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Research Article

Healthcare Services Provision, Mobilisation and Delivery During Covid-19 in Ido Local Government Area of Oyo State, Nigeria

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About Article

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ABSTRACT

The global outbreak of COVID-19 has shown vulnerabilities in healthcare systems around the globe, emphasising the necessity for healthcare delivery that is both adaptable and prompt in its response. The epidemic has exacerbated the existing issues faced by Nigeria's healthcare sector. This study, therefore, explored healthcare services provision, mobilisation, and delivery during COVID-19 pandemic in Ido Local Government Area of Oyo State, Nigeria. The study was anchored on the Healthcare Access Theory and Delivery System Theory. The study utilised a descriptive survey research approach, while the purposive sampling technique was employed to select one-hundred and sixty participants. The quantitative research instrument tagged 'Healthcare Resources Provision, Mobilisation and Delivery during Covid-19 (HRPMD-Covid-19)' was used to obtain information from the participants. The empirical findings indicated that during the COVID-19 pandemic, healthcare services were not prioritized, with resources being redirected towards addressing the situation. Non-health personnel and non-governmental organizations provided healthcare services, but the government's allocation was inadequate. Obstacles faced included insufficient financial resources, limited personnel management capacity, inadequate supervision, lack of community involvement, and low awareness of available services. Strategies to enhance healthcare resources included implementing participatory approaches, regular training programs, monitoring, financial resources, public campaigns, evaluations, modern technology, and mobilising human resources.

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1. INTRODUCTION

The healthcare landscape worldwide exhibits substantial differences in the supply of healthcare services, with low- and middle-income nations encountering several obstacles in obtaining high-quality healthcare (WHO, 2020). According to the World Health Organisation (WHO), almost 400 million individuals globally do not have access to vital healthcare services, with the majority of them living in poor nations (WHO, 2019). The healthcare system in Nigeria encounters substantial obstacles such as insufficient finance, substandard facilities, and a scarcity of proficient healthcare practitioners (Abdulraheem *et al.*, 2020; Ojo & Chukwudeh, 2016).

Nigeria's healthcare system is exacerbated by a significant prevalence of infectious illnesses, including malaria, HIV/AIDS, and TB. This adds strain to an already overwhelmed healthcare system (NACA, 2020). The National Health Insurance Scheme (NHIS) was founded in 2005 with the aim of enhancing healthcare accessibility. However, the number of people registered in the scheme remains low, with just around 5% of the population being covered (NHIS, 2020). Recent research has emphasised the necessity of implementing changes to tackle the fundamental obstacles that Nigeria's healthcare system is now experiencing. These changes should focus on enhancing healthcare finance, infrastructure, and human resources (Erwat *et al.*, 2012; Oleribe *et al.*, 2019; Okoro & Ojo, 2018).

The global outbreak of COVID-19 has shown vulnerabilities in healthcare systems around the globe, underscoring the importance of robust and adaptable healthcare services (WHO, 2020). On a global scale, healthcare systems have encountered substantial obstacles in addressing the pandemic, such as insufficient healthcare infrastructure, a scarcity of healthcare personnel, and restricted availability of healthcare services (OECD, 2020). The attitude of Nigerian citizens especially the rural dwellers towards some of the Covid 19's preventive measures was not positive (Omoriegbe *et al.*, 2020; Chukwudeh & Ojo, 2018). This has further increased the negative impacts of this pandemic on the citizens.

The COVID-19 epidemic in Nigeria has exacerbated the strain on an already overwhelmed healthcare system, presenting considerable difficulties in the supply, mobilisation, and delivery of healthcare services (Abdulraheem *et al.*, 2020). The healthcare system of the country is confronted with substantial financial limitations, insufficient infrastructure, and a scarcity of proficient healthcare practitioners (Babayemi & Isah, 2009; Oleribe *et al.*, 2019; Akinyooye & Adesokan, 2021). The Nigerian government has enacted a range of steps to address the epidemic, such as imposing lockdowns, implementing travel restrictions, and establishing isolation facilities (FGN, 2020). Nevertheless, the implementation of these strategies has proven to be difficult due to the scarcity of resources, insufficient healthcare infrastructure, and suboptimal healthcare seeking behaviour among the Nigerian population (Kuti *et al.*, 2020; Akinyooye & Osamika, 2022).

