 individuals contacted the study about participating resulting in 30 participants over four focus groups. Faith leaders were purposively recruited using a list of local churches and faith organizations who serve Latino communities. Of 21 faith leaders contacted, ten participated in interviews. Interviews and focus groups were held at a variety of times and locations to best accommodate the participants' scheduling and transportation needs. The University of Memphis Institutional Review Board approved all research protocols and consent forms prior to recruitment.

Data Collection and Analysis

Faith leaders and community members were asked about the health needs facing Latino communities, organizations offering health-related services or programs, and gaps in/acceptability of services and programs offered through faith-based organizations in Memphis. Separate analyses of focus group and interview findings were completed using a grounded theory approach (Charmaz 2006; Glaser and Strauss 1967). Participants were free to communicate in either English or Spanish.

Focus groups ranged in size from two to ten participants. Each focus group consisted of an open-ended discussion moderated by the second author, FE, assisted by the first author, BEH, and facilitated by a discussion guide (Table 1). The semistructured interviews with faith leaders were conducted by BEH, if the

Table 1 Questions and probes from focus groups and interview guides

What are the biggest health needs in your community?
What has been your experience with finding health resources in Memphis?
Where do you go for health information?
How about health promotion programs (i.e., screenings, physical activity, healthy eating, disease management)?
How do you feel about churches offering health resources?
Does your church offer any health services or programs to your congregation?
Why should churches offer (or not offer) health promotion programs?
What would need to be in place to help you attend a health promotion program at a church near you (i.e., childcare, transportation, people you know attending)?

Faith leaders were asked about their congregation members using the phrase "your congregation" in place of "you"

participant preferred English, and FE, if the participant preferred Spanish. All interviews were facilitated by an interview guide (Table 1). Data were audio-recorded, transcribed, and coded using NVivo 11 (QSR International).

The credibility and trustworthiness of findings were ensured using the following approach: (1) Focus group transcripts and field notes were reviewed and compared to identify discrepancies. (2) An initial codebook was created with a priori codes based on the interview/discussion guides. (3) The lead, second and third authors, BEH, MS and FE, had a meeting to review transcripts and the a priori codes, establishing similar code interpretations before coding began. (4) FE coded focus groups while MS coded interviews independently. BEH met with MS and FE regularly for peer debriefings and to discuss emergent themes as well as codebook and categorization refinements. (5) Once all focus groups and interviews were coded, MS and FE switched codes and transcripts to review for consistent interpretation of the findings. (6) BEH, MS, and FE met after the review of focus group and interview findings to create a matrix that integrated community and faith leader perspectives into themes. The coding matrix was constructed with interview themes on the Y-axis and focus group themes on the X-axis of a Microsoft Excel 14 (Microsoft Corporation, 2010) spreadsheet. MS cross-referenced each theme with every other theme, constantly comparing their respective contents. FE reviewed the cross-referenced themes and noted changes. MS and FE then compared their matrices for agreement. BEH reviewed the completed matrix to aid in the creation of themes and reporting of findings. (7) Findings were shared with participants for member checking before being incorporated into the manuscript.

Results

Faith leaders interviewed were all male, on average 47.6 years old (SD = 9.83), and 80% were affiliated with a Protestant organization. Community members were 70% female, on average 35.4 years old (SD = 11.52), 70% were born in Mexico, and 47% affiliated with a Protestant church, while nearly 34% had no church affiliation (Table 2). Themes from the interviews with faith leaders and focus groups at times showed similarities and at times differences. Themes are described below with mentions provided in parentheses, see Table 3 for specific quotes.

Health Needs

Faith leaders and community members both noted a variety of similar health conditions facing their communities ranging from chronic disease prevention to dental care. Chronic diseases such as high blood pressure, diabetes, and obesity were most commonly mentioned by both faith leaders ($n = 9$) and community members ($n = 11$).

