ONLINE FIRST

Effectiveness of a Barber-Based Intervention for Improving Hypertension Control in Black Men

The BARBER-1 Study: A Cluster Randomized Trial

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Background: Barbershop-based hypertension (HTN) outreach programs for black men are becoming increasingly common, but whether they are an effective approach for improving HTN control remains uncertain.

Methods: To evaluate whether a continuous high blood pressure (BP) monitoring and referral program conducted by barbers motivates male patrons with elevated BP to pursue physician follow-up, leading to improved HTN control, a cluster randomized trial (BARBER-1) of HTN control was conducted among black male patrons of 17 black-owned barbershops in Dallas County, Texas (March 2006–December 2008). Participants underwent 10-week baseline BP screening, and then study sites were randomized to a comparison group that received standard BP pamphlets (8 shops, 77 hypertensive patrons per shop) or an intervention group in which barbers continually offered BP checks with haircuts and promoted physician follow-up with sex-specific peer-based health messaging (9 shops, 75 hypertensive patrons per shop). After 10 months, follow-up data were obtained. The primary outcome measure was change in HTN control rate for each barbershop.

Results: The HTN control rate increased more in intervention barbershops than in comparison barbershops (absolute group difference, 8.8% [95% confidence interval (CI), 0.8%-16.9%]) \((P = 0.04)\); the intervention effect persisted after adjustment for covariates \((P = 0.03)\). A marginal intervention effect was found for systolic BP change \((\text{absolute group difference,} \ -2.5 \text{ mm Hg [95% CI,} \ -5.3 \text{ to} \ 0.3 \text{ mm Hg]}) \ (P = 0.08)\).

Conclusions: The effect of BP screening on HTN control among black male barbershop patrons was improved when barbers were enabled to become health educators, monitor BP, and promote physician follow-up. Further research is warranted.

Trial Registration: clinicaltrials.gov Identifier: NCT00325533


Uncontrolled hypertension (HTN) is one of the most important causes of premature disability and death among non-Hispanic black men.\(^1\,^2\) Indeed, black men have the highest death rate from HTN of any race, ethnic, and sex group in the United States.\(^2\)

See Invited Commentary at end of article

The age-adjusted HTN-related death rate is 3 times higher among black men than white men;\(^3\) with blood pressure (BP) remaining above recommended levels in 70% of the 4.4 million adult black men with HTN\(^1\)—a chronic medical condition that requires frequent physician interaction for initiation and adjustment of prescription BP medication. Compared with black women, men have less frequent physician contact for preventive care and thus substantially lower rates of HTN detection, medical treatment, and control.\(^3,^4\) Accordingly, the Centers for Disease Control and Prevention has issued a new priority to develop novel HTN outreach programs with community partners and deliver intervention messages that resonate with black men.\(^1\) Existing community-level health promotion research specific to black men and HTN is scarce, with most work having considered blacks of both sexes as a group.\(^1,^3\)

Black churches are conventional community partners for medical outreach, but regular church attendance is less common among black men than women.\(^6,^7\) Thus, popular secular sites—sporting

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events and barbershops—have been approached for HTN outreach to a larger segment of the at-risk male population.5,8 Black-owned barbershops hold special appeal for community-based intervention trials because they are a cultural institution that draws a large and loyal male clientele and provides an open forum for discussion of numerous topics, including health, with influential peers.9-12 Barbershop-based HTN outreach programs are becoming common nationwide,13-17 but whether they are an effective approach for improving HTN control among black men is unknown owing to a dearth of evaluation research. Interventions described in the peer-reviewed literature previously had no evaluation component.

In recent nonrandomized feasibility studies, our research group18 found that a program of continuous BP monitoring and peer-based health messaging in a barbershop can (1) increase physician referrals and lower BP among long-term patrons with uncontrolled HTN and (2) be implemented by barbers rather than research personnel. Based on the encouraging pilot data, we designed and conducted a cluster-randomized trial—the Barber-Assisted Reduction in Blood Pressure in Ethnic Residents (BARBER-1) study.18 To our knowledge, BARBER-1 is the first randomized controlled trial of a barbershop-based health promotion program. The intent was to use the nature of black-owned barbershops—haircut service and socialization—to have barbers become promoters of physician follow-up for BP control. We chose the cluster-randomized trial, knowing that the design needed to avoid contamination between intervention and comparison conditions, and analysis must allow for possible dependency of response between individual patrons within a barbershop as well as withdrawals and additions of individual patrons over time.19-21

