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Evaluation of Access, Satisfaction and Perceived Quality of a Free Community Medical Outreach in Badagry, Lagos, Southwest Nigeria

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ABSTRACT

Background and Objective: Inadequate access to affordable healthcare remains a significant public health concern in Nigeria, especially among difficult-to-reach, underserved, and suburban populations. Free medical outreach programs have often been deployed as stopgap public health measures to address healthcare gaps, yet empirical evaluations of their effectiveness remain limited. This study evaluated access, satisfaction and perceived quality of a free medical Outreach in Badagry, Lagos State.

Methods: The study employed a quantitative cross-sectional design among 212 adult beneficiaries selected through convenience sampling. Data were collected using structured questionnaires adapted from previously validated tools (PSQ-18 and SERVQUAL) and clinical measurements. Descriptive statistics summarized frequencies and means, paired t-tests assessed changes in blood pressure (BP) pre- and post-medication, and chi-square tests examined associations between patient satisfaction and sociodemographic factors, with significance set at $p < 0.05$.

Results: Of all the participants screened, 36.7% were hypertensive, and 4.5% had elevated blood glucose levels. Significant reductions in BP readings were observed in mean systolic (176.2 ± 15.4 to 157.2 ± 13.8 mmHg; $p < 0.001$) and diastolic BP (96.3 ± 11.2 to 88.7 ± 10.5 mmHg; $p < 0.001$) 1 hour after antihypertensive administration. Most respondents (81.6%) reported high satisfaction (mean score = 4.06 ± 0.57), independent of age, gender, or occupation ($p > 0.05$). Perceived service quality was rated highly across health workers' competence, courtesy, and clear communication. However, 47% expressed dissatisfaction with waiting time.

Conclusion and Implications for Translation: The free medical outreach held in Badagry effectively improved short-term clinical outcomes and achieved high patient satisfaction, demonstrating its potential to enhance access and equity in healthcare delivery. However, the quality and efficiency of services and follow-up mechanisms require strengthening to ensure sustained and global benefits.

Keywords: Medical Mission; Healthcare Outcomes Assessment; Beneficiaries; Patient Satisfaction; Blood Pressure Control; Lagos State; Stopgap Public Health Measures; Community Health Intervention

INTRODUCTION

The World Health Organization (WHO) fears that more than half of people worldwide lack access to essential healthcare services^[1] and that healthcare service inequalities are widespread across many sub-Saharan countries, including Nigeria. In Nigeria, poverty, distance to health facilities, limited health infrastructure, and workforce shortages amplify inequities in healthcare delivery.^[2]

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Some of the challenges observed in our public health facilities include unavailability and inequitable service delivery. Those most affected by this scenario are the vulnerable members of the community. We conducted a study during a 1-day free medical outreach in Badagry, Lagos State.

The study is limited to one free medical outreach conducted in Badagry, Lagos State. The services rendered during the outreach include free eye screening and dispensing of reading glasses, blood pressure (BP) checks, treatment of ailments, tuberculosis screening, and health education. The objectives of this study are to evaluate the extent of access to healthcare services provided during the outreach, assess changes in BP control among participants, examine how patients perceive the quality of care provided during the outreach, determine patient satisfaction with services provided during the outreach, and identify areas for improvement in healthcare delivery during outreaches. Results from this study will serve as evidence of the effectiveness of free medical outreaches, help various organizations and individuals plan their future outreaches more effectively, and contribute to the body of literature on community-based health interventions.^[2]

Background of the Study

The advent of the Lagos State Health Scheme (LSHS) has, no doubt, increased access to healthcare services in Lagos State,^[3] but many Lagosians live about 6–10 km from the closest hospital. In comparison, only about 2% were insured, and most could not afford healthcare services.^[4] It is common knowledge that most residents of underserved communities utilize healthcare services only when they are provided free of charge during community medical outreach programs. The deployment of mobile outreach clinics in the Republic of Niger helped improve access to healthcare services for women, children, and older adults in the Diffa region.^[5] Similarly, the WHO organized a community outreach in Osun State to mark its 75th anniversary.^[6] This gesture enabled traders at the Orisunbare market to check their BP and access other healthcare services, such as blood glucose screening and treatment for minor ailments.

