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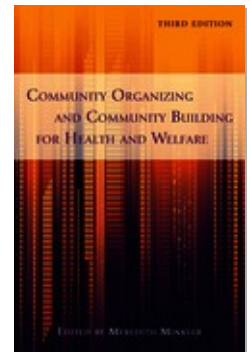
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African American Barbershops and Beauty Salons

An Innovative Approach to Reducing Health Disparities
through Community Building and Health Education

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A goal of Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS] 2011), the nation's road map to achieving health equity, is the elimination of health disparities. Yet despite decades of gains in the overall health status for the general population, racial and ethnic health disparities persist (USDHHS 2011). Racial and ethnic health disparities exist across a broad spectrum of health outcomes and behavioral risk factors, and African Americans carry a greater proportion of the burden of health disparities than do other racial and ethnic groups. Compared with whites, African Americans have higher rates of overall mortality, obesity, cancer, diabetes, heart disease, stroke, and HIV and have the highest rates of infant mortality among all racial and ethnic groups (Flegal et al. 2010; National Center for Health Statistics 2010).

To make progress toward eliminating racial and ethnic health disparities, communities must be engaged in exploring the context of existing health disparities, formulating solutions, and ultimately making the decisions that affect their health. Community building and community organizing are strategies that lie at the heart of addressing racial health disparities. Interventions that address "hot-button issues" identified by community members are critical when attempting to understand and affect the complex interplay of behavioral, environmental, and policy-driven factors that shape health disparities. Building community capacity by engaging with the community at each step of the process is essential for sustainability (Giachello et al. 2003; Wallerstein and Duran 2010). The involvement of community members as equals in decision-making processes can help build relationships based on trust that promote the type of changes that are

the foundation of a serious effort to affect health disparities (Wallerstein and Duran 2010).

Applying community organizing strategies to address health disparities is important for all populations, but particularly perhaps for African Americans, given that traditional interventions have largely failed to reduce health disparities in this population (Adderley-Kelly and Green 2005). The National Cancer Institute (2006) and the Institute of Medicine (2008) both have emphasized the importance of empowerment and working collaboratively with communities in the development of culturally appropriate, evidence-based interventions to address health disparities. Similarly, there is growing consensus at the National Institutes of Health that accelerating efforts to eliminate racial and ethnic health disparities will require innovative community-based interventions and building trust with respected community partners in priority populations, such as African Americans who reside in high-risk urban neighborhoods.

A promising approach in such work is to begin in community settings that are not clinical or academic in nature, but rather shared social spaces. Every ethnic group has safe zones; community-empowered centers where people can gather, share cultural secrets, connect with their ethnicity's historical narrative and engage in writing new chapters of that story. The African American church is one example of this approach that has been documented in the literature (Campbell et al. 2007). However, the urgency of persistent and often growing health disparities demands that we go further in finding new partners and more effective interventions to close the health disparity gap. This is the context within which partnerships with black barbershops and beauty salons have gained credibility. While the practice of working with barbershops and salons is not new, recent community-based participatory research in these settings has ushered in creative new efforts to transform barbershops and salons into reliable venues for interventions that are both scientifically sound and culturally relevant, while also fostering enhanced community building. From the perspective of culturally relevant science, for example, Victor and colleagues (2010) conducted one of the first randomized clinical trials in black barbershops focused on control of hypertension among African American men. The authors concluded that "the effect of blood pressure screening on [hypertension] control among black male barbershop patrons was improved when barbers were enabled to become health educators, monitor BP, and promote physician follow-up" (Victor et al. 2010). Clearly more research is needed if this approach is to be disseminated and scaled for large urban populations. In the African American community, however, beauty salons and barbershops have a legacy of community building and community organizing and have the potential to be places where community members and academics can come together to address health disparities in the community.

