

Some considerations regarding coverage standards

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Problems with SPHERE

SPHERE standards for coverage are **simplistic** :

One figure (e.g. 50%) given for a particular setting :

No consideration of space :

Overall or everywhere?

No notion of time :

How long to achieve the standard?

SPHERE reads as if coverage can be just “switched on”

No method or estimator given (last time I looked)

Problems with SPHERE

No notion of what can be achieved by CMAM :

SPHERE standards for coverage are **unambitious** :

50% when 70 – 80% routinely achieved in CMAM programming

Labelled “minimum” but often a limit to aspiration :

Doing the minimum is not success ...

... it is merely the absence of failure ...

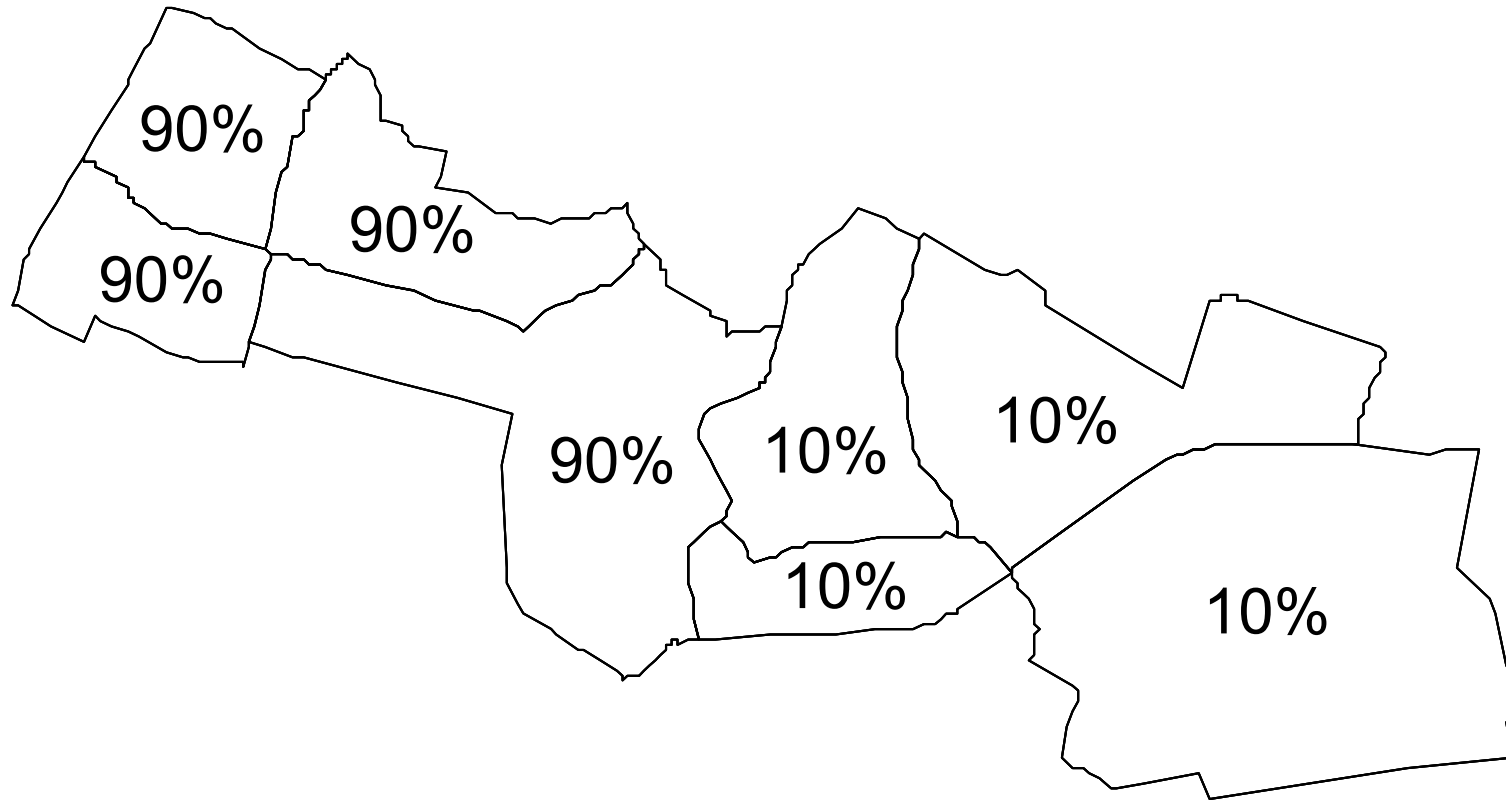
... miserable mediocrity!

