DNDi

Best Science
for the Most Neglected

INNOVATION IS HOPE

2025 ANNUAL REPORT

VISION & MISSION

We use the **power of innovation, open science, partnerships, and advocacy** to forge solutions to a great injustice: the lack of medicines for life-threatening diseases that disproportionately impact poor and marginalized people.

The Drugs for Neglected Diseases initiative, DNDi, is an international not-for-profit organization that discovers, develops, and delivers safe, effective, and affordable treatments for the most neglected patients.

WE INNOVATE

TO SAVE LIVES

We develop urgently needed treatments for neglected patients and work to ensure they're affordable, available, and adapted to the communities who need them.

WE FOSTER

INCLUSIVE AND SUSTAINABLE SOLUTIONS

We work hand in hand with partners in low- and middle-income countries to power our progress and strengthen innovation ecosystems that put people's needs first.

WE ADVOCATE

FOR CHANGE

We speak out for policy change to enable more effective and equitable R&D and access to the fruits of science for all people in need, no matter their income or where they live.

COVER PAGE PHOTO: MBO lives in the town of Kisembo, located deep in the hills of Kwilu province in the west of the Democratic Republic of the Congo. After losing her husband to sleeping sickness, Mbo learned that she, too, had the disease – testing positive when a mobile screening team came to her town. Mbo was taken to Masi-Manimba Hospital, where she was enrolled in DNDi's acoziborole clinical trial and cured.

» Watch Mbo's story!

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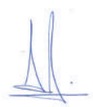
FOREWORD

DR MARIE-PAULE KIENY
CHAIR OF THE BOARD OF DIRECTORS

DR LUIS PIZARRO
EXECUTIVE DIRECTOR



» THERE IS NO QUESTION THAT THOSE HARDEST HIT BY THE EROSION OF GLOBAL HEALTH SOLIDARITY ARE THE COMMUNITIES DNDi EXISTS TO SERVE.

The principles we were built to defend – scientific excellence, open collaboration, sharing knowledge freely, and treating equity as a guiding principle in medical innovation – are facing stronger headwinds than we have known.

Developing the medicines that neglected communities have gone without for generations is a lifeline, not a luxury that can wait for easier times or be traded away for short-term savings.

Standing with our partners, we are proud to look back on a year of proof that perseverance is still delivering against the neglect.

Chief among our shared victories is acoziborole: a revolutionary single-dose oral cure for sleeping sickness. Developed with Sanofi, the national sleeping sickness control programmes of the Democratic Republic of the Congo (DRC) and Guinea, and other long-term partners, it received a positive opinion from the European Medicines Agency in early 2026 and was registered in the DRC within weeks. Just 20 years ago, the only treatment for advanced sleeping sickness was a dreaded arsenic derivative that killed one in every twenty who received it. **Health workers now have a simple tool to cure their patients without fear and bring an end to a disease that has haunted Africa for decades.**

We have travelled a remarkable journey with our partners to make safer, simpler sleeping sickness treatments and the prospect of disease elimination a reality. It was a privilege to be named a laureate of Japan's Hideyo Noguchi Africa Prize, which honoured our successful persistence.

Our long-term focus on developing all-new treatments for leishmaniasis is also bearing fruit. LXE408 – a first-of-its-kind oral candidate in development with Novartis and partners – completed Phase II trials in India and Ethiopia, and early results indicate an encouraging efficacy and safety profile. If its development succeeds, it could be administered as a short course of tablets dispensed at clinics close to home, sparing patients the weeks of hospitalization and toxic injections they have long had to endure. It could also lend fresh force to efforts to eliminate the disease – particularly in Eastern Africa, which now carries more than 70% of the global burden.

We are also advancing in our efforts to be ready for dangers still to come. Among other strides in our pandemic preparedness drug discovery programme, ASAP-0017445 was nominated as a DNDi pre-clinical candidate after showing promising activity against SARS-CoV-2, MERS, and related coronaviruses. It is the first candidate to emerge from COVID Moonshot, a crowdsourced, open science, AI-guided discovery effort that brought together volunteer chemists worldwide who worked to share their science at the height of the last pandemic.

Despite its unprecedented growing spread in recent years, fuelled by the climate crisis, there remains no specific treatment for dengue. **We were grateful to welcome fresh backing from the European Commission through AFD, the French Development Agency, to support our work to deliver the dengue treatments the world so badly needs.** It enables groundbreaking clinical trials led by the Dengue Alliance, a partnership of leading research institutes in Latin America and South and South-East Asia joining forces to address dengue's growing threat – a true model of global health collaboration that we have worked to foster from our very beginnings.

Beneath this progress lies a determined resolve to honour our commitments to patients and put our experience at the service of a global health system being reinvented.

The architecture of cooperation, financing, and delivery is changing quickly, but open scientific collaboration and needs-driven medical innovation must remain at the core. Reform that targets efficiency and impact must deliver the tools to unburden overstretched health systems and reach communities that today's tools cannot.

We stand firm in our commitment to neglected patients – and in our conviction that innovation is hope for families and communities around the world held back by neglected diseases.

To our partners, colleagues, and supporters, and to the patients who have always been our compass: thank you for standing with us.

IN NUMBERS

R&D PORTFOLIO

» **33**
projects in our R&D portfolio, and an additional 14 projects in the treatment access phase

» **20**
projects focused on identifying or developing new chemical entities

20

» **Over 4,610**
researchers, clinicians, and health advocates trained across Africa, Asia, and Latin America

» **81%**
of all R&D partner staff* are based in low- and middle-income countries

» **5**
research networks to strengthen research capacity in Africa, Asia, and Latin America

FOSTERING SUSTAINABLE SOLUTIONS

GENDER AND DIVERSITY

» **52%**
of DNDi leadership positions held by women

» **63%**
of peer-reviewed scientific articles had a female first or last author

» **71%**
of peer-reviewed scientific articles had at least one author from a partner institution in an endemic country

» **€ 52.9 m**
in annual expenditure

» **€ 16.3 m**
in in-kind contributions and collaborative funding from partners

» **85%**
of expenditure on social mission to maximize impact for neglected patients

FINANCES

25

DR WILFRIED MUTOMBO KALONJI, Head of Clinical Operations for DNDi in the Democratic Republic of the Congo, holds acoziborole, our all-new oral treatment for sleeping sickness that requires just a single dose of three pills (see page 20).

» **13**
clinical trials in 6 disease areas, including 9 trials testing new chemical entities

» **41**
clinical trial sites in 16 countries

» **1,796**
participants enrolled in active DNDi clinical studies

CLINICAL TRIALS

MAXIMIZING OUR COLLABORATIVE MODEL

» **212**
R&D and access partner institutions in 47 countries

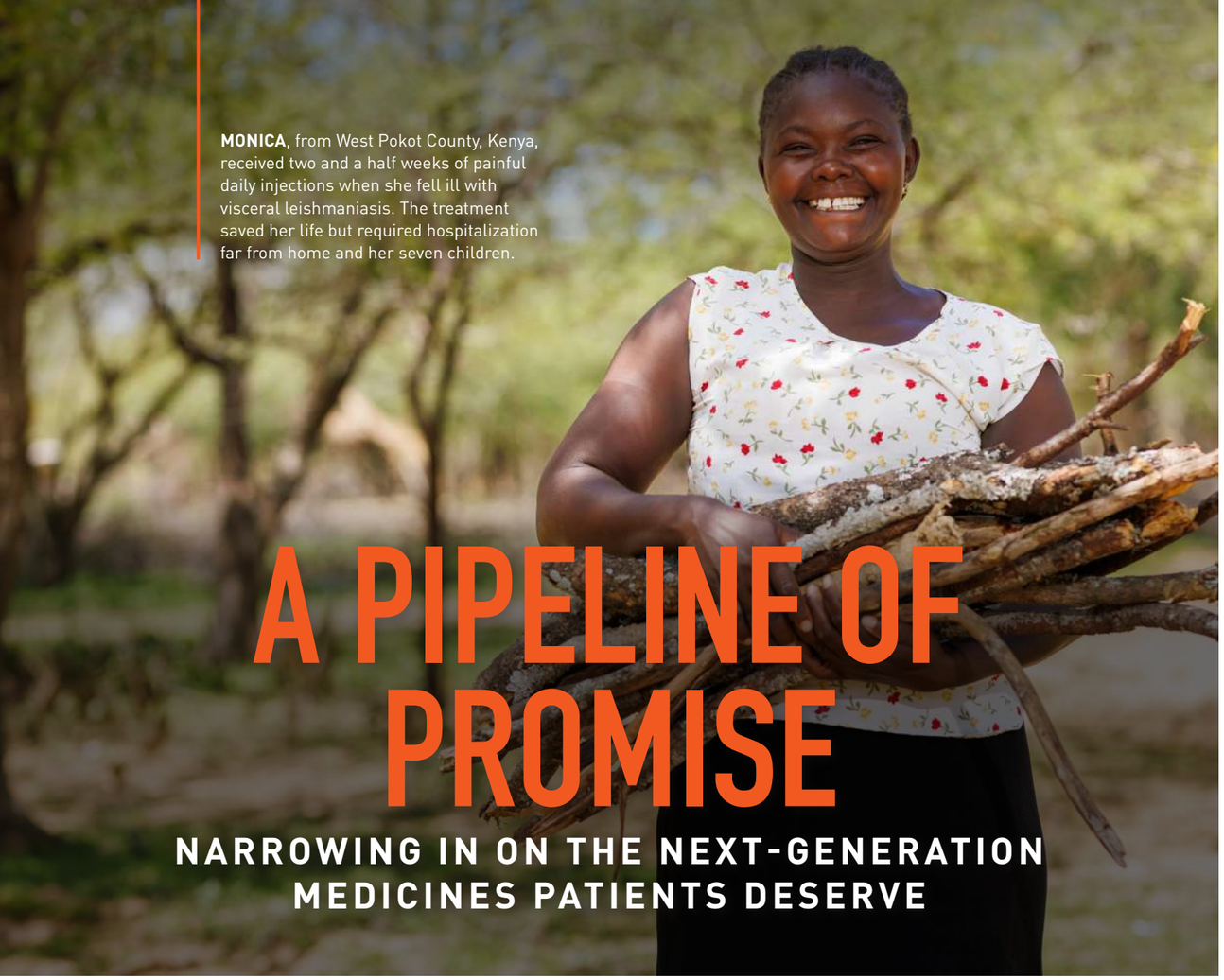
» **2.5:1**
ratio of partner staff vs DNDi staff* worldwide

* Staff in full-time equivalents (FTEs)

» **38**
peer-reviewed scientific articles on DNDi research

» **95%**
of peer-reviewed scientific articles published in open-access journals

SHARING KNOWLEDGE



MONICA, from West Pokot County, Kenya, received two and a half weeks of painful daily injections when she fell ill with visceral leishmaniasis. The treatment saved her life but required hospitalization far from home and her seven children.

A PIPELINE OF PROMISE

NARROWING IN ON THE NEXT-GENERATION MEDICINES PATIENTS DESERVE

From our earliest days, DNDi teams and partners have worked along two tracks to deliver new treatments for neglected patients. The first makes the most of medicines already available by replacing toxic treatments that require long hospital stays with shorter, safer formulations and combinations that improve outcomes, limit side effects, and allow patients to return to family and work sooner.

The second harnesses the best science to get patients what they have deserved all along: simple, safe, and effective oral medicines, purpose-built to be easy to access and administer in remote settings where neglected diseases hit hardest. This longer-term journey starts in the lab, screening compounds to identify those with the potential to hit the mark, and advances from early drug discovery through the long R&D lifecycle and into the hands of doctors and patients. **That long game is challenging for neglected infectious diseases**, requiring resources and commitment in a field long sidelined by traditional industry players. **But the rewards can be huge: hope, healing, and security for communities long excluded from the benefits of medical innovation, relief for overstretched health systems, and clear pathways to sustainable disease elimination.**

» ACOZIBOROLE: PROOF THE LONG GAME PAYS OFF

The clearest evidence yet that long-term determination delivers has just left the pipeline. In February 2026, acoziborole – a single-dose oral cure for the most common form of sleeping sickness – received a positive opinion from the European Medicines Agency. Within weeks, the Democratic Republic of the Congo (DRC) – long the epicentre of the nightmare disease – registered the treatment, which will also help other endemic countries in West and Central Africa accelerate access.

It is hard to overstate the monumental leap this represents. Twenty years ago, the only treatment option for late-stage sleeping sickness was an arsenic derivative so toxic it killed one in twenty patients. A determination to overcome this unacceptable treatment gap drove doctors from MSF to push for DNDi's creation in the early 2000s.

The first new treatment to emerge from DNDi's own lead optimization programme, acoziborole was initially identified in the chemical library of Anacor Pharmaceuticals before being optimized in partnership with Scynexis and Pace University. Developed with Sanofi and the national sleeping sickness control programmes of the DRC and Guinea, it is administered at the point of care as a single dose of three tablets – replacing injections, hospitalization, and treatments requiring complex laboratory staging.

In the late 1990s, nearly 40,000 cases of gambiense sleeping sickness were reported, with an estimated 300,000 undiagnosed. Hard-fought national strategies and improved treatments delivered by DNDi and partners have helped bring reported cases down to just 600 in 2024. The simplicity of acoziborole will help diagnose and cure remaining scattered cases in remote, hard-to-reach communities and reach the final mile to sustainably eliminate a disease that has killed millions in Africa over the past century.

» LXE408: A FIRST-IN-CLASS COMPOUND FOR LEISHMANIASIS

Visceral leishmaniasis (VL) is the second deadliest parasitic disease after malaria. For decades, its treatment has required weeks-long hospital stays and painful injections of toxic, heavy-metal-based drugs – a punishing ordeal for patients and their families.

LXE408 selectively disables a protein-recycling system (the proteasome) of the parasite that causes VL, without which it cannot survive, and that could enable a different future for patients. **A short course of tablets administered at clinics close to home would be transformational** – especially in Eastern Africa, now home to more than 70% of the world's VL cases. If proven safe and effective, its simplicity could also help power regional efforts to eliminate the disease.

Advanced by DNDi in partnership with Novartis, LXE408 completed two Phase II proof-of-concept studies in India and Ethiopia in 2025, with early data showing promising efficacy and safety. Full results will be released in late 2026, and planning for a pivotal Phase III trial in Eastern Africa and further studies in South Asia is underway. Its impact could extend further: a separate Phase II study set to begin in Latin America will test LXE408 for the treatment of cutaneous leishmaniasis, a disfiguring, stigmatizing skin form of the disease with scarce treatment options.

