Year

2006.

Annual Report

A GROWING YEAR

Anticipating significant results, 2006 was a year of building innovative partnerships, filling a robust pipeline, and strengthening existing capacities.

DNDi

Drugs for Neglected Diseases *initiative*

2006 calendar

JANUARY 06

Centre National de Recherche et de Formation contre le Paludisme (CNRFP) staff conclude enrollment for the pivotal Phase III field study examining ASAQ in children.

FEBRUARY 06

A concrete achievement as the first leishmaniasis research and treatment center in Africa opens in Arba Minch (Ethiopia).

MARCH 06

The UK's Department of International Development (DFID) grants 9.5 million Euros to DNDi, followed by the Dutch and French governments.

APRIL 06

The MOU between DNDi and Farmanguinhos is signed on the development of ASMQ for malaria patients.

MAY 06

DNDi presents its Appeal to the WHO DG. The World Health Assembly (WHA) adopts Resolution 59.24 on a global framework for essential health R&D.

JUNE 06

Uganda is invited to join LEAP, which will have four African countries researching new treatments for VL patients.

JULY 06

At its 3-year anniversary, DNDi is working to develop a robust portfolio that addresses patient needs.

AUGUST 06

The HAT Platform has a new coordinator and rehabilitated laboratory at the Katanda, DRC, site.

SEPTEMBER 06

200 African scientists from 34 countries join forces at a DNDi Africa meeting to engender greater regional research partnership.

OCTOBER 06

Future access of the easy-to-use, once-a-day FACT products is near as the registration files for ASAQ and ASMQ near completion.

NOVEMBER 06

At ASTMH, DNDi welcomes partners to present at symposia on FACT and on HAT.

DECEMBER 06

Participants at the PAN4ND in Putrajaya, Malaysia, discuss research trainings at CDRI.

DNDi
Drugs for Neglected Diseases *initiative*

CONTENTS

Greetings from the Executive Director and the Chair of the Board

Dr. Bernard Pecoul,
Executive Director

Dr. Yves Champey,
Chairman of the Board of Directors

2006 has been an important year for DNDi as we continue to strengthen and grow our worldwide partnerships. Since our inception four years ago in 2003, we have made a number of crucial gains, thanks to our partners, who will serve as a foundation for our continuing efforts to research and develop new drugs against the three kinetoplastid diseases of human African trypanosomiasis, visceral leishmaniasis, and Chagas disease.

Our Founding Partners, who have been drawn primarily from the public sector, have continued to serve as the backbone of DNDi by providing expert advice, the benefit of their experience, and key project and event participation, such as the DNDi Africa meeting held jointly by DNDi and the Founding Partner Kenya Medical Research Institute in Nairobi in September 2006.

Our scientific partners have been critical in enabling DNDi to showcase a portfolio which has grown from three projects in 2003 to 22 projects in 2006. By providing material knowledge, compounds, and research facilities, they help DNDi to fortify a portfolio which already contains strong projects for two of DNDi's target diseases (human African trypanosomiasis and visceral leishmaniasis) and which is on the way to filling a robust pipeline for all three target diseases in the future. Partnering with other product development partnerships (PDPs) has allowed us to synergize our efforts and to ensure an efficient R&D process.

For the FACT Project in malaria, 2006 was a transformative year, as the pivotal Phase III clinical trial on ASAQ, or fixed-dose artesunate-amodiaquine, was completed in Burkina Faso and as a critical, multi-thousand patient study on fixed-dose artesunate-mefloquine was started in the Amazon basin by Brazilian authorities. Both of these studies pave the way for ongoing registration activities to be completed in 2007, so that these medications will be made available in 2007 to the patients who most need them.

Other partnerships in clinical development are continuing to bear fruit: the clinical research platforms for sleeping sickness and visceral leishmaniasis in Africa have continued to attract more partners and are allowing for clinical research to be conducted in extremely difficult, resource-poor, rural settings in Africa. The first clinical research & treatment centre for visceral leish-maniasis in Africa broke ground in Ethiopia; and by the end of the year, patient enrollment was completed for the multi-centre trial for a simplified combination treatment regimen for HAT.

Our global network of collaborations is continuing to be strengthened and to strengthen capacity, with research platforms like LEAP, HAT Platform, and the newly formed Pan-Asian Network for Neglected Diseases helping to provide access to chemical diversity, to establish discovery platforms, pharmaceutical and clinical development, and close work with control programmes.

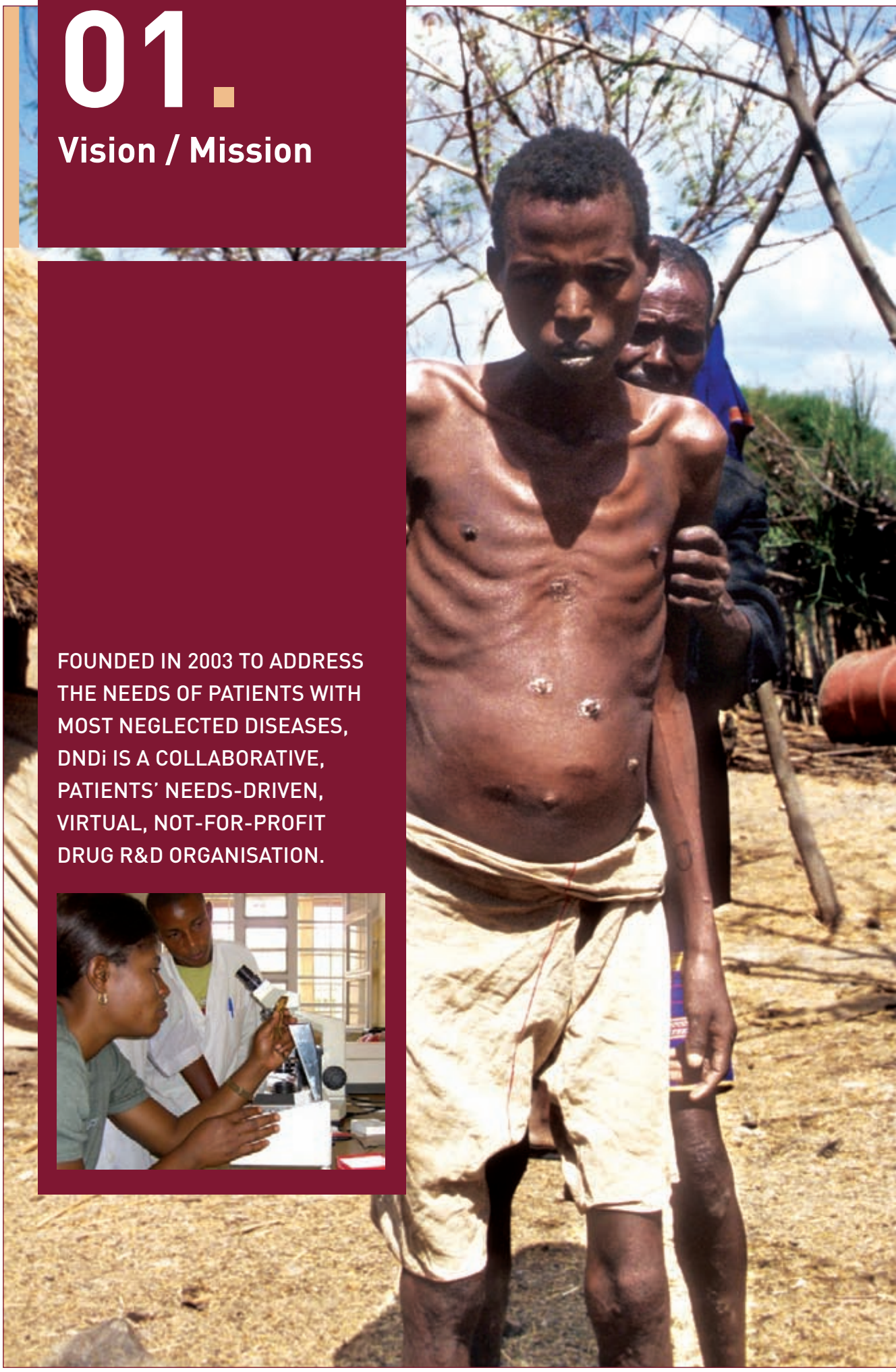
Also, in 2006, we can see the existence of PDPs has helped to accelerate the momentum building for neglected diseases R&D, where greater political and financial commitments have been made this year. In May 2006, the World Health Assembly adopted Resolution 59.24 – which recognizes the key role played by PDPs in addressing the shortcomings of the current profit-driven R&D system, yet also recognizes the limits of PDPs if governments do not provide global public health leadership as well as solid and long-term support to such initiatives.

A number of individual governments have also made financial commitments to combating neglected diseases, and DNDi is happy to welcome a number of new donors, particularly the governments of the United Kingdom, France, and the Netherlands.

In DNDi's full third year, we can see that partnerships have been and continue to be critical to our progress, both as an R&D organization and in influencing the overall landscape. The greater involvement on many fronts gives hope, but with the long and highly attritive R&D process, we must maintain long-term vigilance to fundamentally improve the treatment situation for the patient in the field.

01.

Vision / Mission



FOUNDED IN 2003 TO ADDRESS THE NEEDS OF PATIENTS WITH MOST NEGLECTED DISEASES, DNDi IS A COLLABORATIVE, PATIENTS' NEEDS-DRIVEN, VIRTUAL, NOT-FOR-PROFIT DRUG R&D ORGANISATION.

Developing Treatments for the Most Neglected

A patients' needs-driven R&D model built on South-South and North-South collaboration

Despite revolutionary advances in drug development in recent decades, essential medicines to treat many diseases that affect the world's poor are either too expensive, no longer produced, highly toxic, or ineffective. Recognising these issues from its field experience, Médecins Sans Frontières committed its 1999 Nobel Peace Prize funds to develop an alternative model for the research and development (R&D) of new drugs for neglected diseases.

As a result, in 2003, seven organisations from around the world joined forces to establish DNDi as an independent, needs-driven, not-for-profit organization to research and develop drugs for people suffering from the most neglected diseases. Acting in the public interest, DNDi bridges the existing R&D gaps in essential drugs for these diseases by initiating and coordinating drug R&D projects in collaboration with the international research community, the public sector, the pharmaceutical industry, and other relevant partners.

VISION

To improve the quality of life and the health of people suffering from neglected diseases by using an alternative model to develop drugs for these diseases and by ensuring equitable access to new and field-relevant health tools.

In this not-for-profit model, driven by the public sector, a variety of partners collaborate to raise awareness of the need to research and develop drugs for those neglected diseases that fall outside the scope of market-driven R&D. They also build public responsibility and leadership in addressing the needs of these patients.

MISSION

To develop new drugs or new formulations of existing drugs for patients suffering from the most neglected communicable diseases. Acting in the public interest, DNDi will bridge existing R&D gaps in essential drugs for these diseases by initiating and coordinating drug R&D projects in collaboration with the international research community, the public sector, the pharmaceutical industry, and other relevant partners.

DNDi's primary focus is the development of drugs for the most neglected diseases, such as sleeping sickness (human African trypanosomiasis,HAT), kala-azar (visceral leishmaniasis), and Chagas disease; and it will also consider engaging R&D projects on other neglected diseases. In pursuing these goals, DNDi manages R&D networks built on South-South and North-South collaborations. While using and supporting existing capacity in countries where the diseases are endemic, DNDi helps to strengthen additional capacity in a sustainable manner through technology transfer in the field of drug research and development for neglected diseases.

OBJECTIVES

The primary objective of DNDi is **to deliver six to eight new treatments by 2014 for** leishmaniasis, sleeping sickness, Chagas disease, & malaria, and **to establish a strong R&D portfolio that addresses patient needs for treatment.** DNDi aims to establish a robust pipeline that delivers networked discovery efforts for all three primary diseases, four lead optimisation projects

DNDi'S GOALS

→ Develop six to eight new, field-relevant treatments and a robust pipeline by 2014

→ Strengthen existing research capabilities in endemic countries

→ Advocate for increased priority and funding for research and development for neglected diseases

per annum as of 2008, and several clinical candidates which correspond to the target product profiles for each disease. Utilizing R&D networks built on South-South and North-South collaborations, DNDi aims to bring medical innovation to the patients by developing:

- New drugs from novel compounds identified through screening and lead optimization;
- New drugs from compounds with known antimicrobial/antiparasitic activities (may start at lead optimisation or pre-clinical development);
- New indications for existing medicines into the field of the most neglected diseases (therapeutic switching);
- Reformulations and combinations better adapted to field conditions (paediatric, long-acting, new route of administration; fixed-dose combina-tions, co-packaging, or co-administration);
- Existing drugs for target diseases (geographical extension of registration to additional geographical areas; completion of regulatory dossiers of existing drug candidates).

Within its vision, DNDi also has two other objectives:

→ To use and strengthen existing capacities in disease-endemic countries *via* project implementation;

→ To raise awareness about the need to develop new drugs for neglected diseases and advocate for increased public responsibility.

SINCE 2003...

DNDi has achieved a number of milestones, from portfolio through policy, in a relatively short period of time, though it is important to remember that all milestones are part of a much longer process:

• Founding Partners

Underscoring the need for public leadership on and involvement in neglected diseases, DNDi drew Founding Partners primarily from the public sector in neglected disease-endemic countries: the **Foundation Oswaldo Cruz /Farmanguinhos** in Brazil, the **Indian Council for Medical Research (ICMR)**, **Kenya Medical Research Institute (KEMRI)**, and the **Ministry of Health in Malaysia**, along with the international humanitarian organisation **Médecins Sans Frontières**, the **Institut Pasteur**, and with the UNICEF-UNDPWorld Bank-WHO's Special Programme for Research and Training in Tropical Diseases **(TDR)** as permanent observer.

• Portfolio

A portfolio, based around disease strategies for HAT, leishmaniases and Chagas disease, which already contains strong projects for two of the target diseases and taps networks of expertise in many different fields, has been built. This portfolio serves both the primary R&D objective of making six to eight new treatments available to patients by 2014, and of having a robust pipeline for all target diseases into the future.

• Platforms Enabling Access to Research Capacity

For HAT and VL in Africa, DNDi has helped to establish two disease-specific platforms that develop clinical research capacity in endemic regions by involving relevant scientists, research organisations, international organisations, NGOs, and national programmes. Such platforms have allowed for clinical research to be conducted in extremely difficult, resource-poor, rural settings in Africa.

DNDi has also attracted quality R&D partners for all stages of drug development: from the many partners of the Pan-Asian Natural Products Screening Platform linking top-notch research and institutes across the region in a collaborative network to explore natural products as potential drug candidates against kinetoplastids, to a late-stage industrial partner like sanofi-aventis to develop and distribute **ASAQ**, the fixed-dose antimalarial co-formulation of artesunate and amodiaquine, that will be available early in 2007.

• Products

At the end of 2006, two fixed-dose artemisinin combination therapies (ACTs) dossiers have been submitted for registration in Brazil (artesunate-mefloquine, **ASMQ**) and in Morocco (**ASAQ**), which will become available in 2007as products of the FACT project and will offer the first-ever paediatric strengths in fixed-dose antimalarials. **ASMQ** and **ASAQ** are **easy to use** (fewer tablets in each regimen to ensure the drugs are taken **together** and **in the correct proportions**), and will be **affordable** and **available as public goods**.

ASAQ simplifies treatment of malaria for children, the primary victims of malaria. A three-day dosing regimen consists of one tablet per day, and the tablet can be easily crushed to facilitate administration with liquid or semi-liquid food.

CORRECTING THE 10/90 GAP

Why are some diseases more neglected than others?

MARKET FAILURE: Drug development has largely been confined to the R&D-based pharmaceutical industry, which has grown into one of the most prosperous industries by focusing on lucrative markets. Market-based incentives have transformed drugs into consumer goods, skewing investment toward diseases and patients that guarantee significant financial returns. Although publicly-financed research institutions are involved in the early-stage drug R&D, a robust drug R&D pipeline for neglected diseases does not exist.

A distinction between "neglected" and "most neglected" diseases should be made. The Big Three neglected diseases – HIV/AIDS, malaria, and tuberculosis – primarily affect people in poor countries but also secondarily affect people in industrialized countries, (e.g. people who contract malaria while travelling). Therefore, a small market exists, as do more R&D efforts. For the "most neglected" diseases like human African trypanosomiasis (also known as sleeping sickness), South American trypanosomiasis (also known as Chagas disease), Buruli ulcer, dengue fever, leishmaniasis, leprosy, lymphatic filariasis, and schistosomiasis, patients are so poor that they have virtually no purchasing power and can provide no market stimulus.

PUBLIC POLICY FAILURE: Market failure has been compounded by the failure of public policy – both globally and within endemic countries – to ensure the development of drugs for neglected diseases. In neglected disease-endemic regions, the public sector has not adequately cultivated drug development expertise and capacity. In countries with drug R&D potential, governments lack financial resources and political will to invest in long-term health development. They have also failed to establish public policy incentives that foster viable domestic drug R&D industries. This balance between public and private capacity, investments, and interests has worked reasonably well to provide important health tools for populations in industrialized countries, but it has not been effective in providing new or adapted health tools for diseases occurring almost exclusively in the developing world.

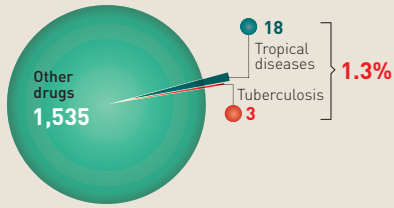
AN ALTERNATIVE MODEL IN THE NEW MILLENNIUM

In recent years, awareness of the lack of effective treatments for neglected diseases has been growing, and some novel approaches have emerged to stimulate R&D and to produce needs-adapted health tools. One such approach is that of product development partnerships (PDPs) which seek to foster R&D for neglected diseases by building partnerships - based on existing capacity, expertise, and resources - in both the public and the private sector. Typically, these initiatives act as coordinators in setting a disease-specific R&D agenda and portfolio, raising funds, and managing R&D projects. Examples include the Medicines for Malaria Venture (MMV), the Global Alliance for TB Drug Development (GATB), the Institute for One World Health (iOWH), the International AIDS Vaccine Initiative (IAVI), and the Foundation for Innovative Diagnostics (FIND).

In order to avoid overlap with research organizations like TDR and other PDPs, pragmatic synergies and collaborations are sought by DNDi: current examples include DNDi's collaboration with the MMV in the case of an 8-aminoquinoline project and DNDi's synergy with the Novartis Institute of Tropical Diseases (NITD) in the case of nitroimidazoles.

There is clearly room for more than one organization to focus on a given neglected disease or category of neglected diseases. Policymakers would not be satisfied leaving cancer or cardiology research to one or two entities – the same should apply for neglected disease research. Therefore, a diversity of efforts in drug development for neglected diseases should be encouraged.

