THE FEASIBILITY OF PARTNERING WITH AFRICAN-AMERICAN BARBERSHOPS TO PROVIDE PROSTATE CANCER EDUCATION

Alton Hart, Jr., MD, MPH; Deborah J. Bowen, PhD

The purpose of this study was to determine the feasibility of partnering with barbershops to implement a community-based prostate cancer preparatory educational decision aid for African-American men. We used African-American newspapers to compile a list of barbershops in King County, Washington, that predominantly serve African-American men. Trained research interviewers conducted proprietor surveys and client surveys. Ninety-six percent of the proprietors surveyed reported they would allow their clients to learn about prostate cancer. Seventy-five percent reported they would consider allowing a computer to be installed to provide information about prostate cancer. Ninety-seven percent of clients reported that they would be willing to look at information about prostate cancer in their barbershops. It will be feasible to work with barbershops and their clients for a community-based prostate cancer screening decision-aid intervention for African-American men. (*Ethn Dis.* 2004;14:269–273.)

Key Words: Prostatic Neoplasms, Blacks, Primary Prevention, Health Education, Public Health

From the Cancer Prevention Research Program, Fred Hutchinson Cancer Research Center, Seattle Washington.

Address correspondence and reprint requests to Alton Hart Jr., MD, MPH; Fred Hutchinson Cancer Research Center; P.O. Box 19024, MP-826; Seattle, WA 98109; 206-667-6405; 206-667-7264 (fax); ahart@fhcrc.org

INTRODUCTION

African-American men bear a disproportionate burden of prostate cancer diagnosis and mortality.[1–5] These disparities may be related to lower screening rates in the African-American community,[6] despite specific screening recommendations for African-American men.[7] Although controversy exists regarding the efficacy of prostate cancer screening,[8] the data suggest that African-American men need to be able to make informed decisions about early detection.

While experts disagree about the mortality-reduction benefits of prostate cancer screening, they agree on the need to inform at-risk males about both the disease, and about the possible benefits or harms of regular screening. This agreement underscores the need to develop provider-neutral decision aids to enable African-American men to make informed decisions based on their own values. However, most studies involving decision aids have been conducted in hospitals, or community clinics.[9–11] By conducting this type of research predominantly in clinical settings, a large percentage of African-American men could potentially be excluded from the recruitment process, due to their lack of routine health care for various reasons.[12] Therefore, community-based intervention sites are needed.

Community-based interventions have proven effective in reaching a broad range of audiences. Studies designed to reach these audiences have varied from randomization of communities to increase quit rates among cigarette smokers, such as in the COMMIT Trial,[13] to using community-based pharmacists to increase smoking cessation.[14] More recently, community-based intervention research has focused primarily on reaching populations of lower socioeconomic status. These efforts have been supported and encouraged as a means to help eliminate health disparities. Community partnerships are of key importance in reaching underserved and vulnerable populations. Therefore, it is important to identify venues that would be most appropriate for such partnerships. For example, health promotion programs have been implemented in African-American communities through beauty salons[15–17] and churches.[18–20] Churches in the African-American community have been sites for dietary interventions,[21–23] smoking cessation initiatives,[24,25] and cholesterol-lowering education.[19] Our previous research suggests that, while religious organizations provide a very good outlet for disseminating dietary information, they do not provide a productive venue for reaching African-American men. Because the vast majority of participants in religious organizations are women, finding men to discuss health issues within these settings can be difficult.[26] Therefore, we began to search for other outlets specific to African-American men, and we identified barbershops as one such place. To our knowledge, there have been no published studies investigating barbershops as potential sites for educational intervention research targeting African-American men.

African-American barbershops are appropriate sites for community-based cancer education programs. We believe the local barbershop is a culturally rel-

Community partnerships are of key importance in reaching underserved and vulnerable populations.

evant setting in the African-American community. The neighborhood barbershop in the African-American community is often more than a place for haircuts and shaves. Traditionally, it has been a place where African-American men, both young and old, have come together to "hang out" and socialize. In his book, *Do Bald Men Get Half-Price Haircuts,* Staten says, "When you talk about Black barbershops, you talk about community."[27] Barbershops patronized by African-American men have been emotional safe havens, where the conversations are as varied as the patrons that frequent them.[28] In this fraternal environment, African-American men discuss topics ranging from sports and local current events, to personal subjects, such as religion and family issues. Staten proposes that there is an openness in African-American barbershops that is not found anywhere else.[27] We propose that the openness of this environment is favorable for conducting a research project about a potentially sensitive topic, such as prostate cancer screening.

