Director's Comments

In accordance with Financial Regulation 14.9 of the Pan American Health Organization (PAHO), I have the honor to present the Financial Report of the Pan American Health Organization for the financial reporting period 1 January 2016 through 31 December 2016.

The Financial Statements and Notes to the Financial Statements have been prepared in compliance with International Public Sector Accounting Standards (IPSAS) and PAHO's Financial Regulations and Financial Rules.

Although PAHO has adopted an annual financial reporting period as stipulated in Financial Regulation 2.2, the budgetary period remains a biennium (Financial Regulation 2.1). Therefore, for the purposes of actual vs. budget comparisons in the Director's Comments, the annual budget figures represent one half of the Biennial Program and Budget as an approximation of annual budgetary figures.

1. Overview

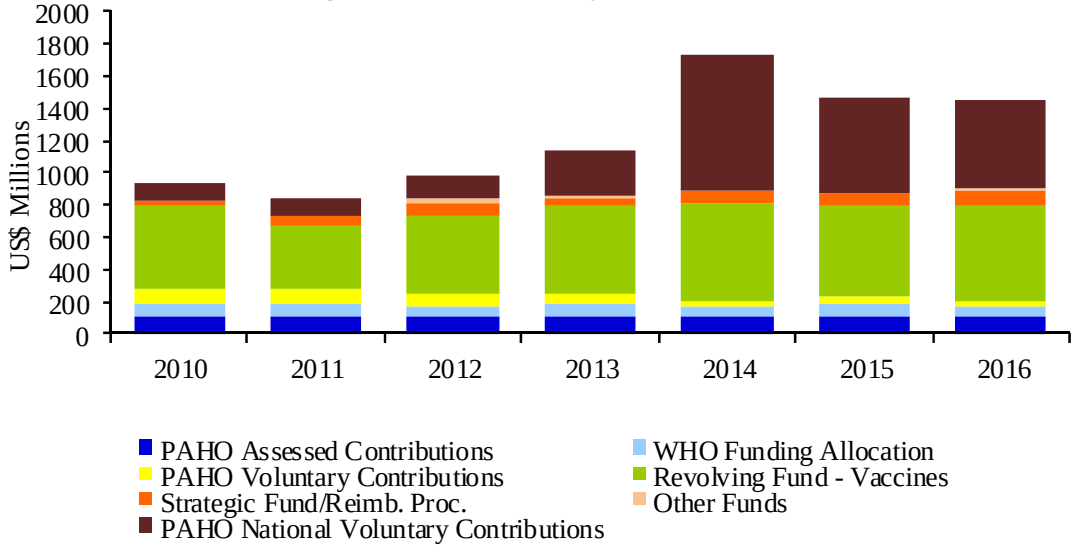
During 2016, PAHO exercised its leadership, convening and catalyst role to improve the health of the peoples of the Americas in collaboration with Member States and partners. The Organization continued to provide direct technical cooperation, mobilize resources, strengthen partnerships and networks, build capacity, generate and provide evidence, and advocate for the necessary actions to continue to make progress on the priorities of the PAHO Strategic Plan 2014-2019 and the new 2030 Agenda for Sustainable Development. Highlights of the progress and achievements during 2016 are included below.

- The Region continued to make progress in the elimination of communicable diseases, with landmark achievements such as the declaration of the Region of the Americas as the first WHO region to be declared free from endemic measles transmission; four UK territories moving towards the elimination of mother to child transmission (EMTCT) of HIV and Syphilis; Argentina and Paraguay prepared for malaria elimination certification; interruption of transmission of *T. cruzi* in new geographic areas in Colombia and Paraguay and recertification of vector interruption in Chile; and verification of the elimination of onchocerciasis in Guatemala and trachoma in Mexico. In response to the ongoing transmission of various arboviruses across the Region, direct technical assistance for vector control was provided to Member States and a new integrated management strategy for the prevention and control of arboviral disease (IMS-Arbovirus) was developed.
- Countries continued to achieve successes in addressing non-communicable diseases (NCD), risk factors and mental health conditions, with a landmark tobacco control ruling won by Uruguay at the World Bank's International Centre for Settlement of Investment Disputes (ICSID). Seventeen countries developed or updated an operational NCD plan, while five countries implemented laws and policies to prevent childhood obesity through taxation and regulation of labeling and advertisement of processed and ultra-processed food and sugar sweetened beverages. Five countries increased tobacco taxes and Panama became the 4th signatory to the Protocol to Eliminate the Illicit Trade in Tobacco Products in the Region. Efforts continued in the integration of mental health into primary care. National alcohol policies and plans were developed or updated in seven countries; two developed road safety plans; and six conducted evaluations on access to rehabilitation services. Support was provided to integrate the psychosocial and rehabilitation elements in response to the Zika Virus (ZIKV).
- In the context of the Sustainable Development Goals, efforts were intensified to promote health throughout the life course and social determinants, with 15 countries updating their national plans on women, maternal and newborn health and eight Ministries of Health signing a high level political resolution committing to incorporate health inequality on Maternal, Child and Adolescent Health (MCAH) measurement and monitoring into existing national strategic information systems. Eight countries implemented the WHO Age-Friendly Cities and Communities framework; and six signed the Inter-American Convention on Protecting the Human Rights of Older Persons. Country profiles on climate change were prepared and launched by four countries in line with PAHO's climate change strategy; and six have national strategies to reduce the use of solid fuels for cooking.