This chapter will review the important social, political, and economic history of U.S.-based African American beauty salons and barbershops, and provide two

examples of how community building and -organizing principles have been used to conduct community-engaged research designed to address health disparities among African Americans living in the inner-city neighborhoods of Pittsburgh, Pennsylvania, and the mixed urban/rural communities of central North Carolina.

Beauty Salons and Barbershops in Contemporary and Historical Perspective

Beauty salons and barbershops are found in almost every town in the United States, and almost seven hundred thousand barbers and cosmetologists were employed in 2008. Almost half are self-employed and many own their own salon or barbershop (Bureau of Labor Statistics 2010). There are approximately 85,500 barbershops and 474,400 beauty salons in the United States, including both self-employed businesses and those that have employees on the payroll (U.S. Census Bureau 2002).

With their rich history and prominent role in the lives of African Americans, beauty salons and barbershops have served as settings for community building and community organizing beginning in the 1800s and continuing today (Bristol 2009; Harris-Lacewell 2004; Willet 2000). Originally a place where black barbers provided shaves, haircuts, and wigs to such notables as Thomas Jefferson and Benjamin Franklin, barbershops evolved and adapted to the racial climate and policies of the United States. Throughout history, barbering was one of the few professions that provided African American men with economic mobility and stability (Bristol 2009).

Although their history does not date as far back as that of barbershops, hairdressing, and owning a beauty salon, provided one of a limited number of avenues for African American women to become entrepreneurs at a time when the majority of African Americans were marginalized with limited access to economic opportunities (Byrd and Tharps 2001; Peiss 1998; Willet 2000). In fact, Annie Turnbo Malone and Madam C. J. Walker, both pioneers in the hair care and beauty industry, are documented as being the wealthiest African American women during the early 1900s, with the latter becoming the first African American millionaire (Bundles 1990; Byrd and Tharps 2001; Willet 2000). Historically, improving the overall health and well-being of African Americans has been an integral part of the community organizing and community building functions of African American-owned barbershops and beauty salons (Bristol 2009; Bundles 1990; Peiss 1998; Willet 2000). As early as the 1830s, some African American barbershops became centers for abolitionists, soliciting customers to sign antislavery petitions and carrying abolitionist publications (Bristol 2009). Barbershops also served as part of the Underground Railroad (Bristol 2009). During the civil rights movement, the African American beauty salon was used as a meeting place for activities, because, unlike the church and other prominent African American institutions, it was a less visible institution within the community (Willet 2000).

Serving as a natural setting for information sharing is one of the critical attributes of the African American barbershop and beauty salon that historically made them optimal sites for organizing and building communities (Bristol 2009; Willet 2000), as well as addressing health disparities (Linnan et al. 2005; Luque et al. 2010).

Another critical attribute of the African American barbershop and beauty salon is the unique relationship between the barber or stylist and his or her customers (Bristol 2009; Harris-Lacewell 2004; Hart et al. 2008). Often, customers establish long-term, friendly, trusted relationships with their preferred barber or stylist (Bristol 2009; Willet 2000). The high number of repeat contacts between the customer and barber or stylist form the type of “weak ties” that are thought to fill important gaps in social support, by extending beyond close family bonds that might be geographically displaced and yet are accessible to everyone within a “limited physical and temporal context” (Adelman et al. 1987; Granovetter 1973). From conversations about politics and the economy, to health and personal relationships, barbers and stylists have routinely served as a sounding board for their customers (Bristol 2009); and are excellent examples of “natural helpers” (Eng et al. 2009) who have been mobilized to promote health within the African American community (see for example Wilson et al. 2008; Hess et al. 2007; Johnson et al. 2010; Luque et al. 2010).

In addition to barbershops and beauty salons providing a safe haven for addressing social justice issues (Bristol 2009; Harris-Lacewell 2004) whose barbers and stylists serve as natural helpers (Bristol 2009), shop and salon owners tend to be deeply concerned about the health and well-being of their communities (Bristol 2009; Linnan et al. 2002; Hart et al. 2008). Engagement with these owners as gatekeepers has been essential for implementing health-promotion activities that address health disparities in the African American community (Linnan et al. 2002; Luque et al. 2010; Releford et al. 2010) while building community.

