

Barbers as Lay Health Advocates— Developing a Prostate Cancer Curriculum

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Purpose: The purpose of this study was to develop and test the efficacy of a prostate health curriculum designed to train African American and Afro Caribbean barbers to deliver prostate cancer control messages to their customers.

Procedures: The curriculum was drafted from information obtained from needs assessment surveys administered to barbers and customers from various barbershops in Brooklyn, New York. Focus groups were conducted to further inform the curriculum, which was pilot tested in training sessions.

Findings: The high incidence of late-stage diagnosis prostate cancer in African Americans has often been attributed to lack of screening. In surveys administered to 92 customers and 19 barbers, only 26% of customers and 42% of barbers reported having some knowledge of the prostate-specific antigen (PSA) screening test. More than 90% of the barbers expressed a willingness to obtain prostate cancer information to specifically share with their customers, and 83% of customers expressed an interest in obtaining prostate cancer information and willingness to receive that information from their barbers. Following the pilot training, barber knowledge of prostate cancer increased significantly ($p < .0001$).

Conclusions: This pilot study suggests that there is a need for intervention programs that will raise awareness and increase prostate health knowledge and behavior in communities with elevated incidence of prostate cancer. The study further suggests that barbers are willing to use their leadership skills to educate and encourage their customers to engage in informed decision making.

Keywords: prostate cancer ■ screening ■ complementary and alternative medicine ■ men's health

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INTRODUCTION

Each year prostate cancer claims the lives of many men in the United States. The American Cancer Society estimated 186 320 new cases of prostate cancer in the United States in 2008, and an estimated 26 660 deaths from prostate cancer.¹ African American men are 2.4 times more likely to die from prostate cancer than white men.² African American men are also more likely to be diagnosed with prostate cancer at a more advanced stage, resulting in lower cure rates, and higher mortality rates among men in this group.²⁻⁵ Likewise, in New York City, the incidence rate of prostate cancer among men of African descent is also elevated, with a rate of 246.6 per 100 000 for African American men compared to 134.5 per 100 000 for white men, and these rates are even higher for African American men in minority neighborhoods in Brooklyn, New York (278.2 per 100 000 for black men compared to 115.6 per 100 000 for white men).⁶

The project detailed in this paper targeted African American and Afro Caribbean men in 3 neighborhoods in Brooklyn. These neighborhoods were Bedford Stuyvesant/Crown Heights, East Flatbush/Flatbush, and East New York, all representing Brooklyn neighborhoods with the highest incidence rates of prostate cancer for African American men (279.5 per 100 000, 270.4 per 100 000 and 213.9 per 100 000, respectively).⁷

Men diagnosed as having prostate cancer in its earliest stages have more options for treatment and cure of the disease compared to those who are diagnosed with late-stage prostate cancer. Those with prostate cancer detected at a later stage have lower survival rates, with African American men with metastatic prostate cancer having a worse prognosis compared with white men.⁸ It has been reported that lack of prostate cancer screening or delayed screening is a contributing factor to the high incidence rates of later-stage diagnosis among men of African descent in the United States.^{3,4} Therefore, intervention to increase prostate cancer screening is crucial. Furthermore, studies have documented the link between targeted educational and behavioral health programs to increased participation in prostate cancer screening.⁹⁻¹¹

Although the importance of prostate cancer screening has been stressed, controversy exists regarding the effectiveness of the prostate-specific antigen (PSA) screening in detecting new prostate cancer.¹² It is important that the prostate cancer controversy be addressed in all prostate cancer intervention programs tailored to educating the public about prostate cancer.

Various studies have used nontraditional settings such as churches, salons, etc for health promotion and the behavioral health interventions in minority communities.¹³⁻¹⁸ There are few studies noted in the literature in which barbershops have been used as the educational campus to deliver health messages.^{13,18-20} One study explored the possibility of partnering with barbershops to conduct a community-based prostate cancer screening education program for African American men and concluded that this was a feasible option.²⁰ Traditionally, barbershops have served as community centers as well as places to obtain health information.²¹ Centuries ago, barbers practiced surgery and dentistry in addition to cutting hair.²¹ Today, the barbershop is a place where African American men gather to talk about various issues, including health, and the barber serves as a trusted member of their social network. The present project purposefully makes use of the natural environment of the barbershop and the communication skills of the barber to deliver tailored health messages about prostate cancer to their customers. The purpose of this paper is to document the steps involved in developing a prostate cancer training curriculum tailored to barbers.

