Foreword

It is important to consider and assess the environmental and social implications (positive or negative) of any policy, plan, program or project with a view on ensuring that adequate safeguards are put in place to address particularly unintended consequences. It is against this background that the National Agency for the Control of AIDS (NACA) worked with other stakeholders to undertake an Environmental & Safeguards Audit with a view of developing a holistic framework for mitigating / eliminating whatever negative issues that may arise as a result of the HIV/AIDS Program Development Project (HPDP II).

This is line with the National Policy on the Environment which aims to achieve sustainable development in Nigeria, and in particular to:

- Secure a quality of environment adequate for good health and well - being;
- Conserve and use the environment and natural resources for the benefit of present and future generations;
- Restore, maintain and enhance the ecosystems and ecological processes essential for the functioning of the biosphere to preserve biological diversity and the principle of optimum sustainable yield in the use of living natural resources and ecosystems;
- Raise public awareness and promote understanding of the essential linkages between the environment, resources and development, and encourage individuals and communities participation in environmental improvement efforts; and
- Cooperate with other countries, international organizations and agencies to achieve optimal use of trans-boundary natural resources and effective prevention or abatement of trans-boundary environmental degradation.

This report is very important as it will improve decision making and its implementation will ensure that the activities carried under HPDP II are environmentally sound and sustainable. Furthermore, it would ensure that principles and procedures of environmental and social safeguards are followed. In addition, it provides a basis for building the capacity of implementers.

Finally, this Environmental & Social Audit Report would contribute significantly to the National Response to HIV/AIDS in Nigeria as it can be used by all stakeholders in the planning and implementation of programs - even beyond the HPDPII.

Professor John Idoko

Director-General, NACA / HPDP II Project Manager

Preface

Right from inception, the HIV/AIDS Program Development Project (HPDP II) recognized the potential to generate some hazardous medical waste in HIV/AIDS testing and treatment centers as well as in other activities aimed at enhancing the quality of HIV/AIDS service delivery. The project did not intend to fund activities that would cause adverse effect on the environment or any form of land acquisition or restriction of access to sources of livelihoods. It envisaged that the environmental and social impacts will be small-scale and site-specific; and thus easily remediable. It therefore provided for the development of project specific medical waste management plan to provide guidance on the management of waste generated by the project.

This Audit was undertaken to assess the compliance of the HPDP II sub-project activities with World Bank Safeguard policies and relevant laws and regulations in Nigeria as they relate to environmental and social issues. The main objective was to assess and establish the performance of the project activities on compliance with environmental and social safeguards especially as outlined by the project's Environmental and Social Management Framework (ESMF), the Waste Management Plan (WMP) and the recommendations provided in the Mid Term Review (MTR) aide memoire. It was also to establish whether the project is on course in achieving the set targets based on the outcome indicators and to provide recommendations intended to deepen these outcome so as to develop a sound Environmental and Social Management System (ESMS).

The audit adopted a random selection method to select the facilities audited across the 35 states and FCT participating in HPDP II. The selection cut across the primary, secondary and tertiary levels of healthcare including private healthcare facilities. The audit covered areas of waste generation, characterization and disposal in health facilities and looked into areas of Emergency Preparedness and Response (EPR).

In terms of findings, the audit identified the availability or otherwise of structures and systems in place in support of Health, Safety and Environment programmes; employee practice, behavior and awareness including implementation of safeguard policies by SACA and Partners. It also identified environmental and social issues associated with HPDPII projects in the states. The findings have been used to develop a Safeguards Management Action Plan that will address potential site specific environmental and social impacts that might occur at Project Implementation Units (PIUs) level.

Dr. Emmanuel Alhassan

Director - Partnerships Coordination, NACA / HPDP II National Coordinator

Acknowledgements

Acknowledgements

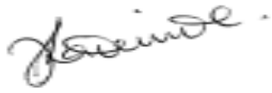
NACA acknowledges the efforts of all that contributed to the conduct of the Environmental & Social Safeguards Audit of World Bank-Assisted HIV/AIDS Program Development Project II. We acknowledge Samjofel Consults Limited for their consulting role and immense technical expertise which was key to the success of the exercise.

Our special appreciation goes to the World Bank for providing financial and technical support for this audit. Members of the World Bank team who provided invaluable technical inputs include the Project Task Team Leader - Dr. Enias Baganizi, Ndella Njie, Dr. Babatunde Ipaye, Dr Eugene Itua, Michael Gboyega Ilesanmi, Dr. Segun Adeoye and Dr. Michael Olugbile. We acknowledge Professor John Idoko for providing excellent leadership and members of the Safeguards Audit Technical Committee in NACA - including Dr. Emmanuel Alhassan, Director Partnerships Coordination, Dr. Funke Oki, Uche Ifeatu-Obi, Dr. Zarah Haruna, Doris Ekeh and Irima Odoh, for their dedication and commitment over the months of planning and activity implementation. Mention must be made also of the contributions of Mr J.D. Alhassan, Mr Danjuma Garuba and all the staff of NACA Partnerships Coordination Department who provided insights during the review of this report.

Furthermore, we appreciate the support, dedication and cooperation of Federal Ministry of Environment (FMoE) and State Teams comprising of States' Agencies for the Control of AIDS (SACAs), States' Ministries of Health (SMoH), States' Ministries of Environment (SMoE) and the interviewers who put in long hours under difficult conditions during the field work.

This acknowledgement will not be complete without mentioning the warm reception and cooperation granted to the survey teams in all the States, the Health Facilities and the communities.

We are confident that the results of this report would go a long way in helping Policy Makers, Program Managers and Funding Agencies to further pay attention to the dynamics of Health Systems Management and Safeguards Compliance in our country and thus maximise the benefits of intervention projects such as the HPDP II.



Kemi Ladeinde

Assistant Director - CSO Division, NACA

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
BCC	Behaviour change Communication
CBOs	Community Based Organizations
CSO	Civil Society Organisation
DfID	Department for International Development
EIA	Environmental Impact Assessment
ESM	Environmental Sound Management
ESMF	Environmental and Social Management Framework
FCT	Federal Capital Territory
FEPA	Federal Environmental Protection Agency
FMEnv	Federal ministry of Environment
FMENV	Federal Ministry of Environment
FMoH	Federal Ministry of Health
FSW	Female Sex Workers
GDP	Gross Domestic Product
HAF	HIV/AIDS Fund
HCF	Health Centre Facility
HCT	HIV Counselling and Testing
HCW	Health Care Waste
HIV	Human Immuno-deficiency Virus
HSDP II	Health Systems Project Development II
HPDP	HIV/AIDS Program Development Project
IDU	Injecting Drug Users
ISDS	Integrated Safeguards Sheet

ITCZ	Inter-Tropical Convergence Zone
LACA	Local Action Committee on Aids
LAWMA	Lagos State Waste Management Agency
LGA	Local Government Area
MAP	Multi-Country AIDS Program for Africa
M&E	Monitoring and Evaluating
MWMP	Medical Waste Management Plan
MSM	Men Having Sex with Men
MARP	Most at Risk Population
NAAQS	National Ambient Air Quality Standards
NACA	National Agency for the Control of AIDS
NHP	National Health Policy
NSF	National Strategy Framework (2005 – 2009)
NSF 2	Second National Strategic Framework 2 (2010 – 2014)
OPS	Organized Private Sector
OVC	Orphans and Vulnerable Children
PAD	Project Appraisal Document
PCN	Project Concept Note
PHC	Primary Health Care
PIU	Project Implementation Unit
PLHA	People Living with HIV/AIDS
PLWA	People Living With AIDS
PLWD	People Living with Disabilities
PMTCT	Prevention of Mother to Child Transmission
PPT	Project Preparation Team
PSP	Private Sector Participation
ROP	Resident Organic Pollutants

RRF	Rapid Respond Fund
SACA	State Action Committee on AIDS/State Agencies
SEPA	State Environmental Protection Agency
SMEnv	State Ministry of Environment
TA	Technical Assistance
TB	Tuberculosis
TDS	Total Dissolved Solids
TOR	Terms of Reference
TOT	Training of Trainers
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
WHO	World Health Organisation

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Executive Summary

Introduction

The World Bank launched the HIV/AIDS Program Development Project II (HPDP II) as a successor to HPDP I, in 2009 and is to be closed in November 2015. It has been tailored to build on the success of Project I and utilizes the existing institutional structures in the national AIDS response. The HPDP II components are as follows:

Component 1: Expanding the Public Sector Response

Component 2: Expanding the civil and private sector engagement and response through the HIV/AIDS Fund

Component 3: Strengthening mechanisms for project coordination and management

This Audit was undertaken to assess the compliance of the HPDP II sub-project activities with World Bank Safeguard policies and relevant laws and regulations in Nigeria as they relate to environmental and social issues. The main objective of the Audit was to assess and establish the performance of the project activities on the compliance of environmental and social safeguards especially as outlined by the project's Environmental and Social Management Framework (ESMF), the Waste Management Plan (WMP) and the recommendations provided in the Mid Term Review (MTR) aide memoire, in order to develop a sound Environmental and Social Management System (ESMS).

Environmental & Social Safeguards Audit Methodology

The Safeguard audit was conducted in randomly selected 1,921 health facilities in Local Government Areas (LGAs) spread across the 35 project states and the FCT. The audit employed a mixed method to collect both qualitative and quantitative data. The qualitative component involved a review of documents, records and procedures used in the day-to-day running of the project and the subprojects. Interviews were also conducted with the responsible personnel for sub- projects at the respective sites to capture operational and social issues. Interviews with relevant stakeholders were also conducted across the geo-political zones. In addition, the quantitative component of the audit included on-site assessment of occupational health and safety parameters and visual inspection of relevant structures, infrastructure and processes which were used to identify environmental, health and safety issues including social concerns. This was also used to assess compliance to pre-agreed procedures and instructions/guidelines as contained in the Project Appraisal Document (PAD), Environmental and Social Management Framework (ESMF) and the Medical Waste Management Plan, among others.

Audit Findings - Brief about sampled HCFs

A total of 1921 health facilities (HCFs) were visited and sampled in the audit representing response rate of 96.0%. The majority of the HCFs sampled in the audit were primary healthcare facilities (64.1%) followed by private health facilities (22.0%), Secondary (12.4%) and Tertiary (1.6%) healthcare facilities.

Waste generation, characterization and disposal in Health facilities

Findings indicated that on the whole, 87.3% of sampled HCFs generated infectious wastes. Furthermore, analysis suggested that most sampled HCFs (88.7%) had biohazard and sharp containers in place but only 22.2% of the facilities had standard incineration facilities. This needs to be addressed urgently in view of the potentials for spreading infections. State-level analysis indicated that 50.0% or less of

healthcare facilities in Katsina, Kebbi and Gombe states could identify and characterize wastes, while few responsible personnel in healthcare facilities in Benue (39.6%), Gombe (32.8%), Katsina (50.0%) and Oyo (44.3%) states were familiar with recommended methods for wastes characterization. Similarly, findings indicated that not many healthcare facilities in Katsina (33.3%) and Oyo (55.7%) states had biohazard and sharp containers at the time of the audit.

Availability of incineration facilities in the states

A total of 73 incinerators of various types, ownership and age were identified in the surveyed states. The distribution of the facilities indicated that majority of the incinerators 69 (94.5%) available for HPDPII activities in the states were Government owned. Most of these, 35 (47.9%), were open pit while 38 (52.1%) were either made of bricks and mortar or closed chamber combustible incinerators. It was observed that all tertiary HCFs under the care of the FMoH had medium and high-temperature incinerators, many of which are said to be in good condition. It is recommended that the use of these incinerators owned by publicly-owned tertiary HCFs is made an important part of any hazardous HCW management for HPDP II.

Emergency preparedness and response (EPR)

Audit findings indicated that overall, less than a quarter of HCFs had written emergency plan (22.6%), only 23.7% had trained emergency coordinators and only 18.0% had personnel with the knowhow to test EPR programme in the facilities. Specifically, findings revealed that some states, namely; Abia, Adamawa, Anambra, Gombe, Kebbi and Osun had trained emergency coordinators in less than 10.0% of their healthcare facilities. Similarly, Bauchi and Gombe states reported very low proportions of healthcare facilities where project staff were aware of emergency actions to take when needed. Findings further suggest that less than 10.0% of healthcare facilities in Bayelsa (8.1%), Jigawa (0.0%), Kebbi (0.0%), Taraba (7.7%) and Zamfara (8.3%) had clean-up materials to handle hazardous spillages.

Structures and systems in place in support of Health, Safety and Environment programmes

Less than half of sampled healthcare facilities across the country have structures and systems in place to support health, safety and environment (HSE) programmes. For instance, only 44.5% of all sampled health facilities had comprehensive written HSE programmes, while only 41.4% had responsibility for HSE programmes delegated to a person or office. The requirement by the WMP for the setting up of a committee at the facility level for such purposes, notwithstanding. Furthermore, only 45.5% of these healthcare facilities had accountability system in place for ensuring staff comply with HSE programme while only 48.8% had a communication system that provides affected staff with the platform to report grievances. Further audit findings also indicate that only 47.6% of healthcare facilities had a system in place to identify and evaluate workplace hazards. Other systems not preponderantly in place in the healthcare facilities to support HSE programmes include the periodic inspection of HSE schedules by managers (48.9%), keeping of inspection records for unsafe practices (32.2%), keeping of incident and accident investigation programme (26.5%).

Management support for HSE programme

Results indicate that top management in HCFs were committed to injury and illness prevention in the work place in 48.3% of cases, even though 63.4% of all the HCFs provide first aid kits and placed such kits in easily accessible work areas. Furthermore, training on the use, care and disposal of PPE was conducted and recorded in only 40.5% of HCFs, as a result, all PPE appear to be maintained in sanitary condition ready for use in only 36.5% of HCFs. The proportions of these indicators were low in Abia, Adamawa, Anambra, Bayelsa, Gombe, Imo, Kebbi, Osun and Oyo states.

Employee practice and behavior

Audit findings indicate that healthcare workers in 54.9% of healthcare facilities were exposed to infectious fluids. Potential exposures were however identified and documented in only 41.2% of sampled HCFs. It is noteworthy though that 60.2% of HCFs provided training and information to staff who were potentially exposed to body fluids in the work place and workers in 70.4% of the HCFs confirmed that the infectious control procedures in place were appropriate.

Awareness and implementation of safeguard policies by SACA and Partners

The awareness of the World Bank Safeguard policies was at a lowly level of 12.9% among state-level survey respondents. Only 5.4% of them could demonstrate an understanding of the safeguard documents of HPDP II even though an equally small 11.1% were familiar with the Environmental and Social Management Framework (ESMF) for HPDP II. Only a similar proportion of respondents (11.5%) were familiar with the HPDP II Waste Management Plan (WMP) and only 7.8% were in possession of copies of the ESMF and WMP. Little wonder then that sub-project ESMPs are not being prepared.

Environmental and social issues associated with HPDPII projects in the states

About a quarter (26.3%) of respondents opined that ordor from the open dumpsites also patronized by HCFs in most places was a problem. A higher proportion (54.2%) indicated that the general atmosphere appeared unfit for human habitation. It is instructive that 21.7% of respondents claim to earn indirectly from the dumpsites, the risk of secondary infection notwithstanding. Though 16.2% were of the opinion that traffic due to waste trucks was a problem. Two out of every five respondents (41.9%) who participated in HPDP II projects indicated that the activities of HPDP II were proceeding well in the communities and 55.5% revealed that their communities had benefitted from HPDP II. On feedback mechanisms in place for reporting grievances, 49.0% of respondents indicated that HPDP II officers were accessible to community members in the event that they had complaints. The audit held discussions and consultations with project beneficiaries such as women, IDUs, MSMs and FSWs. Most of the discussants confirmed that they participate in the HPDP II project as Peer group members or Peer educators. Discussants confirmed that the project was of benefit however there were complaints about occasional snobbish attitude of health workers due largely to professional inexperience in handling issues of social stigma.

Mitigation and Action Plan

To put HPDP II back on a sound footing towards its end, it is recommended that the gains of safeguards compliance awareness achieved since the MTR in November 2013 are quickly consolidated through the following;

- Capacity building and training on HPDP II safeguard issues
- Work with partners to embark on community sensitization
- Improved communication /coordination/working with partners
- Put in place mechanisms for receiving and attending to complaints/grievances from stakeholders including beneficiary communities
- Enforcement of compliance requirements including establishment of HCF waste management committees and the preparation and approval of sub-project ESMPs
- Enforcement of waste characterisation and use of recommended colour codes
- Prepare and implement plans to access, repair, procure waste treatment equipment
- Institute measures to encourage waste storage, disposal and site access control
- Encourage HCFs through implementing partners to enhance employee and public safety
- Implement measures to entrench effective safeguards monitoring and record keeping

Conclusion

As indicated in the Project Implementation Status and Results report of June 2015, HPDP II has already achieved set targets in four out of six outcome indicators. This audit and the recommendations made therefrom are intended only to further deepen these outcomes.

Chapter 1
Introduction/Background

Nigeria is situated in the western portion of Africa, and lies between latitudes 40 00' N and 140 00' N, and longitudes 20 50' E and 140 45' E (figure 1.1). Nigeria is bordered by Chad to the northeast, Cameroon to the east, Benin Republic to the west, Niger Republic to the northwest and the Atlantic Ocean to the south. The country's total area is 923,768 sq km, of which 910,768 sq km is land and 13,000 sq km is water. The country is divided into 36 states and a federal territory. The HIV/AIDS Programme Development Project (HPDP II) covers all the States of the country apart from Kano State.

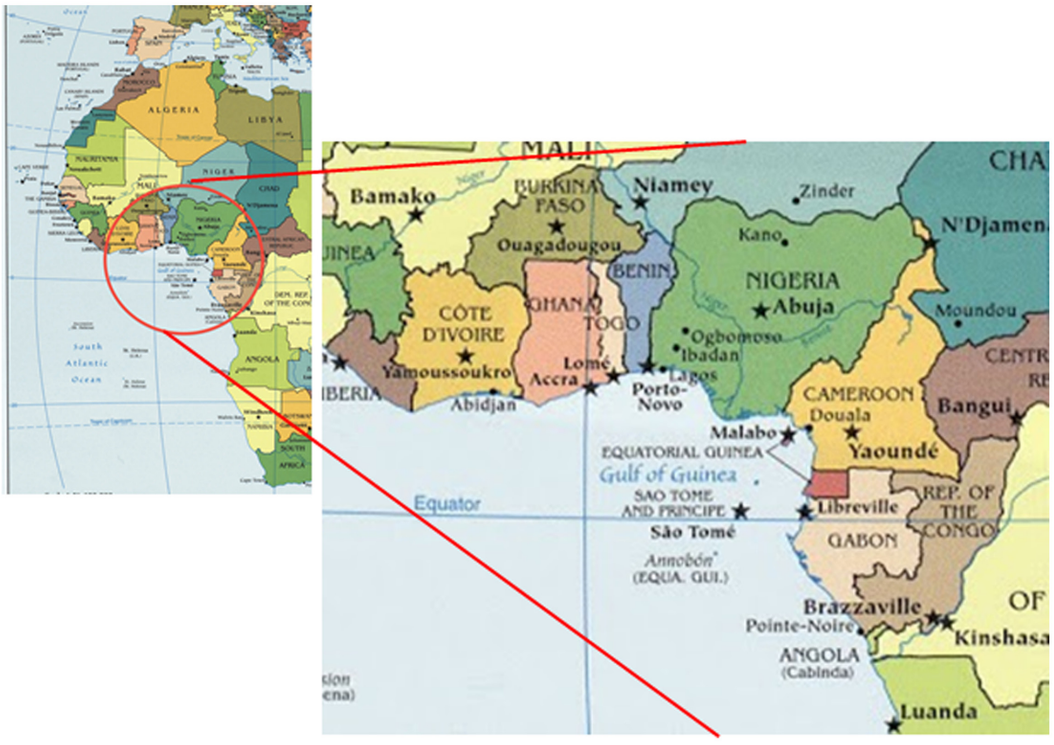
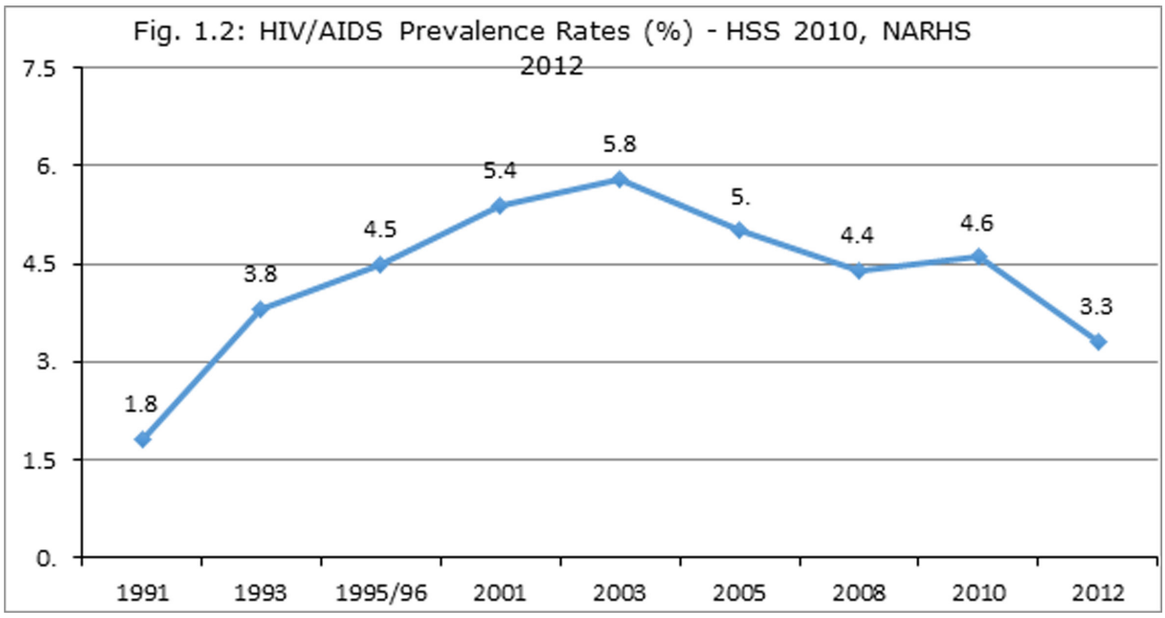


Fig. 1.1: Map of Africa showing Nigeria

Nigeria's Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) epidemic is complex and comprises a 'generalized' epidemic, affecting both urban and rural population, but also pervasive sub-epidemics with high prevalence among geographic and social groupings.

With prevalence rate of 3.3% and an estimated 3.5 million people living with HIV (NARHS Report, 2012; figure 1.2), Nigeria has the second highest burden of HIV in sub-Sahara Africa. In 2011 alone, about 388,864 new infections occurred with an estimated 217,148 AIDS-related deaths, even though there appears to be a gradual trend towards decrease in rates of infections. Nigeria falls within the category of countries classified as having a stable change in the incidence rate of HIV infection amongst adults of between 15–49 years old in the last ten years. The National Agency for Control of AIDS (NACA) is presently leading other federal and state level stakeholders on Nigeria's HIV and AIDS response and the implementation of the second Federal Strategic Framework, 2010 - 2015 (NSF 2).



The World Bank launched the HIV/AIDS Program Development Project (Project 1: $90 million) as part of its Multi-Country AIDS Program for Africa (MAP). The Project became effective in April 2002 and was extended to July 2009, with $50 million of additional financing approved in May 2007. A joint review assessment of the project by DfID and the Bank in 2006 concluded that the Project has been successful in achieving a vibrant multi-sectoral response in Nigeria, through the engagement of a multitude of partners in the response. A joint World Bank/DfID scoping mission conducted in September 2007 revealed that the project was also successful in establishing the institutional framework necessary for a successful HIV/AIDS Program.

The reviews and the evaluation reports encouraged ongoing support by the World Bank, recognizing the Bank as a lead organization in moving the response forward to the next stage. The Second HIV/AIDS Program Development Project (HPDP II) has been tailored to build on the success of Project 1 and utilizes the existing institutional structures in the national AIDS response. The HPDP 2 components are as follows:

Component 1: Expanding the Public Sector Response

Component 2: Expanding the civil and private sector engagement and response through the HIV/AIDS Fund

Component 3: Strengthening mechanisms for project coordination and management

The project, at design stage, trigerred World Bank's Safeguard Policy, Environmental Assessment (OP 4.01), that is triggered if a project is likely to present some risks and potential adverse environmental impacts. This led to the preparation of an Environmental and Social Management Framework (ESMF) to establish the principle and mechanism for managing potential environmental and social impacts of the project investments. A Waste Managenment Plan (WMP) was also developed to ensure sustainable and adequate management of the health care waste especially for the project.

A Mid Term Review (MTR) of the HPDP II conducted from October 30 to November 15, 2013 revealed that HPDP II was not in full compliance with the Safeguards commitments as spelt out especially by the Environmental and Social Management Framework (ESMF) and the Waste Management Plan (WMP). A Preliminary assessment report of Safeguards issues carried out on the project for two States showed areas of concerns. To this end, the MTR subsequently recommended a safeguard audit for the project to cover all project implementing State Agency (ies) for Control of AIDS (SACAs). It is againt this background that this Safeguard Audit was prepared.

1.2 Objectives of the Environmental and Social Safeguards Audit

The main objective of the audit was to assess the compliance of the HPDP II sub-project activities with Nigerian relevant environmental regulations, World Bank Safeguard policies and particularly the various safeguard instruments developed for the project. Specifically, all relevant safeguards good practices as well as gaps and challenges with its implementation were identified; and an action plan designed to strengthen the good practices and to address identified gaps and challenges, including supporting the implementing agencies in the development of specific safeguard instruments such as the Environmental and Social Management Plan (ESMP).

The Specific objectives of the audit included the followings:

1. Establish the performance baseline on the compliance of environmental safeguards and addressed social issues, as outlined by the Environmental and Social Management Framework (ESMF), the Waste Management Plan (WMP) and the recommendations provided in the Mid Term Review (MTR) aide memoire, in order to develop a sound Environmental and Social Management System (ESMS).

2. Explore and outline specific opportunities and actions for improvement of current performance on environmental safeguards, addressing social issues according to audit' findings.

3. Propose remedial measures to address the gaps identified in the audit

4. Facilitate management control of environmental practices, mainly, and social practices relevant to the project.

5. Ascertain whether a section in the quarterly report is devoted to providing an overview of safeguard activities that are being implemented, highlighting environmental and social impacts and capturing plans to manage the impact to acceptable levels.

6. Based on the findings of the audit, design an action plan for managing the identified Environmental and Social non-conformance safeguards issues.

1.3 Scope of Work and Task

The scope of work for the audit included, amongst others, the determination of the application to-date of environmental and social safeguards based on the PAD, ESMF and WMP. It also included the collection of relevant data on how the project is addressing relevant social issues, i.e. issues of inclusion/exclusion, targeted beneficiaries and discrimination.

Specific activities in the audit included:

i) Determination of the exent of the application of safeguards policies in relation to, environmentaland & social issues relevant to the project at the national, state and local level.

ii) Determination of the environmental and social safeguards issues that arose in the course of project implementation and whether any of and/or all project activities have had or have cumulative environmental and social impacts.

Specifically, the following were covered in the audit:

1. An inventory of all sub-projects in all participating States vis a vis compliance with the PAD, ESMF and WMP in addition to assessment of the safeguard operational constraints and concerns facing the project.

2. An assessment of the level of implementation of and adherence to the mitigation measures/ management plans prescribed in the PAD, ESMF and WMP during development and operational phases of sub-project activities.

3. An assessment of the quality of World Bank supervision of the implementation of the Safeguards

policies.

4. An assessment of the environmental, health and safety issues at the various facilities in relation to the components/parameters outlined in the ESMF & WMP as well as measures and standards put in place by the project.

5. Development of a map containing all health care waste incinerators identified with respect to their locations, type, functionality, age and other relevant information.

6. An assessment of the feedback mechanisms put in place for receiving/hearing and effectively responding to grievances or any other feedback from stakeholders, especially the beneficiary communities of the project.

7. Furthermore, the audit, as much as possible collected information on project performance related to the occurrence of social issues, including: a) dynamics (i.e. of exclusion, discrimination), among others within the beneficiaries of the project and which specific populations are being more affected by these dynamics. The Consultant also looked at; b) the situation of vulnerable and most at risk populations (i.e. women, children, female sex workers (FSW), Men who have Sex with Men (MSM) and Injecting Drug Users (IDU)) and; c) how they were being affected by the project regarding accessibility of services provided by the project,; and, d) what were the measures put in place by the project to address these issues.

1.4 Environmental & Social Safeguards Audit Methodology

1.4.1 Introduction

The audit employed mixed methods to collect both qualitative and quantitative data. The qualitative component involved a review of documents, records and procedures used in the day-to-day running of the project and the subprojects. Interviews were also conducted with the responsible personnel for sub- projects at the respective sites to capture operational and social issues. Interviews with relevant stakeholders were also conducted across the geo-political zones. In addition the quantitative component of the audit included, on-site assessment of occupational health and safety parameters and visual inspection of relevant structures, infrastructure and processes which were used to identify environmental, health and safety issues including social concerns. This was also used to assess compliance to pre-agreed procedures and instructions/guidelines as contained in the Project Appraisal Document (PAD), Environmental and Social Management Framework (ESMF) and the Medical Waste Management Plan, among others. For effective coordination of the audit exercise, the country was divided into four zones namely; Abuja (North I), Enugu (South I), Kaduna (North II) and Lagos (South II).

1.4.2 Audit location

The audit was conducted in selected health facilities spread across the 35 project states and the FCT (Table 1.1).

1.4.3 Audit design

1.4.3.1 Determination of Sample size of health facilities in the audit

The sample size of Health Facilities included in the safeguard audit was determined based on a total of 7,667 health facilities contained in the revised National Master Facility List for HIV/AIDS Services in the country (June 2014). Using a simple sample size calculator and assuming a confidence level of 95%, a margin of error of 5%, and 10% inflation due to non-response or dropout, a sample size of 2012 health facilities was selected for the audit. However, since there exists variation in the number of health facilities in the states, the number of facilities to be assessed in each State was determined using probability proportional to size (PPS) of facilities in the States. The required number of Health Facilities allocated to the states were then allocated to the LGAs after which they were randomly selected from Public (primary, secondary, tertiary) and Private strata. This was done in order to ensure a representative sample of health facilities that were included in the audit. Table 1 and Figure 2 shows the stratified spread of the selected HCFs.

