PACIFIC HEALTHY ISLANDS TRANSFORMATION PROJECT (P508550)

STAKEHOLDER ENGAGEMENT FRAMEWORK

1. PURPOSE AND CONTEXT

1.1. Purpose

Under the World Bank's Environmental and Social Standards 1 (ESS1) (Assessment and Management of Environmental and Social Risks and Impacts) and ESS10 (Stakeholder Engagement and Information Disclosure), stakeholder engagement is recognised for its importance in maintaining open and transparent engagement between the Borrower and project stakeholders as an essential element of good international practice. Effective stakeholder engagement can improve the environmental and social sustainability of projects, enhance project acceptance, and make a significant contribution to successful project design and implementation.

It is a requirement under ESS1 and ESS10 to develop stakeholder engagement plans (SEPs) for project activities. The purpose of SEPs is to define a program for stakeholder engagement, including public information disclosure and consultation throughout the entire project cycle, commensurate with the nature and scale, and potential risks and impacts of the project and the level of concern of stakeholders.

The objectives of ESS10 are to:

- Establish a systematic approach to stakeholder engagement that will help Borrowers identify stakeholders and build and maintain a constructive relationship with them, in particular project-affected parties.
- Assess the level of stakeholder interest and support for the project and to enable stakeholders' views to be taken into account in project design and environmental and social performance.
- Promote and provide means for effective and inclusive engagement with project-affected parties throughout the project life cycle on issues that could potentially affect them.
- Ensure that appropriate project information on environmental and social risks and impacts is disclosed to stakeholders in a timely, understandable, accessible and appropriate manner and format.

- Provide project-affected parties with accessible and inclusive means to raise issues and grievances, and allow Borrowers to respond to and manage such grievances.

The Pacific Healthy Islands Transformation (PHIT) Project is a regional project involving Fiji, Kiribati, Tuvalu, Solomon Islands and Tonga, and the Pacific Community (SPC) as a key regional coordinating partner, and encompasses a range of different but integrated activities aimed at transforming and uplifting Pacific health systems to promote health and deliver adequate preventive and curative services.

As a regional project delivered in multiple jurisdictions and involving broad range of activities (sub-projects), SEPs are required to be developed for each specific sub-project relative to the activity (e.g. construction vs technical assistance) and activity location.

This Stakeholder Engagement Framework (SEF) provides the principles and requirements for the development of specific SEPs for each sub-project. It is designed to help Borrowers identify key aspects of stakeholder engagement relevant to each sub-project, particularly where the ESS requirements exceed local requirements under applicable consultation processes (e.g. as might be required under an environmental impact assessment, development approval processes, or not at all for certain types of activities).

A concise and up-to-date SEP will enable different project-related parties (e.g. staff of the project implementing unit, contractors, sub-contractors and project workers) to have a clear understanding of what is required with respect to project stakeholder engagement at different stages and to plan resources and information accordingly. The level of detail contained in the SEP or available to SEP implementers and actors at a given time will depend on the type of project and information available. Where relevant information is not available, this should be noted and the SEP should be updated as soon as possible. SEPs will be version-controlled, periodically reviewed, and updated during implementation to reflect stakeholder feedback, changes in design, or evolving risks.

1.2. Project overview

The PHIT project is designed as a suite of regional investments 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 in the region. It will complement and boost the impact of existing national health systems investments, including national IDA-funded investments such as the Kiribati Health Systems Strengthening Project (P176306), the Health Enhancement and Resiliency in Tonga (HEART) Project (P180965), and the Tuvalu Health Systems Strengthening project (P175170).

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:

Sub-component 1.1: Enhancing quantity and quality of the Pacific healthcare workforce, by (a) Improving professional development and accreditation; (b) Addressing advanced skills gaps; (c) Establishing a regional network of e-learning hubs, (d) Establishing electronic health worker registries, (e) Addressing advanced skills gaps, and (d) Strengthening national training institutions.

Sub-component 1.2: Using digital innovations to create a Pacific model of PHC strengthening, by (a) Establishing a regional telehealth network (RTN), (b) Establishing a regional registry for the RTN, (c) Developing shared instruments to guide regional use of the RTN, (d) Developing an AI-enabled diagnostic application, (e) Developing a regulatory and cooperation framework on use of

AI-enabled software, (f) Developing secure cross-border data-exchange mechanisms, (g) Upgrading selected PHC facilities with digital equipment to maximise reach of RTN.

Sub-component 1.3: Expanding access to tertiary hospital care and upgraded training facilities within Pacific SIDS, by (a) Updating clinical guidelines, protocols, and climate-resilient patient care pathways, (b) Upgrading and expanding the Colonial War Memorial (CWM) Hospital in Fiji.

Component 2: Modernise Fiji's health system and upgrade PHC facilities regionally, with emphasis on establishing networks of care for health promotion, early detection and management of disease:

Sub-component 2.1: Building resilient, person-centred, integrated health service delivery with strengthened capacity to detect and manage NCDs and risk factors, by (a) Establishing networks of care by upgrading, repairing or replacing PHC clinics, (b) Establishing a national digital health architecture in Fiji, (c) Improving health emergency preparedness and response in Fiji, (d) Strengthening supply chain resilience, (e) Upgrading PHC screening, risk assessment, diagnosis, treatment and referral protocols, (f) Assessing resource gaps for NCD management, and (g) Designing and implementing an electronic health record and screening program.

Sub-component 2.2: Scale-up gender and climate sensitive community outreach, risk profiling, wellness and behaviour change programs, by implementing community-based, digitally aided outreach programs.

Component 3: Strengthening stewardship, evidence-based decision making and learning for quality health systems in Pacific SIDSs:

Sub-component 3.1: Support regional implementation capacity, monitoring, evaluation and learning (MEL) for health systems strengthening through a regional Centre of Excellence (COE) approach, by (a) Establishing a COE for Regulatory and Data Safety for Telehealth (Tonga), a COE for Continuity of Care in Disparate Geographies (Kiribati and Tuvalu), and (c) a COE for Fair Access to Regional Specialist Care (Fiji).

Sub-component 3.2: Project Implementation Management by (a) Establishing and operating Project Management Units, (b) Implementing regional activities through SPC, and (c) Engaging UNICEF to provide hands-on implementation support and coordination.

The planned activities by participating country are summarised in Table 1.

Table 1: Planned activities by participating country

Sub-component	Activity description	Fiji	Kiribati	Tonga	Tuvalu	SPC
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) Establish a regional telehealth network (RTN)	✓	✓	✓	✓	✓
	b) Establish a regional registry for the RTN	✓	✓	✓	✓	✓

Sub-component	Activity description	Fiji	Kiribati	Tonga	Tuvalu	SPC
a Pacific model of PHC strengthening	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	✓				
2.1: 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	✓	✓	✓	✓	✓
	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	✓				
3.1: 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	✓				

Sub-component	Activity description	Fiji	Kiribati	Tonga	Tuvalu	SPC
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 high-level activity typology is outlined in Table 2:

Table 2: PHIT project activity typology

Activity type	Activity	Description and inclusions
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.
	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.
	Infrastructure upgrade of 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 Pacific SIDS through SPC. 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 reform and 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

Activity type	Activity	Description and inclusions
	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: • 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 Digitally aided health outreach system
	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.

1.3. Project implementation arrangements

The project management structure, institutional arrangements and implementation framework for the project are as follows.

The PHIT project operates through a three-tiered management system. At the apex is a Regional Steering Committee (RSC) comprising participating Ministers or their delegates, serving as the highest oversight body for strategic direction and political-level guidance. SPC acts as the RSC's secretariat, facilitating annual meetings and ensuring lessons learned are shared with Pacific Island Forum leaders to maximise regional spillovers.

Each participating government selects its most appropriate implementing agency based on financing volumes and existing capacity to manage World Bank funding within their health ministries.

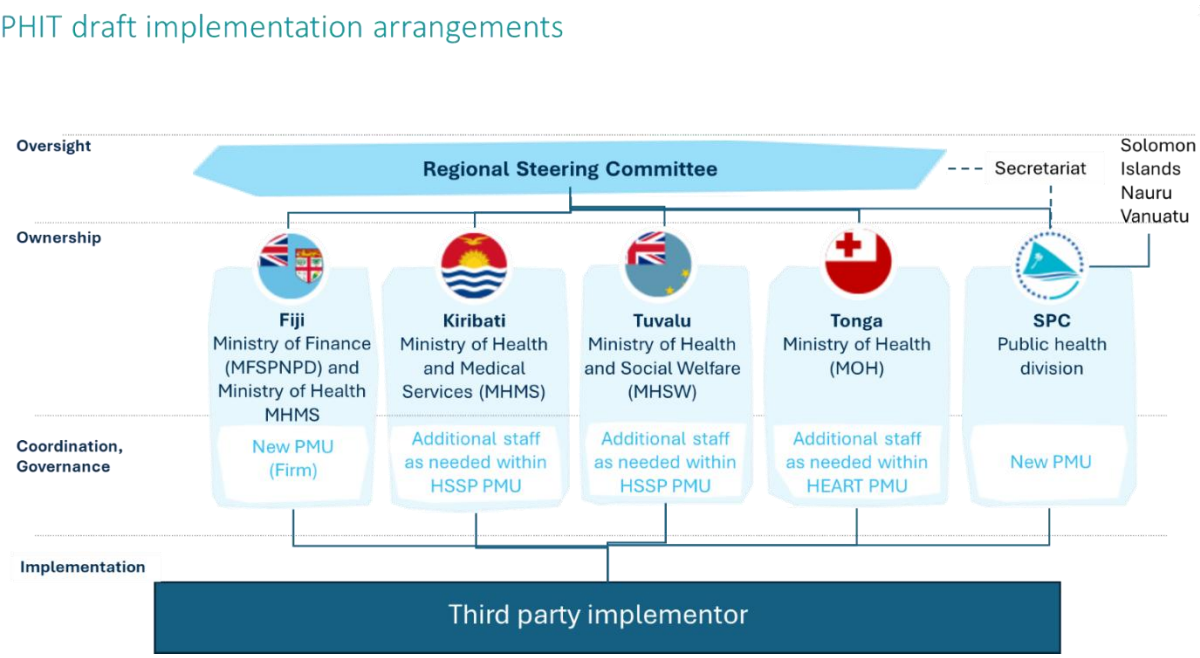

Figure 1: PHIT project implementation and governance arrangements

Project Management Units (PMUs) will be established or reinforced in each country:

- **Fiji** will establish a new PMU hosted within the Ministry of Finance, coordinating with the Ministry of Health to hire specialised firms for major contracts including hospital construction and health facility upgrades;
- **Kiribati** will operate through its existing Health Systems Strengthening Project (HSSP) PMU within the Ministry of Health and Medical Services;
- **Tonga** will operate through its existing Health Enhancement and Resiliency for Tonga (HEART) Project PMU within the Ministry of Health;
- **Tuvalu** will operate through its existing Health Systems Strengthening Project (HSSP) PMU within the Ministry of Health and Social Welfare.