ONLY 21 NEW DRUGS FOR NEGLECTED DISEASES SINCE 1974



Only 21 new drugs, **1.3** percent of the 1,556 new drugs registered between 1975 and 2004 were for tropical diseases and tuberculosis, yet these diseases constitute over **12** percent of the global disease burden. A mere 10 percent of the world's health research expenditure is spent on diseases that account for 90 percent of the global burden of disease.

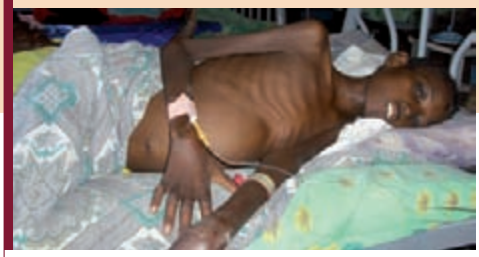
Source: Chirac P. Torreele E. *Lancet*. 2006 May 12; 1560-1561.

ADDRESSING THE HEALTH R&D IMBALANCE

Over the past thirty years, global health has transformed at an unprecedented rate: much of this advancement is due to the dramatic increase in global spending on health research, which has risen dramatically from US$30 billion in 1986 to US$105.9 billion in 2004. Yet, with few exceptions, people living in developing countries have not benefited from this revolution, as only 10 per cent of this money is spent on diseases that beset 90 per cent of the world's population.

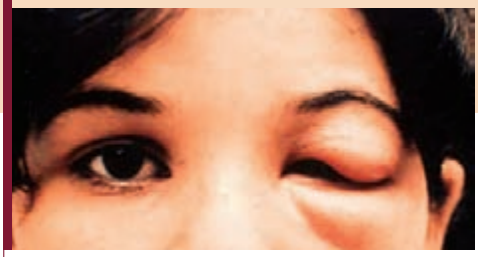
To improve the health care available to the world's three billion people living on less than US$2 a day, adequate and field-adapted health tools must be available, and the wealth of basic knowledge that exists on parasitic research must be translated into practical applications.

A Needs-Driven Approach:

DISEASE	HUMAN AFRICAN TRYPANOSOMIASIS (HAT)	VISCERAL LEISHMANIASIS
		
	50 MILLION AT RISK, WITH AN ESTIMATED 50,000 – 150,000 INFECTED	**500,000 NEW CASES REPORTED EACH YEAR**
DESCRIPTION	HAT, also known as sleeping sickness, threatens people in 36 countries in sub-Saharan Africa and occurs in 2 stages: • 1st stage includes headaches and bouts of fever; • 2nd stage, known as neurological phase, occurs when parasite enters central nervous system and is fatal if left untreated.	Visceral leishmaniasis, fatal if left untreated, is characterized by prolonged fever, enlarged spleen & liver, substantial weight loss, progressive anemia, and is complicated by co-infection with other diseases like malaria and HIV. 90% of cases reported in 5 countries (Bangladesh, Brazil, India, Nepal, and Sudan).
TREATMENT LIMITATIONS	Few in number that are: • Old, toxic; • Difficult to administer and have lost efficacy in several regions; • Stage-specific, with more toxic and difficult-to-administer treatments for stage 2. • Stage 1 – Pentamidine (1940): 7-10 day injections; only works for Stage 1; – Suramin (1920s): used primarily for Stage 1 *T.b. rhodesiense* HAT. • Stage 2 – Melarsoprol (1949): 10 daily IV injections; painful & highly toxic (5% treatment-related mortality); increasingly ineffective (with treatment failure up to 30% in some regions); – Eflornithine (1981): 4 infusions per day for 14 days; difficult administration mainly used as 2nd line for *T.b. gambiense* HAT.	Number of treatments has increased in past decade, but there are drawbacks: • Difficult to administer; • Long treatment course (21 to 28 days); • Toxic; • Expensive, limiting use in most disease-endemic countries; • Pentavalent antimonials: toxic, 30-day, hospital-based parenteral treatment with increasing drug resistance; • Amphotericin B: dose-limiting toxicity, 15-20 day, hospital-based IV treatment; • Liposomal Amphotericin B: excellent, but expensive; • Paromomycin: now registered in India (Sept. 2006), but efficacy in Africa not yet determined; • Miltefosine: first orally available drug now registered in India, but expensive and teratogenic in women of child-bearing age.
PATIENT TREATMENT NEED	• **A safe, effective, and practical stage 2 HAT drug** to replace current first-line treatments, and to improve and simplify current case management. The aim is to develop one drug that is effective against both stages 1 and 2 of HAT. • **A simple stage 1 treatment**, to be used at the local health centre level, which could represent a great improvement by increasing access to treatment and coverage of HAT.	• **An oral, safe, effective, low-cost, and short-course (10-day)** treatment that could replace current treatments, improve and simplify current case management.
DNDi OBJECTIVES BY 2014	→ 1 new drug registered → 1 co-administration recommended	→ 1 new drug registered → 2 geographical extensions in endemic regions outside India by 2014 → 2 co-administrations recommended

Patient Needs and DNDi Objectives

CHAGAS



~8 MILLION INFECTED, 100 MILLION AT RISK IN THE AMERICAS

Chagas disease, or human American trypanosomiasis, occurs in three disease stages: acute (in which 5% of children die), indeterminate, and chronic. Acute illness often spontaneously resolves in 4 to 6 weeks, at which time patients enter an asymptomatic, 'indeterminate' phase that can last 10 years to life.
Chronic stage develops in 10 to 30% of infected persons and usually results in death from cardiac arrhythmia or congestive heart failure.

- Benznidazole, nifurtimox are for primary acute & early indeterminate: long treatment period (30-60 days), dose-dependent toxicity, high rate of patient non-compliance.
- No treatment for indeterminate and chronic disease.

- Drugs for acute and chronic disease.
- Safer and more effective drugs adapted to patient needs – i.e., pediatric formulation.

→ 1 new drug registered

MALARIA

1 MILLION CHILDREN DIE EACH YEAR

Malaria, one of the three most deadly diseases in Africa, is present in over 100 countries and threatens half of world population.
Every year, 350 to 500 million cases of malaria occur worldwide, with a child dying every 30 seconds.

Treatments exist but:
- Widespread drug resistance (parasitic resistance to chloroquine is over 90% in many parts of Africa);
- Existing combination therapies can be expensive and have complicated treatment regimens;
- No paediatric-strength, fixed-dose combinations.

- A fixed-dose Artemisinin Combination Therapy (ACT) as a response to increasing levels of resistance to antimalarial medicines, as recommended by the World Health Organization (WHO) since 2001.

→ 2 new drugs registered in 2007 ensure utilisation and access

02.

R&D Model, Strategy, & Portfolio

DNDi ACTS AS A VIRTUAL ORGANISATION WHICH MANAGES COLLABORATIVE R&D PROJECTS. UTILISING A STEPWISE, INTEGRATED MODEL OF DRUG R&D, DNDi PRIMARILY FOCUSES ITS R&D EFFORTS ON TRYPANOSOMIASIS AND LEISHMANIASIS, WITH NEEDS-DRIVEN PROJECTS THAT CAN BE SOURCED AT ANY STAGE OF THE R&D PIPELINE.

Managing Collaborative R&D Projects to Bridge Gaps

The objective is to build a robust, well-balanced pipeline for HAT, VL, and Chagas.

DNDi follows the virtual research model, whereby most research is outsourced and actively managed by DNDi personnel experienced in different aspects of pharmaceutical development. DNDi proactively identifies research opportunities with the highest potential to translate into improved treatment options, in-sources the project, builds the full development plan, identifies and contracts the appropriate partners for each step, and manages the project as it progresses through the pipeline.

Including public and academic research institutions; governments and disease control programmes of neglected disease-endemic countries; individual pharmaceutical and biotechnology companies; NGOs, foundations and other institutions involved in R&D and/or advocacy for neglected diseases; and individual experts - DNDi's collaborators in both developed and developing countries are essential.

Together with these selected partners, DNDi will also ensure effective post-registration management of these new treatments. Mechanisms must be put into place to ensure treatment, utilisation, and access through partnership with international and national programmes and to ensure timely hand-over of projects to commercial partners.

STRATEGY

As DNDi combines new drug discovery with optimisation of existing drugs and compounds, DNDi's portfolio will be a mix of projects in-sourced at any stage of the development process, from early discovery through clinical development. Five project categories can be distinguished by the nature of the compound/treatment under consideration and by the stage of development or expected time to reach patients:

- New drugs from novel compounds identified through screening and lead optimisation;
- New drugs from compounds with known antimicrobial/antiparasitic activities (may start at lead optimisation or pre-clinical development);
- New indications for existing medicines in the field of the most neglected diseases (therapeutic switching);
- Reformulations and combinations better adapted to field conditions (paediatric, long-acting, new route of administration, fixed-dose combinations, co-packaging, or co-administration);
- Existing drugs for target diseases (geographical extension of registration; completion of regulatory dossiers of existing drug candidates);

The DNDi R&D team will proactively reach out and build a number of exploratory activities which, depending on outcomes, can be built-up to full drug development projects or maintained as backup pipeline projects. Through this approach DNDi will maintain a "feeder" system for the pipelines of each target disease. Successful initial links with the pharma/biotech sector will be used to build further contacts and partnerships, as well as provide some clear indicators of engagement with industry.

PRIORITIES IN 2006

→ **To continue to build a robust portfolio** for HAT, leishmaniasis, and Chagas

→ **To develop projects** from lead selection to lead optimisation, with progression of one candidate into lead optimization

→ **To conduct five clinical trials** and to submit registration files for two Fixed-Dose Artesunate-Based Combination Therapies for malaria

BUILDING A ROBUST PORTFOLIO

In 2006, DNDi's portfolio has grown to 22 projects from an initial three in 2003. The current portfolio ranges from discovery to Phase III clinical trials and focuses on three kinetoplastid diseases (visceral leishmaniasis, Chagas disease, and sleeping sickness) with two projects on malaria. Of the 22 projects, twelve are in the discovery phase, four in preclinical, and six in clinical development.

BRIDGING THE GAPS

The objectives of DNDi's portfolio strategy are to bridge the gaps seen in the drug development pipeline by bringing together all current knowledge and capacities on a treatment in a coordinated manner. From discovery through clinical trials, and on to implementation, new, field-relevant tools will be brought to patients in the shortest possible time.

DNDi implements its pharmaceutical R&D programs in collaboration with public and private partners based upon the priority needs of the populations. The organisation is using existing science and R&D capacity in different countries to develop essential medicines and ensure that they are suitable for, and accessible to, the millions of people suffering from neglected diseases, often living in poverty and in remote areas.

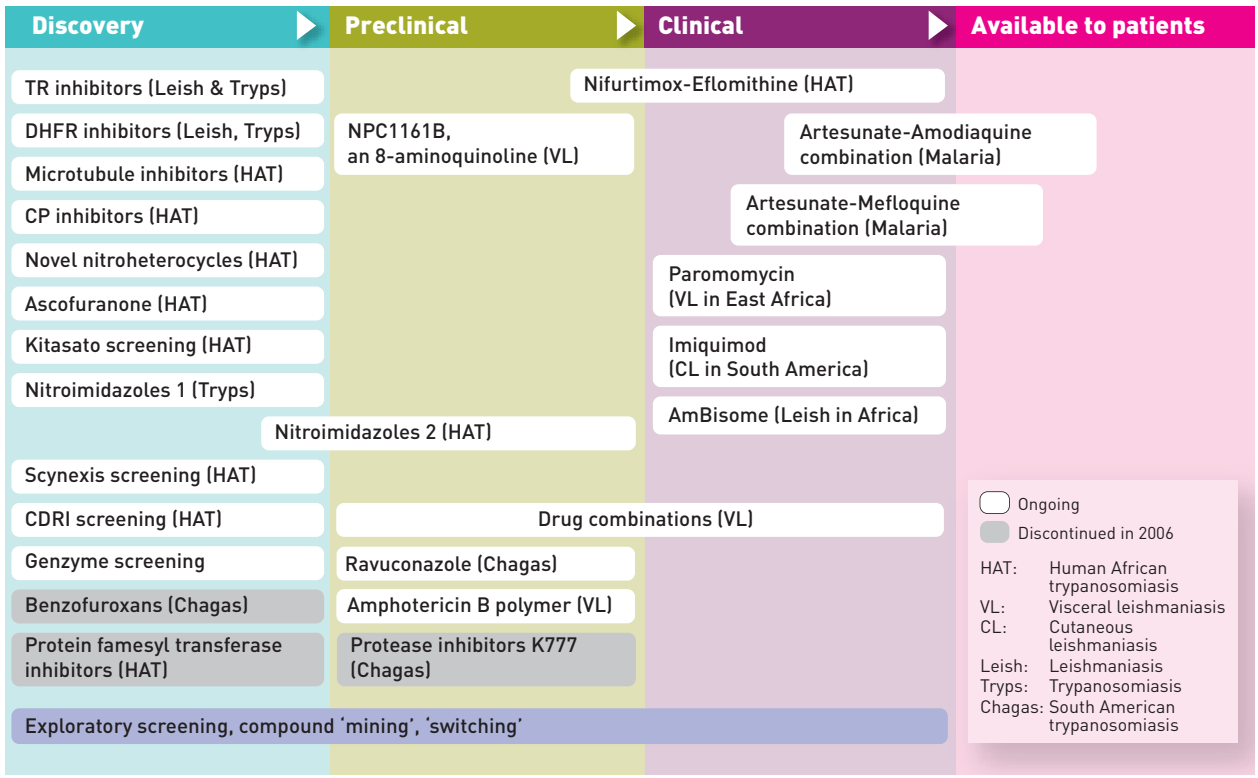
DNDi maintains a portfolio of projects at all stages of development, from screening to drug registration, and has the project management skills to support all aspects of their advancement through the pipeline.

TARGET PRODUCT PROFILE

As a prerequisite to building a portfolio strategy, the desired R&D outcome, or the target product profile (TPP), has to be defined. Each R&D project in the portfolio will be selected, progressed, and managed according to well-defined decision matrices based on these TPPs.

Particularly during drug discovery, the Target Product Profile (TPP) keeps research focused on the endgame – a medicine for a patient. A common format for the TPP is a 'package insert' which contains all of the information necessary for a medical practitioner to effectively prescribe the drug. At DNDi, additional features include a low manufacturing cost, to make the drug more affordable to patients and governments, and a robustness suited to the extremes of climate that our drugs will encounter. The TPP provides a statement of intent very early on in the drug's development program. It starts as a description of an 'ideal' drug, and changes over the development process as limitations in the potential drug emerge.

Sound knowledge of patient needs is essential to a credible TPP. It is necessary to solicit input from health care workers, patients, health regulators and policymakers in disease-endemic countries that are the final destination for the drug. Their inclusion in the early stages of the decision-making process ensures that their needs in the field are reflected in the final product. Used properly, the TPP can play a central role in the entire drug discovery and development process. This role includes effective optimisation of drug candidates, decision-making within an organisation, design of clinical research strategies, and constructive communication with regulatory authorities.



A PRAGMATIC IP POLICY

Contract terms with private and public partners are guided by DNDi's mission to develop safe, effective, and affordable new treatments for patients suffering from neglected diseases, and to ensure equitable treatment access. Contracts are entered into with these principles in mind and according to its IP policy, which is "guided" by the following principles as laid down in the business plan:

- The need to ensure that drugs are affordable and access is equitable for patients who need them;
- The desire to develop drugs as public goods when possible.

The DNDi IP approach is pragmatic, and decisions regarding the possible acquisition of patents, ownership, and licensing terms is made on a case-by-case basis. DNDi puts the needs of neglected patients first, and negotiates to obtain the best possible conditions for them. DNDi's decisions regarding IP will contribute to ensuring access and encouraging further innovation. DNDi regards drug research as a public good that should primarily lead to the advancement of health. In addition to a pragmatic day-to-day approach on IP, DNDi is committed to contributing to the development of IP approaches in health R&D that are aimed at serving the public good.

Discovery Projects

Radical improvement of therapies for the leishmaniases and the trypanosomiases requires the identification, evaluation, and development of novel compounds that are significantly better than current therapies.

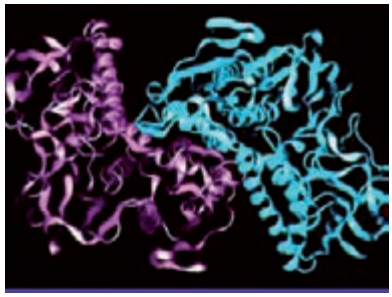
The growth in DNDi's project number to 22 in 2006 from four in 2003 has been largely in discovery (with twelve projects at the end of 2006). The large number of projects in discovery is due to the need to 'feed' three different disease programmes and to compensate for the high attrition rate of the drug development pipeline.

Massive, concerted efforts focused on discovery must and are being undertaken in order to achieve a robust R&D pipeline.

In order to maximize resources, compounds in discovery projects are initially tested against all kinetoplastids. Based on the data at this stage, DNDi then makes a decision on whether to focus the project on a specific disease in further development.

Discovery includes:

- Screening of compounds against the pathogens that cause the target disease;
- Hit expansion, where chemical modification is applied on the hits for improved efficacy and selectivity;
- Lead identification, where further *in vitro, in vivo*, and administration, distribution, metabolism, and extraction (ADME) studies identify a small series of compounds for lead optimisation.



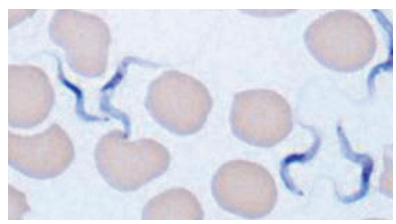
TRYPANOTHIONE REDUCTASE INHIBITORS

- Target disease: trypanosomiasis and leishmaniasis
- Partner: University of Dundee, UK.
- DNDi Project Manager: Denis Martin
- Project start: June 2004

The enzyme trypanothione reductase (TR) is a validated drug target for trypanosomia and leishmania parasites. With that in mind, the project objective is to identify new chemotypes, via the automated screening of large compound libraries and performing rational design and chemistry on possible hits, which potently and selectively inhibit trypanothione reductase.
At the end of 2006, the medium-throughput screening, performed at Dundee, has identified a number of interesting 'hits' among tricyclics and a number of other chemical structures from libraries provided by Sigma and GlaxoSmithKline. Further screening - including molecular target-based, whole cell, and rodent - and additional chemistry of compounds related to the current tricyclic leads and hits will be performed.