Table 2 Demographics of participants in a study of Latino communities in Memphis, TN ($n=40$)

Faith leaders ($n=10$)	
Time at current organization, years *M* (SD)[a]	13.8 (9.77)
Age, *M* (SD)	47.6 (9.83)
Sex, *N* (%)	
Male	10 (100)
Female	0 (0)
Marital status, *N* (%)	
Single	3 (30)
Married *N* (%)	7 (70)
Highest degree, *N* (%)	
High school	1 (10)
Some college	4 (40)
Graduate degree	5 (50)
Number of people in their home *M* (SD)	3.4 (2.17)
Denomination *N* (%)	
Protestant	8 (80)
Catholic	2 (20)
Focus group participants ($n=30$)	
Age, *M* (SD)	35.4 (11.52)
Sex, *N* (%)	
Male	8 (26.7)
Female	21 (70)
Marital status, *N* (%)	
Single	13 (43.3)
Married	17 (56.7)
Children living at home, *M* (SD)	1.9 (11.52)
Country of birth, *N* (%)	
USA	2 (6.7)
Mexico	21 (70)
Central America[b]	7 (23.3)
Church affiliation, *N* (%)	
No affiliation	10 (33.5)
Protestant	14 (46.7)
Catholic	6 (20)
Days per week spent in 30 min or more of physical activity, *M* (SD)	1.6 (1.69)
Fruit and vegetable servings eaten per day, *M* (SD)	2.1 (1.22)
Sugar-sweetened beverages consumed per day, *M* (SD)	1.4 (1.46)

[a]Two faith leaders worked in Latino community outreach through a local faith-based hospital

[b]El Salvador, Guatemala, and Honduras

Table 3 Quotes from faith leaders and community members related to the health needs and resources available to Latino communities in Memphis, TN ($n=40$)

Themes and subthemes	Quotes
Health needs	*I think we have a lot of people with high blood pressure, diabetes, obesity.* (Faith leader)
	Oh, in my case, I have diabetes. I got it when – I've had diabetes for three years. And it is difficult. [Crying]. (Community group)
Diet	*What can I say? I mean you can eat tortilla but please don't eat 20 and they make fun of themselves, like, 'Oh,' they said, 'He keeps me on the making tortilla.' 'Baby, how many?' 'Oh 15.' I go, 'Oh my goodness, you eat 15 tortillas…?'* (Faith leader)
	I think something that we hope in particular with community is if we have somebody that teaches about nutrition because our culture is about eating. (Community group)
Screenings	*And there's a lot of people have cancer. They never know. They don't go every six months for pap smear.* (Community group)
Dental care	*What I have seen as the health needs is more pressing the topic of teeth, eyes, and ears. Especially the teeth. I have… is that many members of this church suffer from the issue of the dental problem. That would be the main thing."* (Faith leader)
	Well, I think that in the Hispanic community, we need more dental care. (Community group)
Barriers to health	
Cost	*For a lot of folks, they don't have insurance, and then those that do, they're paying a lot for that insurance and there are still gaps related to dental care and medications and things like that.* (Faith leader)
	And I just want to say that we're talking about the people who has insurance. Ok. People who can't work because of any problem, any other reason can't afford to go….So I'm going to ring you up. I need your driver's license. I don't have a driver's license. Oh well, I'm sorry. I can't sell it to you. (Community group)
Prevention-seeking behaviors	*One problem we have in Latin America is that we lack a lot of culture around prevention. So we generally go see a doctor because we are already sick. It is not in our culture to prevent…We go because we are already sick*. (Faith leader)
	Community Group Exchange: *I think it's been ingrained in our culture, especially Hispanic culture, to in a way "suck it up" when you grow up and like you see the lack of—like if you have no insurance and especially amongst undocumented people.* (Community Member 1) *I feel like they use [clinics] like the last resort. Like if your cold has been going on for like quite a few days, it's like, "Oh, I need to seek some medical attention. But he's right about people sucking it up. Like even my dad.* (Community Member 2) *It's a cultural thing*. (Community Member 3)

Table 3 (continued)