SPC will additionally form a new PMU under its Public Health Division.

Each PMU coordinates PHIT implementation by validating annual workplans, transferring procurement funds, monitoring activities, managing fiduciary oversight, and preparing comprehensive reporting.

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.

SPC will play a pivotal role as the regional organisation with scientific and technical expertise. Beyond serving as the RSC secretariat, SPC will focus on building regional healthcare workforce capacity through identifying training needs, facilitating clinical guideline updates, rolling out professional development curricula, establishing training partnerships, and building mentorship networks. SPC will also facilitate knowledge sharing and regional dialogue to extend PHIT benefits to non-participating countries (e.g. Nauru, Samoa and Vanuatu), while overseeing monitoring and evaluation activities and preparing consolidated annual progress reports.

2. STAKEHOLDER ENGAGEMENT APPROACH

2.1. Purpose of effective stakeholder engagement

Stakeholder engagement is essential for the success of the Project. In line with the ESS10, stakeholder engagement process will be a continuous and iterative process involving identification, communication and facilitation of a two-way dialogue with the people affected by project decisions and activities, as well as others with an interest in the implementation and outcomes of these decisions and the project. It takes into account the different access and communication needs of various groups and individuals, especially those more disadvantaged or vulnerable, including consideration of both communication and physical accessibility challenges. Stakeholder engagement refers to a process of:

- Sharing information and knowledge in a meaningful manner;
- Seeking to understand and respond to the concerns of individuals potentially impacted or affected by an activity in a transparent, inclusive and timely process;
- Building relationships based on trust.

Engagement starts during Project and subproject preparation through stakeholder consultations with affected and interested parties to allow stakeholders' views and concerns to be considered in the project design, implementation, and operation.

Oversight of stakeholder engagement is the responsibility of the PMU and the host Ministry, and applies throughout the planning, construction, operations and any decommissioning phases of Project activities, to be coordinated with other engagement activities potentially linked to PHIT, particularly where activity overlap the same stakeholder groups. This SEF:

- Builds on and documents all consultations undertaken to-date;
- Presents the plan for stakeholder engagement activities;
- Highlights the regulatory framework for this SEF.

The scope of the SEF covers the Project in its entirety across all participating PHIT jurisdictions and subprojects. As such, the SEF includes the various stakeholders positively, neutrally and adversely affected by the Project. The Project's own employees, workers and contractors, as well as any visitors to the Project's premises shall comply with the requirements of this SEF.

This SEF is intended to be a 'live' document that is updated throughout the Project's lifecycle to document the implementation of the Project's community engagement and communication strategy and changing Project landscape. This SEF will be reviewed regularly by the World Bank and updated as relevant.

2.2. Objectives of the SEF

The specific objectives of the SEF are to:

- Identify and assess the stakeholder groups and their profiles, interests, issues/impacts and concerns relevant to the Project (stakeholder mapping);
- Identify specific initiatives (e.g. community meetings, focus-group discussions, face-to-face meetings, posters in public facilities) to allow meaningful engagement with the different stakeholder groups in a manner that is transparent and accessible and using culturally appropriate communication methods with a specific focus on vulnerable groups;

- Support the building of a relationship with the various stakeholders of the Project based on mutual respect and trust;
- Facilitate adequate and timely dissemination of information on technical, economic, environmental and social risks and impacts to the stakeholder groups in a timely, understandable, accessible and culturally appropriate manner and format;
- Establish systems for prior disclosure/dissemination of information and consultation, including seeking inputs from affected persons, incorporation of inputs, as applicable, and providing feedback to affected persons/groups on whether and how the input has been incorporated;
- Establish mechanisms for feedback and dispute resolution (through a GM);
- Establish a procedure for registering and tracking of grievances of the activities undertaken through reporting and monitoring of the GM.

2.3. Principles of stakeholder engagement and grievance

The stakeholder engagement and grievance redress processes for the Project will be based on the following principles:

- **Transparency and fairness:** The process for grievance resolution shall be transparent, in harmony with the local culture, and in the appropriate language. It should explicitly assure potential users that the mechanism would not impede their access to other judicial or administrative remedies.
- **Accessibility and cultural appropriateness:** Every member of the community or groups will have access to the grievance procedure. Any individual or group that is directly or indirectly affected by the Project's and its contractors' activities, as well as those who may have an interest in the Project or the ability to influence its outcome, either positively or negatively, can raise a grievance. To allow all stakeholders to have access to the mechanism, the grievance mechanism will be published in the local languages (and English) of the community and communicated to any vulnerable social groups in a clear and culturally appropriate manner to them.
- **Meaningful Information:** Meaningful information should be disclosed to the stakeholders to allow for active and informed engagement.
- **Open channels of communication:** Communication channels are to be open throughout the Project for addressing each grievance by persons trained and capable of receiving and communicating with vulnerable social groups in a sensitive and culturally appropriate manner.
- **Written records:** A Grievance Record Register is maintained, in a prescribed form, as discussed in Section 7, which includes the tracking process of resolution. SEA/SH grievances will not be recorded in the public register but logged separately with access restricted to trained personnel.
- **Dialogue and site visits:** All grievances warrant a meaningful response and/or conversation via site visit or telephone conversation between the GM Focal Point (or delegate if deemed inappropriate) and the complainant (and potential other stakeholders of relevance), to verify the nature and severity of the complaint. This will also give a first-hand understanding of the nature of the concern and any related issues or context that may be important to the Project.
- **Incorporation of feedback:** Feedback received from the engagement and grievance redress process shall be incorporated into Project design, and reported back to the stakeholders in a

clear and culturally appropriate manner to all, including vulnerable social groups. The aim being that all parties are agreeable to the resolution (and that this is recorded appropriately).

- **Worker Accessibility** (as detailed in the LMF): All project workers will be informed of their right to access a confidential and responsive worker grievance mechanism. This mechanism will be distinct from the community GM but coordinated at the PMU level to ensure accountability and appropriate resolution.

2.4. Purpose of a grievance mechanism

The purpose of a GM is to provide a forum for internal and external stakeholders to voice their concerns, queries and issues with and provide suggestions on the Project (be that openly or anonymously). Such a mechanism should provide the stakeholders with a responsible Project personnel or channel through which their queries can be communicated with the assurance of timely responses to each query.

Grievances may relate to environmental and social impacts, access to services, construction disruptions, exclusion, labor conditions, or risks such as sexual exploitation, abuse or harassment (SEA/SH). The grievance mechanism will include specific adaptations for SEA/SH grievances and separate pathways for project workers to raise concerns, consistent with ESS10 and ESS2.

The specific objectives of the GM are to:

- Allow stakeholders the opportunity to raise comments/concerns;
- Manage and monitor the handling of comments responses and grievances (via fair and timely investigation);
- Ensure that comments, responses, and grievances are handled in a fair, accessible and transparent manner, in line with the applicable reference framework (with acceptance in genuine cases from both parties).
- Provide a survivor-cantered SEA/SH response pathway that protects confidentiality, avoids retaliation, and enables referral to support services where available.
- Provide a dedicated labour grievance channel for project workers (including contractors and consultants), managed in alignment with ESS2 requirements (detailed in the Project LEF).

2.5. Meaningful consultation

Effective stakeholder consultation requires that all affected and interested parties have access to meaningful, timely, and understandable information about the Project and its impacts and are engaged meaningfully. In the context of the PHIT Project and subprojects, meaningful information disclosure and engagement enables stakeholders — particularly disadvantaged or vulnerable groups — to participate actively and constructively in project-related decisions.

