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Fred Henry Bateganya et Rita Nakanjako

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Résumé de l'article

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Abstract: This study aimed to understand the health-seeking behaviors of the child migrants, commonly known as *Chokola*, who live along the Uganda–Kenya border at the town of Busia. The study used qualitative data collection methods: in-depth interviews, life-histories, focus group discussions, and key informant interviews. At the border, Chokola are accorded a marginal status and identity, limiting their health rights. Chokola face many health challenges, some of which arise from risky sexual behaviors and practices. Their health problems include gonorrhea, HIV, malaria, and cholera. The Chokola in our study exhibited specific health-seeking behaviors, with sniffing aviation fuel being the most pronounced. Although this practice was intended to alleviate common ailments and discomfort, it was also reported to have side effects ranging from loss of appetite to early death. Sniffing aviation fuel as a health-seeking behavior is a construction of individuals. Chokola constructions of the efficacy of aviation fuel are inculcated during socialization and are supported by a shared belief in the fuel as a panacea. Scientific views regarding the risks of side effects are irrelevant to them. In terms of access to health services, Chokola are vulnerable and require affirmative action and targeted interventions.

Keywords: sniffing, aviation fuel, Chokola

Fred Henry Bateganya PhD (corresponding author) is a faculty member in the Department of Sociology and Anthropology, School of Social Sciences, Makerere University, P.O. Box 7062, Kampala. Email: frebat2011@gmail.com

Rita Nakanjako PhD is a faculty member in the Department of Sociology and Anthropology, School of Social Sciences, Makerere University, P.O. Box 7062, Kampala. Email: nrvj79@gmail.com

Child migration is not a new phenomenon in Africa and has been increasing in most African countries (Hashim & Thorsen, 2011; IOM, 2014). Children are faced with enormous pressures to migrate; the drivers for their migration are comparable to those affecting adults: conflict, familial responsibilities, and a lack of viable future prospects at home due to climate-related and other factors (Digidiki & Bhabha, 2023). Thus, for an array of reasons, millions of children are forced into the “child mobility business” (Bhabha & Abel, 2019). Migration is a result of complex configurations of many interdependent and integrating factors (Bhabha & Abel, 2019). Infrastructure development, improved travel, and advancements in communication, individually or in combination, have made migration within and between countries, or even continents, easier for child migrants, the main focus of this study, as much as for migrants in general.

During and after migration, migrants face many challenges, including adapting to the new environment of their final destination (Padilla & Perez, 2003). Many migrants, especially African children, face challenges related to health and social inclusion and face increased health risks (Salami et al, 2021) which predisposes them to a multitude of ailments and thus engage in health-seeking behavior (Ward et al., 1997). Health-seeking behavior for any illness can range from active treatment, whether given by a professional or self-administered, to a complete absence of care (Stoesslé et al., 2015). Self-medication among the migrants is sometimes due to inaccessibility of health services (Heldal et al., 2008), compounding their risk of poor health outcomes.

There are a number of drivers of child migration in Africa. Children from Somaliland, for example, emigrate to escape harsh conditions occasioned by poverty, hunger due to drought, and insecurity due to cattle rustling (IOM, 2018; UNICEF, 2019). Where there is absence of adult support due to death or family separation, the search for employment opportunities, the need to experience a better life, and sometimes the quest for a new lifestyle (Hashim, 2004; Taffa & Chepngeno, 2005) are also drivers of child migration in Africa. Furthermore, rural children in Uganda expect that migrating to a town will enable them to earn a living through street begging and providing cheap labor to traders (Stites & Akabwai, 2012). These are among the factors encouraging child migrants to come to the town of Busia along the Uganda–Kenya border, where they are locally called Chokola.

Busia border is home to many migrants, who come to exploit opportunities offered by the lucrative businesses thriving along the border (Nakanjako et al, 2021), Chokola being among them. Chokola are often despised by and socially excluded from the rest of the community because of the lifestyle they lead as homeless children. Chokola originate mainly from areas within Uganda, Rwanda, South Sudan, and Kenya. When they reach the border, Chokola have difficulty accessing food, shelter, and medical care. They also experience abuses that include sexual and psychological torture from adults and older children. Living a healthy life is a struggle for them.

