adi australian doctors international

Working for a healthier PNG

Annual Report 2019/20

Contents

Cover picture used with permission by PNG Sustainable Development Program Aerial Health Patrols (AHP) and the Debepari community: *Mother and baby visiting an Aerial Health Patrol clinic in Western Province, March 2020*

"A big thanks to the ADI team for coordinating the leadership in delivering specialist care in rural communities through the financial support of NIPG and NIPHA team. This is a great service to our rural communities in the face of challenges."

- Dr Penny Charles, Director Curative Health Services,
New Ireland Provincial Health Authority

A young patient from Upper Fly with Dr Shanta Velaiutham, Western Province, October 2019

Partnerships

We work closely with our local health service delivery partners; and seek to jointly implement health programs.

We ensure there is appropriate governance in place and to this end we have MOUs with:

- the PNG National Department of Health,
- the New Ireland Provincial Government and New Ireland Provincial Health Authority,
- the West New Britain Provincial Government and West New Britain Provincial Health Authority; and
- the Diocese of Daru-Kiunga in Western Province

We also have a good relationship with North Fly District in Western Province and look forward to the opportunity to partner with the newly emerging Western Province Provincial Health Authority.

To support our family planning work we have recently become an implementing partner with United Nations Population Fund (UNFPA); and signed a letter of understanding with Marie Stopes PNG.Through partnerships we are able to leverage additional skills and knowledge under a shared goal of improving the health of rural communities in PNG.

MINISTRY OF HEALTH PNG

NEW IRELAND PROVINCIAL GOVERNMENT OURS AHEAD

WEST NEW BRITAIN

UNFPA

MARIE STOPES PAPUA NEW GUINEA

Diocese of DARU–KIUNGA Papua New Guinea

ADI Office Manager Aron Bale delivers public health education in Tiomnai Village, Western Province, April 2020

Message from our President

Sitting down to write this, I reflect on the scale of change since July 2019. Back then, I was preparing for Bishop Giles from Kiunga, Western Province to attend ADI's annual Gala Dinner in October in Sydney. We were also honoured to have Zali Steggall, James Griffin and Michael Regan in attendance – all three levels of government representing our Australian home base. During the dinner we celebrated the progress ADI had made, rising from a small organisation formed by myself, Anne Lanham, and George McLelland in 2000. This year marks our 20th year of operations.

In marking a number of important anniversaries – both our 20th year of operation and our 10th year in New Ireland - I went over some of our earliest annual reports. Back in 2003 our reported revenue was a mere $165,000. In this year's financial report, you'll note we are now at an income level of $1.8 million. This is a huge step forward for a small NGO started two decades ago by a group of medical and health friends.

Part of the celebrations at the October Gala Dinner was of the investment in and establishment of our work in a new province in PNG – West New Britain. In November, Brent Emmett, ADI Director, and I travelled to West New Britain, Papua New Guinea to meet with the Provincial Governor. Our trip resulted in the signing of a Memorandum of Understanding between the Provincial Government and Provincial Health Authority and ADI to collaborate and provide health support to remote areas of West New Britain, in particular the south coast; and educational support to help health workers operating there. In the same trip I also visited a training session run by an ADI midwife, to witness ten nurses and midwives learning life-saving emergency obstetric techniques.

On my return to Australia from PNG in November, I was greeted by the devastating bushfires wreaking havoc along Australia's East Coast, shortly followed by the announcement of the global coronavirus pandemic - how our world has been completely turned around.

ADI is a health delivery organisation. As details emerged of coronavirus and its arrival on Australia's shore, we at ADI, were immediately deeply concerned about the impact this deadly disease would have on our fragile neighbour PNG. With our health team already on the ground, we set about supporting and preparing them for prevention and management of cases in a low-resource setting. We continued those plans even when we were directed to remove Australian staff from PNG - which we did hastily and safely in March. We were able to continue and even ramp up our work in PNG due to the presence of our skilled and highly motivated PNG team. Details of our COVID-19 response in PNG are outlined throughout this report.

During 2020 the board has looked to renew its composition and has invited a new director, James Sheffield, to join. James comes to ADI having spent eight years on the board of ChildFund – his years of experience in managing an international NGO of this calibre and size makes him a real asset to our board.

If you are in any way a contributor to the work of ADI, you should feel immensely proud of the work and impact we have had in PNG this year.

I invite you to read about that impact here.

Dr Peter Macdonald
OAM MBBS MRCGP DA
DRCOG
ADI President

Message from our CEO

In July 2019 we received our full accreditation grant from the Australian Government through the Australian NGO Cooperation Program – our strategic plan and program of work had set us up to expand into new geographic areas of PNG. Through analysis and consultations in country we focused this expansion strategy into West New Britain and also joined the Aerial Health Patrol team out of Balimo in Western Province with financial support from the PNG Sustainable Development Program (SDP). By August we had deployed a doctor into Balimo, followed in quick succession by a volunteer nurse and second doctor. In West New Britain, we signed a Memorandum of Understanding with the Provincial Health Authority and Provincial Government in November 2019, by January 2020 we had undertaken a safety review, secured an ADI base, deployed a program manager and identified volunteer doctors to rotate through the province during 2020.

Of course like every other organisation, business, family and person on the planet, our plans were altered with the tumultuous and devastating arrival of the COVID-19 pandemic in early 2020, resulting in all ex-pat staff and volunteers being called home in March, and Australian-based staff and board meetings moving to remote working and virtual meetings. However, over time ADI had also been carefully and gradually implementing another objective, to grow our PNG staff base. Importantly for us, this meant when the consequences of the pandemic began to bite in March, our goal to work for a healthier PNG could still be sought through our stellar team on the ground in PNG while the Australian team was 'locked-down' and 'out' of PNG.

ADI is a health service organisation, without a doubt we saw our role amidst the pandemic to respond swiftly and to maximise our health impact and build health security in rural PNG. Every single member of the ADI team stepped up and worked harder, longer and in new areas and ways to ensure we could deliver on that. We responded to calls from the PNG National Department of Health, and Provincial COVID-19 Task Forces. We took on new tasks, designed new programs, innovated in our delivery mechanisms and formed new partnerships – the spirit of cooperation was unlike anything I'd previously been a part of. When we were asked to help – we always responded with yes. Yes, we can provide triaging at Kavieng Hospital. Yes, we can provide PPE for PNG Defence Force personnel visiting remote and border communities in Western Province. Yes, we can purchase and ship essential medical equipment to under-resourced health centres; yes, we can provide educational webinars on how to use scarce PPE and how to care for maternal health patients in times of COVID-19; yes, we can provide community awareness outreach patrols incorporating gender protection to remote islands of New Ireland. Yes, we can support schools in Western Province with educational materials, non-touch thermometers so they can reopen after lockdown. Yes, we can provide soap and buckets to any health centre that needs them across West New Britain, New Ireland and Western Province. We are privileged to be part of PNG's health system and the collective response to COVID-19, whilst also keenly maintaining health services that protect the lives of Papua New Guineans in all the other areas of health need.

We measure our impact through a set of key indicators – see pages 14 to 15 – our growth, even with the COVID-19 pandemic saw the number of days on patrol grow from 215 in 2019/20 to 273 this year; while the number of clinical services delivered was still large at over 20,000 it represents a drop from last year. Unswervingly our commitment to rural and remote areas remained – with the inclusion of two new geographic areas (South Fly, Western Province; West New Britain) our ratio of reach of remote communities remains very high at 99%.

In last year's annual report, I wrote of our commitment to women and children's health – this commitment remains and our program work in this area features heavily in this report. Uncertainty remains and the speed of change is high, but our mission to work for a healthier PNG is resolute.

If you have in any way supported the work of ADI, you should feel proud of the public health approach, and protection and support of rural communities, women and health workers we have been able to provide into PNG this past year. We are grateful for your support and we hope your interest continues.

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

Acronyms

ACFID	The Australian Council For International Development
ADI	Australian Doctors International
AHP	Aerial Health Patrol
ANCP	Australian NGO Cooperation Program
AP	Aid Post
CDC	Centers for Disease Control and Prevention (US)
CHP	Community Health Post
CHS	Catholic Health Services
CHW	Community Health Worker
CMT	Community Mobilisation Training
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Corona Virus Disease 2019
CYP	Couple Years Protection
DFAT	Australian Department of Foreign Affairs and Trade
DTP3	Third dose of the Diphtheria, Tetanus and Pertussis vaccine
EMONC	Emergency Obstetric and Neonatal Care (ADI's training course)
GESI	Gender Equity and Social Inclusion
HC	Health Centre
HEO	Health Extension Officer
HSC	Health Sub-Centre
KRA	Key Result Area
LLG	Local Level Government
MOU	Memorandum of Understanding
NDOH	National Department of Health in PNG
NIPG	New Ireland Provincial Government
NIPHA	New Ireland Provincial Health Authority
NO	Nursing Officer
OCP	Oral Contraceptive Pill
ORS	Oral Rehydration Salts
PHA	Provincial Health Authority
PNGSDP	Papua New Guinea Sustainable Development Program
PPE	Personal Protective Equipment
RDT	Rapid Diagnostic Test
SDG	Sustainable Development Goals
SIC	Sister In Charge
SOE	State of Emergency
STI	Sexually Transmitted Infection
STMs	Standard Treatment Manuals
TB	Tuberculosis
UNFPA	United Nations Population Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WNBPHA	West New Britain Provincial Health Authority

Five year trends

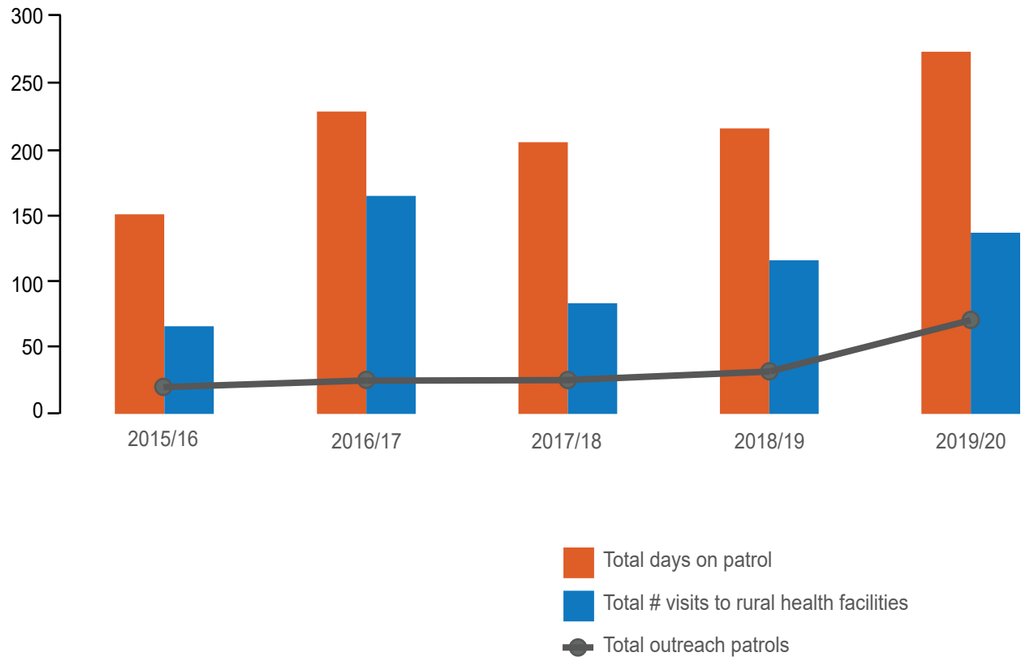
Since 2016, across Western Province and New Ireland, ADI has completed a total of:

1,482 days on outreach health patrol

671 visits to rural health facilities

239 outreach health patrols

Fig 1: Number of days on outreach health patrol per annum, number of visits to rural health facilities and number of outreach health patrols per annum



Since January 2018 ADI has actively worked to grow its reach and impact in PNG through expanding the number of days on outreach health patrol. Each day translates to access to a range of health care for a remote community in PNG. We see the increase take affect in this year's figure even when COVID-19's disruptions are taken into account. The coming year will see an increase in numbers as we continue to expand our work into West New Britain.

Where we work

Each dot represents a remote location visited by an ADI/ partner patrol, including support with PPE, STMs and

WESTERN PROVINCE

This year ADI's program in Western Province has grown in geographic reach and personnel. The employment of a fulltime, permanent Office Manager based in Kiunga to assist with patrol and in-service planning has initiated increased regular patrols and visits to new locations in the North Fly and Middle Fly Districts. In July 2019, the addition of the Aerial Health Patrol (AHP) program, in partnership with the PNG Sustainable Development Program (PNGSDP), has allowed ADI to extend its patrol work to the South Fly District for the first time.

WEST NEW BRITAIN

This financial year marked ADI's expansion in PNG, establishing a new program in West New Britain. After a successful scoping trip to Gasmata in January 2020, ADI conducted its first outreach health patrol to the remote area of Wako on the province's south coast, with a volunteer doctor and West New Britain Provincial Health Authority (WNBPHA) Nurse/Midwife. Both areas were accessed by helicopter.

NEW IRELAND

ADI first established its presence in New Ireland at the invitation of the Provincial Government in 2010. For ten years, ADI has worked closely with the New Ireland Provincial Government (NIPG) and New Ireland Provincial Health Authority (NIPHA) to deliver regular in-service training to rural health workers, and delivering 122 outreach health patrols across the province since 2011. ADI now has eight permanent and casual staff based in Kavieng.

The Sustainable Development Goals (SDGs) are a blueprint and the world's to-do list to end poverty, reduce inequalities, improve wellbeing and protect the planet. They provide a common agenda for the world to measure progress, and specifically call out action to Leave No One Behind in regard to poverty, hunger and discrimination against women and girls. For PNG, the SDGs were included in the Medium-Term Development Plan III (2018-2022) alongside supporting budget and policies.

Progress on the SDGs in PNG is hampered – not only by COVID-19 – but by technical, coordination and financial limitations, heightened by falls in government revenue stemming from drops in commodity prices.

ADI's work focuses on **SDG 3: Ensure healthy lives and promote wellbeing for all at all ages**; and **SDG 5: Achieve gender equality and empower all women and girls**. We contribute to a number of key indicators and targets as shown below.

SDG 3 Health

3.1 reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

3.2 end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

3.3 end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.4 reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.7 ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

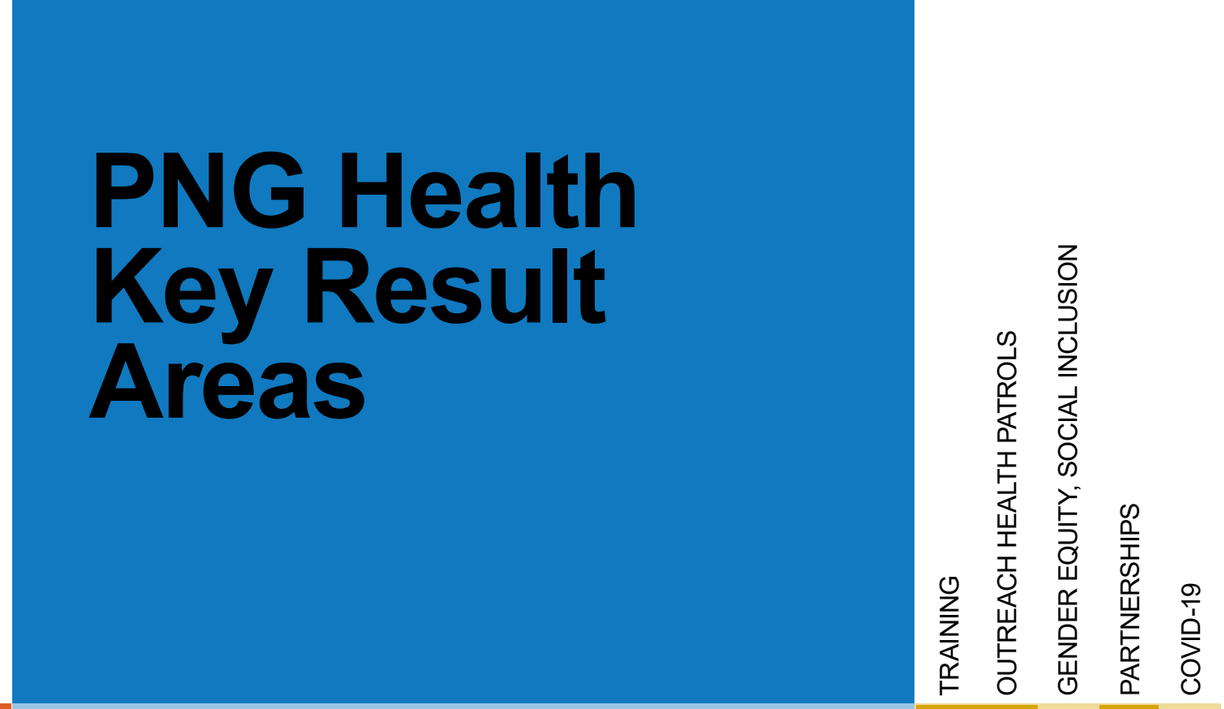
SDG 5 Gender Equality

5.1 End all forms of discrimination against all women and girls everywhere.

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

PNG Health Key Result Areas



Aligning ADI's activities to Papua New Guinea's health priorities ensures that we are actively working towards meeting the needs of those identified by our stakeholders. To do this, the Papua New Guinea National Department of Health (NDoH) National Health Plan (2011-2020) is a guiding document across all of ADI's programs and referred to throughout ADI's project documentation and reporting. Our Memorandum of Understanding (MOU) with the NDoH ensures collaboration and coordination of our results and activities within national standards and expectations.