METHODS

All black men attending the participating barbershops were offered 10-week baseline BP screenings for HTN. Study sites were then randomized to a comparison group of barbershops that received standard HTN education pamphlets written for a broad audience of black men and women or an intervention group in which barbers continually offered their entire male clientele BP checks with haircuts and used personalized sex-specific peer-based health messaging to promote physician follow-up. Intervention barbershop patrons received this message repeatedly from both day-to-day conversations with their barbers (and other male patrons) and large role-model posters on the shop walls showing their own male peers (actual patrons of their barbershop) modeling specific HTN treatment-seeking behavior and using their own words to tell the story. After 10 months, follow-up data were collected to determine if barbershop randomized to the intervention arm showed a larger improvement in HTN control rates (percentage of a barbershop’s hypertensive patrons with recommended BP levels).

PARTICIPATING BARBERSHOPS

The trial was conducted in black-owned barbershops with 95% or greater black male clientele in Dallas County, Texas, from March 2006 to December 2008 (Figure 1 and Figure 2 and eFigure 1, http://www.archinternmed.com). Fifty-five of 222 shops met additional selection criteria (in business for ≥10 years and employing ≥3 barbers). We selected 18 of these to represent 4 geographic sectors with sizeable black populations. All 18 initially agreed to participate, but 1 shop went out of business prior to randomization; 1 intervention shop dropped out before the intervention began; and 1 shop assigned to the comparison group was eliminated on safety concerns (criminal activity in the shop). Randomization was stratified by baseline HTN control rate and sector. Randomization was blinded. The nature of the study, barbers and patrons could not be blinded after randomization; therefore, the evaluation data were collected by independently contracted field interviewers who were not invested in the study’s outcome. The study was...
approved by the institutional review boards of University of Texas Southwestern Medical Center and Temple University Institute for Survey Research, which conducted the evaluation. Patron consent was obtained, and data were collected and stored in accordance with the guidelines of the Health Insurance Portability and Accountability Act.

INTERVENTION AND COMPARISON GROUPS

Before randomization, both groups of hypertensive patrons were treated identically: they had 2 baseline BP screenings performed by field interviewers who provided the patrons with written screening results and standard written recommendations for physician follow-up. After randomization, comparison barbershops received standard pamphlets written by the American Heart Association (High Blood Pressure in African Americans, product code 50-1466). No BPs were measured in the comparison barbershops for 10 months.

In contrast, the intervention barbershops received no pamphlets, but for 10 months the barbers continually offered BP checks during haircuts (eFigure 2). In addition, personalized sex-specific peer-based health messaging was provided—both through conversations with barbers and other male patrons and through peer role-model stories consisting of large posters placed on the barbershop walls depicting authentic stories of other male hypertensive patrons of the same shop modeling the desired treatment-seeking behavior and using the model's own words to tell the story (eFigure 3).

The intervention's theoretical underpinning was adapted from the successful AIDS Community Demonstration Projects that
substantiated by preparatory field work. The final readings were excluded, as recommended by current guidelines and validated oscillometric monitoring. They measured BPs using validated oscillometric monitors for continuous outcome variables. Adjusted models were fit with generalized linear mixed models with logit link functions were used for binary outcome variables, and linear mixed models were used for continuous outcome variables. Adjusted models were fit with centered, individual-level covariates included as additional fixed effects. Model-based significance levels and 95% confidence intervals (CIs) were obtained. P < .05 was considered statistically significant. Analyses were conducted using SAS/STAT software, version 9.1.3 (SAS Institute Inc, Cary, North Carolina).

OUTCOME EVALUATION

Several steps were taken to rigorously evaluate the study’s primary outcome—the change in HTN control rates for shops in each study arm. Baseline and 10-month follow-up BP measurements and computer-assisted health interviews were conducted not by the barbers but rather by independently contracted, trained black field interviewers. The HTN control rates were derived from a second set of multiple BP measurements and prescription pill bottle labels rather than the 1 or 2 BP measurements and subjective treatment rates. The HTN control rates were calculated for each barbershop, while the random effect of patron within barber shop accounts for repeated measures of outcome levels and changes within barbershops, while the random effect of patron within barbershop accounts for repeated measures of outcome levels and changes within barbershops, while the random effect of patron within barbershop accounts for repeated measures of outcome levels and changes within barbershops.
The characteristics of the participating barbershops and the patrons with HTN are summarized in Table 1. The groups were well balanced at baseline across most characteristics. However, at baseline, a higher percentage of patrons in the comparison group reported being married (P = .01). Although at baseline 85% of the hypertensive patrons in both groups reported having health insurance (mostly private insurance) and middle-income levels (Table 1), HTN was uncontrolled in most affected patrons. Overall, 45% of the subjects screened had HTN, and of these, 78% were aware of their diagnosis, 69% were being treated for it, and only 38% had their BP controlled. These rates are all slightly higher than recent national estimates (eTable 4). Baseline HTN control rates were not significantly different between study groups (P = .22) but tended to be lower in the intervention group (33.8% vs 40.0%) (Table 2 and Figure 3).

