THE REPUBLIC OF FIJI
THE REPUBLIC OF KIRIBATI
THE KINGDOM OF TONGA
TUVALU
THE PACIFIC COMMUNITY

PACIFIC HEALTH ISLANDS TRANSFORMATION REGIONAL PROJECT (P508550)

ENVIRONMENTAL AND SOCIAL MANAGEMENT FRAMEWORK (ESMF)

18 July 2025

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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AMU	Asset Management Unit (of MHMS)
CIU	Construction Implementation Unit (of MHMS)
COE	Centre of Excellence
CWMH	Colonial War Memorial Hospital
DFAT	Department of Foreign Affairs and Trade, Australia
DoE	Department of Environment
DoE	Department of Environment, Fiji
E&S	Environmental and Social
EIA	Environmental (and Social) Impact Assessment
EPC	Engineer-Procure-Construct
ESCOP	Environmental and Social Codes of Practice
ESCP	Environmental and Social Commitment Plan
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standard
GBV	Gender-based Violence
GM	Grievance Mechanism
ICT	Information and Communications Technology
IDA	International Development Association
LIMP	Labour Influx Management Plan
LMF	Labour Management Framework
LMP	Labor Management Procedure
MHMS	Ministry of Health and Medical Services, Fiji
MOWE	Ministry of Waterways and Environment, Fiji
NCD	Non-communicable disease
NGO	Non-Governmental Organisation
OHS	Occupational Health and Safety
OMR	Overseas Medical Referrals
PAD	Project Appraisal Document
PHC	Primary Health Care
PIC	Pacific Island Country
PMU	Project Management Unit
SEF	Stakeholder Engagement Framework
SEP	Stakeholder Engagement Plan
SIDS	Small Island Developing States

EXECUTIVE SUMMARY

The World Bank will be supporting the the governments of Fiji, Kiribati, Tonga and Tuvalu and the Pacific Community (SPC) in implementing the Pacific Healthy Islands Transformation (PHIT) Project. The objective of the project is to support the transformation of Pacific health systems into fit-for-purpose, Primary Health Care (PHC) oriented health systems that promote health and deliver adequate preventive and curative services. The project will support the following activities: construction of a new tertiary healthcare facility in Fiji; renovation and refurbishment of Colonial War Memorial Hospital (CWMH); upgrades to PHC facilities and nursing schools; development of digital health platforms including AI-based diagnostic support and telehealth networks; establishment of Centres of Excellence; and healthcare workforce transformation through professional development and training programmes.

The project activities will take place across Fiji, Kiribati, Tonga, and Tuvalu, with major infrastructure works concentrated in Fiji. Specific locations of some subproject activities are not known at this stage, because site selection processes are ongoing for the new hospital facility and specific PHC upgrades are still being identified through needs assessments. The subproject locations will be known during the first year of implementation as detailed planning and consultations are completed.

The Project will support the following activity types:

i. **Infrastructure investments** including the construction of a new tertiary healthcare facility, renovation and refurbishment of the existing CWMH tertiary healthcare facility, and upgrade/replacement of local PHC clinics and/or nursing schools;

ii. **Digital infrastructure** to improve ICT and connectivity across public health authorities and services;

iii. **Technical assistance** including capacity building for healthcare professionals, health initiatives for communities, design packages for healthcare services, digital platforms and content, policy and regulatory reform, program implementation, health outreach programs and training.

The mapping of these activity types to PHIT Project components and subcomponents is as follows:

		Activity type		
Component/subcomponent	**Activity**	**(i) Infra**	**(ii) Digital**	**(iii) TA**
Component 1: Strengthen regional systems to improve access to quality care and essential inputs for greater resilience of Pacific SIDS' health systems				
1.1: Enhance quantity and quality of the Pacific healthcare workforce	**a.** Professional development and accreditation			✓
	b. Establish a regional learning management system			✓
	c. Establish a regional network of e-learning hubs		✓	✓
	d. Establish electronic health worker registries			✓
	e. Address advanced skills gaps			✓
	f. Strengthen national training institutions		✓	✓
1.2: Use digital innovations to create a Pacific model of PHC strengthening	**a.** Establish a regional telehealth network (RTN)		✓	✓
	b. Establish a regional registry for the RTN			✓
	c. Develop shared instruments to guide regional use of the RTN			✓
	d. Develop AI-enabled diagnostic application			✓

Component/subcomponent	Activity	Activity type (i) Infra	(ii) Digital	(iii) TA
	e. Develop a regulatory and cooperation framework on use of AI-enabled software			✓
	f. Develop secure cross-border data-exchange mechanisms			✓
	g. Upgrade selected PHC facilities with digital equipment to maximise reach of the RTN		✓	✓
1.3: Expand access to tertiary hospital care and upgraded training facilities	**a.** Update clinical guidelines, protocols, and patient care pathways			✓
	b. Upgrade and expand CWM Hospital	✓		✓
Component 2: Modernise national health systems and upgrade PHC facilities regionally, with emphasis on establishing networks of care for health promotion, early detection and management of disease				
2.1: Build a resilient, person-centred, integrated health service delivery system	**a.** Establish networks of care by upgrading, repairing or replacing PHC clinics	✓	✓	✓
	b. Establish a national digital health architecture in Fiji		✓	✓
	c. Improve health emergency preparedness and response in Fiji		✓	✓
	d. Strengthen supply chain resilience			✓
	e. Upgrade PHC screening, risk assessment, diagnosis, treatment and referral protocols			✓
	f. Assess resource gaps for NCD management			✓
	g. Design and implement an electronic health record and screening program			✓
2.2: Scale-up gender- and climate-sensitive community outreach programs				✓
Component 3: Support regional implementation capacity and MEL				
3.1: Support regional implementation capacity and MEL	**a.** Establish a COE for Regulatory and Data Safety for Telehealth		✓	✓
	b. Establish a COE for Continuity of Care in Disparate Geographies		✓	✓
	c. Establish a COE for Fair Access to Regional Specialist Care		✓	✓
3.2: Project implementation management	**a.** Establish and operate Project Management Units			✓
	b. Implement regional activities through SPC			✓
	c. Engage UNICEF to provide hands-on implementation support and coordination			✓

This Environmental and Social Management Framework (ESMF) has been prepared to identify the potential environmental and social risks and impacts of proposed Project activities and propose suitable mitigation measures to manage these risks and impacts. It maps out the participating countries' laws and regulations and the World Bank policies applicable to the Project, and describes the principles, approaches, implementation arrangements, and environmental and social mitigation measures to be followed.

The potential environmental and social (E&S) risks for project activities are identified as:

- Construction-related impacts related to major civil works for the offsite expansion of the CWM Hospital (including safety, dust, noise, vibration, erosion, traffic)
- Waste generation from construction debris (including hazardous waste, asbestos), medical waste (biological, cytological, pharmaceutical, infectious), and electronic waste from digital equipment
- Potential land acquisition and economic displacement from existing land uses
- Labour risks including occupational health and safety concerns and potential labour influx
- Community health and safety risks during construction and healthcare service disruptions
- Potential gender-based violence and sexual exploitation risks associated with construction workforce
- Downstream risks associated with the embedding of bias or poor cultural sensitivity in digital content and AI-based tools

These risks will be managed and mitigated on a subproject basis (discretely managed activities) through the application of the following instruments as required according to the outcome of E&S screening:

- Environmental and Social Management Plans (ESMPs)
- Construction ESMPs (CESMPs)
- A Borrower's Environmental Impact Assessment (EIA)
- Labour Management Procedures (LMPs) based on the Project Labour Management Framework (LMF)
- Stakeholder Engagement Plans (SEPs) based on the Project Stakeholder Engagement Framework (SEF)
- Environmental and Social Codes of Practice (ESCOPs)
- Labour Influx Management Plans (LIMPs) as an annex to LMPs
- Sexual exploitation and abuse, sexual harassment (SEA/SH) action plan as an annex to ESMPs, CESMPs and/or LMPs
- Hazardous Waste Management Plans (HWMPs) as an annex to ESMPs and CESMPs
- Land Acquisition and Resettlement Procedures (LARPs)

Note that the Project activities vary widely in risk profile, from major civil works with Substantial potential environmental and social risk rating, to technical assistance with very low risk rating. The risk management instruments required for any given subproject (activity) will be determined by subproject E&S screening.

Implementation Arrangements. Project Management Units (PMUs) in each participating country and the SPC will coordinate project activities and oversee E&S compliance. PMUs will provide support, oversight, and quality control to field staff; collect and review screening forms and ESMPs; monitor implementation of mitigation measures; and report to the World Bank semi-annually. A third-party implementer will support PMUs across all countries. Local contractors will comply with E&S management measures specified in ESMPs, ESCOPs, and contract documents. Training will be

provided through a cascading model from national to local levels, covering E&S risk identification, mitigation measures, incident reporting, and grievance mechanisms. The estimated budget for ESMF implementation is integrated within the overall project budget of US$290 million.

Monitoring. PMUs will be responsible for monitoring through regular site visits, monthly reporting from field staff, and tracking of grievances. Monitoring will cover implementation of E&S instruments, OHS performance, community health and safety, stakeholder engagement, and grievance resolution. Serious incidents must be reported to the World Bank within 48 hours. Third-party monitoring may be employed for high-risk activities. Training will be provided from national to local levels, covering environmental and social risk identification, mitigation, incident reporting, and grievance mechanisms.

A separate Stakeholder Engagement Framework (SEF) has been prepared for the Project, based on the World Bank's Environmental and Social Standard 10 on Stakeholder Engagement.

1. INTRODUCTION

This Environmental and Social Management Framework (ESMF) is developed to support the environmental and social due diligence provisions for activities under the Pacific Healthy Islands Transformation (PHIT) Project financed by the World Bank through the International Development Association (IDA). The Project will support the transformation of Pacific health systems into fit-for-purpose, Primary Health Care (PHC) oriented health systems that promote health and deliver adequate preventive and curative services. The Project will be implemented, and complement existing national health systems investments, in the Pacific Small Island Developing States (SIDSs) of Fiji, Kiribati, Tonga and Tuvalu (the PHIT Countries).

This ESMF follows the World Bank Environmental and Social Framework (ESF) as well as the national laws and regulations of the PHIT Countries. The objective of the ESMF is to assess and mitigate potential negative environmental and social risks and impacts of the Project consistent with the Environmental and Social Standards (ESSs) of the World Bank ESF and national requirements. More specifically, the ESMF aims to (a) assess the potential environmental and social risks and impacts of the proposed Project and propose mitigation measures; (b) establish procedures for the environmental and social screening, review, approval, and implementation of activities; (c) specify appropriate roles and responsibilities, and outline the necessary reporting procedures, for managing and monitoring environmental and social issues related to the activities; (d) identify the staffing requirements, as well as the training and capacity building needed to successfully implement the provisions of the ESMF; (e) address mechanisms for public consultation and disclosure of project documents as well as redress of possible grievances; and (f) establish the budget requirements for implementation of the ESMF.

This ESMF should be read together with other plans prepared for the project, including the Stakeholder Engagement Framework (SEF), Labor Management Framework (LMF) and Environmental and Social Commitment Plan (ESCP).

2. PROJECT DESCRIPTION

2.1. Project summary

The Pacific Healthy Islands Transformation (PHIT) Project, with $200 million IDA financing and $90 million co-financing, is designed to support the transformation of Pacific health systems into fit-for-purpose, PHC-oriented health systems that promote health, and deliver adequate preventive and curative services.

PHIT will sequence investments across key enablers of the regional healthcare ecosystem, including health workforce transformation, construction and/or refurbishment of regional health facilities, digital health, continuity of care, and overall modernisation of the Pacific healthcare system.

The project will invest in shared health infrastructure, including the collaborative development of standardised learning materials, a regionally tailored large language model (AI) for health diagnosis, integrated telemedicine hubs, and a specialised regional healthcare facility, to significantly reduce costs for countries while dramatically expanding regional access to essential health services.

Collectively, these regional initiatives leverage economies of scale, ensure quality consistency, and foster equitable regional access to advanced healthcare.

The PHIT project will make these regional investments in a way that complements existing national health systems investments, including the IDA-funded investments in the Tuvalu Health Systems Strengthening Project (P175170), the Kiribati Health Systems Strengthening Project (P176306) and the Health Enhancement and Resiliency in Tonga (HEART) Project (P180965).

The Project consists of three highly interlinked components:

Component 1: Strengthening of regional systems to improve access to quality care and essential inputs for greater resilience of Pacific SIDS's health systems, by investing in regional solutions to address the shared challenges across PICs, particularly those related to limited specialized human resources, economies of scale for advanced medical services, and the need for standardized quality of care, promoting regional approaches to optimize resource utilization, enhance efficiency, and build collective resilience against shared threats.

Sub-component 1.1: Enhancing the quantity and quality of the Pacific healthcare workforce, by financing:

(a) professional development and accreditation, to substantially strengthen and expand continuing professional development, accreditation processes, and re-accreditation programs for healthcare workers, including developing regional curriculum guidelines and high-quality e-learning materials, incorporating built-in assessment mechanisms and gamification features to enhance engagement and track progress;

(b) a regional learning management system;

(c) a regional network of e-learning hubs;

(d) the development, through SPC, of electronic health worker registries to assess the collective stock of healthcare workers across participating countries;

(e) measures to address advanced skills gaps by providing targeted support (e.g., travel grants, education grants, exchange programs) for entry-level, mid-level and advanced

nursing, physician, and allied health care professionals training programs, focusing on addressing critical skills shortages in NCD and cancer care;

(f) the strengthening of regional capacity to close critical gaps in the availability of mid-level health providers through faculty development and institutional strengthening of nurse and medical training institutions to ensure sustainability in the expansion and quality of mid-level staff.

Sub-component 1.2: Using digital innovations to connect patients, providers and health systems, to enable participating countries to leverage scarce specialised human resources across islands and other regional synergies, by financing:

(a) the establishment of a regional telehealth network (RTNs) across four countries, Fiji, Kiribati, Tonga and Tuvalu, offering telehealth services, including telepathology (electronic transmission of slide images for remote pathological diagnosis) and teleradiology (electronic transmission of diagnostic images like x-rays for remote radiological interpretation);

(b) the establishment, through SPC, of a regional registry of human resources essential to operate the RTN;

(c) the development of shared instruments, such as model consent templates, data-sharing agreements, and baseline cybersecurity protocols, to guide regional use of the RTN, including responsible health data use, to support countries to redesign and reform procedures, processes and regulation needed to safely and ethically implement the integrated solution for cross-border telehealth services;

(d) the development of a tailored AI-enabled diagnostic and treatment application;

(e) technical assistance for the development of a regulatory and cooperation framework on the use of AI-enabled software for basic diagnostic support that countries can use as a baseline for national policies and guidelines as a first step towards a broader governance framework;

(f) the development of secure cross-border data-exchange mechanisms;

(g) the upgrade of selected primary health care facilities across Fiji, Kiribati, Tonga and Tuvalu with digital equipment to maximise the reach of the regional NOEs across all levels of care, with implementation support of UNICEF.

Sub-component 1.3: Expand access to tertiary care and upgraded training facilities within participating PICs, by financing

(a) the update of clinical guidelines, protocols, and climate-resilient care patient pathways across participating countries to harmonise criteria for patient referral from primary to secondary level and from secondary to tertiary specialist services and assist countries strengthen capacity for the management of OMR cases with greater cost efficiencies and quality outcomes;

(b) increased regional specialist care and training facilities at CWM Hospital, Fiji, which the Government of Fiji is upgrading and replacing over time as the region's largest referral and training facility, in line with the recently completed Hospital Priority Infrastructure Plan and Clinical Services Plan (delivered with the support of the Government of Australia as part of an ongoing CWM Master Plan process), including i) climate-resilient and energy-efficient upgrades of critical infrastructure in the existing

CWM buildings to ensure quality and continuity of services, and ii) detailed design, construction and equipping of the first modules of the new hospital, which includes the establishment of a radiotherapy and medical imaging centre prioritising the expansion of comprehensive cancer care services to meet regional demand.

Component 2: Modernisation of national health systems, with emphasis on establishing networks of care for health promotion, early detection and management of disease. This component focuses on strengthening Fiji's health system, by reorienting services towards a person-centred approach and establishing integrated NOCs, as a model for spillover into other PICs. The emphasis is on promoting wellness, early detection, and effective management of diseases, especially NCDs, closer to communities, while enhancing resilience to health emergencies.

Sub-component 2.1: Build resilient, person-centred, integrated health service delivery with strengthened capacity to detect and manage NCDs and risk factors, by modernising the health system in Fiji as a Centre of Excellence for regional spillover, by financing

(a) the establishment of defined 'networks of care' in three distinct settings: maritime, rural, and urban, including PHC facility upgrades in Fiji, Kiribati, Tonga and Tuvalu with the necessary infrastructure and equipment to roll out a revised essential clinical services package for each type of PHC facility, actively removing barriers to care for vulnerable populations, including adolescents, women, people living with disabilities, and the elderly, prioritising existing facilities on government land to avoid land acquisition or resettlement challenges;

(b) the establishment of a national digital health architecture in Fiji by accelerating Fiji's development, implementation, and governance of a standards-based national digital health architecture, aligned with the MHMS's digital health strategy;

(c) technical assistance to strengthen health emergency preparedness and response, supporting implementation of an integrated early warning system (community-based and health facility-based) complemented with expansion of strengthened community-based surveillance and health emergency workforce capacity building strategy using a 'One Health' approach;

(d) technical assistance to strengthen supply chain resilience by integrating adequate storage capacity in PHC facility upgrades, strengthening capacities in facility management to inform procurement, inventory management, warehousing, and stockpiling systems for essential diagnostics, medications, and supplies, with the aim of improving last-mile access to essential medicines even during extreme weather events;

(e) the upgrade of screening, risk assessment, diagnosis, treatment and referral protocols for hypertension and diabetes to ensure a comprehensive approach to PHC strengthening via the NOCs;

(f) the assessment of gaps in human resources, infrastructure, medicines and technologies for NCD management;

(g) the design and implementation of an electronic health record and screening program integrated into the national health information system.

Sub-component 2.2: Scale-up gender sensitive community outreach, risk profiling, wellness and behaviour change programs in Fiji, by financing inputs such as development and production of materials and placement costs to support community-based, and digitally aided outreach to

targeted communities to support the adoption of healthy behaviours, promote screening for NCDs, and refer for early intervention and treatment.

Component 3: Strengthening stewardship, evidence-based decision making and learning for quality health systems in Pacific SIDSs. This component leverages the strengths of each participating country to accelerate critical health systems shifts that are essential to foster digitally enabled, resilient, people-centred and regionally connected networks of care in the Pacific. The project finances evidence-based policy formulation, effective project implementation, and regional knowledge exchange aimed at enhancing regional capacity for health systems governance, oversight, by integrating learning mechanisms necessary for sustainable health system reform and evaluations into implementation activities. This component will expand Pacific-specific data and evidence on what works.

Sub-component 3.1: Establish Centres of Excellence (COEs) for promising health systems solutions to design and implement innovations, and generate, measure and share regionally relevant knowledge through national and regional platforms, including testing and refining solutions addressing persistent service delivery bottlenecks, improve continuity and quality of care for chronic conditions and promote retention in long-term NCD care pathways, by financing the establishment and operationalisation of:

(a) a COE for Regulatory and Data Safety for Telehealth COE in Tonga, centred around teleconsultation protocols for NCDs and cancer screening including medication management and follow, data security protocols, electronic consent and referral protocols to enable remote patient monitoring and virtual support, for adherence treatment plans, design and testing of digital tools and remote triage algorithms for use in hard to reach outer islands, and developing and piloting regulatory framework and data safety requirements for connecting PHC with higher levels of care and procedures to facilitate expansion of telehealth services within and across Pacific borders;

(b) a COE for Developing Continuity of Care in Disparate Geographies in Kiribati and Tuvalu, focused on researching and demonstrating effective models of care to deliver continuity of services across geographically dispersed islands, particularly in low capacity and low resource settings, including innovative approaches to PHC facility upgrades, including bulk procurement of configurable pre-fabricated, climate-resilient facilities adapted to outer island vulnerabilities, multi-disciplinary mobile health models for outer islands to provide NCD and cancer screening, management and follow up including point-of-care testing for NCDs and innovations for cancer screening, and innovative approaches to ensure consistent and timely supply of essential NCD medications and basic cancer diagnostic tools;

(c) a COE for Fair and Equitable Access to a Regional Hub for Specialist Care in Fiji, dedicated to strengthening hospital management to ensure efficient and effective delivery of patient care, particularly for patients traveling from overseas, including piloting of a regional digital referral and tracking system to ensure timely and co-ordinated access to PIC citizens to specialised services in Fiji, strategic purchasing mechanisms with private sector providers aligning with clinical guidelines and patient outcomes, and piloting of regional agreements to ensure fair and equitable access to regional specialist care services, as well as addressing bottlenecks in access training and medical care in Fiji, including possible challenges related to entry visa, and unpaid labour during medical residencies, and enhanaced hospital management systems to handle patient flow.

Sub-component 3.2: Providing project implementation management and regional implementation support, by financing

(a) the establishment and operation of Project Management Units (PMUs), to develop robust coordination mechanisms, recruit technical expertise, expand management staff, advance capacity building and learning;

(b) the implementation of regional level activities through SPC, who will undertake activities aligned with its core regional mandates, in particular regional convening of health workforce capacity building, improving quality of care and digital health.

(c) the engagement of UNICEF to provide hands-on implementation support and co-ordination for delivery of defined regional public goods to further support implementation capacity and reap benefits from potential pooled procurement savings to achieve regional economies of scale, subject to annual feedback loops and a rigorous performance evaluation during the project's mid-term review.

In addition to the PHIT Countries of Fiji, Kiribati, Tonga and Tuvalu, the Pacific Community (SPC) is included in the Project as a key regional coordination partner.

The Project will be implemented via subprojects fulfilling specific activities or suites of activities under the Project Components and Subcomponents.

2.2. Project beneficiaries

The Project has a regional scope and will directly benefit the ~2 million inhabitants of Fiji, Kiribati, Tonga and Tuvalu, and through SPC's role as a regional convener, has the potential to extend to other countries in the region, including but not limited to Solomon Islands, Nauru and Vanuatu. Through strengthening the delivery of PHC services and a more resilient health system, the project will benefit women of reproductive age, adolescents, children and vulnerable populations. With a focus on enhancing non-communicable disease (NCD) prevention and care, including cancer, project beneficiaries will include the large and growing number of patients with NCD-related conditions. Project beneficiaries also will include health workers at all levels and public health systems managers across the Pacific, approximately 16,000 workers, who will receive continued education, professional development and training at Fiji National University (FNU) and the CWM Hospital as well as training in the use of AI and digital solutions to strengthen their competency in delivering services. By improving processes for overseas medical referrals (OMR) and supporting the expansion of the regional tertiary healthcare hub in Suva, Fiji, the Project will benefit patients throughout the Pacific who need to access tertiary care. In addition, the Project aims to create a platform for health sector transformation that can be gradually expanded to increase the advantages that Pacific SIDSs can gain from the project.

2.3. Project components, locations and activity typology

The PHIT project consists of the following typology of activities:

- **Infrastructure investments** including construction of new tertiary healthcare facility; renovation and refurbishment of existing tertiary healthcare facility, and upgrade local PHC facilities and/or nursing schools (i.e. construction, renovation, demolition and upgrade activities);
- **Digital infrastructure** to improve ICT connectivity across public health authorities and facilities;

- **Technical assistance** activities including capacity building for healthcare professionals and wellness initiatives for PIC communities, design packages for healthcare services, digital platforms and content, policy and regulatory reform, program implementation, health outreach programs and training.

The three interlinked components of the project and their constituent sub-components, activities and locations are summarised in Table 1.

Table 1: Project components, activities and activity locations

Component	Sub-component	Activity description	Fiji	Kiribati	Tonga	Tuvalu	SPC
1: Strengthen regional systems to improve access to quality care and essential inputs for greater resilience of Pacific SIDS' health systems	**1.1:** Enhance quantity and quality of the Pacific healthcare workforce	a) Professional development and accreditation	✓	✓	✓	✓	✓
		b) Establish a regional learning management system	✓	✓	✓	✓	✓
		c) Establish a regional network of e-learning hubs	✓	✓	✓	✓	✓
		d) Establish electronic health worker registries	✓	✓	✓	✓	✓
		e) Address advanced skills gaps	✓	✓	✓	✓	✓
		f) Strengthen national training institutions	✓	✓	✓	✓	✓
	1.2: Use digital innovations to create a Pacific model of PHC strengthening	a) Establish a regional telehealth network (RTN)	✓	✓	✓	✓	✓
		b) Establish a regional registry for the RTN	✓	✓	✓	✓	✓
		c) Develop shared instruments to guide regional use of the RTN	✓	✓	✓	✓	✓
		d) Develop AI-enabled diagnostic application	✓	✓	✓	✓	✓
		e) Develop a regulatory and cooperation framework on use of AI-enabled software	✓	✓	✓	✓	✓
		f) Develop secure cross-border data-exchange mechanisms	✓	✓	✓	✓	✓
		g) Upgrade selected PHC facilities with digital equipment to maximise reach of RTN	✓	✓	✓	✓	✓
	1.3: Expand access to tertiary hospital care and upgraded training facilities within Pacific SIDS	a) Update clinical guidelines, protocols, and patient care pathways	✓	✓	✓	✓	✓
		b) Upgrade and expand CWM Hospital	✓				
2: Modernise national health systems and upgrade PHC facilities regionally,	**2.1:** Build resilient, person-centred, integrated health service delivery with strengthened capacity to detect and manage NCDs and risk factors	a) Establish networks of care by upgrading, repairing or replacing PHC clinics	✓	✓	✓	✓	✓
		b) Establish a national digital health architecture in Fiji	✓				
		c) Improve health emergency preparedness and response in Fiji	✓				
		d) Strengthen supply chain resilience	✓	✓	✓	✓	✓

Component	Sub-component	Activity description	Fiji	Kiribati	Tonga	Tuvalu	SPC
with emphasis on establishing networks of care for health promotion, early detection and management of disease		e) Upgrade PHC screening, risk assessment, diagnosis, treatment and referral protocols	✓	✓	✓	✓	✓
		f) Assess resource gaps for NCD management	✓	✓	✓	✓	✓
		g) Design and implement an electronic health record and screening program	✓				
	2.2: Scale-up gender and climate sensitive community outreach, risk profiling, wellness and behaviour change programs	Implement community-based, digitally aided outreach programs	✓				
3: Strengthen stewardship, evidence-based decision making and learning for quality health systems in Pacific SIDS	**3.1:** Support regional implementation capacity, monitoring, evaluation and learning (MEL) for health systems strengthening through a regional Centre of Excellence (COE) approach	a) Establish a COE for Regulatory and Data Safety for Telehealth			✓		
		b) Establish a COE for Continuity of Care in Disparate Geographies		✓		✓	
		c) Establish a COE for Fair Access to Regional Specialist Care	✓				
	3.2: Project implementation management	a) Establish and operate Project Management Units	✓	✓	✓	✓	✓
		b) Implement regional activities through SPC					✓
		c) Engage UNICEF to provide hands-on implementation support and coordination					✓

The activity typology for the PHIT Project is outlined in Table 2:

Table 2: Project activity typology

Activity type	Activities	Description and inclusions	Fiji	Kiribati	Tonga	Tuvalu	SPC
Infrastructure investments	Construction of new tertiary healthcare facility	**1.3:** Construction of offsite expansion of CWM Hospital in Suva, Fiji. Major Engineer-Procure-Construct (EPC) civil works.	✓				

Activity type	Activities	Description and inclusions	Fiji	Kiribati	Tonga	Tuvalu	SPC
	Renovation and refurbishment of existing tertiary healthcare facility	**1.3:** Renovation, refurbishment and/or re-development of the CWM Hospital in Suva, Fiji. Significant re-development works involving demolition, EPC and replacement/installation of medical equipment.	✓				
	Upgrade local PHC facilities and/or nursing schools	**2.1:** Repair, renovate or replace PHC clinics and training facilities, principally in Fiji but also to outer and remote islands of other PHIT countries. May include deployment of new modular flatpack buildings with integrated services (solar, battery, wastewater treatment) for remote sites.	✓	✓	✓	✓	
Digital infrastructure	Digital infrastructure (hardware)	**1.1, 1.2, 2.1, 2.2**: Equip healthcare, PHC and training facilities with necessary digital infrastructure and equipment for telehealth, secure data management, eLearning, accreditation and coordination.	✓	✓	✓	✓	✓
Technical assistance	Policy and regulatory reform, program implementation	**1.1, 1.2, 1.3, 2.1, 3.1:** Various streams of technical assistance, which may include: • Development of needs-based regional curriculum guidelines • Development of electronic healthcare worker registries • Support for national institutions to adopt and implement changes • Policy reforms to increase scope of practice for different levels of PHC workers • Development of coherent and transparent healthcare career pathways • Alignment of regulatory and liability policies to enable cross-border care • Establishment of regional registries of specialists for telehealth • Design and implementation of EHR and screening program integrated into national HIS • Strengthening of health system resilience and workforce capacity building • Support for strategic transition planning for expansion of tertiary healthcare facilities • Support for implementation of Fiji's standards-based national digital health architecture • Establishment and operation of PMUs and COEs	✓	✓	✓	✓	✓
	Policy reform involving downstream risks	**1.1, 1.2, 1.3, 2.1, 3.1:** Various streams of technical assistance for policy reform involving potential downstream risks, which may include:	✓	✓	✓	✓	✓

Activity type	Activities	Description and inclusions	Fiji	Kiribati	Tonga	Tuvalu	SPC
		• Expansion and strengthening of community-based health surveillance • Development of secure cross-border data-exchange protocols • Establishment and dissemination of quality standards, including clinical guidelines, protocols, and climate resilient care pathways for national OMR • Establishment of ethical engagement standards for vulnerable populations • Update of screening, risk assessment, diagnosis, treatment and referral protocols for hypertension and diabetes • Assessment of gaps in HR, infrastructure, medicines & technologies for NCDs • Development of governance for standards-based digital health architecture					
	Digital platforms and content	**1.1, 1.2, 2.1, 2.2**: Technical assistance for digital transformation of the regional healthcare ecosystem through the development of various digital platforms, which may include: • Digital Learning Management System, • Digital platforms for eLearning Hubs • Regional electronic health worker registries • Telehealth networks of excellence and registries • AI-based diagnostic support application • Secure cross-border data-exchange mechanisms • Cross-sectoral health early-warning system (Fiji only) • Digitally aided health outreach system (Fiji only)	✓	✓	✓	✓	✓
	Health outreach programs	**2.2:** Local PHC- and community-based health outreach activities supported by digital technologies.	✓				
	Training	**1.1:** Training of healthcare staff for re-accreditation at existing training facilities and/or using new or upgraded facilities, which may include: • Training for professional accreditation involving movement of staff across borders • Training in systems involving sensitive personal data and diagnostic tools	✓	✓	✓	✓	✓

3. RELEVANT ENVIRONMENTAL AND SOCIAL CONTEXT

3.1. Regional project context

Pacific SIDSs have reached catastrophic levels of non-communicable diseases (NCD), which are responsible for the majority of overall mortality and disability in the Pacific. Healthcare systems in the region are neither appropriately structured nor equipped to prevent and manage the alarming disease burden. In isolation, small island states cannot offer the services needed to meet the population disease burden.