The plan lays out eight Key Result Areas focused on improving health outcomes by focusing on service delivery (KRA 1), partnerships (KRA 2) and strengthening health systems (KRA 3), to address priority health outcomes (KRA 4-8). These KRAs are at the forefront of ADI's objectives when implementing outreach patrols, health worker training and community training, in all three provinces. The diagram above demonstrates how our activities align and intersect with multiple KRAs this financial year.

ADI thanks the NDoH and our partners for contributing to the outcomes achieved during the 2011-2020 National Health Plan period. ADI welcomes the launch of a new phase beginning in 2021, and will continue to harmonise our activities with those of the PNG NDoH.

WOMEN'S HEALTH in PNG is fragile

Maternal mortality ratio is between;
215 to **900** per 100,000 live births (20 per 100,000)

56.5% of **births** are attended by a **skilled provider** (100%)

49% of women aged 15-49 attended four or more **antenatal sessions** (95%)

Infant mortality rate is;
38 per 1000 live births (2.7 per 1000)

Neonatal mortality rate is;
22 per 1000 live births (2 per 1000)

Under five mortality rate is;
41 per 1000 live births (3 per 1000)

GENDER EQUITY

48% of **women** disclosed experience of **physical** or **sexual violence**, or both, by an intimate partner in the last 12 months (1.5%)

Gender Inequality Index score
0.71
(highest in region)

69.8% of **women** consider a **husband justified** in **beating his wife**

CHILDREN

40% of PNG's population is **under the age of 15**

75% of **children** experience **domestic violence at home**

35% of **children** have had **DTP3 vaccine** (95%)

REFUGEES

10,000 **refugees** live in Western Province

RURAL HEALTH in PNG is under pressure

87% of **population** is **rural**

PNG health workforce density
1.36 to 1000 population
(4.45 recommended by WHO)

7.7% of **rural people** using at least **basic sanitation services** (100%)

35% of **rural people** using at least **basic drinking water services** (100%)

55% of **rural population** has access to **electricity**

FAMILY PLANNING needs in PNG are not yet met

32% of married/in-union women have **unmet needs** for **modern contraception**

47% of married/in-union women's demand is **satisfied** with **modern contraception**

MOST VULNERABLE

DISABILITY

15% of PNG population live with a **disability** and less than **2%** receive adequate support

COVID-19 slow to hit PNG

(as at 2nd July):

6273 cumulative **tests**

11 **confirmed cases**

3 **confirmed cases** in **Western Province** (border villages)

*(Australian figures in brackets where available)

The Papua New Guinea context

adi australian doctors international
Working for a healthier PNG

WOMEN'S HEALTH

36 rural health workers trained in Emergency Obstetrics and Neonatal Care techniques

55% of patrol teams are female

51% of clinical services / public health educaton go to women and girls

RURAL HEALTH

19,000 rural health community members received public health education

13 volunteer doctors, nurses and midwives travelled to PNG to work for **273** days on outreach health patrols

99% of patrols went to remote villages (>4 hours of travel time), reaching **40,000** rural health people with clinical health

FAMILY PLANNING

Family Planning Officer on **58%** of outreach patrols (New Ireland only)

11 remote health workers trained in Family Planning

3500 community members attended
40 hours of Family Planning education

252 couple years protection provided

COVID-19

96 health workers trained via webinar on COVID-19

10,000 community members reached with **72** hours of COVID-19 education

1600 health workers benefited from PPE

GENDER EQUITY

195 health workers educated

54% were female (excluding AHP)

149 community leaders received education on gender equity, child protection and disability inclusion

CHILDREN

68 schools received
366 hours of public health education

1800 immunisations

REFUGEES

65 refugee patients treated

120 refugees provided with COVID-19 education

MOST VULNERABLE

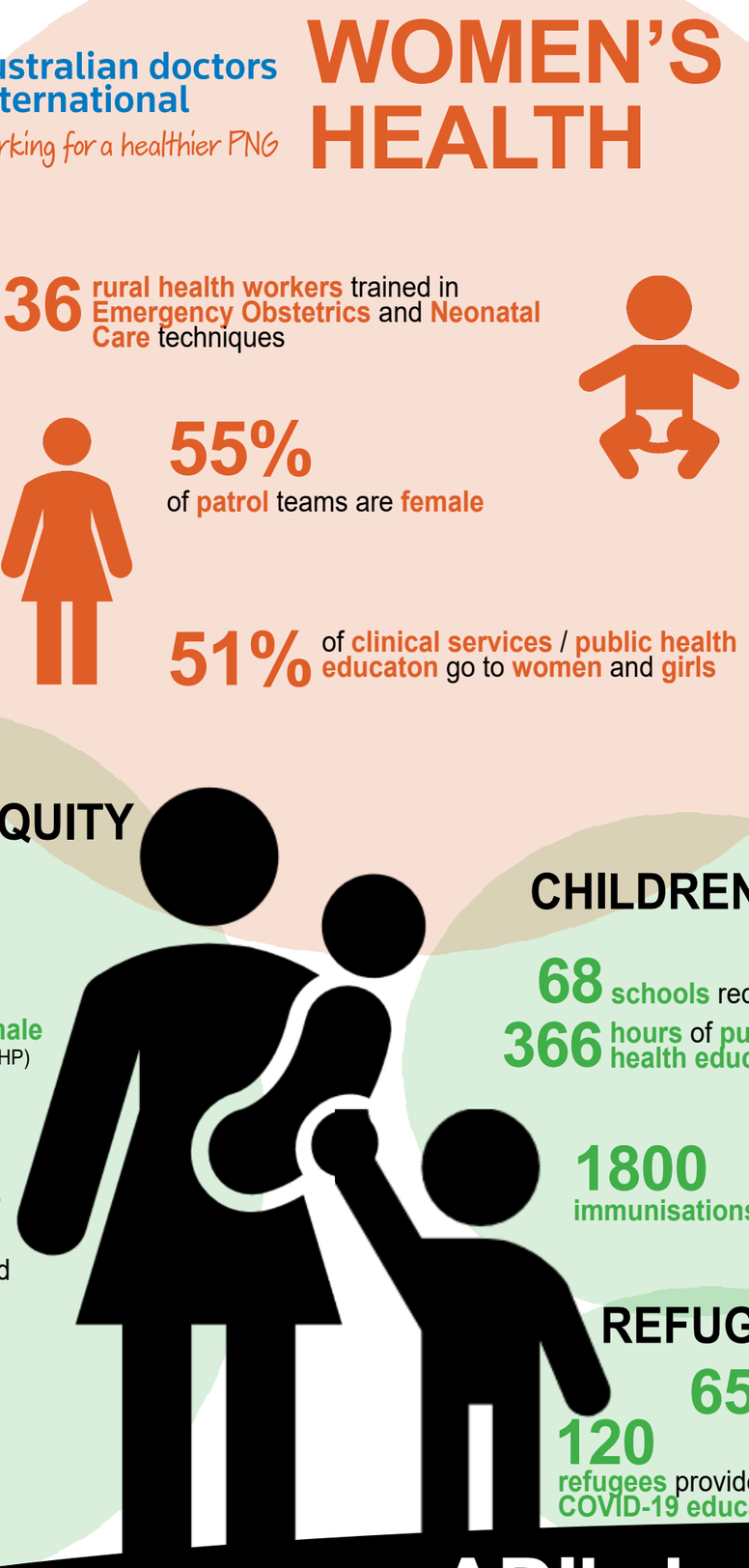
DISABILITY

372 glasses provided

40 new people registered for disability services

146 people with a disability provided with care

46 people with a disability provided with a house call



ADI's impact in PNG

Kavieng Hospital Nursing Officer, Aruke, and SIC Tati with posters and sanitisers donated by ADI, New Ireland, April 2020

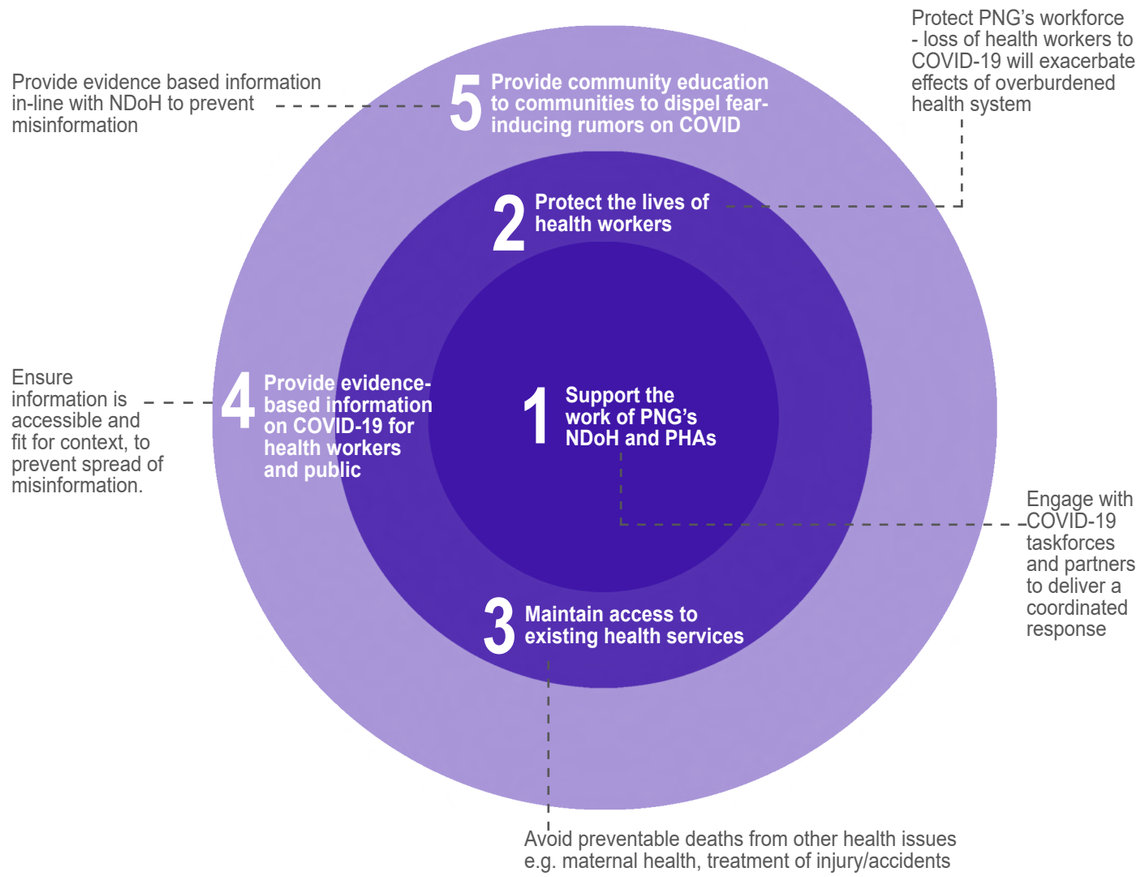
ADAPTING TO CHANGE

Part of an organisation's ability to adapt to a rapidly changing environment is its ability to understand, manage and mitigate risk. Since May 2013 ADI has had a Risk and Compliance Committee. The committee is responsible for managing organisational and program risks, including financial and safety risks. During 2020, with the arrival of coronavirus in Australia and PNG, the risk committee worked closely with the CEO and staff to orchestrate an appropriate and swift response - placing the organisation in the best position possible for a health response in PNG, while at the same time protecting the longevity and sustainability of the organisation. ADI took early advantage of technology, and actively increased the volume of communication between management and the board, and amongst the staff as a whole. From March through to June all staff and board members contributed to a strategic planning process, resulting in a redrafted strategic plan. With input and guidance from MinterEllison, ADI also reshaped its risk framework to facilitate better decision making, information flow and responsiveness.

Paediatric outpatients receiving medical equipment from ADI, Kavieng hospital, June 2020

ADI's COVID-19 Strategy

In April 2020, ADI recognised the urgency to develop a COVID-19 response and developed the following strategy:



"We were very glad to have ADI's PPE to assist in providing Kandrian LLG health workers with their education on COVID-19 preparedness. The trainees were very receptive to the use of PPE and this will provide them with good guidance on infection control not only for COVID-19, but for TB and other health issues facing West New Britain."

– Jennifer Ravakai,
West New Britain Provincial Health Authority

COVID-19 Response

In the first three months of 2020, ADI had volunteer doctors present in all three provinces. Prior to nationwide State of Emergency (SOE) lockdowns in PNG, ADI shipped essential PPE to our doctors and partner health teams to continue conducting patrols and contribute to each province's initial COVID-19 responses.Following Australian Government guidance, expat staff were brought back to Australia in March.

In all three provinces, ADI has been in close contact with Provincial Health Authorities, Provincial COVID-19 Taskforces, hospitals (in Kiunga, Rumginae, Balimo, Kimbe and Kavieng), partners and stakeholders, to offer assistance and support, and contribute towards a coordinated COVID-19 response. In addition to Provincial Health Authorities, ADI worked with other in-country partners on the ground ranging across Provincial and/or District Administrations and Governments, Local Level Governments (LLGs), Catholic Health Services, Evangelical Church of PNG (ECPNG), United Church, mining companies (e.g. Ok Tedi Mining Ltd and Newcrest Mining Ltd.), United Nations Populations Fund (UNFPA) PNG, PNGSDP, schools and local businesses.