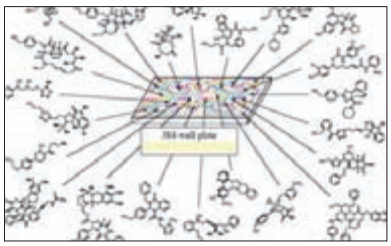
DIHYDROFOLATE REDUCTASE INHIBITORS

- Target diseases: trypanosomiasis and leishmaniasis
- Partners: Institute of Parasitology and Biomedicine Lopez-Neyra, Spain; BIOTEC, Thailand; Basilea, Switzerland; Swiss Tropical Institute, Switzerland.
- DNDi Project Manager: Denis Martin
- Project start: August 2005



Enzymes involved in folate metabolism, especially dihydrofolate reductase (DHFR), have been successfully targeted for cancer and antimicrobial infections by limiting the energy supply to the infectious cell. Most DHFR inhibitors are not suitable candidates for parasitic diseases because they are more selective towards the human

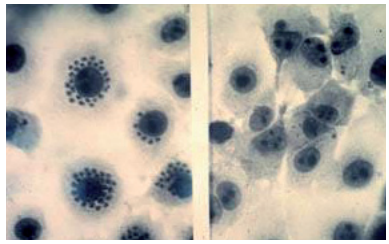
enzyme than towards the parasite enzyme. There may also be a second enzyme, which must also be inhibited in order for DHFR inhibitors to successfully kill the parasite. The objective of the project is to identify, *via in vitro* and *in vivo* screens, parasite-specific DHFR inhibitors that kill the parasite.
At the end of 2006, compounds from Basilea have been screened against the enzyme at the Institute of Parasitology and Biomedicine Lopez Neyra; hits have also been identified for *in vitro* parasite screening at STI. For 2007, STI will study the compounds' *in vivo* efficacies in a mouse model so that a short list of candidates for lead expansion will be ready by the end of the year.



MICROTUBULE INHIBITORS

- Target disease:
  human African trypanosomiasis (HAT)
- Partners:
  Murdoch University, Australia (Principal Investigator and *in vitro T. brucei* assays); Swiss Tropical Institute, Switzerland (*in vivo* models); Epichem, Australia (medicinal chemistry); Centre for Drug Candidate Optimization, Monash University, Australia (pharmacokinetics, ADME, and toxicology).
- DNDi Project Manager: Robert Don
- Project start: September 2006

Previous studies have shown that novel compounds which bind to trypanosome alpha-tubulin have selective activity to *T. brucei* alpha-tubulin *versus* murine alpha-tubulin. The purpose of this project is to assess the development potential of this lead series. At the end of 2006, more than 50 compounds have been synthesized and are being assessed *in vitro* for antiparasitic activity and potential mutagenicity. In 2007, this reiterative medicinal chemistry and screening work will be continued. If promising leads are identified, *in vivo* toxicology may be undertaken.



CYSTEINE PROTEASE INHIBITORS

- Target disease:
  trypanosomiasis (HAT and Chagas)
- Partner:
  University of California, San Francisco, USA.
- DNDi Project Manager: Denis Martin
- Project start: October 2005

Cysteine proteases (CP), especially a subgroup of the papain family which is nearly ubiquitious in protozoan parasites, have been identified as promising targets for the development of antiparasitic chemotherapy.
These proteases play a number of key roles in parasite survival (from nutrition to immune evasion among others), and much is known about the structure/function relationship of the enzyme family. A number of mammalian homologues exist to many of the parasitic enzymes, which means there has been a considerable amount of pharmaceutical research done on inhibitors of this protein family. Therefore, this enzyme family has great potential as a target for discovery research. The objective is to identify novel inhibitors of parasite CPs from three classes (vinyl sulfones, dihydrazides, and thiosemicarbazones) so as to generate lead compounds capable of eliminating the parasitaemia in animal disease models of HAT.

NOVEL NITROHETEROCYCLES

- Target disease:
  human African trypanosomiasis (HAT)
- Partners:
  University of Dundee, UK (Principal investigator); Glasgow University, UK; University of Parma, Italy; Swiss Tropical Institute, Switzerland.
- DNDi Project Manager: Els Torreele
- Project start: June 2005

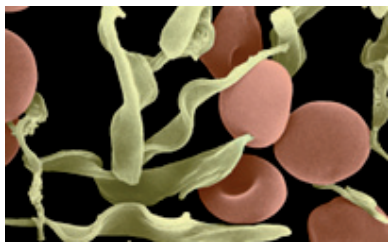
The objective is to identify lead compounds for HAT from a new series of melamine-nitrofuran conjugates. Proof-of-principleis to determine if compounds with good antitrypanosome activity (*in vivo* activity in acute and chronic mouse models for HAT) and with an acceptable toxicity profile can be generated. One common problem of nitroheterocycle compounds, however, is genotoxicity, which is likely to be an issue for the hybrid compounds as well. A second challenge is to generate compounds that can cross the BBB and can cure the CNS-stage of the disease. At the end of 2006, 50 new compounds had been generated and their activity/toxicity profile assessed.

KITASATO SCREENING

- Target disease:
  human African trypanosomiasis (HAT)
- Partners:
  Kitasato Institute (KIT), Japan; Swiss Tropical Institute (STI), Switzerland.
- DNDi Project Manager: Simon Croft
- Project start: April 2005

The goal of this project is to establish screens of natural substances as a possible source of new compounds with activity against *Trypanosoma brucei,* with a research partner who has years of experience in natural products' screening and demonstrated success with the identification of the widely used antibiotic, ivermectin. Staff from another partner, STI, with expertise in kinetoplastid research, were trained in *in vitro* and *in vivo* techniques for *T. brucei*

assays, then transferred the methods to KIT. At the end of 2006, over 12,000 natural products and their synthetic derivatives have been screened, with ten compounds identified as having high activity and not being known anti-cancer compounds. In 2007, further work will be carried out *in vivo* to study the activity of the ten promising compounds, and leads will also be tested against *T. cruzi* and *L. donovani.*



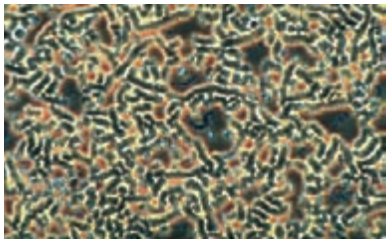
COMPOUND SCREENING WITH SCYNEXIS

- Target disease: human African trypanosomiasis (HAT)
- Partner: Scynexis, USA
- DNDi Project Team: Robert Don, Denis Martin
- Project start: July 2006

The current objective is to establish a *T. brucei in vitro* screen at Scynexis, to screen the Scynexis library of 25,000 compounds in a whole cell *in vitro* screen and to select compounds with selectivity for a full lead optimization programme. At the end of 2006, an action plan and agreement are in place, with *T. brucei* cultures established. Validation of the screening procedures is ongoing. Project-specific templates for the HEOS online database have also been designed.

COMPOUND SCREENING WITH GENZYME

- Target disease: human African trypanosomiasis (HAT)

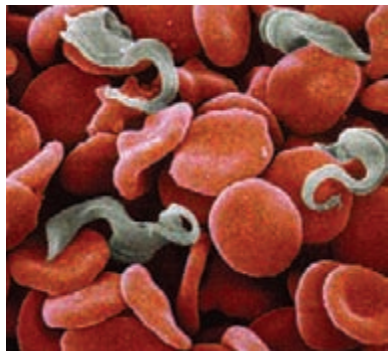


- Partner: Genzyme
- DNDi Project Team: Robert Don, Denis Martin
- Project start: July 2006

Genzyme will provide a number of compounds that impact on the polyamine biosynthesis for screening against *T. brucei* at the Swiss Tropical Institute. These have been studied as part of their oncology programme and this pathway is also the target for DFMO (Eflornithine) in *T. brucei*.
A contract has been signed. All compounds have been supplied to STI and screened. Twelve ceramide analogues show >75% growth inhibition of *T. brucei in vitro* at 0.8 µg/ml.

COMPOUND SCREENING WITH CDRI

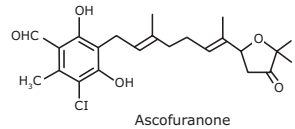
- Target disease: human African trypanosomiasis (HAT)
- Partner: Central Drug Research Institute (CDRI)
- DNDi Project Manager: Simon Croft
- Project start: February 2006



The goal of this project is to identify some chemically diverse compounds with *in vitro* activity against *T. brucei*. CDRI – based in Lucknow, India – is performing a high-thoroughput screening of a library of 16,000 compounds. In 2006, an action plan was agreed upon; staff training, technology transfer, and assay validation were also completed. By the fourth quarter of 2006, screening had begun, with the 2007 plan to complete screening against *T. brucei* and a mammalian cell line. Further lead identification is planned for two or three chemical classes which show promising activity and cytotoxicity profiles.

ASCOFURANONE

- Target disease: human African trypanosomiasis (HAT)
- Partners: University of Tokyo School of Medicine, Japan (Principal Investigator); Tottori University, Japan; Nagayo University, Japan.
- DNDi Project Manager: Simon Croft
- Project start: October 2004



Ascofuranone

Several years ago, researchers at the University of Tokyo School of Medicine identified the *in vitro* and *in vivo* activity of ascofuranone against *Trypanosoma brucei*, the parasite responsible for sleeping sickness. In the veterinary field, subsequent published research has studied the mechanism of action and antitrypanosomal activity in ungulates like cows and sheep. However, there are a number of limitations to this activity which must be further studied. Submitted *via* a letter of interest and approved by the SAC in October 2004, the project objective is to identify ascofuranone derivatives with high selectivity for the HAT parasite and with drug-like properties in a lead refinement project. In 2006, negotiations continued with the Japanese biotech company that owns the IP on the molecules so that the research partners can continue their work on the activity profile and chemistry of this compound in 2007.

PROJECTS DISCONTINUED IN 2006

DISCOVERY:

Protein farnesyltransferase inhibitors (HAT).
Partner: University of Washington, USA.

Benzofuroxans (Chagas).
Partners: Universidad de la Republica, Uruguay (Principal Investigator); Universidad de Navarra, Spain; IIBCE, Uruguay; Universidad Nacional de Salta, Argentina.

PRECLINICAL:

Protease inhibitor K777 (Chagas).
Partners: Federal University of Minas Gerais, Brazil; University of California, USA; Einstein School of Medicine, USA.

DNDi is grateful to the project partners for their dedication during the lives of these projects.

Rediscovering nitroimidazoles as promising drug candidates

NITROIMIDAZOLES-1

- Target disease:
  trypanosomiasis (HAT and Chagas); leishmaniasis
- Partners:
  Swiss Tropical Institute, Switzerland (compound evaluation); several CRO's including Covance, UK; BioDynamics, UK, Absorption Systems, US; and a range of collaborators who have made compounds of interest available for testing, including ENH Research Institute, USA; Tehran Univ of Medical Sciences, Iran; Silesian Univ of Technology, Poland; LaSapienza Univ, Italy; Univ of Alberta, Canada; Univ of Tennessee, USA; Tokushima Univ, Japan; Univ of Auckland, Australia; sanofi-aventis, France; Roche, Switzerland; Novartis/NITD, USA-CH-Singapore; Alkem, India; TB Alliance, USA.
- DNDi Project Manager:
  Els Torreele
- Project start:
  January 2005

In 2004, DNDi commissioned a literature/patent review to explore past and ongoing research activities on megazol and related nitroimidiazole compounds as possible leads for antitrypanosomal drug development because they had previously been shown to possess good antimicrobial activity, including anti-protozoal activity. In the case of megazol, which had proven highly active *in vitro* and *in vivo* as a trypanocidal compound and a promising potential drug candidate against Chagas disease and HAT, it was orally active and could cross the blood-brain barrier. However, due to its toxicity (specifically mutagenicity, or possibility of causing genetic mutation), it was not developed further.

After establishing the potential of the class, DNDi undertook a project to identify a range of new and old nitroheterocycles, to (re)assess their *in vitro* and *in vivo* trypanocidal activity, and evaluate their activity/genotoxicity profile through a series of standard genotoxicity tests. In parallel, other drugability characteristics were summarily compiled to allow comparison of the most promising compounds. Near the end of 2006, the project was also expanded to include leishmaniasis as a target, as several compounds demonstrated good *in vitro* activity against *L. donovani*.

At the end of 2006, over 500 compounds from 15 different sources have been identified, accessed, and tested at STI for *in vitro* antiparasitic activity, and further assessed for *in vivo* selectivity. Several interesting compound series have been identified and selected for further exploration. Two compounds from Roche and sanofi-aventis (ex-Hoechst) were identified as preclinical candidates (see Nitroimidazoles-2).

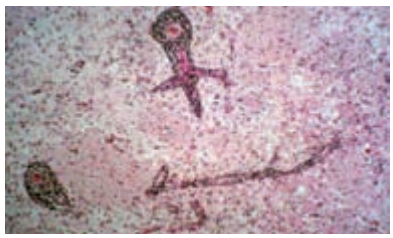
Preclinical Projects

A look at the current status of R&D research for the trypanosomiases and leishmaniases, reveals a clear shortage of projects in preclinical development, which raises concern about potential new drugs in five to ten years time. To redress the balance, DNDi is taking a proactive approach to identify new drugs and projects that have the possibility of filling this preclinical gap. Already, projects on nitroimidiazoles and aminoquinolines have been established to fill this immediate need. DNDi also recognises the need for new disease-specific models to improve the selection of drugs in the development phases, and is working with partners to identify new potential candidates.

NITROIMIDAZOLES – 2

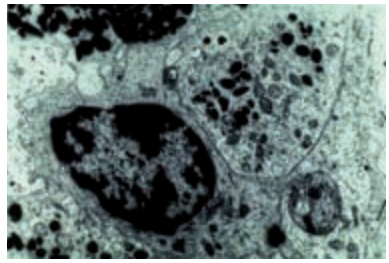
- Target disease: human African trypanosomiasis (HAT)
- Partners: Swiss Tropical Institute (STI), Switzerland (compound evaluation); several CRO's including Covance UK; BioDynamics, UK, Absorption Systems, US; sanofi-aventis, France; Roche, Switzerland.
- DNDi Project Manager: Els Torreele
- Project start: December 2006

In December of 2006, the two most advanced compounds (coming from Roche and sanofi-aventis) of the "Nitroimidazoles-1" (re-)discovery project were separated into their own project. This separation was done in order to further characterize them and to select the most promising of the two to advance into preclinical development in 2007. Further characterization will include metabolic profile, PK, and mutagenic potential of the two candidates.



NPC1161B, AN 8-AMINOQUINOLINE

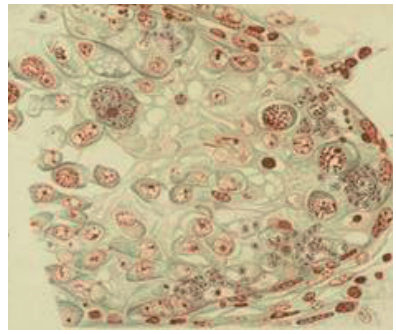
- Target disease: visceral leishmaniasis
- Partners: University of Mississippi (UM), USA (Principal Investigator); Medicines for Malaria Venture (MMV), Switzerland; London School of Hygiene & Tropical Medicine (LSHTM), UK.
- DNDi Project Manager: Denis Martin
- Project start: December 2005



8-aminoquinolines are a class of compounds with considerable anti-parasitic activity, but their potential has been limited in the past due to human toxicity. A team of researchers led by the University of Mississippi recently developed NPC1161B, a new lead compound from the 8-aminoquinoline class, which is very effective against parasites for both malaria and leishmaniasis, and offers promise for reduced hematological toxicity in man. MMV has been working in collaboration with UM to further preclinical development of NPC1161B because of promising oral efficacy against *P. vivax* infection. Through a cooperative agreement, DNDi and MMV will share clinical information, as well as significant scientific findings regarding the non-clinical safety data, metabolism, or other relevant findings. In 2006, DNDi has provided financial support for additional studies on the *in vivo* antileishmanial/trypanosomal activity of NPC1161B. DNDi will undergo a review process with its SAC in May 2007 to decide whether to pursue this project or other 8-aminoquinolines further advanced in the drug development pipeline.

RAVUCONAZOLE

- Target disease: Chagas disease
- Partners: Federal University of Ouro Preto, Brazil; Instituto Venezolano de Investigaciones Cientificas, Venezuela; EISAI Co. Ltd, Japan.
- DNDi Project Team: Robert Don, Isabela Ribeiro
- Project start: 2005



Preclinical studies with antifungal triazoles have shown considerable efficacy in the treatment of Chagas disease in animal models. Two of these compounds have been in development for fungal infections: ravuconazole (Eisai) is currently in Phase II studies, and posaconazole (Schering Plough) was recently registered for treatment of fungal infections in Europe and as an antifungal prophylactic in the USA. At the end of 2006, two of three animal studies have been completed with ravuconazole to find the optimum dosing regimen, and the third has begun (to study bi-daily dosing in dogs). In 2007, the goal of the triazole project is for either posaconazole or ravuconazole to advance into clinical research, if data and conditions are favourable, and to examine other molecules from the same family as potential drug candidates.

Finding a safe and affordable alternative

AMPHOTERICIN B POLYMER

- Target disease:
  visceral leishmaniasis (VL)
- Partners:
  Imperial College, UK (Principal Investigator); London School of Pharmacy, UK; London School of Hygiene and Tropical Medicine (LSHTM), UK; Advinus, India; Shanta Biotech, India.
- DNDi Project Manager:
  Denis Martin
- Project start:
  September 2006

Liposomal amphotericin B (AmBisome), an efficacious yet highly expensive formulation of amphotericin B, has been increasingly used to treat VL. However, its use in the VL-endemic regions of Africa and Asia has been limited due its high cost, which prices it out of use in developing countries with the highest burden of disease. Instead, patients there still receive the acutely toxic, yet more affordable, amphotericin B, a 70-year-old drug which kills 10% of the patients treated with it. This project aims to combine the amphotericin molecule in a way that is similar yet different from the way AmBisome is modified. Instead, in this project, amphotericin B will be surrounded by a less expensive methacrylic acid derived polymer, which is expected to make a drug that is stable in hot climates, highly soluble, relatively inexpensive, safe, and effective in short-term therapy of VL. The early stage proof-of-concept of the efficacy of a modified metacrylic has been shown by the Imperial College team.

At the end of 2006, experimental work has begun in *in vivo* mouse models at LSHTM, where initial efficacy and safety data look promising. In 2007, researchers will optimize the *in vitro* and physicochemical properties of the amphotericin-polymer complex with the aim to have a well-defined polymer weight and ratio between amphotericin B and polymer.

Clinical Projects

The six clinical projects in DNDi's portfolio at the end of 2006 are mainly constituted of a cluster of new formulations of established drugs, drugs switched from other indications, or drug combinations. While there are few novel compounds in this area in R&D for neglected diseases, all of the treatments under investigation can have a real impact on improving patient treatment in the near future and serve to strengthen clinical research capacity that will be used in the future for evaluating novel compounds. Two of the clinical projects, which are currently undergoing the registration process, are expected to be available to patients in Africa and Latin America in 2007.