PRIMARY OUTCOME
Table 2 details the change over time in the primary and secondary outcomes. Figure 3 shows the barbershop-specific changes over time in HTN control rates. In unadjusted analysis that used all available data (17 barbershops at baseline, 15 at follow-up), the enhanced barber-based intervention resulted in a greater improvement in the primary outcome of HTN control rate than the comparison treatment: absolute group difference,
In addition, in a conservative intention-to-treat analysis, which assumed that the 2 barbershops lost to follow-up (1 per arm) both followed the lesser trajectory of the comparison barbershops, the resultant intervention effect was 7.8% (95% CI, 0.4%-15.3%) ($P = .03$).

### SECONDARY OUTCOMES

Borderline intervention effects were observed for several secondary outcomes (Table 2), including systolic BP reduction: absolute group difference, −2.5 mm Hg (95% CI, −5.3 to 0.3 mm Hg) ($P = .08$). However, there was no evidence for an intervention effect on HTN awareness.

### Process Data on Intervention Implementation, Penetration, Incentive Payments, and Acceptability

In the intervention group, follow-up data were collected on 539 patrons with HTN served by 29 participating barbers in 8 barbershops completing the study. Of the 539 patrons, 275 reported that during the intervention, their barbers discussed a model story during every haircut (51%).

### Table 2. Mean Change in HTN Control Rate and Its Components in Barbershops Randomized to Intervention and Comparison Conditions

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Intervention Group</th>
<th>Comparison Group</th>
<th>Intervention Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
<td>Absolute Change, % (95% CI)</td>
</tr>
<tr>
<td>Control rate&lt;sup&gt;a&lt;/sup&gt; among all patrons with HTN</td>
<td>33.8</td>
<td>53.7</td>
<td>19.9 (14.4 to 25.4)</td>
</tr>
<tr>
<td>Control rate&lt;sup&gt;a&lt;/sup&gt; among treated patrons with HTN&lt;sup&gt;d&lt;/sup&gt;</td>
<td>49.1</td>
<td>65.9</td>
<td>16.8 (10.0 to 23.5)</td>
</tr>
<tr>
<td>HTN treatment rate</td>
<td>67.9</td>
<td>79.0</td>
<td>11.2 (7.3 to 15.0)</td>
</tr>
<tr>
<td>HTN awareness rate</td>
<td>79.5</td>
<td>86.3</td>
<td>6.6 (3.3 to 10.3)</td>
</tr>
<tr>
<td>Systolic BP, mm Hg</td>
<td>137.6</td>
<td>129.8</td>
<td>-7.8 (-9.7 to -5.9)</td>
</tr>
<tr>
<td>Diastolic BP, mm Hg</td>
<td>81.5</td>
<td>78.7</td>
<td>-2.8 (-4.0 to -1.6)</td>
</tr>
<tr>
<td>BP medications per patron with HTN</td>
<td>1.4</td>
<td>1.8</td>
<td>0.5 (0.3 to 0.6)</td>
</tr>
</tbody>
</table>

Abbreviations: BP, blood pressure; CI, confidence interval; HTN, hypertension.

*Unless otherwise indicated, data are reported as percentage of barber shop patrons with HTN.

$P$ values were determined by mixed logistic regression for dichotomous study outcomes and by mixed linear regression for continuous outcomes in analyses that used all available data (17 barbershops at baseline and 15 barbershops at follow-up).

Adjusted for effects of age, education, marital status, smoking status, and participation in both baseline and follow-up cohorts.

The HTN control rate is the percentage of hypertensive patrons with BP below recommended out-of-office values (135/85 mm Hg for patrons without diabetes and 130/80 mm Hg for those with diabetes).