What follows are two detailed descriptions of barbershop and beauty salon interventions in two separate locations, Pittsburgh, Pennsylvania, and central North Carolina. Working in collaboration with informal networks of barbershops and salons to disseminate health information in these communities became one viable means of working to reduce health disparities while further building on these establishments’ sense of community. However, we are mindful of the caution of Musa and colleagues (2009) who emphasize that these same informal networks in the black community are also potential means for the spread of rumors, concerns, or conspiracy theories, which may reduce health care service utilization. Thus, efforts to monitor the quality and accuracy of the information provided, addressing myths and misconceptions about health risk and the causes of health problems, as well as taking time to build trust and authentic relationships with barbershop/salon owners and stylists/barbers and their customers, were hallmarks of these efforts.

Overview of Beauty Salon and Barbershop Interventions

It is beyond the scope of this chapter to review the robust and growing literature on beauty salons and barbershops as both intervention settings and places to recruit participants into a wide range of health disparities research studies, but the reader is referred to Linnan and colleagues (under review) for a systematic review of this work. Briefly, barbershop and salon interventions have addressed a variety of health problems, including cancer, hypertension, diabetes, kidney disease, stroke, and cardiovascular disease and health behaviors such as diet, physical activity, and smoking. In these studies, the level and type of stylist/barber involvement, as well as level/type of community collaboration varied, but typically included the development and use of culturally relevant educational materials in barbershop- or salon-based settings (Linnan et al., under review; Luque et al. 2010) and education of barbers and stylists in the health area of interest. An urban beauty salon intervention that randomized salons serving predominantly African American and Afro-Caribbean women to receive breast health messages from trained stylists or to serve as controls also included the use of a community advisory board consisting of community leaders, salon owners, breast cancer survivors, and health care advocates in designing the training curriculum (Wilson et al. 2008). As illustrated in more detail below, when such an approach is used, actively engaging a range of relevant community members as partners in the research from the onset, the goodness-of-fit of such work with principles of community building and organizing may best be realized.

Predominant themes in the literature on community-academic partnerships to address health issues through beauty salons and barbershops included that (1) barbers and stylists felt it important to them personally that they help their clients by sharing health information with them, (2) many already talk to their clients about health, (3) customers are interested in receiving health information from their stylists or barbers, and (4) male customers showed a willingness to obtain not only education but also medical services such as prostate cancer screening tests, blood pressure and blood glucose measurements, physical measurements, and fitness assessments in the barbershop (Linnan et al. 2010).

Although beauty salons and barbershops are promising settings for health interventions, there are challenges to creating successful interventions in these settings to address health disparities. With a few exceptions, such as the BEAUTY project described below, the majority of such interventions are “community placed” rather than community based. That is, even when community partnerships are formed, the issues addressed by interventions have largely been selected by researchers rather than by the community itself. Using the setting to deliver health education messages or provide screenings may provide short-term health benefits to the community. But employing community building and community organizing principles to help ensure that the community itself is deeply involved in deciding which messages should be delivered takes this a step further and may

increase trust and the likelihood of program sustainability, while building community capacity and improving sense of community.

Our review of the literature revealed little about the ways in which community building and organizing approaches were used in studies to date. We therefore turn now to two different approaches to working with beauty salons and barbershops and the ways in which these settings and owners/stylists/barbers were mobilized to address health disparities, as well as challenges faced in the process.

