ANNUAL REPORT 2025

Medicines Development for Global Health | 20 YEARS

Celebrating 20 years

of commitment, innovation & collaboration

Transforming communities for a more prosperous world.

Contents

Medicines Development for Global Health acknowledges the sovereignty of the Peoples of the Boon Warrung/Woj Wurrung clan(s) of the Kulin nation of the land on which MDGH's headquarters stand, and we pay our respects to their ancestors and Elders. We are here to achieve greater equity of access to good health globally, through the development of medicines for the treatment of neglected diseases, whilst respecting the right to self-determination of First Peoples everywhere.

Potential to improve the lives of hundreds of millions of people.

Board Chair and Managing Director

2025 has been a defining year for Medicines Development for Global Health.

This year, we marked two significant milestones: the celebration of our 20th Anniversary, and the launch of the Momentum Project, the first-ever community-led Mass Drug Administration of moxidectin.

It feels fitting that the Momentum Project arrived on our twentieth year, because, in many ways, it represents the clearest expression of why MDGH was founded in the first place.

Twenty years ago, MDGH began with a simple but deeply important belief: that access to life-changing medicines should not depend on where a person lives or what they can afford. That neglected diseases, despite affecting more than one billion people worldwide, deserved the same scientific rigour, urgency and commitment as any other health challenge.

Seeing moxidectin reach communities affected by river blindness is both profoundly moving and deeply significant. It demonstrates what is possible when scientific expertise, long-term commitment and global collaboration come together in service of those too often overlooked.

While the impact numbers that we speak about are large, at the heart of our work are individuals and communities whose lives could be changed through the potential of a better medicine. The mother in Ghana who can continue to work and provide for her family without fear of losing her sight to river blindness. The child in rural Australia able to attend school free from the burden and stigma of scabies. The mother in South East Asia who can receive treatment for leprosy type 2 reaction without risking harm to her unborn child. And communities around the world who are given the opportunity to break free from the burden of diseases that perpetuate disadvantage across generations. These are the people who drive our work forward.

2025 also saw important progress across our broader portfolio.

Moxidectin was added to the World Health Organization's Essential Medicines List and included among medicines eligible for prequalification, a critical step toward expanding access globally. We also saw compelling data from the Washington University in St Louis, DOLF Project, demonstrating the promise of moxidectin as a combination therapy for lymphatic filariasis. Our second investigational medicine, dovramilast, advanced into late planning for a major multinational Phase 2b clinical trial in leprosy type 2 reaction.

None of this progress happens in isolation. To every member of the MDGH team, our research and implementation partners, funders, governments, health workers and local communities - thank you. Your commitment, resilience and belief in this mission have carried us through the inevitable challenges and complexities that come with pioneering a different model of pharmaceutical development. This is truly a global effort with global impact.

As we reflect on twenty years of progress, we also recognise how much work remains ahead. The challenges are significant, but so too is the opportunity before us. We are seeing growing momentum, stronger partnerships and increasing proof that a not-for-profit pharmaceutical model can deliver meaningful change at scale. Twenty years in, and we are only just getting started.

Mark Sullivan, AO
Managing Director

Lorna Meldrum, PhD
Chair of the Board

Celebrating 20 Years

Medicines Development for Global Health (MDGH) was founded on the belief that everyone deserves access to life-changing medicines.

Our 20th anniversary serves as both a testament to two decades of persistence and a launchpad for the impact we are poised to deliver next.

Since founding, we have conducted more than 55 R&D projects, both our own and third party. We have sponsored more than 10 clinical trials and supported at least 19 investigator-led trials, working with 300+ partners and collaborators over the years.

Our most significant achievement to date has been the development of moxidectin 2mg tablets for the treatment of river blindness (onchocerciasis), which we licensed-in from the World Health Organization (WHO) in 2014, completed its development, and secured United States Food and Drug Administration (U.S. FDA) approval in 2018 for treatment in people aged 12 years and older; followed by approval in 2025 for children as young as four. Pilot launches in Ghana and Angola have since reached more than 110,000 people by end of 2025.

While there have been many examples of not-for-profit entities working to achieve access to existing medicines across many diseases, this is the first time a not-for-profit has ever delivered its own novel medicine into the field, creating a new paradigm for how medicines are developed and delivered.

55+
R&D projects

10+
clinical trials sponsored

19+
investigator-led trials

300+
partners and collaborators

TIMELINE

2005

MDGH founded as Medicines Development Limited.

Medicines Development for Global Health

2007

MDGH starts AIDs Vaccine Project with the Massachusetts General Hospital to develop a therapeutic vaccine for the treatment of people infected with Clade C HIV-1.

2010

MDGH initiates the MDGH sponsored Phase 1 study to determine if Opal immunotherapy may have potential utility as a treatment for HIV/AIDS.

2013

MDGH and MCRI begin collaboration on the development of a neonatal oral RV3 rotavirus vaccine RV3-BB.

2014

Moxidectin license transferred to MDGH.

2018

U.S. FDA approval of moxidectin for river blindness and PRV received.

2019

PRV sold to Novo Nordisk.

Clinical evaluation of moxidectin in other neglected diseases begins: scabies, lymphatic filariasis, and soil-transmitted helminths.