For information and engagement to be meaningful, the following principles apply to subproject SEPs, engagement:

- Begins early in the project planning process to gather initial views on the project proposal and inform project design;
- Encourages stakeholder feedback, particularly as a way of informing project design and engagement by stakeholders in the identification and mitigation of environmental and social risks and impacts;

- Continues on an ongoing basis, as risks and impacts arise;
- Is based on the prior disclosure and dissemination of relevant, transparent, objective, meaningful and easily accessible information in a timeframe that enables meaningful consultations with stakeholders in a culturally appropriate format, in relevant local language(s) and is understandable to stakeholders; Meaningful information disclosure principles to be captured in subproject SEPs include the following:
    - Timeliness: Disclosure must occur sufficiently early to allow stakeholders to review, ask questions, and provide input into decisions that are being made or actions to be taken.
    - Clarity and Simplicity: Materials should avoid technical jargon and be presented in a format that is easy to understand.
    - Cultural and Linguistic Accessibility: Information should be made available in the local languages spoken by stakeholders, including translations for remote and linguistically diverse communities.
    - Format Diversity: Recognizing literacy and access constraints, information should be provided using multiple formats — including oral presentations, infographics, posters, mobile messages, and radio or video content.
    - Disability Inclusion: Reasonable accommodations should be made to ensure information is accessible to persons with disabilities, including use of Braille, sign language interpreters, and audio formats.
- Considers and responds to feedback;
- Supports active and inclusive engagement with project-affected parties;
- Is free of external manipulation, interference, coercion, discrimination, and intimidation; and
- Is documented and disclosed by the Borrower

Each SEP prepared under this framework will detail the specific information to be disclosed, the responsible entity, and the communication formats adapted to each subproject's context.

2.6. Role and responsibilities of the PMUs in stakeholder engagement

Each PMU is responsible through the Project duration for:

- Maintaining comprehensive records of all stakeholder consultation conducted in relation to the Project, in the form of a Stakeholder Engagement Register (key details), and a filed memoire document for each consultation.
- Developing SEPs for each subproject, including any consultations related to SEP preparation.
- Establishment, maintenance and operation of the public GM.
- Ensuring effective feedback loops, to:
    - Track how stakeholder inputs are addressed and ensure timely feedback to those consulted.
    - Incorporate feedback into project design, planning, or mitigation measures as appropriate.
    - Prepare summaries of key issues raised and responses given, and make these available to stakeholders in accessible formats.

  - Coordinate periodic updates to stakeholders on project progress and decisions influenced by consultations.
  - Ensure that disadvantaged or vulnerable groups receive tailored follow-up communication, including through trusted intermediaries.
- Plan and allocate adequate human and financial resources for stakeholder engagement and SEP implementation, including the recruitment of community liaison officers or consultants where necessary.
- Ensure translation, printing, event hosting, and communication costs for consultations, disclosure, and grievance handling are included in project budgets and procurement planning.

3. HIGH-LEVEL STAKEHOLDER IDENTIFICATION AND RISK ANALYSIS

A high-level stakeholder identification an analysis for the PHIT project is summarised in Table 3. This analysis is based on the project typology and expected activity locations, and a qualitative risk rating before the implementation of any mitigations. Example mitigations relevant to stakeholder engagement planning are provided as initial guidance, to be reviewed, revised, expanded and refined based on defined subprojects.

Table 3: High-level stakeholder identification and risk analysis for the PHIT project

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
Construction of new tertiary healthcare facility (Fiji only)	Affected stakeholders • Community in the vicinity of the new development site • Community in the vicinity of any separate related waste management or activity site • Future facility users (staff, patients, visitors, trainers, trainees) • CWM Hospital • Suva City Council • Education and training providers • Providers of services (e.g. utilities, transport, waste, infrastructure) Interested stakeholders • Donors and development partners • Relevant ministries and departments • Management of other healthcare facilities	• Site selection process, options and outcomes do not adequately consider, disclose and communicate relevant impacts in relation to: 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. • Construction-related risks: Worker and community safety; labour influx; SEA/SH/GBV; child safeguards; social tensions/conflicts; service disruption; pollution; encroachment • New hospital has significant impacts (e.g. safety, traffic, noise, air pollution, social tensions, transport, services, telecoms) on nearby communities, during construction and/or operations, that have not been considered/mitigated • Waste or logistics facilities have significant impacts on nearby communities (e.g. noise, air pollution, traffic, safety) • New hospital site may pose significant logistical challenges for access by users, reducing its accessibility and utility • New hospital facilities may not be designed in consideration of or to complement existing facilities • Public concerns may arise due to location, impacts or accessibility of new hospital • Demands on services (water, sewerage, power, transport, telecoms, waste) considering capacity constraints and	**HIGH** **HIGH** **HIGH** **HIGH** **HIGH** **HIGH** **HIGH**	• Implement measures in the ESMF to conduct inclusive, transparent site selection with MCA, community input, and heritage/environmental assessment (table #9, action 1.a.a). • Establish an inclusive community reference group (CRG) from the area to be affected by the new development, and conduct multiple meaningful engagement and workshop sessions at different places and times with the CRG on the project and its implications before confirming site selection and then during project design. • Consult with the CRG on the most acceptable and effective community engagement approach to inform the community about the project, its provisions for safety and mitigating impacts. • Ensure information disseminated as part of community consultation aligns with principles for meaningful consultation (section 2.5) • Consider the impacts on services and include any needed service upgrades as part of project design and costing. • Establish a user reference group of diverse patient representatives (including disabled, elderly, youth, women etc.) to be consulted on the design of any new facility to ensure accessibility, safety and suitability. • LMP or LIMP includes active measures for managing specific impacts and consulting with communities on them

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
		impacts on other users may not be adequately considered or addressed in site selection or facility design • New development may be incongruous/incompatible with existing planning schemes for surrounding areas (e.g. transport, zoning, traffic safety, services) • Labor influx management does not adequately plan for impacts on specific stakeholders • Access and transport arrangements, including patient and worker access, and operational logistics, do not adequately consider surrounding land uses, communities or existing activity patterns in the immediate vicinity of the precinct.	**HIGH** **HIGH** **HIGH**	• Consultation on site and facility wide operational management planning, which includes operational labour management and access, transport and logistics arrangements • Develop an Infrastructure and Service Provision Plan (ISPP) by a cross-portfolio working group as outlined in the ESMF
Renovation and refurbishment of CWM Hospital (Fiji only)	Affected stakeholders • CWM Hospital • Current and future facility users (staff, patients, visitors, trainers, trainees) • Affected community near new development site or any separate related waste management or activity site Interested stakeholders • Relevant ministries and departments • Donors and development partners • Suva City Council • Management of other healthcare facilities • Education and training providers • Providers of services (e.g. utilities, transport, waste, infrastructure)	• Construction activities may have significant impacts (noise, dust, asbestos, safety, traffic, waste, construction hazards) on patients, staff, visitors and local community • Demolition may produce significant hazardous waste (e.g. asbestos, medical waste) requiring offsite transport and disposal • Design of renovations may not meet needs of future users (staff, patients, trainers/trainees) due to usability, accessibility issues • Existing service connections (e.g. sewer, water, power, telecoms, waste, road network and site access) may not have the capacity to supply/service the re-developed facility • New or increased use of waste or logistics facilities and/or worker movements may have significant impacts on nearby communities both during construction phase and during operational phases (e.g. noise, air pollution, traffic, safety)	**HIGH** **HIGH** **HIGH** **HIGH** **HIGH**	• Establish a working group of hospital representatives from different areas/departments to be consulted on proposed renovation works and the management and mitigation of potential impacts on hospital staff, patients and visitors. • Coordinate closely with relevant planning authorities (e.g. Suva City Council, Department of Town and Country Planning) on any major redevelopment plans. • Establish a user reference group of diverse patient representatives (including disabled, elderly, youth, women etc.) to be consulted on the design of any renovation to ensure accessibility, safety and suitability. • Ensure information disseminated as part of community consultation aligns with principles for meaningful consultation (section 2.5). • Consultation on site and facility wide operational management planning, which includes opera

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
		• Re-development may be incongruous/incompatible with existing planning schemes for surrounding areas (e.g. transport, zoning, traffic safety, services) • Access and transport arrangements, including patient and worker access, and operational logistics, do not adequately consider surrounding land uses, communities or existing activity patterns in the immediate vicinity of the precinct.	**MEDIUM** **HIGH**	
Infrastructure upgrade of local PHC facilities and/or nursing schools	• Serviced (affected) community • Owners and managers of existing PHC facilities • Relevant ministries and departments • The local government authority • Donors and development partners • Local PHC sector • PHC healthcare and support staff • Providers of services (e.g. utilities, transport, waste, infrastructure)	• New or upgraded PHC facility may not meet priority local needs or be unusable / inaccessible / not culturally accepted by expected users (staff, patients, visitors) • Needs of disadvantaged or vulnerable people and/or medium or long term population health needs are not adequately. • New or upgraded PHC facility relies on services and utilities that are not available or unstable. • Land needs supplementary to existing facility footprint is not easily accessible • Supply of construction materials and labour is unsafe or infeasible • Installed equipment cannot be used and/or maintained safely by local staff • Lack of appropriately skilled workforce during operational phase • Facility may not be financially or logistically supportable in the long term viable across the operational lifecycle (ongoing costs, connectivity and supply logistics not adequately considered)	**MEDIUM** **MEDIUM** **MEDIUM** **MEDIUM** **HIGH** **HIGH** **HIGH** **HIGH**	• Establish inclusive community engagement mechanisms (e.g. design committees, focus groups) comprising diverse representatives (elderly, disabled, women, youth, traditional leaders) who participate in needs assessment and service facility planning and regular consultations to ensure designs are culturally appropriate, accessible, and meet actual community health needs. • Conduct service capacity and needs assessments with local service and facility providers during early planning stages to confirm that water, power, telecommunications, and waste management infrastructure can support upgraded facilities and identify gaps and key upgrades. • Partner with local technical staff and suppliers throughout design and procurement processes to ensure selected equipment can be maintained viably, construction materials are sustainably sourced, and facility operations remain financially viable long-term. • Integrate traditional and cultural elements and perspectives on and practices for wellbeing through meaningful engagement with elders and traditional

