2025/2026



Annual Report

ADI

For a healthier rural PNG



The ADI way

Working with our local government and non-government partners, ADI supports the delivery of health services in rural and remote regions of Papua New Guinea.

We work across numerous provinces including Western, New Ireland, West New Britain, and Gulf, with expansion into other provinces very much on our horizon.

The ADI Way of working has brought great respect from people of the communities we work within, and the partners with whom we collaborate.

The ADI Way of thinking begins by listening to and learning from local voices and lived experiences. We champion those living with disability and social exclusion. We hold fast to principles of equity, are highly sensitive to community values and culture, and ensure our environmental responsibility is upheld.

The ADI Way of working builds confidence that we do what we say, we do the right thing, and we hold true to stakeholder expectations, while operating at the highest level of accountability.

The people of Papua New Guinea are at the centre of all we do.

This is the ADI Way.

Vision

A healthier rural and remote Papua New Guinea.

Mission

ADI is committed to working with partners to provide and strengthen services in rural and remote communities of PNG. ADI strives for sustainable healthcare solutions, ensuring every individual, regardless of location, has access to quality healthcare and a healthy future.

Values

- We keep our promises
- We embrace local voices
- We champion justice and equality
- We respect the natural environment
- We inspire innovation

Message from the CEO and Chair

A look back at the year.

Once again, we are delighted to present ADI's Annual Report. Coming off the celebrations of our **25th year in Papua New Guinea**, 2025/26 was a year of putting that experience to work: opening new services, strengthening our leadership in PNG, and delivering some of the strongest program results in our history.

A milestone for the year was the **opening of TROPHE, Two Rooms of Protection, Hope and Empowerment, at Namatanai District Hospital in New Ireland Province**. These dedicated rooms give survivors of gender-based violence a safe, private and dignified place to receive care and support, and they sit alongside TROPHE's prevention education in schools and communities across Namatanai District. TROPHE was made possible by the World Gold Council, with the support of Newmont, and by the Women's Plan Foundation, which furnished the rooms. We are deeply grateful to them, and to the hospital staff and New Ireland Provincial Health Authority for making TROPHE their own.

In Gulf Province, our family planning program delivered outstanding results. The total couple-years of protection achieved during the year was 5,035, representing women and couples who accessed modern family planning methods during the year. These results reflect the trust our teams have built with communities and health workers in a province where we began working only recently, and they give women real choice over their health and their futures.

In West New Britain,

OUR TEAMS DELIVERED

10,672

SUPPLEMENTARY IMMUNISATIONS

TO

3,200

INDIVIDUAL CHILDREN

reaching many who had missed out on routine vaccination and protecting them against preventable diseases. This work, carried out with the West New Britain Provincial Health Authority, continues to make the province a centre of growth for ADI.

Our volunteer heritage remained strong. Volunteer doctors returned to Western Province, where ADI's story began in 2000, supporting outreach patrols, providing clinical care in remote communities and mentoring local health workers. In March 2026, two volunteer doctors, Dr Hayley Kelly and Dr Liam Byrne, joined ADI's Western Province team, delivering clinical services in Tabubil and Kiunga and participating in two outreach patrols that reached 33 remote communities over 25 days along the Fly and Alice Rivers.

Across all programs,

ADI DELIVERED

23,532

CLINICAL SERVICES

AND

18,627

VACCINATIONS AND SUPPLEMENTS

to children in rural and remote communities during the year. These results highlight the strength of our partnerships with Provincial Health Authorities and our commitment to improving health outcomes in hard-to-reach areas.



Sharon Pondros
Country Manager

We were delighted to appoint Sharon Pondros as PNG Country Manager. Sharon, previously our GEDSI Technical Lead, brings deep knowledge of our programs, our partners and the communities we serve. Her appointment is an important step in our commitment to PNG-led leadership, with program delivery and management in the hands of those who know PNG best.

The Board also welcomed two new Directors, Arabella Koliwan and Anna Madgwick. We thank all our Directors for the time, wisdom and care they give to ADI.



Anna Madgwick
Director



Arabella Koliwan
Director

We rely on donations and grants to fund our work, and we continue to build a pipeline of government, private sector and philanthropic funding. We are grateful to the Australian Government, to the PNG Provincial Governments and to our major funders, who are acknowledged later in this report, and to the many individual donors who support us so faithfully.

The following pages tell the story of a year of impact in some of the most remote communities in Papua New Guinea. They are a testament to the power of partnership and to the passion and commitment of our staff, who make the ADI Way a reality every day. We thank them, along with our volunteers, partners and supporters, for all they have done this year.



Tracey Tatnell
Chief Executive Officer



Brent Emmett
Chair

Our Impact

Stories from the field and our year in numbers.

CLINICAL SERVICES

23,532
COMMUNITY MEMBERS
RECEIVING CLINICAL SERVICES

7,069
INDIVIDUAL CHILDREN
IMMUNISED

18,626
VACCINES & SUPPLEMENTS
DELIVERED

FAMILY PLANNING

2,758
CLINICAL SERVICES
IN FAMILY PLANNING

3,795
COUPLE YEARS OF PROTECTION (CYP)
across 4 provinces

HEALTH EDUCATION & AWARENESS

10,394
COMMUNITY MEMBERS
ATTENDING AWARENESS SESSIONS

264
HOURS
OF PUBLIC HEALTH EDUCATION

915
EDUCATION
SESSIONS DELIVERED

HEALTH WORKFORCE TRAINING

171
HEALTH WORKER TRAINING SESSIONS
over 55 hours
delivered during outreach activities

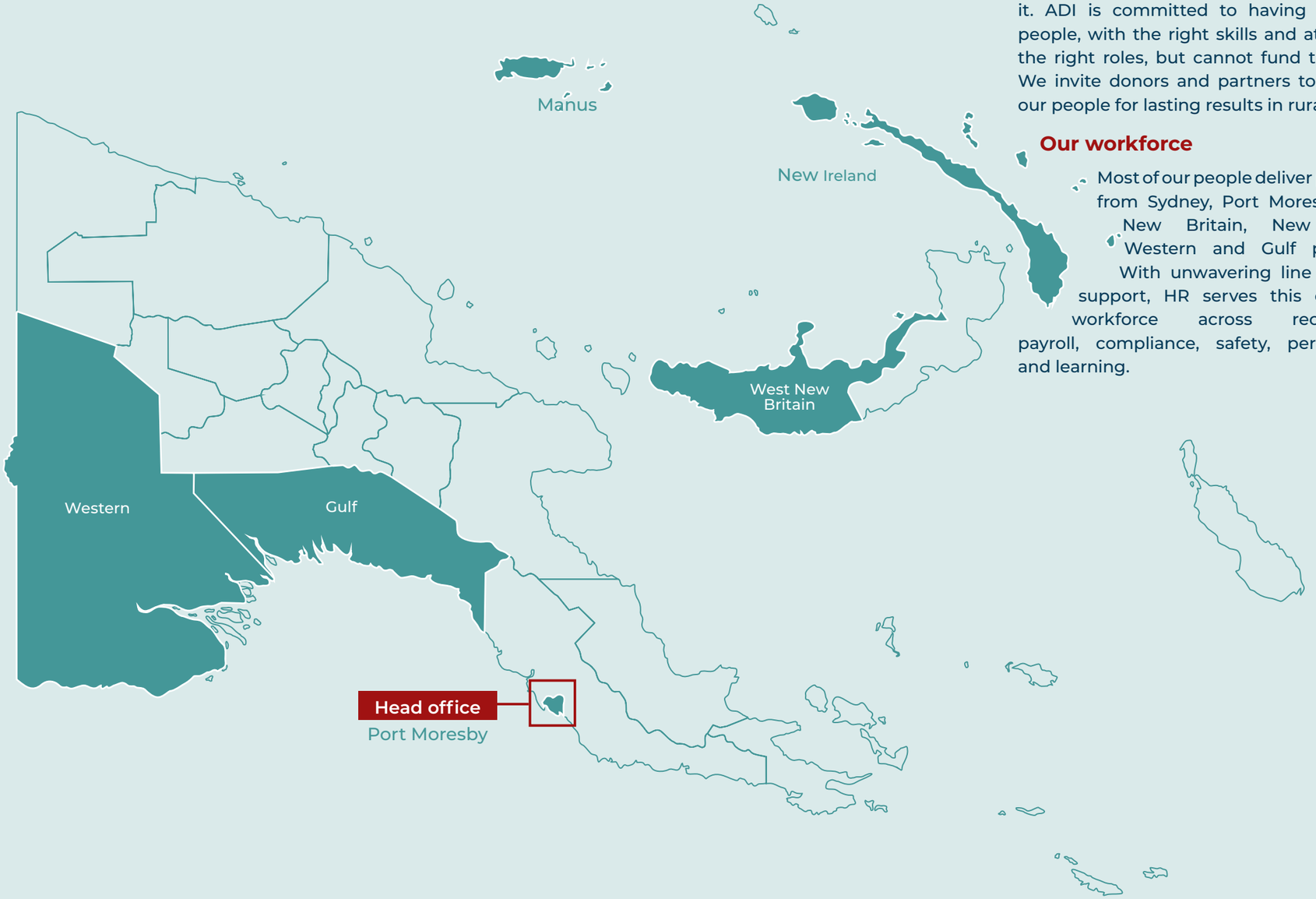
206
HEALTH WORKERS TRAINED
in integrated outreach, family planning outreach and FP supervisory visits, and by ADI volunteer doctors through case and group-based training

