Sociological Probing of Swathed Cultural Health Systems in Yonibana, Tonkolili District, Northern Sierra Leone

Mohamed Bangura
Lecturer One, Department of Sociology and Social Work, University of Sierra Leone, Fourah Bay College, Freetown, Sierra Leone

Abstract
In this sociological inquiry, the researcher explored the pursuit for health and healing in Yonibana, Tonkolili District, Northern Sierra Leone, unearthing the swathed forms of medical awareness and practices. This sociological inquiry organizes to pose novel and further questions about the sociology of health and healing. Incipiently, via published work, then via dominant material and social dialogues. The inquiry negotiates the successive intents: a. To portray the intricate health structure of care in Sierra Leone. b. To portray and scrutinize the social pattern of healthcare seeking behavior in an intricate, inequality and manifold healthcare structure. c. To examine social relations of cultural authority, shame and inequity in a manifold healthcare structure. d. To scan expansive social reflections of how both women and men in Northern Sierra Leone appreciate, steer and utilize divergent shapes of healthcare structures. This inquiry depicts that women and men in this district of Sierra Leone trek an intricate tour in search of their well-being challenged by the cultural inequalities and intricacies of district health care structures. The inquiry summarises by depicting that the folks of this district, manifest agency in their health practices, and their health seeking behaviour and actions are adjusted in an effort to facilitate their wellness. Given the gendered and patriarchal context of Sierra Leonean culture, the findings of this study are perhaps surprising that birthing women reported male midwives to be more gentle, calm, and respectful than female midwives, and that nurses who work in rural health posts are perceived to be more respectful than the nurses who work at central hospitals, thus these findings may suggest more need to explore these two themes.

Introduction
It is a commonplace that in the loyal pursuit for well-being, folks around the districts in Sierra Leone enlists numerous approaches or methods and sketch on several resources and angles of social education. In cultural residents where medical care is symbolized by social discrimination; social destitution, intricate customary systems; chronically contesting and intricate customary infrastructures and overlapping cultures what some have called “a plural cultural health structure” folks sketch on household-lodged, neo-customary, metropolitan, customary, financial, Occident and universal health and biomedical blueprints, governments and pharmaceuticals.

In constituting the cultural sociology of healing in Sierra Leone materialized with the emergence of Occident medicines and of structures of scientific medicine in sub-Saharan Africa are all linked with the inception of settler colonial command; natural deposit extraction via drilling and agriculture; and the coming of the Christian clergies in the previous dark two hundred years [1]. The clergies were coming as partners inside of a universally amplifying colonial and plutocrat system of authority, and appeared with them their possess medicines, medical methods, and comprehensions of diseases still in advent in the 19th century, and during implementation of their tasks, they established and assisted an unequal medical care assistance to the indigenous Africans and settlers. Subsequently, as a colonial medical system started to appear, one of its pivotal traits was a sort of disparate medical disbursing and health social function which imparted to contemporary Sierra Leone another sort of medical diversity lofty operational regularly communal health hubs and institutional, and a hinterland of much further inadequately revived health social realities.
Following the appearance of the epoch of democracy in provincial Sierra Leone and the emancipation of the economy, contemporary sorts of capitalization of cultural health appeared a contrasting from medicine hawkers and classified physicians, these social realities, often with associates to several nations in the West African region, situate classified hospices and clinics that were neither devout nor government authorize or control. Eventually, in Sierra Leone today a mass of its citizens is proclaiming Muslims. Islam takes diverse shapes in Sierra Leone, but a crux path of its cluster of belief is its healing social arrangement or structure.

**Literature Review**

A perception into literature depict swathed sorts of medical education and practices as there is intensity, substituting and intersecting of education, strategies, and practices. Inquiries around fields justify meaningful overspreading of health social networks in which practitioners around several sorts of healthcare grasp and integrate components of other health caring cultural system to meet patient’s health demands. Inquiries also depict that patients hunt care around divergent health networks and healthcare practitioners, identically assimilate definite components and practices of other health networks. This questions the jurisdiction, solitude and global assertion of definite education, such as the scientific and logical assertion of medical education and its practices. As Gomes and Freire (2022) further indicated that the social patterns of education are swathed with indications and shapes of vanquished and the oppressed. Consequently, utilizing overlapping as a device furnishes a contemporary social insight for comprehending of the mingled and affiliated frameworks that appears to be ostracized but establishes an outright model social system. In such a case, the overlapping of health social systems, as Rajamani and Iyer (2023) suggested clouds the extremities and induce transposition, giving surge to modern complicated shapes of genuine template of healthcare networks. In this inquiry, the social researcher can consequently theorize swathing as the overlapping of divergent health networks to bolster, improve and preserve wellbeing of the folks.

