GAMBIA PARTICIPATES

# Documenting Corruption as a Human Rights Crisis in The Gambia

October 2026

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# Executive Summary

Between June and October 2022, at least 70 young children in The Gambia died of Acute Kidney Injury (AKI) after consuming contaminated pediatric cough and cold syrups. The World Health Organization (WHO) and the U.S. Centers for Disease Control and Prevention (CDC), working with The Gambia's Ministry of Health, identified unacceptable levels of diethylene glycol and ethylene glycol — industrial toxins — in four products manufactured by Maiden Pharmaceuticals Limited of Haryana, India, and imported into the country in June 2022. A National Assembly Select Committee subsequently found Maiden Pharmaceuticals responsible for the deaths and recommended legal action and compensation for victims' families. Since 2023, credible and independent investigative journalists documented allegations that an Indian state regulator was bribed to substitute test samples of the syrups before they could be verified as contaminated — allegations under continuing investigation in India at the time of writing.

This report is based on structured, trauma-informed interviews conducted in person between 31st May and 2nd June 2026, with twelve (12) families who lost a child believed to be linked to the AKI outbreak in 2022. All families gave informed consent to participate and to the anonymized use of their accounts for advocacy and research. Interviews were conducted in English and in a local language the respondents are most comfortable with.

The accounts of the victim families, corroborated by publicly available epidemiological, judicial, and media reports, describe a chain of governance failure in The Gambia's public health system before any contaminated syrups were imported in country. This failure includes, but-not-limited to the lack of effective screening and certification of pharmaceutical products before releasing them to the public, a public health system so chronically under-resourced that families and patients were routinely required to purchase medicines, laboratory tests, oxygen, in private pharmacies.

It is the combination of these systemic weaknesses that resulted to the victim families to purchase these contaminated syrups in private pharmacies, which resulted in the death of their sons and daughters.

The report documents violations of the right to life and the right to health under Articles 4 and 16 of the African Charter on Human and Peoples' Rights (ACHPR), the right to survival and development (Article 5), and the right to the highest attainable standard of health (Article 14) of the African Charter on the Rights and Welfare of the Child (ACRWC) and Article 24 of the UN Convention on the Rights of the Child (UNCRC). It also documents conduct, including the confiscation of medicine evidence at a treating facility, instructions reportedly given to a treating physician not to provide evidence without ministerial authorization and offers of payment to victim families, characterized by many, as an inducement attempt to secure silence from the victims. This raises public sector corruption concerns, which is contrary to the object of the African Union Convention on Preventing and Combatting Corruption (AUCPCC) and the UN Convention Against Corruption (UNCAC), both of which The Gambia is a party to, regarding obstruction of accountability and victim intimidation.

## Key findings include:

- All twelve children died after being administered with a pediatric syrup, most often a paracetamol or cough/cold preparation obtained from a public health facility, a private clinic, or a pharmacy, consistent with the WHO- and CDC-identified contamination pathway.
- In at least ten of the twelve (10/12) cases, the victim families, while with their admitted children in the hospital, they were required to buy essential medicines, laboratory tests, intravenous drips, oxygen and other medical products from private providers at their own expense, often while the child's condition was rapidly deteriorating, because the public facility could not supply them.
- Referral pathways to the country's only pediatric dialysis-capable facility (Edward Francis Small Teaching Hospital, Banjul) were repeatedly undermined by a shortage of ambulances (in one case, four critically ill children under the age of four shared a single ambulance), missing dialysis catheters, non-functioning equipment, and gaps in overnight physician coverage.
- Several families reported being met with informal cash or in-kind offers — coordinated through Governors' offices or intermediaries — that they characterized as attempts to forestall accountability rather than genuine redress; multiple families declined or returned these offers.
- Multiple families reported subtle pressure to abandon legal action, ranging from religious appeals by relatives to community members warning that "nothing will come out of it," and in one case, a report that a treating doctor had been instructed not to give evidence without ministerial authorization.
- Every family reported a lasting loss of trust in the public health system, with several now treating other children's illnesses with herbal remedies rather than risking further contact with the formal health sector.
- All twelve families are current parties to, or dependents of parties to, ongoing civil litigation in The Gambia's High Court; as of the date of the interviews, no family reported having received a final judgment, compensation, or a definitive accounting of individual institutional responsibility more than three years after the deaths of their children.

The report recommends, among other measures: completion and public release of all outstanding investigations and the expedited conclusion of pending civil and criminal proceedings; a State-funded, rights-based reparations scheme independent of and additional to any civil damages to victims; accountability for all public officials and pharmaceutical business establishments responsible for the AKI outbreak in The Gambia, structural investment in pediatric emergency and renal care, ambulance capacity, statutory and institutional strengthening of the Medicines Control Agency's (MCA) capacity to conduct rigorous medicine import-screening and post-market surveillance powers; protection against retaliation or inducement for victims and witnesses; and ACHPR to investigate the human rights violation of the Charter by the government of The Gambia.

# 1. Introduction

## 1.1 Background to the AKI Crisis

On 26 July 2022, a pediatric nephrologist at Edward Francis Small Teaching Hospital (EFSTH) in Banjul — the country's sole teaching hospital alerted the Ministry of Health to an unusual cluster of Acute Kidney Injury (AKI) cases among children under five. By 12 August 2022, dozens of cases and a rising number of deaths had been recorded, prompting the Ministry to request epidemiological assistance from the U.S. Center for Disease Control (CDC). Investigators established that affected children had, in the days before falling ill, been given one of four pediatric syrups — Promethazine Oral Solution, Kofexmalin Baby Cough Syrup, Makoff Baby Cough Syrup, or Magrip N Cold Syrup — all manufactured by Maiden Pharmaceuticals Limited of Haryana, India, and imported into The Gambia by a local distributor on or around 21 June 2022.

Laboratory analysis coordinated with the WHO confirmed unacceptable concentrations of diethylene glycol (DEG) and ethylene glycol (EG) — toxic industrial solvents with no legitimate role in oral pediatric medicine and known, since at least the 1930s, to have cause fatal Acute Kidney injury — in samples of the implicated syrups. On 5 October 2022, the WHO issued a global medical product alert. By the time recall and public-awareness measures took hold, at least 70 Gambian children, almost all under five years of age, had died; the government's own Parliamentary Select Committee, reporting in December 2022, attributed the deaths to Maiden Pharmaceuticals and recommended both legal action against the company and compensation for affected families.

Families whose children died, organized as the AKI Victims' Association, filed civil proceedings in The Gambia's High Court in 2023 against Maiden Pharmaceuticals, its local distributor, the Ministry of Health, the Medicines Control Agency (MCA), and the Attorney General, seeking acknowledgment of responsibility and compensation. In October 2024, the High Court permitted the suit against the state defendants to proceed, rejecting government arguments for dismissal. In India, between 2023 and 2024, media reports documented Indian government inquiry into an allegation that a Haryana state drug-testing official accepted a bribe to substitute cough-syrup samples before they could be verified as contaminated — an allegation, if substantiated, that would indicate the manufacturer had reason to know of contamination before the syrups were imported to The Gambian, leading to the death of dozens of children. That inquiry remains unresolved and is referenced here as a documented, still-contested allegation, not an established fact.

## 1.2 Scope of Investigation

This report is confined to the experiences of twelve (12) Gambian families interviewed in person between 31 May and 2 June 2026, read alongside consistent public-record epidemiological, parliamentary, judicial, and media documentation of the wider AKI outbreak. It does not purport to be a comprehensive account of all victims of the outbreak, nor a finding of individual civil or criminal liability, which remains for the competent Gambian courts (and, in respect of the manufacturer, potentially other jurisdictions) to determine. Where the report describes a fact as established, it draws on multiple, mutually corroborating sources; where it relates to a family's account that could not be independently verified from the documentary record available to the research team, this is stated as testimony or allegation.