» THE PUSH FOR ALL-NEW TREATMENTS FOR CHAGAS DISEASE

An estimated 8 million people, mostly in Latin America, are living with Chagas disease. It often hides for decades, damaging the heart and digestive system long before patients feel unwell. Around a third develop life-threatening complications. Although they remain the best option and access must be improved, current treatments can cause significant side effects and are not suitable for women who are – or could become – pregnant.

Our teams and partners have focused on drug discovery for new Chagas treatments for two decades; today, there is reason for cautious optimism. Beyond leishmaniasis, LXE408 has shown promising pre-clinical results for Chagas, and Novartis is conducting a Phase II study in patients with chronic Chagas disease in Latin America and the US.

Another exciting contender, AN2-502998, offers fresh hope of a cure for chronic Chagas infection in the form of safe, oral treatment. Discovered at the University of Georgia, with follow-on development at AN2 Therapeutics, pre-clinical testing showed the candidate can achieve full parasite clearance, and a Phase I trial in healthy volunteers found it safe and well-tolerated. It belongs to the same boron-based chemical family as acoziborole and acts on the same validated parasite target. Drawing on DNDi's extensive network of clinical-trial sites in Latin America, a Phase II proof-of-concept study is set to begin in late 2026 in partnership with AN2.

Running in parallel is a quietly transformative effort: our collaboration with InfYnity Biomarkers to develop the MultiCruzi assay, a simple, reliable 'test of cure'. Recognized as DNDi's 2025 pre-clinical Project of the Year, the collaboration could remove major obstacles to proving new Chagas treatments work, which would facilitate registration and access to any new treatments developed.

» GOING THE DISTANCE

Like every innovation in the making at DNDi, this progress is the product of bold collaboration and steady commitment from patients, partners, and supporters who share in our conviction that all people should benefit from scientific progress. At a moment of unprecedented flux in global health cooperation, we are grateful for the many hands holding steady to keep the pipeline flowing to fruition.

Researcher **JASMIN ASCHENBRENNER** works in the laser crystallography laboratory at Diamond Light Source, Oxford, UK, a partner in the COVID Moonshot and the ASAP Drug Discovery Consortium, both open-science collaborations focused on discovering and developing new medicines for viruses of pandemic potential.

OPEN BY DESIGN

WHY SHARING SCIENCE IS IN OUR DNA

Two opposing truths about modern science were revealed during COVID-19. Researchers collaborated across borders and disciplines at speeds never seen before, delivering vaccines and treatments in record time. Yet those very breakthroughs were locked behind restrictive patents and exclusive supply and pricing deals, leaving billions of people waiting.

This contradiction goes to the heart of the shared conviction that drives our partnerships at DNDi: the raw material of every new medical innovation is knowledge. When knowledge is shared instead of fenced in, science moves faster, costs less, and reaches more people who need it.

THE COST OF PRIVATIZING KNOWLEDGE

Open science is not a new idea. Landmark collective achievements like the Human Genome Project, which released its data within 24 hours of it being generated, show its power. On the flip side is the enclosure of knowledge: undisclosed results and dense webs of patents, confidentiality clauses, and trade secrets that can wall off discoveries from researchers who might build and improve on them.

Patents reward inventors for disclosing their work and give them time to recoup their investment. But they come with a trade-off: for at least 20 years, no one else can use the protected knowledge without permission. Too often in global health, knowledge is locked away, limiting or preventing scientific collaboration, follow-on research, production, and equitable access to life-saving health tools.

A SPECTRUM OF OPENNESS

In developing our very first institutional policy – our Intellectual Property Policy, written at our founding in 2003 – we inverted the usual logic: instead of treating research as closed unless someone argues to open it, we treat it as open unless there is a specific, compelling reason not to.

In our collaborations with partners, we have shown that open science is not a single rule but a spectrum of potential arrangements that can be tailored to the goals and realities of each alliance.

At the fully open end sits the COVID Moonshot, a global grassroots movement of scientists we joined at the height of the pandemic. It asked chemists worldwide to help design molecules to block the virus – expecting a few hundred ideas but receiving more than 18,000. Every result was published immediately, free of patents, with the aim of identifying an affordable generic that anyone could make.

ASAP-0017445, an antiviral that grew directly out of the Moonshot, is now advancing through the AI-driven ASAP consortium – with partners including Diamond Light Source, Memorial Sloan Kettering Cancer Center, PostEra, and Stanford University. It has shown promise against SARS-CoV-2, MERS, and related coronaviruses, and in 2025 was formally nominated as a candidate to move towards first-in-human trials.

The compound's significance reaches beyond any single disease: **it is a working blueprint for how intellectual property can be used to enable equitable access rather than restrict it.** Moonshot exposed an unexpected problem for open science: because no one owned Moonshot's compounds, no manufacturer or funder wished to invest in their development for fear that a competitor could swoop in, patent a small change to a molecule, and seize control. That drove DNDi and our partners towards a breakthrough idea: use a patent not to lock a medicine down, but to keep it free.

We filed what we call a 'minimally defensive, maximally permissive' patent: minimally defensive because it claims only what is needed to prevent anyone else from monopolizing the compound, and maximally permissive because it is paired with open, non-exclusive licensing that allows multiple manufacturers to make the medicine. In 2025, we published the patent far faster than the usual 18-month norm and released the molecule's structure openly so scientists everywhere could build on it.

Further along the spectrum lies ravidasvir, the first hepatitis C drug to be developed through South-South collaboration. It was originally discovered by Presidio Pharmaceuticals, which held patents in selected high- and middle-income countries. In 2016, DNDi signed a non-exclusive licence with Presidio and Egypt's Pharco Pharmaceuticals to test ravidasvir in combination with sofosbuvir, another direct-acting antiviral. Crucially, every partner committed to equitable access from the start: Presidio granted full freedom to operate in the field of hepatitis C, and Pharco committed to affordable pricing and sharing its manufacturing process, as well as the possibility of technology transfer to local manufacturers.

Our shared goal was a hepatitis C cure that patients could afford. At the time, existing treatments were priced at nearly USD 100,000 in some countries. DNDi coordinated a Phase II/III study in Malaysia and Thailand, co-sponsored by the two countries' health ministries. Malaysia approved the combination in 2021 at USD 300-500 per 12-week treatment course. Thailand registered the treatment in early 2026, and registration is also underway in Brazil.

PROOF FROM OUR EXPERIENCE

These are two of many examples of open science collaboration detailed in our policy report, *Open Science in a Closed World* – one of the first comprehensive looks at how openness can be operationalized in real-world R&D collaborations. It explores the tensions and trade-offs between open science and more traditional, proprietary research models, presents a practical framework for embedding openness and equitable access across the innovation lifecycle, and provides actionable recommendations on how governments, R&D funders, academia, and industry can operationalize openness and equity in their innovation policies, practices, and partnerships.

The open-science principles behind our R&D partnerships could reshape medical innovation if widely adopted. That will take real change: funders rewarding openness over secrecy, academia moving beyond IP as a main measure of productivity, and global health actors building equitable access into their agreements from the start.

We are grateful to our partners for continuing to prove that when science is open by design, it is not a constraint on innovation but a driver – and a foundation for health equity.

Read *Open Science in a Closed World*: dndi.org/open-science-in-a-closed-world

CHILDREN FROM KACHELIBA, KENYA and nearby communities participate in a DNDi-sponsored charity run held to mobilize support for neglected patients and raise awareness about neglected diseases. We have worked with partners in Kacheliba since 2005 to conduct clinical trials and improve access to treatment for visceral leishmaniasis.

STRONGER TOGETHER

HOW WE ARE JOINING FORCES TO KEEP OUR PROMISE TO NEGLECTED PATIENTS

The ground beneath global health is shifting. Donor budgets are shrinking, aid commitments are unravelling, and the multilateral cooperation that drove decades of progress is under strain. A clear reckoning is underway: governments and funders are calling for a less fragmented system, led by the countries bearing the heaviest burden of disease. A World Health Organization (WHO) joint process on global health architecture reform and the Accra Reset – a heads-of-state-led push for country sovereignty over donor dependence – are two major initiatives among many focused on delivering this change.

Reform is in the making, but it must be clear about its purpose. A global health system that fails to discover and develop missing health tools will fail the people it serves. We cannot meet today's challenges – let alone tomorrow's – with yesterday's medicines. With pathogens evolving, drug resistance outpacing current medicines, and diseases spreading due to climate change, medical innovation cannot be treated as an optional extra to trade away for efficiency or savings. It is a core function of the system.

Better treatments, diagnostics, and vaccines have brought hope and security to marginalized communities around the world. They have also been the key to making disease elimination a reality. Yet the engines that have powered this scientific progress are faltering. Large pharmaceutical companies have long been indispensable partners, sharing the compound libraries, expertise, and in-kind support that needs-driven R&D is built upon. Over recent years, many have stopped work in infectious disease research in favour of more profitable markets. Others have outsourced essential functions. Either way, vital knowledge and capacity are lost and scattered.

The growing pressures of donor cuts and private-sector disengagement mean that organizations that exist to deliver medical innovation for underserved communities must double down on what we stand for.

» PUTTING PROOF TO THE TEST

There is reason to be hopeful in staying the course. Not-for-profit product development partnerships (PDPs) like DNDi have delivered more than 79 new medicines, vaccines, and diagnostics to 2.4 billion people since 2010. Sustaining this track record requires commitment: leadership from endemic countries, new alliances between them, new financing streams, and new investment in scientific talent and infrastructure in the Global South.

Over more than two decades of delivering on our mission, DNDi teams have assembled expertise building one of the broadest disease portfolios in global health, with cross-cutting skills across parasitic, viral, and fungal diseases that are needed to turn a promising molecule into an approved medicine – from drug discovery and chemistry, manufacturing, and controls (CMC) to clinical operations, regulatory sciences, and implementation. **Our mature partnerships and expert teams in countries most affected by neglected diseases enable us to align these capacities in service to new national and regional alliances working to reshape innovation, manufacturing, and healthcare delivery to meet their populations' needs.** We are deepening collaboration with our fellow PDPs to help power these ambitions: pooling expertise, cutting duplication, and putting scarce, specialized capacity to work for more patients.

» POOLING STRENGTH WITH OUR PEERS

Collaboration among PDPs is not new for us. Since 2016, DNDi and the Global Antibiotic Research & Development Partnership (GARDP) – which DNDi helped co-create with WHO – have shared back-office functions, joint procurement, IT systems, and co-located offices, enabling substantial cost savings and opening new opportunities for mutual learning and support. What is new is the deliberate move to anchor this sharing at the heart of our scientific programmes.

DNDi, GARDP, and Medicines for Malaria Venture (MMV) have recently entered a strategic cooperation agreement to pool expertise and resources, sharpen efficiency, and speak with one voice as calls to reform the global health architecture multiply. The aim is straightforward: **make the most of limited R&D resources and make them go further for patients.**

Two joint platforms established with our partner PDPs show what this looks like in practice. The DNDi-GARDP CMC Platform tackles a costly, often-overlooked problem. Every year, medicines proven to be safe and effective are rejected by regulators due to shortcomings in how they are manufactured. By pooling know-how, the platform reduces duplication, increases the likelihood of technical success, and helps bring quality-assured, affordable treatments to patients. The payoff can be decisive. The platform has already played an instrumental role in the successful development, scale-up, registration, and production of two game-changing treatments: acoziborole, DNDi and partners' new single-dose treatment for sleeping sickness, and zoliflodacin, GARDP and partners' new antibiotic for gonorrhoea – the first to be developed specifically for the disease in decades.

The new DNDi-MMV Joint Regulatory Platform – the first of its kind between two non-profit research organizations – confronts a fragmented regulatory landscape in which registering a medicine can face entirely different requirements across countries. By aligning regulatory strategy and engaging authorities with one voice, the alliance aims to shorten registration timelines and help set new standards where none yet exist. In practice, it works on two levels at once: aligning on the regulatory roadmap and clinical data requirements for individual medicines, and pooling regulatory intelligence to carve clearer pathways across the wider field – so that hard-won lessons from one programme can guarantee success in the next.

As we work with partners to map out further areas of operational alignment – from expanding our use of AI across the R&D lifecycle to joint clinical operations – we are confident that new scientific and operational alliances will allow us to do more together to keep our promises to patients as the system they rely on is reimagined and remade.

ALEX LAGO (Brazilian Association for Leishmaniasis), **POLLYANA MEDEIROS** (Movement for the Reintegration of Persons Affected by Hansen's Disease, Brazil), and **LORENA DI GIANO** (Fundación Grupo Efecto Positivo, Argentina) participate in the inaugural meeting of DNDi's Community Advisory Committee for Latin America, held in Rio de Janeiro in September 2025.

PATIENTS FIRST

IN CONVERSATION WITH VIOLET NAANYU

Associate Professor at Moi University in Kesses, Kenya and Visiting Scientist at Aga Khan University in Nairobi, Violet Naanyu joined the DNDi Board of Directors as Patient Representative in 2025. Having conducted community-engaged research across areas as diverse as HIV care, vaccine acceptance, and hypertension management, she shares her perspective on why medical innovation must be grounded in genuine partnerships with the communities it aims to serve.

How would you describe the value of community engagement in medical research for someone new to the idea? What does good engagement look like?

Medical research is resource-intensive. Anyone who takes it on should invest in ensuring it has real-world relevance and will leave something valuable and lasting behind. Community engagement helps increase the acceptance, feasibility, and long-term positive impact of research projects. **Involving patients and communities meaningfully in the design and implementation of research builds mutual trust.** When local stakeholders feel ownership in the scientific work, it makes it easier to understand their real needs and preferences and, consequently, to design appropriate tools and solutions for their context. It also boosts the potential that evidence can be translated into sustainable change.

Good engagement is deliberate and action-oriented. You start by mapping stakeholders and building representative community advisory boards empowered to help shape decisions. It's a two-way exchange: the research team learns from the community's experience, and the community gains from science that is designed to understand and address their needs and realities.

There are important distinctions between being a subject of research and a participant in it. How do you see the difference — and why does it matter?

Whenever I think about the word 'subject', my mind goes to the colonial era. To be a subject then meant you owed allegiance to a foreign government without the fundamental rights of a real citizen. It was a relationship of unequal power: one active player, one passive – the passive subject stripped of agency.