Health Advocates In-Reach and Research: Mobilizing Black Barbershops to Promote Health and Prevent Disease

In 2001, the Department of Health and Human Services (DHHS) launched a national public awareness campaign designed to address racial and ethnic health disparities by encouraging African Americans to establish a medical home. Although many African American communities hosted Take a Loved One to the Doctor Day, however, one of the authors (Dr. Stephen Thomas) and his colleagues at the Research Center of Excellence on Minority Health Disparities in the University of Pittsburgh's Graduate School of Public Health (hereafter the Pittsburgh Research Center), realized there was a major problem with the campaign. Far too many people in Pittsburgh's black neighborhoods had no doctor, no medical home. Recognizing that the elimination of health disparities required the full array of health professionals and not simply physicians and, further, that a public health approach tailored to the local community context was needed, Dr. Thomas and his team launched Take a Health Professional to the People Day. They partnered with a network of black barbershops and salons in Pittsburgh, as the venue for public health education, clinical screenings, and assessments.

In this approach, teams of health professionals would come to the people in the trusted venue of local barbershops and salons. This innovative twist on the DHHS campaign evolved over time from three barbershops and ten health professionals in 2001 to ten barbershops/salons and over two hundred health professionals screening approximately seven hundred people in one day at the height of the program in 2008 and ultimately became a year-round community-engaged research program, Health Advocates In-Reach and Research (HAIR). The concept of using barbershops and salons to deliver health services to African Americans captured the imagination of local and national media, resulting in a segment on National Public Radio's *Morning Edition* (Jones 2002), and extensive news coverage on the day of the event.

Building Trust and Training the Barbers

Early in the process it became clear that the barbers and stylists were the linchpin for any success. The barbershops/salons were businesses first, and anything that would disrupt their ability to serve their clientele would be inappropriate. Barbers

were well aware of the health problems plaguing the community and they wanted to make a meaningful contribution to a solution. However, there were natural tensions between university researchers and the cultural milieu of black barbershops. To find common ground and establish trust, a full-time staff member engaged barbers using principles of community-based participatory research, which share with community building and organizing a focus on community as a unit of identity, an accent on community strengths, and a commitment to local capacity building and sustainability (Israel et al. 2005). Methods included conducting structured interviews with barbers, carrying out participant observations, and using anthropological field methods to construct a typology of the organization and structure of black barbershops in Pittsburgh. For example, barbershops were classified into three types: owner-operator, independent barbers renting chairs, and absentee landlord. Findings also suggested that those barbershops where the owner was also an active barber were more likely to fully embrace the incorporation of health education and delivery of medical services in their shops.

Theater was used as an innovative approach to gain barbers' trust. A local playwright transformed field notes and observations into a script for a one-act play, *A Healthy Day in the Neighborhood*, that conveyed the full range of human emotion and cultural context of the barbershop where the public health education would take place. Barbers had a chance to "see" themselves on stage as actors played the role of barbers as lay health advocates. For many of the barbers it was an "aha moment"—they got it. The play decreased cultural barriers between barbers and researchers and laid a foundation of mutual respect upon which to build the public health education programs.

Barbers were trained as lay health advocates through a formal program that included becoming certified in cardiopulmonary resuscitation (CPR); in this way they could be legitimately called "lifesavers." In 2008, 700 blood pressure screens, 150 depression screens, and smaller numbers of echocardiograms and prostate exams were conducted throughout the HAIR barbershop network. All clinical screenings were conducted by physicians, nurses, dentists, and other health professionals. Working with their community collaborators, Thomas and his colleagues decided at the inception of HAIR that people needed access to medical care providers and the role of the barbers was to reinforce relevant health promotion and disease prevention messages while at the same time making their shops welcoming to health care professionals.

Gilbert (2010), describes the urban context that anchored the HAIR network barbers and their customers in an extensive interorganizational network consisting of the Pittsburgh Research Center, the Kingsley Association (a community-based service organization), the National Broadcasting Company (NBC) affiliate WPXI-TV and other media partners and the Robert Wood Johnson Foundation and local foundations. Together they established and promoted the Healthy Black Family Project, a community-based intervention designed to provide health promotion and disease prevention services at no cost for people at risk for type 2

