adi australian doctors international

Working for a healthier PNG

ANNUAL REPORT 2017/18

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Infection control training in New Ireland

Dr Peter Macdonald
PRESIDENT'S REPORT

"ADI's vision and mission are based on our commitment to the UN Declaration of Human Rights, Article 25, and our application of our rights-based approach to health. This is central to our work in Papua New Guinea (PNG) "

Message from our President

ADI's vision and mission are based on our commitment to the UN Declaration of Human Rights, Article 25, and our application of our rights-based approach to health. This is central to our work in Papua New Guinea (PNG) where we partner with provincial governments, corporations and faith-based organisations to deliver and strengthen primary health services in rural and remote communities. Article 25 also emphasises the importance of maternal health and ADI with funding from our donors has significantly expanded its family planning services.

This has been a year of increased collaboration with corporations and other non-government organisations- Horizon Oil (Western Province implementing partner), Becton Dickinson (New Ireland Province), and Marie Stopes (Family Planning).

Compliance has loomed large for ADI this year with our five year Australian Government (DFAT) Base Accreditation due for renewal in 2019. ADI has made the decision to apply for a higher level of DFAT accreditation which, if successful, would mean increased funding from the government and more opportunities for expanded service delivery. ACFID, the umbrella organisation for overseas aid organisations, has introduced a much more demanding level of compliance required for membership this year.

With Colin Plowman, a fellow ADI Director, I undertook one of my regular visits to PNG in February this year. We spent time in Port Moresby meeting with the PNG Prime Minister, Hon Peter O'Neill, PNG Minister for Health, Hon Sir Dr Puka Temu, and other government officials. We then visited our program in Kiunga, Western Province, as guests of Bishop Gilles Cote, the Bishop of Daru-Kiunga. Our work is only possible through our partnerships in PNG: our implementing partners are the Diocese of Daru-Kiunga in Western Province and the New Ireland Provincial Government in that Province. Horizon Oil who have been corporate funders in North Fly, Western Province, for more than five years are now also implementing partners as we include a number of government villages and aidposts, which have never previously had a visit by a doctor, in our Western Province schedule.

This time last year there were seven members of the ADI Board. At the time of writing there are now eleven and I am pleased to welcome Boronia Foley, Virpi Tuite, Louise Walker and Richard Schroder to our Board. Expansion of the Board is in keeping with ADI's desire to deliver more services within PNG and possibly other areas of the Pacific. Our new Board members bring a wide range of valuable knowledge and experience in the corporate, government and not-for profit sectors. All the Board and Committee members have played an important role in the Accreditation process and I thank them for their service which ensures a bigger and brighter future for ADI.

ADI welcomed a new CEO in 2018, Dr Klara Henderson, who has a strong academic background and has worked with high-level organisations such as the WHO and the Gates Foundation. Klara was known to ADI as she had previously completed our 5-year independent evaluation of the New Ireland patrol and in-service program. She has very quickly integrated an enthusiastic work ethic with the staff, volunteers and Board members which has contributed to meeting the deadline for our Accreditation submission. I would like to thank Anne Lanham who filled in as Acting CEO in the last quarter of 2017 and all the staff and volunteers for their continuing commitment to ADI.

Dr Peter Macdonald
OAM MBBS MRCGP DA DRCOG
ADI President

OUR IMPACT IN PNG 2017/18

We demonstrate our commitment to upholding the universal right to healthcare by working with local partners to provide and strengthen health services in rural and remote areas.

100% of communities we visit are **remote**

= over **4** hours travel by boat or 4WD

68% coverage of Health Facilities

ACCESS TO HEALTH FOR REMOTE COMMUNITIES

209 patrol days

24,000 clinical services provided

PUBLIC HEALTH EDUCATION FOR COMMUNITY

10,600 community members attended public health education

79% of communities in our patrol catchment area received **public health education**

237 HOURS OF public health education

TRAINING HEALTHCARE WORKERS

61% OF **HEALTHCARE WORKERS** from ADI Health Partners in PNG received training from a doctor or health educator

168 **HEALTHCARE WORKERS** trained = 61% of HCWs in patrol catchment area

360 HOURS of case based **training delivered** to healthcare workers

31% in New Ireland of remote HCWs attended in-service training this year

over **50%** of HCWs receiving training come from remote areas

DISABILITY INCLUSIVENESS

1,400 people received physiotherapy

339 pairs of glasses supplied

173 people with disability received clinical services

FAMILY PLANNING

92% of patrols have a family planning health care worker

21% of rural HCWs complete family planning in-service training

92% of communities in our patrol catchment area receive family planning education

778 couple-years of protection

47% of multidisciplinary health patrol team are women

53% OF clinical services FOR **female** patients

GENDER EQUITY

57% of PNG personnel seconded from our partners to work with ADI are female

CAPACITY BUILDING

83% OF program positions filled by PNG health partner staff

Dr Ganam Namen on patrol

Why are we in PNG?

By many development and health measures PNG keeps company with the poorest performers, countries like Afghanistan, Zimbabwe and Sudan – countries regularly in the news for all the wrong reasons.

The 2018 Human Development Index reports PNG for 2017 to be in the lowest quintile on its composite metric covering: life expectancy, expected years of school and GDP per capita. It is ranked 153 out of 189 countries. This represents a drop in rank since 2012 (-1), and puts PNG slightly above Syria but below Solomon Islands – change has slowed since the 1970s. In 1950 PNG's life expectancy was just 38 year and women were on average having 6.2 babies, by 1975 life expectancy had jumped to 55 years, but women were still having many babies (6). At the turn of the century life expectancy increases had slowed, rising by only 2.7 additional years to 57.6 years, and women were on average having less children (4.5 children). In 2018 we see that if you are born today in PNG you will expect to live until just after your sixty-fifth birthday. An expectation more in line with those born in African countries, than Asian. And women are today having 3.5 babies – on par with countries like Kenya, Zimbabwe, Ghana and Solomon Islands. The average life expectancy worldwide is now 72, in Australia it's 82.9 years. The number of babies per woman world average is now just below 2.5 babies per woman.

The single factor that has a strong connection with large families is extreme poverty. PNG's GDP per capita sits at PPP$2,800 (or more simply put about $7 a day). 3.8% of GPD is spent on health. In Australia it's 9.4%. 87% of people live rurally, and most live a very simple life – subsistence farming, no electricity in their homes, the toilet is outside their house, they spend many hours a week collecting clean drinking water and they are not in the position to save any money.

PNG is Australia's nearest neighbour and the country that also served as the frontline of Australia's defence during WWII. PNG has been in the news more than usual this year. In February PNG suffered an earthquake seeing 160 people killed, many more injured and thousands displaced and we see ripple-on effects with many families, who seven months down the track, still struggling to recover from related damage to their water supply, housing, health facilities and even to re-establish the family vegetable garden. This results in malnutrition, drops in education attendance and overall a decline in health for these communities.

The second reason PNG is included in world news is the outbreak of circulating vaccine-derived poliovirus notified to WHO on the 22nd May 2018. The PNG Government along with partners WHO and UNICEF is working to undertake appropriate measures in line with the requirements under the temporary recommendations of the International Health Regulation's (IHR) Emergency Committee.

Is there a need to be there now? Yes. Is there a moral obligation to be there? Yes. Is there a health security and neighbourhood support reason to be there? Absolutely!

The World Health Organisation (WHO) ranks PNG as having the worst health status in the Pacific region, at 153rd of 189 countries on the United Nation's Human Development Index. Australia ranks third.

What do we do in PNG?

We partner with local healthcare providers to reach remote communities in need of health services, focusing on the areas of greatest need. We create teams of healthcare workers with our partners: to build a patrol team whose composition meets our ideal definition; to build the capacity of our healthcare provider partners; to meet the health needs of the community and to fill the educational skill gaps of the cohort of healthcare workers on the remote frontline of health.

ADI identifies and recruits volunteer doctors for placement in PNG to join with partners in this work. We also identify partners to develop and deliver educational content for in-depth training courses that meet the health and skills gaps we identify on remote patrols. We operate within the framework of the PNG's National Health Plan (2010-2020) and other overarching policies. We create public-private-philanthropic partnerships that build on member strengths and that leverage our proven track record in PNG's remote areas utilising our robust partnership, program and project management tools. We uphold high standards in our policies and practices, adhering to ACFID's Code of Conduct and those of the Australian Government's Australian NGO Cooperation Program.

About PNG at a glance

8 million population

87% rural population

DTP3 immunisation coverage **62%**

Life Expectancy **65**

GDP per capita USD **$7** per day

under 5 mortality rate per 1,000 live births **54**

maternal mortality rate **=733*** per 100,000 live births

1 doctor for every **17,068** people + **1** nurse for every **2,270** people

*Source: PNG National Statistical Office 2006.

Where we work in PNG

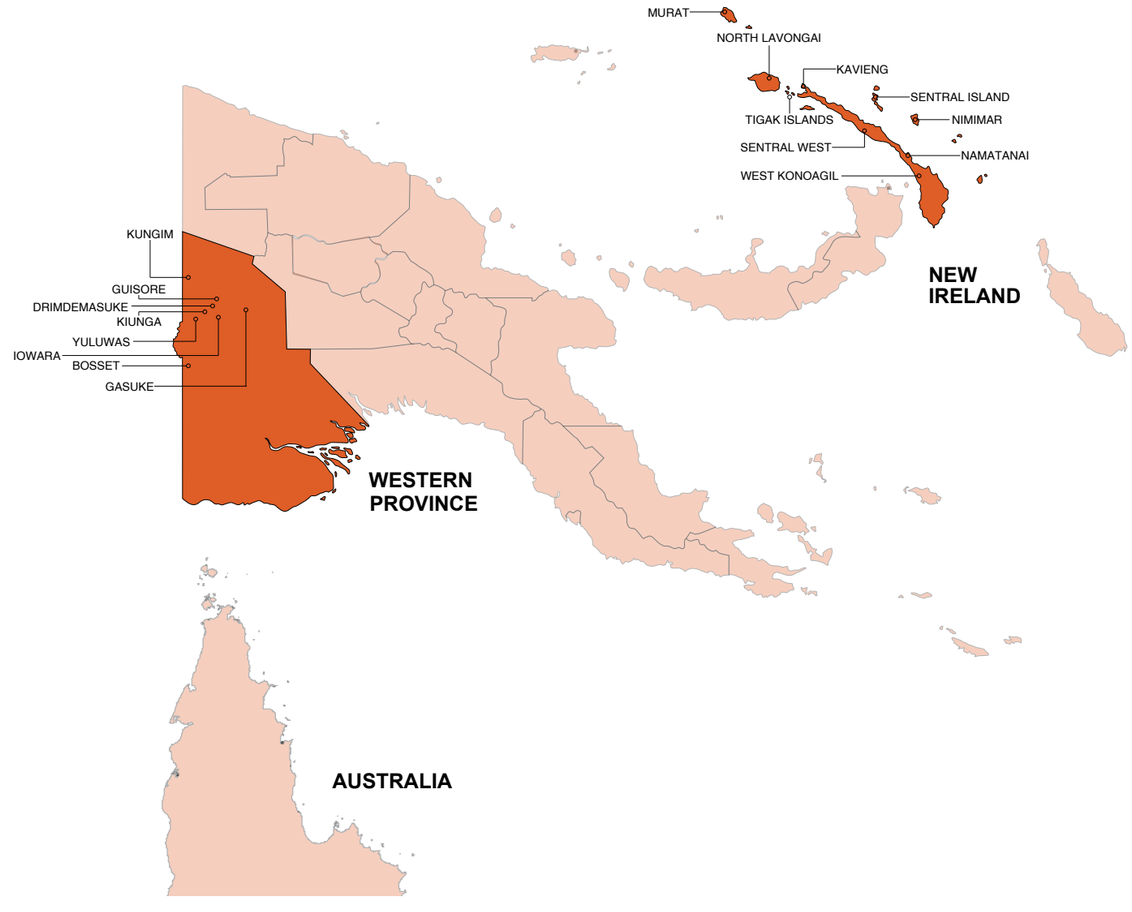
ADI has worked in Western Province since 2002 and New Ireland since 2011. We have undertaken research and situational analysis studies to determine the needs and viability of expanding our reach and impact into additional PNG remote areas.