Knowledge of Chokola social structure is critical to understanding their everyday lives. Chokola are divided into groups, based on age and sex, that constrain the opportunities available to them and — relevant to this study — their patterns of health-seeking behavior. The three dominant groups are called *Simba*, *Machakos*, and *Mawolo*. Each has a clear hierarchical set-up based on age. The groups are led by the eldest member, who is known as either *kaka*¹ or *dada*². Kaka and dada have assistants who are known to all members and whose special status is recognized within the group. There are also smaller groups, most of whose members are Chokola who have either been dismissed from the three dominant groups or have withdrawn because they are dissatisfied with their leadership styles.

Whoever fully subscribes to group expectations and values is, through self-ascription or ascription by others (Barth, 1969), identified as a group member. Group membership bestows upon members certain rights and obligations. Each group member enjoys the right to protection by other members. On the other hand, members are obliged to save some money with the group, take an oath to protect group members, and abide by the rules that govern the group. Group members are expected to respect group leaders, to protect and defend all members whatever the situation, and never to betray each other.

This study, motivated by the need to understand Chokola's health-seeking behaviors along the border as they struggle to live healthy lives, attempts to answer three critical questions: (1) What health challenges do Chokola face? (2) What health-seeking behaviors do the Chokola use? and (3) Are any side effects associated with those behaviors?

This study uses social identity theory to situate and appreciate how the Chokola navigate their everyday lives. One characteristic of social identity theory is that it explains relations between and among groups (Tajfel & Turner, 1979). It also emphasizes the role and position of self and identity in group interactions (Turner et al., 1987). A key aspect of this theory is the definition of social identity as an “individual's knowledge that he belongs to certain group(s) together with some emotional and value significance to him of this group membership” (Tajfel, 1972, p. 292). Using this theory, we can specify and predict the circumstances under which the Chokola are compelled to live as individuals and as group members.

Method

This study adopted an ethnographic design involving interaction with Chokola, selected elders, and local leaders. Ethnography is the study of social interaction and culture groups, whether these groups are defined as societies, communities, organizations, or teams (Reeves et al., 2013). Ethnography studies people in naturally occurring settings by means that aim to capture their social meanings and ordinary activities (Brewer, 2000), taking note of the day-to-day life experiences of

¹ Swahili for big/elder brother(s).

² Swahili for big/elder sister(s).

people as they unfold in the field. Ethnographies are guided by an implicit narrative structure, by a story we tell about the peoples we study (Bruner, 1997). This agrees with Yin (2011), to whom ethnography meant the study of participants in their real world settings over an extended period. Thus, using an ethnographic design helps in the generation of rich data.

An ethnographic design was selected for a number of additional reasons. It permitted the research team to (a) observe and discuss Chokola actions, such as aviation fuel sniffing and its associated rituals; (b) see Chokola intra- and inter-group interactions; (c) interrogate meanings associated with aviation fuel and the behavior of sniffing. Finally, data collected during a long stay with respondents helps the researcher develop a thick description of the subject under interrogation (Geertz, 1973).

Study participants included Chokola girls and boys (the primary respondents), and seven secondary respondents comprising four elders (older persons in the wider community) and three local council leaders. The study was conducted between September 2019 and March 2020, in the Busia municipality along the Uganda–Kenya border.

Purposive and quota-sampling techniques were used to select and identify respondents. Purposive sampling was used to select key informants (secondary respondents) as sources of detailed information and historical perspectives on the Chokola, while quota sampling was used to get representative samples of Chokola-based dominant groups (primary informants). This disaggregation was meant to aid in eliciting the views of each group regarding Chokola health-seeking behaviors.

Various data collection methods were used. Twenty-two in-depth interviews, eight life-histories, and six focus group discussions (FGDs) were held with the primary informants, who ranged in age from 10 to 17. These FGDs were conducted separately with members from each of the dominant groups, three with girls and three with boys. Each FGD had eight Chokola. Seven key informant interviews were conducted with elders and local leaders. All interactions with Chokola were conducted using the four local languages most spoken at the border: Swahili, Samia, Luganda, and Lusoga.