In this paper, we present the findings of a pilot study designed to determine the feasibility of working with barbershops as potential sites for a community-based prostate cancer screening electronic decision-aid intervention for African-American men. Specifically, the pilot study was designed to determine the willingness of proprietors of barbershops to allow customer participation in research-related activities in their establishment during hours of operation, and the proprietors' willingness to store computer hardware at their businesses. Further, the study was designed to assess patterns of barbershops use by clients, and whether African-American men aged 40–70 would use personal computers in barbershops to access information about prostate cancer.

We believe that this pilot study will provide an important contribution to the literature by exploring an alternative venue for recruiting African-American men for future community-based educational interventions.

METHODS

Proprietor Survey Procedures

We used an African-American newspaper to compile a list of barbershops in King County, Washington, that predominantly serve African-American men. Specifically, we reviewed the advertisement section of an African-American newspaper for a listing of barbershops. Using addresses and zip codes, we determined which barbershops were located in Seattle-King County. These selected geographic areas formed the basis for purposeful sampling of barbershops. We also used a technique called snowballing sampling to recruit barbershops. In addition, we identified African-American barbershops by driving through predominantly African-American neighborhoods.

Next, letters were mailed to 'proprietors,' whom we defined as the owners of the barbershops or salons. A detailed information sheet describing the study was included with each letter. After allowing at least 3 business days for the proprietors to receive the letters, a trained research interviewer approached barbershop and salon proprietors. Proprietors signed written consent forms prior to their interviews. Eligibility criteria for the proprietor survey included being the proprietor of either a barbershop or salon located in King County, and serving predominantly African-American clients. The research interviewer conducted a face-to-face, structured interview with each proprietor who agreed to participate in the study. The interviewer wrote notes and took verbatim quotes, whenever possible.

We asked each proprietor several questions about his interest in health, current interactions with clients about health, and interest in allowing several aspects of research to occur in the shop. To verify that we had selected establishments serving predominantly African Americans, we asked the percentage of African-American male clients. To determine whether an adequate sample size could be obtained for our client survey, we asked the proprietor the average number of customers served per week. Finally, to ensure that we could recruit African-American men in the 40–70 years age range to complete the client survey, we asked proprietors to provide an approximate percentage of the number of African-American male clients under the age of 40 years, between 40 and 70 years, and older than 70 years.

Client Survey Procedures

Two African-American barbershops were selected from our pool of completed proprietor surveys because they had high proprietor enthusiasm about the project, and high numbers of African-American male clients in the 40–70 years age group. Our goal was to collect 30 completed client surveys in each of the 2 barbershops. Since a primary goal of our pilot study was to ascertain whether it would be feasible to pursue a large community-based education intervention in Seattle-King County African-American barbershops, rather than to test an intervention, we felt that this sample size would be appropriate.

A trained research interviewer used an approved script to approach each African-American male barbershop client to ask if he would be interested in participating in a study about African-American men and prostate cancer. Each potential participant was given an information sheet about the study. Verbal consent was obtained from each participant prior to completion of the anonymous survey.

Table 1. Barbershop proprietors' (*N*=24) responses to feasibility questions

Questions	% Yes
Do you think men's health is an important topic in the African-American community?	91.7
Do you talk with your clients about health related topics?	79.2
Do you feel health promotion activities and programs should be conducted in the African-American Community?	100
Would you be interested in allowing your barbershop to be involved in a research project promoting African-American men's health?	91.7
Would you allow your barbershop to help African-American men learn about prostate cancer?	95.8
Would you consider allowing a computer to be installed to provide information about prostate cancer?	75.0

Eligibility criteria for the client survey included being an African-American man, a barbershop customer (ever having been a client, including that day), being 40 to 70 years of age, never having been diagnosed with prostate cancer, and being able to complete a self-administered survey in English. The survey was written at the Flesch–Kincaid grade level of 6.8.