Our partnership programs reached people in remote parts of Western and New Ireland provinces delivering 24,000 clinical services and reaching another 10,600 community members with preventative public health education.

ADI strives to deliver our mission by working with local partners to provide and strengthen health services in rural and remote communities. We work where there is an identified health need and we can partner with local healthcare providers to reach out into their remote communities – where the vast proportion of PNG people live. Some of the remote communities and villages we reach on our patrols, to support and work with local healthcare providers and deliver healthcare, are identified below and discussed throughout this report.

In New Ireland: Read about Dr Penny Uther's patrol to North Lavongai (page 14), Dr Roeland Kraan's work in Namatanai Hospital and surrounding aid posts (page 14) and Dr Ganam Naeman's trip from Kavieng to West Konoagil to identify and report a dysentery outbreak (page 15). Meet Anne Phillip a community healthcare worker on the remote island of Murat (page 19) and read about the training conducted for healthcare workers in Namatanai and Kavieng (page 24) as well as our family planning work throughout New Ireland (page 28).

In Western Province: Read about the TB diagnosis of a young boy in the remote village of Gusiore (page 16), the patrol to Kungim with Dr Susanne Leenders (pages 15 and 30) and her patrol down the Fly River from Kiunga to Bosset (pages 14 and 15).



Klara Henderson
CHIEF EXECUTIVE OFFICER

"Through leading ADI, I've gained the privileged opportunity to implement policies and concepts I had previously built with WHO, GAVI, UNICEF and UNDP in a hands-on way. Policies and concepts that seek to answer questions like: What does equitable access to health look like?"

Message from our CEO

Joining ADI as the CEO in January 2018 provided me with the opportunity to build on my knowledge of the not-for-profit sector but bring additional experience gained through working in the health and development sector at the international level. Through leading ADI, I've gained the privileged opportunity to implement policies and concepts I had previously built with WHO, GAVI, UNICEF and UNDP in a hands-on way. Policies and concepts that seek to answer questions like: What does equitable access to health look like? How do you direct health resources to the populations most in need? How do you prepare for the threat of epidemics?

Arriving at the helm of ADI I found an organisation and its individual staff and volunteers deeply committed to the task of providing improved access to health for the most remote, isolated and poor populations of PNG and equipping volunteers with the tools, knowledge and safety equipment they need to provide that healthcare. Members of the Board and staff were simultaneously raising the bar in terms of building a more internally robust and sophisticated organisation – one which we continued to work on throughout the year updating policies and procedures, for example the Fundraising and Community Engagement Handbook and our Finance and Accounting Handbook, amongst others.

Within a week of arriving at ADI I attended the Australasia Aid Conference to listen and learn from a diverse group of colleagues on the opportunities and challenges facing the sector. I also participated in the 3-minute pitch plenary session to argue the case for building skills and capacity of the remote healthcare workers of PNG: *Turning on health services remotely* (DevPolicy Blog, May 2018). This conference is widely recognised as one that provides an important means for development NGOs, like ADI, to learn and share information.

We received recognition of our work with our partners - New Ireland Provincial Health Authority - through the publication of our 2017 results in PNG's national daily newspaper article *ADI outreach a success in 2017* (March 2018). We celebrate our partnerships and are grateful for this local public recognition.

ADI operates within the Australian development and charity sectors, we have base accreditation from DFAT (Australian NGO Cooperation) and at the time of writing are proud to learn we are amongst the first group of NGOs to pass through ACFID's newly introduced Code Self-Assessment.

Like all NGOs in Australia, we are conscious of some public unease and flatlining of donations across the sector. We strive to inform our donors - large and small - of our programs and results and so maintain relations and trust in all that we do. We rely on and are very grateful for generous support from our donors. Despite an environment of somewhat stagnant public donations for Australian charities, we are pleased to see an increase, driven by new fundraising initiatives (as per the photo of me cycling through New Ireland on Pedal4PNG - also see page 37).

We are mindful of upholding the highest standards when it comes to providing safety to our teams, our code of conduct on child safeguards and risk management.

The upcoming APEC conference is set to put PNG on the map, yet our office walls are already plastered with detailed maps of the remote rivers, coastlines and mountains of PNG. We anticipate with that growing international attention on PNG as a trade and economic partner with the world will also draw attention to the health issues ADI knows so well. We look forward to continuing our work in PNG with public, private and philanthropic partners to create a healthier Papua New Guinea.

Dr Klara Henderson
BA. MCom. PhD.(Int Public Health)
ADI CEO

Dr Roeland Kraan with baby weighing sling

Volunteer Doctors making an impact

This year's volunteer doctors placed in Papua New Guinea characterise three vital skill sets to ADI's patrol and education work – rural experience, tropical medicine skills and education focus.

Dr Bruce Slonim, educator Gayle Slonim and Dr Penny Uther, all placed in New Ireland, gained their experience in rural medicine from working in Australia. Doctors with rural medicine experience - like Penny and Bruce - are comfortable dealing with a range of health issues and have that resourcefulness that comes with working single-handedly in isolated settings – a skill transferable from the Australian context to the PNG one.

Dr Bruce Slonim and Gayle Slonim

Dr Bruce Slonim and Gayle Slonim brought a depth of experience to New Ireland with their fourth placement for ADI, joining the patrol teams to remote communities in North Lavongai, Tigak Islands and Murat taking with them their combination of clinical skills and focus on education both at the community level and to their healthcare colleagues. This focus on education is an increasingly important mandate for ADI to fulfil and so build long-term sustainability in the communities and to the healthcare workers we partner with. While our patrols can only get to one health centre or aid post per day per year, by upskilling staff in these remote locations we equip them to provide the much needed healthcare services every day of the year. Gayle Slonim's work over the years in this regard has been invaluable and is a continuing legacy of her contribution.

Dr Penny Uther

Dr Penny Uther's specialty in paediatrics combined with her rural experience, drove her to have a particular focus on the children of New Ireland and this was most welcome. While PNG's under five mortality rate has been reducing, it remains above other lower middle income countries (54 deaths per 1,000 live births to 51) and is reducing at a much slower rate than other lower middle income countries in the region. While on patrol and on her day off, Penny sought out children in special need – see the disability case study on page 14. This motivation and tenancy to go the extra mile is a common trait of doctors and volunteers choosing to undertake a placement with ADI.

Dr Rose Haywood

Dr Susanne Leenders

Along with a cohort of doctors who brought rural medicine skills to their work with ADI, there was another group of doctors who brought tropical medicine skills and experience gained at local and international universities such as James Cook University, Liverpool School of Tropical Medicine and the Royal Tropical Institute Amsterdam.

Prior to their placement with ADI, Doctors Rose Haywood, Roeland Kraan and Susanne Leenders had all studied tropical medicine, placing them in good stead to treat patients with malaria, leprosy and tropical ulcers and to undertake emergency obstetric procedures in resource poor settings (see case study on page 30).

Dr Roeland Kraan

Dr Roeland Kraan undertook two placements with ADI – in the Namatanai Hospital, New Ireland (August – November 2017), and in Western Province (February – June 2018). A key takeaway for both Roeland and ADI was his insights into the underlying causes of maternal and child ill health: mothers have their first child too early, families grow too large to fit into their accommodation, resulting in families living in houses that are poorly ventilated and over-crowded. This combines to create an ideal situation for spreading communicable disease which is the primary killer of children in developing countries. This is known as 'the seven 'too's: Too young, too old, too many, too close together, too sick to have a baby, too far from services and too socially vulnerable'. Tackling these issues requires programs that can educate and implement sustainable change across multiple fronts.

Dr Ganam Naemen

As both part of our transition strategy in New Ireland and building sustainable development, we were pleased this year to have Dr Naeman, the Rural Outreach doctor based in Kavieng Hospital join four patrols. We work closely with our partners on a daily basis and having Dr Naeman on patrol was a positive development bringing the patrol work closer to the work in Kavieng hospital and the newly established New Ireland Provincial Health Authority (see page 18).

We applaud the work of all our volunteer doctors who gave up their time to make a contribution to better the lives of those with health needs in remote PNG.


Patrol team in Western Province

Bringing Healthcare to Remote Areas

At ADI we pride ourselves on our ability to go remote to try and address the inequitable access to healthcare endured by isolated communities. In PNG the often-quoted statistic of 87% of the population living rurally differs from other countries in that PNG has not witnessed a drop in that figure over the last 18 years.

Geography dictates our solutions to providing health care and education remotely. Both New Ireland and Western Province present significant access challenges. Western Province is considered the largest and most remote province in PNG with very few roads and travel by river and air difficult due to the high cost of fuel. Over 200,000 people live in Western Province and they are sparsely spread with the areas around Daru (on the south coast) and Kiunga the most densely populated. Most people living outside these areas require upwards of 4 to 8 hours' travel to gain access to health services.

New Ireland Province is located in PNG's most north-eastern region and is made up of the main island, New Ireland, as well as numerous smaller islands. Of the approximately 243,000 people that live in the province, 90% of the population reside in remote, rural areas.

Although there is a main road between the two main districts of Kavieng and Namatanai, frequent and reliable methods of transportation are still lacking. Travelling by boat, which can take up to 8 hours, is the only mode of transportation available to get to and from the main island where the majority of health facilities are located, making it difficult for people to access the healthcare services that they need. This is particularly the case for those communities in the southern part of the island.