Aron Bale with Matkomnai HC OIC Sr Philomene, Western Province, June 2020

ADI Driver Samuel Piliman assisting Kavieng Hospital with triage, New Ireland, May 2020

Key ADI PPE Distributions

900
Protective goggles

18,000
Pairs of gloves

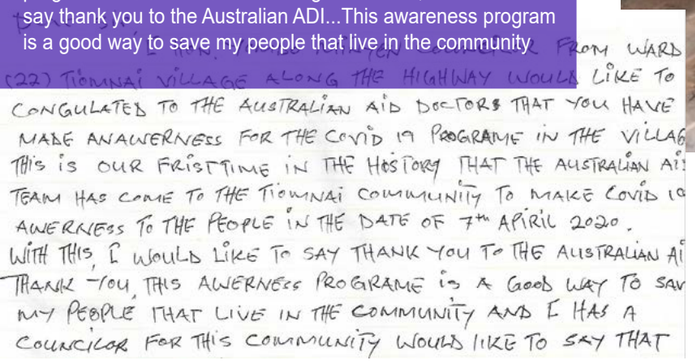
4,990
N95 masks

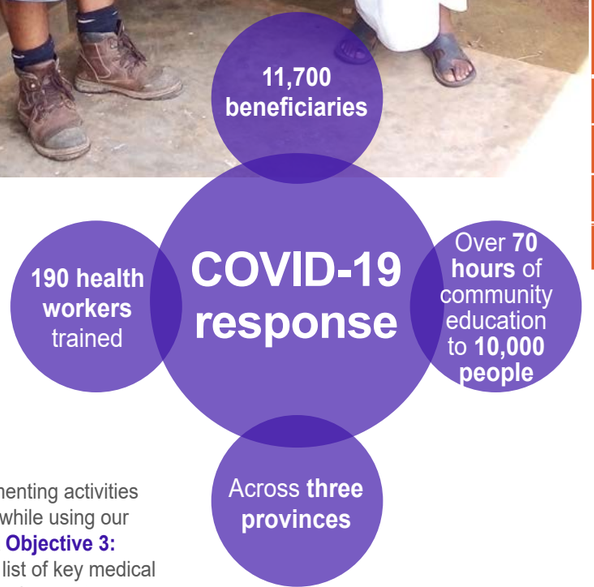
19,000
Surgical masks

942
Face shields

Dear Sir,

I, Hon. Yomdo Minyen, Councillor from Ward (22) Tiomnai Village along the highway, would like to congratulate Australian Doctors International that you have made an awareness program for COVID-19 in the village..With this, I would like to say thank you to the Australian ADI...This awareness program is a good way to save my people that live in the community.


FROM WARD
(22) TIOMNAI VILLAGE ALONG THE HIGHWAY WOULD LIKE TO
CONGULATED TO THE AUSTRALIAN AID DOCTORS THAT YOU HAVE
MADE ANAWERNESS FOR THE COVID 19 PROGRAME IN THE VILLAG
THIS IS OUR FRISTTIME IN THE HISTORY THAT THE AUSTRALIAN AI
TEAM HAS COME TO THE TIOMNAI COMMUNITY TO MAKE COVID 19
AWERNESS TO THE PEOPLE IN THE DATE OF 7TH APIRIL 2020.
WITH THIS, I WOULD LIKE TO SAY THANK YOU TO THE AUSTRALIAN AI
THANK YOU, THIS AWERNESS PROGRAME IS A GOOD WAY TO SAV
MY PEOPLE THAT LIVE IN THE COMMUNITY AND I HAS A
COUNCILOR FOR THIS COMMUNITY WOULD LIKE TO SAY THAT



Distribution of PPE, medical equipment and educational materials during COVID-19

	Western Province	New Ireland	West New Britain	TOTAL
Pieces of PPE	19,070	26,669	18,092	**63,831**
Medical equipment	354	175	164	**693**
Educational materials	1890	2383	970	**5,243**
Total weight in kg	305	375	261	**941**

During the March to June period of 2020, ADI focused heavily on implementing activities that directly supported our overall mission to ***work for a healthier PNG*** while using our newly formed COVID-19 response to guide priorities. In order to support **Objective 3: Maintain access to existing health services**, ADI sought out a priority list of key medical equipment needed to bolster the work of health clinics and health workers in remote areas, purchased and shipped items such as **pulse oximeters, digital blood pressure meters, otoscopes and stethoscopes,** and distributed these into rural clinics. Our support of this was gratefully acknowledged by our health partners and PNG doctors.

In keeping with the adapting to change process and addressing the heightened needs, ADI built on its emerging relationship with Waves For Water (a Northern Beaches, Sydney charity) to purchase, supply, and ship portable water filters to our ADI patrol teams, to provide clean drinking water for remote communities in particular health clinics – many of which operate without clean running water. We also supported our PNG team in the skills to install and use the water filter systems. We donated soap and buckets to any health clinic that requested them. We intend to grow our support for health clinics hygiene in this way.

In purchasing these items and the suite of PPE we selected and shipped, our team used the expertise and skill of ADI's volunteer medical network in Australia to evaluate and recommend items. The PPE supplied included N95 masks (compliant to Centers for Disease Control and Prevention (CDC) - US standards), surgical masks, googles, gloves and protective gowns. This focused on **Objective 2: Protect the lives of health workers**. Distribution of this equipment and tools was directed to the most needy in consultation with our PNG health service partners, and included support not only to the PNG health workers, but also the PNG police force, PNG Defence Force and schools.

We also provided (alcohol based) hand sanitizer and digital thermometers to support the provinces' efforts in assisting health workers and health facilities to triage and maintain sanitation. ADI will incorporate COVID-19 considerations into all of our outreach health patrol work as well as our in-depth health worker training in 2020/2021 and following years.

RURAL NURSES AND MIDWIVES SAVING LIVES

RURAL HEALTH in PNG is under pressure

87% of **population** is **rural**

PNG health workforce density

1.36 to 1000 population

(4.45 recommended by WHO)

7.7% of **rural people** using at least **basic sanitation services** (100%)

35% of **rural people** using at least **basic drinking water services** (100%)

55% of **rural population** has access to **electricity**

Emergency Obstetric and Neonatal Care training, Kimadan, New Ireland, November 2019

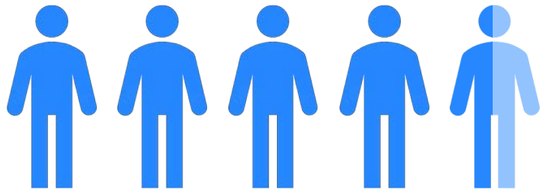
The World Health Organisation (WHO) has designated 2020 as the **Year of the Nurse and Midwife**. Nurses, and in the case of PNG, community health workers form the bulk of the health workforce at 72%; with midwives representing 12% and doctors 10%[i]. Nurses and midwives shoulder the prime responsibility for delivering a range of health priorities including universal health coverage – covering, primary and preventative care; communicable and non-communicable diseases; maternal and child health; immunisations; and serving those with mental health issues and disabilities. The pressure and responsibility on these frontline workers has grown exponentially with the COVID-19 pandemic.

Challenges facing the PNG health workforce

The consequences of an inadequate health workforce density is felt by both health workers and the communities they serve. This gap between recommended and actual health workforce density is wider within the rural network for health clinics and aid posts – the areas where ADI predominately works.

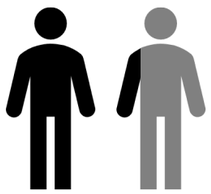
Health workforce density as recommended by WHO:

4.45 to 1000 population



Health workforce density in Papua New Guinea:

1.36 to 1000 population[v]



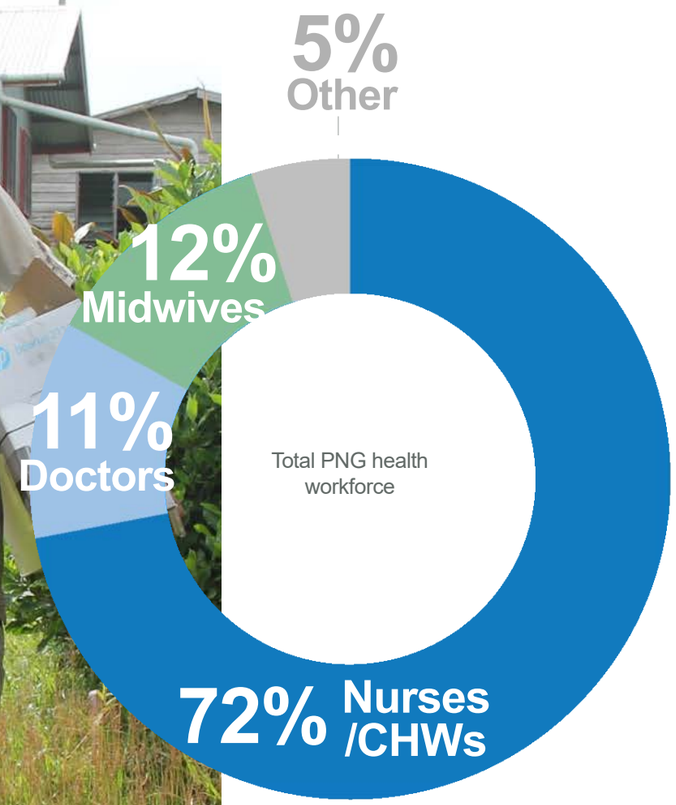
Three further problems compound the sparsity of health workforce in PNG:

1. The ageing health workforce, where estimates place 66% of PNG's nurses over the age of 35[vi]. These health workers will retire in the coming years further dwindling the density of nurses and community health workers unless the graduate rate increases at a faster pace than retirements.

2. The (mal)distribution of health workers between urban and rural does not reflect where the bulk of the PNG population live. We know of aid posts and health centres who service a huge number of community members. For example, Tarakabits, Western Province, where we visited in August 2019, two CHWs support over 3,000 community members.

3. Lack of opportunity for continuing professional support and education.

ADI Office Manager Aron Bale (left) and Nursing Officer Harim Woram (right) on patrol in Drimdemasuk, Western Province, March, 2020

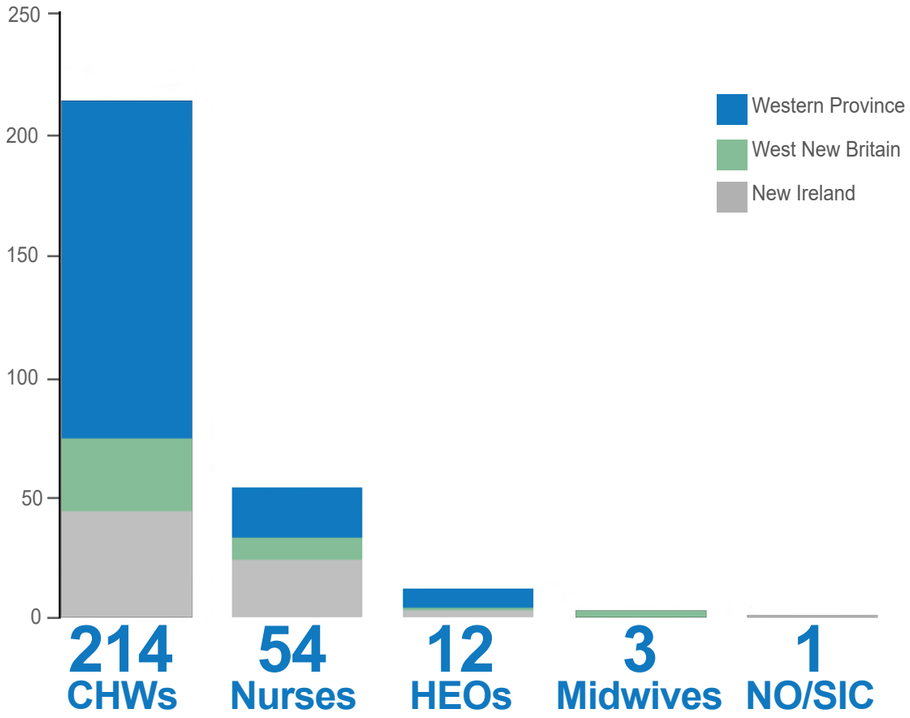


In PNG there are an estimated 700 midwives and 3200 nurses[ii] and 4500 community health workers[iii]. UNFPA estimates there are around 300,000 pregnancies each year[iv] and the resulting combination of these numbers means about 50% of women who need their pregnancies and births supported by the health workforce miss out or do not get the standard care required along the pregnancy to post-natal pathway. Only 56.5% of pregnant women have a 'skilled provider' at the birth of their baby, with a very broad definition of what level of health workers fits under the category of 'skilled'.

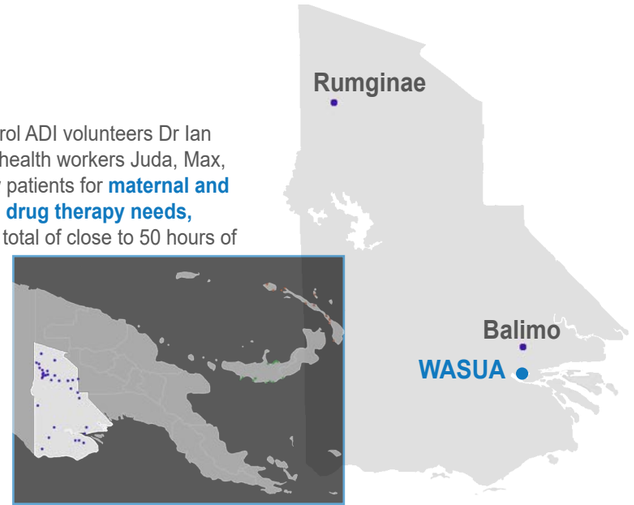
What does ADI do to support the health workforce?

Using strategies to support rural health workforce provided by WHO[vii]; and PNG's National Health Plan, ADI targeted the professional support and development of rural nurses and midwives. Since 2013 we have worked to train and educate midwives, nurses and community health workers to do their work – supporting up to 300 health workers each year to learn new clinical skills and build their confidence. For example in 2019/20 Australian volunteer doctors worked alongside and professionally supported 54 nursing officers, 12 health extension officers and three midwives; and 214 community health workers, as seen in Figure 2 below.

Fig 2: Training engagements between ADI and rural health professionals



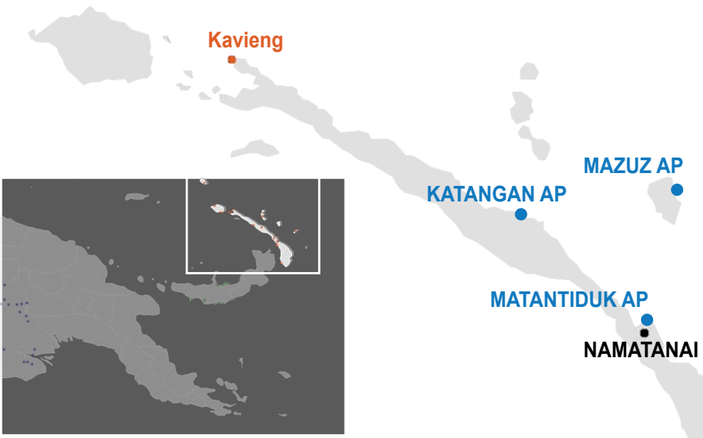
In December 2019 in the remote corners of Western Province patrol ADI volunteers Dr Ian Hunter and Nurse Nick Morris working alongside four community health workers Juda, Max, Fred and Maitonato in their Wasua Health Sub-Centre (HSC) saw patients for **maternal and child health, tuberculosis and malaria, respiratory health and drug therapy needs, sexual and reproductive health and treating of snake bites**. A total of close to 50 hours of training and professional support was provided to these four community health workers while they were on patrol. In the same week at the eastern end of PNG, Dr Nathan Lum was on 12 day patrol which included a day working with nursing officer Claire and CHW Augusta in their Mapua HSC, treating patients together who were presenting with **gastro-intestinal issues and malaria**.



From left to right: Dr Alison, Kavieng Hospital TB Officer Martha Lungagan, and Katangan Aid Post health worker Julie Sonnei during patrol in Sentral East, New Ireland, March 2020

In March 2020 ADI's volunteer doctors and midwives connected in different ways to a different set of rural nurses and midwives. The working relationship between ADI volunteer doctors and local health staff is a two-way knowledge exchange. Each learning from the other and building new skills and experiences. The breadth and diversity of this collaboration with support to nurses and midwives is exceptional:

- While on patrol Dr Alison Brown spent time professionally supporting CHWs Emmah, Fidelis and Johnston from Lengkamin and Kabil aid posts on topics of maternal and child health, drug therapy and cardiovascular health in New Ireland,
- Dr Charlene James worked with seven CHWs and three nursing officers in Wako, Pililo and Kandrian during her south coast helicopter patrol in West New Britain,
- Using case-based instruction Dr Chris McCall and CHW Edward worked through patients presenting with musculoskeletal issues in Tarakbits, Western Province,
- Also in Western Province, Dr Mikaela Seymour, with CHWs from Mougulu and Dodomona, saw patients using case based education on a range of topics including maternal and child health, gastro intestinal issues and sexual health.



In March 2020 ADI hosted a family planning training session reaching 15 health workers (nurses, health extension officers and community health workers) for five in-depth days of training on family planning choices. Participants joined from Namatanai District in New Ireland and aid posts as small and remote as Matantiduk, Mazuz and Katangan.