## 1.3 Purpose of the Report

The report is prepared to: (i) place the lived experience of affected families at the center of the international human rights record of the AKI tragedy; (ii) map the governance and corruption-adjacent failures that connect a substandard pharmaceutical import to the deaths of Gambian children; (iii) analyze the tragedy against The Gambia's binding regional and international anti-corruption and human rights obligations; and (iv) support a formal submission to the African Commission on Human and Peoples' Rights and generate a public advocacy brief.

## 1.4 Relevance to the African Commission on Human and Peoples' Rights (ACHPR)

Although Article 56 (5) stated that complaints against human rights violation by a state party could only be made before the Commission after "exhausting local remedies" however, the same sub-article gives an exception where "...it is obvious that this procedure is unduly prolonged". While GP gives due regard to court proceedings, it is our belief that this case is a public-interest litigation that should be given the utmost urgency and attention. While the case was first heard at the High Court of The Gambia on July 17th ,2023, the case has been going on since then. Even whereas the Court may give a positive verdict, in favor of the 19 family victims' plaintiffs, the state will highly likely appeal against such verdict at the Court of Appeal, which will continue to delay justice and compensation.

In addition, the National Assembly of The Gambia's Special Select Committee's inquiry into the AKI outbreak reported that the cause of death of the affected children is due to the contaminated syrups. The National Assembly report recommended compensation to the victims' families. Although the report acknowledges the institutional weaknesses/inefficiencies of public medical control authorities, the report is completely silent about their culpability in the death of the children. However, the Presidential AKI Task Force, an independent body that investigated the AKI outbreak, attributed negligence to the Medical Control Agency (MCA) in failing to examine pharmaceutical products before its circulation to the public.

It is worth noting that regulators at MCA that are responsible for issuing pharmaceutical license (manufacturing, import and export, etc.) and exercising oversight on pharmacies and pharmaceutical products were allegedly holding such licenses and renting them to pharmacies they were supposed to regulate, thus, financially benefiting from the license rental. This is a conflict of interest which is against section 222(10) of the 1997 Constitution, Article 4(1)(b) of the African Union Convention on Preventing and Combatting Corruption (AUCPCC) and Article 8 of the United Nations Convention Against Corruption (UNCAC).

In line of the above, it is our firm belief that local remedies have been sought (by both the National Assembly, the Executive and Victim Families), amidst the available evidence, there has been no formal declaration that the state violated the rights of the children by failing to prevent the circulation of contaminated medical syrups, that there was corruption and conflict of interest within MCA and that the acts or omission of responsible public medical authorities resulted to the death of the children (in addition to the acts or omission of Maiden Pharmaceuticals and its partners in The Gambia. The state has also failed to take accountability actions against medical authorities at MCA responsible for screening imported medical products, nor has the state provided compensation to the victims, as recommended by the National

Assembly Special Select Committee. This makes this case unique and relevant to the African Commission on Human and Peoples' Right to consider it admissible under Article 55 and Article 56(5) of the ACHPR Charter.

# 2. Methodology

## 2.1 Interviews

Twelve victim families were interviewed in person over three days (31 May – 2 June 2026) across multiple locations in the Greater Banjul Area and West Coast Region, including Tanji, Old Yundum, Brikama and surrounding settlements, Latrikunda, Sancheba, Jabang, Faraba, and Aljama (Niumi). All families had lost a child during the 2022 outbreak and were, at the time of interview, parties to or affiliated with the pending High Court civil proceedings.

## 2.2 Instrument

Interviews used a structured questionnaire ("Documenting Health Harm Linked to Corruption") developed for this study, organized into five sections: (1) consent and confidentiality; (2) incident specifics, covering the circumstances of seeking care, facility characteristics, informal payments, stock-outs, and referrals to private providers; (3) outcome, covering clinical deterioration, institutional response, and barriers to emergency care; (4) human impact, covering financial, psychological, and social consequences and trust in institutions; and (5) accountability, covering prior complaints, barriers to justice, desired remedies, retained evidence, and any experience of threats or attempts at silencing.

## 2.3 Sampling

Families were identified through their prior affiliation with the AKI Victims' Association and existing civil litigation, a purposive rather than random sample. This approach was chosen to reach families already engaged in the formal accountability process and able to speak to both the medical and justice-seeking dimensions of the tragedy; it necessarily means the sample does not include families who have not joined the litigation, who may have different experiences of the accessibility of remedy.

## 2.4 Ethical Safeguards and Informed Consent

All participating families provided informed consent prior to interview, including specific, separately recorded consent to the anonymized use of their account for advocacy and research purposes. Consistent with that consent, this report identifies families and children only by case number and initials, withholding full names, exact addresses, and other identifying details not necessary to the analysis. Interviews followed trauma-informed practice: participants were not pressed for detail beyond what they volunteered. Respondents were free to decline any question and were reminded that participation was unconnected to the outcome of their ongoing legal proceedings.

## 2.5 Translation

Interviews were conducted primarily in English; where a participant was more comfortable in a local language, questions and responses were translated to ensure full comprehension and accurate representation of testimony.

## 2.6 Data Collection and Analysis

Responses were recorded contemporaneously against the structured instrument and subsequently coded thematically across the six analytical themes set out in Section 4 below: healthcare access and circumstances; corruption and systemic failures; harm and human rights impacts; institutional response; accountability and justice; and victim perspectives on justice. Recurring patterns were identified by comparing coded responses across all twelve interviews.

## 2.7 Limitations

- The sample (twelve families) is a small, purposively selected subset of the more than 70 documented deaths and cannot be treated as statistically representative of all affected families' experiences.
- Testimony reflects families' good-faith recollection of acutely traumatic events occurring up to four years before interview; clinical details (e.g., specific diagnoses, medication names) are recorded as reported and, where possible, cross-checked against the wider epidemiological literature, but individual medical records were not systematically obtained and reviewed for this report.
- The research team did not independently interview hospital staff, MCA officials, or government representatives named or referenced in family testimony; institutional accounts of these same events may differ and should be sought before any adjudicative finding is made.
- References to a specific number of related deaths (e.g., 83) that appear in a single family's testimony are recorded as reported by that family; the figure corroborated across independent government, WHO, and CDC sources is at least 70.

# 3. Context and Background

## 3.1 Timeline of Events

| Date | Event |
|---|---|
| 21 June 2022 | A consignment of pediatric syrups manufactured by Maiden Pharmaceuticals Limited (India) is imported into The Gambia by a local distributor and reaches pharmacies and health facilities nationwide. |
| 24 June – 26 July 2022 | A pediatric nephrologist at Edward Francis Small Teaching Hospital (EFSTH), Banjul observes an unusual rise in acute kidney injury cases among children aged five months to seven years. |
| 26 July 2022 | The treating nephrologist formally alerts the Ministry of Health (MoH). |
| 12 August 2022 | Cumulative case count reaches at least 30 pediatric AKI cases known to MoH. |
| 23 August 2022 | MoH requests epidemiological assistance from the U.S. CDC. |
| 16 September 2022 | CDC epidemiologists arrive in The Gambia to support the MoH investigation. |
| 5 October 2022 | WHO issues a global medical product alert on four Maiden Pharmaceuticals syrups after independent laboratory confirmation of diethylene glycol and ethylene glycol contamination; reported case count stands at 82 cases and 66 deaths. |
| October 2022 | Government bans importation and distribution of the implicated products and initiates a recall; police open a preliminary investigation. |
| 15 October 2022 | Cumulative confirmed death toll reaches 70 children; new cases decline sharply following recall and public-awareness measures. |
| December 2022 | A National Assembly Select Committee reports that Maiden Pharmaceuticals is responsible for the deaths and recommends legal action and victim compensation. |
| 2023 | Indian media begin reporting an internal Indian government inquiry into an allegation that a Haryana state regulator accepted a bribe to substitute cough-syrup test samples before contamination could be verified; the inquiry remains open. |
| July 2023 | Nineteen plaintiffs, organized as the AKI Victims' Association, filed a civil suit in the High Court of Banjul against Maiden Pharmaceuticals, its local distributor, the Ministry of Health, the Medicines Control Agency, and the Attorney General. |
| October 2024 | The High Court permits the civil suit against the Gambian state defendants to proceed, rejecting government efforts to have it dismissed. |
| 31 May – 2 June 2026 | Field interviews for this report were conducted with twelve affected families; families report the civil proceedings are ongoing, with no final judgment reached. |