100% of communities we visit are **remote**

= over **4** hours travel by boat or 4WD

87% rural population

98% OF people with disability in PNG receive no support

1,400 people received **physio**

339 pairs of glasses supplied

209 patrol days

173 people with disability received clinical services

71 house-bound people received **home visits** by a patrol team member

Doing whatever it takes

ADI do whatever it takes to reach remote communities in PNG. This financial year, our teams have been on patrol for 209 days and undertaken the following hazardous journeys in order to reach these remote populations to provide lifesaving healthcare services:

- Dr Bruce Slonim and Gayle Slonim, with partners from the New Ireland Provincial Health Authority, drove over five hours from the provincial hospital to Kabanut to reach a rural health centre on the south west coast of New Ireland
- Dr Roeland Kraan conducted an outreach program to support eight remote aid posts surrounding Namatanai Hospital in New Ireland who otherwise would not receive any support. Dr Roeland provided training for the rural HCWs in these aid posts on topics including malaria and proper use of antibiotics
- Dr Bruce Slonim and Gayle Slonim travelled four hours by fast boat to reach the island peoples of Mussau and Emirau, New Ireland who were found to have a high incidence of hypertension and diabetes
- Dr Susanne Leenders, with our partners Catholic Health Services in Western Province, travelled in

Meet Dr Penny Uther,
Volunteer Paediatrician in PNG

Australian Paediatrician and 2018 ADI patrol doctor Penny Uther visited a young patient with a disability on her day-off during our patrol to North Lavongai in New Ireland province PNG in April 2018.

"Joe is 11 years old and was born with Arthrogryposis, a congenital joint contracture in two or more areas of the body which derives its name from Greek (meaning literally 'curving of joints'). We visited Joe at his home on Tsoi island at the request of the chairman of the village.*

"In Australia, this condition would be diagnosed antenatally, and treated with surgery followed by intensive physical and occupational therapy from a young age. Without access to this intervention, Joe and his family have had to creatively devise ways for him to complete the activities of daily living, including the construction of a small canoe for independent transport.

"Joe is a very bright and motivated child. Despite his disability, he has taught himself to write using his feet. The ADI patrol team was able to provide information to Joe's family about appropriate schooling in Kavieng, and are attempting to secure suitable aids to further assist him day to day. It was a real pleasure to meet Joe and his family and remains one of the highlights of my time in PNG."

**name changed to protect identity*

two banana boats on the long journey down the Fly River to Bosset, Middle Fly (over 12 hours by boat) to collectively see and treat close to 1000 patients – 57% women and girls

- Dr Rose Haywood - making 4WD mechanical repairs on route - reached the communities along the remote west coast of New Ireland seeing 268 patients
- Dr Rose Haywood flew to the remote Simberi Island of New Ireland to treat a further 255 patients with a focus on TB
- Dr Ganam Naeman travelled two full days to reach the southern tip of New Ireland - the area furthest from the provincial hospital - at short notice to join a 4WD and boat patrol to West Konoagil. At a local school there, he discovered an outbreak of dysentery and was able to immediately send for medications to treat all students at the school
- Dr Penny Uther travelled over five hours by 4WD and then a further three hours by boat to provide support to the island community of Tanga in New Ireland
- Dr Roeland Kraan and health partners – with the generous support of OkTedi Mining Limited and their donation of a plane - flew to a community in the very remote area of Aiambak and saw close to 600 patients including those presenting with leprosy, and tuberculosis. After ten days, Dr Roeland returned to Kiunga on a 12-hour boat journey on the Fly River
- Dr Susanne Leenders travelled on foot for over seven hours through jungle and rivers to reach the population of Kungim in North Fly, Western Province. She safely delivered a baby boy there who needed resuscitation following a breech birth.

Undertaking these journeys takes grit and determination and supporting our doctors and allied health partners to make these challenging journeys takes significant resources, finely tuned safety protocols and a build-up of logistical and local knowledge - which ADI's programs and partner patrol teams have in spades.

Continuously striving to improve

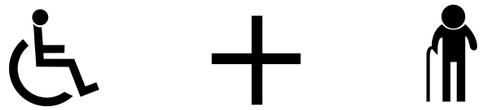
ADI strives to improve our program design and implementation by working collaboratively with our partners. This year our ability to access remote communities and stem a public health issue was directly attributable to the growing strength and investment in outreach patrols made by the New Ireland Provincial Health Authority.

Our patrol program is adaptive in nature and was rewarded for this by having Dr Ganam Naeman step up to take on the role of patrol doctor multiple times in 2017/18.

ADI, with New Ireland Provincial Health Authority, looks forward to continuing to build the strength of outreach patrols to remote communities through participation of such senior medical staff.

Disability Services

ADI policies work together to ensure our disability and impairment inclusivity policy is action-oriented by seeking out the most isolated, vulnerable and marginalised people.



Disability and impairment inclusivity

Seeking out the most isolated, vulnerable and marginalised people

There are no official statistics for the number of people with disabilities in PNG but the World Health Organisation estimates that 15% of the world's populations have some form of disability or impairment. In PNG it is estimated that only around 2% of people with disabilities receive services with the remaining 98% not receiving any support. People living in rural and remote areas are also often denied basic health services due to the topography and lack of accessibility, with the marginalised in these areas being the most disadvantaged.

ADI believes people living with disabilities need to be able to improve the quality of their lives by having access to the same opportunities for participation, contribution, decision making and social and economic well-being as others.

Being cognisant of the PNG National Policy on Disability 2015-25, ADI focuses primarily on strategies to address accessibility issues and on the management of complex cases of people with disabilities ranging from habilitation to rehabilitation.

In order to specifically seek out the most isolated, vulnerable and marginalised people, ADI makes every effort to include a disability officer as well as a doctor on patrols. In New Ireland a nurse physiotherapist from the Provincial Health Authority attends patrols and in Western Province, a Callan Health Services disability officer from Catholic Health Services in the Diocese of Daru-Kiunga joins the patrol team.

Dr Roeland Kraan on a Horizon Oil sponsored flight

ADI intervention on tuberculosis

Tuberculosis is currently the leading cause of death from infectious diseases for children around the world. And the same is true in PNG. TB kills more people in PNG than any other infectious disease. PNG is one of 14 countries worldwide in the unenviable group who have high-burden TB, high TB/HIV burden and high multi-drug resistant TB (MDR-TB).

In 2016 there were close to 30,000 TB notifications, with 27,500 new or relapse cases*. Most worryingly PNG is witnessing a rise in TB and MDR-TB. ADI takes our role of identifying, diagnosing and referring patients with suspected TB very seriously. ADI doctors placed in Western Province are particularly alert for patients with undiagnosed and untreated TB.

In February Dr Roeland Kraan was on patrol to Gusiore. He was already practiced in TB diagnosis due to his time in Namatanai. Dr Roeland recounts the diagnosis of a young boy with an unusual presentation of TB.

"I first saw this boy on one of my earlier patrols to Gusiore," Dr Roeland recalls. *"When I saw him again this time at the aid post, I could see how much strength he had lost down one side of his body. I'd seen something like this before in Namatanai in 2017 so I recognised his condition as a cerebral TB abscess. With timely medical intervention, tuberculosis can be cured."*

The TB treatment regime is challenging - assuming you can obtain access to care and follow-up. TB drugs must be taken with food and require a degree of literacy. Some treatment periods can be as long as two years.

Dr Roeland concludes *"I was able to organise treatment for this boy (six months DOTS treatment). I saw him again four months after diagnosis – just before my volunteer placement ended – and he was doing well. It is an amazing feeling to know that I have been a part of changing the story for this boy and his family. There's nothing like looking into the eyes of a child and knowing that you were responsible for keeping him safe from becoming one of those heartbreaking TB statistics."*

[i] *Global Tuberculosis Report 2017*

"ADI and partner patrol teams have a range of approaches to providing medical support and treatment to people living in rural PNG which fall into two main categories: treating and supporting people living with disability, and providing rehabilitation services to people to allow them to participate more fully in daily life. It's all about making healthcare accessible to all."

- Klara Henderson, ADI CEO

Making healthcare accessible to all

In 2017/18 ADI and our partners:

- made house calls to 71 patients with an apparent disability
- saw 173 patients with an apparent disability (of whom 72 or 42% were female)
- provided crucial rehabilitation services to help people living in remote communities, helping them go about their lives once more, including:
  - providing 339 pairs of glasses in New Ireland
  - referring 215 people for ophthalmology services at the hospital, including156 people for cataracts
  - supplying three mobility aids - two wheelchairs and one cane for a visually impaired person
  - providing 1,400 people with physiotherapy services (53% were females).

During 2017/18, ADI doctors and multidisciplinary patrol members reported providing clinical services to 173 people with a disability, many of whom were not able to come to the clinic and required a specific home visit. These disabilities had been caused through accident or injury, birth trauma, genetic abnormalities, infectious diseases and poor living and working conditions.

This number is very conservative (approximately 1% of all patients treated on patrols) and only includes those people identified to ADI personnel as having a disability or who had an obvious physical disability including visual impairment. 72 women and girls with a disability were treated by the patrols team (42% of total people with a disability). We recognise that under these conditions our patrol team is probably only seeing and recording the more extreme disability cases. However, each of these visits often represents the only health visit that person receives all year and so is vital in terms of the support they receive – in this way ADI seeks to reach the unsupported majority of disabled people in PNG.

Patrol members, with the support of local healthcare workers, seek out seriously incapacitated patients who require a home visit and work with authorities to improve the conditions in which they live. The village chiefs or local health workers also often request ADI patrol members to conduct house calls for those most in need, many of whom are 'house-bound' due to illness (including mental illness), disability, stigma and isolation. During patrols in 2017/18, 71 people were visited in their homes by ADI patrol team members.

We recognise people sit on a spectrum of disability and ability, and our range of patrol services aims to cover that spectrum. The PNG National Policy on Disability

Dr Ganam Naeman seeing an elderly disabled patient

Dr Ganam Naeman conducted the first PNG doctor-led patrol

Dr Ganam Naeman is a PNG national, a graduate of the University of PNG, who was born in Morobe but has called New Ireland his home for the past 10 years where he is the Rural Outreach Doctor in the Provincial Health Authority (NIPHA).

In February 2018 Dr Naeman was released from his role in the internal medicine department of Kavieng Hospital to allow him to temporarily join the ADI patrol team. This was a result of the increased cooperation between ADI and NIPHA in 2018 and demonstrates the increased capacity of the NIPHA.

With a delay to the arrival of the ADI volunteer doctor due to visa issues, Dr Naeman stepped in to conduct the first PNG doctor-led patrol. As the patrol year progressed, Dr Naeman has become a regular on patrols joining ADI's Dr Uther on two patrols and leading another two when she was absent.

Over the four patrols this year, Dr Naeman treated 811 patients (35% women and 42% children) as well as doing house calls for patients with a disability who could not attend clinics.

This a strong example of capacity building through the involvement of NIPHA in ADI's remote patrols as well as their support of the program.