The mobilisation of healthcare services has been crucial in addressing the epidemic, with several players, such as the government, private sector, and civil society organisations, playing significant roles (WHO, 2020). In Nigeria, the mobilisation of healthcare services has been difficult due

to a scarcity of resources, insufficient infrastructure, and inadequate coordination among stakeholders (Abdulraheem *et al.*, 2020). The pandemic has had a substantial effect on the delivery of healthcare services, leading to a situation where many healthcare institutions are unable to cope with the sharp increase of COVID-19 cases (OECD, 2020). In Nigeria, the provision of healthcare services has faced difficulties as a result of limited finances, insufficient infrastructure, and a scarcity of competent healthcare workers (Oleribe *et al.*, 2019).

Telemedicine has become an essential part of delivering healthcare services during the pandemic. It allows for distant consultations and helps reduce the danger of transmission (WHO, 2020). Telemedicine has been used by several healthcare practitioners in Nigeria, but its implementation has been restricted due to insufficient infrastructure and limited availability of digital technology (Kuti *et al.*, 2020). The COVID-19 epidemic has brought attention to major obstacles in the supply, organisation, and distribution of healthcare services in Nigeria, underscoring the necessity for changes to tackle these obstacles and establish a robust healthcare system (Abdulraheem *et al.*, 2020).

Multiple factors have contributed to the difficulties in providing, organising, and delivering healthcare services during the COVID-19 pandemic in Nigeria. The factors contributing to the problem are a lack of sufficient healthcare infrastructure, a scarcity of competent healthcare personnel, and restricted availability of healthcare services (Abdulraheem *et al.*, 2020). In addition, the lack of sufficient funding for healthcare, ineffective management of the supply chain, and insufficient utilisation of digital technologies have impeded the provision and mobilisation of healthcare services (Oleribe *et al.*, 2019; Aransi, 2019). Moreover, the pandemic has shown vulnerabilities in Nigeria's healthcare system, such as insufficient readiness and responsiveness to emergencies, as well as ineffective collaboration among stakeholders (Kuti *et al.*, 2020). Additional issues contributing to the difficulties in providing, organising, and delivering healthcare services during the COVID-19 pandemic in Nigeria encompass insufficient risk communication, subpar healthcare seeking behaviour among Nigerians, and low community involvement (WHO, 2020). Furthermore, the pandemic has emphasised the necessity for enhanced healthcare governance, leadership, and management in Nigeria (OECD, 2020). It is crucial to tackle these aspects in order to enhance Nigeria's healthcare system and enhance the supply, mobilisation, and delivery of healthcare services during COVID-19 and any future health emergencies.

1.1. Statement of the problem

Communities nationwide including Oyo State are currently grappling with a multitude of challenges such as widespread insecurity, political instability, ethno-religious conflicts, ecological issues, economic stagnation, poverty, low literacy rates, severe water scarcity, inadequate sanitation, and above all the outbreaks of pandemic diseases. Regarding health, Nigeria has consistently failed to meet the promised spending target of 15 percent of the yearly budget for the health sector as outlined in the Abuja declaration document. Furthermore, the World Health Organisation (WHO) has disclosed that Nigeria is



rated 187th out of 191 nations in terms of health care delivery. Additionally, over 700 health facilities in the country have been destroyed which accounts for more than one-third of the total. Moreover, around 3.7 million individuals in Nigeria require health support. In addition, the 2015 World Bank worldwide Monitoring Report recognised that poverty rates remain elevated on a worldwide scale with a specific concentration in emerging countries such as Nigeria. Approximately 900 million individuals worldwide are living in extreme poverty which is being defined as having an income below the poverty line of 1.90 US Dollars per day in 2015. Furthermore, when considering factors beyond wealth, a staggering 1.6 billion individuals are classified as impoverished based on their limited access to social services and lack of security. This issue is particularly prevalent in nations located in Sub-Saharan Africa. It is against this background that the study is designed to examine healthcare service provision, mobilisation and delivery during covid-19 in Ido Local Government Area of Oyo State, Nigeria.