diabetes and hypertension identified in the barbershops (Thomas and Quinn 2008; Ford et al. 2009). This constellation of assets contributed to a notion of the community as a “unit of solution” (Eng et al. 1985) whereby capacity for community development was concentrated on promoting health and preventing disease. With the humble barbershop being featured on television news as a neighborhood setting, not for the far too commonly depicted crime scenes, but rather a place where hundreds of physicians, dentist, pharmacists, nurses, and other public health professionals came to listen, learn, and serve the African American community. The burdens of race and history crushing the people living in these communities was lifted, if only for a day, and their stories were heard and elevated beyond the confines of their daily suffering. Public awareness was raised about chronic disease being related not only to individual lifestyle behaviors or access to medical care but also to degradation of the neighborhood environment, racial segregation, and poverty where African Americans lived, worked, played, and worshiped. These broader social determinants of health became new targets for intervention.

Engaging Academic Health Science Professionals in Community Outreach

Over time, the ten barbershops in the HAIR network became a stable infrastructure for conducting ongoing public health education year round. The university dedicated a full-time staff member with responsibility for weekly visits to the shops and service as a liaison to clinical investigators interested in using the HAIR infrastructure for recruitment of participants to other health disparities clinical trials research. Additionally, the stability made it possible to build relationships across selected schools of health sciences that also had a commitment to address health disparities but lacked a coordinated mechanism to engage the community. For example, the HAIR barbershops served as venues to train pharmacy students in communication skills, train dentistry students in oral examinations, serve as a clinical rotation for nursing students, and recruit eligible individuals into clinical trial research through the Asthma Research Center and Department of Psychiatry in the School of Medicine. For the barbers, the addition of health care providers added value to their service delivery and commitment to improving the community. They witnessed firsthand the burdens of chronic disease on their customers, their family members, and themselves and appreciated being able to serve as key venues in these new efforts that ideally would contribute to the health of their communities.

The Mayo Clinic’s Center for Translational Science Activities (CTSA) established a formal course with the Pittsburgh Research Center that included a one-week rotation known as urban immersion (Mayo Clinic 2007) to take place in the city. Physician scientists from the CTSA would be integrated with teams of health professionals who worked in the barbershops. The aim was to build their “cultural confidence” and conduct simulations of advanced screening techniques (Thomas et al. 2011). For example, in 2008, a Mayo physician demonstrated the

use of a laptop echocardiogram on thirteen participants in one of the participating barbershops (Huskins et al. 2008), benefiting customers with diagnosed or suspected heart problems while further demonstrating the viability of the barbershop as an important venue for using sophisticated diagnostic methods designed to improve health care access.

Lessons

The HAIR project transformed a network of trusted barbershops and beauty salons into portals for dissemination of health promotion and disease prevention information and delivery of clinical services. Along the way, however, significant challenges were encountered. These included the intensive time and staff effort needed to establish trusting relations with selected barbershops and salons, and the need to overcome the significant amount of distrust toward the university and medical establishment built up over the years. For example, although several of the HAIR barbershops were located less than one mile from the academic health center, these neighborhoods had significant burdens of preventable chronic disease. This contradiction was not lost on the barbers, who had concluded that their health, and the lives of the people they served, were of less importance than those of white people who lived farther away.

Once trust was established with the barbers and they were willing to host health professionals in their shops, the academic partners also did not fully appreciate the time and effort needed to prepare health professionals (90 percent of whom were white) for the cultural environment they were about to enter. The HAIR barbershops were located in high-crime neighborhoods and the often clear apprehension felt by health care professionals entering the community was observed by the barbers, often creating tension. In time a mandatory orientation was instituted for health professionals, which proved highly successful, although it was another demand on staff time and the budget.

Other obstacles emerged when the success of the program generated even more demand for expansion across the city and into neighboring counties, beyond the capacity of the university to respond to. This led to dashed expectations and exposed the vulnerability of innovative initiatives like HAIR, funded only by federal grants and foundations, and unable to be sustained beyond the life cycle of a grant. Although community building and community-engaged research make a commitment to long-term involvement and sustainability (Israel et al. 2005), such challenges are not uncommon in practice, particularly in difficult economic times.