Each of these training engagements allows ADI to support the frontline health workers of remote and rural PNG. Often this engagement with us on patrol is the only professional clinical support PNG rural nurses, midwives and CHWs receive, yet we know they shoulder the largest share of responsibility for ensuring universal health care.

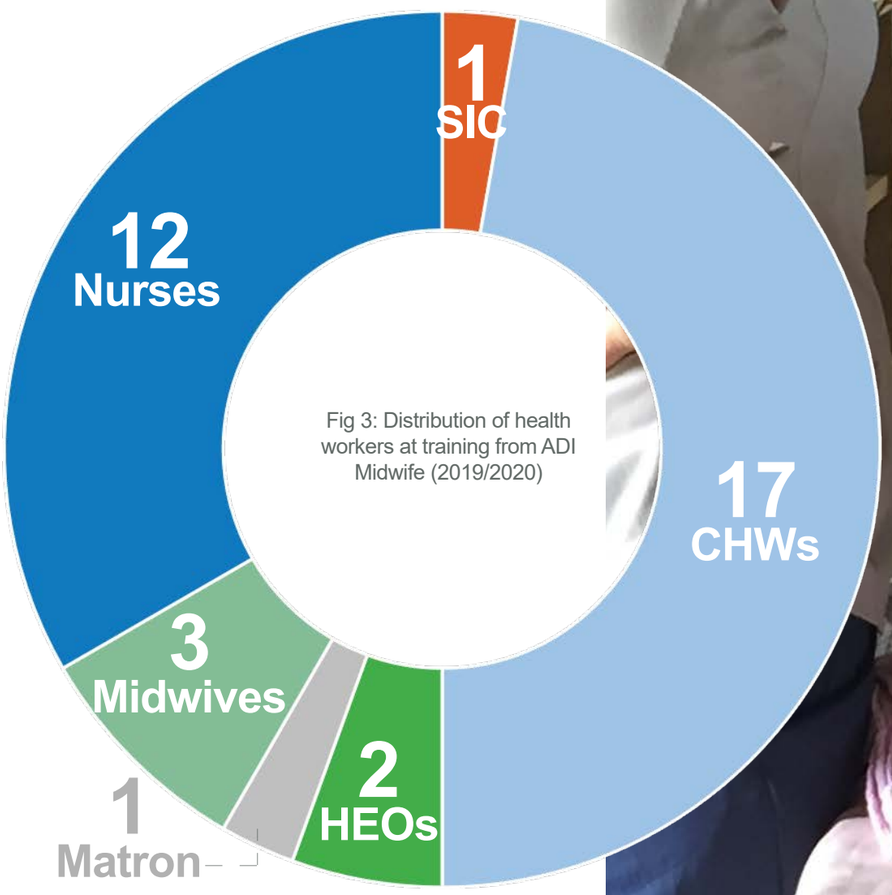


Fig 3: Distribution of health workers at training from ADI Midwife (2019/2020)

Dr Merrilee Frankish EMONC training, Kimadan, New Ireland, November 2019

ADI Midwife Lois Berry, EMONC training, Kimadan, New Ireland, November 2019

ADI started working with Australian volunteer midwife – Lois Berry - in late 2018. Lois' experience includes years working in PNG teaching midwifery followed by time as a remote area midwife in Western Australian, Northern Territory and Torres Strait Islands. Lois' highly honed midwifery skills and expertise in remote settings, with her knowledge of PNG midwifery coursework, makes her connection and support to PNG midwives and nurses invaluable in delivering education. Over the course of 2019, Lois, with colleagues and the ADI team, designed and wrote ADI's Emergency Obstetric and Neonatal Care course, with the first two course sessions held in May 2019. From July 2019 - July 2020, Lois, along with ADI volunteer Dr Merrilee Frankish, ran two further courses in New Ireland and two in West New Britain with the aim of providing PNG's nurses and midwives with life-saving maternal and neonatal skills.

Head Nurse Raquel Lupalrea and Dr Charlene see a young patient visiting Wako Health Centre, West New Britain, March 2020

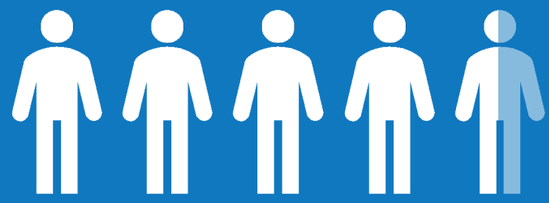
"We're not in Papua New Guinea just to do our thing and then leave. We're there to help upskill local health workers so communities have ongoing health care long after volunteer doctors like myself have returned home."

- Dr. Charlene James

Dr Charlene James and Nurse Raquel Lupalrea in Wako, West New Britain, March 2020

Health workforce density as recommended by WHO:

4.45 to 1000 population



Health workforce density in Wako:

0.47 to 1000 population

Remote nurse builds skills in family planning

From the 16th to 20th March 2020, ADI ventured to the remote southern coastline of West New Britain for their first clinically based health patrol. After three days at Kandrian Health Centre, the ADI patrol team ventured to Wako Community Health Post (CHP) to continue their work. Upon landing, they were introduced to Raquel Lupalrea, the Nursing Officer in Charge (NOIC) of the newly built facility. Raquel has worked at Wako CHP for two years and knows the difficulties of providing clinical care in remote settings.

"The remoteness of Wako is the biggest problem for us. We are not able to communicate with other health centres or main hospitals due to the lack of communication. We must travel 3-4 hours by boat to Kandrian to even make a phone call. If the seas are rough, then we cannot go. This is also for patient transfers back to Kimbe," Raquel said.

Throughout the two days spent in Wako with the ADI team, Raquel and Dr James examined over 200 patients from nearby villages. The ADI team was accommodated in staff housing next door to Raquel and her family which helped foster both a professional and casual relationship between the two parties.

"When ADI comes to Wako in the future, we will all be very excited. They (ADI) have the latest knowledge. Medicine changes all the time and even us out here want to know the most up to date information on treatment techniques and medication delivery," Raquel said.

ADI look forward to visiting Raquel and the nursing team at Wako CHP again.

West New Britain patrol team departing Wako, West New Britain, March 2020

Patient Tina and child, Kandrian, West New Britain, March 2020

WOMEN'S HEALTH in PNG is fragile

56.5% of **births** are attended by a **skilled provider**

49% of women aged 15-49 attended four or more **antenatal sessions**

Infant mortality rate is;
38 per 1000 live births
(2.7 per 1000)

Maternal mortality ratio is;
215 to **900**
per 100,000 live births
(2 per 1000)

Neonatal mortality rate is;
22 per 1000 live births

Under five mortality rate is;
41 per 1000 live births
(3 per 1000)

FAMILY PLANNING needs in PNG are not yet met

32% of married/in-union women have **unmet needs** for **modern contraception**

47% of married/in-union women's demand is **satisfied** with a **modern contraception method**

HEALTHY RURAL WOMEN, HEALTHY RURAL FAMILIES

Social determinants of health are the conditions in which people are born, live, work, grow, age and die. These conditions determine the degree of access to resources, including health resources, families and women have. Integral to this is the status of the health system and health workforce – as discussed previously – people have access to. Women and girls have particular health needs. Access to education and health care; the degree of gender inequity in their environment, their poverty and location all play a role in affecting health outcomes for women, and women are less likely to have access to health care, including essential medicines and commodities. Can the woman reach health care from her house, where the primary mode of transport is by foot or infrequent public bus? Does she have the financial means to access that care? Gendered health inequity is most keenly felt when women are of child-bearing age and status.

The maternal mortality rate for PNG varies in its reported range from 215 to over 900 per 100,000 live births. The three leading causes of maternal death include obstetric haemorrhage, embolism and eclampsia.

Inherently linked to women's health is that of her children. And for the births and babies, the statistics are just as grim – neonatal mortality rate is 22 per 1000 live births; infant mortality rate is 38 per 1000 live births and under-five mortality rate is 41 per 1000 live births.

How does ADI address these challenges?

ADI generates health seeking behaviour in rural communities through provision of regular, accessible health patrols and public health education. Through working in and with communities, in schools, villages and health workers in those communities. We seek to make the rural environment in PNG in areas in which we operate safe for people – and women in particular - by providing community education on family planning and sexual and reproductive health in rural communities. We reached over 6500 individual community members this year. In addition, ADI's Gender Equity Officer in New Ireland delivers education focusing on gender, and its impact on reproductive rights to prevent adolescent pregnancies (46 hours in the past year).

A community leader discusses gender issues in her community during Community Mobilisation Training in Kalil, New Ireland, August 2019

In March COVID-19 changed the nature and content of ADI's outreach patrol work. In particular we were concerned about how COVID-19 would impact women's health and access to family planning services and education. Where possible, women's health needs, family planning and gender equity activities were incorporated into ADI's COVID-19 response, outreach and assistance. Between March to June 2020, ADI's Family Planning and Gender Equity team delivered over 23 hours of education to 51 rural communities and 20 health facilities in New Ireland. This education focused on the importance of continuing access to family planning services, reinforcing gender equality and women's reproductive rights, and the prevention of gender-based violence and social stigmatisation. We also identified how to best support continuation of health services, bearing in mind the special needs of women of child-bearing age and status during COVID lockdowns, leading to the provision of select medical equipment to provincial, district and larger health centres in the areas where we work.

ADI seeks to understand and reduce that inequity by making health for rural women more accessible than it was previously, and in turn further reduce the maternal and child mortality indicators. This reflects the PNG National Department of Health **KRA 5: Improve Maternal Health**, and **KRA 4: Improve Child Survival**:

ADI works to provide clinical services on family planning – these services are provided by ADI volunteer doctors, but also our partner Provincial Health Authority staff of nursing officers and family planning officers from New Ireland and West New Britain. To ensure family planning can be offered when patrols are not visiting, we invest in training health workers with family planning skills and are taking an increasing role in supporting supply of commodities to fill gaps in stock.

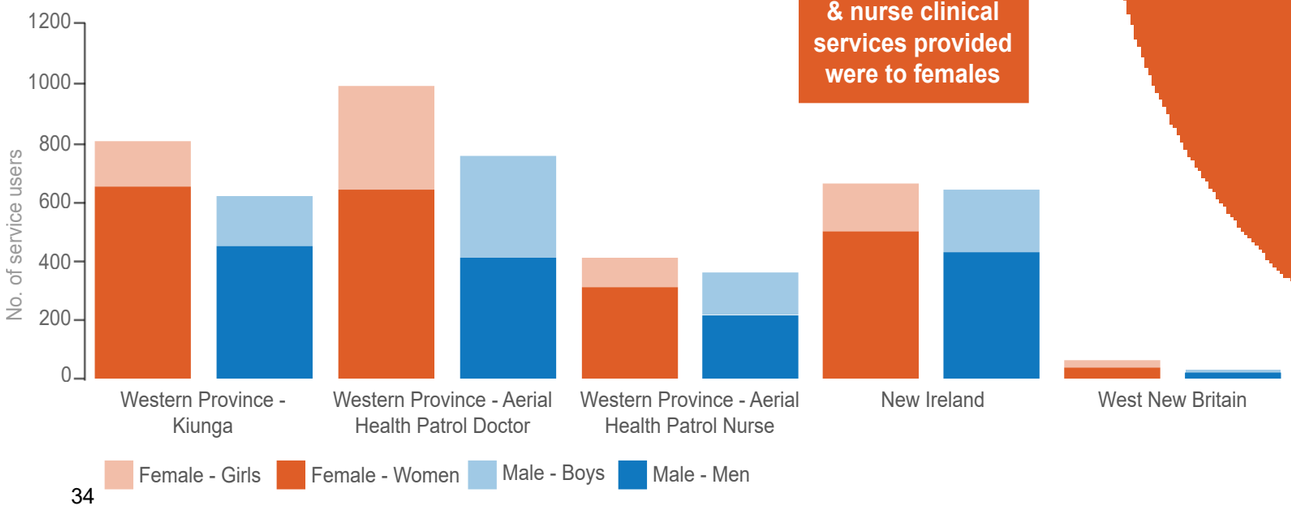
Group of women leaders with Dr Shanta in Timingondok, Upper Fly, Western Province, November 2019

In March 2020 (prior to COVID-19 lockdowns), ADI and Family Planning Australia delivered training to 11 rural health workers in the Namatanai District, New Ireland. Participants were from the more rural and remote areas of the district, with different levels of experience to facilitate and promote peer to peer learning. The New Ireland Provincial Health Authority (NIPHA)'s Training Coordinator and Family Health Services Coordinator, also attended. Learning outcomes of the training included:

- Increasing knowledge on all contraceptive options available in PNG
- Identifying and knowing how to effectively dispel common myths and misinformation that may influence requests for inappropriate implant removal
- Conducting effective client consultation and counselling, including post-partum insertion
- Demonstrating safe and effective Jadelle implant insertion and removal, and managing difficult removals

Five of the 11 trainers also undertook 'train the trainer' course work.

Fig 4: Number of patients who received ADI services July 2019 - June 2020 by region and gender



55%
of ADI doctor & nurse clinical services provided were to females

Along with programs to address demand and supply issues of family planning; ADI also seeks to address the high PNG maternal morality ratio through provision of skills in emergency obstetric care; and the high infant mortality rate, through provision of skills in neonatal care. Following on from the initial training held in Kiunga in May 2019, ADI's midwife and doctor ran the training course in November 2019, twice in West New Britain and twice in New Ireland, reaching 20 and 15 health workers respectively (95% female). The course builds the capacity of health workers to better respond to maternal obstetric and neonatal emergencies, working towards KRA 5: Improve Maternal Health and KRA 4: Improve Child Survival, and builds on the work from the PNG Reproductive Health Training Unit and PNG STMs, incorporating the content outlined below.