The overlapping of health networks generates transformation in person’s arranged health chasing behavior and social observations as they maneuver divergent sorts of health networks in pursuit for wellbeing or health. Enlightened by Lee and Prost swathing approach in which the material and social services traverse and sustain one another prompting in transformations in folk’s patterns of cultural relation, the cultural relation of various health networks attached with cultural atmosphere and socio-economic actuate norms of cultural relation. It is imperative that when a cultural cohort or group of folks relate with the community, contemporary intricate cultural networks, social fabrics, behavioral norm and kinships appear, echelons, regulations and unsubstantial components such as folklore and tenets are constructed. This demonstrate that healthcare networks are unlock systems, induced by internal and external elements but at the similar moment they have the capability to accommodate, transform and react to any incidents in order for them to withstand or endure over time. For instance, customary healthcare networks have been devised and dominated by contemporary healthcare practices but at the same time, it has endured, modified into neo-customary and stay resolute.

**Cultural Gender**

Wellbeing privileges and social disparities are at the crossroad of multiple elements of vulnerability in Yonibana such as, cultural gender, age, social class, sexual orientation, chieftaincy, among other social elements. In cultural communities, health inequalities lie mainly at the intersection of social status and wealth (for example, trader status). Meanwhile, in Freetown, the socio-economic status strongly dictates the type of healthcare services folks utilize. However, age and social class are also other determinant factors. As the inquiry researcher observes that the age, parity and women’s experiences with healthcare networks induce the utilization of certain healthcare mercies. From the biomedical perspective, a woman's old age and parity make her to be categorized as lofty risk, but this also emerges with difficulty, segregation and shame as they pursue care specifically during pregnancy. It is via such obstetric observations that many women feel further comfortable with healthcare providers of their own culture, social class and gender.

The utilization of healthcare networks and therapeutics, report cultural gender divergences. It is considered that women visit and utilize healthcare mercies further often than men utilize. In spiritual healing networks, women visit and pursue assistance from spiritual healers further than men do. Women’s predominant social function in household caring attached with motherhood, elucidates the rationale Yonibana women constantly visit healthcare establishments. Ordinarily, caring for the household members and chores fall within women’s tasks as dictated by the patriarchal constitution of the cultural communities of Yonibana. This also explains cultural gender functions that make women’s observations of motherhood and caring for children divergent from men, hence creating a label and contributing to men and women observed and palliated or cured separately from one another. In this path, caring occupation can be elucidated in terms of “cultural gender segment of labor” [7], in which men and women are immersed in varied responsibilities, for instance the social
replication embracing caring occupation is asexual and care is perceived as a woman’s cultural domain. Albeit there are other antecedent elements linked to care chasing such as spot, price, standard of healthcare services, healthcare pursuing approaches are induced by several elements involving past observations and cultural relations between the patient and the provider. Men and women are involved in commonplace existence social and cultural relations that do not only occur at community threshold but also at national-level whereby social institutions regulate and normalize the practices of cultural gender. At the national level, the influence of institutions carves folk’s cultural observations and inevitably impacts paths in which they arrange their cultural relations. In health institutions for instance, the provider or patient social relation elucidates the authority relations lodged on cultural gender or class station that induce patient care decision-making and can impact health result. This also entails focusing on institutions as arenas in which gender is produced. Nonetheless, social establishments preserve cultural gender disparities via legislation of divergences between men and women. Consequently, authority relations sustain the abiding disparities between men and women, and men are unavoidably perceiving be further cogent or powerful than women, with some oddity for senior older women. Germinating sociological observations demonstrate how patriarchal cultural communities construct divergent shapes of supremacy and abuse via social interaction or relation. It is via social interaction or relation that gender is established as an expression of femaleness and maleness. By stereotyped cultural tasks, such women’s reproduction and caring functions for the household which are widely socio-culturally resolved individuals tend to theorize cultural masculinity and femininity as socio-culturally determined community. In this path, cultural gender is designed by direction of folks interacting with their social community, which too, permits them to comprehend the cultural atmosphere around them. These theories (feminine and masculine) are also perceived as unmatched, imperceptibly arranged, and were cultural masculinity subjects’ femininity. Unlike other healthcare networks, the biomedical networks are portrayed by inter-vocational connections lodged on a gradual model and constructed across specialties and vocational notions. For instance, a nursing occupation is immensely feminized, directing to extremely insignificant numbers of male nurses. The existence of male nurses in Sierra Leone healthcare network as early as 1808, and saw the prevalence of male nurses, specifically Krio male nurses, was a challenge to the gendered and tribal colonial hierarchy of health services, an aspect of Sierra Leone’s health and medical social history that has gone widely unremarked. Despite the fact health caring is immensely dominated by females, the gendering of vocational employment shapes career alternatives, rankings and occupations, which in turn socially establish vocational observations of both male and female health workers, and restricting privileges for institutional stations of authority, and inducement. In view of inter-vocational connections, in biomedical healthcare network, an assistant nurse leans on a nurse, who in succession leans on the doctor as a proficient, who at the same time occupies elevated rank in the chain of technological directive [8]. Thus, clinical practices and constructed connection between the patient, family associates and the care provider are widely reliant on this line of authority and inducement of inter-vocational connection. An inquiry conducted in Ghana by Gyamenah and Asante (2023), revealed, in view of social and medical sequence within hospital setting, that the subordinate rank engaged by patients impact their capability to bargain their care [9]. Consequently, patients subordinate medical hierarchy and sometimes their subordinate social make them lean on medical staff’s decision-making and locates them in a subordinate functions in connection to medical staff. Patients grasp the hospital community and its treatment practices as the procedures in which they are needed to consent and obey directives and adhere to functions whenever they relate with medical staff. In this direction, any engagement by the patient that sounds to be discomforting their care provider means a peril toward their social existence. This social class strives in the hospital community and healing procedure do not only impact patients but also impact medical staff [10]. Relying on culture gender, carnal homogeneity, socio-economic and other antecedent elements, in a society portrayed by pluralist healthcare network, divergent health privileges and various domains of alternatives are prevalent, which in succession induce folk’s health social observations and healthcare pursuing conduct [11]. In a myriad healing network, folks have alternatives even in a restricted direction and the path that they theorize ailments which healer to entrust; and which health network to chase assistance from and in what norm. As mooted previously, social class status nonetheless moderately resolved, and gender and any other shape of social supremacy, are creations of human social relations and of commonplace social existence. For instance, both men and women formulate and convey masculinity and femininity in their social and cultural relations. Consequently, stereotypical cultural gender individualism is designed [7]. In Yonibana, the Tonkolili district northern part Sierra Leone where this sociological inquiry was conducted, comparatively diminutive has been authored about how folks “do
cultural gender,” “enact social class divergences” and how other shapes of unevenness evidence, but a pivotal location in this sociological inquiry is around health and the body and this inquiry is reconciled to demonstrate of the constructing and deconstructing of cultural gender ethos and capabilities in the quest for healing and health in a cultural community.

Social Constructionism

In every social relation, persons portray themselves and their interpretation of narrative as paramount social truth and always want their interpretation of actuality to triumph over other interpretations. Social constructionist has contended that what is perceive to be truth, is actually the outcome of social relations of cultural authority, consequently not independent but always portraying in the concerns of assertive cohorts or groups. Following all sorts of education are established via persons engaging in the social interactions in which social design of certainty happen, social education itself cannot be autonomous and cannot be perceive as global. In the social design of certainty, the assertive person’s interpretation of truth succeeds over the other. This is manifest for instance, in biomedical certainty that primarily holds command of the comprehension, analysis of disease and patient’s observations, accordingly, appreciating the preeminent capacity. An inquiry conducted by Gerrits et al (2022) depicts biomedical education and its practices, delight privilege social status and cultivate to discard the education and health observations of patients [12].

The inquiring of social construction theory in the discipline of sociology of health and disease is considerably situated on the inquiry of social bearings of medicines, the progress of medico-scientific and ordinary medical education and practices. Nonetheless, the theory does not question the cultural actuality of rural disease or physical observations but purely stresses that such communal observations are perceived and consequently, can be construed via cultural engagement, and can also be probed by directions of social and social deconstructions. This concept considers medical education not as gradual expansion against a further polished and special education, but as a batch of relative cultural constructions which are reliant upon the socio-cultural domains in which they are formulated and are progressively adopted. This approach by social constructionists implores optional directions of comprehending and viewing at biomedical assertions of inevitability as social outcomes, resembling novice individual’s comprehension of medicines be it customary or biomedicine.

As demonstrated by Mbiyzzenyuy (2020), the paths in which the medical and scientific education have been utilized and stationed as leading education of the robust cohorts or associations in Africa to the disservice of other education, has inspired feminists’ concerns [13]. Several renowned modern feminist pundits who have come to contend the procedures of education construction and affirmation, which they reasoned, is not impartial. These feminist exponents or ideologues have debated that education is generated with enabled concerns, accordingly, cannot be unbiased. Education formation is competing, dynamic or motivated and ordinarily those un abused conditions cannot have their voice or establish social education without personality diagnostic [14].

Rageth et al (2021) contends that there are positive social establishments that validate education, and these establishments are formed on social interactions of authority [15]. Notwithstanding, Haugaard critic of Foucault (2022) argued that authority is throughout and is not limited to mandatory establishments, as regularly pictured, but Foucault lost the communal and empowering appearance of authority [16]. This is because authority originates from social relations of persons. Where two or more folks are associating, there is frequently an endeavor to wield authority and command above others and paint themselves and their interpretation of the narrative as paramount materiality. Consequently, Foucault dodged the invitation to perceive authority as exerted from an unattached massive ensemble to subordinate sections or gradual, but authority as inconstancy or wavering, can be extensively dissipated and bargained, and admits assorted concerns and numerous locations of authority. Foucault’s concepts of authority and social command is attractively connected to multiple social establishments in contemporary occidental societies, specifically medical establishments where he perceived certain disease as socially constructed and furnished a divergent but extreme path of comprehending the function of medicines in accomplishing certain education and social interactions of authority that are ipso facto slice of medical observations. Social researchers like Strivers and Timmermans who have embraced social constructionist approach prospect medicine and its practices as medical establishment of authority [17], nonetheless the authority does not only dwells in establishments or preeminent cohorts or groupings but also situated or emplaced by every person via nurture of certain values and norms of cultural conduct or demeanor. The present conceptualization of medicine as producing knowledge which changes over time and social space [18], has inspired concerns from pundits from multiple disciplines such as sociology, gender, history, anthropology, specifically. On grounds of medicine or medical establishments conserves social disparities or partisanships, results in possible tussles and employ punitive or corrective authorities on
humanoid bodies, consequently resulting in compliancy or submissiveness. Diverse inquiries in healthcare networks succeed this queue of contemplation or musing.

**Methodology**

Portraying on multiple modes utilized in inquiring health, disease, health networks, caring and healing and to this extent, in other words, research methods in medical sociology, this sociological inquiry on Yonibana immersed qualitative technique in data accumulation and social inquiry. Albeit the inquiries in health and disease have principally utilized quantitative highways in comprehending demographic communal health devices [19], there has been a divergence between the heterogeneities and intricacies of human observations one-on-one the convictions of biomedical results [20], consequently sacrificing a podium for qualitative inquiry of health and disease. Chronically, the discipline of medical sociology has been upgraded by ethnographic and qualitative modes with an insistence on the interpretations, portrayal, and medical theories [21]. Based on Bozkurt (2022), qualitative research modes submit contemporary intuitions, interpretations; authorize the social researcher to overhaul the interpretations, and appreciate a novice, as skilled over his or her own social existence [22]. Nevertheless, Deitz et al (2020) contends that qualitative route, comprehensively scouts human observations in specific social spaces, consequently, contributes elaborate narrative of respondents’ emotions, observations, and sentiments and expound the interpretations of their rural engagement [23].

In this sociological inquiry, mode triangulation for data accumulation was immersed in order to systematically comprehend the social phenomenon and to secure extraordinary qualitative data. Mode triangulation implicates accumulation of data from diverse fountains to obtain divergent standpoints and authentication of data [24]. For instance, “mode triangulation” is utilized in feminist perspective to give privileges to the voices of marginalized cohorts or associations and brought them into explicit dialogues with the data in order to acquire comprehension. For dominant data accumulation, partially structured dialogues were utilized to accumulate data from respondents. Partially structured dialogues were conducted with seven women and seven men who were residents of the inquiry social space and were above eighteen years old. The inquiry respondents were reached and requested to participate in the inquiry after precursory dialogue to determine their relevance for the inquiry. Consequently, essential questions were posed about their matrimony social status; whether they had themselves or on behalf of the household sought care from any of the health providers or facility in the latter two years.

Based on Ruslin et al (2022), partially structured dialogues permit the social researcher to be receptive about the outlines so that during the swap of information with the respondents, theories or concepts can materialize out of the data [25]. Partially structured social dialogues have been broadly utilized and captivated concerns in qualitative sociological inquiries. The augment in utilization of partially structured social dialogues is planted on the premise that research respondent’s standpoints are further probable to be manifested candidly than in a formalized questionnaire or social dialogue [26].

The social dialogues instruct was rephrased into an indigenous pidgin language (Krio) because of low literacy threshold (48.4%) [27] and the social dialogues were conducted in that language. Asserted that the male social researcher conducted the dialogues, it was expected that surveying women on affairs of household health and caring might result in social criticism; female research aides were utilized to conduct such dialogues.

**Results and Discussion**

Converse data deconstruction was utilized to analyze foremost data. Converse deconstruction concentrates on how language is utilized in a social context [28,29,30]. Braced or sustained by the social constructionism that premises that there are diverse and contending actualities, it is imperative to comprehend the lexicon or converse being deconstructed [31]. Social constructionists speculate that language forms actuality and how to comprehend human conduct [32,33]. In this case, language associates to the lexicon or chat or speech and context accredits to the social circumstance in which the lexicon or chat appears [34].

Granting, there was no ordering or gradual procedure pursued by the social researcher when deconstructing converse, the sociological researcher distinguishes clichés, periodic terms, metaphors and similarities utilized and prolixity or wordiness signifying contradictory notions [35]. It was also significant to locate divergences and resemblances of literal converses. Contingent upon, the objective was to comprehend and construe the contact between language and social conditions or ambiance.

For derivative or secondary data deconstruction, discursive deconstruction mode was immersed suitable to diagnose prevailing contents from the lexicons. Based on Vettimo et al (2023), in discursive data deconstruction, the foremost text is retrieved so that critical social contents are noticed and utilized to direct more sociological research [36]. In discursive deconstruction, the “lexicon” resides for anindividual performer, and “data” is observed as placed construction of knowledge [37], via which the perception of meaning is generated [38]. In doing
discursive data deconstruction, prevalent but particular contents were pinpointed; and social narrative versions were established or created, offered and construed.

Findings
This inquiry or exploration of the integrated segments of the health environment with community gendered authority dynamics, in Yonibana, Tonkolili District, Northern Sierra Leonean social existence incorporated with the particular observations of clinical, customary, home, intimate and spiritual healing fountains or springs of respondents in this sociological inquiry, establish the bedrock for this recap of the finding. The inquiry found multiple reasons inducing men and women’s engagements as they chase care in a plural healthcare network where divergent shapes of healthcare networks prevail. In this inquiry, the intricacy of household, and health hunting social conduct amassed with folk’s finances and activity, reveal a crucial function in interpreting and judging health privileges, anticipations and health exigencies. Sufficient to say that the cultural authority dynamics that prevail at household threshold (husband versus wife) in particulars of directing or regulating, considerably induce folk’s engagements about healthcare alternatives and anticipations. Other elements involve; the nature of disease, previous observations with healthcare network, social networks, interval to healthcare network and expense included in contacting the services resolve folk’s alternatives and utilize of healthcare networks.

The sociological inquiry further found multiple shapes of healthcare networks, which can be classified into; biomedical; customary and spiritual healing networks with divergent providers and practitioners wedged to or practicing in string with divergent health networks. The obtainability of divergent shapes of healthcare networks furnishes health privileges and result in intricate trek ventured by women and men in this district as they pursue health and healing. Nonetheless, these divergent shapes of health networks are not assembled jointly on an even plane: numerous government policies and laws ostracize several health networks and practitioners such as customary networks and customary midwives. This plot results in the monitoring of customary healing networks, discrediting and faulting of folks who pursue care from customary networks. Notwithstanding such cultural interventions put in place by the Sierra Leone government to ostracize customary healing network, folks locate the network beneficial, and tipped out differing justifications that entice them, expressly; conviction in vegetative medicines, serenity and appreciative directions in which they are taken care of by providers. For child birthing mothers, customary midwives delivered unpaid services and there was serenity and esteem during child birthing procedure.

Albeit, customary networks fascinated folks, the expense of services and therapeutic failure made folks to abandon and chase care from other cultural networks and purveyors. The inquiry found men and women having access to paid primary healthcare services in multiple government health facilities. These government health facilities co-exist with other shapes of biomedical networks such as drug stores, personal clinics and other private providers educated and certified by the government. These private healthcare networks and its providers were perceived as additional to public healthcare networks. Albeit, services were provided paid in state health facilities, folks of this district disclosed scarcities of medications or supplies, healing bankruptcy, conventional processes and toxic human social relations as the essential grounds why they opted out of the network. For private health services, expense of accessing the services, healing bankruptcy and occasional intervals to the facilities, impeded or hampered access to privatized services. Nonetheless, swift service delivery, serenity and courtesy of providers charmed folks in private biomedical networks.

The prevailing health networks are ingrained with Islamic elements and folks of this district believe in divine powers in healing procedures. Consequently, mass of folk’s incessant spiritual healing networks and more crying for heavenly interventions on any occasion they are unwell. Notwithstanding accounts that there was no pill or exploration oversaw to actuate the nature of diseases or healing modes; folks were pursuing care from spiritual healing network because of their robust devout belief, which strengthens the surviving approaches with disease and distress.

Diverse other health networks, in spiritual healing, there was no medication or any other healing modes expressed or handed, apart from ‘Lasman mi watta’ (in Krio parlance meaning charmed water). Subsequently, the inquiry found that spiritual healing network was the last resort from which folks pursue care because folks assumed that invocations solitary could not cure the disease except merged with remedy. Nonetheless, folks also assumed that there was no disease that could be cured without Allah’s interventions. In order to depict the religiosity, some spiritual healers were giving patients ‘Lasman mi watta’ as a sort of remedy, and security from evil demons as well as fetish of individuals.

Propositions
Consequently, this sociological inquiry proposes the subsequent:
Accustomed the gendered and patriarchal cultural environment of Sierra Leone, it is possibly amazing that male midwives are sensed to be mild, tranquil, and considerate and stay focus when assisting birthing
women, and this may propose more necessitate to inspect this sociological content. Additionally, nurses who work in rural health stations who have further independence over their work system and subordinate hierarchy above them on a commonplace cornerstone are perceived to be further appreciative than the nurses who work at metropolitan hospitals; again this sociological content about authentication of rural positioned nurses further promptly with the cultural community they serve compared to further urban stationed nurses, also consent the demand to conduct inquiries to arbitrate the ground nurses comport diversely in distinct locations and social spaces. Acquainted the transformations in conceiptive health a policy that has spawned in solitude of customary midwives, recent or existing government polices disaffirm what is on the ground and how women observe the healthcare network. Besides accustomed the augmented utilization of customary and other mutual medicine (80%) by Sierra Leonean folks, these findings of this sociological research advocate that relevant specialists require to revisit the synthesis of customary midwives and medicines in public health services. This could not only upgrade community established healthcare services and elevate reliable motherhood but also mitigate the load of interval to health facilities and expense in accessing contemporary healthcare networks. Furthermore, evidence recommends, economic merits in the practice of customary medicine. Nations that have evolved and cultivated customary medicines have made billions of cash. For instance, an IBIS World Industry Research (2023) report pointed, China made $45.4 billion [39].

Conclusion
The quaternate dominant points surfaced from this sociological inquiry, encapsulated inside the blankets of the modern medical network. Incipiently, it materialized that patients pursue care around numerous health networks and health practitioners correspondingly incorporate certain elements and practices of other shapes of healthcare networks. Besides, folks perceive the accessibility of divergent shapes of healthcare networks as obtainable healing alternatives. Additionally, folks (particularly pregnant women) mix biomedicine, customary medicines, spiritual healing and chase care around health networks, spotting this as an efficient path of handling certain diseases. Eventually the aggregation of customary midwives in the accepted public health network by the Sierra Leonean government are analyzed here and is an obvious clue of how healthcare networks, medical education and practices are swathed. This inquiry depicts throughout how the folks of Yonibana Tonkolili District of Northern Sierra Leone exploit diverse approaches and portray on numerous resources and shapes of social education in pursuit of obtainable healing alternatives. Consequently, their quest or chase for health and healing, and their health pursuing conduct, is neither smooth nor deliberate. The intricacy of household’s health chasing conduct mixed with folk’s resources and engagements, and various preeminent elements such as social class, age and gender, assisted to trace and actuate health privileges and health upshots. It also surfaced in this inquiry that as folks cruise multiple shapes of health networks, their health pursuing motifs and conduct transformation, constructing swathed patterns, by reason of attainment of contemporary medical education, current impressions and contemporary practices. Consequently, by taking step during disease and associating with health providers and the network fundamentally, folks of this district confirm vigor and engagement in their health social practices. Their health pursuing conduct and actions are adapted in an effort to promote their health.

References