COMBINATION THERAPY

- Target disease: visceral leishmaniasis (VL)
- Partners: ICMR, India; Kala-azar Medical Research Centre, India; Rajendra Memorial Research Institute, India; University of Varanasi, India
- DNDi Project Team: Catherine Royce, Bhawna Sharma
- Project start: December 2006

The most widely used treatment for VL is sodium stibogluconate (SSG), which is toxic, difficult to use, and poorly tolerated by patients. A number of new therapeutic options have been developed, but they are generally expensive and therefore cannot be adopted by the majority of VL-endemic regions. At a meeting of experts convened by DNDi in February 2005, a number of key drivers were identified for developing combination therapies for VL: ease of use, shorter course of treatment, prevention of parasite resistance, and cost containment. Additionally, combination regimens using already existing drugs offer a short-term solution to assist in protecting the useful life of available drugs while new chemical entities are developed. Therefore, one of the critical issues was to utilize drugs which are already registered in the region (for example, AmBisome, miltefosine, and paromomycin which will be used in this four-armed study).

At the end of 2006, preclinical studies for efficacy and toxicology have been completed. In 2007, a project team will be assembled and a clinical study protocol drafted in the first quarter; and by the end of the year, patient enrolment will be initiated.

IMIQUIMOD ADJUNCT IMMUNOTHERAPY

- Target disease: cutaneous leishmaniasis (CL)
- Partners: McGill University, Canada (Principal investigator); Universidad Peruana Cayetano Heredia, Peru.
- DNDi Project Team: Catherine Royce, Isabela Ribeiro
- Project start: June 2005

Current treatments for CL are administered systematically and require protracted treatment by daily intramuscular injections. With DNDi's ultimate goal to develop a better tolerated, more convenient, and cheaper therapy for CL than current standards, the study objective is to determine the efficacy and safety of a topical administration of imiquimod, an immunomodulator that is used extensively as a topical treatment for genital warts. Imiquimod's mechanism of action is to stimulate a local immune response at the lesion site and therefore resolve the infection. As imiquimod is already available as a generic in a few countries with endemic leishmaniasis, it has the potential to be a readily affordable and available treatment. The primary endpoint of the clinical study, analysis of 3-month follow-up data, was made in December 2006. In 2007, the 12-month follow-up data will be available.

An innovative partnership to bring hope to African malaria patients

ASAQ, FIXED-DOSE ARTESUNATE/AMODIAQUINE COMBINATION THERAPY

- Target disease:
  malaria
- Partners:
  Centre National de Recherche et de Formation sur le Paludisme, Burkina Faso; University Sains Malaysia; Oxford University, UK; Mahidol University, Thailand; Tropival, France; Ellipse Pharmaceuticals, France; Rottendorf Pharma, Germany; Médecins Sans Frontières; TDR; sanofi-aventis.
- DNDi Project Team:
  Jean-René Kiechel, Graciela Diap
- Project start:
  January 2002

ASAQ, the new fixed-dose combination (FDC) of artesunate (AS) and amodiaquine (AQ), will be the first drug to be delivered by DNDi and is intended to treat paediatric and adult uncomplicated *falciparum* malaria, with a primary focus on Africa and some countries in Asia where amodiaquine resistance is low.

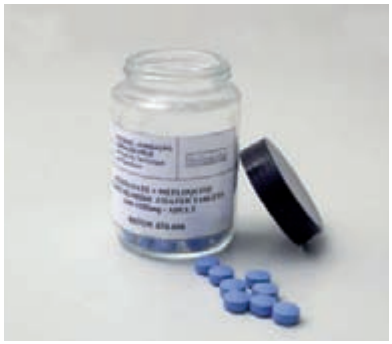
With resistance a major threat to malaria control, artemisinin-based combination therapies (ACTs) offer a way to counter resistance: the combination of AS and AQ was one of four ACTs recommended by WHO in 2001 as first-line treatment for uncomplicated *falciparum* malaria, but it did not yet exist as a FDC nor was it in FDC development. Hence, the FACT (Fixed-Dose, Artesunate-Containing Therapy) Project was undertaken in 2002 by a number of public and private partners coordinated by TDR and MSF (who turned over the project to DNDi upon its foundation).

AS and AQ are well-known drugs, with scientific evidence supporting the use of the combination of AS and AQ in approximately 10,000 patients. ASAQ provides a true innovation in patient treatment by being a tropical-stable bilayer coformulation which allows AS and AQ to be taken together and in the correct proportions in a simplified three-day dosing regimen where the most vulnerable population, children under the age of five, take one tablet per day.

In December 2004, sanofi-aventis signed on as industrial partner and has been involved in industrial, preclinical, and clinical product development, as well as in preparation of all of the registration files. ASAQ will be a quality, easy-to-use product that will be readily available and affordable at cost price (<US$1 for adults and <US$0.50 for children in public markets) as a non-patented public good.

The year 2006 was a milestone year for ASAQ: in February, the pivotal Phase III field study, which enrolled 750 children in Burkina Faso, successfully concluded and showed final results of >95% efficacy, which were presented at the American Society for Tropical Medicine and Hygiene (ASTMH) annual meeting in November; also in November, sanofi-aventis filed for registration in Morocco, the country where ASAQ is manufactured.

2007 holds great promise as the next steps for ASAQ are to: obtain regulatory approval in Morocco, undergo submission for WHO prequalification, and continue to be registered in all sub-Saharan African countries where it can be of substantial public health benefit.



FIXED-DOSE ARTESUNATE/ MEFLOQUINE (AS/MQ) COMBINATION THERAPY FOR MALARIA

- Target disease: malaria
- Partners:
  Farmanguinhos, Brazil; Mahidol University, Thailand; Shoklo Malaria Research Unit, Thailand; University Sains Malaysia; Oxford University, UK; Médecins Sans Frontières; TDR.
- DNDi Project Team:
  Jean-René Kiechel, Isabela Ribeiro
- Project start: January 2002

Among the most studied ACTs is the three-day treatment with artesunate (AS) and mefloquine (MQ), which has shown to be a highly effective therapy against uncomplicated malaria. ASMQ, the new co-formulation of AS and MQ, offers a single daily dose of one or two tablets over three days and provides added regimen simplicity.

Consistent with 2006 WHO treatment guidelines, ASMQ will serve as a fixed-dose combination to treat uncomplicated falciparum malaria in paediatric and non-pregnant adult populations. Drug deployment efforts are initially focused on areas of low transmission, including Southeast Asia and South America, but ASMQ can potentially be used in all endemic regions including those affected by multi-drug resistant *P. falciparum* strains.

In the year 2006, significant progress was made. Results were published and showed the efficacy and side effect profile of ASMQ to be equivalent to the non-fixed combination of a Phase III field study conducted in 500 patients in Thailand in 2005 (Ashley *et al.CID* 2006). In Brazil, a registration file was submitted to regulatory authorities in November by Farmanguinhos, the FACT production partner, which is a state-owned pharmaceutical company. A large-scale intervention study was also undertaken by the Brazilian national control programme.

The future holds even more promise for ASMQ as the registration process continues and extends to other countries in Latin America, a file will be submitted for WHO pre-qualification, and SE Asian authorities and an industrial partner will be identified and engaged to facilitate regional implementation of one of the world's most effective treatments for malaria.

NIFURTIMOX-EFLORNITHINE CO-ADMINISTRATION

- Target disease:
  human African trypanosomiasis (HAT)
- Partners:
  Epicentre, France; Médecins Sans Frontières-Belgium; Médecins Sans Frontières-Holland, the national HAT control programmes of the Democratic Republic of Congo (DRC), the Republic of Congo, Uganda; Swiss Tropical Institute, Switzerland; TDR.
- DNDi Project Manager:
  Els Torreele
- Project start: 2003

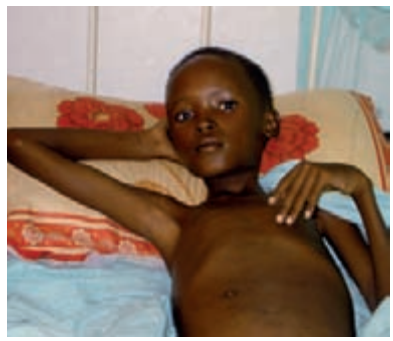
NECT is a multi-centre clinical study to test a simplified combination of nifurtimox and eflornithine (NEC) for stage 2 HAT. Begun as a single center study by MSF-Holland and Epicentre in the Republic of Congo in 2003, the study objective is to demonstrate that the combination is as effective and safe as standard eflornithine monotherapy, but easier to use, as the number of slow, intravenous infusions of nifurtimox is reduced from 56 to 14. The ultimate goal is to build an evidence base on the safety and efficacy of NEC as a new first line treatment suffering from stage 2 HAT, so as to enable a WHO recommendation on its use.

Since 2005, DNDi's activities have mainly focused on the implementation of this study at three sites in DRC (including their rehabilitation and equipment) to complement the data of the initial NECT study in Congo-Brazzaville, where patient numbers were insufficient to complete the study.

At the end of 2006, patient recruitment at the three DNDi sites in DRC was completed after reaching the 280 patient target for the trial (when taking account the number of patients enrolled at the Congo-Brazzavile site). A full safety analysis will be completed by mid 2007. Final results of the trial, including the efficacy analysis at the 18-month follow-up, are expected by the fourth quarter of 2008.

PAROMOMYCIN FOR AFRICA

- Target disease:
  visceral leishmaniasis
- Partners:
  Kenya Medical Research Institute, Kenya; University of Nairobi, Kenya; University of Addis Ababa, Ethiopia; Institute of Endemic Diseases, University of Khartoum, Sudan; Gedaref University, Sudan; National Ribat University, Sudan; IDA; Médecins Sans Frontières-Holland; TDR; London School of Hygiene and Tropical Medicine, UK.
- DNDi Project Team:
  Catherine Royce, Sally Ellis
- Project start: November 2004

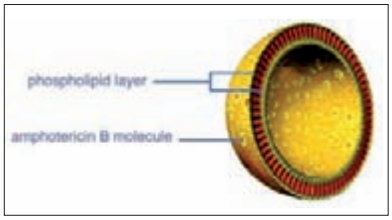


Paromomycin, an aminoglycoside antibiotic that was identified in the 1960s as an antileishmanial, represents an improved treatment at a lower cost that will allow it to be adopted in developing countries suffering the largest disease burden of VL. A critical milestone was met for paromomycin development in 2006 as our partner PDP, the institute for One World Health (iOWH), successfully registered paromomycin intramuscular (IM) injection in India in August.

As iOWH works to make paromomycin available on the Indian sub-continent, DNDi is working in parallel with the Leishmaniasis East Africa Platform (LEAP) to study the efficacy and safety of paromomycin in Africa, specifically in Ethiopia, Kenya, Sudan. The aim

is to register paromomycin as a new treatment in each region and to have it adopted in national treatment guidelines.

At the end of 2006, the study is currently recruiting patients at six sites in Ethiopia, Kenya, and Sudan, five sites where infrastructure has been improved or built (as in the case of the Leishmaniasis Treatment and Research Centre built by DNDi & LEAP in Arba Minch, Ethiopia). The next step for the project will be an interim analysis to be concluded by early 2008.



AMBISOME

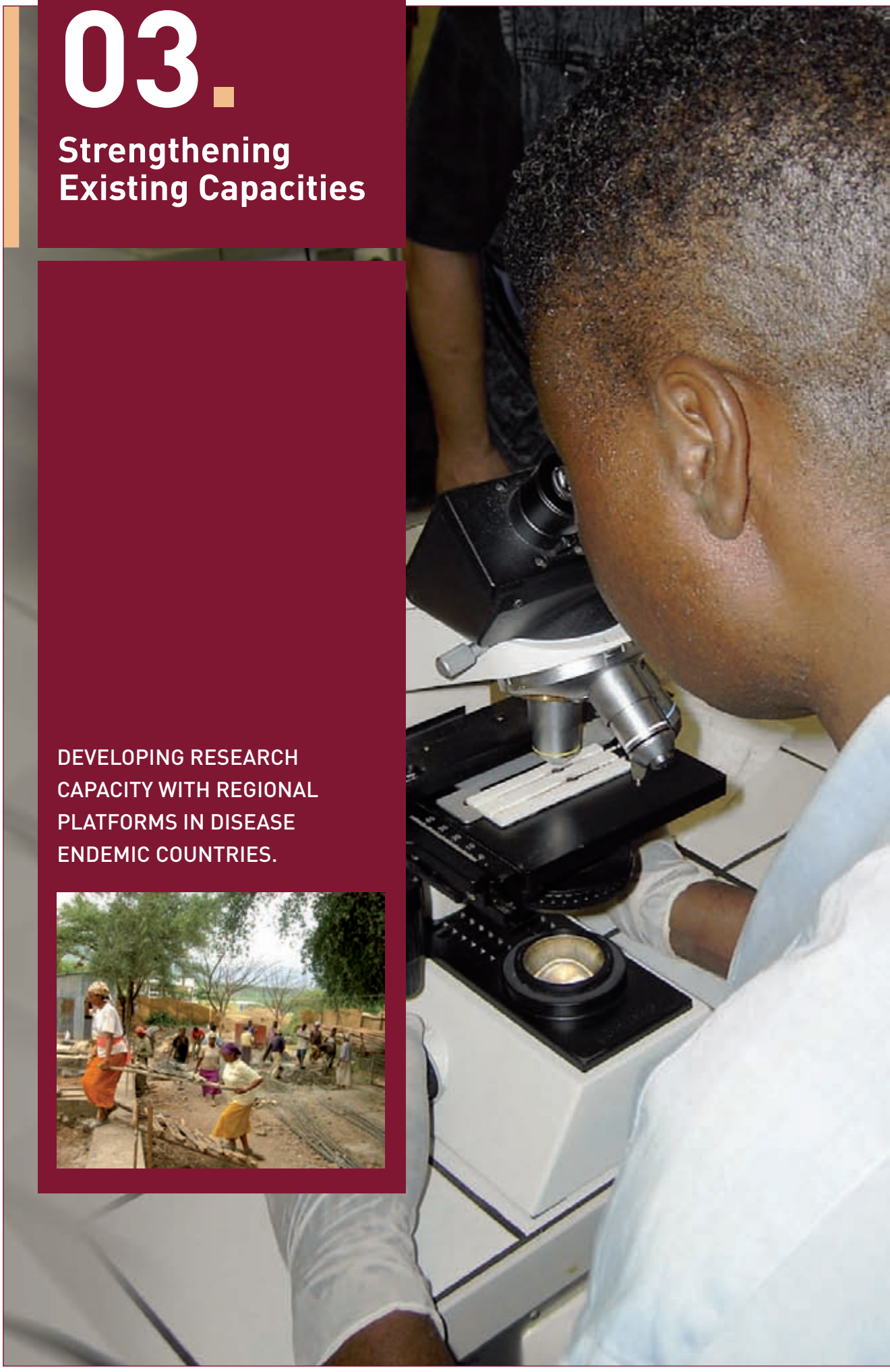
- Target disease: visceral leishmaniasis (VL)
- Partners: Addis Ababa University, Ethiopia; London School of Hygiene and Tropical Medicine, UK.
- DNDi Project Manager: Catherine Royce
- Project start: upon completion of the paromomycin study

AmBisome, a liposomal formulation of amphotericin B manufactured by Gilead, has been used with increasing frequency to treat VL, especially in Europe, over the past decade. Unfortunately, in Africa and Asia, where disease burden is high, drug access is poor because of the high cost of the drug. With recent preferential pricing offered by the manufacturer to patients in the public sector in East Africa, there is a possibility that AmBisome could become economically feasible for first-line treatment, even in resource-poor countries.

The goal of this project, therefore, is to determine the minimum dose of AmBisome that is efficacious, safe, and cost effective in the treatment of VL, to reduce length of hospital stay, and to facilitate registration and adoption of AmBisome in Ethiopia. Identifying the minimum dose for monotherapy will be an important step in developing combinations for Africa.

03.

Strengthening Existing Capacities



DEVELOPING RESEARCH CAPACITY WITH REGIONAL PLATFORMS IN DISEASE ENDEMIC COUNTRIES.

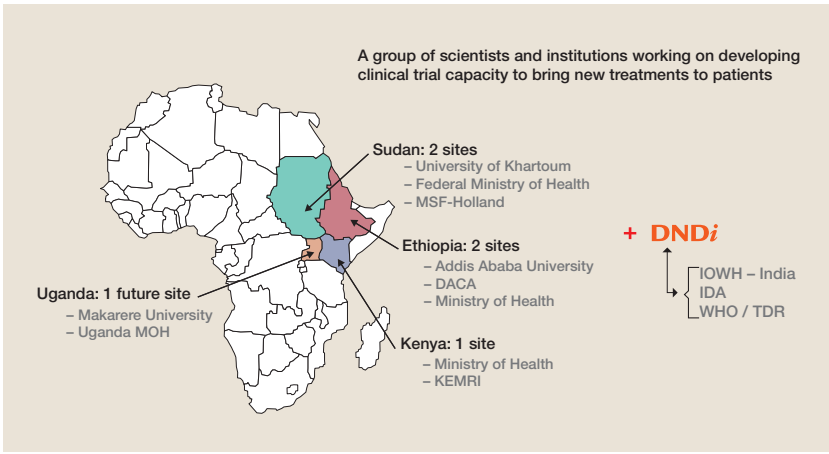
Working Together with the Health Research Community in Endemic Countries to Strengthen Existing Capacities

Using platforms to facilitate international quality research in the lab and in the field.

DNDi works with partners in neglected disease-endemic countries and ensures their involvement in the R&D process through technology transfer and through a global network of collaborations, such as access to chemical diversity, establishment of discovery platforms, pharmaceutical and clinical development, and connections to control programmes through the Leishmaniasis in East Africa Platform (LEAP) and HAT platforms in Africa, Founding Partners, and other existing networks in disease-endemic countries.

In addition, physical upgrading of facilities directly related to clinical trials is taking place within disease-endemic regions. Such capacity building may include the building and renovation of hospital wards, clinics, and health posts; renovation and re-equipping of clinical laboratories; and training of health service personnel with particular emphasis in building expertise in clinical trial methodology, Good Clinical Practice and Ethics, patient treatment and evaluation, and accurate diagnosis and follow-up by parasitology.

LEISHMANIASIS EAST AFRICA PLATFORM (LEAP)



- Target disease:
  leishmaniasis
- Partners:
  KEMRI, Kenya; Addis Ababa University, Ethiopia; IDA Solutions, the Netherlands; Institute of Endemic Diseases, University of Khartoum, Sudan; Makarere University, Uganda; MSF-Holland; national control programmes in Kenya, Ethiopia, Sudan, and Uganda.
- DNDi contact:
  Monique Wasunna
- Project start:
  August, 2003; Khartoum, Sudan

LEAP, the Leishmaniasis East Africa Platform, is **a regional clinical research network that brings together experts from leishmaniasis-endemic East African countries including Ethiopia, Kenya, Sudan, and Uganda.** The platform incorporates partners from across the spectrum of clinical research and disease control organisations/institutions working in leishmaniasis in these countries.