The collected data were audio-recorded, and transcribed verbatim into 43 transcripts. All transcripts were checked for completeness and underwent de-identification. Each transcript was then given a unique identifier for attribution.

Thematic analysis, which allows for a detailed illustration of different interpretations of the data (Alhojailan et al., 2012), was used for this study. Maguire and Delahunt (2017) defined thematic analysis as the process of identifying patterns and themes within qualitative data. In our study, the thematic analysis involved reading and rereading all the transcripts, which permitted the identification and classification of patterns that then informed the derivation of themes and subthemes. Some of the themes were largely related to the broad research questions of the study. The analysis followed Braun and Clarke's (2006) framework, which proceeds in six steps:

interfacing with and understanding the data; identification of initial codes; identification of patterns, themes, and subthemes; review of themes; definition of themes; and write up. In preparation for write up, all themes and subthemes were allocated codes in Atlas.ti, version 8.0, a qualitative data analysis software package.

Chokola were treated as emancipated minors, since they neither had parents nor guardians at the border. As such, all Chokola and key informants were able to consent on their own behalf to participating. The study was approved by the Makerere University School of Social Sciences Research Ethics Committee (MAKSS REC) under number MAKSS REC 03.19.268. The study purpose and objectives were explained to all participants. Standard guidelines and key ethical principles of conducting research involving children were strictly adhered to. Chokola identities were kept confidential both during all interactions and subsequently.

Discussions and interactions were conducted in an open but secluded environment, one that would not invite suspicion and attention from onlookers. To help address any psychosocial challenges encountered in dealings with the participants, the research assistant assigned to this study was a qualified counselor. Furthermore, all participants and informants were informed about their rights, and any benefits and obligations arising from the study. Particular ethical issues like blinding children's faces and names were meticulously adhered to during data collection, analysis, and report writing.

Results

Health Challenges

Our first research question was to identify what health challenges are faced by the Chokola. Health challenges abound for the Chokola and, indeed, for other folks living at the border. Chokola often engage, voluntarily or through coercion, in risky sexual behaviors. The older Chokola boys reported engaging in several such behaviors, including procuring the services of commercial sex workers, cross-generational unprotected sexual acts with older women, and unprotected sex with peers. All these practices exposed Chokola to HIV, Hepatitis B, and other sexually transmitted infections. A 15-year-old boy from the Simba group said:

We go and dance with girls and sometimes when you have sex with them you get sick like syphilis or HIV. Some women and “bitches” [sex workers] use us and we end up getting sick.... We don't know how to prevent ourselves from that HIV because it is killing many of us — even some are now sick.... (FGD participant)

Chokola girls faced the same predicament. A 14-year-old girl from the Machakos group said, “Some drunkards come and sleep on us and we get HIV.” She added, “We are weak or too vulnerable to resist such sexual acts and advances.”

Both boys and girls reported cases of sexual abuse where younger Chokola boys and girls were raped at night by older boys and adults. For example, a 12-year-old boy said:

Uncle [addressing the researcher], ... even some of the older Chokola boys rape [sodomize] the younger ones. Even in this group some have been victims of this act. In addition to being painful, one could easily get sick. These things are left to God's mercy. (FGD participant, Simba group)

With regard to voluntary interactions, drivers of risky sexual behaviors among the Chokola varied. The most pronounced were peer pressure, ignorance, the need to earn money, and adventure.

Health-Seeking Behaviors

The second research question was to identify what health-seeking behaviors were used by Chokola when confronted with health challenges. We found three main behaviors: sniffing aviation fuel, combining sniffing aviation fuel with medicine from the hospital or drug stores, and using herbs from home.

Sniffing Aviation Fuel

The top health-seeking behavior among the Chokola, both boys and girls, was the sniffing of aviation fuel. The aviation fuel is sourced from as far away as Kampala; sometimes it is siphoned from trucks carrying it from Mombasa. Sniffing aviation fuel is a practice that is prevalent at the border; Chokola learnt the practice from older people and other street children.

