

T HE BLACK BARBERSHOP: I NCREASING HEALTH AWARENESS A MONG MINORITY MEN

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Abstract

Minority men are disproportionately affected by heart disease, cancer, diabetes, as well as HIV and AIDS. A uniquely receptive setting to address these special challenges has been found to be the Black barbershop. Black barbershops have also been shown as effective locations for community based health interventions for minority men. This paper reviews health disparities, the history of the barbershop and explores their uses today as a site for health care screening. Finally, findings of the National Male Minority Health Program's efforts to address the health issues of minority men, using barbershop screening programs in Prince Georges County, Maryland are reviewed.

Key Words:

African American Men, Barbershop, Health Care Disparities, Cancer, Hypertension

Introduction

Preventing medical problems among African American men who are disproportionately impacted by often preventable diseases is a challenging health disparity. Addressing this issue involves nontraditional and creative approaches. Historically, the barbershop has been found to be an essential location for social gatherings, haircuts, shaves and more recently, health care screenings (Hart & Bowen, 2004).

History of the Barbershop

As social institutions, barbershops have allowed men opportunity for unfiltered dialogue about personal and social issues in their community (Friedman, 2001). The Black barbershop has been a place where African American men could communicate without concern of judgment. It has been termed the African American men's "*country club*" (Releford, Frencher & Yancey, 2010, p.186). In an early research ethnography, Alexander (2003) describes the Black barbershop as a cultural space; a center where ideas are comfortably exchanged among elders and young boys listen, watch, and learn how the ritualized act of hair cutting can seamlessly be paired with social discussion around such issues as rebuilding a community. "*In the black barbershop..., there were always old men sitting in the corner playing checkers, reading magazines, talking trash, talking community, and talking culture*" (p. 105). Alexander's interpretative ethnography certainly speaks to the historical significance and relevance of the Black barbershop in the lives of Black men.

In the late 1900's, many believed barbershops were also a place of origin for what is termed in the Black community as barbershop harmony. Although there is a lack of information to support this opinion, it was thought that the concept of male quartet singing along with the ability to do so in harmony has been referred to as "Barbershop" (Abbott, 1992).

Minority Men and Health Care Disparities

The most common causes of death among men in the United States are heart disease, cancer, accidents or unintentional injuries, diabetes, vascular disease, lower respiratory disease, flu and pneumonia, liver diseases, and Alzheimer's disease, yet in each of these illness categories, African American men have higher mortality when compared to their White counterparts (Underwood, Berry, & Haley, 2009). Underwood et al. conducted a study to understand perception of African American men about the various challenges regarding health care. Of noteworthy significance were cultural barriers, discrimination and lack of access to affordable health care. In addition, many men indicated that they procrastinated and felt dismissive regarding their health problems.

Even earlier, Williams (2003) offers support for the above stated barriers to health care for Black men. Some of the barriers include social and environmental factors that adversely affect health including unemployment, poverty, and the lack of educational outreach in Black communities. Additionally, there appears to be cultural beliefs associated with manhood which may play a role in accessing health care. For example,

the socialization of men asserts the importance of masculinity displayed by showing strength, stoicism at all cost. Displaying vulnerability is seen as a display of weakness (Williams). Many argue that these gender differences create barriers for men in terms of accessing health care and help in general (Bowman & Walker, 2010; Smith, Tran & Thompson, 2008; Wade, 2008).

Hughes, Sellers, Fraser, Teague, and Knight (2007) indicated similar findings after conducting focus groups of 54 southern African American males who ranged in age from 55 to 79 years. In examining perceptions and knowledge of these men and their female partners or spouses about prostate cancer, they found that many feel the process of these screening tests and exams compromised their masculinity. In addition to discomfort with rectal exams, sexual performance issues were feared. There were also concerns about the legitimacy of health screenings given the legacy of the Tuskegee Study. Focus group responses also captured sentiments regarding the patient-doctor relationship suggesting that non-Black physicians are not relatable or vested in their care. These findings play a major role when considering the generational change impacts which are discussed in greater detail later in the paper.