1.2. Objectives of the study

The study's broad objective is to examine healthcare service provision, mobilization and delivery during covid-19 in Ido Local Government Area of Oyo State, Nigeria. While specific objectives are to;

- i. examine the extent of healthcare services provision during covid-19 in Ido Local Government, Oyo State, Nigeria;
- ii. examine the extent at which healthcare services were mobilized during covid-19 in Ido Local Government, Oyo State, Nigeria;
- iii. identify the hindrances towards delivery of healthcare services during covid-19 within Ido Local Government, Oyo State, Nigeria; and
- iv. suggest the effective strategies towards actualization of healthcare services during covid-19 within the location under consideration?

1.3. Research questions

The following research questions are enumerated to guide the study.

- i. What is the extent of healthcare services provided during covid-19 in Ido Local Government, Oyo State, Nigeria?
- ii. To what extent was healthcare services mobilized during covid-19 in Ido Local Government, Oyo State, Nigeria?
- iii. In what ways were healthcare services delivery affected during covid-19 in Ido Local Government?
- iv. What are the effective strategies towards actualization of healthcare resources during covid-19 within the location under consideration?

1.4. Theoretical framework

This study is anchored on the Healthcare Access Theory and Delivery System Theory.

1.5. Healthcare access theory

This theory is propounded by Andersen in (1973). This theory asserts that the availability of healthcare plays a crucial role in determining health outcomes and is impacted by four primary components: predisposing, enabling, need, and

healthcare system factors. Various factors, such as age, gender, and social standing, affect an individual's inclination to seek healthcare. Enabling variables such as income, insurance, and transportation can either promote or impede access to healthcare. Factors such as an individual's health state and symptoms dictate the necessity for healthcare. Healthcare system elements, such as the presence, ease of access, and level of acceptance, directly impact the delivery and utilisation of healthcare services. According to the notion, the best access to healthcare happens when these elements come together to allow patients to obtain suitable and prompt healthcare.

This Theory is commonly used to analyse the factors that hinder or enable individuals to obtain healthcare services. An example of this is research conducted by Levesque *et al.* (2013) which utilised the theory to investigate the availability of basic healthcare services in Canada. The study emphasised the significance of enabling variables, such as health insurance and transportation in allowing access to these services. In a similar vein, Saurman *et al.* (2016) conducted a study that applied the theory to examine the availability of healthcare services for marginalised communities in the United States. The study highlighted the need of addressing underlying variables such as socioeconomic determinants of health that contribute to this issue. The idea has also been utilised in the context of healthcare service delivery in low- and middle-income nations. For instance, Kruk *et al.* (2018) conducted a study that utilised the theory to analyse the accessibility of maternal healthcare services in Tanzania. The study emphasised the significance of healthcare system elements, such as the presence and standard of care, in enabling access. In a separate investigation conducted by Odogwu *et al.* (2020), the theory was employed to examine the accessibility of healthcare services for elderly individuals in Nigeria.

1.6. The delivery system theory

The Delivery System Theory was formulated by Shortell and Kaluzny in 2006. This theory suggests that efficient healthcare delivery systems demonstrate specific fundamental principles, such as systemness, integration, continuity, and coordination. Systemness is a measure of the level of organisation and unity among healthcare services. Integration involves the harmonisation of services across many levels and environments. Continuity guarantees uninterrupted provision of care across a period, whereas coordination oversees and guides the delivery of care. In addition, the idea highlights the significance of alignment, responsibility, and adaptive learning. Alignment guarantees consistency across system components, while accountability fosters ownership for results. Adaptive learning allows systems to adjust and enhance their performance as the environment changes. These principles together provide excellent, patient-focused care and achieve the best healthcare results.

The use of the Delivery System Theory in healthcare service providing aims to enhance quality, efficiency, and effectiveness. For example, a study conducted by Hung *et al.* (2019) utilised the theory to investigate the influence of integrated delivery systems on the quality and cost of healthcare in Taiwan. The research discovered that integrated delivery systems were linked



to superior healthcare quality and reduced costs, emphasising the significance of systemness and integration in delivering healthcare (Hung *et al.*, 2019). Rivers *et al.* (2020) conducted a study that utilised the Delivery System Theory to examine how coordinated care models in the United States might effectively reduce hospital readmissions. The research discovered that healthcare models that focused on continuity and coordination of care were linked to reduced rates of hospital readmissions, underscoring the significance of these principles in enhancing healthcare outcomes (Rivers *et al.*, 2020).