Client Measures

The first set of survey items was used to determine eligibility. Because the subject of prostate cancer is very personal, we asked clients about their willingness to view information about prostate cancer in a barbershop. In addition, we asked clients whether they would use a personal computer in a barbershop to access information about prostate cancer. To assess knowledge about prostate cancer, we asked questions about prostate cancer screening, therapy, and treatment, modified from Volk.[11]

The authors have no conflict of interest with the presentation of the findings, and accept full responsibility for the completely accessible data from the study.

RESULTS

Proprietor Survey

We collected surveys from 24 barbershop and salon proprietors, out of a total of 41 approached. Our sample response rate for the proprietor survey was 78%. Fifty-nine percent (*N*=10) of those approached for a survey were ineligible because they served very few or no male clients, and the others (*N*=7) were not interested in participating. Based on the proprietor survey responses, the average number of customers served per week across all establishments was 118 (range=10–600). The proprietors reported that between 50% and 100% of their clients were African-American. The percentage of clients aged 40 to 70 years ranged from 10% to 90%, with an average of 40%.

Table 1 contains responses to key research feasibility questions in the proprietor survey. Proprietors gave consistently positive and supportive responses to the variety of questions about research activities in the shops. The proprietors' qualitative responses recorded by the interviewer indicated further support for conducting research in barbershops. In response to our question regarding men's health as an important topic in the African-American community, one proprietor stated, "We need to have more information and take care of men's health in our community." Another proprietor who reported that he talks to his clients about health stated, "Many customers come with [damage] to their hair and scalp [that] leads to a conversation about health." A proprietor who believed health promotion activities and programs should be conducted in the African-American community gave "lack of awareness and myths" as his reason for supporting such activities. Many proprietors responded favorably to a question about allowing their barbershops to be involved in a research project promoting African-American men's health. When asked why they felt this way, one proprietor replied, "Because I think it's important to live healthy. And I like providing community service." Another proprietor, in response to the same question, stated, "Because this is a meeting place in the community."

Table 2. Feasibility of recruiting barbershop clients to a prostate cancer prevention program

Questions	*N*	% Yes	% No	% Don't Know
Would you be willing to use a personal computer in your barbershop that provided information about your health?	56	91	9	N/A
Would you be willing to look at information about prostate cancer in your barbershop?	58	97	3	N/A

Client Survey Results

Overall, the clients were very interested in and receptive to the research interviewer. Over the course of 5 days, we collected surveys from 88 clients, out of a total 89 approached (99% response rate). One client refused to fill out the survey because of lack of interest. Sixty-seven percent (*N*=59) of those who completed a client survey met our eligibility criteria (ie, aged 40 to 70, African-American, no history of prostate cancer); their data are reported here. Twenty-nine were ineligible because they were younger than 40. Table 2

shows the clients' responses to items assessing the feasibility of recruiting barbershop clients to a research project on prostate cancer screening decision aids. A high percentage of men indicated that they would use a computer to access health information, and would be willing to look at information on prostate cancer in the shop.

In general, the responses to the prostate cancer knowledge questions indicated reasonable, but varied, levels of knowledge. The percentage of correct responses ranged from 32% to 81% across all questions, indicating large variability in knowledge. We also explored whether an association exists between knowledge and receptivity to the proposed intervention. Specifically, we looked at knowledge and willingness to view prostate cancer information and willingness to use a personal computer in a barbershop, and did not find any statistically significant associations.

DISCUSSION

We have learned from this feasibility study that many barbershop proprietors in the Seattle-King County area that serve predominantly African-American men have a strong commitment to community health promotion. The survey response rate was high, indicating interest in the topic and comfort with providing information. Proprietors were willing to have several types of research activities occur in their shops. This is very positive for the possibility of using barbershops as a site for male-oriented health promotion activities. Clients' responses also provided support for considering barbershops as future sites for our work.

The strengths of this study include information gathering from 2 levels of individuals (proprietors and clients), the enlistment of proprietors as potential partners in community-based research, and the conduct of research in a community setting. Also, we have identified a potential community setting for testing prostate cancer screening decision aids.