Although hypertension is a well documented health concern within the African American community, it is not well understood. While this affects 73 million Americans each year (American Heart Association, 2009), the impact is more severe for African Americans who die at higher rates (Wong, Shapiro, Boscardin, & Ettner, 2002). A range of etiologic factors have been explored including socio-demographic factors (Fletcher,

Deliakis, Schoch, & Shapiro, 1979; Wagner et al., 1984) and attitudes and circumstances that tend to have an effect on treatment adherence (Bosworth, et al., 2006). Kressin et al. (2009) conducted a study to determine if race impacted blood pressure control after considering “punitive” factors of socio-demographic, thoughts about blood pressure medications, adherence to treatment, and one's experiences of discrimination. The researchers' sample consisted of 806 African American or Caribbean patients aged 21 years or older who had been diagnosed with at least three separate diagnoses of hypertension from an urban hospital. After a brief cognitive screening to determine eligibility, the researchers obtained a self-report of socio-demographic characteristics and medical history. They also obtained from an independent questionnaire a broad spectrum of beliefs and perceptions about hypertension and taking medications. Perceptions of discrimination in health care were also assessed along with medication adherence. The researchers found that disparities in blood pressure outcomes can be improved by education and subsequently treatment adherence.

The Hypertension Detection Follow-Up Program (HDFP), a five year community-based randomized controlled trial, conducted in 1972 was sponsored by the National Heart, Lung, and Blood Institute (Hypertension Detection and Follow-Up Program Cooperative Group, 1976). Using a sample size of 10,940 persons diagnosed with hypertension, HDFP's purpose was to understand the effectiveness of reducing mortality from hypertension among the general population with use of systematic antihypertensive therapy or “Stepped Care” and community referrals for medical

treatment (HDFP Cooperative Group). Results of the study indicated that the use of systematic management of hypertension can likely reduce the rates of death for people with high blood pressure.

In a later study, Smith, Curb, Hardy, Hawkins and Tyroler (1982) investigated hypertensive treatment adherence. Their investigation included factors which were related to study participants returning to an active treatment status and factors related to participants becoming inactive. Analyzing the participant sample from the HDFP, the researchers found factors relating to participants' inactive status. Inactive participants tended to be less educated, of younger age, unemployed and smokers. Additionally they tended to have a low baseline diastolic blood pressure. While factors that were associated with returning to active status were those who had a high diastolic blood pressure, were young and those who were Black. Implications of the Smith et al. study suggest that increasing education about health risks and blood pressure are essential components to establishing treatment adherence.

Rose, Kim, Dennison, and Hill (2000) examined the contexts that supported treatment adherence among African American men with high blood pressure. In a qualitative study, semi-structured interviews were held with a focus on priorities, perceptions of health and health problems as well as concerns of daily living that had an effect on compliance with appointments and medications. Using a very small sample size of 19 individuals, it was concluded that social conditions, alcohol use, and personal

characteristics of the health care provided, impacted adherence to prescribed treatment protocols.

In a study assessing factors related to health relevant attitudes and behaviors of African American men, clinically significant findings were made regarding male identity (Wade, 2008). Two hundred and eight African American men participated in the research by completing questionnaire packets. Results imply that as it relates to health risk behaviors, it is important to understand the extent to which men feel bonded with and connected to other men and that a lack of connection could have an impact on mental health. Therefore, interventions that support peer identity among men would likely have a positive impact on compliance. As a result, it appears that barbershop interventions would be effective and appropriate venues to successfully address health issues.

Barber Shop Health Care Screenings

The Prostate Cancer Education Council of Central New York was formed in 1999 to promote education, prevention, and early detection of prostate cancer in African American men. In 2000, they began planning educational programs that would be offered in barbershops. After recruiting owners of barbershops in Syracuse, on-site education that was purported to raise awareness of cancer, was provided to Black men who were aged 40 and above (Cowart, Brown, & Biro, 2004).