2. LITERATURE REVIEW

2.1. Health care provision

Health care provision includes all services dealing with the diagnosis and treatments of disease, or the promotion, maintenance and restoration of health including personal and non-personal health services (WHO, 2016). While provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions (WHO, 2016). Generally, the goal of health care provision is to improve health outcomes in the population and to respond to people's expectations, while reducing inequalities in both health and responsiveness (Adams, 2012). As an example, in the provision of health services in Malaysia, there are nine essential functions of public health which cover six core areas of activities: promoting health and equitable health gain, health protection, combating threats to public health, injury prevention, and disease control and food safety, with the aims to reduce disease prevalence and health inequalities of the population in the country (WHO, 2012).

Health care service is one of the crucial aspects of health care provision. As mentioned earlier, the ultimate aim is to improve health outcomes and reduce health inequalities (Adams, 2012). There are many inequity issues surrounding the health care services all over the world. This includes health care inequities between urban and rural areas which results from various factors that challenge the health services deliveries.

2.2. Health care mobilization

The health for all movement based on primary health care as the main vehicle of delivery stresses the principles of equity, intersectoral coordination, appropriate technology, political commitment and community involvement, which is at the heart of the health for all movement. Community mobilization concerns the "all" of health for all; in other words, health for all can only be achieved by involving everyone. Indeed, it is sometimes claimed that the outstanding evolution in the thinking as promoted by health for all was the notion of community involvement as the outcome of community mobilization and organization (Emuakpor, 2010).

The components of community mobilization are determined by the national and local social, political and economic circumstances, and by the expectations, needs and abilities prevailing in the locality. It is essential to see the components as a continuum of community organization, mobilization and involvement. Community organization is about creating self-awareness as an active entity. Although communities have implicit systems which have always existed and survived,

from the point of view of health services at least, a community should have a representative body to liaise and communicate with. This will give the community an explicit and functional structure. Community mobilization is more than simply motivation to participate in a particular health activity. Its components relate to the process that allows the creativity of the community to influence health care delivery, through its physical, social, economic, and spiritual potential. This has tremendous effect on health systems and therefore it is clear that with such potential the community should be involved in all aspects of health care (Abosede & Sholeye, 2014).

2.3. Health care delivery

Staying healthy is an important part of everyone's life, since good health determines how productive a person can be and how much they can participate in daily activities. People with good health are free from disease, and their bodies function efficiently. People need guidance in how to stay healthy. Scientists and medical professionals conduct research and develop guidelines to help people manage their health. A health care delivery system is an organization that provides resources and treatments that help people when they are sick or injured, and helps them stay healthy through preventive care. A health care delivery system definition includes all the institutions, organizations, people and resources that help a particular group of people stay healthy.

The World Health Organization (WHO) is an international organization assembled by the United Nations (UN) in 1948. The UN is a group of 193 countries, organized in 1945, that work together to support international peace, justice, respect, human rights, and tolerance. The WHO was organized to promote cooperation in providing health care internationally. The WHO compiles data on health care and outcomes on a global basis. A good example of how the WHO tries to coordinate world health was seen at the beginning of the Covid-19 pandemic in late 2019. The WHO compiled global information about care provided to people with Covid-19 and the outcomes of that care. The global data allowed the WHO to provide "best practices" information and guidance. The WHO has to consider and advise countries based on the resources available to the specific country. The WHO provides indirect patient care, because they provide guidance and information that health care delivery systems use to develop the guidelines and procedures for direct patient care. Since the WHO primarily provides health care guidance, and not direct health care services, they do not have the power to require countries to provide health care to their populations.

2.4. Covid-19 and health care provision

Providing Care: Effective care can best be provided with thorough preparation, quick response to barriers, and an adequate allocation of resources to carry out plans of care. It is important to identify vulnerable populations early and to quickly initiate care plans in order to allocate sufficient resources to assist those in need without loss of time in care. It is essential to be proactive in identifying those needing additional assistance, providing more care and checking in, and assessing the availability of resources for emergencies. Barriers preventing this could increase risk of illness or deterioration of



health (Campbell *et al.*, 2009).