- Countries are progressing in implementing roadmaps for Universal Health (UH), with 15 countries implementing UH strategies and 25 reporting advances in the development of comprehensive financing strategies. Eight countries worked on health services organization development issues (policies, legislation, integrated networks for health care delivery IHSDN, hospital management, strengthening of the first level of care) and five countries tested a new tool for the assessment of progress towards the development of IHSDN. All 52 countries and territories have produced comprehensive health situation analyses that encompass the 2011-2015 periods, as part of the 2017 Health in the Americas Plus. Policy documents were adopted by Member States at the 55th Directing Council on Resilient Health Systems; Health of Migrants; and Access and Rational Use of Strategic and High-Cost Medicines and Other Health Technologies. In response to the Zika outbreak in the Region in 2016, research programs were reoriented resulting in a PAHO Zika research registry of protocols and published research, seven generic research protocols, guidelines, a consultation on ethics and Zika, and research projects involving fifteen countries and territories on Zika-related topics. An Ethics Guidance on Key Issues Raised by the Outbreak was endorsed by The Lancet and integrated into the Organization's technical cooperation.
- Immediate support was provided to all countries requesting assistance for response operations during the year, including: 7.8 magnitude earthquake in Ecuador; Hurricane Earl in Belize; Hurricane Matthew in Bahamas, Cuba, Dominican Republic and Haiti; Hurricane Otto in Costa Rica; nutrition crisis in Guatemala; and during the migrant crisis in Colombia, with persons arriving from Venezuela, and in Costa Rica and Panama with Cubans transiting from Ecuador to the USA. Support included rapid assessments, coordination and resource mobilization, plus technical support in areas such as water and sanitation, vector control, logistics and health services restoration. More than 800,000 people were vaccinated against cholera in Haiti. The Organization provided dynamic leadership and timely technical support and guidance to Member States to prevent and manage the ZIKV outbreak and associated complications and to mitigate the socioeconomic consequences. Highlights of actions include multidisciplinary technical field missions with over 170 staff and experts, including through the Global Outbreak Alert and Response Network, deployed to 30 countries and territories; fifteen new or revised WHO/PAHO technical guidelines to guide Member States' health services in relation to ZIKV, including clinical guides and technologies regarding birth defects surveillance. In line with WHO reform and consistent with WHA Resolution A69/26 the Organization established the new PAHO Health Emergencies Program.
- In support of the achievements above, high level advocacy and leadership brought further and necessary attention to Universal Health, NCDs, maternal mortality and other regional priorities. In addition, PAHO continued to make progress in strengthening and improving its enabling functions and corporate services with efforts focused on finding efficiencies through new management systems, strengthening risk management, and improving the Organization's ability to share key information with different audiences, including for emergencies.
- On 1 January 2016, the Organization went live with the Financial Data Module of its Enterprise Resource Planning System, PMIS, and Headquarters and Country Offices staff began the recording and reporting of technical cooperation activities through the PMIS. The implementation of the PMIS was a complex and difficult process requiring intensive efforts from all staff. Users were required to learn new processes for daily tasks, and PMIS system managers were required to overcome many technical challenges, including unexpected behavior by the system in some business processes. Despite these challenges, all financial operations for the year ending 31 December 2016 have been recorded and reported through the PMIS, and the Organization has completed its first financial closure in PMIS.

The Organization's total revenue in 2016 reached $1,448 million which is a slight decrease as compared to 2015. This decrease in financial resources is mainly due to currency exchange rate depreciation against the US dollar for certain local currency Voluntary Contribution agreements.

Figure A: Revenue by Source of Funds



The total revenue is comprised of four main components:

(a) the Program and Budget, which includes the PAHO Assessed Contributions and Budgeted Miscellaneous Revenue, PAHO Other sources of financing, and the WHO Funding Allocation to the Americas;
(b) the Procurement Funds, which includes the Revolving Fund for Vaccine Procurement, the Regional Revolving Fund for Strategic Public Health Supplies and the Reimbursable Procurement on Behalf of Member States Fund;
(c) the National Voluntary Contributions, and
(d) Other special funds.