Healthcare systems in the Pacific are ill-equipped to prevent, screen, and manage the escalating NCD burden. Global evidence clearly points to the importance of the primary level of care to prevent and manage NCDs. However, across Pacific SIDSs, PHC systems are weak, characterised by poorly coordinated patient pathways and inadequate resources, resulting in low rates of preventative measures, systematic screening, and inadequate treatment for NCDs. Infrastructure is often limited, lacking essential diagnostic supplies and equipment. This manifests in poor clinical management and high rates of complications. Data on the quality of care are limited, but available evidence suggests significant breakpoints in the NCD care cascade resulting in poor control of conditions like diabetes and cardiovascular diseases. Across Pacific SIDSs, control of hypertension is at very low levels, at 5 percent or less. Pacific SIDSs do not have the capacity to manage the resulting complications of poor control and the number of NCD-related referrals to tertiary care is projected to increase.

This challenge is amplified by climate change, geographic isolation, and limited resources, making a regional approach not only beneficial but essential for effective intervention.

The PHIT project will support the uplift of a regional platform for improving health outcomes. Fiji, which serves as a crucial medical hub in the region, will be the initial focus, coordinated with linked activities in Kiribati, Tonga and Tuvalu, and potentially other Pacific SIDSs via SPC.

3.2. Fiji

Fiji comprises an archipelago of more than 300 islands, of which 110 are permanently inhabited. It has a population of approx. 924,000 (2023) people distributed over a total area of 18,273 km², with an annual population growth rate of 0.5%[1]. The population is concentrated on the islands of Viti Levu and Vanua Levu, which together account for about 87% of the total population. Fiji is an economic, political, and social leader across the South Pacific and, given its geographical location, an important hub for transport and many other services in the region.

Demographics. The Indigenous Peoples of Fiji, the iTaukei, represent the mainstream society in Fiji, comprising 63% of the population[2], while 32% of the population are Indo-Fijian (of Indian descent). iTaukei customary cultural, economic, social and political institutions are the mainstream culture of Fijian society. The remaining <5 percent consist of other minority communities, including people from various Pacific Island countries, Australia, New Zealand, the People's Republic of China, and Europe.

Poverty. Fiji is classified as an upper middle-income country (UMIC) and, although it shares the constraints of a small population, remoteness, and vulnerability to natural disasters, it is relatively more developed and larger than most other Pacific SIDSs. Although Fiji has a lower rate of extreme poverty (ca. 1.3%; 2017 PPP) and inequality (Gini index: 30.4) than other Pacific SIDSs and is comparable on this basis with other UMICs, living standards in Fiji are below the UMIC average, with a

lower-middle income poverty rate of 12.4% and upper-middle income poverty rate of 52.6% (nearly double the UMIC average of 23.5%)[3]. It has a 'High' rating of 0.731 on the UNDP Human Development Index[4]. Life expectancy at birth is 73.1 years for women and 67.1 years for men; mean years of schooling is >15 years[5]. Note, however that most indicators are based on pre-COVID data and appreciable changes to these indicators are possible.

Economy. Fiji has a diversified economic base compared to other Pacific Island nations, with tourism, remittances, and agriculture serving as the main pillars of the economy. Tourism is the leading economic activity, contributing 24.4% to GDP in 2019, with over 960,000 visitors (excluding cruise passengers) generating more than $300 million in foreign exchange[6]. The services sector dominates the economy, accounting for the majority of economic activity and leading the post-pandemic recovery with a 7.4% contribution to growth in 2023[7]. Agriculture remains important for subsistence livelihoods, with 67% of the labour force engaged in subsistence agriculture, while sugar exports continue as a traditional foreign exchange earner alongside emerging sectors like gold mining. The economy recorded a GDP of $5.44 billion in 2023, with growth projected at 3.8% for 2024 following strong rebounds of 19.8% in 2022 and 7.5% in 2023[8]. GDP per capita stands at approximately $6,202 (2018), placing Fiji among the more developed Pacific economies. However, economic development faces significant constraints including heavy reliance on imports, vulnerability to natural disasters, labour shortages due to emigration (with around 15% of the workforce migrating abroad), and a narrow export base[9]. Remittances play a crucial role, contributing 9.68% of GDP, while foreign aid and development assistance provide essential support for infrastructure and social programs[10]. Australia remains Fiji's largest bilateral development partner, contributing 23% of total Official Development Finance between 2008-2022, followed by the Asian Development Bank (18%), World Bank (12%), Japan (11%), and China (11%). Public debt has risen significantly from pre-pandemic levels, reaching 80.4% of GDP at end-2023, down from a peak of 91.5% in 2021, with the IMF recommending continued fiscal consolidation to reduce the debt-to-GDP ratio to 50% by 2034[11].

Environment. Fiji faces significant environmental challenges including coral reef degradation, mangrove loss, deforestation, and pollution from coastal development. The nation's coral reefs are severely degraded by overfishing, pollution, sedimentation, and climate-induced bleaching events. In 2000, bleaching caused the Suva barrier reef to lose approximately 30% of coral cover and 45% of coral colonies[12]. Mangrove ecosystems covering 65,243 Ha experienced a loss of 1,135 Ha between 2001 and 2018 at an annual rate of 0.11%, with tropical cyclones accounting for 77% of losses[13]. Forest cover, at 977,000 Ha (54% of land area), continues to decline through agricultural expansion and unsustainable logging practices[14]. Environmental controls exist under the Environment Management Act 2005 and associated EIA Process Regulations 2007[15], requiring environmental impact assessments for development proposals with potential environmental impacts. However, enforcement remains challenging, with ongoing issues of unsustainable coastal development, inadequate waste management, and pollution from agricultural runoff containing fertilizers and chemicals that damage coral reefs[16]. Furthermore, the destruction of mangroves through clear cutting, conversion to aquaculture, and use as rubbish dumps continues despite their critical role in coastal protection.

Vulnerabilities. Fiji is exposed to regular tropical cyclone activity (average one per year) and is highly vulnerable to such impacts (e.g. Tropical Cyclone Winston in 2016 caused damage and losses equivalent to 29.2% of GDP).

Health. Fiji's health expenditure budget accounts for 3.8% of GDP[17]. The nation has below-average access to physicians (8.4 per 10,000 people)[18], a moderate infant mortality rate of 17.4 per 1,000 births[19], and faces significant challenges with non-communicable diseases. The doctor-patient ratio remains an ongoing challenge, with shortages particularly acute in rural areas and outer islands. Fiji's

population is subject to chronic health conditions having recorded increasing cases of tuberculosis (at 66 cases per 100,000 population in 2022)[20] and one of the world's highest diabetes prevalence rates in the Pacific. Other health conditions which place a demand on the existing health sector and families include hypertension, heart disease (responsible for 472 deaths annually), cancer, stroke, chronic kidney disease, obesity, and outbreaks of dengue fever predominantly affecting urban areas[21]. Furthermore, approximately 27% of the adult population are smokers, with particularly high rates among i-Taukei men[22].

Challenges relevant to the Project. Sustainable and inclusive growth in Fiji is held back by low levels of private investment and reliance on public investment to drive economic growth, limited access to quality services and economic opportunities caused in part by infrastructure deficits, and vulnerability to climate and disaster risks and other external shocks that erode fiscal buffers and cause economic volatility. With the recent change of government in Fiji has come a reform of portfolios and policies, and an ongoing review of executive, legislative, regulatory and policy arrangements related in particular to the management of public health services and environmental and social matters associated with construction and approvals. This has the potential to affect the approval processes and legislative requirements related to the PHIT Project and its activities.

3.3. Kiribati

Kiribati comprises 33 coral atolls and one raised coral island (Banaba) scattered across an area of ocean equivalent to the continental United States. It has a population of approximately 135,800 (2024) people distributed over a total land area of 811 km², with an annual population growth rate of 1.7%[23]. The population is concentrated in the Gilbert Islands, with over 52% living on South Tarawa, the capital atoll.

Demographics. The Indigenous Peoples of Kiribati, the I-Kiribati, comprise over 90% of the population, representing a relatively homogeneous Micronesian society[24]. The I-Kiribati speak Gilbertese (an Oceanic language) as the primary language, though English is also official. Of the 33 islands, only 21 are permanently inhabited, with the Phoenix Islands uninhabited except for sparsely populated Canton Island, and several Line Islands uninhabited. The median age is 22.9 years, reflecting a young population structure typical of developing Pacific island states[25].

Poverty. Kiribati is classified as a least developed country (LDC) and one of the least developed Pacific Island countries. Based on the 2019/20 Household Income and Expenditure Survey, 21.9% of the population lives below the national poverty line[25], with a higher proportion in South Tarawa (24.2%) and the Rest of the Gilbert Islands (22.0%). The country has a Human Development Index (HDI) rating of 0.628 (2022), placing it in the medium human development category[26]. Life expectancy varies by source but ranges from 57–67 years for men and 63–73 years for women. Economic development is severely constrained by geographic remoteness, limited natural resources, and vulnerability to climate change impacts.

Economy. Kiribati has one of the narrowest economic bases globally, heavily dependent on fishing licence fees, remittances from seafarers working abroad, and development assistance. The phosphate deposits on Banaba were exhausted by independence in 1979, removing what had been the country's main export earner. The economy remains dominated by the public sector, with government expenditure representing one of the highest ratios to GDP globally. Economic growth has historically struggled to keep pace with population growth, resulting in stagnant real GDP per capita. The Revenue Equalisation Reserve Fund (RERF), established from phosphate earnings, serves as a sovereign wealth fund vital for the country's long-term welfare[27]. Kiribati is highly reliant on remittances (9.68% of GDP)

and on imported goods, and has high unemployment at 30% (54% for youth). Kiribati recorded low levels of internet connectivity, with only 37% of Kiribati's population having access to mobile internet, and the country's total internet penetration being 15%.

Vulnerabilities. Kiribati faces extreme vulnerability to climate change impacts, particularly sea-level rise. With most land areas less than 2–3 metres above sea level (except Banaba at 87 metres), the country is highly susceptible to coastal flooding, saltwater intrusion into freshwater resources, and coastal erosion. Sea levels around Kiribati have risen at 3.9 mm per year since 1992, three times faster than the global average[28]. Two uninhabited islets have already disappeared underwater, and climate projections suggest significant portions of populated areas could be at risk of flooding by 2100, potentially making Kiribati one of the first nations to face large-scale climate displacement. Due to the low level of human development, high inequality, poor healthcare, infrastructure and welfare capacity, Kiribati is highly vulnerable to the impacts of natural disasters and health crises.

Health. Kiribati's health expenditure budget accounts for 12.2% of GDP. The nation has below-average access to physicians (8.4 per 10,000 people), a high infant mortality rate of 53 per 1,000 births, high levels of overcrowding and poor hygiene. Kiribati's population is subject to chronic health conditions having recorded the highest number of cases of tuberculosis (at 421.1 cases per 100,000 population in 2015) and leprosy in the Pacific. Other health conditions which place a demand on the existing health sector and families include Hepatitis B, diabetes (at 15.7% in 2015), sexually transmitted disease (STDs), lymphatic filariasis, heart disease, cancer, stroke, hypertension, soil-transmitted helminths and outbreaks of diarrhea predominantly affecting children under 5 years and the elderly. Furthermore, more than 54% of the population are smokers.

Challenges relevant to the Project. Health sector gaps including unsatisfactory care practices, limited bed capacity, shortages in medical supplies, and limited health and financial resources. Limited availability of water, sanitation and hygiene facilities contribute to poor health and impacts in women, children and the elderly. The nation incurs high costs and pressures associated with managing the ongoing impacts of climate change including migration with dignity, loss of land and relocations. Other challenges include elevated levels of unemployment and crime, rising pressures experienced by women including increased workloads as family carers, formal and informal job losses, and rising rates of gender-based violence (GBV), and long-term health and resilience of vulnerable groups (youth, infant mortality, the ill, remote).

3.4. Tonga

Tonga comprises an archipelago of 171 islands (of which 36 are inhabited) scattered across 700,000 km² of ocean in the southwestern Pacific Ocean. It has a population of approximately 104,000 (2024) people distributed over a total land area of 747 km², with an annual population growth rate of 0.85%[29]. The population is concentrated on the main island of Tongatapu (over 70%), which includes the capital Nuku'alofa.

Demographics. The Indigenous Peoples of Tonga comprise over 98% of the population[30]. The Tongan people speak Tongan (a Polynesian language) as the primary language, although English is also widely spoken and used in education and business. The remaining population consists of Europeans (primarily British), mixed Europeans, and other Pacific Islanders. The median age is 20.8 years, reflecting a young population structure typical of developing Pacific island states[31]. Since the 1970s, large-scale emigration has occurred, with over 150,000 people of Tongan descent now living abroad, primarily in New Zealand, Australia, and the United States.

Poverty. Tonga is ranked 98th out of 193 countries in the UNDP Human Development Index, with a score of 0.739 (2022), placing it in the high human development category[32] and amongst the highest in the Pacific region. Life expectancy at birth is 73.1 years, with mean years of schooling exceeding 15 years[33]. The country maintains relatively high indicators of education and health compared to other Pacific nations, with adult literacy reported near 99%[34].

Economy. Tonga has one of the narrowest economic bases globally, heavily dependent on remittances from the diaspora, development assistance, and tourism. Agriculture contributes 30% to GDP (agricultural exports making up two-thirds of total exports), with squash, coconuts, bananas, and vanilla beans as the main crops[35]. The economy remains dominated by the public sector, with government expenditure representing one of the highest ratios to GDP globally. Economic growth has historically struggled to keep pace with population growth, resulting in a GDP per capita of approximately $5,600 (PPP)[36]. The country recorded a GDP of $0.50 billion in 2022. Tonga is highly reliant on remittances (accounting for a significant portion of GDP) and on imported goods. Economic development is constrained by geographic remoteness, limited natural resources, heavy dependence on remittances and foreign aid, and vulnerability to natural disasters.

Environment. Tonga faces significant environmental challenges including coral reef degradation, mangrove loss, and limited deforestation controls. The nation's coral reefs, which provide storm protection valued at $11 million annually, are threatened by multiple stressors including overfishing, pollution, coral bleaching events, and crown-of-thorns starfish outbreaks[37]. Coral reefs near populated areas experiencing significant anthropogenic threats including destructive fishing practices and increased siltation from coastal development. Mangrove ecosystems face ongoing threats from unsustainable harvesting for tannins used in traditional tapa making, cutting for firewood and building materials, and coastal development. Environmental controls remain limited despite the existence of the Environmental Impact Assessment Act 2003 and associated regulations[5]. While the EIA regulations require permits for development projects, enforcement remains weak, with the current protected area network poorly enforced and covering minimal forest areas[38]. The 2022 Hunga Tonga-Hunga Ha'apai volcanic eruption caused extensive environmental damage, burying coral reefs under volcanic ash deposits and potentially causing acid rain damage to vegetation. Furthermore, Tonga has minimal remaining natural forest cover, with most original forest having been removed for timber, firewood, or agricultural expansion over the past 25-50 years[39].

Vulnerabilities. Tonga faces extreme vulnerability to climate change impacts and natural disasters. Despite less frequent disasters compared to other Pacific Island countries, Tonga experiences high economic shock during disaster years, with over 40% of the population affected and economic losses equivalent to 14% of GDP in a typical disaster year[40]. The country is highly susceptible to volcanic activity, earthquakes, tropical cyclones, and tsunamis. Sea levels around Tonga are rising, with coastal areas facing increased frequency of inundation[41]. With most populated areas of Tongatapu at only 1–2 m above sea level and 90% of people living within 5 km of the coast, the country faces significant long-term threats from sea-level rise and coastal flooding[42].

Health. Tonga's health expenditure accounts for approximately 5% of GDP[43]. The nation has limited access to physicians (5.6 per 10,000 people)[44], a moderate infant mortality rate (9.9 deaths per 1,000 live births)[45], and faces overwhelming challenges with non-communicable diseases. Tonga's population faces an extreme burden of chronic health conditions, with 99.9% of adults at moderate to high risk of developing NCDs[46]. About 80% of deaths are due to NCDs (compared to the global average of 70%), including cardiovascular disease, diabetes (affecting one-third of the population), cancer and stroke. Other health challenges include one of the world's highest obesity rates (48.2% of adults), high

smoking prevalence (48% among men, 14% among women)[47], and the dietary transition from traditional foods to imported processed foods.

Challenges relevant to the Project. Health sector challenges include the overwhelming burden of NCDs, limited medical infrastructure and workforce, heavy reliance on donor funding, and geographic isolation of outer islands affecting healthcare access. The nation faces extreme vulnerability to natural disasters and climate change impacts, with high costs associated with disaster response and recovery. Other challenges include high unemployment (particularly among youth), heavy dependence on remittances and foreign aid, limited economic diversification, rising sea levels threatening coastal communities, and the need to balance traditional governance structures with democratic reforms.

3.5. Tuvalu

Tuvalu comprises nine coral atolls and reef islands with a total land area of only 26 km², forming one of the world's smallest and most isolated nations. It has a population of approximately 9,816 (2023), with an annual population growth rate of –1.7%[48]. The population is heavily concentrated on the capital atoll of Funafuti (over 60%), with the remaining population distributed across eight other inhabited islands. Tuvalu is positioned halfway between Hawaii and Australia and gained independence from the United Kingdom in 1978, making it one of the youngest sovereign states in the Pacific.

Demographics. The Indigenous Peoples of Tuvalu comprise over 96% of the population. The Tuvaluans speak Tuvaluan (a Polynesian language closely related to Samoan) as the primary language, although English is also an official language and widely used in education and government. The median age is 24.2 years, reflecting a relatively young population structure. Approximately 97% of the population belongs to the Congregational Christian Church of Tuvalu, making it one of the most religiously homogeneous nations globally[49]. Population density is exceptionally high at approximately 408 people per km², making Tuvalu one of the most densely populated countries in the world.

Poverty. Tuvalu is classified as a Least Developed Country (LDC) by the United Nations, although it maintains relatively high social indicators compared to other LDCs. Approximately 26% of Tuvalu's population lives below the national poverty line[50]. The World Bank classifies Tuvalu as an upper-middle-income economy, with a GNI per capita of approximately $8,420 (2023). Adult literacy rates approach 99%, reflecting the country's commitment to education, and life expectancy is approximately 65-67 years. However, economic opportunities remain severely constrained by geographic isolation, limited natural resources, and vulnerability to external economic shocks.

Economy. Tuvalu has one of the world's most constrained economic bases, heavily dependent on fishing, fishing licence fees, remittances from overseas workers (particularly seafarers comprising ~15% of the adult male population), revenue from the .tv internet domain, and development assistance. Fishing licence fees, particularly from the South Pacific Tuna Treaty, are a significant source of government revenue. The Tuvalu Trust Fund, established in 1987 with contributions from Australia, New Zealand, and the UK, provides approximately 16% of the annual government budget and serves as a critical economic buffer. Unemployment remains high at 24% (2017), with particularly severe youth unemployment and limited formal employment opportunities outside the public sector[51]. The public sector dominates formal employment, accounting for approximately 65% of wage employment.

Environment. Tuvalu faces existential environmental challenges, primarily from climate change impacts including sea-level rise, coastal erosion, and saltwater intrusion. The country's maximum elevation is only 4.6 m above sea level, making it extremely vulnerable to rising seas[52]. Sea levels

around Tuvalu have risen by approximately 15 cm over the past 30 years, at a rate 1.5 times faster than the global average[53]. Climate change effects include contamination of freshwater supplies, soil degradation affecting traditional crops like taro and breadfruit, and increased frequency of king tides that flood infrastructure including the international airstrip. Coral reef degradation threatens both coastal protection and fisheries resources essential for food security and traditional livelihoods.

Vulnerabilities. Tuvalu faces extreme vulnerability as one of the world's most climate-threatened nations. Sea-level rise projections suggest that much of the country's critical infrastructure will be below average high tide levels by 2050, with 95% of land projected to be flooded by routine high tides by 2100 without adaptation measures[54]. Cyclones expose the nation to catastrophic economic losses, with Cyclone Pam in 2015 causing damages exceeding 25% of GDP[55]. The country's economic base remains extremely narrow and vulnerable to external shocks, including fluctuations in global fishing markets, shipping demand affecting seafarer employment, and volatility in financial markets affecting the Trust Fund. Geographic isolation limits economic diversification opportunities and increases dependency on imported goods, with food imports representing approximately 19% of GDP.

Health. Tuvalu's health expenditure accounts for 19.7% of GDP (2013), among the highest proportions globally[56]. Healthcare is government-funded and free for all citizens, with legislation prohibiting private medical services. The country has one hospital, Princess Margaret Hospital on Funafuti, providing basic primary care, dental, and pharmaceutical services, supported by eight health centres on outer islands staffed by trained nurses. Tuvalu meets the WHO recommended ratio of 2.5 health professionals per 1,000 citizens, though it lacks specialised medical professionals, requiring overseas medical referrals to Fiji and New Zealand for advanced treatments[57]. Non-communicable diseases account for 74% of mortality, with cardiovascular diseases (38%), diabetes, cancer, and respiratory diseases being the leading causes of death[58]. There is a high prevalence of tuberculosis (327 cases per 100,000 recorded in 2013) and diabetes (5%), as well as elevated HIV/AIDS and chlamydia prevalence. The country faces significant health challenges including one of the world's highest obesity rates (65% of men, 71% of women), high smoking prevalence (54% of the population), and increasing rates of diabetes and hypertension linked to dietary changes from traditional to processed foods. Climate change impacts health through increased diarrhoeal diseases from contaminated water, vector-borne diseases, and respiratory infections during drought periods.

Challenges relevant to the Project. Key challenges for Tuvalu include severe healthcare workforce constraints with shortages of specialised medical professionals requiring costly overseas referrals that strain government budgets. The single hospital and limited medical infrastructure struggle to meet population needs, particularly for complex medical cases. High unemployment, especially among youth (32% employment-to-population ratio for ages 15-24), limits economic opportunities and household capacity to contribute to healthcare costs[59]. Geographic isolation results in extremely high costs for medical equipment, pharmaceuticals, and specialist services. Climate change poses escalating threats to health infrastructure and freshwater supplies essential for sanitation and health service delivery. Limited government fiscal capacity constrains ability to fund healthcare initiatives, with heavy reliance on volatile revenue sources including fishing licence fees and external development assistance. Population concentration on Funafuti creates healthcare access disparities for outer island residents who must travel to the capital for most medical services, imposing significant travel costs and time barriers.

UNICEF's recent Situation Analysis of Children in Tuvalu Report found that around 10% of children under 5 years are stunted, childhood wasting prevalence stands at 3%, nearly 50% of school children aged 13–15 were considered overweight, and approximately 21% obese. Tuvalu's 2018 Study on People with Disability[60] estimated that approximately 4 percent of the population has a disability with

many people having more than one disability, almost half of whom said that their disability prevented them from participating in family and community events, largely due to physical barriers and health facilities were inaccessible.

4. ENVIRONMENTAL AND SOCIAL LEGAL FRAMEWORK

4.1. Fiji

4.1.1. Overview of relevant policies, regulations and laws

This section covers Fiji's environmental and social policies, regulations, and laws relevant and directly applicable to the environmental and social risks and impacts of PHIT subproject activities in Fiji, which include:

- Major civil works for CWM Hospital upgrade and expansion
- Repair/upgrade of local PHC clinics
- Digital platform and content development
- Regional healthcare policy alignment and reforms
- Health outreach programs
- Healthcare workforce training

Table 3: Summary of policies, regulations and law relevant to the management of E&S risks for the Project

Policy, regulation or law	Description and relevance to project activities
Constitution	The Constitution of Fiji contains various provisions relevant to management of E&S risks for the PHIT project, including: Clause 24. Right to privacy (confidentiality of personal information) Clause 25. Access to information (particularly with regard to persons) Clause 26. Right to equality and freedom from discrimination (no unfair discrimination) Clause 27. Freedom from compulsory or arbitrary acquisition of property (no law may permit arbitrary acquisition) Clause 28. Rights of ownership and protection of iTaukei, Rotuman and Banaban lands (no permanently alienation except under laws consistent with c. 27). Clause 38. Right to health (State must take reasonable measures within its available resources to...the...realisation of the right of every person to health, and to the conditions and facilities necessary to good health, and to health care services) Clause 42. Rights of persons with disabilities (reasonable access to all places, appropriate means of communication, reasonable access to necessary materials)
Environmental Management Act 2005 (2020 Amendment) and supporting regulations	The *Environment Management Act* is the primary legislation for environmental management in Fiji, supported by the *Environment Management Regulations*, and administered by the Ministry of Waterways and Environment (MOWE) / Department of Environment (DoE). Of particular relevant to the PHIT is Part 4 of the Act, which sets out the requirements for Environmental Impact Assessment (EIA) of any proposed development activity that is likely to cause significant impact on the environment (see section 4.1.2).

Policy, regulation or law	Description and relevance to project activities
Town Planning Act 1946 (2022 Amendment) and supporting regulations	The *Town Planning Act* includes provisions for the public presentation of proposed town planning schemes (including e.g. the proposal for a hospital premises and/or district) and appropriate mechanisms for feedback, objections and appeals prior to approval by the Director of Town and Country Planning (Part 2). Part 5 of the Act also sets out provisions for the purchase or compulsory acquisition of land.
Building Permits Act 2017 and supporting regulations	The Act and supporting regulations provides for the issuance of Development Permission and Building Permits for building, rebuilding or repairing a building.
National Asbestos Management Framework	A national framework guiding the safe collection, transport and disposal of asbestos materials.
Rights of Persons with Disabilities Act 2018	Part 6 of this Act sets out the laws governing discrimination on the basis of disability and the rights of persons with disabilities.
Medicinal Products Act 2011	Part 9 of this Act states that "It shall be an offence for any person to sell, import, manufacture or export a device that is not placed on the Registered Devices Register or Provisionally Authorised Devices Register or in contravention of any conditions imposed by the Board". Medical devices (including clinical therapeutic equipment) are treated under this Act equivalently to medicinal products, requiring registration and approval by the Fiji Medicinal Products Board via due process as provided for under the supporting regulations.
Employment Relations Act 2007	This Act covers recruitment, conditions of employment as well as health and safety aspects. It is administered by the Department of Labour and Employment.
Health and Safety at Work Act 1996	This Act covers the health and safety of works and is administered by Ministry of Employment, Productivity & Industrial Relations
Preservation of Objects of Archaeological and Palaeontological Interest Act 1940	This Act empowers the Fiji Museum to declare any area of land in which any objects of archaeological interest are believed to exist as a monument.
CWM Hospital Master Plan	The CWM Hospital Master Plan is an initiative of the Government of Fiji to guide the refurbishment and upgrade of the CWM Hospital. As part of that initiative, a Priority Infrastructure Plan (PIP) was developed to identify a list of priority projects to address the most urgent infrastructure issues at CWMH in the short to medium term, allowing for continued delivery of medical care while a new or redeveloped hospital is procured. The PIP has identified and costed 27 priority projects related to potable and hot water supply, fire and egress, cyclone compliance and structural repairs, hygiene control, and sewerage, with a total estimated cost of FJ$63 million. DFAT has committed FJ14.5 million to start the refurbishment process.
National Development Plan (2025–2029)	The Ministry of Economy (MoE) National Development Plan (NDP) outlines Fiji's development strategy for the next 5 years. Under the theme of healthcare, the NDP set out an objective to modernise and improve the quality of Fiji's health delivery system as a fundamental platform for reducing NCDs, while meeting the expectations of healthcare service users.

Policy, regulation or law	Description and relevance to project activities
	Commitments under the NDP relevant to the PHIT project include: • Establish Fiji-wide programmes to control the rate of premature deaths due to NCDs • Provide high quality and comprehensive life cycle healthcare including maternal, infant, child and adolescent health family planning and sexual education, and parenting programmes • Improve healthcare literacy and public healthcare awareness Provide access to clinical healthcare services to all Fijians • Expand primary healthcare, with an emphasis on providing a continuum of care and improved service quality and safety • Enhance the effectiveness of healthcare management and delivery system • Modernise and maintain health delivery systems and infrastructure to meet increased demands for quality health services The stated 5-year objectives of the NDP are to reduce maternal mortality by 48%, infant mortality by 45%, and under-5yr mortality by 46%, and increase skilled healthcare workers per 10,000 population by 26%.
Republic of Fiji National Adaptation Plan (2018)	Section 13: Health. 13.3 Retrofit the existing and installing innovative structures, energy and water supplies; medicines and equipment efficiency that guarantees safety and enable lifesaving support through the application of relevant legislations, policies and other reviewed standard health building designs and ensure such legislations, policies and designs are used for new health facilities to prevent vulnerability to CC impacts
MHMS Strategic Plan (2020–2025)	This Strategic Plan sets the strategic direction for the Ministry based on a one system approach, including • Reform public health services to provide a population-based approach for diseases and the climate crisis, by ◦ Reducing communicable disease and non-communicable disease prevalence ◦ Improving physical and mental well-being ◦ Safeguarding against environmental threats and public health emergencies ◦ Strengthen population-wide resilience to the climate crisis • Increase access to quality, safe and patient-focused clinical services, by ◦ Improving patient health outcomes, particularly for women, children, young people and vulnerable groups ◦ Strengthening and decentralising effective clinical services ◦ Improving patient safety, and quality and value of services • Drive efficient and effective management of the health system, by ◦ Cultivating a competent and capable workforce ◦ Improving the efficiency of supply chain management and procurement systems ◦ Ensuring infrastructure is maintained ◦ Harnessing digital technologies ◦ Strengthening planning and governance ◦ Widening collaboration with partners for a more efficient, innovative and higher-quality health system

4.1.2. Environmental management

Environmental management in Fiji is provided through the *Environment Management Act 2005* (the EMA) and the accompanying regulatory instrument, the *Environment Management (Waste Disposal and Recycling) (Amendment) Regulations 2011* (EM Regulations). Both are administered by the Department of Environment (DOE) within the Ministry of Environment and Climate Change under Minister Hon. Mosese Bulitavo and Permanent Secretary Dr Sivendra Michael.

The EMA provides for an integrated system of development control, environmental assessment, and pollution control. Part 1, Section 3 of the Act states the purpose of the EMA, which is to

1) apply the principles of sustainable use and development of natural resources and
2) identify matters of national importance for the Fiji Islands, identified in Section 3(3) as:
    a) The preservation of the coastal environment, margins of wetlands, lakes and rivers;
    b) The protection of outstanding natural landscapes and natural features;
    c) The protection of areas of significant indigenous vegetation and significant habitat of indigenous fauna;
    d) The relationship of indigenous Fijians with their ancestral lands, waters, sites, sacred areas and other treasures;
    e) The protection of human life and health.

Part 2 of the EMA establishes a National Environmental Council and outlines the functions, duties and powers of the Council and the Department.

Part 4 of the EMA requires that any proposed development activity that is likely to cause significant impact on the environment must undergo an environmental impact assessment (EIA) process which includes screening, scoping, preparation, reviewing and decision-making. EIA is a formal study used to predict the environmental consequences of the proposed development, encompassing all aspects of the natural and human environment. Section 32 of the EMA states that a condition of any approved EIA must be that proponents are required to prepare and implement any environmental or resource management plan, monitoring program, protection plan or mitigation measure, which may be subject to inspection by the EIA administrator, or an approving authority. When the preparation of an EIA assessment is completed, a public hearing must be conducted by the proponent within the vicinity of the area of the proposed development.