Dr Rose Haywood, Dr Agnes de Boer and patrol team from NIPHA

Capacity Building on the frontline of health

Community Healthcare Workers

Anne Phillip (pictured left with a patient receiving treatment for diabetes) is a 42-year old community healthcare worker (CHW) at Epokasi Health Centre on the very remote island Mussau in Murat LLG - seven hours by fast boat over the ocean from Kavieng in New Ireland. She is one of three dedicated staff at a newly renovated Health Centre on the island. Anne has a keen interest in maternal health and family planning. In August 2017 ADI's Dr Bruce Slonim and his team visited the health centre during the annual patrol to Murat and Tingwon. Spending time with the patrol doctor provides Anne with highly valued case-based training and professional supervision. Together with Dr Bruce Slonim they saw patients from Murat with TB and malaria and worked through appropriate use of medications and education on treatment of musculoskeletal disease. After a full day of clinic, Anne attended three hours of training with her healthcare worker colleagues on the PNG standard treatment manuals and common obstetric emergencies. 2017 was not the first time Anne worked with Dr Bruce Slonim, she worked alongside him in 2016 on their prior patrol visit to Murat.

ADI brings community healthcare workers like Anne in from their remote communities for in-depth training. In 2016 Anne attended a ten-day course on maternal and child health, and in 2017 she attended a five-day course on family planning jointly hosted by ADI and Marie Stopes. The patrol team will again visit Anne and her colleagues in Murat in 2018 to continue building clinical ability.

ADI sets up a two-pronged continual education and training scheme - on each patrol visit the local community healthcare worker participates in educational opportunities receiving one-on-one professional support, and then healthcare workers are brought together for in-depth training by experts on highly valued topic areas. This two-pronged educational strategy provides continual, practical, appropriate education for remote community healthcare workers.

ADI sees huge potential and an untapped resource in the community healthcare workers on the frontline of health in PNG - community healthcare workers like Anne. They provide valuable healthcare to their communities and by building-up their clinical ability and skills ADI can make an impact on health outcomes like TB, malaria and maternal health.

Community healthcare workers are often the first, only and last line of defence in terms of saving the life of a women in labour in remote PNG. ADI equips healthcare workers like Anne with the skills to do that, and so improve maternal mortality in PNG.

embraces the CRPD (Convention on the Rights of People with Disability) definition, stating *"Disability is an evolving concept... disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others"*.

Given remoteness and extreme lack of access to services, conditions that may seem like minor impairments – visual impairment or musculoskeletal disorders – can severely impact on a person's ability to participate in normal daily subsistence living activities (such as fishing and farming).

During most patrol visits to rural and remote areas, the ADI doctor or partner's physiotherapist provides public health awareness and education to community members on improving work safety, the importance of early detection and prevention of disability and how to manage and support people living with a disability. In New Ireland 9/12 patrols had a physiotherapist from our partner join the patrol.

In the future ADI plans to improve access to health services for people with a disability through continuing to support the implementation of the PNG National Disability Policy 2015-2025 through:

- Improving data collection and reporting on health access and services for both ourselves and our implementing partners (e.g. improve form design to allow better data capture on disability services)
- Increasing awareness of disability and decreasing stigma and discrimination in rural and remote communities to promote greater identification of people living with disability, and for their families to be acknowledged and receive treatment and management
- Continuing to include a disability specialist or physiotherapist from our partners on as many rural and remote outreach patrols as possible to improve access to healthcare for people with a disability as well as rehabilitation services and improved options for living and mobility, and
- Giving consideration to facilitating training for rural health workers on managing patients with disabilities, and so support our PNG partner's National Disability Policy's call to better support nurses and other front line health workers to address the needs of different classes of disability.

Physiotherapists changing lives in PNG

The many hours of paddling canoes, walking up steep slopes to the garden carrying heavy loads on their heads and cutting back the ever-encroaching jungle with a bush knife all take their toll. As a result, chronic back and knee pain is endemic in Papua New Guinea. Locals traditionally treat this pain with panadol and antibiotics (if they are available) with little understanding of the underlying cause of the pain.

Physiotherapists take models of bones and joints on patrol and explain the reasons for this sort of pain. They then share advice on exercises, proper lifting techniques and resting. Many patients still want a 'magic pill' to fix them, however gradually as a result of these training sessions, local health workers are beginning to change their management of chronic pain and educate their patients in preventative measures.

Seven year old Tim* (pictured) was one of the patients to benefit from the physio on the North Lavongai patrol. He was climbing a tree to retrieve Betel nuts and fell, fracturing his arm. His father was very concerned by the extent of his son's injury. *"I knew I had to do something to help his arm,"* he said, *"so I made a bush splint with sticks and a bandage. As soon as I heard the ADI patrol was coming I knew they would help us too."*

The physiotherapist was able to reset Tim's arm and apply a secure plaster cast.

"The father did a good job. Tim's a lucky boy. We see a lot of badly healed fractures where the child is handicapped for life. This is a good result," our partner physiotherapist recalls.

**name changed to protect identity*


Health education training

Training and Retaining Healthcare Workers

Building on our years of work in PNG, ADI is now more than ever turning greater attention to increasing the clinical ability of rural healthcare workers.

We understand that equipping the cohort of remote healthcare workers with skills and knowledge that they can carry with them as they see patients with tuberculosis and attend to women in labour can have a direct and lasting impact on the health of the community where the healthcare worker lives.

She (and our research tells us remote healthcare workers are most often a she) lives in the community she treats and is there 365 days a year. 64% of healthcare workers we trained in New Ireland this year are female.

Through working alongside ADI's patrol team - whether it be in Western Province on the PNG's National Department of Health's Healthy Islands program, or in New Ireland with a physiotherapist - builds her confidence and clinical ability by directly participating in case-based work. And it goes both ways. Remote PNG community healthcare workers and village chiefs provide much needed local knowledge to our patrol team on the particular health concerns of their community.

ADI is building a database of the skills and training of each community healthcare worker we come into contact with. We want to know their skills and skill gaps, and work with them to fill those gaps. Providing education and professional support to rural and remote healthcare workers is acknowledged by WHO as a successful intervention to not only up-skill these scarce and much needed healthcare workers, but to also increase their desire and motivation to remain and practice in areas where access to health is otherwise limited.

This part of our program directly works to the Sustainable Development Goal target 3C: '*increase… the recruitment, development, training and retention of the health workforce in developing countries';* and the PNG Government's own Key Result Area 1 to *'improve service delivery through having the right health professionals work in the right places, are motivated, and deliver (right) quality services'*.

ADI provides educational opportunities in 3 main ways:

1. Case-based Training

While on patrol the doctor or PNG health professional works alongside the community healthcare workers and nursing officers of the health facility the patrol is visiting to triage and treat patients. This is called case-based training. This year we delivered 360 hours of case based training.

2. Group-based Training

At the end of each clinic day, the doctor and PNG health professionals run group-based training on topics identified as pertinent to that community such as malaria and drug treatment.

3. Gather and Train remote HCWs

ADI gathers remote healthcare workers in training centres close to their homes and trains them on in-depth topics that meet their needs, mindful of the medical resources readily accessible to them.

71% of HCW trained in New Ireland by an ADI doctor are **women**

92% of patrols have a female HCW

360 HOURS of case based training to healthcare workers

168 HEALTHCARE WORKERS trained = 61% of HCWs in patrol catchment area

21% OF all remote healthcare workers in New Ireland have now received family planning training

Key takeaway derived from our work in Western Province

As a result of our work in Western Province and cross-location knowledge sharing, ADI has an increased awareness of the need to expand our educational focus in Western Province to include **public health education**. We are working on opportunities to do this in both the short and medium terms, covering key areas of need like maternal and child health, healthy islands and tuberculosis.


Infection control training, New Ireland


Public health education at a school, New Ireland

Infection control training healthcare worker participants

australian doctors international
Working for a healthier PNG

2017/18 Training Courses

Over the 2017/18 period ADI, in conjunction with our technical partner, Marie Stopes, delivered one two-week training course on Family Planning in the Namatanai district; and, in conjunction with BD, delivered one two-week course on Infection Control.

Marie Stopes Family Planning Course

During April 2018, ADI held the fourth family planning in-service training for rural healthcare workers in New Ireland. 15 participants (12 female) attended the two-week intensive training which was conducted in the Namatanai district of New Ireland for the first time. Most of the healthcare workers came from very remote aid posts.

The first week of the training involved theory around family planning methods, cultural sensitivities associated with family planning and appropriate counselling techniques and also included a practical component. Once the participants passed the model assessment, they had supervised practice with clients at local health facilities during the second week of training. All fifteen participants were deemed competent with contraceptive implant insertion and removal to meet the growing demand in their villages.

As a competency-based training, participants were assessed in:

- Knowledge of family planning methods
- Attitude and skills in providing family planning information and supporting clients' decision making
- Skills in the safe provision of contraceptive implant and IUD procedures

The Marie Stopes trainer gave each participant an education toolkit with information on all methods of modern contraception and flip charts and easy to understand educational materials for use in their villages and health centres.

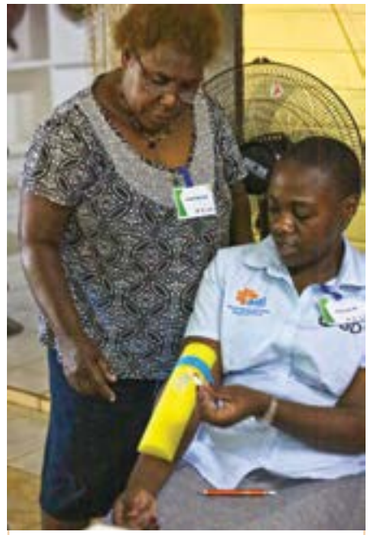
Knowledge gained through this in-depth training equips remote healthcare workers to provide family planning counselling and options. These family planning skills contribute to the health outcomes of reducing maternal mortality (SDG3 target 3.1) and increasing the proportion of women who have their need for family planning satisfied with modern methods (SDG3 target 3.7). Twenty-one percent of all remote healthcare workers in New Ireland have now received this family planning training.

BD Infection Control Course

In response to the identification from ADI's partner of a need for greater infection prevention in New Ireland, BD and ADI held a two-week in-depth training course attended by close to sixty healthcare workers from across New Ireland and Kavieng Hospital in Sept/Oct 2017. ***This represents about 25% of the healthcare workers in New Ireland.*** This was the first time that Infection Control training had been completed by many of the participants since their initial nursing training. Topics covered included:

- Hand Hygiene
- Aseptic Non-Touch Technique
- Safe Blood Collection
- Waste disposal
- Sterilisation and disinfection
- Respiratory disease infection control

As part of the trip, utilising the skills of the laboratory team from BD, an Infection Prevention Audit was also conducted for Kavieng Hospital providing valuable feedback and recommendations.