In 2016, Revenue to the Program and Budget is comprised of $96.4 million from PAHO Assessed Contributions, $15.2 million from Budgeted Miscellaneous Revenue, $63.0 million from WHO funding allocation, and $81.9 million from PAHO Other Sources for a total of $256.5 million for 2016. In 2015 the Organization reported $257.1 million for the Program and Budget. Revenue from Voluntary Contributions from PAHO (net of Program Support Costs) decreased to $31.0 million in 2016 as compared to $34.2 million in 2015. Voluntary Contributions from WHO decreased to $23.0 million in 2016 as compared to $26.7 million in 2015.

Revenue from procurement activities on behalf of Member States (net of Service Charge Revenue) increased from $638.6 million in 2015 to $678.4 million in 2016 due to increases in both the Revolving Fund for Vaccine Procurement and the Regional Revolving Fund for Strategic Public Health Supplies. The level of resources for the Organization's three Procurement Funds represents 47% of the Organization's total revenue.

National Voluntary Contributions funds implemented by PAHO (net of Program Support Costs) decreased to $511.9 million as compared to $554.7 million in 2015 due to the exchange rate impact, as the implementation level in local currency remains relatively the same as in 2015.

2. PAHO Assessed Contributions and Budgeted Miscellaneous Revenue: Financing

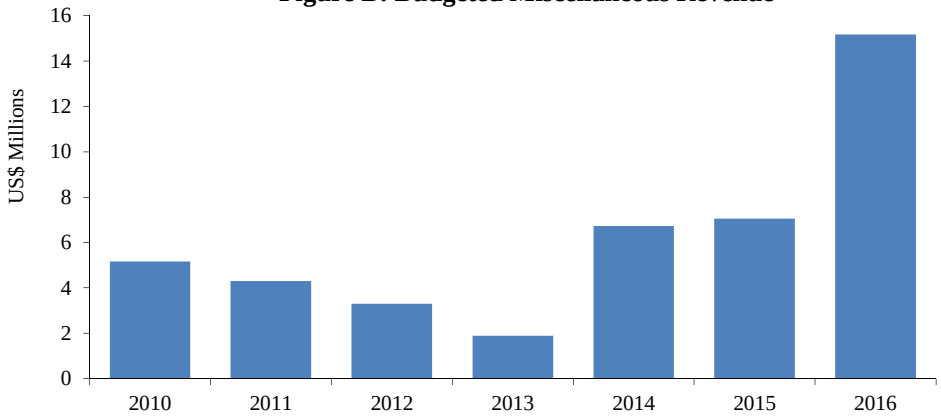
The PAHO Assessed Contributions and Budgeted Miscellaneous Revenue was approved in Resolution CD5.R17 adopted by the 54th Directing Council of the Pan American Health Organization, revenue from Assessed Contributions in the amount of $96.4 million net of the Tax Equalization Fund ($6.0 million) for fiscal year 2016. Revenue from Assessed Contributions was recorded in full on 1 January 2016, the date it became due and payable.

However, in order to ensure that resources are available to fund the Regular Budget, the Organization must carefully monitor and report on the cash flows from Assessed Contributions and other receivables due to the Organization. The cash receipts of current and prior years' Assessed Contributions in 2016 totaled $66.4 million and $39.7 million, respectively. In 2016, the rate of collection of current year Assessed Contributions was 65%, compared with 61% for 2015. During 2016, PAHO received payments towards current and prior years' Assessed Contributions from thirty-eight Member States. Twenty-nine Member States paid their 2016 assessments in full, five Member States made partial payments toward their 2016 assessments, and eight Member States made no payment toward their 2016 assessments.

Total Assessed Contributions outstanding, including amounts due for previous financial periods, decreased from $44.2 million on 31 December 2015 to $40.5 million on 31 December 2016. Each year the Delegates to the Directing Council or the Pan American Sanitary Conference review at length the financial circumstances of those Member States who are in arrears in their Assessed Contributions and subject to Article 6.B of the PAHO Constitution. As of 1 January 2017, there were two Member States subject to Article 6.B.

According to Regulation IV, the Program and Budget shall be financed by Assessed Contributions from Member States, Participating States, and Associate Members and the Budgeted Miscellaneous Revenue. Miscellaneous Revenue includes a portion of investment revenue earned on the funds administered by the Organization, investment fees associated with the portfolios, net currency exchange gains and losses, savings on prior period obligations, and other miscellaneous revenue. Total Miscellaneous Revenue to the PAHO Regular Budget for 2016 was $15.2 million and is comprised of $12.9 million in investment revenue, investment management fees of $0.6 million, a net loss of $0.6 million on currency exchange, $3.3 million in savings on prior period obligations, and $0.1 million in other miscellaneous revenue. The difference between the Budgeted Miscellaneous Revenue for 2016 of $12.5 million and the actual amount realized is due to the local investment of temporarily idle resources pertaining to National Voluntary Contributions.