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
				healers in site selection, design features, and blessing ceremonies to build community ownership and acceptance of modern health facilities. • Create operations phase feedback mechanisms (e.g. regular community meetings/advisory committees, SMS reporting systems, community monitoring) that are inclusive of vulnerable groups to track concerns during construction and ensure facilities remain responsive to evolving community needs.
Digital infrastructure (hardware)	• Participating government departments • Management of healthcare facilities • Education and training providers • Accreditation and oversight authorities • Healthcare workforce: Nursing • Healthcare workforce: Doctors and specialists • Health-related NGOs • Community nurses and PHC staff • The public • ICT infrastructure managers • Owners and managers of existing PHC facilities • PHC healthcare and support staff	• Installed digital infrastructure has inadequate reliability and/or resilience in the local context, is difficult or costly to maintain, does not have local support, or cannot be implemented due to local constraints • Installed digital infrastructure has inadequate interoperability other critical system or cannot support the PHIT digital platforms • Installed digital infrastructure is difficult to use or inaccessible to intended users • Operations and maintenance planning does provide for external specialist support to maintain key features of the	**HIGH** **HIGH** **HIGH** **MEDIUM**	• Prepare a register of and undertake local technical capacity assessments with ICT service providers, facility maintenance staff, and community technicians to document existing skills and infrastructure limitations, ensuring hardware selection matches local maintenance capabilities. • Integrate and complement locally appropriate equipment supply chains for advanced systems requiring external support. • Clearly communicate respective roles in design, development/installation and maintenance of systems and roles and responsibilities. • Create technology user groups including facility managers, local ICT businesses, and technical training institutions who participate in equipment specification, inform vendor selection, and sustainability planning to ensure long-term viability and local ownership of maintenance responsibilities. • Develop tiered training programmes partnering with equipment suppliers to train multiple local technicians in basic troubleshooting, preventive

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
				maintenance, and repair procedures, with certification pathways, refresher training schedules and on-demand help desk functions built into procurement contracts. • Design resilient infrastructure packages through consultation with remote facilities about environmental challenges (humidity, power fluctuations, dust), selecting resilient equipment with extended warranties responsive to remote area maintenance, built-in redundancies, and compatibility with existing systems based on user feedback. • Implement participatory monitoring systems where user representatives regularly assess hardware performance, maintenance needs, and operational challenges through structured feedback mechanisms, with regular reviews adjusting support strategies based on real-world implementation experiences.
Policy and regulatory reform, program implementation	• Participating government departments • Management of healthcare facilities • Education and training providers • Accreditation and oversight authorities • Healthcare workforce: Nursing • Healthcare workforce: Doctors and specialists • Health-related NGOs • Community nurses and PHC staff	• Insufficient consultation and/or collaboration on reforms and systems among stakeholders across jurisdictions could result in a halt to work/progress, or a refusal of acceptance of final system • Regulatory and accreditation reforms may not meet healthcare worker needs • Training providers may lack capacity or willingness to enact reforms • If reforms place onerous training requirements on healthcare workers, participation may fall, impacting public health	**HIGH** **HIGH** **HIGH** **MEDIUM**	• Establish a cross-sector working group including active participants/representatives from identified stakeholders • Ensure meaningful engagement with all user and affected groups during reform design, including providing feedback on met/unmet needs • Test draft reforms with representative user groups and iterate if necessary • Test final draft reforms with representatives of the broader public and incorporate and/or publicly respond to feedback

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
	• The public	• Future users of new systems do not support or are unaware of the changes • New systems are not accepted by all country partners • Program implementation is led / run by non-local staff not meeting decolonised development agenda	**HIGH** **MEDIUM** **HIGH**	• Gain acceptance of reforms from user groups prior to formalisation
Digital platforms and content	• Participating government departments • Management of healthcare facilities • Education and training providers • Accreditation and oversight authorities • Healthcare workforce: Nursing • Healthcare workforce: Doctors and specialists • Health-related NGOs • Community nurses and PHC staff • The public • ICT infrastructure managers	• Due to lack of effective consultation and/or incorporation of stakeholder needs and feedback, downstream risks that digital platforms and content do not meet the needs or use cases for the PHIT countries, including the inadequate localisation of AI tools and eLearning platforms, lack of cultural sensitivity, low accessibility, lack of inclusivity, marginalisation or inaccessibility of vulnerable groups, inbuilt discrimination and bias, lack of language localisation • Inadequate interoperability with critical systems • Inadequate reliability or resilience of platforms • Platforms may not meet needs of government and other operational agencies	**HIGH** **HIGH** **MEDIUM** **MEDIUM**	• Co-design with users as core partners in every design phase—from initial concepts through interface testing—ensuring platforms are genuinely fit for purpose. • Establish diverse technical advisory groups including healthcare workers from all levels, youth representatives, and minority language speakers who review AI algorithms, content accuracy, and cultural appropriateness through iterative testing cycles with documented design changes based on feedback. • Develop and test training materials and ongoing technical support alongside design of systems. • Implement continuous bias monitoring through regular algorithm audits disaggregated by ethnicity, gender, location, and age, with transparent reporting to communities about identified biases and corrective actions taken, including retraining AI models with Pacific-specific health data. • Create multilingual content validation processes where community health workers and local translators ensure health information reflects local contexts, traditional practices, and dialectical variations while avoiding discriminatory language or assumptions.

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
				• Deploy phased community pilots testing platforms with small user groups across diverse settings (urban, rural, maritime) before wider rollout, with mandatory incorporation of pilot feedback into platform modifications and reporting on how user input shaped final designs.
Health outreach programs	• Serviced community • Owners and managers of existing PHC facilities • Relevant ministries and departments • The local government authority • Local PHC sector • PHC healthcare and support staff	• Community health worker safety risks during house-to-house visits, particularly when visiting isolated households 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 • Cultural inappropriateness or discriminatory bias in digital diagnostic tools • AI algorithms trained on non-Pacific data may provide inappropriate or inaccurate health advice for local populations • App content may not reflect local health beliefs, traditional medicine practices, or cultural sensitivities around body/illness discussion • Language translations may use formal register inappropriate for community engagement or miss important dialectical variations • Inadequate matching of health workers to community demographics and needs (e.g. male health workers may be culturally inappropriate for maternal/reproductive health discussions with women; different ethnic/religious	**HIGH** **HIGH** **HIGH** **MEDIUM** **MEDIUM** **MEDIUM** **MEDIUM** **MEDIUM** **HIGH**	• Develop a safety system (a buddy system, check-in protocols, safety training including de-escalation techniques). • Establish community advisory groups including elders, traditional healers, and diverse community representatives to review outreach program and app content • Create visual content using local community members as models and culturally appropriate imagery • Build in user feedback mechanisms to report culturally inappropriate content • Recruit health workers from within target communities who understand local contexts • Ensure gender balance in teams to allow matching with household preferences • Provide comprehensive cultural competency training including local customs, languages, and health beliefs • Partner with community leaders to identify trusted individuals for health worker roles • Create mentorship programs pairing younger workers with experienced community nurses

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
		backgrounds may face acceptance barriers in certain communities)		• Establish clear protocols for when to involve community elders or traditional healers
		• Health workers unprepared to respond appropriately when witnessing or learning about GBV/abuse	**HIGH**	• Develop comprehensive GBV/child protection training mandatory for all outreach workers
		• Risk of escalating violence if perpetrators feel threatened by health worker presence	**HIGH**	• Establish partnerships with local GBV service providers and safe houses
		• Inadequate protocols for mandatory reporting while maintaining victim safety	**MEDIUM**	• Develop safety planning tools workers can use with victims during visits
		• Secondary trauma to health workers from repeated exposure to abuse situations	**MEDIUM**	• Provide psychological support and debriefing for workers exposed to trauma
		• Elderly community members intimidated by technology and refusing engagement	**MEDIUM**	• Implement strict data encryption on all devices with automatic timeout features
		• Privacy and confidentiality breaches in small communities (e.g. household members overhearing sensitive health discussions)	**HIGH**	• Develop clear confidentiality agreements with local health workers • Create anonymous reporting options for sensitive health issues
		• Data security concerns with health information stored on portable devices	**HIGH**	• Community education about health privacy rights
		• Community health workers who are local residents potentially sharing health information informally	**HIGH**	• Partner with traditional healers as respected advisors and partners to the program
		• Erosion of traditional healing relationships and knowledge systems (e.g. 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)	**MEDIUM**	• Map available services before outreach begins, including telehealth • Create clear communication about service limitations during initial community engagement • Establish mobile clinic schedules coordinated with outreach findings
		• Inadequate referral pathways for identified health issues (e.g. outreach identifying serious conditions without accessible treatment options, creating anxiety/demand for services not available in remote areas, frustration when diagnostic app recommends unavailable interventions)	**HIGH**	

Activity	Potentially affected stakeholders	Potential risks related to stakeholders / engagement	Risk*	Example mitigations
Training	• Participating government departments • Management of healthcare facilities • Education and training providers • Accreditation and oversight authorities • Healthcare workforce: Nursing • Healthcare workforce: Doctors and specialists • Community nurses and PHC staff	• Discrimination and exclusion - visiting trainees facing prejudice based on nationality/gender, leading to isolation and limited learning • SEA/SH vulnerability - power imbalances between trainers and trainees lacking support networks • Welfare challenges - mental health impacts from isolation, financial hardship, limited cultural support, inability to respond to family emergencies • Professional exploitation - menial task assignment, excessive work hours, restricted access to meaningful learning • Re-integration difficulties - colleague resistance, lack of equipment for new skills, professional jealousy from peers	**MEDIUM** **MEDIUM** **MEDIUM** **MEDIUM** **MEDIUM**	• Pre-departure engagement • Returned trainee mentorship programs • Cultural orientation sessions • Peer support group formation • Anti-discrimination frameworks • Host institution accountability pledges • Buddy systems with local staff • Cultural competency training for supervisors • Anonymous discrimination reporting mechanisms • SEA/SH prevention • Accommodation risk assessments • Women's safety organisation partnerships • Mandatory codes of conduct for trainers • Pacific diaspora organisation partnerships • Telehealth mental health support • Exploitation prohibition clauses • Clear grievance procedures

*Unmitigated risk rating

4. STAKEHOLDER ENGAGEMENT COMPLETED DURING PROJECT PREPARATION

Extensive consultations have been conducted across the PHIT participating countries and organisation since 2023 regarding the Project and related health sector initiatives. The full consultation record is provided in Annex A.

