I. Introduction and Context

Country Context

Armenia has been a consistent reformer over the years. These reforms favored a steady increase in income over the past decade. After a severe transition recession in the first half of the 1990s, the economy recovered gradually, with growth averaging 6 percent per year during 1994-2000. However, the global financial crisis hit Armenia hard in 2009 and resulted in a major contraction of the Armenian economy. Between 2008 and 2009, the poverty incidence increased from 27.6 to 34.1 percent; and poverty severity increased from 1.4 to 2.4 percent. Inequality in Armenia is relatively low, but has worsened during the crisis.

A slow economic recovery is underway - the economy grew by 2.1 percent of GDP in 2010, while the growth is estimated at 4.6 percent in 2011 - although Armenia is facing possible contagion effects from the ongoing euro-zone crisis. In response to the economic crisis, Armenian households employed several coping strategies, including some which are potentially harmful in the long run (e.g. reduced food consumption and spending on leisure). Cuts in health spending in response to the crisis have been large. Poor households suffered the most.

The proposed Project will address the issue of unequal utilization of health services by focusing on Non-Communicable-Disease prevention and early diagnosis services at primary health care level– where financial barriers to access for poor are lower.

Sectoral and Institutional Context

Armenia has made significant achievements in re-designing its health system since the late 1990s. Major institutional and structural reforms have been undertaken with the overall objective to improve the efficiency, access and quality of health care service provision. The reforms have included (a) strengthening Primary Health Care (PHC) provision; (b) downsizing excess hospital capacity; (c) changes in provider payment; and (d) targeting the poor in providing free of charge health care services.

Starting in the late 1990s, the Government of Armenia has made continuous efforts and investments to introduce family medicine in the primary health care system. Currently, 100 percent of medical personnel at the PHC level have been trained in family medicine and most PHC clinics in rural areas have been upgraded and provided with modern medical equipment and supplies. Similarly, the hospital sector underwent radical optimization of the excess capacity through merging hospitals, vacating redundant spaces, eliminating duplication and overlap of services and downsizing bed capacity. In addition, the hospitals have been granted greater autonomy in making decisions with respect to expenditures and staffing issues. Access to health care has increased as a result of the reforms.

Despite these efforts, Armenia’s health care system is still struggling to catch up with the epidemiological changes in morbidity and mortality patterns over the recent years. The greatest burden of disease in Armenia, as in most European countries, comes from non-communicable diseases (NCDs), a group of conditions that includes cardiovascular disease, cancer, mental health problems, diabetes mellitus, chronic respiratory disease and musculoskeletal conditions. Based on the data of the National Institute of Health (NIH) Statistical Yearbook of 2010, around 50 percent of all deaths are due to cardiovascular diseases (CVD) and 74 percent are due to CVD, neoplasms, and diabetes mellitus combined.

National data for 2010 shows that CVD prevalence is on the rise and is increasing by approximately 4 percent every year. The prevalence of diabetes is also on the rise. WHO finds Armenia to have the highest mortality rate in the region due to diabetes, at 51 per 100 000 population, versus 21 in Georgia, Iran and Turkey. Since 1999, the morbidity and mortality rate from cancer has also
continued to rise. The highest mortality rates are registered from lung cancer among men and from breast and cervical cancer among women. Since 1990, the mortality rate from lung cancer almost doubled from 35.8 to 64.3 (per 1000 population). Similarly, the mortality rate from breast cancer has increased by 1.2 times for the period 2002 to 2008.

Analysis of the current CVD and diabetes treatments in Armenia compared with international best practice shows significant shortcomings, particularly in early detection/treatment and population education. Armenia also lacks comprehensive cancer control, which includes primary prevention, early detection, treatment and palliative care. Establishment of an early diagnosis program is important in order to reduce the proportion of advanced-stage cases and to improve survival rates of selected cancers that may be amenable for effective treatment with limited resources (e.g., cervical, breast, oral or skin cancers). Furthermore, even though qualified and internationally trained surgeons in Armenia perform complex surgery, access to effective modern cancer treatment modalities, such as radiotherapy and chemotherapy, is also limited. The medical equipment at specialized oncology hospitals is often outdated and in the case of radiotherapy, largely absent.

The Government has requested the World Bank’s assistance to help implementing a number of interventions from the NCDs strategies ranging from population based primary prevention measures to tertiary specialized treatment and management. The Government also intends to modernize the tertiary level oncological services. This includes major reconstruction of the Onco-Hematology Center in Yerevan and creation of a new Radiation Treatment Center, including provision of up-to-date diagnostic and radiological equipment. An oncology clinic dedicated to providing cancer treatment according to western standards will close the gap that currently prevents many patients from getting diagnosis and therapy early enough for a cure or long-term remission.

