

HEALTH PROMOTION IN BARBERSHOPS: BALANCING OUTREACH AND RESEARCH IN AFRICAN AMERICAN COMMUNITIES

Promoting health and preventing illness among African American men, who die disproportionately from preventable diseases, is a challenging health disparity that has seen limited progress. However, focusing our efforts in places outside of traditional clinical and community settings such as the barbershop has shown promise for ameliorating these disparities. In particular, barbershop-based health promotion as conducted by the Black Barbershop Health Outreach Program has successfully reached nearly 10,000 men nationwide through a grassroots, volunteer-driven effort. At the same time, researchers have begun to conduct formal clinical trials in barbershops in order to explore interventions targeting this at-risk population. Herein, we describe, in brief a review of barbershop-based health promotion and the experience of this novel community-based organization. We argue for continuing to integrate evaluation and research using community-partnered principles into successful grassroots initiatives without dulling the practical impact of these programs is a crucial next step as we move beyond simply acknowledging health disparities and seek to find solutions. (*Ethn Dis.* 2010;20:185–188)

Key Words: Community Organizing, Health Promotion, Barbershops, African American Men

Bill J. Releford, DPM; Stanley K. Frencher, Jr., MD, MPH;
Antronette K. Yancey, MD, MPH

GOING TO THE BARBERSHOP TO REBUILD TRUST IN HEALTH PROMOTION

Far too many African-American (AA) men die unnecessarily from preventable illnesses.¹ Within the United States, the life expectancy for AA men (68.7 yrs) is by far the lowest across sex and race/ethnicity.² Despite decades spent investigating the myriad reasons for these health disparities, no single or collection of modifiable factors appear to be the definitive cause. Increasingly, factors deemed social determinants of health such as education, socioeconomic status, and environment, are recognized as important contributors to health outcomes. In addition to these important factors, barriers to accessing needed care, disparities in quality of care, and health-related attitudes, beliefs and behaviors all continue to work together to produce the relatively poor health outcomes, particularly among AA men.³

When compared to resources and time expended building the evidence base, far fewer and much less has been devoted to developing and evaluating effective interventions capable of reducing health disparities between AA men and other racial/ethnic groups of men.^{4,5} The academic literature is replete with examples of interventions, brief or extensive, unimodal or multifaceted, focused on individual health behaviors (eg, diet and physical activity, sun protection, and chronic disease self-management), mainly directed toward maternal and child health or disease specific subpopulations. Success has been documented for enhancing knowl-

edge about and attitudes toward certain topics among AA men, although sustained participation in healthy behaviors and improved health outcomes have been elusive in many areas.^{6,7} Public health researchers have largely failed to motivate and engage AA men in health-promoting habits.

Mistrust of the very systems of healthcare and scientific inquiry necessary to improve health outcomes contribute substantially to our inability to reach African Americans.⁸ In earlier times, physicians were members of the communities in which they practiced. These Marcus Welby types went door-to-door, making house calls, growing practices with aging patients who brought along with them generations of family members. In that context, physicians were not only a trusted resource but revered community leaders. That stature within the AA community, however, has been marred by epic transgressions, including clandestine experimentation, deliberate undertreatment and racial discrimination.⁹ Consequently, current generations of AA men have been found to view the healthcare system and efforts to intervene in their health behaviors with suspicion and doubt.^{10,11}

Recognizing the need for innovative health promotion targeting AA men, the lead author, a clinician in private practice in a predominantly AA area of Los Angeles, developed the Black Barbershop Health Outreach Program (BBHOP). A national program designed to address AA men at-risk for cardiovascular disease (CVD) and diabetes, BBHOP engages patrons through a combination of screening, education,

From Charles Drew University of Medicine and Science (BJR) and Geffen School of Medicine, UCLA (SKF) and RAND Institute (SKF) and UCLA Kaiser Permanente Center for Health Equity, School of Public Health (AKY).

Address correspondence to Bill J. Releford, DPM; Office for Research and Health Affairs; Charles Drew University of Medicine and Science; 11705 Deputy Yamamoto Place, Suite B; Lynwood, CA 90262; 323-249-5702; bill.releford@gmail.com

...we explain the rationale for conducting health promotion in barbershops, briefly describe the Black Barbershop Outreach Program model for health promotion, and discuss balancing research and outreach when targeting African American men.

empowerment, and community capacity-building activities. By rebuilding trust using credible, existing, community infrastructures such as barbershops, we have been able to successfully reintroduce health promotion and research to this underserved population. Herein, we explain the rationale for conducting health promotion in barbershops, briefly describe the BBHOP model for health promotion, and discuss balancing research and outreach when targeting AA men.