Themes and subthemes	Quotes
	There are also a couple of places like the Mercados where … they find some natural kind of medicines that they use. From their own experience back in their home countries…. It's just tradition. (Faith leader)
	'Cause some places all they want is the money. And you're going to go there and they're going to say hey, you need to get this, this and this done even if you don't need it. (Community group)
Healthcare services in Spanish	*No, and it's very little – one of the main constraints – it's not a constraint, it's a road block we have, is that there are not enough doctors in this area that can speak the Spanish language.* (Faith leader)
	Sometimes I think that there needs to be more locations in Spanish, where – well, I speak English, but you feel more comfortable speaking Spanish, to be honest. (Community group)
Education	*That is about education. The people that arrive here from our countries are people who are very humble in the sense that they did not have the opportunity to prepare themselves academically. The people that attend this church… my hand… there are more than enough fingers to count who has finished secondary school.* (Faith leader)
	It's pride and also the uneducated part of it. About health, they just don't really know. They don't really know. (Community group)
Awareness of healthcare resources	*So we connect people, and I'm sure the other churches probably do some of that, as well, that they're not necessarily free or whatever, but we get them in contact with the right people.* (Faith leader)
	We have some programs that are being offered right now within the church. But as I said, since I am just beginning to reach out to the Latino community, there's very little they know about these programs. The expectation is that within the next few months, we're going to be able to present these programs to a broader community. (Faith leader)
	I have heard of the Church Health Center. I have also heard of the Christ Community, but those are the only two that I know of and I feel like they are small clinics. I, as far as like having a specialist or going for routine, like checkups, not really….but as far as like dietary plan and all that other stuff, I don't participate in any of that. (Community group)
	Some time ago, Latino Memphis had a program …Christian Brothers University that provided workshops. And there was a church there and they were handing out pamphlets, but to be honest, I lost them (Community group)

Table 3 (continued)

Themes and subthemes	Quotes
Church as a current and potential partner	*So far, what I'm doing is being the outreach person myself towards communities of faith in the Latino community. The long-term goal is to try to work together, using their resources, our resources and putting things together in order to spread the services beyond just one location, but taking it somewhere else. This is very, very early in the process, yet I hope that within the next few months, we're going to start building something more concrete, something more – even more than concrete, more tangible for the population we're expecting to serve.* (Faith leader)
	…and, too, people that are not part of the church a lot of times don't want to go to a church. I mean they're skeptical. Sometimes it's just being smart about how to do them where it's more accessible and they're not threatened, because a lot of folks, Hispanics, are Catholics, so to go to an evangelical church for some kind of an outreach like that, they think there's a double motive, and there is. (Faith leader)
	Then you feel a bit more confident, more relaxed by attending a church rather than attending a hospital. (Community group)
	…There are people who say – No, it's in the church and they're going to talk to us about –people who don't go to church. (Community group)

Diet

Related to high chronic disease rates were concerns about the dietary habits being formed, especially by newly immigrated populations. Portion sizes of traditional foods, especially tortillas and pupusas, as well as the incorporation of fast food and sodas were of particular concern among faith leaders ($n=21$). Community members recognized the need for nutrition education and classes ($n=5$), but to a lesser extent compared to faith leaders.

Dental Care

Another common health need shared by faith leaders ($n=5$) and community members ($n=10$) was dental care. Issues related to accessibility, specifically lack of insurance and cost, were provided as reasons why dental care is a high need for Latino communities.

Screenings

Two faith leaders and two community members mentioned screenings for blood pressure and blood sugar or diabetes. Community members also noted cancer screenings as necessary for their communities ($n=9$). Within the context of men's health, both faith leaders and community members noted the importance of prostate

cancer screenings. Community members, however, stated the need for breast and cervical cancer screenings as well.

Barriers to Health

Cost

Faith leaders ($n=20$) and community members ($n=15$) stated healthcare costs were a significant barrier to seeking services. Difficulty accessing the healthcare system due to lack of insurance, which was often due to lack of documentation, served as a strong deterrent to seeking either primary or acute care until the illness became unbearable. For the insured, faith leaders and community members pointed to large insurance coverage gaps and high coverage costs as reasons for avoiding healthcare visits and worrying over coverage instability, respectively.

Prevention-Seeking Behaviors

Both groups spoke of a lack of "culture around prevention" in their communities. Faith leaders and community members alike described going to a doctor or hospital as a last resort. Faith leaders ($n=11$) and community members ($n=7$) explained community members would only seek medical attention when conditions became severe, exemplified in an exchange between three members of a community focus group (see Table 3). Trust in traditional healing methods, combined with lack of medical insurance, further explained community members' avoidance of hospitals and clinics. Faith leaders ($n=5$) and community members ($n=2$) spoke of easy access to traditional medications, some found in Latino-run pharmacies and others mailed or carried from countries of origin, and a tradition of self-prescribing cures.

Healthcare Services in Spanish

Faith leaders stated patient–provider language differences prevented their congregants from seeking healthcare services ($n=12$), while community members described language barriers in terms of comfort and trust ($n=4$). Community members expressed greater satisfaction with medical conversations conducted in Spanish, less because of language proficiency and more out of comfort as well as a signal of their provider's cultural competency.