271
HEALTH WORKERS TRAINED IN WORKSHOPS
Family planning · EMNC · TB · Immunisation
delivered in conjunction with partner Provincial Health Authorities and CHS

COMMUNITY LEADERSHIP

111
REMOTE COMMUNITY LEADERS & MEMBERS
ATTENDED TRAINING ACROSS A VARIETY OF TOPICS
GEDSI · Gender-based violence

Where we work



Province where ADI currently works

Head Office, Port Moresby

Our People

Good programs don't deliver themselves; people do. Behind every successful proposal is a team that designs, manages and delivers it. ADI is committed to having the right people, with the right skills and attitude, in the right roles, but cannot fund this alone. We invite donors and partners to invest in our people for lasting results in rural PNG.

Our workforce

Most of our people deliver programs from Sydney, Port Moresby, West New Britain, New Ireland, Western and Gulf provinces. With unwavering line manager support, HR serves this dispersed workforce across recruitment, payroll, compliance, safety, performance and learning.

Challenges and opportunities

Like many PNG health organisations, ADI faces strong competition for experienced national staff. Key technical and clinical roles remain vacant, and field clinical teams are under sustained pressure. We see a chance to grow stronger by building career pathways, recognition and local support that make people want to stay, and by developing PNG-based leadership so expertise stays within our national teams.

What we achieved

This year we launched ADI's Rewards & Recognition Awards, our first structured retention strategy, open to staff in every province. It has already proved effective, with staff taking part and colleagues rewarded. We strengthened national leadership by appointing a Papua New Guinean Country Manager and welcoming two senior national staff as Board observers. HR also began using AI to draft policy, analyse workforce data and prepare reports more efficiently

The way forward

Our vision is a well-resourced, responsive HR function enabling all of ADI to deliver safely and well. Next year we will:

- fill critical program roles and expand volunteer doctor recruitment;
- grow the HR team and place HR, M&E and GEDSI officers in every province;
- introduce succession planning and internal training in budgeting, procurement and reporting; and
- secure funding to expand retention initiatives and move towards more competitive salaries, to attract and keep the talent our communities rely on.

Maternal and Child Health

Family planning, emergency obstetric training and immunisation.

Maternal and Child Health

Family Planning

ADI's Family Planning Program improves access to quality family planning information and services for women, men and families in rural and remote Papua New Guinea. Working with Provincial Health Authorities, Church Health Services and local health facilities across Western, Gulf, New Ireland, West New Britain and Central provinces, we build the skills of frontline health workers so women can access contraception close to home, rather than travelling to a major hospital.

Family planning is integrated into ADI's rural outreach patrols and maternal, newborn and child health services. Training covers short-acting, long-acting reversible (including implants) and permanent methods, with a strong focus on counselling, informed choice and birth spacing.



Our approach

- **Training** – practical workshops in counselling, contraceptive methods, implant insertion and removal, and infection prevention.
- **Supervision and assessment** – follow-up clinical practice, mentoring and competency assessment that turn training into confident, quality care.
- **Outreach** – family planning delivered through integrated patrols and static clinics in hard-to-reach communities.
- **Community education** – helping women and couples understand their options, benefits, side effects and informed consent.
- **Partnerships** – working with health authorities, churches and facilities to make services sustainable.

Key results 2025–2026

This year the program trained **53 health workers through five workshops and supervised 54 on their clinical skills**. Together, training and outreach delivered **5,035 couple-years of protection** – the equivalent of protecting 5,035 couples from unintended pregnancy for a full year.

INDICATOR (July 2025 - June 2026)	Result
Couple-years of protection (CYP)	**5,035**
Family planning services delivered during outreach	**2,866**
People reached through community education	**4,198**
Health workers trained in family planning	**53** (38 female)
Family planning training workshops	**5**
Health workers supervised and assessed on clinical skills	**54**
Health facilities visited	**18**
Outreach patrols / static clinics	**5 / 11**
Health workers trained in EMNC (3 workshops)	**29** (19 female)

Trained health workers are now providing counselling and implant services where women live. At Mougulu in Western Province alone, the officer-in-charge performed 86 implant procedures following ADI training.



SUCCESS STORY

From training to confidence

Before the training, I missed many opportunities to provide family planning services to postnatal clients because I lacked the knowledge and skills. Now, I can provide these services with confidence and without fear.

— Waipe Psene, Community Health Worker, Rumginae Rural Hospital

Waipe works in the postnatal ward at Rumginae Rural Hospital. After completing ADI's family planning training and equipped with implant supplies and training videos from ADI, she began offering counselling and implant services at her own facility.

During ADI's clinical competency assessment in June 2026, direct observation and supportive supervision sharpened her skills in counselling, informed consent, infection prevention and documentation. Over the week she counselled 11 clients and completed five implant insertions and six removals.

Waipe has now performed 25 implant insertions and 11 removals. Her story shows why ADI pairs training with practice, supervision and assessment: it turns knowledge into confidence, and confidence into quality care for women and families.

Essential Maternal and Newborn Care

Giving frontline health workers the skills to keep mothers and newborns safe through pregnancy, birth and the first days of life.

1. Introduction

For a woman giving birth in a remote community, the skills of the nearest health worker can make all the difference. When complications arise, recognising them early and responding quickly can save the life of a mother or her baby.

ADI's Essential Maternal and Newborn Care (EMNC) training strengthens the knowledge, practical skills and confidence of frontline health workers to provide safe, timely and quality care during pregnancy, childbirth and the postnatal period, and to newborns immediately after birth. In 2025-26, ADI delivered EMNC training in Western Province, West New Britain and New Ireland, reaching 31 health workers, two-thirds of them women. To our knowledge, ADI is the only organisation currently delivering EMNC training in its project provinces in Papua New Guinea.

EMNC sits alongside our family planning program. Together, they support women from birth spacing through pregnancy, childbirth and the first days of their baby's life. This section describes the training and who it reached and looks at what provincial health data tell us about maternal health trends in the three provinces.

This work is made possible through the Australian Government's Australian NGO Cooperation Program (ANCP), our provincial health partners and our generous donors.

2. About the training

The training aims to improve the care women and newborns receive at every stage. It is designed to help increase antenatal care coverage and supervised deliveries, strengthen postnatal care and encourage more women to take up family planning.