Given the awareness of the disproportionately negative effect of health concerns on Black men, Hart and Bowen (2004) conducted a feasibility study to determine if

barbershops who serve mostly African American men might be interested in participating in disseminating cancer education. The researchers' secondary objective was to explore the feasibility of a community based educational program. Specifically, the authors were interested in determining if shop owners were willing to house electronic screening devices and if customers would be interested in using such devices to increase their knowledge about prostate cancer. The site of the study was Seattle-King County, Washington and the researchers' information was obtained from patrons of the barbershops as well as the owners. Responses were highly favorable, from 97% of barbershop patrons and 75% of shop owners.

Hess et al. (2007) conducted two innovative, non-randomized feasibility studies to determine if barbershop blood pressure monitoring and peer education would lower blood pressure more than standard education and screening. The study participants were low to middle income African American men between the ages of 40 to 60 years and were customers of three barbershops located in Dallas County, Texas. The first study consisted of a screening intervention for customers offered by study personnel. The second study was an intervention administered by the barbers who were taught blood monitoring, recording, and interpreting blood pressure readings of customers. Results indicated that blood pressure monitoring, health education and referrals can appropriately be made by barbers.

Hart, Smith, Tademy, McClish and McCreary (2009) interviewed African American men age 40-70 from 60 barbershops located in Richmond, Virginia to assess

their preferences regarding making health care decisions. They found that 50% of the study's participants preferred that their physician take an active rather than passive role in health decision making. However, the researchers noted several limitations. The sample did not appear to represent "typical" African American urban barbershop clients as their participants included a high percentage of home owners, middle aged to elderly men with higher education, higher income levels and mostly married or living with a partner. The authors considered that men within this group may have greater socioeconomic stability than their younger counterparts and since the cost of haircuts in the shops sampled was as high as \$15, the study participants who reportedly frequented the barbershops at least twice a month, may have had higher incomes. However, it was noted that because barbershops are an important symbol of community among African Americans, they are valid sources of recruitment for participants who might otherwise be excluded from health care studies.

Using a randomized trial, Victor et al. (2009) evaluated whether barbers in barbershops could get customers with high blood pressure to seek treatment and maintain treatment. Using 16 long standing barbershops in Dallas County, Texas, researchers recruited African American men aged 18 or older. The patrons were offered free haircuts as an incentive to give their consent to receive blood pressure screenings. Additionally, financial incentives and training were provided to the barbers. Barbers were trained to check and interpret blood pressure as well as discuss stories of other customers to support and encourage improved health care behavior. For customers

with elevated blood pressures, the barbers were advised to refer customers to either their regular doctor or to a study nurse who would make an appropriate medical referral based on the customer's insurance plan. Results indicated that linking the community to the health care system could reduce risk for cardiovascular issues and hypertension among African American men.

Barbershop Health Care Screening Program

As a member of the National Minority Male Health Project (NMMHP) consortium funded by the US Department of Health and Human Services' Office for Minority Health (DHHS/OMH#US2MPO2001-03-4), the NMMHP at Bowie State University, has developed a comprehensive campus and community-based model program that addresses minority male health issues through community based participatory action research, collecting data previously disregarded and educating a population that is historically distanced from health and wellness. Bowie State University is uniquely situated between Washington, D. C., Baltimore and Annapolis, Maryland, more commonly referred to as the Baltimore/Washington Corridor. While the University is located in a suburban region of Maryland, it has access to two of the major urban areas of the east coast and is located in Prince George's County, where the minority population is large and diverse, making it distinctive in the company of other partnering HBCUs.

The NMMHP at Bowie State University has delivered a comprehensive campus and community-based model program that addresses issues of health for male minorities

that has been distanced from health and wellness. The NMMHP promotes a strategy that provides education and intervention activities to the male population of Bowie State University and to the community surrounding the University.