The most comprehensive engagement has been with Fiji, with activities spanning from February 2023 to May 2025. Key ministries engaged include the Ministry of Health and Medical Services (MHMS) and Ministry of Finance. High-level officials consulted include the Health Minister, Assistant Finance Minister, and various Permanent Secretaries.

Major consultations included the February 2023 Health Sector Review, supply chain management assessments, Primary Health Care Performance Initiative workshops with 52 participants, and CWHM Hospital infrastructure assessments. The November 2024 public launch of the Fiji Health Sector Review was led by Prime Minister Rabuka.

Various regional consultations have been conducted, including as part of the meeting of Pacific Ministers of Finance in March 2025 (attended by ministers from Fiji, Kiribati, Solomon Islands, Tonga, and Tuvalu) in Tokyo for PHIT project briefings.

This was followed by country-specific technical missions, including:

- Kiribati in March 2025, involving technical discussions with representatives from Ministry of Health and Ministry of Finance, focusing on project procurement planning and implementation design for the first 18 months.
- Tonga in March 2025, involving consultations with Ministry of Health and Ministry of Finance representatives, addressing project design and procurement planning.
- Solomon Islands in April 2025, involving discussions with the Secretary for Health, focusing on activity planning, complementarity with national health systems projects, and technical project design.
- Tuvalu in April 2025, involving consultations with the Secretary for Health, covering similar areas including procurement planning and project implementation design.
- The February 2025 Pacific Health Systems Flagship Course in Nadi brought together over 60 policy leaders from health, finance, and planning ministries across eight Pacific countries. Health Ministers from Fiji, Kiribati, Solomon Islands, Tonga, and Tuvalu participated in opening sessions and received briefings on the proposed PHIT project.
- In April 2025, as part of a Pacific Heads of Health meeting involving representatives from the PHIT countries, participated in a PHIT Project *Talanoa* session coordinated by the World Bank and Pacific Community (SPC).
- A PHIT Health Workshop involving multiple representatives from all of the PHIT countries was held on June 11-12 in Suva to discuss in detail the project design and implementation arrangement, with feedback incorporated into the Project Appraisal Document (PAD) and Project instruments (ESMF, LMF, SEF).

- A joint technical mission was conducted on May 26 – June 4, 2025, to advance the preparation of the PHIT project, led by World Bank in coordination with representatives from Government of Australia, Asian Development Bank (ADB) and Organization of the Petroleum Exporting Countries Fund for International Development (OPEC).
- A regional workshop was held on 11–12 June 2025 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 consultations demonstrate comprehensive multi-level engagement across health and finance ministries, with particular emphasis on regional coordination, implementation arrangements and alignment of health system strengthening efforts across the Pacific Island nations.

Full engagement records are provided in Annex A.

5. PREPARING A STAKEHOLDER ENGAGEMENT PLAN

A SEP is required to be developed for each subproject, and to be in place at subproject commencement as part of the subproject's governing instruments.

The purpose of preparing a SEP is to explain how stakeholder engagement will be implemented throughout the course of a subproject and which methods will be used as part of the process, as well as to outline the responsibilities of contractors, consultants, communities, national and local governments, and implementing agencies in the implementation of stakeholder engagement activities. The SEP will outline how people will be notified and given opportunities for consultation and in their preferred language. The SEP shall also outline how project grievances will be identified, received, and responded to, by when and by whom. The nature and scale of project risks varies between subprojects, and SEP shall be commensurate with the potential subproject impacts.

Note that the development and preparation of the SEP for a subproject is itself a consultative process involving progressive and iterative engagement with subproject stakeholders as they are identified through consultation and subproject planning activities.

The process to be undertaken to prepare the SEP for each subproject is stepped out in the following subsections.

5.1. Step 1: Stakeholder mapping

Stakeholder mapping is a process of identifying stakeholder groups and assessing the degree to which that group might be impacted by the subproject (e.g. safety issues, discrimination, pollution) or have the power to influence the subproject (e.g. in the approval or design process). The purpose of stakeholder mapping is to:

- Study the profile of the stakeholders identified and the nature of the stakes;
- Understand each group's specific issues, concerns and expectations related to the project; and
- Gauge their influence on the project and the nature of that influence.

This process must be conducted for each subproject. The procedure and high-level guidance for this process is as follows:

1. **Map the project Area of Influence (AoI):** The AoI of a sub-project is determined by its potential relevant environmental and/or social impacts, such as noise, traffic, air pollution, social tensions and impacts on services, amenity, living conditions. The AoI may include, for example, potential impacts not just on nearby stakeholder but also stakeholder impacted more remotely such as due to offsite waste management, additional strain on public transport networks, wastewater treatment capacity, telecommunications capacity, reliability of power and water, etc.
2. **Identify Affected Stakeholders:** These are the stakeholders within the AoI of the planned activity who stand to be directly impacted, and includes direct users of the subproject outputs.
3. **Identify Interested Stakeholders:** In addition to those communities living within the Project's primary AoI, other Interested Stakeholders such as NGOs, media, government officials, external communities, professions and service providers are also accounted for in the SEF/SEP.
4. **Identify Disadvantaged/Vulnerable stakeholders:** Within the identified stakeholders, assess whether there are any disadvantaged/vulnerable/marginalised subgroups that may be disproportionately affected by subproject impacts and flag these for additional consideration.

Note that it is essential that consultations be conducted with the identified stakeholders as part of the stakeholder mapping process above to ensure that all relevant stakeholders are accounted for. Any additional stakeholders discovered or referred to through these consultations should also be added to the stakeholder list where relevant. These consultations can be conducted through a working group of representatives and/or through a series of bilateral meetings. All such consultations should be recorded in the PMU's stakeholder engagement register.

5.2. Step 2: Analyse stakeholder impacts, risks and influence

Once the stakeholders have

1. **Screen for potential impacts, key risks and influence:** Assess the potential risks and impacts of the subproject on each identified stakeholder. These include potential impacts on stakeholder welfare as well risks associated with vestment of influence and approval power.
2. **Assign stakeholders an engagement importance rating:** Assign an engagement importance of High, Medium or Low for each stakeholder with respect to the degree of impact and degree of influence. The engagement importance is a gauge of the urgency, frequency, nature and level of engagement.
3. **Determine the engagement level:** The level of engagement (inform, consult, involve) is set according to the highest engagement importance rating in either impact or influence, and/or by the role of the stakeholder in the subproject. A guide to the level of engagement is determined by the stakeholder engagement importance as per Table 4.
4. **Consult with representatives of each stakeholder group:** To ground-truth risks and concerns, direct consultation with representatives of each stakeholder group is essential, particularly for High importance stakeholders. Maintain records of such consultations.

5. **Update stakeholder analysis as the basis for the SEP:** Once any preliminary consultations have been completed, update the stakeholder mapping and analysis as the starting point for the SEP.

Table 4: Stakeholder engagement levels for subproject SEPs

Engagement importance	Engagement level	Examples of engagement
High	Involve	A commitment to work with the stakeholder group to ensure that their concerns and aspirations are directly reflected in subproject design and implementation, including providing feedback on how inputs have influenced decision-making. Involvement should be meaningful, inclusive and culturally safe, and conducted in a manner that is sensitive to stakeholder needs and concerns.
Medium	Consult	A commitment to keep the stakeholder group informed, listen to and acknowledge their concerns and aspirations, and provide feedback on how their input has influenced decision-making. Consultation should be meaningful, inclusive and culturally safe, and conducted in a manner that is sensitive to stakeholder needs and concerns.
Low	Inform	A commitment to keep the stakeholder group informed by providing balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions, using communication channels durations/timings suitable to reasonably cover the entire audience.

Note that stakeholder mapping and analysis must be completed separately for each subproject. Although many stakeholders may be common to multiple subprojects, their priority and/or influence will differ depending on their proximity to the subproject and the degree to which they might be affected.

A stakeholder mapping and analysis template is provided in Annex B.

5.3. Step 3: Plan for vulnerable, disadvantage and/or marginalised stakeholders

It is particularly important to understand whether the subproject may disproportionately impact or fail disadvantaged, vulnerable or marginalised individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project.

Vulnerable, disadvantage and/or marginalised groups include:

- Female-headed households, who may be impaired from accessing information because they are disproportionally impacted by poverty, access to resources or lack of voice in the community, or because they have limited time to participate because of their activities and various commitments, but could be adversely impacted by Project activities such as worker influx;
- Elderly people, who may be impaired from accessing information, maybe because they are incapacitated to read, to hear or to walk, or because they live alone and at a distance that prevent them from accessing information available in public places or near the sub-project sites, even though they might be adversely impacted by construction activities such as noise;
- People with disability who may also be impaired from accessing information and yet be adversely impacted by Project activities if for instance these generate obstruction works on a road which

would adversely impact people using wheelchairs or visually impaired persons, or are designed without sufficient provisions for accessibility;

- Youth and children, whose views may not be listened to but who may be adversely impact by Project activities such as increased traffic or community health and safety impacts;
- Indigenous or ethnic minority households, whose values, land or culture may be directly or indirectly affected by the Project, or may not be adequately incorporated into subproject design and implementation; and
- Households deemed to reside below the poverty lines, or whose income is significantly lower than the average income of their surrounding communities, that may be affected by the Project in such a way that their income status could be further impacted.