Table 1. What the training covers, across the continuum of care

PREGNANCY	• Antenatal care
LABOUR & BIRTH	• Monitoring labour • Early identification of obstetric complications • Infection prevention
AFTER BIRTH	• Managing postpartum haemorrhage • Postnatal care
NEWBORN CARE	• Essential newborn care • Newborn resuscitation
EMERGENCIES	• Referral of mothers and newborns needing emergency care

Table 2. Health workers trained in 2025-26

Province	Women	Men	Total
Western Province	8	4	12
West New Britain	8	2	10
New Ireland	5	4	9
Total	**21**	**10**	**31**

3. Maternal health trends in our provinces

ADI monitors two key maternal health indicators drawn from provincial health data: the share of pregnant women completing at least four antenatal care visits, and the share of births attended by a skilled health worker, such as a midwife, nurse or doctor. These indicators reflect the performance of whole provincial health systems and are shaped by many factors beyond training, but they help show where progress is being made and where support is most needed.



Table 3. Key maternal health indicators, 2021–2025

At least four antenatal care visits (% of pregnant women)				
Province	**2021**	**Best Year**	**2025**	**Trend**
Western Province	17%	31% (2023)	25%	Down from peak
West New Britain	32%	42% (2023)	39%	Recovering
New Ireland	28%	40% (2023)	26%	Down from peak

Supervised deliveries (% of births with a skilled health worker)				
Province	**2021**	**Best Year**	**2025**	**Trend**
Western Province	29%	46% (2025)	46%	Steady rise
West New Britain	-	62% (2024)	57%	Highest overall
New Ireland	-	54% (2024)	37%	Sharp fall in 2025

Source: provincial health data

Antenatal care

All three provinces improved between 2021 and 2023, but coverage has since fallen in Western Province and New Ireland. West New Britain recovered from 34% in 2024 to 39% in 2025, the highest of the three. Helping women keep attending antenatal care throughout pregnancy remains a priority, particularly in Western Province and New Ireland.

Supervised deliveries

West New Britain recorded the highest rate in four of the five years. Western Province improved steadily to reach its highest level in 2025. New Ireland made strong gains to 2024 but fell sharply in 2025, and the reasons for this decline need to be understood. Year-to-year fluctuations across all three provinces show that gains in skilled birth attendance are hard won and need sustained support, particularly for women in remote communities.

4. Looking ahead

The data reinforce the value of continuing to invest in health workers' skills and in services that reach women wherever they live. In the year ahead, priorities include:

- continued EMNC training, supportive supervision and mentoring for health workers
- community awareness to encourage women to start antenatal care early and attend all their visits
- following up pregnant women who miss appointments
- accessible outreach services and better access to skilled birth attendance for remote communities
- further analysis of provincial health data to understand year-to-year changes and guide targeted support.

Through this work, ADI aims to help more mothers and newborns in rural Papua New Guinea receive safe, skilled care when they need it most.





Immunisation

Reaching every child in West New Britain

AIHSS2 Project, West New Britain Province

In the most remote corners of West New Britain, getting a vaccine to a child can take days. Health teams travel by dinghy, four-wheel drive and on foot to villages that may not have seen a health worker in months. Through the Accelerated Immunisation and Health System Strengthening Program Phase 2 (AIHSS2), ADI makes that journey alongside the West New Britain Provincial Health Authority (WNBPHA).

AIHSS2 is a four-year (2024 to 2027), PGK 78 million investment funded by Gavi, the Vaccine Alliance, and the Governments of Australia and New Zealand, and administered through the Papua New Guinea–Australia Transition to Health (PATH) program. ADI supports 18 of the province's 38 health facilities across the Kandrian-Gloucester, Talasea and Nakanai districts. These were chosen because they had the lowest immunisation coverage and the most zero-dose children, who had never received a single vaccine.

The project has three goals: more children vaccinated and fewer zero-dose children; stronger planning and financial management in the Provincial Health Authority; and immunisation services that reach everyone, including women, girls and people with disabilities.

#	HEALTH FACILITY	DISTRICT
1	Aka HC	Kandrian-Gloucester
2	Amio SC	Kandrian-Gloucester
3	Bitokara CHP	Talasea
4	Bola SC	Talasea
5	Buvussi HC	Talasea (now Nakanai)
6	Eslei SC	Kandrian-Gloucester
7	Gasmata HC	Kandrian-Gloucester
8	Kandrian HC	Kandrian-Gloucester
9	Malalia SC	Talasea (now Nakanai)
10	Melenglo SC	Kandrian-Gloucester
11	Milimata SC	Kandrian-Gloucester
12	Pililo SC	Kandrian-Gloucester
13	Sagsag SC	Kandrian-Gloucester
14	Sauren SC	Kandrian-Gloucester
15	Turuk SC	Kandrian-Gloucester
16	Unea HC	Talasea
17	Vitu (Paruru) SC	Talasea
18	Wako CHP	Kandrian-Gloucester

Table 1. The 18 AIHSS-supported facilities in West New Britain



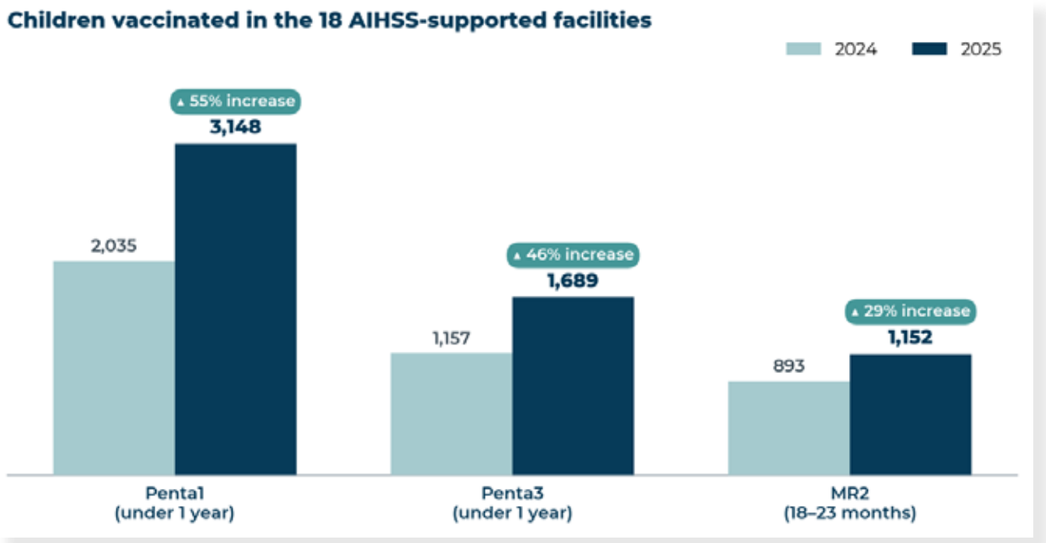
Key achievements



More children protected than ever before

Immunisation coverage across West New Britain has nearly doubled since 2021. Province-wide, coverage of the third Pentavalent dose (Penta3), which protects against five serious diseases, rose from 32.7% in 2021 to 61% by June 2026. Coverage of the second measles-rubella dose (MR2) climbed from 28% to 61%. The national target of 70% is now within reach.

The biggest gains are in the 18 AIHSS facilities, the communities most likely to be missed. In 2025, 3,148 children there received their first Pentavalent dose, 1,113 more than in 2024, and coverage rose from 34% to 73%, beating the 70% annual target.