2020

MDGH licenses-in a new molecule, dovramilast (CC-11050; AMG 634), from Amgen Inc to advance development as a potential treatment for tuberculosis and leprosy type 2 reaction.

2023

MDGH receives U.S. FDA Orphan Drug designation for dovramilast to treat leprosy type 2 reaction.

2025

Ghana rolls out moxidectin, a new treatment for river blindness.

Global health equity through accessible, innovative medicines.

MDGH — The Early Days

Amanda Handley, Vice President & Head of Development, reflects on the early days at MDGH.

I found myself at a crossroads in my career. After returning to Melbourne from years working in the pharmaceutical industry overseas, I was searching for work that could make a meaningful impact on global health.

Then I met Mark.

What struck me in our first conversation was how deeply he was driven by the reality of global inequity in access to medicine—that people in low- and middle-income countries can't access the medicines they need and, worse, are denied the best medicines simply because they can't afford them. Mark's vision to build a pharmaceutical company that put people before profit was something I wanted to be part of then, and it still drives me 20 years later.

In the early days, Medicines Development for Global Health was a small team in a small office, gathered around a whiteboard—there's always a whiteboard—and piling into Mark's old Valiant to get to meetings. We had a clear vision, but the "how" was still taking shape.

Initially we took on consultancy projects to provide an income stream for Medicines Development, including work on the Opal HIV vaccine technology. It was complex, some even called us crazy, but the need and potential were undeniable. That's when I realised: if you lead with the science and the need, the model can evolve around it.

The turning point came in 2012 when we committed to developing moxidectin. By its approval in 2018, we were able to step away from consultancy and fully focus on developing medicines for those who need them most.

It soon became clear our biggest challenge wasn't just scientific, it was explaining who we are. We sit outside the conventional pharmaceutical model. People hear "pharma" and think of profit, but we prioritise impact, while holding onto the industry's rigour and standards.

Seeing our medicines reach the communities they were developed for still moves me. When the first mass drug administration took place in Ghana in 2025, I watched in tears as Mark addressed the media. A moment that captured everything this journey has been about.

We've remained understated because our goal isn't prestige, it's equity of impact. Equity isn't just a value; it's part of our DNA. I often think of Mark's belief that a packet of sausages fixes everything. Whether it's a Christmas party or a Friday lunch, we're often found gathered around a grill. It keeps us grounded.

The next 20 years are about building on that foundation, bringing the same impact to people affected by leprosy, scabies, lymphatic filariasis and other neglected diseases.

I've been part of this journey from the beginning, and I feel incredibly fortunate. We didn't just build a company, we built something that makes changing the world possible.

Impact Highlights

2025 was a major year of progress and celebrations at MDGH!

From the launch of the very first community-led Mass Drug Administration (MDA) of moxidectin 2mg tablets in Ghana, to beginning trials of dovramilast in leprosy type 2 reaction and celebrating 20 years of MDGH, these milestones lay the foundation for greater impact in global health and the future of medicine development.

January 2025

The Momentum Project launched in Ghana, the first-ever community-led MDA of moxidectin. It marked the culmination of more than 25 years of work in developing moxidectin for the treatment of river blindness, initiated by the UNICEF/ UNDP/ World Bank/ WHO Special Programme for Research and Training in Tropical Disease (TDR) and Wyeth Pharmaceuticals in the 1990s.

Our contribution was recognised in February 2025 by the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, who, in his remarks to the 156th session of the WHO Executive Board, highlighted MDGH and TDR's work in the development of moxidectin.

February 2025

The U.S. FDA expands indication for moxidectin to treat river blindness in children as young as four.

April 2025

Dovramilast received clearance from the U.S. FDA to proceed with our major multinational Phase 2 clinical trial in leprosy type 2 reaction (MDGH-DOV-2001).

July 2025

A new paper published in the journal Parasites & Vectors by Medicines Development for Global Health scientists and collaborators report findings from the first paediatric clinical study of moxidectin (MDGH-MOX-1006).

Mark Sullivan's paper in the Royal College of Physicians' Future Healthcare Journal (FHJ), was published: "Rethinking Pharmaceutical Development: A Not-for-Profit Model to Address Global Health Inequities."

September 2025

WHO listed moxidectin on its Model List of Essential Medicines and Model List of Essential Medicines for Children as a therapeutic alternative to ivermectin for the treatment of river blindness (onchocerciasis) and lymphatic filariasis, and added it to its list of medicines eligible for prequalification. These steps are critical in enabling broader country procurement and access.

October 2025

The Death to Onchocerciasis and Lymphatic Filariasis (DOLF Project) at Washington University in St Louis published their data in The Lancet Infectious Diseases revealing that the majority of study participants receiving moxidectin and albendazole (MoxA) combination treatment remained free of worm larvae that cause lymphatic filariasis even after 24 months, suggesting long-lasting protection with just one treatment.

November 2025

In collaboration with the Global Institute for Disease Elimination (GLIDE), we organised a symposium at the American Society of Tropical Medicine and Hygiene (ASTMH) Annual Meeting in Toronto. Country leaders and collaborators came together to discuss the introduction of moxidectin, an alternative treatment for river blindness, and to reflect on its path to scale-up to support elimination of transmission.