The EIA process is provided in Figure 2.

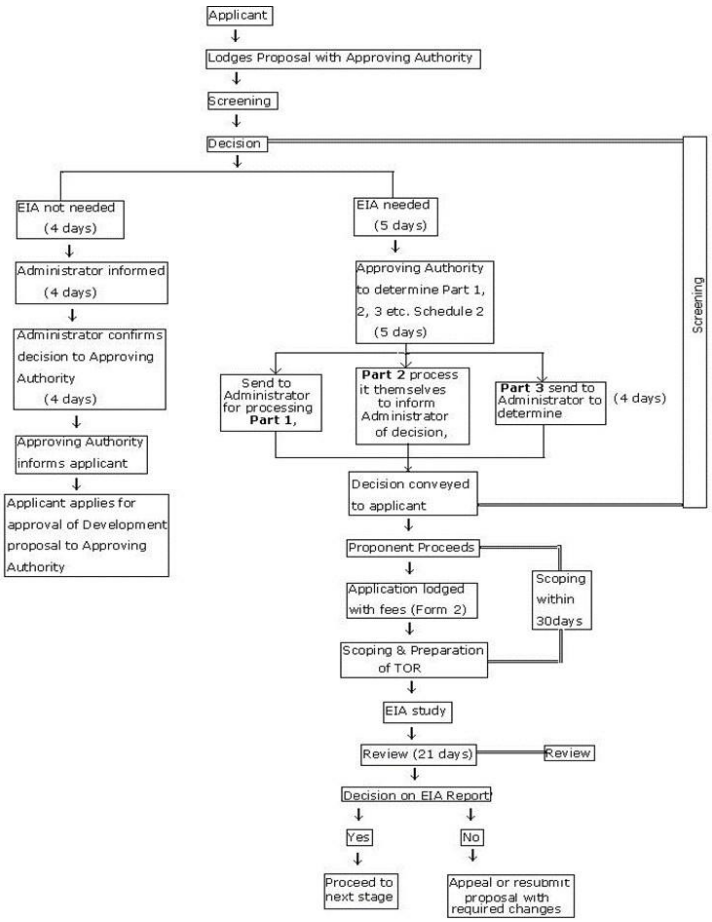

Figure 1: Flow diagram of EIA procedure in accordance with the Environment Act (2005) and Environment Management Regulations (2007)[61].

After an EIA application is approved, the proponent is required to submit a Construction Environment Management Plan (CEMP) that must be approved by the Department of Environment before any construction (including earthworks) can commence[6].

Most classes of activities that impact key environmental components, such as erosion of land, degradation of waters or the loss of species, are to be assessed by the EIA Administrator[62].

Relevance to PHIT Project. Project activities with the potential to be assessed under Fiji's EIA provisions include:

- Construction of a new hospital on a yet-to-be-selected site in Suva, Fiji
- Refurbishment and/or renovation of the CWM Hospital and PHC facilities in Fiji

The classification of these activities under the EIA Guidelines is provided in Table 4.

Table 4: Classification of PHIT project activities with respect to EIA requirements

Project activity	EIA category
Construction of a new hospital in Suva, Fiji	Expected to be **Required** under Category 1 (approval by MoE Administrator): (b) a proposal that could result in the pollution of any marine waters, ground water, freshwater body or other water resource (k) a proposal that would introduce pollutants or properties to the air that are disagreeable or potentially harmful to people and wildlife (l) a proposal that could jeopardise the continued existence of any protected, rare, threatened or endangered species or its critical habitat or nesting grounds (n) a proposal that could harm or destroy designated or proposed protected areas including, but not limited to, conservation areas, national parks, wildlife refuges, wildlife preserves, wildlife sanctuaries, mangrove conservation areas, forest reserves, fishing grounds (including reef fisheries), fish aggregation and spawning sites, fishing or gleaning areas, fish nursery areas, urban parks, recreational areas and any other category or area designated by a written law (s) a proposal that is controversial from an environmental standpoint, or is not supported for environmental or resource management reasons by a significant number of representatives from the local community, local government, churches, villages and other groups (w) **a proposal financed by an international or local development finance institution and which requires an EIA as a condition of the finance** **Note:** Although civic or community development (including a hospital or health care centre) is identified under Category 2(d), requiring processing only by the Approving Authority, the potential E&S risks and impacts of the new hospital development warrant a Category 1 EIA approved by the MoE Administrator to be required under clause (w) as a condition of finance.
Refurbishment and/or renovation of the CWM Hospital and PHC facilities in Fiji	May be **Required** under Category 2 (approval by Approving Authority): (d) A proposal for civic or community development (including a hospital or health care centre) **Note:** IEA screening recommended to be completed for all renovation projects.

Environment Management (EIA Process) Regulations 2007 (EIA Regulations), defined under section 61 of the EMA, provides the details of the EIA approval process. The EIA Regulations state:

a) what information must be contained in the application form when a development proposal is submitted for screening;

b) how the approving authority is to screen proposals to decide whether they need an EIA report;

c) how development proposals are to be submitted to the approving authority for EIA processing;

d) if a report is needed, how the terms of reference for the report are drawn up, and what needs to go into the report;

e) how the EIA report is published and reviewed; and

f) how approval of the report is granted or refused.

Schedule 1 of the Regulations contains a number of forms: Form 1 - EIA Screening application; Form 2 - EIA processing application; and Form 3 - Application for registration/renewal EIA/review consultants. Schedule 2 contains the schedule of fees. A proponent who wishes to apply for screening of a

proposal must apply to the approving authority on Form 1 in Schedule 1 to these Regulations and pay the prescribed fee.

The potential environmental impacts of a development proposal are to be identified during the EIA Scoping process. The EIA Guidelines provides a Scoping Checklist as a point of guidance for this scoping process, which includes:

1. Air Quality: Gaseous, dust or odour emissions
2. Noise: Noisy operations, Night time operations
3. Water Quality: Liquid effluent, discharge or contaminated run-off
4. Solid Waste: Generation of waste/spoil materials at the landfill or public fill
5. Land Contamination
6. Ecology: Loss of native species or genetic diversity, deterioration to areas of high conservation value (e.g., with endangered/rare/protected flora and/or fauna species), stress on Ramsar sites, country parks, marine parks/reserves or conservation areas, damage or removal of important habitats (e.g., woodland, wetland, etc.)
7. Fisheries: Jeopardizing the mariculture zones by traveling or operating dredger, discharge close to mariculture zones/fishponds
8. Visual and Landscape: Unsightly visual appearance
9. Sites of Cultural Heritage: Damage to sites of cultural heritage by excavation works, structural vibration of historical buildings or structures
10. Hazards: Explosions, spillage, fires, etc. of hazardous materials during storage, handling, transport or structure, pollution or hazard resulting from risk of accidents

A public consultation process is a mandatory component of Fiji's EIA framework under the EMA, designed to ensure community input and transparency in the environmental assessment process. The proponent must conduct public consultation on the EIA report, including at least one public meeting held in the vicinity of the proposed development. Once submitted, the EIA report enters the review stage, and the DoE makes the complete EIA report available at appropriate locations for inspection by the public (and for purchase). Notice of the publication and review meeting must be given by the proponent on every radio/television station and newspaper that cover the area of the site, in the indigenous and commonly used languages of the area.

4.1.3. Land access and town planning

The laws and regulations governing access to land in Suva, Fiji are complex and involve multiple pieces of legislation.

Ethnic Fijians communally hold approximately 87 percent of all land. Crown land owned by the government accounts for four percent while the remainder is freehold land, held by private individuals or companies.

iTaukei native land may only be leased or licensed with approval from the iTaukei Land Trust Board under the *iTaukei Land Trust Act 1940*. The control of all native land shall be vested in the Board and all such land shall be administered by the Board for the benefit of the Fijian owners. The maximum term of lease that the Board may grant is 99 years. The Act sets out that Native land shall not be

alienated by Fijian owners whether by sale, grant, transfer or exchange except to the Crown, and shall not be charged or encumbered by native owners.

State or Crown Land is administered by the Department of Lands under the *State Lands Act 1945* under the administration of the Director of Lands. State Land is not sold outright but some is available for leasing.

Freehold land ownership and dealings are regulated in Fiji under the *Land Transfer Act 1971*. This legislation establishes a system of indefeasible title using the Torrens System.

The Town Planning Act establishes the framework and system for managing land use and development, including Town Planning Schemes. The Subdivision of Land Act provides the framework for creating and reconfiguring lots, altering boundaries or amalgamating lots, to create allotments.

In areas with an Approved Town Planning Scheme (including Suva), development applications are considered by the local authority. In the case of Suva, the Suva City Council works closely with the Department of Town and Council Planning to process the application.

Land acquisition for public purposes in Fiji is governed under the State Acquisition of Lands Act (SALA). Under the Act, all types of land can be acquired for public purposes. The law provides that in cases of land acquired for public purposes, legal title holders have a right to compensation. The law also provides for the right of land owners to legal proceedings for solving disputes and grievances. The customary rights of indigenous peoples without formal title are also protected.

The SALA guarantees compensation to those with recognized legal rights or interests in land. Compensation is paid at market values effective from the date at which notice of the State's intention to acquire the land is given. Structures are, however, compensated only at book/depreciated values. Compensation includes for land, crops and trees, damage to portions of land not acquired (if any), changes in use and restrictions on use of any unacquired portions – and any reasonable expenses associated with necessary changes of residence or places of business.

Relevance to PHIT Project. Land will need to be acquired for the new hospital site in Suva. The pathway for acquisition will be dependent on the land tenure type. If the land has existing formal or informal use (which is to be expected), additional provisions as set out in a Land Access and Resettlement Plan (LARP) compliant with ESS5 will be required.

4.1.4. Building construction and town planning

The *Regulation of Building Permits Act 2017* provides for the issuance of Building Permits. The purpose of building permits is to certify—for public health and safety—that construction methods are sound. When an application for Development Permission for building or rebuilding is lodged, applicants can also lodge an Application for Permission to Erect, Alter, Re-Build, Add to or Repair a Building, which can be considered simultaneously with the Application for Development Permission. Information (fees and requirements) and forms relating to Building Permits can be obtained at the offices of the respective local authorities. A local authority cannot issue a Building Permit until the Director provides consent to the Application for Development Permission.

Hospitals and health care centres are classified as civic or community developments under Fiji's planning framework. As Suva has an approved Town Planning Scheme, development applications are considered by the local authority (Suva City Council). Depending on the selected site, a hospital may be a Permitted Development (can be approved directly by Suva City Council), a Conditional Development (requires specific conditions or consent from the Director of Town & Country Planning), or a Non-permissible Development (require rezoning). However, the current Planning Schemes for

Suva were prepared more than 30 years ago, and the schemes and policies are broadly considered outdated. New master planning is underway for Suva.

Typical Development Process (Construction Permits):

1. Apply for In-Principle Approval (IPA) to develop the acquired land (in the case of Suva, the Suva City Council will work closely with the Department of Town and Council Planning to process the application)
2. Complete an EIA to be submitted to the Department of Environment for review and approval.
3. Building Plan Approval by National Fire Authority
4. OHS (Occupational Health & Safety) Approval
5. Water and Wastewater Connection Approvals
6. Final Building Permit (commence construction).

Relevance to PHIT Project. The Building Permit process is expected to be relevant to the construction of the new hospital in Suva and associated facilities, and potentially to the renovation of PHC facilities. A full Development Application will need to be made to Suva City Council for the new hospital facility, and may require additional processes such as rezoning, which may lead to E&S impacts. The permissibility of hospital development on any given site can only be made by Suva City Council's Town Planning Department.

4.1.5. Occupational health and safety

The *Health and Safety at Work Act 1996* is the primary legislation for health and safety in Fiji, administered by the Ministry of Employment, Productivity & Industrial Relations (MEPIR). This Act establishes the fundamental framework for workplace safety across all industries, including construction.

The *Health and Safety at Work (General Workplace Conditions) Regulations 2003* supplements the HSW Act, providing detailed requirements for matters such as workplace design, ventilation, lighting, first aid, and personal protective equipment.

Key provisions for construction include:

- Regulation 63 of the GWC states that every building that is used as a workplace shall be of sound construction and kept in a good state so that it does not expose the occupants to unacceptable OHS risks.
- Regulation 64 of the GWC states that the design of any new workplace must be granted prior approval by the Chief Health and Safety Inspector before the rural and local authorities can proceed with the building application.

Under the HSW Act, employers in construction must:

- Provide and maintain safe work environments, machinery, and systems. Ensure safe use, handling, transport, and storage of substances. Provide information, instruction, training, and supervision to employees. Develop OHS risk management plans and procedures. Report and investigate workplace incidents.

The primary agency responsible for enforcing these standards and conducting inspections is the National Occupational Health and Safety Service (NOHSS), which operates under the Ministry of

Employment, Productivity, and Industrial Relations. Inspectors have broad powers to enter workplaces, conduct investigations, issue notices, and prosecute violations.

Compliance Requirements for Construction:

1. OHS Business License: All OHS Business License applications must be lodged with the Ministry of Employment.
2. Safety Management System: In line with these regulations, the Ministry requires that businesses have a Safety Management System (SMS) in place that governs the workplace OHS practices.
3. Design Vetting: The Risk Engineering and Capital Projects Unit is responsible for the vetting of plant and machinery designs gazetted under Schedule 4 of the Health and Safety at Work (Administration) Regulations 1997.
4. Workplace Inspections: Required documents include Company OHS Policy, Company Registration Certificate, NFA Certificate Emergency Evacuation Plan (in compliance to National Building Code of Fiji under Public health Act 1935, Health and Safety at Work Act 1996 and NFA Amended Act 2009).

In addition to legislation, Fiji adopts various standards and best practices to guide OHS implementation, including the National OSH Policy, which outlines the government's commitment and strategies for improving workplace safety and health.

Construction companies operating in Fiji must ensure compliance with all these regulations and maintain proper documentation, training records, and safety management systems to meet OHS requirements.

4.1.6. Healthcare and health infrastructure

Fiji has a well-established regulatory and policy framework that provides measures to improving health services. The Ministry of Health and Medical Services (MHMS) is responsible for managing Fiji's overall health care system. The MHMS administers a number of Acts, including the *Public Health Act* (2002), the *Public Hospitals and Dispensaries Act* (1955), and the *Medicinal Products Act* (2011).

The MHMS sets standards through powers delegated to the Minister of Health, and these are enforced and monitored by the various regulatory bodies appointed under the relevant legislation[63].

Whilst there is not a detailed written description of internal Government process pertaining to development, infrastructure and construction of Government Facilities, there is a systematic approval process that needs to be followed in Fiji.

The MHMS has a well-established Asset Management Unit (AMU) that has the responsibility for planning, asset surveys and management, minor and major projects, maintenance and development works and to oversee MHMS facilities.

Any development application before being submitted for building approvals or legislative approvals undergoes an internal vetting process. A working team is formed consisting of recipient division/sub-division and the AMU team. This working team is expected to research and make the recommendations to the Permanent Secretary MHMS for approvals.

Upon approval, the development project seeks the support and assistance of the Ministry of Public Works, Meteorological Services & Transport (MIMS). The application also undergoes a vetting and approval process with the Construction Implementation Unit (CIU) based at the Ministry of Economy.

Relevance to PHIT Project. These processes, while not well-documented, are necessary and mandatory for healthcare-related development projects in Fiji. The timelines for approvals under the CIU may vary from a few weeks to months. These processes will be required to be adhered to when undertaking development and construction under the PHIT project.

4.1.7. Waste management

Management of general, medical, hazardous and infectious waste from existing and new health service facilities will be a major consideration related to construction of the New Pacific Hospital in Fiji under the PHIT project.

A medical waste incinerator was previously commissioned under the Fiji COVID-19 Emergency Response Project (World Bank: P173903). Commissioning of this incinerator is pending but recognised as essential to fulfil waste management requirements of any new or expanded hospital facilities.

The Environment Management (Waste Disposal and Recycling) Regulations 2007 under the Environment Management Act 2005 provides for the management and disposal of waste. The Waste and Pollution Control Administrator is delegated the power to issue permits for solid and liquid waste discharge. The regulations include criteria for the discharge of liquid and solid waste.

Section 4(1) of the regulation's states:

4. – (1) Subject to this regulation, every commercial or industrial facility that disposes of solid waste or pollutant from any of its premises must hold a solid waste permit in respect of the disposal.

5. – (1) Subject to this regulation, every commercial or industrial facility that discharges liquid waste or pollutant from any of its premises must hold a liquid waste permit in respect of the discharge.

Note: No exemption under part 4 of section 4 or 5 is applicable as a new hospital would be regarded as a significant discharger.

6. – (1) Before issuing a liquid waste permit to any facility, the WPC Administrator must, at the expense of the facility – (a) inspect the facility, the surrounding area and the receiving waters, and (b) assess the capacity of the receiving waters to accept a discharge without detrimental effect on the local ecosystem.

A separate waste permit is also required for the construction phase:

8. – (1) A solid or liquid waste permit may relate to either construction or operation of a facility or any premises.

(2) A construction waste permit –

(a) relates to solid or liquid waste and pollutants generated during construction or demolition of premises of a facility; and

(b) lapses upon completion of the construction or demolition work

Any new major healthcare facility will also likely require permitting of air pollution via the same regulations.

Section 14(1) of the regulation states:

14. – (1) Subject to this regulation, every commercial or industrial facility that emits exhaust gases, smoke, steam or dust from any of its premises, must hold an air pollution permit in respect of the emission.

Relevance to PHIT Project. Medical waste related to the CWM Hospital in Suva and its potential expansion requires particular attention under the PHIT Project. The Central Board of Health (CBH), under the Ministry of Health, is responsible for collection, treatment, and disposal of medical waste (including biological, infectious, cytological, pharmaceutical and sharps waste) from the three regional hospitals in Fiji, including the CWM Hospital in Suva. A CBH vehicle collects waste from all the government hospitals around Suva to be incinerated at the CWM hospital (loading capacity of 260 kg per day), the ash from which is then disposed in designated cells at the Naboro Landfill. However, the CWM incinerator is old and inefficient. A new dedicated medical waste incinerator facility at the Naboro Landfill is due to be commissioned by September 2025. The availability of adequate medical waste incineration and disposal capacity will be a key point of consideration in the EIA approval for the hospital expansion. MHMS will follow the Fiji waste permit application process to determine what permits, if any, will be needed for the construction and operation of the new hospital facility.

4.1.8. Labor legislation

Labor legislation relevant to the project is summarised in the Labor Management Framework (LMF).

4.1.9. Data privacy

There is no specific legislation for personal data protection in Fiji, and a unified data privacy framework remains lacking.

The primary legal protection for data privacy comes from Clause 24 of the Constitution (2013), which provides the right to personal privacy, includes right to confidentiality of personal information.

The Constitution guarantees:

- Confidentiality of personal information
- Confidentiality of communications
- Respect for private and family life

While there's no general data protection law, some sector-specific laws criminalise (or expose to other serious action) the unauthorised disclosure by others of personal / client information. Of relevance to the PHIT, this includes:

- Medical and Dental Practitioner Act 2010 - Protects medical data obtained by statutory administrators
- Cybercrime Act 2021 - Cybercrime Act 2021 defines "computer data" which is broad enough to capture personal data if it is stored in a computer system.
- Information Act 2018 - This Act focuses on access to information rather than data protection, providing citizens with rights to access government-held information.
- Online Safety Act 2018 - Addresses online safety issues but is not primarily focused on data privacy.
- Fiji's National Digital Strategy 2025–2030 expresses a strong commitment to enhancing data privacy as part of its foundational focus on cyber resilience and trust, recognising that safeguarding

personal information is essential for digital adoption and public confidence. The strategy explicitly calls for a comprehensive review of the country's data protection framework and prioritizes the development of a Data Protection Legal Framework by 2026, signalling intent to introduce explicit protections for data subject rights, controller obligations, and lawful handling of personal data. These Frameworks are not yet in force.

There is no dedicated data protection authority or regulator overseeing data privacy compliance across all sectors. Common data protection principles found in modern legislation (such as data minimisation, purpose limitation, consent requirements, and data subject rights) are not comprehensively addressed.

Relevance to PHIT Project. Data privacy provisions in Fiji are lax and the provisions set out in this ESMF and subsidiary instruments, which encapsulate best practice reputable jurisdiction, will prevail in the design and management of digital health systems under the PHIT. Further gap and consistency analysis between the ESMF provisions and Kiribati legislation will be undertaken during implementation.

4.1.10. Summary of relevance to project

The elements of Fiji's legal framework applicable to Project activities include:

- The Fiji EIA process must be followed by MHMS to determine what EIA approvals will be needed for the construction of the new hospital and refurbishment of the CWM Hospital. Appropriate town planning, development and building approvals and permits will also be required.
- All health facility and infrastructure projects will require approval via Fiji's Health & Government Infrastructure Approvals Process.
- Construction and/or demolition will generate waste requiring disposal, including potentially hazardous waste (e.g. asbestos, chemical or medical/infectious waste). A solid and/or hazardous waste permit will be required.
- Operation of the new healthcare facilities will produce new streams of general, medical, infectious and hazardous waste requiring relevant waste permits and waste capacity assessment; the new facility will also require a sewerage connection permit and sanitation capacity assessment, and potentially permits related to air, water and noise pollution.
- Data privacy considerations must be designed and implemented in reference to best practice guidance provided in the PHIT project documents and will supersede the limited available Fiji legal provisions.

4.2. Kiribati

The activity types planned for Kiribati are:

- Participation in digital platform and content development
- Participation in regional healthcare policy alignment and reforms
- Healthcare workforce training

The relevant areas of legislation relate to data privacy and health.

4.2.1. Data privacy

Under the Digital Government Act 2023 (Kiribati), government departments must manage private information with strict safeguards: Section 29 requires that access to personal data stored in the Government Computer Data Repository be granted only with written approval from a Senior Responsible Officer and written consent from the individual concerned. Sections 44 to 48 mandate that personal data must be classified, collected for lawful and specific purposes, and protected through appropriate security measures to prevent unauthorized access or misuse. Additionally, Sections 49 to 53 establish that any inter-agency data sharing must occur under formal agreements that uphold data privacy, define ownership, and ensure compliance with national data handling standards. It is not known the extend.

Relevance to PHIT Project. Data privacy provisions in Kiribati are clearly defined and the provisions set out in this EMSF and subsidiary instruments will require review and a check for consistency with Kiribati Legislation. Further gap and consistency analysis between the ESMF provisions and Kiribati legislation will be undertaken during implementation.

4.2.2. Healthcare and health infrastructure

Kiribati's healthcare system is managed by the Ministry of Health and Medical Services (MHMS), which is responsible for the overall governance and delivery of health services across the nation's dispersed atolls. The MHMS operates under several key pieces of legislation, including the *Public Health Ordinance* and related regulations that govern public health standards and healthcare facility operations. Healthcare infrastructure development in Kiribati follows a government approval process that involves coordination between MHMS, the Ministry of Infrastructure and Sustainable Energy (MISE), and the Ministry of Finance and Economic Development (MFED). The MHMS maintains a Health Infrastructure Unit responsible for planning, maintenance, and development of health facilities across the Gilbert, Line, and Phoenix island groups. Any healthcare infrastructure development must undergo internal vetting through a working committee comprising representatives from the recipient health division and relevant technical units. Development proposals require approval from the Permanent Secretary of MHMS before seeking technical support from MISE for design and construction oversight. All health infrastructure projects must incorporate climate resilience measures and comply with the National Adaptation Programme of Action requirements.

Relevance to PHIT Project. These processes will need to be followed for any healthcare infrastructure upgrades or digital health installations under the PHIT project in Kiribati. The approval timelines may be extended due to the logistical challenges of coordinating across multiple atolls and the need for climate-resilient design specifications for physical infrastructure.

4.3. Tonga

The activity types planned for Tonga are:

- Participation in digital platform and content development
- Participation in regional healthcare policy alignment and reforms
- Healthcare workforce training

The relevant areas of legislation relate to data privacy and health.

4.3.1. Data privacy

Tonga's approach to data privacy is evolving, with the Digital Government Strategic Framework (2019–2024) emphasising that personal data must be protected through strong security, privacy, and interoperability standards. The framework calls for a forthcoming Cybersecurity Manual and national digital security standards to ensure secure handling and sharing of citizen information. Tonga is preparing to introduce a Data Protection & Privacy Bill to complement these frameworks by outlining explicit data controller responsibilities, consent mechanisms, and data subject rights—though it has not yet been tabled or enacted. Until this legislation is enacted, data privacy protection relies primarily on sectoral guidelines and the principles outlined in the Digital Government Strategic Framework.

Relevance to PHIT Project. Given the evolving nature of Tonga's data privacy framework, the provisions set out in this ESMF and subsidiary instruments will require careful review to ensure compatibility with Tonga's emerging legal framework. The project should anticipate and prepare for compliance with the forthcoming Data Protection & Privacy Bill. Further gap and consistency analysis between the ESMF provisions and Tonga's legislation will be undertaken during implementation.

4.3.2. Healthcare and health infrastructure

Tonga's healthcare system is managed by the Ministry of Health, which is responsible for the overall governance and delivery of health services across the Kingdom's island groups. The Ministry operates under the Public Health Act and associated regulations that establish standards for healthcare facilities and public health services. Healthcare infrastructure development in Tonga follows a government approval process involving coordination between the Ministry of Health, the Ministry of Infrastructure, and the Ministry of Finance and National Planning. The Ministry of Health maintains an Infrastructure and Assets Unit responsible for planning, maintenance, and development of health facilities across Tongatapu, Vava'u, Ha'apai, 'Eua, and the Niuas. Development proposals require internal review by a technical committee including representatives from relevant health divisions before approval by the Chief Executive Officer of Health. Following health ministry approval, projects must seek technical clearance from the Ministry of Infrastructure for design and construction standards. All health infrastructure projects must incorporate disaster resilience measures and comply with the National Building Code requirements for cyclone resistance.

Relevance to PHIT Project. These processes will need to be followed for any healthcare infrastructure upgrades or digital health installations under the PHIT project in Tonga. Project planning should account for the additional time required for multi-ministry coordination and the need to meet stringent disaster resilience standards in all infrastructure designs.

4.4. Tuvalu

The activity types planned for Tuvalu are:

- Participation in digital platform and content development
- Participation in regional healthcare policy alignment and reforms
- Healthcare workforce training

The relevant areas of legislation relate to data privacy and health.

4.4.1. Data privacy

Tuvalu's approach to digital data privacy is guided by the ICT Act 2012 and the National ICT Policy (2021–2030), which outline general obligations for securing personal data and promoting responsible ICT use. However, Tuvalu lacks a dedicated data protection law, a national cybersecurity agency, and formal mechanisms to enforce privacy rights. As it advances its "Digital Nation" agenda, these legal and institutional gaps present significant risks to data privacy and digital trust. The ICT Act 2012 provides basic provisions for electronic transactions and communications but does not establish comprehensive data protection principles or individual rights regarding personal data processing.

Relevance to PHIT Project. Given the limited data privacy framework in Tuvalu, the provisions set out in this ESMF and subsidiary instruments will provide essential protections that exceed current national requirements. The project's data privacy standards will need to serve as the primary framework for protecting health information in digital systems. Further assessment of how to operationalise these protections within Tuvalu's existing legal context will be undertaken during implementation.

4.4.2. Healthcare and health infrastructure

Tuvalu's healthcare system is managed by the Ministry of Health, Social Welfare and Gender Affairs, which oversees the delivery of health services across the nation's nine atolls. The Ministry operates under the Public Health Act and associated regulations governing healthcare standards and facility operations. Healthcare infrastructure development follows a government approval process coordinated between the Ministry of Health, the Ministry of Infrastructure and the Central Planning and Coordination Department under the Office of the Prime Minister. The Ministry of Health maintains a Health Planning and Infrastructure Unit responsible for health facility planning and maintenance across all inhabited islands. Any healthcare infrastructure development requires approval from the Director of Health before proceeding to the Public Works Department for technical design review. Projects must also align with the Te Kete (National Strategy for Sustainable Development) and incorporate climate adaptation measures. All infrastructure must meet stringent requirements under the Building Act 2022, Building Regulations 2021, and National Building Code of Tuvalu 2024, with particular emphasis on elevation, flood resistance, and sustainable design.

Relevance to PHIT Project. These processes will need to be followed for any healthcare infrastructure upgrades or digital health installations under the PHIT project in Tuvalu. The approval process may be particularly complex given the need to coordinate across multiple government departments and ensure compliance with climate resilience requirements. Project timelines should account for the logistical challenges of implementing activities across dispersed atolls and the critical importance of climate-adaptive design in all infrastructure components.

4.5. World Bank Standards and key gaps

4.5.1. World Bank Environmental and Social Standards

The project will follow the World Bank Environmental and Social Standards (ESSs), as well as the World Bank Group Environmental, Health and Safety (EHS) Guidelines. The World Bank ESSs applicable to project activities are summarised in Table 5 below.