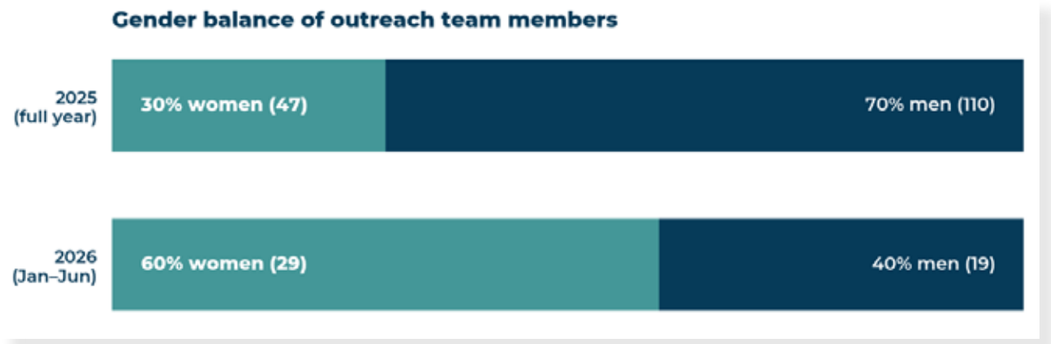
Taking health care to the village

Outreach clinics were rarely possible in these communities because of cost, distance and logistics, so the children furthest from services were the most likely to miss out. Joint ADI and WNBPHA teams now bring vaccines directly to villages, together with outpatient care, family planning, antenatal care, nutrition checks and health education.

In 2025, teams delivered 30 outreach activities across all 18 facilities. ADI and WNBPHA also combined resources with three national immunisation campaigns, and the province reached its 95% polio campaign target. In early 2026, Cyclone Maila halted most sea travel from April to June, yet teams still completed 12 outreach activities and vaccinated 1,769 children.

Outreach also reaches people who are often left out. In 2025, about 117 children with disabilities were vaccinated, and representatives of the West New Britain Differently Abled Persons Organisation and women's groups joined outreach activities. Women now make up 60% of outreach team members, up from 30% in 2025, which helps more mothers and caregivers feel comfortable taking part.





Stronger local health systems

Health workers from 14 facilities took part in Immunisation in Practice training in 2025 and a Progress Review Workshop in February 2026, building skills in microplanning, cold chain management and data reporting. By mid-2026, 15 of the 18 facilities had microplans and 83% had submitted all their monthly health reports, a marked improvement on 2025.

Provincial leadership has also grown stronger. WNBPHA confirmed its Chief Executive Officer in April 2026, and District Health Manager positions were reinstated after ten years. In May 2026, 74 participants from across WNBPHA attended a three-day financial management and health service improvement training, which WNBPHA co-funded, a clear sign of growing local ownership.



Key challenges

Distance, cost and weather remain the biggest obstacles. Many communities can only be reached by sea or after days of walking, and Cyclone Maila showed how quickly climate events can cut them off. Most remote facilities still rely on project support for fuel, logistics and supervision.

Keeping children on schedule is the next big task. One in four children who start the Pentavalent series do not finish it, and in Kandrian-Gloucester the dropout rate is 47%, well above the target of below 10%. Long gaps between outreach visits and poor network coverage make follow-up and reporting difficult, and reporting often depends on a small number of trained staff.

Some change is slower than hoped. The Provincial Health Authority's financial management score has stayed at 22% since December 2025, with many senior roles still filled on an acting basis. Only two children with disabilities were recorded as vaccinated in the first half of 2026, so better identification and recording remains a priority. Concurrent campaigns also stretched staff, and budgeting is not yet fully integrated.

Looking ahead

ADI and WNBPHA will build on what works: more frequent outreach so children can complete their vaccinations on time, closer work with District Health Managers on supervision and reporting, microplans for all 18 facilities, and continued joint planning with other immunisation programs. ADI will also update the project's inclusion plan, extend disability and gender training to more WNBPHA staff, and provide further financial management support.

Behind every figure in this report is a child who is better protected, and a health worker who travelled further to make it happen. ADI thanks Gavi, the Vaccine Alliance, the Governments of Australia and New Zealand, PATH and WNBPHA, and honours the facility staff and Village Health Assistants who make this work possible.

Impact Story. Immunisation Health

When families can't come to us, we go to them

Bringing care to Kumburi, Bali/Vitu, West New Britain

As told by AIHSS2 outreach team.

For families in Kumburi 1 and Kumburi 2, getting to a health centre is hard. The villages are remote, and the area is affected by fighting. To see a health worker, mothers must travel a long way and cross places where it isn't safe. Many stay home, so pregnant women miss their check-ups and children miss their vaccines.

So our outreach team went to them.

We set up a clinic in the village. We treated people who were sick, checked pregnant women, vaccinated children and checked them for malnutrition. For several women, it was the first time they had seen a health worker in months. We helped each pregnant mother plan for a safe birth and showed families the warning signs that mean a mother needs help quickly.

One mother from Kumburi 1 had missed every check-up during her pregnancy because she was too afraid to travel through the fighting areas. When we came, she finally had a full check-up, received supplements and made a plan for the birth of her baby.

> *She told us the visit gave her confidence, and helped her plan for a safe delivery.*
>
> **— A mother from Kumburi 1**

We also vaccinated young children, including some who had never had a single vaccine. Children who showed signs of malnutrition were listed for follow-up, and we talked with mothers about feeding their babies and keeping them healthy.

What stayed with our team most was how people responded. Community leaders thanked us and asked us to come back. Families said they felt safe and valued because someone had come to them despite the conflict, and mothers said they would now seek care earlier.

One visit is a good start, but children need several vaccines and pregnant women need regular check-ups. That's why we will keep going back to Kumburi and other villages like it. When families can't come to us, we will keep going to them



Tuberculosis (TB)

Our work to tackle TB.

Tuberculosis Program in Gulf Province



Building the Foundations for Stronger Tuberculosis Services in Gulf Province

In July 2025, Australian Doctors International (ADI) was engaged by the Santos Foundation to implement a Tuberculosis (TB) Program in partnership with the Gulf Provincial Health Authority (GPHA). The program aims to strengthen TB detection, treatment, case management, monitoring and coordination across Gulf Province. It focused on establishing the foundations for long-term success through workforce mobilisation, governance development, stakeholder engagement and implementation planning. The engagement was guided by five End of Investment Outcomes (EOIOs):

	Description
EOIO 1	Increased access to quality TB services
EOIO 2	Early TB detection, treatment, and patient-centred care to control the spread of TB
EOIO 3	Reduced number of lost-to-follow-up patients and Multidrug-resistant tuberculosis cases
EOIO 4	Reduced risk of TB transmission within communities and among the Santos workforce operating in Gulf Province
EOIO 5	Effective governance, coordination, and oversight of the provincial TB response

Key groundwork was completed to support future service improvements. Findings from baseline Basic Management Unit (BMU) and TB service assessments informed planning for facility refurbishment, procurement and workforce development. ADI worked closely with GPHA to identify priority equipment, consumables and infrastructure requirements for targeted BMUs and TB wards, laying the groundwork for future upgrades to TB diagnostic and treatment capacity across the province.

Community awareness and prevention activities were advanced through World TB Day held in March 2026, with outreach conducted across six communities, three market and community locations, and two schools. Health workers delivered awareness sessions on TB symptoms, transmission, prevention, early diagnosis and treatment adherence. Student performances and community-led activities helped reinforce key messages, promote treatment compliance and reduce stigma associated with TB.

A major achievement was the delivery of the Provincial TB, HIV and Laboratory Training in Kerema from 22 June to 3 July 2026. Implemented in collaboration with GPHA, the National TB Program, National HIV Program and Central Public Health Laboratory, the training strengthened frontline healthcare worker capacity in TB, HIV and laboratory service delivery. A total of 51 participants attended, including healthcare workers and laboratory personnel from Kikori District, Kerema District Health Services, TB Ward, Medical Ward, OPD/ED, O&G, COPD programs and Kerema Hospital Laboratory. Training covered TB diagnosis and management, drug-resistant TB, infection prevention and control, HIV services, laboratory quality systems, and recording and reporting requirements, resulting in improved knowledge, confidence and integration of TB and HIV services.