Despite such challenges, the gratifying opportunities and outcomes of this work made it well worth the effort. Examples of the benefits include the following:

1. Establishment of the HAIR barbershop network galvanized the academic health center to incorporate community outreach into formal training programs, internships, clinical rotations, and coursework for academic

credit. This legitimized the community as an important venue for turning out culturally sensitive practitioners, adding value to the teaching, research, and service mission of the university.

2. The HAIR barbershop network provided a venue for “proof of concept” sophisticated clinical assessments. As noted above, the use by cardiologists of a laptop echocardiogram in the barbershop to determine the feasibility and acceptability of this diagnostic tool for African Americans proved a major success (Huskins et al. 2008) and, in the process, brought access to this high-tech assessment tool to community members who otherwise would likely have gone without.
3. Over the years, as establishment of the HAIR barbershop network matured, the Comprehensive Cancer Center conducted quarterly prostate cancer-screening services through these venues on a routine basis (Browne 2007) and the Cancer Center established a seven-hundred-thousand-dollar fund to cover costs associated with case finding for individuals with no insurance. In Big Tom’s Full-Service Barbershop, a white female nurse conducted rectal digital exams and PSA blood draws. The barbershop in turn received a mini-grant, used to renovate space to meet state guidelines for privacy. This development was evidence of significant institutional commitment made possible by creating the infrastructure for ongoing community engagement.

As community-engaged research moves “from the margins to the mainstream” (Horowitz et al. 2009) so too will innovative partnerships with natural leaders and the cultural spaces they occupy, such as black barbershops and salons. Passage of the Patient Protection Act of 2010 (see chapter 21) creates new opportunities for sustainable funding mechanisms focused on supporting culturally relevant interventions like the HAIR barbershop network, and will hopefully translate into more such interventions, “with” communities rather than “on” communities, in the years ahead.

The North Carolina BEAUTY and Health Project: Preventing Cancer in African American Beauty Salons

The North Carolina Bringing Education and Understanding to You (BEAUTY) and Health Project (hereafter the BEAUTY Project) is an eleven-year-old, ongoing partnership between researchers at University of North Carolina, Chapel Hill, and beauty salon owners, licensed stylists, and their customers, with an aim of reducing health disparities among African American women. In 2000, one of the authors (Dr. Laura Linnan) and an interdisciplinary team of researchers from the university’s Gillings School of Global Public Health convened an advisory board that consisted of a group of salon owners, stylists, directors of local beauty schools, and product distributors to ask them the question, “What do you think of the idea of promoting health in beauty salons?” A community-based participatory research

approach (CBPR) (Israel et al. 1998; Minkler and Wallerstein 2008) was used, both to help answer this question and subsequently to work collaboratively with salon owners and their customers to build a series of participatory research projects. Over the past decade, this initial effort has blossomed to include work with over eighty beauty salons and more than eighteen hundred of their customers. Although not a focus of this chapter, we also expanded efforts in 2004, based on the urging of our advisory board, to adapt and use the model in more than forty barbershops with over one thousand of their customers. Ongoing, funded CBPR continues in both beauty salons and barbershops at this writing, with efforts expanded to new populations (Latina salons), new methods (online continuing education courses for licensed stylists), and new health issues (occupational health and safety, prostate/colorectal cancer, and weight loss/weight gain prevention).