*Patrons with HTN receiving prescription BP medication.

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8.8% (95% CI, 0.8%-16.9%) ($P = .04$); the intervention effect persisted after adjustment for covariates ($P = .03$).

In addition, in a conservative intention-to-treat analysis, which assumed that the 2 barbershops lost to follow-up (1 per arm) both followed the lesser trajectory of the comparison barbershops, the resultant intervention effect was 7.8% (95% CI, 0.4%-15.3%) ($P = .04$).

**Figure 3.** Baseline and follow-up hypertension (HTN) control rates for individual barbershops in intervention (A) and comparison (B) groups. Delta symbol indicates change in HTN control rate, reported as mean (SEM). Paired data are shown for each barbershop except for 1 barbershop in each group lacking follow-up data (black squares). Boxes with error bars indicate group means (SEMs). The significance of the intervention effect on HTN control was not affected by adjustment for baseline blood pressure, age, marital status, college education, smoking status, and participation at both baseline and follow-up ($P = .03$).
175 reported that their barbers discussed a story during half of their haircuts (32%); and 89 reported that their barbers never discussed one (17%). The barbers measured BP for 417 of the 539 hypertensive patrons (77%), recording 3350 sets of BPs (8 sets per patron), and successfully counseled 180 of 350 patrons with elevated BP readings to have documented physician visits (51%) (including 36 documented nurse-assisted referrals).

The mean total incentive payment was estimated at $133 per hypertensive patron, calculated as follows: barbers were paid $60.474 in total for intervention activities for 539 hypertensive patrons ($112 per patron). These patrons returned 939 signed physician-referral cards to the barbers and received 1 free $12 haircut per card ($21 value per patron). In the intervention group, 530 of the 539 hypertensive patrons completing the study (98%) and all 29 participating barbers reported that they would like the barber-based intervention program continued indefinitely.

Cost-effectiveness Simulation

If the intervention could be implemented in the approximately 18,000 black-owned barbershops in the United States (eTable2) to reduce systolic BP by 2.5 mm Hg in the approximately 50% of hypertensive US black men who patronize these barbershops (N = 2.2 million persons), we project that about 800 fewer myocardial infarctions, 550 fewer strokes, and 900 fewer deaths would occur in the first year alone, saving about $98 million in CHD care and $13 million in stroke care (but offset by $6 million in additional non-CHD costs contributed by persons who would otherwise have died). For this intervention to be cost-neutral from a health care system perspective, therefore, the program costs (including performance incentives, medication, and other health care delivery costs) could be as high as about $5800 per barbershop or about $50 per hypertensive barbershop patron.

COMMENT

Black-owned barbershops are rapidly gaining traction as potential community partners for health promotion programs targeting HTN as well as diabetes, prostate cancer, and other diseases that disproportionately affect black men. Yet to our knowledge, the effectiveness of barber-based HTN screening and referral programs on BP control previously has not been evaluated by a randomized trial. In this cluster-randomized controlled trial, we found that an enhanced intervention program—in which barbers continuously monitored BP and actively promoted physician follow-up with personalized sex-specific messages—resulted in improved BP control among black male barbershop patrons with HTN. Although BP control also improved in the comparison group, which received standard written information about high BP, the improvement was greater with the enhanced intervention. A marginal intervention effect was seen for medication treatment rates, BP levels, and other secondary outcomes. Thus, the results of this study provide the first evidence for the effectiveness of a barber-based intervention for controlling HTN in black men and indicate that more research is needed to develop a highly effective and sustainable intervention model prior to large-scale program implementation.

We detected a positive intervention effect despite an unexpectedly large improvement in BP control in the comparison group, which was not an inactive comparator. In collecting thorough baseline BP data, we unavoidably intervened in both groups: patrons with HTN in all participating barbershops were repeatedly exposed to research staff measuring their BP at 2 baseline haircut visits. For ethical reasons, those with elevated BP readings in both groups were given detailed written recommendations for physician follow-up. In addition to this Hawthorne effect, educational pamphlets written for black individuals were distributed only to comparison shops.