SPHERE standards may be applicable only to humanitarian response :

CMAM is about much more than “humanitarian response”

Consideration of space

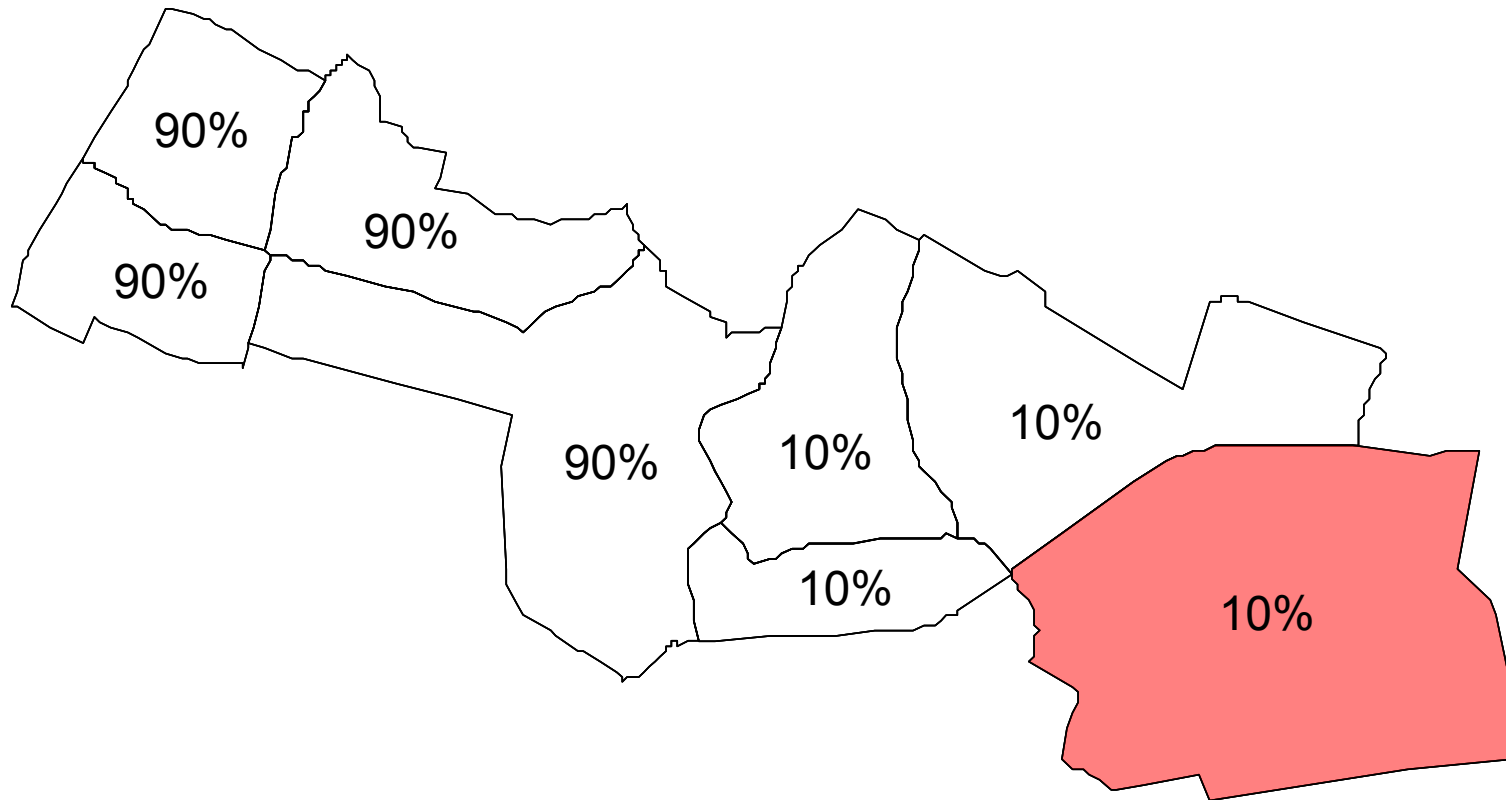
Example :



