

CHILDHOOD DREADLOCKS (DADA HAIR): PERCEPTION AND HEALTHCARE SEEKING BEHAVIOUR OF CARE-GIVERS IN A DEVELOPING COUNTRY.

Ndu IK¹, Ayuk AC², Osuorah DIC³, Ubesie A.² Ekwochi U¹,
Chinawa JM², Asinobi IN¹, Amadi OF¹, Okeke I¹, Obu HA²

¹ Department of Paediatrics Enugu State University Teaching Hospital

² Department of Paediatrics University of Nigeria Teaching Hospital

³ Child Survival Unit, Medical Research Council UK

*Author for Correspondence: chidi.osuorah@yahoo.com

ABSTRACT

The word "dada" is used to describe dreadlocks. Several cultural beliefs and practices are associated with concept of the "dada" child and this influence the health care seeking behaviour of caregivers. To determine the perception of caregivers about childhood dreadlocks (Dada hair) and its effect on the health care seeking behaviour of care givers in Enugu South-East Nigeria. A cross sectional study involving care-givers seen at the two tertiary health institutions in Enugu State, South Eastern Nigeria. Interviewer administered questionnaires were used to obtain data from the study participants. There were 273 respondents, 90.1% of whom were females and 40% were of low socioeconomic status (SES). One hundred and twenty three (45%) participants believed in the concept of childhood dreadlock but only 27 (9.9%) reported previously or currently having a child with dreadlocks. Thirteen percent were of the view that under no circumstances should dreadlocked hair be washed or combed while 20% opined that a special ritual should be performed by a religious representative before cutting or shaving the dreadlocked hair. Fourteen percent of the caregivers believed that illness in a child with dreadlocks was of supernatural origin and would not respond to treatment with conventional medicine. For respondents that accept the use of conventional healthcare medicine during ill health of a dada child, twenty nine (11%) would refuse any medical interventions that would involve shaving the hair for venous access or neurosurgical procedures until the necessary ceremony had been performed. Only mother's level of education was significantly associated with belief in the concept of the "dada" child. There is need for appropriate enlightenment of parents and care givers especially in the lower educational group about the importance of seeking healthcare and other necessary preventive strategies for the dada child while still respecting their cultural belief in the concept of childhood dreadlocks.

Keywords: Dada, Dreadlocks, Children, Caregiver, Healthcare, Africa

INTRODUCTION

Historically, dreadlocks originated with Indian sages and yogis. Possessing nothing, renouncing the world and possessions, they eschewed even personal grooming, hence the inevitable dreadlocks (Andrew, 2006). However, the term dreadlock is of Jamaican origin and was used to refer to the "Rasta" men who were feared and "dreaded" (Suzanne, 2008). Famous biblical figures like Samson and John the Baptist had dreadlocked hair and were revered. In Yoruba parlance, the word "dada" is used to describe dreadlocks and it has entered the widely spoken Nigerian English (Suzanne 2008). Since most children in Nigerian culture, wear their hair in its natural state, if it looks like dreads or "dada" it is assumed that the child is a naturally born "dada" as distinct from adults where it may be a style done by choice (Suzanne,

2008).

The form, curvature and pigmentation of natural hair are determined by genetics and are controlled by single nucleotide polymorphisms (SNPs). These give rise to the three primary hair forms - African, Asian, and Caucasian (Clarence, 2012). Unlike the others, African hair texture is coarse and curvature ranges from wavy to woolly or wiry (Clarence, 2012; Deborah et al. 2006). Tangles, knots and matted locks will eventually form in all textures of hair if it is not styled or combed. However, people with African ancestry due to their tight, kinky hair tend to form dreadlocks more easily (Sailor, 2015).

There are basically two different two ways to develop deadlocks, the chemical method and the neglect method (Sailor, 2015). The chemical method involves the use of various

combinations of shampoo, special hair wax, backcombing, twisting the hair, braiding or perming. The neglect method as the name implies is to simply neglect the hair which will naturally become matted and knot up into dreadlocks over time. Neglect may occur in children because combing such hair without adequate lubrication is a very painful experience. Such pains may trigger breath holding spells or other bizarre temper tantrums and this may have led to the belief that such children may develop somatic symptoms like fever, headaches, diarrheal disease etc if their dreadlocked hair is touched or tampered with in any way.

These wrong associations may influence the perception of the cause of any illness in the child with dreadlocks and thus the health seeking behaviour of the caregivers (Macknin, 2000). Similar cultural beliefs have been previously identified as a cause of delay for parents to access medical care for their children (Chibwana et al. 2009; Dillip et al. 2012). Therefore understanding the impediments to optimal health-seeking behaviour could greatly contribute to reducing the impact of severe illness on children's growth and development (Abubakar et al. 2013).