The Lagos State government recognizes the importance of both formal and informal medical outreach, organizing the latter periodically across various parts of Lagos. Informal medical outreach is an additional effort to bring healthcare services to underserved and vulnerable communities. Conversely, formal community outreach is officially embedded in primary healthcare services in Nigeria.^[7] From the famous “Jigi Bola” program initiated by His Excellency Bola Ahmed Tinubu when he was the executive Governor of Lagos State,^[8] to the Alafia Eko free medical outreach initiated by Governor Babajide Sanwo-Olu’s administration, Lagos conducts these health interventions to reduce the burden of the cost of health care services among Lagosians.^[9]

These outreach programs can improve patient satisfaction, enhance medication adherence, facilitate early detection of non-communicable diseases such as hypertension and diabetes, and improve health indices.^[10] However, there is limited empirical evidence on the outcomes of such initiatives, particularly regarding BP control, patient satisfaction, and overall quality of life. This absence of robust evidence hinders policymakers and health program managers from optimizing outreach interventions.

The prevalence of hypertension has been reported to be in the region of 30%–35% with inadequate BP control, highlighting the importance of outreach-based screening and management.^[10] Poor access to health services by hypertensive patients, defaulting from clinic appointments, or poor adherence to medications are often influenced by predisposing, enabling, or need factors of the Anderson Behavioral Model.^[11] The patient’s perception of quality and satisfaction can be determined by assessing structure, process, and outcome, as elucidated in Donabedian’s model, which underscores how the care environment, provider behavior, and service delivery affect outcomes and satisfaction.^[12]

Measurement Considerations

BP control usually follows standard protocols, with an emphasis on immediate changes in readings and on referral uptake.^[10] The perceived quality of the free medical outreach was assessed using adapted PSQ-18 and SERVQUAL items.^[13] At the same time, patient satisfaction was captured through Likert-based composites and analyzed against drivers such as waiting time and staff attitude.^[14] Few studies in Lagos have comprehensively assessed access, clinical outcomes, perceived quality, and satisfaction in a single outreach study. Additionally, many do not provide actionable recommendations for improvement. This study addresses these gaps.

METHODS

A quantitative research design was adopted, and convenience sampling was used to recruit participants from the study’s outreach beneficiaries. Data were collected using structured questionnaires and clinical measurements. Secondary data collected during the outreach and from the clinical measurements were reviewed and analyzed. The study was conducted in Badagry town, Lagos State, Nigeria. Badagry constitutes the border between Nigeria and the Republic of Benin,^[15] while the coastal town shares a boundary with Ogun State (north) and the Atlantic Ocean (south). Although the original settlers of Badagry are the Ogu,^[15] the Awori sub-ethnic group of Yoruba can also be found in their numbers. Farming, fishing, and trading are the primary occupations in Badagry. The 2019 population of Badagry Local Government was estimated at 572,927.^[16]

The study sample frame included all 600 expected beneficiaries of the outreach, and all adult participants who attended constituted the study population. The inclusion criteria were adults (≥ 18 years) who received care during the outreach and provided consent. Critically ill patients unable to respond to surveys and unwilling beneficiaries were excluded from participating in the study.

Study Instrument

While clinical measurements, such as BP, were obtained with a validated sphygmomanometer before and after consultation for those with an initial BP of 140/90 mmHg or higher,^[17] the research instrument was a structured questionnaire to assess access, satisfaction, and perceived quality. It was adapted from an erstwhile paper published in Nigeria.^[18] An expert validated the instrument's content; however, reliability was not tested because there was no prior free medical outreach during the study period.

The instrument contains four sections, plus an additional section for socio-demographic details. Section A contains five items, Section B comprises eight items, Section C contains seven items, and Section D contains two items, bringing the total to 22.

Data Collection Procedure

The investigator trained three research assistants to administer the questionnaires to participants, and QR codes and links were also provided alongside the hard copies. The research assistants had thoroughly revised the instrument, which was designed in English, and agreed on a Yoruba translation. Registered Community Health Extension Workers (CHEWs) recorded clinical BP measurements on the left arm at heart level twice, 5 minutes apart, found the average, and noted those with high BP ($>140/90$ mmHg) in red ink on their forms. Those with a random blood sugar (RBS) of 180 mg/dL or higher were also included. The medical doctors assessed the patients and gave prescriptions for antihypertensives to known hypertensive beneficiaries whose BP was higher than 140/90 mmHg. The beneficiaries then took their prescriptions to the drug stand, where the pharmacists dispensed their medications per the doctor's instructions and water to take the medicines right there. The BP medicines available during the outreach were Lisinopril, Aldomet, Amlodipine, Moduretic, and Nifedipine. Their BP was rechecked at the nearby provided tent by a designated CHEW after an hour. The results of the checks were recorded and communicated to the patients, and questionnaires were administered. They were all counseled and referred to the nearest health facility for follow-up.