December 2025

The second round MDA of moxidectin in Ghana was conducted, including an expansion into a second district. More than 110,000 Ghanaians received a dose of moxidectin.

We celebrated 20 years of commitment, innovation and collaboration at the State Library of Victoria. This achievement would not have been possible without the dedication of our team, funding partners, collaborators, and a shared vision of bringing access to medicines to the world's most disadvantaged communities.

Our core skill is pharmaceutical development and regulatory science in the context of global health.

Portfolio Update

We are currently developing two medicines: moxidectin and dovramilast. Together, these medicines are targeting more than seven different diseases that collectively impact more than 1 billion people.

Our core skill is pharmaceutical development and regulatory science in the context of global health, bringing a novel approach to addressing health inequity. We are developing moxidectin and dovramilast for at least seven underserved diseases of global importance.

Moxidectin is approved in Ghana and USA for the treatment of river blindness. We are working to extend the use of moxidectin to treat other neglected diseases. Phase 2 clinical trials on the use of moxidectin in scabies completed in 2024, and a Phase 3 clinical trial for lymphatic filariasis will begin in Fiji in 2026. In addition, clinical evaluations of moxidectin in treating strongyloidiasis, loa loa, and soil transmitted helminths also show potential.

Beyond moxidectin, we continue to progress the development of our second medicine, dovramilast, for the treatment of leprosy type 2 reaction as well as for complications of tuberculosis (TB), including post-TB lung disease, TB meningitis and TB-/HIV-AIDS-/cryptococcal-mediated immune reconstitution syndrome.

In addition, we spent much of 2025 reviewing additional clinical assets and disease indications to add to our portfolio. We also continued our collaborations with other organisations to help advance additional medicines, including the neonatal oral rotavirus vaccine (RV3-BB) with the Murdoch Children's Research Institute.

PROGRAM UPDATE

After trachoma, river blindness is the second leading cause of blindness from infection.

Moxidectin in (Onchocerciasis) River Blindness

13 MILLION
people infected [2]

250+ MILLION
at risk [3]

15.75 MILLION
suffer skin disease or blindness [4]

Accelerating progress toward elimination

Despite significant progress, existing treatment strategies have been inadequate to achieve the elimination of river blindness. The challenge remains vast: nearly 250 million people continue to require preventive chemotherapy for river blindness.

In 2025, MDGH reached a defining milestone with the rollout of moxidectin, the first alternative treatment for river blindness approved in over 30 years. Moxidectin is superior to ivermectin in the treatment of river blindness and has a similar safety profile.[1]

“Every day I’m inspired by the dedication and talent of the fabulous team at MDGH. The many challenges we have faced over almost a decade to reach this milestone has stretched me to be the best collaborator and leader I can be. This award is a particular honour because it acknowledges not only my role, but our amazing achievement as a team.”

Sally Kinrade
MDGH Vice President & Project Leader for Onchocerciasis & Lymphatic

HIGHLIGHT

Sally Kinrade was an honouree of the 2025 BioMelbourne Network Women in Leadership Awards. As the recipient of The Inspiring Leadership Award – Making it Happen, Sally is recognised for her exceptional leadership in driving impactful projects, partnerships, and collaborative initiatives.

Moxidectin gains momentum

The Momentum Project, the first-ever community-led MDA of moxidectin, launched in Twifo Atti-Morkwa, Ghana in January 2025. Delivered in partnership with the Ghana Health Service. By the end of 2025 the program had reached more than 110,000 people.

During the year, World Health Organization added moxidectin to its Model List of Essential Medicines and Model List of Essential Medicines for Children as a therapeutic alternative to ivermectin for the treatment of river blindness (onchocerciasis) and lymphatic filariasis. The decision followed a comprehensive review by the World Health Organization Expert Committee on the Selection and Use of Essential Medicines and represents the culmination of extensive scientific evaluation and demonstration of public health value.

This decision by the World Health Organization acts as a catalyst for access. It signals the importance of moxidectin and encourages countries to add it to their own national essential medicines lists. In turn, enabling wider uptake, distribution, and use in endemic countries.

- Expanding treatment access for all relevant ages.

Use of moxidectin in children

Moxidectin was first approved in 2018 for use in people over 12 years and older. However, young children can also be bitten by the black flies transmitting the *onchocerca volvulus* worm, the parasite that causes river blindness. If left untreated, they will also develop the debilitating effects of the infection, particularly affecting their skin and eyes. Children can also act as a reservoir for the disease, contributing to continued transmission in affected communities.