In order to overcome the legacy of distrust, healthcare providers and public health researchers and health advocates have introduced health information and education in contexts thought to be both culturally appropriate and trustworthy such as churches, community centers, fairs and other community-based organizations including beauty salons.¹²⁻¹⁴ In these contexts, public health efforts have had success in reaching AA women and children but still have been less successful in connecting with AA men. After realizing that outreach efforts in traditional settings were often not resonating with AA men, Kong, a public health researcher, included barbershops, a place known to be frequented by AA men, in a consortium of community partners focused on combating the epidemic of undiagnosed hypertension.¹⁵ In Michi-

gan, Madigan and others trained nearly 700 hair stylists to deliver health promotion messages to almost 14,000 clients resulting in 60% of clients reporting taking steps to prevent diabetes, hypertension and chronic kidney disease.¹⁶ Eric Whitaker, as a physician and founder of Project Brotherhood, brought medical care into the barbershop—holding clinics in south Chicago barbershops. Virgil Simons, a prostate cancer survivor, began raising awareness in barbershops through a program called Prostate Net, which trained barbers as community health educators for AA men, partnered with local medical centers, and now provides culturally-appropriate information to AA men in barbershops through internet-based kiosks nationwide. Meanwhile, formative work has continued evaluating the impact of health promotion in barbershops.^{17,18} Generally, the researchers in each of these studies have demonstrated that the barbershop, heralded within the AA community for its credibility as a forum for in-depth discussions, information-gathering, and the relaying of shared experiences, represents an opportune venue for positively influencing health behavior and outcomes.^{15,17-24}

Importantly, it is the barbershop, a place for unfettered dialog that enables successful health promotion in this community setting. While some researchers suggest and have conducted their work under the premise that barbers, given their trusted role in the community, can act as peer educators, we contend that it goes beyond that. The setting itself, one of open, frank communication, is the conduit through which these activities can and should take place regardless of the barbers' personal health knowledge. That open dialog and trust is predicated on the institution or tradition of the barbershop, one of the few places African Americans could congregate in the pre-Civil Rights era. Unlike other community settings, the barbershop, by its very

nature, invites men of varied backgrounds to let their hair down without judgment, prejudice or expectation. It is African American men's "country club."

THE BBHOP MODEL AS A HYBRID APPROACH TO IMPROVING COMMUNITY HEALTH

The BBHOP is a community-based approach to combating prevalent diseases (eg, diabetes, hypertension, and prostate cancer) in a historically vulnerable population by bringing together previously disconnected resources, committed local organizations, academic institutions, and most importantly, dedicated human capital. This program has, to date, reached over 7,000 AA men through barbershop-based health education, targeted screening, and facilitated referrals to care across six states in a more potentially sustainable way than many medical or public health models. In its use of culturally-appropriate and sex-specific messaging combined with innovative partnerships, BBHOP has been able to engage, excite and inspire AA men around issues of health.

Although fitting squarely within the definition of hybrid approaches forwarded by a recent Institute of Medicine report (those approaches derived from a combination of clinical, community, and other heterogeneous sources such as public health and policy),²⁵ the idea to promote health in the barbershop did not arise from an exhaustive review of the literature. Rather, it originated with a discussion between the lead author and his own barber. An informal and expanded dialog with local barbers around Los Angeles then ensued. Most, if not all, of the barbers could recall a patron, family member or fellow barber having a heart attack, stroke or amputation. The community input into the design of the

program was integral to informing an appropriate strategy for widespread implementation. This approach has emerged from the targeted population, rather than being adapted from mostly unsuccessful interventions developed by and for affluent Whites.⁴

In order to repeatedly conduct outreach events at dozens of barbershops, BBHOP relies on scores of volunteers to inform, screen and refer patrons with abnormal findings to participating physicians or health care facilities. We utilize technology to mobilize distant resources and create virtual networks of volunteers, nurses and community workers. Rather than serving as a barrier to outreach efforts targeting AAs, we have demonstrated that the use of select advanced technologies facilitates network building, fosters information-sharing, and assists in data collection. While the BBHOP has mainly utilized barbershops as staging venues to target individuals, the project aims to build lasting community networks and perform other health-related activities to foment sustainable changes in health behavior.