Overall coverage is 50%

Consideration of space

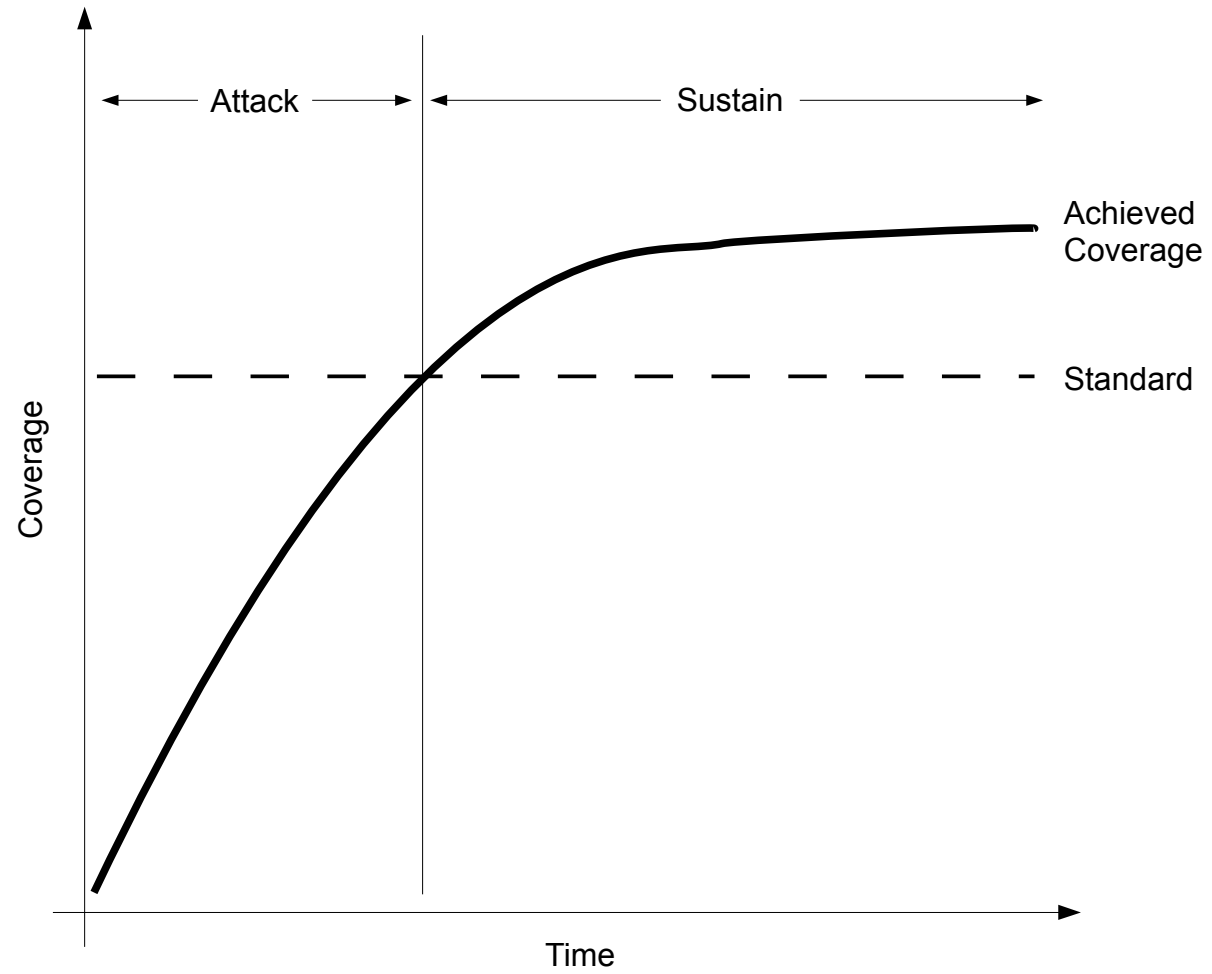
What about here?