Medical research can fall into the same trap. **A subject is treated as a passive source of data; a participant is something else entirely – an active partner, involved at every stage of the scientific process.**

And this matters enormously for neglected diseases, because we are so often working with people who are already shut out from essential services and economic opportunity, often facing illness in very isolated communities with little access to quality healthcare. They frequently become passive recipients of whatever science arrives on their doorstep. Working with integrity as a researcher means keeping these realities in mind and committing to working with and through neglected communities to advance science.

How would you contrast traditional, top-down research with community-led research? In which category do most clinical trials sit today?

In the top-down model, academics make all the decisions: what is worth studying, what methods are used, and how the study is run. When their research is complete, they often leave with their data and study specimens in hand. In community-led research, communities are the lead actors; they own the process, name their own problems, and invite researchers to help solve them.

Most clinical trials still sit firmly in that first camp, with communities treated as passive sources of data. I think that a careful blend of the two models is ideal. We still need academics out front, lending expertise and building on the work of others in their discipline to move science forward. **But we also need to end the practice of treating participants as subjects and move towards real partnership, transparency, and genuine sharing of power, data, and resources.** This requires intentional reflection before, during, and after clinical research is conducted to ensure appropriate community engagement throughout the project cycle. In my own work, what's made that hybrid possible is having a qualified local principal investigator working alongside community and scientific advisory boards.

DNDi has established Community Advisory Committees in Africa, Latin America, and South Asia. How do you see their role in shaping DNDi's decisions and strategic priorities?

The Committees can be instrumental in strengthening and streamlining meaningful engagement with people affected by neglected diseases across our research programmes. **Most important is their ability to help ensure our research remains grounded in what patients and communities actually need.** They can press us to continue exploring areas of unmet need that we may be well placed to address and help steer resources to initiatives with the greatest chance of positively impacting patients' lives. They can also facilitate continuous reflection and improvement in critical areas like informed consent, community participation and feedback, sharing outcomes and results, and translating evidence into better policy and practice.

From your vantage point in your new role as Patient Representative on the Board of Directors, where should DNDi teams and partners focus their energy to deepen patient and community engagement in the coming years?

Empowering patient groups and the advocates who represent them should remain a constant focus. Continuing to build from their perspectives is essential for achieving health equity and safeguarding patients' rights and dignity. That can really only come through relationships that centre on transparency, dialogue, and continuous feedback. I am happy to be a part of making this a cornerstone of the progress we are making in medical innovation to meet the needs of underserved communities.

DNDi WORLDWIDE

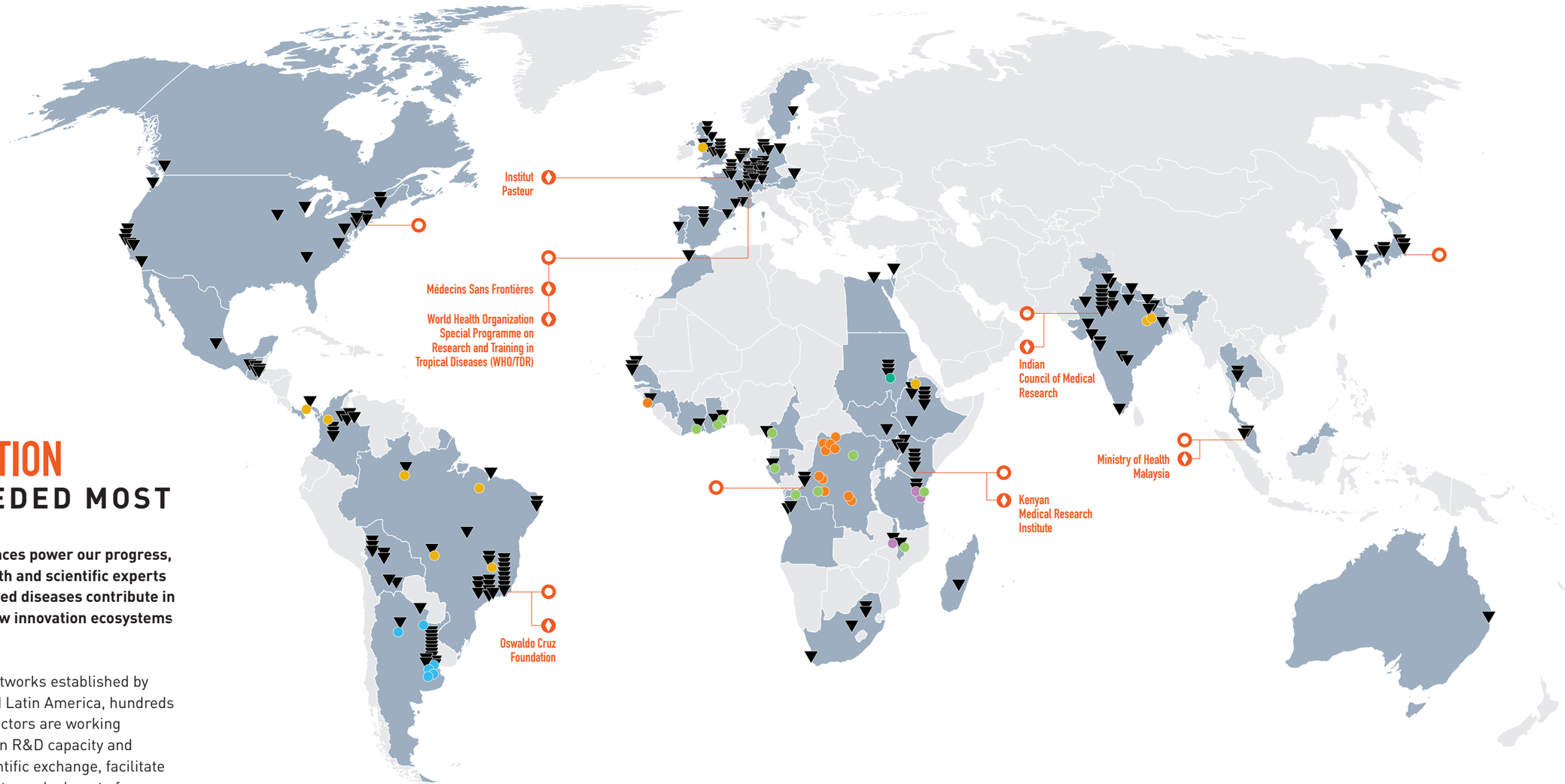
Putting patients first through partnerships that span the globe

» 212 R&D and access partners in 47 countries

» 8 offices on 5 continents

» 41 clinical sites in 16 countries, active in 6 disease areas

» 7 founding partners



ADVANCING MEDICAL INNOVATION WHERE IT'S NEEDED MOST

While a wide range of strategic alliances power our progress, DNDi's partnerships with public health and scientific experts in countries most affected by neglected diseases contribute in unique and vital ways to fostering new innovation ecosystems centred on patients' needs.

Through disease-specific research networks established by DNDi and partners in Africa, Asia, and Latin America, hundreds of medical, science, and civil society actors are working together to consolidate and strengthen R&D capacity and clinical trials expertise, promote scientific exchange, facilitate access to and uptake of new treatments, and advocate for an enabling policy and regulatory environment to meet the needs of the most neglected

» Learn more: dndi.org/global-networks

R&D PORTFOLIO (DECEMBER 2025)

Acting as a 'conductor of a virtual orchestra', we collaborate with research partners around the world at all stages of the R&D process. Our R&D portfolio includes nine disease areas and 47 projects, 20 of which are focused on identifying or developing new chemical entities.

	DISCOVERY			TRANSLATION			DEVELOPMENT		IMPLEMENTATION
	SCREENING	HIT-TO-LEAD	LEAD OPTIMIZATION	PRE-CLINICAL	PHASE I	PHASE IIa/ PROOF-OF-CONCEPT	PHASE IIb/III	REGISTRATION	TREATMENT ACCESS
SLEEPING SICKNESS								Acoziborole ⊕	Fexinidazole for *T.b. gambiense* * ⊕
									Fexinidazole for *T.b. rhodesiense* * ⊕
									Nifurtimox-eflornithine combination therapy (NECT) *
LEISHMANIASIS				DNDI-8526 (S07 series) ⊕	DNDI-6148 ⊕	LXE408 for VL ⊕		Miltefosine + paromomycin for VL (Africa)	SSG + PM (Eastern Africa) *
					DNDI-6899 (GSK899 DDD853651) ⊕	LXE408 for CL ⊕		Miltefosine + paromomycin or LAmB for PKDL (Eastern Africa)	New VL treatments (South Asia) *
					DNDI-6174 ⊕			LAmB +/- miltefosine for PKDL (South Asia)	New treatments for VL/HIV *
					CpG-D35 (DNDI-2319) for CL ⊕			Miltefosine + thermotherapy for CL	New VL treatments (Latin America) *
CHAGAS DISEASE	Screening	Hit-to-Lead	UW series ⊕	Biomarkers	Oxaborole ⊕		New benznidazole regimens		Benznidazole paediatric dosage forms *
			Series-5824 (MT) ⊕						
PARASITIC WORMS incl. filariasis and schistosomiasis				DNDI-6166 (CC6166) (filarial) ⊕		Emodepside (filarial) ⊕	Paediatric ivermectin (filarial)		
				Translational platform (schistosomiasis)		Oxfendazole (filarial) ⊕	Praziquantel/ anti-inflammatory (FGS)		
MYCETOMA				Translational platform				Fosravuconazole	New treatments for mycetoma
DENGUE				Pre-clinical profiling					
HIV						SR 5FC (cryptococcal meningitis)			Super-booster for children with HIV/TB *
									4-in-1 (ABC/3TC/LPV/r) * and other DAAs
									▶ 2-in-1 LPV/r pellets
									▶ AHD access (incl. 5FC, LAmB for cryptococcal meningitis)
HEPATITIS C									Ravidasvir * and other DAAs ⊕
PANDEMIC PREPAREDNESS	Flavivirus screening		TMEM16 series ⊕	ASAP-0017445 (Moonshot ASAP) ⊕					
			AViDD ASAP ⊕						
MALARIA ⏭									Fixed-dose combination ASMQ *
									Fixed-dose combination ASAQ *

In addition to implementing the R&D projects in our portfolio in 2025, we continued to map and assess opportunities for collaboration across the snakebite envenoming innovation landscape, with a particular focus on advancing negotiations on development of and access to promising small-molecule treatments.

⊕ New chemical entity (NCE) or NCE-enabling project

* Treatments delivered by DNDi with partners

▶ Treatments not delivered by DNDi, but DNDi working on access

⏭ Implementation transferred to the Medicines for Malaria Venture in 2015

FACTS

» **1.5 million**

people with moderate to high risk of being infected

» **61%**

of reported cases in the last 5 years were in the DRC

» **97%**

reduction in reported cases in the last 20 years

SLEEPING SICKNESS

Delivering all-new treatments to eliminate a deadly disease

Sleeping sickness – or human African trypanosomiasis (HAT) – is caused by a parasite transmitted by the bite of the tsetse fly. It can result in severe neuropsychiatric symptoms, coma, and death if left untreated. For decades, the most widely available treatment was melarsoprol – an arsenic-derived drug so toxic it killed one in twenty patients.

» THE PUSH FOR PROGRESS

In the 1990s, medical teams from our founding partner Médecins Sans Frontières (MSF) were on the front lines of devastating outbreaks of sleeping sickness in endemic African countries, treating patients in remote settings with melarsoprol as their only option. The gap between medical need and safe, practical treatments for deadly diseases sparked a clarion call for better treatments that prioritized patients' needs over profits.

We have been focused on making treatment for sleeping sickness safer and simpler since our founding in 2003. While DNDi and partners' nifurtimox-eflornithine combination therapy (NECT), delivered in 2009, met the urgent need for a less toxic treatment, its complex administration and need for refrigeration posed logistical challenges in remote and under-resourced areas. Continued innovation and a long-term strategy to develop oral, field-adapted treatments were needed. Following its identification in 2005, DNDi and partners began clinical trials of fexinidazole in 2009. Nine years later, the paradigm-changing all-oral treatment for both stages of *T.b. gambiense* sleeping sickness received a positive opinion from the European Medicines Agency (EMA), followed in 2023 by the expansion of its indication to include *T.b. rhodesiense* sleeping sickness, the less common but more acute form of the disease.

In early 2026, the long road to a safe, simple, field-adapted treatment that could be deployed in the most remote areas reached a turning point when acoziborole – an all-new, single-dose oral treatment for *T.b. gambiense* sleeping sickness developed by DNDi in partnership with Sanofi – received a positive opinion from the European Medicines Agency (EMA).

These remarkable innovations were achieved through strong collaboration with national control programmes and the DNDi-supported HAT Platform, a network of experts and institutions that helps coordinate research, evaluate new tools, and support access. For the less common, more acute *T.b. rhodesiense* form of the disease, we also coordinated the HAT-r-ACC consortium, bringing together partners with expertise in research, training, and community engagement in remote endemic settings in Uganda and Malawi.

OUR GOAL IS NOW to make the final push towards eliminating sleeping sickness by ensuring access to treatment for all who need it, including children, while strengthening disease surveillance and response in endemic countries and exploring simplified screen-and-treat strategies to support elimination goals.

ONE DOSE, ONE CURE

Registered for use in the DRC in June 2026, acoziborole represents a scientific breakthrough that helps ensure the long and devastating history of sleeping sickness can finally be brought to a close.

> When I took the medicine, I felt better quickly.

PASSY, from Kwilu in the Democratic Republic of the Congo, fell ill with sleeping sickness in 2017. In pain and unable to work, her brother took her to Masi-Manimba Hospital, where she received treatment as a participant in the acoziborole clinical trial.

Following the identification of a promising prototype compound in the Anacor Pharmaceuticals chemical library in 2009, DNDi later joined with its industrial partner, Sanofi, to continue developing acoziborole. A pivotal clinical trial demonstrated the safety and efficacy of the single-dose cure in 2022, with high treatment success rates across both stages of the disease.

With this milestone achieved, DNDi teams and partners are now focused on facilitating registration in other endemic countries and preparing for access. This includes working with national authorities, WHO, and implementing partners to support country-level regulatory pathways, readiness planning, and introduction strategies aligned to elimination goals.

MOVING TOWARDS SIMPLIFIED MODELS OF CARE

As countries move closer to elimination, the remaining cases of sleeping sickness are increasingly concentrated in remote communities and detected through targeted screening campaigns. **Acoziborole represents an important step change in how the last cases will be treated.** As a single-dose oral treatment designed for use at the point of care, the drug enables simpler, more practical strategies for achieving and sustaining elimination gains.