Knowing, training and supporting the remote healthcare workforce contributes to the SDG3 outcome and target 3.C.

The ADI team and training participants also updated Standard Operating Procedures (SOPs) for a number of routine diagnostic tests, which will now be utilised across many laboratories in New Ireland. The SOPs written, completed and agreed on include the following procedures:

- Blood collection
- Aseptic Non Touch Techniques
- Chemical Disinfectant
- Five moments of Hand Hygiene
- Hand washing
- Sterilisation
- TB Detection
- Waste Management

Knowledge gained through this training session and captured in the updated SOPs will provide a lasting resource for the healthcare workforce in New Ireland.

Aid Post in New Ireland province,PNG.

Working with Healthcare Partners

ADI takes an adaptive partnership coalition building approach to identify and implement our program work. We work with a range of partners, dynamically sourcing and creating partnerships driven by the identified need to meet our program objectives and our mission.

We provide leadership to the partnership and strive to see our PNG health implementing partners advance their capacity across a range of technical and functional areas. We listen to our partners' feedback to improve our program and increase capacity of our PNG health partners.

Implementing partners

New Ireland Provincial Health
Horizon Oil
Catholic Health Services - Diocese of Daru-Kiunga

Collaborating NGOs and partners

Marie Stopes PNG
The Fred Hollows Foundation
Callan Health Services
BD (Becton Dickinson & Co)
Good Samaritan Society
Griffith University
Mercy Works

Gayleen Mathew, ADI Patrol Coordinator, New Ireland

We dynamically source and create partnerships to achieve our program objectives and mission

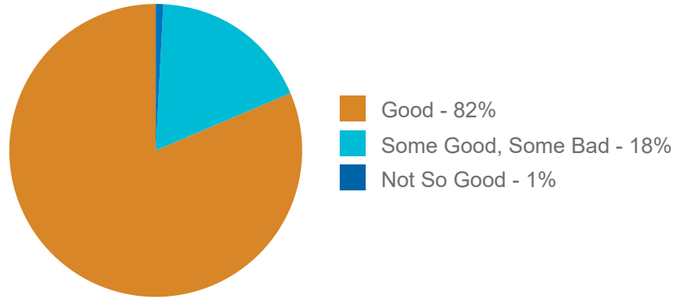
In New Ireland our partnership with New Ireland Provincial Health has grown in strength this last 12 months:

- We have seen a third of all patrols covered by the PNG Rural Outreach Doctor from New Ireland Provincial Health Authority, Dr Ganam Naeman (see case study page 18).
- We have seen a growing skillset in our Patrol Coordinator Gayleen Mathew (pictured above) to allow her to take a greater role in planning patrols, logistics and budget preparations.
- We have identified a need to provide family planning options for the population of New Ireland. We sourced experts in the field, like Marie Stopes, to deliver the content and held a two-week family planning training course in the district of Namatanai in April 2018.

We work closely with partners like Callan Health Services in Western Province who provide a Disability Officer, from Catholic Health Services in the Diocese of Daru-Kiunga, to join our patrols.

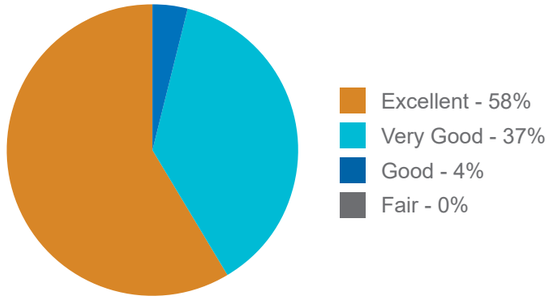
Feedback ratings from communities ADI and partner patrols visited (New Ireland, 2017/18)

We track the views of the remote communities we visit, finding 82% rated the experience as good.



Feedback ratings from health facilities ADI and partner patrols visited (New Ireland, 2017/18)

96% of the healthcare workers we partnered with and visited in remote locations rated the patrol team visit as either very good or excellent.



We provide leadership to the partnership

- In New Ireland we steer the annual outreach patrol planning cycle and facilitate workshops to allow a range of inputs to produce the best possible schedule.
- We have an enduring partnership with Catholic Health Services - Diocese of Daru-Kiunga with a growing shared responsibility.

We listen to our partners

- We actively seek feedback across all forms of our partnerships, from meetings with senior health officials to engaging with our community beneficiaries to understand how our program approaches could better serve their needs.
- We issue regular reports to our partners that capture and reflect back to them program outputs, outcomes and lessons learnt. These reports provide an opportunity for our partners to jointly discuss and assess direction and capacity.

Tooth extraction on patrol, New Ireland

Gender Equity

ADI shares the view of the UN that gender equality is not only a fundamental human right but a necessary foundation for a peaceful, prosperous and sustainable world.

Gender affects opportunities and participation in every aspect of life. ADI considers gender equity and Sustainable Development Goals in the design of all programs.

What is Gender Equity?

Gender Equality refers to goods or services that are measurable and evenly distributed between men and women. Gender Equity is about ensuring that social and cultural practices and the distribution of goods and services, are based on fairness and justice. The central issue is the dynamics between those with power and those without, and the fact that it is necessary to work with all irrespective of gender. Two main strategies are needed to reach the goal of gender equity, namely gender mainstreaming and targeted actions in response to a gender analysis.

Gender affects opportunities and participation in every aspect of life. ADI acknowledges the need to ensure that the specific health needs of men and boys, women and girls in PNG are considered and addressed in all programs with a dedicated focus on Sustainable Development Goal 5 - *Gender Equality: Achieve gender equality and empower all women and girls.*

ADI considers gender mainstreaming in the design of its programs as a means of attaining gender equality.

53% OF **clinical services** FOR **female** patients

778 couple-years of protection and family planning

68% OF healthcare workers we trained are **women**

57% of PNG personnel seconded from our partners to work with ADI are female

Gender inequity in PNG

The Gender Inequity Index (GII) produces a ranking to reflect gender-based inequities across reproductive health, empowerment and economic activity. The GII can be interpreted as the loss in human development due to inequality between female and male achievements. PNG is ranked 159th out of 160 countries.

ADI's active gender equality program approach

On an average patrol during 2017/18 for both Western Province and New Ireland, 50% of patients seen by doctors were female and 53% of patients seen by any member of the patrol team were female. For our in-depth training of healthcare workers 68% are women.

There aren't enough services for people having suffered family violence, with rural and remote areas having fewer services than larger towns and cities. ADI challenges all types of violence, including violence against women and girls and records and reports on cases of serious family violence. In New Ireland, a gender equity specialist is included on patrols whenever possible to provide counselling as well as community education on gender equity to people living in rural and remote areas. At the end of 2017 ADI started a partnership with a local gender equity specialist. She has been described as the **'best gender equity trainer in PNG'**. She has joined our two-week New Ireland patrols, visiting schools and mining camps as well as communities. During 2017/18 almost 3,000 men and women from rural and remote villages came to hear information on gender and culture, PNG laws and penalties on domestic and sexual violence, and the different forms and effects of gender-based violence including physical, sexual and economical.

Maternal health and family planning

As PNG has one of the highest rates of maternal death in the Asia Pacific region, it is a dedicated area of focus for ADI. The PNG National Department of Health sets Key Result Area 5 to Improve Maternal Health including:

- increase family planning coverage
- increase the capacity of the health sector to provide safe and supervised deliveries
- improve access to emergency obstetric care
- improve sexual health and reproductive health

Figures on maternal deaths vary, the Demographic Health Survey of Papua New Guinea conducted by the National Statistical Office in 2006 estimated that the National rate of maternal deaths was 733 deaths from pregnancy related causes for every 100,000 live births. This is a much higher figure than the more recent estimates from UNICEF (230) and UNDP (250). And as ADI is acutely aware, unsupervised births at home are four times higher in rural areas than urban ones.

During 2017/18 ADI started to increase its work in family planning as a proven strategy to curb maternal deaths. Fruits of that increased effort are demonstrated through the results detailed here, however our increased focus on this area will continue into 2018/19 with additional program staffing.

In the 2017/18 period ADI has conducted one family planning training program for rural health workers from across New Ireland and provided follow up support via ADI's patrols. We also ran the same course in the previous financial year (May 2017). Fifteen health care workers successfully completed the course (see page 24 for details). The training takes a holistic approach to family planning with education for women and girls the core focus.

In New Ireland there are now 50 health workers who have completed training in family planning (about 21% of the estimate rural health workforce). By the middle of 2019, it is estimated that 30% of rural health workers will have completed family planning training.

ADI aims to have a family planning health worker on all outreach patrols in New Ireland to support the local health workers, provide counselling and contraceptive services to women living in rural and remote areas as well as deliver education on family spacing to the community.

During these visits to rural and remote aid posts, many women and couples attended family planning consultations and were able to receive counselling and access to modern contraceptive methods. Last year a trained family planning health worker from our partner was included on 11 out of 12 patrols in New Ireland, contributing to 448 family planning services that were provided to women across two provinces. Our collective work with our partners in provision of modern contraceptive methods has resulted in 778 couple years of protection (CYPs) provided during 2017/18 in New Ireland. In addition, public health education sessions were given by the family planning officer at remote locations including 24 schools and 102 villages, increasing awareness and understanding of

Staffing

ADI recognises that advancing gender equality is essential in reducing poverty, increasing the effectiveness of aid and is a development goal in its own right. ADI supports equal opportunity for both male and female workers in PNG to participate in conducting the programs. Overall 57% of PNG personnel in both Western Province and New Ireland currently seconded from our partners to work with ADI in administrative and clinical roles are female (Gender Marker Stage 3: Sensitive). On our outreach patrols in Western Province 55% of health patrol team were female, and 40% in New Ireland (Gender Marker Stage 3: Sensitive).

ADI does not discriminate against prospective and existing staff members and Directors on the basis of gender. Currently 68% of Australian ADI personnel comprising both staff and volunteers are female and 64% of ADI board directors are female.

ADI is committed to working with partners to strengthen their understanding of gender equality and women's empowerment.

family planning in these communities.

Data from 2015 shows 31.5% of births in New Ireland were supervised, and in Western Province more than 50% of the babies born each year are village births occurring without a qualified health worker in attendance.

Given these statistics, ADI has identified a program course of action to conduct our first emergency obstetrics in-service training in October this year in New Ireland, with the aim of rolling that out to Western Province in 2019 in partnership with our partner health service providers. It is anticipated that 40 health workers from rural and remote areas in each province will attend this in-depth two-week hands-on training.

The *Western Province Strategic Health Services Development Plan 2017-2020 (Vol 1)* has called for a focus on women and children through the following:

- better access to family planning services
- pregnancy support services
- better access to supervised deliveries
- nutrition and immunisation
- HIV and STIs
- training for staff in obstetric care and integrated management of childhood illnesses

In response to this, ADI has applied for and successfully received seed funding for a grant to place a volunteer maternal and child health educator on our patrols.