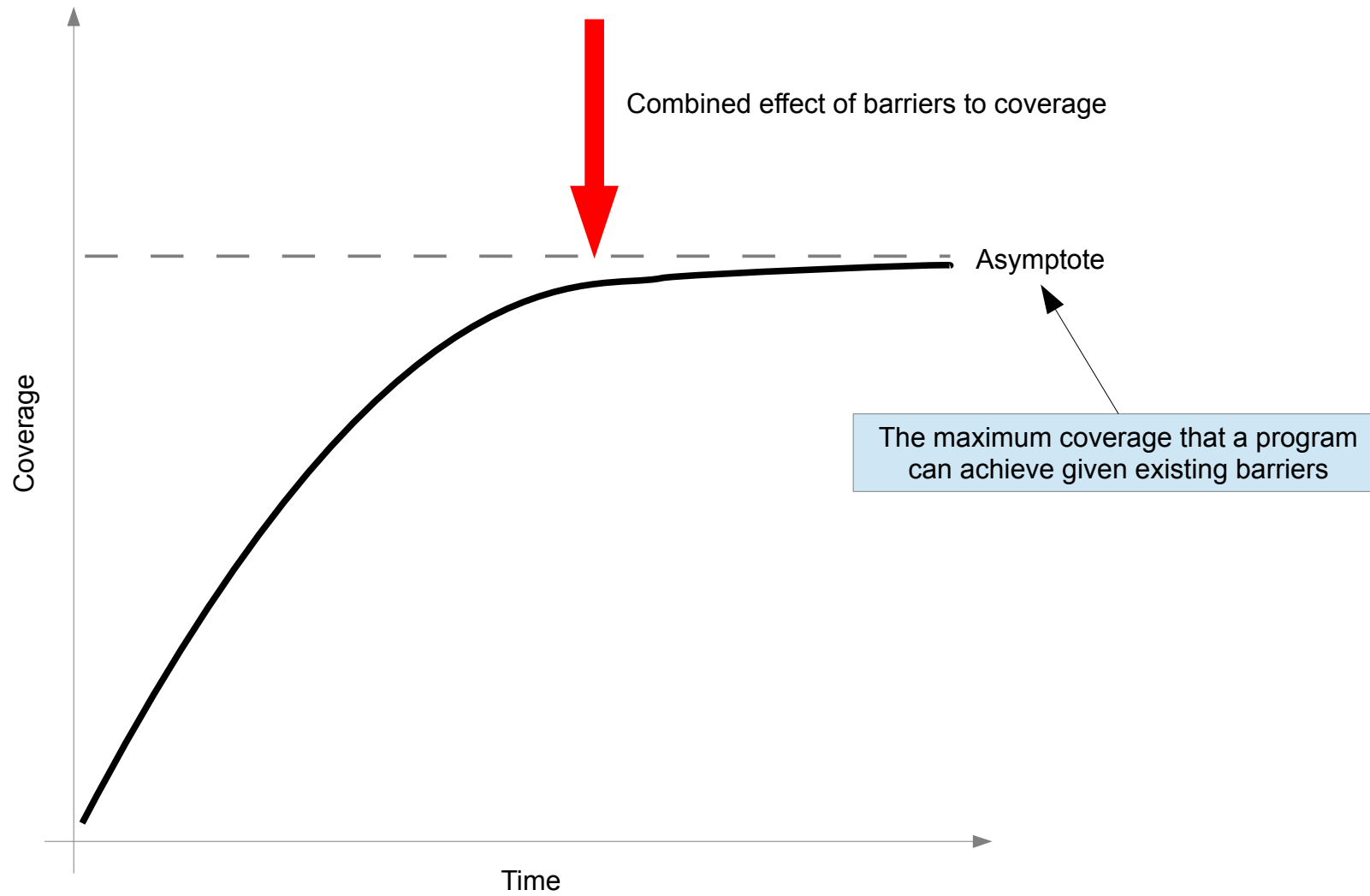
This is part of the lack of methodological guidance in SPHERE