Table 5. Relevant World Bank ESSs

ESS	Relevance / Project Activities
ESS1: Assessment and Management of Environmental and Social Risks and Impacts	**Relevant**. The project activities and aspects of implementation relevant to ESS1 include: a. **Complex regional implementation:** The project involves spatial complexity as it spans multiple countries and impacts rural, urban, and remote (outer island) populations, presenting risks concerning effective project management and inter-jurisdictional coordination as it related to maintaining E&S standards in project delivery, noting that the enforcement of E&S laws, regulations, and the ESF has historically been weak in this region. b. **Construction and refurbishment:** The project includes a significant component of civil construction, refurbishment and renovation works, predominantly in Fiji but also in Kiribati, Tonga and Tuvalu. Some demolition may be required as part of renovations. The proposed infrastructure investments include the renovation of existing healthcare facilities (including the CWM Hospital and regional PHC clinics), and construction of a new regional hospital in Suva. The location and magnitude of construction and refurbishment works is yet to be confirmed. Potential E&S risks associated with construction works (construction phase) include: i. worker and community health and safety ii. poor stakeholder engagement iii. waste management and disposal (including hazardous wastes such as asbestos, contaminated oil, medical waste) iv. construction dust and noise pollution v. water and soil pollution, sediment control vi. ecological (biodiversity) impacts vii. cultural and indigenous heritage viii. land access and economic displacement ix. migrant construction workers / labour influx c. **Design and operation of facilities:** With regard to the design and implementation of new constructions and refurbishments, potential E&S risks include: i. community, transport, service and infrastructure impacts associated with siting and planning for the new hospital ii. potential exclusion of vulnerable stakeholders to project benefits (e.g. disabled, elderly, women and girls, vulnerable and minority ethnic groups) iii. lack of co-design with stakeholders to ensure needs are met iv. operational general and medical waste management (including new streams of hazardous, infectious and medical waste), including but not limited to the full installation, operationalisation and maintenance of the waste incinerator procured under the Fiji COVID-19 ERP, P173903, due for installation at the Naboro landfill by September 2025 v. water, air and soil pollution, noise pollution, and community and occupational safety. d. **Equipment lifecycle:** The project also includes the installation and commissioning of new medical technologies and equipment, including advanced oncological radiotherapy (linear accelerator). Potential E&S risks include: i. resource efficiency and pollution related to operation ii. general and hazardous waste associated with decommissioning (e.g. LINACs have a design life of 15 years and may include active radionuclide waste). e. **Digital infrastructure and data management:** The project includes a substantial investment in digital platforms (including physical infrastructure), digital content (training materials) and data management (including security, sharing, transmission,

	safe storage and associated infrastructure). Potential E&S risks associated with these investments include: i. resource/energy efficiency ii. service continuity iii. medical data privacy iv. accessibility (particularly to vulnerable and identified groups) v. sustainability (cost and maintenance) vi. usability. f. **Downstream digital content risks:** Digital platforms, services, applications may embed bias or discrimination, be poorly localised and/or culturally insensitive, and may not be sufficiently accessible resulting in exclusion particularly for vulnerable and minority groups. g. **Community-based health outreach programs:** Local outreach programs involve personal and social risks associated with house-to-house h. **Movement of workers, students and patients for training:** The project involves the movement of healthcare workers and patients both domestically and internationally (among SIDSs), introducing the potential for: i. disease transmission ii. sexual exploitation, abuse and harassment (SEA/SH) iii. exclusion of vulnerable groups iv. social tensions, and v. medical data breaches.
ESS2: Labor and Working Conditions	**Relevant**, particularly with respect to the construction and refurbishment of healthcare facilities. The project will involve the engagement of direct and contracted workers according to the scope of each subproject. The risks associated with construction workers and labour influx for project implementation that need to be managed include: a. Traffic/travel accidents during travel to project sites, including travel to/from remote and isolated areas, and maritime transit b. Psychological distress, fatigue and stigma among project workers c. Insecure terms of employment (employment period, remuneration, tax and insurance payments etc.) under subcontractual agreements d. Discrimination and/or lack of equal opportunity in employment e. Use of child or forced labour f. Occupational health and safety and workplace accidents, particularly when operating construction equipment, when working at height on building construction, and when handling heavy equipment and materials g. Exposure to hazardous substances (dust, cement, chemicals, asbestos) h. Accidents or emergencies i. SEA/SH risks to the community and among project workers j. Transmission of disease k. Abuse of power, discrimination, stigma during employment screening. **Note:** Labour and working conditions are addressed in the Project's LMF.
ESS3: Resource Efficiency and Pollution Prevention and Management	**Relevant.** Relevant project activities include: a. Demolition/renovation: Air, water and noise pollution, disposal of demolition waste and potentially hazardous wastes such as asbestos, medical and infectious waste; b. Contaminated land: Lands after demolition or new sites may be contaminated with asbestos, medical/infectious waste, hydrocarbons, or toxic and/or persistent chemicals.

	c. Construction: Air, water and noise pollution, sediment erosion, hydrocarbon/chemical spills, d. refurbishment/renovation of healthcare facilities, e. installation of digital infrastructure, f. regional movement of workers, students and patients, g. waste, including potentially hazardous wastes such as asbestos will require management for civil works. Procurement of digital infrastructure equipment may generate waste downstream which requires management. Screening and site specific environmental and social risk management documents are required to be prepared and/or followed.
ESS4: Community Health and Safety	**Relevant.** Relevant project activities include: a. **Construction/renovation/demolition:** The health and safety of the community, including hospital/clinic patients and visitors as well as nearby community, could be affected by: a. construction area safety b. air, noise and water pollution c. exposure to hazardous substances (e.g. dust, cement, chemicals, asbestos) d. increased heavy traffic b. **Labour influx:** Community health and safety risks associated with significant labour influx. c. **Disposal of electronic and medical equipment:** The project involves replacement of digital infrastructure and medical equipment. Disposal of electronic and medical equipment waste must be achieved in a manner that presents to risk to community health and safety. d. **Operation of new hospital:** The new hospital will increase visitations and traffic in the area, and existing infrastructure (roads), services (water, sewerage, waste collection) and policing (safety) may be insufficient to meet new requirements.
ESS5: Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	**Relevant.** The project includes the acquisition or assignment of land for the construction of a new hospital and/or the renovation or expansion of existing facilities. The Project is expected to prioritise the use of uninhabited government land, but site selection is still in progress. Potential risks include: a. Economic displacement of existing uses of land (e.g. for subsistence cropping, pig raising, other informal uses) b. Allocation of customary land (e.g. for PHC clinics), which will require formalisation of lease agreements or voluntary land donation in accordance with national laws c. If informal settlements exist, these will need to be managed through an involuntary resettlement procedure
ESS6: Biodiversity Conservation and Sustainable Management of Living Natural Resources;	**Relevant.** The project includes the acquisition or assignment of land for the construction of a new hospital and/or the renovation or expansion of existing facilities, as well as the generation of new streams of waste. Civil works have the potential to impact biodiversity both onsite and downstream via poor management of sediment controls or hazardous material. The exact locations of the works are still to be determined. Screening and site specific environmental and social risk management documents are required to be prepared and/or followed for each subproject involving relevant activities, including consideration of the impact of land acquisition, new/expanded facilities and waste management.
ESS7: Indigenous Peoples	**Relevant.** Although Indigenous Fijians form the majority population in Fiji, the standard applies for this Project since Indigenous Peoples possessing the four characteristics listed in paragraph 8 of ESS7 are present in the project area and among project affected

	parties. The elements of required standards with respect to Indigenous Peoples are included in the overall project design and the Project SEF.
ESS8: Cultural Heritage	**Relevant.** The site selected for the new hospital facility will be subject to a site-specific screening process and any cultural values evaluated and protected/avoided in accordance with ESS8. Contractors will implement the Chance Find Procedures located in Annex 6.
ESS10: Stakeholder Engagement and Information Disclosure	**Relevant.** This standard is relevant to all subprojects given the need to engage with beneficiaries and stakeholders on development activities that affect their lives. Stakeholder Engagement and Information Disclosure is address in the Project SEF, and standalone SEPs will be developed for each subproject.

4.5.2. Gap analysis

A gap analysis between the Fiji legal framework and the WB ESS requirements relevant to project activities and risks is provided in Table 6. The analysis also considers the Fiji regulatory approaches and capacity for managing these aspects. Where the national legal framework differs from the WB requirements, the Project is expected to align to whichever is more stringent.

Note that the Borrower's framework is to be used for activities evaluated as being of moderate or lower risk following E&S screening (Annex 2), except where explicitly specified otherwise in Table 6. A preliminary evaluation of the risk level of each activity is provided in Table 7 and Table 8.

Table 6: Gap analysis between relevant national legal frameworks and WB ESSs for the PHIT countries (with respect to planned project activities in each country)

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
FIJI (INCLUDING REGIONAL PROJECTS)				
Risks associated with major civil works (construction of new tertiary healthcare facility in Suva)	• MHMS AMU and CIU approval and implementation process as delegated under Public Hospitals and Dispensaries Act (1955). • EIA approval process under Environment Management Act (2005) and Environment Management (EIA Process) Regulations (2007). • Development and building approvals and permits under Regulation of Building Permits Act (2017) and Town Planning Act (1946).	• The World Bank's ESF addresses construction-related impacts and the potential E&S impacts of the completed facility through various ESSs, particularly ESS1, ESS2, ESS3, and ESS4, which collectively ensure that projects mitigate environmental, social, and health risks during construction and post-construction.	• Under EIA regulations, hospitals are designated Cat. 2 and may be exempt from EIA approval via MOWE (but can be elevated to Cat. 1 requiring MOWE approval under part (w)). • EIA provisions are comprehensive but may not cover all of the risks identified in the ESMF, including concerning public consultation. • Proposed locations for the new facility could have a range of social impacts during construction and operation not covered under the EIA or development approval process, including community health and safety (traffic, safety, service reliability), accessibility (including private and public transport), waste management, and stress on services (power/water/sewerage). • Managing impacts on power, water, sewerage, waste and transportation services and infrastructure, and any provisions thereto, may not be well coordinated among relevant ministries and authorities.	This civil works subproject will use the Borrower's EIA framework with the following specific requirements: • The development of the new hospital is to require a full EIA approved by MOWE under Cat. 1(w) of the EIA guidelines. • A public consultation process considering local community impacts is to be conducted prior to selection of a site for the new hospital in accordance with the Project SEF. • A full EIA study is to be conducted covering all identified E&S risks as outlined in this ESMF. • Social impacts associated with the new development are to be addressed in the EIA as set out in this ESMF. • The EIA is to include the development of an **Infrastructure and Service Provision Plan** (ISPP; see Annex 1) developed by a cross-portfolio working group of the Government of Fiji that includes representatives of relevant authorities (e.g. MHMS, MIMS, Water Authority of Fiji, Energy Fiji Limited, Fiji Roads Authority, Suva City Council, Department of Town and Country Planning), which considers the adequacy and reliability of essential services including capacity for safe disposal of medical waste as set out in Annex 1. • Specifically, the ISPP and EIA approval must consider the adequacy of available medical waste incineration capacity, and in the case that it is

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
				insufficient, this capacity will need to be included in the design proposal for the proposed health facility expansion as evaluated under the EIA. • The design of the new facility is to consider stakeholder feedback and service provisioning (including medical waste management), and aim to minimise adverse E&S impacts as identified in the EIA. • The subproject is to require an ESMP and CESMP aligned with the approved EIA and this ESMF, an LMP aligned with the Project LMF (including LIMP if applicable), a LARP (if applicable), and a HWMP for operations.
Risks associated with renovation and refurbishment of existing tertiary healthcare facility in Suva	• Building permit, MHMS AMU and CIU • Suva City Council scheme planning	• ESS1, ESS2, ESS3, and ESS4	• Provisions in existing processes may not sufficiently capture and address risks related to hazardous waste and dust, heavy traffic, and the potential impacts on staff, patients, visitors and neighbouring community in operating facilities.	The renovation civil works subproject will use the Borrower's applicable building approval processes, and additionally ensure that: • renovation / refurbishment subprojects are designed in full with subproject-specific ESMPs/CESMPs incorporating adequate mitigations for the risks outlined in the ESMF, as a condition of approval by approving authorities.
Public consultation, project information disclosure	• EIA approval, development / building permit approval for new hospital and renovations as above.	• ESS10 emphasises continuous stakeholder engagement and consultation throughout the project lifecycle, including disclosure of project documents.	• Fiji's EIA provisions require a minimum of one public consultation on the EIA report, including public disclosure of the report. • No provisions in Fiji laws or regulations for public consultation related to renovations. • For construction of the new hospital in Fiji, additional rounds of public consultation, during site selection and planning stages, are needed to meet the objectives of ESS10.	This Project will ensure that: • a minimum of three public consultations are conducted as part of the EIA process for the new hospital, at the site-selection, master planning and EIA report review stages, and feedback reasonably considered in all design, planning and management documents, • at least one public consultation with impacted/served communities is conducted for each renovation subproject (consolidated as needed),

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
			• For renovation of the CWM Hospital, consultation with potentially impacted groups should be conducted as part of the design and management of each subproject. • For PHC clinic renovations, consultation with served community should be conducted as part of the design and management of each subproject. • For the Project as a whole, provisions need to be made for continuous disclosure, public notification of grievance focal points, and the consultations needed for specific subprojects.	• general Project disclosure and communication provisions are implemented by the PMU in accordance with the SEF. Other specific requirements with respect to public consultation and continuous disclosure are specified in the Project SEF.
Land access	• Land access is governed under various acts, including iTaukei Land Trust Act 1940, State Lands Act 1945, and Land Transfer Act 1971	• ESS5 ensures that land acquisition and resettlement are conducted in a fair, transparent, and inclusive manner, with compensation and assistance provided to affected people, emphasising minimising displacement and preserving cultural heritage, while complying with national laws and international best practices.	• Land access provisions in Fiji are robust, but it is imperative that all relevant procedures, consents and agreements are followed and upheld when land is acquired, donated or provisioned for the new hospital or expanded facility sites • The selection of any new site should follow a transparent and consultative process (including potentially affected local community). • Land acquisition provisions are weak in relation to informal economic use of land.	The Project will ensure that: • a Land Access and Resettlement Procedure (LARP) compliant with ESS5 is developed for each subproject requiring land acquisition, which may include a grievance mechanism, arrangements related to economic displacement of informal activities on the site, and/or due diligence reporting depending on the land tenure type and acquisition mechanism, • public consultations are conducted in relation to site selection as above, • if access to customary land is required (e.g. for PHC clinics), that lease or voluntary donation agreements are formalised prior to subproject commencement, • any land provided in advance for the Project by the Borrower meets the requirements of ESS5 and meets the expectation of a LARP.

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
Community health and safety	• EIA provisions under the Environment Management Act (2005)	• ESS4 protects community health and safety by requiring risk assessments and mitigation measures to ensure safe construction, waste management, and emergency preparedness, while ensuring community engagement to address concerns.	• The Act includes provisions for protection and management of community health and safety as part of the EIA process. • However, there is generally weak enforcement of health and safety standards for community protection in Fiji, particularly for construction projects that do not require and EIA.	The Project will ensure that: • every subproject is to be screened with respect to potential community health and safety risks during construction and operation, • an ESMP specifying risks and mitigations with respect to community health and safety is prepared prior to subproject commencement. • community health and safety risks are included in the contractor CESMP for civil works.
Labour risks and OHS	• The MEPIR is guided by the Employment Relations Act 2007 and Health and Safety at Work Act 1996 and supporting regulations. • The Employment Relations Act 2007 sets the minimum working age at 15 (s. 92). • The Employment Relations Act 2007 includes provisions for employee grievance and redress by tribunal (s. 111). • The HSW Act requires employers to implement effective OHS measures and identify, assess, and manage workplace hazards (ss. 8-9). Employers must take all reasonably practicable steps to provide a safe and healthy work environment, including	ESS2 requires that: • all parties who employ or engage Project workers develop and implement procedures to establish and maintain a safe working environment, • working conditions are safe, fair, and non-discriminatory • child and forced labour are prohibited, • occupational health and safety standards are met • a grievance mechanism is in place • differentiation be made between different categories of Project workers,	• While all provisions aligned with ESS2 are available in Fiji's employment framework, there is a high risk of non-compliance at the practical level, particularly in relation to civil works. • Fiji's OHS framework is materially consistent with ESS2, although compliance and practical, effective risk management are generally lax compared with international standards.	The Project will ensure that: • an LMP is prepared for each subproject addressing the risks and compliance items specified in the LMF and relevant local laws, • subproject LMPs define the different categories of Project workers and the provisions that apply to each, • OSH screening is conducted prior to the commencement of subprojects, • OHS requirements are integrated into LMPs and are binding on contractors, • for civil works, OHS requirements are elaborated upon in the contractor's CESMP, • subproject LMPs include specific directives for minimum working age and a workers' GM. Other specific requirements with respect to labour risks and OHS are specified in the Project LMF.

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
	eliminating hazards where possible and using protective equipment to minimise risk.	• an appropriate risk assessment is conducted prior to work commencing, • measures relating to OHS are applied and take into account the General EHSG and, as appropriate, industry-specific EHSGs		
Hazardous, medical and electronic waste management	• Environment Management (Waste Disposal and Recycling) Regulations 2007 under the Environment Management Act 2005 provides for the management and disposal of waste, including hazardous waste. • A waste permit is required for construction / demolition and other significant waste generators from the Waste and Pollution Control Administrator. • Hazardous waste materials are defined in the Public Health Act 1935 and HSW Act 1996, including the Health and Safety at Work (Control of Hazardous Substances) Regulations 2006. Permits are issued with specific conditions	• ESS3 emphasises avoiding the generation of hazardous and non-hazardous waste. • Where waste generation cannot be avoided, ESS3 requires minimising the generation of waste, and reuse, recycle and recover waste in a manner that is safe for human health and the environment.	• Electronic waste is not specifically mentioned under Fiji's acts or regulations, and is managed through the existing solid waste management framework. Most e-waste is currently landfilled or burned with other solid waste, and there's no formal e-waste recycling industry. Suva City Council conducts occasional e-waste collection drives, but these are limited in scope. • Disposal of asbestos and other recognised forms of toxic, chemical and medical/biological waste is regulated, but policing and compliance may be inadequate. • The operational capacity of suitable facilities for the disposal of hazardous waste may be insufficient to meet Project needs.	The Project will ensure that: • all forms of hazardous waste and their management are included and considered in the E&S screening for each subproject, • the ESS3 mitigation hierarchy is applied to hazardous and non-hazardous waste management, including due consideration of the capacity of any disposal facilities to safely dispose of hazardous wastes, • waste management arrangements of sufficient capacity are incorporated into the design and approval of subprojects where this is relevant (e.g. civil works, hospital operations).

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
	related to the handling, transportation, and disposal of hazardous waste. The disposal facility must manage risks to human health and the environment.			
Exclusion of vulnerable and marginalised groups	• Fiji Constitution 2013 establishes that all Fijians have equal status and identity, and that English, Fijian and Hindustani languages have equal status • Constitution Bill of Rights 1997 provides for explicit protection from discrimination on the basis of sexual orientation and disability • Rights of Persons with Disabilities Act 2018 • Fiji National Council for Disabled Persons Act 1994 • Fiji National Policy for Persons with Disabilities 2024-2033 (draft) • Fiji Human Rights and Anti-Discrimination Commission • National Gender Policy (2014) • Gender Equality and Social Inclusion (GESI) Policy • National Development Plan emphasises women's	• ESS1 and ESS7 emphasise the need to ensure that vulnerable and marginalised groups are not excluded or adversely impacted, including women and girls, persons with disabilities, and other socially or economically disadvantaged populations.	• While general provisions under Fiji law and policy are well aligned with the ESF, practical compliance and observance of inclusive directives can be lax.	The Project will: • develop activity and subproject criteria to ensure equitable benefits for vulnerable and marginalised groups, • design engagement activities to be inclusive, safe, and actively seek input from vulnerable, disadvantages and marginalised groups, • design facilities to be accessible and safe to all, including vulnerable, disadvantaged and marginalised groups, • mitigate exclusion risks by accounting for all likely user groups in design, and by adherence to national policy and international best practice, including communication in appropriate local languages, • ensure that digital platforms and applications are appropriately localised, culturally sensitive, and account for and are accessible by all likely user groups including vulnerable, disadvantages, marginalised and minority groups, • ensure SEPs include strategies for engaging vulnerable groups and diverse ethnicities through inclusive and culturally safe consultations.

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
	empowerment and social inclusion			
Gender-based violence, sexual exploitation and abuse and sexual harassment (SEA/SH)	• National Policy on Sexual Harassment in the Workplace (2007) • Employment Relations Act 2007 • Crimes Act 2009 (sexual offences, human trafficking and sexual servitude) • National Action Plan to Prevent Violence Against All Women and Girls (2023-2028)	• While the ESF itself does not explicitly mention SEA/SH/GBV, various ESSs include provisions for addressing SEA/SH, including ESS1, ESS2, ESS4, and ESS10. • Management of SEA/SH/GBV emphasises assessing the risks of SEA/SH, implementing appropriate SEA/SH risk mitigation and monitoring measures, and response to and referral of any reported GBV allegations to GBV service providers.	• While Fiji law and policy are aligned with the prevention of SEA/SH/GBV, practical implementation of safeguards, policing of incidents and enforcement of laws can be lax.	The Project will ensure that: • the E&S screening of all subprojects includes consideration of SEA/SH/GBV risks both in the workplace and in the community in relation to Project activities, • for civil works involving labour influx and identified SEA/SH risk, an SEA/SH Action Plan is developed and implemented as set out in this ESMF, • responsibility for implementing safeguards to prevent SEA/SH is included in construction contractor contracts, • an effective public grievance redress mechanism is in place for the duration of the Project.
Grievance mechanisms	• Provisions for workplace grievance raising and tribunal redress are available under the Employment Relations Act 2007 (s. 111).	• ESS10 requires accessible grievance mechanisms for all stakeholders.	• Lack of effective systematic grievance frameworks. Mostly handled at the project level.	The Project will ensure that: • an effective public grievance redress mechanism is in place for the duration of the Project and that grievances are addressed in a timely and sensitive manner in accordance with the SEF, • an effective worker grievance mechanism is in place for the duration of the Project as set out in the LMF, and that all contractors maintain equivalent GMs for their workers.
Data privacy	• The Constitution (2013) covers the right to personal privacy, confidentiality of personal information	• Although not directly addressed in the ESF, protection of personal data privacy is a specific	• While data protection is covered under various sectoral legislative instruments, there is no unified data protection framework that would ensure adequate	The Project will ensure that:

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
	• Medical and Dental Practitioner Act 2010 protects medical data obtained by statutory administrators • Cybercrime Act 2021 covering defines 'computer data' • Information Act 2018 covers citizens' rights to access government-held information • National Digital Strategy 2025–2030 includes a commitment to enhancing data privacy	E&S risk in relation to the storage, transfer and security of personal health data and identifying information.	protection for the cases considered under the PHIT.	• patient and personal data are stored, transferred and disclosed securely and made available only to authorised users, • all Project workers sign and adhere to a Code of Conduct prohibiting sharing/use of personal data other than for the use authorised by the patient, • adequate sanctions are available in employment contracts and/or under law in relation to breaches of data confidentiality, • secure and compliant mechanisms are established for the cross-border exchange of personal health data prior to the implementation of any such service (e.g. telehealth), • a cross-country data governance working group is established to provide support across multiple PHIT subprojects on inter-jurisdictional alignment on data security, sharing, transfer and privacy protocols, legislation and mechanisms.
KIRIBATI				
Data privacy	• Digital Government Act 2023 covers data classification, consent requirements, security measures, and inter-agency sharing agreements	As above	• Kiribati's data privacy framework (Digital Government Act 2023) is more comprehensive than other PHIT countries, creating practical challenges in alignment with cross-border data sharing requirements, ensuring compatibility with other PHIT countries' frameworks, and technical capacity to implement robust security measures	The same provisions as for Fiji will apply.
Exclusion of vulnerable and	• General constitutional provisions	As above	• While general provisions under Kiribati law and policy are well aligned with the ESF,	The same provisions as for Fiji will apply.

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
marginalised groups	• Limited specific legislation for disability rights or vulnerable group protection • Ministry for Women, Youth, Sports and Social Affairs • National Human Rights Taskforce • National Policy on Gender Equality and Women's Development		practical compliance and observance of inclusive directives can be lax.	
Labour risks and OHS	• Employment and Industrial Relations Code Act 2015 • Occupational Health and Safety Act 2015	As above	• While all provisions aligned with ESS2 are available in Kiribati's employment framework, there is a high risk of non-compliance at the practical level, particularly in relation to civil works. • Kiribati's OHS framework is materially consistent with ESS2, although compliance and practical, effective risk management are generally lax compared with international standards.	The same provisions as for Fiji will apply. See the Project LMF for further details.
TONGA				
Data privacy	Digital Government Strategic Framework (2019–2024) emphasises that personal data must be protected through strong security, privacy, and interoperability standards	As above	• The project should anticipate and prepare for compliance with the forthcoming Data Protection & Privacy Bill. • Further gap and consistency analysis between the ESMF provisions and Tonga's legislation will need to be undertaken during implementation.	The same provisions as for Fiji will apply.
Exclusion of vulnerable and	• Constitutional provisions for equality exist but are limited in scope	As above	• While gender anti-discrimination policy is in place, practical application is expected to be limited.	The same provisions as for Fiji will apply.

E&S risk	Applicable law/process	Applicable WB ESSs	Key gaps	Gap filling measure
marginalised groups	• Gender Equality Policy (2019–2025)		• Provisions for preventing exclusion of other vulnerable, marginalised, minority or disadvantaged groups are lacking	
Labour risks and OHS	• Employment Relations Act 2007 • Public Health Act 2008	As above	• Tonga lacks comprehensive employment legislation. • An Employment Relations Bill 2020 has been drafted but has yet to be passed. • The Ministry of Health is responsible for developing and enforcing OHS regulations, although enforcement mechanisms may be underdeveloped	The same provisions as for Fiji will apply. See the Project LMF for further details.
TUVALU				
Data privacy	• ICT Act 2012 • National ICT Policy (2021–2030)	As above	• Tuvalu lacks a dedicated data protection law, a national cybersecurity agency, and formal mechanisms to enforce privacy rights • The ICT Act provides basic provisions for electronic communications but does not establish data protection principles or individual rights	The same provisions as for Fiji will apply.
Exclusion of vulnerable and marginalised groups	• Constitution now explicitly prohibits discrimination on the grounds of sex and disability • Labour and Employment Relations Act 2017 prohibits workplace discrimination	As above	• While general provisions under Tuvalu law and policy are well aligned with the ESF, practical compliance and observance of inclusive directives can be lax.	The same provisions as for Fiji will apply.
Labour risks and OHS	• Employment Relations Act 2017 covers worker health and safety	As above	While provisions aligned with ESS2 are available in Tuvalu's employment framework, there is a high risk of non-compliance at the practical level, particularly in relation to civil works.	The same provisions as for Fiji will apply. See the Project LMF for further details.

5. POTENTIAL ENVIRONMENTAL AND SOCIAL RISK IMPACTS AND STANDARD MITIGATION MEASURES

5.1. Summary of main environmental risks

A general summary of the main environmental risks associated with Project activities is provided in Table 7.

Table 7: Summary of main environmental risks and risk rating

Risk type / Activity:	New hospital	CWMH Renovation	PHC upgrade	Training program dev.	Telehealth, AI, data mgmt dev.	Digital infra. - telehealth, continuity, data mgmt	Policy reform	Program implementation	Health outreach	Training
Air pollution	✓	✓								
Noise	✓	✓								
Water pollution	✓	✓	✓							
Soil pollution / land contam.	✓	✓	✓							
Sediment control	✓		✓							
Solid waste - general	✓	✓	✓							
Demolition/construction waste	✓	✓	✓							
Hazardous waste	✓	✓	✓							
Medical/infectious waste	✓	✓	✓							
Electronic waste		✓	✓			✓				
Ecological impacts	✓									
Visual amenity impacts	✓									
Sewage management	✓		✓							
Construction hazards	✓	✓	✓							
Risk Rating*	**S**	**S**	**S**			**M**				

**H = High, S = Substantial, M = Moderate, L = Low*

The project is rated as having a **Substantial** potential environmental risk level based on the civil works activities, its complexity, and historically inconsistent practical enforcement of environmental standards. The potential environmental impacts of these activities are significant and serious (hazardous waste, pollution, construction hazards), but can be effectively mitigated and are mostly temporary, predictable and/or reversible.

5.2. Summary of main social risks

A general summary of the main social risks associated with Project activities is provided in Table 8.

Table 8: Summary of main environmental risks and risk rating

Risk type / Activity:	New hospital	CWMH Renovation	PHC upgrade	Training program dev.	Telehealth, AI, data mgmt dev.	Digital infra. - telehealth, continuity, data mgmt	Policy reform	Program implementation	Health outreach	Training
Land acquisition	✓									
Community health & safety	✓	✓	✓							
Worker health & safety	✓	✓	✓							
Cultural acceptability			✓	✓	✓		✓	✓	✓	✓
Cultural/indigenous heritage	✓									
Disease transmission	✓	✓	✓						✓	✓
SEA/SH/GBV	✓	✓	✓							✓
Accessibility	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Social tensions	✓	✓	✓							
Medical data security				✓	✓	✓				✓
Economic/physical displacement	✓	✓	✓							
Migrant labour / labour influx	✓	✓								
Impacts on services	✓	✓								
Impacts on safety	✓	✓								
Traffic impacts	✓	✓								
Risk Rating*	**S**	**S**	**S**	**L**	**M**	**L**	**M**	**L**	**M**	**M**

**H = High, S = Substantial, M = Moderate, L = Low*

The project is rated as having a **Substantial** potential social risk level based primarily on the civil works activities, its complexity, and historically lax practical enforcement of social standards. The potential social impacts of the civil works activities are significant and serious (hazardous waste, pollution, construction hazards, safety, social tensions, SEA/SH), but can be effectively mitigated.

Some technical assistance activities such as policy reform and the role out of digital platforms and outreach program have a range of immediate safety and also downstream impacts warranting a Moderate rating of potential social risk.

5.3. Positive project impacts

The PHIT project is expected to deliver significant positive impacts across economic, health, and social dimensions, as follows:

Health system improvements

- Enhanced service delivery: The project will enable more efficient delivery of an expanded range of health services across the region, reducing per-person costs whilst improving access to secondary and tertiary care.
- Reduced overseas medical referrals: By strengthening regional healthcare capacity, the project will lower costs currently incurred for overseas medical referrals whilst ensuring better continuity of care.
- Digital health transformation: Implementation of telehealth, AI diagnostic tools, and electronic health records will enable earlier diagnosis and better management of chronic conditions.

Social and equity benefits

- Strong equity dimension: The strengthening of primary care will particularly benefit people in urban informal settlements, rural and disadvantaged areas, ensuring more equitable access to healthcare.
- Increased women's workforce participation: By improving adult survival rates and reducing the caregiving burden on women, the project will enable greater female participation in the workforce.
- Job creation: Direct employment through scaling up healthcare worker training and creation of mid-level positions for nurses and allied health workers, plus indirect jobs in digital health support and maintenance.

Survival and quality of life

- Improved survival rates: The monetary value of gains from improved survival is estimated at US$1.05 billion for the four countries between 2025–2050, with an average per-person cumulative gain of US$1,694.
- Climate resilience: The project aligns with climate adaptation goals, financing resilient infrastructure and energy-efficient equipment to ensure healthcare continuity during disasters.

Economic benefits

- Macroeconomic gains: The project is projected to add approximately US$750 per capita annually to GDP in Fiji, Kiribati, Tonga and Tuvalu by 2050, totalling US$0.97 billion annually. Over 2025–2050, the aggregate discounted national income gains are estimated at US$4.2 billion.
- Improved productivity: Through better prevention and management of NCDs, the project will increase worker availability and productivity, with healthier individuals having fewer sick days and longer working lives.
- Healthcare cost savings: Digital health interventions are estimated to generate savings of US$500–638 million through 2050 by creating more efficient service delivery systems, including virtual consultations, remote monitoring, and paperless data sharing.

Regional integration benefits

- Regional collaboration: Development of regional public goods including centres of excellence, shared specialist resources, e-learning platforms, and cross-border telehealth capabilities.
- Standardised care: Regional accreditation and regulatory frameworks will enable safer cross-border care and more efficient use of scarce specialist skills across countries.

The project represents a transformational investment in Pacific health systems, addressing the dual challenges of rising NCDs and climate vulnerability whilst creating a more integrated, efficient and equitable regional health system.

5.4. Preliminary risk analysis

Table 9 provide a preliminary risk analysis of the type of project activities identified for each component, the potential social and environmental impacts that may result from these activities, the key mitigation methods and residual impacts, and the environmental and social risk management tools that are required to be developed and/or followed. Where relevant, the risks at each project stage (planning, implementation, post-implementation) are assessed.

The preliminary analysis covers the expected project typologies, which include:

- **Infrastructure investments** including construction of new tertiary healthcare facility; renovation and refurbishment of existing tertiary healthcare facility, and upgrade local PHC facilities and/or nursing schools (i.e. construction, renovation, demolition and upgrade activities);
- **Digital infrastructure** to improve ICT connectivity across public health authorities and facilities;

Technical assistance activities including capacity building for healthcare professionals and wellness initiatives for PIC communities, design packages for healthcare services, digital platforms and content, policy and regulatory reform, program implementation, health outreach programs and training.