## 3.2 Pharmaceutical Supply Chain Context

The Gambia has no domestic pharmaceutical manufacturing capacity and imports the overwhelming majority of its medicines. Import screening relies on documentary checks (certificates of analysis and Good Manufacturing Practice certification issued by the exporting country's regulator) rather than routine independent laboratory testing of incoming consignments — a gap that the 2022 AKI outbreak exposed starkly, since no toxin was detected in the implicated syrups until after dozens of children had already died

and testing was conducted reactively, following clinical suspicion rather than routine surveillance. Distribution runs through a mixture of public health facility pharmacies, which are frequently understocked, and a dense network of private pharmacies operating with limited regulatory oversight, from which families in this study routinely purchased medicines the public facility could not supply.

## 3.3 Regulatory Environment

The Medicines Control Agency (MCA) is the statutory body responsible for registering, licensing, and monitoring the quality and safety of locally manufactured or imported medicines in The Gambia. Section 4 of the Medicines and Related Products Act, 2014, gives regulatory powers to the MCA, which includes, but not limited to, pharmacovigilance of medical products globally before accepting the use of such medicines in The Gambia.

This report does not make an independent finding on the adequacy of MCA's institutional resources and capacity to execute its legal mandate, at the time of reporting. It records, however, that MCA failed in its statutory pharmacovigilance responsibilities on contaminated medical products that claimed the lives of dozens of children. The MCA is repeatedly referenced by interviewed families as the body they associate with the failure to prevent contaminated medicine reaching their children, and that at least one family reported a serving MCA staff member making informal, unsolicited contact with them after the death of their child.

## 3.4 Public Healthcare Context

The Gambia's public health system is characterized, according to consistent family testimony, by chronic shortages of essential medicines, laboratory reagents, functioning diagnostic and dialysis equipment, and ambulances, and by concentration of tertiary and pediatric renal care in a single teaching hospital in Banjul. Families from as far as Sancheba, Faraba, and Niumi described being referred, often more than once, to Banjul, with several noting that multiple critically ill children shared a single ambulance for the journey. This concentration of capacity, combined with resource shortages at every referral point along the way, forms an important structural backdrop to the individual failures documented in Section 4. In a country, like The Gambia, that is faced with chronic shortages of essential medical materials, must at all costs, be vigilant to the importation of contaminated medical products that will not only overwhelm its under-resourced medical facilities, but it will also cost the lives of innocent citizens and non-citizens.

# 4. Findings

## 4.1 The Corruption and Governance Failure Pathway

Family testimony, read together with the public epidemiological and parliamentary record, supports a chronological reconstruction of how a single substandard pharmaceutical import translated into dozens of preventable child deaths. The pathway below distinguishes conduct independently corroborated by multiple sources (marked "Established") from conduct reported by families that remains, at the time of writing, a documented allegation pending verification (marked "Alleged/Reported").

| Stage | Decision Point / Actor | Governance Failure | Status |
|---|---|---|---|
| 1. Manufacture | Maiden Pharmaceuticals Ltd. (Haryana, India) | Production of pediatric syrups contaminated with diethylene glycol and ethylene glycol, industrial solvents with no therapeutic role, at levels later confirmed by independent WHO-coordinated laboratory testing. | Established |
| 2. Sample testing (India) | Haryana state drug-testing authority | Credible reporting alleges a state regulator accepted payment to substitute test samples before contamination could be verified, allowing the product to continue in circulation for export. | Alleged / under Indian government inquiry |
| 3. Export certification | Indian export/regulatory authorities | Export-only manufacturing license issued without the same safety assurance regime applied to products for the domestic Indian market, reflecting a documented double standard in pharmaceutical export oversight for a lower-income destination market. | Established (regulatory structure); policy critique reflects independent commentary |
| 4. Importation | Local Gambian distributor; Medicines Control Agency | Consignment entered the country on or around 21 June 2022 without independent laboratory verification of contents ahead of distribution to pharmacies and public facilities. | Established |
| 5. Distribution | Public health facilities; private pharmacies | Syrups reached families through both public facility pharmacies and loosely unregulated private pharmacy sales, in several cases without any clinical assessment of the child before dispensing. | Established, per family testimony |
| 6. Clinical recognition | Treating clinicians; Ministry of Health | A cluster of unexplained pediatric AKI cases was recognized by front-line clinicians by late July 2022, but the causal product was not identified and recalled until October 2022, a gap of over two months during which children continued to be exposed. | Established |
| 7. Referral and emergency care | Regional health centers; EFSTH Banjul | Shortages of ambulances, dialysis catheters, functioning dialysis machines, oxygen, and overnight physician coverage meant that even after a child's condition was correctly identified as an emergency, care was frequently delayed or unavailable. | Established, per consistent family testimony |

| | | | |
|---|---|---|---|
| 8. Cost-shifting to families | Public and private facilities | Families were routinely required to purchase medicines, laboratory tests, and consumables privately, at cost, during a life-threatening emergency, effectively transferring a public health system funding gap onto grieving families. | Established, per consistent family testimony |
| 9. Post-death institutional response | Facility management; Ministry of Health; Governors' offices | Responses ranged from a facility admitting a medicine was unrecorded and of unknown origin, to informal cash/in-kind offers several families characterized as attempts to secure silence rather than acknowledged compensation. | Established that offers were made; families' characterization of intent is their own assessment |
| 10. Accountability | Police; National Assembly; High Court; MCA | A parliamentary committee assigned responsibility to the manufacturer in December 2022; civil litigation was not filed until mid-2023 and remains unresolved as of the 2026 interviews, more than three years after the deaths. | Established |

Two features of this pathway are salient for a corruption and governance analysis. First, at no single stage was there a designed, independent checkpoint capable of intercepting a contaminated consignment before it reached a child — sample-substitution allegations in India (Stage 2), the absence of routine independent import testing in The Gambia (Stage 4), and reactive rather than proactive clinical surveillance (Stage 6) each represent a missed opportunity that, addressed, could plausibly have prevented some or all of the deaths. Second, the burden of the system's resource gaps (Stages 7–8) fell overwhelmingly on families at the point of their children's greatest medical need, a pattern consistent with what anti-corruption and health-systems literature terms informal cost-shifting: care that should be a state-funded entitlement is, in practice, conditioned on a family's ability to pay out of pocket in real time.

## 4.2 Victim Experiences

The twelve cases below are presented in the order the interviews were conducted. Names have been withheld and replaced with case numbers and initials, consistent with each family's informed consent to anonymize use of their account; other identifying details (precise addresses, facility staff names) has similarly been generalized where not essential to the analysis.