In the DRC, the STROGHAT clinical trial conducted by DNDi, the Institute of Tropical Medicine (ITM) Antwerp, the national sleeping sickness control programme of the DRC, and other partners is helping to establish how acoziborole can be used to enable simplified 'screen-and-treat' approaches that do not depend on complex laboratory testing or direct observation in hospital.

Started in 2024, the trial continued to recruit participants and generate reassuring safety data in 2025. DNDi teams also continued to work with in-country partners to strengthen pharmacovigilance systems necessary to support wider use of oral therapies, build confidence among health workers and communities, and enable access to treatment closer to people's homes.

INNOVATING FOR THE MOST VULNERABLE

Current treatments for children with *T.b. gambiense* sleeping sickness who are less than six years old or under 20 kilograms still require painful lumbar punctures, hospitalization, and treatments administered through intravenous infusion.

Together with African and European experts in the ACOZI-KIDS consortium, DNDi teams and partners completed recruitment for the ACOZI-KIDS trial in March 2025, enrolling 35 children across all weight bands in the study. **If proven effective, acoziborole could transform the way young children receive – and experience – treatment for sleeping sickness.**

FACTS

Over 1 billion

people at risk of leishmaniasis worldwide

Over 600 thousand

new cases of CL every year

About 50%

of people with leishmaniasis are children

LEISHMANIASIS

Delivering safer, simpler treatments to save lives and reduce social stigma

Caused by parasites transmitted through the bite of a sandfly, leishmaniasis is a climate-sensitive disease that takes its heaviest toll on people affected by poverty, malnutrition, poor housing, and displacement.

Visceral leishmaniasis (VL) – also known as kala-azar – is the second deadliest parasitic disease after malaria and causes fever, weight loss, spleen and liver enlargement, and, if not treated, death. Cutaneous leishmaniasis (CL) leaves lifelong scars, including on the face, causing social stigma, particularly for women and children. Post-kala-azar dermal leishmaniasis (PKDL), a complication of VL, appears as a rash or skin condition months or years after successful VL treatment, and may act as a reservoir for VL infection. Although CL and PKDL are not deadly, they can be disfiguring and highly stigmatizing.

Leishmaniasis treatment depends on several factors, including the form of the disease, parasite species, and geographic location. For decades, treatments have required long hospital stays and painful injections of toxic, heavy-metal-based antimonial drugs, such as sodium stibogluconate (SSG).

When I was diagnosed with kala-azar, I became too weak to continue going to school. I still wish I had completed my education and found a job so I could help support my family.

MADHURI lives in the small town of Garkha in Bihar, India. She was first diagnosed with kala-azar in 2017 and later with PKDL. Illness and financial strain forced her to leave school; she now works in the fields to support her family.

THE PUSH FOR PROGRESS

Together with our partners, DNDi has delivered four safer, simpler treatments for VL and VL/HIV co-infection – and we are making major strides towards our longer-term goal: developing all-new drugs that can revolutionize treatment and help boost global efforts to eliminate the disease. We have established two endemic country-led research networks that are powering progress against the disease. Founded in 2003, the Leishmaniasis East Africa Platform (LEAP) includes 60 experts from 20 institutions who are helping drive progress in Kenya, Ethiopia, Uganda, South Sudan, and Sudan. Established in 2014, redeLEISH is a global network of CL experts working across 91 institutions in 28 countries who share know-how and design and conduct vital clinical research.

OUR GOAL IS NOW to continue implementing safer, shorter treatments with existing drugs while advancing the development of all-new treatments that can be delivered in primary healthcare settings, closer to affected communities. With better treatments, we aim to help reduce the burden of all forms of leishmaniasis and ultimately eliminate VL as a public health problem in affected regions.

A PIVOTAL MOMENT IN THE FIGHT AGAINST VISCERAL LEISHMANIASIS

For decades, leishmaniasis treatment was defined by painful, toxic drugs that required weeks of hospitalization and disrupted lives already strained by poverty, insecurity, and limited access to healthcare. Now, sustained innovation, hard-won evidence, strong partnerships, and political commitment are beginning to reshape how the disease is treated, controlled, and ultimately eliminated. **At the core of these advances is a simple belief: treatments must be adapted to patients' needs, simple and safe to use, and accessible to affected communities.**

As the front-running candidate in DNDi's leishmaniasis portfolio, LXE408 offers new hope for a long-held ambition: to deliver a short-course, oral treatment that can be used at the primary healthcare level. LXE408 is a first-in-class oral compound active against multiple Leishmania species developed in partnership with Novartis. All study visits for the two Phase II proof-of-concept studies for VL were completed in 2025, with early results showing good efficacy and safety. Full results are expected to be released in 2026, and planning for a pivotal Phase III trial for VL in Eastern Africa is now underway.

While LXE408 shows significant promise, the reality remains that a single drug is unlikely to meet the treatment needs of all patients, including patients affected by certain parasite species. DNDi's balanced and robust portfolio intentionally reflects this reality, with two further oral compounds – DNDI-6899 and DNDI-6174 – in clinical development.

Designed for combination use to preserve the long term goals of our leishmaniasis programme, DNDI-6899 is the second most advanced candidate, progressing towards studies in patients. Developed through a collaboration between the GSK Global Health Unit and the Drug Discovery Unit at the University of Dundee, DNDI-6899 entered Phase I food effect and multiple ascending dose studies in April 2025 at the Royal Liverpool University, UK, in partnership with the University of Liverpool and the Liverpool University Hospitals NHS Foundation Trust. The trial is expected to conclude in 2026, and its results will determine whether DNDI-6899 is suitable for later trials in patients with VL, with a primary focus on Africa, and for potential clinical development for patients with CL, as well.

With a new mode of action among compounds in DNDi's leishmaniasis portfolio, DNDI-6174 has a predicted low human dose and a promising safety margin. DNDi and Eisai Co., Ltd. have collaborated on developing the compound since its nomination as a pre-clinical candidate in 2019. DNDi completed pre-clinical development of DNDI-6174 and selected it as a clinical candidate in 2024, with results from pivotal 28-day toxicity studies supporting its progression to Phase I studies. A formal Scientific Advice Meeting with the Medicines and Healthcare products Regulatory Agency in 2025 determined that the available pre-clinical data supported the planned first-in-human trial and that the study design was acceptable. Phase I studies are expected to begin in 2027.

DELIVERING BETTER TREATMENTS NOW FOR THOSE MOST AT RISK

Science only delivers impact when it changes practice to improve lives and protect livelihoods. **Years of research into improving treatments with existing drugs will soon bear fruit in new treatment guidelines for VL in Eastern Africa and PKDL in Eastern Africa and South Asia to be issued by the World Health Organization (WHO).** More than a technical update, the new guidelines will send a clear signal that cures for leishmaniasis must move beyond toxic, painful antimonial injections and long hospital stays, ambitions which have been the mainstay of the DNDi strategy for leishmaniasis R&D since our founding.

The forthcoming combination treatment of oral miltefosine (MF) and the injectable antibiotic paromomycin (PM) for VL in Eastern Africa was developed following clinical trials in Ethiopia, Kenya, Sudan, and Uganda conducted by DNDi and partners, including members of the AfriKADIA consortium. **Results showed MF+PM was as effective as SSG+PM – the current standard of care in Eastern Africa – for children and adults, but with fewer injections, a shorter treatment duration, no risk of SSG-related toxicity, and a decreased risk of subsequent PKDL.**

The forthcoming combination treatments MF+PM and liposomal amphotericin B (LAmB)+MF for the treatment of PKDL in Eastern Africa were evaluated by DNDi and the Institute of Endemic Diseases, Khartoum University in Sudan, where nearly 20% of former VL patients develop PKDL – the highest rate in the world. Results showed that the combinations achieved a satisfactory cure rate against PKDL with a much shorter hospitalization period of 7 or 14 days compared to 60-90 days for the previous treatment based on SSG injections.

In South Asia, PKDL contributes to perpetuating the VL transmission cycle and could undermine hard-won progress towards elimination. The current treatment for PKDL in South Asia is based on long administrations of MF, which are associated with low adherence and risks such as ocular toxicity. A study conducted by DNDi and partners in India and Bangladesh confirmed that LAmB as monotherapy or in combination with a short three-week course of MF achieves cure rates similar to previous regimens while reducing overall treatment duration and associated risks. **We anticipate that these and other results will be reflected in new WHO guidelines recommending LAmB as monotherapy or in combination with MF for the treatment of PKDL in South Asia.**

CUTANEOUS LEISHMANIASIS

Current treatments for cutaneous leishmaniasis (CL) have been in use for more than 70 years. Patients – many of them children – still endure weeks of painful injections with toxic antimonial drugs for a disease that can leave lifelong scars and cause severe social stigma.

DNDi's strategy for CL recognizes the need to move away from one-size-fits-all treatment approaches and towards regimens tailored to disease severity, causative parasite species, and specific healthcare settings. For uncomplicated CL, this means reducing or eliminating systemic exposure as much as possible in favour of topical and localized therapies. For patients requiring systemic treatment, it means developing simpler oral therapies that can replace painful and often unsafe treatments, as well as treatments that address the needs of patients with complicated forms of CL that do not respond to oral therapies.

TURNING THE CORNER IN NEW TREATMENT RESEARCH

Following promising pre-clinical research showing LXE408 to have potent activity against the parasites that cause CL, DNDi, Novartis, and partners are preparing for a Phase II study evaluating the compound against CL in the Americas, set to begin in 2026. **This first clinical trial of a new chemical entity for CL signals renewed commitment to innovation for shorter, better-tolerated treatments for a disease long sidelined in drug development.**

In partnership with Ajinomoto Bio-Pharma Services (GeneDesign, Inc.) and the University of Tokyo, our teams have also continued work to advance development of CpG-D35 (DNDI-2319), an immunomodulator designed to stimulate the immune system to fight infection. For use in combination with drug therapy for complicated forms of CL, we aim to meet the needs of patients with multiple or large lesions, facial lesions, prior treatment failure, or diffuse and disseminated forms of CL. Preparations are underway for a new sequential study of CpG-D35, consisting of a multiple-ascending-dose study followed by a proof-of-concept trial. The study synopsis was reviewed and endorsed by both SwissMedic and the World Health Organization in 2025.

SAFER, SIMPLER, MORE ACCESSIBLE TREATMENTS FOR UNCOMPLICATED CL

Thermotherapy – where controlled heat is applied directly to lesions – offers a practical, effective option for uncomplicated CL with small lesions, avoiding systemic toxicity altogether. For years, access to the simple but effective treatment has remained limited, particularly in remote settings.

In partnership with the Pan American Health Organization (PAHO) and the redeLEISH network, DNDi has worked to expand access to thermotherapy across the Americas, supporting the provision of equipment and training healthcare workers in its use.

In Sri Lanka, DNDi provided technical advice and thermotherapy devices for a clinical trial testing the treatment against CL caused by *L. donovani*. In Ethiopia, a separate study testing the effectiveness of thermotherapy against CL caused by *L. aethiopica* was completed in 2025, with publication of results expected in 2026.

FACTS

About
» 8 million
people living with Chagas worldwide

About
» 35%
experience cardiac or other organ damage

Over
» 1 million
women of childbearing potential living with Chagas

CHAGAS DISEASE

Searching for shorter, safer, more effective treatments to stop a silent killer

Chagas disease, also known as American trypanosomiasis – is caused by the *T. cruzi* parasite. Spread by the bite of 'kissing bugs', it can also be passed from mother to child during pregnancy and childbirth. In Latin America, Chagas causes more deaths than any other parasitic disease. Often unnoticed and undiagnosed, it can lead to irreversible damage to the heart and other organs.

Current treatments were discovered more than 50 years ago. They must be taken for at least eight weeks, often cause significant side effects, and are not suitable for women who are – or could become – pregnant.

» THE PUSH FOR PROGRESS

Together with our partners, DNDi delivered the first paediatric formulation of benznidazole in 2011. In 2009, we established the Chagas Clinical Research Platform, now a global network of over 500 members from more than 100 institutions across 28 countries, working to coordinate research priorities, support the development of new treatments, and advocate for improved access to diagnosis and care with and for people most at risk.

OUR GOAL IS NOW to continue advancing the development of all-new potential treatments while working to improve current treatments with simpler, safer, shorter regimens using existing drugs. Our teams are also working with partners in the most affected countries to simplify diagnosis, treatment, and follow-up, strengthen access to timely and appropriate diagnosis and care, and help eliminate transmission during pregnancy and childbirth.

MEETING THE URGENT NEED FOR INNOVATION

For decades, drug discovery and development for Chagas have been slow and fraught with challenges. **In 2025, DNDi and AN2 Therapeutics, Inc. initiated a new collaboration to advance the clinical development of AN2-502998 – a promising new oral drug candidate for chronic Chagas disease.** A Phase I clinical trial of the compound led by AN2 in 2025 is expected to be followed by a Phase II proof-of-concept trial in 2026 – leveraging DNDi's expertise and extensive network of clinical trial sites in Latin America. We are also providing expertise to support a Novartis Phase II study of LXE408 in patients with chronic indeterminate infection.

With additional advances in DNDi's earlier-stage research into novel drug candidates, the R&D pipeline for Chagas is looking more promising than ever. In partnership with GSK, the University of Dundee Drug Discovery Unit (DDU), and the University of Washington, our drug discovery teams have identified and prioritized the most promising leads in the UW series. More than 150 promising compounds in the MT series were synthesized in collaboration with Tanabe Pharma, with a strong focus on improving drug metabolism and pharmacokinetic properties.

ADVANCING DEVELOPMENT OF A CRITICAL TEST OF CURE

One of the main challenges in drug development for Chagas is the lack of analytical tools to monitor disease progression and response to treatment.

> **Interrupting Chagas in future generations depends on diagnosing and treating women of childbearing potential so the disease is not transmitted to children during pregnancy.**

DR RAFAEL HERAZO is DNDi medical focal point and specialist in Chagas disease in Colombia, where DNDi is working with local partners to improve access to testing and treatment among Indigenous groups that are heavily impacted by Chagas.

After initial work with the NHEPACHA Iberoamerican Network, DNDi partnered with InfYnity Biomarkers to develop a test that can detect treatment response more quickly than conventional techniques.