Further, NMMHP addresses minority male access and utilization of health services, including the examining and sharing of cutting-edge research that considers attitudes and behavior towards medical care and the strategies employed to improve access and delivery of services to minority males. NMMHP contributes its voice and research to understanding and eradicating the distancing of minority men from America's health care system.

The purpose of the project was to gather health related information from African American men as a result of their health screenings conducted in their local barbershops during a routine visit for a haircut. The unique and innovative approach provided free comprehensive health screening to men in seven health areas. These health screening results were measured: blood pressure, body mass (BMI), glucose level (Diabetes level), prostate- specific antigen (PSA), cholesterol, (HDL), triglyceride level, and carotid ultrasound scan.

Method

Population

The population was comprised of African American males ages 16-65, who resided in Prince Georges County, Maryland. Prince George's County has the largest

racial or ethnic minority population (81.7%) in the state of Maryland which is a population of over 60,000 African American males.

Sample

The sample was comprised of 42 African American males, age 16-65 years, who visited the barbershop for their routine haircut and received a health screening in seven areas. While there, they were offered a comprehensive free health screening. Subjects who accepted a health screening were asked to independently complete an anonymous written survey. Questions reflected education level, gender, age, mental status, and race/ethnicity. The survey instrument included an initial confidential statement and instructions.

Results

The design of the study used a survey research approach and analyzed data using descriptive statistics.

Blood Pressure Results

The blood pressure screening revealed that 86 % of men had diastolic blood pressure levels that were above normal. Only 14 % were in the normal range, while 9 % were high to extremely high.

Body Mass Index (BMI)

Body mass screening revealed that 68 % of men had above normal BMI levels. The results indicated that 66 % of BMI levels were 14 points above normal for their age and weight groups, while 2 % of men had elevated BMI levels beyond 14 points.

Glucose Level - Diabetes Test

The normal glucose level, which may be a risk factor for diabetes is 65 - 99. The results indicated that 73 % of men were in the normal range, while 12 % were between levels 100-110. There were 10 % in the 111 - 200 range, and 5 % above 200, which indicates high risk for diabetes.

Prostate Specific Antigen (PSA)

The normal level for PSA is a range from 0.0 - 4.0. PSA is a blood test that indicates indication of the presence of prostate cancer. Screenings indicated 95 % of men were in the normal range. Only 5 % were higher than 4.1.

Cholesterol Levels

The normal cholesterol level range is between 125 - 200. Data indicated that 82 % of men were in the normal range, with only 2 % exceeding 251 (high Level). There were 16 % percent whose levels were between 200 - 250.

Screenings included measuring HDL levels. HDL (high density lipoprotein) indicates risk of heart disease; less than 40 mg HDL increases risk of heart disease. HDL levels of 60 mg HDL or more helps lower risk of heart disease. Screenings found that 14 % of men had abnormal levels of HDL.

Triglyceride levels were measured and 7 % of men had levels above 200 (abnormal levels).

Carotid Ultrasound

A very unique and innovative addition to the screenings was the carotid ultrasound scan. The scan found plaque buildup in the carotid artery of men. While 90 % of men had normal results, 10 % revealed mild plaque buildup. Two men were referred immediately to the hospital for follow-up. Both men later stated that the health screening saved their lives.

Summary

The Bowie State University's Barbershop Health Care Screening Program provided screening to 42 minority men. The study, comprised of African American male's age 16-65 years, who visited the barbershop for their routine haircut, offered a comprehensive free health screening in seven areas. During these events, three participants were referred to the hospital due to high blood pressure. Two participants referred to a hospital who were in danger of developing a stroke due to carotid artery blockage were detected during the screening.

Results indicated that linking the men in the community to health care screenings could reduce risk for cardiovascular issues and hypertension among African American men. For customers with elevated blood pressures, the barbers were advised to refer customers to either their regular physician or an appropriate medical referral based on the customer's insurance plan. The osteoporosis scans were provided for women as an incentive to get them to bring their men to screenings. Four women participated in these scans.