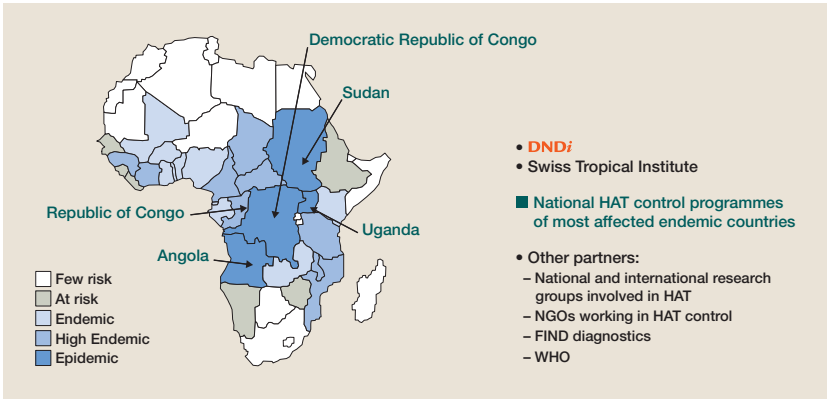
LEAP serves to strengthen clinical research capacity, which is lacking in part due to the remoteness and geographic spread of the patients (most of whom are in the most impoverished regions of Africa). This platform also serves a base for ongoing educational

cooperation between the countries in the East African region and standardisation of procedures and practices within the region, as far as is possible within the confines of local regulations. LEAP projects are carried out as collaborative efforts.

LEAP, in collaboration with DNDi is currently conducting a large-scale, multi-centre clinical trial in East Africa to assess the field effectiveness of paromomycin in Sudan, Ethiopia, and Kenya. Also as part of its role, LEAP brings its members together at biannual meetings. In addition, physical upgrading of facilities directly related to clinical trials is taking place within disease-endemic regions. Such capacity strengthening includes the building and renovation of hospital wards, clinics, and health posts; renovation and re-equipping of clinical laboratories; and training of health service personnel with particular emphasis on building expertise in clinical trial methodology, Good Clinical Practice and Ethics, patient evaluation, treatment and safety, accurate diagnosis, and follow-up by parasitology.

A 'concrete' achievement: LEAP members and DNDi officials attend the inaugural ceremony of Africa's first research and treatment centre for visceral leishmaniasis in Arba Minch, Ethiopia (February 2007).

THE HAT PLATFORM



- Target disease:
  human African trypanosomiasis (HAT)
- Partners:
  STI; national HAT control programmes in Angola, DRC, Republic of Congo, North Sudan, South Sudan, and Uganda. Other partners include NGOs, national and international research organisations.
- DNDi contact:
  Augustin Ebeja
- Project start:
  August 2005; Kinshasa, DRC

The HAT Platform - which was inaugurated in Kinshasa, Democratic Republic of Congo in 2005 - is a **clinical research capacity strengthening network** that brings together experts, clinicians, and researchers from trypanosomiasis-endemic countries or from neighbouring countries, as well as international clinical trial and HAT specialists.

The overall aim of the HAT Platform is to build and strengthen treatment methodologies and clinical trial capacity in HAT-endemic countries, so that new and promising interventions for this fatal disease can be rapidly and effectively evaluated, registered, and made available to the patients. The primary goals of the HAT Platform are to develop appropriate clinical trial methodologies for HAT, to overcome system challenges related to administrative and regulatory requirements, to strengthen clinical trial capacity (human resources, infrastructure, and equipment), and to share information and strengthen communications between endemic countries. Activities include an annual meeting, training workshops, and a quarterly newsletter.

The core partners of the HAT Platform consist of **the national control programmes of the major endemic countries (Angola, DRC, RoC, Sudan, and Uganda). DNDi**, in collaboration with **STI**, facilitates the platform both financially and through general administrative and logistical support provided by the STI-DNDi Africa office in Kinshasa. Other partners of the platform include national and international research organisations, NGOs (such as MSF, Epicentre), and representatives of health ministries and regulatory authorities of other African countries.

Over 30 attendees from 9 countries were present at the 2nd annual HAT Platform meeting of in Nairobi, Kenya – September 2006.

PAN ASIAN NETWORK FOR NEGLECTED DISEASES (PAN4ND)

Attendees at the first PAN4ND meeting co-hosted with the Kitasato Institute in Tokyo, Japan (May 2006).

- Target disease:
  human African trypanosomiasis (HAT), leishmaniasis
- Partners:
  CDRI, India; Eskitis Institute, Australia; Forest Research Institute Malaysia; Institut Pasteur, Korea; Kitasato Institute, Japan; Malaysian Institute of Pharmaceuticals and Neutraceuticals, Malaysia; Novartis Institute of Tropical Diseases, Singapore; Shanghai Institute of Materia Medica, China
- DNDi contact:
  Jean-Robert Ioset
- Project start:
  May 2006; Tokyo, Japan

The objective of PAN4ND, which officially convened its first network meeting in Tokyo in May 2006, is to create a climate suitable for collaborative research on the identification of novel molecules that could be used as for neglected diseases. In its inaugural year, PAN4ND convened two network meetings to discuss current R&D to identify new bioactive molecules from natural substances and how best use standardized methodologies to generate and manage data that could be employed to prepare an investigational new drug. With members including research institutions from seven countries, PAN4ND also held a network training session in collaboration with the Central Drug Research Institute (CDRI).

By encouraging research collaboration between member institutes, **PAN4ND seeks to maximize the potential for discovery of hits and leads from natural products** for development as drugs for neglected diseases and will do so by:

- Linking natural products' researchers and institutes as a collaborative network;
- Incorporating neglected diseases as part of our drug candidate screening programs;
- Standardizing screening methodologies against parasitic targets and other pathogens within the network.

Activities include an annual meeting, training workshops, development of a training manual, website, and a network newsletter.

For patients suffering from neglected diseases, the world has been asleep to their needs. These platforms are key elements in bridging gaps in the R&D pipeline so that they are better needs-adapted treatments in the future.

04.

Advocacy and Fundraising

DNDi WORKS TO BUILD AWARENESS ABOUT MOST NEGLECTED DISEASES IN BOTH DEVELOPED AND DISEASE-ENDEMIC COUNTRIES SO AS TO INCREASE AND TO SUSTAIN SUPPORT FOR INCREASED PUBLIC INVOLVEMENT.

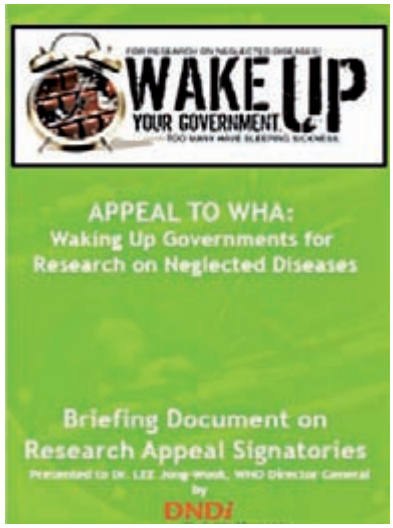
Waking Up for R&D on Neglected Diseases

To stimulate innovation in essential health R&D, public leadership is key.

Political leadership is essential in securing sustainable financial support, in defining priorities, in creating a more favourable environment that will stimulate health R&D, and in ensuring equitable access of new health tools. In May 2006, the World Health Assembly (WHA) adopted Kenya- and Brazil-led Resolution 59.24 for a "Global Framework for Essential Health R&D," inspired in part by the WHO-commissioned report from the Commission on Intellectual Property, Innovation and Public Health (CIPIH) published earlier in the year.

The resolution calls for government leadership to set global health priorities, fund R&D for neglected diseases, increase access to knowledge, and create an enabling environment for health R&D, while the CIPIH report reiterates the moral imperative for governments to play a major role in promoting innovation adapted to the needs of sick and neglected patients. An Intergovernmental Working Group of Member-States within **WHO** has been set up in order to deliver a final report with concrete proposals to the Executive Board in January 2008.

DNDi will continue to ask for greater political leadership from donor and neglected disease-endemic governments, in addition to international bodies, such as the WHO and its Intergovernmental Working Group. Enabling relationships between concerned scientists, research institutes, PDPs, and NGOs is critical to accelerate the momentum that has been building since 2000. With the objective to promote an alternative model that will enable a new environment for R&D for neglected diseases, DNDi is working with independent, academic experts to examine issues, such as intellectual property, regulatory processes, access to knowledge, and economics, in order to stimulate a new environment for R&D for neglected diseases and essential health.



An Appeal That Worked to Wake Up Governments In Its Yearlong Campaign

In June 2005, DNDi and its partners launched a year-long advocacy campaign with an appeal to governments to boost innovation for neglected diseases. The appeal was designed to:

- Stimulate public commitment and funding support to R&D for neglected diseases;
- Raise grassroots and public awareness about the lack of R&D for neglected diseases;
- Implement new rules to stimulate essential health R&D.

19 NOBEL LAUREATES SIGN ON

More than 7,800 concerned scientists, policymakers, industry and NGO members and concerned individuals, including 19 Nobel laureates, signed the Research Appeal over the course of one year. In May prior to the WHA, Dr. Yves Champey, Chair of DNDi's Board of Directors, presented the Appeal and its signatories to the Director-General of the WHO, Dr. Jong-Wook Lee.

BUILDING REGIONAL PARTNERSHIPS, NAIROBI 2006

African scientists and policy makers join forces to facilitate research of new treatments for neglected diseases. Over 200 African scientists from 34 countries met from 19 to 23 September at a DNDi-organised international conference to engender greater regional research partnership to combat the most neglected diseases, such as sleeping sickness, visceral leishmaniasis, and malaria.

Since the first meeting in Nairobi in 2003, when there was a call for greater research cooperation, significant progress has been made: clinical research platforms for visceral leishmaniasis and sleeping sickness have been established on the continent, and African scientists have contributed to the clinical trials of ASAQ, the new fixed-dose antimalarial.

"This meeting of the best scientific minds will consolidate the endeavour of African researchers to work together in the search for new drugs to fight neglected diseases," remarked Hon. Charity Ngilu, Kenya's Minister of Health. "Kenya has its share of these burdensome diseases and is proud to be a member of this regional partnership, so we can share information and expertise with fellow scientists from Africa and the rest of the world."

At the regional meeting, there were also a number of sub-meetings held in addition to the DNDi Africa public day:

- A FACT workshop engaging representatives from 13 African national malaria control programmes among other international experts to discuss how best to overcome challenges facing ACT implementation in Africa;
- With 51 attendees from seven countries at the biannual LEAP meeting, numerous training workshops for LEAP team members expanded the team's clinical trial expertise and reinforced good practices;
- The second full meeting of the HAT Platform, with over 30 attendees from nine countries, was praised by Dr. Pere Simarro of the WHO for its creation and mission.

DNDi SYMPOSIA IN 2006

12th International Congress on Infectious Diseases (ICID), Lisbon, Portugal

→ The FACT Project: New Fixed-Dose Artesunate Combination Therapies to Treat Falciparum Malaria – June 17, 2006

11th International Congress of Parasitology (ICOPA), Glasgow, UK

→ The FACT Project – Partnerships in R&D for neglected parasitic diseases - August 8, 2006

Global Forum, Cairo, Egypt

→ Special Session – "Neglected Diseases: Supporting the Global Framework on Essential Health R&D" – October 30, 2006

Congrès Palu-Sida-Tuberculose, Ouagadougou, Burkina Faso

→ November, 2-4, 2006

American Society of Tropical Medicine and Hygiene (ASTMH), Atlanta, USA

→ HAT symposium – Challenges Ahead: R&D of New Drugs for Sleeping Sickness – November 15, 2006

→ FACT symposium – The Final Leg: New Fixed-Dose Artesunate-Based Combination Therapies to Treat Falciparum Malaria – November 16, 2006

TEAM AND PARTNER PUBLICATIONS IN 2006

- **"Drug resistance in leishmaniasis"**
  Croft SL, Sundar S, Fairlamb AH. Clin Microbiol Rev. 2006 Jan;19(1): 111-26.
- **"No drugs in an age of plenty: urging governments to redress the balance"**
  Torreele E. Interdiscip Sci Rev. 2006 Mar;31(1):3-8.
- **"Current scenario of drug development for leishmaniasis"**
  Croft SL, Seifert K, Yardley V. Indian J Med Res. 2006 Mar;123(3):399-410.
- **"Accelerating momentum on neglected disease research"**
  Banerji J, Dentico N, Sevcsik AM. The Commonwealth Ministers Book 2007. 2006 May: 90-91.
- **"Global framework on essential health R&D"**
  Chirac P, Torreele E. Lancet. 2006 May 13;367(9522):1560-1.
- **"To Fully Tackle the Gang of Four, Needs-Driven R&D Is Essential"**
  Torreele E, Royce C, Don R, Sevcsik AM, Croft S. PLoS Med. 2006 Jun;3(6):e282.
- **"Population pharmacokinetic assessment of a new regimen of mefloquine used in combination treatment of uncomplicated falciparum malaria"** Ashley EA, Stepniewska K, Lindegardh N, McGready R, Hutagalung R, Hae R, Singhasivanon P, White NJ, Nosten F. Antimicrob Agents Chemother. 2006 Jul;50(7):2281-5.
- **"An open label randomized comparison of mefloquine-artesunate as separate tablets *vs.* a new co-formulated combination for the treatment of uncomplicated multidrug-resistant falciparum malaria in Thailand"**
  Ashley EA, Lwin KM, McGready R, Simon WH, Phaiphun L, Proux S, Wangseang N, Taylor W, Stepniewska K, Nawamaneerat W, Thwai KL, Barends M, Leowattana W, Olliaro P, Singhasivanon P, White NJ, Nosten F. Trop Med Int Health. 2006 Nov;11(11):1653-60.
- **"Miltefosine-discovery of the antileishmanial activity of phospholipid derivatives"**
  Croft SL, Engel J. Trans R Soc Trop Med Hyg. 2006 Dec;100 Suppl 1: S4-8.

48 million Euros raised out of 275 million needed!

A total of 48 million Euros has been committed to DNDi to fund its activities from 2003 through 2009. 2006 was marked by the first important contributions from governments: DNDi was pleased to welcome **the French Development Agency, the Netherlands Ministry of Foreign Affairs, and the Department for International Development of the United Kingdom** as new public donors.

While the establishment of product development partnerships (PDPs), like DNDi, represents an important evolution for neglected diseases research, until now these PDPs have been mainly supported by philanthropic organizations, such as the Bill & Melinda Gates Foundation. In the case of DNDi, Médecins Sans Frontières (MSF) supported its creation with an initial commitment of 25 million Euros over five years. Others private donors have brought their support either as core funding to the initiative or through project related grants.

Despite these first successes, continued significant commitments are needed to address the urgent needs of patients suffering from these poverty-related diseases.

"Forgotten and neglected diseases threaten up to half a billion people worldwide. Developing better and new treatments, and giving people the tools to tackle disease, is vital if we are to address the long term health, not only of individuals, but of poor nations too. Funding initiatives such as these are key in our fight against poverty."

Gareth Thomas,
UK International Development Minister

"This partnership with DNDi stems from the commitment of AFD to support innovative initiatives with public and private partnerships, aimed not only at providing health solutions to populations in developing countries in need of appropriate treatments, but also at reinforcing the technological capacity and know-how of developing countries."

Jean-Michel Severino,
Executive Director, Agence Française du Développement

Governance

THE BOARD OF DIRECTORS

The **Board of Directors** is made up of ten to thirteen members, including one patient representative. Each of the six founding members nominates one board member. Board members serve for a term of four years.

DNDi BOARD MEMBERS (AS OF DECEMBER 2006)

01 **Yves Champey**, Chairman
02 **Reto Brun**, Secretary, Swiss Tropical Institute (STI)
03 **Bruce Mahin**, Treasurer, Médecins Sans Frontières (MSF)
04 **Alice Dautry**, Institut Pasteur, France
05 **Rowan Gillies**, Médecins Sans Frontières International (MSF)
06 **Lalit Kant**, Indian Council of Medical Research (ICMR)
07 **Davy Kiprotich Koech**, Kenya Medical Research Institute (KEMRI)
08 **Datuk Mohd Ismail Merican**, Health Ministry of Malaysia
09 **Carlos Morel**, Oswaldo Cruz Foundation (FIOCRUZ), Brazil
10 **Robert G Ridley**, TDR (Permanent Observer of Board)
11 **Paulina Tindana**, Navrongo Health Research Centre, Ghana

THE SCIENTIFIC ADVISORY COMMITTEE (SAC)

The SAC is composed of no fewer than five prominent scientists with expertise in various scientific disciplines relating to drug discovery & development and/or the specific reality of neglected diseases and neglected patients. They operate independently of the Board of Directors and the Executive Team. The SAC has the mandate to advise the Board of Directors on matters related to research and development and the choice of projects, as well as, the quality of the scientific production.

DNDi SCIENTIFIC ADVISORY COMMITTEE MEMBERS (AS OF DECEMBER 2006)

01 **Dyann Wirth**, Chairwoman. Harvard School of Public Health & Harvard Malaria Initiative, USA
02 **Khirana Bhatt**, University of Nairobi, Kenya
03 **Marleen Boelaert**, Institute of Tropical Medicine Antwerp, Belgium
04 **Pierre-Etienne Bost**, Institut Pasteur, France
05 **Alan Hutchinson Fairlamb**, University of Dundee, UK
06 **Peter Folb**, Medical Research Council, South Africa
07 **Chhitar Mal Gupta**, Central Drug Research Institute, India
08 **Maria das Graças Henriques**, FIOCRUZ Farmanguinhos, Brazil
09 **Paul Herrling**, Novartis International AG, Switzerland
10 **Marcel Hommel**, Institut Pasteur, France
11 **Shiv Dayal Seth**, Indian Council for Medical Research, India
12 **Bennett Shapiro**, Board member of various biotechnology and pharmaceutical companies, USA
13 **Julio Urbina**, Instituito Venezolano de Investigaciones Cientificas, Venezuela
14 **Muriel Vray**, Institut Pasteur, France
15 **Haruki Yamada**, Kitasato Institute for Life Sciences, Japan
16 **Yongyuth Yuthavong**, National Science and Technology Development Agency (NSTDA) BIOTEC, Thailand
17 **Shadida Khairullah Nor**, Infectious Diseases Research Center, Malaysia

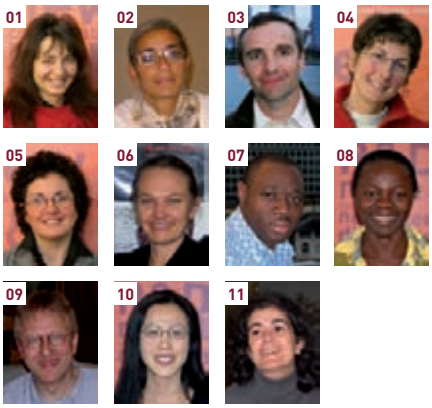
THE EXECUTIVE TEAM

DNDi is composed of a small team of permanent staff in Geneva along with four regional support liaison offices, two regional project support offices, and several short-term consultants: at the end of 2006, there were 34 staff members (equal to 23.2 full-time employees).