MATERIALS AND METHODS

The 3 communities selected for the program—Bedford-Stuyvesant/ Crown Heights, East Flatbush/Flatbush and East New York—represent neighborhoods within Brooklyn, New York, with higher incidence rates of prostate cancer.⁷ These neighborhoods consist of primarily African American and Afro Caribbean populations with high rates of unemployment and low-income families.²²

Barbershops were selected from the Brooklyn Yellow Pages, the Internet, and through site visits. Given that blacks from the Caribbean represent the majority of the foreign-born blacks in the United States,² barbershops were selected that served primarily African American and Afro Caribbean clients. A list of approximately 50 barbershops was generated, and barbers were recruited from 6 barbershops in each of the selected neighborhoods. The random list was developed by selecting every other barbershop. The selected barbershops were included on the generated “barber participation” list. The other barbershops were included on the “customer participation” list. The latter list was utilized in the recruitment of participants for the customer surveys.

An initial contact was made to ascertain that the business was operational, the hours of operation, and the

contact information of the owner or manager. An estimated general description of the barbershop clientele (gender, race, age group) was also obtained from the barber during the site visit.

At the site visit to the barbershop, the field researcher gave the barber a recruitment packet consisting of a letter outlining the project, the Arthur Ashe Institute for Urban Health’s newsletter, and a list of barbershops that participated in previous institute programs. The institute’s newsletter, *TOPSPIN*, is a 4-page publication that highlights various programs conducted by the organization. Letters of support from some of the previously participating barbershops were also given to the barber. The field researcher administered a 15-minute questionnaire to the barbers. This instrument was designed to identify knowledge needs, myths and beliefs, perceptions of roles, and communication comfort levels of barbers related to prostate cancer. In addition, the field researcher spent an additional hour in each barbershop to observe communication patterns, communication role of barbers, and communication topics and themes in the barbershop. This information was used to inform the content of the curriculum as related to the barbershop environment.

Another cohort of randomly selected barbershops was recruited to participate in a customer survey. The selection of these barbershops was similar to that for the barber survey, except that the barber’s consent to interview 5 customers in his barbershop was obtained prior to data collection. Anonymous questionnaires were administered to obtain the prostate cancer knowledge base, stages of change characteristics, and receptivity of a sample of 92 men served by the barbershops in the target communities.

Curriculum Development

The development of the curriculum was informed by formative work, which included focus groups and surveys. The initial focus groups were conducted with male health professional graduate students of African descent and urologists. Revisions to the curriculum were informed by data collected from the barber and customer surveys, as well as from barber focus groups. Barbers from barbershops previously included in the barber and customer surveys were also approached to participate in barber focus groups. All focus group sessions were audiotaped and transcribed. Barbers participating in the focus groups were given a \$30 stipend, refreshments, and provided with reimbursement for public transportation to and from the focus group if needed. The focus groups, which lasted for approximately 2 hours, were conducted at one of the institute’s offices as well as in barbershops within the target communities, based on convenience.

Focus groups were conducted utilizing questions generated to determine the cultural, linguistic, and content appropriateness of the curriculum and knowledge

measurement tools. The training curriculum was designed to address the following aims: (1) to increase the risk perception and knowledge (understanding) of methods of early detection for prostate cancer; (2) to develop the ability to associate language regarding prostate health behavior choices with stages of readiness (moods, attitudes, beliefs) for change (eg, I never think about it, I don't know when I will, I am not going to, etc.); (3) to develop the ability to match communications with stages of change;²³ (4) to increase confidence in ability to deliver prostate cancer control messages; and (5) to develop a personal understanding/connection to the issues of prostate cancer survivorship. In general, the curriculum focused on educating men about prostate cancer and training barbers to deliver prostate health messages. Approaches utilized to obtain the data during the focus groups included information sharing, Q&A, role play, story telling, and problem solving. The stages-of-change section of the curriculum was informed by work previously designed to train lay health educators to deliver messages related to breast cancer.²⁴ Soul Sense of Beauty, a salon-based behavioral health intervention, was conducted in beauty salons within Brooklyn.¹⁵ This project provided information on the feasibility of training stylists to deliver health messages. An important lesson learned from the breast health project was the importance of understanding the culture within each establishment (salon). Salons, like barbershops, vary in size, demographics, etc; and recognizing the uniqueness of the environment is vital to tailoring of the message.

The development of items for the preassessment and postassessment tools was linked to the specific objectives of the curriculum guide, and the assessment tools were comprised of items that measured the extent to which the training objectives were met.