In order to improve the ways in which this often-neglected population of men were reached, BBHOP, after mainly endeavoring to provide education and clinical services in the barber-shop, began integrating data collection into its health promotion. First, by evaluating health behaviors, attitudes and disease prevalence among a relatively diverse population of African American men encountered through barber-shop-based health promotion, compiling information on nearly 2,145 participants. Next, BBHOP built collaborations with local academic institutions to formalize those data collection methods into research questions designed to inform interventions aimed at reducing preventable chronic diseases. Finally, spurred by input from barbers and community members, two project emphases arose resulting in research protocols and grant proposals: (1) pilot

testing the barber-shop as a means to manage hypertension and diabetes among African American men; and (2) testing the effectiveness of using shared decision-making tools in barber-shops on preference-sensitive decisions such as prostate cancer screening. We believe the evolution of starting from a targeted, promising community-based program to formal pilot testing to intervention development and implementation followed by broad dissemination is the recipe for a sustainable community partnership.

BALANCING COMMUNITY OUTREACH AND RESEARCH

Given that much of the need to develop creative methods to reach AA men with health information arose out of negative experiences and betrayal by physicians and scientists, research designs must be carefully balanced with and incorporated into outreach goals. Moreover, the institutional bureaucracy associated with academic pursuits can potentially inhibit the action of community-academic partnered approaches needed to address health-related problems. Such impediments can translate into real lost lives and further disen-

We believe the evolution of starting from a targeted, promising community-based program to formal pilot testing to intervention development and implementation followed by broad dissemination is the recipe for a sustainable community partnership.

franchise the populations we aim to reach by removing or compromising the productivity of valuable community assets at their peak. We must therefore be aware of and monitor how research may influence our interactions with the community. Certainly, formalized community-partnered or community-based participatory research is an emerging and potentially powerful tool to combat health disparities.²⁶ However, we must remain vigilant in reassessing stated goals and objectives from the perspectives of all stakeholders, especially from the perspective of vulnerable, grassroots partners in order to avoid perversion of and minimize divergence from intended outcomes. Fundamentally, we believe not only that outreach and research are complementary in the various forms it may take, but that together they catalyze progress toward reducing variation in health outcomes. We, as AA clinicians, believe that it is through sustainable, community-centric approaches such as barber-shop-based health promotion supported by culturally appropriate, clinically sound provider networks that we can build new bridges between our communities and the medical community to achieve our common goal of reducing health inequities and improving outcomes.

ACKNOWLEDGMENTS

The authors would like to acknowledge the following individuals: Norm Nixon, BBHOP national spokesperson, Donte Kelly, national BBHOP coordinator, Margo LaDrew, BBHOP program director, Courtney White, executive assistant to Dr. Releford, Damon Forcey, vice president of community affairs BBHOP, Dwayne Thomas, vice president of corporate relations BBHOP, Robert Branscomb, vice president of logistics BBHOP, Larry Proctor, PhD, Louisiana program director, Carol Adams, PhD, secretary of Human Services, State of Illinois, California Congresswoman Maxine Waters, Los Angeles County Supervisor Mark Ridley-Thomas, and Danielle Osby, assistant to Dr. Yancey. This work was supported in part by a grant to the Diabetes Amputation Prevention Foundation from

the Abbott Fund, to UCLA/RAND from the Robert Wood Johnson Foundation Clinical Scholars, to Charles R. Drew University from the National Institutes of Health (NIH) (RR019234, RR003026 and MD000182), and to UCLA from the CDC REACH US Initiative (U58DP000999-01).