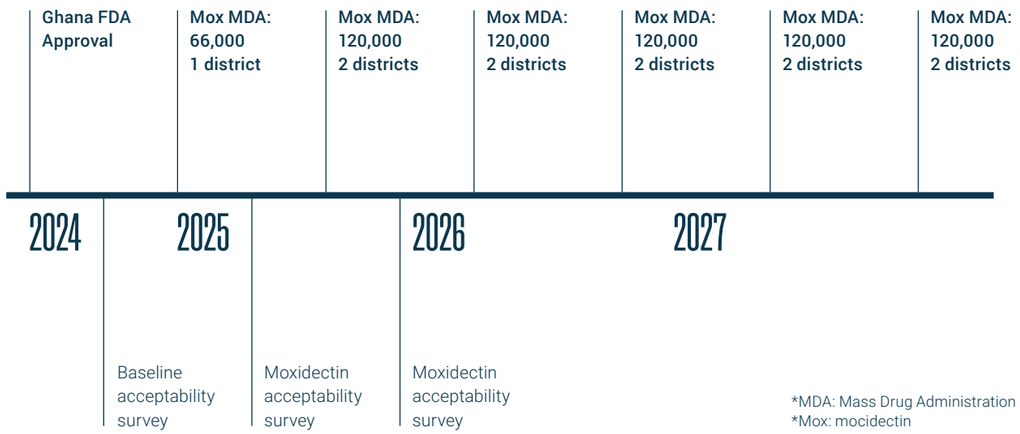
MDGH conducted a paediatric study which assessed the safety and pharmacokinetics of moxidectin in children aged 4 to 17 years, with the aim of identifying appropriate doses for those under 12. This was an important step toward expanding treatment access for all relevant ages in MDA programs. Findings were published in 2025, which helped inform recent regulatory approvals by the U.S. FDA and Ghana Food and Drugs Authority for use of moxidectin in children as young as four years old.

Where to next?

In parallel to the moxidectin MDA, researchers from Ghana's University of Health and Allied Sciences (UHAS) and the Bruyère Research Institute in Canada are conducting a social research study to evaluate the acceptability and feasibility of moxidectin distribution through community-based MDA.

We are committed to ensuring moxidectin reaches communities that need it the most. We plan to make moxidectin accessible at the cost of production and supply for low- and middle-income countries, and we will continue working with partners to make moxidectin available without cost to river blindness communities wherever possible.

Timeline of the Momentum project in Ghana



Widespread access to moxidectin has the potential to accelerate ongoing disease elimination efforts and improve health outcomes for millions of individuals in endemic regions.

PROGRAM UPDATE

- Current treatments for lymphatic filariasis are not suitable for co-endemic countries.

Moxidectin in Lymphatic Filariasis

485+

MILLION
people are at risk across 39 countries [5,6]

36

MILLION
people live with chronic disease manifestations

1.31

MILLION
years of healthy life are lost each year worldwide because of the disease [2]

Accelerating elimination

Lymphatic filariasis (elephantiasis) is caused by parasitic worms spread by infected mosquitoes. This painful and debilitating disease affects the lymph system, leading to severe swelling, chronic pain and long-term disability, often accompanied by social stigma and financial hardship.

More than 657 million people across 39 countries still need treatment for lymphatic filariasis. While the burden is global, the challenges to elimination vary by region. In areas co-endemic with onchocerciasis, ivermectin in combination with diethylcarbamazine (DEC) and albendazole (IDA) cannot be used due to severe reactions caused by DEC. In other settings, while treatment is available, it is not delivering the progress needed to achieve elimination as a public health problem.

"Efforts to eliminate lymphatic filariasis in parts of Africa are falling behind because DEC-containing regimens aren't safe to use in mass drug administration programs where another disease, onchocerciasis (river blindness), also exists. A safer, equally effective alternative is urgently needed so these communities aren't left behind."

Sally Kinrade
MDGH Vice President & Project Leader for Onchocerciasis & Lymphatic

Progress

We are evaluating moxidectin-based regimens to help accelerate the elimination of lymphatic filariasis as a public health problem, particularly in co-endemic areas with onchocerciasis, in Africa as well as other regions where transmission remains persistent.

Results from a Phase 2 clinical study (NCT04410406) in Côte d'Ivoire published in 2025 showed that, at 12 months, a single dose of moxidectin in combination with albendazole albendazole (MoxA) was superior to ivermectin in combination with albendazole (IA) for achieving sustained clearance of microfilaremia in people with lymphatic filariasis infections, with similar efficacy to DEC-containing combinations.[7] Moxidectin combination regimens were well-tolerated in lymphatic filariasis infected patients, with a safety profile comparable to ivermectin-containing regimens.[7] A co-sponsored study by Kumasi Centre for Collaborative Research in Tropical Medicine (Ghana) and the National Institute for Medical Research (Tanzania) (ISRCTN15320064) continued in 2025 across Ghana and Tanzania, comparing MoxA with IA for regional elimination of lymphatic filariasis.

A DFAT-funded, MDGH-sponsored, Phase 3 clinical study will commence in 2026 in Fiji, assessing the safety and efficacy of MDA with moxidectin versus ivermectin in combination with DEC and albendazole (MoxDA vs IDA) for lymphatic filariasis and other neglected tropical diseases (NCT07159373).

PROGRAM UPDATE

Moxidectin in Scabies

- Scabies can be found worldwide and is more prevalent in tropical and under-resourced settings.

- Dr Victoria Ryg-Cornejo, Project Leader for the scabies program, meeting with one of the study Investigators, Dr Elizabeth Barranco and her team at CAIMED Center, Ponce Research Institute, Puerto Rico.

Progress

In partnership with Atticus Medical, we are advancing the development of moxidectin as a single-dose oral treatment that would significantly simplify the treatment of scabies, lowering the risk of transmission and improving patients' quality of life.