Figure B: Budgeted Miscellaneous Revenue



3. PAHO Assessed Contributions and Budgeted Miscellaneous Revenue: Implementation

Total expenses for PAHO Assessed Contributions and Budgeted Miscellaneous Revenue activities in support of the implementation of international health programs reached $100.3 million in 2016 compared to budgeted expense of $108.9 million, resulting in a financial implementation rate of 92% for 2016. Implementation is usually lower in the first year of the biennium. The Organization ended 2016 with a Financial Net Surplus from Operations of $11.3 million in the PAHO Assessed Contributions and Budgeted Miscellaneous Revenue Segment.

Table 1. PAHO Assessed Contributions and Budgeted Miscellaneous Revenue: Financial Highlights (in US$ millions)

	Actual	Budgeted*
Revenue:		
2016 Assessed Contributions	102.4	102.4
Less: Tax Equalization	(6.0)	(6.0)
Other Revenue	-	-
Miscellaneous Revenue	15.2	12.5
Total Revenue	111.6	108.9
Expenses:		
2016 Operating Expenses	(100.3)	(108.9)
Financial Net Surplus from Operations for 2016	11.3	-

**For the purposes of actual vs. budget comparisons in this narrative, the budget figures represent one half of the Biennial Program and Budget to approximate annual budgetary figures.*

4. Working Capital Fund

The 53rd Directing Council approved an increase to the authorized level of the Working Capital Fund from $20.0 million to $25.0 million. As of 31 December 2016, the Organization's Working Capital Fund was $20.7 million.

5. WHO Allocation and Other Sources Funds

The Pan American Health Organization implemented $54.0 million from the WHO Funding Allocation in support of the international health programs established by the World Health Assembly for the Region of the Americas. In addition, the Organization implemented $9.0 million in Other Sources Funds from WHO. Therefore, total implementation of WHO funds during 2016 reached $63.0 million. In comparison, during 2015, the Organization implemented $80.1 million from the WHO Funding Allocation and $9.4 million in Other Sources Funds from WHO for a total of $89.5 million.

6. PAHO Voluntary Contributions

PAHO Voluntary Contributions are comprised of (1) the Voluntary Contributions Fund, (2) the Voluntary Contributions-Emergency Preparedness and Disaster Relief Fund, and (3) other funds. Voluntary Contributions received are categorized by:

- Governments
  - PAHO- Member States
  - Non-PAHO Member States;
- International organizations
  - United Nations
  - Non-United Nations;
- For Profit Organizations;
- Non-Government Organizations;
- Foundations;
- Other Voluntary Contributions.

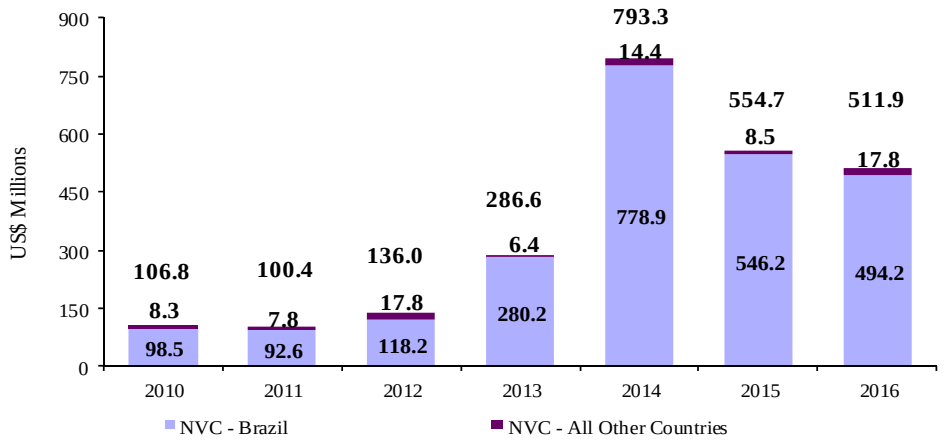
During 2016, PAHO's total revenue from Voluntary Contributions net of Program Support Costs reached $31.0 million as compared to $33.2 million in 2015. However, deferred revenue totaled $149.0 million in 2016 as compared to $67.2 million in 2015, which is an increase of $81.8 million.