Limitations to the present study include the fact that the client sample was restricted to 2 barbershops with enthusiastic proprietors. If the clients frequenting these 2 barbershops are systematically different from clients frequenting the other barbershops in Seattle-King County, the results from the client survey may not generalize to all African-American male barbershop clients aged 40–70 in Seattle-King County. A second limitation of our study was the brevity of the survey. The survey was kept brief to increase participation rates and to reduce participant burden. We plan to keep this latter approach as a consistent part of our future research. Lastly, we did not examine the range of costs of services across the barbershops. The barbershops in our pilot study were located in neighborhoods with median household incomes above the poverty line. We plan to explore costs of services and variations in socioeconomic status in our future research.

Despite the limitations mentioned above, we feel that the lessons learned from this pilot study can contribute to the literature on how barbershops can be used as recruitment sites for community-based interventions. Future research should certainly address the issue of generalizability through different sampling methodology.

As previously discussed, community-based partnerships are vital in our efforts to help eliminate health disparities. Successful community-based health programs have utilized locations where people congregate to provide health services to underserved populations. These locations have included churches and beauty salons.[16] Beauty salons have been used for screening programs designed to reach low-income African-American populations.[29] For years, the American Cancer Society has supported the use of beauty parlors serving African-American women. Forte reported that conventional breast cancer programs have not effectively reached African-American women aged 50 years and older.[17] Therefore, the beauty salon was chosen as an appropriate setting in which to offer culturally sensitive educational pamphlets and a video to promote mammography, clinical breast examinations, and breast self-examination. More recently, Bridge and colleagues conducted a study to evaluate the effectiveness of a community outreach prostate health education program designed for men at risk for prostate cancer. The authors found that the community-based educational program significantly increased knowledge.[30]

By thinking about where people live and play and work, even where they get their hair cut, we can find individuals and larger groups, and transfer information.

Researchers have to think creatively about how to reach populations historically underrepresented in studies. By thinking about where people live and play and work, even where they get their hair cut, we can find individuals and larger groups, and transfer information. The results from this study suggest that the local barbershop is a culturally relevant, feasible, and appropriate setting in the African-American community for conducting community-based education programs. Since many African-American men lack routine health care,[12] and females overwhelmingly outnumber males at religious organizations, studies conducted in neighborhood barbershops have the potential to reach more African-American men than studies conducted in clinical settings or churches.

ACKNOWLEDGEMENTS

This work was supported by a grant (RO1 CA79077) from the National Cancer Institute.