'Following successful Phase 2 clinical trials, with results to be published shortly, we are actively seeking partners to help advance this promising new treatment option for use in both adults and children.

Paediatric formulation development has also commenced to support access to a broad patient population.

400+
MILLION
people affected each year [8]

200+
MILLION
cases at any one time [9]

5.3
MILLION
years of healthy lives lost due to disease [10]

Developing a simplified scabies treatment

Scabies is one of the most common contagious skin conditions, affecting people of all ages and backgrounds, worldwide, with more than 200 million people infected at any given time.

Far from a benign skin condition, scabies can cause a cascade of serious health complications that include bacterial infections, kidney disease and rheumatic heart disease. These complications contribute to substantial but under-recognised morbidity and mortality, and pressure on already over-burdened healthcare systems.

The burden of scabies infection extends to a person's whole life, impacting sleep and mental health which leads to time away from work and school. Affected individuals and communities often face stigmatisation, and it presents financial burden with the cost of accessing treatments. For marginalised populations scabies perpetuates the cycle of poverty and disadvantage.

One of the biggest challenges for treatment is that options remain outdated and poorly suited to real-world, low-resource setting use. Current treatments require repeated dosing and strict adherence, and which are poorly suited to treat entire families or communities. Treatment challenges are particularly acute for children, who bear a disproportionate burden of disease yet have limited access to tolerable and practical treatment options.

"We are developing moxidectin as a new single oral dose scabies treatment designed explicitly to address concerns with existing treatments, to be delivered affordably within the global health setting. Moxidectin is a tool that has the potential to enhance patient compliance, alleviate suffering and contribute to reducing prevalence and transmission of scabies."

– Dr Victoria Ryg-Cornejo, Project Leader, Scabies

PROGRAM UPDATE

- Leprosy type 2 reaction carries stigma and can lead to permanent deformities, affecting a person's whole of life.

Dovramilast in Leprosy Type 2 Reaction

200+

THOUSAND
new cases of leprosy are reported each year [12]

45%

of leprosy patients are women and children [12]

50

THOUSAND
people are estimated to be at risk of leprosy type 2 reaction each year [13]

Advancing treatment for improved outcomes

Leprosy type 2 reaction can occur as a complication of leprosy, most commonly in patients who are receiving multi drug therapy but can occur before treatment or long after treatment is completed.

Patients typically experience fatigue, fevers and painful skin lesions, which can appear on the face and limbs. Consequences can be acute, recurrent or chronic, in the worst cases leading to permanent nerve damage, deformities and limb amputation, and even death. The disease causes stigma and can impact a patient's ability to attend school or work, and provide and care for their family, only compounding the challenges already faced by the disadvantaged people that leprosy commonly affects.

Current therapies for leprosy type 2 reaction, while effective, often cause significant side effects and may not be suitable for everyone.[11] Prednisolone requires prolonged use and is linked to serious side effects, with many patients relapsing as it's tapered. Thalidomide is not suitable for children and pregnant women.

Progress

Dovramilast offers the potential for more effective, better-tolerated, and easier-to-administer alternative treatment for people affected by leprosy type 2 reaction.

Following Orphan Drug Designation by the U.S. FDA in 2023 the Project Team has been actively preparing for a Phase 2 study, set to commence in 2026 with completion expected in early 2027, across the U.S., Philippines, Indonesia, Madagascar, Benin and Côte d'Ivoire. These trials will evaluate optimal dosing, safety, and the effectiveness in adults with moderate to severe acute or recurring leprosy type 2 reaction.

If studies are successful, the target is for regulatory approval by 2030.

> "Having met people suffering from leprosy type 2 reaction underscored for me how urgently better medicines are needed for this devastatingly debilitating disease. Our clinical studies will advance progress towards longstanding efforts for new treatment options to improve the lives of those suffering from leprosy type 2 reaction"

Lydia Lannazzo PhD PMP MBA
Associate Director, Project Leader, Leprosy type 2 reaction

Access to medicines helps build a fairer, healthier, and more prosperous world.

Other Disease Areas

Expanding therapeutic potential

In addition to our four primary disease areas, we continue to explore the potential for moxidectin and dovramilast to improve treatment outcomes in other disease areas:

Soil-transmitted helminths

We are evaluating moxidectin as a more effective treatment for soil-transmitted helminths in endemic regions. A Phase 2/3 study in Tanzania, in collaboration with the Swiss Tropical and Public Health Institute (Swiss TPH), revealed moxidectin-albendazole (MoxA) combination therapy in school-aged children is superior to albendazole alone in terms of cure rate and egg reduction for soil-transmitted helminths.

In 2025, the Kirby Institute initiated a five-year cluster-randomised trial in Angola, to compare the efficacy of moxidectin and ivermectin delivered through mass drug administration in reducing the prevalence and intensity of river blindness, soil-transmitted helminths, and scabies.

A more effective and longer-lasting treatment could reduce both the prevalence and severity of infection, enabling communities held back by this disease to thrive.

Loiasis

A major barrier to eliminating river blindness in Central Africa and West Africa is its co-endemicity with loiasis, a filarial infection that puts more than 40 million people at risk. Individuals with high infection with Loa loa baby worms can develop severe, potentially fatal encephalopathy following treatment with ivermectin, the cornerstone of mass drug administration (MDA) program.