Table 9: Environmental and social risks and mitigation measures for the PHIT project

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
Infrastructure investments	**Construction of new tertiary hospital facility in Suva, Fiji** **a) Site selection and design:** • Local social impacts (traffic, local services, social tensions) • Ecological impacts (sensitive or conserved biota) • Land access and resettlement • Cultural / indigenous heritage • Availability of adequate water, waste, sewage and transport services • Impacts of residual air, water, noise pollution • Local impacts of waste management • Visual amenity impacts • Community consultation • Accessibility and inclusion **b) Construction:** • Community health & safety • Worker labour conditions, health & safety • SEA/SH/GBV • Social tensions • Labour influx (and related risks) • Air & noise pollution, vibration • Soil pollution / land contamination • Water pollution and sediment control • Demolition/construction waste • Hazardous waste • Medical/infectious waste • Electronic waste • Ecological impacts • Sewage management	 **S / P** **M / P** **M / P** **M / P** **S / P** **M / P** **M / P** **L / P** **M / T** **M / P** **S / T** **S / T** **S / T** **M / T** **S / T** **S / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T**	**a) Site selection analysis** • Undertake a thorough and transparent site selection process resulting in a Site Selection Analysis including a consultation-informed multicriteria analysis (MCA) that considers accessibility, land size and suitability, cost of land acquisition / development / operation, environmental impacts, regulatory approvals and zoning, infrastructure and utilities, proximity to key services, community impact, hazard and climate resilience, and future expansion. • Community consultation on shortlisted sites or the preferred site based on the MCA should be conducted to understand and consider impacts on nearby community, and to incorporate any concerns into site suitability assessment (including any provisions for mitigations). • Relevant consultation with community representative during the site selection process to ensure any concerns of local affected community are considered. • Follow-up engagement with affected stakeholders on the provisional selection decision, any mitigations and outcomes. • A stakeholder engagement plan should be developed as set out in the Project SEF prior to announcing any final decision on site selection that considers and addresses any sensitivities or contentions. • The preferred site should be surveyed with respect to environmental, social and ecological sensitivities, and the presence of cultural or indigenous heritage values. • Screen and document subproject land access requirements and options using Screening Form (annex 2) • Apply the objectives of ESS5 and, if required prepare a Land Acquisition and Resettlement Action Plan in the event of economic and/or physical displacement and/or Cultural Heritage Management Plan in the event of existing or impacted cultural heritage.

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Construction hazards • Emergency management **c) Equipment and operations:** • Site and facility-wide integrated operational planning • Solid waste - general • Medical/infectious/hazardous waste • Air and noise pollution • Water pollution • Sewage management • Energy and resource efficiency • Access and transport including: patient and worker access, operational logistics. • Ensuring adequate training and continuity of human resources for use and maintenance of specialist medical equipment, systems and services • Secured funding for ongoing operations and maintenance	**S / T** **M / T** **M / P** **M / P** **S / P** **M / P** **M / P** **M / P** **S / P** **M / P** **M / P** **S / P**	**b) Design and planning** • A rigorous E&S Scoping Study involving preliminary site surveys (site, downstream and affected community areas) and consultations with stakeholders and affected community should be conducted before the commencement of project planning and design to identify the full range of potential risks and impacts, including specifically assessment of: ◦ land contamination (including buried contamination) ◦ economic displacement ◦ cultural heritage, artifacts and chance finds (see Annex 6) • The identified risks and impacts should be explicitly addressed in project planning, design and the subproject EIA based on the Scoping Study findings, including any provisions for expansion of local services (e.g. waste, water, power, sewerage, telecomms, transport). • The Scoping Study should be updated in reference to the proposed facility design to incorporate new risks and impacts and any designed mitigations. • The full scope of potential risks and impacts of the final design should be included in the EIA study and report, incorporating both the results of the Scoping Study and the proposed facility design. **c) Construction** • A labour management plan (LMP), including if necessary a labour influx management plan (LIMP), is to be developed by the Contractor and approved by the PMU as part of mandatory subproject preparations (as specified in the Project LMF). • All construction-related risks are to be identified and addressed in the Construction Environmental and Social Management Plan (CESMP) developed by the Construction Contractor (or supervising EPC engineer) and approved by the PMU before works commence. • Construction risk mitigations should be identified and designed commensurate with the risk profile of the construction activities considering all reasonable potential impacts. • Specific impacts to consider include:

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
			◦ Safety of community near traffic routes ◦ Effective exclusion of community from construction zones ◦ Risk to / impact on community of transport / disposal of hazardous waste ◦ Sediment control and impacts on downstream waterways ◦ Dust and air pollution ◦ Noise/vibration and impacts on community of nearby long-term construction activity • Conduct a risk hazard assessment (RHA) and prepare an Emergency Response Plan (ERP) in coordination with the relevant local authorities and the affected community, and will take into account the emergency prevention, preparedness and response arrangements put into place with project workers under ESS2, including, inter alia: ◦ engineering controls (such as containment, automatic alarms, and shutoff systems) proportionate to the nature and scale of the hazard; ◦ identification of and secure access to emergency equipment available on-site and nearby; ◦ notification procedures for designated emergency responders; ◦ diverse media channels for notification of the affected community and other stakeholders; ◦ a training program for emergency responders including drills at regular intervals; ◦ public evacuation procedures; ◦ designated coordinator for ERP implementation; and ◦ measures for restoration and cleanup of the environment following any major accident. • Conduct a risk assessment of aggregate supply for the subproject, including availability and quality of suitable aggregate materials, and due diligence on primary suppliers' labour management practices, particularly in terms of observance of basic workers' rights, non-discrimination and child and forced labour (as set out in the LMF).

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
			d) Equipment and operation • Facility operations should adequately address and mitigate residual risks and impacts as identified in the EIA process, and be incorporated into budgets and normal operating procedures. • New major medical equipment will need to go through full medical devices approval. • Selection and commissioning of new major equipment should consider the full lifecycle material, energy and decommissioning/waste requirements. • A site and facility wide operational plan of management is to be prepared, including inter alia: ◦ Access and transport including: patient and worker access, operational logistics. ◦ Linkages to training and human resource plans for use and maintenance of specialist medical equipment, systems and services • A hazardous waste management plan (HWMP) is to be developed for hospital operations, including adequate provisions for medical and other hazardous waste incineration and/or disposal and ensuring that disposal transporters and facilities hold all applicable waste permits.
	Renovation of CWMH in an operating hospital environment: • Patient and staff safety: ◦ Exposure to construction dust, noise, and vibrations ◦ Disruption of critical care services (ICU, emergency, surgery) ◦ Contamination of sterile environments ◦ Blocked emergency exits and evacuation routes ◦ Oxygen and medical gas line disruptions ◦ Power outages affecting life support equipment • Air quality and infection control: ◦ Airborne particles entering clinical areas ◦ Compromised ventilation systems	**S / T** **S / T**	**Comprehensive planning:** • E&S screening must be conducted for each renovation subproject (including any consolidated activities). • ESMP, LMP and SEP instruments must be prepared for each subproject as indicated by E&S screening. • All construction-risk mitigations as outlined above need to be covered in the ESMP and CESMP. • Development of ESMP, LMP and SEP instruments is required to include adequate consultation with hospital users (staff, patients, visitors) to plan and implement risk mitigations. • Pre-works assessment of hazardous material risks associated with any demolition and renovation works, including potential presence or disturbance of,

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	◦ Construction workers accessing patient areas ◦ Disruption to waste management flows ◦ Cross-contamination between construction and clinical zones • Hazardous materials: ◦ Extensive asbestos likely in roofing, insulation, floor tiles, pipe lagging ◦ Friable asbestos in deteriorated areas ◦ Risk to patients, staff, and workers during removal ◦ Lead paint on walls and pipes ◦ PCBs in old electrical equipment ◦ Mercury in medical equipment and thermometers ◦ Medical/biological contamination in walls/floors ◦ Chemical residues in laboratory areas • Infrastructure vulnerabilities: ◦ Electrical systems at capacity/outdated ◦ Plumbing with lead pipes and frequent failures ◦ Structural issues in older buildings ◦ Inadequate fire safety systems ◦ Non-compliant disability access • Service interruptions: ◦ Water supply disruptions during pipe work ◦ Power outages during electrical upgrades ◦ Medical gas supply interruptions ◦ IT/communications system downtime ◦ Air conditioning failures in tropical climate • Waste management: ◦ Existing incinerator inadequate/failing ◦ No alternative during renovation	**S / T** **S / T** **S / T** **S / T**	and/or exposure of workers, hospital occupants (staff, patients, visitors) and community to, asbestos and hazardous building materials, hazardous chemicals, biological/medical/infectious materials or other material-related risks. • Planning for management and mitigation of such risks considering removal, transport and disposal of hazardous materials and potentially affected workers, community and stakeholders on transport routes and near disposal sites. • Careful planning and management of demolition/renovation activities to ensure minimal impact on hospital operations, staff, patients and visitors. • Assess hazardous materials and material conditions (certified professional) • Assess structural integrity (structural engineering), infrastructure and service capacity • Assess clinical service impact and plan phased renovation planning to minimise clinical disruption • Infection control risk assessment • Identify swing spaces for temporary relocations • Plan for maintaining minimum service levels • Emergency contingency planning • Buffer zones between construction and clinical areas **Establish robust governance and decision-making structure:** • Daily coordination meetings with clinical heads • 24/7 hospital liaison officer from contractor • Clinical staff on construction oversight committee • Clear escalation procedures • Real-time communication systems • Joint emergency response protocols • Clinical sign-off for each work phase • Stop-work authority for safety issues

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	◦ Accumulation of infectious waste ◦ Mixing of construction and medical waste ◦ Limited storage capacity ◦ Large volumes of demolition waste ◦ Hazardous waste requiring special disposal ◦ Limited capacity at Naboro Landfill ◦ Transport through busy hospital grounds • Operational impacts: ◦ Department relocations ◦ Longer routes for patient transport ◦ Emergency access complications ◦ Staff stress and fatigue ◦ Visitor access restrictions ◦ Bed numbers reduced during works ◦ Operating theatre availability ◦ Diagnostic service limitations ◦ Increased referrals to other facilities ◦ Overcrowding in remaining spaces ◦ Ensuring adequate training and continuity of human resources for use and maintenance of specialist medical equipment, systems and services • Emergency management • Community health & safety (hospital staff, patients, visitors) • Worker labour conditions, health & safety • SEA/SH/GBV • Labour influx (and related risks) • Air & noise pollution, vibration • Soil pollution / land contamination	**S / T** **S / T** **S / T** **S / T** **M / T** **M / T** **M / T** **M / T**	**Patient and staff safety:** • Consults with staff and patients during project planning to ensure all risks are adequately identified and proposed mitigations are acceptable • Communication strategy to include daily updates on work areas, multilingual signage, patient information leaflets, staff briefings by department, visitor guidance systems, social media updates • Safety measures to include vibration monitoring near sensitive equipment, noise limits and monitoring, security for construction zones, escort procedures through work areas, emergency evacuation drills, incident reporting systems **Hazardous materials:** • Establish asbestos removal protocol, including engaging a certified asbestos removal contractor, completing removal before general construction, maintaining negative air pressure containment, air quality monitoring during removal, decontamination procedures, and safe disposal at an approved facility • Inventory all decommissioned equipment for hazardous materials, including professional decontamination services where needed, proper disposal of mercury-containing devices, chemical inventory and disposal, biological decontamination of surfaces • A hazardous waste management plan (HWMP) is to be developed, including adequate provisions for hazardous waste removal and disposal, and ensuring that disposal transporters and facilities hold all applicable waste permits. **Air quality and infection control:** • Air quality controls including sealed construction zones with negative pressure, separate construction entrances/exits, dust suppression systems, protective walkways for patients/staff, anteroom systems for access control, continuous particulate monitoring, temporary ventilation modifications, protection of air intakes, regular filter changes, infection control officer inspections, Immediate response to breaches **Critical systems redundancy:** • Temporary backup power systems • Parallel medical gas supplies

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Water pollution and sediment control • Access and transport arrangements, including patient and worker access, operational logistics • Construction hazards incl. electrical works • Equipment-related risks as above	**M / T** **M / T** **M / T** **M / T**	• Water storage tanks • Mobile air conditioning units • Redundant IT/communication systems • Emergency equipment stockpiles • Advance notice of all service shutdowns to all departments • Service mapping to avoid accidental cuts • Time-limited shutdown windows • Contingency plans for emergencies • Testing before recommissioning • Clinical sign-off for restarts **Waste management:** • Construction waste segregation, including separate streams for hazardous/non-hazardous, colour-coded bins and clear labelling, staff training on segregation • Dedicated construction waste routes and covered transport vehicles • Safe transport of hazardous waste, including manifests and transfer protocols to approved disposal facilities • Medical waste continuity - commission new incinerator before renovation, increase collection frequency, provide additional temporary storage, establish contingency disposal arrangements • Monitoring for compliance **General construction risks** above **Equipment and operations** as above
	Upgrade / replacement of local PHC facilities and/or nursing schools: **a) Renovation / Construction / Demolition** risks as above, and specifically removal and/or disposal of demolition/construction waste including hazardous materials	**M / T**	**Comprehensive pre-construction planning,** including**:** • Hazardous materials surveys before any demolition • Land tenure investigations with legal documentation including boundary surveys and registration • Site environmental assessment • Infrastructure capacity evaluations

	b) Transport and assembly of modular, flatpack building structures: • Use of unseaworthy/under-specification vessels or overloading for transport of heavy/bulky structural elements • Poor load securing risks • Insurance of materials in transit • Weather-related delays and safety risks • Damage to materials from saltwater exposure • Untrained crew handling heavy materials • No safety equipment on vessels • Manual loading/unloading risks • Working in hazardous weather conditions • Fuel spills from vessels • Damage to coral reefs from anchoring/grounding • Disturbance to marine protected areas • General small-scale construction risks (suspended loads, excavations, unsecured structures, heavy manual handling) **c) Land tenure / community risks:** • PHC facilities on customary land without formal agreements • Disputed ownership between clans/families • Expired or verbal lease arrangements • Church land with unclear donation terms • Government assumptions about "public" land • Conflict/competing claims emerging during upgrade planning • Demands for compensation • Exclusion of certain groups from facility access • Political manipulation of land disputes • Decisions made without local inclusive input encompassing female, youth, vulnerable and disadvantages groups • False assumptions about community priorities • Culturally insensitive facility design (including birthing room layouts)	 **S / T** **S / T** **L / T** **L / T** **L / T** **M / T** **M / T** **S / T** **M / T** **M / T** **L / T** **L / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / T** **M / P** **M / T** **M / P** **M / T** **M / P**	• Climate vulnerability assessments • Telecommunications hub possibilities • Design to meet requirements for accessibility, cultural appropriateness and cultural/gender safety based on consultations • Service continuity planning (e.g. temporary facility arrangements, emergency care protocols during construction, medicine and vaccine storage solutions) • Infrastructure Planning (water supply upgrades, appropriate sewage treatment systems, telecommunications needs assessment, power load calculations and system sizing, waste management plans for facilities, climate-resilient infrastructure design) **Safe demolition and waste management**, including: • Asbestos/hazardous materials assessment • Contractors for safe removal of hazardous materials • Community safety controls (incl. dust) • Safe temporary storage facilities • Inter-island waste transport arrangements • Proper disposal at approved facilities • Worker protection equipment and training • Effective worker and community construction risk controls and safety protocols **Land use and access,** including**:** • Community agreements on facility use and access • Legal review of all existing arrangements • Formal lease agreements or MOUs with landowners (as required) • Agreements for shared infrastructure benefits (as appropriate) • Community access to power/water improvements • Shared maintenance responsibilities • Facility management committees with diverse representation • Clear roles for community vs government maintenance **Community risk management**, including: • Mandatory consultation periods with documented outcomes

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Marginalisation of traditional medicine	L / T	• Separate focus groups for women, youth, elderly, disabled
	• Ignoring gender-separate space requirements	M / P	• Traditional leader engagement following cultural protocols
	• Disrespect for sacred sites or taboo areas	L / P	• Public display of plans with feedback periods
	d) Equipment installation, including electrical works and batteries		• Grievance mechanisms established before work begins
	• Lack of qualified technicians on remote islands	M / P	• Conflict resolution mechanisms
	• Incompatible equipment with local conditions	M / P	• Performance monitoring systems
	• Salt corrosion of electronic equipment	M / P	• Regular community feedback mechanisms
	• Cyclone damage to solar panels	M / P	**Maritime transport safety:**
	• Battery disposal issues	M / P	• Pre-approved vessel inspection checklist
	• No local skills for solar system repairs	M / P	• Minimum vessel standards for cargo capacity
	• Inability to source spare parts	M / P	• Certified operators only
	• No maintenance budgets allocated	M / P	• Insurance requirements for cargo and crew
	• Equipment abandoned when faulty	M / P	• Weather monitoring and go/no-go protocols
	• Reversion to diesel generators	M / P	• Designated landing sites to minimise damage
	• Inadequate sewage treatment capacity	M / P	• Spill kits on all vessels
	• No reliable water supply for increased usage	M / P	• Coral reef protection measures
	• Telecommunications infrastructure absent	M / P	• Environmental monitors during transport
	• Power requirements exceeding solar capacity	M / P	• Provision of suitable loading/offloading equipment
	• No waste collection services	M / P	• Full safety risk assessment of building structures handling protocols
			Equipment sustainability
			• Equipment selection based on local capacity
			• Standardisation across facilities for spare parts
			• Robust equipment suitable for marine environments
			• Modular systems allowing partial repairs
			• Extended warranties with local support
			• Climate-resilient installation methods
			• Local technician training before installation

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
			• Hands-on maintenance training during installation including video guides in local languages • Remote support mechanisms • Tool kits provided to facilities • Dedicated maintenance budgets in facility operations • Service contracts with regional suppliers • Spare parts inventory on each island • Preventive maintenance schedules • Performance monitoring systems • Equipment replacement planning • MEL (review of facility performance, community satisfaction surveys, equipment performance tracking) • Independent verification of installations • Community engagement on design and operational planning including (as necessary) **Operational waste management** • A hazardous waste management plan (HWMP) is to be developed for clinic operations, including adequate provisions for removal and disposal of medical and other hazardous waste and ensuring that disposal transporters and facilities hold all applicable waste permits.
Digital infrastructure	**a) Sustainability risks:** • Systems designed for developed country contexts with 24/7 IT support • Multiple incompatible platforms requiring different skill sets • Proprietary software requiring expensive annual licenses • Vendor lock-in preventing local modifications or repairs • Complex authentication systems unsuitable for shared terminals • High-spec requirements exceeding local hardware availability	**M / P** **M / P** **M / P** **M / P** **L / P** **M / P**	**a) Sustainability**: • Technology selection criteria to prioritise open-source or widely-used platforms, select equipment with local/regional vendor presence, standardise on single vendor/platform where possible, choose systems with offline functionality, implement modular systems allowing partial operation, avoid technology requiring frequent updates, vendor track record in Pacific, preference for proven technologies • Establish a regional technical support hub by partner with a university for IT training, create IT technician apprenticeship programs, develop video-based

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Reliance on international vendors for troubleshooting	M / P	troubleshooting guides, implement peer-support networks, certify local repair businesses • Remote support infrastructure including remote desktop access for troubleshooting, IoT sensors for predictive maintenance, automated error reporting systems, WhatsApp/Viber support groups • Sustainable sourcing and procurement strategy, including multi-year maintenance contracts with response times, regional framework agreements for common items, spare parts inventory, group purchasing across PHIT countries, standardised equipment lists, local assembly • Total cost of ownership approach, including 10-year operating costs factoring in training and support costs, power consumption, replacement cycles • Establish vendors requirements, such as mandatory local presence, training of local staff, performance bonds for support obligations, handover requirements in contracts, exit strategies preventing vendor lock-in **b) Environmental hardening:** • Specify equipment for tropical conditions (conformal coating on circuit boards, IP65 or higher ratings for equipment enclosures, stainless steel, positive pressure equipment rooms, dehumidifiers with auto-drainage, insect screens on all ventilation) • Raised equipment floors in flood-prone areas • Sealed cable entries with expanding foam • Sacrificial zinc anodes for corrosion protection • Regular cleaning and inspection schedules **c) Power resilience design**: • Online double-conversion UPS systems • Surge protection at multiple levels • Voltage regulators for brown-out protection • Isolation transformers for sensitive equipment • Power factor correction equipment • Automated shutdown sequences
	• Time zone differences delaying critical support	M / P	
	• Expensive on-site vendor visits for maintenance	M / P	
	• Software updates breaking local workarounds	M / P	
	• No local language support documentation	L / P	
	• Inability to source compatible components locally	M / P	
	• No local technicians familiar with specific systems	M / P	
	• Long lead times (3-6 months) for spare parts	M / P	
	• Customs delays and duties on equipment	M / P	
	• No local inventory of common components	M / P	
	• Incompatibility with locally available alternatives	M / P	
	b) Environmental vulnerabilities:		
	• Extreme humidity (>80%) causing circuit board corrosion	M / P	
	• Salt spray penetration even in "sealed" equipment	M / P	
	• Fungal growth inside electronic equipment	M / P	
	• Insect infiltration damaging components	M / P	
	• Cyclone damage to external infrastructure	M / P	
	• Flooding of ground-level equipment rooms	M / P	
	• Equipment overheating without 24/7 air conditioning	L / P	
	• Thermal cycling stress from power outages	L / P	
	• Inadequate ventilation in equipment rooms	L / P	
	• Battery degradation in high temperatures	L / P	
	c) Power infrastructure limitations:		
	• Grid instability and frequent black/brownouts damaging sensitive equipment	M / P	
	• Voltage spikes from lightning strikes	M / P	
	• Dirty power from diesel generators	M / P	
	• Complete outages (lasting up to days) common	M / P	

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Solar power issues for remote sites with no grid backup, including inadequate battery systems, lack of power during extended cloudy periods (common), inverter failures with no local repair, competing demands for limited power **d) Installation phase:** • Worker health and safety risks during equipment installation, including electrical safety • Disruption to healthcare services during installation, including risk of significant downtime • Electronic waste from replaced equipment • Inadequate infrastructure (power, cooling, connectivity)	**M / P** **M / T** **M / T** **L / T** **M / T**	• Oversized battery banks for off-gride sites (3-day autonomy minimum) • Hybrid solar-diesel systems • DC-powered equipment where possible • Low-power consumption specifications • Smart load management systems • Manual bypass options for all systems **d) Installation phase:** • Develop installation plans that minimise disruption to healthcare services • Ensure proper e-waste management protocols following ESS3 hierarchy • Conduct infrastructure assessments before installation to ensure adequate power, cooling, and connectivity • Establish redundancy systems and backup power solutions • Create maintenance schedules and train local technicians
Technical assistance	**a) AI-based diagnostic application:** • Embedded algorithmic bias and discrimination • AI trained on non-Pacific datasets may misdiagnose conditions in Pacific populations • Bias against minority ethnic groups, women, or specific age groups • Failure to recognise conditions • Inappropriate treatment recommendations based on non-local clinical guidelines, including culturally inappropriate recommendations • Risk of misdiagnosis leading to delayed or inappropriate treatment • Over-reliance on AI reducing clinical judgment • Liability issues when AI recommendations cause harm • Lack of validation for Pacific-specific disease presentations **b) Personal health data** • Insecure storage / reuse of private health data	 **M / P** **M / P** **M / P** **M / P** **M / P** **M / P** **M / P** **M / P** **M / P** **M / P**	**Cross-cutting measures:** • Establish a Regional Digital Health Ethics Committee • Develop Pacific Digital Health Standards and Guidelines • Create feedback and grievance mechanisms for all digital platforms • Regular user experience evaluations with diverse user groups • Continuous monitoring for unintended consequences • Budget allocation for ongoing localisation and updates **a) AI-based diagnostic application:** • Include Pacific medical experts in AI development and validation • Use diverse Pacific population health data for training (with consent) • Conduct extensive validation studies in each PHIT country • Build in uncertainty indicators and require human verification for critical decisions • Develop clear protocols for when AI should not be used • Ensure transparency in AI decision-making processes • Mandate human oversight for all AI-generated diagnoses

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Unauthorised access to sensitive health data	M / P	• Provide comprehensive training on AI limitations and appropriate use
	• Cross-border data transfer without adequate protections	M / P	• Establish clear liability frameworks and insurance requirements
	• Use of patient data for AI training without consent	M / P	• Create feedback mechanisms to report and correct errors
	• Data breaches expose personal health data	M / P	• Regular audits for bias and accuracy across different population groups
	c) Healthcare training content		• Develop Pacific-specific clinical validation protocols
	• Training materials showing inappropriate dress, behaviour, or practices	M / P	**b) Personal health data**
	• Case studies not reflecting Pacific contexts	M / P	• Implement end-to-end encryption for all health data
	• Language excludes/stigmatises certain groups	M / P	• Establish clear data governance agreements between countries
	• Gender stereotypes in healthcare roles	M / P	• Ensure explicit consent processes for data use
	• Local language use and incorrect translations	M / P	• Regular security audits and penetration testing
	• High bandwidth requirements excluding remote or poorly connected areas	M / P	• Data localisation options for sensitive information
	• Complex interfaces unsuitable for low digital literacy users	L / P	• Clear data retention and deletion policies
	• Lack of offline functionality	M / P	**c) Healthcare training content**
	• Outdated medical information	M / P	• Establish Pacific content review committees including diverse stakeholders
	• Conflicts with local treatment protocols	M / P	• Engage cultural advisors from each PHIT country
	• Insufficient localisation of drug names, dosages, or procedures	L / P	• Use local healthcare workers as models and case study subjects
	• Copyright violations in training materials	L / P	• Develop content in local languages with professional translation
	d) Health outreach tools		• Include traditional medicine perspectives where appropriate
	• Inaccurate health messages causing harm	M / P	• Ensure gender balance and diversity in all materials
	• Conflicting advice with traditional practices	M / P	• Follow WCAG 2.1 accessibility standards
	• Panic or stigma from poorly communicated health information	M / P	• Provide multiple formats (video, audio, text, pictorial)
	• Spread of unverified information through digital channels	M / P	• Enable offline download and low-bandwidth versions
	• Messages not reaching illiterate populations	M / P	• Use simple, intuitive interfaces tested with users
	• Digital tools exclude elderly, disabled, disadvantaged, minority users	M / P	• Provide assistive technology compatibility
	• Gender-biased health messaging	M / P	• Include sign language interpretation where feasible
	• Minority languages not represented	M / P	• Establish medical review boards for all content
			• Regular updates aligned with international and local guidelines
			• Clear version control and update notifications

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Collection of personal data through outreach apps	M / P	• Copyright clearance for all materials
	• Tracking of individual health behaviours	M / P	• Peer review by Pacific healthcare professionals
	• Sharing of community health data without consent	M / P	• Pilot testing with target audiences before full release
	• Targeted messaging revealing health conditions	M / P	**d) Health outreach tools**
	e) Policy and regulatory reform		• Community consultation on health messaging approaches
	• Changes adversely impact women, youth, elderly, disabled, minority and other disadvantage and/or marginalised groups	M / P	• Pre-test all messages with diverse focus groups • Use plain and local language and visual communications
	• Exclusion of vulnerable groups from policy consultation processes	M / P	• Avoid stigmatising language or imagery
	• Inadequate consideration of existing practice and norms, cultural contexts and influence of traditional practices across the PHIT countries	M / P	• Include or acknowledge traditional knowledge where appropriate • Design gender-specific, culturally appropriate messaging • Disability-inclusive communication strategies
	• Resistance to change from healthcare workers	M / T	• Minimal data collection principles
	• Inconsistent implementation across different islands/regions	M / P	• Anonymous options for health information access
	• Lack of coordination between jurisdictions	M / P	• Clear privacy notices in local languages
	• Privacy concerns with cross-border data sharing agreements	M / P	• Opt-in rather than opt-out for data collection
	• Potential job displacement or role changes	M / P	• Community consent processes for aggregate data use • Regular privacy impact assessments
	f) Health outreach programs		**e) Policy and regulatory reform**
	• Community health worker safety risks ◦ Physical safety concerns when visiting isolated households, particularly in areas with limited mobile coverage or difficult terrain ◦ Risk of harassment or violence against female health workers visiting homes alone ◦ Potential for being caught in domestic disputes or encountering intoxicated/aggressive individuals ◦ Safety risks from dogs, livestock, or environmental hazards at remote properties	S / T	• Conduct inclusive stakeholder consultations following SEP guidelines that encompass all impacted groups, including healthcare staff, training providers, health professionals, applicable accreditation bodies, governing bodies and ministries, representative community groups • Ensure representation of vulnerable groups, women, youth, and minorities in policy development • Conduct a comprehensive policy impact analysis (PIA) for major changes covering potential risks including job displacement, healthcare workforce impacts, accessibility, coverage, international policy alignment, amongst other factors.
	• Domestic violence and neglect	M / T	

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	◦ Encountering domestic violence, child abuse, or neglect during household visits ◦ Health workers unprepared to respond appropriately when witnessing or learning about GBV/abuse ◦ Risk of escalating violence if perpetrators feel threatened by health worker presence ◦ Inadequate protocols for mandatory reporting while maintaining victim safety ◦ Secondary trauma to health workers from repeated exposure to abuse situations • Privacy and confidentiality breaches ◦ Household members overhearing sensitive health discussions intended for individuals ◦ Data security concerns with health information stored on portable devices ◦ Community health workers who are local residents potentially sharing health information informally ◦ Screenshots or photos of health data being shared inappropriately via social media • Community tensions ◦ Erosion of traditional healing relationships and knowledge systems ◦ Community elders and traditional healers feeling undermined by digital health tools ◦ Risk of creating conflict between modern and traditional health advice ◦ Communities rejecting outreach if seen as dismissive of traditional practices ◦ Need for chief/elder permissions ◦ Gender restrictions on household visits	**M / P** **L / T**	• Develop local and culturally appropriate implementation strategies for each country • Provide change management support and training for healthcare workers • Establish inter-jurisdictional coordination mechanisms • Develop robust data governance frameworks aligned with international best practices • Create transition plans for workers whose roles may change • Pilot reforms in selected areas before full rollout **f) Health outreach programs** • Community-centred planning, including: ◦ Participatory mapping with communities defining priorities ◦ Integration with existing gatherings, partnerships with traditional healers and churches ◦ Youth involvement in planning • Implement safety protocols, including: ◦ A buddy system with health workers visiting in pairs, particularly in isolated areas ◦ Daily check-in protocols with supervisors including GPS location sharing ◦ Safety training including de-escalation techniques and environmental hazard awareness ◦ Household risk assessment tools to identify potentially unsafe situations before visits ◦ Equip workers with panic buttons linked to local police/security services ◦ Clear protocols for leaving unsafe situations immediately • Cultural adaptation and anti-discrimination measures, including: ◦ Establishing community advisory groups of elders, traditional healers, and diverse community representatives to review all outreach content ◦ Local testing to identify and correct biases ◦ Content streams that reference traditional health practices