Many Chokola had a strong belief in the efficacy of aviation fuel, believing that it played the dual role of both preventing and treating disease: you couldn't get sick as long as you sniffed it, and if already sick, you would get well instantly. Sniffing aviation fuel was the first remedy they turned to when dealing with illness; in medical parlance, they were using aviation fuel as a first-line medication. Mawolo group members participating in an FGD nodded in approval when a 16-year-old boy said, "For us, we know that this drug [aviation fuel] cures us when you are sick. Even when you get HIV you cannot die very fast because it is stronger than septrin [antibiotic used in HIV treatment]. When you take it you can live longer." Chokola girls use aviation fuel for similar reasons. A 16-year-old girl from the Simba group said, "Aviation fuel is sniffed for precautionary measures. We use it to help us insulate ourselves from getting sick."

A 14-year-old boy from the Machakos group shared that he had been hit by a motorcycle, used aviation fuel, and recovered without needing medicine. A 15-year-old boy from the same group also told us that because of fuel sniffing they could not get cholera, even when they ate food from the rubbish bins. Most Chokola from the three groups shared their belief that, due to sniffing aviation fuel, no Chokola had contracted cholera even though there was an outbreak in the town. Their belief in the efficacy of aviation fuel prevents most Chokola from seeking medical attention.

A 17-year-old Chokola girl from the Simba group, who sorts beans in the market, shared how aviation fuel had enabled “her body to repel diseases”. As well as taking it every morning as a precaution, she took it very often in small quantities, believing that it boosted her immune system and also gave her the energy to work the 12-hour days required to eke out a living at the border. She also stated that most of her friends in the market sniff it. She observed, “If you don’t work, you will not get money to eat, so that is why we devise all the precautions not to get sick, and sniffing this has been helpful.”

Echoing the same opinion regarding aviation fuel, a 14-year-old Chokola boy participating in a Mawolo FGD said:

We realized that we cannot do without it [aviation fuel] because it is the one that has made us survive most of the diseases. If it was not there, we would not be living. Most of us would have died because we live a hard lifestyle here at the border. We have to survive! So, when you sniff this fuel, even when you have a lot of pain inflicted on you, you cannot feel it because you become numb.

Some Chokola believed that aviation fuel, when taken, not only caused instant pain relief for some ailments but also achieved a complete cure. To them, it worked much faster than other drugs, both as a pain killer and as an immediate cure for most diseases. For example, a 17-year-old boy said:

If someone cuts you and you apply aviation fuel, you get instant cure. One time I was vomiting and having a terrible stomach pain but when I sniffed the fuel I was cured instantly. Many of us sniff it when we have pain and it goes instantly. (FGD participant, Machakos group)

Chokola sometimes sniff aviation fuel as a measure to prevent diseases and to cope with other harsh conditions they face on the streets. During a life-story interaction, a 17 – year-old boy, an elder in the Simba group, reported that:

For us when we sniff aviation fuel, it makes us numb not to feel any coldness because we sleep in the cold and when we are “high” we don’t feel the coldness.... Even when people come and beat you, you don’t feel any pain because you are numb. I sometimes also sniff it in case I am hungry and I don’t have food. It has been helping me because then I don’t get stomach pain of ulcers because of hunger. I can survive for like two days after I have sniffed it.

Our participants affirmed that they believe they cannot live without aviation fuel: in their view, it cures all the diseases they are exposed to and allows them to endure cold weather and other harsh conditions. For them, the many cures and fixes attributed to aviation fuel justified its use as a first response to any kind of disease they were exposed to, before seeking other medical attention. Apart from their belief in the efficacy of aviation fuel, Chokola use it because they fear side effects from

other medicines, because they are unable to buy other medicines, and as a rite of passage that confirms their membership in a group.

Some Chokola felt that drugs like septrin, antiretroviral drugs, and antimalarial tablets would make them sick and weak. They believed that they had less immunity than other populations and so were likely to die faster if they took these drugs. They regarded aviation fuel as the best replacement on the grounds that it avoided the side effects of the drugs:

I was told that I have HIV, they gave me septrin and other drugs but when I take them I become very weak and I cannot work.... I now take this [he shows me aviation fuel]. It relieves me because the body gets stronger. (16-year-old boy, Mawolo group, informal interview. When I went back after 3 months he had passed on.)