### Case 1: I.D. (F, 4 yrs 10 mo) — Tanji, Dec 2022 – Jan 2023

| | |
|---|---|
| **Facilities involved** | Tanji Health Centre (public); Brikama Main Hospital (public); private lab (Tendako Medical Clinic) |
| **Medicine administered** | Cough/fever syrup and vomiting medicine dispensed at Tanji Health Centre |
| **Clinical course** | Fever treated at Tanji Health Centre with syrup; child developed swelling and puffy eyes; admitted at Brikama Main Hospital where family was required to obtain lab work and IV drips from private providers (~D1,500, reduced to D1,200 at a private clinic) before results were used to issue a transfer to Banjul; brother noticed the child had stopped passing urine. |
| **Outcome** | Died following transfer to Banjul. |

| | |
|---|---|
| **Institutional response** | Tanji Health Centre later admitted to the family that the syrup administered "was not on any of their official records" and should not have been given, and that its origin was unknown. The Ministry of Health triggered a police investigation; the facility's Managing Director was arrested. |
| **Family and community impact** | Financial and emotional hardship; a surviving sibling who later fell ill was treated with herbal remedies instead of hospital care because the family no longer trusted the public health system. |
| **Accountability efforts** | Only the pending High Court civil case (referred to by the family as the "AKI case"); no threats reported. |

> *"Health institutions are the only place for hope, but they failed us."* — *Parent, Case 1*

### Case 2: L.S. (M, 3 yrs) — Old Yundum, July 2022

| | |
|---|---|
| **Facilities involved** | Bakoteh Precious Clinic (private, via employer health plan); Africmed Medical Centre, Brusubi (private); Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Medication for "serious malaria" dispensed at Bakoteh Precious; further medicines purchased privately after referral |
| **Clinical course** | Diagnosed with malaria at a private clinic; the father recorded that clinic nursing staff were inattentive ("on their mobile phones"); child deteriorated overnight, was later diagnosed with a "kidney problem," and referred to Banjul with no ambulance available, forcing the father to drive him personally. On arrival, the child was found to lack necessary equipment and medicines, which the family had to source privately, including from a pharmacist who extended credit. |
| **Outcome** | Died in hospital following an unsuccessful operation. |
| **Institutional response** | Ministry of Health belatedly directed a private laboratory (AQA) to waive fees for affected children. No government visit to the hospital was recorded by the family despite proximity to the seat of government. |
| **Family and community impact** | Severe emotional and financial impact; siblings were initially told the child had gone abroad rather than that he had died. |
| **Accountability efforts** | Ongoing civil case; the family reports periodic contact from the Ministry of Health and a parliamentary select committee expressing sympathy, but no threats. |

> *"Take me home."* — *Final words of the child, recounted by his father, Case 2*

### Case 3: A.S. (F, 3 yrs (twin)) — Tanji, August 2022

| | |
|---|---|
| **Facilities involved** | Tanji Health Centre; Kanifing General Hospital (public); Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Paracetamol syrup and cough syrup |
| **Clinical course** | Treated for fever with syrups; condition deteriorated; diagnosed with "low blood" and given further medicine; admitted at Kanifing for two nights before referral to Banjul, where the family reported power outages that interrupted oxygen supply during treatment. |

| | |
|---|---|
| **Outcome** | Died. |
| **Institutional response** | Family reports that after the death, unidentified intermediaries — including individuals identifying themselves as government-linked — sought to arrange informal apologies, provisions (bag of rice), and a signed consent form in partnership with an NGO, without the involvement of the family's legal representatives or victims' association. |
| **Family and community impact** | Profound grief compounded by the loss of a twin; loss of confidence in the health system; reliance on herbal remedies for surviving children. |
| **Accountability efforts** | Civil cases are ongoing; family redirected informal settlement approaches to the victims' association leadership rather than negotiate individually. |

> *"If there were a good system in place, [she] could have survived. The system failed her."*
> *— Parent, Case 3*

### Case 4: M.L.D. (M, 3 yrs) — Tanji, 2022 (exact date not recorded)

| | |
|---|---|
| **Facilities involved** | Pharmacy (Tanji); AMARCY medical facility |
| **Medicine administered** | Syrup dispensed directly by a pharmacy without clinical assessment |
| **Clinical course** | Fever treated with pharmacy-dispensed syrup without medical examination; condition worsened, including cessation of urination. On arrival at AMARCY the facility gate was locked as it was after operating hours; the family reports the child died while waiting outside the gate. |
| **Outcome** | Died at the facility gate before being admitted. |
| **Institutional response** | A physician at the facility reportedly questioned staff about why the family had been refused entry after the child had already died. |
| **Family and community impact** | Complete loss of trust in the health system; a surviving child has an unresolved post-surgical complication (an open stoma) for which the family struggles to fund further care. |
| **Accountability efforts** | Civil case only; a community member reportedly discouraged the father from pursuing litigation. |

> *"My child died in my arms while waiting at the gate with no rescue."* *— Parent, Case 4*

### Case 5: J.J. (F, 6 months) — Sancheba, 2022

| | |
|---|---|
| **Facilities involved** | Serrekunda Health Centre (public); Kanifing Health Centre (public); Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Medicine purchased at an outside pharmacy on the instruction of Serrekunda Health Centre staff |
| **Clinical course** | Treated for fever; stopped urinating after medication; family was charged an unexplained D3,000 fee at Kanifing; staff were unable to locate a vein for IV drips; child was referred to Banjul sharing a single ambulance with three other families whose children presented with the same symptoms. |

| | |
|---|---|
| **Outcome** | Died. |
| **Institutional response** | No documented facility-level accountability response reported by the family. |
| **Family and community impact** | Severe financial strain on the family's small trading business; heightened vulnerability as a non-Gambian national resident in the country; no community support received. |
| **Accountability efforts** | Civil case only; no reported threats. |

> *"This is not an act of God. The authorities should make sure this does not happen again."*
> *— Parent, Case 5*

### Case 6: M.K. (M, 2 yrs) — Latrikunda, July 2022

| | |
|---|---|
| **Facilities involved** | Kanifing General Hospital (public); AQA private laboratory; Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Medicine purchased at a private pharmacy after referral from the public hospital |
| **Clinical course** | Father, himself a healthcare worker, reported that the child developed anuria, vomiting, and seizures; renal failure was identified at a private laboratory after the hospital's own dialysis machine was found non-functional; four children under age four shared one ambulance to Banjul; no physician was on duty between midnight and 5 a.m.; no dialysis catheter was available. The father's request for referral to Dakar, Senegal was initially refused by the attending doctor before being granted. |
| **Outcome** | Died on 5 August 2022. |
| **Institutional response** | An MCA staff member known personally to the family made informal contact; the family was told that the treating doctor had been instructed not to provide evidence without ministerial authorization. |
| **Family and community impact** | Severe financial and psychological impact, including self-blame; ongoing distrust of the health system despite the father's own profession; family now sources medicines from relatives abroad. Community mobilized transport and support for the failed Dakar referral. |
| **Accountability efforts** | No civil filing recorded by this respondent at time of interview; a grandmother urged the family to abandon the matter on religious grounds; the family reports being asked whether they were part of the "victims' coalition." |

> *"The right people in the right place. Health is not a joke."* *— Parent, Case 6*

### Case 7: I.Da. (M, 1 yr 9 mo) — Brikama, August 2022

| | |
|---|---|
| **Facilities involved** | Brikama Health Centre (public); private pharmacy; AQA private laboratory; Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Medicines purchased at a private pharmacy; drips and oxygen sourced outside the facility |
| **Clinical course** | Treated multiple times for a diagnosis of pneumonia; discharged and re-admitted as condition worsened; referred to Banjul, where laboratory staff flagged the case as an emergency, but no doctor attended until the following morning; a private pharmacist |

| | |
|---|---|
| | noted the medicine the family had been sent to buy outside was, **in fact, in stock at the hospital.** The child underwent two operations and died during the second. |
| **Outcome** | Died in theatre. |
| **Institutional response** | The Governor's office provided condolence payments to some families; several respondents, including this family, reported that money was later returned by other families who believed it was intended to secure silence. |
| **Family and community impact** | Severe emotional impact; the father formally raised concerns with hospital staff before the civil case began. |
| **Accountability efforts** | Civil case ongoing; family reports being discouraged by acquaintances from continuing to pursue the matter. |