Recognized by the DNDi Scientific Advisory Committee as the 2025 Project of the Year in pre-clinical research, DNDi's work on biomarkers for Chagas showed that the MultiCruzi assay demonstrated a measurable decline in antibodies to *T. cruzi* within only a few months in patients who had been treated for Chagas. **This achievement paves the way for a critical test of cure that can be used in clinical trials to help facilitate regulatory decision-making, and in treatment settings to determine treatment outcomes more quickly.** Additional studies are now underway to further assess the potential of the MultiCruzi assay as a marker for parasitological cure in adult patients treated with antiparasitic drugs. We have also advanced development of target product profiles for Chagas disease biomarker assays in collaboration with the Chagas research community.

EXPANDING ACCESS TO TIMELY DIAGNOSIS AND TREATMENT

Only an estimated 10% of people living with Chagas have been diagnosed – and even fewer treated. In 2015, DNDi launched the Chagas Access Project, working with local, regional, and national partners in several endemic countries in Latin America to expand access to diagnosis and treatment using 'test-and-treat' approaches.

In partnership with FIND and local health authorities, DNDi has evaluated the performance of rapid diagnostic tests in test-and-treat strategies in Colombia, Guatemala, and Argentina, with favourable results.

Faster and simpler than traditional lab-based testing, the tests have the potential to help expand access to diagnosis and treatment and eliminate mother-to-child transmission. In 2025, Colombia incorporated rapid tests into its national technical guidelines, based on studies conducted by the National Institute of Health (INS) with technical support from DNDi. Internal validation processes are underway in Argentina and Guatemala to assess how the approach could be implemented in these two countries.

Alongside these efforts, the Nuestroben Phase III clinical trial testing shorter regimens of benznidazole expanded to two new sites in Bolivia in 2025, complementing six sites already active in Argentina. Conducted by DNDi in partnership with the Chagas Clinical Research Platform, Fundación Mundo Sano, and Laboratorio Elea Phoenix, the study is expected to complete recruitment in 2027.

PARASITIC WORMS

Breaking the cycle of infection, disability, and stigma

An estimated 1.5 billion people are living with parasitic worm diseases. Most prevalent in tropical and subtropical areas, schistosomiasis, river blindness, and lymphatic filariasis take their heaviest toll on communities already vulnerable due to poverty and limited access to clean water and sanitation. They can cause significant illness, lifelong harm, permanent disability, and in severe cases, death. **Existing treatments are often insufficient.** They may not provide a complete cure, face risks of emerging resistance, and remain unavailable outside of preventive mass drug administration campaigns.

Current strategies to interrupt transmission rely on large-scale, periodic distribution of anti-helminthic drugs that must be given to nearly all people in endemic areas for up to a decade. While this approach has enabled progress, it is increasingly unsustainable due to global health funding shifts, and people living in remote and insecure settings, pregnant women, and young children often go untreated. **New treatments that can cure parasitic worm diseases before they cause irreparable harm are urgently needed – including for young children and pregnant women.**

FACTS

Over 12 million
people living with river blindness

Over 58 million
people living with lymphatic filariasis

Over 30 million
women living with female genital schistosomiasis

THE PUSH FOR PROGRESS

We are advancing in our efforts to develop safe, effective, field-adapted treatments for river blindness, lymphatic filariasis, and schistosomiasis – including female genital schistosomiasis, a devastating form of the disease that causes severe pain, stigma, and lasting harm to reproductive health for millions of women and girls. Our work with partners also extends to other neglected worm diseases where treatment candidates have shown promise.

OUR GOAL IS NOW to advance the development of at least one new treatment for both river blindness and lymphatic filariasis, while continuing work with partners to improve awareness, diagnosis, and treatment of FGS.

NEW HOPE FOR POTENTIAL CURES

Current treatments for river blindness and lymphatic filariasis are only effective against juvenile worms – not adult worms that can live for up to 10 years inside the human body – and require up to a decade of repeated annual administration. **New treatments effective against both adult (macrofilaricidal) and juvenile (microfilaricidal) worms are critical to end suffering and stop transmission.**

In collaboration with Bayer AG, DNDi began evaluating emodepside as a potential macrofilaricidal drug for river blindness in 2013. Originating at Japanese pharmaceutical company Astellas Pharma Inc., emodepside was initially commercialized as a veterinary anti-helminthic. In 2023, DNDi began part 1 of a Phase II trial evaluating the drug's safety and efficacy against river blindness together with partners Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR), Kwame Nkrumah University of Science and Technology (KNUST) in Ghana, and the national neglected tropical diseases preventive chemotherapy control programme (PNLMTN-CTP) in the Democratic Republic of the Congo (DRC). **In 2025, analysis of trial data confirmed emodepside is safe and effective against both juvenile and adult *O. volvulus* worms – the first drug to show macrofilaricidal efficacy in clinical trials.** This significant milestone prompted DNDi's Scientific Advisory Committee to select the project as the 2025 Project of the Year in clinical research. Preparations for part 2 of the Phase II trial investigating the safety, tolerability, and efficacy of selected doses are underway.

DNDi continued work with partners to evaluate a second very promising candidate, oxfendazole, as another potential macrofilaricidal treatment for multiple parasitic worm diseases. Several concurrent Phase II trials conducted by partners in the eWHORM consortium are evaluating the drug's safety and efficacy against river blindness (led by Institut National de Recherche Biomédicale in the DRC); loiasis (led by Lambaréné Medical Research Center in Gabon); and trichuriasis (led by the Ifakara Health Institute in Tanzania). All three trials began recruitment in 2025, with the Tanzanian study also completing recruitment.

In India, DNDi continued to support a separate Phase IIa study led by the Indian Council of Medical Research testing the safety and efficacy of oxfendazole against lymphatic filariasis. **If proven effective, the drug could boost efforts to eliminate the disease in India.** In Africa, we are supporting FAME, a consortium working to develop a shorter and safer treatment for river blindness by repurposing fusidic acid as an anti-Wolbachia therapy.

ADVANCING EARLY-STAGE RESEARCH

Schistosomiasis affects over 250 million people worldwide, but only one drug – praziquantel – is available to treat the disease. It is only partially effective, as it kills adult worms but has limited effect against juvenile worms. For women living with FGS, praziquantel is even less effective.

We are working with partners in Brazil, Ghana, Germany, Japan, Thailand, and the United States to boost schistosomiasis drug discovery through the Schistosomiasis Translation Platform. The project aims to bridge the research gap between *in vitro* activity and *in vivo* efficacy while strengthening early-stage research in endemic countries. Platform partners have begun evaluating a Merck compound library with the goal of establishing a 'compound box' that can be made available to researchers for further studies within an open-science drug discovery model.

RESTORING DIGNITY AND HOPE

An estimated 30-56 million women and girls are living with FGS, yet the deeply stigmatizing disease is seldom correctly diagnosed. The only available treatment – praziquantel – does not reduce painful inflammation or help repair damage already done.

Together with partners in the WINGS-4-FGS consortium, DNDi is working to pioneer a new treatment approach that combines praziquantel with safe, available anti-inflammatory drugs to reduce pain, prevent long-term harm, and improve quality of life. The project officially launched under the auspices of the Institute of Health Research of the University of Health and Allied Sciences in Ho, Ghana in November 2025. Preparations for the Phase III trial continued, and activities to strengthen partnerships and women's healthcare capacity began in Côte d'Ivoire, DRC, Ghana, Madagascar, and Malawi.

FACTS

» Unknown

burden hinders global response

Current treatments last up to

» 12 months

with many side effects

Delayed treatment can lead to

» amputation

MYCETOMA

Expanding treatment access and closing evidence gaps for one of the world's most neglected diseases

Mycetoma is a slow growing infection that destroys skin, muscle, and bone. Primarily affecting the feet and legs, it most likely begins after a cut or thorn prick allows fungi or bacteria from the soil to enter the body. Occurring across five continents in multiple countries across the so-called 'mycetoma belt' between the latitudes of 15° S and 30° N, the fungal form of the disease, eumycetoma, is particularly devastating. **Often characterized as the most neglected of neglected diseases, eumycetoma can cause severe disfigurement and disability and result in stigma, social isolation, and mental health difficulties.**

» THE PUSH FOR PROGRESS

Following advocacy from DNDi, the Mycetoma Research Center (MRC), and other partners, mycetoma was added to the World Health Organization (WHO) list of neglected tropical diseases (NTDs) in 2016. **The following year, DNDi partnered with the MRC, a WHO collaborating centre in Khartoum, Sudan, and pharmaceutical company Eisai Co., Ltd., to conduct the first-ever randomized controlled trial for eumycetoma treatment.** Completed in 2021, the trial showed that the drugs fosravuconazole and itraconazole, combined with surgery, are both effective, with fosravuconazole offering practical advantages, including once-weekly dosing and no need to administer the drug with food. **New treatments that are shorter and have the potential to cure the disease without surgery are still urgently needed to prevent amputation and devastating disability.**

OUR GOAL IS NOW to continue advancing research to identify new potential treatments while working with partners to register fosravuconazole in Sudan and expand access to existing – but often unavailable – drugs in mycetoma-endemic countries.

DELIVERING CARE AMID CONFLICT

Disrupted access to healthcare is one of many devastating consequences of the war in Sudan. In 2024, the MRC in Khartoum was destroyed, threatening to bring an end to the critical role it has long played in advancing R&D and delivering treatment for people across the region. **Although conflict continues to take a terrible toll in the country, there are signs of recovery for the MRC – and hope for the patients who rely on it.** In early 2026, donor support enabled the centre to be rebuilt and reopened, enabling patients in Sudan to access specialized diagnosis and treatment for eumycetoma once again.

DNDi teams continued working with the MRC, Eisai Co., Ltd., and other partners to facilitate registration of fosravuconazole and enable access to the treatment. Long delayed by the conflict, a fosravuconazole early-access protocol was launched in August 2025 with an initial cohort of 40 patients. A collaboration between DNDi, Eisai Co., Ltd., Médecins Sans Frontières (MSF), and local partners enabled successful delivery of the treatment, which required extraordinary logistical efforts, including security escort over a final 600-kilometre desert journey.

Together with WHO, DNDi teams made progress advancing a global regulatory plan for the registration of fosravuconazole in mycetoma-endemic countries.

"You are only useful to people when you have something to offer. When you have nothing, you are nobody.

EROT is a 49-year-old mycetoma patient from Katong'un village in Turkana County, Kenya. Once a pastoralist, he is now unable to work or provide for his family and has been alienated by most of his friends and relatives.

To expand the evidence base required to support registration, DNDi and partners will conduct a Phase III multi-country clinical trial to assess the safety and efficacy of fosravuconazole on a larger scale. Recruitment is expected to begin in late 2026 at trial sites in India, Kenya, and Senegal.

CLOSING KNOWLEDGE GAPS TO STRENGTHEN CARE

The burden of mycetoma outside of Sudan is very poorly characterized, hindering efforts to develop treatments and ensure they reach all who need them. **To bridge the evidence gap, DNDi teams joined with partners in India, Senegal, and Ethiopia to collect much-needed epidemiological data.**

In collaboration with the Fungal Infections Study Forum (FISF) in India and Cheikh Anta Diop University in Senegal, DNDi conducted a retrospective review of hospital records, identifying more than 1,400 cases of mycetoma and generating data on disease burden, distribution, clinical presentation, and management.

In Ethiopia, one of the first large-scale community-based initiatives for mycetoma screened over 100,000 people across more than 25,000 households. Led with Arba Minch University, this effort identified over 100 suspected cases and referred them for laboratory confirmation. In addition to raising awareness, strengthening community engagement, and piloting a model for future surveys, the study provided the first population-level insight into the burden of mycetoma in the country.

In Kenya, DNDi partnered with the African Institute for Health and Development (AIHD), Kenya Medical Research Institute (KEMRI), Turkana County Hospital, Surgery in Turkana Foundation, and the US CDC to conduct a cross-sectional study of the social, behavioural, and economic factors influencing the prevention and management of mycetoma in Turkana. By engaging directly with affected communities, the study seeks to identify healthcare gaps and better understand the needs of affected populations to inform the development of culturally appropriate interventions, policy recommendations, and practical tools such as training manuals and standard operating procedures.

SETTING A FIRM FOUNDATION FOR CONTINUED R&D

In earlier-stage research, DNDi teams continued working with partners Erasmus University Medical Center and the University of Antwerp to develop a new *in vivo* model to assess antifungal efficacy. Expected to become the first validated pre-clinical model for eumycetoma, the achievement would signify a major advance in efforts to identify new treatments for the disease. DNDi teams also advanced work with Uppsala University to develop pharmacokinetic models to support dosing and treatment optimization.

FACTS

» 67%

of the world's population at risk

» 100-400 million

estimated infections each year

Endemic in over

» 100 countries

around the world

DENGUE

Developing urgently needed treatments for a rapidly spreading climate-sensitive disease

Dengue has entered a new phase of global public health urgency. Over 2024 and 2025, record-breaking outbreaks were driven by climate change, rapid urbanization, and increased population mobility. Despite promising innovation in vaccines and vector control, dengue incidence continues to rise across endemic regions, and new areas are increasingly threatened, exposing a major and persistent gap in patient care: the absence of approved, effective treatments that can stop dengue progression and prevent severe illness.

Caused by a virus that is spread by the bite of the Aedes mosquito, dengue symptoms can include fever, nausea, vomiting, rashes, fatigue, and intense eye, muscle, joint, and bone pain. For some, dengue infection can become severe, with complications such as bleeding and plasma leakage that can lead to shock, organ dysfunction, and death. Pregnant women, children, older adults, and people with comorbidities are most at risk. Patient care – even for serious cases – remains purely supportive, placing burdens on health systems that can become rapidly overwhelmed during outbreaks. **Effective treatments that can prevent mild cases from becoming severe are urgently needed.**

"I didn't know it was dengue fever until I was taken to the hospital. The signs and symptoms were like malaria, but more severe. I could barely walk.

RACHAEL runs a small business in Mombasa County, Kenya, which she had to close for two weeks when she was ill with dengue. She spent five days in the hospital, and the fees for her care exacerbated the financial loss that her family had to face.

» THE PUSH FOR PROGRESS

We established the Dengue Alliance, a global partnership of leading public health institutes in key endemic countries, to discover and develop new treatments that are effective against the disease. Together, we are actively searching for new treatments and have advanced two candidates to Phase II and III clinical trials. Our teams and partners are also carrying out much-needed research on the under-reported burden of dengue in Africa.