The assessment tools were specifically tailored to customers of the barbershops as well as to the barbers themselves. The barber focus groups were also used to review the pretraining and posttraining assessment tools. All participants were given general questions related to basic demographics and background (eg, prior experience with prostate cancer and prostate cancer screening). Questions were adapted from studies conducted on knowledge and cultural factors in health behavior.²⁵⁻²⁹ In addition, 15 items were drawn from the Prostate Cancer Knowledge questionnaire.²⁹ Based on these items, a score reflecting the percent of correct responses was calculated and used to measure changes in knowledge about prostate cancer.

Barbers were given a set of 6 Likert-type questions on attitudes and beliefs related to prostate cancer. These questions asked them to rate how often they thought about their chances of developing prostate cancer, how certain they were of their chances, how often they thought about doing something about prostate cancer, how willing they were to discuss it with others, and how

certain they were about having the power to make a change. The survey also included a yes/no question that asked whether screening could save a man's life. Finally, there were several questions directed specifically to barbers that asked about information regarding the number of clients served by the barbershop, whether or not the barber was also the shop owner, the number of years of barbering, etc. The curriculum was constructed as a PowerPoint (Microsoft Corp, Redmond, Washington) presentation with color, graphics, images, and text. Pretraining and posttraining assessment tools were created that included demographic questions as well as questions that assessed knowledge, attitudes, and stages of change related to prostate cancer.

Prostate Cancer Training

Barbers from barbershops not participating in either the needs assessment surveys or the focus groups were recruited to participate in the pilot testing of the curriculum. The curriculum was piloted with barbers because they would be the ones to deliver the prostate cancer education messages to their clients. The training sessions were initially conducted at one of the institute's offices, which is centrally located and accessible via mass transit. However, due to low attendance, subsequent training sessions were held at barbershops within the target communities.

The training was conducted over a 2.5-hour period and at a time when barbers reported being less busy (usually Mondays). Barbers were given a small honorarium (\$30) for their participation. A pretraining assessment of the barber was conducted at the training workshop immediately before the training. Posttraining assessments were administered at 2 points in time. The first was immediately after the training. The second posttest occurred at a prearranged barbershop visit, at least 3 months posttraining. The second postassessment measured knowledge and skill retention, behavior, and attitude changes.

Data Analysis

Data collected in this project included needs assessment surveys of barbers and customers; focus group information; and pre-, post-, and follow-up assessments of the barber training. The responses collected from the needs assessment surveys were tabulated, and the frequency of each need was tabulated separately for barbers and customers. The audiotapes from the focus groups were transcribed, and a qualitative analysis of the focus group responses was conducted in order to identify recurrent themes and clusters. The computer program N6 (QSR International, Doncaster, VIC, Australia) was used to carry out all qualitative analyses.

Quantitative variables were described as mean \pm standard deviation in the case of normally distributed continuous variables and as frequency (percent) in the

case of categorical variables. Mixed-model regression was used to test for any improvements that occurred in terms of knowledge and attitude (eg, think about chances of developing prostate cancer) between pretraining and posttraining, and between pretraining and the 3-month follow-up. Mixed-model regression allowed for the inclusion of measurements from barbers who did not have complete follow-up data. Mean contrasts were calculated to test for differences between preresults and postresults between time periods. The Fisher's exact test was used for the yes/no question, "Do you think that screening can save a life?" The size of the sample of barbers was relatively small, and so information about statistical significance was supplemented by effect sizes (Cohen's *f*) and by estimates of the sample sizes that

would be needed to achieve an 80% level of power to detect a significant difference. Smaller samples (eg, $n = 22$ for "thinking about doing something") were reflective of greater improvement. Quantitative analyses were performed using SPSS software (SPSS Inc, Chicago, Illinois) for all descriptive results, while SAS (SAS Inc, Cary, North Carolina) was used for carrying out the mixed-model regression. Statistical significance was set at a 2-sided α value of .05. The study protocol was reviewed and approved by the institutional review board at SUNY Downstate Medical Center.