For us we know that this drug [aviation fuel] cures us when you are sick. Even when you get HIV you cannot die very fast because it is stronger than septrin. When you take it you can live longer. (17-year-old boy, Simba group, informal interview)

When I take medicine, I feel dizzy especially when I have not eaten food, but when I sniff aviation fuel, I feel very okay and yet I remain satisfied and continue doing my work in the market. (17-year-old girl, informal interview)

Our participants saw sniffing aviation fuel as a rite of passage (ritual) for every Chokola, regardless of sex, age, or ethnicity. Thus, sniffing aviation fuel is a behavior learnt through group socialization.

Combining Sniffing Aviation Fuel with Medicine From Health Facilities and Drugstores

The second of the health-seeking behaviors reported by our participants was the dual use of aviation fuel and medicines and drugs from health facilities and drug shops. Machakos and Mawolo leaders encouraged group members to seek medical care from the government hospital whenever they were sick. Some Chokola reported that they had a contact at the hospital who helped them whenever they went there.

Participants shared several experiences in which they had encouraged fellow group members, especially those living with HIV, to seek care and treatment from health facilities in addition to sniffing aviation fuel. For example, groups supported four Chokola living with HIV to get medicine from the government hospital, which they often called “Red Cross”. One remarked that:

When I get sick I go to our dada [elder sister] who advises me on what do. When I get very sick, my brothers take me to Red Cross [the government hospital]. When I am not very sick, they advise me to sniff aviation fuel and I become okay. (15-year-old boy, Machakos group)

Some of our participants, especially those from the Mawolo group, reported that in instances where they could not afford medicine or the hospital, they encouraged their members to sniff aviation fuel. A 16-year-old Mawolo FGD participant stated that, “When you get sick everyone contributes money to make sure that you are treated. If you don’t have money for treatment, you sniff aviation fuel; when you have sniffed aviation fuel you will be cured faster.”

Use of Traditional Herbs From Home

Reliance on social and familial networks for addressing health challenges is the third health-seeking behavior we identified. When faced with health challenges, some participants — in addition to using aviation fuel — activated their social and kinship networks for support. This was especially so for those who had migrated from Karamoja³, a region in northeastern Uganda that is about seven hours from Busia by car. Chokola whose origin was Karamoja took advantage of the ease of transport to request and receive herbs from home. The Karamojong’s access to herbs is partly facilitated by the frequent arrivals of child migrants from the region.

These Chokola preferred not to go to the hospital. Their use of herbs seems to be embedded in their culture. One said, “When we get sick we take local herbs. We inform our relatives and when our friends go to Karamoja they come with the medicine. It cures all the diseases so we rarely go to the hospital.” Participants from Karamoja believed that taking medicine not prescribed by their elders might bring them bad luck. Another stated, “This medicine is prescribed by the elders, and if you do not follow the instructions, you may be cursed.”

Side Effects Associated with Health-Seeking Behaviors

The third research question was to identify whether any side effects were associated with Chokola health-seeking behaviors. Participants mentioned two main negative effects of sniffing aviation fuel: loss of appetite, and early death. We categorize these effects as minor and major, respectively.

Most participants said that addiction to aviation fuel causes loss of appetite, which can last three or four days. A 17-year-old boy from the Simba group, was one of many who reported loss of appetite: “When I sniff aviation fuel, I spend like five days with no food.” This leads to malnourishment and has a severe negative impact on health and development: most Chokola become stunted.

Still more drastically, another side effect of sniffing aviation fuel is early death. Participants reported that those who are both addicted to aviation fuel and HIV+ are most likely to die. In the 7 months during which we collected data, participants reported that four Chokola lost their lives

³ Some Chokola who leave their homes and come to the border maintain ties and connections with family and kin. However, these Chokola are still classified as “emancipated minors”, since they live by and fend for themselves.

to AIDS-related illnesses; this was said to have been aggravated by aviation fuel. Some older Chokola reported that they had lost as many as 10 friends since 2014. Some participants reported their responses to the death of a friend:

I don't want to die, but when death comes to one of our friends we fear terribly, we know there is no one to look after us so we all have to be there to ensure that our friend is buried. (14-year-old girl, Machakos group, FGD participant)

Another said:

Last year we lost one of our colleagues who had HIV. We organized and got clothes and where to bury him and then after burying, we came back and mourned him. (16-year-old girl, Simba group, FGD participant)