OUR GOAL IS NOW to complete development of at least one affordable and accessible dengue treatment solution, advance the pre-clinical development of both host-directed therapies (HDTs) and antiviral candidates, evaluate promising biomarkers that can predict development of severe dengue, and help close the epidemiological data gap on the burden of dengue in Africa.

ADVANCING INNOVATION WITH ENDEMIC COUNTRIES

A global partnership led by institutions from dengue-endemic countries, the Dengue Alliance provides scientific leadership, governance, and operational coordination across drug discovery, clinical development, epidemiology, and access planning – ensuring that research priorities are shaped by the realities of those most affected.

Current members include the Translational Health Science and Technology Institute, India; Faculty of Medicine, Siriraj Hospital, Mahidol University, Thailand; Ministry of Health, Malaysia; Oswaldo Cruz Foundation (Fiocruz), Brazil; Federal University of Minas Gerais, Brazil; and DNDi. The Alliance is expected to expand further in 2026, with institutions from additional dengue-endemic countries joining to strengthen regional leadership in research, development, and access.

In 2025, DNDi teams and Alliance partners made significant progress towards the late-stage development of a monoclonal antibody treatment for dengue. The treatment's safety and antiviral activity were demonstrated in pre-clinical studies and Phase I and II trials conducted by Serum Institute of India (SII) – the world's largest vaccine manufacturer. With a pivotal Phase III trial of the treatment led by SII currently underway in India, DNDi will lead additional Phase III trials at sites in Brazil, Malaysia, and Thailand in close collaboration with Dengue Alliance partners – providing trial leadership, sponsorship, and implementation.

Dengue severity results from a complex interaction between viral replication and host-mediated pathological responses. Addressing both may prove critical to achieving meaningful results and improving patient outcomes. **In line with this risk-balanced approach, DNDi and Hyundai Bioscience Co., Ltd. continued discussions on advancing clinical trials of the small-molecule antiviral compound Xafty,** currently undergoing Phase II proof-of-concept evaluation in Vietnam. If proven safe and effective, Xafty could expand future treatment options in outpatient settings as an affordable, oral treatment for early dengue infection.

DNDi teams and Alliance partners also continued work to strengthen the dengue therapeutics pipeline through advanced pre-clinical studies on three HDTs and two antiviral candidates, moving promising compounds closer to clinical trials. Work to identify and validate prognostic and pharmacodynamic biomarkers that could help predict progression to severe disease is ongoing.

CLOSING KNOWLEDGE GAPS TO INFORM THE GLOBAL RESPONSE

Cases of dengue have been documented on the African continent for over 200 years, and the infection has been reported in 34 countries – but the current burden of disease remains unclear. **Accurate, up-to-date epidemiological data are critical for informing decision-making on the deployment of prevention tools such as vaccines and vector control strategies, as well as future treatments.**

DNDi teams continued working with partners Imperial College London; Institut Pasteur de Dakar, Senegal; Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR), Kwame Nkrumah University of Science and Technology (KNUST), Ghana; and National Biomedical Research Institute (INRB), DRC to complete a retrospective study on the prevalence of dengue in Senegal, Ghana, and the DRC. Interim results were presented at several scientific conferences and meetings, and a manuscript detailing the study's results is expected in 2026.

HIV

Protecting progress in a fragile era

Improved access to better antiretroviral treatment (ART) has prevented over 20 million deaths in the past three decades, but gaps in treatment access and pharmaceutical R&D continue to claim more than half a million lives every year. As global funding priorities shift, disrupting supply chains and access to treatment, that gap is widening, placing millions more people at greater risk of severe illness and death from opportunistic infections such as cryptococcal meningitis.

The second leading cause of death among people living with advanced HIV disease (AHD), cryptococcal meningitis can cause life-threatening swelling of the membrane surrounding the brain and spinal cord in people with severe immune suppression. In sub-Saharan Africa, where the burden of disease is highest, 70% of people who develop cryptococcal meningitis die from the infection.

FACTS

» Over 40 million
people living with HIV

» Over 1 million
people acquire HIV every year

» Over 630 thousand
people die from advanced HIV-related illnesses every year

» THE PUSH FOR PROGRESS

Joining forces with national HIV programmes, clinicians, researchers, and community organizations, our teams are supporting country-level initiatives to expand screening, simplify treatment, and improve access to life-saving interventions against AHD, including diagnostics and medicines for cryptococcal meningitis that are already available. Building on earlier achievements, including the development of an easy-to-administer HIV treatment for young children, we are working to advance the development of an improved treatment for cryptococcal meningitis.

OUR GOAL IS NOW to complete development of an easier-to-use treatment for cryptococcal meningitis, continue to improve access to existing treatments, and help advance integrated models of care for AHD that make diagnosis and treatment simpler and more accessible.

IMPLEMENTING INTEGRATED STRATEGIES WHERE NEEDS ARE GREATEST

The Democratic Republic of the Congo (DRC) experienced some of the most severe consequences of global health funding cuts in 2025 as acute shortages of HIV tests and other medical tools disrupted screening, diagnosis, and treatment for people living with HIV. **The prolonged mpox outbreak added further pressure, particularly among people with AHD who face a higher risk of severe disease.**

DNDi teams collaborated with the National HIV/AIDS Programme (PNLS), Mpox Programme, National Public Health Institute (INSP), World Health Organization (WHO), PATH, and other partners to redistribute available health commodities, coordinate emergency imports, and integrate mpox screening into existing HIV and AHD care pathways. As mpox cases declined in Kinshasa, they persisted in other regions, making coordinated planning crucial for stabilizing services.

Through the Improved Access to AHD Care and Treatment for HIV (IMPAACT4HIV) project consortium, DNDi supported work to catalyse implementation of the WHO recommended package of care for AHD. Using a replicable ‘hub-and-spoke’ model of decentralized healthcare, severely ill patients were treated at a central hospital in Kinshasa, while nine surrounding health centres treated more stable patients closer to their homes. Around 80% of patients could be adequately treated at health centres, with 20% requiring referral to more specialized hospitals.

In the first year of the project, 329 people were enrolled, with 267 receiving the full AHD care package. National AHD guidelines and an operational manual underwent technical validation, with approval expected in 2026. A multi-year training programme also began, with DNDi and partners equipping health staff to train others working in related facilities and services.

IMPAACT4HIV partners also worked to implement an integrated bidirectional approach to linking AHD and mpox services at HIV care sites and mpox centres in Kinshasa – screening people presenting with AHD for mpox, and those presenting with mpox for HIV and AHD. Monthly mentorship visits strengthened clinical screening, patient flow, and on-site problem solving. Our teams also supported the Congolese Union of Organizations for People Living with HIV (UCOP+), National Network of Community-Based Organizations and Support Groups for People Living with HIV (RNOAC), Jeunesse Espoir, and other community partners in reconnecting more than 100 people to treatment through a ‘welcome back programme’ designed to reduce loss to follow up amidst supply and funding shortages.

ADVANCING SAFER, SIMPLER TREATMENTS FOR CRYPTOCOCCAL MENINGITIS

Over 70% of people who develop cryptococcal meningitis can survive if they receive early treatment, but left undiagnosed and untreated, the disease is almost always fatal. In Africa, where the burden of disease is greatest and treatment is not easily obtained, only 30% of patients recover.

The WHO-recommended standard of care for the disease is amphotericin B and flucytosine, but standard formulations of flucytosine – delivered in four doses per day – are poorly adapted for use in resource-constrained settings. For critically ill patients, the drug often needs to be crushed and given by nasogastric tube. Together with our partner Mylan Laboratories Limited, India (a Viatris company), DNDi began work in 2020 to develop a sustained-release formulation of flucytosine that can overcome this difficulty.

A Phase I trial at FARMOVS in Bloemfontein, South Africa, completed in early 2023, enabled the selection of a sustained-release prototype formulation and dosage for use in Phase II clinical trials now underway at sites in Tanzania and Malawi. Strengthening existing clinical trial capacities in the two high-burden countries, comprehensive training on good clinical practice, safety monitoring, sample handling, data management, and patient care has also been delivered in collaboration with project partners the National Institute for Medical Research, Tanzania; University of North Carolina Project, Lilongwe, Malawi; Luxembourg Institute of Health; St George’s, University of London; and FARMOVS.

HEPATITIS C

Expanding access to affordable cures to end a silent epidemic

Hepatitis C is caused by the blood-borne hepatitis C virus (HCV) and can lead to chronic liver disease, cirrhosis, cancer, and, if not treated, death. Symptoms can take decades to develop, and most people living with the disease do not know they are infected.

The past decade has seen a revolution in medical innovation for HCV, which can now be cured with just 8 to 24 weeks of safe, simple treatment with direct-acting antivirals (DAAs) – but these drugs have historically been often priced out of reach of vulnerable populations in middle-income countries. While 'test-and-treat' strategies offer the potential to eliminate HCV altogether, high prices, a lack of prioritization, and a challenging global health funding environment are threatening further gains against the silent epidemic.

FACTS

About 50 million
people are living with chronic HCV globally

Only 20%
of diagnosed cases are treated

Over 650
people die from HCV every day

THE PUSH FOR PROGRESS

In 2021, we completed development of a simple-to-use, affordable cure for HCV through a unique South-South collaboration, working in close partnership with the ministries of health of Malaysia and Thailand, and industrial partner Pharco Pharmaceuticals. **Together, we have demonstrated that ravidasvir, an affordable, novel DAA, can cure the disease in 8 to 24 weeks when used with sofosbuvir.** Added to the World Health Organization (WHO) Essential Medicines List in 2023, the treatment is paving the way for more cost-effective cures for HCV.

Together with partners, governments, and civil society organizations, we have advocated for the roll-out of affordable all-oral cures, community-based testing, and improved access in key countries. Sharing lessons from the South-South collaborative effort and the political commitment that made ravidasvir possible, we have shone a light on the potential of alternative pharmaceutical innovation models and how neglected populations can benefit when research, regulatory strategy, and access planning are built around public health needs instead of purely commercial priorities.

OUR GOAL IS NOW to continue supporting partner-led registration of affordable DAA treatments, wider access to treatment for vulnerable populations, and the implementation of test-and-treat strategies to protect gains against HCV.

EVIDENCE FOR SHORTER, MORE AFFORDABLE TREATMENT REGIMENS IN MALAYSIA

Results from the EASE study, led by the Malaysian Ministry of Health, showed that an 8-week regimen of ravidasvir in combination with sofosbuvir was non-inferior to 12 weeks for people living with hepatitis C without cirrhosis. Results presented at the European Association for the Study of the Liver (EASL) Congress in May 2025 supported approval of the shorter regimen by Malaysia's National Pharmaceutical Regulatory Agency, with five years of safety follow-up to monitor for the development of resistance. In Malaysia, this shorter course is expected to reduce treatment costs by around 40%, strengthening the public health case for wider access.

> The development of ravidasvir offers insights into how regional collaboration and targeted investment can lead to affordable medical innovations.

DATUK DR MUHAMMAD RADZI ABU HASSAN, former Director-General of Health, Ministry of Health Malaysia, and former DNDi Scientific Advisory Committee Member, has played a leading role in shaping Malaysia's hepatitis C elimination strategy, including the country's partnership in the development of ravidasvir.

While further studies are needed to build the evidence base for broader implementation of shorter regimens in countries and regions where genotypes and drug-response patterns differ, the results are encouraging. Current treatment options for an 8-week hepatitis C cure remain limited, especially in low- and middle-income countries. An additional, affordable option could help widen access and also increase competitive pressure in markets where a small number of higher-cost products dominate.

EXPANDING ACCESS IN A CHALLENGING GLOBAL CONTEXT

Progress against HCV is facing new challenges as reduced international funding, geopolitical and economic shocks, and the high cost of active case finding make elimination harder to achieve – even as better tools become available. Relatively low levels of public awareness, competing economic priorities, and difficulty mobilizing the political will and financing to invest in testing, decentralization, training, and procurement are now the biggest threats to WHO 2030 elimination goals.

At the same time, partner-led work continues to show what progress can look like in practice.

The Dreamlopments-led C-FREE study in Thailand is generating encouraging evidence on community-based test-and-treat approaches for marginalized populations, with preliminary results presented at the 2026 World Hepatitis Summit showing the ravidasvir and sofosbuvir combination to have high cure rates comparable to clinical trial outcomes.

In April 2026, Thailand's Food and Drug Administration approved ravidasvir in combination with sofosbuvir as a safe and effective treatment against all HCV genotypes following clinical trials conducted in Thailand and Malaysia. In Brazil, regulatory processes towards registration continued under the Drug Technology Institute (Farmanguinhos), Oswaldo Cruz Foundation, and Pharco Pharmaceuticals, while regulatory discussions continued in Argentina.

Lessons from DNDi's HCV programme are helping shape our thinking about how to work in complex markets where regulatory and access barriers are tightly intertwined. Standing as proof of concept for a broader model of pharmaceutical innovation rooted in South-South collaboration and public health partnership, the programme continues to demonstrate how access-oriented innovation can deliver results even in difficult circumstances.

FACTS

» 23

viral pathogens of pandemic potential prioritized by WHO

» Only 3

have fully licensed treatments

It can take

» 10 to 15

years to discover and develop a new drug – far too long to start after outbreaks begin

PANDEMIC PREPAREDNESS AND RESPONSE

Advancing innovation and equity for the next pandemic

Recent outbreaks of Ebola Bundibugyo virus and hantavirus are stark proof that the world remains dangerously ill-prepared to face the rising threat of emerging and re-emerging infectious diseases. Viral diseases of pandemic and epidemic concern – including flaviviruses (such as dengue and Zika), togaviruses (such as chikungunya), and coronaviruses – remain chronically underprioritized, with few or no therapies available for these and other priority viral pathogens highlighted by the World Health Organization (WHO).

New treatments that can readily enter clinical trials are needed. Robust global rules and policies that guard against profiteering, protectionism, and inequitable access to health tools must also be established.

» THE PUSH FOR PROGRESS

Since our founding, DNDi has been committed to ensuring medical innovation serves the most neglected. Building on our contribution to the COVID Moonshot drug discovery initiative – a global grassroots movement of scientists we joined at the height of the pandemic – our collaborative antiviral discovery efforts have expanded the pipeline of candidate compounds and created one of the most substantial open antiviral discovery resources of its kind. Our policy advocacy team has worked to bring DNDi's proven model for linking innovation and equity into global policy discussions, strengthening the case for fairer rules on innovation and access.