The recommended procedure for considering the viewpoints of these groups, is as follows:

1. Identify vulnerable or disadvantaged individuals or groups and the limitations they may have in participating and/or in understanding project information or participating in consultation processes.
2. Assess what might prevent these individuals or groups from participating in the planned process (e.g. language differences, lack of transportation to events, accessibility of venues, disability, lack of understanding of a consultation process).
3. Consult with representatives of these groups to understand how they normally get information about the community, projects and activities.
4. Find out whether they have limitations about time of day or location for public consultation.
5. Find out what additional support or resources might be needed to enable these people to participate in the consultation process (e.g. providing translations, sign language, large print or Braille information; choosing accessible venues; providing transportation for people in remote areas; having small, focused meetings where vulnerable stakeholders are more comfortable asking questions or raising concerns.)
6. If there are no organizations active in the project area that work with vulnerable groups, such as persons with disability, contact medical providers, who may be more aware of marginalized groups and how best to communicate with them.
7. Incorporate this information into planned stakeholder engagement activities set out in the SEP.

5.4. Step 4: Plan stakeholder engagement strategies

The next step in preparing a SEP is to develop an engagement strategy for each stakeholder. Using the stakeholder mapping and analysis matrix:

1. Identify the timing of engagement, including during planning and design (i.e. to incorporate views and feedback into the project), during construction / implementation, and at commissioning / completion. This will be determined the expected or assigned role of the stakeholder in each phase of project implementation.

2. Determine the frequency of engagement, such as daily, weekly, monthly, ad hoc or other. Specify different frequencies for different project phases if needed.
3. Determine what materials will be shared and what modes of communication will be used with this stakeholder, including any provisions for disadvantaged parties.

5.5. Step 5: Develop a stakeholder engagement program

The stakeholder engagement program will provide detail on the activities set out in the stakeholder mapping and analysis matrix.

For each stakeholder group or grouping, the program should provide sufficient detail to proceed with engagement activities, including the communication channels, formats of any meetings, invitees and arrangements for cultural sensitivity and inclusion.

Typical engagement formats are outlined below.

5.5.1. Public information disclosure

The PHIT initiative is a project of national and regional interest that will involve and affect many people across many different stakeholder groups. Public dissemination of information about the Project and major subprojects is important to maintain alignment with ESS10.

Multiple communication channels should be used to inform the public about the project at key points of project implementation, including inception, calls for consultations and inputs, advice on upcoming works, notification of upcoming outreach campaigns, and major changes to public health systems.

The communication channels, and the frequency and duration of each communication campaign, should be selected to provide sufficient coverage commensurate with the importance of the message being communicated. Communications should be in all the languages relevant to the area, including minority languages where identified.

Relevant public communication channels include:

- Television and radio
- Newspapers, mail drops
- Public posters and billboards
- Website, social media
- Information centres and exhibitions
- Brochures, leaflets, posters, documents and reports
- Public meetings

Examples of public information disclosure and communication channels are provided in Table 5.

Table 5: Example stakeholder engagement strategies for public information disclosure.

Project message	Communication channel	Timing / duration	Accessibility
General static project information, lead ministry, contact information (including GM)	Major billboards in area » TV public service announcement » Radio public service announcement	For project duration » Prime time, multiple channels, 1/day for project duration » Multiple stations, local and national, 1/day for project duration	In all local languages Different times of day to reach different demographics
Traffic safety associated with construction works, altered traffic arrangements, traffic management plan	Posters and billboards in area » Local radio advice » Mail drops » Information at local public centres	Starting 4 weeks prior to works and then throughout works » Daily starting 2 weeks prior to works, twice daily during works » One information sheet dropped 2 weeks prior to works » Available from 4 weeks prior to works and then throughout	In all local languages At different times od day to reach different demographics Postal service and also physical mail drops to reach homes without postal services Centre opening hours to include selected weekends and evenings, attended by informed project representatives

5.5.2. Public meetings

Public meetings serve as essential forums for transparent dialogue between project implementers and diverse stakeholder groups. For PHIT subprojects, these gatherings should be structured to maximise community participation and meaningful input into project design.

Schedule meetings at multiple times and venues to accommodate different work schedules and mobility constraints. Consider holding separate sessions in different neighbourhoods, particularly for major infrastructure projects like the CWM Hospital development. Venues must be physically accessible, with ramps, adequate seating, and proximity to public transport. Provide childcare facilities to enable participation by parents and caregivers.

Begin each meeting with clear presentations in all relevant local languages, using visual aids and avoiding technical jargon. Allocate substantial time for questions and feedback—at least 50% of the meeting duration. Use trained facilitators who understand cultural protocols and can encourage participation from traditionally marginalised voices. Document all feedback systematically using standardised forms and rapporteurs.

Stakeholder views expressed at such meetings must be carefully considered and adequately responded to, by consideration in design and planning, and by providing feedback back to the stakeholders. Establish a clear feedback loop: explain how input will be reviewed, which design elements are negotiable, and commit to reporting back on decisions made. Create visual displays showing how previous community

input has influenced project modifications. Consider establishing community reference groups from meeting participants to provide ongoing design input throughout the project lifecycle.

Record attendance disaggregated by gender, age, ethnicity, and disability status to monitor inclusivity. Follow up with under-represented groups through targeted outreach if participation gaps emerge.

5.5.3. Targeted communications

Targeted communications recognise that different stakeholder groups require tailored approaches to ensure meaningful engagement. This strategy moves beyond one-size-fits-all messaging to address specific concerns, capabilities, and communication preferences of distinct audiences.

For example, for healthcare workers affected by training reforms or digital platform implementation, develop technical briefings that respect their professional expertise while addressing practical concerns about workload and implementation. Use professional networks, staff meetings, and internal communication channels. Provide detailed technical specifications and implementation timelines that allow for informed feedback on system design.

For vulnerable populations—including elderly patients, people with disabilities, or remote island communities—partner with trusted community organisations and healthcare providers who already have established relationships. Develop simplified materials using pictographs and local language translations. Radio programmes during evening hours can reach those with limited literacy or internet access.

Youth engagement requires digital channels and social media platforms, with interactive content that encourages participation. Partner with schools and youth organisations to facilitate design input sessions focused on their unique healthcare needs and digital literacy capabilities.

For each group, establish clear pathways for design input: comment forms for technical specifications, community liaison officers for vulnerable populations, and digital feedback platforms for youth. Create stakeholder-specific advisory panels that meet regularly during design phases to review and influence project elements relevant to their needs.

5.5.4. Interviews and focus groups

Interviews and focus groups provide depth of understanding that broader consultation methods cannot achieve. These intimate settings allow exploration of sensitive topics, detailed design preferences, and nuanced cultural considerations essential for successful healthcare transformation.

Structure focus groups homogeneously to create safe spaces for open discussion—separate sessions for women, youth, healthcare workers, and patients with chronic conditions. Limit groups to 8–10 participants to ensure everyone can contribute meaningfully. For infrastructure projects, conduct separate sessions with different user groups: patients, visitors, staff, and support service providers.

Develop semi-structured discussion guides that explore both predetermined topics and allow organic conversation about unexpected concerns. For digital health platforms, include interactive demonstrations where participants can provide real-time feedback on interface design and functionality. Use visual aids, mockups, and journey mapping exercises to help participants articulate their needs and preferences.

Select facilitators who match participant demographics and speak local languages fluently. Train them in cultural sensitivity, active listening, and techniques for encouraging participation from quieter members.

For sensitive topics like GBV services or mental health facilities, ensure facilitators have appropriate counselling skills.

Document sessions through detailed notes and, with consent, audio recordings. Analyse feedback thematically to identify design priorities and concerns. Create feedback reports showing how focus group input influenced specific design decisions—from room layouts in health facilities to user interface elements in digital platforms.

5.5.5. Surveys, polls and questionnaires

Quantitative methods complement qualitative engagement by providing measurable data on stakeholder preferences and priorities. Well-designed surveys can reach larger populations and provide statistical validation for design decisions while ensuring inclusive participation.

Develop surveys using simple, culturally appropriate language tested with community members. Questions should directly relate to design choices: facility locations, service priorities, digital platform features, or training program structures. Use Likert scales sparingly and provide visual rating options for participants with limited literacy. Include demographic questions to analyse responses by vulnerable group status.

Deploy surveys through multiple channels to maximise reach. Paper surveys distributed through health facilities, churches, and community centres can reach those without internet access. SMS-based polls work well for simple questions in areas with mobile coverage. Online surveys should be mobile-optimised for smartphone users. Partner with community health workers to assist elderly or disabled participants in survey completion.

For inclusive design feedback, structure questions around specific project elements: "Which clinic services are most important to you?" or "What features would make the health app easier to use?" Include open-ended questions for unexpected insights. Pre-test surveys with diverse community members to ensure questions are understood consistently across different groups.

Analyse results disaggregated by demographics to identify differing needs. Share summary findings publicly and demonstrate how quantitative data influenced design decisions—for example, how survey results showing high demand for maternal services led to expanded maternity ward designs.

5.5.6. Participatory methods

Participatory methods are an option for community-, user- or patient-centred design, to allow these stakeholders to actively contribute to the design of facilities and tools. These approaches recognise community and user expertise and create ownership of project outcomes.