MAMMA CARE

Respectful Maternity Care

Post-partum haemorrhage: aortic compression, condom balloon tamponade

Manual Removal of the Placenta

Puerperal sepsis

NEONATAL CARE

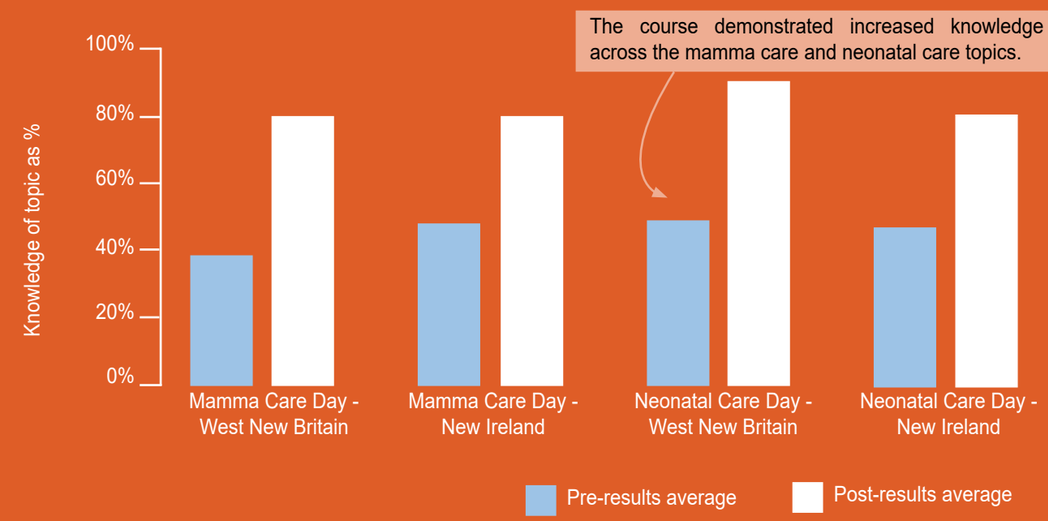
Neonatal sepsis

Early Essential Newborn Care

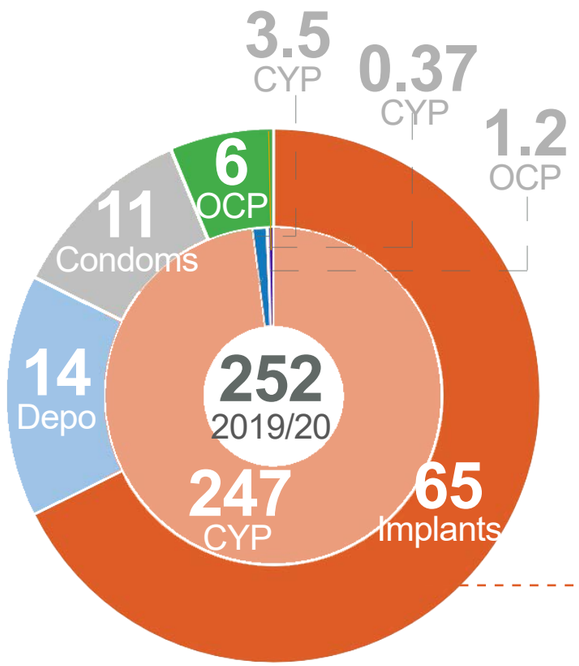
Neonatal resuscitation

Kangaroo Mother Care

Fig. 5: Emergency Obstetric and Neonatal Care - Knowledge and skill increase through training



Method	CYP (outer ring)	# distributed per person by ADI (inner ring)
Condoms	120 condoms = 1 CYP	Average of 4 condoms/person
Depo injections	4 x 3 month injections = 1 CYP	1 injection/person
Oral Contraceptive Pills	15 pill cycles = 1 CYP	3 pill cycles/person
Implants (Jadelle, 5 year)	1 implant/person = 3.8 CYP	1 implant/person

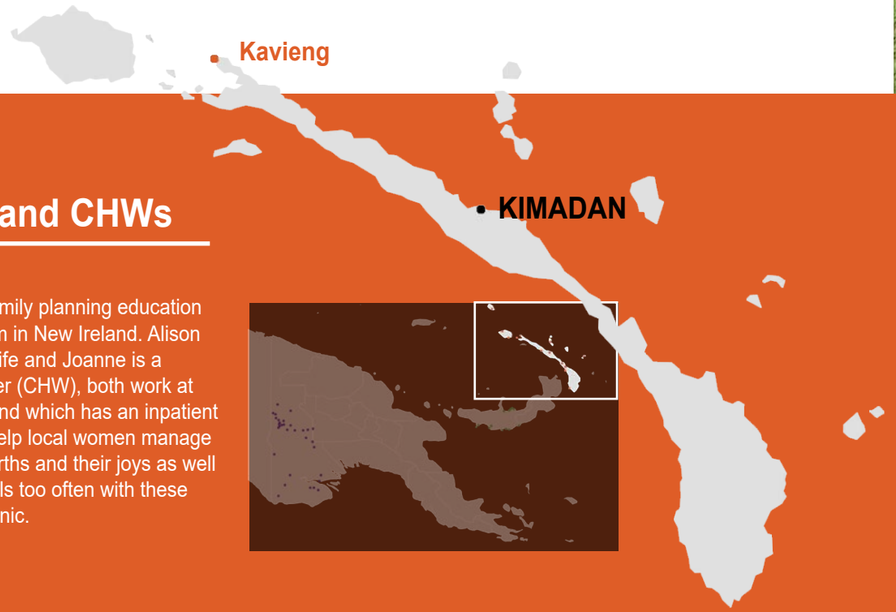


Couple-years-protection (CYP) refers to the estimated protection provided by contraceptive methods during a one-year period[xi]. Each type of contraceptive method has a different CYP value, for example one implant is worth 3.8 times 120 condoms, making implants a high value CYP.

- Depo Provera (depo)
- Implants
- Condoms
- Oral Contraceptive Pill (OCP)

Overall, this year ADI contributed to 252 CYPs through a combination of services provided during our outreach patrols and in-service training.*

*Note: This result is less than previous years, primarily due to implant supply. Since identifying these issues, ADI has sought solutions to ensure continuity in supplies of family planning commodities through partnering with UNFPA PNG. In May 2020, ADI successfully applied for Implementation Partner status with UNFPA PNG.



Training midwives and CHWs

Emergency obstetrics training and family planning education are key components of ADI's program in New Ireland. Alison is an experienced PNG trained midwife and Joanne is a PNG trained community health worker (CHW), both work at Kimadan Health Centre in New Ireland which has an inpatient maternity ward. Alison and Joanne help local women manage their health and pregnancies, their births and their joys as well as dealing with the despair that travels too often with these mothers through the doors of their clinic.

Rural health workers with their certificates after completing Family Planning in-service training in Namatanai, New Ireland, November 2019

Joanne attended ADI community educator training on family planning in 2019 and this stirred her to get rural husbands more involved in their wives' health.

Alison has attended both ADI's Emergency Obstetrics Training and Family Planning training in 2018 and 2019 and is focused on keeping mothers healthy before, during and after pregnancy.

Joanne recalls a time when a husband attended his wife's delivery for the first time, it was their fourth child. The labour was long, and the birth was difficult and both Alison and Joanne utilised all their experience and skills.

Seeing what his wife went through both during and after the delivery the husband now understood the importance of birth spacing and supported his wife in her discussion on modern family planning techniques with Joanne the following day.

Both health workers believe that the best way to improve women's health is through regular antenatal assessments, facility-based births and birth spacing through modern family planning. Changing societal and cultural norms is the challenge they face each day.

ADI is working with their local health authority to help improve health workers skills, knowledge and confidence through professional development training especially for remote health workers.

ADI Dr Shanta giving a Suturing demonstration to CHWs, Matkomnai, Western Province, November 2019

Alice Rosario, STI/HIV Nursing Officer at Kiunga hospital, giving an HIV talk, Drimgas school, Upper Fly, Western Province, November 2019

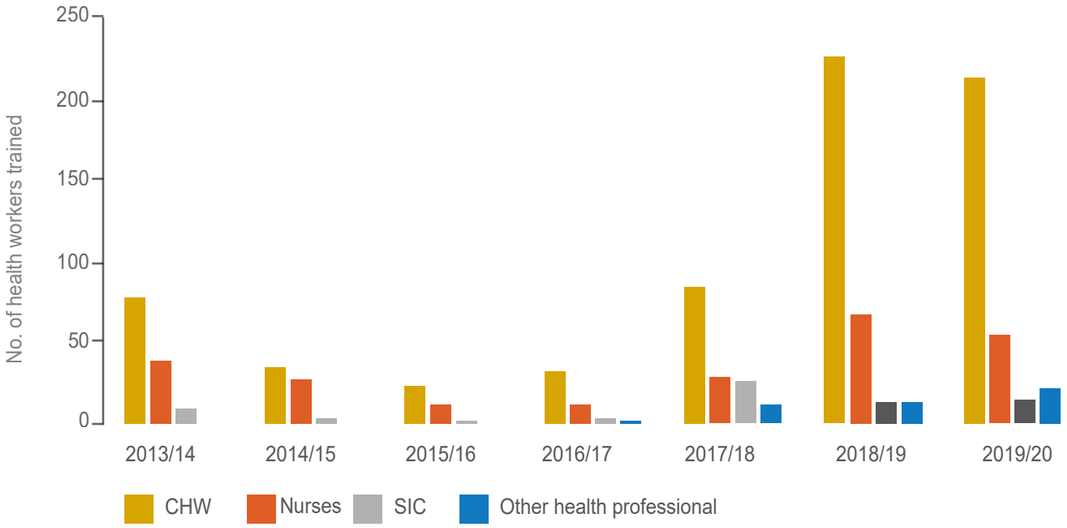
Improving health security through education

By providing health education opportunities for both remote and rural health workers, and the communities they work in; ADI seeks to make sustainable and lasting impacts on rural health security. These two educational agendas work hand in hand. In this section we demonstrate the impact we have had over the last seven years in bringing professional development and support – building skills and confidence - of PNG health workers.

Equipping both health workers and their communities with public health knowledge and tools creates lasting impacts and builds health security for the population where those health workers and their communities reside . ADI is often the only organisation providing this support in remote communities.

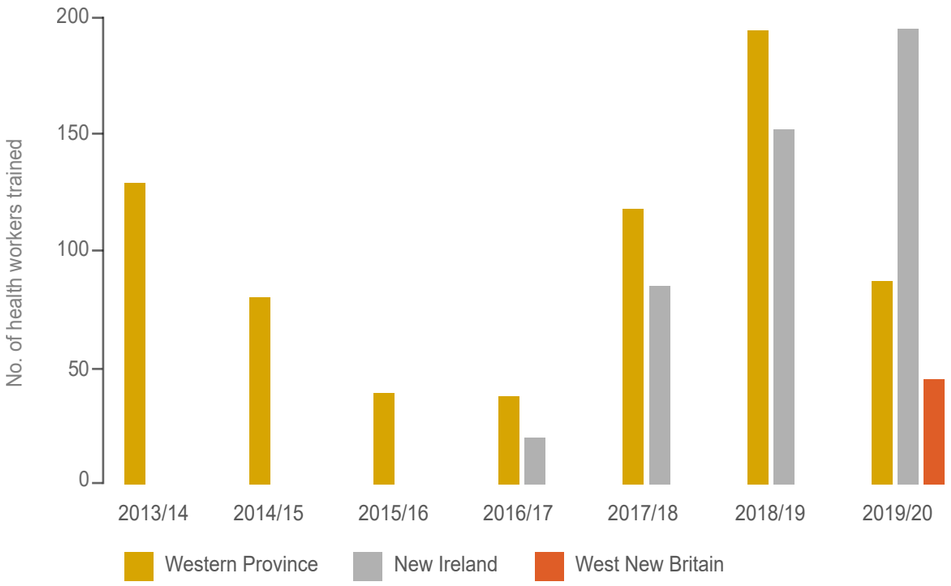
Dr Shanta educating on back exercises in Upper Fly, Western Province, October 2019

Fig 6: Number of health workers trained per annum by ADI



For the last two years we have trained about 300 health workers per annum, up from the previous five year period which averaged 75 health workers per annum. We primarily work with community health workers – who form the bulk of PNG health workforce. We reach to the outer areas of PNG to remote communities to professionally support and train health workers across Western Province, West New Britain and New Ireland.

Fig 7: Number of health workers trained per annum by province



This graph reflects the history of our involvement in each province. We are keen to continue expanding this educational reach; responding to health needs of our partners and their health workers. This year our training of health workers took a different shape. In order to continue providing health education we adapted our training to be delivered through webinars, reaching 70 health workers in this new way.

Dr Vijay running case-based training during Tarakbits patrol, Western Province, August 2019

This year when we look at the in-depth training we provided, we reached more health workers than previous years – this was possible with the augmented webinar delivery mechanism.

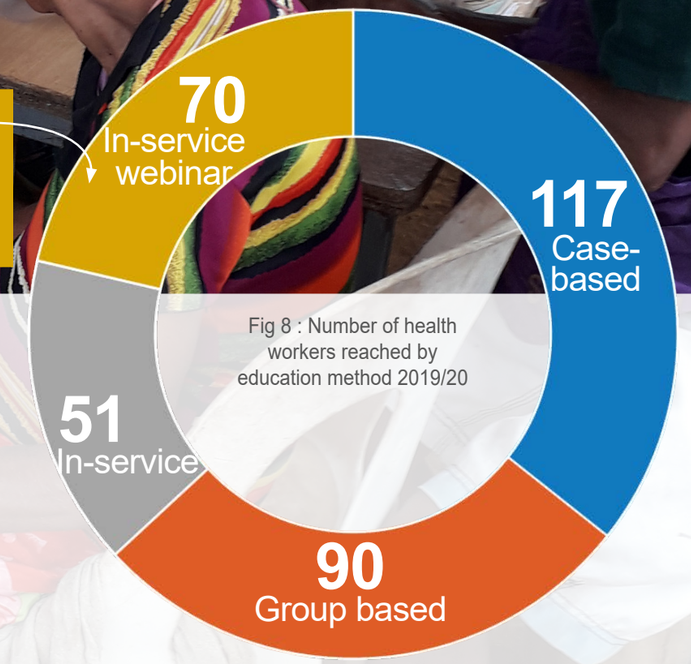
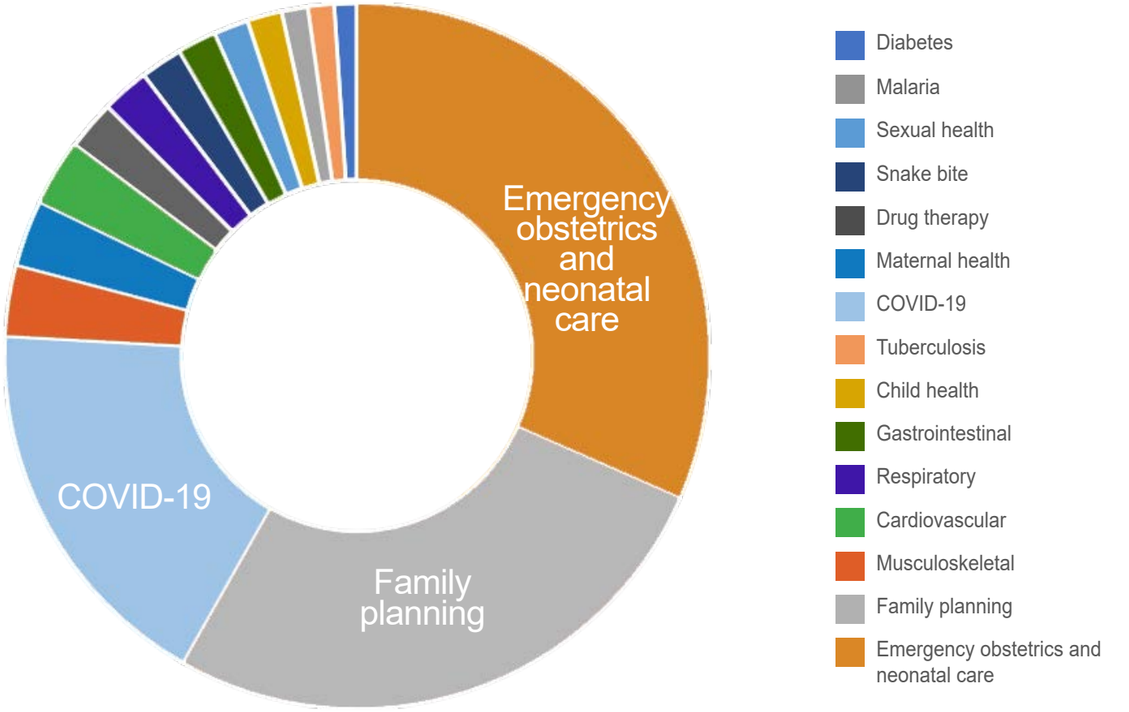


Fig 8 : Number of health workers reached by education method 2019/20

ADI designs and conducts training on topics that meet the needs of our health partners. This year the topics covered were in the **maternal health sphere - emergency obstetrics and neonatal care; family planning; sexual health and maternal health; in communicable diseases – tuberculosis, malaria and COVID-19; and lifestyle issues such as musculoskeletal problems and diabetes**. Of note, the most time has been invested in emergency obstetrics, family planning and COVID-19 knowledge as illustrated in Figure 9.