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	◦ Church authority competing with health messages ◦ Difficult health topics (sexual health, mental health) • Referral pathways for identified health issues ◦ Outreach identifying serious conditions without accessible treatment options ◦ Creating anxiety/demand for services not available in remote areas ◦ Raising expectations for healthcare that the system cannot deliver ◦ Frustration when diagnostic app recommends unavailable interventions • Cultural appropriateness ◦ Discriminatory bias in digital tools ◦ App content may not reflect local health beliefs, traditional medicine practices, or cultural sensitivities around body/illness discussion ◦ Language translations may be inappropriate ◦ Visual representations in app may not reflect local dress, body types, or cultural contexts • Health worker matching ◦ Health workers not matched to community demographics and needs ◦ Male health workers may be culturally inappropriate for maternal/reproductive health discussions with women ◦ Young health workers may lack credibility with elderly community members on traditional health practices ◦ Workers from different ethnic/religious backgrounds may face acceptance barriers in certain communities ◦ Urban-based workers may not understand rural/remote community contexts and challenges	**M / P** **M / P** **M / T**	◦ Visual content using local community members as models and culturally appropriate imagery ◦ User feedback mechanisms to report culturally inappropriate content • Recruitment of health workers to ensure: ◦ Recruitment from within target communities who understand local contexts ◦ Gender balance in teams to allow matching with household preferences ◦ Comprehensive cultural competency training including local customs, languages, and health beliefs ◦ Partnerships with community leaders to identify trusted individuals for health worker roles ◦ Clear protocols for when to involve community elders or traditional healers • Implement a GBV/child protection response framework, including: ◦ GBV/child protection training for all outreach workers ◦ Clear reporting protocols balancing mandatory reporting with victim safety ◦ Partnerships with local GBV service providers and safe houses ◦ Safety planning tools workers can use with victims during visits ◦ Psychological support and debriefing for workers exposed to trauma ◦ Discreet referral pathways that don't require immediate confrontation with perpetrators • Implement privacy and confidentiality safeguards, including: ◦ Data encryption on all devices ◦ Training workers on conducting private health discussions ◦ Clear confidentiality agreements with local health workers ◦ Anonymous reporting options for sensitive health issues ◦ Community education about health privacy rights • Establish realistic referral networks by: ◦ Mapping available services before outreach begins ◦ Building realistic referral options into the outreach app/content

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	g) Training • Discrimination and social exclusion of visiting trainees ◦ Trainees from smaller Pacific nations facing prejudice or stereotyping in host countries ◦ Language barriers and accent discrimination affecting learning participation ◦ Cultural misunderstandings leading to social isolation from local healthcare staff ◦ Exclusion from informal learning networks and after-hours professional discussions ◦ Gender-based discrimination, particularly for female trainees in male-dominated specialties • Sexual exploitation and abuse, and sexual harassment ◦ Power imbalances between senior trainers and visiting trainees creating vulnerability ◦ Accommodation arrangements placing trainees in unsafe situations ◦ After-hours social events where alcohol consumption increases SEA/SH risks ◦ Lack of trusted reporting mechanisms for visiting trainees fearing visa/training consequences ◦ Cultural differences in professional boundaries being exploited • Support systems for trainees away from home ◦ Mental health impacts from isolation and homesickness without culturally appropriate support ◦ Financial hardship if stipends don't match living costs ◦ Family emergencies at home with limited ability to respond or return ◦ No advocacy when facing unfair treatment or training quality issues	**M / T** **M / T** **L / T**	◦ Developing telehealth connections for specialist consultations where physical referral isn't possible ◦ Creating clear communications about service limitations during initial community engagement ◦ Establishing mobile clinic schedules coordinated with outreach findings ◦ Developing holding protocols for conditions requiring delayed treatment **g) Training** • Anti-discrimination frameworks, including: ◦ Host institution accountability pledges ◦ Buddy systems with local staff ◦ Cultural competency training for supervisors ◦ Anonymous discrimination reporting mechanisms • SEA/SH prevention ◦ Accommodation risk assessments ◦ Independent reporting hotlines via home PMUs ◦ Women's safety organisation partnerships ◦ Mandatory codes of conduct for trainers • Welfare support networks ◦ Pacific diaspora organisation partnerships ◦ Emergency funds for crises ◦ Virtual family connection facilitation ◦ Telehealth mental health support • Professional development agreements ◦ Specified learning objectives ◦ Exploitation prohibition clauses ◦ Clear grievance procedures ◦ Regular training quality reviews

Activity type	Potential risks and impacts	Risk*	High-level recommendations for mitigating risks and impacts
	• Exploitation and unfair treatment ◦ Visiting trainees assigned menial tasks rather than meaningful learning opportunities ◦ Excessive work hours justified as "training requirements" ◦ Limited access to advanced equipment or procedures reserved for local trainees ◦ Unrealistic expectations about training content and living conditions ◦ Limited understanding of rights and recourse mechanisms ◦ Poor financial planning leading to debt or exploitation	**M / T**	◦ Pre-relocation engagement and training of trainees on rights, expectations, planning and outcomes

** Unmitigated risk rating (estimate). H = High, S= Substantial, M = Moderate, L = Low. T = Temporary, P = Permanent.*

5.5. Specific risks and mitigation measures

5.5.1. Vulnerable and disadvantaged groups

Specific measures to address risks associated with disadvantaged, vulnerable, minority and marginalised groups for the PHIT project include:

Healthcare access and PHC service reinforcement

- Inclusive stakeholder consultations (following SEF guidelines) that encompass all impacted groups, including healthcare staff, training providers, health professionals, accreditation bodies, governing bodies, ministries, and representative community groups to ensure vulnerable groups' voices are heard in policy development.
- Community-based digital health outreach programs will target communities, schools, and childcare centres, specifically designed to support adoption of healthy behaviours, provide psychosocial interventions, conduct NCD screening, and refer for early intervention, with focus on women, children, young people, and vulnerable groups.
- All facilities will be required to comply with disability standards, incorporating ramps, accessible toilets, tactile surfaces, and appropriate signage to ensure physical access for people with disabilities, and include culturally appropriate spaces such as separate consultation areas for women, birthing rooms that respect traditional practices, and prayer/meditation spaces.

Digital inclusion and non-discrimination

- Standards and guidelines specifically tailored to Pacific contexts will be established for digital content development, including the recommendation to establish a Regional Digital Health Ethics Committee to oversee implementation and prevent discrimination.
- Continuous bias monitoring and algorithm audits disaggregated by ethnicity, gender, location, and age.
- Establish diverse advisory groups including healthcare workers from all levels, youth representatives, and minority language speakers to review AI algorithms, content accuracy, and cultural appropriateness through iterative testing cycles with documented design changes based on feedback.
- Include Pacific medical experts in AI development and validation, use diverse Pacific population health data for training (with consent), conduct extensive validation studies in each PHIT country, and build in uncertainty indicators to prevent over-reliance on AI recommendations.
- Incorporate user feedback mechanisms to report culturally inappropriate content.

Targeted engagement strategies

- Vulnerable population partnerships through trusted community organisations and healthcare providers who have established relationships with elderly patients, people with disabilities, and remote island communities
- Accessible communication materials including simplified materials using pictographs and local language translations to reach those with limited literacy.

- Structured separate sessions for women, youth, healthcare workers, and patients with chronic conditions to create safe spaces for open discussion, with facilitators matched to participant demographics who speak local languages fluently.
- Engagement with female-headed households to address specific barriers including poverty, limited access to resources, lack of voice in community, and time constraints due to multiple commitments.

Other measures to consider in subproject planning

- Specific measures for protecting indigenous values, land, and culture to be incorporated based on consultations for relevant subprojects.
- Specific measures for ensuring mental health services are accessible and culturally appropriate for vulnerable groups, particularly in remote areas.
- Youth-specific health services including youth-friendly health services design and delivery, particularly for sensitive health topics.
- Economic vulnerability safeguards for households below poverty lines to ensure project activities don't further impact their economic status.
- Recognition of traditional medicine to ensure vulnerable groups who rely on traditional practices aren't excluded from modern healthcare access.
- Subproject-specific gender-based violence response protocols for vulnerable women accessing health services.
- Emergency healthcare access to ensure vulnerable groups can access emergency services, particularly in remote islands during climate events.

5.5.2. Sexual exploitation and abuse, sexual harassment, gender-based violence (SEA/SH/GBV)

The governments of the PHIT countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). By ratifying CEDAW, they have made a commitment to ensure that the principles of equality are adhered to and that discriminatory practices including sexual exploitation and abuse and sexual harassment are abolished. Provisions to prevent sexual exploitation and abuse and sexual harassment will be included in the Code of Conduct for Project staff and for contracted workers in line with relevant international standards and national legislation.

The initial risk screening for the civil works activities of the PHIT project indicate a **Substantial** level of SEA/SH risk. This is principally due to the significant SEA/SH risk associate with the civil works planned at the CWM Hospital, which include both renovation and new construction. These activities will result in significant labour influx, as construction workers—often from outside the local community—are brought in to complete the works. The presence of non-local workers can disrupt local dynamics, create power imbalances, and increase the risk of SEA/SH, especially for women, children, and other vulnerable groups. Risks include increased opportunities for exploitation and abuse, potential for sexual harassment and abuse of both community members and workers, and heightened vulnerability of women and girls in the vicinity of construction sites. The possibility of exacerbating pre-existing social problems and harmful practices is also a concern, as has been observed in other contexts involving major civil works and labour influx.

These project-related risks are layered on top of existing contextual challenges. Widespread socio-economic hardship and limited job opportunities—particularly for women and youth—lead to increased risk of exploitation and abuse, compounded by limited access to health, legal, and social support services for SEA/SH survivors and gaps in project supervision. Gender-based violence is prevalent, and cultural norms may discourage reporting of abuse due to stigma or fear of retribution.

Other potential SEA/SH risks relate to movement of health workers from various Pacific Island countries to Fiji's Colonial War Memorial (CWM) Hospital for specialised training, as well as the expansion of health care workers' community engagement through school-based and community health interventions. Such activities introduce new SEA/SH risks for both health care workers and the communities they serve, particularly as workers travel to foreign countries and visit new, often rural or remote, worksites that may lack adequate oversight. There are also specific concerns about SEA/SH risks to children as a result of healthcare workers' presence in schools.

For these risks to be adequately and properly addressed, an effective **SEA/SH Action Plan** contained in the Project ESMF which includes an Accountability and Response Framework, is mandatory for major civil works subprojects (being construction of the new hospital in Suva and renovation / re-development of the CWM Hospital).

The SEA/SH Action Plan sets out:

- The necessary protocols and mechanisms that the project will put in place to address SEA/SH risks;
- How any SEA/SH allegations that may arise are to be addressed;

The Action Plan must set out specific arrangements for addressing SEA/SH risks for both workers and the community, including:

- An awareness raising strategy setting out how workers and local communities will be sensitised to SEA/SH risks and worker's responsibilities under the project Code of Conduct;
- The information that will be provided to employees and the community on how to report cases of SEA/SH via the workers GM;
- The WGM process for notifying the Contractor of allegations;
- GBV service providers to which GBV/SEA/SH survivors will be referred, and the services which will be available, including specific provisions for child survivors of GBV;
- Plans to coordinate with others working on GBV/SEA/SH and child safeguards locally.

The SEA/SH Accountability and Response Framework sets out how allegations of SEA/SH will be handled (investigation procedures) and disciplinary action for violation of the Code of Conduct by workers, and is to include at a minimum:

- How allegations will be handled, in what timeframe, and the range of possible disciplinary actions for violation of the CoC by workers, taking account of due process;
- Procedures to report SEA/SH allegations internally for case accountability;
- Protocols on responding to survivors, applying the survivor-centred approach, including a referral pathway to refer survivors to appropriate support services;
- Procedures that clearly lay out confidentiality requirements for dealing with cases;

- Specific provisions to address allegations involving children who are survivors of SEA/SH, including the consideration of the best interests of the child, specialist support services, and the role of parents/guardians in the response process;
- Protocols to comply with mandatory reporting requirements, if applicable under national law, including to inform survivors (ideally prior to disclosure) of this obligation and any limits on confidentiality;
- Procedures for review of complaints or incident reports, including information on the investigation and verification process and related information-sharing and reporting requirements; and
- Protocols for protection of whistleblowers and prohibition on retaliation against survivors, consistent with the World Bank's Commitments on Reprisals.

5.6. Risks and mitigation measures related to regional data privacy provisions

Many PHIT activities will involve developing shared policies, protocols and data-sharing arrangements among the PHIT countries. This is a key challenge being addressed by the PHIT project. Aligning arrangements for data sharing and data privacy will be of particular concern. An overview of the status, key challenges and recommended approach is provided below.

General status on data privacy and sharing among PHIT countries

- Limited existing frameworks: All four countries currently have limited comprehensive data protection legislation, creating a relatively blank slate for establishing common standards. This absence of conflicting frameworks could facilitate the development of harmonised regional approaches.
- Constitutional privacy protections: Fiji explicitly recognises the right to personal privacy and confidentiality of personal information in its Constitution (Clause 24). While not detailed specifically, most Pacific nations have similar constitutional provisions that could serve as a foundation for regional alignment.
- Sectoral health data protections: All countries appear to have some form of medical confidentiality provisions within their health legislation or professional regulations (e.g., Fiji's Medical and Dental Practitioner Act 2010), establishing a baseline expectation of health data protection.
- Shared development trajectory: All four countries are actively developing or planning digital government frameworks and data protection legislation, suggesting openness to modernising their data governance approaches.

Key Challenges

The PHIT countries are at different stages of data protection maturity:

- Fiji lacks comprehensive data protection law despite having the most developed digital economy
- Kiribati has the most developed framework with its Digital Government Act 2023, including specific provisions for data classification, consent requirements, and inter-agency sharing

agreements (which may be over-engineered for the local context using frameworks from advanced economies)

- Tonga has a strategic framework but awaits enacted legislation
- Tuvalu has the most limited framework, relying on general ICT policy without enforceable mechanisms

The PHIT countries have different regulatory approaches:

- Fiji relies on constitutional provisions and sectoral laws without unified oversight
- Kiribati requires written approval from Senior Responsible Officers and individual consent for data access
- Tonga and Tuvalu lack specific operational requirements for health data handling

There are no established regional data transfer mechanisms:

- None of the countries have established frameworks for cross-border health data transfers, which will be essential for telehealth services, regional patient registries, and overseas medical referrals under PHIT.
- No country has a dedicated data protection authority
- Enforcement mechanisms are weak or non-existent
- Different ministries oversee digital/data initiatives (e.g., Ministry of Finance in some cases, dedicated ICT ministries in others)
- Countries have vastly different levels of digital infrastructure and connectivity, which could complicate standardised data-sharing protocols.

Implications for PHIT

The project will need to:

- Establish a regional data governance framework that exceeds current national standards while remaining implementable
- Create standardised consent mechanisms for cross-border health data sharing
- Develop common technical standards for data security and interoperability
- Build institutional capacity for data protection oversight
- Navigate the tension between enabling regional health service integration and respecting national sovereignty over health data

5.7. Transboundary and cumulative impacts

Potential transboundary risks include international people movements (construction workers, healthcare workforce, trainees/students), international data transfers (see section 5.6), and regional health policy alignment. These are principally risks to effective project delivery rather than impacts.

There are no identified cumulative impacts other than those related to essential services for the new hospital facility, as identified under the Infrastructure and Service Provision Plan (Annex 1).

5.8. Planning and design considerations for avoidance of environmental and social risks and impacts

Activity	Planning and design considerations
Construction of new regional hospital facility in Suva, Fiji	• Select a suitable site with low potential for local social and environmental impact, considering any conservation or heritage values of the proposed footprint, land tenure and rights, resettlement, local neighbourhood density, impacts of residual local pollution (e.g. air, noise), and availability of services (power, water, sewage, telecom capacity). • Consider the full implications of waste management and plan for significant new streams of medical and hazardous waste (i.e. planning and investment should encompass the entire waste management lifecycle). • Consider the implications of significant new sewage streams and available treatment capacity. • Consider the implications of public and private transport availability for any proposed site.
Renovation / refurbishment of CWM Hospital in Suva, Fiji	• Renovation/refurbishment should be planned and designed in discrete packages considering the impacts of active construction works on the operation and occupant health and safety of the hospital, and the safe transport and disposal of any hazardous waste, with the expectation that substantial asbestos might be encountered.
Upgrade / replacement of local PHC facilities and/or nursing schools	• Clinic upgrades should be planned individually with an appropriate level of local consultation to ensure upgrades are needs-based and are not objectionable to the community served or impacted. • Land tenure or lease arrangements need to be formalised in writing. • The significant risks associated with transport of modular structural materials by boat to remote location, including loading/offloading, must be adequately addressed. • The sustainability and suitability of solar-powered and ICT-enabled clinics in remote locations needs to be carefully considered and planned.
Digital platforms and content	• Substantial consultation and testing needs to be undertaken to avoid substantial risks of embedding discrimination or culturally inappropriate content in healthcare training materials and AI-based diagnostic tools.
Digital infrastructure (hardware)	• Vendors and ICT systems must be carefully selected on the basis of a needs-based assessment, and local maintainability and longevity with respect to the tropical conditions, unstable power grid, limited local technical capacity and limited public financial resources.
Policy and regulatory reform, program implementation	• Extensive consultation and testing must be conducted to ensure that changes to healthcare accreditation, policies, data sharing and privacy arrangements and other regulatory reforms are acceptable to healthcare workers, patients and the broader community, and improve rather than degrade quality healthcare access for all.
Health outreach programs	• Careful planning and mitigations needs to be put in place to protect health outreach workers from harm and equip them to handle situations of domestic violence and child abuse that they may encounter.

	• This will involve meaningful local engagement to ensure the local suitability of outreach programs and staff.
Training	• Effective measures need to be put in place to protect visiting trainees from exploitation and SEA/SH risks.

6. IMPLEMENTATION ARRANGEMENTS AND PROCEDURES

6.1. Project management structure and institutional arrangements

The Project will be implemented through Project Management Units (PMUs) established with the host ministries of the respective PHIT Countries and the SPC Public Health Division, coordinated under a Regional Steering Committee (RSC) and supported by a third-party implementor and UNICEF. The overall management structure for the PHIT regional project is outlined in Figure 2.

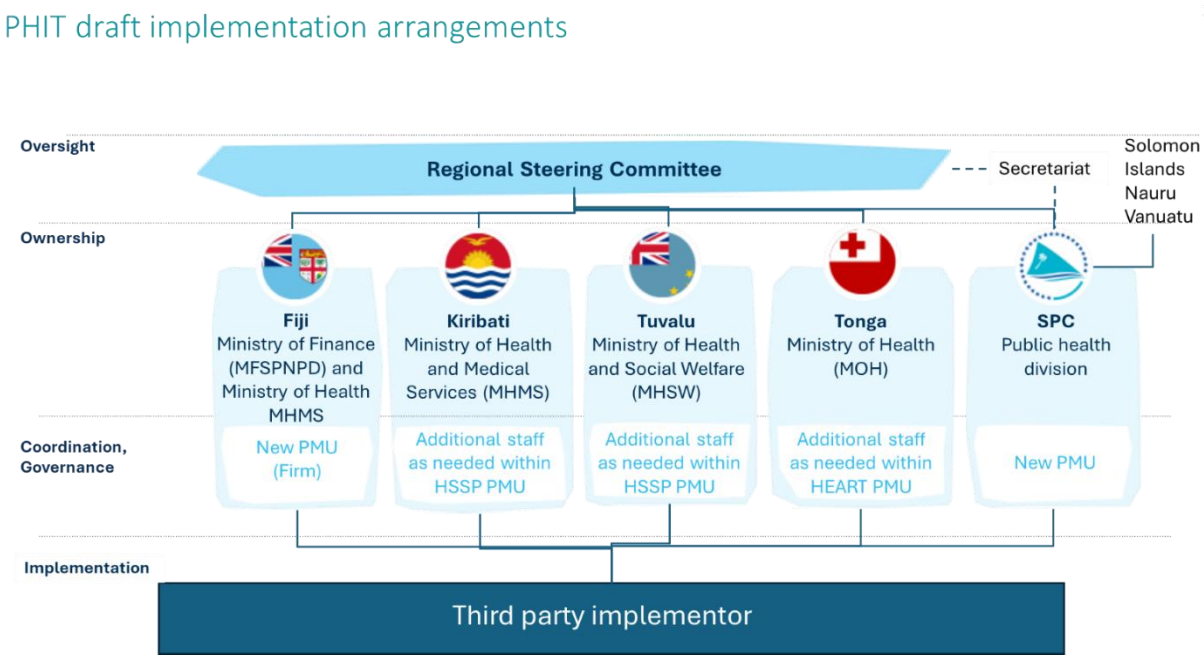

Figure 2: Outline of project management and institutional arrangements for the PHIT project

6.1.1. Regional Steering Committee

A RSC will be formed and will meet within 12 months of project effectiveness and annually thereafter, to i) provide strategic advice related to the progress made towards the delivery of PHIT's regional public goods; ii) provide high levels of political oversight, ownership, and commitment toward the attainment of PHIT regional public goods ; and iii) facilitate cross-country knowledge sharing on results, implementation progress, and lessons learned. RSC will be comprised of Ministers (or his/her delegated representative) from the PHIT implementing agencies from Fiji, Kiribati, Tuvalu, and Tonga. SPC will serve as a Secretariat to the RSC and will organize annual meetings and provide logistical and technical support. This aligns with the role the SPC plays in events such as the Pacific Health Ministers' meeting. The RSC will meet annually, preferably on the sidelines of existing regional meetings, such as the Pacific Health Ministers' meeting to maximize regional spillovers and share results beyond participating countries.

6.1.2. Project Management Units

The Project will establish (where not extant) or expand (where extant) and maintain Project Management Units (PMUs) under the supervision of PHIT implementing agencies, with qualified staff

and sufficient resources to support the day-to-day management of environmental, social, health and safety risks and impacts related to the Project including identified positions set out in this ESMF. This will be through 'E&S staff', either a national and/or international E&S Specialist, national E&S Officer, and/or via E&S resources within a contracted third-party implementer firm (henceforth 'Firm'). Expected arrangements for PMU establishment/expansion as at July 2025 are below:

- Fiji: Establishment of a new PMU in the Ministry of Finance, which will work in coordination with the Ministry of Health. The Government of Fiji, considering the wide scope of PHIT in the country, will hire a firm to fulfil the function of the PMU for the project.
- Kiribati: Expansion of the existing PMU for the Kiribati Health Systems Strengthening Project (P176306), implemented by the Ministry of Health and Medical Services with fiduciary and safeguards support from Kiribati Fiduciary Support Unit;
- Tonga: Expansion of the existing PMU for the Health Enhancement and Resiliency in Tonga (HEART) Project (P180965);
- Tuvalu: Expansion of the existing PMU for the Tuvalu Health System Strengthening Project (P175170), which is supported by the Central Project Management Office (CPMO) under the Ministry of Finance, and the United Nations Office for Project Services (UNOPS);
- SPC: Establishment of a new PMU under SPC's Public Health Division.

Implementing agencies will ensure that the key positions of the Project Coordinator and Financial Management, Procurement, Environment and Social Safeguards, and Monitoring and Evaluation Specialists, are staffed, within three months of project effectiveness and maintained throughout the lifetime of PHIT. To complement these key roles, hiring of specialized positions that are conducive to the successful implementation of PHIT, such as a civil engineer, a health specialist, a hospital manager, and an expert in private sector engagement in health can be considered on a needs basis as relevant to each implementing agency under PHIT.

Each PMU will be responsible for coordinating the implementation of the Project on behalf of the implementing agencies, leveraging the third-party implementor for regional procurements of goods and services. This includes monitoring and evaluating activities per contractual arrangements; carrying out fiduciary management and oversight; and preparing quarterly and annual financial and technical implementation reports agreed activities for PHIT. All PMUs will be significantly supported in all aspects of project implementation, including planning, procurement, implementation of PHIT activities by the shared third-party implementor.

6.1.3. Pacific Community

The Pacific Community (SPC) will play a pivotal role as a Pacific regional organisation with a scientific and technical mandate owned and governed by 27 country and territory members. PHIT will leverage and build capacity within SPC's public health division to maximise regional spillovers and build capacity for sustained impact of PHIT interventions. SPC will receive project funds directly through a regional IDA grant. PHIT countries will sign a MOU with SPC as recipients of its services.

SPC's responsibilities under PHIT include:

ii. Serve as Secretariat to the RSC; organise annual meetings of the participating countries to discuss achievements, issues, and lessons learned;

iii. Support regional convening and technical assistance to build a stronger Pacific workforce empowered and enabled to deliver a modernised Pacific model of care (e.g. identify training

needs and competency gaps among PHC and specialist staff, facilitate meetings for the regional networks and partners to update clinical guidelines, clinical pathways and NCD care protocols, facilitate regional roll out of continued professional development (CPD) curricula and simulation-based learning modules, establish or strengthen regional training partnerships across select teaching institutions in PHIT countries, build a regional network of mentors, trainers and local champions to ensure sustainability, institutionalise CPD frameworks through accreditation and professional standards);

iv. Facilitate knowledge sharing, regional dialogue and maximise regional spillover of PHIT to other countries including but not limited to Solomon Islands, Nauru and Vanuatu;

v. Oversee and support M&E activities across the countries and of the regional activities under its responsibility and prepare consolidated annual project status reports on progress in implementing country and regional activities.

SPC will only manage grant funds for participating countries that do not have a legal agreement with the WB, including in the first phase, e.g., Nauru, Samoa, Solomon Islands and Vanuatu, to build critical regional competencies and expand the volume of the regional health workforce.

6.1.4. Third-part Implementer

A third-party implementer will be engaged as a shared project implementation partner, to provide substantial implementation support, build PMU capacity, and enable bulk procurement. Based on guidance from the Ministries of Finance during in-country missions to PHIT countries, and lessons from recent portfolio reviews highlighting low disbursement capacity, PHIT countries have agreed to use a shared third-party implementor to (a) provide hands-on implementation support; (b) leverage and build PMU capacity; and (c) procure in bulk to deliver in each country civil works, equipment, inputs and technical assistance, achieving regional economies of scale, cost efficiencies and quality for small markets with low purchasing power. To ensure coordination across project components and countries, a single entity will be contracted as the third-party implementor. Each PHIT country will enter into a subsidiary agreement with the third-party implementor, stipulating the terms of reference of expected support (mirroring the legal agreement on project activities that each country will have under PHIT). The recruitment of a third-party implementor will be done by going to market during the preparation of PHIT, could comprise single firms or consortia. The selected implementer will be responsible for supporting PMUs to achieve the project development objectives and results targets for PHIT and to build capacity to sustain project impact over time.

6.1.5. UNICEF

UNICEF will provide regional implementation support to boost implementation capacity. Countries will leverage UNICEF's field presence, global leadership role in procurement, and proven experience in civil works and digital innovation in the Pacific, to provide hands-on implementation support to countries to achieve regional coordination, pooled procurement and delivery of regional coordination around public goods for defined activities under subcomponents 1.2, 1.3, 3.1 and 3.2. Each PHIT implementing agency will enter into a standard form of agreement (SFA) with UNICEF.

6.1.6. Implementation arrangements

Error! Reference source not found. below summarises the roles and responsibilities regarding the i mplementation arrangements for environmental and social management.

Table 10: Implementation Arrangements

Level / responsible party	Roles and responsibilities
National (PMU Project Manager)	• Provide support, oversight, and quality control to field staff working on environmental and social risk management. • Collect, review, and provide quality assurance and approval to Screening Forms and ESMPs as relevant. Keep documentation of all progress. • Oversee overall implementation and monitoring of environmental and social mitigation and management activities, compile progress reports from local levels/subprojects, and report to the World Bank on a semi-annual basis. • Train central and field staff and contractors who will be responsible for implementing the ESMF. • Ensure that all bidding and contract documents include all relevant E&S management provisions per screening forms, ESMPs, and ESCOPs.
Contractors	• Comply with the Project's environmental and social mitigation and management measures as specified in ESMPs, ESCOPs, and contract documents, as well as national and local legislation. • Take all necessary measures to protect the health and safety of workers and community members, and avoid, minimise, or mitigate any environmental harm resulting from project activities.

6.2. Environmental and social risk management procedures

E&S risk management procedures will be implemented as an integral part of the development process for each subproject following the steps outlined in Table 11 and explained in the following sections.

Table 11: Subproject cycle and E&S management procedures

Subproject stage	E&S Management Procedures
1. Screening: Subproject assessment and analysis	• During subproject identification, ensure subproject eligibility by referring to the *Exclusion List in table 5* below. • For all activities, use the *Screening Form in Annex 1* to identify and assess potential environmental and social risks and impacts, and identify the appropriate mitigation measures for the subproject. • Identify the documentation, permits, and clearances required under the government's Environmental Regulation.
2. Formulation and planning: Formulation and planning of subproject activities, including human and budgetary resources and monitoring measures	• Based on *Screening Form* adopt and/or prepare relevant environmental and social procedures and plans. • Environmental and Social Management Plans (ESMPs) are to be reviewed by the World Bank and given a no-objection prior to initiating bidding processes (for subprojects involving bidding processes) and/or launching activities (for subproject activities not subject to bidding). • Ensure that the contents of the ESMPs are shared with relevant stakeholders in an accessible manner and consultations are held with the affected communities in accordance with the SEP. • Complete all documentation, permits, and clearances required under the government's Environmental Regulation.

	• Train staff responsible for implementation and monitoring of plans. • Incorporate relevant environmental and social procedures and plans into contractor bidding documents; train contractors on relevant procedures and plans.
3. Implementation and monitoring: Implementation and continuous monitoring of subprojects	• Ensure implementation of plans through site visits, regular reporting from the field, and other planned monitoring. • Track grievances/beneficiary feedback. • Continue awareness raising and/or training for relevant staff, volunteers, contractors, communities.
4. Completion, review and evaluation: Qualitative, quantitative, and/or participatory data collection and review	• Assess whether plans have been effectively implemented. • Ensure that physical sites are properly restored.

6.3. Step 1: Screening

All proposed activities should be screened to ensure that they are within the boundaries of the Project's eligible activities, and that they are not considered activities listed on the E&S activity exclusion list in Table 12.

Table 12: Activity exclusion list

Excluded activities
• Weapons, including but not limited to mines, guns, ammunition, and explosives • Support of production of any hazardous good, including alcohol, tobacco, and controlled substances • Any construction in protected areas or priority areas for biodiversity conservation, as defined in national law • Activities that have the potential to cause any significant loss or degradation of critical natural habitats, whether directly or indirectly, or which would lead to adverse impacts on natural habitats • Activities that involve extensive harvest and sale/trade of forest resources (post, timber, bamboo, charcoal, wildlife, etc.) for large-scale commercial purposes • Activities involving changing forestland into agricultural land or logging activities in primary forest • Purchase or use of banned/restricted pesticides, insecticides, herbicides, and other dangerous chemicals (banned under national law and World Health Organization (WHO) category 1A and 1B pesticides) • Construction of any new dams or rehabilitation of existing dams including structural and or operational changes; or irrigation or water supply subprojects that will depend on the storage and operation of an existing dam, or a dam under construction for the supply of water • Activities that involve the use of international waterways • Any activity affecting physical cultural heritage such as graves, temples, churches, historical relics, archaeological sites, or other cultural structures • Activities that may cause or lead to forced labour or child abuse, child labour exploitation or human trafficking, or subprojects that employ or engage children, over the minimum age of 14 and under the age of 18, in connection with the project in a manner that is likely to be hazardous or interfere with the child's education or be harmful to the child's health or physical, mental, spiritual, moral, or social development

- Any activity on land that has disputed ownership or tenure rights
- Any activity that will cause physical relocation of households or will require the use of eminent domain
- Any activity that will require Free, Prior and Informed Consent (FPIC) as defined in ESS7
- Any activity that poses a High Risk pursuant to the WB ESF
- Any activity that causes substantial negative effects on critical habitats or species (such as those classified as Endangered or Critically Endangered by the IUCN), where mitigation efforts cannot achieve No Net Loss or Net Gain of biodiversity (and residual impacts cannot be offset)
- Any activity that requires permanent acquisition of land that indigenous peoples are in the process of requesting recognition for as indigenous peoples' collectively owned land

The PMU will use the ***E&S Screening Form in Annex 2*** to identify and assess relevant environmental and social risks specific to the activities, and identify the appropriate mitigation measures. The *Screening Form* lists the various mitigation measures and plans that may be relevant for the specific activities (such as the Environmental and Social Codes of Practice, the Environmental and Social Management Plan, the Labor Management Procedures, Chance Find Procedures, etc.)