RESULTS

Approximately 50 barbershops were evaluated to assess eligibility to participate in program. Data were

Table 1. Characteristics of Sample (Barbers and Customers)

Characteristics	Barber Needs Assessment (N = 19)	Customer Needs Assessment (N = 92)	Barber Pilot Training (N = 14)
US born	8 (42.1%) ^a	66 (71.7%)	6 (42.9%)
Education			
None	0	1 (1.1%)	1 (7.1%)
Primary/elementary	3 (15.8%)	5 (5.4%)	0
Junior high	2 (10.5%)	4 (4.3%)	0
High school	9 (47.4%)	45 (48.9%)	7 (50.0%)
College	4 (21.1%)	27 (29.3%)	5 (35.7%)
Graduate	0	8 (8.7%)	1 (7.1%)
Marital status			
Married	11 (57.9%)	33 (35.9%)	3 (21.4%)
Separated	1 (5.3%)	6 (6.5%)	2 (14.3%)
Divorced	1 (5.3%)	7 (7.6%)	1 (7.1%)
Never married	6 (31.6%)	41 (44.6%)	8 (57.1%)
Age			
20-39	7 (36.8%)		1 (7.1%)
30-39	3 (15.8%)		12 (85.7%)
40-49	1 (5.3%)		0
50-59	1 (5.3%)		0
60-69	3 (15.8%)		0
≤70	0		1 (7.1%)
Barbering, y		NA	13 ^b
Number of customers (busiest days)	27.2	NA	
Own shop	12 (63.2%)	NA	3 (21.4%)

Abbreviation: NA, not applicable.

^a Frequency (percent).

^b Mean.

Table 2. Barber and Customer Needs Assessment (Important Characteristics)

Response Characteristics	Barber Needs Assessment (N = 19)	Customer Needs Assessment (N = 92)
Having health insurance (= yes)	10 (52.6 %) ^a	50 (54.3 %)
Knowledge of prostate-specific antigen (= yes)	8 (42.1 %)	24 (26.1 %)
Surgery causes cancer to grow (= yes, don't know)	12 (63.2 %)	60 (65.2 %)
Normal life with prostate cancer (= yes)	6 (31.6 %)	36 (39.1 %)
Willingness to learn and share prostate cancer info with customers (= yes)	18 (94.7 %)	NA
Interested in hearing from barber (= yes)	NA	76 (82.6 %)

Abbreviation: NA, not applicable.

^a Frequency (percent).

collected from barbers and customers in barbershops within the 3 target neighborhoods. Nineteen barbers (6-7 barbers from each of the 3 target neighborhoods) from 18 barbershops completed the barber needs assessment questionnaire. Ninety-two customers completed the customer survey.

Customers tended to be US born (72%), while 42% of barbers in the needs assessment sample and 42% of those in the training group were non-US born. All groups were similar with regard to education and marital status. No information about age was obtained from the customers, but the needs assessment of the barber sample showed a greater spread of age groups than did the barber training group (Table 1).

The results of the needs assessment survey of the barbers and customers, respectively, are shown in Table 2. Health insurance was the most frequent need stated in both groups. Forty-two percent of barbers and 26% of customers expressed having knowledge of PSA. Thirty-one percent of barbers and 39% of customers reported that a man can lead a normal life with prostate cancer. A majority of both the barbers and the customers said

“yes” or “don’t know” to the question about whether surgery causes prostate cancer to grow. Barbers (95%) expressed a willingness to learn and share information about prostate cancer with their customers, while 83% of customers expressed an interest in hearing about prostate cancer from their barbers.

Twenty-one barbers participated in the focus groups; 60% of these barbers self-identified as African American, while 35% self-identified as Afro Caribbean. Table 3 shows the basic themes brought up in the barber focus groups and how the curriculum was adapted to address those themes. The need to educate and provide information about all aspects of prostate cancer, from how it develops to how it is detected and treated and the way the message is delivered to the customer were stated by barbers as being important in the context of the typical barber-customer social interaction. The fears that men may have about prostate cancer, including the fear of going to a doctor, were also discussed. However, the greatest fear reported was “loss of manhood,” or a fear that there will be some inability to perform sexually as a result of one having prostate cancer. Access to care,