In 2016, the largest partners/stakeholders with respect to the implementation of Voluntary Contributions Fund were as follows: the United States of America ($13.0 million), the United Kingdom ($2.8 million), the Global Alliance V.I. ($2.8 million), Brazil ($2.2 million), Canada ($2.2 million), the PAHO Foundation ($1.0 million) and the Gates Foundation ($0.9 million). The largest partners/stakeholders for Emergency Preparedness and Disaster Relief were the European Community ($1.2 million) and Canada ($1.0 million).

7. National Voluntary Contributions

A main component of PAHO's revenue is the National Voluntary Contributions Fund, which includes financial resources from governments exclusively for internal projects. During 2016 PAHO implemented $511.9 million (2015: $554.7 million) from governments for internal projects. The decrease is mainly due to the exchange rate impact, as the implementation level in local currency remains the same as 2015. Revenue pertaining to the Mais Medicos Project in 2016 reached $443.1 million, net of Program Support Costs (2015: $473.5 million). Revenue for NVC in Brazil excluding the Project Mais Medicos reached $51.4 million in 2016 (2015: $74.0 million). Furthermore, revenue for NVC in all other countries reached $17.8 million in 2016 (2015: $8.5 million).

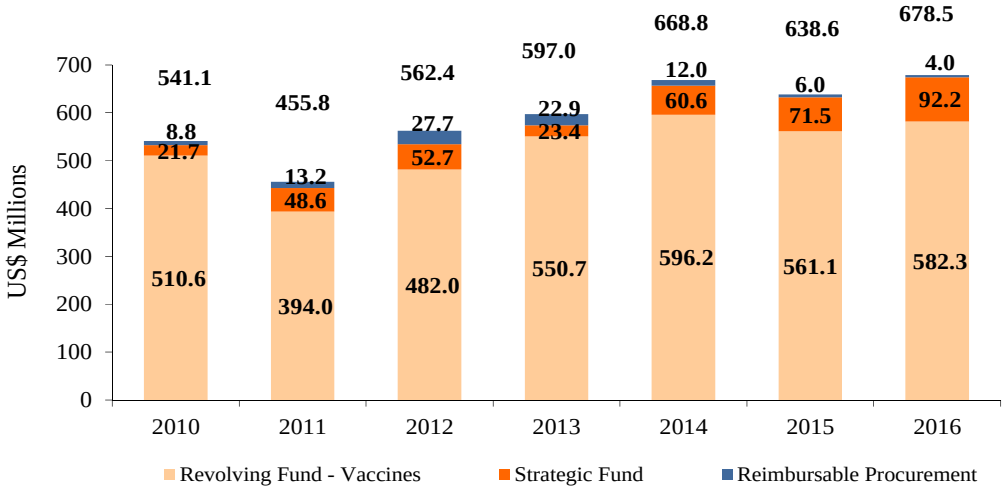
Figure C: National Voluntary Contributions (NVC) Revenue



8. Procurement on Behalf of Member States

During 2016, the total financial activity realized for procurement services on behalf of Member States increased to $678.5 million compared with $638.6 million in 2015. Through extensive international bidding, PAHO is able to purchase vaccines, public health supplies and equipment, and literature on behalf of Member States and international institutions at affordable prices.

Figure D: Procurement Funds Revenue



The **Revolving Fund for Vaccine Procurement**, the oldest Fund established in 1977, was established as a purchasing mechanism to guarantee the quality and timely mobilization of vaccines at lower prices. The Fund increased from $561.2 million in 2015 to $582.3 million in 2016. This was mainly due to additional demand from some countries such as Panama (2 million doses of Influenza vaccine), Argentina (1.5 million doses of Meningococcal ACWY) and Brazil (36 million doses of Hepatitis B and 6 million doses of Pentavalent). In 2016, 41 Member States have used the Fund. The Member States with the largest volume of procurement purchases were Argentina, Bolivia, Brazil, Chile, Costa Rica, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Panama, Paraguay, Peru and Venezuela.

The **Regional Revolving Fund for Strategic Public Health Supplies** was created in 1999 in order to facilitate the procurement of strategic public health supplies at lower, more stable prices, to improve availability of strategic supplies, and to enhance planning capacity for procuring and distributing products. The Strategic Fund has historically focused on assisting Member States increase access to public health products to treat and prevent communicable diseases (HIV/ADIS, malaria, Tuberculosis, Neglected Tropical Diseases). However, at the request of PAHO's Member States, beginning in 2013 the Organization has strengthened the Strategic Fund in order to better respond to Member States' needs and improve access to quality, essential medicines for Non-communicable Diseases (NCDs), particularly for hypertension, diabetes and cancer. Revenue to the Fund increased from $71.5 million in 2015 to $92.2 million in 2016. This was mainly due to a significant increase in the number of antiretroviral and vector control product requests. Member States that traditionally used this mechanism occasionally increased their use in a more systematic way. Furthermore, the process for accessing the capitalization account was streamlined, which resulted in doubling the amount of Member States who accessed the capitalization account. In 2016, 22 Member States have used the Fund. The Member States with the largest volume of procurement purchases were Brazil, Colombia, Ecuador, Guatemala, Honduras and Venezuela. The growth in use demonstrates that the Regional Revolving Fund for Strategic Public Health Supplies is providing significant value added to Member States and is improving access to quality and affordable essential Public Health Supplies in the Region.