> *"Somebody should be held responsible. Whoever is responsible should take responsibility."* — *Parent, Case 7*

### Case 8: F.B. (F, 2 yrs) — Brikama Mandura, September 2022

| | |
|---|---|
| **Facilities involved** | Traditional healer; Brikama Health Centre (public); private pharmacy; private scan clinic (Farato); Edward Francis Small Teaching Hospital, Banjul (public); Ndemban Health Centre (public) |
| **Medicine administered** | Medicine purchased outside the facility (not stocked on-site) |
| **Clinical course** | Initial leg injury treated by a traditional healer; developed fever, treated at Brikama Health Centre; referral note delayed by three days; catheter inserted; the family reports being shuttled between Banjul and Ndemban Health Centre five times by ambulance — on one leg of the journey riding alongside an uncovered body — while doctors reportedly discussed the case without using diagnostic equipment; a hospital-wide water shortage lasting three days forced the family to purchase bottled water; the family also witnessed clinicians disagree openly over diagnosis and medication in front of patients. |
| **Outcome** | Died on 28 September 2022. |
| **Institutional response** | Public attention (referenced by the family as following a public post/complaint) reportedly prompted a visit by the Minister of Health regarding the water shortage. |
| **Family and community impact** | Complete loss of confidence in the health system; a surviving sibling refuses hospital care; family raised concern about possible long-term effects of adult-formulated medicines on children who survived. |
| **Accountability efforts** | Civil case only; no threats reported. |

> *"Leadership is a responsibility — household, community, even the presidency. The rights of the population need to be protected by the leaders."* — *Parent, Case 8*

## Case 9: B.N. (M, 11 months (twin)) — Jabang, 2022

| | |
|---|---|
| **Facilities involved** | Brikama Health Centre (public); private pharmacies; Edward Francis Small Teaching Hospital, Banjul (public) |
| **Medicine administered** | Paracetamol syrup following routine vaccination, followed by additional syrups over repeat visits; mother noted an unusual colour in one syrup |
| **Clinical course** | Treated over several visits with escalating combinations of liquid medicines; on a later visit, staff confiscated the family's remaining supply of the medicines administered; child was diagnosed with a kidney infection; only the affected twin could be accommodated in the referral ambulance, requiring the family to pay separately to transport the healthy twin; no oxygen was available on arrival in Banjul and the family reports being bypassed in a scanning queue. |
| **Outcome** | Died after two days without treatment in Banjul. |
| **Institutional response** | A treating physician later privately told the mother that clinicians had recognised kidney failure from the second hospital admission onward. The Ministry of Health, through the Governor's office, offered a payment of D14,285, which the family returned, believing it was intended to buy silence. |
| **Family and community impact** | Severe emotional and financial impact, compounded by spiritual expenditures (including ritual offerings) undertaken on the advice of religious/spiritual advisors while seeking a cause for the child's illness; family reports being largely unsupported by relatives in pursuing accountability, including from her own husband. |
| **Accountability efforts** | Civil case and media engagement; husband and some relatives discouraged further pursuit on religious grounds. |

> *"I no longer give syrup to any of my children. I have lost trust in the health institution."*
> *— Parent, Case 9*

## Case 10: A.De. (F, 1 yr 10 mo) — Brikama, July 2022

| | |
|---|---|
| **Facilities involved** | Brikama Health Centre (public); Edward Francis Small Teaching Hospital, Banjul (public); private ambulance evacuation to Dakar, Senegal |
| **Medicine administered** | Medicine partly dispensed at the health centre, remainder purchased at an outside pharmacy |
| **Clinical course** | Treated for cough and fever; two days later developed swelling and stopped passing urine; a senior doctor ordered the medication stopped and told the family he had already seen 23 similar cases, none of which had survived; the family, alarmed by conditions in Banjul, privately funded an emergency cross-border ambulance evacuation to Dakar. |
| **Outcome** | Died after a quarantine period in Dakar delayed clinical assessment. |
| **Institutional response** | The family rejected a compensation cheque offered at a Governor's office meeting, proposing instead that funds be redirected to equipping and staffing hospitals. The family also reported distress at a government official publicly attributing the deaths to flooding rather than contaminated medicine. |
| **Family and community impact** | Ongoing, unresolved trauma; the family no longer uses pharmaceutical products, relying instead on herbal treatment. |

| | |
|---|---|
| **Accountability efforts** | Civil case only; discomfort reported at the Governor's office compensation meeting; no other threats. |

> *"I felt very bad when I heard a government official blaming the deaths on floods rather than the bad medications that were the actual cause."* — *Parent, Case 10*

### Case 11: M.J. (F, 10 months) — Faraba, August 2022

| | |
|---|---|
| **Facilities involved** | Private pharmacy (health centre closed for a public holiday); public hospital |
| **Medicine administered** | Medicine dispensed by a pharmacist without referral to a health facility, the local public health post being unstaffed on the holiday |
| **Clinical course** | Treated at a pharmacy because the health post was closed; developed lethargy and vomiting after dosing, initially misread by the mother as dislike of the medicine's taste, leading to continued administration; family unable to secure transport at night; on admission the child was given initial priority, but the attending doctor was reported absent from Thursday until Monday; the family raised concerns about changes in stool color without clinical response; oxygen was limited to a single shared tank. |
| **Outcome** | Died. |
| **Institutional response** | No facility-level accountability response reported. |
| **Family and community impact** | Severe psychological impact on the family, including a surviving sibling; community members have questioned the mother's decision to seek pharmacy rather than hospital care, a form of secondary blame. |
| **Accountability efforts** | Civil case only; the family reports discouragement from a community member early on. |

> *"I am calling upon the authorities to control the medication coming into the country."* — *Parent, Case 11*

### Case 12: O.Da. (M, 5–6 yrs) — Aljama, Niumi, 2022

| | |
|---|---|
| **Facilities involved** | Albadi Hospital (public); private pharmacy opposite Essau Hospital, Barra |
| **Medicine administered** | Paracetamol tablets given on-site; paracetamol syrup and a mixed suspension purchased at a nearby pharmacy |
| **Clinical course** | Treated for fever with tablets and syrup; developed difficulty urinating and passing stool, and back pain. |
| **Outcome** | Died. |
| **Institutional response** | The family reports the treating doctors later returned to retrieve the syrups administered. |
| **Family and community impact** | Significant emotional and financial impact; community support during mourning. |
| **Accountability efforts** | Civil case ongoing for more than three years at time of interview, with no verdict; family reports no threats but declines further engagement outside the court process. |

> *"I don't blame the health care personnel, but the bad medicines. People who were allowed to import the medications are to be blamed."* — *Parent, Case 12*

## 4.3 Patterns Across Cases

### 4.3.1 Common Clinical Presentation

All twelve children presented with a broadly consistent clinical trajectory: an initial mild illness (most commonly fever, with or without cough, vomiting, or a minor injury) treated with a pediatric syrup, followed within one to several days by oliguria or anuria (reduced or absent urination), oedema (swelling, including of the face, hands, feet, or abdomen), and in several cases vomiting, lethargy, seizure, or changes in stool colour, progressing to death despite hospital intervention. This trajectory is consistent with the clinical picture of diethylene glycol/ethylene glycol-induced acute kidney injury documented in the CDC and WHO investigations of the wider outbreak.