This study thus set out to determine the perception of caregivers about childhood dreadlocks and its effect on the health care seeking behavior of care givers in Enugu South-East Nigeria. The findings of the study will help direct policy formulation and promote public enlightenment programs targeted at harmful practices associated with 'dada hair'.

MATERIAL AND METHOD

This cross sectional study was conducted in two tertiary institutions in Enugu State, South Eastern Nigeria: Enugu State University Teaching Hospital (ESUTH) and the University

of Nigeria Teaching Hospital (UNTH) Ituku/Ozalla Enugu. The participants were caregivers who attended the outpatient clinics of the Paediatric and Obstetric Departments in the respective tertiary hospitals.

The sites: Enugu State University Teaching Hospital (ESUTH) and the University of Nigeria Teaching Hospital (UNTH) Ituku/Ozalla Enugu are the major public hospitals serving inhabitants of Enugu metropolis and thus attend to a wide variety of patients from all socio-economic classes. Caregivers provided written informed consents before recruitment and ethical approval was obtained from the Ethics and Research Committee of the ESUTH, Enugu.

Data on demographic and clinical characteristics including age, gender, place of domicile and relationship of child to caregiver were obtained using interviewer administered questionnaires. Other information obtained were religion, tribe, perception of caregivers on childhood dreadlocks and impacts on health seeking behaviors. All participants were grouped according to socioeconomic status of parents as those from high, middle, and low socio-economic class (Oyedeji, 1985).

Data was analyzed using Statistical Package for Social Sciences (SPSS) version 19 (Chicago IL). Chi-square statistical test and student t test was used for categorical and continuous variables respectively. All reported p-values were two sided.

RESULTS

Characteristics of study participants

There were 273 respondents aged between 16 and 63 years. Two hundred and forty-six (90.1%) of the respondents were females. Caregivers between the ages of 26 to 35 years made up about half of the study population. Of the caregivers surveyed, one hundred and ten (40%) were of low SEC with approximately 30% each from middle and high SEC respectively. The detailed socio-demographic characteristics of the study participants are shown in Table 1.

Table 1: The socio-demographic characteristics of the study participants

	Frequency	Percent
Age group		
<=20	12	4.4
21 - 25	39	14.3
26 - 30	73	26.7
31 - 35	51	18.7
36 - 40	48	17.6
41 - 45	23	8.4
46 - 50	22	8.1
> 50	5	1.8
Gender		
Male	27	9.9
Female	246	90.1
Number of children		
1	74	27.1
2	57	20.9
3	46	16.8
4	39	14.3
5	37	13.6
≥6	20	7.3
Tribe		
Igbo	269	98.5
Yoruba	1	0.4
Hausa	2	0.7
Igala	1	0.4
Religion		
Christianity	272	99.6
Islam	1	0.4
Socio-economic class		
Upper	77	28.2
Middle	86	31.5
lower	110	40.3

General perception of dreadlocks

Table 2 shows the general perception of respondents about “dada”. Twenty-seven participants (9.9%) reported that they had children with dreadlocks. Two hundred and fifty-nine (94.9%) caregivers had heard of “childhood dreadlocks” and 45% believed in its practice. A total of ninety-four respondents (34.4%) thought dreadlocks were genetically inherited while sixty-three (23%) considered them to be different from other “normal” children. Specifically,

twenty-six (41.3%) of respondents were of the opinion that they were prone to frequent childhood illnesses or convulsions, ten (16%) believed they had spiritual powers, while nine (14%) said they had a tendency to be more “stubborn” than other children. There were thirty-six (13.2%) who believed that the child with dreadlocks was still being stigmatized in the society.

Table 2: Perception of “dada hair” by the caregivers

Items	Frequency	Percent
Have you heard of dreadlocks in children (dada hair)		
Yes	259	94.9
No	14	5.1
Do you believe in the concept of “dada children”		
Yes	120	44.0
No	153	56.0
Do you believe dada hair is hereditary or runs in families?		
Yes	94	34.4
No	179	65.6
Do you have children born with dreadlocks		
Yes	27	9.9
No	246	90.1
Have you had children who previously had “dada hair”		
Yes	25	9.2
No	248	90.8
Do you believe dreadlocked children are different compared to other children		
Yes	63	23.1
No	210	76.9

Perception on how caregivers manage dreadlocks

Thirty five (13%) of the respondents thought dreadlocked hair should not be touched or even washed with water while bathing the child. Seventy five (27.5%) of the respondents believe that the first hair cut for children with dreadlock should be at a specific age (mean age of 22± 30.71 months) while fifty five (20%) were of the opinion that the hair cutting ritual should be performed by a religious representative.