OUR GOAL IS NOW to advance the development of promising broad-spectrum antiviral compounds so they can rapidly enter clinical trials in the next pandemic, while working to embed equitable access, open science, and public-interest conditions into the rules, partnerships, and financing structures that will shape future outbreak responses.

HARNESSING AI FOR OUTBREAK READINESS

Together with partners in the AI-driven Structure-enabled Antiviral Platform (ASAP), DNDi is working to progress the development of broad-spectrum small molecules targeting coronaviruses, flaviviruses, and enteroviruses up to clinical readiness, with results openly shared. By 2025, the project had generated and released over 80,000 data points, 125 validated protocols, and over 1,250 crystal structures to public repositories – underscoring both the scale of the scientific effort and DNDi and ASAP partners' commitment to open science.

Emerging from the AViDD-ASAP project and our work with the COVID Moonshot initiative, the compound ASAP-0017445 was selected as a pre-clinical candidate in September 2025. Showing confirmed efficacy against both SARS-CoV-2 and MERS-CoV in *in vivo* testing, the compound is the first coronavirus antiviral candidate developed through crowdsourcing using an open-science approach, and the first to use artificial intelligence to support early-stage advancement. When the molecule's structure was made public in May 2025, DNDi filed a novel minimally defensive, maximally permissive patent on the compound, strategically designed to prevent predatory patenting and preserve the possibility of non-exclusive manufacturing and broad global access.

> From the outset, our antiviral has been designed to directly become a generic, so it can save as many lives as possible.

ANNETTE VON DELFT, Head of Anti-Infectives at the Centre for Medicines Discovery (CMD), University of Oxford, in the laser crystallography laboratory at Diamond Light Source, Oxford, UK. Diamond and CMD partner with DNDi in the COVID Moonshot initiative and ASAP Drug Discovery Consortium.

PURSUING A PROMISING ANTIVIRAL PIPELINE FOR THE NEXT PANDEMIC

Nucleoside analogues have shown remarkable success in antiviral drug development, with current treatments including molnupiravir (COVID-19) and sofosbuvir (hepatitis C). **DNDi and the German Center for Infection Research (DZIF) completed assessment of a collection of 145 nucleoside analogues to determine their broad-spectrum activity across viruses of pandemic potential**, including chikungunya, dengue, Zika, Ebola, Marburg, Nipah, Lassa, MERS, SARS-CoV-2, influenza, and Crimean-Congo viruses, narrowing the field to six compounds. Results will be made available by DZIF through a public database hosted by the Scripps Research Institute.

Our teams continued to work with the Translational Health Science and Technology Institute (THSTI) of India to further optimize the TMEM16F series, a class of salicylamide-based derivatives that continue to show encouraging broad-spectrum antiviral activity against dengue, influenza, SARS-CoV-2, and Zika viruses.

In partnership with Eisai Co., Ltd., Japan, and Institut Pasteur Korea (IPK), we have also completed screening of a 20,000-compound Eisai proprietary collection against both dengue and Zika viruses, with three distinct chemical series selected for further optimization.

SPEAKING OUT FOR INCLUSIVE AND EQUITABLE R&D

Alongside our R&D programmes, our teams have also continued work advocating for solutions to public policy shortcomings that leave the world unprepared for future pandemics and epidemic outbreaks – and place neglected communities at greatest risk.

In May 2025, we welcomed the adoption of the WHO Pandemic Agreement following years of work with Médecins Sans Frontières and other civil society allies to ensure the Agreement includes binding commitments to securing global readiness and equity in future health emergencies. While Member States continue to finalize the Agreement's annex on pathogen access and benefit-sharing, Article 9.5 already offers a powerful tool for change.

For the first time, an international health agreement obliges governments to attach conditions to ensure equitable access to new medical tools developed with public support. No country needs to wait for the Agreement's full ratification to implement Article 9.5 in its national policy.

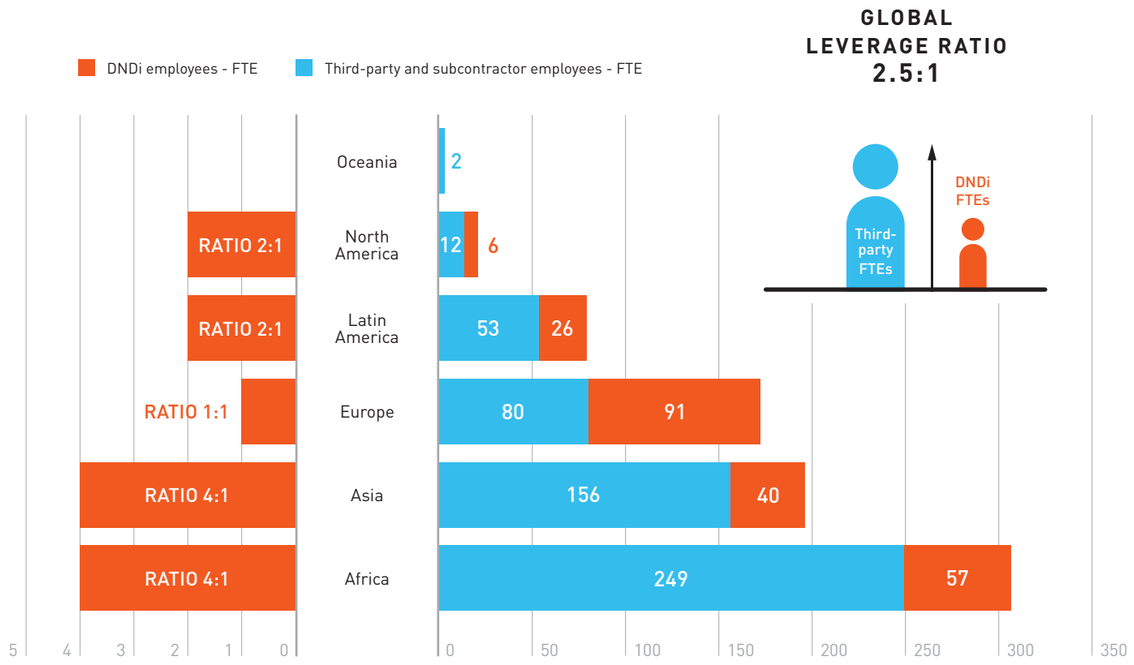
We have carried this call in our engagement with Member States ahead of the 2026 UN High-Level Meeting on Pandemic Prevention, Preparedness, and Response – urging decision-makers to demonstrate strong political will to operationalize the Pandemic Agreement. We have also continued to draw from our experience to call on governments to recognize biomedical R&D as an essential building block of preparedness – including by supporting and financing a Therapeutics Development Coalition to accelerate antiviral discovery and development of Phase II trial-ready candidates for priority pathogens of pandemic potential.

OUR R&D PARTNERS

DNDi is deeply grateful to 210+ R&D partners around the world who propelled progress for neglected patients in 2025

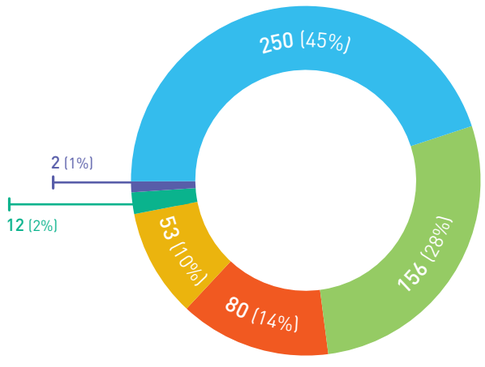
COLLABORATION IS AT THE CORE OF DNDi'S MODEL

DNDi's 210+ R&D partners based in 47 countries (see pages 16-17) contribute to our strong global leverage ratio: for every full-time staff member at DNDi in 2025, we could count on 2.5 more among our partners globally.



552 PARTNER STAFF

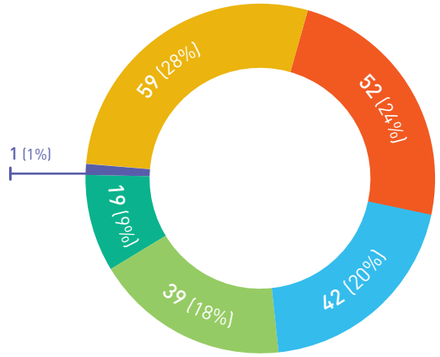
contributed to DNDi projects in 2025, anchoring our proximity to neglected patients around the world



Staffing figures on this page presented in full-time equivalents, with ratios adjusted to reflect staff engaged on a part-time basis.

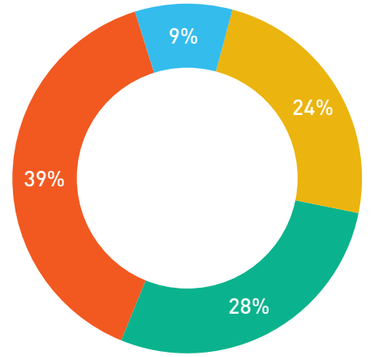
DNDi'S WORLDWIDE FOOTPRINT IS ANCHORED IN ENDEMIC COUNTRIES

with 61% of partner institutions based in LMICs



PARTNER INSTITUTIONS BY REGION

- Latin America
- Asia
- Europe
- North America
- Africa
- Oceania



PARTNERS INSTITUTIONS BY COUNTRY INCOME GROUP

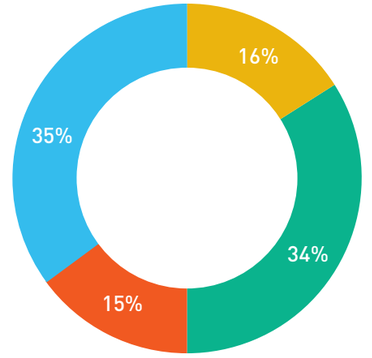
- Low income
- Upper middle income
- Lower middle income
- High income

A DIVERSE RANGE OF ALLIANCES

with essential public and private partners who power our collaborative efforts

PARTNER INSTITUTIONS BY TYPE

- Ministries of health and governments
- Universities, research centres, and healthcare providers
- Industry
- Not-for-profits and foundations



WE ARE GRATEFUL TO THE PUBLIC AND PRIVATE PARTNERS

who provided EUR 16 million in in-kind contributions of goods and services to DNDi programmes in 2025*

Armauer Hansen Research Institute, Ethiopia; Clinical Research Malaysia, Malaysia; CNPEM: The Brazilian Center for Research in Energy and Materials, Brazil; Doctors Without Borders/Médecins Sans Frontières USA; Dongbang Future Tech & Life Co., Ltd., South Korea; Eisai Co., Ltd., Japan; Epicentre, France; Faculty of Medicine Siriraj Hospital, Mahidol University, Thailand; ICMR-National Institute of Pathology, India; ICMR-Rajendra Memorial Research Institute of Medical Sciences, India; Institut Pasteur Korea, South Korea; Instituto de Salud Carlos III, Spain; Médecins Sans Frontières, the Netherlands; Ministry of Health, Malaysia; Novartis Pharma AG, Switzerland; Pharco Pharmaceuticals, Egypt; Pharmaniaga Berhad, Malaysia; Shionogi & Co., Ltd., Japan; Tanabe Pharma Corporation, Japan; Universidade Estadual de Campinas, Brazil; University of Dundee, UK; University of Gondar, Ethiopia; University of São Paulo, Brazil; University of Washington, USA; Virginia Commonwealth University, USA; White & Case LLP, USA.

To view a full list of DNDi partners, visit: dndi.org/partnerships

* Partners listed submitted auditable records of 2025 in-kind contributions for DNDi programmes.

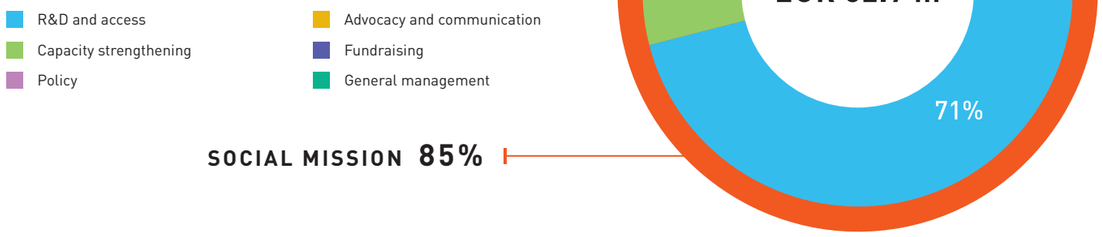
PERFORMANCE

In 2025, DNDi disbursed EUR 52.9 million in support of its activities.

We are grateful to the government, multilateral, philanthropic, and other donors who sustained our progress this year (see pages 46-47).

» To learn more, please visit: dndi.org/Financial-Report-2025

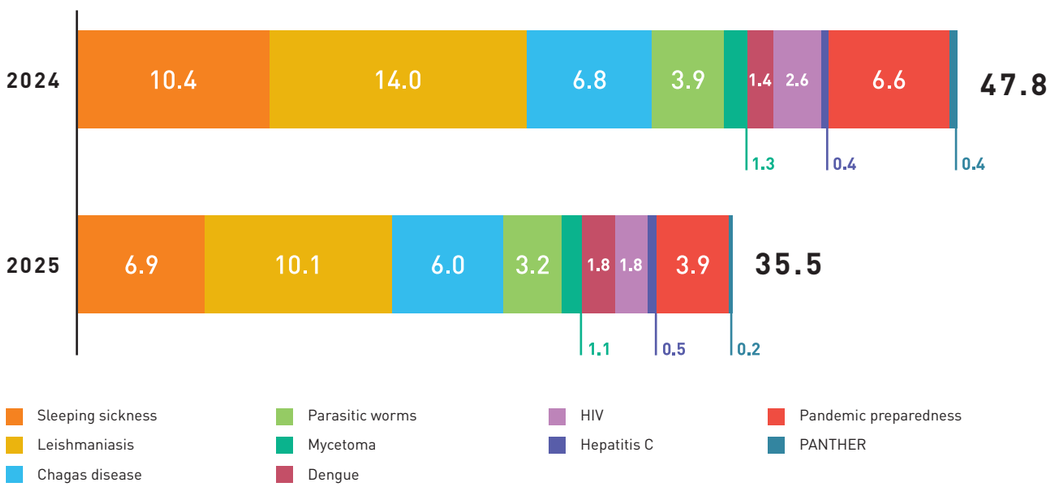
85% of 2025 DNDi expenditure was for our social mission across R&D and access, capacity strengthening, policy, and advocacy and communication



» 2025 EXPENDITURE ON R&D AND ACCESS ACTIVITIES

R&D and access expenditure decreased by EUR 12.3 million from 2024 to 2025, mainly as a result of the completion of specific NTD portfolio access activities

R&D EXPENDITURE BY DISEASE AREA* (EUR MILLION)



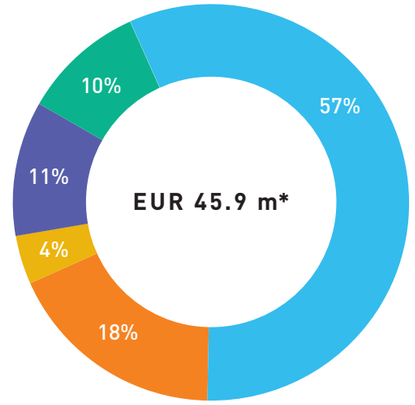
* Figures by disease include a proportion of R&D coordination expenditure. GARDP expenditure is not included in the graph.