REFERENCES

1. Hoffman RM, Gilliland FD, Eley JW, et al. Racial and ethnic differences in advanced-stage prostate cancer: the Prostate Cancer Outcomes Study. *J Natl Cancer Inst.* 2001;93: 388–395.
2. Surveillance, epidemiology and end results. Available at: http://seer.cancer.gov/.
3. Boring CC, Squires TS, Health CW Jr. Cancer statistics for African Americans. *CA Cancer J Clin.* 1992;42:7–17.
4. Ries LA, Kosary CL, Hankey BF, Miller BA, Harras A, Edwards BK, eds. *SEER Cancer Statistics Review, 1973–1994: Tables and Graphs.* Bethesda, Md: US National Cancer Institute; 1997. NIH Publication No. 97-2789.
5. Landis SH, Murray T, Bolden S, Wingo PA. Cancer statistics, 1999. *CA Cancer J Clin.* 1999;49:8–31.
6. Barber KR, Shaw R, Folts M, et al. Differences between African-American and Caucasian men participating in a community-based prostate cancer screening program. *J Community Health.* 1998;23:441–451.
7. Smith RA, von Eschenbach AC, Wender R, et al. American Cancer Society guidelines for the early detection of cancer: update of early detection guidelines for prostate, colorectal, and endometrial cancers. Also: update 2001—testing for early lung cancer detection. *CA Cancer J Clin.* 2001;51:38–75.
8. Litwin MS, Hays RD, Fink A, et al. Quality-of-life outcomes in men treated for localized prostate cancer. *JAMA.* 1995;273:129–135.
9. Wolf AM, Nasser JF, Schorling JB. The impact of informed consent on patient interest in prostate-specific antigen screening. *Arch Intern Med.* 1996;156:1333–1336.
10. Myers RE, Chodak GW, Wolf TA, et al. Adherence by African-American men to prostate cancer education and early detection. *Cancer.* 1999;86:88–104.
11. Volk RJ, Cass AR, Spann SJ. A randomized controlled trial of shared decision making for prostate cancer screening. *Arch Fam Med.* 1999;8:333–340.
12. Krieger N, Rowley DL, Herman AA, Avery B, Phillips MT. Racism, sexism, and social class: implications for studies of health, disease, and well-being. *Am J Prev Med.* 1993; 9(suppl 1):82–122.
13. The COMMIT Research Group. Community intervention for smoking cessation (COMMIT): I. Cohort results for a four-year community intervention. *Am J Public Health.* 1995;85:183–192.
14. Maguire TA, McElnay, Drummond A. A randomized controlled trial of smoking cessation intervention based in community pharmacies. *Addiction.* 2001;96:325–331.
15. Linnan LA, Kim AE, Wasilewski Y, Lee AM, Yang J, Solomon F. Working with licensed cosmetologists to promote health: results from the North Carolina beauty and health pilot study. *Prev Med.* 2001;33:606–612.
16. Kong BW. Community-based hypertension control programs that work. *J Health Care Poor Underserved.* 1997;8(4):409–415.
17. Forte DA. Community-based breast cancer intervention program for older African-American women in beauty salons. *Public Health Rep.* 1995;110(2):179–183.
18. Thomas SB, Quinn SC, Billingsley A, Caldwell C. The characteristics of northern Black churches with community health outreach programs. *Am J Public Health.* 1994;84:575–579.
19. Wiist WH, Flack JM. A church-based cholesterol education program. *Public Health Rep.* 1990;105(4):381–388.
20. Levin J. The role of the Black church in community medicine. *JAMA.* 1984;76:477–483.
21. Campbell MK, Denmark-Wahnefried W, Symons M., et al. Fruit and vegetable consumption and prevention of cancer: the Black churches united for better health project. *Am J Public Health.* 1999;89(9):1390–1396.
22. Campbell MK, Motsinger BM, Ingram A, et al. The North Carolina Black churches united for better health project: intervention and process evaluation. *Health Educ Behav.* 2000; 27(2):241–253.
23. Resnicow K, Jackson A, Wang T, et al. A motivational interviewing intervention to increase fruit and vegetable intake through Black churches: results of the eat for life trial. *Am J Public Health.* 2001;91:1689–1693.
24. Voorhees CC, Stillman FA, Swank RT, Heagerty PJ, Levine DM, Becker DM. Heart, body, and soul: impact of church-based smoking cessation interventions on readiness to quit. *Prev Med.* 1996;25:277–285.
25. Schorling JB, Roach J, Siegel M, et al. A trial of church-based smoking cessation interventions for rural African Americans. *Prev Med.* 1997;26:92–101.
26. Bowen DJ, Beresford S, Vu T, et al. Conceptual design for a randomized intervention study of dietary change in religious organizations. *Prev Med.* In press.
27. Staten V. *Do Bald Men Get Half-price Haircuts?: In Search of America's Great Barber Shops.* 1st ed. New York, NY: Simon & Schuster; 2001.
28. Murphy MK. *Barber Shop Talk: The Other Side of Black Men.* 1st ed. Merrifield, Va: Murphy & Melvin; 1998.
29. Ferdinand KC. Lessons learned from the Healthy Heart Community Prevention Project in reaching the African-American population. *J Health Care Poor Underserved.* 1997; 8:366–371, discussions 371–372.
30. Bridge PD, Berry-Bobovski L, Bridge TJ, Gallagher RE. Evaluation of a preparatory community-based prostate health education program. *J Cancer Educ.* 2002;17:101–105.

AUTHOR CONTRIBUTIONS

Design and concept of study: Hart, Bowen
Acquisition of data: Hart
Data analysis and interpretation: Hart, Bowen
Manuscript draft: Hart, Bowen
Statistical expertise: Hart, Bowen
Acquisition of funding: Bowen
Administrative, technical, or material assistance: Bowen
Supervision: Hart, Bowen