Consideration of time

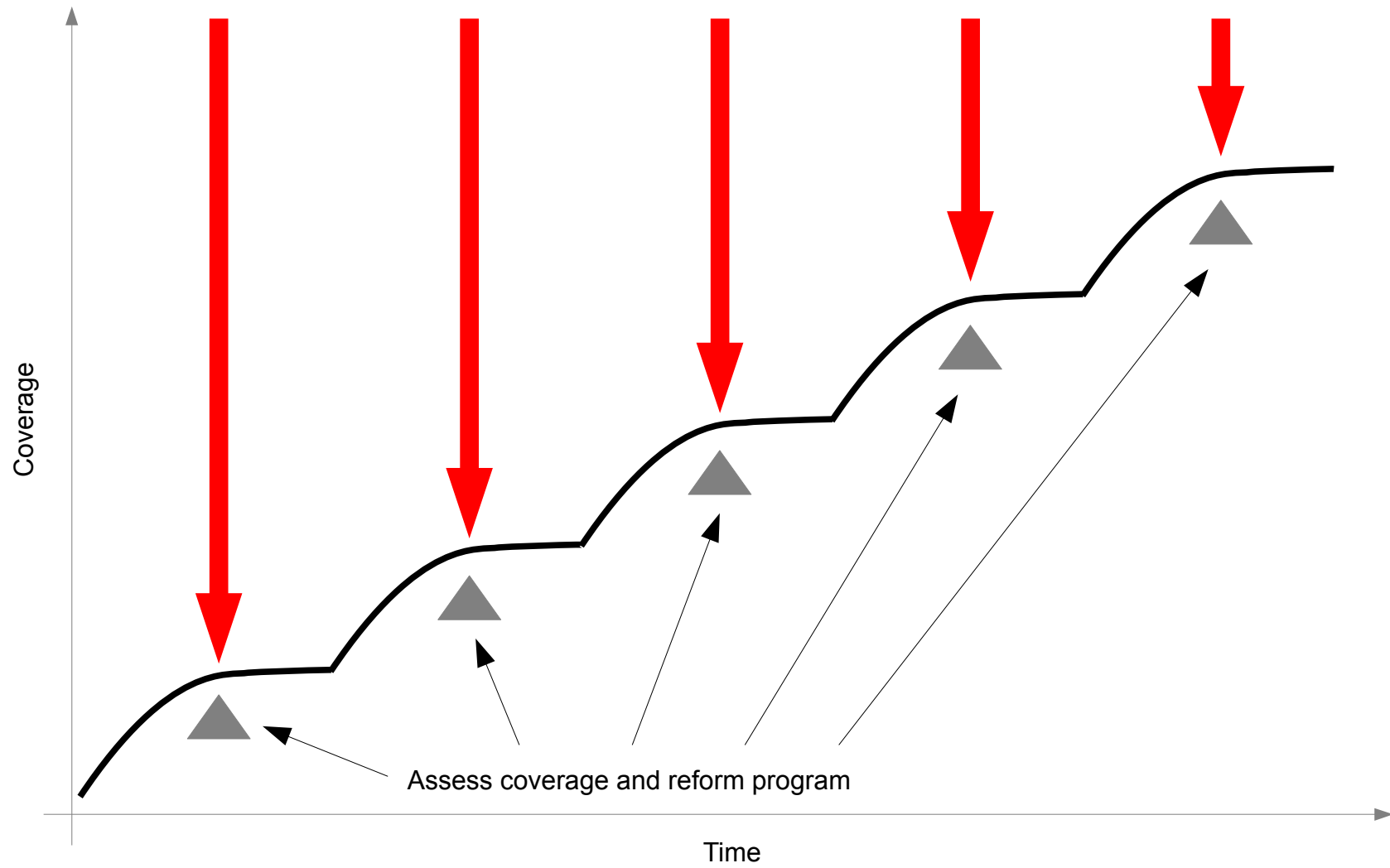
Coverage takes time :