Forty seven (17.2%) of the respondents believe that children with dreadlocks will have serious consequences such as frequent sickness, death and loss of presumed special spiritual powers (61.7%, 34% and 4.3% of respondents respectively) if the special ceremony was not performed for the first haircut. A further thirty nine (14%) of caregivers reported that they had witnessed death in a child with dreadlocks whose special ceremonies had not been performed or not performed properly.

Perception of dreadlocks and its Health implications

A hundred and forty nine respondents (55%) obtained information on the best

approach to handle a child with dreadlocks from friends and family member. Only two respondents (0.7%) obtained such information from health workers. There were thirty eight (14%) of caregivers who thought that illness in a child with dreadlocks is of supernatural origin and so would not need the intervention of conventional medicine when a child is ill.

A hundred and eighteen (43%) of the respondents would visit a health facility if a child with dreadlocks became ill while thirty (11%) would rather visit a prayer house or a church. One hundred and twenty eight (47%) of respondents believe that avoidance of certain food, fruits or vegetable is right and one hundred and twenty six (46%) believe that disease preventive strategies such as immunization could lead to death in these children.

Twenty nine (11%) of respondents would refuse medical interventions that involve hair cutting such as shaving a child's hair for venous access or for neurosurgical procedures if the special ceremony had not been done first. Table 3 shows that maternal education is significantly associated with belief in the concept of dreadlocks (P<0.05)

Table 3: Association between demographic variables and belief in concept of dada

	Belief in concept of dada		χ^2	P value
	Yes n (%)	No n (%)		
Age group				
≤20	8 (66.7)	4 (33.3)	4.176	0.124
21 – 30	53 (47.3)	59 (52.7)		
>30	59 (39.6)	90 (60.4)		
Gender				
Male	15 (55.6)	12 (44.4)	1.637	0.201
Female	105 (42.7)	141 (57.3)		
Father's education				
University	60 (46.5)	69 (53.5)	4.363	0.359
School Cert. & other training	2 (50.0)	2 (50.0)		
School cert or Grade II cert	29 (43.9)	37 (56.1)		
JSSC, Primary 6 cert.	1 (11.1)	8 (88.9)		
No education	28 (43.1)	37 (56.9)		
Mother's education				
University	71 (46.1)	83 (53.9)	10.231	0.037
School Cert. & other training	11 (68.8)	5 (31.2)		
School cert or Grade II cert	27 (42.2)	37 (57.8)		
JSSC, Primary 6 cert.	7 (22.6)	24 (77.4)		
No education/illiterate	4 (50.0)	4 (50.0)		
Socio-economic class				
Upper	27 (35.1)	50 (64.9)	4.104	0.128
Middle	38 (44.2)	48 (55.8)		
Lower	55 (50.0)	55 (50.0)		

DISCUSSION

We believe this is the first institutionalized study of the perception and healthcare seeking behaviour of care-givers in a developing country concerning children with dreadlocked hair. The erroneous perception of the cause of the illness in the child with dreadlocks has been identified as a cause of delay for parents to access medical care for their children (Sailor, 2015). This wrong belief was further corroborated by our study which showed that majority of care givers would not seek medical help for their children with dreadlock when they fall ill. This may contribute to the unacceptably high child morbidity and mortality rates in our setting. While it is necessary to respect the cultural context and belief of individuals and communities in many developing countries, it is also important to

educate them about the wrong assumptions in some of these cultural beliefs. This we believe will improve the health seeking behaviour of caregivers and encourage the use of preventive health strategies such as immunization.

The belief that illnesses in children with dreadlocks are caused by supernatural forces and need supernatural cures is also a cause for concern. This belief is related to the phenomenon of recurrent reincarnation called “Ogbanje” and “Abiku” in the Igbo and Yoruba cultures respectively (Nzewi, 2001). These children are believed to be possessed by evil spirits and undergo repeated physical and psychological trauma in the search for a cure. Some of these children may end up uneducated, chronically abused and abandoned becoming children on the street and children of the street that grow up to become miscreants and

psychotic adults (WHO, 1995). It therefore underscores the need for continued advocacy and joint effort by traditional, religious, health and political leaders to come together to correct these misconceptions.

