

# **CONCLUSIONS**

**1. Better clinical performance of staff trained in IMCI than those untrained**



**IMCI training can improve quality of outpatient child care**

**2. Very low clinical performance of staff not trained in IMCI**



**Issue of pre-service training standards**

### **3. Weak health systems support elements**



**Major constraint to delivery of  
quality child care services and  
IMCI implementation**

**RECOMMENDATIONS**  
**TO FURTHER IMPROVE**  
**OUTPATIENT CHILD**  
**HEALTH SERVICES**

## **POLICY: EQUITABLE ACCESS TO DRUGS AND SERVICES**

**Consideration should be given to protecting children below 2 years old, especially in poor families, by issuing a policy and establishing mechanisms to provide affordable drugs to them**

**States should commit to making key drugs regularly available to the health facilities where IMCI-trained staff work, to make the most of the substantial investment placed in IMCI training**

## **TRAINING: BASIC SKILLS AND SKILL REINFORCEMENT**

**Consideration should be given to strengthening pre-service training curriculum of medical assistants and introducing the IMCI outpatient care approach as a way to develop basic skills**

**The Federal level and States concerned should jointly plan to develop and commit adequate human resources to follow up visits after IMCI training, to conduct them on a timely basis and according to standard methodology**

## **SUPERVISION: MALARIA LABORATORY AND ROUTINE SUPERVISION**

**Close supervision by Federal and State levels with quality control of malaria microscopic diagnosis should be carried out regularly to improve the quality of malaria laboratory diagnosis**

**A training package on supervision of child health services should be developed. Supervisors responsible for routine supervision should be trained in child health supervisory skills and involved in IMCI follow-up visits**