To address this challenge, MDGH and its collaborators are evaluating moxidectin for use in areas co-endemic with both river blindness and loiasis parasitic worms, for whom no MDA option currently exists. One clinical study has been completed,[14] and two Phase 2 studies are underway or commencing in Gabon, Cameroon, and the Republic of the Congo to evaluate the safety, tolerability, and efficacy of moxidectin across a range of Loa loa infection intensities.

Strongyloidiasis

Treatment options for strongyloidiasis are limited, with ivermectin as the gold standard and alternatives like albendazole less effective in single doses. In partnership with the Swiss TPH, we supported trials in Cambodia and Laos showing moxidectin to be as effective as ivermectin in treating chronic strongyloidiasis.

We are leading a Phase 3 trial in Fiji (MDGH-MOX-3003), funded by the Australian Government, comparing the impact of MDA with moxidectin in combination with diethylcarbamazine, and albendazole versus with ivermectin in combination with diethylcarbamazine and albendazole on the community prevalence of strongyloidiasis, measured by change in seroprevalence. This study is expected to begin in mid-2026.

Post-tuberculosis lung disease

We are investigating the potential of dovramilast as a host-directed therapy for the treatment of post-tuberculosis lung disease (PTLD). PTLD is an increasingly recognised but neglected global health condition affecting millions of people who have successfully completed tuberculosis (TB) treatment. While TB programs focus on microbiological cure, up to 50% of TB survivors are left with chronic respiratory impairment and reduced lung function. People suffering from PTLD face numerous ongoing health challenges including chronic breathlessness, recurrent infections, reduced physical capacity, and increased mortality.

Dovramilast has shown promising early results in the clinic as a host-directed therapy in pulmonary TB, suggesting it has better outcomes such as reduced lung impairment. We are actively engaging with stakeholders in this space to understand the potential of dovramilast in the treatment of PTLD, as well as other complications of TB infection such as TB meningitis, and TB-/HIV-associated Immune Reconstitution Inflammatory Syndrome.

Together we can eliminate neglected diseases.

Thanks to Our Supporters

Our work and its impact on global health is only made possible through productive partnerships with industry, research institutes, governments, impact investors and donors.

We are grateful to everyone who supports the development of and access to our medicines. Thank you.

The following list of supporters includes those who gave $1,000 or more in funding to MDGH in 2025 through donations, grants, impact investment and in-kind contributions:

Amgen, Inc
Atticus Medical Pty Ltd
Australian Government
The Cubit Family Foundation
Gates Foundation
Givewell
Hibou Holdings Pty Ltd
Hibou Holdings Foundation
Kladne Nuly Foundation
Leona M. and Harry B. Helmsley Charitable Trust
Lonza Group AG
Phastar
Salt Catalyst Pty Ltd
Special Programme for Research and Training in Tropical Diseases (TDR)
The European and Developing Countries Clinical Trials Partnership
The Luxembourg National Research Fund
I and D Gust Family Trust

The role of philanthropy in medicine

At Medicines Development for Global Health, impact sits at the heart of our mission. We know that a new medicine has the potential to create catalytic change for entire communities.

When the burden of disease is removed from a community, its potential is unleashed. Children can return to school, parents can return to work, and local economies have the opportunity to flourish. Indeed, access to new medicines can break cycles of poverty for billions of people and reshape a future of improved global health.

Grants, impact investments and philanthropic gifts are critical to advancing our medicine development programs and providing access to new medicines.

We are grateful to our many partners and supporters who share our vision.

If you would like to join us and help build a fairer, healthier and more prosperous world, we invite you to connect with our team via philanthropy@mdgh.com.

Yours in good health

Emily McCaffrey
Head of Philanthropy

"Why do we support MDGH? It's easy. They have decades of experience and a passion to make a difference to neglected communities, along with a track record of success in both product development and innovative financing structures. What's not to like?"

Mark Cubit, The Cubit Family Foundation

Throughout 2025, we have continued to engage with global health partners and collaborators in support of our mission. This included sponsoring the American Society of Tropical Medicine and Hygiene (ASTMH) symposium, showcasing our short film 'The Momentum Project' at the Global Health Film Festival 2025, and attending the Association of Australian Medical Research Institutes (AAMRI) Annual Convention.

"We are committed to supporting Medicines Development for Global Health in changing the trajectory of river blindness through the development of moxidectin, a next-generation treatment with the potential to accelerate progress towards elimination in overstretched health systems."

Walter Panzer, Trustee, Helmsley Charitable Trust

DEDICATED TEAM

Addressing the unmet needs of disadvantaged people worldwide.

Leadership & Governance

We are governed by several bodies which oversee portfolio programs and operations, including the Board of Directors, Leadership Team, Program Review Committee, Development Committee, Access Advisory Committee, and Project Teams. Our experienced and dedicated team works collaboratively and effectively to lead MDGH towards addressing the unmet medical needs of disadvantaged people worldwide.

Board of Directors

The Board of Directors is the highest decision-making body in MDGH and is comprised of predominantly independent Directors (themselves governed by the Board Charter), who are experienced in pharmaceutical development, risk management, corporate compliance.