Education

Faith leaders and community members both recognized a considerable gap in community member's understanding of health risks and health protective behaviors. Faith leaders pointed to their congregants' lack of formal education as one reason for this health knowledge gap ($n=4$). Community members believed the problem stemmed from pride and stubbornness ($n=6$) or a lack of health education ($n=3$).

Awareness of Healthcare Resources

Awareness of healthcare resources formed the greatest disparity in faith leader and community member responses. Faith leaders knew of more resources ($n=37$) than community members ($n=23$). Faith leaders described numerous connections with individuals and organizations involved in both health promotion and healthcare provision. Community members were knowledgeable about the region's major healthcare institutions serving Latino communities, but they were unaware of the many resources available through churches—responding only "no" when asked.

Community members found little difficulty locating the resources they did know about, responding in the affirmative when asked whether they were able to find health resources. The ease of locating resources appeared to be attenuated by whether the community member was new to the region. Participants also accessed health information online using social media apps (Facebook was mentioned by 12 faith leaders, Google by one faith leader and one community member, and WebMD by two community members). Despite access to and use of the Internet, both faith leaders and community members spoke of radio and word of mouth ($n=3$ and $n=2$, respectively) as important tools for notifying community members of available resources.

Church as a Current and Potential Partner

Churches represented by the faith leaders interviewed exhibited four different types of community health engagement: (1) distributing information provided by healthcare providers ($n=6$), (2) hosting programs conducted by healthcare providers ($n=9$), (3) providing church-organized programs and clinics ($n=3$), and (4) establishing formal partnerships between healthcare providers and the church ($n=5$).

The acceptability of faith-based organizations as a place to participate in health engagement met with more positive responses ($n=16$) from community members than negative ($n=7$). Trust was a key factor underpinning both positive and negative responses. Those responding positively said they would feel more comfortable in a church setting, and those responding negatively were wary of churches' motives to preach to or attempt to convert them. Faith leaders were conscious of community members' concerns, with the more evangelical leaders trying to find a mutually satisfactory line between their mission as pastors and their commitment to serving community health needs.

Discussion

As Latino populations grow in number and diversity in the USA, faith-based organizations may be particularly helpful in addressing their health needs. This may be especially true in the Bible Belt where Latino populations are increasing (Castaneda and Cayuela 2017), may differ in religious affiliation compared to other locations in

the USA (Pew Research Center Religion & Public Life 2014b), or may seek secular services from faith-based organizations (Marquardt 2006). Faith leaders and community members in this study identified similar health needs and barriers facing Latino communities in the Memphis area. While faith leaders knew of more health-related programs, community members knew about and accessed major healthcare institutions in the area, and both groups acknowledged the use of online resources by community members searching for health information. Faith leaders talked about varying levels of engagement in providing healthcare services and programs to their congregations. Community members had primarily positive reactions to faith-based organizations offering services and programs. However, participants' religious concerns and a lack of prevention-seeking behaviors may limit the use of faith-based health programs.

Health needs identified in this study included healthcare services and prevention programs aimed at chronic conditions such as diabetes and obesity, which match conditions facing Latino communities nationally (Centers for Disease Control and Prevention 2018; Hubert et al. 2005; Kaplan et al. 2014; Ogden et al. 2015). While most faith-based health promotion programs have been conducted with African American churches, diabetes and obesity programs with Latino congregations have shown success (Bopp et al. 2011; Gutierrez et al. 2014; Krukowski et al. 2010). However, overcoming language differences, changing dietary behaviors, and working with organizations not familiar with changing health behaviors have been noted barriers (Bopp et al. 2011; Gutierrez et al. 2014; Krukowski et al. 2010). These are barriers future faith-based programs will need to overcome as our participants noted the need for dietary education and for programs delivered in Spanish as important.

Participants in this study also identified dental care and screenings for cancer as important health needs. These needs were due in part to barriers related to cost and lack or gaps in insurance coverage. Nationally, Latino populations are the largest uninsured racial/ethnic group (Kaiser Foundation Family 2013). The Affordable Care Act's expansion of Medicaid coverage increased the number of individuals eligible for coverage; however, documentation status and other regulations prevent many Latino community members from obtaining insurance (Castaneda and Melo 2014; Kaiser Foundation Family 2013). Given these barriers to insurance coverage, faith-based organizations make important health partners. They can serve as locations for increasing knowledge of eligibility status and insurance options (Harmon et al. 2014) and as sites for health fairs and other programs that do not require insurance (Campbell et al. 2007; Krukowski et al. 2010; Wilson 2000).