The data were analyzed using Statistical Package for the Social Sciences (SPSS) v. 25. Descriptive statistics (means,

standard deviations, and frequencies) were computed. Paired t-tests were used to compare pre- and post-consultation BP, and chi-square tests were used to determine the associations between satisfaction and patient characteristics. The level of significance was set at $p < 0.05$.

Ethical Considerations

Informed consent was obtained from the participants, and confidentiality was maintained.

RESULTS

Secondary Data Collected During the Outreach

The secondary data showed that 36.7% of all beneficiaries of the medical outreach aged 20 years or older who had their BP checked were hypertensive ($\geq 140/90$ mmHg). Using ≤ 180 mg/dL as the reference for RBS, the majority (4.5%) of the 400 beneficiaries with an RBS check recorded had elevated levels (>180 mg/dL). Hepatitis B screening revealed that 2.2% of the 275 beneficiaries tested positive; 0.5% of the 400 beneficiaries screened for Human Immunodeficiency Virus (HIV) tested positive; and those who tested positive for malaria are 3.4%. All 37 men aged 40 and above screened for prostate-specific antigen tested negative.

Results from the Survey

A total of 229 questionnaires were administered, of which 212 (92.6%) were valid. The respondents mostly (27.8%) fell within the 46–55-year age group, followed by those aged 66 and above (24.5%), while the youngest age group, 18–25 years, constituted the fewest respondents (8.0%) in the study. A whopping 138 (65.1%) of the respondents were female, while 74 (34.9%) were male. Secondary education was the most common level of educational attainment among the respondents, with 68 (32.1%), while only 16 (7.5%) had postsecondary qualifications. Almost half (104) of the respondents (49.1%) heard about the medical outreach from their family and friends. In comparison, 4 (1.9%) of them heard it from sources other than fliers (20.8%), radio (3.3%), social media (6.6%), or the motorized campaign (39%). Students constituted 4.7%, unemployed respondents 10.2%, and business/trading 40.0%.

Blood Pressure Changes Before and After Medication

A total of 97 participants had their BP measured by health workers before and 1 hour after medication. To determine whether there was a significant change in BP following medication administration, a paired-samples t-test was conducted.

Table 1: Summary of paired-sample t-test.

Measurement	Mean difference (mmHg)	95% CI (lower–upper)	t-value	df
Systolic BP	19.01	16.11–21.91	12.99	96
Diastolic BP	7.62	5.37–9.87	6.72	96

Table 2: Descriptive statistics of satisfaction items (n = 212).

Satisfaction item	Mean	SD
C4 – Ease of access to care and treatment received	4.06	0.63
C6 – Staff courtesy and competence	3.99	0.68
C7 – Overall satisfaction with outreach experience	4.12	0.61
Composite satisfaction (C4–C7 mean)	4.06	0.57

Descriptive and Inferential Statistics

As illustrated in Table 1, the mean systolic BP of the participants before medication was 176.2 ± 15.4 mmHg, which decreased to 157.2 ± 13.8 mmHg 1 hour after medication. This figure represents a mean reduction of 19.01 mmHg (95% CI: 16.11–21.91). The difference was statistically significant ($t(96) = 12.99, p < 0.001$).

Similarly, the mean diastolic BP decreased from 96.3 ± 11.2 mmHg before medication to 88.7 ± 10.5 mmHg after medication. The mean difference was 7.62 mmHg (95% CI: 5.37–9.87). This is also statistically significant ($t(96) = 6.72, p < 0.001$).