The PMU will also identify the documentation, permits, and clearances required under the government's Environmental Regulation.

6.4. Step 2: Formulation and planning

Based on the process above and the Screening Form, the PMU[1] will adopt the necessary environmental and social management measures already included in the Annexes of this ESMF (such as the ESCOPs, the LMP, etc.) or develop relevant site-specific environmental and social management plans.

If site-specific ESMPs are necessary, the PMU will prepare these ESMPs and other applicable documents as needed. The PMU will provide approval and compile ESMPs and other applicable forms. The contents of the ESMPs will be shared with relevant stakeholders in an accessible manner, and consultations will be held with the affected communities on the environmental and social risks and mitigation measures. If certain subprojects or contracts are being initiated at the same time or within a certain location, an overall ESMP covering multiple subprojects or contracts can be prepared. Some moderate risk subprojects may also benefit from the preparation of a site-specific environmental and social assessment prior to the preparation of an ESMP.

ESMPs will also be submitted to the World Bank for prior review and no objection. The World Bank and the PMU will assess whether prior review is only needed for ESMPs in a certain category (e.g. activities exceeding a certain budget, for certain types of activities).

The PMU will also complete the documentation, permits and clearances required under the government's Environmental Regulation before any project activities begin.

At this stage, staff who will be working on the various subproject activities should be trained in the environmental and social management plans relevant to the activities they work on. The PMU should provide such training to field staff.

The PMU should also ensure that all selected contractors, subcontractors, and vendors understand and incorporate environmental and social mitigation measures relevant to them as standard operating

[1] Or responsible party in the implementing agency

procedures for civil works. The PMU should provide training to selected contractors to ensure that they understand and incorporate environmental and social mitigation measures; and plan for cascading training to be delivered by contractors to subcontractors and vendors. The PMU should further ensure that the entities or communities responsible for ongoing operation and maintenance of the investment have received training on operations stage environmental and social management measures as applicable.

6.5. Step 3: Implementation and monitoring

During implementation, the PMU will conduct regular monitoring visits. The PMU working to implement the project will ensure that monitoring practices include the environmental and social risks identified in the ESMF and will monitor the implementation of E&S risk management mitigation plans as part of regular project monitoring.

At a minimum, the reporting will include (i) the overall implementation of E&S risk management instruments and measures, (ii) any environmental or social issues arising as a result of project activities and how these issues will be remedied or mitigated, including timelines, (iii) Occupational Health and Safety performance (including incidents and accidents), (iv) community health and safety, (v) stakeholder engagement updates, in line with the SEP, (vi) public notification and communications, (vii) progress on the implementation and completion of project works, and (viii) summary of grievances/beneficiary feedback received, actions taken, and complaints closed out, in line with the SEP. Reports from the local levels will be submitted to the PMU at the national level, where they will be aggregated and submitted to the World Bank on a semi-annual basis.

Throughout the Project implementation stage, the PMU will continue to provide training and awareness raising to relevant stakeholders, such as staff, selected contractors, and communities, to support the implementation of the environmental and social risk management mitigation measures.

The PMU will also track grievances/beneficiary feedback (in line with the SEP) during project implementation to use as a monitoring tool for implementation of project activities and environmental and social mitigation measures.

If the PMU becomes aware of a serious incident in connection with the project, which may have significant adverse effects on the environment, the affected communities, the public, or workers, it should notify the World Bank within 48 hours of becoming aware of such incident. A fatality is automatically classified as a serious incident, as are incidents of forced or child labour, abuses of community members by project workers (including gender-based violence incidents), violent community protests, or kidnappings.

6.6. Step 4: Completion, review and evaluation

Upon completion of Project activities, the PMU will review and evaluate progress and completion of project activities and all required environmental and social mitigation measures. Especially for civil works, the PMU will monitor activities with regard to site restoration and landscaping in the affected areas to ensure that the activities are done to an appropriate and acceptable standard before closing the contracts, in accordance with measures identified in the ESMPs and other plans. The sites must be restored to at least the same condition and standard that existed prior to commencement of works. Any pending issues must be resolved before a subproject is considered fully completed. The PMU will

prepare the completion report describing the final status of compliance with the E&S risk management measures and submit it to the World Bank.

6.7. Technical assistance activities

The PMU will ensure that the policy reform activities, studies (including feasibility studies, if applicable), capacity building, training, and any other technical assistance activities under the Project are carried out in accordance with Terms of Reference acceptable to the Bank, that are consistent with the ESSs. They will also ensure that the outputs of such activities comply with the Terms of Reference.

6.8. Contingency emergency response component

A Contingency Emergency Response Components (CERC) Manual is to be prepared for the Project, which will include a description of the environmental and social risk assessment and management arrangements if the CERC component becomes activated. This may include a CERC ESMF or an Addendum to this ESMF based on the subproject activities that will be funded under the CERC component. If such additional documentation or revision to documentation is needed, the PMU will prepare, consult, adopt, and disclose these in accordance with the CERC Manual, and implement the measures and actions necessary.

6.9. Grievance mechanism

The GRM is set out in the Project SEF.

6.10. Proposed training and capacity building

Training and capacity building plans are to be developed by each PMU with respect to local implementation arrangements. General guidance and the provisions in such plans is provided in Table 13.

Table 13: Proposed training and capacity building approach

Level	Responsible party	Audience	Topics/themes that may be covered
National level (PMU)	National staff	National staff responsible for overall implementation of ESMF	ESMF and approach: • Identification and assessment of E&S risks • Selection and application of relevant E&S risk management measures/instruments • E&S monitoring and reporting • Incident and accident reporting • Application of LMF, including Code of Conduct, incident reporting, SEA/SH • Application of SEF and the grievance mechanism
Local/site level	Local staff	Local staff, local contractors	• Application of SEF and the grievance mechanism

			• Application of LMF, including Code of Conduct, incident reporting, SEA/SH • Application of ESCOPs or ESMPs, as relevant • Workers' grievance mechanism • Community health and safety issues • OHS measures and procedures

7. STAKEHOLDER ENGAGEMENT, DISCLOSURE, AND CONSULTATIONS

7.1. Stakeholder engagement plan and consultations

A separate Stakeholder Engagement Framework (SEF) has been prepared for the Project, based on the World Bank's Environmental and Social Standard 10 on Stakeholder Engagement.

This ESMF, as well as the SEF, LMF and the Environmental and Social Commitment Plan (ESCP) that have been prepared for this project, have been disclosed in draft for stakeholder consultations on the following website [provide website address] on [date]. Key feedback, if any, on the disclosed ESMF is listed here [summary of feedback].

7.2. Consultation record related to preparation of the ESMF

The record of consultations undertaken in preparation of this ESMF and related instruments for the PHIT project is provided in Table 14.

Table 14: Record of consultation related to ESMF preparation

Date	Activity	Description
2023 February	Fiji Health Sector Review initial Mission	**Meeting with Ministry of Finance:** Hon. Minister Prasad, Hon. Assistant Minister Immanuel, PS Gounder, Manager Social Services Budget and Planning Division Ravono, Senior Budget Analyst Singh, Budget Analyst Rokowaqa **Meeting with Ministry of Health and Medical Services:** Acting Minister for Health Tabuya, PS Fong, Director Policy and Planning Goundar **Site Visits and Discussions with health care workers + community health workers:** Colonial War Memorial Hospital, Nadera Dialysis Center, Central and Eastern Divisional Offices (Public Health), Raiwaqa Health Center. Aide Memoire available
2023 July	Supply Chain Management Mission	The mission involved site visits and discussions with central level and health care facility staff to inform: Mapping legislative frameworks for the management of pharmaceutical goods as well as current supply chain practices across the health system, e.g., supply, demand, inventory management, development partner supported stock and frequency of stock-outs at each level. Mapping and quantify the contribution of the sector's key domestic and foreign stakeholders, international trade, example price levels, highlighting existing cross-country/regional collaboration where relevant. Quantifying the health sector's total current procurement volume as supported by both domestic and external financing, including sources and volatility of financing. Supporting the operationalisation of the Fiji and Kiribati warehouse expansion Aide Memoire available
2023 August	EAP VP and Pacific/PNG CD Visit	Site visits and discussions with staff and community health workers at Colonial War Memorial Hospital and Raiwaqa Health Center
2023 October	Primary Health Care Performance Initiative mission (PHCPI) Primary Health Care system assessment	The PHCPI mission was planned to align with a 3-day MHMS, United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) organised workshop on "Rejuvenating Primary Health Care in Fiji". It included the finalisation of the findings of the Vital Signs Profile (VSP) assessment conducted by the World Bank and the Primary Health Care Performance Initiative (PHCPI) in collaboration with Fiji's Ministry of Health and Medical Services (MHMS). The VSP provides an opportunity to assess the state of the primary health care (PHC) system in Fiji. 52 participants attended the workshop representing the Ministry of Health and Medical Services leadership team, national public health program leads, clinical services network leads, community representatives, other government representatives (Provincial administrators,

		Ministry of Youth and Sports, Ministry of Finance, Ministry of Women, Children and Social Protection), academia, development partners (UNFPA, WHO, UNAIDS, MFAT, DFAT, JICA, KOICA, UNDP, Diabetes Fiji, UN Women and UNICEF) and professional associations (Fiji Medical Association and Fiji Nursing Association). Aide Memoire available
2023 November	CWM Hospital light assessment mission	The mission team conducted a light assessment of CWM's 14 buildings including (i) a light structural assessment (ii) a light health services assessment, (iii) initial review of proposed areas for constructing new buildings in the CWM compound. The discussion involved staff at the Ministry of Health and Medical Services and the Ministry of Infrastructure and Transportation. Aide Memoire available
2024 January	EAP VP and Pacific/PNG CD Visit, accompanying 10 World Bank Executive Directors	Interact first-hand with beneficiaries to: (i) learn how they experience primary healthcare services in one of Fiji's largest urban primary healthcare catchment areas; and (ii) see first-hand how, beyond supporting the successful response to the COVID19 pandemic, the World Bank's COVID-19 Emergency Response Project supports health system strengthening investments, such as enhanced digital connectivity, which strengthens resilience. The mission met with Hon. Atonio Rabici Lalabalavu, Minister for Health and Medical Services, Hon. Esrom Immanuel, Assistant Minister Finance, Dr. Jemesa Tudravu, Acting Permanent Secretary for Health, Dr Tevita Qoriniasi, Divisional Medical Officer – Central Division, Dr. Akesh Narayan, Sub Divisional Medical Officer – Suva, Dr. Joji Naqaravatu, Senior Medical Officer and Officer in Charge, Nuffield Health Center + Nuffield Health Center staff and community health workers, Ms. Sisilia Nalaide, Manager Debt Management, Ministry of Finance, Mr. Soro Toutou, Project Manager, COVID-19 Emergency Response Project
2024 February	World Bank Health, Nutrition, and Population Mission	The objectives of the mission were to discuss the concluding stages of the health sector review and propose next steps in presenting findings to the Government of Fiji and other stakeholders; and discuss ongoing operational and analytical collaboration in the health sector and strategic directions to further strengthen our collaboration and support to the Government of Fiji. The mission team met with the COVID19 Emergency Response Project team, staff of CWM Hospital, Social Sectors Budget team of the Ministry of Finance, and representatives from the Fiji National University
2024 April	Pandemic Fund Application Support Mission	The objectives of the mission were to: quantify human and animal health, health security needs and highlighting gaps and priorities identified by the MOHMS' most recent State of Party Annual Report (International Health Regulations reporting) and based on country experience from the COVID-19 pandemic response, conduct in-person consultations with relevant health security stakeholders to further explore and validate identified strategic priorities, map domestic and external resources supporting the One Health and Health Security agenda, develop a costed and prioritised action plan with an implementation monitoring and results framework; and support the MOHMS in finalizing and submitting a proposal. The mission team met with representatives from USAID, DFAT, Fiji Meteorological Office, Civil Society Organizations, Ministry of Agriculture and Waterways/ Biosecurity Authority of Fiji, and for Ministry of Health and Medical Services - Clinical Services (Laboratory), Human Resources for Health Unit, Environmental Health Unit, Digital Health Unit, Fiji Center for Disease Control and Divisional (Public Health Units)

2024 September	EAP VP and Pacific/PNG CD Visit, accompanying World Bank President	The site visit and discussion with health workers and community health workers aimed to see the impact of the World Bank supported COVID-19 Emergency Response Project and hear from Fiji's healthcare workers. Participants from the Ministry of Health and Medical Services included Hon. Dr. Ratu Atonio Lalabalavu, Minister for Health, Dr. Jemesa Tudravu, Permanent Secretary of Health and Medical Services, Dr. Tevita Qoriniasi, Divisional Medical Officer: Central, Dr. Anaseini Maisema, Primary Health Care Team Leader (Medical Officer in charge during the COVID-19 response), Dr. Joji Naqaravatu, Medical Officer in charge of Nuffield Health Center, Ms. Susana Tinai, Acting Sister in Charge at Nuffield Health Center
2024 November	Public Launch of the Fiji Health Sector Review led by the Prime Minister of Fiji, Honorable Sitiveni Ligamamada Rabuka, Stephen Ndegwa (World Bank Country Director, Papua New Guinea and Pacific Islands), and Ronald Mutasa (World Bank Practice Manager for Health Nutrition and Population, East Asia and Pacific Region)	A World Bank mission for Health, Nutrition and Population was held in Suva, Fiji from 26-29 November 2024 to participate in the public launch of the Fiji Health Sector Review (HSR). A high level presentation and recommended way forward accompanied the launch which was attended by leadership teams from the ministries of health and finance, Office of the Prime Minister, academia, development partners (Australia, New Zealand, USA (State and USAID), Japan, China, India, UK, European Union, France, SPC, PIANGO, Fiji Red Cross, Fiji Council of Social Services, Adventist Health Fiji, UNFPA, WHO, UNAIDS, MFAT, DFAT, JICA, KOICA, UNDP, PATH, UNICEF, UNRCO, Church of the Latter Day Saints,) and professional associations (Fiji Medical Association, Fiji College of General Practitioners, Fiji Nursing Council, Fiji Medical and Dental Secretariat, and Fiji Nursing Association). Aide Memoire available
2025 January	Identification Mission for the Prepared and Healthy Islands Transformation Project	The mission team undertook several field visits including to the central and referral hospitals in Suva and PHC facilities in and outside of Suva and conducted discussions with several key stakeholders at all levels of the system. The recently released Fiji Health Sector Review was shared and discussed at a workshop attended by senior MHMS managers from all regions of Fiji held during the mission. The Workshop made the following recommendations: i) A recommitment for the need to prioritise a primary health care approach especially strengthening the primary and secondary level of health services ii) enhance PHC services – improving preventative care and early disease detection to reduce reliance on secondary and tertiary healthcare; iii) strengthen healthcare networks – establishing a specialised hospital and referral system to enhance access to quality tertiary care; iv) build healthcare workforce management and capacity– strengthen support, distribution and technical capacity of skilled healthcare professionals; v) develop and implement more effective preventive and promotive programs. Aide Memoire available

2025 February	Technical Mission for the Prepared and Healthy Islands Transformation Project	A World Bank Mission was centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project the Pacific Health Nutrition and Population PASA and at the occasion of the World Bank Pacific Health Systems Flagship Course. The mission was led by Juan Pablo Eusebio Uribe Restrepo, the World Bank Global Director for Health, Nutrition, and Population and the mission team undertook several field visits including to the central and referral hospitals in Suva and PHC facilities in and outside of Suva and conducted discussions with several key stakeholders at all levels of the system. Bilateral meetings with development partners (DPs) explored the ongoing and planned technical and financial support for the health sector, including synergies with the proposed PHIT project. The mission team also attended the Pacific Health Flagship Course in Nadi which hosted more than 60 policy leaders from health, finance, and planning ministries from eight Pacific countries; Fiji, Kiribati, Papua New Guinea, Marshall Islands, Samoa, Solomon Islands, Tonga, and Tuvalu. Five health ministers – representing Fiji, Kiribati, Solomon Islands, Tonga, and Tuvalu - joined the opening high-level sessions of the workshop, outlining their visions for improved health outcomes in their respective nations. Also joining these guiding sessions were Juan Pablo Uribe, HNP Global Director, Dr Ronald Mutasa, HNP Practice Manager for East Asia and the Pacific, Dr Lucas de Toca, Australia's Global Health Ambassador, and Dr Sunia Soakai, Special Representative for the World Health Organization. The five health ministers attended a briefing session on the side of the Flagship Course where the PHIT task team outlined the proposed project and solicited early feedback on the relevance of the challenges and corresponding interventions. Aide Memoire available. The Fiji Ministry of Finance invite the World Bank to present the findings of the Fiji Health Sector Review and proposed recommendations to all development partners as part of the FY26 budget consultations. In attendance were ministers or permanent secretaries from all ministries, and representatives from all development partner agencies. The presentation was followed by the government's call to development partners for a coordinated approach to transforming the health sector in Fiji.
2025 March	PHIT Technical Mission/ Pacific Ministers of Finance briefing	Pacific Minister of Finance Briefing (Tokyo): The Pacific and PNG Country Director and Sout Pacific Country manager met with Pacific Ministers of Finance from Fiji, Kiribati, Solomon Islands, Tonga and Tuvalu, in Tokyo to provide a briefing on the evolving scope of PHIT and the highlight how the project aims to address common regional challenges. Fiji: A World Bank mission team held discussions centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project aimed to: Advance activity and project procurement planning, with focus on the first 18 months of project implementation, Conduct technical discussions with SPC and MHMS to further the project design and implementation plan, including for the pandemic fund activities, Initiate the drafting of terms of

		reference for implementation support as part of the ongoing dialogue on implementation arrangements, Introduce to SPC and update MHMS on the financial assessments as well as environmental and social safeguard instruments to be completed as part of PHIT project preparation. Aide Memoire available Tonga: A World Bank mission team held discussions centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project aimed at: advancing activity and project procurement planning, with focus on the first 18 months of project implementation, and conducting technical discussions with MOH to further the project design and implementation plan. The mission met with representatives from both ministries of health and finance. Kiribati: A World Bank mission team held discussions centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project aimed at: advancing activity and project procurement planning, with focus on the first 18 months of project implementation, and conducting technical discussions with MOH to further the project design and implementation plan. The mission met with representatives from both ministries of health and finance.
2025 April	PHIT Technical Mission	Tuvalu: The task team held discussions with the Secretary for Health centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project aimed at: advancing activity and project procurement planning, with focus on the first 18 months of project implementation, complementarity with national health systems project, and conducting technical discussions with MOH to further the project design and implementation plan. Solomon Islands: The task team held discussions with the Secretary for Health centered around the Bank's engagement in the health sector in the Pacific, including the ongoing preparation for the PHIT project aimed at: advancing activity and project procurement planning, with focus on the first 18 months of project implementation, complementarity with national health systems project, and conducting technical discussions with MOH to further the project design and implementation plan. The World Bank in coordination with the Pacific Community (SPC) invited Heads of Health from Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu was held as a side event during the 2025 Pacific Heads of Health Meeting. The Pacific Healthy Islands Transformation (PHIT) Project Talanoa session aimed to share progress updates and seek participant input and advice, along with that of other senior leaders, on the design and preparation of the PHIT Project.
2025 May 22	PHIT stakeholder coordination meeting	Coordination meeting between WBG task team (M. Harrit, R. Ramsey, M. Namedre, B. Davis) and Fiji Min. Health (L. Cikamatana, O. Sadranu)

2025 May	Pacific Healthy Islands Transformation Project (PHIT) Joint Technical Mission	A joint technical mission to advance the preparation of the Pacific Healthy Islands Transformation Project (PHIT) was held on May 26th - June 4th, 2025. The mission was led by World Bank in coordination with representatives from the World Bank (WB), Government of Australia (Australia), Asian Development Bank (ADB) and Organization of the Petroleum Exporting Countries Fund for International Development (OPEC Fund). The mission objectives were to: • Deepen dialogue on Colonial War Memorial (CWM) Hospital infrastructure planning • Advance discussions on the implementation planning for CWM Hospital's Clinical Services Plan • Coordinate next steps of the CWM Hospital master plan, including engaging health architects for drafting design packages • Continue discussions on aligning ongoing CWM Hospital upgrades with the broader national and regional health systems strengthening
2025 June	PHIT Health Project Joint Workshop	A regional workshop was held on 11-12 June 2025 which was attended in person by SPC and representatives of Ministries of Health from Fiji, Nauru, Tonga, Tuvalu and Vanuatu, and virtually by Ministry of Health Kiribati. Bilateral follow-up conversations were conducted with Fiji, Kiribati, Tonga, Tuvalu, and SPC (completed on 27th June). The objectives of the follow up bilateral discussions were to: • Discuss key outcomes of the regional workshop, • Confirm alignment of the regional public goods resourced through the PHIT project, with national sectoral priorities, and • Finalizing proposed activities outlined in the country annex, The discussions and feedback from the regional workshop and bilateral follow up have been incorporated into the PAD.

ANNEX 1: INFRASTRUCTURE SERVICE PROVISION PLAN

Indicative Terms of Reference (ToR)

Cross-Portfolio Working Group for the Infrastructure and Service Provision Plan (ISPP) – Suva New Hospital Project

1. Background and Rationale

As part of the PHIT Project, the Government of Fiji is planning to upgrade and expand the Colonial War Memorial (CWM) Hospital as the first phase of the Government of Fiji's CWM Hospital Master plan to update and expand (onsite and to a new site) the region's largest referral and training tertiary healthcare facility, with a focus on expanding cancer care services. Given the scale and complexity of the project, an integrated Infrastructure and Service Provision Plan (ISPP) is required to ensure coordinated planning, design, and delivery of core infrastructure and services, including roads, water supply, electricity, waste management, sanitation, communications, and urban planning integration.

The ISPP will be developed by a Cross-Portfolio Working Group comprising key stakeholders from relevant government agencies and statutory authorities.

2. Purpose

The purpose of this Working Group is to guide the development of a comprehensive ISPP that ensures timely, cost-effective, and sustainable infrastructure and utility service provision to support the design, construction, and operation of the new hospital in Suva. The ISPP is to form part of the EIA documentation for the development, and is to be given due consideration with respect to EIA approval.

3. Objectives

- To identify infrastructure and utility requirements for the new hospital across all sectors.
- To assess existing service capacity and identify infrastructure gaps.
- To identify impacts of increased service demand on availability and accessibility to nearby communities.
- To develop coordinated strategies for infrastructure upgrades, new works, service connections, and associated capital and operational funding.
- To align infrastructure planning with hospital design, construction timelines, and Suva's urban planning framework.
- To ensure compliance with relevant legislation, policies, and planning standards.
- To coordinate inter-agency contributions, resource commitments, and approvals.

4. Scope of Work

The Working Group will:

- Review hospital concept designs and master plans.
- Map existing infrastructure and service capacity within the proposed site and surrounding areas.

- Determine future demands for and possible gaps in:
    - Medical waste incineration and disposal (including minimum essential incineration capacity)
    - Water supply and wastewater/sewage management
    - Electricity supply and backup systems
    - Road access, parking, and transport links
    - Stormwater drainage and flood mitigation
    - Solid waste management
    - ICT and telecommunications infrastructure
    - Planning controls, zoning, and land use integration
- Identify infrastructure investments and timelines required to meet hospital commissioning.
- Propose infrastructure design and service delivery standards.
- Identify required delivery responsibilities and finance
- Coordinate with the Ministry of Economy and Ministry of Health and Medical Services (MHMS) on project phasing.
- Prepare detailed plan including governance arrangements

5. Membership

The Working Group shall include representatives from the following agencies:

Agency	Activity
Ministry of Health and Medical Services (MHMS)	Chairing body; project lead and client
Ministry of Infrastructure and Meteorological Services (MIMS)	Coordination of national infrastructure planning and medical waste management
Water Authority of Fiji (WAF)	Water supply and sewerage planning
Ministry of Environment (MoE)	Waste management and permitting, EIA approvals
Energy Fiji Limited (EFL)	Power supply planning and grid integration
Telecom Fiji Ltd (TFL)	Telecommunications
Fiji Roads Authority (FRA)	Road access, traffic flows, and mobility design
Suva City Council (SCC)	Local government interface and compliance
Department of Town and Country Planning (DTCP)	Land use planning, zoning, and development approvals

ANNEX 2. E&S SCREENING FORM

The **E&S Screening procedure** comprises of two stages-process:

(1) Initial screening by using the **Exclusion List** in Table 5 of the ESMF; and

(2) Screening the proposed activities to identify the approach for E&S risk management.

This Screening Form is the second stage of screening process and is to be used for all subproject activities. The completed forms will be signed and kept in the Project ESF file. The World Bank may review a sample of the forms during implementation support visits.

1. Subproject Information

Subproject Title	
Subproject Location	
Regional Unit in Charge	
Estimated Cost	
Start/Completion Date	
Brief Description of Subproject	

2. Environmental and Social Screening Questionnaire

Questions	**Answer**		**Next Steps**
	Yes	**No**	
ESS1			
Is the subproject likely to have significant adverse environmental impacts that are sensitive and unprecedented that trigger the 'Ineligible Activities' or other exclusion criteria?			If "Yes": Exclude from project.
Does the subproject involve new construction or significant expansion of ponds, solid waste management systems, shelters, roads (including access roads), community centres, schools, bridges or jetties?			If "Yes": 1. Prepare a site-specific E&S Assessment and/or ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.
3. Does the subproject involve renovation or rehabilitation of any small-scale infrastructure, such as groundwater wells, latrines, showers/washing facilities, or shelters?			If "Yes": 1. Apply relevant measures based on the ESCOPs in Annex 2 (unless one of the questions below raises specific environmental risks and requires a site-specific ESMP). 2. Include E&S risk management measures in bidding documents.
4. Will construction or renovation works require new borrow pits or quarries to be opened?			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.

Questions	Answer		Next Steps
	Yes	No	
5. Does the project lead to any risks and impacts on, individuals or groups who, because of their particular circumstances, may be disadvantaged or vulnerable.[1]			If "Yes": Apply relevant measures described in the ESMF and SEF.
ESS2			
6. Does the subproject involve uses of goods and equipment involving forced labour, child labour, or other harmful or exploitative forms of labour?			If "Yes": Exclude from project.
7. Does the subproject involve recruitment of workforce including direct, contracted, primary supply, and/or community workers?			If "Yes": Prepare a subproject-specific LMP in reference to the Project LMF.
8. Will the workers be exposed to workplace hazards that needs to be managed in accordance with local regulations and EHSGs? Do workers need PPE relative to the potential risks and hazards associated with their work?			If "Yes": Prepare a subproject-specific LMP in reference to the Project LMF.
9. Is there a risk that women may be underpaid when compared to men when working on the project construction?			If "Yes": Prepare a subproject-specific LMP in reference to the Project LMF.
ESS3			
10. Is the project likely to generate solid or liquid waste that could adversely impact soils, vegetation, rivers, streams or groundwater, or nearby communities?			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.
11. Do any of the construction works involve the removal of asbestos or other hazardous materials?			If "Yes": Apply asbestos guidance provide in the ESCOP
12. Are works likely to cause significant negative impacts to air and / or water quality?			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.
13. Does the activity rely on existing infrastructure (such as discharge points) that is inadequate to prevent environmental impacts?			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.
14. Is there any potential to have impact on soil or water bodies due to agro-chemicals (e.g., pesticides) used in farmlands as a consequence of subproject activities (e.g., development of irrigation system, agriculture related activities, seed and fertilizer assistance, procurement of pesticides)?			If "Yes": Apply Fertilizer and Pest Management Plan in Annex 7.

[1] "Disadvantaged or vulnerable" refers to those individuals or groups who, by virtue of, for example, their age, gender, ethnicity, religion, physical, mental or other disability, social, civic or health status, sexual orientation, gender identity, economic disadvantages or ethnic peoples status, and/or dependence on unique natural resources, may be more likely to be adversely affected by the project impacts and/or more limited than others in their ability to take advantage of a project's benefits.

Questions	Answer		Next Steps
	Yes	No	
ESS4			
15. Is there a risk of increased community exposure to communicable disease (such as COVID-19, HIV/AIDS, Malaria), or increase in the risk of traffic related accidents?			If "Yes": Apply LMF and relevant measures in SEF.
16. Is an influx of workers, from outside the community, expected? Would workers be expected to use local health services? Would they create pressures on existing community services (water, electricity, health, recreation, others?)			If "Yes": Prepare a subproject-specific LMP and LIMP in reference to the Project LMF.
17. Is there a risk that SEA/SH may increase as a result of project works?			If "Yes": Prepare a subproject-specific LMP in reference to the Project LMF.
18. Would any public facilities, such as schools, health clinic, church be negatively affected by construction?			If "Yes": Apply relevant measures based on the ESCOPs in Annex 2 (unless one of the other questions in the screening form raises specific environmental and social risks and requires a site-specific ESMP).
19. Will the subproject require the government to retain workers to provide security to safeguard the subproject?			If "Yes": Prepare a site-specific ESMP for the proposed subproject, including an assessment of potential risks and mitigation measures of using security personnel.
ESS5			
20. Will the subproject require the involuntary acquisition of new land (will the government use eminent domain powers to acquire the land)?[1]			If "Yes": Develop and apply a Resettlement Framework (RF).
21. Will the subproject lead to temporary or permanent physical displacement (including people without legal claims to land)?			If "Yes": Refer to and apply the project RF.
22. Will the subproject lead to economic displacement (such as loss of assets or livelihoods, or access to resources due to land acquisition or access restrictions)?			If "Yes": Refer to and apply the project RF.
23. Has the site of the subproject been acquired through eminent domain in the past 5 years, in anticipation of the subproject?			If "Yes": Refer to and apply the project RF.
24. Are there any associated facilities needed for the subproject (such as access roads or electricity transmission lines) that will require the involuntary acquisition of new land?			If "Yes": Refer to and apply the project RF.
25. Is private land required for the subproject activity being voluntarily donated to the project?			If "Yes": Refer to and apply the project RF.
ESS6			
26. Does the subproject involve activities that have potential to cause any significant loss or degradation of critical habitats whether directly or indirectly, or which would lead to adverse impacts on natural habitats?			If "Yes": Exclude from project.