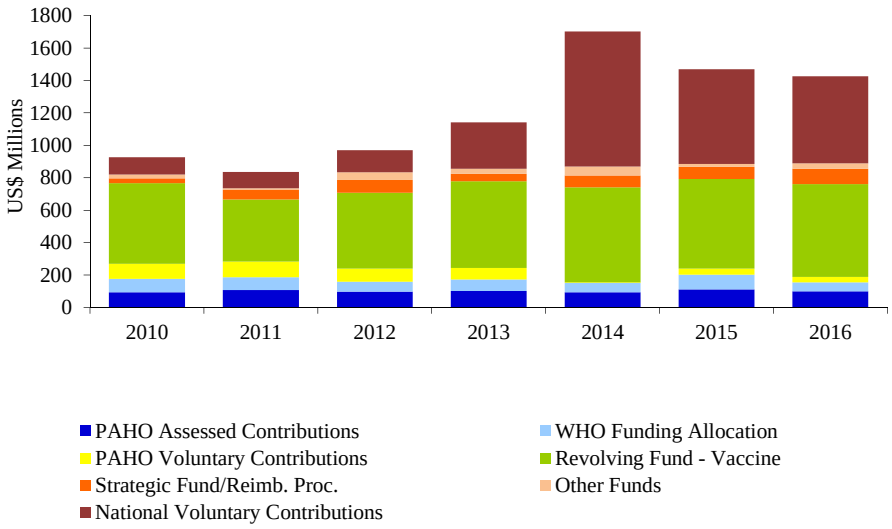
The average use by Members States of the lines of credit of these two Funds increased in 2016 as compared to 2015 from $42.4 million to $46.5 million for the Revolving Fund for Vaccine Procurement and from $2.2 million to $2.7 million for the Regional Revolving Fund for Strategic Public Health Supplies.

During the same period, funding for the purchase of medical supplies, medical equipment, and literature processed through the **Reimbursable Procurement on Behalf of Member States Fund**, decreased from $6.0 million in 2015 to $4.0 million in 2016 as a larger number of products are included in the Strategic Fund. In 2016, 25 Member States have used this Fund.

9. Expenses by Source of Fund

PAHO's total expenses, reflecting disbursements and accrued liabilities, decreased slightly to $1 426.5 million in 2016 from $1 468.9 million in 2015. This decrease is mainly attributable to the decrease in the U.S. dollar value of the implementation of National Voluntary Contributions projects, mainly in Brazil, due to exchange rate fluctuations.

Figure E: Expenses by Source of Funds



The primary PAHO expense categories are shown below in millions of United States dollars:

Table 2. PAHO Expense Categories (Net of Eliminations)

Staff and Other Personnel Costs	173.9
Supplies, Commodities, Materials	680.5
Equipment, Vehicles, Furniture, Intangible Assets, Depreciation and Amortization	2.0
Contractual Services	80.3
Travel	36.2
Transfers and Grants to Counterparts	441.3
General Operating and Other Direct Costs	12.2
Total PAHO Expense	1 426.5

The two most significant expense categories for the implementation of international health programs are Supplies, Commodities, Materials, and Transfers and Grants to Counterparts. The Supplies, Commodities, Materials category represents the procurement of vaccines, strategic public health medications, syringes, and medical supplies for Member States through the Procurement Funds. The Transfers and Grants to Counterparts category is primarily comprised of expenses linked to the National Voluntary Contributions.

10. Liquidity and Investment Management

The financial stability of the Organization depends not only upon the timely receipt of Assessed Contributions, Voluntary Contributions, and other receivables, but also on the effective management of the resources administered by the Organization. The PAHO Investment Committee has been delegated the authority to establish and implement appropriate investment policies, reflecting best practices and prudent financial management. The Investment Committee regularly reviews the investment portfolio's performance, keeping in mind the primary objective to preserve the capital value of resources and maintain adequate liquidity, while maximizing the yield on the portfolio. In order to take advantage of the rising interest rate environment, the Investment Committee approved a change to the mandate of the managed portfolios to reflect a longer overall duration beginning in January 2016. Investment revenue earned in 2016 totaled $12.9 million.