Recommended practices to reduce pandemic spread can exacerbate some conditions and may decrease needed resources for others in the vulnerable population. For instance, social distancing can cause worsening of conditions among the elderly. "Social isolation is one of the most important contributors to all-cause mortality in older adults" (Finset, 2020). Maintaining social distancing in shelters for the homeless can limit capacity, thus leading to a greater need of more shelters during a pandemic. Those who live in senior living facilities, nursing homes or long-term care facilities are also vulnerable (Vergara *et al.*, 2020). Vergara *et al.*, (2020) emphasizes the importance of explaining why a telehealth visit is being used versus in office visit. Telehealth may be a foreign concept to many older adults. Older adults need to be educated about the history of telehealth, the benefits of telehealth, and be assured of the quality care being delivered remotely.

Telehealth and telemedicine are being utilized to provide remote care and eliminate unnecessary exposure to the virus. As noted by Quin *et al.*, (2018), older adults want to live independently for as long as they can. However, the elderly may not have access to resources such as a phone and/or computer or have an understanding of how to receive telehealth or telemedicine services. It is essential to identify these populations prior to a pandemic and make accommodations to provide continuity of care and limit exposure to the virus. In addition to minimizing exposure to the virus, potential benefits of telehealth for older adults may reduce the burden of cost and travel.

Those suffering from mental illness, may have additional resource challenges due to resistance, noncompliance, and possible instability in living conditions. Additional challenges also exist for those providing mental health care in inpatient facilities. Due to the structural challenges of inpatient facilities and restriction of certain resources to reduce the risk for harm to self or others, care for the vulnerable population of mental health patients can present unique challenges (Li, 2020). Limited ability to comprehend directions due to psychiatric illness or cognitive impairment may represent a barrier to following typical pandemic protocols such as hand washing (Li, 2020). With hospitals restricting access in response to COVID-19, group and family therapy becomes limited and can impact psychiatric patient treatment course (Li, 2020). These challenges must be met by the team of healthcare professionals and clinical leaders through effective communication in providing the best care and safety for their patients.

Good health is a predictor of economic growth as well as a prominent component of the general well-being of the country's population. This has made health to be universally accepted as a merit good, such that, a minimum of which should be entitled to by each individual irrespective of his/her ability to pay. In health care markets, the equity issue is manifested by widespread public subsidization or direct provision of health care to the general public regardless of socio-economic status of the majority as an individual needs some minimum amount of health human capital to survive.

This has made Mwabu, (2007) to acknowledge that there are large returns to health improvements in developing countries. This is because, consumption of health care, particularly

preventive care, is often associated with positive externalities. For example, treatment of a patient with an infectious illness does not only benefit the person treated, but also other persons because they are protected from exposure to infection. Similarly, immunization of an individual against a communicable disease protects other people from the disease. Moreover, health improvements in poor nations can be achieved through implementation of simple interventions such as dietary supplements, control of parasitic diseases, and pro-poor social expenditures.

3. METHODOLOGY

3.1. Research design

The study utilised a descriptive survey research approach. Descriptive survey research design is commonly understood as a method in which a small number of individuals or products are researched to gather and analyse data that is believed to be representative of the full target population (Nworgu, 2006). The design is deemed suitable when the research candidate intends to utilise the acquired data to depict the relationship that exists among the variables of interest. Furthermore, it does not allow for any manipulation of variables, as it neither adds to nor subtracts from the existing fact.

3.2. Population, sample and sampling techniques

The research population included of all healthcare professionals employed at public healthcare centres in Ido LGA of Oyo State, Nigeria, during the COVID-19 epidemic. A total of 160 individuals were selected via purposive sampling technique. This enables the researcher to deliberately and thoughtfully select the participants to be included in the sample, ensuring that the sample aligns with the study's purpose. Therefore, only those who were directly engaged in carrying out the covid-19 policy implementation were selected and included in the research.

3.3. Instrumentation

Structured questionnaire was used to obtain information from the respondents. The questionnaire titled "Healthcare Resources Provision, Mobilisation and Delivery during Covid-19 (HRPMD-Covid-19)". This questionnaire has two sections. The section A dealt with demographic information of the respondents, while remaining sections were basically designed in structured form to cater for the research questions and objectives.