### 4.3.2 Facilities and Medicines Involved

| Case | First point of care | Medicine type first administered | Referral pathway |
|---|---|---|---|
| 1 | Tanji Health Centre | Cough/fever syrup and vomiting medicine dispensed at Tanji H | Not referred to Banjul per account |
| 2 | Bakoteh Precious Clinic | Medication for “serious malaria” dispensed at Bakoteh Precio | Referred to EFSTH, Banjul |
| 3 | Tanji Health Centre | Paracetamol syrup and cough syrup | Referred to EFSTH, Banjul |
| 4 | Pharmacy | Syrup dispensed directly by a pharmacy without clinical asse | Not referred to Banjul per account |
| 5 | Serrekunda Health Centre | Medicine purchased at an outside pharmacy on the instruction of the hospital | Referred to EFSTH, Banjul |
| 6 | Kanifing General Hospital | Medicine purchased at a private pharmacy after referral from the hospital | Referred to EFSTH, Banjul |
| 7 | Brikama Health Centre | Medicines purchased at a private pharmacy | Referred to EFSTH, Banjul |
| 8 | Traditional healer | Medicine purchased outside the facility (not stocked on-site) | Referred to EFSTH, Banjul |
| 9 | Brikama Health Centre | Paracetamol syrup following routine vaccination | Referred to EFSTH, Banjul |
| 10 | Brikama Health Centre | Medicine partly dispensed at the health center | Referred to EFSTH, Banjul |

| | | | |
|---|---|---|---|
| 11 | Private pharmacy | Medicine dispensed by a pharmacist without referral to a health Center | Not referred to Banjul per account |
| 12 | Albadi Hospital | Paracetamol tablets given on-site | Not referred to Banjul per account |

### 4.3.3 Reported Barriers to Care

- Out-of-pocket costs for medicines, laboratory tests, drips, oxygen, or ambulance fuel. Reported in at least 10 of the 12 cases assessed.
- Ambulance shortages, including multiple critically ill children sharing a single vehicle. Reported in at least 3 of the 12 cases.
- Missing or non-functioning equipment (dialysis machines/catheters, oxygen tanks, working diagnostic equipment). Reported in at least 5/12 cases.
- Gaps in overnight or weekend physician coverage. Reported in at least 3 of 12 cases.
- Facility closure or unavailability of staff (including on public holidays): reported in at least 2 of 12 cases.
- Confusing or repeated inter-facility transfers without treatment being provided: reported in at least 2 of 12 cases.

### 4.3.4 Economic Losses

Families reported direct out-of-pocket costs for private laboratory work, medicines, and transport ranging from approximately D1,200 ($16) to D3,000 ($41) or more per episode of care, sums several families described as difficult or impossible to raise on short notice, in a country where such amounts represent a significant share of average monthly income. Beyond direct costs, families described ongoing impacts on small businesses, foregone income during hospitalization and mourning, and continuing legal costs associated with the civil case, more than three years after the deaths.

### 4.3.5 Institutional and Community Response Patterns

- Informal compensation or in-kind offers (cash, provisions, or both), typically coordinated through Governor's office or an intermediary, were reported in at least 5 of 12 cases; several families explicitly stated they believed these offers were intended to secure silence rather than constitute genuine redress, and at least two families returned the money on this basis.
- Discouragement from pursuing accountability from relatives on religious grounds, from community members predicting futility, or both, was reported in at least 6 of 12 cases.
- Reports of restrictions on a treating clinician's ability to provide evidence without ministerial authorization, and of informal enquiries about a family's affiliation with the victims' association, were each reported once, by a father who is himself a healthcare worker.

- Strong community emotional and, in some cases, material support (e.g., funeral attendance, transport assistance) was reported in the majority of cases, standing in contrast to the more mixed and, in several cases, actively discouraging response from state and facility actors.

#### 4.3.6 Loss of Trust in the Health System

Every one of the twelve families reported a significant and, in most cases, still-unresolved loss of trust in the formal health system. Several families reported now treating other children's illnesses with herbal or traditional remedies rather than seeking hospital or pharmacy care, a pattern that itself carries public health risk and reflects the depth of the breach in trust caused by the tragedy and its aftermath.

# 5. Human Rights Analysis

This section analyses the facts documented in Sections 3 and 4 against The Gambia's binding obligations under regional and international human rights and anti-corruption instruments to which it is a State Party. For each instrument, the applicable legal standard is stated first, followed by the relevant evidence and a brief violation analysis. This analysis addresses State responsibility and systemic failure; it does not purport to resolve the individual civil or criminal liability of any named or unnamed defendant, which remains for the competent courts.

## 5.1 African Charter on Human and Peoples' Rights

### Article 4: Right to Life

**Standard:** Article 4 provides that human beings are inviolable and that every human being is entitled to respect for life and the integrity of the person; no one may be arbitrarily deprived of this right. The African Commission has interpreted the right to life to encompass a positive State obligation to take reasonable steps to protect life, including through regulation of products and services that pose a foreseeable risk of death, and to investigate suspicious deaths effectively.

**Our Findings:** At least 70 children died nationally during the AKI outbreak, including all 12 children whose families were interviewed for this report. The causal product entered the country without independent public health safety verification; the clinical pattern that would have permitted earlier recall was recognised by front-line clinicians more than two months before the product was withdrawn; and multiple families describe emergency referral pathways that could not deliver dialysis, oxygen, or timely physician review at the point children's lives were most acutely at risk.

**Our Position:** The cumulative effect of an unscreened import, a delayed recall, and an under-resourced emergency referral chain constitute, at minimum, a failure of the positive obligation to protect children’s right to life through reasonably foreseeable and preventable public health risk management. Whether this rises to a finding of arbitrary deprivation of life attributable to specific State organs is a matter for adjudication, but the pattern documented here, repeated across independently interviewed families with no contact with one another at the time of their children's deaths, supports a credible, prima facie case of a systemic Article 4 violation warranting the Commission’s attention.

### Article 16: Right to Health

**Standard:** Article 16 guarantees the right to enjoy the best attainable state of physical and mental health and obliges States Parties to take necessary measures to protect the health of their people and to ensure medical attention when sick, including regulation of the safety and quality of medicines in circulation.

**Our Findings:** Families report syrups dispensed without warning of side effects; medicines, laboratory tests, oxygen, and dialysis consumables unavailable at public facilities and requiring private, often costly, procurement during emergencies; non-functioning dialysis equipment; and, in one case, a health facility closed to an emergency case, resulting to the death of one of the victims.

**Our Position:** The right to health under Article 16 encompasses both the safety of medicines placed into circulation and the availability, accessibility, and quality of health facilities, goods, and services. The evidence here documents failures across four dimensions: availability (shortage in medical stocks, non-functioning medical equipment), accessibility (cost-shifting onto families, ambulance shortages, closed medical facility), acceptability (no prior warning or information on side effects), and quality (a contaminated product circulating within the regulated supply chain). These failures are systemic rather than isolated to any one facility or region.

## 5.2 African Charter on the Rights and Welfare of the Child

**Standard:** The African Charter on the Rights and Welfare of the Child requires States Parties to accord the best interests of the child paramount consideration in all actions (Article 4), to recognize the right of every child to enjoy the best attainable state of physical, mental, and spiritual health (Article 14), and to take measures to reduce infant and child mortality and to ensure the provision of adequate nutrition and safe drinking water, among other health protections.

**Our Findings**: All twelve children in this study were under six years of age, the population identified by WHO and CDC investigators as almost exclusively affected by the contaminated syrups. Several families describe their children being deprioritized in queues, transported multiple children per ambulance, or subject to repeated inter-facility transfer without treatment.

**Our Position:** The concentrated impact of this tragedy on young children, precisely the population the Charter identifies for heightened protection, together with the demonstrated resource gaps in pediatric emergency and renal care, indicates a failure to accord the best-interests and child-specific health protections the Charter requires. The Committee of Experts on the Rights and Welfare of the Child may have an independent complementary role to the Commission in addressing this dimension of the case.