Table 3. Focus Group Outcomes

Focus Group Themes	Focus Group Observation (Barber Comments)	Curriculum Focus/Adaptation
Educational messages	<ul style="list-style-type: none"> • Important to connect prostate cancer with other broader health issues • Expressed interest in knowing all aspects of disease (detection to treatment) • Showing the digital rectal exam (DRE) was important in reducing anxiety about the exam. 	<ul style="list-style-type: none"> • Recognized importance of barbers being screened for prostate cancer (age appropriate), facilitated screening process for those eligible to be screened • Addressed the controversy surrounding screening—choice made to stress the importance of both DRE and PSA (use American Cancer Society guidelines) • Included diagram of DRE • Incorporated analogy of body being like a car, in terms of the care that is needed
Message delivery	<ul style="list-style-type: none"> • Personal experience or connection with prostate cancer was helpful in delivering prostate cancer message. • Relationship to customer was important in assessing approach to delivering the message. 	<ul style="list-style-type: none"> • A prostate cancer “Survivor’s Story” incorporated into curriculum • Role plays incorporated to address stages of change and readiness
Fears	<ul style="list-style-type: none"> • Loss of manhood (greatest fear) • Sexual performance after surgery • Fear of being screened attributed to fear of cancer. 	<ul style="list-style-type: none"> • Fears were openly addressed in curriculum to allay fears and be truthful.
Access/empowerment	<ul style="list-style-type: none"> • Fear of going to the doctor • Secrecy may prevent men from accessing services. • Secrecy is often driven by fear, embarrassment, stigma. • Having money increased access to care. 	<ul style="list-style-type: none"> • Message of personal advocacy was stressed in curriculum • List of screening sites was included and facilitation of screening for barbers incorporated.

along with willingness to acknowledge the need for that care, was another common theme. Possible cultural differences in the community were brought up as something that needed to be addressed in the training program. For instance, the barbers mentioned that their customers were not a homogenous group in that their countries of origin varied. The focus group participants also considered differences in the culture of the individual barbershops in terms of the personal style of the barber as well as the composition of the customers to be important. Age was something that was also considered important to take into account. There were also themes related to possible barriers such as linguistic differences. Language and immigration status were reported as barriers to accessing care. Barbers reported that it was important to connect prostate cancer with other broader issues. Personal experience or connection to someone

with prostate cancer was viewed as being helpful in delivering prostate cancer messages. Incidentally, 1 of the barbers participating in a focus group was a prostate cancer survivor.

Fourteen barbers participated in the pilot training to test the prostate cancer curriculum. Table 4 shows the results of the outcome instrument given to the barbers in the training program, before and immediately after the training, and then at the follow-up after 3 months. However, it is important to note that the range of time from training to follow-up was from 3 to 6 months. Some barbers had relocated and were lost to follow-up. Barbers showed significantly higher levels of knowledge about prostate cancer immediately after training ($p < .001$), and this tended to be maintained at follow-up ($p = .049$). No other comparisons were significant, with the exception of the question about thinking about doing something about

Table 3. Focus Group Outcomes (cont)

Focus Group Themes	Focus Group Observation (Barber Comments)	Curriculum Focus/Adaptation
Culture (general) and language	<ul style="list-style-type: none"> African American vs African Caribbean was not an issue in the way the curriculum was presented. Culture of the clinician and trainer matters (Afro Latino barber identified with Afro Latino trainer). Recognized that women play an important role in men's health and would often advocate on behalf of the men in their lives Language (eg, Haitian barbers thought that the curriculum should also be presented in Creole) 	<ul style="list-style-type: none"> Recognized diversity in barbershops and clients (multicultural, multiethnic, multilingual) Referenced terminology that may be used by various groups (eg, stoppage of water for inability to urinate)
Culture (barbershop)	<ul style="list-style-type: none"> Individual barbershop culture matters, especially as it relates to the leadership. Barbers will deliver messages tailored to the specific culture of the barbershop and customers. 	<ul style="list-style-type: none"> Curriculum stressed the importance of the barber's role in the community, incorporated the history of the barbershop Role plays included to demonstrate diversity of culture
Age	<ul style="list-style-type: none"> Age matters in one's receptivity to the DRE. Men over age 30 were viewed as being more receptive to DRE. One barber stated that "this information was not for young men; they would not understand" 	<ul style="list-style-type: none"> Recognized that barbers encounter diversity in age—more holistic approach taken to health (something for everyone—eg, everyone needs to obtain age-appropriate screening)
Barriers, stereotypes/myths	<ul style="list-style-type: none"> Accent and intelligence level (especially related to accent treatment within system by all categories of health care workers) Immigration status Fears Misinformation/lack of information about prostate cancer/general health 	<ul style="list-style-type: none"> Validated recognition of each customer being different Included role plays to identify stages of change Anatomy of prostate added to curriculum Included myth/fact game to directly address myths Stressed empowerment message (advocates for own health)—included questions to ask your doctor

prostate cancer. For this question, barbers were more likely to think about doing something immediately after training relative to before training (p value .04). Although there was no significant difference shown at the 3-month follow-up, the sample size needed to find a significant difference is relatively small, indicating that there was a strong effect size underlying this difference.