During 2018/19, a health educator will provide teaching and training to healthcare workers at remote centres as well as case-based and group training to patrol staff who have limited access to further training in updated methods and drug treatment for mothers and children. These patrols will occur monthly, seeing about 200 women and children each visit.

Future ADI Plans

In the future, ADI will continue to monitor and report on our program approaches for gender equity, and those that we jointly implement with our partners, seeking where possible to move program approaches to build greater gender equity.

In New Ireland, ADI will:

- Aim to include both a gender equity specialist and family planning officer in all outreach patrols to rural and remote areas.
- Commence a new program in New Ireland to identify and train school teachers and key community leaders as community educators to improve understanding and uptake of family planning.
- Continue with twice yearly in-service training on family planning for rural health workers in order to increase the proportion of rural healthcare workers who are trained in family planning.
- Expand the role of gender equity specialist to conduct research in rural New Ireland villages on the issues and barriers to women accessing and using modern contraception methods.
- Recruit a PNG maternal health and family planning coordinator to expand ADI's reach and program delivery into other provinces. This step is well advanced with the key candidate offered the position which will take effect January 2019.

In Western Province, ADI will:

- Employ a volunteer maternal and child health educator
- Aim to repeat the emergency obstetrics training course in Western Province with rural and remote health care workers.

Dr Susanne on patrol

Meet Volunteer Doctor, Susanne Leenders

I accepted a placement as a doctor on patrol for Australian Doctors International (ADI) in September 2017 and was selected to work in the Western Province of Papua New Guinea (PNG).

ADI runs development programs in PNG, Australia's nearest neighbour, to provide immediate medical aid, and more importantly, to build the skills and resources of the locals so they can help themselves. Each year ADI sends volunteer doctors to New Ireland and Western Province in PNG for anywhere up to six months where doctors join local health experts on long and difficult patrols through jungle, over mountains or on banana boat to access remote aid posts.

I chose to work with ADI after positive reports from my doctor friends that had already experienced what it was like to be part of the ADI team.

I really enjoyed working on the patrols in very remote areas, rather than being based in a hospital. In Western Province, there are no roads and all the villages are really far from each other. To get around we would have to take a boat on the Fly River (the third largest river in PNG). It's like the main road - only on water.

When you visit the remote aid posts and health centres it's unbelievable how the locals do their work as they hardly have any medical supplies. Sometimes they don't even have any way to communicate with the outside world so they have to make all the decisions by themselves. I think this would be the hardest part of the job as they can't talk with the hospital or doctors when they need a second opinion. If they had a functioning radio they could at least contact a doctor to talk through a case and ask questions to guide them. They only have their standard treatment manual to rely on but these can be out of date and only cover certain diseases, not all situations.

A highlight for me occurred when I undertook my third patrol to a sub health centre in Kungim, of the North Fly district of Western Province, as part of a team of four. It was an eight day patrol. It was amazing to experience a remote area like Kungim which is up to 12 hours by boat from the closest town. For many locals, they don't have much money so buying fuel for the boat trip makes going to a hospital difficult.

On the first day of my patrol I came into contact with a mother in labour. The mother was about 35 weeks along and had been in labour all day. Around 6:00pm I was asked to assess her as her progress had stopped and there was a malpresentation.

After consulting the obstetric doctor in Tabubil by radio, we decided to augment her labour. We had good progression and foetal condition until the last phase. The baby needed to be resuscitated after it was born and it was hard to get air into the lungs because of swelling to the face and little choice of masks. Eventually we managed to successfully resuscitate and we put the baby with the mother to ensure warmth and bonding.

I later learned that both mother and baby were doing just fine. I felt really fortunate to be in the right place at the right time given the Kungim sub health centre only does about three deliveries every month. I was also especially pleased that it was a great teaching opportunity for the three PNG health workers that assisted with the delivery. It was a great example of ADI's work in the region, being available to save lives while building local capacity and working as a team. I know my story is just one example of the positive impact ADI is having in PNG and I'm grateful for the opportunity to be part of something so special.

Our People

L - R: Klara Henderson (CEO), Irina Blackmore (Events coordinator volunteer), Kay Nevill (Family Planning Officer volunteer), Yaman Kutlu (Program Manager), Dianne O'Brien (Finance and Operations Manager), Maeve May (Website support volunteer), Mark Newcombe (M&E Officer), Lili Koch (Revenue Committee member), Linda Koops (Office administrator) and Michele Burton (Events coordinator volunteer).

Not pictured: Aisha Kakinuma Hassan (Program's Support Researcher volunteer), Fiona Russell (Marketing Co-ordinator volunteer), Caroline Busvine (newly appointed Human Resource and Learning Officer), Carmel MacLeod (Book-keeper), and Mike Bayles (Database Developer volunteer).

Behind the scenes of providing access to health in remote PNG there is an enormous amount of work done to ensure our programs are effective, good value for money, safe and supportive for volunteers and partners, and hold the highest standards in regards to ACFID's Code of Conduct. This takes a team of staff and volunteers who bring a diverse range of expertise and skills to ADI from human resources and recruitment; development and public health; fundraising; media; to financial accounting. Our small office in Sydney is, on many days, close to overflowing with staff and volunteers as the team goes about our work. You can find us doing anything from sourcing mosquito nets and satellite phones, preparing budgets for the upcoming patrol, writing quarterly reports for our partners and stakeholders or interviewing potential doctors for placement in PNG.

Our Volunteers

Volunteers started this organisation and to this day are a vital part of what we do. Every day our wonderful volunteers give their time, energy and passion.

This financial year we had 25 wonderful people volunteering with us at some point in time. Together, they volunteered their time collectively reaching 1,000 days! We could not do the work we are doing to change lives for a healthier PNG without you. On behalf of everyone here at Australian Doctors International, we thank you!

We acknowledged our volunteers' contribution and celebrated with the Australian National Volunteer Week in May with the theme: Give a little. Change a lot.

Our Supporters

Australian Government
Department of Foreign Affairs and Trade

BD

Women's Plans Foundation

Horizon Oil

With much gratitude, ADI would like to acknowledge our generous donors and sponsors that have supported us with our vision in the past year. This list includes some long-time supporters of ADI as well as some new donor friends.

Austpac Chemicals and Commodities Pty Ltd
Brent and Vicki Emmett
Graham & Gail Smith
Hunt Family Foundation
ISG Foundation - Iain Gray
John Forsyth
Lili Koch
Midnight Oil
Three Flips Foundation

Dr Mark Newcombe & George Barrett
Health Co-ordinator volunteers

The health coordinator provides a vital role in supporting the joint ADI and New Ireland Provincial Government patrols. This year Dr Mark Newcombe and George Barrett consecutively took on the role.

Mark took leave from his position in the Sydney office as Monitoring and Evaluation (M&E) Officer and set up in Kavieng. This created an excellent opportunity for knowledge exchange – building the patrol team's knowledge on how ADI's monitoring and evaluation fits into the patrol reporting cycle, and for our M&E officer to see first-hand how data is collected. George Barrett stepped into the role in April, accompanied by his wife – Lou Belle Barrett – who had previously been ADI's Office and People Co-ordinator in the Sydney Office.

Fiona Russell
Marketing Co-ordinator volunteer

Fiona has been volunteering with ADI one day a week since May 2018 working on e-newsletters, marketing materials and the annual report.

"It's been a really rewarding experience. I didn't realise how amazing the work is that ADI do in PNG. Being in the office on a regular basis like this means that I hear lots of stories from in the field. They have so much passion and continually go the extra mile to make sure that as many people as possible get access to medical care in PNG. I'd love to go visit one day and see it in person!"

Board Members

L - R: Liza Nadolski, Dr Peter Macdonald, Louise Walker, George McLelland, Richard Schroder, Judy Lambert, Virpi Tuite, Colin Plowman, Anne Lanham and Boronia Foley. Not pictured: Margarita Krasteva

PRESIDENT

Dr Peter Macdonald OAM, MBBS MRCGP DA DRCOG

Peter ran his own General Practice in Manly for more than 25 years and followed up his environmental and public health concerns by becoming an active and effective politician at both local and NSW State levels. He then volunteered with Medecins sans Frontieres and Timor Aid (post independence) before establishing ADI in 2001. He is currently working as a doctor in remote and indigenous health programs in Australia.

VICE PRESIDENT

George McLelland OAM, CA

George was NSW Secretary of Lend Lease's construction company Civil and Civic, and Company Secretary for an Investment Bank. In retirement, he became ADI's Treasurer at its inception and has been a very committed and active member of the Manly community through Rotary, Manly Community Centre and Seaforth Bowling Club.

TREASURER

Margarita Krasteva CPA BCom GradDipCom M Com

Early in her career Margarita worked in London as a Financial Analyst; then on her return to Adelaide as a Business Analyst. Moving to Sydney, she is now in the travel industry. As Financial Controller she leads the finance team of a major travel wholesaler.

SECRETARY & PUBLIC OFFICER

Patricia Anne Lanham OAM, BSc MHID

Anne followed an extensive career working as a microbiologist in major hospitals in Australia and Canada with eight years as electorate officer for Peter Macdonald when he was NSW State Member of Parliament. She is a co-founder of ADI and since completing her Masters in International Development has worked on Accreditation and Compliance issues for ADI.

Liza Nadolski BA LLB LLM

Liza has had extensive experience in clinical governance and risk within the healthcare sector across hospitals, insurance agencies and a number of large corporate organisations. Liza has been a member of the ADI Risk and Compliance Committee since March 2013 and a Board Director since August 2014.

Dr Judy Lambert AM, BPharm BSc (Hons) PhD GradDipEnvMgt Grad DipBusAdmin

Judy is an environment, social and medical sciences expert who has worked in research, policy, ministerial consultancy, advocacy and community development roles. Until recently, she was Director of Community Solutions.

Colin Plowman BA MSc

Colin has been a highly credentialed public sector senior executive with demonstrated success as a leader and manager and in delivering strong governance, corporate and operational services. He is highly experienced in policy development and delivery of high value programs and projects, including a number to Australian Indigenous communities.

Virpi Tuite BBA (Int Studies)

Virpi is a human resources generalist and a strong believer in the way volunteering contributes to the society and mental well being. She is experienced in team leadership, people management and strategy, with the ability to work effectively with colleagues and stakeholders to achieve the best HR solutions. Virpi volunteered in the ADI office for six years and joined the Board in 2017.

Boronia C Foley BA Dip Ed, MA

Boronia worked across NSW public education for 32 years – moving from schools through to Senior Management. She developed particular expertise in Workplace Relations, Organisation Development and Governance.

Since retiring she has worked as an Australian Business Volunteer in Indonesia, Cambodia and the Solomon Islands.