Relationship to CAS

The proposed Project is consistent with the objectives of the current Armenia’s Country Partnership Strategy (CPS) for FY09-12, which was extended to FY13 in July 2011. The proposed Project will address the following objective of the CPS:

Objective 1: Addressing vulnerabilities; Results 2: Adverse poverty impact limited amidst assured health and social protection.
Outcome 2: Increased utilization of basic health services by the poor, with a decline in out-of-pocket payments (OOPs). By strengthening NCD services at the primary care level -- for which barriers to access are lower in both financial and geographic terms -- the project would make a significant contribution to social inclusion in the health arena.

II. Proposed Development Objective(s)

Proposed Development Objective(s)

The proposed Project Development Objectives (PDOs) are to improve the health care system’s responsiveness (effectiveness) in prevention, early detection, and management of selected non-communicable diseases.

Key Results

The PDO indicators are:

- Number of people aged 40–74 under treatment for high blood pressure;
- Number of poor people under treatment for hypertension and high cholesterol at PHC level;
- Percentage of increase in prevalence of women aged 30–60 screened for cervical cancer at least once during the last 3 years.

III. Preliminary Description

Concept Description

The proposed Project will comprise four components as follows:

Component 1: Improving Specialized Hospitals. This component would aim at improving infrastructure and capacity in the treatment of selected NCDs at specialized tertiary level hospitals. The project could finance major reconstruction of the Onco-Hematology hospital and the establishment of tertiary level Radiation Treatment Center, provision of equipment, training of staff, revisions and development of clinical guidelines and treatment standards. The possibility of developing a public-private partnership (PPP) scheme in partnership with IFC is being explored.

Component 2: CVD and Cervical Cancer Screening. This component would aim at improving prevention and management of (a) CVD through increased screening coverage of the adult population over 40 years old, particularly those with hypertension and high cholesterol. Some of the activities could include revision of CVD reference guidelines and protocols, training of PHC staff on CVD management, provision of bonuses for PHC providers, etc.; and (b) cervical cancer through increased screening coverage of women at age 30-60. Some of the activities could include revision of guidelines and treatment standards, training of staff at PHC facilities, laboratory (cytology) equipment and supplies at secondary hospitals, etc.

Component 3: Health Promotion. This component would aim at reducing NCDs risk factors through increasing public awareness on major risks associated with NCDs and through population based actions to encourage behavior change. The component would finance public information campaigns, policy development on mechanisms that restrict marketing foods high in saturated fat, trans-fatty acids, sugars and salt, anti-smoking measures. It would also finance risk factor surveys, training, etc.
Component 4: Project Management. This component would support day-to-day project management, including fiduciary tasks and monitoring and evaluation.

### IV. Safeguard Policies that might apply

<table>
<thead>
<tr>
<th>Safeguard Policies Triggered by the Project</th>
<th>Yes</th>
<th>No</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Assessment OP/BP 4.01</td>
<td>✗</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Habitats OP/BP 4.04</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Forests OP/BP 4.36</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Pest Management OP 4.09</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Physical Cultural Resources OP/BP 4.11</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Indigenous Peoples OP/BP 4.10</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Involuntary Resettlement OP/BP 4.12</td>
<td></td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Safety of Dams OP/BP 4.37</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Projects on International Waterways OP/BP 7.50</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Projects in Disputed Areas OP/BP 7.60</td>
<td></td>
<td>✗</td>
<td></td>
</tr>
</tbody>
</table>

### V. Tentative financing

<table>
<thead>
<tr>
<th>Financing Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BORROWER/RECIPIENT</td>
<td>0.00</td>
</tr>
<tr>
<td>International Bank for Reconstruction and Development</td>
<td>5.00</td>
</tr>
<tr>
<td>International Development Association (IDA)</td>
<td>25.00</td>
</tr>
<tr>
<td>Total</td>
<td>30.00</td>
</tr>
</tbody>
</table>

### VI. Contact point

**World Bank**

Contact: Susanna Hayrapetyan  
Title: Senior Health Specialist  
Tel: 473-5227  
Email: shayrapetyan@worldbank.org

**Borrower/Client/Recipient**

Name: Ministry of Finance & Economy  
Contact: Vache Gabrielyan  
Title: Minister  
Tel: 59-53-04  
Email: press@mfe.am

**Implementing Agencies**

Name: Ministry of Health, HSMP-PIU  
Contact: Gurgen Dumanyan  
Title: Director  
Tel: (374-10) 582-413  
Email: hpiu@gmail.com

### VII. For more information contact:

The InfoShop  
The World Bank  
1818 H Street, NW  
Washington, D.C. 20433  
Telephone: (202) 458-4500  
Fax: (202) 522-1500  
Web: http://www.worldbank.org/infoshop