DNDi STAFF IN GENEVA (AS OF DECEMBER 2006)

01 **Bernard Pécoul**, Executive Director
02 **Brigitte Crotty**, Executive Assistant
03 **Simon Croft**, Research & Development Director
04 **Robert Don,** Senior Project Manager
05 **Catherine Royce**, Senior Project Manager
06 **Denis Martin**, Senior Project Manager
07 **Jean-René Kiechel**, Senior Project Manager, FACT project
08 **Els Torreele**, Project Manager
09 **Sally Ellis**, Senior Clinical Research Associate
10 **Elodie Namer**, Research & Development Assistant
11 **Jean-François Alesandrini**, Advocacy & Fundraising Director
12 **Jana Armstrong**, Fundraising Manager
13 **Ann-Marie Sevcsik**, Press Officer & Medical Writer
14 **Cécile Bridel**, Communication Officer
15 **Ralf de Coulon**, Finance & Administration Director
16 **Béatrice Mouton**, Legal Affairs & Human Resources Manager
17 **Laurence Vielfaure,** Financial Controller
18 **Janine Millier**, Accountant

CONSULTANTS



In Europe:

01 **Antonella Caminiti**, Project Coordinator FACT project
02 **Graciela Diap**, Medical Coordinator FACT project
03 **Jean-Robert Ioset**, Scientific Collaborator Natural Substances project
04 **Bernadette Bourdin Trunz**, Scientific Collaborator Nitroimidazole project
05 **Nicoletta Dentico**, Policy & Advocacy Advisor
06 **Samantha Bolton**, Media Communications Consultant

In Africa:

07 **Augustin Kadima Ebeja**, Coordinator of the Regional Platform for Human African Trypanosomisasis, Democratic Republic of Congo (DRC)
08 **Angèle Ngo-On**, Logistician for NECT project, DRC

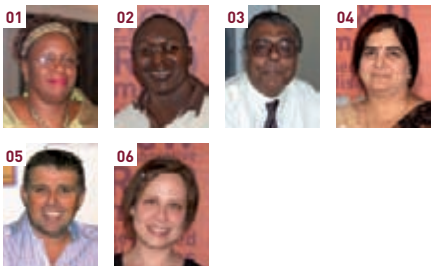
In Asia:

09 **Chris Bruenger**, Consultant, Japan
10 **Fumiko Hirabayashi**, Pharmacist Advisor on Kitasato project, Japan

In South America:

11 **Isabela Ribeiro**, Medical Coordinator, FACT project, Brazil

REGIONAL SUPPORT OFFICE



Africa:

01 **Monique Wasunna**, Head of Regional Support Office Nairobi, Kenya
02 **Simon Bolo**, Finance and Administration Officer, Kenya

Asia:

03 **Visweswaran Navaratnam**, Head of Regional Support Office Penang, Malaysia
04 **Bhawna Sharma**, Head of Regional Support Office New Delhi, India

South America:

05 **Michel Lotrowska**, Head of Regional Support Office Rio de Janeiro, Brazil
06 **Christina Zackiewicz**, Pharmacist Advisor, Brazil

05.

Financial & Performance Report

An Important Transition Year Filled with Growth

SUMMARY

The third year of DNDi operations has been an important transition year during which the foundation pursued its growth, increasing its overall expenditure by 44%. 2006 showed a significant increase of expenditures: EUR 8.3 million in 2006 *versus* EUR 5.7 million in 2005. Partners and donors have shown their trust in DNDi's mission through increasing their contributions by 79% to EUR 10.3 million as compared with EUR 5.7 million in 2005 and EUR 4.2 million in 2003-2004.

This income growth has enabled DNDi to develop unrestricted operating funds to support the long-term viability of the organisation. The specific objective is to create net assets of three months of the annual operating budget by the end of 2007. As of 31 December 2006, DNDi had a total of EUR 2.3 million in net assets.

The number of DNDi staff and consultants has increased in accordance with the growing R&D activities: four scientists were hired in 2006. The financial infrastructure and procedures of DNDi have been further improved to meet growing organisational needs.

In December 2006, Deloitte SA was engaged as DNDi's Auditor. The audit was conducted according to Swiss auditing standards, as well as International Standards on Auditing (ISA).

The present financial and performance report is written in accordance with the regulations of the Swiss General Accounting Accepted Practices, Swiss GAAP, notably its FER/RPC 21, which is applicable to charitable and social not-for-profit organisations.
The report provides financial information and some efficiency indicators regarding DNDi activities in 2006, notably the social mission ratio and the breakdown by stage of development and disease. It also highlights the evolution of public institutional versus private sources of funds and the independence ratio pertaining to the diversity of resources.

STATEMENT OF ACTIVITIES

STATEMENT OF OPERATIONS *for the year ended December 31, 2006 (Summary in Euros)*

	2006	2005
INCOME *(in Euros)*		
Public Institutional Funding	4,902,153	376,587
Private Resources	5,398,048	5,364,215
Total Income	**10,300,201**	**5,740,802**
EXPENDITURE		
Research & Development	5,855,204	3,686,723
Strengthening Capacities	557,741	447,794
Advocacy	649,292	537,055
Fundraising	249,587	212,614
General & Administration	961,344	853,214
Total Expenditure	**8,273,168**	**5,737,400**
Operating Surplus	2,027,033	3,402
Other income (net)	184,568	49,430
Net surplus for the year	**2,211,601**	**52,832**

RESEARCH & DEVELOPMENT EXPENDITURE

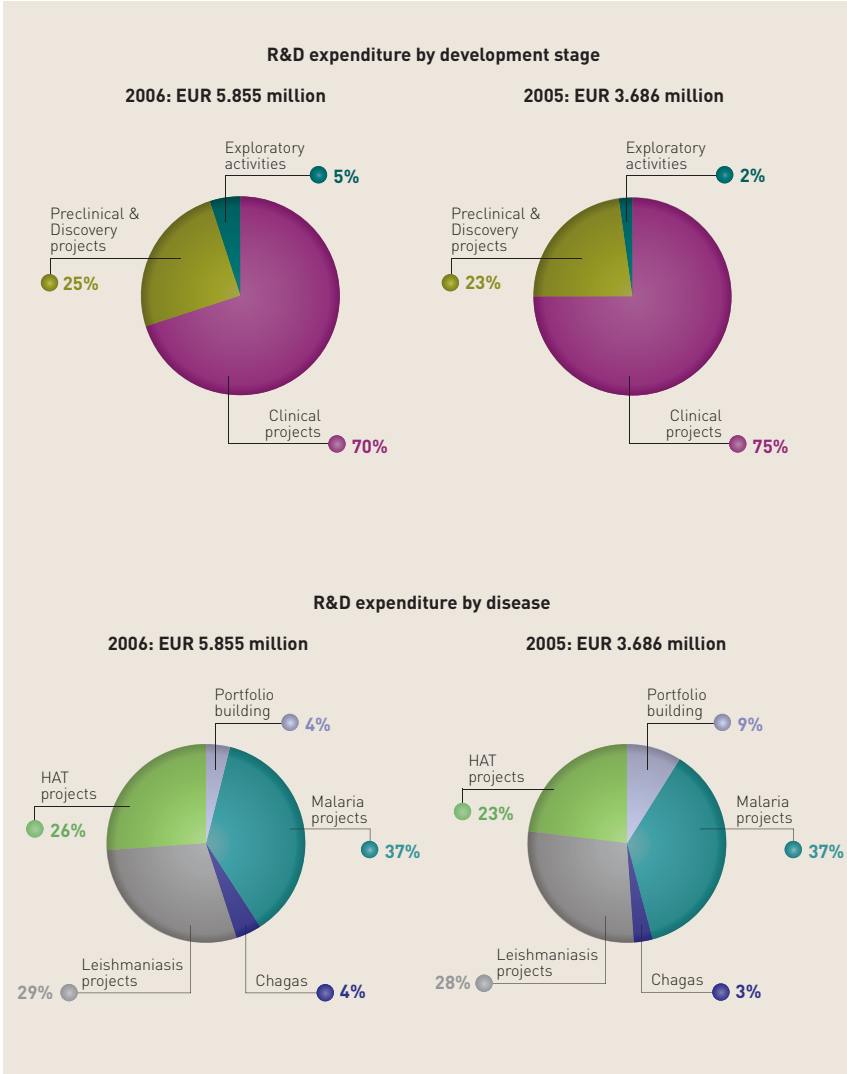
During 2006, DNDi continued to establish a strong portfolio of drug discovery and development projects for its core diseases and ensured the further development of current R&D projects, particularly those in clinical development (nifurtimox-eflornithine combination to treat human African trypanosomiasis, fixed-dose combinations of artesunate/amodiaquine and of artesunate/mefloquine to treat malaria, paromomycin to treat visceral leishmaniasis). Consequently, R&D expenditure increased by 59% (EUR 5.9 million in 2006 up from EUR 3.7 million in 2005). In December 2006, DNDi had five projects in clinical development amounting to EUR 4.1 million; thirteen projects in preclinical and discovery stages for EUR 1.5 million and pro-actively developed exploratory activities for EUR 0.3 million.

Breakdown of R&D expenditure by stage of development

As shown in the adjacent graphs, clinical development is the majority of spending and is comprised of the three larger projects mentioned above. In 2006 versus 2005, more investments have been made into exploratory activities.

Breakdown of total R&D expenditure per disease

The breakdown of expenditure per disease is similar between 2005 and 2006.



STRENGTHENING CAPACITIES EXPENDITURE

Strengthening capacities expenses amounted to EUR 557,741 in 2006 as compared with EUR 447,794 in 2005. These expenses comprise costs for construction and rehabilitation of medical wards that are used for clinical trials in East Africa; training costs of partners' medical and paramedical staff to upgrade their skills and knowledge; and cost of local representatives to support DNDi's field activities.

COMMUNICATION & ADVOCACY EXPENDITURE

Communication and Advocacy expenses increased to EUR 649,292 in 2006, as compared to EUR 537,055 in 2005. Advocacy activities focused on raising DNDi's profile in key targeted international scientific congresses and raising the awareness of political leadership during the World Health Assembly (WHA) regarding the need for R&D for most neglected diseases.

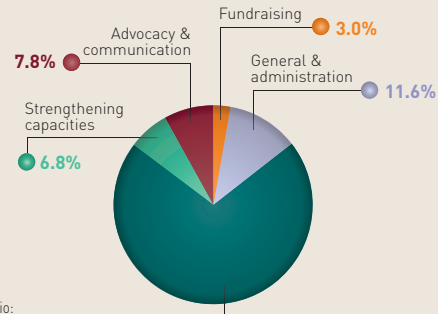
FUNDRAISING & GENERAL MANAGEMENT EXPENDITURE

The 2006 fundraising objective was to secure new funds from a mix of public and private sources, while at the same time implementing a strategy to secure sustainable funding for the following years (see below). Fundraising (EUR 249,587 in 2006 and EUR 212,614 in 2005) and General Management (EUR 961,344 in 2006 and EUR 853,214 in 2005) expenses represent the costs to raise funds (personnel, travel, and document production) and the costs to manage the organisation (expenses incurred by the Board, the Executive Director and the Financial & Administrative department).

SOCIAL MISSION EXPENDITURE: GREATER THAN 85%

Social mission expenditures comprise the operational expenses to implement the mission of DNDi as defined in its charter (Research & Development, Strengthening Capacities and Advocacy) as opposed to non-social mission expenditures represented by the supporting costs (Fundraising and General Management). In 2006, social mission expenditures increased by 51% to EUR 7.1 million in 2006 from EUR 4.7 million in 2005.
The social mission ratio increased to 85.4% in 2006 compared with 81.4% in 2005. Hence, Fundraising and General Management expenses, as a percentage of total expenses, decreased from 18.6% to 14.6%. This is due to the normal development of DNDi's R&D activities.

Social mission ratio of 2006 total expenditure of EUR 8.273 million



Social mission ratio:	
+ Research & development	70.8%
+ Strengthening capacities	6.8%
+ Advocacy	7.8%
= Total	85.4%

STATEMENT OF FINANCIAL POSITIONS

NET ASSETS

DNDi increased its internally generated funds by EUR 2.2 million reaching a total of EUR 2.3 million as of 31 December 2006, enabling DNDi to have 28% of its 2006 overall expenditure covered by net assets, representing 3.3 months of 2006 activities.

BALANCE SHEET at December 31, 2006 *(summary in Euros)*

ASSETS	2006	2005
Cash & securities	2,308,397	763,713
Current accounts & receivables	1,882,388	545,506
Non current assets	64,954	74,188
Total Assets	**4,255,739**	**1,383,407**

LIABILITIES	2006	2005
Payables & accruals	1,069,837	1,167,971
Deferred income	759,110	75,777
Provisions	129,849	54,317
Paid-in capital	32,510	32,510
Intern. generated unrestricted funds	2,264,433	52,832
Total Liabilities	**4,255,739**	**1,383,407**

STATEMENT OF CHANGES IN CAPITAL *for the year ended December 31, 2006 (in Euros)*

	Opening balance	Allocation	Internal fund transfers	Closing balance
Internally generated funds				
Paid-in capital	32,510	–	–	32,510
Internally generated unrestricted capital (cumulative)	52,832	–	2,211,601	2,264,433
Surplus for the year	–	2,211,601	(2,211,601)	–
Capital of the organisation	**85,342**	**2,211,601**	**–**	**2,296,943**

CASH-FLOW

The increase of cash-flow in 2006, due to the development of internally generated reserves, has led to the need to develop treasury management (time-deposit and marketed securities). UBS SA, a major Swiss bank, is providing these services as well as global banking relationships. As a consequence, financial income started to increase in 2006 to EUR 61,099 as compared with EUR -8,547 in 2005.

THE FUTURE

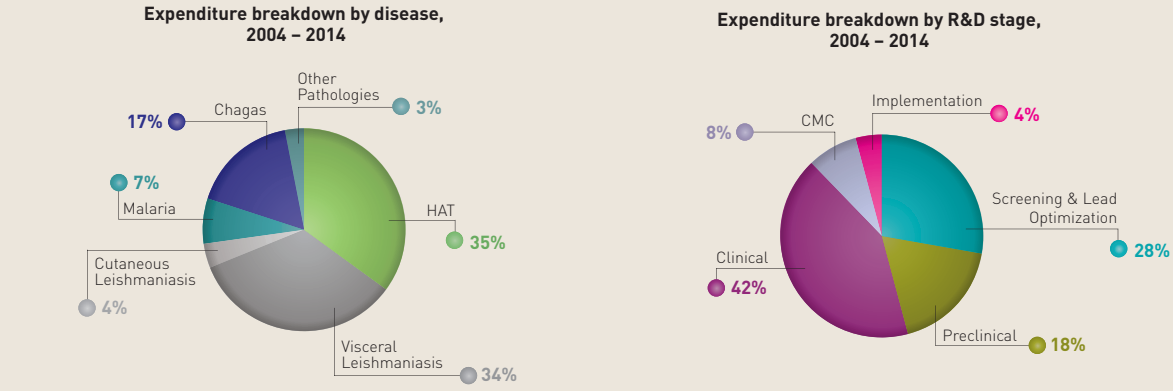
In 2006, DNDi launched a process to review and update its Business Plan, with the support of Ernst & Young Business Advisory Services to reflect significant changes in the landscape of neglected disease research and incorporate new information gathered during the first years of DNDi operations. The outcome, approved in July 2007 by the Board of Directors, will constitute a benchmark for the development of new treatments in 2014 for leishmanisasis, trypanosomiasis, and Chagas disease. The annual budget is projected to grow from EUR 4 million in 2004 to EUR 40 million in 2014. The overall expenditure during this period is projected to be EUR 274 million, with a possible outcome of six to eight new treatments for neglected diseases and the creation of a healthy portfolio of projects throughout the development pipeline. DNDi will dedicate the majority of funding towards the development of treatments for visceral leishmaniasis (33%), sleeping sickness (34%), and Chagas disease (16%). As described on page four, projects will be divided into five categories of drug development.

On average, the vast majority of funds will be devoted to R&D (84%), with a secondary programmatic focus on strengthening capacities (4%) and advocacy (3%). This focus shows a clear emphasis on the social mission with 91% of the funds allocated in this area. From a disease perspective, two thirds of overall expenses are devoted to visceral leishmaniasis and human African trypanosomiasis R&D, which shows the commitment of DNDi towards these two diseases.

SOCIAL MISSION BREAKDOWN DNDi 2004 – 2014 *(in million Euros)*

R&D	230	(84%)
Strengthening Capacities	11	(4%)
Advocacy	10	(3%)
Fundraising	10	(4%)
General Management	13	(5%)
Total	**274**	**(100%)**

R&D COST APPORTIONMENT, 2004 – 2014, EUR 230 MILLION (84% OF TOTAL EXPENDITURE)



FUNDING: THE FIRST IMPORTANT CONTRIBUTIONS FROM GOVERNMENTS

DNDi is pleased to thank the various donors who are committed to the mission and vision of DNDi; and without whom, DNDi would not have been able to achieve its initial successes. DNDi seeks diverse funding sources including cash donations, in-kind contributions, grants, sponsorships, and legacies – from individuals, governments, public institutions, companies, foundations, NGOs and alternative mechanisms. DNDi accepts donations of core funding to the organisation, earmarked support for a project, or a contribution to several projects pertaining to one or multiple diseases. Due to the long-term nature and inherent risk associated with drug development, DNDi's priority is to raise unrestricted core funding which allows for greater flexibility in decision-making.

As independence is a cornerstone of DNDi's development, diversified sources of funding are necessary in order to prevent dependence upon contributions from a specific donor. At its inception in 2003, Médecins Sans Frontières (MSF), as a founding partner of DNDi, provided EUR 5 million per year in funding for the first five years of operation. Since that commitment in 2003, DNDi has been working to diversify its funding sources; and in 2006, while MSF is still the largest donor contributing 49% of funding, this is a significant reduction from the 100% funding in 2003-2004 and 87% in 2005.

A key component of the mission of DNDi is to stimulate increased involve-

ment and responsibility of national governments and international organisations in R&D for neglected diseases. In accordance with this commitment, DNDi strives to obtain a majority of its funding from public sources. In its short history, DNDi has attempted to achieve this balance of public and private funding. In 2006, the total of public institutional contributions amounted to EUR 4,902,153 (48%) as compared to EUR 5,398,048 (52%) in private grants. This increase in public funding was a result of important first contributions from governments including the United Kingdom, France, and the Netherlands.