State	No of LGAs	No of HCFs in the States	Sites Selected per State
Abia	17	465	122
Adamawa	21	34	9
Akwa Ibom	31	422	110
Anambra	21	405	106
Bauchi	20	77	20
Bayelsa	8	155	41
Benue	23	454	119
Borno	21	49	13
Cross River	18	553	145
Delta	25	541	142
Ebonyi	13	205	54
Edo	18	111	29
Ekiti	16	38	10
Enugu	17	348	91
Gombe	11	225	59
Imo	27	301	79
Jigawa	27	38	10
Kaduna	23	467	123
Katsina	34	23	6
Kebbi	21	29	8
Kogi	21	275	72
Kwara	16	56	15
Lagos	32	373	98
Nasarawa	13	239	63
Niger	25	142	37
Ogun	20	76	20
Ondo	18	56	15
Osun	30	53	14
Oyo	33	261	69
Plateau	17	357	94
Rivers	23	341	90
Sokoto	23	41	11
Taraba	16	98	26
Yobe	17	8	2
Zamfara	14	49	13
FCT	6	302	79

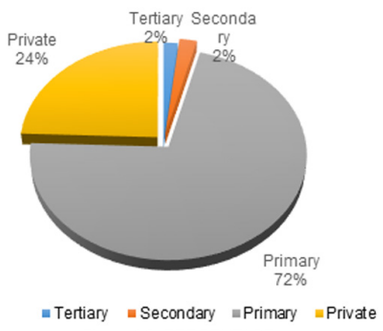


Figure 1.3: PERCENTAGE DISTRIBUTION OF HEALTH CARE FACILITY TYPES AUDITED

1.4.4 Data collection, management and analysis plan

1.4.4.1 Data collection instruments

The audit exercise utilized survey questionnaires instrument to elicit responses from responsible personnel at the health facilities, interviews with relevant stakeholders and consultation meetings with key implementing Partners such as SACAs and LACAs to gather information from all the participating States in order to test existing management of environmental and social concerns. Structured instruments were also used to conduct interviews with the hidden group. In order to ensure confidentiality interactions with the hidden group were conducted from NACA office via telephone conversations. However, field visits were conducted to relevant sites for visual appreciation and assessment of issues of interest in the health facilities.

1.4.4.2 Data collectors

Experienced Data collectors were recruited and engaged for the purpose of data collection from the health facilities in the states. A total of 82 qualified and trained data collectors were identified to work in the 35 audit states and the FCT. The 82 data collectors were pooled together in Lagos, Abuja, Kaduna and Enugu, and provided one-day training on the tools and what was expected of them in the field. The essence of the training was to provide all data collectors a shared understanding of the tools and to have a common understanding of the terms used in the questionnaire and data collection templates.

1.4.4.3 Quality assurance

In order to ensure accurate and reliable result of fieldworks, the following procedures were implemented during the fieldwork:

- The tools for the audit were pre-tested, standardized and approved by NACA before field work.
- Only experienced data collectors (who had participated in similar surveys in the past) were deployed for the field work in the study locations
- All field personnel were trained at the zonal levels in Kaduna, Lagos, Enugu and Abuja before field work to ensure that all personnel had a shared understanding of the tools and what was expected of them in the field
- In order for the Field supervisors and assistants to be familiar with the instrument of data collection, this was first administered as part of the practical session during the training were made to work first as interviewers during the training session before assuming supervisor roles. This was done in order to familiarize all data collectors with the methodology and intricacies of the audit. The supervisors performed the following tasks in the course of the fieldwork:
- Reviewed all completed questionnaires for legibility, accuracy and consistency
- Monitored the accuracy of individual interviews
- Spot field checked on interviewers to eliminate fraud and inaccurate filing of forms

1.4.4.4 Data collation, entry and analysis/Reporting plan

Field data from the 35 states and FCT were collated and entered into a prepared template in SPSS statistical software. The data was then cleaned, edited and analyzed in SPSS to obtain findings to provide reliable information with a view to understanding the compliance of HCFs with the ESMF and WMP in Nigeria. Data collected from other stakeholders were managed and analyzed in MS Excel. The findings were then articulated in this audit report.

1.4.5 Consultations with Stakeholders

Series of interactive discussions and consultative meetings were held with various groups including

NACA, SACAs and LACAs in the various states. Consultations with State SACAs and LACAs were facilitated by NACA at the National level. Two such national consultations were conducted in December 2014 (Pre-audit consultation) and in June 2015 (Post-audit consultation). Routine consultations also took place with the NACA Project Team to review and approve the survey tool, to discuss audit challenges, to review initial audit findings and to source information to fill obvious gaps. The Project Managers and CSOs in the various states facilitated consultations with special groups such as the Most at Risks (MARS), female groups and the Community Based Organizations (CBOs). Most At Risks groups were identified by Network coordinators through the SACA focal persons who assisted to set up meetings with members of IDUs, MSM and FSWs. Meetings were also held with NACA and the World Bank to discuss issues that pertained to the conduct and reporting of the audit. Representatives of the World Bank and NACA were also at the training sessions that were conducted for Data collectors. This was to provide oversight and to ensure the proper conduct of the audit exercise.

Pictures Showing SACA Safeguards Desk Officer at the Pre -Audit Kick off Planning Workshop, Lagos

S/No.	When it took place	Participation	Number Present	Reason for it/Issues Raised	Responses	Remarks
1	December 2014	NACA, SACAs, CBOs, SSOs	301	- Need for the audit - Modality of exercise - Timing of exercise - Expected roles of stakeholders	- Reference to project documents - Audit method explained - Audit workplan was shared - Need for availability and cooperation of all was stressed	
2	February 2015	NACA	12	General discussion and review of audit tool	Interactive	Tool agreed-to by NACA and the Consultant
3	March 2015	NACA	14	Review of revised audit workplan	Interactive	Revised workplan agreed for implementation
4	March 2015	SACAs	Various but not less than 30 per Zone	Zonal consultations - Logistic needs & responsibilities for audit exercise - Implications of the exercise • Available feedback avenues	- SACAs required to facilitate but Consultant pays survey staff - Findings meant to improve HPDP 2 performance • Audit findings will be validated by stakeholders	

5	April 2015	World Bank	5	Progress review meeting - Challenges of the audit exercise & how to quicken progress thereafter	- Inadvertent causes of the delay were identified to include the rescheduling of the 2015 general elections - Revised workplan was presented and agreed	- The workplan was meant to ensure submission of draft report in time for the June 2015 ISM.
6	May 2015	NACA	11	Review / validation of audit findings - the need for the colour codes for interpreting results - the absence of map on incinerators - the seemingly erroneous indication of instances of non-use of PPE by project staff 1. the absence of cost estimates for activities in the proposed action plan	- The colour code was introduced to make the tables easier to understand and for ease of reference - Data on improvised incinerators was available but that on closed-chamber incinerators was sparse. Emphasis should be on the latter. - Field data confirmed that 3rd party personnel handling HCW from HCFs weren't using PPE. • Activity cost estimates were to be jointly determined between the consultant and the project	This meeting reviewed the draft report prior to its submission to the World Bank

7	June 2015	NACA, SACAs, SSOs	165	Review / validation of audit findings - need for state-specific findings - implications of findings on implementation of approved workplans - inadequacy of time for the exercise	- Findings are to be disaggregated - Workplans not cast in stone. The Bank will treat cases on individual merit - The audit needed to be concluded quickly to allow for corrective safeguards decisions	
8	July 2015	NACA, World Bank	11	-Review of NACA and World Bank comments on draft Audit report -Need for the submission of final report as quickly as possible	- Comments were discussed and positions agreed - The 29th of July was agreed as the date for the submission of final audit report	
9	July 2015	NACA	6	Discussion on hidden groups and contacts with Coordinators of FSW, IDU & MSM	It was agreed that telephone interviews were to be conducted with the coordinators to fill observed data gaps	

Chapter 2
Policy, Administrative and Legal Framework

2.0 Introduction

There is a wide variety of legislation relating to the environmental (and social) issues, which are of potential importance for the HIV/AIDS project. This Chapter covers the relevant Nigeria's legislative and World Bank Safeguards Policy requirements for environmental protection.

2.1 Relevant Nigerian Regulatory Instruments

In Nigeria, there are a number of relevant governmment policies and regualtions at Federal and State levels that are related to giving direction towards a safe and healthy environment of which effective management of healthcare waste in the country is critical. These laws emphasize protection, prevention and conservation of the natural resources and general environmental management. Some of these are highlighted below:

2.1.2 Federal Level Policies/Legislations

2.1.1 National Policy on the Environment 1989 (revised 1999)

The National Policy on the Environment aims to achieve sustainable development in Nigeria, and in particular to:

- Secure a quality of environment adequate for good health and well - being;
- Conserve and use the environment and natural resources for the benefit of present and future generations;
- Restore, maintain and enhance the ecosystems and ecological processes essential for the functioning of the biosphere to preserve biological diversity and the principle of optimum sustainable yield in the use of living natural resources and ecosystems;
- Raise public awareness and promote understanding of the essential linkages between the environment, resources and development, and encourage individuals and communities participation in environmental improvement efforts; and
- Co-operate with other countries, international organizations and agencies to achieve optimal use of trans-boundary natural resources and effective prevention or abatement of trans-boundary environmental degradation.

2.1.2 Some Thematic (Area) Policies on Environment-

In addition to the National Policy on Environment, there are other policy documents on some thematic areas of the Ministry's mandate. These include:

- Environmental Enforcement Policy:

This policy aims at providing actions to take in enforcing environmental legislation, standards, regulations and guidelines fairly and appropriately in a manner that will protect environmental quality and safeguard public health.

- National Environmental Sanitation Policy:

This policy seeks to stimulate, promote and strengthen all government regulations concerned with housing and urban development, food security water supply, sanitation related endemic diseases and illnesses, flood and erosion control, drought control, school health services and environmental education.

- National Policy Guidelines on Sanitary Inspection of Premises: This policy seeks to promote clean and healthy environment for the populace.

- National Policy Guidelines on Solid Waste Management: The aim of this policy is to improve and safeguard public health and welfare through efficient sanitary Solid Waste Management methods that will be economical, sustainable and guarantee sound environmental health.

- National Policy Guidelines on Pest and Vector Control: This policy is to establish and strengthen pest and vector control units at the three tiers of government.

- National Policy Guidelines on Food Sanitation: The main objective of the policy is to enhance food security, public health and quality of life through the promotion of sound food sanitation practices in all food premises in the country.

- National Environnemental Sanitation Action Plan: This plan is aimed at increasing National productivity and foster Economic Development through improved Environmental sanitation practices.

2.2. Environmental Laws/Acts

Environmental Impact Assessment (EIA) Act No. 86 of 1992

This act stipulates that the public or private sector of the economy shall not undertake or embark or authorize projects of activities without prior consideration at an early stage, of their environmental effects. It also makes it a mandatory requirement for all existing industries to carry out an Environmental Audit once in three years after the initial Environmental Impact Assessment (EIA).

Guidelines on Environmental Audit (1999 updated in 2010)

This made it mandatory for existing industries to carry out environmental audit that involves systematic, documented, periodic and objective evaluation of how an existing industrial facility with its management and equipment are complying with regulatory standards.

The Harmful Waste (Special Criminal Provision Etc.) Act 1988

The Act was enacted with the specific object of prohibiting the carrying, depositing and dumping of hazardous wastes on any land, territorial waters and matters relating thereto. This Act is essentially a penal legislation. The offences are constituted as doing any of the act or omission stated in the section 12 of the act. The jurisdiction of the Act is far reaching as it sought to remove any immunity conferred by diplomatic immunities and privileges Act on any offender for the purpose of criminal prosecution. Section 6 of the Act provides a very stringent sentence of life imprisonment and in addition the forfeiture of any aircraft, vehicle or land connected with or involved with the violation.

Criminal Code

The Nigerian Criminal Code makes it an offence punishable with up to 6 month imprisonment for any person who:

- Violates the atmosphere in any place so as to make it noxious to the health of persons in general dwelling or carry on business in the neighbourhood, or passing along a public way: or

- Does any act which is, and which he knows or has reason to believe to be likely to spread the infection of any disease dangerous to life, whether human or animal.

National Environmental Standards and Regulations Enforcement Agency (Establishment) Act, 2007

This Act established NESREA and charged it with the responsibility of protecting and developing the environment in Nigeria, as well as enforcing all environmental laws, regulations, standards, policies, guidelines and conventions on the environment to which Nigeria is a signatory. By the NESREA Act, the Federal Environmental Protection Agency Act Cap F 10 LFN 2004 was repealed.

The Act also enables Agency to also:

- Prohibit process and use of equipment or technology that undermine environmental quality.
- Conduct field follow-up of compliance with set standards and take procedures prescribed by law against any violator

2.3 Environmental Regulations

Many laws and regulatory measures have been put in place to promote sustainable environmental management in many sectors of the economy. Some of the critical acts include:

- National Environmental (Sanitation and Wastes Control) Regulations, S. I. No. 28 of 2009: The purpose of this Regulation is to provide the legal framework for the adoption of sustainable and environment friendly practices in environmental sanitation and waste management to minimize pollution.

- National Environmental (Ozone Layer Protection) Regulations, S. I. No. 32 of 2009: The provisions of this Regulation seek to prohibit the importation, manufacture, sale and the use of ozone-depleting substances.

- National Environnemental (Noise Standards and Control) Régulations, S. I. No. 35 of 2009:The main objective of the provisions of this Regulation is to ensure tranquillity of the human environment or surrounding and their psychological well-being by regulating noise levels.

- National Environmental (Control of Bush/Forest Fire and Open Burning) Regulations, S. I. No. 15 of 2011: The principal thrust of this Regulation is to prevent and minimize the destruction of ecosystem through fire outbreak and burning of any material that may affect the health of the ecosystem through the emission of hazardous air pollutants.

- National Environmental (Construction Sector) Regulations, S. I. No. 19 of 2011: The purpose of this Regulation is to prevent and minimize pollution of the Nigerian Environment from the impacting activities of Construction, Decommission and Demolition.

- National Environmental (Control of Vehicular Emissions from Petrol and Diesel Engines) Regulations, S. I. No. 20 of 2011: The purpose of this Regulation is to safeguard the Nigerian environment against pollutants from vehicular emission.

- National Environmental (Surface and Groundwater Quality Control) Regulations, S. I. No. 22 of 2011: The purpose of this Regulation is to restore, enhance and preserve the physical, chemical and biological integrity of the nation's surface waters, and to maintain existing water uses.

2.4 The Social Context of Legal Framework

The National Policy on HIV/AIDS was developed in 2009 by the National Agency for the Control of AIDS. The policy provides regulations and guiding principles on topics ranging from prevention of new infections and behavior change, treatment, care and support for infected and affected persons, institutional architecture and resourcing, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by the various stakeholders in the national response. The national policy was developed in agreement with key national and international frameworks relevant to the HIV/AIDS response in Nigeria, including:

- The 1999 Constitution of the Federal Republic of Nigeria, which affirms the national philosophy of social justice, and guarantees the fundamental right of every citizen to life and freedom from discrimination.

• Complementary government policy documents which provide the framework for the National HIV policy, including the NACA Act, Medium Term Strategy, National Economic Empowerment and Development Strategy (NEEDS) I and II, National Gender Policy, and the Seven Point Agenda of the Federal Government of Nigeria.

• Commitments to and ratification of numerous international conventions including Universal Declaration of Human Rights (1948), the Convention on Economic, Social and Cultural Rights (1976), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), Convention on the Rights of the Child (1989), and the African Charter on Human and People's Rights (2003)

• Nigeria's ratification of agreed international community goals including the Programme of Action of the International Conference on Population and Development ICPD (1994), The Political Declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action (2000), Political Declaration at the World Summit for Social Development (1995), The United Nations Millennium Declaration (2000) which target 2015 for the reversal of the epidemic trajectory, Greater Involvement of People with AIDS (GIPA) and Meaningful Involvement of People with AIDS (MIPA) principles, The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa (2001) and the United Nations General Assembly Special Session on

HIV/AIDS (UNGASS) (2001).

• Nigeria's Commitment to Universal Access and to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV/AIDS, the African Union's Abuja Call for Accelerated Action towards Universal Access for HIV/AIDS (2006), and the Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010.

In modern times, the earliest conceptualization of a right to health did not so much emanate from a human rights organ, but from an international health authority – the World Health Organisation (WHO). In the preamble to the Constitution of the WHO, which was written in 1946, the WHO proclaimed that 'the enjoyment of the highest attainable standard of living is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition'. The WHO's Constitution defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The right to health has since become an integral part of most of human rights instruments at both an international and regional level.

The array of human rights instruments and documents that deal with the right to health is vast. At an international level, the following treaties contain provisions that address the right to health including the HIV/AIDS:

- the Universal Declaration of Human Rights (1948)
- the Standard Minimum Rules for the Treatment of Prisoners (1955)
- the International Convention on the Elimination of All Forms of Racial Discrimination (1965) (CERD)
- the International Covenant on Economic, Social and Cultural Rights (1966) (CESCR)
- the International Convention on the Elimination of All Forms of Discrimination Against Women (1979) (CEDAW)
- the Convention Concerning Indigenous and Tribal peoples in independent Countries(1989)
- the Convention on the Rights of the Child (1989)(CRC)
- the International Convention on the Protection of the Rights for All Migrant Workers and Members of their Families (1990)

While the above instruments directly address the right to health, it is important to appreciate that because the right to health overlaps with other rights such as environmental rights and the rights to life, food, shelter, housing and so on, there is also a host of other international instruments with provisions that impact on the right to health, albeit indirectly or implicitly.

The Nigerian government has been pro-active in its efforts to confront the HIV scourge with its overarching strategy elaborated in the bottom-up poly-stakeholder and multi-sectoral National Strategic Plan (NSP). The NSP is derived from the architecture of the National Strategic Framework, 2010-15 (NSF II) and has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2015. With the condition that where appropriate, the targets of the NSP should be population-based, the Federal Government of Nigeria implicitly recognizes HIV care and treatment as a national public health good. To this effect, the NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); Government Ministries, Departments and Agencies (MDAs); and the constituent coordinating entities of Civil Society Organization (CSOs) Networks. The NSF II is linked to Universal and MDG targets and Vision 20:2020 and has an overriding emphasis on HIV prevention.

It builds on the National HIV Policy and provides a broad structural framework for the implementation of this policy. Considerations that informed the development of this framework include the burden of HIV/AIDS in the country, the public health challenge of HIV/AIDS, comprehensive HIV/AIDS services, feminization of the epidemic and strategy for gender streaming, young people, MARPs, modes of HIV transmission, drivers of the epidemic, stigma and discrimination, cultures, traditions and religion, human rights and multisectoral partnership.

Other policy documents that the national response to HIV draws from are: the National Action Plan on Orphans and Vulnerable Children and the National HIV/AIDS Prevention Plan.

In spite of the numerous policies, minimal progress has been made in addressing the human rights and legal issues surrounding HIV/AIDS. This is mainly due to the fact that, in Nigeria at the moment, there are no HIV/AIDS specific laws on the statutes.

Currently, the 1999 Nigerian constitution and international treaties ratified by the country have provided the major sources of human rights for PLHIV and PABA in the country. However, as none of these treaties or the constitution specifically addresses the situation of PLHIV and PABA, the case of their applicability often has to be made through advocacy and lobbying. One outcome of this advocacy agenda has been the efforts made by civil society networks in spearheading the pressure for the passage of the anti-discriminatory bill. Anti- stigma and discrimination bill has passed through Senate and House of Representatives. The bill is waiting to be signed into law by the President.

Four (4) states have passed the bill into law. Efforts by civil society networks have recently included advocacy for increased government investment in the HIV response, facilitation of the use of available policies and guidelines and promotion of the establishment of the legal framework for protection of prospective employees and intending couples.

For most-at-risk and other vulnerable population groups like sex workers, men who have sex with men (MSMs) and injecting drug users (IDUs), there remains a clear absence of non- discrimination laws or regulations specifying protection for these groups. The National Assembly has passed a bill to prohibit same sex marriage. Tagged Same-Sex Prohibition Law, the law proposed up to 14 years imprisonment each for gay couples that decided to solemnize their union while witnesses to the marriage or anyone who assisted the couples to marry could be sentenced to 10 years behind bars. Also proscribed by the new Bill is “public show of same-sex amorous relationships directly or indirectly” with 10 years’ imprisonment stipulated as punishment. The President of the Federal Republic of Nigeria has since signed the bill into law. It criminalizes gay groups and organizations and promotes the discrimination and persecution of persons on the basis of their sexual orientation and gender identity. However, according to the Director-General of NACA:

“Nothing in the same sex Marriage (Prohibition) Act 2013 refers to or prohibits programs targeted at prevention, treatment, care and support for people living with HIV or affected by AIDS in Nigeria. No provision of this law will deny anybody in Nigeria access to HIV treatment and other medical services.”

Under the Constitution of the Federal Republic of Nigeria, human rights of persons living with HIV/AIDS can be discussed under the following:

(a) FREEDOM FROM DISCRIMINATION

S.42 (1) of the Constitution provides as follows: A citizen of Nigeria of a particular community, ethnic group, place of origin, sex religion or political opinion shall not, by reason only that he is such a person:

a) Be subjected either expressly by, or in the practical application of any law in force in Nigeria or any executive or administrative action of the government, to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic group, places of origin, sex, religions or political opinions are not made subject to; or

b) Be accorded expressly by; or in the practical application to any law in force in Nigeria, or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic group, places or origin, sex, religions or political opinion.

Further, S. 42(2) provides: No citizen of Nigeria shall be subjected to any disability or deprivation of merely by reason of the circumstances of his birth

(b) RIGHT TO DIGNITY OF HUMAN PERSON

The constitution provides for right to dignity of the human person, that no person shall be subjected to torture, or inhuman, or degrading treatment, no person shall be held in slavery or servitude, and that no person shall be required to perform forced or compulsory labour.

From the perspective of HIV/AIDS it means that segregation and stigmatization of person living with HIV/AIDS because of their sero-positive status violates their right to dignity.

2.5 Overview of the Nigeria Health Care Waste Management Policy, Plan and Guidelines:

Presently, there is a new National Health-Care Waste Management Plan, National

Health-Care Waste Management Guidelines and National Health-Care Waste Management Policy in Nigeria with specific legislation to regulate the management of healthcare waste in Nigeria. The implementation of safe practice of Healthcare Waste Management (HCWM) in public and private medical institutions is a priority issue, which the Federal Ministry of Environment in collaboration with Federal Ministry of Health and other stakeholders have decided to address.

In view of the challenges presented by healthcare waste and its management in Nigeria, the Federal Ministry of Health in collaboration with the Federal Ministry of Environment instituted the National Healthcare Waste Management (NHCWM) Working Committee for the development of a National Healthcare Waste Management Policy, Guidelines and Plan of actions.

These documents which are standalone but complementary were validated by stakeholders at a National Stakeholders forum and are intended to address environmental and health problems associated with poor management of healthcare wastes. They provide the roadmap to introducing Safe Healthcare Waste Management (HCWM) practices to all Healthcare facilities in Nigeria. The development of this policy will set out clear guidelines for the national framework on HCWM in the country. The implementation of the Policy follows the existing governance and healthcare delivery system structures in the country. The operation of the HCWM plan and guideline covers activities at the national, state and local government levels. Both the public and private medical institutions in the country are expected to set up their HCWM plans following the guidelines provided and in line with national policy.

A brief highlight of the intended objectives of the three instruments designed to standardise Healthcare Wastes Management (HCWM) practices in Nigeria is presented below:

National Healthcare Waste Management Policy, 2013

The HCWM Policy subscribes to the vision, goals and principles and the regulatory approach set out in

the National Environmental Policy.

The policy applies to both public and private medical/health institutions in Nigeria, and at the national, state and local Government levels. The healthcare waste management policy is to be implemented in a holistic manner in the generation, storage, collection, transportation, treatment, the final disposal of the waste, and after care of the disposal site. The Policy also serves as statement of intent by the Government of Nigeria on how to manage and minimize waste generated from both the public and private health institutions, in a way that takes cognizance of the health of those handling the healthcare waste, the environment and the community so affected.

The goal of the Policy is to create an enabling environment that contributes to effective and efficient healthcare waste management practices with minimal harmful environmental impact.

This policy which seeks to hold every Health Care facility accountable for the safe handling and disposal of health care waste it generates has specific objectives as follow:

- To promote best practices in healthcare waste management in all Health Care institutions in Nigeria
- To institute mechanisms for effective and sustainable healthcare waste management practices at all levels in Nigeria
- To promote the development of institutional and human capacities for effective implementation of healthcare waste management activities in all medical institutions in Nigeria.
- To provide a mechanism, for effective coordination of healthcare waste management activities in all medical establishments in Nigeria.
- To mobilize resources for effective and sustainable implementation of healthcare waste management activities in all medical institutions in Nigeria.
- To set standard of healthcare waste management practices that meet international requirements.
- To promote partnership among various key players involved in environmental protection/ conservation efforts
- To promote/support operational research in healthcare waste management practices and their impact on environment/community.

The main features of the policy include: Justification for the HCWM Policy, Purpose of the HCWM Policy, Policy Goal & Objectives, Guiding Principles, Policy Statement, Safe Healthcare Waste Management Practices, Protection of Staff, Patients and Environment from risks associated with Healthcare Waste, Institutional Framework for Policy Implementation (Operational Guidelines), setting up of Infection Prevention and Control committees with Health Care Waste Management Committees as subset in all Health Care Facilities (HCFs), Infrastructural & Human Capacities Development, Resource Mobilization, Public-Private Partnership (PPP), The Greenhouse Effect, Research, Monitoring & Evaluation and Legislation.

National Healthcare Waste Management Strategic Plan (2013-2017)

The National Healthcare Waste Management Plan (NHCWMP) is a five-year implementation plan for healthcare waste management in the country designed to provide an approach to the management of healthcare waste that is safe for HCFs, waste handlers, the public and the environment as well as being cost effective and practical.

The plan contains the following main parts or features situational analysis, organization of health system in Nigeria, legal and regulatory HCWM frameworks, characterization of HCW production in Nigeria, characterization of HCW practices in Nigeria, appraisal of the institutional capacities of the health system and recommendations for HCWM at all levels with national action plan strategy and

implementation, estimations of cost for NHCWMP and a five-year calendar of activities

The NHCWMP objectives include:

- Develop and implement a National Action Plan based on the analysis of current HCW management and disposal practices;
- Develop standardized and simple HCWM procedures in the HCFs of the country and provide appropriate treatment and disposal technologies, taking into consideration the financial and institutional capacities of local, regional institutions;
- Develop a strategy for the implementation of the national HCWM Plan in Nigeria.
- The implementation of the objectives contained in the National HCWM Plan requires the development of specific actions included in the National Action Plan (NAP), which is recommended for periodic monitoring and review with a typical timeframe of around 5 years.

The NHCWM Plan recommends the establishment of a NHCWM steering committee, to ensure the coordination and supervision of the NHCWM Plan at the National level and State and LGA HCWM steering committees.

The Plan strongly recommended the following levels of supervision and coordination:

- At National level, the NSCHCWM is in charge of the monitoring and supervision of the National HCWM Plan. The PC is in charge of its implementation and supervises the activities of the Work Groups;
- At State level, the SSCHCWM is in charge of the monitoring and supervision of the HCWM plan. They nominate a state Coordinator who is responsible for the smooth implementation of the HCWM plans at state level. He/she reports to the PC and the SSC;
- At Facility level, Hospital Management is administratively responsible for the implementation of a HCWM plan within the institution. The Hospital Management nominates the HCWMO, who shall be a licensed Environmental Health Officer who has the entire responsibility with the HCWMC/IPCC to set-up Hospital HCWM Plans.

National HealthCare Waste Management Guidelines, 2013

The National HCWM Guidelines are intended to identify appropriate HCWM methods that can be applied to both public and private health care facilities in Nigeria. The guidelines are designed to provide better knowledge of the fundamentals of HCWM systems and planning, including a better understanding of the risks associated with health care waste.

Specifically, they are designed to:

- Identify HCWM procedures and plans that are protective for both human health and the environment, in compliance with current and pending environmental and health legislation in Nigeria and taking into consideration the characteristics of each health facility.
- Set priority actions in order to tackle the most sensitive problems related to HCWM (e.g. disposal of sharps).
- Review appropriate and sustainable technologies to treat and dispose of health care waste (HCW).
- Facilitate the analysis of HCWM problems and develop strategies for safe management of HCW at all levels

The National Health Care Waste Management Guidelines are to be implemented in all the medical institutions in Nigeria. The National HCWM Guidelines are intended for medical staff having “duty

of care" at all levels of both private and public health facilities, namely: Directors, hospital heads of department, Chief Executive Officers of Tertiary health facilities, administrators, doctors, matrons, infection control officers, pharmacists, laboratory scientists, environmental health officers and waste handlers in addition to policy makers in charge of developing, implementing, and evaluating HCWM plans at Federal state and Local Government levels as well as Environmental Health Officers in charge of implementation and monitoring of HCWM plans. Others are; Teaching hospitals, schools of nursing and midwifery, schools of health technology and schools of hygiene, International Organizations, NGOs, and all Stakeholders in HCWM in Nigeria.

Essentially the guideline contained the following main features: The audience, definitions of health care waste in Nigeria, risks associated with health care waste principles of safe health care waste management, collection, storage, and transportation of HCW, health care waste treatment and disposal options in Nigeria, accidents and spillage, development and implementation of HCWM plans in HCF.

2.6 Administrative Framework

The following institutions and agencies are responsible for regulating and monitoring human, information and waste management standards in Nigeria:

- Federal Ministry of Health (FMoH)
- Federal Ministry of Environment (FMEnv)
- State Ministries of Environment/Environmental Protection Agency (SEPA)

2.6.1 Federal Ministry of Health

The Federal Ministry of Health (FMoH) has responsibility to manage health services for the prevention and control of communicable and non-communicable diseases. For the HPDP2 and under the implementation of ESMF the Ministry has the following responsibilities:

- Coordinate the efforts of state, local government and private health care providers and development partners to ensure effective implementation.
- Ensure the provision of adequate equipment in tertiary and specialized hospital services.
- Provide technical assistance to state ministries of health in the development of plans, technical materials, policies and standards to properly perform their functions.
- Issue and promote adherence to norms and standards, and provide guidelines on health matters, and any other matter that affects public health, promoting adherence to norms and standards for the training of human resources for health.
- Supervise the provision of health services for the management, prevention and control of communicable and non-communicable diseases e.g. HIV/AIDS.

2.6.2 Federal Ministry of Environment

The Federal Ministry of Environment (FMEnv) has responsibility to administer and enforce environmental laws in Nigeria. The specific responsibilities of the ministry include:

- Monitoring and enforcing environmental protection measures;
- Enforcing international laws, conventions, protocols and treaties on the environment
- Prescribing standards for and making regulations on air quality, water quality, pollution and effluent limitations, atmosphere and ozone protection, control of toxic and hazardous substances; and
- Promoting cooperation with similar bodies in other countries and international agencies

connected with environmental protection.