The larger improvement in HTN control seen in the intervention group is not explained by baseline values, which were taken into account by the mixed-effects model. Moreover, within either group, barbershops with lower baseline values did not show larger increments in HTN control, and there was no ceiling effect. The new data confirm and extend earlier pilot data by indicating that the characteristic long-term patronage in black-owned barbershops (almost a decade) and frequent haircut visits (1 every 3–4 weeks) provided much opportunity for barbers to repeatedly monitor BP and deliver intervention messages. The process data indicate that, in general, the intervention was implemented as intended with reasonably high levels of intervention implementation and penetration: barbers measured BP on 3 of every 4 patrons with HTN, and each of the participating patrons averaged 8 barber BP checks in 10 months. The barbers motivated 50% of their patrons with elevated BP readings to visit a physician, supporting the theoretical underpinning of the behavior theory–based intervention, namely that barbers, as influential peers, can increase HTN treatment–seeking behavior. The intervention effect on primary and secondary BP outcomes may have been larger than observed if barbers had motivated the other 50% of high-BP patrons to see a physician.

A salient finding is the middle-income status of the barbershop clientele. Although most participating barbershops were in low-income areas, patrons need financial resources to afford frequent haircuts. Because socioeconomic status and affordability of health insurance are major determinants of HTN control, the low baseline HTN control rates among the barbershop patrons may seem disproportionate to income level and health care access. However, for reasons that require more study, middle-income status alone does not protect black men from many poor health indicators, including underutilization of available medical services to control HTN and prevent its complications. For example, sociocultural factors related to masculinity (such as a desire to avoid showing vulnerability) also can deter men from fully utilizing available preventive medical services. Our data suggest that barbers can deliver health messages that resonate with men and, more broadly, that the barbershop constitutes a unique opportunity for further research on improving the health status of this particularly vulnerable and understudied group of men—middle-income black men.
Our study has several important limitations. The impact of the barber-based intervention was less than optimal because not all barbers participated fully, and not all patrons agreed to have their BP monitored and be referred for physician follow-up. Because study sites were confined to 1 county, the results cannot be generalized to other geographic areas without further study. Because the barbershops’ clientele were predominately middle-income, the intervention had limited ability to reach very low-income individuals who will require other types of intervention. The evaluation strategy provided a snapshot of BP improvement at a point in time and does not demonstrate whether the outcomes are sustainable, particularly because financial incentives were paid to barbers for conducting the intervention and to patrons for following their advice in seeking medical attention. However, the $112 incentive paid per barber per hypertensive patron and the $21 paid per patron in free haircuts for HTN-related physician visits is far less than the $750 cash incentive per patient used in a recent smoking-cessation study.32

Because hypertensive patrons chose their individual physicians, we could not collect actual data on increased antihypertensive treatment costs associated with the intervention. Our CHD Policy Model simulation indicates that the projected cost savings from reduced HTN-related cardiovascular disease (CVD) events in the first year alone would substantially offset intervention costs. More extensive simulations are needed to project the cost savings and quality-adjusted life-years from reduced CVD that would accumulate beyond the first year (eg, long-term care savings from prevented strokes), particularly if the modest reductions in systolic BP observed in BARBER-1 could be sustained or augmented in this high-risk black male population.29,33,34

Despite these limitations, the study establishes an important precedent for future quantitative evaluation research on this and other health promotion programs in barbershops. The results provide proof of concept for 1 effective barber-based intervention, which lowered systolic BP by about 8 mm Hg from baseline—2.5 mm Hg more than in the comparison group. Based on the observed intervention effect of an 8.8% greater improvement in HTN control rate, we estimate that 12 hypertensive black male patrons would need to be exposed to this intervention to achieve BP control in 1 more patron.

The study addresses the newly recommended policy shift away from a traditional case-management system toward novel population-based systems and community-based support for persons with HTN.35 The data add to an emerging literature on the effectiveness of community health workers in the care of people with HTN36; contemporary barbers constitute a unique workforce of community health workers whose historical predecessors were barber-surgeons.37 Future studies should evaluate the potential effectiveness of the intervention in other urban centers, alternative incentive structures, comparative effectiveness of the intervention with and without certain components (eg, model stories), and projected long-term cost-effectiveness of alternative strategies (eg, targeting barbershops with a mainly older clientele to enhance screening efficiency and prevent more HTN-related events). The public health potential is intriguing.

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REFERENCES


INVITED COMMENTARY

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A Bald Fade and a BP Check

As a black man with HTN who has frequented the same community barber for 17 years, I reviewed with great fascination the article by Victor et al. I typically get a “bald fade” haircut, which camouflages my frontal baldness, and sit quietly as the barbers and other patrons address the burning issues of the day. More importantly, the black barbershop experience is a remarkable social barometer that pro-