While challenges remain, including limited diagnostic capacity and the need for stronger patient follow-up and reporting systems, important foundations have now been established to address these priorities. With strengthened partnerships, increased community awareness and enhanced health worker capacity, the program is well positioned to accelerate progress towards improved TB detection, treatment outcomes and disease control across Gulf Province.







GEDSI and Gender-Based Violence

Gender equality, disability and social inclusion, and TROPHE.

Ending gender-based violence

Safety, dignity and care for women and girls across rural Papua New Guinea

For a woman or girl in remote Papua New Guinea, help after violence can feel a world away. A trained health worker, a private room and someone who listens can make the difference between suffering in silence and beginning to recover.

In 2025-26 we took a major step forward. At Namatanai District Hospital in New Ireland, we opened TROPHE (Two Rooms of Protection, Hope and Empowerment), our first dedicated project to prevent gender-based violence (GBV) and care for survivors. In Western Province and West New Britain, GBV awareness travelled with our maternal and child health teams on outreach patrols, in health worker training and at community events



Our year at a glance

- **2,441 people** joined sessions on gender equality and women's rights
- **70 services** were delivered to survivors of sexual and gender-based violence
- **28 women and girls** received mental health and psychosocial support
- **526 students and teachers** took part in violence prevention sessions in Namatanai

Our GBV work runs along a continuum. In Western Province and West New Britain, prevention is woven into maternal and child health programs. In New Ireland, TROPHE offers a dedicated, survivor-centred response. Our spending reflects this: the share of project expenditure focused on ending violence against women and girls was 2% in Western Province, 5% in West New Britain and 30% in New Ireland.

Western Province: starting conversations on patrol

Working with the Western Provincial Health Authority in North Fly, our outreach patrols bring GBV awareness alongside maternal and child health, immunisation, family planning, nutrition and screening. Having both male and female health workers on each patrol helps communities talk openly about a subject that is often kept hidden.

We marked the International Day for the Elimination of Violence Against Women with more than 80 people, including people with disabilities, and International Women's Day with more than 90, combining women's rights advocacy with family planning and disability inclusion. In all, 131 people (76 women and 55 men) took part in sessions on gender and women's equal rights.

Our next step is to work with health facilities to establish clear GBV referral pathways, with a goal of 14 facilities using them by 2027-28.

West New Britain: reaching nearly 1,800 people

With the West New Britain Provincial Health Authority, GBV education is built into the community health sessions our teams deliver on patrol. Project staff trained in SGBV and Child Trauma Counselling so they can better support survivors, and in Kandrian District 38 people, equal numbers of women and men, completed GEDSI sensitisation training.

Across the year, 1,784 people joined sessions on gender issues and women's equal rights, including 86 adults and children with disability.

Provincial support for this work remains limited, with the GEDSI Committee inactive and the GEDSI position vacant. The 2026 Gender Sensitisation Training was postponed until after the GEDSI Learning and Reflection Workshop in July 2026.

New Ireland: TROPHE opens its doors

Two rooms at Namatanai District Hospital have been transformed into a safe space for survivors, refurbished in line with Family Support Centre guidelines. Supported by ANCP and a $150,000 contribution from the World Gold Council, TROPHE is believed to be the first project of its kind for ADI in New Ireland and in PNG.

A baseline survey mapped local services and referral pathways and shaped our prevention work. An ADI Nursing Officer was recruited and trained to lead the safe space, and GBV data reporting at district level has already improved.

Care when it matters most

In its first year, TROPHE delivered 70 services to survivors and 14 hours of trauma-informed counselling, and 28 women and girls received psychosocial support. Fifteen health workers were trained in medical and psychosocial care for survivors, lifting the share of district staff trained to over 20% on the way to our 60% target.

Young people leading change

For the first time, we took GBV prevention into a secondary school, reaching young people at a formative age. At Namatanai Secondary School, a permanent information corner now shares messages on GBV and children's rights, new peer support groups have formed, and students led International Women's Day for the first time. In all, 526 students and teachers took part.

Every activity followed ADI's Child Safeguarding Policy, with no incidents reported. The team also identified serious risks at the school, including unfenced dormitories and high pregnancy and dropout rates among girls, and ADI is seeking support to address them.

Standing firm through a hard year

The year tested the team. The end of Newmont's funding halted integrated outreach patrols, expected provincial funding did not eventuate and the Kavieng office closed. Through it all, ADI chose to protect TROPHE. When Cyclone Maila washed away a highway bridge during SGBV training, the team crossed on a makeshift raft and resumed the next day.

The greatest gap for survivors is the shortage of support services beyond the hospital: every referral this year went to police. Encouragingly, NIPHA has committed to fund the Project Assistant role and provide an additional social worker beyond the life of the project, a strong sign of local ownership.

This work is made possible through the Australian Government's Australian NGO Cooperation Program (ANCP), our provincial health partners and our generous donors.

Gender Equality, Disability and Social Inclusion

Making sure every woman, man, girl and boy, including people with disabilities, can access and benefit from health services

A health service is only as good as the people it reaches. In 2025-26, gender equality, disability and social inclusion (GEDSI) shaped how we worked across Western Province, West New Britain and New Ireland, from who joins an outreach patrol to the language a health message is shared in. Our projects reached more than 23,000 people directly, just over half of them women and girls and more than 1,100 people with disabilities. Our work on gender-based violence is covered in its own section.

The year at a glance

Table 1. Direct participants by sex and disability, 2025-26.

Province	Total Participants	Female	Male	People with disability
Western Province (PRJ01)	14,828	7,540	7,288	742
West New Britain (PRJ04)	7,049	3,687	3,362	352
New Ireland (PRJ14)	1,189	650	539	59
Total	**23,066**	**11,877**	**11,189**	**1,153**



One approach, three provinces

All three projects use a twin-track approach: inclusion built into everyday outreach, training and education, backed by targeted action such as International Women's Day events, support for organisations of persons with disabilities (OPDs) and disability-specific services. Each was rated Significant on the OECD DAC gender and disability markers, and our GEDSI Technical Lead tracks results by sex, age and disability.

Table 2. GEDSI indicator results, 2025-26. A dash indicates no result was reported for that project.

Indicator	Western Province	West New Britain	New Ireland	Total
G.02 People in sessions on gender issues and women's equal rights	131	1,784	526	2,441
G.06 Women's groups, organisations and coalitions actively involved	7	90	3	100
G.07 People with disabilities receiving disability support services	26	-	133	159
G.08 Disabled persons organisations actively involved	1	2	-	3
G.09 People trained in disability awareness and inclusion	1,272	1,393	560	3,225
G.11 OPDs receiving capacity building support	-	1	4	5

Table 3. Other GEDSI highlights, 2025-26. *Estimate.

Result	Western Province	West New Britain	New Ireland
GEDSI awareness sessions delivered in communities	27	111	-
Health workers and partners trained in GEDSI	22 leaders	38	15
Students receiving GEDSI sensitisation	-	-	495
Children with disabilities immunised	162*	-	-
Children immunised in early-2026 outreach (boys / girls)	-	1,769 (908/ 861)	-
Share of clinical services delivered to women and girls	-	52%	-
People with disabilities and carers trained in sign language	-	-	13

Western Province: bringing care to the doorstep

Mixed teams of male and female health workers help communities talk openly about sensitive topics, and more than 170 people joined International Women's Day and the International Day for the Elimination of Violence Against Women. Women's groups were active partners (G.06), and community members joined sessions on gender and women's rights (G.02).

Where people with disabilities could not reach a clinic, our vehicles brought them in or doctors visited them at home, and adults received support tailored to their needs (G.07). A Disability Inclusion Training united government, police, partners and OPDs (G.09), with a disabled persons organisation actively involved (G.08). More than 84% of our staff are Indigenous Papua New Guineans, and our outreach extends to the Iowara refugee camp on the West Papua border.