2.6.3 State Environmental Protection Agency or Authority

Each state within Nigeria is empowered to make laws for the protection of its own environment, within its jurisdiction. State Environmental Protection Agency or Authorities (SEPAs) are responsible for the assessment of all public or private projects activities within the states. The roles of SEPAs in this project include;

- Conducting public enlightenment on environmental sanitation and management;
- Co-operating with the Federal and Local Governments, Statutory bodies and Research Agencies on matters relating to the project;
- Pollution control and environmental health in the states;
- Collaborating with FMEnv and other agencies to achieve effective prevention of abatement of trans-boundary movement of waste

2.7 World Bank Safeguard Policies

The second HIV/AIDS Program Development Project (HPDP 2) has been categorized as B, implying that the expected environmental impacts are largely site-specific, that few if any of the impacts are irreversible, and that mitigation measures can be designed relatively readily. The environmental assessment for a Category B project examines the project's potential negative and positive environmental impacts, recommend measures to prevent, minimize, mitigate, or compensate for adverse impacts, and recommends measures to improve environmental performance

The World Bank has 10 +2 Environmental and Social Safeguard Policies to reduce or eliminate the adverse effects of development projects, and improve decision-making. These operational policies include:

Environmental Policies
- OP 4.01 Environmental Assessment
- OP 4.04 Conservation of Natural Habitats
- OP 4.09 Pest Management
- OP 4.36 Forestry
- OP 4.37 Safety of Dams

Social Policies
- OP 4.11 Cultural Property
- OP 4.12 Involuntary Resettlement
- OP 4.10 Indigenous Peoples

Legal policies
- OP 7.50 Projects on International Waterways
- OP 7.60 Disputed Areas
  +
- OP 4.00 Use of Country Systems
- OP 17.50 Disclosure Policy

- The HPDP2 triggered the Environmental Assessment Policy, OP4.01 as the project was thought to present some risks and potential adverse environmental and social impacts in its area of influence. The adverse impacts were considered to be site-specific and are not sensitive, diverse, unprecedented and mostly reversible hence the HPDP project was categorised as B project. An ESMF and WMP were prepared for managing the arising impacts.

2.7.1 OP 4.01 Environmental Assessment

The objective of OP 4.01 is to ensure that projects financed by the Bank are environmentally and socially sustainable, and that the decision-making process is improved through an appropriate analysis of the actions including their potential environmental impacts. Environmental assessment (EA) is a process

whose breadth, depth, and type of analysis depend on the nature, scale, and potential environmental impact of the proposed project. EA takes into account the natural environment (air, water, and land); human health and safety; social aspects (involuntary resettlement, indigenous peoples, and cultural property); and trans-boundary and global environmental aspects:

2.8 Nigerian EA Guidelines and World Bank EA Guidelines

The National Guidelines for Environmental Audit in Nigeria, 1999 revised in 2011 provides the Audit Process and protocols, which shall be followed in the Auditing of the facilities in Nigeria.

World Bank Policy specific requirements relating to Audit are set out in Appendix 2 of the Bank's OP 4.01 which states that the bank requires environmental assessment (EA) of projects proposed for Bank financing.

Both recognise the need to determine the nature and extent of all environmental areas of concern at an existing facility- auditing with a view to ensuring improvement in or enhancement of the decision made with regard to the impacts identified earlier in the project formulation and design as well as implementation. Both are directed at ensuring that the project or facility is environmentally sound and sustainable.

Usually for World Bank supported projects, where, there is conflict between World Bank Safeguard Policies and local/national Laws, that of the Bank is seen to take precedence.

Chapter 3
Overview of the Project/Project Description

This chapter presents a brief overview of the HPDP II project including the various activities, design and expectations. An outline of the achievements of the project to-date is also presented in this section.

3.1 Project Location

The HPDP II project supports HIV/AIDS prevention and care and support activities in all states of the federation and the FCT, the exception being Kano State (masked out in figure 3.1) that declined support. The activities target beneficiaries via identified Health Care Facilities ranging from primary through secondary to tertiary and both publicly and privately-owned. MARPs and other hidden persons are reached through accredited networks.

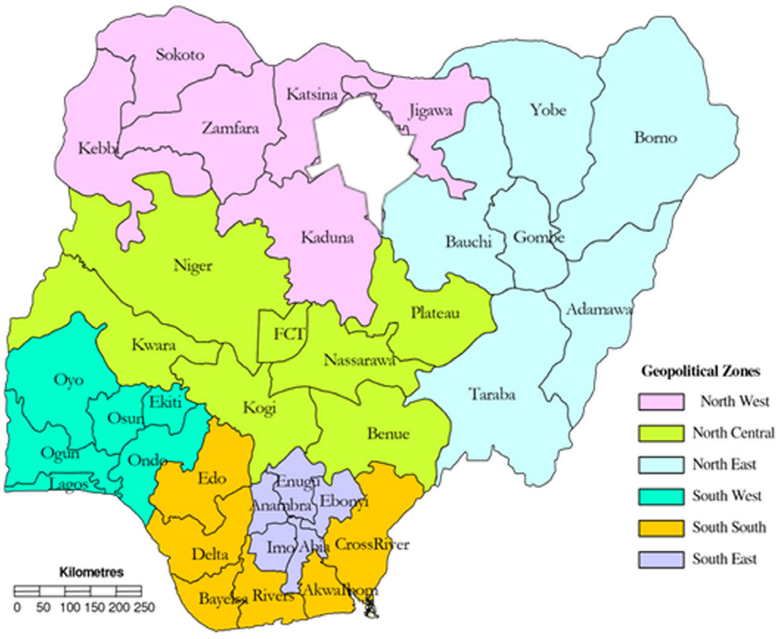


Figure 3.1: Map of Nigeria showing the states and FCT.

3.2 Project Components

The Project Development Objective is to reduce the risk of HIV infections by scaling up prevention interventions and to increase access to and utilization of HIV counseling, testing, care and support services. The project is tailored to reflect the World Bank's comparative advantage in its contribution to a rapidly evolving and complex HIV/AIDS arena. In 2007, a joint Scoping Mission with DfID considered the current and projected AIDS financing context within which key thematic areas are covered in varying degrees by partners and their interests. The components have been designed to build on the solid foundation laid by Project 1, and to move towards a more strategic response. There are three main components:

3.2.1 Component 1: Expanding the Public Sector Response

This component supports HIV/AIDS activities in NSF 2 carried out by the line ministries. Building from the success of Project I, which catalyzed HIV mainstreaming in a range of line ministries at the Federal and State levels, the project will select key high impact line ministries to receive increased funds,

according to agreed criteria. Funds under this component will support scaling up high impact evidence based interventions targeting the clients of line ministries. Component 3 will complement this support by building the capacity of HIV units within the selected line ministries, through NACA and SACAs.

Specifically, the component:

1. Allocate increased funds to key line ministries to achieve greatest impact. At the national level this project is focusing on increased resources on a reduced set of ministries. Agencies that are identified as having a more central role in the fight against HIV/AIDS including Health, Education, Women's Affairs and Defense, are receiving more funds to scale up their activities. FMoH is the key actor in a variety of critical activities including: a) prevention of mother to child transmission (PMTCT), b) integration of HIV/AIDS control with TB treatment, c) laboratory services and safe blood transfusion, d) Antiretroviral (ARV) treatment, if necessary, e) strengthening linkages between the LGAs and PHC in the response process and f) safe waste disposal using the appropriate guidelines. This project started with an institutional assessment of the division responsible for HIV/AIDS in the FMoH to determine how best to strengthen its governance structures and capacity so it can effectively lead the Universal Access agenda, and optimally plan and utilize the substantial funding available from other donors.

2. Support the design and implementation of client-oriented, evidence-based HIV/AIDS plans.

Funds are allocated to the implementation of strategic HIV/AIDS work plans, tailored to the specific client base and issue areas within the national and state-level response most appropriately addressed by each line ministry. Credit funding to workplace policies were limited in line with the expected increase in government allocation to HIV/AIDS to selected line ministries.

3. Receive complementary capacity building support through Component 3. The capacity building exercise under Component 3 defines the roles and skill sets required of i) NACA / SACAs, and ii) HIV units within the selected line ministries to deliver this component. It comprises a multifaceted approach to systems and individual training in core functions: strategic planning for scaling up high-impact, client-oriented interventions, resource mobilization, M&E, fund management, governance and leadership, for a sustainable and effective public sector response.

3.2.2 Component 2: Expanding the civil and private sector engagement and response through the HIV/AIDS Fund.

This component is building on the substantial accomplishments of Project 1. The institutional architecture and procedures for this component were in place and well tested in Project I. Based on several reviews of the HAF, this project: (i) tightens the link between situation analyses and the choice of priority activities for NGOs; (ii) lengthens the funding period and amounts going to individual NGOs; (iii) combines the demand-driven approach of Project 1 with an increased capacity for NACA and the SACAs to address gaps in the response by contracting NGOs to fill the gaps.

The component supports financing for civil society and private sector prevention, care and support activities, including technical assistance, training and implementation to national and local NGOs and CBOs, associations of persons living with AIDS, religious organizations, and private sector to prepare and implement Programs that they propose. Funding are being allocated in line with the HIV/AIDS Fund Guidelines which detail the eligibility criteria, application process, responsibilities and accountabilities and monitoring and evaluation requirements of proposals.

Specifically this component:

1. Supports the design and implementation of a revised HIV/AIDS Guideline expanding and scaling up the non-public sector response to HIV/AIDS.

The project supports strategic expansion of civil society activities to promote HIV counseling and testing (HCT), behavior change communication (BCC), condom social marketing and universal precautions, increases support to people living with HIV/AIDS (PLWHA), orphan and vulnerable children (OVC) and better target high risk behaviors and high risk groups.

The project links World Bank-supported capacity-building interventions for NGOs and CSOs with DfID

funded technical assistance activities.

2. Receives complementary capacity building support through Component 3. The capacity building exercise under Component 3 defines the roles and skill sets required of i) NACA / SACAs, and ii) CSOs to effectively deliver this component. The capacity of SACAs and NACA are being strengthened to utilize data from surveys to target NGO activities to high-risk groups and geographic hot spots and to identify best practice models for scale up. The capacity of CSOs is being addressed through trainings in core functions including strategic planning, resource mobilization, M&E, fund management, governance and leadership.

3. Provides funding to civil society networks through a separate dedicated funding line. Funding were awarded following a call for proposals to deliver a set of agreed deliverables capitalizing on network capacity to identify and scale up best practice models, sustainability planning, conduct outreach to communities to ensure equitable and widespread information on the HAF and its procedures and assisting, to build smaller CSO project management systems and proposal writing.

4. Provides support for private sector HIV/AIDS service provision. Project 1 successfully supported a range of private sector actors including several networks of private sector companies interested in HIV/AIDS. This project is providing targeted support to catalyze and to strengthen HIV/AIDS prevention, treatment care and support programs in the private sector, through a separate call for proposals under the HAF.

3.2.3 Component 3: Strengthening mechanisms for project coordination and management

Evaluations of Project I have demonstrated its success in building the institutional capacity of the public and private sector, as well as the capacity of the national and state project teams to fulfill their coordination mandate.

The component supports a cohesive approach to capacity building with the objectives to deliver strengthened evidence-based planning, increased coordination, harmonization and alignment by all stakeholders, and stronger, sustainable and more responsive HIV/AIDS financing and programming.

It builds from the institutional structures established under Project 1, draws from lessons learned and scales up existing effective capacity building models; it complements existing technical support from other partners and identified and capitalizes on institutions in country that can address generic systems and individual capacity building needs.

The component supports i) a bottom up exercise to identify core competencies and skills sets required by the key actors of the national response (local organizations and NGOs, LACAs and LGAs, line ministries, SACAs and NACA); ii) the assessment of capacity gaps across sectors and administrative levels; and iii) the subsequent identification and roll out of various mechanisms to address the identified needs. This comprises a multifaceted approach including assessing and accrediting selected training organizations with the capacity to deliver both theoretical and practical work base related programs; strengthening Technical Working Groups; identifying and scaling up existing effective models including flexible short and long term TA; mentoring; and Training of Trainers (TOT).

The component also provides strengthened support to NACA in its stewardship role in giving technical support to States to identify the capacity gaps of implementers and SACAs, and to subsequently address them. It ensures that capacity building is linked to the delivery of national priorities and agreed work plans.

3.3: Project Activities

Since the MTR in November 2013, the project has continued to raise the tempo of its activities with resultant achievements. Annex 2 presents a snapshot of ongoing activities resulting from decisions taken during the November 2014 and March 2015 ISMs. To-date, overall disbursement has risen above 50% and is rising steadily as disbursements are made following workplan approvals for NACA, SACAs and other implementing partners. The June 2015 Implementation Status and Results Report indicates that of the six outcome indicators, four indicators have already been met or are close to meeting their end of project targets. These Include: (i) the percentage of young women and men aged 15-24 reporting the

use of a condom during the last sexual intercourse with a non-regular partner of those reporting sexual intercourse with a non-regular partner in the last 12 month is currently at 43% for women (compared to 34.3% at baseline) and 61.2% (up from 52.2% at baseline) for men; (ii) the percentage of Female Sex Workers – FSW- (brothel-based and non-brothel-based) reporting consistent condom use with casual partner in the last 12 months is currently at 70.2% for brothel-based FSW (compared to 68% at baseline) and 62.4% for non- brothel-based FSW (compared to 61% at baseline); (iii) the number of women and men aged 15-49 who received an HIV test in the last year and who knew their results rose from 2,287,805 at baseline in 2010 to 6,448,480 last year in 2014, representing a 182% increase; and (iv) number of pregnant women living with HIV who receive a complete course of antiretroviral prophylaxis to reduce the risk of Mother To Child Transmission (MTCT) is 63,350 which has already surpassed the end of project target of 40,000.

Chapter 4

Existing Management of Environmental and Social Concerns of HPDP2

4.1 Introduction

The audit exercise utilized survey questionnaires, telephone conversations and one-on-one meetings and interviews to gather information from stakeholders in all the participating States in order to determine existing environmental and social concerns. Field visits were conducted to relevant sites for visual appreciatiaon and assessment of issues of interest.

4.2 Management and Cordination of Environmental and Social Safeguard Issues

NACA has the primary responsibility to ensure that the project meets all its obligations on safeguard issues with support from SACA. However, in doing this, as recommended by the ESMF and WMP, the Federal Ministry of Environment and the State Environmental Protection Agencies/State Ministries of Environment are copted to ensure this responsibility is met at the Federal and State levels, respectively. There is however no documentation to suggest that the FMEnv and the SEPAs/State Ministries of Environment have been involved in Safeguard implementation and Compliance Monitoring and reporting as envisaged in the project documents`such as the WMP.

With respect to the implementation of the Medical Waste Management Plan (WMP), it is recommended that each PIU (SACA) recruit an environmental specialist/consultant on a part time basis that will be responsible for following up the recommendations of the WMP. This was not the situation during the audit.

However, as revealed during the audit, NACA and all SACAs with the exception of Imo and Bayelsa States with staffing difficulties, have appointed staff as safeguards desk officers. The list of States Project level Safeguard Desk Officers is presented in Annex 4.

Coordinating activities between SACAs and Project Partners, especially with regard to safeguard issues require much to be desired, as there was not evidence of any such collaboration or coordinations. Overall, there is poor linkage with other line MDAs to ensure safeguard compliance.

At the Health care Facilities level, Waste Management Committees are to be constituted to ensure adequate and appropriate health care waste management in their respective facilities.. The audit revealed that virtually all the health facilities have not constituted this all-important committee, respectively

4.2.1 Level of Institutional and Capacity Building on Safeguards

Institution and capacity building are significant components of World Bank's lending operations. The audit revealed that this aspect of the project management was generllay at very low ebb as safeguards training activities on environmental management principles were hardly carried out.

The safeguards desk officers appointed by NACA and SACA do not seem to have a good grasp of the safequards requirements of the project.

The level of familiarity with the relevant safeguard documents of the project amongst project staff and other stakeholders are generally low (Table 4.1).

Table 4.1: Assessment of Safeguards Awareness and Compliance Amonsgt Stakeholders

Issues	Number	%
Awareness of legal provisions underpinning HPDP II	240	12.5
Awareness of the World bank Safeguard policies	248	12.9
Those with the legal documents of HPDPII	100	5.2
Those familiar with Environmental and Social management Framework for HPDPII	214	11.1
Those familiar with HPDPII Waste Management Plan	220	11.5
Those in possession of copies of the ESMA and WMP	149	7.8
Those who have received formal training in ESMP development	58	3.0
Those who regularly monitor compliance with safeguards requirements	136	7.1
Those who have discussed the ESMP and WMP with Partners	146	7.6
Those who have participated in any World bank implementation support mission for HPDPII	172	9.0
Those who showed evidence of participation in such mission	162	8.4
Those who report regularly on safeguards	78	4.1
Those who presented evidence of such reports	61	3.2
HPDPII access to active incinerator in states	96	5.0

The WMP outlined the following as part of consultation strategies for information dissimenation on safeguard issues, especially waste management for the project:

- Develop and distribute a project newsletter

- Develop presentations and organize seminars and workshops

- Develop and maintain a project web site

- Develop radio and television adverts

- Establish and maintain a project telephone information line

- Prepare project press releases

- Prepare posters and erect billboards.

No evidence was provided on the execution of this by the project in the course of the audit as they relate to safegaurd issues.

4.3 Environmental Safeguard Instruments and Records

To ensure compliance with relevant safeguard policy, Environmental and Social Management Framework and HIV/AIDS Medical Waste Management Plan were prepared and disclosed for the HPDP II to guide implementation of projects at the outset. Since then, no other safeguard instruments such as site-specific ESMP, safeguard montiring records, etc have been prepared for any sub-project activities as

revealed during the audit. Also, regular reports from the project do not contain sections devoted to discussing environmental and social issues.

4.4 Project& Contractors Adherence to Environmental Due Diligence

nsertions of safeguard clauses to ensure compliance by Contractors are usual in the Scope of work contracts as provided for in the ESMP/WMP to ensure adherence in the course of work. No records were provided in the course of the audit at NACA or SACA level to ensure adeherence to safeguard due diligence.

4.5 Record Keeping

There were no maintained records or documentation of Environmental and Social concerns or management for any aspect of the project at all levels. For instance, no available scorecards to show compliance by the various health care facilities facilities/contractors to safeguard issues and particularly to the management/movement of health care waste.

4.6 General Safeguard Issues & Adequacy of Appropriate measures taken

The project, although designed to strengthen institutional capacity to deal with HIV/AIDS generates medical wastes as well as small site-specific negative environmental and social impacts related to construction and rehabilitation of health facilities. Unfortunately, against stipulations by the World Bank safeguard policies and existing national regulations, the Medical Waste Management Plan (MWMP) prepared to address current medical waste management problems and the Environmental and Social Management Framework (ESMF) to address small environmental and social impacts associated with the rehabilitation and construction of health related infrastructures, are poorly communicated and therefore not receiving full implementation. For instance, while categorizing and segregating medical wastes received over 67% implementation amongst the health facilities sampled, there are major gaps in the area of storage, collection and disposal of medical waste. Most of the wastes, including potentially hazardous ones, are currently treated in less than acceptable ways with some simply carted away by third party agents and dumped onto open municipal dumpsites. Measures in place for tackling these challenges such as colour coding of waste receptors, establishment of waste management committees, use of appropriate PPE and appropriate equipment for waste treatment, are not adehered to

4.7 Safeguard Monitoring

There is no evidence that State Environmental Protection Agencies/State Ministries of Environment are aware of or are practically involved in HPDP II Projects in the preparation and approval of ESMPs for sub-projects in the entire project States. Similarly, there is no evidence of conscious monitoring of Safeguard issues even though SACA Project Team leaders have all been repeatedly required to act in compliance since the MTR in November 2014. The major challenge appears to be that the Safeguard Officers designated in different States (See Annex 4), who are not as yet familiar with the Medical Waste Management Plan and the ESMF developed for the Project (See Table below) with some claiming not to have sighted it before the audit.

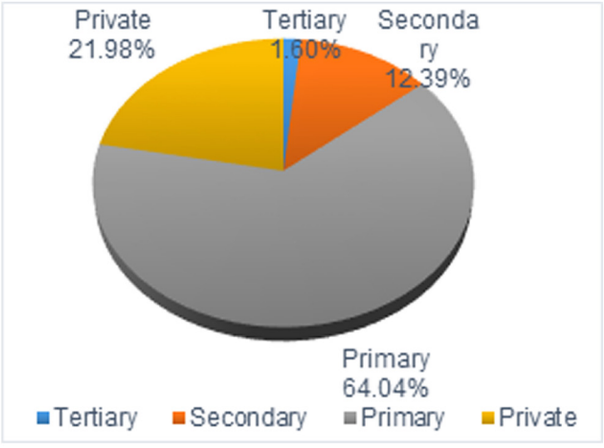
Chapter 5
Report of Specific Site Inspection

5.1 Introduction

This chapter presents the findings from the field assessments and surveys carried out to address the terms of reference for this assignment.

5.2 Sites Visited

The number of Health Care Facilities visited per State was estimated from the total number Health Facilities available as contained in the National Master Facility List for HIV/AIDS Services in the country (June 2014) as earlier discussed in Chapter 1. Nationwide, there are 7, 667 Health Care Facilities out of which the audit focused on 1,921. The list of these facilities visited is shown in annex 7.



The distribution of HCFs in the states is presented in Table 4.1 and inferences were drawn from this sample size since the original sample size was inflated by 10%. Furthermore, findings indicated that the majority of HCFs sampled in the audit were primary healthcare facilities (64.1%) followed by private health facilities (22.0%) Figure 3.

5.3 General Environmental and Social Baseline Conditions

5.3.1 Waste generation, characterization and disposal in Health facilities

Table 5.1 presents the percentage distribution of healthcare facilities according to waste generation, characterization and disposal methods employed in the healthcare facilities. Findings indicate that 87.3% of sampled HCFs generated infectious wastes, while the wastes generated were identified and characterized in 89.2% of these facilities. Further analysis indicated that while 88.7% of the sampled HCFs had biohazard and sharp containers in place, only 22.2% of the facilities had standard incineration facilities for proper treatment of hazardous waste. In all, audit findings indicate that nearly 30% of HCFs are not in a position to dispose of their infectious wastes properly. State level analysis (annexes 1 - 4) indicates that only 50.0% or less of healthcare facilities in Katsina, Kebbi and Gombe states could identify and characterize wastes. Similarly, half or less of the responsible personnel in healthcare facilities in Benue (39.6%), Gombe (32.8%), Katsina (50.0%) and Oyo (44.3%) were familiar with recommended methods for waste characterization. Findings also indicated that few healthcare facilities in Katsina (33.3%) and Oyo (55.7%) states had biohazard and sharp containers at the time of the audit. Furthermore, less than 10.0% of healthcare facilities in Abia (2.6%), Akwa-Ibom (5.4%), Anambra (7.5%), Benue (8.2%), Cross River (6.4%) Lagos (4.9%) and Ogun (6.7%) had incineration facilities in the health facility.

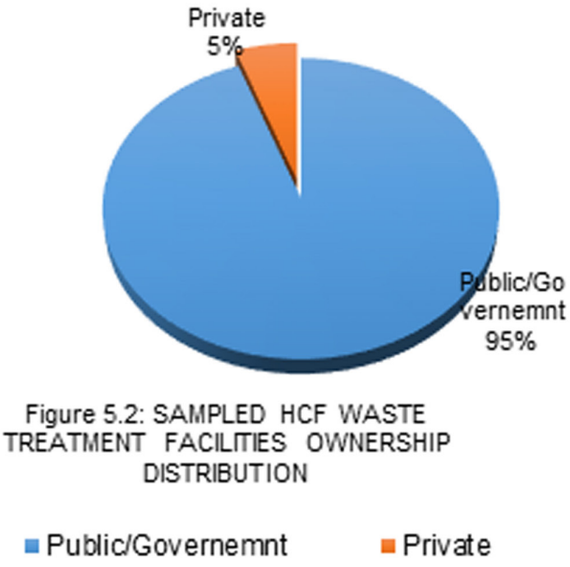


Figure 5.2: SAMPLED HCF WASTE TREATMENT FACILITIES OWNERSHIP DISTRIBUTION

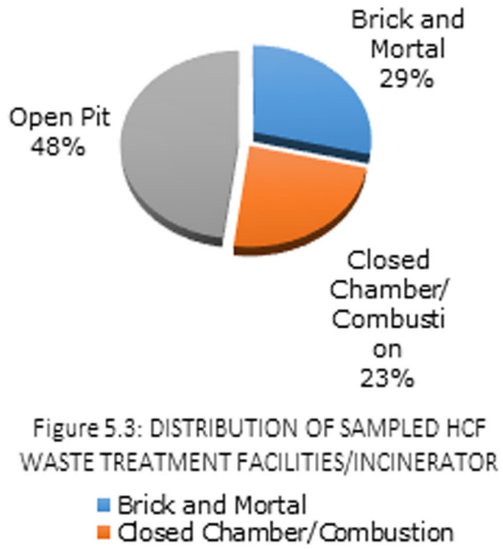


Figure 5.3: DISTRIBUTION OF SAMPLED HCF WASTE TREATMENT FACILITIES/INCINERATOR

Table 5.1 Percentage distribution of Health facilities according to waste generation, characterization and disposal methods

Characteristics of health Facility	Identify and characterize wastes	Generate hazardous waste	Familiar with recommended methods for waste characterization	Can demonstrate management of waste	Generate universal waste	Manage& recycle Universal wastes	Generate infectious waste	Have biohazard and sharps containers	Have incineration facility	Incinerator owned by project Partner	Disposing infectious waste properly	Generate waste banned from landfill	Recycling banned wastes
Type of facility													
Tertiary	96.7	100.0	90.0	82.1	93.3	82.1	96.7	100.0	76.7	35.7	90.0	71.4	55.6
Secondary	87.2	85.9	79.8	67.4	82.3	62.7	87.0	91.0	36.5	18.8	71.8	48.3	27.1
Primary	89.0	83.7	80.3	62.0	81.6	50.8	86.9	87.8	19.5	12.7	72.4	43.3	27.5
Private	90.4	83.1	80.2	69.9	81.8	55.6	88.2	89.0	18.1	13.4	73.2	52.1	26.5
Location													
Rural	88.7	84.4	79.2	60.3	83.5	51.6	87.8	86.9	18.7	12.2	70.9	46.7	31.0
Urban	89.9	83.7	82.1	70.8	79.7	56.8	86.7	91.1	27.1	16.8	75.3	45.8	22.8
Geo-Political Zone													
North East	67.8	71.2	51.7	52.0	52.1	45.0	65.5	95.7	19.0	7.9	49.6	41.7	12.7
North West	87.0	81.9	71.7	64.4	70.4	43.9	64.5	80.1	45.9	17.1	69.0	35.7	22.4
North central	85.9	82.5	74.6	75.7	80.1	65.5	90.0	85.4	27.4	15.1	72.1	47.7	33.9
South East	94.6	85.7	86.8	55.0	97.3	48.9	95.9	90.0	19.9	11.9	73.1	50.7	29.9
South West	82.9	83.2	76.3	66.7	77.5	61.5	84.8	85.9	15.0	8.6	75.6	28.2	10.3
South South	95.3	88.1	91.0	65.0	82.2	49.2	90.6	92.6	15.6	18.8	78.4	51.8	30.2
Total	**89.2**	**84.1**	**80.4**	**64.7**	**81.9**	**53.8**	**87.3**	**88.7**	**22.2**	**14.0**	**72.7**	**46.3**	**27.6**

5.3.2 Emergency preparedness and response (EPR)

Table 5.2 presents the percentage distribution of healthcare facilities' preparedness to respond to emergencies. Audit findings indicate that less than a quarter of HCFs had written emergency plans (22.6%), 23.7% had trained emergency coordinator, 18.0% had personnel experienced enough to test EPR programme in the facilities. However, a little higher proportions had trained personnel with specific response task (30.5%), 41.8% facilities reported that all project staff were aware of emergency actions and 25.1% had clean up materials.

State level analysis indicates that a number of states (Abia (9.2%), Adamawa (0.0%), Anambra (8.4%), Gombe (5.1%), Kebbi (0.0%) and Osun (7.1%)) had trained emergency coordinators in less than 10.0% of the healthcare facilities visited. Similarly, Bauchi and Gombe states reported very low proportions of healthcare facilities where project members of staff were aware of emergency actions to take when needed. Findings further suggested that less than 10.0% of healthcare facilities in Bayelsa (8.1%), Jigawa (0.0%), Kebbi (0.0%), Taraba (7.7%) and Zamfara (8.3%) had clean-up materials to handle spillages. Furthermore, audit findings indicated that very few healthcare facilities in most states met MWM requirements for handling hazardous wastes. The states that were most affected include Adamawa (0.0%), Anambra (0.9%), Bauchi (0.1%), Delta (7.7%), Edo (4.5%), Ekiti (0.0%), Gombe (1.7%), Kebbi (0.0%), Kogi (8.6%), Ondo (6.7%), Oyo (1.8%), Plateau (5.2%), Rivers (7.7%), Taraba (0.0%) and Zamfara (8.3%).

Table 5.2 Percentage distribution of health facilities according to their preparedness to respond to emergencies

Characteristics of health Facility	Have written emergency plan	Have a trained emergency coordinator	Have trained personnel with specific response task	Have spill clean-up materials	All project staff aware of emergency actions	Have exercise to test EPR programme	Meet local limits for pollutants waste
Type of facility							
Tertiary	66.7	65.5	69.0	69.0	85.7	62.1	48.0
Secondary	36.9	41.3	45.5	34.4	48.7	25.3	17.5
Primary	17.6	18.8	24.9	21.3	37.0	14.4	15.3
Private	25.5	24.3	35.0	27.6	48.3	20.7	17.4
Location							
Rural	18.6	21.3	25.1	22.1	38.2	16.6	15.0
Urban	47.5	27.0	37.9	29.3	46.6	19.9	18.8
Geo-Political Zone							
North East	10.7	12.7	19.5	19.3	20.7	6.8	1.8
North West	24.5	17.1	20.1	22.6	32.5	15.9	16.0
North central	19.5	36.0	44.0	32.7	54.3	20.6	12.1
South East	16.4	11.3	14.1	15.6	19.7	11.1	14.5
South West	29.5	32.2	36.9	23.5	53.7	18.8	10.2
South South	30.3	25.5	37.3	29.5	55.1	24.9	29.2
Total	**22.6**	**23.7**	**30.5**	**25.1**	**41.8**	**18.0**	**16.5**

5.3.3 Structures and systems in place in support of safeguard management

Audit findings in Table 5.3a show that an appreciable proportion of sampled healthcare facilities across the country have structures and systems in place to support health, safety and environmental (HSE) programmes. For instance, 44.5% of all sampled health facilities had comprehensive written HSE programmes, while 41.4% had responsibility for HSE programmes delegated to a person or office.