Total cash and investments for the Organization at 31 December 2016 were $669.4 million, an increase of $47.3 million over the cash and investment balance as of 31 December 2015. The terms of the various investments in the portfolio reflect the nature and liquidity needs of the Organization and, therefore, are primarily short-term in duration (less than 12 months). These short-term investments are held to finance the Biennial Program and Budget activities, the procurement on behalf of Member States, the implementation of Voluntary Contributions agreements, and other activities. Long-term investments (from one to ten years) represent special funds held in reserve for long-term liabilities of the Organization, including future entitlements of current staff members for termination and repatriation, and after-service health insurance

11. Financial Statements

In accordance with IPSAS, a complete set of Financial Statements has been prepared as follows:

- *Statement of Financial Position* measures the financial strength of PAHO and displays in monetary value the assets and liabilities as of the end of the financial reporting period.

- *Statement of Financial Performance* shows how well PAHO used its assets to generate revenue. It is a general measure of PAHO's financial health over a given period of time (12 months) and can be compared with similar organizations.

- *Statement of Changes in Net Assets* shows all the activity in net assets during a financial period, thus reflecting the increase or decrease in PAHO's net assets during the year.

- *Cash Flow Statement* explains the changes in the cash position of PAHO by reporting the cash flows classified by operating, investing, and financing activities.

- *Comparison of Budget and Actual Amounts* reflects actual utilization of revenue in comparison with the Biennial Program and Budget Plan approved by the 52nd Directing Council in 2013.

- *Notes, comprising a summary of significant accounting policies and other relevant information.*

In order to provide the reader of PAHO's Financial Statements with more detailed information to fully understand the breadth of the activities of the Organization, an unaudited informational annex has been provided after the Report of the External Auditor. This annex includes summaries for the individual segments, Assessed Contributions, Voluntary Contributions, Procurement Funds, funding for the Regional Office of the Americas (AMRO)/World Health Organization, and Other Centers.

12. Other Highlights

ZIKA Virus (ZIKV)

In February 2014, autochthonous circulation of Zika virus (ZIKV) in the Region of the Americas was first confirmed on Easter Island, Chile. In May 2016, the first autochthonous cases of Zika virus in Brazil were confirmed, and in October 2016,

Brazilian public health authorities detected an unusual increase in microcephaly cases in both public and private healthcare facilities in Pernambuco state, Northeast Brazil. In December 2016 neurological syndrome, congenital malformations and Zika virus infections were detected signifying serious implications for public health in the Americas.

Epidemiological alerts and updates were published under the International Health Regulations structure to promote both Member State awareness and provide technical guidance starting on 7 May 2016 and subsequently for the periods of 16 October, 17 November and 1 December 2016.

Given the rapid dissemination of Zika virus in the Region of the Americas as well as the detection of severe outcomes potentially related to Zika virus infection, the PAHO Director activated PAHO/WHO's Incident Management System (IMS) on 8 December 2016 in order to make the best possible use of the expertise of the PAHO Secretariat to expedite support to the Member States. At this time, the Director designated $500,000 to the PAHO Epidemic Emergency Fund to initiate operations. PAHO provided dynamic leadership and timely technical support and guidance to Member States to prevent and manage the ZIKV outbreak and associated complications and mitigate the socioeconomic consequences. Highlights of actions include: just over $15M mobilized to support the response efforts and strengthen arbovirus vector control in the region; multidisciplinary technical field missions with over 170 staff and experts, including through the GOARN network, deployed to 30 countries and territories; 20 regional and sub-regional workshops in various technical areas; fifteen new or revised WHO/PAHO technical guidelines to guide Member States' health services in relation to ZIKV and compilations. Since epidemiological week 44 of 2016, no additional countries or territories of the Americas have confirmed autochthonous vector-borne transmission of Zika virus disease.

The Incident Management System (IMS) reports to the Director and is supported by the Emergency Operations Center platform. It articulates the work of all technical departments involved in the response and is also linked to the WHO IMS system activated in WHO Headquarters and the five other WHO Regional Offices.

Modernization of the PASB Management Information System

Pursuant to the instructions of the 50th Directing Council of the Pan American Health Organization (PAHO) in 2010, the Pan American Sanitary Bureau (PASB) launched a project to modernize the PASB Management Information System (PMIS). The PMIS was designed to play an increasingly critical role in providing effective support for delivering technical cooperation to Member States by leveraging available technology to streamline administrative processes, maximize transparency, foster accountability through clearly defined roles and responsibilities, as well as facilitate the delegation of authority to improve the efficient execution of technical and administrative functions.