Fig 9: Time invested in topic areas with rural health workers 2019/20



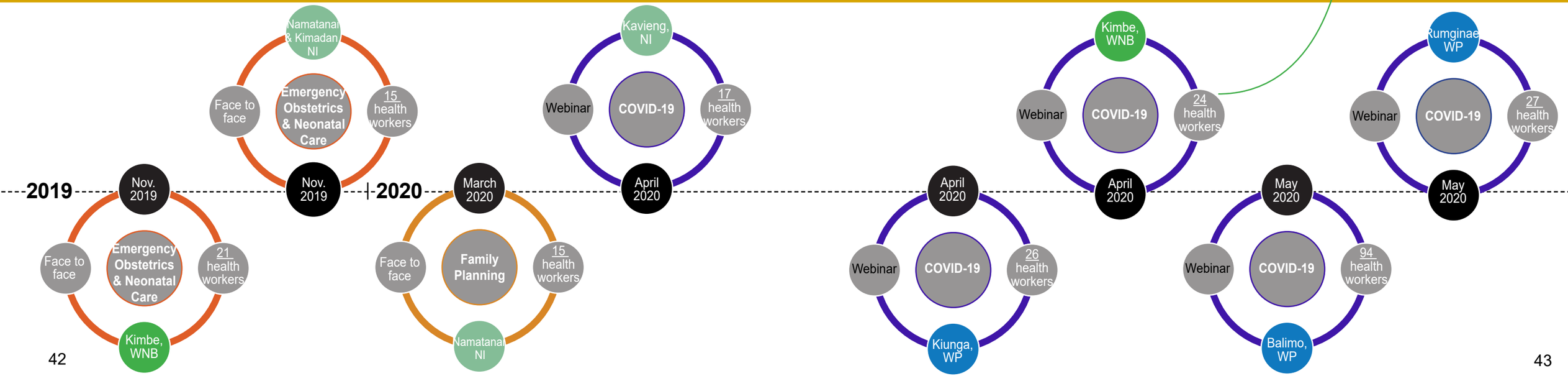
Family Planning in-service implant insertion practice, Namatanai, New Ireland, March 2020

COVID-19 webinar training, Kimbe Hospital, West New Britain, April 2020

ADI is conscious of supporting health workers even when there is no ADI health patrol visiting. And as health workers rely on the suite of PNG Standard Treatment Manuals (STMs) to guide their health care , treatment and decision-making – especially when operating solo in a remote health clinic - ADI arranged and printed 1500 copies of the suite of STMs and is in the process of distributing these remotely in West New Britain, New Ireland and Western Province.

"The impact of health-education is rather difficult to measure, however it may be one of the most significant interventions a person may receive, in becoming empowered about their health and rights."

- ADI Dr Nathan Lum, New Ireland trip report, December 2019



Creating community health security

ADI works to create community health security by empowering the communities themselves. To this end we create public health materials, speak in public forums and distribute posters to inform and reach remote communities. The following table highlight both the diversity of topics we have provided public health education on and the reach of that education. The underlying concept here is to build health solutions and security within the community themselves thus preventing health issues escalating to need the level of health care provided by nurses and doctors in more urban settings.

ADI Office Manager Aron demonstrates hand washing during COVID-19 awareness patrols, Tiomnai, Western Province, April 2020

Children with Colgate PNG toothbrush packs on Namatanai Patrol, New Ireland, November 2019

5,706
tooth brush kits distributed as part of oral health education training

	Number of community members	Hours invested in public health education
COVID-19	10,000	72
Gender and child protection	6,600	46
Tuberculosis	5,400	15
Family planning	3,400	40
STI/HIV/AIDS	2,400	3
Snake bite	1520	4.5
Disability inclusivity	310	2

Of note from this table is the prominence of education ADI provided to communities on **COVID-19, gender and child protection and tuberculosis**. The data also demonstrates how ADI responds to regional differences with the inclusion of snake bite education which is most relevant in Western Province. We seek to include public health education on disability inclusivity.

Dental education during Namatanai patrol, New Ireland, November 2019

REACHING THE MOST VULNERABLE

Dr Alison with patrol team, Nia Ailan, New Ireland, February 2020

DISABILITY

15% of PNG population live with a **disability** and less than **2%** receive adequate support

GENDER EQUITY

48% of **women** disclosed experience of **physical** or **sexual violence**, or both, by an intimate partner in the last 12 months

69.8% of **women** consider a **husband justified** in **beating his wife**

CHILDREN

40% of PNG's population is **under the age of 15**

75% of **children** experience **domestic violence at home**

35% of **children** have had **DTP3 vaccine**

REFUGEES

10,000 **refugees** live in Western Province

ADI seeks out all people in a community ensuring that the most vulnerable (people with disability, refugees, women and children) are able to access and benefit equally from development assistance. In this section of the annual report we want to showcase our work in making health accessible to the most vulnerable in PNG.

Reaching those with a disability

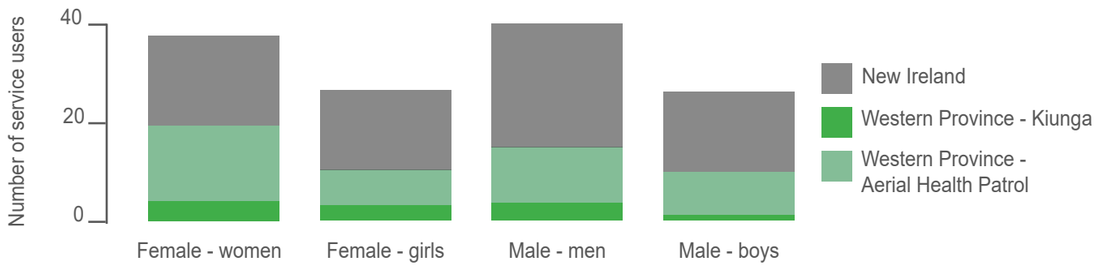
The PNG National Department of Health identifies the needs of people with a disability within – **KRA 7: Promote Healthy Lifestyles, 7.4: Reduce morbidity and mortality from non-communicable diseases.** On each patrol the ADI doctor, nurse and partner team seek out people who may need special attention due to their disability. In some provinces we partner with services like Callan Services (Kiunga), in other locations we work with physiotherapists from the PHA. We also reach out to those that may need a house-call – making 46 house calls due to illness (including mental illness), disability, stigma and isolation this year. 146 services were provided for disability support across our programs in PNG, with 40 new patients registered with a disability.

Dr Ian Hunter, whilst seconded to the Aerial Health Patrols at Kapal, seeing patient with radial nerve palsy, Kapal, Western Province, October 2019

During the Kapal patrol, the team saw a patient with radial nerve palsy from an old injury which had caused his hand to flop downward. As a result, he had very little ability to hold or grip objects. Dr Ian Hunter worked with the local health worker Bonri, to teach him how to apply a back slab splint made from plaster of Paris. With this splint, the patient's hand can be moved into a 'cocked' position, and he can now grip more easily. Bonri is now able to use this skill to apply a new splint when the old one wears out and assist other patients in the future with similar health issues.

146
services provided for disability support across our PNG programs

Fig 10: Number of services provided for disability support by gender and province



Not included in these figures are people with **impairments** such as poor eye-sight, poor hearing or impairments in need of physiotherapy support.

Impairments also reduce an indviduals ability to participate in daily life. To this end, ADI and partners provide physiotherapy, as well as eye and ear health services to increase participation.

Callan Disability Services health worker, Cornelius Cosmas, carries out an eye examination on patrol in Tarakbits, Western Province, March 2020

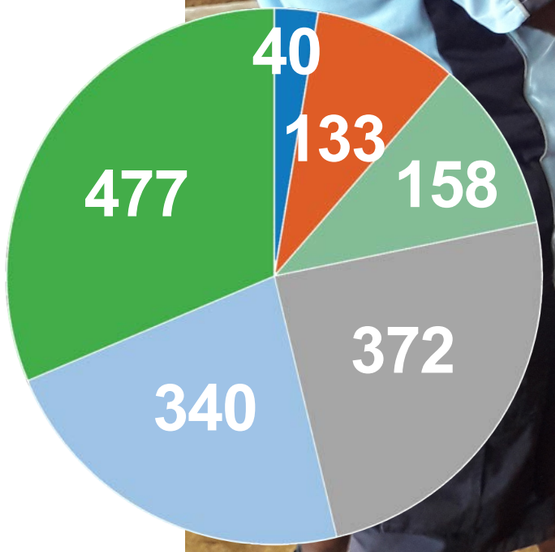


Fig 11: Specialised physiotherapy and optometry in New Ireland 2019-20

- Physio - new patients registered with a disablity
- Eyes - clinical services cataracts
- Eyes - Opthalomogy booking/referrals
- Eyes - glasses provided
- Physio - peripheral problems
- Physio - vertebral problems

Remote services for the disabled

A new patrol zone in Western Province was visited in October 2019 covering the Upper Fly health facilities of Temipen, Trimingondok and Drimgas and their catchment villages. The ten-day patrol team included two ADI doctors, two nursing officers from district health and two disability clinicians from CHS's Callan Services. Amongst this team they provided close to 2000 clinical services – notably including 288 hearing and 73 eye-sight services for people with impairment.

Focus on Gender Equity

Gender Equity Community Mobilisation Training

Between July and December 2019 ADI's gender equity community mobilisation training (CMT) was delivered in six rural and remote wards in the Namatanai district of New Ireland - Messi, Dampet, Kalil, Kabanut, Konogogo, Komalabuo. ADI's CMT team, led by Lucy Berak, conducted six training sessions with village and church leaders, court magistrates, school teachers and other community representatives, reaching 149 community leaders in total.

About 35% of participants showed increased knowledge on topics of gender equity, domestic violence, child protection and disability inclusion whilst about half the participants showed increased knowledge of PNG laws associated with child rights, gender-based violence rights and disability rights. Encouragingly an average of 96% of participants showed increased confidence in their ability to educate their communities on these important social issues.

The training also deals with social topics associated with marriage, adolescence, teen pregnancy and drug use. The participants are asked to complete a number of surveys during the three-day sessions to assess the consequential changes in their knowledge and confidence to ascertain their ability to impart information and advice within their communities on these topics. The program is still in its infancy and has been born out of ADI's regular placement of a gender equity education officer on outreach patrols since the beginning of 2018 in New Ireland.

ADI placed a gender equity officer on nine of the 12 New Ireland patrols - where she delivered 46 hours of public health education on these sensitive issues to over 6500 remote community members.

Community leaders attending Community Mobilisation Training, Kabanut, NI, October 2019

"We the leaders of the three villages...have come to realise that we are being empowered and well equipped to advance in our areas in dealing with gender equity, child safety, disability rights and other social issues affecting our community...it is a great privilege for the people of this ward to have this service"

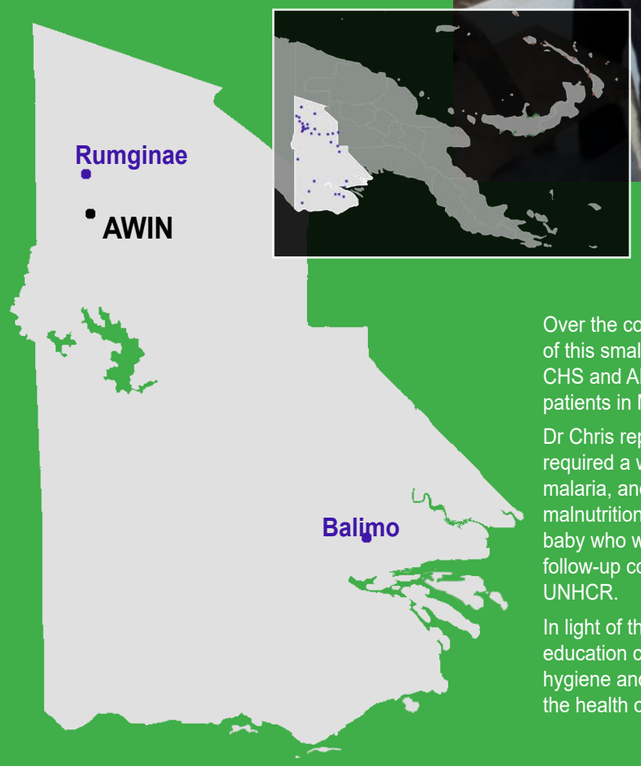
- Village leaders from Konogogo (Ward 15), New Ireland

Focus on refugees

The Montfort Mission West Papuan refugee camp operates on the outskirts of Kiunga, close to the border of West Papua with about 120 refugee residents recognised by UNHCR. These refugees are related to the thousands of Muyu tribespeople whose ancestors fled from their traditional lands on the border in 1984 to seek freedom and a new home. It is estimated that over 3,400 Muyu are still living in the official UNHCR Awin refugee camp (PNG side) whilst another 7,000 Muyu are, like this small Montfort group, are scattered amongst the PNG border communities.

ADI seeks out and provides care to the most vulnerable communities, and under the advice of Catholic Health Services (CHS), ADI's main partner in the region, Dr Chris McCall made a number of healthcare visits to the refugees during his deployment. As the refugees do not hold formal documentation, their status is complex, and they are unable to access government healthcare. Dr Chris believes these refugees have significant health needs and are living amongst a population of PNG nationals who are struggling for adequate healthcare.

Dr Chris running COVID awareness at Awin refugee camp, March 2020



Over the course of two outreach visits, Dr Chris consulted with around 50% of this small refugee community. His team included a nurse and CHW from CHS and ADI's Aron Bale. Fortunately, Dr Chris was able to speak with his patients in Malay.

Dr Chris reported that of the 65 patients who attended the clinics, 11% required a work-up for TB or potential TB, 14% required treatment for malaria, and a significant number of children appeared to be suffering from malnutrition. He noted that amongst the patients were a mother with a baby who was unwell with malaria and would not feed. Dr Chris organised follow-up consultations for urgent patients and reported his findings to the UNHCR.

In light of the current global pandemic, the ADI team also ran a COVID-19 education clinic for the refugees, utilising buckets and soap for basic hand hygiene and posters for ongoing awareness. ADI will continue to monitor the health of this group of refugees and intends to provide ongoing support.

Improving the lives of children

Demographically PNG is a young country, 40% of the population are under the age of 15 with most living rurally and in poverty. Immunisation rates have stagnated – with DTP3 coverage sitting at just 35% down from 60% in 2013[xii], and the country has witnessed outbreaks of polio and measles – both severe childhood illnesses. Malnutrition is the leading cause of about half of the under five deaths and nearly half of all children are stunted[xiii]. Family violence rates are high with 75% of children experiencing violent discipline in their homes[xiv].

We strive to reach children with a range of health services which they need, driven through the objectives of the PNG's Government's **KRA 4: Improve Child Survival**. We have worked to increase immunisation coverage; diagnosis respiratory illness and identify malnutrition. For example, in partnership with the Aerial Health Patrol team in Balimo, Western Province we have delivered 1800 immunisations, including first doses of polio, pentavalent and pneumococcal vaccines (PCV) this financial year.

PNGSDP health workers and Dr Mikaela sorting child health books by age before administering immunisations on patrol, Western Province, February 2020

During the first half of 2020, we purchased and shipped special medical equipment to specifically to assist with child health in New Ireland, Western Province and West New Britain, for example we provided:

- **300 MUAC nutrition bands** – these bands measure the child's level of malnutrition
- **31 Pulse oximeters** – are helpful in identifying children with severe illness in outpatient facilities in PNG, including pneumonia as defined by the Integrated Management of Childhood Illness (IMCI) definitions[xv]
- **35 neonatal resuscitation bag-masks**

ADI Maternal Health & Family Planning Coordinator, Devlyn Olan, using a MUAC band on a child in Kavieng , New Ireland, October 2020

Treating a malnourished baby

A lethargic seven-month-old baby girl was brought into Kungim health clinic, Western Province, with diarrhoea and dehydration. The child had been cared for by her aunt since birth as her mother had developed post-partum psychosis and was unable to breastfeed. As a result, the baby had only been given solid food since birth with formula unaffordable.