For example, participatory mapping exercises can enable community members to identify healthcare access barriers, difficult transportation routes, areas lacking services, or cultural factors affecting facility use. Three-dimensional modelling can enable participants to physically explore facility layouts and provide feedback based on their needs and cultural preferences. These tangible exercises help bridge language and literacy barriers while generating specific design inputs.

Other examples include establishing community scorecards for ongoing projects, where diverse stakeholder groups regularly assess project performance against their priorities; training community monitors from vulnerable groups to ensure their perspectives remain central throughout implementation;

and using photovoice techniques where participants document healthcare challenges through photography, creating powerful narratives that influence design decisions.

For digital health initiatives, conduct participatory design workshops where users co-create interface elements, test prototypes, and iterate solutions. Include elderly users, people with disabilities, and those with limited digital literacy as core design partners, not just end-user testers. Their input during initial design phases prevents costly retrofitting for accessibility.

Finally, create feedback loops showing how participatory inputs directly influenced outcomes: display community maps next to final facility designs, showcase photovoice exhibitions that led to specific service improvements, or demonstrate user interface changes resulting from co-design sessions. This validation encourages continued engagement and builds trust that participation produces meaningful change.

5.6. Indicative engagement during implementation

While stakeholder engagement defined in the subproject SEPs begin during subproject preparation, continued engagement throughout implementation is critical to maintaining trust, accountability, and project responsiveness. Each subproject SEP will include a targeted plan for engagement during implementation. This will:

- Provide updates on project activities and timelines;
- Communicate adjustments to designs or mitigation measures;
- Share results of consultations and monitoring;
- Maintain open channels for feedback and grievances; and
- Ensure inclusive participation, especially from disadvantaged and vulnerable groups.

The scope, methods, and frequency of engagement will vary by subproject and stakeholder group, and will be proportionate to risks and impacts. Annex D provides an indicative engagement matrix to guide SEP preparation.

5.7. SEP Lifecycle: Review, Update and Disclosure

Each SEP prepared under this SEF is a living document that will be:

- Reviewed and updated periodically to reflect changes in project design, risks, stakeholder feedback, or implementation context;
- Version-controlled, with updates recorded by date and summary of key changes for transparency and accountability;
- Disclosed publicly, in draft and final form, through accessible channels (e.g. websites, community boards, radio) in relevant local languages;
- Re-disclosed when significant changes are made or new risks arise that affect stakeholder interests or mitigation measures.

Each PMU is responsible for ensuring regular SEP review and disclosure as part of project reporting and adaptive management.

6. RESOURCES, ROLES AND RESPONSIBILITIES

6.1. PMU Coordination

The PMUs will be responsible for project management, implementation and coordination, including stakeholder engagement. Stakeholder engagement is a core project function and requires dedicated resources to be implemented effectively and equitably across participating countries. Each Project Management Unit (PMU) will include stakeholder engagement in its annual workplans and budgets, proportionate to the risks and complexity of the subproject. The Project Manager will lead day-to-day project management and implementation, supported by Environment and Social staff. Responsibilities of the PMU include:

- Implementing this SEF and sub-project SEPs;
- Planning for, securing Project/subproject resources and maintaining adequate stakeholder engagement resources including:
    - Personnel: stakeholder engagement officers, translators, grievance focal points, or community liaison consultants. It is noted that E&S specialists/officers in PMUs/MC may be able to fulfil this role for certain activities.
    - Operational costs: venue hire, travel for consultations, materials, printing, interpretation, and accessibility measures;
    - Communication and disclosure: radio segments, SMS campaigns, posters, and digital tools.
    - Resource requirements should be reviewed and updated annually and tracked through project reporting. An example SEP budget is provided in Annex E;
- Ensuring that Contractors comply with this SEF and sub-project SEPs;
- Monitoring Contractors' implementation of this SEF and sub-project SEPs;
- Ensuring that the grievance mechanism is established and implemented and that workers are informed of its purpose and operation;
- Have a system for regular monitoring and reporting on stakeholder engagement performance as part of the Project's MEL activity;
- Reporting on SEF/SEP implementation within the six-monthly report to the World Bank;
- Notify the World Bank within 24 hours of any significant grievance or allegation, incident or accident related to the Project which has, or is likely to have, a significant adverse effect on the affected communities, the public or workers; providing sufficient detail regarding the incident or accident, indicating immediate measures taken or that are planned to be taken to address it, and any information provided by any contractor and supervising entity, as appropriate;
- Preparing a report on any incident or accident per WB's request and propose any measures to prevent its recurrence.

The key responsible staff in each PMU are set out in Table 6

Table 6: Responsible staff for the PHIT project

PMU / Ministry	Focal Point
Fiji PHIT PMU Fiji Ministry of Health and Medical Services	Stakeholder Focal Point Grievance Focal Point
Kiribati HSSP PMU Kiribati Ministry of Health and Medical Services	Stakeholder Focal Point Grievance Focal Point
Tonga HEART PMU Tonga Ministry of Health	Stakeholder Focal Point Grievance Focal Point
Tuvalu HSSP PMU Tuvalu Ministry of Health and Social Welfare	Stakeholder Focal Point Grievance Focal Point
SPC PHIT PMU	Stakeholder Focal Point Grievance Focal Point

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

Community SEA/SH/GBV risks have been identified as potentially being substantial for certain Project activities, such as major civil works involving worker influx. Provisions to prevent SEA/SH/GBV will be included in the Code of Conduct for all Project staff and contracted workers in line with the Project LMF and relevant international standards and national legislation.

For these risks to be adequately and properly addressed, an effective SEA/SH Action Plan and SEA/SH Accountability and Response Framework will be developed as a mandatory requirement for major civil works subprojects (being construction of the new hospital in Suva and renovation / re-development of the CWM Hospital). Details on these mandatory instruments are provided in the Project ESMF.

6.3. Project-related labour influx

The construction and renovation activities of the PHIT project have the potential to involve in the influx of labour into the activity locations from outside of Suva and Fiji. Whenever there is a labour influx of such a nature, there is a risk of adverse social and environmental impacts that need to be managed as part of the Project's ESMF and Labour Management Framework (LMF). Refer to the LMF for details, including the requirement to prepare a Labor Influx Management Plan (LIMP) for subprojects involving potentially impactful labour influx as an annex to the subproject LMP.

7. GRIEVANCE MECHANISM

A publicly accessible grievance mechanism (GM) is to be provided to allow any member of the public affected by the Project and/or the actions of Project works to raise legitimate concerns.

The GM must be established prior to Project commencement by each country PMU, and detailed in each sub-project SEP.

The mandatory principles that apply to the GM in accordance with ESS2 are as follows:

- Affected community is to be informed of the GM prior to the commencement of Project activities, including measures put in place to protect them against any reprisal for its use.
- Measures are to be put in place to make the GM easily accessible to the public.
- The GM is to be proportionate to the nature and scale and the potential risks and impacts of Project activities.
- The GM is to address concerns promptly, using an understandable and transparent process that provides timely feedback to those concerned in a language they understand, without any retribution, and will operate in an independent and objective manner.
- The GM may utilise existing grievance mechanisms where available, providing that they are properly designed and implemented, address concerns promptly, and are readily accessible to eligible project workers.
- Existing GMs may be supplemented as needed with project-specific arrangements.
- The project GM will not impede access to other judicial or administrative remedies that might be available under the law or through existing arbitration procedures.

Specifically, noting the risks identified in Table 3, the GM for the PHIT project will:

- Be established within the Ministry hosting the PMU;
- Be accessible via an email address and phone number published on the Ministry's public website;
- Ensure that all grievances of a sensitive nature (e.g. GBV, SEA/SH, bullying, incidents) are directed to trained professionals (e.g. within the human resources department);
- Ensure that the Grievance Focal Point is notified of all complaints (for sensitive complaints, upon vetting and anonymisation by trained professionals);
- Ensure that complaints are acknowledged within 24 hours (including non-business days);
- Ensure that complaints are addressed or resolved within 7 days;
- Ensure that if a complaint cannot be resolved within 7 days, the matter will be escalated to the Grievance Focal Point to coordinate with the Project Manager and relevant departments / organisations and persons to address the grievance;
- Ensure there is no unnecessary delay in addressing complaints;
- Ensure that affected community is informed directly of the GM before the commencement of subproject activities, including that:
    - Grievances can be submitted and handled in confidence;
    - The complainant is protected from reprisal and all complaints handled sensitively by trained staff to avoid potential harm;

  - The GM can be used to raise any issue of concern related to the Project, including (but not limited to) the behaviour of Project workers, Project impacts, SEA/SH, GBV, and unsafe or unhealthy conditions.

- Ensure that Contractors have in place equivalent public GMs that meet these requirements prior to commencing work, and that grievances of a sensitive or significant nature are reported to the Contract Manager (PMU).

The GM will operate as follows:

1. The complainant may report their grievance in person, by phone, text message, mail or email (including anonymously if required) via the publicly available GM or the Contractor's GM.
2. The grievance is to be addressed/resolved and the outcome communicated to the complainant, or escalated according to the GM protocol and the nature of the grievance.
3. For complaints that are satisfactorily resolved at this stage, the incident and resultant resolution are to be logged and reported to the PMU Grievance Focal Point.
4. Where the complaint is not resolved, the matter will be reassigned to the Grievance Focal Point, who will advise the Project Manager to decide further action or resolution.
5. If the matter remains unresolved, or the complainant is not satisfied with the outcome, the Project Manager will refer the matter to the Permanent Secretary of the host Ministry to decide on further action or resolution.
6. If the complaint remains unresolved with 30 days of the initial complaint or the complainant is dissatisfied with the outcome proposed by the Permanent Secretary, the complainant may refer the matter to the appropriate legal or judicial authority, at the complainant's own expense. A decision of the Court will be final.