Discussion

Health Challenges

The Chokola use their explanatory model to deal with the dominant health challenges they face. According to Dinos et al. (2017, p. 106), “Kleinman et al. (1978) ... defined it [explanatory model] as the complex, culturally determined process of making sense of one's illness, ascribing meanings to symptoms, evolving causal attributions, and expressing suitable expectations of treatment and related outcomes.” To understand Chokola health-seeking behaviors, we examined the way they construct their illnesses and what they believe they have to do to address them. This constitutes their explanatory model (Fabrega, 1974; Foster & Anderson, 1978; Kleinman, 1980). Explanatory models are not static entities or single constructs but are fluid, multilayered, and complex (Dinos et al., 2017; Ghane et al., 2010; Kirmayer & Bhugra, 2009).

We discerned two distinct agents, or groups, that were responsible for — or perpetrators of — the ailments and diseases suffered by Chokola: some health ailments and conditions were transmitted by Chokola themselves, while some were caused by others (“outsiders”). The influence of other groups is key to Chokola culture. The reasons why the Chokola community exists, and persists, as well as the forces that shape their health, are rooted in their interactions with others (Barth, 1969).

Health-Seeking Behaviors

We found three main health-seeking behaviors among the Chokola: sniffing aviation fuel, dual use of aviation fuel and Western medicine, and dual use of aviation fuel and traditional herbs.

Sniffing Aviation Fuel

Most Chokola in our study turned to aviation fuel as their first-choice health-seeking behavior. To them, aviation fuel was a “magic bullet⁴” with the capacity to sort out all manner of illnesses and health challenges. Furthermore, the behavior of sniffing aviation fuel can be likened to turning to the *popular sector* to manage ailments. The popular sector was described by Helman (1990, p. 55) as:

the lay, non-professional, non-specialist domain of society, where ill-health is first recognized and defined, and health care activities are initiated. It includes all the therapeutic options that people utilize.... Among these options are: self- treatment or self-medication; advice or treatment given by a relative, friend, or neighbor; healing and mutual care activities in a church, cult, or self-help group.

The Chokola practice of according authority to their group in health care matters captures what Helman described as the influence of the popular sector.

The adoption of sniffing aviation fuel as a first-line treatment for all ailments resonates to some extent with Barth’s (1969) reasoning that identity and practices are inculcated during the processes of generating and maintaining a group identity, and when recruiting and assimilating newcomers into the group. Chokola have a desire to belong, to identify as Chokola and be part of a group. The groups exert influence over their members, and expect conformity to their norms, rituals, and practices (Abrams, 2001). Sniffing aviation fuel is expected from all group members. The fuel is self-prescribed or prescribed by group members who are not medical professionals. Older Chokola provide treatment guidelines and expect group members to abide by and respect them. All Chokola, in their respective groups, have to conform to group behavior. In our sample, Chokola who chose a health-seeking behavior other than aviation fuel were considered to be deviants and non-conformists.

Furthermore, it appears that, for the Chokola, sniffing aviation fuel is both a “ritual” and a rite of passage. Van Gennep (1960) described rites of passage as events, actions, or practices that mark an individual’s transition from one life stage to another. For the Chokola, sniffing aviation fuel acted as an incorporation rite, symbolizing entry into the group and adherence to group behaviors.

In terms of what belonging to a group meant and how it influenced individual Chokola behavior, we noted that membership helped them construct their identities, but also imposed certain obligations on them. Aviation fuel sniffing thus becomes part of their identity and the practice quickly becomes a way of life. Social identity theory stipulates how a group member will be treated and regarded by others (Brewer & Campbell, 1976). The requirement that one sniffs

⁴ “Magic bullet” as a concept pertaining to medicine was first used by Paul Ehrlich (Strebhardt & Ullrich, 2008), a German scientist, to symbolize drugs that are powerful in addressing certain conditions.

aviation fuel when faced with health challenges demonstrates the Chokola's acceptance and acknowledgment of sniffing aviation fuel as a way of life.