REFERENCES

1. Smedley BD, Adrienne Y, Stith AR, Nelson E. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003.
2. Murray CJL, Kulkarni SC, Michaud C, et al. Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Med*. 2006;3(9):e260.
3. Cheatham CT, Barksdale DJ, Rodgers SG. Barriers to health care and health-seeking behaviors faced by Black men. *J Am Acad Nurse Pract*. 2008;20(11):555–562.
4. Yancey AK, Robinson RG, Ross RK, et al. Discovering the full spectrum of cardiovascular disease: Minority Health Summit 2003: report of the Advocacy Writing Group. *Circulation*. 2005;111(10):e140–e149.
5. Smith SCJr, Clark LT, Cooper RS, et al. Discovering the full spectrum of cardiovascular disease: Minority Health Summit 2003: report of the Obesity, Metabolic Syndrome, and Hypertension Writing Group. *Circulation*. 2005;111(10):e134–e139.
6. Wilkinson S, List M, Sinner M, Dai L, Chodak G. Educating African-American men about prostate cancer: impact on awareness and knowledge. *Urology*. 2003;61(2):308–313.
7. Taylor KL, Turner RO, Davis JL. Improving knowledge of the prostate cancer screening dilemma among African American men: an academic-community partnership in Washington, DC. *Public Health Rep*. 2001;116(6):590–598.
8. Heitman E, Wells A. Ethical issues and unethical conduct: race, racism and the abuse of human subjects in research. In: Beech BM, Goodman M, eds. *Race & Research: Perspectives on Minority Participation in Health Studies*. Washington, DC: American Public Health Association, 2004;xii, 212.
9. Thomas SB, Quinn SC. The Tuskegee Syphilis Study, 1932 to 1972: implications for HIV education and AIDS risk education programs in the black community. *Am J Public Health*. 1991;81(11):1498–1505.
10. Swanson GM, Ward AJ. Recruiting minorities into clinical trials: toward a participant-friendly system. *J Natl Cancer Inst*. 1995;87(23):1747–1759.
11. Shavers VL, Lynch CF, Burmeister LF. Racial differences in factors that influence the willingness to participate in medical research studies. *Ann Epidemiol*. 2002;12(4):248–256.
12. Bowen DJ, Beresford S, Vu T, Shu J, Feng Z. Design and baseline findings for a randomized intervention trial of dietary change in religious organizations. *Prev. Med.* 2004;39(3):602–611.
13. Linnan LA, Ferguson YO. Beauty salons: a promising health promotion setting for reaching and promoting health among African American women. *Health Educ Behav*. 2007;34(3):517–530.
14. Sadler GR, Ko CM, Cohn JA, White M, Weldon RN, Wu P. Breast cancer knowledge, attitudes, and screening behaviors among African American women: the Black cosmetologists promoting health program. *BMC Public Health*. 2007;7:57.
15. Kong W, Saunders E. Community programs to increase hypertension control. *J Natl Med Assoc*. 1989;81 Suppl:13–6.
16. Madigan ME, Smith-Wheelock L, Krein SL. Healthy hair starts with a healthy body: hair stylists as lay health advisors to prevent chronic kidney disease. *Prev Chronic Dis*. 2007;4(3):A64.
17. Hart AJr, Bowen DJ. The feasibility of partnering with African-American barbershops to provide prostate cancer education. *Ethn Dis*. 2004;14(2):269–273.
18. Hart AJr, Underwood SM, Smith WR, et al. Recruiting African-American barbershops for prostate cancer education. *J Natl Med Assoc*. 2008;100(9):1012–1020.
19. Cowart LW, Brown B, Biro DJ. Educating African American men about prostate cancer: the barbershop program. *Am Journal Health Stud*. 2004;19:205–213.
20. Drake BE, Keane TE, Mosley CM, et al. Prostate cancer disparities in South Carolina: early detection, special programs, and descriptive epidemiology. *JSC Med Assoc*. 2006;102(7):241–249.
21. Hess PL, Reingold JS, Jones J, et al. Barbershops as hypertension detection, referral, and follow-up centers for Black men. *Hypertension*. 2007;49(5):1040–1046.
22. Holt CL, Theresa A. Wynn, IveyLewis, et al. Development of a barbershop-based cancer communication intervention. *Health Education*. 2009;109(3):213–225.
23. Knight M. The Barbershop Initiative. Available at: <http://www.state.nj.us/health/ccp/index.shtml>. Last accessed June, 2009.
24. Magnus M. Barbershop nutrition education. *J Nutr Educ Behav*. 2004;36(1):45–46.
25. Cohen JA. Challenges and successes in reducing health disparities: workshop summary. Presented at Roundtable on Health Disparities 2007; St Louis, MO.
26. Jones L, Wells K. Strategies for academic and clinician engagement in community-participatory partnered research. *JAMA*. 2007;297(4):407–410.

AUTHOR CONTRIBUTIONS

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