## 5.3 UN Convention on the Rights of the Child

**Standard:** Article 3 of the UN Convention on the Rights of the Child requires the best interests of the child to be a primary consideration in all actions concerning children. Article 6 recognizes the inherent right to life and requires States to ensure to the maximum extent possible the survival and development of the child; Article 24 recognizes the right of the child to the highest attainable standard of health and obliges States to ensure the provision of necessary medical assistance and to take appropriate measures to combat disease and malnutrition, including through the application of available technology.

**Our Findings:** The same evidentiary record supporting the Article 4 and Article 16 African Charter analysis applies here. The Convention's emphasis on ensuring survival "to the maximum extent possible" is particularly engaged by testimony describing correctable, resource-based barriers-missing catheters, non-functioning dialysis machines, ambulance shortages, child in kidney failure and available treatment technology that, on this record, existed in the country but was not reliably accessible when needed.

## 5.4 International Covenant on Economic, Social and Cultural Rights

**Standard:** Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and requires steps for the prevention, treatment, and control of disease and the creation of conditions assuring medical service and medical attention to all in the event of sickness. The Committee on Economic, Social and Cultural Rights has interpreted this to require, at minimum, core obligations including access to essential medicines and to health facilities, goods, and services on a non-discriminatory basis, particularly for children.

**Our Findings:** Reliance by twelve separate families on private, out-of-pocket purchase of medicines, laboratory testing, and consumables at the point of medical emergency indicates that essential health goods were not, in practice, assured through the public system as Article 12 requires. This is compounded by geographic concentration of tertiary pediatric renal capacity in Banjul, which, combined with ambulance shortages, created unequal practical access to care depending on a family's location and resources, a pattern in tension with the Covenant's requirement of accessibility, including physical and economic accessibility, on a non-discriminatory basis.

## 5.5 UN Convention Against Corruption (UNCAC)

**Standard:** The Convention requires States Parties to establish effective, coordinated anti-corruption policies (Article 5), to promote integrity and prevent corruption among public officials (Article 7-8), to maintain appropriate systems of procurement based on transparency and objective criteria (Article 9), and to criminalize and take measures against bribery of, and abuse of function by, public officials (Articles 15, 18-19), while also protecting witnesses, experts, and victims from potential retaliation (Article 32) and ensuring victims have access to compensation and redress (Article 35).

**Our Findings:** The documented allegation of bribery of an Indian state drug-testing official to substitute cough-syrup samples, if substantiated, engages Article 15/16 anti bribery provisions directly, albeit as conduct in a foreign jurisdiction under separate national inquiry. Domestically, family testimony describing a facility's admission that a syrup was administered outside official records and of unknown origin raises concerns about internal diversion or concealment consistent with Article 19 (abuse of functions). Reports that a treating clinician was instructed not to give evidence without ministerial authorization raise concerns under Article 32 regarding protection of witnesses, and reports by multiple families of informal payments they characterized as attempts to secure silence raise concerns under both Article 32 (victim protection from intimidation, broadly construed) and Article 35 (the right to seek compensation through a genuine, rather than pressured, State-facilitated process).

**Our Position:** While matters occurring in India fall to the jurisdiction and inquiry processes of that State, the domestic Gambian conduct described informal, non-transparent settlement approaches outside the

litigation process, and reports of restricted evidence-giving is, at minimum, in tension with the transparency, victim-protection, and anti-retaliation norms the Convention establishes, and merits independent review by the appropriate Gambian oversight bodies.

# 6. Evidence Review

This section catalogues the categories of documentary and testimonial evidence identified in the course of this study and assesses their evidentiary value and reliability. It does not attach or reproduce primary documents, which remain in the custody of individual families, their legal counsel, or the relevant institutions, and should be secured through the evidence-management protocol at Annex A before any formal submission.

| Evidence category | Source | Evidentiary value | Reliability considerations |
|---|---|---|---|
| Structured interview transcripts (this study) | 12 families, 31 May – 2 June 2026 | Primary testimonial evidence of lived experience, institutional interaction, and harm. | Consistent, cross-corroborating patterns across independently interviewed families strengthen reliability; individual clinical/technical detail should be read alongside medical records where available. |
| WHO medical product alert and laboratory findings (Oct. 2022) | World Health Organization | Independent confirmation of toxic contamination (DEG/EG) in four named products. | High reliability; internationally peer-reviewed alert process. |
| CDC/MoH epidemiological investigation (MMWR, 2023) | US CDC, Gambia Ministry of Health | Independent epidemiological confirmation of the AKI cluster, case count, and product association. | High reliability; peer-reviewed public health surveillance methodology. |
| National Assembly Select Committee report (Dec. 2022) | Parliament of The Gambia | Domestic official finding attributing responsibility to the manufacturer; recommends legal action and compensation. | High reliability as an official record; recommendations not self-executing and require monitoring for implementation. |
| High Court civil suit and subsequent rulings (2023–2024) | AKI Victims' Association and co-plaintiffs vs MCA, Ministry of Health and Others | Establishes the formal legal claims, named defendants, and procedural status of the litigation. | High reliability as to procedural facts; underlying factual/legal findings remain sub judice. |
| Reporting on Indian regulatory sample-substitution allegation (2023–2024) | Independent investigative journalism; Indian government inquiry | Supports an inference of foreknowledge of contamination; not yet a final finding. | Credible, multiple-sourced reporting; treat as an unresolved allegation pending the Indian inquiry's conclusion. |
| Prescriptions, receipts, and private payment records | Individual families (retained per families' own report) | Would corroborate specific out-of-pocket cost and referral claims. | Not systematically collected for this study; recommend follow-up collection with consent, per Annex A protocol. |
| Hospital/clinic medical records | EFSTH Banjul and regional facilities | Would corroborate diagnosis, treatment timeline, and | Access requires facility/MoH cooperation or lawful |

| | | | |
|---|---|---|---|
| | (not obtained for this study) | equipment/staffing gaps described in testimony. | disclosure order; not yet obtained. |
| MCA registration, import, and inspection records | Medicines Control Agency (not obtained for this study) | Would corroborate import screening practice and any prior red flags on the implicated products. | Access requires MCA cooperation or lawful disclosure order; not yet obtained. |

The research team recommends that any formal ACHPR submission be accompanied by a supplementary, confidentially managed annex compiling primary documents (prescriptions, receipts, referral notes, and any retained correspondence) that individual families indicated they were willing to share, subject to renewed, document-specific consent and to the secure evidence-handling protocol set out at Annex A.

# 7. Accountability Assessment

## 7.1 State Responsibility

The Government of The Gambia bears primary responsibility for the regulatory and health-system failures documented in this report, both directly (through the Ministry of Health's operation of public facilities and the Medicines Control Agency's statutory regulatory function) and through its overarching duty to protect the rights of children within its jurisdiction from foreseeable harm caused by third parties, including private distributors and pharmacies. The government's own parliamentary Select Committee has acknowledged systemic failure by recommending both legal action against the manufacturer and compensation for victims; more than three years after the deaths, however, families report neither a completed judicial process nor a comprehensive, State-funded reparations mechanism independent of the still-pending civil suit.

## 7.2 Regulatory Responsibility

The Medicines Control Agency is named as a defendant in pending litigation seeking an admission that it failed in its statutory duty to regulate the quality and safety of medicines imported in The Gambia. The evidentiary record available to this study, an unscreened import that reached patients before any independent testing occurred, is consistent with, though it does not on its own conclusively establish, such a regulatory failure; a full assessment requires access to MCA's own import and inspection records, which fall outside the scope of the testimonial evidence gathered here.