3.4. Validity and reliability of the instrument

Validity refers to the degree to which an instrument accurately measures what it is intended to measure and functions as intended. To confirm the accuracy of the instruments used in this study, content validity measurement was conducted which includes assessing face validity and predictive validity. The items are provided in basic English to ensure easy comprehension by the respondents. Additionally, they are logically and systematically structured in accordance with the research topics. The researchers verified the validity of the instruments by ensuring that the contents align with both the study's objectives and research questions. The reliability of a research instrument refers to its capacity to consistently produce the same findings



when used several times. While some degree of inaccuracy is inevitable, a high-quality instrument will often yield consistent findings when used at different periods. The tendency towards consistency found in repeated measurements is referred to as reliability. The instrument was trial-tested among twenty-five (25) health official in Oluyole LGA of Oyo State who are not part of the respondents slated for the study. The Cronbach Alpha reliability technique produced 0.62 which indicated that the instrument was reliable for the study.

3.5. Method of data administration and analysis

The research instrument was administered by the researchers accompanied by two experienced research assistants who are knowledgeable with the study's scope. Nevertheless, the

research assistants were provided with detailed instructions regarding the objectives, advice, strategy, and explanations for the respondents on how to complete the questionnaire if necessary. The data to be generated was analysed using descriptive statistical methods. Charts were utilised to represent the demographic section of the instrument. The study objectives and research questions were addressed using a basic percentage calculation.

4. RESULTS AND DISCUSSION

4.1. Results based on research questions

Research question I: What is the extent of healthcare services provided during covid-19 in Ido Local Government, Oyo State, Nigeria?

Table 1. Descriptive statistics on the extent of healthcare services provided during covid-19 in ido local government, oyo state, nigeria.

ITEM	Mean	S. D
Availability of medicine for patient	1.03	0.34
Provision of free immunization vaccine	1.54	0.53
Provision of enough health officers	1.26	0.47
Availability of health facilities for other health services	1.42	0.50
Provision of sanitary services	1.40	0.49
Provision of health service for pregnant women	1.25	0.45

4.2. Interpretation and discussion

Table 1 contained descriptive statistics of the extent of healthcare services provided during covid-19 in Ido Local Government, Oyo State, Nigeria. The empirical findings indicated that during COVID-19 there were availability of medicine for patient, provision of free immunization vaccine, provision of enough health officers, availability of health facilities, provision of sanitary services and provision of health service for pregnant women were not really order of the day though they received attention but the level with which it happened were low having mean value of 1.03, 1.54, 1.26, 1.42, 1.40 and 1.25 respectively which are within the region of low degree.

In their study, Kumar *et al.* (2020) discovered a substantial scarcity of vital medications such as antibiotics and antivirals, in several nations during the COVID-19 pandemic. This research confirms the limited accessibility of medication for patients, with a mean value of 1.03. According to Li *et al.* (2020), the distribution of free immunisation vaccinations was interrupted in some countries during the pandemic, resulting in a decrease in vaccination rates.

This study confirms the limited availability of free immunisation vaccinations with an average value of 1.54. According to WHO (2020), several nations had a scarcity of healthcare professionals like as physicians and nurses within the epidemic. This conclusion confirms the limited availability of sufficient health personnel as indicated by the mean value of 1.26.

According to Alvarado *et al.* (2020), several nations effectively employed tactics such as stockpiling and rationing to ensure continued availability of vital medications during the epidemic. This contradicts the conclusion that there is a limited supply of medication for patients. Patel *et al.* (2020) found that country like India, effectively executed extensive vaccination initiatives within the pandemic, which encompassed the provision of free immunisation vaccines. This contradicts the discovery of insufficient availability of complimentary immunisation vaccinations.

Research question II: To what extent was healthcare services mobilized during covid-19 in Ido Local Government, Oyo State, Nigeria?

Table 2. Descriptive statistics showing the extent with which healthcare services was mobilized during covid-19 in ido local government, oyo state, nigeria.