Similar studies have also been conducted regarding other health care issues for minority men. Luque et al. (2010) conducted a community-based barber health adviser pilot intervention and developed educational materials that would increase awareness and knowledge about prostate cancer for the barbershops' African American patrons. Results showed that after the barbershop education about prostate cancer, patrons self-reported greater knowledge and were more likely to talk about prostate cancer with their physicians. This study also lends support for the viability of utilizing barbershops to increase awareness of health concerns among African American men.

Discussion

The barbershop health screening approach has potential to bring about a generational change in the perception of health care screening in the African American population. The participants in the current study range in age from 16- 65 years. There are multiple historical causes of negative perceptions about preventative health care among older and lower income minority men in the United States. These perceptions include having their masculinity compromised (*prostate examinations*), fear of the legitimacy of health screenings (*Tuskegee Study*), fear of finding out they are ill, and fear that their potential illness is incurable as well as concerns that one's sexual performance will be negatively impacted (Hughes et al., 2007). In the current study, early exposure to health care screenings for younger African American men could help change current erroneous views on early prevention. Participation by young males increases opportunity for an attitude shift regarding health education and prevention.

There are several limitations to this study. The generalization of findings is limited by the moderate sample size and the non-random selection of barbershops and clients. Secondly, there is limited information regarding the population who visited the barbershop on the day of the screening. It is unknown if they are representative of the population who reside near the location of each barbershop. Although the study results have limited generalizability, the study was well received by both the barbers and the community. There have been many requests from other barbershops and communities to provide screening services.

Health professionals, researchers and activists are finally paying attention to the need to reduce racial and ethnic disparities in health. But efforts to address these disparities often omit minority men, a forgotten demographic in health policy and practice. Men of color are less healthy than any other group and more likely to suffer chronic conditions. They have reduced access to care and are more severely affected by the underlying causes of disease. Thus far, men of color have been underrepresented in proposed solutions to health disparity problems.

Primary contributing factors to the high death rate of African American men are late stage diagnosis, low levels of awareness, and knowledge and access to low cost health screening. A clear and direct impact on the above contributing factors was made by providing free comprehensive health care screenings in local barbershops during a routine visit for a haircut. A major factor in men's acceptance of their health screenings appeared to be that all screenings were conducted at no cost. Another important factor

of the study was that participants appeared to understand the benefits of health care screenings. This study continues to support the utilization of barbershop to increase awareness of health issues.

References

- Abbott, L. (1992). "Play that barber shop chord": A case for the African-American origin of barbershop harmony. *American Music*, 10(3), 289-325.
- Alexander, B. (2003). Fading, twisting, and weaving: An interpretive ethnography of the black barbershop as a cultural space. *Qualitative Inquiry*, 9(1), 105-128.
- American Heart Association. Heart Disease and Stroke Statistics: 2009 Update At-A-Glance. At-A-Glance. Available at: <https://www.americanheart.org/downloadable/heart/1240250946756LS-1982%20Heart%20and%20Stroke%20Update.042009.pdf>. Assessed November 20, 2009.
- Bosworth, H.B., Dudley T., Olsen M.K., Voils C.I., Powers B., Goldstein, M.K., et al. (2006). Racial differences in blood pressure control: Potential explanatory factors. *American Journal of Medicine*, 119(70), 9-15.
- Bowman, E.K.O., & Walker, G.A. (2010). Predictors of men's health care utilization. *Psychology of Men & Masculinity*, 11(2), 113-122.
- Cowart, L.W., Brown, B., & Biro, D.J. (2004). Educating African American men about prostate cancer: The barbershop program. *American Journal of Health Studies*, 19(4), 205-213.
- Fletcher, S.W., Deliakis, J., Schoch, W.A., & Shapiro SH. (1979). Predicting blood pressure control in hypertensive patients: An approach to quality-of-care assessment. *Med Care*, 17(3), 285-292.
- Friedman, E. (2001). Haircut. *The American Scholar*, 60, 433-439.
- Hart, A., & Bowen, D. (2004). The feasibility of partnering with African-American barbershops to provide prostate cancer education. *Ethnicity & Disease*, 14, 269-273.
- Hart, A., Smith, W., Tademy, R., McClish, D., & McCreary, M. (2009). Health decision-making preferences among African American men recruited from urban barbershops. *Journal of The National Medical Association*, 101(7), 684-689.
- Hess, P.L., Reingold, J.S., Jones, J., Fellman, M.A., Knowles, P. A., Ravenell, J. E., et al. (2007). Barbershop as hypertension detection, referral, and follow-up centers for black men. *Hypertension*, 49,1040-1046.