Furthermore, 45.5% of these healthcare facilities had accountability system in place for ensuring staff comply with HSE programme while 48.8% had communication system that provides affected staff with the platform to report grievances. Further audit findings also indicated that 47.6% of healthcare facilities had a system in place to identify and evaluate workplace hazards. Other systems in place in some healthcare facilities to support HSE programmes include the periodic inspection of HSE schedules by managers (48.9%), keeping of inspection records for unsafe practices (32.2%), keeping of incident and accident investigation programme (26.5%). Additionally, some HCFs also had other structures in place to support HSE programmes in healthcare facilities including institutionalization of immediate correction of unhealthy conditions or practices (69.2%), and the training of all new staff on HSE (62.5%). State level analysis of the structures and systems in place to support HSE indicate that HCFs in majority of the states reported sub-optimal proportions in all the variables of interest as seen in Annex 3. Results were particularly poor in HCFs located in rural compared to urban Locations and in facilities in the North East zone (Table 5.2). Findings in Table 5.3b indicated that additional systems in place in some healthcare facilities include provision of personal protective equipment, which is used and maintained in 68.3% of cases. Written standard operating procedure on the other hand, is available only in 33.4% of HCFs. Restrooms and washrooms are kept clean and sanitary in 86.9% of cases but fire extinguishers are mounted in accessible locations in much less (42.9%) and, even worse, members of staff are trained in use of fire extinguisher only in 33.4% of sample HCFs.

Table 5.3a Percentage distribution of health facilities according to presence of structures to support SHE programme

Characteristics of health Facility	Facility have comprehensive written HSE programme	Responsibility for HSE programme delegated to person/office	All project staff carry out HSE responsibilities	Accountability system for ensuring staff comply with HSE programme	A system that provides communication with affected staff	A system to identify and evaluate workplace hazards	Periodic inspection for HSE schedules by managers	Inspection records kept for unsafe practices and conditions	Have incident and accident investigation programme	Unhealthy conditions corrected immediately	Staff know health hazards specific to job	Training provided for all new staff
Type of facility												
Tertiary	79.3	82.8	90.0	76.7	80.0	83.3	86.2	65.5	76.7	89.7	93.3	83.3
Secondary	51.4	57.2	63.2	55.4	57.6	56.4	58.5	40.4	38.2	74.9	81.2	63.6
Primary	42.9	37.7	54.1	42.1	45.0	45.0	45.3	30.7	20.9	66.7	73.1	60.4
Private	44.2	40.5	55.1	47.5	52.4	47.5	51.1	34.0	32.8	74.9	77.9	66.5
Location												
Rural	43.6	38.8	53.9	42.3	45.7	46.2	46.0	32.2	22.5	64.4	69.3	59.6
Urban	46.6	45.1	59.0	49.9	53.2	49.6	52.9	34.6	32.2	77.5	84.1	66.6
Geo-Political Zone												
North East	16.1	21.6	30.3	25.6	27.7	21.2	26.1	13.6	12.7	45.4	59.7	34.5
North West	34.2	37.3	44.2	34.0	40.0	36.9	46.3	30.2	17.5	60.6	72.3	46.9
North central	51.0	66.3	76.3	63.3	67.2	62.4	67.1	34.7	36.6	80.6	87.1	69.3
South East	28.9	18.2	36.4	24.2	31.3	27.5	33.3	22.7	10.2	58.9	63.0	54.0
South West	50.6	45.1	54.0	40.4	47.4	46.1	43.7	34.8	26.9	69.5	73.4	65.8
South South	62.7	44.6	66.9	60.1	57.4	63.9	55.6	47.1	39.1	80.1	82.5	75.5
Total	**44.8**	**41.4**	**56.0**	**45.5**	**48.8**	**47.6**	**48.9**	**33.2**	**26.5**	**69.9**	**75.5**	**62.5**

Table 5.3b Percentage distribution of health facilities according to presence of structures to support SHE programme

Characteristics of health Facility	Alarm system maintained and tested regularly	All work areas properly lighted	Work areas ventilation appropriate for work	Personal protective equipment provided, used and maintained	Written standard operating procedures provided	Restrooms and washrooms kept clean and sanitary	All water provided potable	All water outlets clearly identified	Health Facility has written fire prevention plan	Fire alarm system tested as required	Fire extinguishers mounted in assessable locations	Fire extinguishers recharged regularly	Staff trained in use of fire extinguishers
Type of facility													
Tertiary	65.4	93.1	100.0	90.0	80.0	93.3	90.0	70.4	76.7	77.8	92.9	90.0	73.3
Secondary	28.8	81.0	89.6	75.0	44.4	91.6	77.3	72.0	35.7	25.5	63.0	43.8	47.0
Primary	11.8	62.0	75.5	63.6	25.8	84.4	67.4	59.0	17.9	11.4	30.7	22.2	21.1
Private	30.7	80.8	86.0	76.8	45.5	91.2	82.1	66.9	35.3	28.0	61.8	53.3	50.7
Location													
Rural	12.9	61.7	76.0	63.8	26.1	83.4	66.9	58.8	19.2	12.5	33.8	34.7	26.2
Urban	27.5	79.0	85.6	74.5	43.4	91.8	79.5	67.6	32.8	25.5	55.1	54.9	42.7
Geo-Political Zone													
North East	11.3	68.9	74.4	50.4	17.9	79.6	76.9	57.4	19.1	11.2	30.0	32.1	17.0
North West	18.8	57.9	70.9	61.1	25.3	77.6	70.5	68.0	19.4	11.6	33.6	31.5	22.8
North central	15.7	70.7	84.6	71.1	37.8	88.1	79.4	680.	20.1	16.2	50.9	48.6	30.1
South East	10.2	61.4	78.4	62.1	26.2	80.3	55.9	42.7	15.2	11.0	27.0	28.1	22.5
South West	20.9	82.2	87.1	65.6	38.2	90.3	64.7	56.1	34.2	20.9	51.4	500.	42.4
South South	31.7	73.0	79.1	79.4	40.4	95.1	82.8	77.1	38.1	29.3	54.1	58.0	51.7
Total	**19.0**	**69.0**	**80.1**	**68.3**	**33.4**	**86.9**	**72.3**	**62.5**	**25.0**	**18.0**	**42.9**	**43.4**	**33.4**

5.3.4 Management support for HSE programme

Table 5.4 presents the distribution of healthcare facilities in the states according to management support for Health, Safety and Environment (HSE) programmes in the states. Results indicate that top management in only 48.3% of HCFs were committed to injury and illness prevention in the work place, even though 63.4% of all the HCFs provide first aid kits and placed such kits in easily accessible work areas. Jobs were assessed for hazards that require personal protective equipment (PPE) in 53.9% of the sampled HCFs. Training on the use, care and disposal of PPE was conducted and recorded in less than half (40.5%) of the HCFs. Unsurprisingly, all PPE are maintained in sanitary condition ready for use in only 36.5% of HCFs. The proportions of these indicators were reported low in Abia, Adamawa, Anambra, Bayelsa, Gombe, Imo, Kebbi, Osun and Oyo states.

Table 5.4 Percentage distribution of Health facilities according to management support for HSE

Characteristics of health Facility	Top management is committed to injury and illness prevention	First Aid kits easily accessible to work areas	Jobs assessed for hazards that require PPE	Hazard assessments properly certified	Training on use, care and disposal of PPE conducted and recorded	All PPE maintained in sanitary condition ready for use	Lunches eaten in areas of no health hazards
Type of facility							
Tertiary	83.3	86.2	89.7	62.1	69.0	100.0	75.9
Secondary	62.6	63.2	66.7	40.6	49.1	79.5	67.4
Primary	41.5	60.6	49.3	38.4	33.0	75.5	62.3
Private	57.6	70.4	57.6	44.8	37.8	88.4	68.0
Location							
Rural	42.1	60.6	48.6	38.2	31.4	75.8	61.8
Urban	56.9	67.4	61.3	43.7	43.8	83.9	68.0
Geo-Political Zone							
North East	26.1	24.8	39.0	13.9	22.4	70.1	60.7
North West	48.4	49.0	46.2	30.4	23.6	59.5	54.8
North central	62.0	61.1	65.8	49.7	41.0	81.7	71.4
South East	24.9	62.2	27.1	29.1	19.9	82.8	49.3
South West	47.9	52.9	48.9	33.0	41.6	66.0	55.1
South South	62.4	84.2	74.9	55.0	53.0	87.5	78.4
Total	**48.3**	**63.4**	**53.9**	**40.5**	**36.6**	**79.2**	**64.4**

5.3.5 Employee practice and behaviour

The audit also assessed employee practice and behaviour in the work place and the generally pleasant findings are presented in Tables 5.5 and 5.6 showing percentage distributions of findings at the state and zonal levels respectively. The single exception to the rosy picture of compliance in the employee practice and behaviour is that overall, while health workers in 54.9% of healthcare facilities were exposed to infectious fluids, potential exposures were identified and documented in only 41.2% of the HCFs. On an encouraging note, 60.2% of HCFs provided training and information to staff potentially exposed to body fluids in the work place and workers in 70.4% of the HCFs confirmed that infectious substances control procedures in place were appropriate. Similarly, staff in 82.3% of HCFs were aware of specific workplace practices to mitigate exposure when appropriate but staff in only 44.3% of HCFs were in a position to confirm that appropriate equipment were provided in the facilities for mouth to mouth resuscitation on infected patients. Personnel in most HCFs (88.1%) also opined that the work place environment was always cleaned and disinfected after contamination with blood. In addition,

infectious wastes were placed in closable and leak-proof holders in 71.1% of HCFs while medical surveillance and vaccination were made available to those exposed to infectious fluids. State specific findings are captured in Table 5.5, which shows that Adamawa, Bauchi, Katsina, Ondo, Plateau and Sokoto States are the worst with respect to employee safety as all workers are exposed hazardous substances. Of the lot, systemic support framework is lacking to support any worker in the event of an accidental infection.

Table 5.5 Percentage distribution of health facilities according to employee practice and behavior in the states

State	Are staff exposed to infectious body fluids	Infectious control procedures appropriate	Equipment to comply with workplace practice available	Work environment cleaned and disinfected after contact with blood	Infectious waste placed in closable, leak-proof holders	Medical surveillance and vaccination available to exposed staff
Abia	66.1	94.2	30.6	92.6	28.9	15.7
Adamawa	100.0	50.0	0.0	100.0	66.7	16.7
Akwa-Ibom	33.9	75.5	50.9	98.2	97.3	77.5
Anambra	36.4	52.3	37.4	93.5	84.1	29.0
Bauchi	100.0	75.0	47.4	100.0	68.4	20.0
Bayelsa	36.7	31.3	33.3	65.6	67.7	32.4
Benue	34.4	68.1	51.6	91.3	73.3	64.1
Bornu	75.0	75.0	100.0	75.0	62.5	37.5
Cross-River	63.5	75.4	49.1	99.2	87.8	67.9
Delta	62.5	64.2	56.4	90.1	76.8	25.0
Ebonyi	67.9	58.8	28.0	73.1	58.5	49.1
Edo	96.0	100.0	60.0	96.0	76.0	41.5
Ekiti	66.7	96.6	66.7	88.9	88.9	58.3
Enugu	38.6	96.6	34.8	98.9	73.9	62.5
FCT	47.8	61.2	42.5	92.2	85.7	25.8
Gombe	34.5	3.4	12.1	39.7	24.1	47.4
Imo	54.8	62.2	48.6	71.6	54.1	3.4
Jigawa	70.0	60.0	10.0	90.0	60.0	4.7
Kaduna	53.6	54.9	32.1	80.0	56.3	41.8
Katsina	100.0	50.0	33.3	83.3	33.3	0.0
Kebbi	57.1	62.5	50.0	62.5	25.0	0.0
Kogi	29.6	90.1	78.9	94.4	88.7	87.3
Kwara	53.3	66.7	86.7	100.0	86.7	60
Lagos	74.7	82.3	68.1	91.1	87.3	57.7
Nasarawa	32.3	79.0	53.2	82.3	79.0	50.0
Niger	52.8	63.9	52.8	80.6	38.9	41.7
Ogun	68.8	93.8	84.6	100.0	86.7	60.0
Ondo	100	80.0	21.4	93.3	93.3	80.0
Osun	64.3	64.3	35.7	78.6	78.6	50.0
Oyo	51.0	68.3	23.3	69.5	31.7	41.7

Plateau	100.0	100.0	21.8	98.9	96.6	57.3
Rivers	45.5	73.8	54.5	90.1	80.5	42.5
Sokoto	100.0	100.0	100.0	100.0	100.0	100.0
Taraba	65.4	46.2	23.1	100.0	65.4	34.6
Zamfara	46.2	76.9	38.5	76.9	50.0	38.5
Total	**54.9**	**70.4**	**44.3**	**88.1**	**71.1**	**47.4**

Table 5.6 Percentage distribution of Health facilities according to the work practice and behaviour of staff

Characteristics of health Facility	Are staff exposed to infectious body fluids	Potential exposure identified and documented	Training and information provided to staff potentially exposed to body fluid	Infectious control procedures appropriate	Staff aware of specific workplace practices when appropriate	Equipment provided for administering mouth-mouth resuscitation on infected patients	Equipment to comply with workplace practice available	Work environment cleaned and disinfected after contact with blood	Infectious waste placed in closable, leakproof holders	Medical surveillance and vaccination available to exposed staff
Type of facility										
Tertiary	83.3	83.3	86.7	100.0	100.0	83.3	100.0	96.7	83.3	76.7
Secondary	72.0	49.1	65.2	74.3	89.0	56.8	84.7	91.7	74.7	54.6
Primary	50.8	36.8	55.9	66.2	79.4	35.6	70.7	85.7	69.2	43.1
Private	55.1	46.6	68.1	78.1	85.7	59.4	84.5	92.6	74.0	53.7
Location										
Rural	51.0	37.0	56.5	66.6	78.2	37.8	70.5	84.9	68.1	40.9
Urban	60.4	47.0	54.5	75.5	88.0	53.4	83.5	92.7	75.3	56.4
Geo-Political Zone										
North East	58.5	23.5	30.8	32.2	65.3	25.0	67.8	68.6	45.3	16.1
North West	59.2	37.4	45.9	54.1	71.5	36.8	61.4	81.0	56.6	40.5
North central	50.8	40.3	66.6	78.3	87.6	50.3	83.4	91.7	81.3	59.9
South East	51.8	38.7	58.2	75.0	78.8	35.9	63.6	88.3	58.9	30.6
South West	67.5	42.9	65.8	77.8	83.4	47.8	80.9	83.9	69.4	53.9
South South	54.1	49.0	65.8	70.6	88.0	52.2	85.0	93.4	84.4	58.3
Total	**54.9**	**41.2**	**60.2**	**70.4**	**82.3**	**44.3**	**76.0**	**88.1**	**71.1**	**47.4**

5.3.6 Awareness and implementation of safeguard policies by SACA and Partners

The audit also assessed the awareness and implementation of SACAs and CSO in the various states and findings are presented in Table 4.1. Overall, the awareness of the World Bank Safeguard policies was only 12.9% amongst SACAs and CSOs. Only 5.4% of respondents could provide verifiable evidence of familiarity with the legal documents of HPDP II. Respondents who were familiar with Environmental and Social Management Framework for HPDP II were very few (11.1%), the number of opportunities utilised by the project to reiterate the importance of safeguards compliance notwithstanding. Similarly, only a few respondents (11.5%) were familiar with the HPDP II Waste Management Plan and only 7.8% were in possession of copies of the ESMF and WMP. Unsurprisingly, only this proportion of respondents had discussed the ESMF and WMP with Partners. Furthermore, only 5.0% of respondents from Partner organizations had access to active incinerators in the states.

5.3.7 Environmental and social issues associated with HPDPII projects in the states

Table 5.7 presents the percentage distribution of respondents' perception of environmental and social issues encountered due to proximity to dump sites or incinerators. About a quarter (26.3%) of respondents opined that odour from the dumpsites was a problem. A higher proportion (54.2%) indicated that the general atmosphere appeared unfit for human habitation. 21.7% of respondents claim to make a living indirectly from the dump sites. 16.2% were of the opinion that traffic due to waste trucks was a problem and 57.2% of all respondents expressed unhappiness about the location of the various improvised incinerators.

Taken together with findings in the previous sections, poor waste management practices, weak emergency preparedness and response mechanisms and plans, poor attention to details in the disposal of potentially hazardous wastes, all combine to expose workers within the HCFs, visitors to the facilities, as well as members of the immediate community neighbouring the facilities, to dangers of secondary infection.

Characteristics	Odour from dump site a problem	Leachate from dump site a problem	Traffic due to waste trucks a problem	General atmosphere appear unfit for human habitation	Not Happy about the incinerator location	Not Comfortable with the visual sight/aesthetics of site	Aware that waste from dump facility is being processed	Employed by the facility	Earn indirectly from the dump site	knowledge of what is made at the compost facility	Use compost from the facility
Gender											
Male	35.0	32.0	24.1	38.1	68.7	64.7	73.1	17.2	17.8	19.5	5.4
Female	32.0	20.3	20.3	64.9	47.4	40.0	48.8	14.0	16.3	23.3	4.8
Location											
Rural	28.1	23.7	18.4	40.7	75.3	70.2	75	6.2	8.2	11.3	5.2
Urban	38.3	31.7	27.2	50.3	55.9	52.9	64.3	21.7	21.9	24.2	3.9
Distance from HPDPII site											
≤5 KM	53.1	46.9	32.7	65.6	56.1	53.5	60.2	29.5	31.8	29.5	6.8
>5KM<10KM	11.7	5.0	3.4	11.7	87.8	88.0	90.2	3.9	5.9	5.9	3.9
>10KM	15.5	7.0	6.9	41.4	78.4	72.0	76.3	7.9	5.3	10.5	2.6
Geo-political Zone											
North East	39.3	35.7	30.4	53.6	62.5	61.5	92.9	35.7	29.3	53.7	20.0
North West	33.1	27.6	24.6	60.3	53.4	48.4	48.4	28.7	26.6	20.3	10.9
North Central	21.0	14.5	10.1	53.0	70.0	66.5	73.2	14.7	20.8	25.6	11.4
South East	33.3	22.2	11.1	55.6	44.4	50.0	50.0	25.0	12.5	12.5	12.5
South West	21.0	12.5	12.7	49.4	20.0	8.9	8.0	9.6	7.7	7.8	2.0
South South	31.3	13.3	12.5	50.0	40.0	58.3	61.5	7.7	23.1	7.7	7.7
Total	**26.3**	**19.6**	**16.2**	**54.2**	**57.2**	**53.3**	**59.1**	**20.4**	**21.7**	**23.7**	**10.8**

5.3.8 The participation of social Networks/CBOs in HPDPII activities

The audit also assessed the participation of Social Network/Community Based Organizations in HPDP II activities. The findings are reported in Table 5.8. Overall, more than half of the respondents (> 50%) have participated in, and benefited from HPDP II activities. While there do not appear to be clear-cut gender or rural-urban dichotomy in this regard, there is a distinct geopolitical tilt with the North West lagging behind other zones in the spread of HPDP II coverage. On feedback mechanisms in place for reporting grievances, 49.0% of respondents indicated that HPDP II officers were accessible to community members in the event that they had complaints. A little over half of them are not satisfied and this represents a lot of room for improvement. The audit also involved the conduct of interviews with HCF staff and other stakeholders. The list of individuals interviewed is shown in annex 8.

Table 5.8 Percentage distribution of social Networks/CBOs according to their participation in HPDPII programme

Characteristics	Participate in HPDPII project	The community has benefitted from HPDPII	HPDPII Officers are easily accessible to community members	HPDPII activities are well known in the community
Gender				
Male	60.2	77.0	76.6	69.5
Female	47.8	61.8	54.4	50.0
Location				
Rural	50.0	74.1	72.2	71.3
Urban	59.9	70.9	68.4	58.6
Geo-political Zone				
North East	29.8	40.0	53.5	34.9
North West	22.7	33.1	24.6	19.7
North Central	44.7	66.8	56.9	50.0
South East	100.0	87.5	87.5	100.0
South West	56.2	67.6	63.5	59.5
South South	46.2	54.5	36.4	16.7
Total	**40.0**	**55.5**	**49.0**	**41.9**

Additionally, of the 35 participating states and FCT, 12 states were known to work with injectable drug users, 3 with persons with disability and 12 with men that have sex with men. The audit held discussions and consultations with project beneficiaries such as women, IDUs, MSMs and FSWs (Figure 4). Most of the discussants confirmed that they participate in the HPDP II project as Peer group members or Peer educators. They also confirm that the project is meeting their needs but complained about the tendencies of inexperienced health workers to be hostile and unfriendly especially in the general population and hospitals.

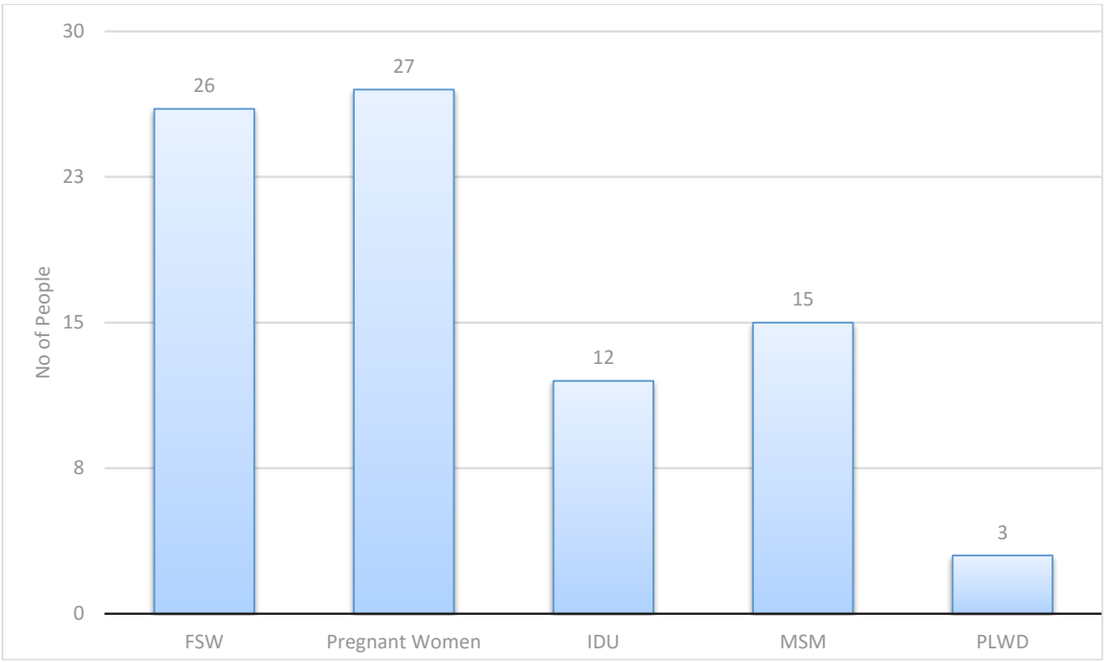


Figure 5.4: Number of people consulted in the audit

5.3.9 Waste Management practices in states with high HIV prevalence rates

The audit also assessed the waste management practices in states reporting high HIV prevalence in the 6 Geo-political zones, (NARHS, 2012). Findings are presented in Table 5.9. Findings suggest that 80.4% of healthcare facilities in the states were familiar with recommended methods of waste characterization, while responsible personnel (64.2%) in the facilities could demonstrate the proper management of hazardous wastes with the woeful exception of Abia where only 37.2% of personnel could do so. Furthermore, findings suggested 88.7% of HCFs in these states had proper biohazard and sharp collection containers in place and potential exposure could be identified and documented in 41.2% of the health facilities in the states. Further analysis indicated that 70.4% of these healthcare facilities had instituted procedures for infectious control and provided PPE in 68.3% to healthcare workers. On the troubling side however, not only are potential hazards of infection not properly identified and documented, there are no written emergency preparedness plans and there isn't access to incinerators. Taraba and Kaduna states add to these negatives by not instituting infection control procedures.

Table 5.9 Percentage distribution of states with current high prevalence of HIV in the geo-political zones according to key waste management practices

Zone	State	HIV Prevalence*	Familiarity with recommended methods of waste characterization	Can demonstrate managing hazardous wastes	Generate medical wastes	Have proper biohazard and sharps collection containers	Have Incinerator	Have written emergency plans	PPE provided and used	Potential exposure identified and documented	Infection control procedures instituted
North East	Taraba	10.5	69.2	96.2	100.0	95.8	15.4	7.7	53.8	23.1	46.2
North West	Kaduna	9.2	67.6	61.9	55.6	85.8	45.0	20.9	65.5	30.0	45.9
North Central	Nasarawa	8.1	85.5	82.3	80.6	95.2	43.5	14.8	83.9	35.5	79.0
South East	Abia	3.3	81.0	37.2	88.4	79.2	2.6	5.8	50.4	76.0	94.2
South West	Ondo	4.3	80.0	66.7	100.0	93.3	60.0	46.7	100.0	66.7	80.0
South South	Rivers	15.2	90.6	75.0	62.4	89.4	38.6	29.1	81.0	34.2	73.8
Total			**80.4**	**64.2**	**87.3**	**88.7**	**22.2**	**22.6**	**68.3**	**41.2**	**70.4**

*NARHS 2012 Report

5.4 State-specific Environmental and Social Baseline Conditions

Table 5:10 State summaries of audit findings

(Depicted patterns are only slightly different from state to state as they share very similar strengths and weaknesses with respect to safeguards compliance)

S/No	States	Audit Findings
	ABIA	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers. There is partial compliance in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. There are non-conformities in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF), training of Safeguard Officers and partners. There is also partial compliance in appropriate hazardous waste storage and the use of protective gears. There was also an observed partial compliance with the safeguard standards on the disposal. No Compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste observed. Open air burning was noted as not discouraged in the State. It was observed that there is no environmental consultant/specialist recruited; effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.
	ADAMAWA	The State has appointed a Safeguard Desk Officer but needs to be trained. Regular meetings with partners exist. The State is Compliant in waste identification and characterization and provision of biohazards and sharps containers, partially compliant in familiarization with recommended method for waste characterization and in demonstrating waste management. There is non-compliance with availability of Waste Treatment Facility across the state. There are non-conformities in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF), training of Safeguard Officers and partners. There is also partial compliance in hazardous waste storage and the use of protective gears. There was ample evidence to suggest that safeguards standards on the disposal of HCW were not being complied with. No record of training was maintained on waste management and a knowledge gap on what was needed and when, was noted. HCF non-compliance with waste segregation from source was rampant. Non compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste was observed. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.

	AKWA IBOM	The State has appointed a Safeguard Desk Officer but needs to train him.The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers. There is partial compliance in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. There is conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance observed in waste Storage implies that unauthorised or inappropriate access to or contact with hazardous medical wastes were routinely likely. Luckily, the staff appear to be adept at the use of protective gears. No record of training was maintained on waste management, knowledge gap was noted. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning is common in the state. It was observed that there is no environmental consultant/specialist, effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.

	ANAMBRA	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers. There is partial compliance in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. Regular meetings with partners exist. There are non-conformities in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance was observed in waste storage and compliance in the use of protective gears. No record of training was maintained on waste management thus constituting a knowledge gap. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on waste disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Open air burning is common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was deficient. There are no waste management committees and sub-project ESMPs are not being prepared.

	BAUCHI	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers. There is partial compliance in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. Regular meetings with partners exist. There are partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance observed in waste Storage and compliance in the use of protective gears. Locally built Incinerators were in use, burn and bury sites were observed. Poor access control to waste dump site. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	BAYELSA	The State has no Safeguard Desk Officer. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, provision of biohazards and sharps containers and in the area of demonstrating waste management and non-compliant with availability of Waste Treatment Facility across the state. There is also partial compliance in Storage and no compliance in the use of protective gears. No record of training was maintained on waste management. Shredding and compaction of waste was available but not sufficient. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.

	BENUE	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners are held but they do not cover safeguards topics. The State is partially compliant in waste identification and characterization, provision of biohazards and sharps containers and in the area of demonstrating waste management and non-compliant in the familiarization with recommended method for waste characterization and availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is also a partial compliance in Storage and in the use of protective gears. No record of training was maintained. No compliance with waste segregation from source at health facilities in the state. There was also only an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.
	BORNO	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners exist but do not cover safeguards matters. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is a partial compliance in Storage and in the use of protective gears. No record of training was maintained. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was lacking.

	CROSSRIVER	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners exist but do not cover safeguards. The State is compliant in waste identification and characterization, familiar with recommended method for waste characterization, provision of biohazards and sharps containers and in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). No record of training was maintained. Burn and bury sites were observed. Poor access control to waste dump site. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist, non-compliance in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.
	DELTA	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners exist but do not cover safeguards. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, provision of biohazards and sharps containers and in the area of demonstrating waste management and non-compliance with availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is also partial compliance in Storage and compliance in the use of protective gears. No record of training was maintained on waste management. Shredding and compaction of waste is practiced. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was lacking. There are no waste management committees and sub-project ESMPs are not being prepared.

	EBONYI	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners exist. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers. There is partial compliance in the area of demonstrating waste management and availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is also partial compliance in Storage and in the use of protective gears. No record of training was. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	EDO	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners exist. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers, in the area of demonstrating waste management and non-compliance in the availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is also partial compliance in Storage and compliance in the use of protective gears. No record of training was. Incinerators, burn and bury sites were observed. Poor access control to waste dump site noted. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	EKITI	The State has appointed a Safeguard Desk Officer but needs to train her. Regular meetings with partners exist. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization and provision of biohazards and sharps containers, in the area of demonstrating waste management and partial compliance in the availability of Waste Treatment Facility across the state. There is conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is partial conformity in waste storage and compliance in the use of protective gears.No record of training was maintained on waste management, a knowledge gap was noted. Incinerators, burn and bury sites were observed. Partial compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; partial compliance in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.
	ENUGU	The State has appointed a Safeguard Desk Officer but needs to train her. Regular meetings with partners exist. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, provision of biohazards and sharps containers, in the area of demonstrating waste management and non-compliance in the availability of Waste Treatment Facility across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is also partial compliance in Storage and no compliance in the use of protective gears. Incinerators, burn and bury sites were observed. Poor access control to waste dump site was the norm rather than the exception. There was partial compliance with waste segregation from source. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	GOMBE	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliance in the provision of biohazards and sharps containers and Non-Compliance in waste identification and characterization, familiar with recommended method for waste characterization, in the area of demonstrating waste management and in the availability of Waste Treatment Facility across the state. There is Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is also partial compliance in Storage and no compliance in the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist, conformity on effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.
	IMO	The State has no appointed Safeguard Desk Officer. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, provision of biohazards and sharps containers, in the area of demonstrating waste management and non-compliance in the availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is also partial compliance in Storage and in the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	JIGAWA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliance in waste identification and characterization and partial compliance in familiarization with recommended method for waste characterization, in the area of demonstrating waste management, the provision of biohazards and sharps containers and in the availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is also partial compliance in Storage and compliance in the use of PPEs. No record of training was. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	KADUNA	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, in the area of demonstrating waste management and provision of biohazards and sharps containers. Partially familiar with recommended method for waste and non-compliance in the availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is partial conformity in waste storage and the use of protective gears. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	KANO	Not Participating in the Project

	KATSINA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is partially compliant in waste identification and characterization, familiarization with recommended method for waste, demonstrating waste management and availability of Waste Treatment Facility across the state and non- compliance provision of biohazards and sharps containers. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State.. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	KEBBI	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in familiarization with recommended method for waste and in the provision of biohazards and sharps containers. Partial conformity in waste identification and characterization. Non-compliance in demonstrating waste management and availability of Waste Treatment Facility across the. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. There is partial conformity in waste storage and the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; partial compliance in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.