The Organization is pleased to report that the Project to implement PMIS has been successfully completed. On 1 January 2016, the Phase 2 financials portion of the system joined the Phase 1 Human Resources and Payroll System live in production. 2016 saw the completion of the non-Go-Live critical components that were not addressed prior to Go Live in January 2016, in particular the annual financial closure and reporting processes. Considerable effort was also devoted to systems stabilization, training and enhancements. PMIS is now fully operational in 4 languages, handling 24 currencies and 180 business processes, and being used by over 2,000 staff and consultants in 30 locations throughout the Americas.

Mais Medicos

The Mais Médicos Project, as part of the larger National Program carrying the same name, continued to develop successfully throughout 2016, maintaining the provision of basic health care to 3,785 municipalities in Brazil. This Project includes the recruitment and placement of 11,429 Cuban doctors among these municipalities and 34 indigenous health districts. The Project aims at developing strategies to ensure universal access to health care provided by the Brazil Unified Health System (SUS - Brazilian acronym). Since 2015, the National Program has some 7,000 additional medical doctors, both Brazilian and other foreign nationals, totaling 18,240 doctors. It also aims to improve the infrastructure and expand access to medical education. These other components of the National Program are being executed directly by the Ministry of Health and the Ministry of Education. In all, more than 60 million people in Brazil are benefiting from the Program, and around 40 million are served by Cuban medical doctors, through PAHO technical cooperation.

PAHO's added value to the Project has included the selection of Cuban medical professionals according to criteria established by the Government of Brazil, as well as the implementation of the Induction Module (a three-week course which covers information on SUS structure and protocols as well as additional training on Portuguese language). An additional Induction Module at the municipal level is carried out immediately after the initial Induction program. PAHO also monitors the registration of the participating Cuban doctors in the specialization course for Family Health, following the requirements established by the Brazilian Ministry of Education.

Total funds implemented by PAHO in 2016 pertaining to this Project amounted to $ 465.0 million, including Program Support Costs. All staff requirements for Project implementation have been fulfilled. A new Term of Agreement (TA 10) has been signed in order to formalize decisions that have been taken during the Tripartite Meeting in September 2016. The project monitoring and evaluation framework has been successfully implemented, through the application of measuring tools and methodology, fostering and financing research, and sharing relevant knowledge and results. The Cuban Doctors' database and IVS related application have been upgraded during 2016 and, according to internal audit results, was proven to be effective in improving accountability and transparency. The risk monitoring has been periodically reviewed by the PAHO Risk Committee chaired by the Director of Administration. A new version of the contingency plan has been elaborated, taking into consideration the complex political situation in Brazil. During 2016, IES/WDC performed four internal audits, and the PAHO external auditors visited PWR Brazil in January 2017. All auditors' recommendations have been implemented or are presently in the process of implementation.

By the end of 2016, all Brazilian municipalities that had requested to participate in the Program established by the Federal Government of Brazil were accommodated. No relevant changes have been recorded from the 2016 situation: 89% of the 11,429 participating doctors were located in priority areas. Doctors exiting the project represent a small percentage of total doctors (less than 10%), while among Brazilian Doctors this percentage is much higher (around 40%). A solid scientific instrument (Primary Care Assessment Tool) has been implemented to evaluate quality of PHC practices of Cuban Doctors. More than 8,000 doctors participated to this evaluation. Results were very satisfactory: Cuban Doctors had either the same or better performance than their Brazilian colleagues. The vast majority of the participating doctors are working in basic healthcare teams (traditional basic healthcare team, the family health teams, or the indigenous health districts) located in vulnerable areas. PAHO monitors the compliance of the municipalities with the commitment of providing lodging and food, as well as transportation to the participating doctors as a specific contribution to complement the effort of the Federal government in covering the salaries of these physicians.

13. Accounting Policies and Basis of Preparation

The Financial Statements of the Pan American Health Organization (the Organization) have been prepared on the accrual basis of accounting in accordance with International Public Sector Accounting Standards (IPSAS), using the fair value valuation convention. Where an IPSAS does not address a particular issue, the appropriate International Financial Reporting Standard (IFRS) has been applied.

These Financial Statements were prepared under the assumption that the Organization is a going concern and will continue in operation and will meet its mandate for the foreseeable future. The Governing Bodies of the Organization have not communicated through any means that there is an intention to terminate the Organization or to cease its operations. Furthermore, at the time of the preparation of these Financial Statements the Executive Management of the Organization was not aware of any material uncertainties related to events or conditions that may cast significant doubt upon the ability of the Organization to continue as a going concern.

The Financial Statements of the Organization were authorized for issue by the Director of the Organization under the authority vested in her by the Pan American Sanitary Conference as stated in the Resolution CSP28.R7 in September 2012. This issuance approval is dated 27 April 2017**.** No other authority has the power to amend the Financial Statements after issuance.

Carissa F. Etienne

Director

Pan American Health Organization