DNDi WOULD LIKE TO THANK THE FOLLOWING DONORS FOR THEIR SUPPORT OF DNDi ACTIVITIES SINCE JULY 2003:

Public Institutional Donors

- Department for International Department (DFID), United Kingdom
- European Union – Framework Partnership 5 and 6
- French Development Agency - Agence Française du Développement (AFD)
- Dutch Ministry of Foreign Affairs (DGIS)
- Canton of Geneva, Switzerland
- Swiss Development and Cooperation Agency (DDC)

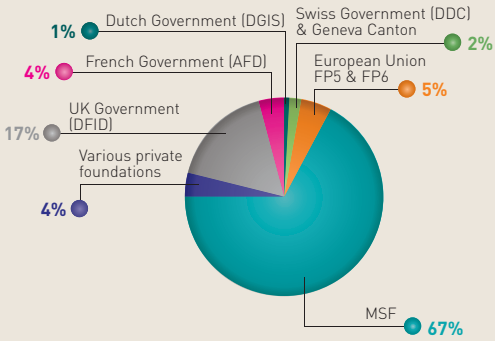
Private Donors

- Leopold Bachmann Foundation, Switzerland
- Médecins Sans Frontières, International
- Sasakawa Peace Foundation, Japan
- UBS Optimus Foundation, Switzerland
- Other Private Foundations and individual donors

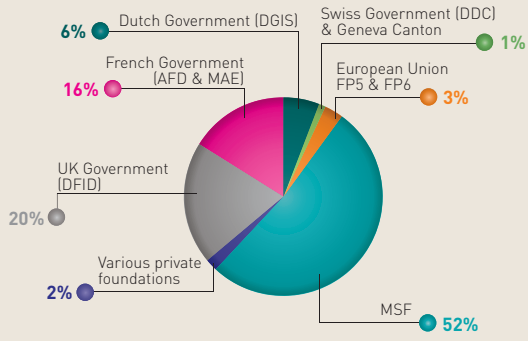
FROM 2003 TO END OF 2006, A TOTAL OF EUR 21 MILLION WAS CONTRIBUTED TO DNDi

In 2006, DNDi was pleased to welcome the French Development Agency, the Dutch Ministry of Foreign Affairs, and the Department for International Development of the United Kingdom as new public donors; a private Swiss Foundation and the Sasakawa Peace Foundation as new private donors.

From 2003 to end of 2006, a total of EUR 21 million was contributed to DNDi

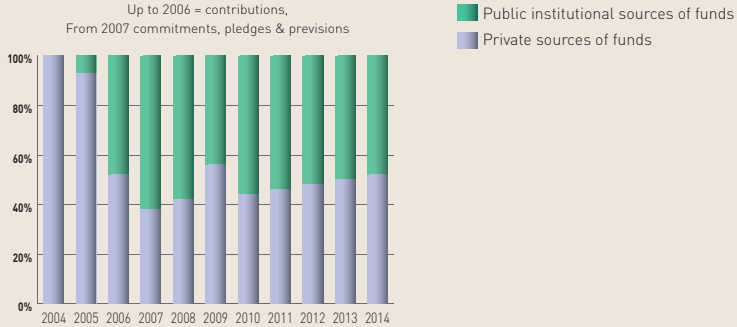


As of May 2007, a total amount of EUR 48 million has been committed to DNDi to fund its activities from 2003 through 2009



Evolution of public institutional versus private sources of funds

Up to 2006 = contributions,
From 2007 commitments, pledges & previsions



Financial Statements and Audit Report

DRUGS FOR NEGLEGTED DISEASES INITIATIVE (DNDi)

BALANCE SHEET AT DECEMBER 31, 2006 *(with 2005 comparative figures, expressed in EUR)*

ASSETS	Notes	2006	2005
CURRENT ASSETS			
Cash and marketable securities			
Cash and banks at head office		976,726	710,275
Cash and banks at subsidiaries		31,671	53,438
Time deposits		1,100,000	–
Marketable securities		200,000	–
Total cash and marketable securities		**2,308,397**	**763,713**
Current accounts and receivables			
Advances to officers and liaison offices		32,227	32,376
Advances to partners related to projects	*3 a*	623,238	162,683
Receivables from public institutional donors	*3 b*	817,433	295,057
Receivables from founders	*3 c*	270,750	-
Other receivables		51,731	33,797
Prepaid expenses		87,009	21,593
Total current accounts and receivables		**1,882,388**	**545,506**
Total current assets		**4,190,785**	**1,309,219**
NON-CURRENT ASSETS			
Tangible fixed assets, net	*4*	50,259	59,078
Bank guarantee		14,695	15,110
Total non-current assets		**64,954**	**74,188**
Total		**4,255,739**	**1,383,407**

LIABILITIES & CAPITAL			
CURRENT LIABILITIES			
Payables to partners related to projects	*5 a*	339,227	510,670
Accounts payable to founders	*5 b*	1,596	60,208
Other payables and accrued expenses	*5 c*	729,014	597,093
Deferred income	*5 d*	759,110	75,777
Provisions	*6*	129,849	54,317
Total current liabilities		**1,958,796**	**1,298,065**
CAPITAL OF THE ORGANISATION			
Paid-in capital		32,510	32,510
Internally generated unrestricted operating funds		2,264,433	52,832
Total capital of the organisation		**2,296,943**	**85,342**
Total		**4,255,739**	**1,383,407**

EXPENDITURES FOR THE YEAR ENDING ON DECEMBER 31, 2006 *(with 2005 comparative figures, expressed in EUR)*

	Notes	2006	2005
INCOME			
Public institutional funding			
Govern. & public int. organis. unrestricted		3,597,640	-
Govern. & public int. organis. restricted		1,304,513	376,587
Total public institutional funding		**4,902,153**	**376,587**
Private resources			
Private foundations, corporations and individuals, unrestricted		156,925	170,060
Private foundations, corporations and individuals, restricted		241,123	194,155
Total private resources		**398,048**	**364,215**
Resources from founders			
Médecins Sans Frontières, unrestricted		5,000,000	5,000,000
Total resources from founders		**5,000,000**	**5,000,000**
Total income	*7*	**10,300,201**	**5,740,802**
SOCIAL MISSION EXPENDITURE			
Research & development expenditure			
Research & development coordination and supervision		963,873	750,139
Human African trypanosomiasis projects		1,293,323	662,428
Leishmaniasis projects		1,416,658	814,775
Chagas diseases projects		179,524	79,290
Other projects	*9*	1,782,759	1,113,180
Portofolio building		219,067	266,911
Total research & development expenditure	*8*	**5,855,204**	**3,686,723**
Strengthening capacities	*10*	557,741	447,794
Advocacy expenses	*11*	649,292	537,055
Total social mission expenditure		**7,062,237**	**4,671,572**
NON SOCIAL MISSION EXPENDITURE			
Fundraising	*11*	249,587	212,614
General and administration	*11*	961,344	853,214
Total non social mission expenditure		**1,210,931**	**1,065,828**
Total expenditure		**8,273,168**	**5,737,400**
Operating surplus		2,027,033	3,402
OTHER INCOME (EXPENSES)			
Financial income (expenses), net		61,099	(8,547)
Exchange loss, net		(42,455)	(17,930)
Other income		165,924	75,907
Total other income, net		**184,568**	**49,430**
Net surplus for the year prior to allocations		2,211,601	52,832
Allocation to internally gener. unrestricted funds		(2,211,601)	(52,832)
Net surplus for the year after allocations		–	–

FUNDS FLOW STATEMENT FOR THE YEAR ENDING ON DECEMBER 31, 2006

(with 2005 comparative figures, expressed in EUR)

	2006	2005
FUNDS FLOW FROM OPERATIONS		
Operating surplus for the year	2,211,601	52,832
Depreciation of fixed assets	43,778	39,273
Increase (decrease) in provisions	75,532	54,317
(Increase) decrease in advances	(460,407)	428,407
(Increase) decrease in receivables from donors	(522,376)	(295,057)
(Increase) decrease in founders and other receivables	(288,683)	4,408
(Increase) decrease in prepaid expenses	(65,417)	(16,567)
Increase (decrease) in payables to partners related to projects	(171,443)	268,228
Increase (decrease) in accounts payable to founders	(58,612)	(263,961)
Increase (decrease) in other payables and accrued expenses	131,921	(1,256)
Increase (decrease) in deferred income	683,333	52,837
Funds flow from operations	**1,579,227**	**323,461**
FUNDS FLOW FROM INVESTING ACTIVITIES		
(Investments) in tangible fixed assets	(34,959)	(34,047)
(Increase) decrease in bank guarantee	416	157
Funds flow from investing activities	**(34,543)**	**(33,890)**
FUNDS FLOW FROM FINANCING ACTIVITIES	**–**	**–**
Cash increase (decrease)	1,544,684	289,571
Cash and marketable securities – beginning of year	763,713	474,142
Cash and marketable securities – end of year	**2,308,397**	**763,713**

DRUGS FOR NEGLECTED DISEASES INITIATIVE (DNDi), GENEVA

STATEMENT OF CHANGES IN CAPITAL FOR YEAR ENDING ON DECEMBER 31, 2006

(with 2005 comparative figures, expressed in EUR)

Internally generated funds	Opening balance	Allocation	Internal fund transfers	Closing balance
Paid-in capital	32,510	–	–	32,510
Internally generated unrestricted capital (cumulative)	52,832	–	2,211,601	2,264,433
Surplus for the year	–	2,211,601	(2,211,601)	–
Capital of the organisation	85,342	2,211,601	–	2,296,943

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 2006

1. GENERAL INFORMATION

a) Legal aspects

The Drugs for Neglected Diseases initiative (DNDi) is a Swiss foundation, established as a not-for-profit legal entity, registered in Geneva under statutes dated July 17, 2003. DNDi is managed by a Board, an Executive Director, and three senior managers.

With its head office in Geneva, DNDi aims to:

a) stimulate and support research and development of drugs, as well as vaccines and diagnostics for neglected diseases;

b) seek equitable access and development of new drugs, to encourage the production of known effective drugs, diagnostics methods and/or vaccines for neglected diseases;

c) adapt new treatments for neglected diseases, to meet patients' needs, as well as to meet the requirements of delivery and production capacity in developing countries;

d) raise awareness of the need to research and develop drugs for neglected diseases.

As with all Swiss foundations, DNDi is monitored by the Swiss Federal Supervisory Board for Foundations.

b) Income tax

DNDi is exonerated from income tax from the Geneva Cantonal & Communal tax authorities for a five-year period commencing 2003 and from Swiss federal income tax for an indeterminate period.

c) Situation of Regional support offices (RSO)

DNDi has four Regional support offices to help identify patients' needs, support project managers, identify and support regional partners, seek funding, and undertake regional advocacy work for DNDi. The RSO, together with regional networks, ensure the participation of disease-endemic countries and foster South-South collaboration. In addition, RSO can begin to explore fundraising potential in their regions. Their tasks and duties are further developed in the DNDi Business Plan.

RSO have no legal structure, are hosted by a Founding Partner, often for free, and are represented by an experienced senior person as the RSO Director bearing a consultant contract with DNDi. For local or operational reasons, DNDi may deem necessary to establish the RSO as a legal entity, usually a branch of DNDi Foundation. Establishment of a DNDi legal entity outside Switzerland requires the authorization of the Board of Directors.

As of January 2005, DNDi established a legal entity in Kenya in the form of a branch for its African RSO. A legal entity has been set up in France in the form of a not-for-profit Association for administrative purposes, this legal body is not a RSO. Other DNDi support offices are in Brazil, Malaysia, India, Japan, and Democratic Republic of Congo.

RSO accounting is fully incorporated in DNDi accounts.

2. SIGNIFICANT ACCOUNTING POLICIES

a) Statement of compliance

The financial statements have been prepared in accordance with Swiss GAAP RPC. They include:

a) Balance sheet,

b) Statement of operation (activity based method),

c) Funds flow statement,

d) Statement of changes in capital,

e) Notes, and

f) Performance report

These financial statements present all activities by the Foundation. A list of in-kind income and expenditures is disclosed in note 13.

b) Basis of preparation

The financial statements have been prepared on a historical cost basis. The principal accounting policies are set out below.

c) Social mission expenditure

Social mission expenditures represent expenses made according to the purposes defined in article 5 of DNDi's statutes. They are defined in the present general notes under point 1.a Legal aspects. Research & Development, Strengthening existing capacities and Advocacy, are the three chapters that comprehend "Social mission expenditures."

d) Functional currency

The Board of DNDi has determined that the assets, liabilities, and operations should be measured using EUR as functional currency. The environment in which the entity primarily generates and expends cash determines this decision. All amounts presented in the financial statements are stated in EUR, except when specified.

e) Foreign currency translation

Transactions in currencies other than the entity's measurement and reporting currency (EUR) are converted at the average monthly rate of exchange. Year-end balances in other currencies are converted at the prevailing rates of exchange at the balance sheet date. Resulting exchange differences are recognized in the statement of operations.

The following are the principal rates of exchange used at the end of the year to revalue the balance sheet items to EUR for reporting purposes:

	2006	2005
USD	0.7587	0.8442
CHF	0.6222	0.6416
GBP	1.4914	1.4507
100 CDF	0.1493	0.1925
100 INR	1.7111	1.8669
100 KES	1.0951	1.1612
100 JPY	0.6384	0.7160

f) Income

Public and private donations are recorded on an accrual basis. Individual and spontaneous donations are recorded on a cash basis.

g) Funding committed to projects

After Board approval of grants for projects, a contract is set up and signed by the Executive Director. Thereafter, funds are allocated to the partner(s) in charge of the project. Expenditures are recorded:

a) According to a financial report presenting expenditures incurred during the year on an accrual basis; or

b) If financial reports are unavailable as of the deadline of the 15th of March of the following year, an estimated amount is calculated on a *prorata temporis* basis, based on the time between the date of the signature of the contract and December 31. This estimated amount is considered as an accrued expense following Swiss GAAP RPC to be regularized on the following year. The unpaid portion remaining at year-end is included under current liabilities.

h) Expenditures incurred for projects and activities

The annual action plan and budget are approved by the Board. They include grants for projects and current expenditures required to achieve the objectives of the year. All expenditures incurred on behalf of a project or for any activity of DNDi is recorded on an accrual basis.

i) Credit risk, cash-flow management

DNDi's liquid assets are maintained in cash, low-risk short-term deposits or capital guaranteed investments. At the balance sheet dates, there are no significant concentrations of credit risk. The maximum exposure is primarily represented by the carrying amounts of the financial assets in the balance sheet, including accounts receivable and cash.

j) Tangible fixed assets

Tangible fixed assets are stated at cost less accumulated depreciation. Depreciation is charged to the statement of operations on a straight-line basis over the estimated useful lives of the tangible fixed assets.

The rates of depreciation used are based on the following estimated useful lives:

Office fittings and equipment	20%
IT equipment	33%

k) Bank guarantees

Guarantees are presented as non-current assets. To date, DNDi has one guarantee representing a deposit related to office rental. It is recoverable, subject to prevailing contract terms, upon vacating the premises.

l) Provisions

A provision is recognised on the balance sheet when the organisation has a legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation.

Provisions are measured at the management's best estimates of the expenditure required to settle that obligation at the balance sheet date.

m) Capital of the organisation

The founding capital (paid-in capital) of EUR 32,510 (CHF 50,000) referenced in the statutes was received from the founding members of DNDi, including the Indian Council of Medical Research, the Institut Pasteur, the Kenya Medical Research Institut and the International office of Médecins Sans Frontières. The capital is fully subscribed.

n) Restricted and unrestricted reserves

Restricted and unrestricted reserves represent the excess of income over expenditure since the inception of DNDi. Restricted reserves are available for future operations and project funding costs by DNDi as its evolving research and development project pipeline dictates. Unrestricted reserves will be utilized for expenditures of DNDi as these are incurred.

o) In-kind donations

Gifts-in-kind are not recorded but disclosed in the notes to the financial statements and valued at fair market values according to the following principles:

- Goods transferred to a DNDi project or services rendered to DNDi must be free, excluding the involvement of a monetary transfer.
- They must be clearly identifiable and part of DNDi's projects and activities, as defined by DNDi's action plans and budgets.
- Recognizable as a visible contribution to DNDi's projects and activities, benefiting to DNDi's, and fitting into DNDi's mission and objectives.
- Partners' voluntary involvements in joint projects and activities, in particular if the Partner does not aim to achieve DNDi's project objectives, are not considered as gifts-in-kind.
- For goods or services paid for at below market prices, the difference between the real payment and the current market price is not considered as a gift-in-kind, but the current market price reached after negotiations.
- Fair market value is defined as the price DNDi would have paid to utilize the good or the service. Fair market value can be suggested by partners; however, DNDi will be careful not to overestimate such valuations in compliance with Swiss GAAP RPC three basic principles of materiality and prudence.
- Gifts-in-kind estimated at 5,000 EUR and above are taken into accounts. Exceptions can be made by DNDi when it serves the purpose of providing consistency and completeness of a project's accounts.