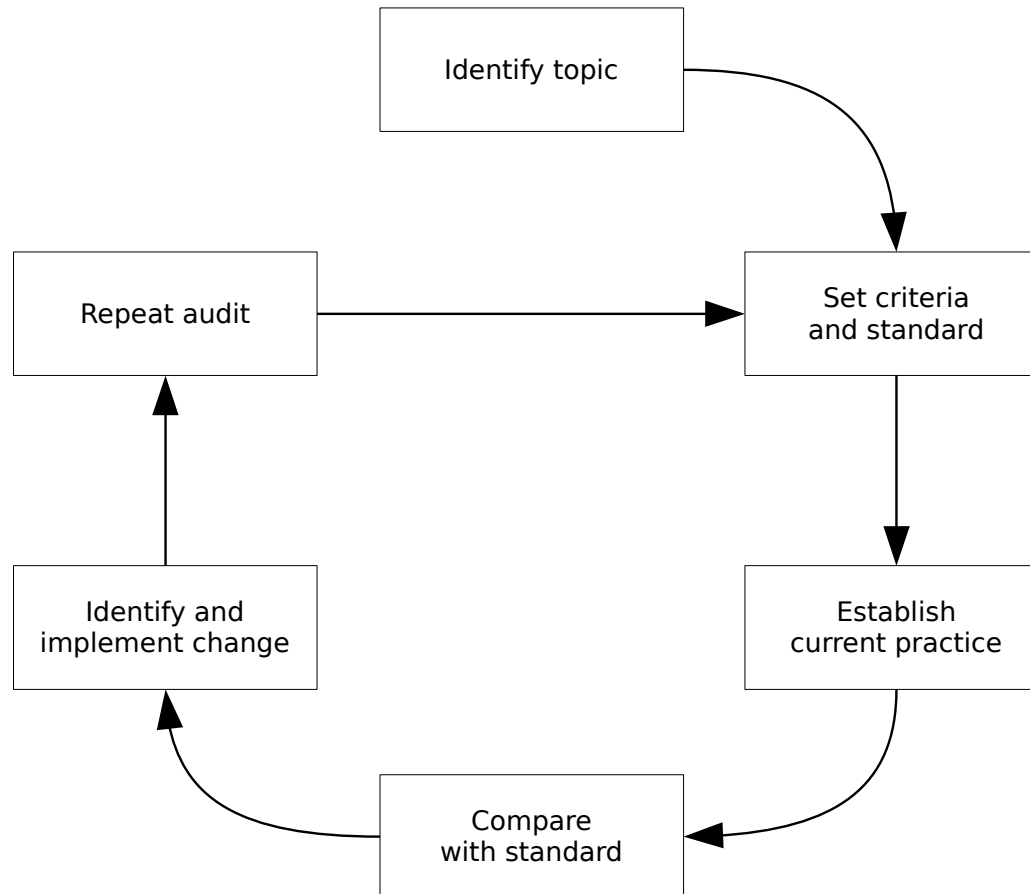
A useful model



Improving coverage



The audit cycle



The audit cycle aims to provide continual and incremental improvements to practice. This means that the standard should be increased once a previous standard has been met. The aim of clinical audit is to approach *best practice* over a number of audit cycles. Once best practice has been achieved (e.g. in CMAM programs in rural settings this means coverage levels of 80% or higher), the audit process continues in order to confirm that best practice is being sustained.

Standards change as a
program improves

50% at program start
is ludicrous

50% after _____

is _____