Richard Schroder BS (Hons)

Richard has 40+ years of experience in the resources business which extends to both the UK and Norwegian sectors of the North Sea, Africa, Indonesia, PNG, NZ and onshore/offshore Australia, managing companies such as Santos and Sydney Oil Company. Richard has taken an active interest in social factors that affect PNG. Many of Kina Petroleum's assets are located in Western Province an area where ADI has extensive operational experience and an area of acute medical need.

Louise Walker BEc, MComm, CAIA, GAICD

Louise has more than 25 years' experience in funds management, mainly at Macquarie Group and now at Brookvine. She is also President of Mosman Football Club. Louise joined ADI's fundraising committee in 2017 and joined the board in August 2018.

The Board of ADI relies on the support of members of their volunteer committees who have been chosen for their exceptional knowledge in their specific areas. The CEO is an invited member to all Board committees.

COMMITTEE MEMBERS

Accreditation Committee:
Anne Lanham (Chair), Dr Peter Macdonald, George McLelland, Judy Lambert, Colin Plowman, Margarita Krasteva, Liza Nadolski, Liz Mackinlay (resigned Sept 2017) and Boronia Foley.

Program Committee:
Dr Judy Lambert (Chair), Dr Klara Henderson, Dr Bernie Hudson, Wamiq Khan (resigned June 2017), Anne Lanham, Dr Peter Macdonald, George McLelland, Dr Mark Newcombe, Dr Becky Taylor, Yaman Kutlu, Dr Joanne Epp and Liz Mackinlay (resigned Sep 2017).

Risk and Compliance Committee:
Dr Peter Macdonald (Chair), David Buxbaum (resigned Aug 2017), Turner Massey, Richard Magee, Liza Nadolski, Liz Mackinlay (resigned Sep 2017) and Dr Klara Henderson.

Revenue Committee:
Colin Plowman (Chair), Dr Peter Macdonald, George McLelland, Lili Koch, Margarita Krasteva, Liz Mackinlay (resigned Sep 2017), Dr Klara Henderson, David Buxbaum (resigned Aug 2017) and Louise Walker.

Finance and Audit Committee:
Margarita Krasteva (Chair), George McLelland, Dr Klara Henderson and Dianne O'Brien.

Dr Penny Uther conducting public health education

On route to Iowara, Western Province

Board of Directors' Report
Declaration of Financial Statements

The names of members of the Board of Directors during the year ended 30 June 2018 and at the date of this report are:

- Dr Peter Alexander Cameron Macdonald – President
- George McLelland – Vice President
- Margarita Krasteva – Treasurer
- Patricia Anne Lanham – Secretary & Public Officer
- Liza Nadolski
- Dr Judy Lambert
- Colin Plowman
- Virpi Tuite (appointed 16/11/2017)
- Boronia Foley (appointed 16/11/2017)
- Richard Schroder (appointed 16/11/2017)
- Louise Walker (appointed 23/07/2018)

Each of the Board members provided their services on a voluntary basis, with reimbursement for out-of-pocket expenses incurred in the discharge of duties. The Board is supported by the Program, Revenue, Accreditation, Finance and Audit and Risk and Compliance Committees. Each of these committees has Terms of Reference that define their roles and responsibilities and report to the Board on a regular basis.

Declaration

The Board of Directors declares that:

(a) The financial statements and notes, as set out on page 40 – 44 are in accordance with the Associations Incorporation Act 2009 and:

  a. Comply with relevant Australian Accounting Standards as applicable; and

  b. Satisfy the requirements of The Australian Charities and Not-for-profits Commission Act 2012 (ACNC Act 2012); and

  c. Give a true and fair view of the financial position as at 30 June 2018 and of the performance of the association for the year ended that date;

(b) In the opinion of the Board of Directors there are reasonable grounds to believe that the association will be able to pay its debts as and when they become due and payable.

This report and declaration dated this 25th day of October 2018 is made in accordance with a resolution of the Board of Directors.

Dr Peter Macdonald, OAM
President

George McLelland, OAM
Vice President

Financial Overview

for the year ended 30 June 2018

Your directors present this report to the members of ADI for the year ended 30 June 2018.

ADI's net surplus as at 30 June 2018 was $57,965 which was an increase from the previous year (2016/17 $2,352).

Total revenue for the year was $1,089,663 which is slightly (2%) lower than the previous year. This figure includes the non-monetary contributions of our in-country volunteer doctors and health coordinators ($241,437). ADI continued to receive support from the New Ireland Provincial Government and the Australian Government's Department of Foreign Affairs and Trade (DFAT) along with corporate sponsorship from Horizon Oil and Becton Dickinson and support from a number of foundations and individuals. ADI introduced two new fundraising initiatives during the financial year. The Cabaret Dinner, a community event held at the Seaforth Bowling Club and the inaugural ADI Adventure Bike Ride, Pedal4PNG. With the support of ADI team members, riders cycled the 260kms from Namatanai to Kavieng, New Ireland Province. Both initiatives were well received and supported.

Total expenditure in 2017/18 was $1,031,698, down 7% from last year. Our international program work was performed wholly within PNG and made up 71%* of our total expenditure.

The board would like to acknowledge our Auditor, Raymond Patmore, for auditing ADI's Financial Statements.

The Board of Directors acknowledges there have been:

1. No significant changes in the state of affairs of ADI;
2. No changes to the principal activities of ADI during the financial year;
3. No matters or circumstances that have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the company;
4. No environmental issues that have arisen during the financial year;
5. Insurance premiums paid to provide indemnity cover for ADI's Board members.

Finances at a Glance

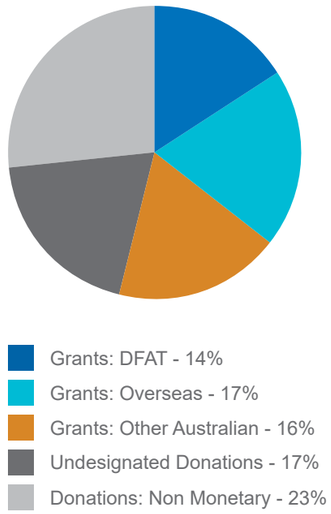
for the year ended 30 June 2018

	2017/18
REVENUE	$
Grants - DFAT	150,000
Grants - Overseas	187,500
Grants - Other Australian	173,000
Undesignated Funding	324,476
Donations - Non Monetary	254,687
Total Revenue	**1,089,663**

EXPENDITURE	$
Fundraising & Community Education	70,312
Accountability & Admin	226,246
Non Monetary Expenditure for International Programs	254,687
International Program and support costs	480,453
Total Expenditure	**1,031,698**

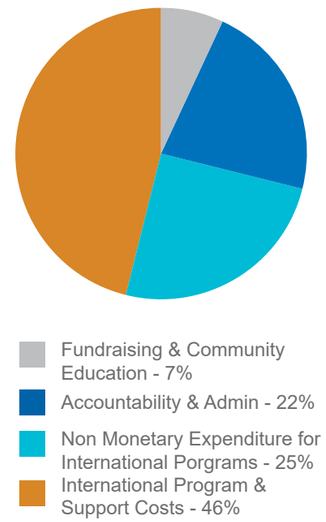
Total Revenue

$1.1 million FY 2017/18



Total Expenditure

$1.0 million FY 2017/18



Auditor's Report

for the year ended 30 June 2018

Raymond J.Patmore B.Ec F.C.A J.P
Chartered Accountant
P.O. Box 175
FRESHWATER NSW 2096
Telephone: (02) 9938 5685
Fax: (02) 9939 6269
Email: raymondjpatmore@hotmail.com
ABN 86 665 216 632

To the members of Australian Doctors International Incorporated

Scope

I have audited the financial report of Australian Doctors International Incorporated for the year ended 30 June 2018. The Association directors are responsible for the financial statements and have determined that the accounting policies used are consistent with the financial reporting requirements of the Association and are appropriate to meet the needs of the Association. I have conducted an independent audit of these financial statements in order to express an opinion on them. No opinion is expressed as to whether the accounting policies used are appropriate to the needs of the company.

I disclaim any assumption of responsibility for any reliance on this report or on the financial statements to which it relates to any person other than the directors, or for any purpose other than for which it was prepared.

The audit has been conducted in accordance with Australian Auditing Standards. The procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statement and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion whether in all material aspects, the financial statements are presented fairly in accordance with the accounting policies described in the financial statements. These policies do not require the application of all Accounting Standards and other mandatory professional reporting requirements (Urgent Issues Group Consensus Views).

The audit opinion expressed in this report has been formed on the above basis.

Independence

In conducting the audit, I have complied with the independence requirements of Australian professional ethical pronouncements.

Audit Opinion

In my opinion, the financial report of Australian Doctors Incorporated is in accordance with:

a) The Associations Incorporation Act 2009 including:

1) Giving a true and fair view of Australian Doctors International Incorporated financial position as at 30 June 2018 and its performance for the year ended on that date;
2) Complying with Accounting Standards; and
3) Australian Doctors International Incorporated Constitution; and

b) ACFID Code of Conduct – Compliant Financial Statements; and
c) Other mandatory professional requirements.

RAYMOND J PATMORE F.C.A

25 October 2018
Freshwater NSW

Liability limited by a scheme approved under Professional Standards Legislation

Chartered Accountant

Income Statement

for the year ended 30 June 2018

	Notes	2018	2017
REVENUE		**$**	**$**
Donations and gifts			
Monetary		280,241	143,398
Non Monetary	4	254,687	367,328
Bequests and Legacies		-	-
Grants			
DFAT		150,000	150,000
Other Australian		173,000	232,000
Other overseas		187,500	191,489
Investment Income	5	4,610	4,778
Other Income	6	39,625	28,069
Revenue for International Political or Religious Prosellytisation		-	-
Programs		-	-
TOTAL REVENUE		**1,089,663**	**1,117,062**
EXPENDITURE			
International Aid and Development Programs Expenditure			
Funds to international programs	2	306,957	299,525
Program support costs		173,496	199,900
Community education		1,580	2,322
Fundraising Costs			
Public	7	68,732	28,463
Government multilateral and private		-	-
Accountability and Administration	8	226,246	217,172
Non-Monetary Expenditure	4	254,687	367,328
Total International Aid and Development Programs Expenditure		**1,031,698**	**1,114,710**
Expenditure for International Political or Religious Proselytisation		-	-
Programs		-	-
Domestic Programs Expenditure *(Incl Monetary and Non Monetary)*		-	-
TOTAL EXPENDITURE		**1,031,698**	**1,114,710**
EXCESS/(SHORTFALL) OF REVENUE OVER EXPENDITURE		**57,965**	**2,352**

Balance Sheet

for the year ended 30 June 2018

	Notes	2018	2017
Assets		$	$
Current Assets			
Cash and cash equivalents	3	684,282	587,479
Trade and other receivables		5,038	6,249
Inventories		-	-
Assets held for sale		-	-
Other financial assets		-	-
Total Current Assets		**689,320**	**593,728**
Non Current Assets			
Trade and other receivables		-	-
Other financial assets		-	-
Property plant and equipment		-	-
Investment property		-	-
Intangibles		-	-
Other non current assets		-	-
Total Non Current Assets		-	-
TOTAL ASSETS		**689,320**	**593,728**
Liabilities			
Current Liabilities			
Trade and other payables	9	12,532	5,827
Borrowings		-	-
Current tax liabilities	10	3,789	4,998
Other financial liabilities	11	5,675	5,075
Provisions	12	11,256	16,725
Other	13	37,000	-
TOTAL CURRENT LIABILITIES		**70,252**	**32,625**
Non Current Liabilities			
Borrowings		-	-
Other financial liabilities		-	-
Provisions		-	-
Other		-	-
Total Non Current Liabilities		-	-
TOTAL LIABILITIES		**70,252**	**32,625**
Net Assets		**619,068**	**561,103**
Equity			
Reserves		-	-
Retained Earnings		**619,068**	**561,103**
TOTAL EQUITY		**619,068**	**561,103**

The above financial statement should be read in conjunction with the accompanying financial notes.