[1] ESS5, Footnote 10: "In some circumstances, it may be proposed that part or all of the land to be used by the project is donated on a voluntary basis without payment of full compensation. Subject to prior Bank approval, this may be acceptable providing the Borrower demonstrates that: (a) the potential donor or donors have been appropriately informed and consulted about the project and the choices available to them; (b) potential donors are aware that refusal is an option, and have confirmed in writing their willingness to proceed with the donation; (c) the amount of land being donated is minor and will not reduce the donor's remaining land area below that required to maintain the donor's livelihood at current levels; (d) no household relocation is involved; (e) the donor is expected to benefit directly from the project; and (f) for community or collective land, donation can only occur with the consent of individuals using or occupying the land. The Borrower will maintain a transparent record of all consultations and agreements reached."

Questions	Answer		Next Steps
	Yes	No	
27. Will the project involve the conversion or degradation of non-critical natural habitats?[1]			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Include E&S risk management measures in bidding documents.
28. Will this activity require clearance of mangroves?			If "Yes": Exclude from project.
29. Will this activity require clearance of trees, including inland natural vegetation?			If "Yes": 1. Prepare a site-specific ESMP for the proposed subproject, based on the template in Annex 3. 2. Exclude from project if more that x hectares of tree and vegetation cutting is expected. 2. Include E&S risk management measures in bidding documents.
30. Will there be any significant impact on any ecosystems of importance (especially those supporting rare, threatened or endangered species of flora and fauna)?			If "Yes": Exclude from project.
ESS7			
31. Are there any Indigenous Peoples present in the subproject area and are likely to be affected by the proposed subproject negatively?			If "Yes": Prepare an Indigenous Peoples Plan OR Include the requirements of an Indigenous Peoples Plan in the SEP.
ESS8			
32. Is the subproject to be located adjacent to a sensitive site (historical or archaeological or culturally significant site) or facility?			If "Yes": Apply Chance Find Procedures in Annex 6.
33. Locate near buildings, sacred trees or objects having spiritual values to local communities (e.g. memorials, graves or stones) or require excavation near there?			If "Yes": Apply Chance Find Procedures in Annex 6.

3. Conclusion

Based on the result from the screening above, please list the E&S risk management instruments to be prepared / adopt and implemented:

a) ESMP (including LARP where required)
b) SEP
c) LMP (including LIMP where required)
d) ESCOPs

Name and title of person who conducted screening:

Date of screening:

[1] Environmental and Social Standard 6, paragraph 23: "Critical habitat is defined as areas with high biodiversity importance or value, including (a) Habitat of significant importance to Critically Endangered or Endangered species, as listed in the IUCN Red List of threatened species or equivalent national approaches; (b) Habitat of significant importance to endemic or restricted-range species; (c) Habitat supporting globally or nationally significant concentrations of migratory or congregatory species; (d) Highly threatened or unique ecosystems; and (e) Ecological functions or characteristics that are needed to maintain the viability of the biodiversity values described above in (a) to (d)."

ANNEX 3. ENVIRONMENTAL AND SOCIAL MANAGEMENT PLAN (ESMP) TEMPLATE

Instructions: *This is an example template for an ESMP for subprojects where the E&S screening has indicated that this instrument is required. Environmental and social risks and impacts are strongly linked to subproject location and scope of activities. This ESMP should be customised for each specific subproject location and activities.*

1. Subproject Information

Subproject Title:	
Estimated Cost:	
Start/Completion Date:	

2. Site/Location Description

Instructions: *Concisely describe the proposed location and its geographic, ecological, social and temporal context including any offsite investments that may be required (e.g., access roads, water supply, etc.). Include a map of the location.*

3. Subproject Description, Rationale and Activities

Instructions: *List all the activities that will take place under the subproject, including any associated activities (such as building of access roads or transmission lines, or communication campaigns that accompany service provision).*

4. Project alternatives

For Substantial Risk activities: *Identify and describe alternatives to the described project that may have lower risk rating, and explain why the described project is preferable.*

5. Scoping results

For Substantial Risk activities: *Summarise the key findings of the Scoping Study that have informed project design and risk mitigation measures.*

6. Legal framework

For Substantial Risk activities: *Describe the legal framework that applies to the subproject, including any approval pathways and applicable laws and regulations.*

7. Borrower's framework

For Substantial Risk activities: *Set out the elements of the Borrower's framework that will be used or applied for the subproject, and what additional requirements are needed to meet the requirements of the ESMF.*

8. Baseline assessment

For Substantial Risk activities: *Provide information on the baseline conditions related to the subproject as used for the Scoping Study.*

9. ESMP Matrix: Risk and Impacts, Mitigation, Monitoring

Instructions: *Identify anticipated site-specific adverse environmental and social risks and impacts and their significance; describe mitigation measures to address these risks and impacts; and list the monitoring measures necessary to ensure effective implementation of the mitigation measures, including roles and responsibilities. Draw from the ESMF's pre-identification of potential risks/impacts and mitigation measures, and drill down further to ensure relevance and comprehensiveness at the site-specific level. For subprojects involving construction, prepare separate tables for the construction phase and the operation phase. State the implementation timeline for the mitigation measures and the cost estimate for implementation (the cost estimate can focus on the line items that will be covered by the project implementing agency, with costs of mitigation measures to be implemented by the contractor left to the contractor to calculate).*

Anticipated E&S Risks and impacts	Signif-icance	Risk mitigation and management measures	Impact mitigation		Impact/mitigation monitoring			Schedule	Estimated cost
			Location / timing / frequency	Responsibility	Parameter to be monitored	Methodology, location and frequency	Roles and responsib-ilities		

10. Capacity Development & Training

Instructions: *Based on the implementation arrangements and responsible parties, outline any capacity building, training or new staffing that may be necessary for effective implementation, and the schedule for completion.*

11. Attachments

Instructions: *Include any supporting attachments, such as ESCOPs and site-specific SEPs/LMPs.*

12. Review & Approval

Prepared By: ……(Signature) Position: …… Date ……	
Reviewed By: ……(Signature) Position: ……Date ……	**Approved By**: ……(Signature) Position: …… Date ……

ANNEX 4: SEA/SH ACTION PLAN

Mitigation actions	Responsible for action	Timeline for action	Budget	Indicators	Responsible for monitoring and reporting
RISK ASSESSMENT					
Assess the subproject's underlying SEA/SH risks and reflect risks in all E&S project documentation (ESMF/P, C-ESMP, LMP, SEP)	PMU, SEA/SH consultant	During preparation of subproject LMP/ESMP		SEA/SH risks integrated in E&S assessment report	PMU, SEA/SH consultant
Consultations with women and girls and other groups at risks, including on SEA/SH, as part of the project SEP to inform on project, identify risk groups, get feedback on project design and safeguard issues, knowledge and efficacy of mitigation measures. Consultations to be conducted in a safe and enabling manner, with facilitator of the same sex and with the right expertise and culturally sensitive approaches.	PMU, SEP consultant	During preparation of subproject LMP/ESMP		# women and girls involved in consultations # community members consulted # focus women only groups # relevant CSOs/NGOs consulted	PMU, SEP consultant
Develop SEA/SH Action Plan based on assessed risks and consultation, including key indicators, estimated budget, timelines for implementation and monitoring indicators. Reflect this in ESMP, LMP, C-ESMP.	PMU, SEA/SH consultant			SEA/SH Action Plan in place	PMU
Integrate responsibilities and expectations related to SEA/SH in all contracts, including those related to E&S and incident reporting and in the C-ESMP.					
Define timelines and processes to update the SEA/SH action plans throughout implementation, based on emerging risks and the evolution of the project.				SEA/SH Action plan regularly updated	PMU
BEHAVIOURAL STANDARDS					
Develop an Accountability and Response Framework, including the steps for handling, reviewing, verifying and investigating allegations, including timeframe, and responsibilities for each stage of the process, reporting requirements, and specific provisions for child survivors; and include this in subproject ESMP.	PMU			SEA/SH Prevention and Response Action Plan in place SEA/SH Accountability and Response Framework in place	PMU

Mitigation actions	Responsible for action	Timeline for action	Budget	Indicators	Responsible for monitoring and reporting
Ensure that the Accountability and Response Framework is reflected in bidding documents, offers, contracts, and operation manuals.					
Update the accountability and response framework based on lessons learned from incident response and other feedback.					
Establish mandatorily enforceable Codes of Conduct and training requirements for each category of project worker, and integrate CoC and training as mandatory requirements into all contracts, to be in place before workers start project-related activities.	PMU, all project consultants and contractors			Code of Conduct signed by every worker Every worker has completed training on behavioural standards and CoC before work commencement	PMU, supervising engineer, all project consultants and contractors
Conduct refresher or on-the-job training / awareness as part of worker and civil servant ongoing training.	PMU, all project consultants and contractors			# of project actors re- trained on CoC / total # training session carried out	Supervising engineer, all project consultants and contractors, GBV service providers
GRIEVANCE MECHANISM AND INCIDENT RESPONSE					
Map GBV service providers in all areas of project implementation; Identify suitable providers and gaps; Address gaps; Develop localised referral protocols and integrate into Accountability and Response Framework.	PMU, SEA/SH consultant			GBV providers engaged Localised referral protocols in place for all areas of project implementation	PMU
Establish SEA/SH pathways in WGMs (community-based and for workers) and capacity to safely and ethically receive and respond to SEA/SH cases Develop survivor-centred SOPs to receive and response to SEA/SH complaints Develop intake forms, referral protocols, information sharing tools, etc. Develop training plans for all stakeholders involved in management of SEA/SH complaints Carry out WGM training plans Mobilise expertise as needed to provide TA to operationalisation and training related to SEA/SH WGM Roll out SEA/SH-sensitive WGM	PMU			SEA/SH-sensitive SOPs in place as part of broader WGM SOPs WGM actors trained in survivor-centred support # of SEA/SH cases received by the project, (disaggregated by age, sex, form of violence reported, status/open/closed, etc.);	PMU

Mitigation actions	Responsible for action	Timeline for action	Budget	Indicators	Responsible for monitoring and reporting
Reflect key elements of the WGM in the Accountability and Response Framework and Ops Manual					
Respond to SEA/SH incidents reported to the project in line with a survivor-cantered approach Offer referral to GBV services based on mapping and referral protocols Verify and take action, prioritizing survivors' rights and wishes Identify and implement corrective actions	PMU, GBV service providers (if relevant), all project consultants and contractors			% of SEA/SH cases where survivors were connected to services (disaggregated by services)	PMU
Raise community awareness on SEA/SH, standards of conduct, WGM and GBV services available: Develop plan for mobilization, depending on project timelines and risk level Integrate responsibility in TOR of actor raising awareness on broader WGM or of GBV actor to be mobilized for SEA/SH TA Develop and review awareness materials, messages, IEC, etc. regularly, based on community's feedbacks, consultations and evolving understanding of risks	PMU, GBV service provider			# of community members targeted by awareness raising (disaggregated by sex)	PMU
MOBILISATION OF TECHNICAL EXPERTISE					
Mobilize GBV expert in the PMU Reflect requirement for GBV specialist in PIU in ESCP and allocate funding Plan to mobilize adequate expertise during preparation Develop TOR and recruit	PMU			The PMU has a GBV specialist in place (Y/N)	PMU
Clearly define the SEA/SH requirements and expectations, including on CoC, in bid documents and contracts: Include requirements on CoC, workers training, SEA/SH reporting, etc. in the bidding documents, based on project action plan and risk level. Explain SEA/SH requirements to bidders. Assess SEA/SH risk mitigation proposal as part of bidding evaluation	PMU (social specialists and procurement)			SEA/SH requirements and expectations are clearly defined in the bid documents (Y/N) SEA/SH requirements and expectations are clearly defined in the procurement documents (Y/N)	PMU

Mitigation actions	Responsible for action	Timeline for action	Budget	Indicators	Responsible for monitoring and reporting
SEA/SH requirements reflected in C-ESMP and part of offer evaluation, including of contractor's Accountability and Response Framework. Requirements on SEA/SH in contracts of consultants with escalation clauses for non-compliance. SEA/SH costs clearly reflected in contracts (i.e. line items in bill of quantities for clearly defined SEA/SH activities (such as preparation of relevant plans, or specified provisional sums for activities that cannot be defined in advance, such as for implementation of relevant plan/s, etc.)					
For supervision, have a social specialist in the supervising engineer's team with GBV specific skills to supervise issues related to SEA/SH. Include responsibilities around SEA/SH monitoring in TOR of supervising engineers social specialist (e.g. supervise signing of CoCs, training of workers, and compliance with other commitment by contractor)	PMU, supervising engineer			Supervising engineer with SEA/SH responsibilities and expertise in place (Y/N)	PMU
Action to be considered Ensure oversight through an independent Third-Party Monitoring (TPM) organization/Independent Verification Agent (IVA) with experienced GBV staff to monitor implementation of the SEA/SH Action Plan Include responsibilities around SEA/SH monitoring in TOR of TPM Mobilize TPM Integrate SEA/SH monitoring in TPM reports	PMU, TPM			TPM with SEA/SH responsibilities and expertise in place (Y/N)	PMU
Recruit GBV service provider(s) to facilitate access to timely, safe and confidential services for survivors disclosing incidents to the projects in areas where these services are otherwise unavailable. GBV service provider(s)/consultant(s) may also provide technical assistance with the implementation of some of the above mentioned SEA/SH risk mitigation measures at the community level (i.e. workers training, awareness raising, WGM operationalization, etc.)	PMU			# of survivors that were provided GBV services funded by the project (disaggregates by type of service, project link (Y/N), etc.) # of referrals to GBV services GBV service provider (consultant) in place (Y/N)	PMU

Mitigation actions	Responsible for action	Timeline for action	Budget	Indicators	Responsible for monitoring and reporting
Enable funding Develop TOR Recruit Supervise contract and review reports Enable coordination with all different project stakeholders					
Train all project stakeholders on project approach to SEA/SH risk management	PMU				
MONITORING AND EVALUATION					
Undertake regular M&E of progress on SEA/SH prevention and response activities, including reassessment of risks as appropriate. Integrate advancement of SEA/SH action plan implementation in E&S reporting (all stakeholders) and reports on ESCP implementation (IA) Update the ESCP and/or the relevant E&S management tools to incorporate necessary corrective and preventive actions.	PMU, contractors, consultants (including GBV actor), supervising engineer.			Protocol for M&E of the project is in place (Y/N) E&S instruments are updated throughout the life span of the project (Y/N)	PMU

ANNEX 5. ENVIRONMENTAL AND SOCIAL CODES OF PRACTICE (ESCOP)

To manage and mitigate potential negative environmental impacts, the project applies Environmental Codes of Practice (ESCOPs), which contain specific, detailed and tangible measures that would mitigate the potential impacts of each type of eligible subproject activity under the project. They are marked as relevant for the planning phase, the implementation phase, or the post-implementation phase of activities. They are intended to be simple risk mitigation and management measures, readily usable by the Recipient and contractors.

General ESCOP for infrastructure subprojects

Issue	Environmental prevention/mitigation measures	Responsible Party
1. Noise during construction	a) Plan activities in consultation with communities so that noisiest activities are undertaken during periods that will result in least disturbance. (Planning phase) b) Use when needed and feasible noise-control methods such as fences, barriers or deflectors (such as muffling devices for combustion engines or planting of fast-growing trees). (Implementation phase) c) Minimize project transportation through community areas. Maintain a buffer zone (such as open spaces, row of trees or vegetated areas) between the project site and residential areas to lessen the impact of noise to the living quarters. (Implementation phase)	Contractor
2. Soil erosion	a) Schedule construction during dry season. (Planning phase) b) Contour and minimize length and steepness of slopes. (Implementation phase) c) Use mulch, grasses or compacted soil to stabilize exposed areas. (Implementation phase) d) Cover with topsoil and re-vegetate (plant grass, fast-growing plants/bushes/trees) construction areas quickly once work is completed. (Post-Implementation phase) e) Design channels and ditches for post-construction flows and line steep channels/slopes (e.g., with palm frowns, jute mats, etc.). (Post-Implementation phase)	Contractor
3. Air quality	a) Minimize dust from exposed work sites by applying water on the ground regularly during dry season. (Implementation phase) b) Avoid burn site clearance debris (trees, undergrowth) or construction waste materials. (Implementation phase) c) Keep stockpile of aggregate materials covered to avoid suspension or dispersal of fine soil particles during windy days or disturbance from stray animals. . (Implementation phase) d) Reduce the operation hours of generators /machines /equipment /vehicles. (Implementation phase) e) Control vehicle speed when driving through community areas is unavoidable so that dust dispersion from vehicle transport is minimized. (Implementation phase)	Contractor

4. Water quality and availability	a) Activities should not affect the availability of water for drinking and hygienic purposes. (Implementation phase) b) No soiled materials, solid wastes, toxic or hazardous materials should be stored in, poured into or thrown into water bodies for dilution or disposal. (Implementation phase) c) Avoid the use of waste water pools particularly without impermeable liners. d) Provision of toilets with temporary septic tank. (Implementation phase) e) The flow of natural waters should not be obstructed or diverted to another direction, which may lead to drying up of river beds or flooding of settlements. (Implementation phase) f) Separate concrete works in waterways and keep concrete mixing separate from drainage leading to waterways. (Implementation phase)	Contractor
5. Solid and hazardous waste	a) Segregate construction waste as recyclable, hazardous and non-hazardous waste. (Implementation phase) b) Collect, store and transport construction waste to appropriately designated/ controlled dump sites. (Implementation phase) c) On-site storage of wastes prior to final disposal (including earth dug for foundations) should be at least 300 metres from rivers, streams, lakes and wetlands. (Implementation phase) d) Use secured area for refuelling and transfer of other toxic fluids distant from settlement area (and at least 50 metres from drainage structures and 100 metres from important water bodies); ideally on a hard/non-porous surface. (Implementation phase) e) Train workers on correct transfer and handling of fuels and other substances and require the use of gloves, boots, aprons, eyewear and other protective equipment for protection in handling highly hazardous materials. (Implementation phase) f) Collect and properly dispose of small amount of maintenance materials such as oily rags, oil filters, used oil, etc. Never dispose spent oils on the ground and in water courses as it can contaminate soil and groundwater (including drinking water aquifer). (Implementation phase) g) After each construction site is decommissioned, all debris and waste shall be cleared. (Post-Implementation phase)	Contractor
6. Asbestos	a) If asbestos or asbestos containing materials (ACM) are found at a construction site, they should be clearly marked as hazardous waste. (Implementation phase) b) The asbestos should be appropriately contained and sealed to minimize exposure. (Implementation phase) c) Prior to removal, if removal is necessary, ACM should be treated with a wetting agent to minimize asbestos dust. (Implementation phase) d) If ACM is to be stored temporarily, it should be securely placed inside closed containers and clearly labeled. (Implementation phase) e) Removed ACM must not be reused. (Implementation and post-implementation phase)	Contractor
7. Health and Safety	a) When planning activities of each subproject, discuss steps to avoid people getting hurt. (Planning phase) It is useful to consider:	Contractor

	• Construction place: Are there any hazards that could be removed or should warn people about? • The people who will be taking part in construction: Do the participants have adequate skill and physical fitness to perform their works safely? • The equipment: Are there checks you could do to make sure that the equipment is in good working order? Do people need any particular skills or knowledge to enable them to use it safely? • Electricity Safety: Do any electricity good practices such as use of safe extension cords, voltage regulators and circuit breakers, labels on electrical wiring for safety measure, aware on identifying burning smell from wires, etc. apply at site? Is the worksite stocked with voltage detectors, clamp meters and receptacle testers? b) Mandate the use of personal protective equipment for workers as necessary (gloves, dust masks, hard hats, boots, goggles). (Implementation phase) c) Follow the below measures for construction involve work at height (e.g. 2 meters above ground (Implementation phase): • Do as much work as possible from the ground. • Do not allow people with the following personal risks to perform work at height tasks: eyesight/balance problem; certain chronic diseases – such as osteoporosis, diabetes, arthritis or Parkinson's disease; certain medications – sleeping pills, tranquillisers, blood pressure medication or antidepressants; recent history of falls – having had a fall within the last 12 months, etc. • Only allow people with sufficient skills, knowledge and experience to perform the task. • Check that the place (eg a roof) where work at height is to be undertaken is safe. • Take precautions when working on or near fragile surfaces. • Clean up oil, grease, paint, and dirt immediately to prevent slipping; and • Provide fall protection measures e.g. safety hardness, simple scaffolding/guard rail for works over 4 meters from ground. d) Keep worksite clean and free of debris on daily basis. (Implementation phase) e) Provision of first aid kit with bandages, antibiotic cream, etc. or health care facilities and enough drinking water. (Implementation phase) f) Keep corrosive fluids and other toxic materials in properly sealed containers for collection and disposal in properly secured areas. (Implementation phase) g) Ensure adequate toilet facilities for workers from outside of the community. (Implementation phase) h) Rope off construction area and secure materials stockpiles/ storage areas from the public and display warning signs including at unsafe locations. Do not allow children to play in construction areas. (Implementation phase) i) Ensure structural openings are covered/protected adequately. (Implementation phase) j) Secure loose or light material that is stored on roofs or open floors. (Implementation phase) k) Keep hoses, power cords, welding leads, etc. from laying in heavily	

	traveled walkways or areas. (Implementation phase) l) If school children are in the vicinity, include traffic safety personnel to direct traffic during school hours, if needed. (Implementation phase) m) Control driving speed of vehicles particularly when passing through community or nearby school, health center or other sensitive areas. (Implementation phase) n) During heavy rains or emergencies of any kind, suspend all work. (Implementation phase) o) Fill in all earth borrow-pits once construction is completed to avoid standing water, water-borne diseases and possible drowning. (Post-Implementation phase)	
8. Other	a) No cutting of trees or destruction of vegetation other than on construction site. [Implementing agency] will procure locally sourced materials consistent with traditional construction practices in the communities. (Planning phase) b) No hunting, fishing, capture of wildlife or collection of plants. (Implementation phase) c) No use of unapproved toxic materials including lead-based paints, un-bonded asbestos, etc. (Implementation phase) d) No disturbance of cultural or historic sites. (Planning and implementation phases)	Contractor
9. Buildings	p) Provide adequate drainage in the building's immediate surroundings to avoid standing water, insect related diseases (malaria, etc.) and unsanitary conditions. (Implementation phase) q) Include sanitary facilities such as toilets and basins for hand-washing. (Implementation phase) r) Restrict use of asbestos cement tiles as roofing. (Implementation phase) s) Tiled floors are preferred for easier cleaning and more hygienic. (Planning and implementation phases)	Contractor
10. Shelters, community centres,	t) Design of schools, community centres, markets should follow relevant requirements on life and fire safety required by National Building Codes and relevant guidelines from the concerned Ministries. (Planning phase) u) Schools: Maximise natural light and ventilation systems to minimise needs for artificial light and air conditioning; use large windows for bright and well-ventilated rooms. (Planning phase)	Contractor

ANNEX 6. CHANCE FIND PROCEDURES

Cultural heritage encompasses tangible and intangible heritage which may be recognized and valued at a local, regional, national or global level. Tangible cultural heritage, which includes movable or immovable objects, sites, structures, groups of structures, and natural features and landscapes that have archaeological, paleontological, historical, architectural, religious, aesthetic, or other cultural significance. Tangible cultural heritage may be located in urban or rural settings, and may be above or below land or under the water. Intangible cultural heritage, which includes practices, representations, expressions, knowledge, skills—as well as the instruments, objects, artefacts and cultural spaces associated therewith— that communities and groups recognize as part of their cultural heritage, as transmitted from generation to generation and constantly recreated by them in response to their environment, their interaction with nature and their history.

In the event that during construction, sites, resources or artifacts of cultural value are found, the following procedures for identification, protection from theft, and treatment of discovered artefacts should be followed and included in standard bidding documents. These procedures take into account requirements related to Chance Finding under national legislation including [list relevant cultural heritage legislation in country].

- Stop the construction activities in the area of chance find temporarily.
- Secure the site to prevent any damage or loss of removable objects. In cases of removable antiquities or sensitive remains, a guard shall be arranged until the responsible local authorities take over. These authorities are [list the responsible authorities under national legislation].
- Notify the relevant [implementing agency field staff] and the relevant [list the responsible local authorities under national legislation] immediately. [Implementing agency field staff] will inform the [implementing agency management].
- The relevant [list the responsible local authorities under national legislation] shall promptly carry out the necessities and inform the [national level cultural heritage or archaeology ministry] immediately from the date on which the information is received.
- The [national level cultural heritage or archaeology ministry] would be in charge of evaluation /inspection of the significance or importance of the chance finds and advise on appropriate subsequent procedures.
- If the [national level cultural heritage or archaeology ministry] determines that chance find is a non-cultural heritage chance find, the construction process can resume.
- If the [national level cultural heritage or archaeology ministry] determines chance find is an isolated chance find, [national level cultural heritage or archaeology ministry] would provide technical supports/advice on chance find treatment with related expenditure on the treatment provided by the entity report the chance find.

ANNEX 7. CULTURAL HERITAGE MANAGEMENT PLAN (CHMP)

This Annex provides an indicative outline of the elements of the Cultural Heritage Management Plan (CHMP) referred to in ESS8 and World Bank ESF Guidance Note 8: Cultural Heritage. Appendix A, page 14.

The CHMP shall address the following as relevant to the project:

(a) A review of the legal and institutional framework applicable to cultural heritage;

(b) Roles and responsibilities of the project parties and other interested parties, for example, the Borrower, contractors, project-affected people, and cultural heritage authorities;

(c) The steps to identify and manage cultural heritage throughout the project life cycle;

(d) Proposed mitigation measures to be undertaken;

(e) Steps for incorporating relevant requirements relating to cultural heritage into project procurement documents, including chance find procedures;

(f) Implementation schedule and budget; and

(g) Monitoring and reporting requirements.

ANNEX 8: RESETTLEMENT ACTION PLAN (RAP) TEMPLATE

1. Executive Summary

Overview of the health project and its objectives.

Summary of anticipated physical and economic displacement (not land acquisition).

Key mitigation and support measures for all Project Affected Persons (PAPs), including non-title holders.

2. Project Description

Description of the project (e.g., construction/rehabilitation of health facilities).

Identification of project components that may cause involuntary physical or economic displacement (e.g., temporary relocation of vendors, loss of access to business premises during construction).

Statement that no involuntary land acquisition will occur under the project.

3. Potential Impacts

Physical displacement: Loss of shelter or business premises due to project activities (e.g., temporary relocation of health facility staff housing, vendors near construction sites).

Economic displacement: Loss of income or livelihood due to restricted access to assets, businesses, or services (e.g., vendors, informal workers, service providers affected by construction).

Non-title holders: Explicit recognition that informal occupants, squatters, and encroachers may be affected and are eligible for assistance.

Identification of affected groups (title holders, tenants, non-title holders, business owners, informal vendors, employees).

Geographic scope and scale of impacts.

4. Objectives of the Resettlement Program

Ensure that all physically and economically displaced persons—including non-title holders—are assisted to restore or improve their livelihoods and living standards.

Avoid, minimize, and mitigate adverse impacts from displacement.

Ensure that no involuntary land acquisition occurs.

5. Census Survey and Socio-Economic Baseline

Conduct a census of all persons and businesses affected by physical or economic displacement, including non-title holders (squatters, encroachers, informal vendors).

Socio-economic profiling of affected persons, including:

Household composition and vulnerability (e.g., women-headed households, elderly, disabled).

Nature of business or employment affected.

Baseline income and sources of livelihood.

Inventory of affected assets (structures, business equipment, etc.), including those owned or used by non-title holders.

Mechanism for updating data as project design evolves.

Establishment of a cut-off date for eligibility, with clear communication to all PAPs, including non-title holders.

6. Legal and Policy Framework

Overview of relevant national laws and regulations on resettlement, displacement, and compensation.

World Bank ESS5 requirements for involuntary resettlement, including explicit provisions for non-title holders.

Project-specific policy: No involuntary land acquisition; only physical and economic displacement addressed.

Gap analysis between national law and World Bank policy, and measures to address any gaps, especially regarding non-title holders.

7. Institutional Arrangements

Identification of agencies/units responsible for RAP implementation (e.g., Ministry of Health, Project Implementation Unit).

Roles and responsibilities for census, compensation, livelihood restoration, and monitoring.

Coordination mechanisms with local authorities and community organizations.

8. Eligibility and Entitlements

Eligibility criteria: All persons present before the cut-off date and affected by project activities, including:

- Title holders (legal owners)
- Tenants and leaseholders
- Non-title holders (squatters, encroachers, informal occupants, vendors)
- Employees and wage earners

Entitlement matrix:

- Title holders: Assistance for physical/economic displacement (as relevant).
- Tenants: Assistance for loss of business/residence, moving allowance, livelihood restoration.
- Non-title holders:
    - No compensation for land, but compensation for structures/assets at replacement cost.
    - Assistance for loss of business or residence (e.g., moving/shifting allowance, transitional support, livelihood restoration).
    - Right to salvage materials from affected structures.
    - Additional support for vulnerable non-title holders (e.g., women-headed households, elderly, disabled).

- Employees: Transitional assistance for loss of employment.

Cut-off date: Clearly defined and communicated; only those present before this date are eligible.

9. Valuation and Compensation for Losses

Methodology for valuing lost assets (structures, business equipment, inventory), including those owned by non-title holders.

Approach for calculating compensation for lost income or business interruption (e.g., based on average earnings over a defined period).

Procedures for delivering compensation and support.

10. Resettlement Measures and Livelihood Restoration

Measures to assist physically displaced persons (e.g., identification of suitable temporary or permanent alternative premises, moving assistance).

Measures to assist economically displaced persons (e.g., cash compensation, business re-establishment support, training, access to microcredit).

Livelihood restoration programs tailored to the health sector context (e.g., support for vendors near health facilities, retraining for affected workers).

Special support for vulnerable groups, including non-title holders.

11. Community Participation, Consultation, and Disclosure

Summary of consultations with affected persons, health facility staff, local communities, and other stakeholders, including non-title holders.

Mechanisms for ongoing participation and feedback during RP implementation.

Disclosure of RAP and entitlements in accessible formats and languages.

12. Grievance Redress Mechanism

Procedures for affected persons—including non-title holders—to raise concerns or complaints.

Steps for grievance resolution, including timelines and responsible parties.

Accessibility of the mechanism to all affected persons, including vulnerable and non-title holders.

13. Implementation Schedule

Timeline for key RP activities (census, consultations, compensation, relocation, livelihood restoration).

Linkages to overall project implementation schedule.

14. Costs and Budget

Itemized budget for all RP activities (compensation, support measures, monitoring), including provisions for non-title holders.

Funding sources and arrangements for timely disbursement.

15. Monitoring and Evaluation

Arrangements for internal and external monitoring of RP implementation.

Key performance indicators (e.g., number of persons assisted, restoration of income/livelihoods), with disaggregation for non-title holders.

Involvement of affected persons, including non-title holders, in monitoring and evaluation.

16. Annexes

Maps of affected areas and project sites.

Census and survey forms (including for non-title holders).

Consultation records.

Sample grievance forms.

Any other relevant supporting documentation.

Key Notes on Non-Title Holders

- Explicit Inclusion: Non-title holders (squatters, encroachers, informal vendors) are recognized as eligible for assistance if present before the cut-off date, even if they have no legal claim to the land
- Entitlements: They are entitled to compensation for structures/assets, moving/shifting allowances, transitional support, and livelihood restoration, but not for land itself.
- Vulnerable Groups: Non-title holders who are also vulnerable (e.g., women-headed households, elderly, disabled) receive additional support.
- Consultation and Grievance: Non-title holders must be included in all consultations and have equal access to grievance redress mechanisms.

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