What Routine Monitoring Misses: embedding lived experience to strengthen quality of care monitoring in a fragile and conflict-affected hospital in South Sudan

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Background

In fragile and conflict-affected settings, quality-of-care monitoring habitually relies on routine quantitative indicators, such as medication availability, staffing, service use, and selected outcomes. These data are essential, but they may miss relational and behaviour-dependent elements of care, including communication, trust, patient involvement, staff wellbeing, and organizational learning.

Study aim: To explore how patients, caregivers, community members, and frontline staff experience quality of care at Lankien MSF Hospital in South Sudan, and to identify process-level gaps that may be missed by routine monitoring.

Method

Cross-sectional qualitative assessment at Lankien MSF Hospital, South Sudan.

- 11 focus group discussions
- 7 key informant interviews
- Participants: medical and non-medical staff, community members, patients/caregivers, and people with prior hospital use.
- Analysis guided by WHO's seven dimensions of quality and Donabedian's structure–process–outcome model.
- Thematic analysis in NVivo using deductive coding with inductive expansion

Sustained quality of care improvement requires more than one-off assessments. It depends on consistent follow-up, shared accountability, and continuous feedback and engagement with those who deliver and experience care.

"There has been a lot of improvement from 15 years back." *(community respondent)*

Routine monitoring captured visible constraints: medicines, diagnostics, staffing, timely access, and infrastructure.
Lived experience revealed less visible process gaps: communication, explanation of diagnosis, patient involvement, supervision, incident learning, trust, and staff wellbeing.

Conclusions

Routine data tells us what is happening. Lived experience helps explain why and what needs to change ***(fundamental to person centered care).***

Routine quality monitoring must include the voices and experiences of patients, caretakers, and staff to reflect the lived reality of care provided and ***it is feasible.***

Result

What lived experience revealed

Key issues mentioned by staff and community respondent groups. Darker shading indicates more frequent mention.

	Key issue	Staff (n=7)	Community (n=11)
Visible constraints	1. Medication availability	6/7	10/11
	2. Staff shortage	6/7	9/11
Process gaps	3. Problematic patient–staff communication	6/7	11/11
	4. Patients insufficiently informed	5/7	9/11
	5. Limited shared decision-making	7/7	4/11
	6. Unequal admission / gatekeeping	1/7	7/11
Organisational and staff issues	7. Internal communication gaps	7/7	—
	8. Incident reporting unclear / unsafe	6/7	—
	9. Staff privacy / wellbeing concerns	4/7	—

Counts show the number of respondent groups mentioning each issue.

Voices from the study

Four quotes illustrating what routine monitoring misses.

Essential resources matter

"The only thing you need to do is bring more medicine."

Source: Community respondent (R13)

Patients remain insufficiently informed

"Patient-centred care is suffering. You find patients going home without knowing what was treated."

Source: Staff respondent (R3)

Reporting does not yet translate into learning

"We just keep talking about it, and nothing changes."

Source: Staff respondent (R3)

Staff wellbeing shapes care

"This is not welfare."

Source: Staff respondent (R1)

Lived experience reveals process and trust-related gaps that routine indicators may miss.

What it does mean for programs

Routine monitoring is essential, but not sufficient. In Lankien hospital, lived experience revealed actionable gaps in communication, patient involvement, supervision, incident learning, trust, and staff wellbeing. Embedding low-burden qualitative feedback loops alongside routine indicators can strengthen quality monitoring and guide feasible improvement in fragile conflict affected settings.

From indicators to insight

How lived experience adds value to routine quality monitoring

Routine monitoring often shows

Medicines · Staffing · Admissions · Delays · Hygiene · Outcomes

Lived experience explains

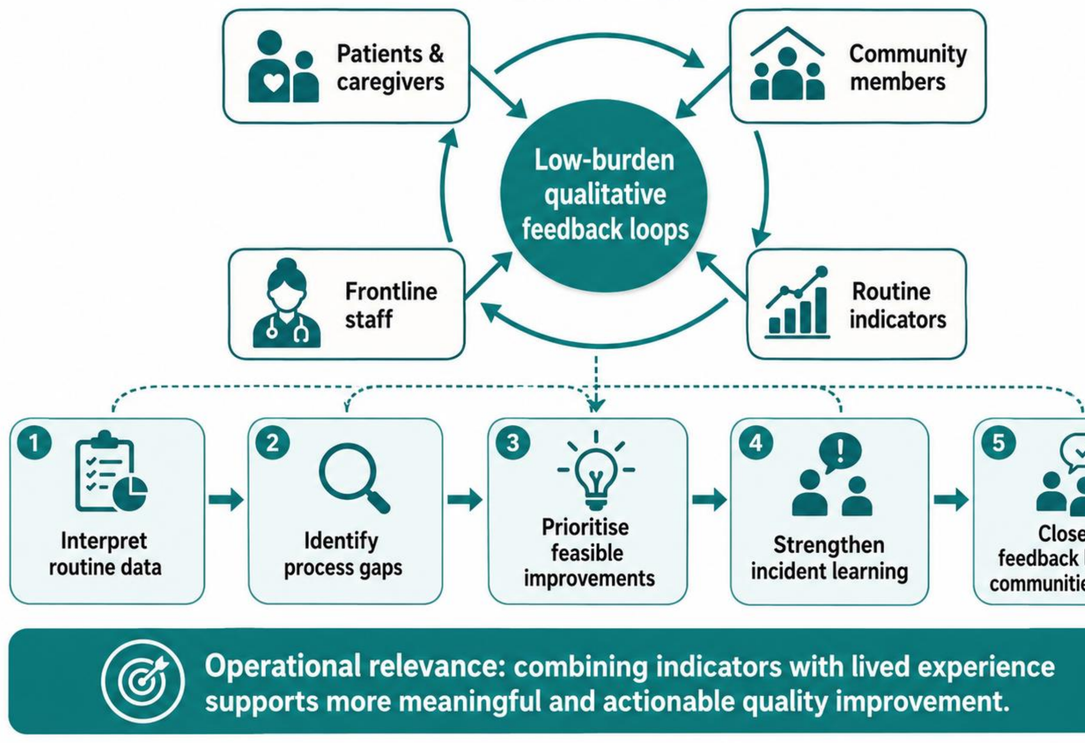
- Why patients feel uninformed
- Why admission is perceived as gatekeeping
- Why incident reporting feels unsafe
- Why communication breaks down
- Why staff motivation affects proactive care

Quality improvement should act on

Feedback loops · Just culture · Patient explanation · Community dialogue · Staff wellbeing · Clear supervision

Implications for practice

Quality monitoring in fragile settings should combine routine indicators with simple, low-burden qualitative feedback loops from patients, caregivers, community members, and frontline staff.



Operational relevance: combining indicators with lived experience supports more meaningful and actionable quality improvement.

For questions or comments contact: scientificday@london.msf.org

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Routine monitoring remains essential, but it is insufficient to understand quality of care in fragile and conflict-affected settings. In Lankien, lived experience revealed actionable gaps in communication, patient involvement, supervision, incident learning, trust, and staff wellbeing. **Quality improvement in fragile settings requires listening systems not system where focus is on collecting and reporting on quantitative indicators**

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