	KOGI	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, demonstrating waste management and provision of biohazards and sharps containers and non-compliance with availability of Waste Treatment Facility across the state. Regular meetings with partners exist. There is Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance observed in waste Storage and Compliance in the use of protective gears. Partial compliance in training on waste management. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	KWARA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, in the area of demonstrating waste management and provision of biohazards and sharps containers. Partially familiar with recommended method for waste and non-compliance in the availability of Waste Treatment Facility across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and Compliance in the use of protective gears. Partial compliance in training on waste management. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Colour coded waste bin available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; partial conformity in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.

	LAGOS	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, demonstrating waste management and provision of biohazards and sharps containers and non-compliance with availability of Waste Treatment Facility across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance observed in waste Storage and Compliance in the use of protective gears. Medical Waste is collected by designated government authority and private operators. There is a system in place for medical waste management including segregation from source, handling and disposal. Regular training is provided to stakeholders. Health Care Facilities have colour coded bins to sort and dispose. Open air burning is discouraged. An impressive attempt at waste management was observed at the landfill sites. Colour coded waste bin available. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. Shredding and compaction observed but not adequate. The Health Care Facility ensures standard practices and materials for personnel protection. Sharps are managed according to stipulated guidelines (shredding)

	NASARAWA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste and provision of biohazards and sharps containers. Partial conformity in the area of demonstrating waste management and non-Compliance in the availability of Waste Treatment Facility across the state. There is no Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and Compliance in the use of protective gears. No record of training was maintained on safeguards. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Colour coded waste bin available. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor.
	NIGER	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in demonstrating waste management and provision of biohazards and sharps containers. Partially in waste identification and characterization and familiar with recommended method for waste and non-compliance in the availability of Waste Treatment Facility across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and Compliance in the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; partial conformity in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.

	OGUN	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste and provision of biohazards and sharps containers. Partial conformity in the area of demonstrating waste management and non-Compliance in the availability of Waste Treatment Facility across the state. There is no Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and Compliance in the use of protective gears. No record of training was maintained. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; partial conformity in effective communication with stakeholders on safeguard issues. There are no waste management committees and sub-project ESMPs are not being prepared.
	ONDO	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste and provision of biohazards and sharps containers. Partial conformity in the area of demonstrating waste management and non-Compliance in the availability of Waste Treatment Facility across the state. There is partial Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Regular meetings, workshops and stakeholders coordination with partners exist. Apart from compliance with safeguard policies on waste management, there were trainings on waste segregation and disposal. Medical Waste is collected by designated operators. There is a system in place for medical waste management including segregation from source, handling and disposal. Regular training is provided regularly to stakeholders. Incinerator, burn and bury sites observed in health facilities. Health facilities in the State were documented as compliant with waste segregation from source. There was also an observed partial conformity with the safeguard standards on the disposal. The use of Colour coded waste bin is ensured. Storage compliance and the use of protective gears were respectively noted as insufficient and inadequate. No record of training was maintained on waste management betraying the existence of a knowledge gap. It was observed that there is no environmental consultant/specialist; partial compliance in effective communication with stakeholders on safeguard issues. Partial compliance in Shredding and compaction. There are no waste management committees and sub-project ESMPs are not being prepared.

	OSUN	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization and provision of biohazards and sharps containers. Partial conformity in familiarization with recommended method for waste and in the area of demonstrating waste management and non-Compliance in the availability of Waste Treatment Facility across the state. There is no Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and Compliance in the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	OYO	The State has appointed a Safeguard Desk Officer but needs to train her. The State is partially compliant in waste identification and characterization, demonstrating waste management and provision of biohazards and sharps containers and non- compliance familiarization with recommended method for waste and availability of Waste Treatment Facility across the state. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. No compliance in waste Storage and the use of protective gears. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	PLATEAU	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste and provision of biohazards and sharps containers. Partial conformity in the area of demonstrating waste management and non-Compliance in the availability of Waste Treatment Facility across the state. There is no demonstrable familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance was observed in waste storage and the use of protective gears. No record of training was maintained on waste management and safeguards monitoring. Burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	RIVERS	The State has appointed a Safeguard Desk Officer but needs to train her. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, demonstrating waste management and provision of biohazards and sharps containers and non-compliant with respect to the availability of Waste Treatment Facilities across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance was also observed in waste storage and Compliance in the use of protective gears. No record of training was maintained on waste management. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well managed sanitary landfill site dedicated to medical waste. Poor access control to waste dumpsite. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. Shredding and compaction observed but not adequate. There are no waste management committees and sub-project ESMPs are not being prepared.

	SOKOTO	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste characterization, demonstrating waste management and provision of biohazards and sharps containers and non-compliance with availability of Waste Treatment Facility across the state. There is partial conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance observed in waste Storage and no Compliance in the use of protective gears. Incinerators, burn and bury sites were observed. Poor access control to waste dump site. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	TARABA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, in the area of demonstrating waste management and provision of biohazards and sharps containers. The staff demonstrated partial familiarity with recommended method for waste and non- compliance in the availability of Waste Treatment Facility across the state. There is Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance observed in waste Storage and the use of protective gears Burn and bury sites were observed. Poor access control to waste dumpsite. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bin not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	YOBE	The State has appointed a Safeguard Desk Officer but needs to train him. Regular meetings with partners do exist but the depths are doubtful as they do not cover safeguards issues. There is non-conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). There is also partial compliance in Storage and in the use of protective gears. No record of training was seen. No compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards related to the disposal of hazardous wastes and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. There is non-compliance with waste segregation from source at health facilities in the state. Colour coded waste bins not available. Open air burning was noted as common in the State. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.
	ZAMFARA	The State has appointed a Safeguard Desk Officer but needs to train him. The State is Compliant in waste identification and characterization, familiar with recommended method for waste and the availability of Waste Treatment Facility across the state. Partial conformity in the area of demonstrating waste management and provision of biohazards and sharps containers. There is no Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF) in the State. Partial compliance was observed in waste Storage and there was no evidence of compliance in the use of protective gears. Incinerators, burn and bury sites were observed. Poor access control to waste dumpsites was also noticed. There is non-compliance with waste segregation from source at health facilities in the state. There was also an observed partial conformity with the safeguard standards on the disposal and no compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bins not available. Open air burning was noted as common in the state. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

	F.C.T ABUJA	The Territory has appointed a Safeguard Desk Officer but needs to train him. FCT is Compliant in waste identification and characterization, familiar with recommended method for waste and provision of biohazards and sharps containers. Conformity in the area of demonstrating appropriate waste management techniques is only partial and non-Compliance in the availability of Waste Treatment Facility is prevalent across the Territory. There is Conformity in familiarization with Medical Waste Management Plan (MWMP) and Environmental Social Management Framework (ESMF). Partial compliance was observed in waste Storage and Compliance in the use of protective gears. Incinerators, burn and bury sites were observed everywhere. Poor access control to waste dumpsite. There is non-compliance with waste segregation from source at health facilities. There was also an observed partial conformity with the safeguard standards on the disposal and non compliance with the provision of a properly engineered and well-managed sanitary landfill site dedicated to medical waste. Colour coded waste bins were not available. Open air burning was noted as common across the Territory. It was observed that there is no environmental consultant/specialist; effective communication with stakeholders on safeguard issues was poor. There are no waste management committees and sub-project ESMPs are not being prepared.

5.5 Availability of Incineration Facilities in the States

A total of 73 incinerators of various types, ownership and age were identified in the surveyed states. The distribution of the facilities indicated that the majority of incinerators 69 (94.5%) available for HPDPII activities in the states were Government owned. Most of this were open pit 35 (47.9%) while 38 (52.1%) either made of bricks and mortar or closed chamber combustible incinerators. These were mapped and presented in Figure 5.5. In the light of the generation by these HCFs of hazardous wastes, an attempt was made to specifically identify and map the presence of appropriate incineration facilities capable of managing the wastes without the risk of producing potentially harmful substances. In this light, reference was made to the technical report of a study commissioned by the USAID on behalf of the FMoH on mapping HCW management equipment in Nigeria. Published in October 2013, the report lists 65 such facilities fitted with either medium or high temperature incinerators (Figure 5.6).

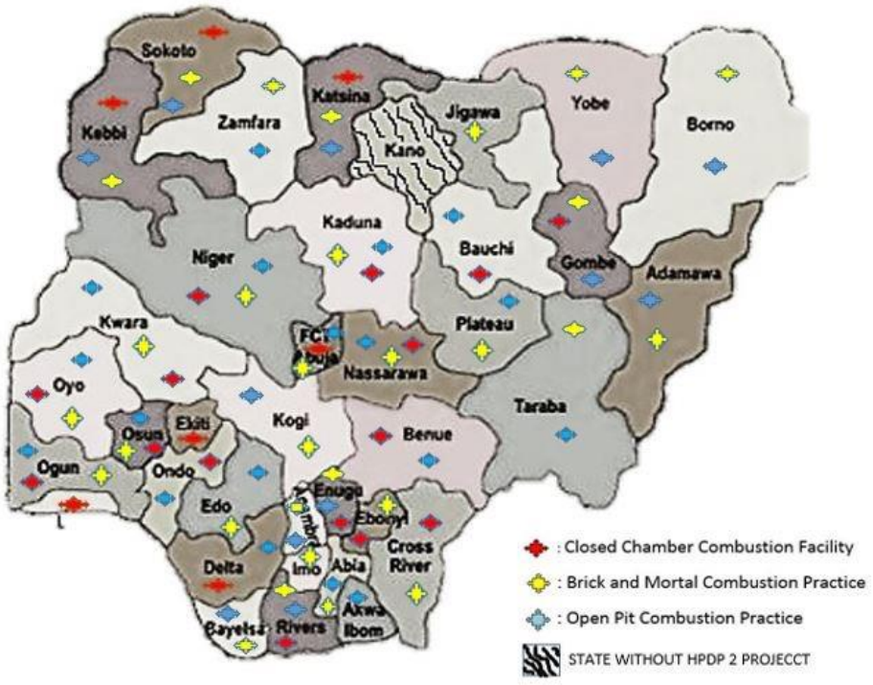


Figure 5.5: Distribution of Types of Incinerators. Source: HPDP II Safeguards Audit Survey Field Data, 2015

As is clear from figure 5.7, all geopolitical zones have at least one functional high temperature incinerator. This suggests that a national framework for managing hazardous medical waste can be developed with the hazardous wastes collected, transported and treated within these facilities. Other segregated, less harmful wastes could be handled by other means and tools as appropriate.

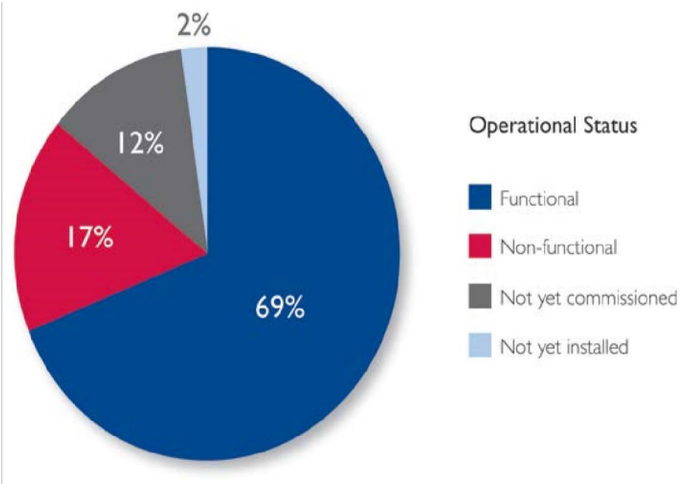


Figure 5.6: Waste Treatment Equipment Status (n=65)
Source: USAID, 2013

Characteristics of Incinerators	Number	%
Ownership		
Public/Government	69	94.5
Private	4	5.5
Type		
Brick & Mortar	21	28.8
Closed chamber/Combustion	17	23.3
Open pit	35	47.9
Age of incinerator		
≤ 1 Year	10	3.7
> 1year	63	86.3

Table 5.11 Incinerators identified in the survey

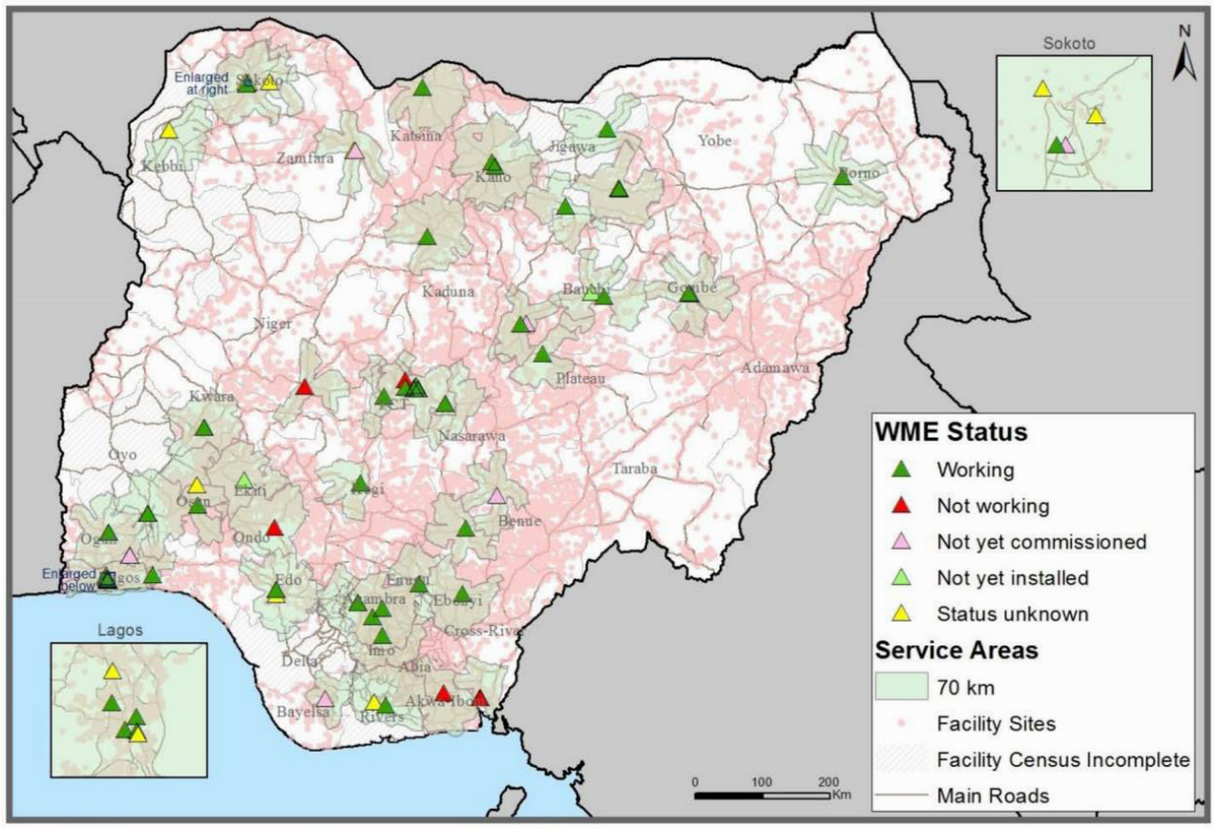


Figure 5.7: Status of Waste Management Equipment in Assessed Catchment Areas, Source: USAID, 2013

Chapter 6
Recommendations and Action Plan

6.1 Introduction

The audit exercise identified series of issues of concern requiring adequate management or mitigation. This chapter is crafted to ensure remedial actions undertaken for areas of non-conformance. The section has been drafted as action plan detailing mitigation activities/corrective actions to be carried out, with responsible parties proposed and means of monitoring the performance of the activities clearly stated to guarantee sustainability and maximization of the benefits of HPDPII in Nigeria.

6.2 Recommended actions to address observed concerns

In the light of the findings of the audit, the following key recommendations are indicated to ensure the enhanced safeguards compliance by the project and secure its long-term positive outcomes.

1. Capacity Building and Training on HPDP II Safeguard Issues

It is imperative that the safeguards desk officers are equipped with the requisite know-how to drive safeguards compliance and compliance monitoring of sub-projects. Project implementation partners with roles to play in this regard, such as the SEPAs/SMEnvs should also receive urgent training to support implementation as designed. The preparation of ESMPs for all activities about to be implemented should serve as the incentive for the urgent conduct of hands-on capacity development.

2. Working with Partners/Communication

Blurred lines of communication still existing among project partners that need to be cleared out to enhance implementation coordination. Safeguards focal persons need to be provided a platform for routine sharing of experiences to enhance quick adaptation to work requirements. Stakeholder sensitization and engagement is necessary to deepen achievements and drive project toward desired targets.

3. Waste Segregation and Use of Recommended Colour Codes

The enforcement of regulations regarding waste segregation, handling, storage and treatment, including placement of appropriate restrictions and notices against unauthorised access to storage and disposal locations should be driven with a carrot and stick approach that encourages HCF compliance

4. Waste Treatment Equipment Infrastructure

A framework needs to be developed that identifies the categories of wastes that can and should be handled at the HCFs without appropriate equipment. The WMP already provides the basis for doing this. Logistic arrangements need to be put in place for those to be stored and transported to other facilities for treatment. While plans are afoot to procure some incinerators for the use of HPDP II, it is recommended that effective planning and coordination with the FMoH is established for the use of incinerators procured for and in use by tertiary health facilities across the country. With each geopolitical zone having at least one such well-equipped HCF, HPDP II should work out availability and accessibility arrangements with the FMoH to save costs. Where necessary, HPDP II should, rather than acquire any piece of equipment for a facility, identify and repair/refurbish serviceable ones owned by FMoH or SMoH for the use of supported HCFs. This should kick in an era of data and other resource sharing that is often lacking amongst public institutions in Nigeria.

5. Waste Disposal and Site Access Control

In addition to the enforcement of extant guidelines and regulations on notices and access control,

HPDP II should enhance liaison with state-level waste management agencies where they exist to take advantage of their logistic and technical resources in managing HCW. HPDP II should also institute the use of accredited waste management contractors to bring an end to the current use of non-professional contractors sighted in the course of the audit – with attendant potentially negative consequences. The guidelines for Public Private Partnership arrangements provided in the NHCWMP, 2013, are instructive in this regard.

6. Effective Monitoring and Record Keeping

HPDP II should produce a template for routine safeguards reporting and ensure it is embedded in the project reports. Effective feedback mechanisms should be encouraged by incentivising good HCF practices that proactively respond to social concerns.

7. Community Sensitizations

Continually sensitise the public particularly those near HCFs on the benefits and potential dangers of being around them. HPDP II should liaise with HCFs and project partners to ensure appropriate warning signs and statements are used to guide and educate the larger society on the hazards of unauthorised contact with hazardous HCW.

8. Employee and Public Safety

HSE regulations should be strictly enforced in all HCFs by the SACAs, the SMoH, NACA and FMoH. Workers should be educated on compliance and of the need to demand its facilitation by the HCF as a right. HPDP II should work with some HCFs to prepare and document best-practice plans for popularisation amongst HCFs and project implementation partners.

Proposed action plan for implementation is presented in the next section:

6.3: Proposed Action Plan

Table 6.1: Action Plan for Significant Areas of Non-Conformance

S/N	Issue	Action/Measures	Responsibility	Parameter	Time
1	EAR	Submission to the Regulatory Agency & World bank	NACA	Evidence of completion and submission to World Bank	Oct, 2015
2	Environmental Safeguard Instrument	Develop TOR for subprojects requiring ESMP and submit to NACA and World Bank Prepare ESMP and disclose all the Safeguard instruments in line with World Bank Policy and FMENv	SACA SACA & NACA	Submission to World Bank and Disclosure	Complete Oct. 25, 2015

3	Capacity building	Train NACA and SACA Project Management Staff on environmental and social safeguard management with particular reference on the needs of projec understanding the relevant safeguard instruments guiding the project, Good Practices in, waste management, Monitoring and reporting system, Train the Safeguard Desk officers on World Bank Safeguard Policies and other relevant instruments and subjects that will ensure capability to support the project Train Health Care Facilities Managers at all levels on proper waste segregation, colour codes, collection, storage and general management: Train contractors on appropriate health care waste management, use of Personal Protective Equipment and good environmental practices (See Appendix .. for Capacity Building Needs of the various Stakeholders)	SACA, NACA & HCF	Capacity to follow through and adhere to Safeguard principles No of person trained Training records	Commence Oct 19, 2015 and Complete first Round Oct 30, 2015 and then routinely
4	Working with Other MDAs	Ensure adequate and proper linkage Ministry of Environment Bridge the communication lacuna between all involved parties (SACA and Project partners	SACA & NACA	Evidence of good synergy and communication	Immediately and routinely

5	Health Care Waste management	Follow the appropriate guidance provided in the medical waste management plan (WMP) Follow recommended color codes and segregation methods contained in the MWMP Clear marking of waste disposal containers Conduct regular inspections of waste containers Maintain a high degree of orderliness and housekeeping At HCF secure all waste collecting points from members of the public Use only accredited waste management contractor for waste evacuation	HCF, SACA, Contractors monitored by Ministry of Environment and NACA & FMoH	Proper waste management, functional equipment, Zero incident, aesthetics	During work
	Health Care Waste management Facilities	Discontinue the use of open air burning and/or use of drums as incinerators for waste, Do not bury health care waste Install adequate management/treatment facilities at reasonable distance for all HCFs Establish collaborative arrangement for HCFs in the use of waste treatment facilities that ensures sharing of cost and adequate maintenance Good housekeeping at facilities	HCF, SACA, LGA Contractors monitored by Ministry of Environment and NACA & FMoH	Evidence of Effective and functional equipment, adequate management	Immediately and completion within the next four months (Dec, 2015)

6	Contractor Responsibility	Ensure contractors submit work plan proposal that include how Safeguard issues will be handled in the course of project execution	SACA & NACA	Safeguard compliant	Before commencement of work and throughout work period
7	Waste Management Committees	Establish at all HCF with the Chief Medical Directors as Chairmen.	HCF, SACA, NACA & FMoH	Existence and performance of the committee	Conclude Oct, 2015
8	Monitoring & Reporting	Use the indicator for monitoring as identified in the WMP and ESMF and as identified in this audit for monitoring and performance measurement Report adequately on all indicators	HCF Committee and Safeguard officers	Records of monitoring and evidence of Ministry of Environment participation	Immediately and routinely
9	Poor Record Keeping	Develop mechanism for proper paper trail and documentation for safeguard issues	Safeguard officers	Document control and access	Immediately and frequently
10	Risk/Hazard Identification at HCFs	Ensure routinely hazards and risk are assessed at the various HCF and arising issues dealt with. Ensure Safe system to eliminate the risk wherever possible and where elimination is not possible then other means adopted including engineering and management techniques to reduce the risks to As Low As is Reasonably Practicable (ALARP)	HCF Committee members, SACA and NACA Safeguard officers	Zero incident	Commence immediately and routinely or when there are installation of new equipment or removal of any old ones

11	PPE & First Aid	Adequate Provision and use for staff at HCF and contractor staff	HCF, SACA, NACA & FMoH	Zero incident	Oct 2015 and routinely
12	Information Dissemination/ Community Sensitizations	National and State Project Coordinators should ensure Safeguards issues are part of the routine reports for the project Follow the information and consultation strategies outlined in the WMP Continuously sensitize communities, especially children around the HCFs potential risks of the tampering with health care waste Provide instructional/warning signs and posters conspicuously displayed Post phone numbers for emergency	HCF, SACA, NACA, FMoH LGA & Ministry of Environment/Waste Management Authority,	Zero incident, support from the stakeholders and greater understanding of safeguard issues	Immediately in all facilities
13	Emergencies	Identify line of commands and responsibilities Post phone numbers for emergencies at the various facilities	HCF, SACA, NACA &	Zero incident, support from the stakeholders and greater understanding of safeguard issues	Immediately in all facilities
14	Public Concerns/Complaints	Put mechanism in place for responding quickly to reports of the public	HCF, SACA, NACA	Support from the public members	Immediately in all facilities

6.3.1 Institutional Capacity Building & Training

Based on the audit, to enhance the respective roles and collaboration of the relevant stakeholders, specific areas for capacity building have been identified as deserving of attention for effective implementation of this Audit Report and overall Safeguard management of the project as outlined in Table 6.2:

Table 6.2.: Training/Capacity Building Needs

Programme/Description	Participants	Form of Training	Duration	When	Conducted by	Agency Coordinating
General environmental awareness seminar that will include ecological and social science principles, legal responsibilities, consequences of non-sustainable development, environmental and social costs of poor management decisions, and introduction to the EIA process and the use of the environment and social screening mechanism.	Project Coordinators and Teams (SACAs, NACA)	Seminar	3 days	Immediate	World Bank	NACA
An in-depth comprehensive course on environmental management including legal requirements, EIA methodology, Impact determination (methods) and mitigation analysis, public involvement methods, ESMP preparation, monitoring techniques, preparation of EIAs, TORs, and other. Course will include field visits and classroom exercises.	Environmental specialist/consultant, officials of SEP As and LGA environmental and social specialists	Workshop	5 days	Immediate	World Bank	NACA
General environmental awareness seminar that will include ecological and social science principles and introduction to the EIA process.	CBOs/NGOs in the health sector	Workshop	1 day	Immediate	World Bank	NACA
Transport, Treatment and Disposal of HCW	Contractors	Workshop	2 days	Immediate	World Bank	NACA
Emergency Planning and Management in HCFs	SACA & HCF Staff	Workshop	3 days	Immediate	World Bank	NACA

6.3.2 Budgets for the Audit Implementation

To effectively implement the environmental and social management measures suggested as part of this Audit Report, necessary budgetary provisions have been be made as shown in Table 6.3. It is important to identify financial resource requirements even if indicative. This ensures upfront appreciation of the financial requirements and allows early planning and budgeting accordingly.