» 2025 EXPENDITURE BY DONOR

a diverse array of committed public and private partners

EUR 3.6 million in programme-related financing and other income excluded

- **Government donors** – UK International Development (20.5%); Federal Ministry for Economic Cooperation and Development (BMZ) through KfW, Germany (8.7%); Federal Ministry of Research, Technology and Space (BMFTR) through KfW, Germany (6.7%); Dutch Ministry of Foreign Affairs, the Netherlands (6.1%); US Government (NIH-NIAID) (4.2%); Swiss Agency for Development and Cooperation, Switzerland (4.1%); Global Health Innovative Technology Fund, Japan (3.5%); The Research Investment for Global Health Technology Foundation, Republic of Korea (1.3%); The Hideyo Noguchi Africa Prize, Japan (1.1%); International Development Research Centre, Canada (0.6%); and others
- **Major science donors** – Wellcome (9.5%); Gates Foundation (8.2%)
- **Founding partners** – Médecins Sans Frontières (MSF) (4.4%)
- **Multilateral donors** – European and Developing Countries Clinical Trials Partnership (EDCTP2 programme) and Global Health EDCTP3 (9.0%); Unitaid (1.3%)
- **Other partners and philanthropies** – Novo Nordisk Foundation (1.7%); Instituto Imbuzeiro (0.9%); Dutch Postcode Lottery – Nationale Postcode Loterij (0.7%); Dioraphte Foundation (0.5%); and other individuals and private organizations

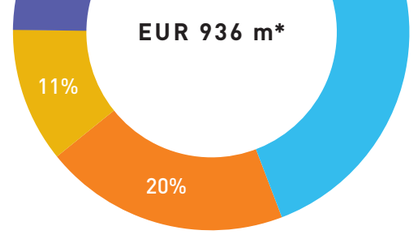


» DONOR CONTRIBUTIONS 2004–2025

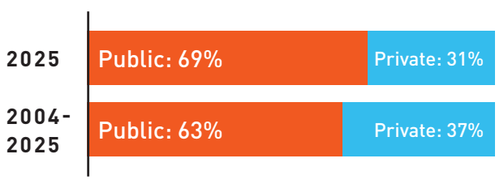
driving action for neglected patients for over 20 years

EUR 45 million in programme-related financing and other income excluded

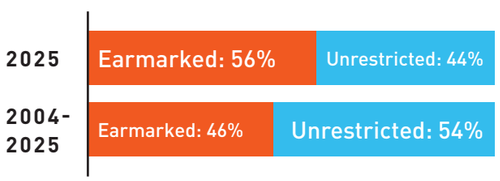
- **Government donors** – UK International Development (21.9%); Federal Ministry of Research, Technology and Space (BMFTR) through KfW, Germany (6.6%); Dutch Ministry of Foreign Affairs, the Netherlands (5.4%); Global Health Innovative Technology Fund, Japan (3.9 %); Swiss Agency for Development and Cooperation, Switzerland (3.8 %); Federal Ministry for Economic Cooperation and Development (BMZ) through KfW, Germany (2.1%); French Development Agency (AFD), France (1.8%); Spanish Agency for International Development (AECID), Spain (1.3%); US Government (NIH-NIAID/USAID) (1.3%); Government of Norway (0.8%); French Ministry for Europe and Foreign Affairs (MEAE), France (0.8%); The Research Investment for Global Health Technology Foundation, Republic of Korea (0.4%); Republic and Canton of Geneva, Switzerland (0.4%); and others
- **Major science donors** – Gates Foundation (15.1%); Wellcome (4.8%)
- **Founding partners** – Médecins Sans Frontières (MSF) (10.6%); World Health Organization TDR (0.3%)
- **Multilateral donors** – European and Developing Countries Clinical Trials Partnership (EDCTP2 programme) and Global Health EDCTP3 (4.4%); Unitaid (3.1%); European Union (2.0%); and others
- **Other partners and philanthropies** – Takeda Pharmaceutical Company Limited Global CSR Program (0.8%); Medicor Foundation (0.5%); Novo Nordisk Foundation (0.4%); Associação Bem-Te-Vi Diversidade, Brazil (0.4%); and other individuals and private organizations
- **GARDP Incubation** – Funding allocated to GARDP activities from the following donors during 2016-2019 incubation period: Governments of Germany, the Netherlands, Switzerland, and UK; Grand Duchy of Luxembourg; Principality of Monaco; Gates Foundation; Wellcome; MSF; South Africa Medical Research Council; and Leo Model Foundation



PUBLIC VS PRIVATE FUNDING*



DONOR FUNDING*



* Excluding programme-related financing, in-kind contributions, collaborative funding, and other income sources.

GOVERNANCE

BOARD OF DIRECTORS - 2025

Marie-Paule Kieny – Chair | Formerly with Institut national de la santé et de la recherche médicale (Inserm), France, and formerly with WHO, Switzerland

Paul Herrling – Secretary | Formerly with Novartis International AG, Switzerland

Frédéric Vallat – Treasurer | Ville de Genève, Switzerland

Noor Hisham Abdullah – Ministry of Health, Malaysia* (until June 2025)

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Taruna Madan – Indian Council of Medical Research and Department of Health Research, India* (since December 2025)

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Jorge Bermudez – Fiocruz, Brazil* (until June 2025)

Mario Moreira – Fiocruz, Brazil* (since June 2025)

Christos Christou – Médecins Sans Frontières* (until June 2025)

Javid Abdelmoneim – Médecins Sans Frontières* (since June 2025)

Maricianah Onono – Kenya Medical Research Institute, Kenya*

John Reeder – Permanent observer | Director, WHO-TDR Special Programme for Research and Training in Tropical Diseases, Switzerland* (until June 2025)

Chris Bird – Wellcome, United Kingdom

Silvia Gold – Mundo Sano Foundation, Argentina (until June 2025)

Suerie Moon – Graduate Institute of International and Development Studies, Switzerland

Kristine Husøy Onarheim – Bergen Centre for Ethics and Priority Setting, University of Bergen, Norway

Violet Naanyu – Patient Representative (since June 2025)

* DNDi Founding Partner | Members of the Board of Directors serve independently unless affiliated with a DNDi Founding Partner. DNDi regional offices are governed by regional Boards of Directors.

» Learn more: dndi.org/our-people/regional-boards

SCIENTIFIC ADVISORY COMMITTEE - 2025

Pauline Williams – Chair | former SVP and Head of Global Health, GSK, London, UK (since October 2025)

Nick White† – Mahidol University, Thailand and Oxford University, UK (Chair until March 2025)

Anup Anvikar – ICMR | National Institute of Malaria Research, India

Rashmi Barbhaiya – Formerly with Advinus Therapeutics Ltd, India

Mike Barrett – University of Glasgow, UK

Kirana Bhatt – University of Nairobi, Kenya (until March 2025)

Pierre Buffet – Institut Pasteur, France (until March 2025)

Joseph Camardo – Formerly ADC Therapeutics, Switzerland

Andre Daher – Farmanguinhos | Fiocruz, Brazil

Walderez Dutra – Federal University of Minas Gerais, Brazil

Valérie Faillat – Independent Regulatory and Access consultant, France

Nor Fariza Ngah – Ministry of Health, Malaysia

Lisa Frigati – Tygerberg Hospital, South Africa

Dale Kempf – Formerly with AbbVie, USA

Steve King – Formerly with AbbVie, USA

Saye Khoo – University of Liverpool, and Honorary Consultant Physician in Infectious Diseases, Royal Liverpool University Hospital (since October 2025)

Lois Larsen – Formerly with AbbVie, USA

Lucy Lum Chai See – University of Malaya Medical Center, Kuala Lumpur, Malaysia

Tomoyoshi Nozaki – University of Tokyo, Japan

Koert Ritmeijer – Médecins Sans Frontières

Mark Sullivan – Medicines Development for Global Health, Australia

NOTE: Lists include membership from January to December 2025, unless otherwise specified.

IN MEMORIAM

PROFESSOR SIR NICHOLAS WHITE

Message on the passing of Professor Sir Nicholas White from DNDi Board Chair Dr Marie-Paule Kieny and DNDi Executive Director Dr Luis Pizarro

We were deeply saddened by the passing of Professor Sir Nicholas White in early 2026. Nick was a towering leader in medical science and global health and a cherished member of our community. He was a trusted advisor, generous mentor, passionate advocate for DNDi's mission, and tireless champion of the communities we serve.

Over decades of commitment to scientific excellence, Nick advanced groundbreaking research and world-class science – for neglected diseases and for marginalized communities that benefit least from scientific progress.

From 2016 to 2025, Nick served as Chair of DNDi's Scientific Advisory Committee, embracing the role with extraordinary dedication over a decade of tenure. He helped steer the scientific direction of our R&D portfolio, challenged us to be ambitious and rigorous, and helped ensure that the highest scientific standards remained central to our mission and day-to-day decision-making.

Nick's scientific contributions reshaped the treatment of infectious diseases and saved countless lives. His role in the development and global adoption of artemisinin-based combination therapies for malaria transformed the treatment landscape for the disease and dramatically reduced mortality across endemic regions. His work on the clinical management of severe malaria set enduring standards that still guide practice today.

Working with Nick was a privilege. With his exceptionally sharp intellect and quick wit, Nick challenged assumptions, advised with candour, and helped our teams to navigate difficult scientific and operational terrain. We are profoundly grateful for the wisdom, integrity, and humanity he brought to DNDi and our mission.

Nick's legacy will endure through the patients whose lives he improved, the scientists he inspired, and the institutions he shaped to advance science driven by public health need. He will be deeply missed, but we take comfort in the certainty that Nick's wisdom and dedication will continue to guide and inspire our work. On behalf of DNDi, we extend our heartfelt condolences to Nick's family, friends, and colleagues around the world.

A WORD OF THANKS

DNDi has delivered 14 new treatments for six neglected diseases since 2003.

We thank every DNDi supporter for their contribution to advancing our mission and are deeply grateful to the following major donors for sustaining our progress in 2025.

» For a complete list of all DNDi's donors since 2003, please visit: dndi.org/donors

PUBLIC INSTITUTIONAL SUPPORT

- Canada – International Development Research Center (IDRC)
- European and Developing Countries Clinical Trials Partnership Association (EDCTP2[1] programme) supported by the European Union
- Global Health EDCTP3[2] and its members
- European Commission Directorate General Health Emergency Preparedness and Response Authority (DG HERA) under a delegation agreement implemented by the French Development Agency (AFD)
- European Union – funding from the European Union's Horizon Europe and Horizon 2020 research and innovation programme[3]
- Germany – Federal Ministry of Research, Technology and Space (BMFTR) through KfW
- Germany – Federal Ministry for Economic Cooperation and Development (BMZ) through KfW
- Japan – Global Health Innovative Technology Fund (GHIT Fund)
- Japan – The Hideyo Noguchi Africa Prize
- The Netherlands – Dutch Ministry of Foreign Affairs (DGIS)
- Republic of Korea – The Research Investment for Global Health Technology Foundation (The RIGHT Foundation)
- Switzerland – Municipality of Corsier
- Switzerland – Republic and State of Geneva
- Switzerland – Swiss Agency for Development and Cooperation (SDC)
- Switzerland – Swiss State Secretariat for Education, Research and Innovation (SERI)
- UK – UK International Development
- Unitaid
- US – National Institute of Allergy and Infectious Diseases of the National Institutes of Health (NIAID-NIH)[4]

PRIVATE AND PHILANTHROPIC SUPPORT

- Anonymous
- Bennett Shapiro and Fredericka Foster
- Brian Mercer Trust
- Broadway Cares / Equity Fights AIDS
- The Broder Family Foundation
- Charina Endowment Fund
- Clifford N. Burnstein and Sabra C. Turnbull
- Darin Portnoy and Glenda Hersh
- Dioraphte Foundation
- Dutch Postcode Lottery – Nationale Postcode Loterij
- Gates Foundation[5]
- George H. Stout
- Instituto Imbuzeiro
- Jeffrey Nelson
- LEO Foundation via Erasmus University Medical Center
- Médecins Sans Frontières (MSF) International
- Nancy and Jesse Ishikawa
- Novo Nordisk Foundation
- Perpetual Kindness Foundation
- Peter Mensch and Anita Bitton
- The Stainman Family Foundation
- Starr International Foundation
- Wellcome

COLLABORATIVE FUNDING

- Brazil – Funding Authority for Studies and Projects (Financiadora de Estudos e Projetos - Finep) via the Foundation for Scientific and Technological Development in Health (Fiotec)
- Brazil – The São Paulo Research Foundation (Fundação de Amparo à Pesquisa do Estado de São Paulo - FAPESP) via State University of Campinas (UNICAMP)
- Spain – Spanish Agency for International Development Cooperation (AECID) via Fundación Salud Naturaleza Integral (SANIT), Bolivia

1 Grant number RIA2018CO-2516 - 5FC HIV-Crypto; RIA2019PD-2890 - ACOZI-KIDS; RIA2020S-3301 - LeishAccess; RIA2020I-3290 - VL INNO. | 2 STROGHAT, eWHORM, WINGS4FGS, IVM-KIDS, FAME. | 3 Grant agreement No 101046314; Grant agreement No 815628. | 4 Award number U19AI171399 through Memorial Sloan-Kettering Cancer Center (MSKCC). | 5 Support to HAT and onchocerciasis -INV-055656, INV-063515.

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