Note that the GM is not an alternative or substitute for the legal system for receiving and handling grievances and will not preclude access to other judicial or administrative remedies that might be available under the law or through existing arbitration procedures. While the public will always have the right to access the legal system, the purpose of establishing a grievance mechanism is to provide an accessible and practical means to mediate and seek appropriate solutions, wherever possible.

The Project Labour Management Framework outlines the Worker GM for issues that are worker or workplace related.

The Grievance Focal Points and GM access points for each PMU are set out in Table 7.

Table 7: Public grievance mechanism details for the PHIT project

PMU / Ministry	Grievance Focal Point / Responsible Executive	GM access points
Fiji PHIT PMU Fiji Ministry of Health and Medical Services	TBA PS MHMS	Website: https://www.health.gov.fj/contact-us/ Email: Phone: Mail:

PMU / Ministry	Grievance Focal Point / Responsible Executive	GM access points
Kiribati HSSP PMU Kiribati Ministry of Health and Medical Services		Website: Email: Phone: Mail:
Tonga HEART PMU Tonga Ministry of Health		Website: Email: Phone: Mail:
Tuvalu HSSP PMU Tuvalu Ministry of Health and Social Welfare		Website: Email: Phone: Mail:
SPC PHIT PMU		Website: Email: Phone: Mail:

8. MONITORING AND REPORTING

Monitoring of stakeholder engagement activities is important to ensure that consultation and disclosure efforts are effective and in particular that stakeholders have been meaningfully consulted throughout the process. Monitoring also allows the Project to improve its strategies by using information acquired through monitoring activities. The Project's environmental and social management system will be used as a platform to monitor the stakeholder engagement activities and in particular:

- The implementation of this SEF and tracking the implementation of SEPs for each subproject, including outreach, consultation, and disclosure activities;
- Consultation and disclosure activities conducted with all stakeholders;
- The effectiveness of engagement processes in managing impacts and expectations by tracking and summarising feedback received from engagement activities and actions taken;
- Identifying emerging issues or trends requiring response or SEP updates;
- Reporting results and responses to stakeholders through accessible and timely mechanisms.; and
- All grievances received and resolved, whether anonymous (no name will be recorded) or non-anonymous (names and contact details for replies will be recorded).

Performance will be reviewed and reported on semi-annually as part of half-yearly project reporting, by tracking:

- Materials disseminated: type, frequency and location;

- Place and time of formal engagement events and level of participation by specific stakeholder categories and groups against the plans set out in the SEP;
- Number of comments by issue / topic and type of stakeholder, and details of feedback provided;
- Number and type of grievance and the nature and timing of their resolution;
- Recording and tracking commitments made to stakeholders; and
- Community attitudes and perceptions towards the Project based on media reports and stakeholder feedback.

Any learnings and trends from the collected monitoring data are to properly considered in forward project planning.

Throughout the Project:

- All grievances will be received, tracked, recorded and responded to in a timely manner.
- Any grievances of a sensitive nature will be kept strictly confidential to only those required to know (e.g., for SEA/SH complaints, the Grievance Focal Point, the GBV provider, the Police). Any broader advice of such grievances must be anonymised.
- A Project Stakeholder Engagement Register will be established and maintained by the Stakeholder Focal Point at the PMU.
- A grievance database will be established and maintained by the Grievance Focal Point at the PMU.

ANNEX A: STAKEHOLDER ENGAGEMENT RECORD

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 operationalization 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) organized workshop on "Rejuvenating Primary Health Care in Fiji". It included the finalization 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

Date	Activity	Description
		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 prioritized action plan with an implementation monitoring and results framework; and support

Date	Activity	Description
		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 prioritize 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 specialized hospital and referral system to enhance access to quality tertiary care; iv) build healthcare workforce management and

Date	Activity	Description
		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.

Date	Activity	Description
		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.

Date	Activity	Description
		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 11-12	Pacific Healthy Islands Transformation Project (PHIT) Health 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 B: STAKEHOLDER MAPPING TEMPLATE

Stakeholder / group	Stakeholder type	Affected, Interested, Vulnerable	Relationship to subproject, key concerns	Degree impacted*	Degree influential	Eng'ment level	Engagement timing	Engagement frequency	Mode of communication and information disclosed
Subproject: Construction of new hospital campus									
Water Authority of Fiji	Government	Interested	Receiving and treating wastewater and trade waste; Supply potable water; Capacity concerns	High	High	Involve	Throughout, including planning and design	Weekly, incidental	Coordination meetings between WAF and project actors, onsite inspections, workshops, meetings with project engineers. Project design documents, ESMP, EIA, CESMP
Subproject: Renovation of existing hospital									
Patients of CWMH	Public	Affected, Vulnerable	Health and safety impacts during renovation and demolition works	Medium	Low	Consult	Throughout, including planning	Once during planning, daily during works	Meetings with patients or their representatives. Project information including daily/weekly workplans and arrangements.

*After other mitigations (e.g. safety management)

ANNEX C: INFORMATION DISCLOSURE MODALITIES

Consistent with the requirements of ESS10 and good international practice, the PHIT Project is committed to disclosing environmental and social information in a timely, transparent, and accessible manner. This section outlines the principles, modalities, and responsibilities for information disclosure across all subprojects and participating jurisdictions that would be available for inclusion in subproject SEPs.

1. Types of Information to be Disclosed

At a minimum, the following documents and information types will be disclosed, where relevant to a given subproject:

- Stakeholder Engagement Plans (SEPs) and updates
- Environmental and Social Impact Assessments
- Environmental and Social Management Plans (ESMPs)
- Labor Management Procedures (LMPs)
- Grievance Mechanism procedures (public and worker GMs)
- Summary of stakeholder consultation outcomes
- Project benefits, design updates, timelines, and construction schedules
- Monitoring results and feedback responses

2. Timing of Disclosure

- Draft SEPs and relevant risk management documents will be disclosed prior to project appraisal or subproject implementation, for example no later than 90 days after subproject approval.
- Updated or revised materials will be disclosed as new risks emerge or mitigation measures are modified.
- Consultation summaries and reports will be disclosed within a period defined in the SEP from completion of each major consultation round.

3. Language and Format

- All key documents will be made available in English and, as appropriate, a summary in local languages of each subproject location (e.g., i-Kiribati, Tongan, Fijian, Tuvaluan).
- Where relevant and proportionate to the scale of the engagement or subproject, materials will be adapted to low-literacy and oral communication contexts, including the use of infographics, storytelling, audio, and radio broadcasts.

4. Channels of Disclosure

Information can be disclosed using a combination of communication channels suitable for the audience and proportional to the scale of the subproject, including:

- Project and Ministry of Health websites

- Village and municipal notice boards
- Community meetings and religious gatherings
- Radio announcements and local broadcast networks
- Distribution through clinics, hospitals, and training facilities
- Printed flyers, mobile phone messaging (SMS), and local newspapers
- SPC's regional dissemination platforms and technical networks

5. Responsibilities for Disclosure

Each PMU the E&S Officer will be responsible for managing the timely, accurate, and locally appropriate disclosure of project information.

The SPC PMU will coordinate cross-country information dissemination, ensure consistency across jurisdictions, and support translation, publication, and regional sharing of lessons and guidance.

6. Feedback and Clarification Mechanism

All disclosed materials will include details on how stakeholders may:

- Request clarification or additional information
- Provide feedback, suggestions, or objections
- Submit a grievance via the Project's Grievance Mechanism

ANNEX D: SAMPLE STAKEHOLDER ENGAGEMENT TABLE FOR IMPLEMENTATION

Project Stage	Target Stakeholder Group	Engagement Objective	Engagement Method	Frequency / Timing	Responsible Entity
Construction / Civil Works	Neighbouring communities, facility users, Suva City Council	Inform on construction timeline, disruptions, safety risks; receive feedback	Public notices, site meetings, radio, SMS, posters	Monthly or as needed	Fiji PMU + contractor
Facility Renovation	Hospital staff, patients, unions, utilities providers	Consult on phasing, access issues, utilities, safety	Staff briefings, consultation forums	Before and during major works	PMU (MoH)
Community Health Outreach	Community members, traditional leaders, health volunteers	Inform on outreach schedules and procedures; gather feedback	Community meetings, radio, women's groups, SMS	Quarterly or campaign-based	Country PMUs + SPC
Digital Platform Deployment	Health workers, ICT staff, training institutions	Collect feedback on usability, support needs, training	Focus groups, pilot demos, training sessions	Before rollout, then follow-up	SPC PMU + contractors
SEA/SH / Labor Safeguards	Community members, workers, women's orgs, labor officers	Disseminate grievance options, raise awareness	Posters, hotline, briefings, trusted focal points	Ongoing	PMUs + contractors

ANNEX E: SAMPLE STAKEHOLDER ENGAGEMENT BUDGET

Budget Category	Item/Activity	Estimated Quantity	Unit Cost (USD)	Total (USD)	Remarks
1. Human Resources	Stakeholder Engagement Consultant / Liaison Officer	X months	$	$	Local or regional consultant
2. Consultations	Venue hire, refreshments	X sessions	$	$	Including for remote islands
3. Transport	Staff travel for consultations	X trips	$	$	Based on national context
4. Communication	Social media, Posters, flyers, radio	Lump sum	—	$	Translations, design, printing
5. Training	GM focal point training	1 event	$	$	Includes SEA/SH protocols
6. Grievance Mechanism	Suggestion boxes, hotline, documentation	Lump sum	—	$	Installation and setup
7. Monitoring & Reporting	SEP progress tracking tools	Lump sum	—	$	May include field verification
TOTAL	—	—	—	**$X,XXX**	Budget to be refined per SEP