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Annex 1: Percentage distribution of health facilities in states according to waste characterization and disposal

States	Have a trained emergency coordinator	Have spill clean-up materials	All project staff aware of emergency actions	Meet local limits for pollutants waste
Abia	9.2	10.0	12.5	10.9
Adamawa	0.0	20.0	20.0	0.0
Akwa-Ibom	29.2	39.6	41.9	25.3
Anambra	8.4	21.7	14.0	0.9
Bauchi	26.3	18.8	5.6	0.0
Bayelsa	23.1	8.1	20.6	35.5
Benue	48.4	22.0	64.0	11.6
Bornu	75.0	50.0	75.0	14.3
Cross-River	55.7	46.3	76.8	74.0
Delta	38.5	23.1	69.2	7.7
Ebonyi	30.0	13.0	35.3	10.0
Edo	60.0	20.0	72.0	4.5
Ekiti	44.4	57.1	88.9	0.0
Enugu	19.3	20.0	20.9	19.7
FCT	36.5	36.5	37.0	12.9
Gombe	5.1	20.3	6.8	1.7
Imo	13.3	11.9	27.8	37.8
Jigawa	20.0	0.0	20.0	10.0
Kaduna	12.4	19.8	30.1	10.2
Katsina	50.0	33.3	16.7	40.0
Kebbi	0.0	0.0	25.0	0.0
Kogi	30.6	25.0	53.5	8.6
Kwara	40.0	35.7	66.7	26.7
Lagos	44.6	26.2	52.3	21.7
Nasarawa	22.0	21.7	21.7	13.3
Niger	36.1	38.9	52.8	22.2
Ogun	26.7	26.7	25.0	14.3
Ondo	53.3	13.3	73.3	6.7
Osun	7.1	42.9	61.5	10.0
Oyo	31.6	12.2	51.7	1.8
Plateau	74.7	51.7	79.1	5.2
Rivers	24.7	14.7	37.8	7.7
Sokoto	100.0	100.0	100.0	90.0
Taraba	34.6	7.7	46.2	0.0
Zamfara	23.1	8.3	23.1	8.3
Total	**30.5**	**25.1**	**41.8**	**16.5**

Annex 2: Percentage distribution of health facilities according to structures and systems in place for HSE activities

State	Facility have comprehensive written HSE programme	Responsibility for HSC programme delegated to person/office	Accountability system for ensuring staff comply with HSC programme	A system to identify and evaluate workplace hazards	Unhealthy conditions corrected immediately	Staff know health hazards specific to job	Training provided for all new staff	Personal protective equipment provided, used and maintained	Written standard operating procedures provided
Abia	1.7	5.1	5.0	14.0	51.2	51.2	56.2	50.4	23.1
Adamawa	0.0	0.0	0.0	0.0	83.3	83.3	16.7	66.7	0.0
Akwa-Ibom	65.7	37.6	43.4	66.7	77.4	81.4	73.6	79.6	43.4
Anambra	13.1	9.3	21.5	15.0	19.8	33.6	52.3	83.2	11.8
Bauchi	35.0	36.8	15.0	60.0	80.0	100.0	85.0	84.2	35.7
Bayelsa	23.7	23.7	21.6	19.4	81.1	47.1	25.0	45.7	21.2
Benue	54.4	59.6	52.7	48.4	73.6	83.9	61.5	62.7	27.3
Bornu	71.4	100.0	75.0	87.5	100.0	100.0	62.5	50.0	75.0
Cross-River	87.7	67.4	77.1	87.6	83.2	100.0	96.9	74.0	33.6
Delta	26.5	23.6	45.0	56.1	75.7	78.9	75.9	90.6	30.0
Ebonyi	53.2	39.2	56.0	47.1	85.4	89.8	78.0	68.6	46.8
Edo	66.7	76.0	72.0	64.0	80.0	84.0	79.2	90.9	57.1
Ekiti	55.6	50.0	33.3	75.0	100	100.0	100.0	100.0	40.0
Enugu	68.9	30.0	16.9	20.5	96.7	93.3	26.1	48.3	30.8
FCT	42.9	52.6	60.3	42.6	77.6	88.1	66.2	83.3	32.9
Gombe	3.4	5.3	3.4	5.1	18.6	27.1	20.3	36.2	3.4
Imo	30.7	23.9	40.8	61.8	64.0	69.7	69.9	63.0	33.8
Jigawa	50.0	70.0	40.0	10.0	60.0	90.0	20.0	80.0	40.0
Kaduna	29.4	27.7	31.0	29.5	56.3	70.3	48.2	65.5	24.3
Katsina	50.0	66.7	66.7	83.3	100.0	83.3	66.7	100.0	50.0
Kebbi	14.3	0.0	0.0	0.0	50.0	62.5	37.5	50.0	0.0
Kogi	81.4	87.3	65.7	78.6	90.1	85.9	84.5	72.2	61.1
Kwara	73.3	53.3	40.0	53.3	73.3	80.0	53.3	92.9	66.7
Lagos	60.6	48.1	56.8	58.2	81.8	92.5	83.1	83.6	43.3

Nasarawa	40.7	32.2	54.1	45.9	85.2	85.2	37.1	83.9	36.1
Niger	45.5	91.7	77.8	55.6	55.6	91.4	80.6	63.9	38.9
Ogun	28.6	26.7	25.0	56.3	66.7	57.1	50.0	93.8	14.3
Ondo	33.3	33.3	33.3	53.3	93.3	100	86.7	100	53.3
Osun	77.8	71.4	16.7	38.5	100.0	92.9	42.9	91.7	18.2
Oyo	43.2	40.5	36.7	22.0	35.6	36.7	41.4	18.6	38.6
Plateau	32.1	82.8	95.5	93.3	91.0	91.0	87.4	57.3	24.7
Rivers	77.1	45.0	57.1	50.9	85.2	67.9	63.0	81.0	66.7
Sokoto	100.0	100.0	100.0	100.0	90.9	81.8	45.5	9.1	27.3
Taraba	19.2	26.9	32.0	12.0	53.8	84.6	23.1	53.8	26.9
Zamfara	15.4	53.8	38.5	69.2	61.5	69.2	53.8	41.7	25.0
Total	**44.8**	**41.4**	**44.5**	**47.6**	**69.9**	**75.5**	**62.5**	**68.3**	**33.4**

Annex 3: percentage distribution of health facilities according to management support on safeguard issue

States	**Top management is committed to injury and illness prevention**	**First Aid kits easily accessible to work areas**	**Jobs assessed for hazards that require PPE**	**Training on use, care and disposal of PPE conducted and recorded**	**All PPE maintained in sanitary condition ready for use**
Abia	15.7	48.8	8.3	0.8	91.7
Adamawa	33.3	0.0	83.3	0.0	66.7
Akwa-Ibom	61.3	94.6	85.6	47.7	95.3
Anambra	7.5	60.7	24.3	23.3	83.7
Bauchi	50.0	5.3	100.0	90.0	85.0
Bayelsa	39.4	41.2	42.4	3.0	59.4
Benue	70.3	65.6	59.8	15.6	79.6
Bornu	75.0	75.0	75.0	50.0	75.0
Cross-River	71.3	96.2	87.0	65.4	100.0
Delta	58.0	74.8	73.6	55.1	88.3
Ebonyi	54.7	66.7	56.0	36.7	76.9
Edo	44.0	72.0	54.2	33.3	95.5
Ekiti	88.9	77.8	88.9	85.7	87.5
Enugu	42.2	72.4	27.3	24.4	88.1
FCT	49.3	57.1	63.5	50.0	83.1
Gombe	3.4	8.6	5.2	1.7	62.1
Imo	23.0	71.6	42.5	31.3	64.9

Jigawa	40.0	80.0	50.0	0.0	50.0
Kaduna	43.8	44.1	39.6	18.0	58.6
Katsina	83.3	83.3	83.3	50.0	100.0
Kebbi	14.3	0.0	25.0	0.0	28.6
Kogi	81.9	77.8	55.6	39.4	88.7
Kwara	86.7	92.9	93.3	33.3	80.0
Lagos	59.0	73.1	68.8	63.2	90.5
Nasarawa	66.1	52.5	77.4	23.0	80.6
Niger	37.1	66.7	60.0	61.1	77.1
Ogun	50.0	81.3	50.0	14.3	93.8
Ondo	85.7	73.3	50.0	100.0	100.0
Osun	30.8	25.0	93.3	7.7	85.7
Oyo	20.3	16.7	23.1	8.5	13.3
Plateau	50.0	44.9	8.9	65.2	79.3
Rivers	71.3	82.5	70.8	62.5	62.5
Sokoto	100.0	100.0	100.0	90.9	100.0
Taraba	42.3	65.4	46.2	12.0	76.0
Zamfara	53.8	33.3	50.0	33.3	38.5
Total	**48.3**	**63.4**	**53.9**	**36.0**	**79.2**

Annex 4: Percentage distribution of respondents according to specific HPDP II participation and implementation issues in the communities

States	Participate in HPDPII project	The community has benefitted from HPDPII	HPDPII Officers are easily accessible to community members	HPDPII activities are well known in the community	Displaced by any HPDPII project	Incurred losses due to HPDPII activities
Abia	100.0	100.0	100.0	100.0	0.0	0.0
Adamawa	50.0	100.0	100.0	100.0	0.0	0.0
Akwa-Ibom	83.3	80.0	80.0	16.7	0.0	0.0
Anambra	100.0	100.0	100.0	100.0	0.0	0.0
Bauchi	0.0	0.0	0.0	0.0	0.0	0.0
Bayelsa	0.0	0.0	0.0	0.0	0.0	0.0
Benue	0.0	0.0	0.0	0.0	0.0	0.0
Bornu	0.0	0.0	0.0	0.0	0.0	0.0
Cross-River	0.0	0.0	0.0	0.0	0.0	0.0
Delta	0.0	0.0	0.0	0.0	0.0	0.0
Ebonyi	100.0	66.7	66.7	100.0	0.0	0.0
Edo	33.3	33.3	0.0	33.3	0.0	0.0
Ekiti	66.7	100.0	100.0	100.0	0.0	0.0
Enugu	100.0	100.0	86.4	100.0	0.0	0.0
FCT	18.2	90.9	0.0	54.5	9.1	4.8
Gombe	11.1	11.1	0.0	0.0	12.5	12.5
Imo	0.0	0.0	0.0	0.0	0.0	0.0
Jigawa	0.0	0.0	100.0	0.0	0.0	0.0
Kaduna	9.8	16.0	16.0	11.8	7.1	3.0
Katsina	0.0	0.0	0.0	0.0	0.0	0.0
Kebbi	100.0	100.0	100.0	100.0	0.0	0.0
Kogi	100.0	100.0	100.0	100.0	0.0	0.0
Kwara	0.0	0.0	0.0	0.0	0.0	0.0
Lagos	90.9	91.7	83.3	83.3	0.0	0.0
Nasarawa	6.8	40.9	22.7	13.6	0.0	6.8
Niger	0.0	0.0	5.6	0.0	0.0	0.0
Ogun	100.0	100.0	100.0	100.0	0.0	0.0
Ondo	77.8	88.9	88.9	88.9	0.0	0.0
Osun	64.3	92.9	78.6	57.1	0.0	0.0
Oyo	8.7	8.7	8.7	8.7	0.0	0.0
Plateau	35.4	59.1	41.8	37.3	2.3	2.3
Rivers	0.0	0.0	0.0	0.0	0.0	0.0
Sokoto	100.0	100.0	100.0	100.0	0.0	0.0
Taraba	42.3	46.2	69.2	38.5	3.8	3.8
Zamfara	50.0	100.0	8.3	0.0	0.0	0.0
Total	**40.0**	**55.5**	**49.0**	**41.9**	**3.1**	**5.4**

Annex 5: Proportion of (SACA and Partners) respondents' awareness and implementation of safeguard policies

States	Awareness of legal provisions underpinning HPDP II	Awareness of the World bank Safeguard policies	Those with the legal documents of HPDPII	Those familiar with Environmental and Social management Framework for HPDPII	Those familiar with HPDPII Waste Management Plan	Those in possession of copies of the ESMA and WMP	Those who have received formal training in ESMP development	Those who have discussed the ESMP and WMP with Partners
Abia	50.0	50.0	50.0	-	-	0.0	0.0	No
Adamawa	83.3	50.0	16.7	33.3	33.3	33.3	16.7	Yes
Akwa-Ibom	57.1	66.7	28.6	71.4	50.0	28.6	14.3	Yes
Anambra	33.3	33.3	33.3	33.3	33.3	66.7	0.0	Yes
Bauchi	75.0	80.0	40.0	60.0	65.0	31.6	10.0	Yes
Bayelsa	40.0	60.0	20.0	20.0	20.0	0.0	20.0	No
Benue	0.0	25.0	25.0	25.0	25.0	25.0	25.0	No
Bornu	0.0	60.0	0.0	0.0	25.0	0.0	40.0	No
Cross-River	33.3	66.7	33.3	33.3	33.3	33.3	33.3	Yes
Delta	12.5	12.5	0.0	12.5	15.2	0.0	12.1	No
Ebonyi	100.0	50.0	50.0	50.0	50.0	5.3	0.0	No
Edo	73.7	40.0	35.0	35.0	30.0	100.0	11.1	Yes
Ekiti	100.0	100.0	100.0	100.0	100.0	66.7	0.0	No
Enugu	66.7	66.7	33.3	66.7	66.7	100.0	33.3	Yes
FCT	100.0	100.0	100.0	100.0	100.0	42.1	100.0	No
Gombe	84.2	73.7	52.6	84.2	84.2	0.0	36.8	Yes

Imo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	No
Jigawa	40.0	60.0	20.0	20.0	20.0	7.3	40.0	Yes
Kaduna	12.8	22.9	9.3	15.6	15.6	0.0	0.0	No
Katsina	0.0	0.0	0.0	0.0	0.0	0.0	25.0	No
Kebbi	50.0	75.0	0.0	50.0	50.0	25.0	2.8	Yes
Kogi	100.0	100.0	2.8	98.6	98.6	100.0	50.0	No
Kwara	66.7	83.3	40.0	57.1	83.3	33.3	7.7	Yes
Lagos	60.7	59.3	33.3	55.6	51.9	22.2	0.0	Yes
Nasarawa	83.3	66.7	16.7	33.3	33.3	16.7	0.0	No
Niger	68.0	50.0	30.8	61.5	46.2	26.9	26.9	Yes
Ogun	25.0	33.3	0.0	0.0	0.0	0.0	0.0	Yes
Ondo	100.0	87.5	75.0	50.0	50.0	37.5	25.0	Yes
Osun	30.8	64.3	14.3	21.4	64.3	14.3	7.1	No
Oyo	18.2	10.0	18.2	18.2	18.2	18.2	9.1	No
Plateau	0.0	0.0	0.0	0.0	0.0	0.0	0.0	No
Rivers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	No
Sokoto	100.0	100.0	100	100.0	100.0	100.0	0.0	No
Taraba	100.0	100.0	0.0	100.0	100.0	0.0	0.0	No
Zamfara	23.1	30.8	7.7	15.4	46.2	0.0	15.4	Yes
Total	**52.3**	**54.0**	**21.7**	**46.2**	**47.7**	**32.5**	**12.6**	

Annex 6: HPDP 2 UPDATE FOR THE WORLD BANK IMPLEMENTATION SUPPORT MISSION (March 16-20, 2015)

	Agreed action(s) from Implementation Support Mission	**Responsible agency**	**Due date**	**Update as at 11th March 2015**
	Next Implementation Supervision Mission	World Bank; NACA	January 12-16, 2015	Next mission now confirmed for March 16-20, 2015. Mission announcement letter dispatched to FMOF and NACA
	Letter to request restructuring of HPDP 2 will be sent to World Bank	NACA/FMOF	December 15, 2014	World Bank received FMOF request letter on Feb 23, requesting to revise the results framework as agreed at the MTR
	Finalize SACAs and Line Ministries costed 2015 work plans	SACAs	December 12, 2014	34 states have submitted workplans which are either with the Bank or with the states. • 20 have received NO or clearance • 6 have CNO (Lagos, Niger, Adamawa, AkIbom, Borno & Bayelsa) • 4 have represented WP to the Bank • 2 yet to respond to Bank commnets • 1 (IMO) just submitted WP to NACA : Imo was with NACA on the week of 9th-13th March for TA to develop workplan • Ebonyi not very cooperative; Ebonyi was in NACA on the week of 16th-20th for TA to develop workplan but PM has not sent even though Bank has written to request for it. • Sokoto does not have funds under Component 1 and 3 but NACA has written them to plan for their counterpart funds • Imo completed its staffing and signatories are yet to be cleared. • The Imo team was in NACA for TA to develop their work plan, procurement plan and disbursement plan
	Review and recommend to World Bank to clear SACA and Line Ministry 2015 costed work plans so procurement plans can be developed ahead of Procurement Clinic	NACA	December 15, 2014	• The following 20 state work plans have been provided No Objection or clearance: - Kebbi, Osun, Ekiti, Ondo, Edo, Bauchi, Gombe, Delta, CR, FCT, Oyo, Zamfara, Katsina, Ogun, Anambra , Taraba, Abia, Benue, Jigawa & Rivers • The Bank to assist in providing clearance for Imo SACA to drawdown from its Naira account for component 1 & 3 pending the time signatories are to be cleared. **FOR PROCUREMENT PLANS:** • In the interest of time, the SACA have been advised to go ahead and procure test kits, condoms and consummables for HPDP 2 using the procurement plans cleared at the Procurement Clinic while work plan and procurement plans are under review for No Objection.
	Sign agreements with SACAs and Line Ministries for the implementation of their approved 2015 costed work plans	NACA, SACAs, Line Ministries	December 19, 2014	• NACA developed template for the agreement but proposed a meeting with PMs and Procurement Officers from each state. • The Bank expects to clear all work plans before the next World Bank mission in March
	Prepare a summary table of targets by States to be monitored	NACA	January 9, 2015	• NACA did not set target for the states. States used targets in their State Strategic Plans. • NACA had shared the summary table of targets with the Bank.
	NACA Workplan & Procurement			• NACA work-plan submitted on Sunday 15TH March with FMDA work-plans attached

	Inform the Bank which procurement method it will use to procure commodities at the federal level – International Competitive Bidding or UN Agencies.	NACA	February 4, 2015	• NACAs decision to procure test-kits through UNICEF, condoms and lubricants through UNFPA has been conveyed to the Bank • NACA held meeting with UN on the 3rd of March and provided specification, quantification and the national testing algorithm. Response from the UN was expected on Tuesday 10th March and NACA sent a reminder on 13th March. • STI and OI drugs are to be procured using NCB method. The amounts agreed were: 1. Rapid Test kits - $4.25 Million 2. Condoms and Lubricants - $2.95 Million 3. STIs& OI drugs - $1.3 Million • Because NACA work-plan and PP are not yet approved, the NCB documents prepared by procurement was sent to the Bank for prior-review on Thursday 12th March
	Provide States with short, user-friendly, procurement checklist to guide them in the implementation of approved 2015 work plans.	NACA, World Bank	January 9, 2015	• The Bank attaches the check list to all cleared work plans and those given No Objection
	Communicate to the Bank the outcome of discussions with SFH to conduct a National HIV/AIDS survey in 2015 and send for review and No Objection, a draft ToR and sole source justification	NACA	December 15, 2014	• Protocol developed & sent for ethical approval, • Concept note on preparatory activities was submitted on the 9th of March: 1.) Meeting for the adaptation of the questionnaire guides and training manual 2.) Piloting of the NSH survey tool and 3.) Review of the pilot report and advocacy meeting with states stakeholders.
	Develop concept note on private sector engagement for HPDP 2 and send to the Bank for review and inputs ahead of the next supervision mission in January 2015.	NACA	December 23, 2014	NACA and the Bank have reached an agreement on the method of engagement of the private sector and this will be reflected in the concept note
	Continue discussions with FHI360, APIN and IHVN to develop modalities for private facilities engagement in the provision of relevant HIV/AIDS services in selected States and agree on way forward	NACA, World Bank	January 31, 2015	
	Conduct supervisory visits to problem and high priority States to find solutions impeding implementation	NACA, World Bank	March 31, 2015 (10 states); May 31, 2015 (8 states)	• NACA had visited Plateau, Nasarawa, Sokoto • Oyo is planned for the week of 23rd March • In the process of booking appointments for Kaduna, Anambra, Ebonyi, Enugu, Bayelsa, Imo

	NACA to provide intensive technical assistance to Akwa-Ibom, Bayelsa, and Ebonyi states in the engagement of CSOs and signing of HAF contracts.	NACA, World Bank	Ongoing	• The Bank team had asked Akwa Ibom to send the contract negotiation report by surface mail to fast track the review process as the state had not fully completed all the fields in PROCYs. • Akwa Ibom concept note for startup workshop has been reviewed and sent back to the state.
	Design and conduct a survey on a sample of CSOs in 12+1 States to see how well they are implementing activities as stipulated in the contractual document and reporting on results.	NACA, World Bank	April 30, 2015	• A revised concept note based on bank comments has been submitted
	Communicate to all the states, the importance of disbursing to CSOs according to the schedule agreed to in the contract agreement	NACA	December 15, 2014	N/A
	Update on how many CSOs have received their second tranche disbursement	NACA	January 12, 2015	• The states that have not disbursed the 2nd tranche have been asked by NACA to disburse against set criteria without waiting for cleared work plans. • Out of 530 CSO in 32 states, 313 had received 2nd tranche as at February 28th
	Send to Imo State, recruitment guidelines for new project team and provide support as needed	NACA	December 15, 2014	• The Bank had provided a No Objection to the project team and change of signatory is in progress. • The state was advised to submit a withdrawal application by the end of the month to avoid being asked to move funds in its dollar account to the Bank's IDA account in Lagos. • The Imo team were in Abuja for TA from NACA on developing their 2015 workplan
	SACAs will remind all their CSOs that they signed a contractual agreement which clearly articulates the importance of abiding by the procedures and processes outlined in the HAF implementation manual.	SACAs, NACA	December 15, 2014	• DONE

	NACA to hire 6 technical persons (one per geopolitical zone) to provide technical assistance to States on a regular basis. The recruitment for these technical persons should be open and have a diverse selection committee including representatives from development partners (Global Fund, PEPFAR and UNAIDS)	NACA	January 31, 2015	• The Bank cleared the ToR subject to NACA addressing comments and representing the final ToR for No Objection. • NACA to indicate to the Bank which procurement method it will use and once NACA's procurement plan had been cleared, NACA can proceed with the recruitment of these technical persons. • The Bank recommended that NACA engaged with other development partners in the selection process of these technical persons as it brings diversity and adds value to the process
	Follow up with the Office of the Secretary to the Government (SSG) of the Federation to expedite the constitution and inauguration of NACA Board	NACA	January 15, 2015	• The Board cannot be constituted for now. This may happen after the President is sworn in. In the interim, related decisions can only be taken by the SGF.
	Follow up with states without Boards to expedite the constitution and inauguration of SACA Board	NACA; SACA	January 15, 2015	• NACA has communicated to relevant states the need to expedite advocacy for the constitution & inauguration
	Write a letter to Kano State Government to confirm and document their non-acceptance of the Credit and include as part of restructuring of HPDP 2	NACA	November 30, 2014	• Awaiting response from FMoF on Kano. NACA has received approval for restructuring
	Monthly meeting of HPDP 2 project team from NACA and World Bank with TTL participating via audio or conferencing facilities	World Bank	3rd Wednesday of every month at 4 PM Abuja Time	• Ongoing • Next meeting would be during the implementation support mission in March 2015
	Submission of quarterly procurement reports	NACA; SACA	Quarterly	Documentations for procurement of goods and services has been sent to the Bank.
	Conduct procurement clinic	NACA	December 8, 2014	DONE
	Contract signing for safeguards audit	NACA	December 15, 2014	DONE
	Meeting/training of designated Safeguard Officers (NACA and SACA) with the Consultants	NACA; WB; Consultant	December 18, 2014	Ongoing: Scheduled for Lagos, Kaduna, Enugu & Abuja on 17th & 19th March.

	Submission of safeguard audit inception report to NACA	Consultant	December 23, 2014	DONE
	Safeguard audit inception report sent to the Bank for review and inputs	NACA	January 14, 2015	The report was shared with the Bank team, Bank comments shared with the firm.
	Presentation of safeguards findings from the field	Consultant; NACA	January 17, 2015	The safeguard audit is ongoing
	Submission of draft audit safeguard report	Consultant; NACA	January 27, 2015	Timeline revised and now due in April 2105
	Feedback from World Bank on draft audit report	World Bank	April 3, 2015	N/A
	Submission of final safeguard audit report to NACA	Consultant; NACA	April 24, 2015	N/A
	Submission of final safeguard audit report with Implementation Plan to World Bank	NACA	May 1, 2015	N/A
	NACA to develop FM checklist to be used in conjunction with the FM manual.	NACA		In progress.
	Report of NACA FM supervision mission			30 states have been completed, 3 are expected to be completed after the elections. Reports of 19 states have been finalized

Annex 7: List of Health Care Facilities Visited

S/N	Name of facility	LGA	State
1	Asaokpulor Primary Health Centre	Aba North	Abia
2	Umuahia Federal Medical Centre	Umuahia North	Abia
3	Dike Ukwu Health Centre	Umuahia South	Abia
4	Ikemba Health Centre	Ikwuano	Abia
5	Nkweogwu PHC	Umuahia North	Abia
6	Our Lady of Apostle Maternity	Umuahia North	Abia
7	ELSHADIA HOSPITAL	Umuahia North	Abia
8	Grace Land Specialist Hospital	Umuahia North	Abia
9	All Saint Maternity & Clinic	Umuahia North	Abia
10	APUGO Medical Clinic	Umuahia North	Abia
11	Dennis Blessing Hospital	Umuahia North	Abia
12	Amarajane Hospitals & Maternity	Umuahia North	Abia
13	Ahiaeke Ndume PHC	Umuahia North	Abia
14	Anelechi Hospital	Umuahia North	Abia
15	Okwulaga Afara Health Clinic	Umuahia North	Abia
16	Okwuta Health Centre	Umuahia North	Abia
17	OSSAH Health Centre	Umuahia North	Abia
18	Amuzukwu PHC	Umuahia North	Abia
19	Madonna Catholic Hospital	Umuahia North	Abia
20	IHITE UDE OFEME HEALTH CENTRE	Umuahia North	Abia
21	MARANATHA Hospital	Umuahia North	Abia
22	Life Gate Hospital	Umuahia North	Abia
23	Fountain Hospital	Umuahia North	Abia
24	Hebrew Women Matter	Umuahia North	Abia
25	Life Essential Hospital	Umuahia North	Abia
26	Chidinma Specialist Hospital	Umuahia North	Abia
27	Umuegwu Okpuala Health Centre	Umuahia North	Abia
28	Obuohia PHC	Ikwuano	Abia

29	Umudike Ukwu Health Centre	Ikwuano	Abia
30	Isiala Health Centre	Ikwuano	Abia
31	Ibereta PHC	Ikwuano	Abia
32	Usaka Ukwu Health Centre	Ikwuano	Abia
33	Amaba Health Centre	Ikwuano	Abia
34	Ariam I Health Centre	Ikwuano	Abia
35	Ahia Orie Health Centre	Ikwuano	Abia
36	Ogbo Diukwu Health Centre	Umuahia South	Abia
37	Ogbodinibe Health Centre	Umuahia South	Abia
38	Amawum Outreach Unit	Ikwuano	Abia
39	Nsirimo PHC	Umuahia South	Abia
40	Obougwu PHC	Ikwuano	Abia
41	Oboro Health Centre	Ikwuano	Abia
42	Hu Pace Community Pharmacists	Umuahia South	Abia
43	FMC Comprehensive Health Centre	Ikwuano	Abia
44	Amangwu Health Centre	Umuahia South	Abia
45	Old Umuahia PHC	Umuahia South	Abia
46	Amizi Health Centre	Umuahia South	Abia
47	Umuitowe PHC	Umuahia South	Abia
48	Umuokpara Ozoro	Umuahia South	Abia
49	Vinific Hospital	Umuahia South	Abia
50	Umunwanwa Health Centre	Umuahia South	Abia
51	Ohiya Health Centre	Umuahia South	Abia
52	Ijeoma Hospital	Umuahia South	Abia
53	Eziama Health Centre	Umuahia South	Abia
54	Overcomers Clinic	Umuahia South	Abia
55	Ezeleke Health Centre	Umuahia South	Abia
56	Amuzu Primary Health Centre	Umuahia South	Abia
57	Umuanya Health Centre	Umuahia South	Abia

58	Anglican Hospital and Maternity	Umuahia South	Abia
59	Ekenobizi	Umuahia South	Abia
60	Ubakala Health Centre	Umuahia South	Abia
61	Amakama Health Centre	Umuahia South	Abia
62	Ehume Health Centre	Umuahia South	Abia
63	Impact Hospital and Maternity	Aba North	Abia
64	Noscar Concar Stone Clinic	Aba North	Abia
65	Goodness and Mercy Hospital	Aba North	Abia
66	Ikechukwu Maternity and Hospital	Aba North	Abia
67	Kahabiri Specialist Hospital	Aba North	Abia
68	Isaac Okwuonu Memorial Hospital	Aba North	Abia
69	Nissi Hospital	Aba North	Abia
70	Nazereth Hospital	Aba North	Abia
71	Group Medical Practice	Aba North	Abia
72	New life Clinic and Maternity	Aba North	Abia
73	God's Will Clinic	Aba North	Abia
74	Land Mark Hospital	Aba North	Abia
75	Osoke Primary Centre	Aba North	Abia
76	Good Samartan Hospital	Aba North	Abia
77	Eziama PHC	Aba North	Abia
78	Aba Berma Hospital	Aba North	Abia
79	Angels of Mercy Hospital	Aba North	Abia
80	Blessed Haven Hospital	Aba North	Abia
81	Emmanuel Medical Centre	Aba North	Abia
82	Euna Hospital and Maternity	Aba North	Abia
83	Evergreen Clinic and Maternity	Aba North	Abia
84	Daughters of mary mother of mercy Hospital	Umuahia North	Abia
85	Austin grace Specialist Hospital	Aba North	Abia
86	Umumeato Compresive PHC	Bende	Abia

87	Akoh Health Centre	Bende	Abia
88	Isiegbu Ozuitem PHC	Bende	Abia
89	Ezeukwe Health Centre	Bende	Abia
90	Umuoke	Bende	Abia
91	Tjeoma Maternity Home	Bende	Abia
92	Ugnueke Royal Cross Hospital	Bende	Abia
93	Igbere Primary Heaith Center	Bende	Abia
94	Umusi Primary Heaith Center	Bende	Abia
95	Ngwu Health Center	Bende	Abia
96	Bende Maternity Home Primary Health Center	Bende	Abia
97	Okpuhu Nkpa Primary Primary Health Center	Bende	Abia
98	Agbanuzu Primary Health Center	Bende	Abia
99	Standard Health Center	Bende	Abia
100	Okwe Ukwe Primary Health Center	Bende	Abia
101	Obuohia Ibere Health Center	Bende	Abia
102	Aduanu Health Center	Bende	Abia
103	Nkasi Maternity	Bende	Abia
104	Awomukwu Primary Health Center	Bende	Abia
105	Nkata P.H.C	Bende	Abia
106	Amankalu Primary Health Center	Bende	Abia
107	Amaegibuato Primary Health Center	Bende	Abia
108	Uzuakoli Primary Health Center	Bende	Abia
109	Amaukwu Primary Health Center	Bende	Abia
110	Amaba Ugwueke Health	Bende	Abia
111	Ezinne Model Maternity Home	Bende	Abia
112	Nkechi Colwill Hospital	Bende	Abia
113	Okporoenyi Primary Health Center	Bende	Abia
114	Ndiwo Itumbuzo Primary Health Center	Bende	Abia
115	Chijioke Osogbo Methodist Memory Hospital	Bende	Abia

116	Alayi Maternity Primary Health Center	Bende	Abia
117	Umana Ndume Primary Health Center	Bende	Abia
118	Zenith Hopital	Bende	Abia
119	Umukabia PHC	Bende	Abia
120	Amaokwe Maternity Home	Bende	Abia
121	World Bank Health Clinic	Bende	Abia
122	Gonita	Gwagwalada	Abuja
123	Kaida Tsoho PHC	Gwagwalada	Abuja
124	General Hospital Numan		Adamawa
125	Specialist Hospital Yola	Yola North	Adamawa
126	General Hospital Ganye	Ganye	Adamawa
127	Major Aminu Urban Health Centre Doubeli	Yola North	Adamawa
128	Primary Health Care Centre	Guyuk	Adamawa
129	Primary Health Care Centre		Adamawa
130	Ifa Ikot Okpon Health Centre	Uyo	Akwa Ibom
131	Mount Olive Clinic & Maternity	Uyo	Akwa Ibom
132	Mbiabong PHC	Uyo	Akwa Ibom
133	Ikot Ebo Ikono PHC	Uyo	Akwa Ibom
134	Gateway Hospital	Uyo	Akwa Ibom
135	Primary Health Care Okon	Essien Udim	Akwa Ibom
136	Health Post Odoro Ikot I	Essien Udim	Akwa Ibom
137	Health Centre Atan Ikot Okoro	Essien Udim	Akwa Ibom
138	Ikot Ekpene Infectious Disease Hospital	Ikot Ekpene	Akwa Ibom
139	Ikot Ekpene Primary Health Centre	Ikot Ekpene	Akwa Ibom
140	Abiakpo Ikot Essien Health Centre	Ikot Ekpene	Akwa Ibom
141	Ikot Udoe Health Centre	Ikot Ekpene	Akwa Ibom
142	Health Centre Ekpeyong I	Essien Udim	Akwa Ibom
143	Primary Health Care Afaha Ikot Ebak	Essien Udim	Akwa Ibom
144	Primary Health Care Ukana West II	Essien Udim	Akwa Ibom

145	Adiasm Health Centre	Essien Udim	Akwa Ibom
146	Health Centre Ukama East	Essien Udim	Akwa Ibom
147	Health Centre Ikpe Annong	Essien Udim	Akwa Ibom
148	St. Athanasius & Testing Centre	Uyo	Akwa Ibom
149	Kaizo Specialist Clinic	Uyo	Akwa Ibom
150	Life Care Clinic	Uyo	Akwa Ibom
151	Uyo Base PHC	Uyo	Akwa Ibom
152	Uwana Family Hospital	Uyo	Akwa Ibom
153	Premier Medical Services	Uyo	Akwa Ibom
154	Idoro Obio Health Centre	Uyo	Akwa Ibom
155	Dyem Hospital & Maternity	Uyo	Akwa Ibom
156	Sifon Clinic	Uyo	Akwa Ibom
157	Nissi Specialist Hospital	Uyo	Akwa Ibom
158	Alma Clinic	Uyo	Akwa Ibom
159	Dammy Memorial Hospital	Uyo	Akwa Ibom
160	Ifa Atai Health Post	Uyo	Akwa Ibom
161	Ubongabasi Specialist Clinic	Uyo	Akwa Ibom
162	Ikot Ayan Ikono	Uyo	Akwa Ibom
163	Mainland Clinic	Uyo	Akwa Ibom
164	Ikot Ikubu PHC	Uyo	Akwa Ibom
165	Confidence Health Centre	Uyo	Akwa Ibom
166	Oku Model Health Centre	Uyo	Akwa Ibom
167	NC1 Medical Centre	Uyo	Akwa Ibom
168	Mbak Etoi PHC	Uyo	Akwa Ibom
169	Aka Affot Health Centre	Uyo	Akwa Ibom
170	Ikot Ibidang Health Centre	Uyo	Akwa Ibom
171	Numg Ndem Health Centre	Onna	Akwa Ibom
172	Atiamkpat Primary Health Centre	Onna	Akwa Ibom
173	Iko Eket Health Centre	Eket	Akwa Ibom