West New Britain: changing who is on the team

GEDSI training has brought more women onto once male-dominated outreach teams, and the results show: boys and girls were immunised in almost equal numbers, and more than half of clinical services went to women and girls. Women's groups were closely involved (G.06), with strong turnout at gender sessions (G.02).

A Women in Disability Network representative and a Health Promotion Officer with a disability now join outreach patrols as full team members. Disability awareness training reached health workers and partners (G.09), two disabled persons organisations were involved (G.08) and a national OPD received capacity support (G.11). Next, we will improve how disability is recorded across facilities and re-energise the provincial GEDSI Committee, guided by the July 2026 GEDSI Learning and Reflection Workshop.

New Ireland: young people and women leaders show the way

Schools became a powerful platform. For the first time, Namatanai Secondary School led International Women's Day, and students formed new peer support groups. Women made up most health workers trained in maternal care and family planning. Women's groups were active partners (G.06), and the community joined gender sessions (G.02).

The Niu Ailan Women in Disability Network led its own workplan, meeting twice its target, and ten women leaders with disabilities completed governance training. Physiotherapy patrols delivered community-based rehabilitation (G.07), disability training reached health workers and the community (G.09), and four OPDs received capacity support (G.11). The end of Newmont's funding and the Kavieng office closure reduced our reach, and disability-inclusive GBV response is an area to strengthen.

What we learned

- **Stronger OPD partnerships.** New Ireland's model of OPD-led planning offers lessons for other provinces.
- **Women with disabilities as leaders.** Women in Disability Networks are moving from beneficiaries to leaders.
- **Better disability data.** Recording disability consistently remains our biggest gap.
- **Schools extend our reach.** New Ireland's school-based approach could be adapted elsewhere.



Looking ahead

Every province will deepen GEDSI awareness, co-deliver activities with OPDs and strengthen disability data at facility level. West New Britain aims for one in five activities planned jointly with OPDs and women's groups.



Table 4. Western Province GEDSI targets, 2026-27 and 2027-28

Western Province target	2026-27	2027-28
GEDSI awareness sessions	70	80
Children with disabilities immunised	275	300
Activities co-delivered with OPDs	2	2
Health facilities recording disaggregated disability data	14	14

This work is made possible through the Australian Government's Australian NGO Cooperation Program (ANCP), our provincial health partners and our generous donors.





Our approach to rural and remote health

STAP GUT

ADI's integrated model for primary health care in rural and remote Papua New Guinea.

Bai yumi stap gut.

We will be well.

Papua New Guinea's most intractable health problems are not concentrated in its cities. They sit in catchments of thousands of people reached by dinghy, single-lane track or a day's walk - where the aid post may have no power, no water and no staff, where a woman in obstructed labour is a fuel cost away from care, and where a child's third dose of anything is a matter of chance.

These are the places the national indicators are made of, and they are the places most delivery models cannot reach economically. Vertical programs arrive for a disease and leave. Infrastructure programs build and depart. Visiting teams generate activity but not continuity. The result is a rural population that has been surveyed, piloted and consulted repeatedly, and served intermittently.

Stap Gut is ADI's answer to that problem: hold a permanent, staffed presence in a catchment, and move outward from it on a published rhythm — with one integrated program rather than a stack of unconnected projects, and with the community and the Provincial Health Authority holding the plan from the first day.

Stap — to stay, to be, to live, to remain.
Gut — good, well.

Together: to be well, to stay well, to live well. The phrase carries health, security and general wellbeing at once, and it is understood across a country of more than 800 language groups without translation.

Stap Gut replaces the generic language of "hub, sub-hub and outreach" with terms that name the movement rather than the buildings.

TERM	WHAT IT IS
Stap Gut Centre	A permanent staffed facility providing integrated primary health care, and the base for all patrol activity.
Stap Gut Station	A smaller satellite facility operating under a Centre, with its own defined catchment.
Stap Gut Circuit	The scheduled patrol route reaching communities beyond fixed facilities — the rhythm that distinguishes ADI.
Stap Gut Network	ADI's full system of Centres, Stations and Circuits across its provinces of operation.



The program modules

Every catchment begins with a baseline and is built from the modules below. The mix, the sequence and the depth are set by what the baseline finds — no two catchments receive the same package.

WASH	Safe water, sanitation and hygiene — the foundation of every Stap Gut catchment.
MATERNAL & NEWBORN CARE	Emergency obstetric and neonatal skills built into the frontline workforce.
IMMUNISATION	Routine coverage and cold chain integrity in hard-to-reach communities.
TUBERCULOSIS	Case finding, treatment support and community stigma reduction.
SCHOOL HEALTH	Screening, hygiene, deworming and gender-based violence prevention education.
GEDSI	Gender equality, disability and social inclusion mainstreamed through every module.
SOLAR	Reliable power for lighting, vaccine cold chain and essential equipment.
FAMILY PLANNING	Counselling, method choice and long-acting method training — delivered with PHAs since 2019.
MALARIA	Prevention, diagnosis, case management and household-level protection.
BABY BUNDLES	Birth incentives that move women from unsupervised to supervised delivery.
SPECIALIST OUTREACH	Volunteer specialists delivering advanced care and case-based teaching in the village.
CLIMATE & LIVELIHOODS	Adaptation planning, women's local leadership and green livelihood development.

The outcomes ADI holds itself to

Reduced maternal and neonatal mortality	Through emergency care training, skilled attendance and supervised delivery.
Higher contraceptive prevalence	Through access, method choice and trained providers.
Higher immunisation coverage	Through outreach, cold chain and defaulter tracing.
Reduced malnutrition	Through integrated health, food security and WASH activity.
Fewer waterborne disease cases	Through clean water access, sanitation and hygiene behaviour change.
Reduced malaria and TB burden	Through prevention, early detection and treatment adherence.
Greater equity in access	For women, people with disability and other marginalised groups.
Strengthened system resilience	Powered facilities, trained local workforce, functioning referral.

Stap Gut is not a parallel system.
It is the province's own plan, delivered further out.

Our Volunteers

The people who give their time and skills to our work.

Medicine Without a Safety Net

For three months, two Australian volunteer doctors filled a critical gap in Western Province's health workforce — from a stretched hospital ward in Kiunga to remote river patrols along the Fly and Alice Rivers.



Dr. Hayley Kelly consulting a patient on outreach patrol in Membok, Western Province.



Dr. Liam Byrne examines a musculoskeletal injury on outreach in Membok.

Dr. Hayley Kelly & Dr. Liam Byrne. Tabubil & Kiunga. Late March - 30 June 2026

Hayley and Liam arrived in Western Province in late March 2026, generously supported by OTML. They began at Tabubil Hospital and its urban clinics, orienting to PNG healthcare under the mentorship of the local paediatrician and learning to recognise local disease patterns — including the diagnosis of tuberculosis. From there they moved to Kiunga to join the ADI team, supporting our partners WPHA and Catholic Health Services, and living at the Catholic Mission. Between outreach patrols, they split their time between Kiunga District Hospital's outpatient and emergency departments and the Catholic-run urban clinic — filling a role in a province facing a critical shortage of doctors.

One Doctor, One Hospital

Kiunga District Hospital is staffed by a single doctor, supported by four Health Extension Officers, nurses and nursing students. There is no emergency consultant or surgeon; the resuscitation trolley's medications are expired, and its defibrillator has no pads. Pathology is limited to full blood counts and troponins — when reagents are in stock. It is here, in Emergency, paediatrics and outpatients, that Hayley and Liam have spent much of their placement.