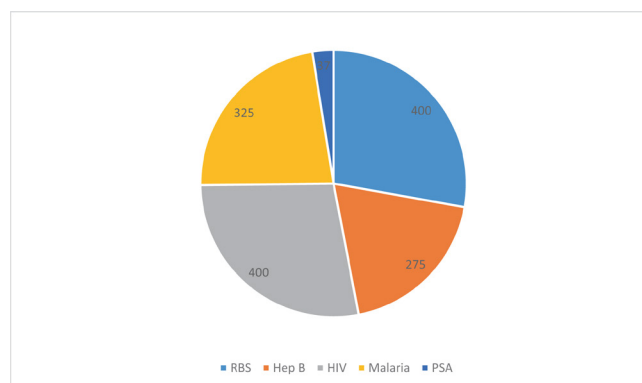
These findings indicate that both systolic and diastolic BP decreased significantly 1 hour after administration of antihypertensive medication.

Interpretation

The paired t-test results demonstrate a statistically and clinically significant improvement in BP control within 1 hour of medication intake, suggesting that the treatment regimen effectively lowered both systolic and diastolic BP acutely among participants.

Quality of Care

Over half (59.5%) of the respondents strongly agreed or agreed that the available medical equipment and supplies were adequate for their care. In comparison, most (87.9%) strongly agreed or agreed that the healthcare workers clearly explained their diagnosis and treatment options, and 80.5% strongly agreed or agreed that they felt confident in the healthcare workers' competence. Similarly, 91.1% of the respondents strongly agreed and agreed that the


Figure 1: Distribution of screening tests conducted.

registration and consultation processes were smooth and well-coordinated. The highest scores were for the Mean of “The healthcare workers were courteous and respectful to patients,” “The healthcare workers clearly explained my diagnosis and treatment options,” and “The registration and consultation processes were smooth and well-coordinated” (Section B3 = 4.679, B5 = 3.948, and B8 = 4.212). Conversely, the lowest mean, “The healthcare workers attended to me promptly” (B4 = 2.458), is below the section average. The standard deviation of “The outreach center was well organized and conducive for healthcare delivery” (0.2877) shows that the responses cluster around the mean.

Level of Satisfaction of Respondents

A total of 212 respondents participated in the survey. Overall satisfaction was derived from three key items—C4 (ease of access to care and treatment received), C6 (staff courtesy and competence), and C7 (overall satisfaction with outreach experience)—as shown in Table 2. The mean scores for these

items ranged from 3.99 ± 0.68 to 4.12 ± 0.61 , with an overall composite mean satisfaction score of 4.06 ± 0.57 , indicating generally high levels of patient satisfaction. Based on the composite score, 81.6% of participants were classified as satisfied, while 18.4% were not satisfied. Chi-square analyses revealed no statistically significant associations between satisfaction and patient demographic characteristics, including sex ($\chi^2 = 1.12$, $p = 0.291$), age group ($\chi^2 = 4.38$, $p = 0.223$), or occupation ($\chi^2 = 8.46$, $p = 0.133$). These findings suggest that satisfaction with services was generally high and consistent across demographic groups.

Interpretation

Respondents generally reported high satisfaction across all dimensions, with the highest overall satisfaction rating ($C7 = 4.12 \pm 0.61$).

DISCUSSION

Prevalence of Common Diseases Among Beneficiaries

From this study, 36.7% of beneficiaries screened for BP were hypertensive. This means that at least one in three adults screened is hypertensive. These findings align with previous reports and submissions that hypertension remains the leading non-communicable disease in Nigeria, with prevalence rates between 30% and 40% among adults.^[19] The high burden of hypertension detected among these outreach participants underscores the need for intensified community-based screening and follow-up interventions, especially given the largely asymptomatic nature of the condition. Many people discover that they are hypertensive for the first time during some of these screenings.

The RBS results showed that 4.5% had elevated glucose readings. These figures are lower than findings from other community screenings in Lagos and other parts of Nigeria, which reported hyperglycemia rates ranging from 7% to 12%.^[20] Other glucose level screening tests, such as Fasting Blood Sugar (FBS), are more reliable than RBS. The organizers opted for RBS because the screenings were conducted after 9 am, which was too late to perform an FBS. This relatively lower prevalence may reflect the limited duration of the outreach and the demographic characteristics of attendees, who may not represent the general population. Similarly, infectious disease screening revealed low prevalence rates: 2.2% for hepatitis B, 0.5% for HIV, and 3.4% for malaria. These findings are consistent with national trends showing declining HIV prevalence.^[21] The malaria positivity rate of 3.4% in this study is considerably lower than the national average of 22%,^[22] suggesting possible seasonal variation, prior preventive interventions in the area, or a declining malaria prevalence in Lagos State.