174	Mkpok Health Centre	Onna	Akwa Ibom
175	Emmanuel General Hospital	Eket	Akwa Ibom
176	Ikwe Primary Health Centre	Onna	Akwa Ibom
177	Effoi Primary Health Centre	Eket	Akwa Ibom
178	Ikot Eko Ibon General Hospital	Onna	Akwa Ibom
179	Assurance Medical Centre	Eket	Akwa Ibom
180	Hillcrest Medical Centre	Eket	Akwa Ibom
181	Ikot Ebark Poly Clinic	Eket	Akwa Ibom
182	Edem Idim Ishiet Primary Health Centre	Onna	Akwa Ibom
183	Edem Idim Ibakasi Health Centre	Onna	Akwa Ibom
184	Idua Health Clinic	Eket	Akwa Ibom
185	Mkpok Model Health Centre	Eket	Akwa Ibom
186	GoodCare Medical Centre	Eket	Akwa Ibom
187	Holifield Medical Centre	Eket	Akwa Ibom
188	Ikot Annang Primary Health Centre	Onna	Akwa Ibom
189	Onna Comprehensive Health Centre	Onna	Akwa Ibom
190	Ememobong Clinic & Maternity Home	Ikot Ekpene	Akwa Ibom
191	Cottage Hospital Ukana	Essien Udim	Akwa Ibom
192	PHC Operational Base Idu-Uman	Uwan	Akwa Ibom
193	St. Joseph Rehabilitation Centre Ukana Iba	Essien Udim	Akwa Ibom
194	PHC Nwaniba	Uruan	Akwa Ibom
195	Amanyam Primary Health Centre	Ikot Ekpene	Akwa Ibom
196	Ikot Inyang Health Post	Ikot Ekpene	Akwa Ibom
197	Demak Clinic & Maternity	Ikot Ekpene	Akwa Ibom
198	Health Centre Ikot Akpanefia	Essien Udim	Akwa Ibom
199	Health Post Ekpenyong Abai II	Essien Udim	Akwa Ibom
200	Evergreen Medical Centre	Ikot Ekpene	Akwa Ibom
201	Utu Edem Usung Health Post	Ikot Ekpene	Akwa Ibom
202	Health Ikot Otu Ukana West I	Essien Udim	Akwa Ibom

203	Health Centre Odoro Ikot II	Essien Udim	Akwa Ibom
204	PHC Ibokwe Area	Mkpat Enin	Akwa Ibom
205	PHC Ikot Ididng	Mkpat Enin	Akwa Ibom
206	Health Centre	Uyo/Aks	Akwa Ibom
207	PHC Etinan	Etinan	Akwa Ibom
208	Jafaar Clinic Ndon Eyo	Onna	Akwa Ibom
209	Ikot Eso Ekong Health Post	Eket	Akwa Ibom
210	Nuug Oku Ekanem	Nna	Akwa Ibom
211	PHC Ikot Eda	Mkpat Enin	Akwa Ibom
212	Iwok Nsit Health Post	Mkpat Enin	Akwa Ibom
213	PHC Ikot Uyo	Mkpat Enin	Akwa Ibom
214	Cottage Hospital Ikot Ekpaw	Mkpat Enin	Akwa Ibom
215	Health Centre Ikot Mkpor	Mkpat Enin	Akwa Ibom
216	PHC Minya	Mkpat Enin	Akwa Ibom
217	PHC Etok Nung Ukiki	Mkpat Enin	Akwa Ibom
218	Health Centre Ikot Itie Udung	Mkpat Enin	Akwa Ibom
219	PHC Edem Ekpat	Etinan	Akwa Ibom
220	PHC Ikot Akata	Mkpat Enin	Akwa Ibom
221	PHC Mkpat Enin	Mkpat Enin	Akwa Ibom
222	PHC Ikot Akpaden	Mkpat Enin Akwa Ibom	Akwa Ibom
223	PHC Efa	Etinan	Akwa Ibom
224	PHC Ikot Udo Abia	Etinan	Akwa Ibom
225	PHC Ikot Inyang Okop	Mkpat Enin	Akwa Ibom
226	PHC Ikot Udo Otto	Etinan	Akwa Ibom
227	General Hospital Mbioto II	Etinan	Akwa Ibom
228	Health Centre Ikot Edehe	Mkpat Enin	Akwa Ibom
229	PHC Ikot Inyang	Tinan	Akwa Ibom
230	PHC Ikot Ekan	Etiana	Akwa Ibom
231	PHC Iwo Eto	Etinan	Akwa Ibom

232	PHC Ikot Akpan Ntembom	Etinan	Akwa Ibom
233	PHC Ekpene Udo	Etinan	Akwa Ibom
234	Ikotedem Udo	Onna	Akwa Ibom
235	Abasi Ekeme Specialist Clinic	Eket	Akwa Ibom
236	Afaha Atai Health Post	Eket	Akwa Ibom
237	Abat Primary Health Centre	Onna	Akwa Ibom
238	Idung Iniang Primary Health Centre	Eket	Akwa Ibom
239	Pamo Clinc And Hospital Rumuomasi	Obio/Akpo	Akwa Ibom
240	Inadum Medical Centre Bor	Khana	Akwa Ibom
241	General Hospital, Okomoko	Eteue	Akwa Ibom
242	Modez Primary Health Centre Umusia	Oyigbo	Akwa Ibom
243	PHC Ndon Eyo	Etinan	AkwaIbom
244	Onitsha Basic Health Centre	Onitsha North	Anambra
245	Primary Health Centre Urudunu Ifite Oraifite	Idemili North	Anambra
246	Nkpo Uno Modern Health Centre	Idemili North	Anambra
247	Abagana PHC	Njikoka	Anambra
248	Ibollo Primary Health Centre	Ekwusigo	Anambra
249	Ogidi Primary Health Centre	Idemili North	Anambra
250	Grace Land Foundation Hospital Nkpor	Idemili North	Anambra
251	Crown Hospital	Idemili North	Anambra
252	Akwa-Etiti Primary Health Centre	Idemili South	Anambra
253	Moon Hospital Nnbobi	Idemili South	Anambra
254	Alor Primary Health Centre	Idemili South	Anambra
255	Immaculate Heart Hospital Nkpor	Idemili North	Anambra
256	Nnobi General Hospital	Idemili South	Anambra
257	Iyi-Enu Hospital	Idemili North	Anambra
258	Trauma Centre Oba	Idemili South	Anambra
259	Chukwunonso Hospital Nnobi	Idemili South	Anambra
260	Afor Ilo Primary Health Ozubulu	Ekwusigo	Anambra

261	Ogidi Maternity and Child health clinic	Idemili North	Anambra
262	Kandudi Specialist Hospital	Aguata	Anambra
263	Oko Community Hospital	Orumba North	Anambra
264	Afoudo Nanka Primary Health Centre	Orumba North	Anambra
265	Ifite Oko Community Health Centre	Orumba North	Anambra
266	Uke Primary Health Centre	Idemili North	Anambra
267	Oraifiye General Hospital	Ekwusigo	Anambra
268	Ndiowu Model PHC	Orumba North	Anambra
269	Umuchu General Hospital	Aguata	Anambra
270	Ndiowu Primary Health Centre	Orumba South	Anambra
271	Achina Comprehensive Health Centre	Aguata	Anambra
272	Umuchu Visitation Hospital	Aguata	Anambra
273	Isi Ebele Achina PHC	Aguata	Anambra
274	Oye Achina PHC	Aguata	Anambra
275	Nnokwa Primary Health Centre	Idemili South	Anambra
276	Holy Family Hospital and Maternity	Idemili North	Anambra
277	Nkwele Ezunaka Health Centre	Oyi	Anambra
278	Awkuzu Primary Health Centre	Oyi	Anambra
279	Nkwele Umunachi Primary Health Centre	Dunukofia	Anambra
280	Community Reproductive Referral Health Centre Neni	Anaocha	Anambra
281	Nteje Primary Health Centre	Oyi	Anambra
282	Oze Nkwele Ezunaka PHC	Oyi	Anambra
283	Ojoto Uno Primary Health Centre	Idemili South	Anambra
284	Umuoji Basic Health Centre	Idemili North	Anambra
285	Umunya Comprehensive		Anambra
286	Nri Primary Health Centre	Anaocha	Anambra
287	Adazi Enu Primary Health Centre	Anaocha	Anambra
288	Ogbunike Primary Health Centre	Oyi	Anambra
289	Neni Comprehensive Centre Nauth	Anaocha	Anambra

290	Neni 1 Primary Health Centre	Anaocha	Anambra
291	Umunya Primary Health Centre	Oyi	Anambra
292	Ezi Owelle Primary Health Centre	Idemili North	Anambra
293	Ebenesi Primary Health Centre	Idemili South	Anambra
294	Awuda Nnobi Primary Heath Centre	Idemili South	Anambra
295	Ogidi General Hospital	Idemili North	Anambra
296	PHC Odida Abatete	Idemili North	Anambra
297	Ideani PHC	Idemili North	Anambra
298	Ogbu Primary Health Centre Abatete	Idemili North	Anambra
299	Chiamaka Hospital	Idemili South	Anambra
300	Akira Etiti Primary Health Centre	Idemili South	Anambra
301	Akwa Ifitedunu PHC	Dunukofia	Anambra
302	Ichida PHC	Anaocha	Anambra
303	General Hospital Ukpor	Nnewi South	Anambra
304	Ezinifite PHC	Nnewi South	Anambra
305	Ukpo PHC	Dunukofia	Anambra
306	Ezioma Igbo PHC	Njikoka	Anambra
307	Akwa Eze PHC	Anaocha	Anambra
308	Enugu Agidi PHC	Njikoka	Anambra
309	Nawfia Primary Heath Centre	Njikoka	Anambra
310	Nimo General Hospital	Njikoka	Anambra
311	Egbengwu Nimo PHC	Njikoka	Anambra
312	Abba Primary Health Centre	Njikoka	Anambra
313	Agulu Uzoigbo PHC	Anaocha	Anambra
314	Umuabani PHC Neni	Anaocha	Anambra
315	Agulu Nkitaku PHC	Anaocha	Anambra
316	General Hospital Agulu	Anaocha	Anambra
317	Ukpo Comprehensive PHC	Dunukofia	Anambra
318	St. Joseph Hospital Adazi	Anaocha	Anambra

319	Umuanugwo Ifitedunu	Dunukofia	Anambra
320	Isuaniocha PHC	Awka North	Anambra
321	Mgbaukwu PHC	Awka North	Anambra
322	Achalla PHC	Awka North	Anambra
323	General Hospital Enugu-Ukwu	Njikoka	Anambra
324	Okpuno-Otolo PHC Nnewi	Nnewi North	Anambra
325	Model PHC Nkpologwu	Aguata	Anambra
326	Faith Hospital Awka	Awka South	Anambra
327	Zenith Hospital and Maternity	Aguata	Anambra
328	Beacon Hospital	Awka South	Anambra
329	Umunze Comprehensive Health Centre	Orunba South	Anambra
330	Rushgreen Hospital	Onitsha North	Anambra
331	Inland Town Health Centre	Onitsha North	Anambra
332	Onitsha General Hospital	Onitsha North	Anambra
333	Ifebi Medical Centre	Awka South	Anambra
334	Primary Health Care Centre Umuokeu	Awka South	Anambra
335	Ezira PHC	Orunba South	Anambra
336	Aguata Diocesan Hospital Umunze	Orunba South	Anambra
337	Amawbia Maternal and Child Health Clinic	Awka South	Anambra
338	Aku Ezinifite PHC	Aguata	Anambra
339	Aguata PHC	Aguata	Anambra
340	Umuona PHC	Aguata	Anambra
341	Igboukwu PHC Ifite	Aguata	Anambra
342	Nkpologwu Community Hospital	Aguata	Anambra
343	Nkwelle PHC	Awka South	Anambra
344	PHC Nibo	Awka South	Anambra
345	PHC Umuaw Ulu	Awka South	Anambra
346	PHC Nise	Awka South	Anambra
347	Amesi PHC	Aguata	Anambra

348	Regina Caoli Hospital Awka	Awka South	Anambra
349	Anambra State University Teaching Hospital	Awka South	Anambra
350	Basic Health Centre Nibo	Awka South	Anambra
351	Al-Ameen Hospital Bauchi	Bauchi	Bauchi
352	Primary Health Care Kangare	Bauchi	Bauchi
353	Apple Clinic & Maternity	Bauchi	Bauchi
354	MCH International Unit Nassarawa Jahun	Bauchi	Bauchi
355	AMSAD CLINICS	Bauchi	Bauchi
356	General Hospital Alkaleri	Alkaleri	Bauchi
357	ATBU Teaching Hospital Bauchi	Bauchi	Bauchi
358	Bauchi State Specialist Hospital	Bauchi	Bauchi
359	Gadar Maiwa Primary Health Care	Ningi	Bauchi
360	General Hospital Azare	Katagum	Bauchi
361	State Lowcost PHC	Bauchi	Bauchi
362	Town Maternity DASS	Dass	Bauchi
363	General Hospital Ningi	Ningi	Bauchi
364	Primary Health Care DOTT	Dass	Bauchi
365	Kafin Madaki Primary Health Care	Ganjuwa	Bauchi
366	Maijama'a Clinic & Maternity	Bauchi	Bauchi
367	Infectious Disease Hospital Bayara	Bauchi	Bauchi
368	Nasaru Model Primary Health Care	Ningi	Bauchi
369	Town Maternity Misau	Misau	Bauchi
370	Federal Medical Centre	Katagum	Bauchi
371	Aseifai Hospitals Ltd	Yenagoa	Bayelsa
372	Glory Land Inri Medical Centre	Yenagoa	Bayelsa
373		Yenagoa	Bayelsa
374	I Care Save A Soul Initiative	Yenagoa	Bayelsa
375	PHC Opolo	Yenagoa	Bayelsa
376	Kpansia PHC	Yenagoa	Bayelsa

377	Glory Land Medical Centre	Yenagoa	Bayelsa
378	Bright & Ruffman clinic	Yenagoa	Bayelsa
379	Everly Medical centre	Yenagoa	Bayelsa
380	Kuro Specialist clinic	Yenagoa	Bayelsa
381	Tobis clinic & consultancy Hospital	Yenagoa	Bayelsa
382	PHC Yene-Gene Yenagoa	Yenagoa	Bayelsa
383	General Hospital Amassana	Southern Ijaw	Bayelsa
384	General Hospital Aguoama Ekpetiama	Yenagoa	Bayelsa
385	Creche clinic	Kpansia	Bayelsa
386	Bay clinic	Yenagoa	Bayelsa
387	Palen clinic & Marternity	Yenagoa	Bayelsa
388	TBL Referral Hospital Igbogene	Yenagoa	Bayelsa
389	St. Peter's Hospital	Yenagoa	Bayelsa
390	Tombra PHC	Yenagoa	Bayelsa
391	Trinidex Hospital	Yenagoa	Bayelsa
392	New Uchena Hospital	Yenagoa	Bayelsa
393	King Sasim Hospital	Yenagoa	Bayelsa
394	Yenagoa Hospital & Maternity	Yenagoa	Bayelsa
395	Yeneqwe PHC	Yenagoa	Bayelsa
396	Comm. Health Centre Agudama-Epe	Yenagoa	Bayelsa
397	PHC Koroama	Yenagoa	Bayelsa
398	PHC Amrata	Yenagoa	Bayelsa
399	Basic Health Centre, Azikoro	Yenagoa	Bayelsa
400	Believers Faith Medical Centre, Onopa	Yenagoa	Bayelsa
401	St. John Clinic	Yenagoa	Bayelsa
402	General Hospital Kolo	Ogbia	Bayelsa
403	Compehensive Health Centre Otuoker	Ogbia	Bayelsa
404	Katama Health Centre	Kolokuma/Opokuma	Bayelsa
405	General Hospital Odi	Kolokuma/Opokuma	Bayelsa

406	General Hospital Sagbama	Sagbama	Bayelsa
407	Comprehensive Cottage Hospital Otuoke	Ogbia	Bayelsa
408	Comprehensive Health Centre Odi	Kolokuma/Opokuma	Bayelsa
409	Comprehensive Health Centre Kolo	Ogbia	Bayelsa
410	PHC Oloibiri	Ogbia	Bayelsa
411	Comprehensive Health Centre Ogbia	Ogbia	Bayelsa
412	Madia Hospital	Buruku	Benue
413	General Hospital	Gboko	Benue
414	Victory Hospital	Gboko	Benue
415	General Hospital	Buruku	Benue
416	Wawune General Hospital	Tarka	Benue
417	N.K.S.T Clinic	Tarka	Benue
418	St Christopher Health Clinic	Tarka	Benue
419	Wannune Township Clinic	Tarka	Benue
420	Jordan Clinic and Maternity	Gboko	Benue
421	N.K.S.T Hospital	Urum	Benue
422	Zaki-Biam City Clinic and Maternity	Ukum	Benue
423	Ajo Comprehensive Health Centre	Tarka	Benue
424	General Hospital	Logo	Benue
425	N.K.S.T Hospital and Clinic	Gboko	Benue
426	Baku Clinic and Maternity	Gboko	Benue
427	N.K.S.T PHC	Gboko	Benue
428	PHC	Buruku	Benue
429	MPHC Utsumbi	Buruku	Benue
430	N.K.S.T PHC	Buruku	Benue
431	Atuna Clinic and Maternity	Gboko	Benue
432	TBT Hospital	Gboko	Benue
433	N.K.S.T CH		Benue
434	Tse-Kucha Primary Health Care	Gboko	Benue

435	Gboko south PHC	Gboko	Benue
436	Community Health Center	Gboko	Benue
437	Anyin Primary Health Care		Benue
438	Mbagen Community Hospital	Buruku	Benue
439	Tyowanye Primary Health Center	Buruku	Benue
440	Taraku Primary Health Centre	Giver	Benue
441	Mbatsina	Buruku	Benue
442	Kyado PHC	Ukum	Benue
443	Kator Clinic	Gboko	Benue
444	N.K.S.T	Gboko	Benue
445	Bethany Hospital	Gboko	Benue
446	Pewaren Hospital	Gboko	Benue
447	Seta Clinic	Gboko	Benue
448	N.K.S.T Hospital	Logo	Benue
449	Ugba Comprehensive Health Centre	Logo	Benue
450	Sev-Av Foundation	Gboko	Benue
451	Myom Hospital	Gboko	Benue
452	St Joseph Clinic	Otukpo	Benue
453	May Memorial Hospital	Otukpo	Benue
454	Ipolo Primary Health Centre	Otukpo	Benue
455	St Joseph Hospital	Otukpo	Benue
456	St Joseph's Clinic	Otukpo	Benue
457	Otabo Caregivers and help for Orphans	Otukpo	Benue
458	Methodist Hospital	Otukpo	Benue
459	Efeyi Primary Health Centre	Otukpo	Benue
460	General Hospital	Otukpo	Benue
461	Nazareth Hospital	Otukpo	Benue
462	Family Support/MCM Clinic	Makurdi	Benue
463	Primary Health Centre	Otukpo	Benue

464	St Charles' Hospital	Otukpo	Benue
465	St James Clinic	Otukpo	Benue
466	Odugbeho Primary Health Centre	Otukpo	Benue
467	Auke	Otukpo	Benue
468	Usha Primary Health Centre	Otukpo	Benue
469	Ogbaulu Primary Health Centre	Otukpo	Benue
470	CACAGHDO	Otukpo	Benue
471	Akpegede Primary Health Centre	Otukpo	Benue
472	St. Daniel Hospital	Otukpo	Benue
473	EV-AV-FOUNDATION OTUKPO	Otukpo	Benue
474	ENUGBA Primary Health Centre	Otukpo	Benue
475	Ipole Community Development Organisation	Otukpo	Benue
476	Success Hospital	Otukpo	Benue
477	Huma Primary Health Centre	Otukpo	Benue
478	Jhotu Clinic & Maternity	Otukpo	Benue
479	Otia Hospital	Otukpo	Benue
480	Leke Clinic & Maternity	Otukpo	Benue
481	Primary Health Centre Otukpo-Icho	Otukpo	Benue
482	Madonna Hospital	Makurdi	Benue
483	Opa Adoka Primary Health Centre	Otukpo	Benue
484	Salem Hospital	Otukpo	Benue
485	Primary Health Centre Eyokpa	Otukpo	Benue
486	New Era Clinic	Otukpo	Benue
487	New Life Clinic & Maternity	Otukpo	Benue
488	St. Johns Clinic	Otukpo	Benue
489	Otukpo Comprehensive Health Centre	Otukpo	Benue
490	City Hospital Makurdi	Makurdi	Benue
491	Sandra Hospital	Makurdi	Benue
492	Federal Medical Centre	Makurdi	Benue

493	PHC Gwarche	Makurdi	Benue
494	LGHC TORTYU	Makurdi	Benue
495	Queen Clinic	Makurdi	Benue
496	PHC Tse Akii Shi	Makurdi	Benue
497	MCH JOR	Makurdi	Benue
498	PHC ADAA UKUSU	Makurdi	Benue
499	Hemko Hospital	Makurdi	Benue
500	PCH Angorough	Makurdi	Benue
501	PCH Asiasa	Makurdi	Benue
502	LGHC ATIGHIR	Makurdi	Benue
503	Hospital of Immaculate Conception	Makurdi	Benue
504	First Step Action For Children Initiative	Makurdi	Benue
505	Oligbo Primary Health Centre	Makurdi	Benue
506	Fidi PHC	Makurdi	Benue
507	City Hospital	Makurdi	Benue
508	St. Mary Primary Health Centre Chito	Makurdi	Benue
509	PHC Uchi	Makurdi	Benue
510	General Hospital Makurdi	Makurdi	Benue
511	Jato Clinic	Makurdi	Benue
512	Wadata PHC	Makurdi	Benue
513	CHC Onmba Aondo	Makurdi	Benue
514	Health Information Centre	Makurdi	Benue
515	PHC Awenebo	Makurdi	Benue
516	Rahama Clinic	Makurdi	Benue
517	Benue State University Teaching Hospital	Makurdi	Benue
518	Ayala Primary Health Centre	Makurdi	Benue
519	King Cross Clinic & Maternity	Makurdi	Benue
520	Jireh Foundation	Makurdi	Benue
521	Rapal	Makurdi	Benue

522	Bishq Muray Medical Centre	Makurdi	Benue
523	Positive Media	Makurdi	Benue
524	Family Support Clinic	Makurdi	Benue
525	UMTH	Maiduguri	Borno
526	Mamman Shewa Memorial Hospital		Borno
527	Usman Shehu Hospital Bulumkuti	Jere	Borno
528	Mafa General Hospital	Mafa	Borno
529	General Hospital Benishekh	Kaga	Borno
530	Kirenowa General Hospital	Marte	Borno
531	Damasak General Hospital	Mobbar	Borno
532	Ngoshe General Hospital	Gwoza	Borno
533	Akim Health Centre	Calabar	Cross River
534	Navy Hospital	Calabar	Cross River
535	BIOCEE Zion Maternity	Calabar	Cross River
536	Immanuel Infirmiry	Calabar	Cross River
537	Primary Health Centre	Calabar	Cross River
538	Primary Health Post, Bacoco	Calabar	Cross River
539	Bakor Medical Centre	Calabar	Cross River
540	Positive Development Foundation	Calabar	Cross River
541	Ekpri Obutong Health Centre	Bakassi	Cross River
542	Akpad Okon Eneita Health Post	Bakassi	Cross River
543	Ifiang Ayong	Bakassi	Cross River
544	Edik Idim Health Post	Bakassi	Cross River
545	Health Centre Ekpri Obio Abakpa	Bakassi	Cross River
546	Edik Okon Idem Health Post	Bakassi	Cross River
547	Ikot Iwang Health Post	Bakassi	Cross River
548	First Contact Clinic & Maternity Home	Bakassi	Cross River
549	Ine Abasi Health Post	Bakassi	Cross River
550	Ikot Ebiok Ikang Health Post	Bakassi	Cross River

551	Nsidung Health Post	Bakassi	Cross River
552	Primary Health Centre Ikang	Bakassi	Cross River
553	Efut Esighi Health Centre	Bakassi	Cross River
554	Esighi Health Centre	Bakassi	Cross River
555	Ekpri Ikang Health Centre	Bakassi	Cross River
556	Ifiang Nsung Health Centre	Bakassi	Cross River
557	Anderson PHC	Calabar South	Cross River
558	National Youth Service Corps	Calabar South	Cross River
559	Peace Medical Centre	Calabar South	Cross River
560	Mt. Zion Medical Centre	Calabar South	Cross River
561	Madonna Specialist Hospital	Calabar South	Cross River
562	Primary Health Centre Henshaw Town	Calabar South	Cross River
563	Mambo Clinic & Maternity	Calabar South	Cross River
564	Ekpo Abasi Primary Health Centre	Calabar South	Cross River
565	Crutech Medical Centre	Calabar South	Cross River
566	Dr. Lawrence Henshaw IDH	Calabar South	Cross River
567	Primary Health Care Centre	Calabar South	Cross River
568	Akani Esuk Primary Health Centre	Calabar South	Cross River
569	Primary Health Care Centre Anantigha	Calabar South	Cross River
570	Peace Medical Centre	Calabar South	Cross River
571	General Hospital Calabar	Calabar Municipality	Cross River
572	Unical Medical Centre (UMC)	Calabar Municipality	Cross River
573	Teaching Hospital Calabar	Calabar Municipality	Cross River
574	Primary Health Care Centre	Calabar Municipality	Cross River
575	Primary Health Care Centre	Calabar Municipality	Cross River
576	Primary Health Centre Big Qua	Calabar Municipality	Cross River
577	Ministry of Health Centre	Calabar Municipality	Cross River
578	Primary Health Care Ediba	Calabar Municipality	Cross River
579	Ministry of Health and Social Welfare HC	Calabar Municipality	Cross River

580	Faith Foundation Clinic	Calabar Municipality	Cross River
581	Goldie Clinic	Calabar Municipal	Cross River
582	Victoria Itam Hospital	Calabar Municipal	Cross River
583	Blessed Seaatoe Maternity Clinic	Calabar Municipality	Cross River
584	Primary Health Care Centre	Calabar Municipality	Cross River
585	Primary Health Care Centre	Calabar Municipality	Cross River
586	Primary Health Care Centre	Calabar Municipality	Cross River
587	Ikot Ekpo Health Centre	Calabar Municipality	Cross River
588	Mission Hill Clinic	Calabar Municipality	Cross River
589	Primary Health Care Centre	Calabar Municipality	Cross River
590	Health Centre Nyahasang	Calabar Municipality	Cross River
591	Akwa Ibutong Health Post	Bakassi	Cross River
592	Atimasam Health Centre	Akpabuyo	Cross River
593	Ikot Edem Odo Health Centre	Akpabuyo	Cross River
594	Health Centre Ifondo	Akpabuyo	Cross River
595	Health Centre Akpabetim	Akpabuyo	Cross River
596	PHC Ikot Ekpo	Akpabuyo	Cross River
597	Eto Mkpe Health Centre	Akpabuyo	Cross River
598	Esuk Idebe Health Centre	Akpabuyo	Cross River
599	Asabanka Health Post	Akpabuyo	Cross River
600	Akansoko Health Centre	Akpabuyo	Cross River
601	PHC Idundu	Akpabuyo	Cross River
602	Nkakat Nyamba Health Centre	Akpabuyo	Cross River
603	Ikot Offiong Ambai Health Centre	Akpabuyo	Cross River
604	Alji Health Centre	Akpabuyo	Cross River
605	Ikot Otu Abasi Health Centre	Akpabuyo	Cross River
606	Usung Ibawa Ifiang Health Post	Akpabuyo	Cross River
607	Ikot Okpoene Health Post	Akpabuyo	Cross River
608	ST Joseph Hospital Ikot Ene	Akpabuyo	Cross River

609	Ikot Anakanda PHC	Akpabuyo	Cross River
610	Ikot Uba Clinic	Akpabuyo	Cross River
611	Ikot Effang PHC	Akpabuyo	Cross River
612	Ikot Ene Umoh	Akpabuyo	Cross River
613	Ijiman PHC	Yakurr	Cross River
614	Adadama PHC	Abi	Cross River
615	Ijiman Health Post	Yakurr	Cross River
616	Inyima PHC Yakurr	Yakurr	Cross River
617	Ito Central Health Centre	Odukpani	Cross River
618	Usung Esuk PHC	Odukpani	Cross River
619	Ukwa Ibom PHC	Odukpani	Cross River
620	Ubamat Health Post	Odukpani	Cross River
621	Ukwa Ibom Health Centre	Odukpani	Cross River
622	Ndonwong Health Centre	Odukpani	Cross River
623	Okoyong Usang Abasi Health Post	Odukpani	Cross River
624	Akpapa Okoyong PHC	Odukpani	Cross River
625	Odukpani PHC	Odukpani	Cross River
626	Atan Onoyom	Odukpani	Cross River
627	Asang Eniong	Odukpani	Cross River
628	Ataneki PHC	Odukpani	Cross River
629	Ikot Effiong Otop Comprehensive Health Centre	Odukpani	Cross River
630	Obio Usiere	Odukpani	Cross River
631	Adiabo Health Centre	Odukpani	Cross River
632	Ekpene Eki Health Post	Odukpani	Cross River
633	Ikoneto Health Centre	Odukpani	Cross River
634	Creek town Primary Health Centre	Odukpani	Cross River
635	Ekut Ibonda Health Centre	Odukpani	Cross River
636	Mfamosing Health Centre	Akamkpa	Cross River
637	Osomba Health Centre	Akamkpa	Cross River