In the case of the other questions about whether the barbers thought about their chances of getting prostate cancer, whether they were willing to discuss prostate cancer with customers, and whether they thought they had the power to make changes in their lives, the barbers made modest but statistically nonsignificant gains from pre to post. These largely disappeared by the 3-month follow-up. On the question of whether screening can help save a life, there was virtually no agreement with this statement at any time the barbers were asked to respond to it. This may be in keeping with the controversy that exists regarding prostate cancer screening. While barbers were encouraged to be screened for prostate cancer, as well as to obtain general health screening, they were also informed of the controversy surrounding screening (PSA and digital rectal exam) for prostate cancer.¹²

DISCUSSION

The purpose of this study was to develop and test the efficacy of a prostate cancer curriculum designed to train African American and Afro Caribbean barbers to deliver prostate cancer control messages to their customers. The project resulted in a curriculum that was feasible and well received in the barbershop setting. This study suggests that barbers are willing to use their leadership skills to educate and encourage their customers to engage in informed decision making around their health. Furthermore, customers also expressed great interest (83%) in hearing about prostate cancer from their barbers.

The barbers participating in the focus groups were interested in obtaining as much information as possible

on prostate cancer and expressed the importance of educating customers on prostate cancer.

The increase in barber knowledge of prostate cancer following the training is encouraging. This finding is in keeping with another study which demonstrated an increase in prostate cancer knowledge after a 1-hour seminar.¹² There was a decrease in knowledge during the follow-up period in the months following the training. The change in knowledge at follow-up compared to immediately following the training indicates that barbers may need additional training or booster training sessions during this period.

One of the limitations of this study was that the target neighborhoods, although representative of the study group, were not equally divided in their representation of African American and Afro Caribbean men. There were neighborhoods that had higher numbers of African American men as compared to Afro Caribbean and vice versa. The focus groups were comprised of both African American and Afro Caribbean men. Nevertheless, the information obtained from the focus groups revealed that it was not necessary for the curriculum to be presented differently for African American men and Afro Caribbean men. However, the diversity in terminology from one group to another was acknowledged in the curriculum. Given this was a pilot study, we had small numbers, and we were more interested in seeing trends. Another limitation is the ability to generalize our findings to other barbershops with a different client demographic profile.

This study is unique in that information obtained from men of African descent in Brooklyn, New York, was utilized to develop a curriculum guide to train barbers to deliver prostate health messages to their customers.

This study suggests that there is a need for intervention programs that will raise awareness and increase prostate health knowledge in communities with elevated incidence of prostate cancer. Educating men about pros-

Table 4. Result of Outcome Measures (Before and After Training and at Follow-Up)

Outcome Measures	Pretraining (Mean ± SD)	Posttraining (Mean ± SD)	P Value Pre vs Post	Follow-Up (Mean ± SD)	P Value Pre vs Follow-Up	Effect Size (Sample Size ^d)
Knowledge	51.4 ± 14.4 ^a	75.7 ± 12.2	< .001	60.0 ± 18.1	.049	1.4 (4)
Think about chances?	2.1 ± 0.9	2.5 ± 0.9	.11	2.5 ± 0.9	.46	0.35 (40)
What are your chances?	2.4 ± 0.9	2.6 ± 0.6	.35	2.4 ± 0.5	.82	0.21 (110)
Think about doing?	2.2 ± 1.0	2.9 ± 0.8	.04	2.8 ± 1.1	.17	0.47 (22)
Willing to discuss?	2.8 ± 0.4	2.9 ± 0.4	.61	2.7 ± 0.5	.46	0.26 (72)
Do you think you have the power to make this change?	2.6 ± 0.4	2.8 ± 0.4	.34	2.6 ± 0.4	.82	0.28 (62)
Screening can save a life	0 (0%) ^b	1 (7%)	1.00 ^b	0 (0%)	NA	NA

Abbreviation: NA, not applicable.

^a Mean ± standard deviation.

^b Frequency (percent).

^c Based on Fisher exact test.

^d Sample size needed for 80% power to detect a significant difference.

tate cancer will enable them to be better equipped to make informed decisions about screening and treatment. Various studies have cited the importance of patient education to the informed decision making process.²⁸

This curriculum guide will be tested in a future intervention to ascertain the effectiveness of barber delivered messages on impacting prostate health behaviors of their customers. Future studies could include exploring the delivery of a prostate cancer control program designed and tailored to influence prostate cancer screening behaviors of African American and Caribbean customers.

The study to emerge from this immediate effort will utilize the natural role of the barber to present health education and outreach within a cultural venue uniquely suited for African American men.

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