Dr Lorna Meldrum
Chair of Board

Professor (Hon.) Mark Sullivan, BSc, AO
Managing Director

Professor Andrew Wilks
Non-Executive Director

David McGregor, BSc, CA
Non-Executive Director

Daren Armstrong, BSc, LLB (Hons) LLM
Company Secretary

Leadership Team

The Leadership Team meets biweekly to consider and make decisions in relation to corporate operational matters, emerging risks and opportunities.

Professor (Hon.) Mark Sullivan, BSc, AO
Managing Director

Brett Carter, BSc, MBA, GAICD
Chief Operating Officer

Amanda Handley, BSc, MPH
Vice President, Head of Development

Danielle Smith, BSc, PhD
Vice President & Global Head of Regulatory Affairs

Sally Kinrade, BPharm, MPH
Vice President, Project Leader Onchocerciasis & Lymphatic Filariasis

Janine Pickering, BSc, PhD
Head of People

Program Review Committee

The Program Review Committee is responsible for scientific portfolio review and oversight of R&D teams' progress, budgets and risk management and provides guidance and monitoring with respect to annual team goals and strategic imperatives. The committee meets monthly and in 2025 consisted of:

Professor (Hon.) Mark Sullivan, BSc, AO
Managing Director

Brett Carter, BSc, MBA, GAICD
Chief Operating Officer

Amanda Handley, BSc, MPH
Vice President, Head of Development

Danielle Smith, BSc, PhD
Vice President & Global Head of Regulatory Affairs

John Lambert, BSc, PhD
General Manager, Atticus Medical Pty Ltd

Development Committee

The Development Committee is a group of external product development experts who provide their input and guidance into the medicine development programs on an annual or biannual basis. The committee consists of:

Joe Camardo MD (Chair), George Morstyn MD, Jerry Fisher PhD, Fran Brown PhD, Ralph Smalling MS, Brian Kearney PharmD, Craig Rayner PharmD

Members

As a not-for-profit, MDGH has members, rather than shareholders:

Richard Fiora, BA, LLB
Professor (Hon.) Mark Sullivan, BSc, AO
Professor Ian Gust, AO

Medicines Access Committee

The Medicines Access Committee is a strategic and advisory body which informs and guides the access activities for MDGH medicines to ensure that they respond to the needs of target end users. The committee consists of:

Prof (Hon.) Helen Evans AO (Chair), Shreehari (Shree) Acharya, Dr Deborah Atherly, Kelvin Storey, Michelle Childs, Professor Leanne Robinson, Dr Natalie Carvalho, Michael Nunan, Dr Patrick Lammie, Simon White, Dr Vipul Chowdhary.

The Project Team

The Project Team is at the heart of MDGH's execution of its medicine development programs, in line with industry best practice. Each project has an appointed project leader and, if warranted by the stage and complexity of the program, a development manager.

Project Leadership within each project team is responsible for setting the strategy and ensuring the execution of the agreed workplan and budget. Programs have clearly defined milestones and 'Go-/No-Go' decision points monitored by the Project Leader. The Project Team model ensures that our programs are resource-efficient and cost-effective, thereby reducing the expense of achieving regulatory approval for new medicines. Specifically, it means that MDGH operates with a deliberately lean in-house team of experts, supplemented only with targeted input from leading global consultants and contractors as needed across the development pathway.

FY2025

Financial Summary

Statement of Income & Expenditure

For the Year Ended 30 June 2025

	2025 $	2024 $
REVENUE BY TYPE		
Revenue from research & development fees	6,189,850	5,690,710
Grants	6,861,795	2,778,793
Donations	103,589	1,575
Investment income	559,153	456,553
Foreign currency / Other gains	1,585,613	775,583
Total Revenue	**15,300,000**	**9,703,214**
USE OF FUNDS		
Research and development project costs	8,402,384	5,137,896
Employee benefits expense, including R&D & corporate	5,113,649	4,942,407
Administration and other	1,847,198	1,482,090
Investment related expenses	1,807,354	1,609,709
Total Expenses	**17,170,585**	**13,172,102**

Total Operating deficit for FY2025: $(2,123,188)
Total comprehensive deficit for FY2025: $(1,870,585)

Consolidated Statement of Financial Position

As at 30 June 2025

	2025 $	2024 $
CURRENT ASSETS		
Cash and cash equivalents	10,344,097	9,906,259
Trade and other receivables	1,266,420	546,099
Financial assets	441,333	666,213
Other assets	73,640	25,403
Total Current Assets	**12,125,490**	**11,143,974**
NON-CURRENT ASSETS		
Financial assets	16,853,453	15,142,977
Property, plant and equipment	99,048	87,231
Right-of-use assets	694,129	816,622
Investments accounted for using the equity method	5,428,725	7,158,939
Total Non-Current Assets	**23,075,355**	**23,205,769**
Total Assets	**35,200,845**	**34,349,743**
LIABILITIES		
CURRENT LIABILITIES		
Trade and other payables	1,689,542	1,730,460
Lease liabilities	123,665	112,551
Other liabilities	9,185,388	7,107,286
Provisions	641,967	486,444
Total Current Liabilities	**11,640,562**	**9,436,741**
NON-CURRENT LIABILITIES		
Borrowings	3,250,000	2,500,000
Lease liabilities	745,886	869,551
Provisions	288,815	397,284
Total Non-Current Liabilities	**4,284,701**	**3,766,835**
Total Liabilities	**15,925,263**	**13,203,576**
NET ASSETS	**19,275,582**	**21,146,167**
MEMBERS' EQUITY		
Reserves	1,403,666	975,825
Retained earnings	17,871,916	20,170,342
TOTAL EQUITY	19,275,582	21,146,167