Currently, in Memphis, health service knowledge is compartmentalized such that community members only knew about services they had used. Faith leaders had more information and described themselves as sources of health service information for community members. Some faith leaders had formed partnerships with local health organizations to provide more programs and services, but most of these connections were new and evolving. Community members overall reacted positively to the idea of faith-based organizations in the community taking a more active role in health promotion. In a study of denomination affiliation, nearly 50% of Latinos who moved from Catholicism to Protestantism did so because they "found a congregation that reaches out and helps its members more" (Pew Research Center Religion

& Public Life 2014a). Evangelical faith leaders in the current study were uncertain how to balance physical and spiritual caretaking, while community members were likewise conflicted, some expressing opposition to being sermonized. In addition, Catholic priests were unwilling to collaborate with some health organizations due to religious beliefs. Previous faith-based initiatives with Latino communities have noted strong religious connections within these communities, which may increase both enrollment and retention (Allen et al. 2014; Gutierrez et al. 2014; Krukowski et al. 2010). Nevertheless, faith-based organizations may not be able to reach beyond their congregations when recruiting due to issues of trust. Given faith leaders' potential unfamiliarity with health promotion programming, and to help them address physical health needs within Latino communities, faith leaders may benefit from training in program development and implementation (Bopp et al. 2011).

Faith leaders will also need to overcome Latino community members' lack of prevention-seeking behaviors, identified in our study as a major barrier to accessing health services that may be especially prominent among Latino males. Previous research with Latino families noted the importance of recruiter gender (Martinez et al. 2012). Male recruiters reached males and females, while female recruiters primarily reached females (Martinez et al. 2012). All of the faith leaders we interviewed were male, although at least two had wives who also pastored churches. Given that many religious leaders are male (Carroll 2006), additional work should be done to explore how Latino faith leaders can engage male congregation members in health promotion programs and interventions.

An important strength of this study is our recruitment strategy. By recruiting both Latino community members and faith leaders, we gained a more complete perspective on the health needs, barriers, and acceptability of faith-based health programming. Additional strengths of this study are its location in the Mid-South, an area experiencing growth in its Latino populations (Castaneda and Cayuela 2017), and our recruitment of individuals with Protestant, Catholic, and no religious affiliation, given the growth in religious affiliation diversity across Latino populations (Pew Research Center Religion & Public Life 2014a). Past studies have focused on agricultural workers, one religious denomination, or regions of the country where Latino populations are more established (Allen et al. 2014; Krukowski et al. 2010; Lopez-Cevallos et al. 2013; Martinez et al. 2012). This study provides insight into Latino populations using a lens that recognizes people and communities are neither monolithic nor stagnate, especially when health and place intersect.

Despite these important strengths, there are limitations to our findings. While we were successful in recruiting a diverse population in some areas, our community members were still primarily female. In addition, most of our participants identified as Protestant and collection of community member perspectives via focus groups did not allow for an examination of perspectives by denomination. Although we recruited individuals who spoke English or Spanish, we were unable to interview new immigrants who spoke indigenous languages. In addition, participants' length of residence in the USA or Memphis was not collected; thus, it is unknown whether participants were long-time residents, newly immigrated from within the USA, or newly immigrated from their country of origin. Lastly, one faith leader noted an increase in behavioral and emotional health issues in part due to the "current

political environment towards immigrants" during member checking. Such issues have likely increased since this study was conducted making this concern a focus of future studies. Other researchers have noted the impact social, legal, economic, and political changes have on Latino communities (Martinez et al. 2012). Therefore, it is important to acknowledge the need to remain current on how changes in our social and political environment affect the health of this diverse population.

Conclusion

Findings from faith leaders and community members in Memphis suggest faith-based organizations are important partners for sharing health promotion programs and preventive health services to Latino communities, especially those related to diet, dental care, and screenings. This finding holds true despite growth in religious affiliation diversity. It is important that health practitioners and faith leaders are culturally and religiously respectful when designing and implementing health promotion programs. However, these groups working together with Latino community members have the potential to develop strategies that overcome resistance to prevention-seeking behaviors and engage communities who feel marginalized by traditional systems and current social environments.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed involving human participants were in accordance with the ethical standards of the University of Memphis Institutional Review Board and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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