Effect of the Outreach Intervention on Blood Pressure

The paired t-test analysis demonstrated statistically significant reductions in both systolic (mean difference = 19.01 mmHg, $p < 0.001$) and diastolic (mean difference = 7.62 mmHg, $p < 0.001$) BP following administration of antihypertensive medication. This suggests the immediate effectiveness of the medicines provided. These results are comparable to findings from similar outreach programs in Sub-Saharan Africa, which have reported significant reductions in BP following medication and counseling.^[23] Although the follow-up duration was brief (1 hour post-administration), which is a possible limitation, the statistically and clinically meaningful reduction in BP highlights the role of medical outreaches in providing immediate relief and initiating care for hypertensive patients who may otherwise lack access to treatment. The importance of long-term follow-up and linkage to primary health centers cannot be overstated for sustaining these improvements.^[24]

Perceived Quality of Care

The majority of respondents expressed satisfaction with key aspects of service delivery, including the courtesy and respect shown by health workers (mean = 4.68) and the clarity of explanations regarding their diagnoses and treatments (mean = 3.95). These findings are consistent with earlier studies showing that interpersonal communication and empathy strongly influence patients' perceptions of the quality of care.^[25] However, nearly half (47%) of respondents disagreed that they were attended to promptly. This may reflect the large patient turnout relative to available staff and resources, a common challenge in community medical outreaches.^[26]

Satisfaction of Beneficiaries with Healthcare Services

With 81.6% of respondents expressing satisfaction (mean composite score = 4.06 ± 0.57), overall satisfaction was high during our outreach. The program was perceived positively across different population subgroups, as indicated by the absence of significant associations between satisfaction and demographic variables such as age, gender, and occupation. This suggests equitable access and consistent service quality, which are essential during public health interventions.^[24]

A previous study of similar community-based health programs also reported satisfaction rates above 75%.^[27] The high satisfaction reported here likely reflects both the quality of interpersonal interactions and the relief of receiving free medical services in a context of widespread financial barriers to healthcare access.^[28] It also reflects the quality of the equipment, the availability of medications, and the overall organization of the outreach.

CONCLUSION AND IMPLICATIONS FOR TRANSLATION

The findings demonstrate that our medical outreach effectively identified individuals with chronic diseases, provided short-term therapeutic benefits, and delivered patient-centered care with high satisfaction. Linkage to care and sustainable integration with existing primary healthcare structures could amplify the long-term impact of such programs on community health outcomes. This study showed significant short-term improvements in BP following treatment and patient satisfaction, demonstrating that free medical outreaches can positively impact people's health and healthcare outcomes. Future outreach efforts could improve staffing ratios, workflow management, and crowd-control measures to minimize wait times. The study has added to the body of knowledge on community-based outreaches. It has been shown that community medical outreaches can serve as a stopgap public health intervention to improve universal health coverage.

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COMPLIANCE WITH ETHICAL STANDARDS

Conflicts of Interest: The authors declare no competing interests. **Financial Disclosure:** The investigators were involved in organizing and evaluating the outreach. To reduce bias, and protect participants, participation in the research was voluntary and separate from access to outreach services. **Funding/Support:** There was no funding for this study. **Ethics Approval:** The study was approved by the Lagos State Health Research Ethics Committee (LSHREC), number LSHREC/2024/0020/004. **Declaration of Patient Consent:** The authors certify that they have obtained all appropriate consent. **Use of Artificial Intelligence (AI) - Assisted Technology for Manuscript Preparation:** The authors confirm that there was no use of Artificial Intelligence (AI) - Assisted Technology for assisting in the writing or editing of the manuscript, and no images were manipulated using the AI. **Disclaimer:** None.

Key Messages

1. Free Medical Outreaches can contribute positively to Universal Health Coverage as it can increase access to healthcare services among the underserved communities, if well planned. 2. It is a veritable means of identifying new cases of non-communicable diseases and link them to proper healthcare service. 3. Beneficiaries of medical outreaches with severe and chronic ailments must be linked to nearest

health facilities to continue care. 4. Public-spirited individuals and organisations should continue to sponsor free medical outreaches planned and organised by qualified personnels as part of their corporate social responsibility.

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