Background on the BEAUTY Project: Building Relationships and Trust

In 2000, the BEAUTY advisory board members decided to meet monthly to discuss and plan the project. Consistent with the community organizing principle of “starting where the people are” (Nyswander 1956) and to understand whether the idea of promoting health in the salons was even viable, board members emphasized that the cooperation of licensed stylists was needed, and recommended that they be polled to determine whether they would be interested in participating in a salon-based project. Advisory board members reviewed the survey instrument, assisted in the administration of the survey to all fifty-eight stylists in one North Carolina county, helped the research team interpret the survey results, and actively shared key findings with salons and stylists in the county (for detailed findings, see Linnan et al. 2001). Briefly, findings revealed that (1) stylists routinely talked with their customers during visits, including talking about health; (2) stylists were interested in attending training in how to deliver health messages in the salon; and (3) stylists were most comfortable and willing to talk with their customers about exercise, healthy eating, and healthy weight. Since these behaviors are preventable risk factors for many chronic diseases and were the most comfortable for stylists to talk about, they were selected as the first issues to be addressed. The survey results were also used to develop the initial stylist training workshop, which was the preferred method for receiving training, as reported by cosmetologists.

While stylists were clearly supportive of the idea of promoting health, the CBPR team embarked on a second formative study to observe “how things worked” in the salon so as to create the most culturally and contextually appropriate intervention. Using a standardized protocol, an observational study in ten salons (five African American and five white salons) was conducted to assess which health topics were talked about most, which were not discussed, who initiated the conversations, how much time was spent in the salon, what health myths or misconceptions were raised, and so forth. The CBPR partnership then drew on this information to create an intervention that was appropriate for the salon and

effective for initiating conversation between the stylist and the customer about health. Once again, the advisory board's review of initial findings provided important insights and guidance. For example, when we shared our data, advisory board members pointed out that health talk was initiated equally by customers and stylists, so we decided that our intervention focus must include mirror stickers with the slogan "Ask Me about the BEAUTY Project" as customers sat in the chair to prompt discussion with her stylist, as well as training for the stylist on how to start the conversation during a typical visit. Observational findings confirmed that (1) health topics were discussed in approximately one in five conversations; (2) diet, exercise, and stress were among the most commonly discussed health topics; (3) there were few differences in the topics discussed in African American versus white salons, but African American women spent more time in the salons, on average, than did white customers (Solomon et al. 2004). These results were extremely helpful in gaining an understanding of what type of intervention might be culturally and contextually appropriate, what methods might be useful, and how to begin with health topics of greatest interest to the customer that matched the comfort level of the stylist. For example, it was important to focus our initial intervention efforts on diet, exercise, and stress versus some other topics such as tobacco or health screenings. If stylists were not comfortable with the topic, or customers were not ready to discuss it, we would set up unnecessary barriers to intervention success at the outset. Thus, we started with topics and methods that were the best "fit" for the salon environment, the stylists and the customers.

Focus group discussions also were conducted with salon customers to discover their thoughts about health, beauty, and the possibility of promoting health in the salons (Kim et al. 2007). These revealed that women were very interested in receiving health information in the salons and that at different ages, women had different thoughts about beauty and health. Using this formative research the partnership developed an intervention that included a training workshop for stylists, as well as materials for the salons (educational display) and print materials for customers, all packaged in a campaign format. The stylist training workshop agenda focused on dispelling myths and misconceptions about health and cancer prevention, sharing the "good news" about cancer prevention with specific messages about physical activity and healthy eating. Particular attention was focused on specific public health recommendations regarding diet and physical activity. The messages were introduced at the stylist training workshop through discussion, with staff demonstrations of how to weave messages into a typical visit with a customer. Stylists then tried out via role playing how best to deliver the messages during a typical customer appointment. The educational displays and print materials were interactive and encouraged customers to ask stylists questions about key health messages.

The BEAUTY CBPR partnership recruited two salons to participate in a pilot test of the intervention materials and campaign developed. Results of this eight-week

pilot study revealed that stylists were enthusiastic partners in the training workshops and reported a willingness to deliver the targeted health information in conversations with their customers. In addition, customers reported an increase in self-efficacy and actual behavioral changes in diet and physical activity, with these changes significantly more likely among customers who had more contact with their stylists (Linnan et al. 2005). Changes were evident both at immediate postintervention and as part of a twelve-month follow-up. The results provided encouraging support for a larger effectiveness trial, funded in forty African American beauty salons by the American Cancer Society (Linnan et al. 2007) as well as several barbershop-based intervention studies funded by the National Cancer Institute and the Centers for Disease Control and Prevention.