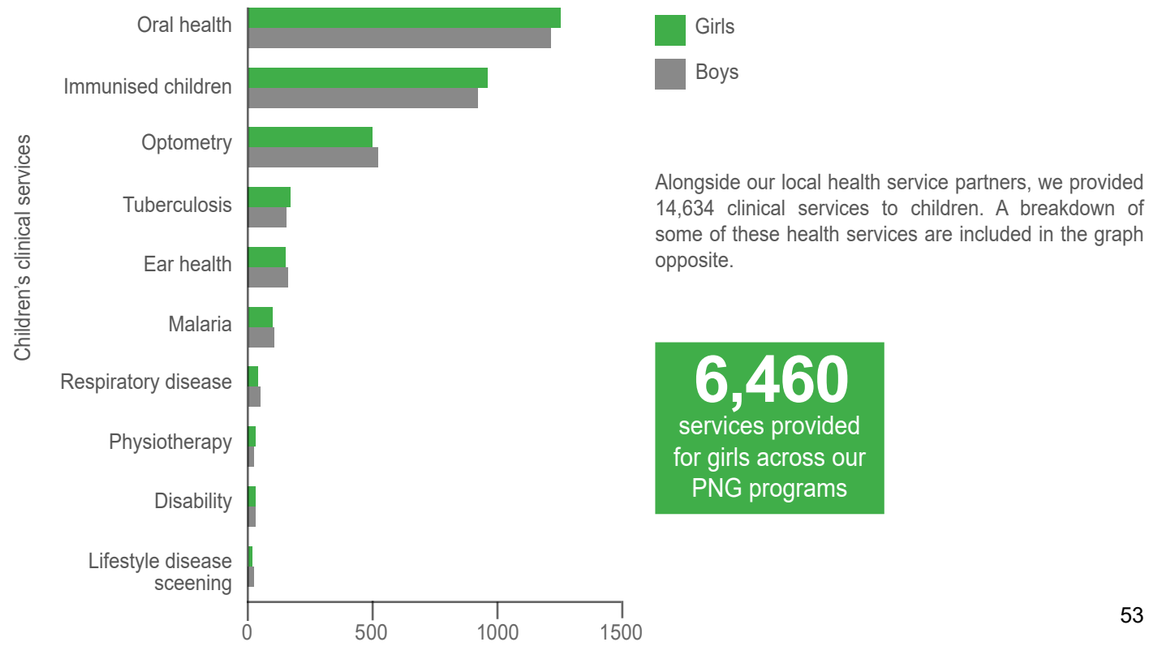
The baby was malnourished and barely breathing. Dr Vijay and Dr Shanta were on hand to implement the resuscitation of the infant by providing IV fluids and glucose.

In this case the clinic had access to IVs and fluids and the health staff did a great job assisting the patrol doctors. The child responded well to the treatment and appeared more active after a few hours. The team prepared Oral Rehydration Salts (ORS) solution to be continued at home, and upon review the next day, the baby's condition had improved.

A referral was made to Kiunga Hospital to address the issue of malnutrition, and the aunt agreed to admit the baby there.

Dr Vijay treating a malnourished baby, Kungim health clinic, Western Province, September 2019

Fig 12: Number of services provided for girls and boys



Alongside our local health service partners, we provided 14,634 clinical services to children. A breakdown of some of these health services are included in the graph opposite.

6,460
services provided for girls across our PNG programs

ADI Volunteers

This year the contribution from volunteers has been overwhelming and of strategic importance to our ability to respond to the changing needs in PNG.

13 volunteer doctors, nurses and midwives travelled and worked with us in PNG this year.

We upscaled the number of doctor/nurse PNG placements, and a couple of snapshots in time illustrate this growth:

- In October 2019, we had Dr Nathan Lum deployed in New Ireland; Dr Vijay Kumar and Dr Shanta Velaiutham based in Kiunga, Western Province and Dr Ian Hunter and Nurse Nick Morris working out of Balimo in the Aerial Health Patrol team, also in Western Province.
- In November 2019, Midwife Lois Berry and Dr Merrilee Frankish delivered Emergency Obstetrics and Neonatal Care training in New Ireland (and Lois also delivered it in West New Britain in the same month).
- In February 2020, we had two doctors in Western Province (Dr Chris McCall in Kiunga; and Dr Mikaela Seymour in Balimo with Aerial Health Patrols); Dr Alison Brown in New Ireland and our first ever provided doctor into West New Britain – Dr Charlene James - worked alongside our ADI staff Program manager for West New Britain. By the end of March – due to COVID-19 – we had brought them all home.

Over the March to June 2020 period, we received enormous support in our response to COVID-19 in PNG from clinical staff and our volunteer doctor network in Australia, including BD staff (David Carr, Debra Davidson and Martin Eagles (not pictured); Dr Rebecca Taylor, Dr Alison Brown, Dr Mikaela Seymour and Dr Chris McCall.


Dr Alison Brown


Dr Ian Hunter


David Carr


Nurse Nick Morris


Dr Chris McCall


Dr Charlie Coventry


Dr Nathan Lum

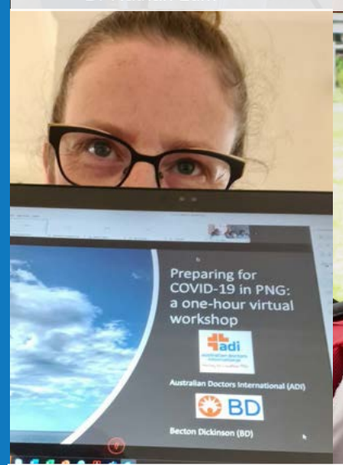

Irina Blackmore


Dr Shanta Velaiutham


Dr Merrilee Frankish

Dr Mikaela Seymour


Dr Vijay Kumar



Debra Davidson


Dr Charlene James

Lois Berry


Dr Rhoda Ila


Dr Roeland Kraan


Dr Rebecca Taylor

Doctors and health professionals that choose to work with ADI carry unique characteristics – these are hard to characterise but include tenacity, curiosity and depth of knowledge in their speciality area. Doctors and health professionals that joined brought with them diverse skills ranging from degrees in pharmacy; fluency in Malay; diplomas in child health, skills gained overseas in Australian Army Reserves and many have degrees in international public health or tropical medicine. Most have spent time working in rural Australia or a developing country.

Volunteers such as Irina Blackmore, Clare Holberton, Eliza Kitchener, Felicia Whiting, Maeve May, Marge Overs, Marlea Maltz and Martin Eagles contributed behind the scenes to host our events, deliver communications, build our website and database and conduct public health research and evaluations.

Thank you to these volunteers. Your contribution makes a direct impact to improve the lives of mothers, children and families in Papua New Guinea, on behalf of these communities we send you a heart-felt thank you.

Our People

ADI Sydney team, from left to right: Mark Newcombe - Program Officer, Dr Klara Henderson - CEO, Aisha Hassan - Program Officer, Brooke Briggs - HR and Administration Officer, Kay Nevill - New Ireland Program Manager and Family Planning Project Advisor, Andrew Noble - Finance Manager, Yaman Kutlu - Senior Program Manager

This year the team at ADI have demonstrated their commitment to work for a healthier PNG – COVID-19 demanded a huge step up in effort to ensure the safety and wellbeing of our team; taking on new tasks; innovating in how we deliver health care services and even what we deliver. This called on the team to work extraordinary hours – often into the night and over weekends. Every single person did this with passion, concern and without hesitation. The team felt as a health focused development organisation – working in rural PNG – we had a responsibility to respond. This year found the team – booking flights for doctors to return home; identifying sources for personal protection equipment and coordinating with partners for its speedy delivery to remote PNG; redesigning and delivering gender equity messaging to build in safe COVID-19 messages; tracking and reporting on PNG COVID-19 cases and testing rates; purchasing soap and buckets for delivery to remote health clinics; designing new content for managing health clinics in times of COVID-19 for webinar delivery; and managing new safety issues and risks in a dynamic environment.

ADI's team of health professionals, based in Sydney and PNG includes qualified nurses, midwives, pharmacists and dentists, four of our team hold masters degrees in public health and two hold masters degrees in international development. We have a close network of volunteer doctors, nurses and midwives; as well as of public health researchers in both Australian and PNG academic institutions. Our program work is backed up by our financial management team and the processes it supports.

We are proud to grow our PNG public health team, over the year new team members started with us in Western Province and New Ireland, we see this trend continuing.

Western Province: Aron Bale - Office Manager

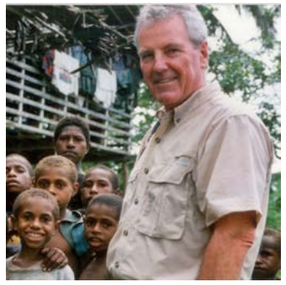
New Ireland: Devlyn Olan - Maternal Health & Family Planning Coordinator, Sherel Nama - Office Manager, Lucy Berek - Gender Equity Coordinator

West New Britain: Jack O'Shea - Program Manager

Our Supporters

With much gratitude, ADI would like to acknowledge our generous donors and supporters that have facilitated our growth and helped us with our vision in the past year. This list includes some long-time supporters of ADI as well as welcoming some new donor friends.
Your support of our work is intrinsic to our success – thank you.

- Australian NGO Cooperation Program (ANCP)
- ATS Charitable Foundation
- Austpac Commodities Pty Ltd
- BD
- Brent and Vicki Emmett
- Colgate PNG
- Direct Aid Program (DAP), Australian Government Department of Foreign Affairs and Trade (DFAT), Australian High Commission of Papua New Guinea in Port Moresby
- Ela Motors
- Graham and Gail Smith
- Horizon Oil
- Lili Koch
- Mary Alice Foundation
- MinterEllison
- Mundango Abroad
- Newcrest
- New Ireland Provincial Government
- Old Dart Foundation
- PNG Sustainable Development Program
- PwC PNG
- Three Flips Foundation
- West New Britain Provincial Government
- Women's Plans Foundation









Top, left-right; Peter Macdonald (President), Colin Plowman, Louise Walker & Brent Emmett.

Middle, left-right: Richard Schroder, James Sheffield & Liza Nadolski.

Bottom, left-right: David Miles and Judy Lambert.

Board Members

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
Colin Plowman, BA MSc DIC

Colin was a public sector senior executive in a number of Commonwealth and State agencies. He is experienced in policy development and delivery of high value programs and projects, including a number to Australian Indigenous communities. Colin took on the role of Vice President effective from the AGM, held in November 2018.

SECRETARY & PUBLIC OFFICER
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.

James Sheffield, LLB (Bachelor of Law) and GAICD

James Sheffield is a consultant in financial services with over 20 years experience in the sector as a General Manager. He has previously been a Board member of several organisations including Childfund Australia from 2004 to 2012. During this time he served on the Governance and Nominations Committee; the Fundraising Committee and was Chairperson for the last two years of his two terms. He has an honours degree in Law and is a Graduate of the Australian Institute of Company Directors.

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.

Brent Emmett, BSc (Hons)

Brent Emmett has over 40 years' experience in petroleum exploration, exploration and production management and investment banking. He first worked as an explorationist in Australia, Papua New Guinea and New Zealand then filled general management roles in North and South America and Australia. Brent was the Chief Executive Officer and Managing Director of Horizon Oil for 17 years. He retired as CEO in 2018 but remains actively involved in the oil business as a senior advisor to industry participants. Brent has been actively engaged in the oil business in Papua New Guinea since 1975. He joined the Board of ADI in April 2019.

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.

Richard Schroder, BS (Hons)

Richard is currently CEO of Kina Petroleum Corporation and 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.

TREASURER
David Miles, BComm, FCA

David worked as a chartered accountant for 33 years with Price Waterhouse and JPMorgan in Sydney, Canada, Jakarta and Tokyo. Roles with JPMorgan included Finance Director for Australia and Indonesia, COO of the Investment bank in Australia, CEO of JP Morgan Trust Bank in Japan and CEO of a JPMorgan/Aust Post JV which employed 300 staff in Australia.

In the latter part of his career, David helped setup Investment Banking startup Moelis Australia (now $600mill ASX listed). Since retiring, David spends his time raising Angus beef cattle in the Central West of NSW. David was invited to join the Board as Treasurer in June 2019.

A patient visits Dr Shanta post-operation after a lipoma removal during patrol in Kungim, Western Province, September 2019

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

Program Committee:
Dr Judy Lambert (Chair), Dr Peter Macdonald, Dr Rebecca Taylor, Dr Joanne Epp, Rohan Langstaff, Dr Bruce Slonim; along with a member of ADI's program team on rotation.

Risk and Compliance Committee:
Dr Peter Macdonald (Chair), Richard Magee, Liza Nadolski, Turner Massey and Dr Klara Henderson.

Revenue Committee:
Colin Plowman (Chair), Dr Peter Macdonald, George McLelland, Dr Klara Henderson, Brent Emmett, Ian Munro and Louise Walker.

Finance and Audit Committee:
David Miles (Chair and Treasurer), George McLelland, Andrew Noble (Finance Manager) and Dr Klara Henderson

Board of Director's Report

Declaration of Financial Statements

The names of members of the Board of Directors during the year ended 30 June 2020 and at the date of this report are:

- Dr Peter Alexander Cameron Macdonald – President
- Colin Plowman – Vice President
- David Miles – Treasurer
- Liza Nadolski – Secretary & Public Officer (appointed November 2019)
- Dr Judy Lambert
- Richard Schroder
- Louise Walker
- Brent Emmett
- James Sheffield (appointed April 2020)
- Boronia Foley (resigned November 2019)
- Patricia Anne Lanham (resigned November 2019)
- Virpi Tuite – Secretary & Public Officer (resigned November 2019)

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, 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 61-70 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 2020 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 19th day of October 2020 is made in accordance with a resolution of the Board of Directors.

Dr Peter Macdonald, OAM
President

David Miles, Treasurer

Financial Overview

For the year ended 30 June 2020

Your directors present this report to the members of ADI for the year ended 30 June 2020.

Change in Accounting Policy

Due to a change in accounting standards, ADI has changed the way it recognises designated Grant income. This income is now recognised over time based on the expenditure incurred in relation to the specific purpose of each Grant. Previously income was recognised when received. The financial statements reflect the change in the income recognition policy and the impact of the change is provided in the notes to the accounts.

Key Financial Results:

ADI's net surplus as at 30 June 2020 was $92,899 compared to last year's deficit of $(7,375)

Total income of $1,852,453 increased by 46% with Grant income of $1,342,191 increasing by 86% on last year.

Donations from appeals and fundraising activities decreased by 35% to $90,235.

Grant income now represents 91% of total monetary income compared to 79% for the previous financial year.

ADI continued to receive support from the New Ireland Provincial Government and the Australian Government's Australian NGO Cooperation Program (ANCP) along with corporate sponsorship from Horizon Oil and increasing support from a number of foundations and individuals including the Old Dart Foundation. New support was also received from the West New Britain Provincial Government.

The non-monetary contribution from our in-country volunteer doctors and other health professionals increased from $360,286 last year to $378,449 for the current financial year.

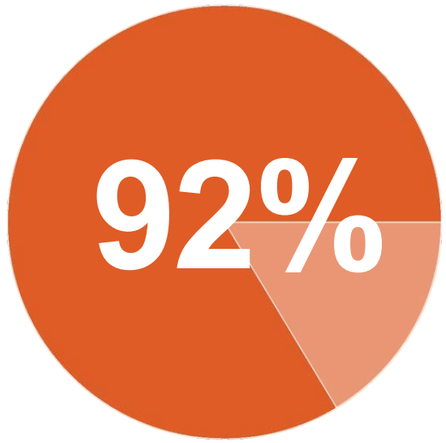
The impact of COVID-19 pandemic has had a minimal impact on ADI's financial position.

Total expenditure in 2019/20 was $1,759,554 up 38% from last year.

Excluding non monetary volunteer expense, costs increased by 50% with a 90% increase in program costs.

Our international program takes place in PNG. 92%* of total expenditure was on our international progam (an increase from last year of 12%).

Cash at the end of the financial year was $663,553, a decrease of $57,029 on last year mainly due to increased program expenditure.



of expenditure on international programs

12% from 2018/2019

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.