3. CURRENT ACCOUNTS & RECEIVABLES

a) Advances to partners, related to projects	2006	2005
Oxford University (UK)	12,629	12,629
National Institute of Malaria Research (India)	25,857	0
Kassab Hospital, University Khartoum (Sudan)	149,085	0
Addis Ababa University (Ethiopia)	18,871	13,696
Arba Minch Hospital - Clinical study (Ethiopia)	13,671	4,317
Gondar University (Ethiopia)	37,151	0
University of Ouro Preto (Brazil)	14,328	0
Kitasato University (Japan)	27,578	21,086
University of Peru (UPCH, Peru)	29,754	22,714
University of California, San Francisco (USA)	4,509	29,019
Murdoch University (Australia)	87,678	0
Antwerp University (Belgium)	22,637	0
Imperial College London (UK)	169,548	0
University of Sains (Malaysia)	0	36,262
Centre National de la Recherche sur le Paludisme et la Formation (Burkina Faso)	0	22,135
Data Safety Monitoring Board Group (Sudan)	0	825
Progr. National de Lutte contre la Trypanosmiase (RD Congo)	9,942	0
Net book value at 31 December 2006	**623,238**	**162,683**

b) Receivables from donors		
European Community (EU)	222,536	295,057
Agence Française du Développement (AFD)	579,510	0
Swiss Development Cooperation (SDC)	14,933	0
UBS Optimus Foundation	454	0
Net book value at 31 December 2006	**817,433**	**295,057**

c) Receivables from founders		
Médecins Sans Frontières International	270,750	0
Net book value at 31 December 2006	**270,750**	**0**

4. TANGIBLE FIXED ASSETS, NET

	Computer Equipment	Office fittings & Installations	Office Equipment	Total
Net carrying amounts 1 January	**39,722**	**12,728**	**6,628**	**59,078**
Gross values of cost				
Beginning of the period 1 January	99,918	20,839	9,416	130,173
Additions	8,731	21,317	6,719	36,767
Disposals	0	0	– 1,807	– 1,807
End of the period 31 December	108,649	42,156	14,328	165,133
Cumulated amortisation				
Beginning of the period 1 January	– 60,196	– 8,111	– 2,788	– 71,095
Systematic amortisation	– 32,538	– 8,390	– 2,851	– 43,779
End of the period 31 December	– 92,734	– 16,501	– 5,639	– 114,874
Net carrying amounts 31 December	**15,915**	**25,655**	**8,689**	**50,259**

5. CURRENT LIABILITIES

a) Payables to partners related to projects	2006	2005
University of Sains (Malaysia)	17,406	0
Centre National de la Recherche sur le Paludisme et la Formation (Burkina Faso)	16,799	0
Arba Minch Hospital – Ward Construction (Ethiopia)	3,860	7,100
Data Safety Monitoring Board Group (Sudan)	1,862	0
London School of Hygiene and Tropical Medicine (UK)	29,238	62,723
University of Dundee (UK)	138,198	99,589
Swiss Tropical Institute (Switzerland)	65,000	448
Médecins Sans Frontières (clinical study in DR Congo) (Belgium)	66,864	94,710
University of Bordeaux (France)	0	28,779
Instituto Farmanguinhos (Brazil)	0	42,366
University of Khartoum (Sudan)	0	7,159
Harvard Medical School (USA)	0	40,366
University of Washington (USA)	0	52,526
Fundaquim, University of Montevideo (Uruguay)	0	15,585
Institut of Parasitology and Biomedicine Lopez-Neyra (Spain)	0	21,770
Moorhouse School of Medicine (USA)	0	19,259
Médecins Sans Frontières (clinical study FACT) (France)	0	17,734
Gondar University (Ethiopia)	0	556
Net book value at 31 December	**339,227**	**510,670**
b) Payable to founders		
Kenyan Medical Research Institute (Kenya)	1,596	0
Médecins Sans Frontières International	0	60,208
Net book value at 31 December	**1,596**	**60,208**

c) Other payables & accruals	2006	2005
Médecins Sans Frontières Belgium (Liaison office in Rio de Janeiro)	126,807	0
Winterthur Insurance	30,080	0
FER - CIAM	18,559	0
Suppliers	336,289	265,310
Other payables	20,487	126,201
Accrued expenses	196,792	205,582
Net book value at 31 December	**729,014**	**597,093**

d) Deferred income		
Dutch government (DGIS)	750,000	0
Sasakawa Peace Foundation	8,368	0
Médecins Sans Frontières International	742	11,470
Swiss Development Cooperation (SDC)	0	55,901
Fondation Bachmann	0	8,406
Net book value at 31 December	**759 110**	**75,777**

6. PROVISIONS

	Provision for taxes	Provision for running expenses (transport)	Total
Carrying amount as per 1.1.2005	**0**	**0**	**0**
Creation	54,317	0	54,317
Utilization	0	0	0
Reversal	0	0	0
Carrying period as per 31.12.2005	**54,317**	**0**	**54,317**
Carrying period as per 1.1.2006	**54,317**	**0**	**54,317**
Creation	69,462	6,070	75,532
Utilization	0	0	0
Reversal	0	0	0
Carrying period as per 31.12.2006	**123,779**	**6,070**	**129,849**

7. INCOME

a) Donations committed to DNDi and received in 2006 *(in EUR)*

DONATION		Total Committment	Received in or before 2006	Accrued in 2006
Médecins Sans Frontières International	EUR	25,000,000	13,966,074	270,750
Swiss Government (DDC)	CHF	120,000	96,000	110,400
Canton of Geneva	CHF	600,000	600,000	0
UK Government (DFID)	GBP	6,500,000	2,500,000	0
EU FP5 FACT	EUR	1,163,698	989,162	0
French Government (AFD)	EUR	1,500,000	351,769	579,510
Dutch Government (DGIS)	EUR	2 ,975,000	875,000	0
Sandoz Foundation	CHF	500,000	250,000	0
Bachman Foundation	EUR	91,900	91,900	8,406
Sasakawa Peace Foundation	EUR	87,000	70,000	0
UBS Optimus Foundation	CHF	540,000	135,000	135,000
EU FP6 HAT	EUR	340,000	0	48,000
Total				

b) Funding per project (restricted and unrestricted)

	Total	Médecins Sans Frontières International (Unrestricted)	Swiss Government (DDC) (Restricted)	Canton of Geneva (Restricted)	UK Government (DFID) (Unrestricted)	French Government (AFD) (Restricted)
R&D Coordination, Supervision costs	963,873	162,751			793,841	
Paromomycin for VL	859,270	694,293		129,400	35,577	
FACT (AS/AQ & AS/MQ) for malaria	1,782,759	502,732	70,834		152,914	931,279
Nifurtimox + Eflornithine for HAT	615,755	67,864			547,891	
Nitroimidazoles for tryps	207,281	36,195			0	
Natural Substance Screening Platform & Kitasato	146,311	33,293			58,667	
Other projects	1,279,955	144,424			1,135,531	
Capacity strengthening activities	557,741	33,455			467,880	
Advocacy	649,292	573,932			75,360	
Fundraising	249,587	14,381			235,206	
General management costs	961,344	788,109			94,773	
Year-end result	2,211,601	1,948,571			0	
Grand Total	**10,484,769**	**5,000,000**	**70,834**	**129,400**	**3,597,640**	**931,279**

Accrued in 2005/ Deferred to 2007	Cash yet to be received	As per I&E account 2006 in Currencies	As per I&E account 2006
0	11,033,926	5,000,000	**5,000,000**
0	24,000	110,400	**70,834**
0	0	200,000	**129,400**
0	4,000,000	2,500,000	**3,597,640**
120,521	174,536	0	**0**
0	1,148,231	931,279	**931,279**
750,000	2,100,000	125,000	**125,000**
0	250,000	250,000	**156,925**
0	0	8,406	**8,406**
8,368	17,000	61,632	**61,632**
0	405,000	270,000	**171,086**
0	340,000	48,000	**48,000**
			10,300,202

Dutch Government (DGIS) (Restricted)	Sandoz Foundation (Unrestricted)	Bachmann Foundation (Restricted)	Sasakawa Peace Foundation (Restricted)	UBS Optimum (Restricted)	European Union EU FP6 HAT (Restricted)	Other Income
			7,281			
125,000						
				171,086		
			54,351			
		8,406			48,000	
	78,463					
	78,463					184,567
125,000	**156,925**	**8,406**	**61,632**	**171,086**	**48,000**	**184,567**

8. R&D PROJECTS RELATED EXPENDITURE

	2006	2005
DEVELOPMENT Projects		
Nifurtimox - Eflornithine co-admin for stage 2 *T.b.gambiense* HAT [1]	615,755	408,361
Paromomycin for VL in Africa [2]	859,270	683,048
Artesunate+Amodiaquine for Malaria [3]	803,696	1,113,180
Artesunate+Mefloquine for Malaria [3]	979,063	
Imiquimod for cutaneous leishmaniasis [7]	178,256	0
Ambisome for VL [8]	251	0
Total Development Projects	**3 ,436,291**	**2,204,589**
DISCOVERY & PRE-DEVELOPMENT Projects		
Benzofuroxans for Chagas [4]	45,754	34,869
Cysteine Protease Infibitors for HAT [5]	85,169	30,515
DHFR Inhibitors [6]	27,698	22,017
Kitasato Natural substances screening [18] (Exploratory in 2005)	91,960	0
Nitroimidazoles for tryps [19] (Exploratory in 2005)	207,281	0
Nitroheterocycles for HAT [10]	161,569	116,418
Protein Farnesyl-transferase inhibitors for tryps. [11]	23,880	53,011
Trypanothione reductase inhibitors for leish. & tryps. [13]	20,922	929
Drug Combination for visceral leishmaniasis [15] (Exploratory in 2005)	249,731	0
8-Aminoquinoline NPC1161B for VL [20]	2,214	0
Ascofuranone for HAT [9]	1,086	0
Amphotericin B polymer [14]	1,883	0
Microtubule Inhibitor [17]	74,716	0
Imiquimod for cutaneous leishmaniasis [7]	0	104,015
New drug for Chagas disease K777	0	75
Combination therapy for VL [24]	0	20,063
Whole cell African trypanosome screen [23]	0	46,474
Total Discovery & Pre-Development Projects	**993,863**	**428,386**
EXPLORATORY & PRO-ACTIVE Projects		
Ravuconazole / Posaconazole [12]	9,994	36,698
Screening at SCYNEXIS [22]	158,952	0
Pan-Asian Natural Substances Screening Network [23]	54,351	0
8-Aminoquinoline NPC1161B for VL [20]	0	18,000
Kitasato Natural substances screening [18] (Project in 2006)	0	73,981
Nitroimidazoles for tryps [19] (Project in 2006)	0	55,071
Drug Combination for visceral leishmaniasis [15] (Project in 2006)	0	68,692
Other exploratory activities [16]	237,880	51,167
Total Exploratory & Pro-active Projects	**461,177**	**303,609**
Project-related variable expenditure		
– Coordination & Supervision [21]	963,873	750,139
Total of Projects related expenditure	**5,855,204**	**3,686,723**

Main partners:

1. *Swiss Tropical Institute (STI), Switzerland/ WHO/TDR Geneva / Epicentre, France / COCTU, Uganda / Programme national de Lutte contre la Trypanosomiase Humaine (PNLTH), R. du Congo*
2. *Kenya Medical Research Institute, Kenya / University of Khartoum, Sudan / IDA Foundation, Holland / Addis Ababa University, Ethiopia / Médecins Sans Frontières Holland / WHO/TDR, Geneva*
3. *WHO/TDR, Geneva / Université de Bordeaux, France / University Sains, Malaysia / Oxford University, UK / University Mahidol, Thailand / Instituto Farmanguinhos, Brazil / CNRFP, Burkina Faso / Fondation Médecins Sans Frontières / Ellipse pharmaceuticals*
4. *University of the Republic, Uruguay / University of Navarra, Spain / Universita Nacional de Salta, Argentina*
5. *University of California, San Francisco, USA*
6. *Basilea AG, Switzerland / Biotech Inc, Thailand / Institute of Parasitology and Biomedicine Lopez Neyra, Spain / STI*
7. *McGill University, Canada / Universidade Peruana Cayeto Heredia, Peru*
8. *Addis Abeba University / London School of Hygiene and Tropical Medicine (LSHTM), UK*
9. *University of Tokyo, Japan*
10. *University of Dundee & Glasgow University, UK / STI / Parma University, Italy*
11. *University of Washington (Seattle), USA*
12. *Instituto Venezuelano de Investigaciones Cientificas IVIC / ESAI Co Ltd, Japan / Universidade Federale de Ouro Preto ,Brazil*
13. *University of Dundee, UK*
14. *Imperial College London, UK*
15. *Indian Council of Medical Research (ICMR) and Rajendra Memorial Research Institute, India / Advinus Therapeutics, India / TetraQ, India*
16. *Advinus Therapeutics, India / Genzyme Inc, USA / Central Drug Research Institute (CDRI), India / LSHTM, UK / STI / Antwerp University, Belgium / ICMR*
17. *Murdoch University, Australia / Monash University, Australia / STI*
18. *Kitasato Institute, Japan / STI*
19. *STI*
20. *University of Mississippi, USA / Medical Malaria Venture (MMV), Switzerland*
21. *Includes costs related to the R&D Director, to legal advice, to services for contract negotiations, to various consultancies, and to various travels related to the supervision and the coordination of the projects*
22. *Synexis Inc, USA*
23. *Harvard Medical School, USA / University of Dundee, UK, WHO/TDR*
24. *LSHTM, UK*

9. OTHER PROJECTS (FACT)

Other projects include the two FACT projects for the treatment of malaria: the first, combining artesunate and amodiaquine, is primarily for use in Africa; and the second, combining artesunate and mefloquine, is targeted for potentially all endemic regions, including multi-drug resistance areas, and with a particular focus on East Asia and South America. As of December 31, 2006, the total DNDi expenditures for FACT over the period 2002 – 2006 were EUR 3,651,300 (EUR 755,360 in 2003-2004; EUR 1,113,180 in 2005 and EUR 1,782,759 in 2006).

FACT PROJECT FUNDING (2002-2006) *(in Euros)*

		Partners as donors					
Partners as receivers	**TDR[1]**	**MSF[2]**	**Fax-M[3]**	**USM[6]**	**DNDi[4]**	**EU[5]**	**Total to 12.2006**
Médecins Sans Frontières International	–	21,047	0	0	107,344	113,392	**241,783**
University of Bordeaux, France	217,353	0	0	0	158,460	182,387	**558,200**
Oxford University, UK	–	0	0	0	85,076	26,351	**111,427**
University Sains, Malaysia	–	0	0	116,306	351,418	400,000	**867,724**
Mahidol University, Thailand	–	0	0	0	132,262	78,152	**210,414**
Instituto Farmanguinhos, Brazil	10,080	0	506,777	0	7,574	171,000	**695,431**
CNRPF, Burkina Faso	–	0	0	0	117,109	83,000	**200,109**
DNDi, Switzerland	–	0	0	0	2,692,057	109,415	**2,801,472**
Total	**227,433**	**21,047**	**506,777**	**116,306**	**3,651,300**	**1,163,698**	**5,686,560**

Though the FACT project began in 2002, DNDi has been involved in this project only since July 2003.

Cumulative other expenses incurred by FACT partners of EUR 2,035,260 (EUR 1,845,773 in 2005) were not recorded in DNDi's accounts despite DNDi being the co-scientific coordinator of both projects.

1. Special Programme for Research & Training in Tropical Diseases (TDR), WHO Geneva
2. Médecins Sans Frontières International
3. Instituto Farmanguinhos, Brazil
4. Foundation Drugs for Neglected Diseases initiative, Switzerland
5. European Union funding through the European Commission Research Directorates, Contract number: ICA4-CT-2002-10046-FACT
6. University Sains Malaysia

10. STRENGTHENING CAPACITIES EXPENDITURE

DNDi expenditures on strengthening existing capacities in developing countries aim to:

- build networks around specific projects between researchers from developing and developed countries;
- establish working partnerships, including technology transfers, with public and private institutions and researchers from developing and developed countries; and
- invest in sustainable capacity and leadership in developing countries at all stages of research and development.

	2006	2005
Liaison offices: Brazil, India, Kenya, Malaysia	332,224	248,303
Paromomycin for VL - Lab Equipment Arba Minch Hospital, Ethiopia	37,043	81,216
Leishmaniasis East Africa Platform	97,990	53,787
Human African Trypanosmiasis Platform	90,484	64,488
Total	**557,741**	**447,794**

11. ADVOCACY, FUNDRAISING & GENERAL AND ADMINISTRATION EXPENSES

	Advocacy		Fundraising		General & Administration	
	2006	2005	2006	2005	2006	2005
Human resources	333,515	248,606	185,023	158,422	540,151	514,608
Office charges	16,365	11,888	7,013	7,927	24,754	25,082
Travel expenses	77,895	82,695	13,236	12,390	85,159	103,472
Administration	31,458	56,524	35,550	25,578	197,096	154,512
IT & telecommunication	24,569	17,045	4,215	1,432	59,802	31,930
Communication	155,762	105,280	1,038	293	38,396	1,014
Depreciation	8,064	5,396	3,456	3,598	11,982	11,056
Exceptional expenses	1,664	9,621	56	2,974	4,004	11,539
Total	**649,292**	**537,055**	**249,587**	**212,614**	**961,344**	**853,213**

12. INDEMNITIES & REMUNERATIONS GIVEN TO DIRECTORS

All members of the Board are volunteers. With the exception of the Treasurer, the members do not receive any remuneration for their mandate. The Treasurer was involved in the capacity of a consultant during 2006. Part of the Treasurer's salary, which amounted to EUR 11,017, was invoiced to DNDi by his employer, Médecins Sans Frontières France. DNDi received authorization from the Swiss Federal Supervisory Board for Foundations to remunerate a member of the Council until June 2007.

13. IN-KIND VALUATION

DNDi, as an independent needs-driven not-for-profit organisation, is developing drugs for people suffering from the most neglected diseases around the world. Its operations and activities are financed through donations. In addition to financial donations, generous partners, companies or individuals provide DNDi with goods or services at zero cost, as gifts-in-kind.

IN-KIND CONTRIBUTIONS, PER CATEGORY AND PER PROJECT, FOR 2006 *(in Euros)*

	Staff Scientific	Staff Non-Scientific	R&D Services	Legal & Comm Services	Office, Furniture & Admin.	Total
FACT	183,181		118,906			**302,087**
NECT					3,034	**3,034**
Natural substances			37,027		29,000	**66,027**
Exploratory: (screening, buparavaquone, Bio Malaysia)			236,893	12,020		**248,913**
R&D coordination	42,800					**42,800**
Regional support offices					56,297	**56,297**
Fundraising				15,681		**15,681**
General management		10,667			3,000	**13,667**
Total	**225,981**	**10,667**	**392,826**	**27,701**	**91,331**	**748,506**

Main in-kind contributors: J.-R Kiechel, France; Ch. Brünger, Japan; Genzyme Inc, USA; Kitasato Institute, Japan; Simpson-Thatcher-Bartlett Law, USA; KEMRI, Kenya; Sains University, Malaysia; Instituto Farmanguinhos, Brazil.

Auditor's report

To the Board of

Drugs for Neglected Diseases initiative (DNDi), Geneva

As statutory auditors, we have audited the accounting records and the financial statements of Drugs for Neglected Diseases initiative (DNDi) for the year ended December 31, 2006. In accordance with Swiss GAAP RPC 21, the content of the performance report is not audited. The prior year's corresponding figures shown in the financial statements were audited by another auditor, which in his report dated June 2, 2006 issued an unqualified audit opinion.

These financial statements are the responsibility of the Board. Our responsibility is to express an opinion on these financial statements based on our audit. We confirm that we meet the legal requirements concerning professional qualification and independence.

Our audit was conducted in accordance with Swiss Auditing Standards, as well as with International Standards on Auditing (ISA), which require that an audit be planned and performed to obtain reasonable assurance about whether the financial statements are free from material misstatement. We have examined on a test basis evidence supporting the amounts and disclosures in the financial statements. We have also assessed the accounting principles used, significant estimates made, and the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements give a true and fair view of the financial position, the results of operations and the cash flows in accordance with Swiss GAAP RPC. Furthermore, the accounting records and financial statements comply with Swiss law, as well as with the charter of foundation and regulations.

We recommend that the financial statements submitted to you be approved.

Without qualifying our opinion, we draw your attention to the expenses related to DNDi's coordinated activities that have not passed through the accounts as they were incurred by other entities as further explained in Note 9.

DELOITTE SA

Peter Quigley
Auditor in charge

Jürg Gehring

20th September, 2007

HOW YOU CAN HELP

In order to meet its objective to build a robust pipeline and to deliver six to eight new treatments by 2014 for leishmaniasis, human African trypanosomiasis, Chagas disease, and malaria, DNDi still needs EUR 227 million in funding. Your support to meet this challenge is greatly appreciated as you will help to provide new tools that will improve the lives of patients suffering from these neglected diseases.

To join our efforts, please contact the DNDi Fundraising Manager at +41.22.906.9240 or **supportdndi@dndi.org**.

Photograph credits: Asrat Hailu, Cyril Hou (Fotolia), Cecile Schmidt, DNDi, Institut Pasteur, Médecins Sans Frontières, the Roll Back Malaria Partnership, Shoklo Malaria Research Unit, Swiss Tropical Institute, the UNICEF-UNDP-World Bank-WHO Special Programme for Research and Training in Tropical Diseases, World Health Organization.
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Best Science
for the Most Neglected

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