- Hughes, G.D., Sellers, D.B., Fraser, L., Teague, R., Knight, B. (2007). Prostate cancer community collaboration and partnership: Education, awareness, recruitment, and outreach to southern African-American males. *Journal of Cultural Diversity, Vol, 14:2, 68-74.*
- Kressin, N.R., Orner, M.B., Manze, M., Glickman, M.E., & Berlowitz, D. (2009). Understanding contributors to racial disparities in blood pressure control. *Cardiovascular Quarterly Outcomes, 3(2), 173-180.*
- Luque, J.S., Rivers, B., Gwede, C., Kambon, M.B., Green, L., & Meade, C. (2010). Barbershop communications on prostate cancer screening using barber health advisers. *American Journal of Men's Health, XX(X), 1-11.*
- Releford, B.J., Frencher, S.K., & Yancey, A.K. (2010). Health promotion in barbershops: Balancing outreach and research in African American communities. *Ethnicity & Disease, 20, 185-188.*
- Rose, L.E., Kim, M.T., Dennison, C.R., & Hill, M.N.(2000). The contexts of adherence for African Americans with high blood pressure. *Journal of Advanced Nursing, 32(3), 587-594.*
- Smith, E.O., Curb, J.D., Hardy, R.J., Hawkins, C.M., & Tyroler, H.A. (1982). Clinic attendance in the hypertension detection and follow-up program. *Hypertension, 4(5), 710-715.*
- Smith, J.P., Tran, G.Q., & Thompson, R.D. (2008). Can the theory of planned behavior help explain men's psychological help seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity, 9(3), 179-192.*
- The hypertension detection and follow-up program: Hypertension detection and follow-up cooperative group. (1976). *Prev. Med, 5(2), 207-215.*
- Underwood, S.M., Berry, M., & Haley, S. (2009). Promoting health and wellness of African American Brethren: Because we are our brothers' keeper. *The ABNF Journal, 20(2), 53-58.*
- Victor, R.G., Ravenell, J.E., Freeman, A., Lenard, D., Bhat, D. G., Shafiq, M., et al. (2009). A barber-based intervention for hypertension in African American men: Design of a group randomized trial. *American Heart Journal, 157(1), 30-36.*

- Wade, J. (2008). Masculinity ideology, male reference group identity dependence and African American men's health related attitudes and behaviors. *Psychology of Men & Masculinity*, 9 (5), 5-16.
- Wagner, E., H., James, S.A., Beresford, S.A., Strogatz, D.S., Grimson, R.C., Kleinbaum, D.G., et al. (1984). The Edgecombe County high blood pressure control program: I. Correlates of uncontrolled hypertension at baseline. *American Journal of Public Health*, 74(3), 237-240.
- Williams, D.R. (2003). The health of men: Structural inequalities and opportunities. *American Journal of Public Health*, 93 (5), 724-731.
- Wong M., Shapiro M, Boscardin W, & Ettner S. (2002). Contributions of major disease to disparities in mortality. *New England Journal of Medicine*, 347, 1585-1592.