> *Without the safety net of extensive investigations or specialist support, medicine returns to its foundations: clinical judgement, teamwork, adaptability and resourcefulness.*
>
> **— Dr Hayley Kelly**

Doctor Deployment March - June 2026

604
patients treated — outreach, clinics & hospital

24
health workers trained by our doctors

33
remote communities reached

57
team members on patrol with our doctors, from ADI & partners

2
clinical workshops — Family Planning & EMNC

2
outreach patrols — Membok & Atkamba

25
days in the bush — transport by banana boat, troop carrier, on foot

The doctors, when not on outreach ran emergency and outreach clinics at Kiunga Hospital from Monday to Thursday each week while utilising the CHS Urban Clinic to see complex patients and train health workers on Fridays, backing up their overworked local colleagues.

Training that stays behind: alongside direct patient care, Hayley and Liam have spent as much time building the skills of the local health workforce who will carry that care forward long after they leave.

On Patrol: Two Rivers, Two Weeks Each

In May and June, Hayley and Liam joined two integrated outreach patrols — six hours down the Fly River by dinghy to Membok, and a drive, river crossing and walk to Dome on the Alice River — each based in the bush for around two weeks. Alongside ADI's own community health workers, the patrols brought together WPHA, World Vision, the Burnet Institute, a TB team, eye and ear specialists from Callan Services, and a child nutrition worker — running outpatient clinics, vaccinations, TB screening, eye and ear care and nutrition support from rural clinics, aid posts, and sometimes the shade of a family home.



The integrated patrol team at Membok, on the banks of the Fly River — ADI, WPHA, World Vision and Burnet Institute staff alongside local health workers.

The Nurse Who Does Everything

On their first day in Membok, Hayley and Liam watched the village nurse — on call every hour of every day — tourniquet a deep angle-grinder wound to a man's calf, then close muscle, fascia and skin layer by layer with a skill that would not have looked out of place in a major Australian trauma centre. In remote PNG, she told them, nurses must be ready to manage almost any emergency themselves. She and her husband hosted the pair in their home for the full two weeks.

> *Even hard news — a TB diagnosis, arthritis that can't be reversed — is often met with a smile, a handshake, a finger click, and a heartfelt thank you. Patients have gifted us bilums and fruit from their own gardens: a reminder that gratitude isn't measured by the value of a gift, but by the generosity behind it.*
>
> **— From the doctors' field diary**

A Reminder to Show Up

In Dome, an elderly woman who'd suffered a stroke from severe uncontrolled hypertension had fallen into her family's cooking fire and been badly burned. Hayley and Liam couldn't offer the specialist care she truly needed — but they started blood pressure treatment, dressed her burns and supported her family's ongoing care. In nearby Yogi, another woman with a likely fractured hip faced a referral to Port Moresby few families could afford. "Sometimes," Hayley writes, "the greatest impact comes simply from showing up."

Life in Kiunga

Home for three months: a small house inside the Catholic Mission compound, alongside the brothers and Sisters (and seven dogs). Power drops out about once a week; an old twin-tub washing machine handles the week's sweat and red dirt, and rambutan season made up for the end of pineapples at Saturday markets. No television, patchy internet — "a blessing" that "forces us to slow down". Simple, safe and, in their words, "a gift, especially when the work itself is intense".



Margaret Sibert, ADI's Provincial Program Manager in Kiunga, at the MCM Urban Clinic's International Nurses Day celebration.

This story isn't over: Hayley and Liam returned to Kiunga in September, after a short break, to finish their deployment. With thanks to OTML and our partners WPHA, Catholic Health Services, World Vision, the Burnet Institute and Callan Services. This work relies on the generous volunteering of Australian medical personnel and the ongoing support of the Australian Government.





Our Partners

Our work in Papua New Guinea is only possible because of the partners who share our vision for a healthier rural PNG. We are deeply grateful for their support.

Australian Government (DFAT) and PATH

Through the Department of Foreign Affairs and Trade's Australian NGO Cooperation Program (ANCP), in which ADI holds full accreditation, the Australian Government funds our maternal and child health, family planning, emergency maternal and newborn care training and gender-based violence work across our project provinces. Through the Papua New Guinea–Australia Transition to Health (PATH) program, ADI also delivers the Accelerated Immunisation and Health System Strengthening Program (AIHSS2) in West New Britain, funded by Gavi, the Vaccine Alliance, and the Governments of Australia and New Zealand.

Santos Foundation

In July 2025, the Santos Foundation engaged ADI to deliver a Tuberculosis and Family Planning Program in partnership with the Gulf Provincial Health Authority. In its first year, the program laid strong foundations for better TB services in Gulf Province, from facility assessments and planning for equipment and ward upgrades, to World TB Day awareness activities in communities, markets and schools.

Women's Plan Foundation

The Women's Plan Foundation support most of our Family Planning across our three provinces. Recently they generously furnished the Safe Space Room under the GBV Prevention & Response Project in Namatanai District, New Ireland Province. Its support helped turn the rooms into a warm, private and dignified space where survivors of gender-based violence can receive care, counselling and support.

Newmont and the World Gold Council

The GBV Prevention & Response Project was made possible through the support of the World Gold Council, Newmont and the Australian NGO Cooperation Program (ANCP). With a $150,000 contribution from the World Gold Council ADI transformed two rooms at Namatanai District Hospital into a safe space for survivors of gender-based violence (GBV). We acknowledge their support and contribution to GEDSI and GBV programs in New Ireland Province.

Old Dart Foundation

Is our staunch supporter in a variety of our programs carried across our centres.

National Department of Health (NDOH)

ADI works alongside the National Department of Health to strengthen health services in rural and remote Papua New Guinea. This year ADI's work has been strengthened through the renewal of the MOU with NDOH.

WNBPHA & WNBPG

The West New Britain Provincial Health Authority (WNBPHA) and West New Britain Provincial Government (WNBPG) work closely with ADI to strengthen the delivery of integrated primary healthcare across the province. Together, our teams deliver the AIHSS2 immunisation project across 18 of the province's most remote health facilities, run joint outreach patrols, and build GBV education into community health sessions.

Good Governance

Our Board and Executive Management Team.

Board of Directors



Brent Emmett
Chair



Gillian Biscoe
Chair, Strategic Program Committee



Adelina Dal Pra
Chair, Finance, Audit and Risk Committee



Tracey Tatnell
Director and CEO



Pascoe Kase
Director



Arabella Koliwan
Director



Anna Madgwick
Director

Executive Management Team



Tracey Tatnell
CEO



Bhawna Chandna
Head of Finance



Sharon Pondros
PNG Country Manager



Kim Roe
Operations and Compliance Manager



Mackenzie Fono
National HR Manager

Compliance

How we meet our standards and obligations.

1. Compliance Statement

Australian Doctors International (ADI) is committed to the highest standards of governance, financial management and transparency in supporting health services in Papua New Guinea (PNG).

Australian Doctors International Limited (ABN 15 718 578 292) is an Australian company limited by guarantee and a charity registered with the Australian Charities and Not-for-profits Commission (ACNC).

ADI is endorsed by the Australian Taxation Office as a Deductible Gift Recipient (DGR), so donations of $2 or more are tax deductible for Australian taxpayers. As a registered charity, ADI is GST exempt and staff can access FBT concessions.

ADI is a member of the Australian Council for International Development (ACFID) and a signatory to the ACFID Code of Conduct, a voluntary, self-regulatory code setting minimum standards of governance, financial management, program effectiveness and stakeholder accountability for Australian international development organisations. The independent ACFID Code of Conduct Committee monitors compliance.

ADI holds full accreditation under DFAT's Australian NGO Cooperation Program (ANCP), which involves regular independent assessment of our organisational and financial systems, safeguards and program effectiveness.

ADI's annual financial statements are independently audited and lodged with the ACNC. The 2025-2026 audit, completed by SDJ Audit Pty Ltd t/a SDJA (Michael Payne, Partner), is included in this report.