Sniffing aviation fuel is a behavior supported by strong social motivations among the Chokola, and is thus amenable to consideration by social identity theory. Some Chokola sniff aviation fuel out of a desire to maintain a positive image within their group, and to show conformity with group behaviors and norms. Thus, aviation fuel sniffing plays two roles in a Chokola's life: first, as a health-seeking behavior; and second, as a sign of conformity with group behaviors, practices, and norms.

Furthermore, sniffing aviation fuel should be looked at as a behavior and practice that presents a dichotomy between Chokola and "others" (non-Chokola), creating a social boundary. While non-Chokola go to health facilities, drug stores, or pharmacies to get treatment or medicines, Chokola turn to aviation fuel. This type of difference in practice and action is what Barth (1969) called dichotomization.

Dual Use of Sniffing Aviation Fuel and Traditional Herbs

The Chokola who use herbs from Karamoja alongside aviation fuel as a first-line treatment exhibit a search for a local remedy based in their "indigenous communities' healing systems and understandings" (Biehl & Petryna, 2014). The medicinal use of herbs falls under the *folk sector*, which Helman (1990) described as:

a sector where certain individuals specialise in forms of healing which are either sacred or secular, or a mixture of the two. These healers are not part of the 'official' medical system, and occupy an intermediate position between the popular and professional sectors.... Folk healers form a heterogeneous group, with much individual variation in style and outlook, but sometimes are organised into associations of healers, with rules of entry, codes of conduct, and the sharing of information. (p. 59)

The belief that only local herbs from their childhood communities can heal plays an important role in the lives of these Chokola. Requesting and receiving the transported herbs helps them maintain kinship and familial ties.

Side Effects

Chokola shared their knowledge of two main effects of sniffing aviation fuel: a minor effect — loss of appetite, and a major effect — death. These effects are to some extent similar to what other scholars have reported regarding the use of aviation fuel. One of the toxins commonly found in aviation fuel is lead, which, if ingested, can have catastrophic long-term health effects (Daly, 2017). Ingesting or inhaling lead can cause severe vomiting and other gastrointestinal symptoms, circulatory disturbances, enlarged liver, damage to the brain and nervous system, and eventually death (Mahurpawar, 2015).

Feedback from participants underlined the fact that despite their moderate awareness of the dire effects of inhaling aviation fuel they resolved to continue using it nevertheless. Knowing the implications of inhaling or ingesting toxins would not deter them from continuing to sniff aviation fuel, which is not only a health-seeking behavior, but a way of life, and thus difficult to change (Bah, 2018).

Chokola also face health challenges arising from risky sexual behaviors. Some Chokola engaged in these behaviors because of peer pressure, ignorance, or poverty. This agrees with studies showing that young people's exposure to HIV/AIDS is often due to a lack of knowledge and of the skills needed to protect themselves (Birungi et al., 2011). Chokola boys and girls reported engaging in both voluntary and involuntary sexual acts. Due to their lack of bargaining power, they were vulnerable, as our results indicate, to being either lured or forced into unprotected sexual acts.

From an HIV and AIDS programmatic perspective, the vulnerability of the Chokola is shown by their identified lack of bargaining power in relations with adults, such as those members of the larger community who sometimes engage Chokola in cross-generational sex. Sexual acts involving Chokola, whether voluntary or compelled, reflect the level of vulnerability this subpopulation faces and how it could fit into the overall HIV and AIDS programming for most-at-risk populations (MARPs). At present, Chokola are not recognized as a category among MARPs with respect to HIV and AIDS programming.

Conclusion

Chokola health-seeking behavior is influenced by many factors, a major one being the difficulty, once they reach the border, of accessing health services. Health problems and how they are handled are constructions of individuals; during the process of socialization, the Chokola absorb constructions of aviation fuel as being efficacious. Sniffing aviation fuel thus becomes a first-line health-seeking behavior for the majority of Chokola. To them, it is a way of life. Whether aviation fuel is scientifically efficacious is not of concern to the Chokola since they have grown to believe that it is a “magic bullet”. For some Chokola from Karamoja, the health-seeking behavior of obtaining and using herbs from home — herbs that are a key element of their material culture — is a demonstration that, whatever the circumstances, they still maintain kinship ties and bonds, thus demonstrating ethnic boundary maintenance. For these Chokola, their ethnicity is not forgotten: they still belong, regardless of where they are located.

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