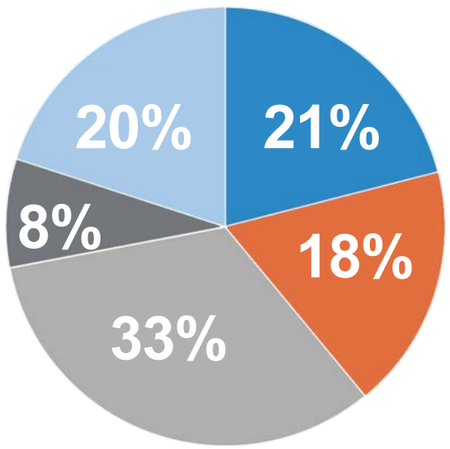
** International program work is calculated as Funds to international programs; Program Support costs and Non monetary expenditure as a percentage of Total Expenditure.*

Finances at a glance

For the year ended 30 June 2020

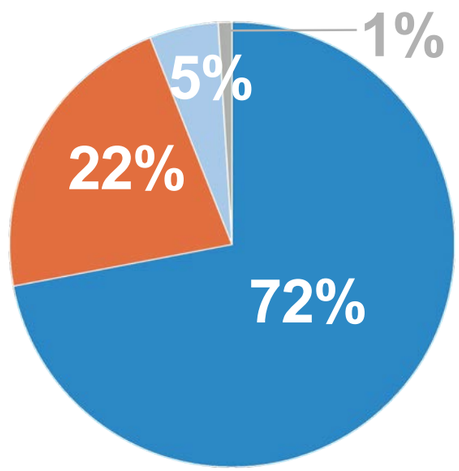
	2019/2020	2018/2019
INCOME	**$**	**$**
Grants - DFAT	382,358	192,128
Grants - Other Australian Government	7,000	22,000
Grants - Overseas	329,355	216,742
Grants - Other Australian	603,478	281,793
Undesignated Funding	151,813	197,594
Donations - Non-Monetary	378,449	360,286
Total Income	**1,852,453**	**1,270,543**
EXPENDITURE	$	$
International Program and support costs	1,267,058	664,572
Accountability & Administration	95,257	239,086
Fundraising & Community Education	18,790	13,974
Non-Monetary Expenditure for International Programs	378,449	360,286
Total Expenditure	**1,759,554**	**1,277,918**

Total Revenue $1.9 million FY 2019/20



- Grants: Australian Government - 21%
- Grants: Overseas - 18%
- Grants: Other Australian - 33%
- Donations: Non-Monetary - 20%
- Undesignated Funding - 8%

Total Expenditure $1.8 million FY 2019/20



- International Programs & support costs - 72%
- Non Monetary Expenditure - 22%
- Accountability & Administration - 5%
- Fundraising & Community Education - 1%

Auditor's report

For the year ended 30 June 2020

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 2020. 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 2020 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

6 November 2020
Freshwater NSW

Liability limited by a scheme approved under Professional Standards Legislation

Chartered Accountant

Income Statement

For the year ended 30 June 2020

	Notes	2020	2019
INCOME		**$**	**$**
Donations and gifts			
Monetary		90,235	139,816
Non-Monetary	5	378,449	360,286
Grants	2	1,342,191	722,663
Investment Income	6	4,322	5,382
Other Income	7	37,256	42,396
Total Income		**1,852,453**	**1,270,543**
EXPENDITURE			
International Aid and Development Programs Expenditure			
Funds to international programs	3	716,539	390,189
Program support costs	3	550,519	274,383
Community education		0	299
Fundraising costs - Public	8	18,790	13,675
Accountability and Administration	9	95,257	239,086
Non-Monetary Expenditure	5	378,449	360,286
TOTAL EXPENDITURE		**1,759,554**	**1,277,918**
EXCESS/(SHORTFALL) OF INCOME OVER EXPENDITURE		**92,899**	**(7,375)**

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

Balance Sheet

As of 30 June 2020

	Notes	2020	2019
Assets		$	$
Current Assets			
Cash and cash equivalents	4	663,553	720,582
Trade and other receivables		67,128	18,553
Current tax receivables	11	9,787	0
Total Current Assets		**740,468**	**739,135**
TOTAL ASSETS		**740,468**	**739,135**
Liabilities			
Current Liabilities			
Trade and other payables	10	61,591	46,547
Current tax liabilities	11	0	5,886
Other financial liabilities	12	4,425	5,250
Provisions	13	27,284	9,645
Deferred Income	14	369,538	487,076
Total Current Liabilities		**462,838**	**554,404**
TOTAL LIABILITIES		**462,838**	**554,404**
Net Assets		**277,630**	**184,731**
Equity			
Reserves		-	-
Retained Earnings		277,630	184,731
TOTAL EQUITY		**277,630**	**184,731**

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

Cashflow Statement
For the year ended 30 June 2020

	Notes	2020	2019
Cash flow from operating activities		**$**	**$**
Receipts from Operations		1,293,782	914,478
Operating Payments		1,355,133	883,560
Net Cash provided by (used In) operating activities	16	-61,351	30,918
Cash flow from investing activities			
Investment Income		4,322	5,382
Payments for property, plant, equipment		0	0
Net Cash provided by (used in) investing activities		4,322	5,382
Net increase (decrease) in cash held		-57,029	36,300
Cash at beginning of financial year		720,582	684,282
CASH AT END OF FINANCIAL YEAR		**663,553**	**720,582**

Changes in Equity
Retained Earnings

	Notes	2020	2019
		$	**$**
Balance at beginning of year		184,731	192,106
Excess/(shortfall) of revenue over expenses		92,899	(7,375)
BALANCE AT END OF YEAR		**277,630**	**184,731**

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

Financial Notes
For the year ended 30 June 2020

Note 1.Summary of significant accounting policies and basis of accounting

The following 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 straight-line 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 by the board of directors 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. Goods and services tax (GST.)

Revenues, expenses and assets are recognised net of the amount of GST except where the amount of GST incurred is not recoverable from the Australian Taxation Office or the PNG Inland Revenue. In which case it is recognised as part of the cost of acquisition of an asset or as part of an item of expense. Receivables and payables are recognised inclusive of GST, if applicable.

E. 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.

F. Change in accounting policy - Revenue recognition - AASB 15 and AASB 1058

Australian Doctors International Incorporated (ADI) has adopted AASB 15 Revenue from Contracts with Customers and AASB 1058 Income of Not-for-Profit Entities for the first time in the current year.

ADI has applied AASB 15 and AASB 1058 to both the current and comparative financial results.

All adjustments on adoption of AASB 15 and AASB 1058 for contracts modified prior to 1 July 2018 have been taken to accumulated funds at 1 July 2018.

The following changes to accounting policy occurred on adoption of AASB 15 and AASB 1058.

- Grants – operating under AASB 1004, most grant income was recognised as revenue on receipt. Under AASB 1058 and AASB 15, the revenue is recognised over time based on the expenditure made in relation to the specific purpose of each grant, resulting in deferral of revenue in many cases.

- Donations and unrestricted Grants. No change to policy with revenues recognised on receipt.

The impact on the financial report from applying AASB 15 and AASB 1058 are shown in Note 17.

G. 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 Grant income

	2020	2019
Grants Designated	$	$
DFAT	382,358	192,128
Other Australian Government	7,000	22,000
Grants - Overseas	329,355	216,742
Grants - Other Australian	603,478	281,793
Total Designated Grants	1,322,191	712,663
Undesignated Funding	20,000	10,000
Total Grant Income	**1,342,191**	**722,663**

Note 3 International aid and development programs

	2020	2019
Doctors, education and training	$	$
Non-monetary	378,449	360,286
Funds to international programs	716,539	390,189
Program support costs	550,519	274,383
TOTAL	**1,645,507**	**1,024,858**

Note 4 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				
Integrated Patrols	0	223,887	223,065	822
NIPG Patrols (NIPG)	210,818	0	163,643	47,175
Family Planning	154,835	130,000	172,250	112,585
Emergency Obstetric Care	14,000	68,000	26,726	55,274
Pathology	0	0	0	0
Western Province, PNG				
Catholic Health Improvement	-15,885	235,000	212,950	6,165
Aerial Patrols	-10,940	134,175	119,055	4,180
Emergency Obstetrics Care	53,267	-44,500	8,759	8
West New Britain, PNG				
Integrated Patrols	103,379	365,195	331,866	136,708
Family Planning	0	15,000	16,205	-1,205
Emergency Obstetrics Care	0	41,500	27,679	13,821
Other Projects				
Non Designated	211,111	171,813	94,901	288,022
Total Cash Movements	**720,582**	**1,340,070**	**1,397,099**	**663,553**

Note 5 Non-monetary revenue/expenditure

	2020	2019
International and development programs	$	$
Medical volunteers	353,789	325,074
Non-medical volunteers	24,660	35,212
Medical equipment and supplies	0	0
Total international and development programs	378,449	360,286
Other	-	-
Total non-monetary revenue/expenditure	**378,449**	**360,286**

Note 6 Investment Income

	2020	2019
	$	$
Bank Interest	4,322	5,382

Note 7 Other Income

Annual Gala Dinner	37,256	42,396

Note 8 Fundraising Costs

Campaign Costs (EOFY and Christmas)	850	4,632
Annual Gala Dinner Costs	17,940	8,710
Adventure Bike Ride to PNG	0	333
	18,790	**13,675**

Note 9 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 10 Trade and Other Creditors

Trade creditors	9,349	8,100
Accrued charges	52,242	38,442
	61,591	46,542

Note 11 Current Tax Liabilities

Australia GST Receivable	(7,789)	(2,350)
PNG GST Receivable	(1,998)	(8,611)
PAYG	-	16,847
	(9,787)	5,886

Note 12 Other Financial Liabilities

Prepaid member subscriptions	4,425	5,250

Note 13 Provisions

Annual Leave Accrual	21,284	9,645
Other Provisions	6,000	0
	27,284	9,645

Note 14 Other Current Liabilities

Deferred Grant Revenue	369,538	487,076

Note 15 Remuneration of Auditor

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

Note 16 Reconciliation of Excess (Shortfall) to Net Cash Flow from Operating Activities

Excess (Shortfall) of revenue over expenditure	92,899	(7,375)
Depreciation	(9,691)	(8,596)
Increase (Decrease) in creditors	41,646	31,729
Increase (Decrease) in deferred income	(117,538)	23,119
Investment Income	(4,322)	(5,382)
Capital Expenditure	9,691	8,596
PAYG & GST	(15,674)	2,342
Decrease (Increase) in trade and other receivables	(58,362)	(13,515)
Decrease in loans payable	-	-
Cash inflow (outflow) from operating activities	**(61,351)**	**30,918**

Note 17 Comparison of financial report line items under AASB 15 compared to previous standards for the current year

The following tables show the impact of adopting AASB 15 and AASB 1058 on the Company's financial report for the year ended 30 June 2020 and the previous comparative year.

	Notes	2020			2019		
		Income statement and comprehensive income under AASB 15 and AASB 1058	Reclassification	Income statement and comprehensive income under previous revenue standards	Income statement and comprehensive income under AASB 15 and AASB 1058	Reclassification	Income statement and comprehensive income under previous revenue standards
		$	$	$	$	$	$
Assets							
Current Assets							
Cash and cash equivalents		663,553		663,553	720,582		720,582
Trade and other receivables		67,128		67,128	18,553		18,553
Total Current Assets		730,681	0	730,681	739,135	0	739,135
Total Non Current Assets		0		0	0		0
Total assets		**730,681**	**0**	**730,681**	**739,135**	**0**	**739,135**
Liabilities							
Current Liabilities							
Trade and other payables		61,591		61,591	46,547		46,547
Current tax liabilities		(9,787)		(9,787)	5,886		5,886
Other financial liabilities		4,425		4,425	5,250		5,250
Provisions		27,284		27,284	9,645		9,645
Deferred Grant income		369,538	(369,538)	0	487,076	(356,476)	130,600
Total Liabilities		**453,051**	**(369,538)**	**83,513**	**554,404**	**(356,476)**	**197,928**
Net Assets		**277,630**	**369,538**	**647,168**	**184,731**	**356,476**	**541,207**
Equity							
Retained Earnings							
- Opening Retained Earnings		184,731	356,476	541,207	192,106	426,957	619,063
- Current year excess/(shortfall) of revenue over expenses		92,899	13,062	105,961	(7,375)	(70,481)	(77,856)
Retained Earnings		277,630	369,538	647,168	184,731	356,476	541,207
Total Equity		**277,630**	**369,538**	**647,168**	**184,731**	**356,476**	**541,207**

Income Statement

for the year ended 30 June 2020

REVENUE							
Donations and gifts							
- Monetary		90,235		90,235	139,816		139,816
- Non Monetary		378,449		378,449	360,286		360,286
Grant Income		1,342,191	13,062	1,355,253	722,663	(70,481)	652,182
Investment Income		4,322		4,322	5,382		5,382
Other Income		37,256		37,256	42,396		42,396
TOTAL REVENUE		**1,852,453**	**13,062**	**1,865,515**	**1,270,543**	**(70,481)**	**1,200,062**
EXPENDITURE							
- International Aid and Development Programs expenditure		1,759,554		1,759,554	1,277,918		1,277,918
TOTAL EXPENDITURE		**1,759,554**		**1,759,554**	**1,277,918**		**1,277,918**
EXCESS/(SHORTFALL) OF REVENUE OVER EXPENDITURE		**92,899**	**13,062**	**105,961**	**(7,375)**	**(70,481)**	**(77,856)**

Note 18 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.

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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, conflict of interest policy, child safeguarding policy and prevention of sexual exploitation and abuse 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
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 accredited with the Australian Government's Australian NGO Cooperation Program (ANCP).

Australian Aid

Australian Government
Department of Foreign Affairs and Trade

Annual Report Graphic Design: Amelia Hunt

Endnotes

i WHO, State of the world's nursing, Papua New Guinea, 2020 https://apps.who.int/nhwaportal/Sown/Files?name=PNG&lang=EN (accessed Aug 2020)

ii WHO, Global Health Observatory data repository, Papua New Guinea – Nursing and midwifery personnel https://apps.who.int/gho/data/node.main.HWFGRP_0040?lang=en (accessed Aug 2020)

iii WHO, Global Health Observatory data repository, Papua New Guinea – Community Health Workers https://apps.who.int/gho/data/view.main.HWFCOMv (accessed Aug 2020)

iv UNFPA, The State of the World's Midwives, Papua New Guinea https://www.unfpa.org/data/sowmy/PG (accessed Aug 2020)

v Thiessen, Jodi & Rumsey, Michele & Homer, Caroline & Bagoi, Athalia & McCracken, Christine. (2017). Making change and sustaining new learning after reproductive health training in Papua New Guinea. 1. 10.18313/pjrh.2017.920.

vi WHO, State of the world's nursing, Papua New Guinea, 2020 https://apps.who.int/nhwaportal/Sown/Files?name=PNG&lang=EN (accessed Sep 2020)

vii WHO, Increasing access to health workers in remote and rural areas through improved retention, 2010 https://www.who.int/hrh/retention/guidelines/en/ (accessed Aug 2020)

viii Papua New Guinea FP2020 Core Indicator Summary Sheet: 2018-2019 Annual Progress Report - http://www.familyplanning2020.org/sites/default/files/Data-Hub/2019CI/Papua_New_Guinea_2019_CI_Handout.pdf

ix UNICEF Data Warehouse - https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=PNG.MNCH_ANC4..&startPeriod=1993&endPeriod=2018 (accessed Sep 2020)

x UNICEF Data Warehouse - https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=PNG.IM_DTP3.&startPeriod=1970&endPeriod=2020 and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6290803/ (accessed Sep 2020)

xi MEASURE Evaluation, Family Planning and Reproductive Health Indicators Database, https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/cyp (accessed Sep 2020)

xii WHO and UNICEF, Papua New Guinea: WHO and UNICEF estimates of immunization coverage: 2019 revision

xiii UNICEF, The State of the World's Children 2019 Statistical Tables, https://data.unicef.org/resources/dataset/sowc-2019-statistical-tables/ (Accessed Sept 2020)

xiv Save the Children, Ending Violence in Childhood Global Report' (2017) https://www.savethechildren.org.au/getmedia/29d0e266-a7d2-4200-ae47-d5e46e34bc79/STC01615_Unseen-Unsafe-Report_Web-(1).pdf.aspx

xv Blanc J, Locatelli I, Rarau P, Mueller I, Genton B, et al. (2019) Retrospective study on the usefulness of pulse oximetry for the identification of young children with severe illnesses and severe pneumonia in a rural outpatient clinic of Papua New Guinea. PLOS ONE 14(4): e0213937. https://doi.org/10.1371/journal.pone.0213937

All photos in our report are sourced by ADI staff or partners and we have obtained consent for their use.

From left to right: Leontyne Taumomoa (dental), Merrilyn Aruke (optometry) and HEO Shirley Lalen (optometry), Primary school in Namatanai, New Ireland, November 2019

Navigating rural landscapes on patrol in Lengakamin, Lelet Highlands, New Ireland, March 2020

A mother and son visit Dr Vijay and Dr Shanta after receiving treatment for a scalp abscess on patrol, Upper Fly, Western Province, November 2019

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