2. Code of Conduct, Child Safeguarding and PSEAH

ADI has zero tolerance for fraud, corruption, exploitation and abuse across all our programs, partnerships and workplaces in Australia and PNG. Our conduct, safeguarding and integrity framework includes:

- The ACFID Code of Conduct, which we report against annually
- ADI Code of Conduct V2.00 (29 July 2025)
- ADI Child Safeguarding Policy V4.00 (29 July 2025)
- ADI Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) Policy V2.5 (11 August 2025)
- ADI Whistleblower Policy V1.2 (12 August 2025)

These policies apply to all ADI Board members, staff, volunteer doctors, contractors and partner organisations, and are regularly reviewed by the Board. Copies are available on request or at

www.adi.org.au/policies

3. Risk Management and Accountability

Governance Statement

Ultimate responsibility for ADI's governance rests with the Board of Directors: Brent Emmett (Chair), Gillian Biscoe (Chair, Strategic Program Committee), Adelina Dal Pra (Chair, Finance, Audit and Risk Committee), Tracey Tatnell (CEO), Pascoe Kase, Arabella Koliwan, and Anna Madgwick.

Governance and risk oversight

The Board sets ADI's strategic direction and oversees its finances and risk management framework, with risk overseen through the Board's Finance, Audit and Risk Committee (FARC). ADI's risk register is reviewed annually, and each program keeps an in-country risk register that is reviewed at regular management meetings.



Feedback and complaints

ADI welcomes feedback and takes all complaints seriously, whether about our programs, people, fundraising or conduct. Anyone — including PNG community members, donors, staff, volunteers and partners — can raise a concern with the CEO via the feedback form at:

www.adi.org.au/feedback-complaints

Complaints are handled promptly, confidentially and impartially under ADI's Complaints Policy.

Concerns about a possible serious breach of the ACFID Code of Conduct by ADI can also be raised directly with the independent ACFID Code of Conduct Committee:

ACFID's contact details

Private Bag 3, Deakin ACT 2600, Australia

+61 2 6285 1816

main@acfid.asn.au

www.acfid.asn.au

Separation of aid and development activity

ADI does not raise funds for welfare, religious or partisan political (non-development) purposes. Funds raised for ADI's PNG health programs are not used for partisan political activity, religious proselytisation, or anything that does not contribute to sustainable, community-led health outcomes. Our financial controls and reporting systems ensure this.

Financials

A snapshot of our finances.

Australian Doctors International Limited

Statement of Profit or Loss and Other Comprehensive Income

For the Financial Year Ended 30 June 2026

	Notes	2026 $	2025 $
Revenue			
Donations and gifts			
• Monetary		83,689	556,227
• Non-monetary	6	209,079	89,108
Grants			
• Department of Foreign Affairs and Trade	4	1,034,089	2,039,275
• Other Australian	4	596,013	1,067,628
• Other overseas	4	1,058,597	686,234
Investment income		10,781	25,899
Other income	5	84,314	156,041
Total revenue		**3,076,562**	**4,620,412**
Expenses			
International Aid and Development Program Expenditure			
International program			
• Funds to international programs		(2,230,415)	(3,590,876)
• Program support costs		(251,609)	(554,464)
Accountability and administration		(228,180)	(339,446)
Non-monetary expenditure	6	(209,079)	(89,108)
Total International Aid and Development Programs Expenditure		(2,919,283)	(4,573,894)
Other expenses		(100,000)	
Total expenses	7	**(3,019,283)**	**(4,573,894)**
Surplus before income tax		**57,279**	**46,518**
Income tax expense		-	-
Surplus for the year		**57,279**	**46,518**
Other comprehensive income		-	-
Total comprehensive income		**57,279**	**46,518**

The accompanying notes form part of these financial statements.

Australian Doctors International Limited

Statement of Financial Position

As at 30 June 2026

	Notes	2026 $	2025 $
Assets			
Current			
Cash and cash equivalents	8	681,043	1,265,197
Trade and other receivables	9	1,051,343	392,493
Other assets	10	32,001	46,108
Total current assets		**1,764,387**	**1,703,798**
Non-Current			
Property, plant and equipment	11	163,300	215,646
Right-of-use assets	12	-	3,053
Total non-current assets		**163,300**	**218,699**
Total assets		**1,927,687**	**1,922,497**
Liabilities			
Current			
Trade and other payables	13	87,169	164,246
Provisions	14	71,983	128,367
Lease liabilities	15	-	3,218
Contract liabilities	16	1,031,584	928,112
Total current liabilities		**1,190,736**	**1,223,943**
Non-Current			
Provisions	14	19,346	38,228
Total non-current liabilities		**19,346**	**38,228**
Total liabilities		**1,210,082**	**1,262,171**
Net assets		**717,605**	**660,326**
Equity			
Accumulated funds		717,605	660,326
Total equity		**717,605**	**660,326**

The accompanying notes form part of these financial statements.

Australian Doctors International Limited

Statement of Changes in Equity

For the Financial Year Ended 30 June 2026

	Note	Accumulated Funds $	Total Equity $
Balance at 1 July 2024		613,808	**613,808**
Surplus for the year		46,518	**46,518**
Other comprehensive income		-	**-**
Total comprehensive income		46,518	**46,518**
Balance at 30 June 2025		660,326	**660,326**
Balance at 1 July 2025		660,326	**660,326**
Surplus for the year		57,279	**57,279**
Other comprehensive income		-	**-**
Total comprehensive income		57,279	**57,279**
Balance at 30 June 2026		717,605	**717,605**

The accompanying notes form part of these financial statements.

Australian Doctors International Limited

Statement of Cash Flows

For the Financial Year Ended 30 June 2026

	Notes	2026 $	2025 $
Cash flows from operating activities			
Receipts from donors, grants and others		2,223,508	4,126,819
Payments to suppliers and employees		(2,784,307)	(4,564,056)
Interest paid		-	(6,009)
Net cash used in operating activities		**(560,799)**	**(443,246)**
Cash flows from investing activities			
Payments for property, plant and equipment		-	(104,354)
Interest received		10,781	25,899
Net cash provided by/(used in) investing activities		**10,781**	**(78,455)**
Cash flows from financing activities			
Net payments on lease liabilities		-	(32,602)
Net cash used in financing activities		**-**	**(32,602)**
Net change in cash and cash equivalents		(550,018)	(554,303)
Cash and cash equivalents at beginning of financial year		1,265,197	1,917,117
Effects of exchange rate changes on cash and cash equivalents		(34,136)	(97,617)
Cash and cash equivalents at the end of financial year	**8**	**681,043**	**1,265,197**

The accompanying notes form part of these financial statements.

Acronyms

ACFID	Australian Council for International Development
ACNC	Australian Charities and Not-for-Profits Commission (Federal Government)
ADI	Australian Doctors International
ANCP	Australian NGO Cooperation Program (DFAT)
AP	Aid Post
CAP	Community Action Participation
CHS	Catholic Health Services
CHW	Community Health Worker
CYP	Couple Years Protection
DFAT	Department of Foreign Affairs and Trade (Federal Government)
EMNC	Essential Maternal and Neonatal Care
FP	Family Planning
GEDSI	Gender Equity, Disability and Social Inclusion
GULFPHA	Gulf Provincial Health Authority
HC	Health Centre
HCW	Healthcare Worker
HEO	Health Extension Officer
LLG	Local Level Government
M&E	Monitoring & Evaluation
MPHA	Manus Provincial Health Authority
NGO	Non-Governmental Organisation
NIPHA	New Ireland Provincial Health Authority.
NO	Nursing Officer
PHA	Provincial Health Authority
PNG	Papua New Guinea
POM	Port Moresby
PPH	Post Partum Haemorrhage
PWD	People with Disabilities
TB	Tuberculosis
TROPHE	Two Rooms of Protection, Hope & Empowerment
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WNB	West New Britain Province
WNBPG	West New Britain Provincial Government
WNBPHA	West New Britain Provincial Health Authority
WP	Western Province (PNG)



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