Abstract Title: ***The status of child size medicines in Uganda: the context, prospects and limitations***

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Background: The '*making medicines child size'* campaign by WHO and UNICEF aimed to improve access to medicines that suit the child's weight and physiological condition. This study explored: (1) whether there are policies for child size medicines and (2) stakeholders' perspectives on child size medicines in Uganda.

Materials and Methods: We reviewed policy documents; developed and applied a child size assessment index to some medicines recommended for childhood diseases and interviewed national stakeholders. Documents were retrieved from MOH and development partners and included policy strategies, policy statements, treatment guidelines and essential medicine and health supplies lists. Analysis was based on Gil Walt and Gilson's policy analysis model of looking at context, actors, process and content.

Results: According to the policy documents: The Ugandan policies id not enumerate "child size medicines". The Uganda Clinical Guidelines (UCG) and the Essential Medicines and Health Supplies List of Uganda (EMHSLU) implicitly covered some aspects of child size medicines. The child size assessment index indicated that some medicines for malaria, diarrhea, epilepsy, HIV/AIDS and pneumonia had elements of 'child size'. Stakeholders demonstrated that:(1) most of the child size medicines were procured by the development partners (2) they had a vague understanding of 'child size medicine' concept (3) in the context of limited resources, medicines were highly politicized and policy decisions were determined by powerful and influential government officials and development partners because they controlled the budget (4) in terms of content, opinions of stakeholders regarding medicine package for children reflected the interests of the institutions they were serving. For example, the ministry of health managers who were pediatricians and pharmacists did not support the idea of child size due to costs of the medicines and the public health interest view. On the other hand, pediatricians and pharmacists outside MOH offices emphasized the need for child size medicines based scientific rationale and their nasty experiences of administering adult medicines to children (5) all the stakeholders recommended dispersible tablets and suppositories for children. Practicing pediatricians advocated for the use of syrups for very young children. Conversely, government officials preferred adult medicine formulations and maintained that syrups were bulky, messy and expensive (6) the preferred dispersible tablets were being procured by development partners and were limited to a few diseases (malaria, pneumonia diarrhea, epilepsy, asthma and HIV/AIDS) and were only being procured by donors (7) child size medicines were diverse in the unregulated private pharmacies and were often provided without prescriptions. While government did not procure syrups for their health facilities; it tolerated their existence in the private sector regardless of the high prices and the possibility of poor quality due to insufficient regulation.

Conclusions: Uganda has not yet developed specific policy on child size medicines and the stakeholders do not understand child size concept. The study recommends that WHO should: (1) should provide more details about how low income countries should operationalize child size medicine concept (2) have an affirmative action prioritizing pediatric medicines among essential medicines. Government of Uganda should (1)institutionalize procurement of child size medicines currently being procured by the development partners (2) include more pediatricians in policy design so as to generate more appropriate policies about medicines for children.

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