Lessons Learned

With a foundation of community organizing and CBPR principles, such as starting where the people are, engaging natural helpers (Eng et al. 2009), and in other ways building on community strengths, the North Carolina BEAUTY and Health Project has evolved based on an ongoing collaboration with advisory board members. Active participation of residents, stylists, and other advisory board members made it possible for the BEAUTY CBPR team to get a high (85 percent) response rate to the initial survey of stylists, to help identify salons to participate in a series of formative research studies, and to create a recruitment video and then successfully recruit salons into both the initial pilot study and larger effectiveness trial. The BEAUTY advisory board members were crucial in developing strategies to recruit salons and cosmetologists, developing key messages, and designing a culturally appropriate cosmetologist training workshop.

The BEAUTY advisory board members and the participating cosmetologists/owners provided assistance with the interpretation of the preliminary results, with the advisory board also helping the academic researchers in pursuing continued funding for a wide range of additional studies. Indeed, without the advisory board members' inside knowledge of the beauty industry and of the local community and a high level of motivation to improve the health of their customers, the BEAUTY Project and subsequent salon and barbershop-based studies would not have been possible.

There are a number of important challenges when working with beauty salon owners and stylists. First, stylists/owners are busy people. There is not a lot of time to add new tasks or training opportunities into their day. Some owners are present in the salons daily, others less often. Stylists may be permanent, full-time employees, rent space in a salon and work full or part time, or have other arrangements with owners. When in the salon, they are seeing as many customers as possible. Thus, finding ways to help them integrate brief messages into their typical conversations is essential. Second, and related to the first, is the need to be mindful of not asking too much of the stylists, as in their attending trainings, starting conversations, offering advice, and so on. We learned along the way

that as part of their professional training, stylists are typically taught to be great listeners but not necessarily to initiate conversations with their customers. As a result, our training and intervention materials have to take that reality into account by encouraging customers to initiate conversations and by providing materials (mirror stickers, displays in the salon) as cues for customers to ask questions. Third, salons are not like other settings (e.g., worksites, schools, or churches) where individuals come on a particular day or time for a specific duration. In salons, most women schedule an appointment, but others just walk in when services are required. The amount of time spent depends on the hair care services being provided. Nearly 20 percent of women in this study visited the salons weekly, and up to 80 percent returned at least once every eight weeks. Thus, initial campaigns were designed to change messages about every eight to ten weeks, with the knowledge that these would reach women and yet not bore customers who came more often. During this collaboration, the academic researchers also learned about the best ways to enhance the business of the salon via local newspaper coverage and other media exposure. In subsequent studies that included randomized trials, training workshops were offered, in the “comparison” salons, on tax preparation and marketing strategies that would enhance these small businesses.

Despite the challenges, there are many advantages to working with community partners in designing and intervening in historically deeply valued community settings. These include the prevalence of salons in most communities, the “natural helper” role of stylists, and the fact that salons are places where social connections occur regularly and where many women spend considerable time. With the added benefit of a community building and CBPR approach to work in partnership with owners, stylists, and their customers, we have witnessed and have contributed to the growing literature on how to best address disparities in health within these important public health settings.

Summary

This chapter presented two examples of interventions based in beauty salons and barbershops, interventions guided by community organizing and community building principles and by community-based participatory research approaches in Pennsylvania and North Carolina, respectively. Given the unique historical, political, economic, and social realities of beauty salons and barbershops in the African American community particularly, there are a number of excellent opportunities for employing community organizing approaches to mobilizing these settings to promote health. Recognizing and building on the role of beauty salons and barbershops as places of strength, safety, rich cultural heritage, and social connections, these two examples contribute to the growing evidence in support of working collaboratively with beauty salon/barbershop owners and stylists/barbers and their customers to address disparities in health.

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