ITEM	Mean	SD
Attention was mainly on healthcare service delivery during covid-19	3.05	0.58
Government made available needed material for healthcare delivery during covid-19	1.52	0.07
Non-health officers were involved in the healthcare service delivery during covid-19	3.05	0.58
Non-governmental organisations provide resources for healthcare centres	3.50	0.75



Isolation centers within my area are fully equipped with required health equipment.	1.52	0.07
Facemask was made available within all the healthcare centers in my location	3.50	0.75
Running water and soap were made available in some of the strategic areas	2.55	0.09

4.3. Interpretation and discussion

Table 2 indicated the extent with which healthcare services was mobilized during covid-19 in Ido Local Government, Oyo State, Nigeria. The empirical outcomes indicated that all resources were diverted towards addressing COVID-19, non-health officers were engaged in the healthcare service delivery during this period, non-governmental bodies were not left out in the course of making resources available to healthcare centers for effective healthcare delivery during the menace and facemasks were made available within all healthcare centers with means values of 3.05 and 3.50 respectively which are within the high extent decision criterion. While, the provision of needed resources by the government during covid-19 was considered very low and even the isolation centers were not fully and well-equipped as indicated with the mean value of 1.52. It further indicated that

running water and soap were in moderate level made available in some of the strategic areas having mean value of 2.55.

Khan *et al.*, (2020) discovered that individuals who were not health professionals, such as retired healthcare workers and volunteers actively participated in providing healthcare services during the COVID-19 pandemic. This study indicates that individuals who were not health officials were involved in providing healthcare services with an average value of 3.50. According to Legido-Quigley *et al.* (2020), isolation centres during the COVID-19 pandemic were frequently lacking in proper resources and personnel, such as insufficient availability of running water and soap. This contradicts the conclusion that isolation centres were inadequately equipped.

Research question III: In what ways were healthcare services delivery affected during covid-19 in Ido Local Government?

Table 3. Descriptive statistics showing the perceived hindrances confronting healthcare service delivery during covid-19 in ido local government.

ITEM	Mean	SD
Inadequate financial resources	3.25	0.72
Weak personnel management capacity	2.89	0.67
Inadequate supervision and evaluation of healthcare service delivery.	3.25	0.72
Inadequate involvement of members of the community in the planning and implementation of the projects	3.76	0.88
Inadequate utilisation of modern technologies for effective delivery of healthcare service.	0.12	0.01
Low level of awareness of the available healthcare service	3.33	0.74

4.4. Interpretation and discussion

Table 3 exhibited the participants' perspective towards the hindrances confronting healthcare service delivery during covid-19 within the location under investigation. The empirical findings showed that the hindrances confronting healthcare service delivery during covid-19 comprised; inadequate financial resources (3.25, 0.72), weak personnel management capacity (2.89, 0.67), inadequate supervision and evaluation of healthcare service delivery (3.25, 0.72), inadequate involvement of members of the community in the planning and implementation of the projects (3.76, 0.88) and low level of awareness of the available healthcare service (3.33, 0.74). While, inadequate utilisation of modern technologies for effective delivery of healthcare service was not considered hindering healthcare service delivery during covid-19 within the study location.

The consequences of reduced healthcare expenditure on the delivery system are overwhelming, leading to a situation where the demand exceeds the system's capability during public health crises or any other health crisis. The study findings indicate that African countries, including Nigeria, have a limited number of clinics, hospital beds, and ventilators per capita, with just one

for every one hundred thousand (100,000) individuals. Nigeria is estimated to have 0.5 clinic beds per one thousand residents, which places it among the countries with a lower number of beds per person (below 1.7 per capita). Intensive care and ventilator support are essential for Coronavirus patients in a severe (critical) state. In addition to inadequate beds, ventilators, and per capita finance in Nigeria's healthcare delivery system, there is also a shortage of workers, particularly in the volatile regions of the nation. Without caution, the healthcare system is in risk of being quickly overwhelmed by the exponential and unhindered rise in the number of Coronavirus cases in Nigeria (Hellewell *et al.*, 2020).

Ajiye (2014) supported this claim by citing reasons such as a shortage of human resources, an inadequate and unreliable data system, and financial constraints as obstacles that hinder the successful execution of developmental programs, particularly in healthcare delivery. Benyin and Ugochukwu (2015) argued that obstacles to effective healthcare delivery include citizens' exclusion from policy-making, insufficient human and financial resources, corruption, and lack of trustworthy leadership, among other factors. Dike (2010) found that the lack of strong technological capability and poor governance are major



obstacles to the successful implementation and utilisation of developmental projects in developing countries such as Nigeria.