## 7.3 Corporate Responsibility

Maiden Pharmaceuticals Limited, as manufacturer of the implicated products, bears responsibility for the contamination identified by independent WHO-coordinated laboratory testing. The credible, still-unresolved allegation that a state regulator in India was paid to substitute test samples before contamination could be verified would, if established, indicate the company had reason to know of a quality failure before export; this allegation remains under investigation in India and should not be treated as a final finding of fact. The local distributor, also named in the civil suit, bears a related responsibility for its role in bringing an inadequately verified product to market in The Gambia.

## 7.4 Individual Accountability

The arrest of a facility Managing Director following a police investigation (Case 1) indicates that individual accountability mechanisms have been activated in at least one instance; families were not, however, able to identify a comprehensive individual accountability process addressing the broader chain of decisions described in Section 4.1. Reports that a treating clinician was instructed not to provide evidence without ministerial authorization, if accurate, would itself constitute an accountability gap requiring independent examination, since it would place a barrier between a first-hand witness and any investigative or judicial process.

## 7.5 Unresolved Issues

- The civil suit filed in 2023 remained unresolved as of the families' 2026 interviews, with no family reporting a final judgment, more than three and a half years after the first deaths.
- No family reported having received a comprehensive, State-administered reparations package; several explicitly declined informal payments they viewed as attempts at silencing rather than accountability.
- The status and outcome of the Indian regulatory bribery-allegation inquiry remains unresolved and should be monitored for developments relevant to the broader accountability picture.
- It remains unclear from the evidence available to this study whether the reported instruction to a clinician not to give evidence without ministerial authorization has been reviewed by any independent oversight body.
- No comprehensive public accounting was identified of MCA's import-screening practice at the time of the June 2022 shipment, nor of any changes made since to prevent recurrence.

# 8. Conclusions

The 2022 AKI tragedy was not a single, isolated failure but the product of compounding gaps across an international pharmaceutical supply chain and a domestic health system operating without the resources or redundancy needed to intercept, or respond to, a foreseeable mass-casualty event affecting young children. Twelve families interviewed for this study each independently described a strikingly similar sequence: a common childhood illness, a pediatric syrup obtained from a public facility, private clinic, or pharmacy, a rapid and largely uniform clinical deterioration, a referral chain undermined at multiple points by shortages of equipment, medicine, transport, and staff, and a death that, in every case, might have been prevented had any one of several earlier checkpoints, quality testing before export or import, adequately resourced emergency care, or a faster recall once the clinical pattern was recognized, functioned as it should.

The human rights implications are severe and multidimensional. Violations of the right to life and the right to health under the African Charter and complementary international instruments; a distinct and heightened failure to protect the rights of young children under child-specific instruments; and a pattern of post-tragedy institutional conduct including informal settlement approaches families characterized as attempts to buy silence, and a reported restriction on a clinician's ability to give evidence — that itself raises serious governance and anti-corruption concerns independent of the original contamination event.

The governance implications point toward systemic rather than merely individual failure: an import-screening gap, a chronically under-resourced referral system concentrated in a single tertiary facility, and a regulatory body whose adequacy at the relevant time remains to be fully and independently assessed. The justice pace is equally concerning. More than three and a half years after the first deaths, no family interviewed for this study reported a completed judicial process, a comprehensive reparations mechanism, or a full public accounting of individual institutional responsibility. The persistence of this gap between acknowledged State responsibility reflected in the National Assembly's own December 2022 committee findings and the delayed in providing reparatory justice to the victims is, in itself, a continuing rights concern warranting sustained international attention.

# 9. Recommendations

The following recommendations are addressed to specific institutional actors. Each is intended to be specific, measurable, and actionable, and is grounded in the rights and evidentiary analysis set out above.

## To the Government of The Gambia

- Establish, within twelve months, a State-funded reparations scheme for all families affected by the 2022 AKI outbreak, independent of and without prejudice to the pending civil litigation, with transparent eligibility criteria, published payment schedules, and an accessible, victim-informed application process.
- Commission an independent (non-governmental) audit of the informal settlement approaches reported by families in this study, to determine whether any constituted improper inducement, and publish its findings.
- Guarantee, by public statement and administrative instruction, that no public official or facility employee will face sanction or restriction for providing truthful testimony or evidence to courts, the National Assembly, or oversight bodies in connection with this matter.

## To the Ministry of Health

- Conduct and publish a nationwide facility-level audit of pediatric emergency and renal care capacity (dialysis machines and catheters, oxygen supply, ambulance fleet, and overnight physician coverage), with a costed, time-bound plan to close identified gaps, prioritizing regions outside Greater Banjul.
- End the practice of requiring families to purchase essential medicines, laboratory tests, and consumables privately during medical emergencies at public facilities, including through emergency stock-guarantee arrangements and a reviewed, transparent facility fee-waiver policy for indigent and emergency cases.
- Establish or strengthen an active, real-time adverse drug/clinical-cluster surveillance system, with a defined maximum response time between clinical alert and public recall decision, to prevent the two-month gap documented in this case from recurring.
- Provide affected families with full, plain-language access to their children's medical records and a documented, individualized explanation of cause of death and treatment timeline, without requiring litigation to obtain it.

## To the Medicines Control Agency (MCA)

- Introduce mandatory independent laboratory testing of a statistically representative sample of every imported pharmaceutical consignment before release for distribution, with results published on a public register.
- Investigate the allegations that MCA staff rented their license to drug imports

- Publish a public, redacted account of the Agency's import-screening record for the June 2022 Maiden Pharmaceuticals consignment, and the specific regulatory changes made since to prevent recurrence.
- Establish a confidential, protected channel for pharmacists, clinicians, and members of the public to report suspected substandard or falsified medicines, with statutory protection against retaliation for good-faith reports.

## To Parliament

- Conduct a follow-up inquiry, building on the December 2022 Select Committee report, specifically assessing implementation of its recommendations and the status of victim compensation more than three years on.
- Enact or strengthen legislation mandating independent import testing of pharmaceuticals, establishing statutory timelines for recall decisions following clinical-cluster alerts, and providing explicit whistle-blower and witness protection for health-sector personnel.
- Require regular public reporting on the implementation status of all recommendations arising from this and any future health-system parliamentary inquiries.

## To the Judiciary

- Prioritize and expedite the pending civil proceedings, recognizing the exceptional public interest and the cumulative harm to families of continued delay now exceeding three years.
- Ensure any settlement or compensation arrangement reached is approved through, or reviewed by, the court, to safeguard against informal, non-transparent inducements outside the judicial process.
- Consider case-management measures (e.g., consolidated hearings, protected witness testimony procedures) to reduce the burden of repeated court attendance on grieving families balancing litigation with ongoing caregiving responsibilities.

## To Development Partners

- Provide technical and financial support for the establishment of independent pharmaceutical import-testing capacity in The Gambia, reducing reliance on documentary certification alone.
- Fund the pediatric emergency and renal care capacity gaps identified in this report, including regional decentralization of dialysis-capable facilities.
- Support independent, victim-informed monitoring of the implementation of this report's recommendations and of the pending litigation's outcome.

## To the African Commission on Human and Peoples' Rights

- Institute a full and impartial investigation on violation of the ACHPR by the government of The Gambia
- Consider a country/fact-finding visit, drawing on the Commission's Article 45-46 mandate and its seat in Banjul, to engage directly with affected families, the Ministry of Health, the Medicines Control Agency, and the judiciary.
- Coordinate with the African Committee of Experts on the Rights and Welfare of the Child on the child-rights dimensions of this case, given the near-exclusive impact on children under six.
- Consider the admissibility of a formal communication under Article 55 of the African Charter, on behalf of affected families, addressing the right to life, right to health, and related violations documented in this report.
- Encourage the Government of The Gambia to engage with relevant Indian authorities and the WHO on preventing recurrence, given the cross-border sourcing of the contaminated product and the ongoing Indian regulatory inquiry.

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