The need for public enlightenment and one-on-one health education in preventing harmful child practice especially in Africa cannot be over-emphasized. Our study demonstrated that a very low proportion of respondents (less than 1 in 10) obtained information on childhood dreadlock from health personnel compared to 1 in 2 that got the same information from relatives and friends. This raises serious questions about the amount of time spent by physicians and other health professionals on educating patients and care-givers during consultation. It is fair to hypothesize that incorporating extensive health education on a variety of cultural issues that affects the health and well-being of a child during antenatal clinics, well child visits and other physician-patient contacts would go a long way to re-educate and inform care-givers on common misconceptions.

Finally, maternal educational level was seen in this study to be significantly associated with belief in the concept of dreadlocks. It was noted that mothers with lower educational attainment were more likely to believe in the concept of dreadlock and its associated harmful practices. This is hardly surprising because mothers with higher education are more likely to be better informed about many cultural and mythical beliefs. They are also more likely to be aware of the overwhelming benefits of seeking prompt healthcare intervention for their sick child irrespective of the cultural beliefs and practices prevalent in the community. This is why maternal education has been long recognized as one of the child survival strategies adopted by the United Nations Children's Fund in its GOBIFF strategy (UNICEF, 1996). This therefore stresses the need for improved quality of care delivered by the primary health centers so they can reach out to educationally disadvantaged mothers who reside in the villages

CONCLUSION

There is high awareness and belief in the practice of belief in the concept of dreadlock in

children in the study setting. This belief delays proper healthcare seeking for these children. There is need for appropriate enlightenment of parents and care givers especially in the lower educational group about the importance of seeking healthcare and other necessary preventive strategies for the dada child in spite of their cultural belief in the concept of childhood dreadlocks.

Acknowledgement

We thank all the respondents that agreed to participate in this study. We are also grateful to the junior resident doctors for their help in data collection and entire management of ESUTH and UNTH for their kind permission to carry out this study in various sections of their respective hospitals.

REFERENCES

- Abubakar A, Van Baar A, Fischer R, Bomu G, Gona JK, Newton CR. (2003). Socio-Cultural Determinants of Health-Seeking Behaviour on the Kenyan Coast: A Qualitative Study. PLoS ONE. 8:719-98
- Andrew HT. (2006). The history of dreadlocks. Article published on Dreadlock.org. Available from: <http://www.dreadlocks.org/the-history-of-dreadlocks/> Accessed November 3, 2015.
- Chibwana AI, Mathanga DP, Chinkhumba J, Campbell CH. (2009). Socio-cultural predictors of health-seeking behaviour for febrile under-five children in Mwanza-Neno district, Malawi. Malaria Journal. 8: 219.
- Robbins CR. (2012). "Chemical and physical behavior of human hair," in Genetic Control/Involvement in Hair Fiber Traits. Springer, Berlin, Germany, 5th edition chapter 3; 177-203.
- Deborah RL. Wavy, Curly, Kinky (2006). The African American Child's Hair Care Guide. John Wiley & Sons publishers, Pg 1-5.
- Dillip A, Alba S, Mshana C, Hetzel MW, Lengeler C, Mayumana I, Schulze A, Mshinda H, Mitchell G, Weiss GM, Obrist B. (2012). Acceptability – a neglected dimension of access to health care: findings from a study on childhood convulsions in rural Tanzania. BMC Health Serv. Res 12; 112-3.
- Macknin ML, Piedmonte M, Jacobs J, Skibinski C. (2000). Symptoms associated with infant teething: a prospective study. Pediatrics. 105:747-52.

- Nzewi E. (2001). Malevolent Ogbanje. Recurrent reincarnation or sickle cell disease? Soc. Sci Med. 52:1403–1416. <http://neologisms.rice.edu/index.php?a=term&d=1&t=2896>. Accessed November 3, 2015.
- Oyedeji GA. (1985). Socioeconomic and cultural background of hospitalized children in Ilesha. Niger J Paediatr. 12: 111-117. United Nations Children's Fund. Rehydration Project (1996). UNICEF's GOBI-FFF Program. Available from <https://www.cabdirect.org/cabdirect/abstract/19871849394>. Accessed November 8, 2015.
- Sailor M. (2015). How Dreadlocks Work. Article on Culture Magazine. Available from: <http://people.howstuffworks.com/dreadlock2.htm>. Accessed November 4, 2015. World Health Organisation (1985). Working with street children. WHO/MSD/MDP/00.14. https://www.unodc.org/pdf/youthnet/who_street_children_introduction.pdf. Accessed November 8, 2015
- Kemmer S. (2005). Dada or Dreds The Rice University Neologisms Database 2008. Available from: