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COVID-19 Public Health and Social Measures in Southeast Nigeria and Its Implication to Public Health Management and Sustainability

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Received: 06-30-2022 **Revised:** 07-25-2022 **Accepted:** 08-09-2022

Citation: Okafor, S. O., Ugwu, C. I., Nkwede, J. O., Onah, S., Amadi, G., Udenze, C., & Chuke, N. (2022). COVID-19 public health and social measures in Southeast Nigeria and its implication to public health management and sustainability. *Oppor Chall. Sustain.*, *1*(1), 61-75. https://doi.org/10.56578/ocs010107.

Abstract: Southeast Nigeria witnessed the COVID-19 pandemic and the ensuing public health crises. The crises manifest as the conflicts between citizens, policy-makers and leaders over public health policies, creating the circumstance for innovative research. This study examines the public response to the public health and social measures (PHSMs) implemented by the federal government of Nigeria in curtailing the spread of COVID-19, during the height of the pandemic. The focus is to unravel the underlying factors of the public response to the PHSMs, as well as their implications to the overall public health policies and institutions in the region. Guided by the ethnomethodology model, the authors applied qualitative methodology to the research. In-depth interview (IDI) and focused group discussion (FGD) were adopted to gather data from leaders of religious institutions, public and private health institutions, local market institutions, and state security institutions in the 5 states of Southeast Nigeria. The collected data were parsed through thematic analysis and interpretive phenomenological analysis (IPA). The results reveal a range of problems, such as shallow knowledge and misinformation at the local level, gap in public health knowledge and policy, crises of mistrust and misinterpretation of public health objective, citizens-policy-leadership crises, as well as the abuse of PHSMs. These problems were put in perspectives to portray the lessons and the public health policy implications of citizens-policy-leadership crises.

Keywords: COVID-19; Ethnomethodology; Pandemic; Public health policy; Epidemiology; Southeast Nigeria

1. Introduction

Public health management, as part and parcel of public health policy, is the macro-level control of health issues. It informs citizens about how to manage their health based on the extant orders and available facilities/services. There is a complex relationship between the government and the citizens via the public institutions. Any error would project the power and capability of the government as irresponsible and unpopular within the territory and beyond. This is clearly manifested in the way the citizens value and observe whichever government policy in response to existing and emerging public health issues.

In developing nations like Nigeria, public policy faces so many challenges anchoring on the relationship between the political leaders via the public institutions and the citizens who interpret government policies based

on their experiences and daily observations (Okafor & Ugwuibe, 2020; Okafor et al., 2021). These challenges are particularly the case in the area of public health and its management, in view of global realities and emerging public health issues.

During the early phase of the COVID-19 pandemic, Nigeria, especially the southeastern region, encounters problems in the citizens' response to public health policy, raising questions over the government capability in managing public health of global pedigree. Immediately following the outbreak of COVID-19, the federal government of Nigeria adopted Non-Pharmaceutical Intervention (NPI) measures, such as lockdown, and other socio-environmental measures. These measures eventually resulted in some level of crises with socioeconomic and policy implications, calling for empirical evaluation of the underlying factors in the relationship between public policy and citizens in Southeast Nigeria.

Pandemic, as a socio-medical concept, has outlived many generations and still appears as a phenomenon intertwined with the existence of human beings. In the definitional framework, a pandemic is a disease that appears in and disappears from human population. In the socio-medical reality, however, pandemic may not be eliminated from the web of socio-medical existence of humanity. After all, humans will continue to interact with lower infra sentient beings, as well as other aspects of the natural environment, which act as the host for pathogens and other microorganisms responsible for disease outbreak.

The word pandemic is coined from two Greek words, pan and demos, and could be loosely translated as "all the people" (Qiu et al., 2017). Over the years, the concept has been connected with the degrees of contagious diseases (Honigsbaum, 2009). Compared with the concept of epidemic, pandemic has a lesser degree of spreading of a contagious disease. It has gained popularity in the literature, and used as a specialized term of epidemiology for any public health situation affecting a gamut of geographical locations and possibly the globe (Morens et al., 2009).

In essence, pandemic is connected to the socio-medical situation, and presents a challenge to the global community socially, politically and economically. The multidimensional impacts of pandemic are felt by a large chunk of the global population. In a quasi-classification, some scholars have narrowed down the concept of pandemic to the level of regional segmentations (Taubenberger & Morens, 2009). From the coinage and circumstances of the word "pandemic", however, there are underlying factors differentiating the pandemic capacity of any infectious or contagious disease among the global population. Such factors include wide geographical extension, movement, novelty, severity, high attack rate/explosiveness, minimal population immunity and contagiousness (Qiu et al., 2017).

Over the years, a number of pandemics in its raw definition have greeted human beings with different degrees of effects (Frith, 2012). From the Asiatic cholera pandemic of 1817 to the recent COVID-19, humans have encountered pandemics in different dimensions for more than 200 years, and responded with different public health policies (Qiu et al., 2017; Snyder & Ravi, 2018). While the degree of influence of different pandemics is proportionate to the pedigree of science and technology within the timeframe (Folayan & Brown, 2015; Youri, 1994), the behavioral disposition of leaders and followers towards pandemics in the framework of public health policy has affected the morbidity and fatality rates (Gostin & Friedman, 2015; World Health Organization, 2017).

In terms of leadership capacity, proactive polices appear as a force to curb pandemics. In terms of followership capacity, positive and sincere response to policies underpins the scientific formulation in policy statements. This was demonstrated in the case of Spanish flu of 1918, where Australia did not record a single case (Spinney & Rider, 2017). However, the human behavioral dimension of pandemic response seems to be locked up in the context of policy development, and the public interpretation of such policies. Garfinkel (1967) captured this condition in this ethnomethodology theoretical model, which portrays the realities of social order and the documentary lives of social members, and measures the degree of civilization, cohesion and trust between the leaders and the led in the social system. According to Garfinkel and the subsequent ethnomethodologists, human beings are not cultural dopes or suspended in the system to be encapsulated to any definite order. Rather, the social order is relative to individuals, groups, context and time (Fox, 2006; Garfinkel, 1988; Hayakawa, 2017; Theofanis et al., 2020). What appears to be social order among the population and collective obedience can be taken at most on the surface, because the superficial social order may vary from people to people (Kilpinen, 2003; Weik, 2010; Zimmerman & Wieder, 2017).

COVID-19, clinically designated as severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2; HCoV-19), is closely related to severe acute respiratory syndrome corona virus-1 (SARS-CoV-1) (Bourouiba, 2020; van Doremalen et al., 2020). It is one of the diseases that eventually enter the definitional framework of a global pandemic. So far, the scientific community found COVID-19 and its variants highly infectious (Bourouiba, 2020; van Doremalen et al., 2020; Ong et al., 2020).

The clinical strength of COVID-19 really challenged the technological and scientific capacities of human beings, especially in most affected places. The human behavioral disposition towards the pandemic as a socio-medical challenge has raised public health policy issues in many parts of the world, such as Nigeria. This is reflected in the actions and reactions to the public health and social measures (PHSMs) imposed by the country, especially in the southeast region, including movement restrictions, closure of schools and businesses, geographical area quarantine, and international travel restrictions.

From the first reported case of COVID-19 in February 2020, Nigerian unconsciously joined the global network of the pandemic, and started to take a number of PHSMs (Akinmayowa & Amzat, 2020). Initially, the measures were implemented as emergency public health policies, namely, close monitoring of the international routes between Nigeria and other countries, public enlightenment via the social and public media, and restriction of movement in the majorly affected areas, to name but a few (Nigeria Centre for Disease Control, 2020). Some of the measures are not compatible with the local situation, as they were borrowed from the global community (Allen, 2021; Aparicio & Grossbard, 2021; Bjørnskov, 2021; Stockenhuber, 2020). In general, the measures were in line with the extant global health institution for threating global health emergencies (World Health Organization, 2020). Despite the implemented measures and the realities of the pandemic, there were crises in response to the PHSMs by the citizens, especially in southeast Nigeria. Therefore, this study intends to unravel the unseen factors related to the diverse responses from the general public to the PHSMs against COVID-19.

In Southeast Nigeria, the federal government of Nigeria's explicit public order and the quantity of PHSMs via the ministry of health appeared to have been undermined by the populace with some degree of crises in the effort to enforce the order by the government institutional agents. This established some level of awareness for the better understanding of the elements influencing public health policies in Southeast Nigeria and the responses of the citizens, although demonstrating certain flaws in the public policy connection between the government and the citizens. According to science, a pandemic is a socio-medical situation that has been identified as posing a threat of global proportions. This has necessitated the development of carefully thought-out management strategies for the situation that are encapsulated in public health policies, which demand the population's compliance for both personal and public uses. The citizens' role, however, is more to accept the policy and follow the implementation instructions, whereas the government's function in this context is more to formulate the policy and the potential implementation method. In the case of the emergence of COVID-19, the citizens-policy-leaders relationship appeared to have failed in southeast Nigeria as a result of the government's bad reputation and its compromised strategy for implementing policy. This situation was reflected in the prevalent usage of Garfinkel's ethnomethodology proposition, which included documentary, reflexivity, and indexicality.

According to data released by the Nigeria Centre for Disease Control, at least 63,325 confirmed cases of the COVID-19 virus have been reported in Nigeria (Nigeria Centre for Disease Control, 2020). According to the statistics and breakdown of the affected states and regions that are currently available, Lagos state has the highest number of confirmed cases with 21,483, followed by Abuja (6,165), Plateau (3,652), Oyo (3,461), Rivers (2,846), Edo (2,669), Kaduna (2,668), Ogun (2,061), Delta (1,816), Kano (1,749), Ondo (1,687), Enugu (1,314), Kwara (1,069), Ebonyi (1,049), Katsina (953), Gombe (938), Osun (930), Abia (919), Borno (745), and Bauchi (715). There have been 619 cases reported in Imo State, 493 in Benue, 483 in Nasarawa, 413 in Bayelsa, 335 in Ekiti, 325 in Jigawa, 295 in Akwa Ibom, 277 in Anambra, 277 in Niger, 257 in Adamawa, 165 in Taraba, 151 in Kebbi, 93 in Cross River, 87 in Yobe, and 82 in Zamfara (79). Meanwhile, Kogi state has recorded at least 69 cases.

The above breakdown demonstrates the evidence of the COVID-19 pandemic in Nigeria. It was confirmed on February 27, 2020 that the epidemic in the country got off to a dramatic start with the first index case from Italy by an Italian. Following the outbreak, the Nigerian government planned for policy intervention to slow the pandemic's spread (Amzat et al., 2020). The National Center for Disease Control collaborated with 22 Nigerian states to establish emergency operations centers for the management of surveillance and establish connections with the national incidence coordination centers, among other things (Ihekweazu, 2020). Government spending on non-pharmaceutical interventions (NPI) such airport monitoring, a networked effort to track down index cases, mobility restrictions, and public health measures rose in order to take more harsh measures (Muanya et al., 2020).

The response to the public health policy in the face of COVID-19 in the Southeastern states of the federation, which include Enugu, Imo, Anambra, Ebonyi, and Abia states, appears to be rather mockery of the whole process in itself, because a sizeable portion of the population subverted the measures put in place to control the spread of the disease. Others were carried away by the failures of the commencement and implementation of the PHSMs by the government agents, while some were misled by the "covidiots" who outshone the public enlightenment via social and public media by the NCDC and other local and foreign media channels. The public's response to the PHSMs to stop the spread of COVID-19 appears to be empirical indicators to the issue of public health institutions and policy measures in relation to the public acceptance of such in the Southeast region of Nigeria, which calls for research intervention. This is true even though there are drawbacks in the way that government agents approached the emergence of COVID-19 in the initiation and implementation of the PHSMs.

The goal of the current study was to comprehend and explain the underlying causes of the public's reaction to the PHSMs on the COVID-19 epidemic in Southeast Nigeria. In Nigeria, key players in the execution of public health policy, including religious leaders, managers of both public and private health institutions, security agencies, and leaders of market institutions, were interviewed for the study's qualitative methodology.

The research was directed by the ensuing inquiries:

What extent are regional public health policy stakeholders aware of and knowledgeable about the COVID-19 pandemic?

What are the fundamental causes of the local public's reaction to PHSMs related to COVID-19?

What signs point to a citizens-policy-leadership crisis in the region's COVID-19-related PHSM implementation?

What are the consequences of the citizens-policy-leadership crises in regard to the PHSMs associated with COVID-19 in the region?

2. Literature Review

The Methodology section should be written concisely, yet provide enough details to allow others to replicate and build on published results. The well-established methods can be introduced briefly with proper citations. Do not describe these published methods in details. In contrast, detailed descriptions are required for new methods. If multiple methods are adopted in the work, this section may be divided into several subsections, each providing details on a specific method. Note that the publication of your manuscript means all materials, data, codes, and protocols associated with the publication must be made available to readers. Remember to disclose restrictions on the availability of materials or information at the submission stage. If your manuscript uses large datasets deposited in an opensource database, please specify where the data have been deposited. If your study requires ethical approval, do not forget to list the authority and code of the ethical approval.

Since roughly 400 years ago, various diseases and infections have been the driving force behind numerous pandemics (Ghendon, 1994). In various socio-medical historical eras, these pandemics and the infections through which they emerged have become social identifiers. Inferentially, there are some differences in the scope, uniqueness, and clinical classification pedigree of the various pandemics over the years. Their disagreements centered mostly on the degree to which humans managed the virus or pathogen that caused the pandemic as it related to human behavior in managing pandemics (Okafor et al., 2021).

Hippocrates mentioned an outbreak that modern medical professionals now consider to be influenza in the year 412 BC in medical and philosophical writings (Youri, 1994). Even though such was presented with fewer details, it at least painted a picture of the fact that a condition dating back to 412 BC existed and fits the definition of a pandemic. This pandemic appears to have passed into history without precise documentation of the size in terms of morbidity and fatality due to the dearth of standard scientific research. There were several influenza pandemics in Europe between 1173 and 1510 that were reported after the Middle Ages (Beveridge, 1991). While the pandemic of the 16th century (1510) was acute respiratory disease, it was recognized as influenza with global magnitude. It spread from Asia through North Africa to Europe, unlike the influenza of the 12th century (1173) which was recognized as epidemic within the confines of Europe (Potter, 2001; Hecker & Babington, 1859). Morens et al. (2011) estimated that the pandemic had a 1% fatality rate. The same thing happened in 1557 when a worldwide influenza epidemic spread from Asia to the Ottoman Empire across Europe, the Americas, and Africa (Vaughan & Warren, 1921). When compared to the influenza pandemic of 1510, which children and the elderly were particularly susceptible to, Creighton (1891) claimed that the influenza was so severe across the board and even among pregnant women.

By the year 1580, a pandemic of influenza with some mortality spread from Asia Minor to Northwest Africa to Europe (Taubenberger & Morens, 2009). At least 8,000 fatalities were reported in Rome, which had a catastrophic impact on countries like Spain (Potter, 2001). Many events that were vaguely classified as pandemics and epidemics occurred between 1729 and 1747 and had some degree of consequences (Taubenberger & Morens, 2009). Finkler (1898) and Webster (1799) placed the genesis of the influenzas during this time between America and Russia, despite the fact that there are differing theories on their origin. Another influenza pandemic originated in America between 1761 and 1762, with some degree of return as an epidemic in various regions of the world around 1775. (Taubenberger & Morens, 2009). By 1780, a new influenza epidemic had spread from Southeast Asia through Russia, Europe, and ultimately the rest of the world. Although there were few fatalities, this influenza was described as being catastrophic in terms of infection rate (Morens & Fauci, 2007). Another influenza pandemic with a life expectancy of roughly 20 years occurred in 1788-1806.

An influenza pandemic came out in 1830-1833, with China thought to be the source, but it eventually affected the entire world after spreading to the Philippines, India, and America. Despite the population's attack rate being between 20 and 25 percent, the death rate was just mild (Leichtenstern, 1896; Potter, 2001). A flu pandemic known as the "Russian pandemic" spread throughout the world in just 70 days after it first appeared in Saint Petersburg in 1889-1890 due to Russia's quicker circulation rate (Valleron, 2010). The Spanish flu (H1N1) pandemic, which occurred between 1918 and 1920, had unparalleled macroeconomic effects (Shimizu, 1997; Smith et al., 1933). While the flu pandemic was thought to have originated in three places, including Haskell County, Kansas (Barry, 2004), Etaples in Northern France (Barry, 2004), and China’s inland provinces (Spinney & Rider, 2017), its spread was believed to have been aided by colonialism and World War I's movement across the globe (Snyder & Ravi, 2018).

The influenza (H2N2) pandemic of 1957, which originated in Guizhou (China) and expanded to the nearby provinces of Yunnan and Hunan, came after the Spanish flu epidemic of 1918. Despite being categorized as a category 2 Spanish flu pandemic, this outbreak’s mortality rate, which fluctuated between 1 and 4 million deaths, was less severe than that of the 1918 pandemic, which claimed the lives of over 500 million people worldwide

(Potter, 2001; Taubenberger & Morens, 2009). The 1957 influenza (H2N2) pandemic was followed by the 1968 Hong Kong flu (H3N2) pandemic, which started in Eurasia and moved over North America (Viboud et al., 2005). The H1N1 influenza virus first surfaced in 2009, causing a pandemic. It was initially identified in the Mexican state of Veracruz before fast spreading over the rest of the world. More than 18,500 people died as a result of this worldwide epidemic, which affected around 74 countries.

COVID-19 spread like a wildfire since its outbreak in December 2019. Further laboratory testing revealed the illness to be severe acute respiratory syndrome-corona virus-2 (SARS-Cov-2) (Lai et al., 2020), which shared genetic components with the earlier observed in 2003 SARS-Cov-1 and MERS-Cov Middle East Respiratory Syndrome Corona virus (MERS-Cov) (World Health Organization, 2020). Only the Spanish flu pandemic of 1918 has been found to have a faster and wider spread than COVID-19. According to John Hopkins University's current estimates, more than 17 million people worldwide are infected, while a fatality rate of 3.9% translates to more than 1 million deaths. Although there appears to be global homogeneity in data collection, there are disparities in information, particularly among developing nations like Nigeria, where the virus has killed a significant number of people and infected many more without being discovered due to a lack of equipment and the social stigma associated with the disease in the public.

The socio-medical responses to these pandemics among various communities around the world, including both pharmaceutical and non-pharmaceutical approaches, have been an important countermeasure to pandemics that have been documented. There is evidence from the available regional and country-by-country statistics that socio (human behavioral aspect)-medical (clinical aspect) approaches really affected the rate and magnitude of each of the pandemics, despite the difficulties of functional global networks, technological strength, and limited scientific progress affecting each historical epoch. While the speed and efficacy of responses to these pandemics in various historical eras were more significantly influenced by scientific and technological advancements (Arnold, 1993; Baldwin, 1999; Echenberg, 2011; Slack, 1985), the effectiveness of policy or clinical approaches adopted to mitigate the pandemics was also influenced by human behavior among various populations worldwide (Potter, 2001; Qiu et al., 2017; Frith, 2012; Snyder & Ravi, 2018). Therefore, it is necessary to transform and renovate the design and operations of public health policies.

3. Methodology

In various historical eras and socioeconomic circumstances, human behavioral interaction—or rather, tendency toward social order—has been seen from many perspectives and theoretical ideas. In addition to other theoretical approaches, ethnomethodology, as it was first described by Harold Garfinkel in 1967, portrayed human behavior towards social order as well as inter-human contact as a complex phenomenon demanding caution while being explained or interpreted in any setting. Although Garfinkel agreed with Schutz (1972) that there is no such thing as social order, he distinguished himself by focusing on socio-psychological behavior and acknowledging that social order exists in society but that it is relative to time, context, and circumstance. In essence, according to Garfinkel, the social other is a fiction created by society's members as they attempt to make sense of their day-to-day experiences (Garfinkel, 1967; Haralambose et al., 2008). This occurs when the interaction between citizens, policy, and leaders leads to a misinterpretation and improper management of social order or policy.

The goal of ethnomethodology, according to Zimmerman & Wieder (2017), is to clarify how individuals of the society approach the task of observing, characterizing, and elucidating order in the environment in which they exist. According to Garfinkel's definition of “documentary method,” people in society use it to explain and account for the social reality and give it the illusion of order (Garfinkel, 1967). In order for a policy to be properly domesticated for effectiveness, residents must be involved in its creation and implementation as well as include it in their daily lives. According to Garfinkel's interpretation of the reflexivity idea, the methods and accounting practices used to identify, characterize, and explain the social environment shape it. As a result, the documentary approach is used by its participants to construct the social environment. Additionally, based on the idea of indexicality, Garfinkel came to the conclusion that social order and human interaction are contextually relative. Garfinkel contends that any object or activity derives its sense from its context; it is indexed in a specific circumstance (Garfinkel, 1967). Following gradual public knowledge and adaption by the populace, public policy via already-existing institutions in the society organizes the human population into order. This is facilitated by appreciable citizens-policy-leaders relationship obtainable among the population.

The complexity of Garfinkel's theoretical claim can be appreciated in the emerging sociological and policy issues obtainable in the current societies across the globe, especially in the developing countries. This is true even though his earlier assertion that the mainstream sociology projected humans in society as cultural dope appeared to be in opposition to it. The social institutions based on socioeconomic principles are seen from the outside as a fictitious orderliness to depict how people behave toward ongoing social activities (Bourdieu, 1985; Hayakawa, 2017; Theofanis et al., 2020). However, those who are not privy to the socioeconomic policies' observing powers misinterpret and reapply the same wherever it is appropriate for their present needs (Garfinkel, 1988; Zimmerman & Wieder, 2017). The members of society redefine and apply caution through documentary method and

indexicality from the point of socioeconomic policy factors to the process of policy execution. What the same circumstance—or rather, circumstance through time—offered them as comprehension becomes the model for actions and decisions toward the phenomenon of interest within the system (Kilpinen, 2003; Weik, 2010).

Some members of the society may not perceive what many developing countries, including Nigeria, would consider to be lawlessness in terms of the law if they had a voice to express it. This is not because they are unaware of the law's or policy's goals or are hostile to the system of government; rather, it is because they can categorize the phenomenon and simply see the law enforcement officers or the process of policy implementation as something they can avoid to achieve their immediate goals. Even those in positions of leadership in nations like Nigeria can easily ignore the laws currently in effect, of which they are actually a part, in order to pursue an immediate agenda without following a clear protocol for defining any improvised changes to the situation. As a result, there are many instances of government officials—even Mr. President—violating the constitution he swore to uphold. As seen during the COVID-19 pandemic PHSMs, similar cases are now commonplace in Nigeria among both followers and those in positions of leadership. The followers simply follow the trajectory of their past experiences, understanding of the system as a whole, and their basic interests in opposition to the current laws and policies attainable in the public institutions, while the leaders pursue their ends in the leadership capacity with their knowledge of the system and circumstances surrounding them in the control of the public resources.

The discursive and practices elements of the ethnomethodological model received a lot of attention from post-Garfinkel ethnomethodologists based on their research and areas of interest, but the model itself still has many unexplored dimensions (Coulter, 1991; Denzin, 1971; Fox, 2006; Heritage, 1984; Livingston, 1986; Linstead, 2006; Lemert, 2002; Lynch, 2000; Livingston, 1986; Stokoe, 2006; Theofanis et al., 2020). For instance, the model offers promising potential in the policy area for underdeveloped countries. While the discursive and practice dimensions appear to provide a hint into additional interpretations and responses that people and groups may give to social phenomena like interactions and communications (Fox, 2006), the model's apparent policy dimension appears to point to the unseen interpretation and values that members of society can give to what appears to be an attainable social order. This has frequently led to a lack of discipline in public institutions, the leadership and management of public institutions disobeying the law, an unseen mass uprising against unpopular policies, and the misinterpretation of some conventional issues, all of which have negative effects on the system and its constituents. The extent of the crises in the implementation of the WHO-instigated domestic policies in Nigeria and the underlying causes among the citizens simply demonstrated Garfinkel's position via the ethnomethodology model that members of society are not cultural ignoramuses but rather use documentary method, reflexivity, and indexicality in understanding the circumstances around them.

The study was carried out in the southeast region of Nigeria, which includes five administrative states, namely, Abia, Anambra, Ebonyi, Enugu and Imo (Figure 1). These states are home to the Igbo ethnic group.

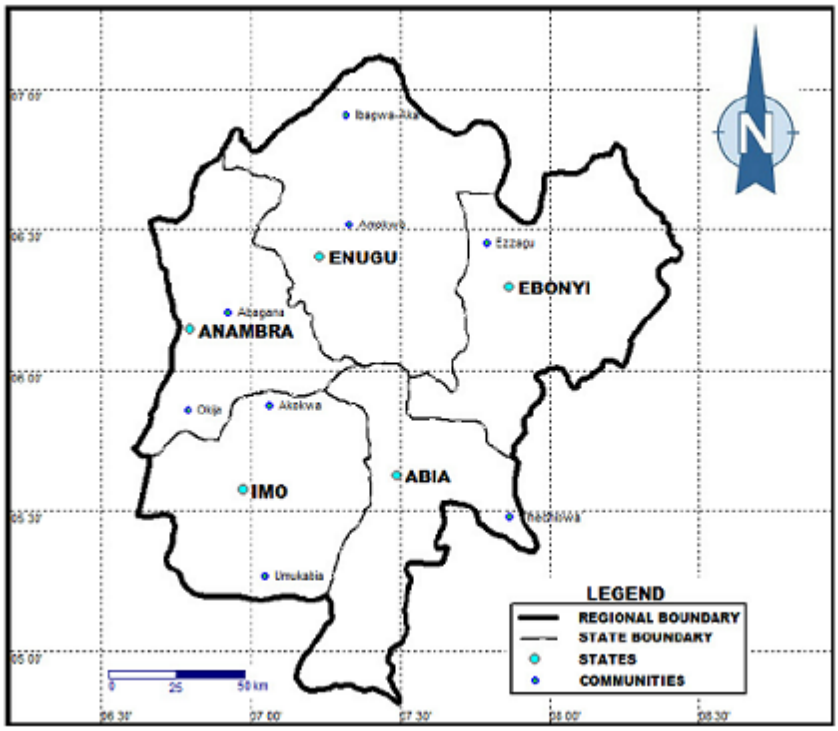

Figure 1. Map of the study area

Study units were developed for the sample in accordance with the development of local government councils and public institutional structures throughout Southeast Nigeria. This made it easier to divide the main informants and participants into groups that on the surface appeared to be quite distinct from one another. In each of the five states in the Southeast of Nigeria, the study made use of about 10% of the local governments. This equated to three local government districts from each of the five states in the region, which served as a conduit for local markets, public and private health facilities, satellite national security units (police and civil defense), and religious organizations.

In each local council, this study targets the divisional police stations, civil defense units, public health centers, two private hospitals, two orthodox churches (Roman Catholic, Anglican, Methodist, Presbyterian, or Sabbath depending on the one that is available with many worshipers), one "protestant church" that dominates the area, one mosque (if available), and three community markets (1st daily market, 4th day market and 8th day market). Every local council in the area has at least one divisional police headquarters, but the same is not true of civil defense units. Every local council has at least one public health facility run by government employees, but every local council also has at least one approved private hospital run by people or organizations. The religious institutions run on the line of orthodox, Protestants and Islamic worship centers in the region. Additionally, there are daily markets spread throughout the local villages in the region as well as 4 days markets (this sort of market holds every four days), 8 days markets (this type of market holds every eight days), and daily markets located in the region's market centers. In terms of the regional grassroots population, all of the institution outlets and participants in the study were placed strategically within the traffic lens of PHSMs implementation and assessment capacities.

Following the local council, community, religious, security, and health institution structures in the area, 60 informants and participants were purposefully chosen from among local councils in both urban and rural locations. The informants and participants were chosen based on a wide range of criteria, including their involvement in the implementation of COVID-19 PHSMs, their regular hospital duty (at least from April to July 2020 and between February and April 2021), their position as a religious leader during the period of April to July 2020, their role as a liaison between the government and the market unions, and their role in educating market patrons about COVID-19 PHSMs.

In order to find the pertinent informants and study participants, the snowball method was used. The majority of the informants were chosen through face-to-face interviews in the context of their official roles, while others were chosen through referrals (with the application of snowballing techniques). An interview was conducted over the phone with 14 informants who were chosen from local councils in the states of Abia, Ebonyi, Anambra, Enugu, and Imo. This was done to address the problem of physical distance as well as protocols linked to COVID-19. Other informants from these five states were subject to direct visitation, which was based on timetables that complied with federal and state directives pertaining to COVID-19.

Focused Group Discussions (FGDs) and in-depth interviews (IDIs) with 46 informants and participants were conducted across the five states. In order to collect data, 26 IDIs and five FGDs were organized. Leaders from the included institutions were chosen for the FGDs using the snowballing technique. However, the questions posed to the groups followed the same format as those posed to the IDI informants. All of the informants who took part in the study gave permission for the interview. Those in positions of leadership who were unavoidably unavailable on the day of the interview suggested another person in their position for the interview with careful consideration of the inclusive criteria for the study participants.

The study used a qualitative research approach, employing IDI and FGD with informants and participants from particular groups, including business executives, hospital administrators, religious leaders, and security personnel. Unstructured interviews were used to extract data from the IDI and the FGDs. Unstructured questions about knowledge of the virus, observations of its effects, perceptions of the government's response to the pandemic, and the indexicality, reflexivity, and documentary importance of these to the public health policy order among the population served as the information-eliciting tool. The interviews and responses were expanded to fit the interviewer's questions and the informants' in-depth discussions, but they were still led by their thematic interests.

In order to organize the data gathered, the study used theme analysis and interpretative phenomenological analysis (IPA). The acquired data were transcribed and evaluated in accordance with the study's thematic focus.

4. Result

The appearance and effects of COVID-19 were a multidimensional phenomenon that affected the entire world. Given the multifaceted effects of the COVID-19, the design of the research instrument and subsequent data collection centered on the phenomenon's socio-medical policy component. The sociodemographic data of the participants was not lost, but compiled in Table 1 below.

The sociodemographic data of the study participants and informants was shown in Table 1 below. The table shows that men make up the bulk of participants (65%), while women make up 35%. According to the participants' age distribution, the majority (30%) were between the ages of 44 and 49, while 20% were between the ages of 38

and 43; 16.7% were between the ages of 50 and 55; 11.7% were between the ages of 56 and above; and 13.3% and 8.3%, respectively, were between the ages of 26 and 31 and 32 and 37.The distribution of participants' educational backgrounds reveals that the majority of participants (50%) were in possession of a Higher National Diploma and a first-degree certification, while 21.7% had certifications at the master's degree and above, 18.3% had a national certificate in education and a diploma, and 10% had only elementary or secondary education. According to the participant's occupational distribution, 30% were employed by a health services institution, 25% were artisans and traders, another 25% were employed by a religious organization, and 20% were employed by a security organization.

Table 1. Socio-demographic information of the informants/participants

Socio-demographic Variables		N	Percentage (%)
Gender	Male	39	65%
	Female	21	35%
Age	26-31	8	13.3%
	32-37	5	8.3%
	38-43	12	20%
	44-49	18	30%
	50-55	10	16.7%
	56 and above	7	11.7%
Education	Primary/High School	6	10%
	NCE/Diploma	11	18.3%
	HND/Degree	30	50%
	MSC and above	13	21.7%
Occupation	State security	12	20%
	Artisan/Trader	15	25%
	Health workers	18	30%
	Religious leaders	15	25%
Total		60	100%

Source: Compiled from the field work of this study

The following themes were constructed for systematic analysis and discussion in accordance with the study's purpose, research questions, data collection tool, and collected data: Local knowledge deficit and false information; A knowledge and policy gap in public health; mistrust and misconception of the goal of public health policy; Citizens-Policy-Leadership crises; and abuse of PHSMs.

5. Local Knowledge Deficit and False Information

People have a lot to say about COVID-19, but the condition has not been fully understood in this part of the world, for the lack of understanding about how it works. We are also closer to those who spread false information for partisan or other purposes that are best known to them. And based on observation, the stories being told about the sickness are largely incorrect, despite the fact that many individuals buy into them. It is ludicrous to spread the myth that a disease that was killing people all over the world is a Whiteman's disease when it was impacting practically everyone, even though some people lacked clinical awareness about the illness (IDI: A local market leader).

The local population's understanding of COVID-19 looked to be limited and clouded with false information. Misinformation, which takes the form of subjective and incorrect definitions of verifiable issues in contrast to the objective realities and understanding of the phenomenon in question, is just as dangerous as ignorance toward empirically verifiable phenomena. This is especially true among the uninformed community. The majority of people in the area seemed to be unaware of the details of the PHSMs invoked during the first and second waves of the global COVID-19 crisis regarding the COVID-19 phenomenon in Southeast Nigeria during the application of NPIs like PHSMs. Although the people lacked a more definite clinical interpretation of the virus and its operational structures and dimensions, their lack of knowledge made them more susceptible to those who spread rumors at the time. As storytellers finally seized the stage through social media to distort the notion and realities of the virus in the consciousness of a sizable segment of the population, this eventually provided space for disinformation among the populace.

Southeast Nigeria was dominated by local misinformation agents who were peddling unfounded narratives capable of subverting the realities of the COVID-19 pandemic as well as countering the purpose of the PHSMs introduced during the first and second waves of the virus. This was due to the lack of access to information from the verifiable local and international media outlets as well as the dominance of self-proclaimed experts on global pandemic and the likes.

Even though the bulk of survey participants (52.6%) lacked access to internationally recognized media sources, only a negligible portion (17.4%) received updates on the evolving circumstances surrounding the COVID-19 pandemic during these times. A significant portion of the population appeared to have adopted individual narratives about COVID-19 as a result of conflicting and difficult-to-verify information between the social media champions and the government, according to some underlying indicators in the data collected during the study; this can be inferred from the interview data below.

People got discouraged from listening to news about COVID-19 especially in view of the conflicting information from the public media and the social media. However, there are indications that the sickness was formed in the lab to destroy the blacks, but things worked contrary against the conspirators. It is a disease that was announced and followed up but cannot be substantiated as far as this place is concerned (IDI: A religious leader from one of the churches involved the study).

COVID-19, a pandemic that has been declared worldwide, emerged in the Southeast region of Nigeria, but the local population mistook the PHSMs as merely an announcement and COVID-19 as a disease that is only found in white people (Europeans, Americans, and Asians). The availability of information communication technology for updates on the incidence of COVID-19 during the period can attest to the region's population's apparent blame for their ignorance of global realities, but the Nigerian government as a whole seemed to have made things difficult for the populace. The government of Nigeria was expected to carry out a serious responsibility during the season, which was to provide the international community with an update on the local situation. While the global community can be accessed in terms of information via globally designated media outlets, not all people have access to them. However, the manner in which this problem was handled merely demonstrated some degree of official betrayal. According to key word indicators from the findings, numerous interviewees and participants continually called attention to the government's fabrications, which led many individuals to assume that the COVID-19 controversy was a hoax and political ploy to further other agendas.

There was no reliable information on the family or the specific person, despite the fact that they had raised the alarm that someone had tested positive for the COVID-19 in a certain community. When people checked to see if the family of the afflicted person bore the name, which was purported to be kept private from the public, it turned out that no family bore the name (IDI: A religious leader from one of the churches involved in the study).

While many people perceived COVID-19 as a global issue because of its prevalence and consistent news coverage, the Nigerian government's handling of the situation merely painted it as a domestic and global government conspiracy. This was a reflection of how the government handled the updates and the management of the reported cases, including the social stigmatization of the process and the opportunity to plunder the public coffers through the clumsy pandemic relief and palliatives program. More crucially, the majority of the population was kept at a distance from the objective facts in order to follow their own experiential interpretations and categorizations, which is referred to in ethnomethodological terminology as documentation, indexicality, and reflexivity. The global popular discussion on COVID-19, which focused on the collective measures to tackle the epidemic, eventually became corrupted among the local people owing to misinformation because of the community's limited understanding of the disease and their lack of public enlightenment.

6. A Knowledge and Policy Gap in Public Health

People were perplexed by the government's COVID-19 proclamation since it was not apparent whether it was directed at a certain religious sect or whether a disease outbreak had truly occurred. Because the lockdown (limited mobility) and public harassment were more conspicuous than the crucial coordinated efforts to combat the sickness, people are unable to confidently or comfortably explain how the virus acts or spreads. We were able to convince the church members to follow government regulations on the subject out of concern for safety, despite the fact that the majority of worshipers absolutely avoided using the wash-hand buckets during church services. (FGD: A pastor from one of the participating local churches).

Although the world society was unprepared for the COVID-19 pandemic, its presence in the definition of viruses and pandemics is relatively comparable to that of other viruses in epidemiological documentations and repository. Its origin and operation, which are rather unusual, required expertise of public health to protect the populace from the virus's plague. Inferentially, well-coordinated public education was sufficient to mobilize the masses to make a concerted effort to stop the virus from spreading across the population. The way the virus problem was handled by the federal and state levels of government, however, overshadowed the need for public health knowledge and adaptation into the PHSMs designed and implemented to stop the spread of the disease in Southeast Nigeria due to the gap in public health knowledge, which is peculiar to the population in this region of the world.

Although the epidemic itself was the focus of public media during the first and second waves, there appeared to be a disconnect between the message delivered by the accredited news organizations and how the public responded to the messaging. This was understandable in light of the knowledge gap in public health and the poor policy communication between the public and the government, which appears to be the primary issue causing other crises at the height of the pandemic. These manifested in the government's misreading, misinformation, and disregard

for the PHSMs at the height of the pandemic. The lack of knowledge regarding the phenomena of COVID-19 occasionally leads to some degree of uncertainty. While some people misinterpreted the facts in the public media, most people lost interest in the investigation of the COVID-19 epidemic due to a lack of understanding of medical language and the socio-medical realities of the disease. Because of this, the illness was often simply referred to as “waterproof sickness” whereas in other places it was called "white man sickness." People in the population had varying understandings of the virus (COVID-19), which ultimately affected how they reacted to the PHSMs proposed to stop the pandemic from spreading.

7. Mistrust and Misconception of the Goal of Public Health Policy

Although the government's actions to control the disease's spread were correct and necessary, they lacked discipline in their execution. A few institutions and groups stood out as the least capable candidates to be utilized as a test case for the lockdown, e.g., when it was implemented negatively. Although there was no COVID-19 around us, the government's treatment of local markets in particular gave the impression that they were polluted. The fact that the same government that shut down the local markets eventually devised a new method of extorting the struggling vendors by establishing partitions around these markets and charging the vendors exorbitant prices for the privilege of conducting business during the height of the COVID-19 pandemic is extremely concerning (FGD: One of the leaders of the local markets).

The paradigm of public health order and the option of policy adaptation among the populace changed as a result of the spread of COVID-19 on a global scale, which Nigeria as a nation started observing by February 2020. As a result, government and the populace entered into another dimension of policy making and policy implementation experience. Prior to COVID-19, public health regulation in Nigeria appeared to be passive, with little to no explanation to the general public. However, COVID-19 significantly transformed that posture, resulting in unusual consciousness among the general public and the government. This was not unrelated to the repercussions of any and all policies implemented in response to the establishment of COVID-19 in terms of religion, politics, economics, and other sociocultural aspects. Every action taken, whether by the international community or the local government in this region of the world, elicited some sort of response from various social groupings. While some people responded from a religious perspective, others responded based on how it affected them, such as financial losses, professional obstacles, or violations of human rights. However, the PHSM to contain COVID-19 experienced a colossal failure due to in-depth interpretations of the issue as a result of the many contextual experiences, indexing of inconsistency, and perceived persecution by the government.

Due to the public's perception of the government's hypocrisy and the population's economic struggles during the height of the COVID-19 first and second waves, the PHSMs implemented were misunderstood. Following the already elevated inflation and poverty among the people before to the advent of COVID-19, the obstacles were seen by the population as being more serious than the virus's plague. This is depicted in the excerpt that follows.

When the corona virus actually infected someone, it actually caused more severe crises than the actual plague of the disease. Corona virus prevalence down here has caused poverty and hunger to spread their tendrils among the populace. Markets have been shut down and business networks have been hindered during this shutdown. The consumers of these primarily food commodities were prohibited from leaving their own states and localities, while local producers were unable to access the majority of the key markets. And the lockdown just served as a means of profit for the security personnel in charge of it as well as the newly established smugglers (FGD: One of the leaders of the local markets in the region).

The measures (lockdown) that the Nigerian government implemented were seen from a variety of angles as having varying degrees of mistrust and misalignment with their intended goals. Although the general public was skeptical of the measures, their attitude toward the measures ultimately resulted in the misdirection of the policy's main objective. For instance, outside of Lagos, Ekiti, Abuja, and Ondo states, there was essentially no incidence of COVID-19 infection prior to the shutdown. However, due to a lack of knowledge and emphasis given to the PHSMs' goals during the lockdown, the virus spread across the country via breached international and local borders. Due to the social stigma already associated with the illness, infected politicians disobeyed the screening order by seeking private treatment in secret locations. However, the virus spread rapidly among Islamic beggars (Almajiris) in the Northern axis, and the government's plan to relocate many of these Almajiris to the South ultimately served as the vehicle for the virus' spread throughout the nation. More importantly, the government's apparent hypocrisy in the situation led the general populace to perceive the whole thing as phony and undeserving of their assistance.

The government's PHSMs were not in dispute; rather, the issue was how the government was acting toward the measures. It was absurd for a government to declare a state of emergency throughout the federation while also promoting the mass migration of Almajiris from Northern Nigeria and neighboring countries down to Southern Nigeria under the pretense that they were seeking greener pastures; weren't they susceptible to the disease or even bringing it with them? (IDI: One of the regional research participants' heads of a health facility).

From the critical perspective of ethnomethodology indexicality and reflexivity, it can be seen that the citizens' interpretations of the entire process revealed the region's isolated knowledge and responses to the public health

order. While the religious leaders saw the government's approach to health order as a conflict between the religious institution and the government, the poor masses, particularly the local traders who make up the majority of the population in the region, saw the government violating their basic human rights and taking away their source of income. This ultimately resulted in a series of events that hindered the public health order. As an illustration, the way that religious leaders perceived the issue finally won over the followers who mostly obeyed them rather than the government. The misconception of the PHSMs put in place spread from the religious institutions to the neighborhood market and, eventually, to the majority of people on the street.

8. Citizens-Policy-Leadership Crises

Maintaining the lockdown procedures while traveling was more difficult than any other task the security agency has undertaken because of how tough it can be to control desperate drivers and passengers. During the COVID-19 lockdown, the majority of checkpoints observed the movement of currency (money) from the poor drivers and passengers who were in urgent need of a way to get through the cities and states. More importantly, many drivers, working with the passengers, flagrantly disregarded the mild measures implemented to reduce the stress, such as transporting a moderate number of people to preserve social distance in the vehicles (IDI: One of the security operatives involved in the study).

There are signs that the overarching objectives of the Nigerian (Southeastern Nigeria) government's efforts to stop the COVID-19 pandemic's first and second waves of propagation may have been misunderstood. They were all inappropriate in theory and in practice, including social isolation, respiratory hygiene, sanitary precautions, and movement restrictions. In particular, each of the actions follows specific guiding principles that make them efficient in reducing the spread of the illness. Even if there are some signs that the measures were implemented haphazardly, these actions were changed. First, it was advised that people maintain some distance from one another at social gatherings and the like, whether or not someone is harboring the virus, for the safety of those who have not yet contracted the disease. Some people in the community transformed this legislation into something to be laughed at. People were ordered to sit or stand apart from one another in places including churches, markets, hospitals, and public transportation, but this was only done temporarily when it appeared that some task force members might be present. Some drivers, for example, transport more passengers than specified and bribe security personnel at various checkpoints. The passengers are only concerned with passing through the checkpoints without incident for their various businesses. Where the checkpoint appears to be difficult, passengers and drivers worked together to appeal to security personnel. A similar situation could be found in markets, churches, and other social gatherings.

The security taskforce clashed with some religious leaders, resulting in the arrest and punishment of some church leaders for insincerity in enforcing the social distance order. The security taskforce discovered that some religious communities were unable to maintain social distance unless the government taskforce arrived (security agents). Some churches hold worship services as early as 4 a.m. and close by 6 a.m. (IDI: One of the security operatives involved in the study).

There are indices of citizens-policy-leaders crises resulting from the indexing and documentary of citizens' everyday activities and experiences in the face of COVID-19 crises. While the Covid-19 lockdown became an opportunity for the security agents to make extra money from the poor passengers and drivers, the drivers and passengers simply interpret their interactions with the security agents as a way of avoiding what has been interpreted as punishment from the government, thus making meaning of the overall public and social health measures in their own contexts. The issue of COVID-19 and public health measures was contextualized, indexed, and documented from religious institutions to the general public, and it eventually became reflexive to the majority of the population obstructing, the implied essence of the PHSMs among the population.

9. Abuse of PHSMs

From the international community (the World Health Organization) to the Nigerian government (from the federal to state governments), all the procedures put in place to prevent the spread of COVID-19 were in order and adhered to their scientific and logical core. However, as this study found, the government agents who put these safeguards into place merely turned them against the local populace. During this time, government agents as well as other privileged individuals utilized each of these measures against the local population. For instance, when it was decreed that there should be no interstate or, later, intercity mobility, security personnel all around the country took advantage of this profitable opportunity. Drivers must pay anywhere from 500 (about $1.50) to 35,000 (about $87.50) at different checkpoints in order to travel through the checkpoints legally or illegally. When individuals or groups of drivers paid the state-recommended fees in this situation, it was legal; however, when security agents paid the costs after coordinating with the drivers to violate the movement restriction order, it was criminal. When drivers and transportation businesses are required to pay a set amount of money to cross interstate and city borders,

they shift the burden to the poor masses using their services. A distance that used to take approximately 500 as a transportation fare jumped to about 1,500.

Social isolation and respiratory hygiene implementation both led to several crises that had a negative impact on the populace. The deployment of the COVID-19 pandemic control measures was seen by many medical professionals as a means of punishing unknowing people. If it was thought that a patient's condition might have symptoms in common with COVID-19, some patients were denied care. Numerous hospitals have flat-out turned away people upon arrival without even checking their COVID-19 status. Even though the majority of these facilities lacked the COVID-19 administrative and technical norms, they were unable to adequately handle patient cases due to the social stigma that had already been established. Many hospitals simply turned away problematic cases at the door since testing kits were not available, and they suspended some services, such advanced diagnosis for specific illnesses, until the limitations on the COVID-19 epidemic were loosened.

The poor traders and residents of the region were punished by the movement restrictions, social isolation, and respiratory hygiene. While the government quickly planned through its extortion agents to force the traders to come to a makeshift shop outside the market centers, to sell in order to maintain the so-called social distance, local security agents were collecting money from the small traders in some market places before they could sell their goods under the lockdown. The traders were instructed to buy and sell at the emergency makeshift parts set up by the local government management for the selling of “critical products” while the main market centers were ostensibly closed. The traders were forced to do this by either paying up to 2,500 (approximately $6.25) per day or staying at home until the lockdown ended. No one thought to organize and run the temporary stores with the lockdown (COVID-19 pandemic and the PHSMs) in mind during any of these processes. Any driver or passenger travelling without a nasal mask was subject to penalties in several states and towns. As a result, the defaulters paid the police and other security personnel 1,000 (about $2.50). Most often, security personnel on the road began to cause car accidents as some drivers were being sought after because it was a lucrative business for them.

10. Conclusions

When considering the variety of approaches accessible to fight any disease, the socio-medical aspect of a disease appears to have more significant components (Fisher et al., 2013; Cooke & French, 2008). This is one of the variables that has historically enabled the management of illnesses with a history of pandemics because it is anchored on policy and human behavioral responses (Spinney & Rider, 2017). Knowledge of the disease among the population, policy strategies, and public reaction to the policy strategies among the population in question are all included in the socio-medical dimension of pandemic management (Okafor et al., 2021). As one of the diseases that have ever affected humans, COVID-19 has a socio-medical component that was more crucial in the early stages of the outbreak for the efficient management of the virus's propagation. However, as this study found, the government and the governed in Southeast Nigeria appeared to have compromised this crucial part of the disease control of the viral transmission. This is explained by the ethnomethodology model’s components, such as indexicality, documentation, and population-wide reflexivity, as this study has documented.

One of the effective tactics for mobilizing the populace to stop the development of the disease in issue is spreading awareness of an epidemic of the disease. And if this goal is not met, a mistake has been made, particularly in cases of pandemic diseases. The difficulty of controlling the issue becomes more difficult when the knowledge of the condition in question is susceptible to fragmented and isolated interpretation by the individuals and groups within the system outside of the usual definitional framework. The government and local media appear to have handled the problem of disease awareness poorly in the case of COVID-19 in Southeast Nigeria. Even while there were signs that the incident had been reported in the local media, the result as it was seen by the general public simply showed a population that was uninformed. In reality, the pandemic gained popularity in a fairly counterintuitive way, with the therapeutic implications of the epidemic being perceived as more of a class and racial issue than a universal human one. This was demonstrated by the names that the ailment was given among the populace, such white man disease, waterproof sickness, oria-bigman, and so on. This highlighted the problems facing citizens, policymakers, and the general public in regard to their day-to-day experiences as they noted and considered the social phenomena they had encountered (Fox, 2006; Linstead, 2006; Theofanis et al., 2020). For instance, when the COVID-19 situation and phenomenon were isolated and interpreted differently by different people and groups, such as religious organizations, security personnel, market vendors, and healthcare professionals, what appeared to be social order in the handling of the outbreak was merely downplayed in favor of the commonplace experiences of the society's constituents.

The process of treating the socio-medical component of any disease epidemic through PHSMs can be quite complicated, particularly in emergency situations, where using only a clinical approach may be next to impossible. This is complicated because of the anticipated concepts and steps that would need to be taken to make it happen, given how little people in the current population know about the disease. Given the plausibility of the chosen measures and their implementation, complexity pertains to those who create and carry out policies, but it also has an impact on the citizens who receive and incorporate policy measures into their daily lives.

When it came to the COVID-19 outbreak in Nigeria, the PHSMs appeared to follow the lead of worldwide knowledge centers like the World Health Organization and the American Center for Disease Control. Although the policies were created in theory, they failed in practice as a result of the approaches' incompatibility with the social environment and compromise on the part of government institution representatives. This was because the principles and procedures for implementing such policies encountered a resistant environment. Politicians and government officials who should have exemplified the application of controls against the spread of COVID-19 disregarded almost all of the precautions put in place.

The lockdown and other precautions against COVID-19 also seemed to be a punishment for the underprivileged masses, as the political class looked to be spared from the limitations on movement, as they were seen traveling freely throughout states and even entire regions with their entourages. Politicians have occasionally held events that are vaguely political and draw large crowds of people all at once. The context of an ethnomethodological explanation indicates to the predominant situation within the population. The COVID-19 season was simply one of those times when government can statutorily dish out policy measures for the vulnerable population without such applying to the political class, despite the fact that those in control of the system have historically seen the policy process as little more than paper work.

In light of their daily documentation of society in this region, the people, who appear to have become accustomed to viewing policy measures as little more than paper labor, perceived the PHSMs as a form of punishment. This caused them to act in a like manner, looking for a method to get past wherever it affected them by working with the corrupt government agents to undermine the fundamental principles of the measures. The members of society have the choice to reinterpret the world around them in response to the order of public policy. The divide and lack of confidence between the general public and the system's policy makers made the reinterpretation much worse, leading to crises between citizens, policymakers, and leaders. Where there was a gap, misinformation agents had a chance to exploit it, but when there was suspicion, there was potential for reinterpretation, which ethnomethodology encapsulated in the ideas of documentation, indexicality, and reflexivity.

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Data Availability

The data type supporting our research results are included within the article or supplementary material.

Conflicts of Interest

The authors declare no conflict of interest.

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