Cash Flow Statement

for the year ended 30 June 2018

	Notes	2018	2017
Cash flow from operating activities		$	$
Receipts from Operations		831,577	795,383
Operating Payments		739,384	768,396
Net Cash provided by (used In) operating activities	15	92,193	26,987
Cash flow from investing activities			
Investment Income		4,610	4,778
Payments for property, plant, equipment		-	-
Net Cash provided by (used in) investing activities		4,610	4,778
Net increase (decrease) in cash held		96,803	31,765
Cash at beginning of financial year		587,479	555,714
CASH AT END OF FINANCIAL YEAR		**684,282**	**587,479**

Reconciliation of cash

For the purposes of the cash flow statement,cash includes cash on hand and in banks and investments in money market instruments,net of outstanding bank overdrafts. Cash at the end of the financial year as shown in the statement of cash flow is reconciled to the related items in the statement of financial position as follows:

Cash	3	-	391,718
NIPG advance funding		-	195,761
CASH AT END OF FINANCIAL YEAR		**-**	**587,479**

Changes in Equity

	Retained Earnings		Total	
	2018	**2017**	**2018**	**2017**
Balance at beginning of year	561,103	558,751	561,103	558,751
Excess/(shortfall) of revenue over expenses	57,965	2,352	57,965	2,352
Amount transferred (to) from reserves	-	-	-	-
BALANCE AT END OF YEAR	**619,068**	**561,103**	**619,068**	**561,103**

Financial Notes

Note 1 Summary of significant accounting policies and basis of accounting

The summary financial statements have been prepared in accordance with the requirements set out in the ACFID Code of Conduct. For further information on the Code please refer to ACFID Code of Conduct Guidelines available at www.acfid.asn.au. This general purpose financial report has also been prepared to meet the requirements of the *Associations Incorporations Act 2009*, comply with Accounting Standards and other mandatory professional requirements and to be in accordance with the constitution of Australian Doctors International Incorporated. It has been prepared on the basis of historical costs, and except where stated does not take into account current values of non current assets. These non-current assets are not stated at amounts in excess of their recoverable values. Unless otherwise stated, the accounting policies are consistent with those of the previous year. Australian Doctors International Incorporated is a not for profit charitable organisation and this financial report complies with such of the prescribed requirements as are relevant thereto.

A. Foreign currency. Transactions denominated in a foreign currency are converted at exchange rates prevailing during the financial year. Foreign currency receivables, payables and cash are converted at exchange rates at balance sheet date.

B. Depreciation of property, plant and equipment. Property, plant and equipment acquired for international aid and development programs is charged to these programs in the year of acquisition. Depreciation on other property, plant and equipment is calculated on a straightline basis to write off the net cost of each item over its estimated useful life.
The carrying amount of property, plant and equipment is reviewed annually to ensure it is not in excess of the recoverable value of these assets.

C. Income Tax. Australian Doctors International Incorporated is exempt from income tax under the *Income Assessment Act 1997*.

D. Cash and cash equivalents. For the purposes of the statements of cash flows, cash includes cash on hand, deposits held at call with banks ,and investments in money market instruments which are readily converted to cash on hand and are subject to insignificant risk of changes in value.

E. Comparative figures. When required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

Note 2 International aid and development programs

	Notes	2018	2017
Doctors, education and training		$	$
Non-monetary	(Note 4 below)	254,687	367,328
Funds to international programs		306,957	299,525
Program support costs		173,496	199,900
Total		**735,140**	**866,753**

Note 3 Table of cash movements for designated purposes

Program	Cash available at beginning of year	Cash raised during the year	Cash disbursed during year	Cash available at end of year
New Ireland Province, PNG				
Namatanai Hospital	34,440	0	34,440	0
Inservice Training (NIPG)	84,042	20,833	29,324	75,551
Integrated Patrols	35,483	135,000	128,759	41,724
Pathology	38,844	30,000	71,445	-2,601
NIPG Patrols (NIPG)	196,485	166,667	150,182	212,970
Western Province, PNG				
Catholic Health Improvement	22,602	50,000	44,197	28,405
Other Projects				
Family Planning	43,997	93,000	6,695	130,302
Non Designated	131,586	339,476	273,131	197,931
Total Cash Movements	**587,479**	**834,976**	**738,173**	**684,282**

Note 4 Non-monetary revenue/expenditure

International and development programs	2018	2017
Medical volunteers	241,437	328,334
Non-medical volunteers	11,983	25,494
Medical equipment and supplies	1,267	13,500
Property,plant and equipment	-	-
Total international and development programs	254,687	367,328
Other	-	-
Total non-monetary revenue/expenditure	**254,687**	**367,328**

Note 5 Investment Income

	2018	2017
Bank Interest	4,610	4,778

Financial Notes

Note 6 Other Income

	2018	2017
Annual Gala Dinner	39,625	28,069

Note 7 Fundraising Costs

	2018	2017
Costs of attracting Corporate Sponsorship	3,472	9,022
Campaign Costs (EOFY and Xmas)	4,289	5,720
Annual Gala Dinner Costs	17,235	13,721
Adventure Bike Ride to PNG	43,736	-
	68,732	**28,463**

Note 8 Accountability and Administration

These costs relate to the operational ability of the organisation and include the cost of running the Sydney office. This includes staff costs which are not able to be allocated to program support costs and other costs such as rent, stationery and IT.

Note 9 Trade and Other Creditors

	2018	2017
Trade creditors	0	1,827
Accrued charges	12,532	4,000
	12,532	5,827

Note 10 Current Tax Liabilities

	2018	2017
Australia GST Receivable	(2,596)	(2,515)
PNG GST Receivable	(8,120)	(5,277)
PAYG	14,505	12,790
	3,789	4,998

Note 11 Other Financial Liabilities

	2018	2017
Prepaid member subscriptions	5,675	5,075

Note 12 Provisions

	2018	2017
Annual Leave Accrual	11,256	16,725

Note 13 Other Current Liabilities

	2018	2017
Deferred Project Revenue - Western Province	37,000	-

Note 14 Remuneration of Auditor

The auditor, Mr. R J Patmore Chartered Accountant, does not receive any remuneration for his services.

Note 15 Reconciliation of Excess (Shortfall) to Net Cash Flow from Operating Activities

	2018	2017
Excess (shortfall) of revenue over expenditure	57,965	2,352
Depreciation	(5,570)	-
Increase in creditors	(1,088)	(28,012)
Increase in deferred revenue	37,000	-
Investment Income	(4,610)	(4,778)
Capital Expenditure	5,570	-
PAYG	1,715	6,997
Decrease in trade and other receivables	1,212	50,428
Decrease in loans payable	-	-
Advances	-	-
Cash inflow (outflow) from operating activities	**92,193**	**26,987**

Note 16 Presentation of Graphs

The graphs included are based on the information contained in the current year's financial statements and relate to one period only.
Revenue shows each revenue type as a percentage of total revenue received by the organisation.
Undesignated Revenue includes monetary donations, investment income and other income.
Non-Monetary Revenue includes voluntary services and donations of goods in kind.
Expenditure shows each expenditure type (from the ACFID Option 2 Income Statement template) as a percentage of total expenditure.
International Program Expenditure shows the percentage of total International Program and program support costs incurred on each program.

adi australian doctors international

Working for a healthier PNG

Governance Statement

Australian Doctors International is incorporated in New South Wales under the *Associations Incorporation Act 1984*. Ultimate responsibility for the governance of the company rests with the Board of Directors, who control and manage the affairs of the Association.

Risk and Ethical Standards

ADI acknowledges that it faces many risks including operational, reputational, financial reporting and compliance risks. Through our Risk and Compliance Committee and operational management ADI works to reduce and mitigate these risks to protect all our stakeholders and ensure these risks do not stop us achieving our goals. Board members, staff and volunteers are expected to comply with all relevant laws and the codes of conduct of relevant professional bodies and to act with integrity, compassion, fairness and honesty at all times. ADI shows a commitment to this through its Governance and Administration Handbook and Staff Handbook which detail ADI's ethical standards, code of conduct, conflicts of interest policy and child safeguarding policy.

Accountability

ADI is a member of the Australian Council for International Development (ACFID) and a signatory to the ACFID Code of Conduct. ADI is fully committed to the Code, the main parts of which concern high standards of program principles, public engagement and organisation. More information about the Code may be obtained from ADI or ACFID (www.acfid.asn.au). Any complaint concerning an alleged breach of the Code by ADI should be lodged with the ACFID Code of Conduct Committee.

ACFID's contact details
Postal address:
Private Bag 3, Deakin ACT 2600, Australia
Telephone: +61 2 6285 1816
Fax: +61 2 9949 8231
Email: main@acfid.asn.au

ACFID MEMBER

Any other complaint concerning ADI should be addressed to ADI's President and Vice President.

ADI's contact details
Postal address:
PO Box 324 Seaforth NSW 2092 Australia
Office address: BUPA Building 550C Sydney Road, Seaforth NSW 2092
Telephone: +61 2 9907 8988
Email: adioffice@adi.org.au
ABN: 15 718 578 292 **Website**: www.adi.org.au

ADI holds a charitable fundraising authority (number 17073) under section 13A of the *Charitable Fundraising Act 1991* and is bound to comply with the provisions of the Act. ADI is also endorsed as an income tax exempt charitable entity and endorsed as a Deductible Gift Recipient under the *Income Tax Assessment Act 1997*. ADI is one of only about 50 Australian NGOs accredited with the Department of Foreign Affairs and Trade (DFAT) (formally AusAID); and received funding through the Australian NGO Cooperation Program (ANCP).

Annual Report Graphic Design: Fiona Russell

Australian Aid

Australian Government
Department of Foreign Affairs and Trade

adi australian doctors international

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