Consolidated Statement of Cash Flows

FortThe Year Ended 30 June 2025

	2025 $	2024 $
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from grants and research activity	14,266,791	15,122,622
Payments to suppliers and employees	(14,741,467)	(10,949,189)
Interest received	169,030	13,074
Financial costs	(196,405)	(145,619)
Income tax paid	–	–
Net cash provided by (used in) operating activities	**(502,051)**	**(4,040,888)**
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property, plant and equipment	(25,751)	(14,633)
Investment income	559,153	456,553
Investment expenses	(77,140)	(74,316)
Net Proceeds from disposal of (Purchase of) investments	(153,822)	1,559,104
Net cash provided by (used in) investing activities	**302,440**	**1,926,708**
CASH FLOWS FROM FINANCING ACTIVITIES		
Receipts from interest bearing loans	750,000	450,000
Repayments of Lease Liabilities	(112,551)	(102,130)
Net cash provided by (used in) financing activities	**637,449**	**347,870**
Net increase (decrease) in cash held	437,838	6,315,466
Cash at beginning of financial year	9,906,259	3,590,793
Cash at end of financial year	**10,344,097**	**9,906,259**

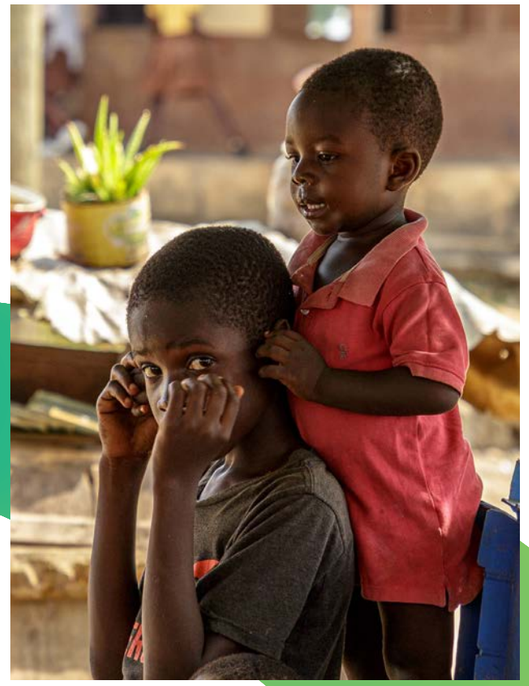
End notes

The above financial summary is based on Medicines Development for Global Health's audited financial statements, audited by Kidmans Partners. Detailed financial reports are available on the Australian Charities and Not-for-profits Commission website (click here). Medicines Development for Global Health is incorporated in Australia (Australian Company Number 116 977 523) and registered as a charity with the Australian Charities and Not-for-profits Commission, making it a Deductible Gift Recipient (DGR, type 1). Our affiliate offices are also registered charities in the United Kingdom (Medicines Development for Global Health Limited, a UK Charitable Incorporated Organisation (CIO) with registered charity number #1200620) and United States (Medicines Development for Global Health, Inc., a 501(c)(3) tax-exempt charity).

- Local partners coordinate programs to best meet the needs of their communities.

Our Model

Our business model prioritises impact over profit.



We have been self-funded from the outset and, as such, has been independent of major philanthropic funders, governments and companies. We channel our resources to where they matter most, and with no shareholders to support, we re-invest surplus to expand the scope of our work and deepen our impact.

By focusing on medicines already in the clinical development phase, we increase the probability of success, shorten the time to impact, and minimise the potential financial loss due to failure. After development we shepherd our medicines through the relevant regulatory pathways and hold and maintain the respective authorisations to ensure access by those who need the medicines most. Where possible we use innovative financing structures to leverage opportunities to achieve a financial return. This allows us to attract impact investment and reduce donor dependency.

Over the past decade, for every dollar received in grants or philanthropy, we have raised approximately eight dollars through impact investment and other innovative financing mechanisms.

By focusing on medicines already in the clinical development phase, we increase the probability of success, shorten the time to impact, and minimise the potential financial loss due to failure.

Group structure

We have two subsidiaries, both registered charities in their registered countries:

Medicines Development for Global Health Limited (company number 09622645) of Cambridge, United Kingdom and Medicines Development for Global Health, Inc., of New Jersey, USA.

Partnerships

We have a 39% ownership stake in Atticus Medical Pty. Ltd., an Australian for profit, for purpose company which holds high-income country rights to moxidectin. Atticus was established in 2019, as a joint-venture between Medicines Development for Global Health and the Global Health Investment Corporation using part of their respective proceeds of the 2019 sale of a priority review voucher awarded by the U.S. FDA. Atticus is directed and governed by its own board with representative directors from each of the founding organisations.

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If you would like to partner with us and help advance our work, please contact us:

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