Igbokwe-Ibeto (2015) affirmed this statement by recognising that the government experiences significant financial losses as a result of inadequate project monitoring and assessment. Furthermore, this aligns with the review analysis carried out by Ayodeji *et al.* (2017), which identified late start-up activities, limited funding, lack of consistent evaluation, weak coordination, duplication of developmental projects,

and unhealthy competition among donors as challenges that impede the effective evaluation of healthcare service delivery. Akinyooye and Aransi (2020) and Aransi, (2020) acknowledged that awareness level of the developmental projects and programmes like health-oriented and poverty-eradication events would not only go a long way in attracting community members' participation but also in achieving SGD-goal one.

Research question IV: What are the effective strategies towards actualization of healthcare resources during covid-19 within the location under consideration?

Table 4. Descriptive statistics showing the respondents view towards the effective strategies towards actualization of healthcare resources during covid-19 within the location under consideration.

ITEM	Mean	SD
Involvement of the community stakeholders in the formulation and implementation of the developmental programmes.	3.05	0.69
Regular orientation and training on the application of the developmental projects installed in the community.	3.27	0.76
Provision of sufficient land space for sustainable development projects like Water Bore Hole	0.15	0.03
Adequate monitoring and supervision of the projects by the community.	3.35	0.79
Provision of financial resources to all developmental projects.	3.01	0.66
Constant and effective evaluation of the community projects.	3.20	0.75
Provision of modern technological equipment.	3.04	0.69
Public campaign on projects like hospitals, health centres,	3.04	0.69
Mobilisation of human resources by the community	3.56	0.82

4.5. Interpretation and discussion

Table 4 contained the participants' perspective towards the effective strategies towards actualization of healthcare resources during covid-19 within the location under consideration. The empirical outcomes revealed that participatory approach to developmental projects, organisation of constant training programmes for community members, adequate monitoring and supervision of the projects, proper finance to enhance the standard of living in the community, public campaign on projects like hospitals, health centres, effective evaluation of the community projects, provision of modern technological equipment and mobilization of human resources by the community were some of the strategies towards actualization of healthcare resources during covid-19 within the location under consideration as having mean values of 3.05, 3.27, 3.35, 3.01, 3.04, 3.20, 3.04 and 3.56 which were within the positive region of the decision rule. On the other hand, provision of adequate land space for projects like farm settlements, water borehole was not considered as a viable strategy for effective implementation of developmental project as attracted mean value of 0.15, this could be attributed to the fact that provision of land for developmental project hadn't been a barrier as the stakeholders in the communities under considerations are always ready to donate land whenever the need arises.

This aligns with the submission made by Igbokwe-Ibeto (2015), which emphasises the importance of following proper procedures in all aspects of project planning and management. It

also highlights the involvement of local communities in project initiation, formulation, and execution, as well as the need for continuity in government projects regardless of changes in leadership. Additionally, the presence of visionary and mission-driven leadership is identified as a key factor for progress.

5. CONCLUSION

The study concluded that there was a collective effort to mobilise and execute healthcare resources during the COVID-19 pandemic in Ido Local Government Area of Oyo State, Nigeria. However, this procedure was not without obstacles. Several issues, such as a bottom-down approach to policy, insufficient mobilisation of people and material resources, and others, have been recognised as obstacles to the efficient mobilisation and execution of healthcare services resources.

RECOMMENDATIONS

The following recommendations are suggested.

- i. There should be public health sensitization efforts aimed at promoting adherence to containment measures and facilitate access to healthcare centers by the concerned people.
- ii. There should be room for innovative service delivery in the healthcare services during global pandemic like covid-19 such as provision of mobile outreach clinics, integrated community vaccination and testing programmes, targeted service provision to vulnerable populations and telemedicine.
- iii. Stakeholders should mobile greater investment in



community level mobile apps to support contact tracing and sensitization efforts all in the name of addressing the spread of the pandemic.

iv. Stakeholders should invest in transportation, power, equipment and communication costs in order to alleviate pressures and positively impact health service delivery during pandemic.

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