638	Oban Health Centre	Akamkpa	Cross River
639	Ekong Anaku Health Centre	Akamkpa	Cross River
640	Ayaeba health Centre	Akamkpa	Cross River
641	Ikot Esai PHC	Akamkpa	Cross River
642	Aninegje PHC	Akamkpa	Cross River
643	Iwuru Health Centre	Akamkpa	Cross River
644	Nyaje PHC	Akamkpa	Cross River
645	Uyanga Primary Health Centre	Akamkpa	Cross River
646	Mma effa Health centre	Akamkpa	Cross River
647	Ojor health Centre	Akamkpa	Cross River
648	Mbarakom	Akamkpa	Cross River
649	Ayaebam Health Centre	Akamkpa	Cross River
650	Old Netim PHC	Akamkpa	Cross River
651	Hmai Health Post	Biase	Cross River
652	Ijiman Health Post	Biase	Cross River
653	Itu Agwagune health Post	Biase	Cross River
654	Agwagune Health Centre	Biase	Cross River
655	Akpet Central Cottage Hospital	Biase	Cross River
656	Akpet I. PHC	Biase	Cross River
657	Akpet Central Health Post	Biase	Cross River
658	Adim PHC	Biase	Cross River
659	Akparavuni Health Clinic	Biase	Cross River
660	Abini PHC	Biase	Cross River
661	Aya Medical Centre	Biase	Cross River
662	Orida Health Post	Biase	Cross River
663	Ekpi Iko Health Centre	Biase	Cross River
664	Idoma Health Post	Biase	Cross River
665	Ehom Village Health Centre	Biase	Cross River
666	Ehom Health Centre	Biase	Cross River

667	Iwuru PHC	Biase	Cross River
668	Health Clinic Betem	Biase	Cross River
669	Okureke Health Centre	Biase	Cross River
670	Ijom Health Centre	Biase	Cross River
671	Primary health centre Ikot Okpora	Biase	Cross River
672	PHC Ibogo	Biase	Cross River
673	Prison Clinic	Amocha	Delta
674	General Hospital Isele Uku	Aniocha North	Delta
675	PHC Uku-Oba	Aniocha South	Delta
676	Primary Health Centre Ubulu Uku	Aniocha South	Delta
677	General Hospital Ubulu-Uku	Aniocha South	Delta
678	Saint Anthony Clinic	Aniocha South	Delta
679	St. Theresa's Hospital & Maternity	Aniocha North	Delta
680	Ajulu Clinic	Aniocha North	Delta
681	Anglican Maternity & Hospital Complex	Aniocha South	Delta
682	Primary Health Centre Isele-Uku	Aniocha North	Delta
683	Glory To God Clinic Isele-Uku	Aniocha North	Delta
684	Good News Clinic & Maternity Issele-Uku	Aniocha North	Delta
685	Alpha Clinic & Mat88ernity	Aniocha South	Delta
686	Primary Health Care Centre Ushie	Ndokwa East	Delta
687	Primary Health Care Centre Umuchi	Ndokwa East	Delta
688	Primary Health Care Umu-Oshimili	Ndokwa East	Delta
689	Primary Health Care Iselegu	Ndokwa East	Delta
690	Primary Health Centre Ubulu-Okiti	Aniocha South	Delta
691	Health Clinic Inyi	Ndokwa East	Delta
692	BIOMED Lab	Sapele	Delta
693	EBOR PHC	Ughelli North	Delta
694	Owanta PHC	Ika North	Delta
695	Orogun GH	Ughelli North	Delta

696	Agbarho GH	Ughelli North	Delta
697	Agbarho PHC	Ughelli North	Delta
698	May Flour Clinic & Maternity	Oshimilli South	Delta
699	Madumezie Hospital & Maternity	Oshimilli South	Delta
700	Life Shield Specialist Clinic	Oshimilli South	Delta
701	Marilo Clinic & Maternity	Oshimilli South	Delta
702	Icon Clinic & Maternity	Oshimilli South	Delta
703	Up-Christ Clinic & Maternity	Oshimilli South	Delta
704	Kanayo Hospital & Maternity	Oshimilli South	Delta
705	PCH Cable point	Oshimilli South	Delta
706	General Hospital Ogwashi-Uku	Oshimilli South	Delta
707	Onome Specialist Hospital	Uvwie	Delta
708	Primary Health Centre Oloh	Aniocha South	Delta
709	SKYPHON Medical Clinic	Uvwie	Delta
710	Oweh Clinic & Maternity Oleh	Isoko South	Delta
711	Virtue Clinic Agbor	Ika North	Delta
712	LIZMART Clinic	Uvwie	Delta
713	Boji-Boji Model Primary Health Centre	Ika South	Delta
714	Government Hospital IBUSA	Oshimilli North	Delta
715	Jesus Heals Clinic & Maternity	Sapele	Delta
716	Victory Nursing & Maternity Home	Ika North	Delta
717	Central Hospital Agbor	Ika North	Delta
718	Amukpe PHC	Sapele	Delta
719	Primary Health Centre Abavo Alizomor	Ika South	Delta
720	Primary Health Centre Alihagu	Ika South	Delta
721	Royal Clinic	Sapele	Delta
722	Primary Health Centre Awaahwa	Ughelli South	Delta
723	General Hospital Umunede	Ika North-East	Delta
724	Primary Health Care	Ogwashi-Ukwu	Delta

725	Divine Care Hospital		Delta
726	PHC Oko	Oshimili South	Delta
727	PHC Okwe	Oshimili South	Delta
728	Federal Medical Centre	Oshmili	Delta
729	Temple Clinic And Maternity	Oshimili South	Delta
730	St. Joseph's Catholic Hospital And Maternity	Oshmili	Delta
731			Delta
732	St. Lukes Hospital Asaba	Oshimili South	Delta
733	Siri Hospital	Oshmili	Delta
734	St. Veronica's Clinic	Oshmili	Delta
735	PHC Utagbo-Uno	Ndokwa West	Delta
736	Comprehensive Health Centre, Okpanam	Oshimili North	Delta
737	PHC Okpanam	Oshimili North	Delta
738	PHC Ekiugbo-Iyede	Isoko North	Delta
739	PHC Alifekede	Ika South	Delta
740	St. John's Cath. Hospital Agbor	Ika South	Delta
741	Brema Hospital Kwale	Ndokwa West	Delta
742	PHC Agbor Obi	Ika South	Delta
743	PHC Idumesah	Ika South	Delta
744	PHC Boji Agbor	Ika South	Delta
745	PHC Umueze	Ndokwa East	Delta
746	PHC Umu-Oshimili	Ndokwa East	Delta
747	PHC Ekuoma	Ika North east	Delta
748	Sapele Clinic	Sapele	Delta
749	Ekete-Inland PHC	Udu	Delta
750	PHC Agborho	Ughelli North	Delta
751	Egini PHC	Udu	Delta
752	General Hospital Okwe	Oshimile South	Delta
753	Nke Akam Maternity	Ika North East	Delta

754	PHC Agbor Obi	Ika South	Delta
755	CERPHEC	Ika South	Delta
756	Aliagwa PHC	Ika South	Delta
757	PHC Asaba	Aniocha South	Delta
758	PHC Oniocha Uku	Aniocha North	Delta
759	PHC Igbide	Isoko South	Delta
760	PHC Aviara	Isoko South	Delta
761	PHC Ogodo	Aniocha North	Delta
762	PHC Ewulu	Aniocha South	Delta
763	Stone Hill Clinic	Isoko South	Delta
764	PHC Aligwa	Ika South	Delta
765	PHC Adonte	Aniocha South	Delta
766	PHC Ute Erumu	Ika North East	Delta
767	PHC Obomkpa	Aniocha North	Delta
768	General Hospital Isheagu	Aniocha South	Delta
769	PHC Etua	Ndokwa West	Delta
770	Obule Medical Centre	Sapele	Delta
771	Ekwuoma PHC	Ika North East	Delta
772	PHC Abbi	Ndokwa West	Delta
773	St. Elizabeth Catholic Hospital, Umunede	Ika North East	Delta
774	St. Rebecca's Hospital	Oshimili South	Delta
775	Blessed Maternity	Ika North	Delta
776	St. Maximillian Hospital Okwe	Oshimili South	Delta
777	PHC Mbiri	Ika North East	Delta
778	PHC Umunnede	Ika North East	Delta
779	PHC Abaro	Ika South	Delta
780	St. John's Catholic Hospital	Ika North	Delta
781	PHC Alisieme	Ika South	Delta
782	PHC Oko-Anala	Oshimili South	Delta

783	Uwheru PHC	Ughelli	Delta
784	Afiesere PHC		Delta
785	Prison's Clinic Asbor	Ika South	Delta
786	Institute of Human Virology of Nigeria		Delta
787	St. Pataik;s Hospital Mile Four	Ebonyi	Ebonyi
788	National Obstetric Fistula Centre	Abakaliki	Ebonyi
789	Federal Teaching Hospital	Abakaliki	Ebonyi
790	Mercy Hospital Abakaliki	Abakaliki	Ebonyi
791	Sudan United Mission Hospital Onuenyim	Izzi	Ebonyi
792	Chinenye Maternity	Abakaliki	Ebonyi
793	Azuebonye Idemba Health Centre	Ezza south	Ebonyi
794	Good Shepherd Hospital	Abakaliki	Ebonyi
795	St. theriza Hospital And Maternity	Abakaliki	Ebonyi
796	Ezza Ofu Health Centre	Izzi	Ebonyi
797	MDG Odeaguikenyi Health Centre	Izzi	Ebonyi
798	Model PHC	Abakaliki	Ebonyi
799	Nonyelum Maternity	Abakaliki	Ebonyi
800	Amachara Health Centre	Izzi	Ebonyi
801	Oferekpe Health Centre	Izzi	Ebonyi
802	Sudan United Hospital, Iboko	Izzi	Ebonyi
803	Community Health Practice Centre	Izzi	Ebonyi
804	Ephuenyim Health Centre	Abakaliki	Ebonyi
805	Chidera Health Clinic And Maternity	Ebonyi	Ebonyi
806	MDG Nwofo Health Centre	Ebonyi	Ebonyi
807	Fatima Specialist Hospital	Abakaliki	Ebonyi
808	MDG Amudo Health Centre	Ezza	Ebonyi
809	MDG Azuoffia-Edda Health Centre	Abakaliki	Ebonyi
810	General Hospital Oneke	Ebonyi	Ebonyi
811	Hely Trinity Hospital And Maternity	Abakaliki	Ebonyi

812	St. Vincent Hospital Ndubia	Izzi	Ebonyi
813	Sudan United Mission Hospital, Iziogo	Izzi	Ebonyi
814	Nigeria Prison Service Abakaliki	Ebonyi	Ebonyi
815	Omega HC	Ezza North	Ebonyi
816	MDG Ododokpa	Izzi	Ebonyi
817	Christ The King Hospital	Abakaliki	Ebonyi
818	Chidinma Health Clinic And Maternity	Ebonyi	Ebonyi
819	MDG Onuebonyi HC	Abakaliki	Ebonyi
820	MDG Obegu Ikenyi HC	Izzi	Ebonyi
821	Nwofe HC	Izzi	Ebonyi
822	Divine Mercy Hospital And Maternity	Ebonyi	Ebonyi
823	MDG Inyene HC	Ezza North	Ebonyi
824	Ekka HC	Ezza North	Ebonyi
825	General Hospital, Umuezeoka	Ezza North	Ebonyi
826	MCH Okposi Umuoghera	Ezza North	Ebonyi
827	Ukpachacha HP	Ebonyi	Ebonyi
828	Ette HC	Izzi	Ebonyi
829	Okania HC	Ebonyi	Ebonyi
830	Ugbodo HC	Ebonyi	Ebonyi
831	MDG Mgbabeluzor	Abakaliki	Ebonyi
832	MDG Ekka Hc	Ezza North	Ebonyi
833	Gmelina HC	Abakaliki	Ebonyi
834	Ndieborisiagu HC	Izzi	Ebonyi
835	Ndubuisi Hospital	Ezza North	Ebonyi
836	MDG Onyiringbo HC	Ebonyi	Ebonyi
837	Imoha Cottage Hospital Ogboji	Ezza North	Ebonyi
838	Azunramura HC	Ezza North	Ebonyi
839	St. Peakinys Maternity	Ezza North	Ebonyi
840	MDG Amana HC	Ezza South	Ebonyi

841	Egelle PHC	Igueben	Edo
842	Evbuodia PHC	Oredo	Edo
843	New Benin PHC	Oredo	Edo
844	Irrua Specialist Teaching Hospital	Esan Central	Edo
845	PHC Lampese	Akoko Edo	Edo
846	Osumegbe PHC	Etsako	Edo
847	Auchi Central Hospital	Etsako west	Edo
848	PHC Ososo	Akoko Edo	Edo
849	General Hospital Igarra	Igarra	Edo
850	Eko-Ewu PHC	Esan Central	Edo
851	Central Hospital Uromi	Esan North East	Edo
852	Ibillo General Hospital	Akoko Edo	Edo
853	Ikpema PHC		Edo
854	UBTH	Egor	Edo
855	Dept. of Health services Runder catholic Arch of Benin	Oredo	Edo
856	Fugar PHC	Etsako	Edo
857	Imoga PHC	Akoko Edo	Edo
858	Emwinyomwanru PHC	Oredo	Edo
859	Ubiaja General Hospital	Esan South East	Edo
860	Stella Obasanjo women and Childeren	Oredo	Edo
861	Iruekpen General Hospital	Esan West	Edo
862	Okugbe PHC	Etsako	Edo
863	Santa Maria catholic Hospital	Esan West	Edo
864	St. Camilus Hospital	Esan North East	Edo
865	PHC Dagbala	Akoko Edo	Edo
866	Comprehensive Health Centre	Ekiti west	Ekiti
867	Comprehensive Health Centre Afao	Ikere	Ekiti
868	Comprehensive Health Centre Afao	Ekiti south west	Ekiti
869	Oye Ekiti General Hospital		Ekiti

870	Ekiti State University Teaching Hospital	Ado Ekiti	Ekiti
871	Comprehensive Health Centre Afao	Ise/Orun	Ekiti
872	General Hospital	Emure	Ekiti
873	General Hospital	Gbonyin	Ekiti
874	State Specialist Hospital	Ikere	Ekiti
875	Amodu Health Centre	Nkanu West	Enugu
876	Model PHC	Nkanu West	Enugu
877	Ogbeke Health Centre	Nkanu West	Enugu
878	Ogui Nike Health Centre	Enugu west	Enugu
879	Our Lady Health of te sick Hospital	Nkanu West	Enugu
880	Akegbeugwu Health Centre	Nkanu West	Enugu
881	Cukwuasokam Hospital Enene	Enugu East	Enugu
882	Umueze Health Centre	Enugu west	Enugu
883	Jubilee Maternity	Enugu North	Enugu
884	Ukpoka Health Centre	Isi-Uzo	Enugu
885	Umujiovu Health Post	Isi-Uzo	Enugu
886	Umuhu Health Centre	Isi-Uzo	Enugu
887	St. Anthony Hospital	Isi-Uzo	Enugu
888	Ihenyi Health Centre	Isi-Uzo	Enugu
889	St.Teresa Hospital and Maternity	Enugu East	Enugu
890	Apeh Health Centre	Isi-Uzo	Enugu
891	Agu-Amede Health Centre	Isi-Uzo	Enugu
892	Mbu Akpoti Healt Centre	Isi-Uzo	Enugu
893	Mbu Amon Health Center	Isi-Uzo	Enugu
894	Agudene Mbu Health Centre	Isi-Uzo	Enugu
895	Isu Model Health Centre	Isi-Uzo	Enugu
896	Iji-Nike Cottage Hospital	Enugu East	Enugu
897	Mabuji Health Centre	Isi-Uzo	Enugu
898	Neke Health Centre	Isi-Uzo	Enugu

899	Amede Health centre	Isi-Uzo	Enugu
900	Hqtre Clinic	Isi-Uzo	Enugu
901	Redeemer Hospital and Maternity	Enugu East	Enugu
902	Ogbuzor/Heanyi Health Centre	Isi-Uzo	Enugu
903	Agudene Health Centre	Isi-Uzo	Enugu
904	Ikem District Hospital	Isi-Uzo	Enugu
905	Akpoga Mbu Health Centre	Isi-Uzo	Enugu
906	Ikem Nkwor Health Centre	Isi-Uzo	Enugu
907	Infant Jesus Maternity	Enugu East	Enugu
908	Holy Family Hospital and Maternity	Enugu East	Enugu
909	Onueme Health Centre	Isi-Uzo	Enugu
910	Umualor Health Centre	Isi-Uzo	Enugu
911	Semino Specialist Hospital	Enugu East	Enugu
912	Ikem Health Centre	Isi-Uzo	Enugu
913	Abakpa Health Centre	Enugu East	Enugu
914	Annunciation Specialist Hospital	Enugu East	Enugu
915	First Metrodame Specialist Hospital	Enugu East	Enugu
916	Mother of Christ Specialist Hospital	Enugu East	Enugu
917	Asata Health Centre	Enugu East	Enugu
918	Central Maternity	Enugu North	Enugu
919	Amechi Cottage	Enugu South	Enugu
920	Eastern Nigeria Medical Centre	Enugu South	Enugu
921	Goodnews Hospital	Enugu South	Enugu
922	The Good Shepherd Hospital	Enugu South	Enugu
923	Balm of Gilead Hospital	Enugu South	Enugu
924	Ibezim Medical Clinic	Enugu South	Enugu
925	Divine Grace Hospital	Enugu South	Enugu
926	Nigerian Police Medical Centre	Enugu South	Enugu
927	Uwani Cottage Hospital	Enugu South	Enugu

928	Poly Sub District Hospital	Enugu South	Enugu
929	Obinagu Umanu Akpogu	Nganu West	Enugu
930	Obe Health Centre	Nganu West	Enugu
931	Amuri 1 HC	Nganu West	Enugu
932	Amuri 2 HC	Nganju West	Enugu
933	ST Patrick Hospital	Enugu North	Enugu
934	Kenechukwu Specialist Hospital	Enugu East	Enugu
935	Mother of Mercy, IHE	Agwu	Enugu
936	Agbadala HC	Oji	Enugu
937	Achi Joint Hospital	Oji	Enugu
938	Uewuoba HC	Oji	Enugu
939	Ogudu HC	Oji	Enugu
940	Enugu Inyi HC	Oji	Enugu
941	IHE HC	Awgu	Enugu
942	Awgu District Hospital	Awgu	Enugu
943	Achi Agu 1 Health Post	Oji	Enugu
944	Obune Inyi HC	Oji	Enugu
945	Model HC Ahani	Oji	Enugu
946	Basic HC	Oji	Enugu
947	Achi Cottage Isikwe	Oji	Enugu
948	General Sub. District Hospital	Oji	Enugu
949	Awlaw HC	Oji	Enugu
950	Elugula Nkpokolo HC	Oji	Enugu
951	Inyi Cottage Hospital	Oji	Enugu
952	Ezere Health Centre	Oji	Enugu
953	Mgbowo Health Centre	Awgu	Enugu
954	MCH Awgu(Material and Child)	Awgu	Enugu
955	Umuonwu HC	Oji	Enugu
956	Mgbidi HC(CH)	Awgu	Enugu

957	Mmaku Health Centre	Awgu	Enugu
958	Ugbo HC	Awgu	Enugu
959	Agbogugu Health Centre	Awgu	Enugu
960	Ugwuleshi HC	Awgu	Enugu
961	Nkwe Health Centre	Agwu	Enugu
962	Ugwueme HC	Awgu	Enugu
963	Amoli HC	Awgu	Enugu
964	Ogugu HC	Awgu	Enugu
965	community life advancement project	AMAC	FCT
966	PHC	Gwagwalada	FCT
967	Tsuani PHC	Gwagwalada	FCT
968	National Hospital	Amac	FCT
969	Gwagwalada specialist Hosp.	Gwagwalada Area counci	FCT
970	Kubwa General Hospital	Bwari Area council	FCT
971	Byazhin Health clinic	Bwari Area council	FCT
972	Centre for Health education, economic Rehabilitat and social security	Amac	FCT
973	Gurdi Primary Healthcare centre	Abaji Area council	FCT
974	Mawgi Primary Health centre	Abaji Area council	FCT
975	Rimba clinic	Abaji Area council	FCT
976	Adbgba Clinic	Abaji Area council	FCT
977	Old kutunku Health care centre	Gwagwalada Area counci	FCT
978	Sant mary's catholic Hospital	Gwagwalada Area counci	FCT
979	Dagiri primary Healthcare centre	Gwagwalada Area counci	FCT
980	Our Lady of Fatima Hospital	Bwari Area council	FCT
981	Gwagwalada town clinic	Gwagwalada Area counci	FCT

982	New Township clinic	Abaji Area council	FCT
983	Ayuara Primary Healthcare	Abaji Area council	FCT
984	Kutunku II primary healthcentre	Gwagwalada Area counci	FCT
985	Kwaku PHC	Kuje Area Council	FCT
986	Diff Hospital	Amac	FCT
987	Kabiru Mangoro PHC	Kuje Area Council	FCT
988	PHC Yanga	Kuje Area Council	FCT
989	Rouz Hospital	Amac	FCT
990	Bwari Medical centre	Bwari Area council	FCT
991	Gaube Comprehensive primary healthcare centre	Kuje Area Council	FCT
992	PHC Deidei	Bwari Area council	FCT
993	Modern Health hospital	Bwari Area council	FCT
994	Owner occupier Hospital	Bwari Area council	FCT
995	(KMC) Kubwa Muslim community	Bwari Area council	FCT
996	Mpape Health Clinic		FCT

Annex 8: Individuals interviewed in the course of the audit

S/N	Location	Name of Interviewee	Designation of Interviewee
1	Kogi	Rev.Sr. Cecelia Dike	Hospital Matron
2	Abuja	Mrs Fajobi	Chief NursingOfficer
3	Ondo	Mrs Tugbiyele R.A	Chief NursingOfficer
4	Ondo	Okundalaye E.A	Community health Offi
5	Ondo	Dr.Olatunde O.S	CMD
6	Ondo	Mr Oluwasesan Kehinde	Higher Technical Officer
7	Ondo	Mr Omoge C.T	Deputy Director Health
8	Ondo	Dr. Akintan	CMD
9	Ondo	Mr. Akinnagbe Segun	Accountant II
10	Benue	Dr. Ansawass I.D	Medical Doctor
11	Benue	Mr Adetunji	Dump Attendant
12	Oyo	Mr A. Bello	Plant Coordinator
13	Oyo	Mrs Kadiri Adenike K.R	Chief Hospital Secretary
14	Oyo	Oke Modupe O.	CNO
15	Oyo	Oriola Augustina 'T.	Chief Nursing Officer
16	Ogun	Bakare Gbolahan	Senior Engineer
17	Ogun	PHC UNG. FATICA	I/U
18	Cross River	Mr. Offiong Offiong	Health Officer HIV De
19	Cross River	Nya Edet Bassey	Chief Community Healt
20	Cross River	Mr. Alex Edem	Assistant Chief Healt
21	Bauchi	Suleman Bala	Environmental Health
22	Bauchi	Dr. Andy Ugboji	MD
23	Bauchi	Maryam Sani	Secretary Infection C
24	Bauchi	Adamu Bala	Health Educator
25	Bauchi	Usman Yunusa	M&E HIV/AIDS Dass
26	Bauchi	Sama'ila Mato Jahun	Chief Nursing Officer
27	Bauchi	Shehu Gandi	Medical Attendant

28	Bauchi	Jamilu Munkaila Nasaru	Focal Person Infectio
29	Bauchi	Sani Datti	E.H.O II
30	Kaduna	Jummai Ibrahim	CNO
31	Kaduna	Col IS Ekpo	HOD Preventive Health
32	Kaduna	Khazi B.M	ACNO
33	FCT	Aishatu B.Muhammed	Health Attender
34	Niger	Aliyu Bagudu	Sanitory Officer
35	Niger	Sanda	MLS
36	Niger	Kabiru Tanko	TO
37	Niger	Usman G.K	HOD Lab.
38	Niger	Dr. Ogbechi Ogochukwu	Medical Officer
39	Niger	Idris Mohammed Mokwa	Chief Nursing Officer
40	Niger	Mohammed Bello Lapai	Incharge
41	Niger	Hai Kaka dantani	Incharge
42	Niger	Abubakar Bala	Engineer
43	Niger	Mal. Umar Abdullahi	Craft Man
44	Imo	Eneh Maryann Ngozi	SCHEW
45	Nasarawa	Mohammed Manga	Transport
46	Taraba	Dearsley Peter Dabale	Hospital Secretary
47	Taraba	Felix D. Musa	
48	Taraba	Ahmed Isa	
49	Taraba	Geogenia Ndulaka	Matron
50	Ebonyi	Ogbaga Stephen Omaka	HOD Enveronment Healt
51	Ebonyi	Mr. Agwu Samson O HOD	HOD Enviroment
52	Ebonyi	Ogji	Environmental Supervo
53	Ondo	Dr. Nuhu Tari	PMO
54	Adamawa	Dr. Chinedu Nnabue	PMO
55	Adamawa	Yetunde Isa	Lab Scientist/ Safety
56	Plateau	Mrs. Nandi	

57	Plateau	Mrs. Danter Nandi	Chief Nurse
58	Plateau	Mrs. Nfulul	Officer in-charge
59	Plateau	Mr. Gotep Moses	Matron
60	Plateau	Mr. Danjuma Gongshing	Incharge
61	Plateau	Lydia B, Bulndi	Managing Director
62	Plateau	Mrs. Mafwallal	Officer in-charge
63	Plateau	Mrs. Grace Jacob	Incharge
64	Plateau	Patrick Osu	Program Manager
65	Plateau	Mrs. Elaigwu	Matron
66	Plateau	John Mary Lami	Officer Incharge
67	Plateau	Kadel Haruna	
68	Plateau	Mr. Ezekiel John	Matron
69	Plateau	Mr. John D. Daltop Mat	Matron
70	Plateau	Sati	Cleaner
71	Plateau	Christiana Bello	CCHEW
72	Plateau	Dr. Yero Sambo	Head Of Lab.
73	Plateau	Mrs. Talatu Saleh J.	Incharge
74	Plateau	Azi Bala	Incharge
75	Plateau	Mrs. Sandra	Matron
76	Plateau	Dr. Luka Sambo	Medical Supretendent
77	Plateau	Mr. John	Matron
78	Plateau	Pankyes David	Officer Incharge
79	Plateau	Mr. Dusu Philip	In-charge
80	Plateau	Shehu Istifanus	Maintenance Officer
81	Plateau	Lydia	In-charge
82	Plateau	Iliya	Maitenance Officer
83	Plateau	Dr. Dandi Clement	Medical Superintenden
84	Plateau	Dr. Julfa Nandum	Chief Laboratory Scie
85	Plateau	Inspector Philemon Musa	Medical Officer

86	Plateau	Dr. Samuel Dido	chief Medical Suprete
87	Plateau	Gotorong P. Chundung	C.N.O
88	Plateau	Musa Sati	Program Administrator
89	Plateau	Mrs. Choji	Dep. In-Charge
90	Plateau	Mrs Dabat	CHEW
91	Akwa Ibom	Cecelia A. Okorie	CWO
92	Akwa Ibom	Esther A Umoh	Chief Nursing Officer
93	Akwa Ibom	Ekaete Samuel	CNO
94	Akwa Ibom	Udeme Ekpe	Safety Officer
95	Akwa Ibom	Mfon S William	CNO
96	Akwa Ibom	Comfort Edet	CNO
97	Akwa Ibom	Dr.Samson Etuke	Dn
98	Akwa Ibom	Victor Ubong	ENS
99	Akwa Ibom	Enobeng Inyang	AEN
100	Akwa Ibom	Meresa U Eleperyong	Mid-Wife
101	Akwa Ibom	Friday Udofiu	CNO
102	Akwa Ibom	Christiana Effiong	CNS
103	Akwa Ibom	Eno U Bensen	Nouns
104	Akwa Ibom	Helen W Wkpo	CON
105	Akwa Ibom	Mary Essien	CNO
106	Akwa Ibom	Inyang Ekong	CNS
107	Akwa Ibom	Emem Udoh	CNO
108	Akwa Ibom	Emanuel W Udo	CNS
109	Akwa Ibom	Edidi A Okon	CON
110	Akwa Ibom	Akon U Essien	CNO
111	Akwa Ibom	Udule Ikpe	Nours
112	Akwa Ibom	Glory S Akpan	NOURS
113	Akwa Ibom	Akpoan Friday	NOURS
114	Akwa Ibom	Philip Ekoong	CNS

115	Akwa Ibom	Alice Udo	CNO
116	Akwa Ibom	Abasianu Edet	CNS
117	Akwa Ibom	Patiendure Infon	CNO
118	Akwa Ibom	Uduak Bassey	Waste Manager
119	Akwa Ibom	Apatience Ibok	Environmentalist/Semi
120	Delta	Dr. Ngozi	Medical Officer
121	Nasarawa	Danjuma Sabo	CHEW
122	Nasarawa	Joshua Kaya Gbyah	Data Clerk
123	Nasarawa	Dr. Esther S. Audu	Consultant Med. Micro
124	Nasarawa	Maryahim Egbuam Ibr	C.N.O
125	Nasarawa	Victoria Kwada	I.C
126	Nasarawa	GraceA. Alu	M.L.A
127	Nasarawa	Margreat Abashi	CHEW
128	Nasarawa	Jonathan Stephen	ART Unit Volunteer
129	Nasarawa	Muktar Abdullahi	OIC
130	Nasarawa	Mrs. Rafkat Y. Aku	Deputy OIC
131	Nasarawa	Musa D. Ahmed	M.L.A
132	Nasarawa	Talatu Baje	S.H. Att.
133	Nasarawa	Abdullahi Musa A.	Hospital Secretary
134	Nasarawa	Abraham Peter	J-CHEW
135	Nasarawa	Adamu Bako	J-CHEW
136	Nasarawa	Tabitha L. Reuben	CHEW
137	Nasarawa	Mbirme Kadon Rize	Technical officer
138	Nasarawa	Susan Maida	CHEW
139	Nasarawa	Haj. Aishat Dalhatu	CWO/CHO
140	Benue	Abdullahi Isiaku	OIC
141	Jigawa	Abdullahi Mohammed	OIC/Focal Person
142	Jigawa	Bello Abdullahi	PNO
143	Jigawa	Sani Abdullahi	

144	Jigawa	Abubakar Hassan	PNO
145	Jigawa	Alh. Idris Wuriwa	Officer in charge
146	Jigawa	Suleiman Bala	OIC
147	Jigawa	Dahiru Musa	CNO
148	Jigawa	Sakina Shuibu	ART Nurse
149	Jigawa	Jamila Adamu Abdullah	HACNO
150	Kebbi	Na-Allah Garba Jiga B	Cleaner
151	Kebbi	Abubakar Mohammed	Zonal Health Officer
152	Delta	Usman Umar	Facility Support Staf
153	Katsina	Engr. S. Yusuf	Maintenance Officer
154	Katsina	Adamu Suleiman	HOD, Maintenance
155	Lagos	Mr. Lateef Ogunleye	Chief Environmental H
156	Lagos	Ogunleye Kolawoaole	Principal Environment
157	Sokoto	M.K. Mai-Akwai	SEPA
158	FCT	Iheanaetu Angela	R/M
159	FCT	Shehu sufiyanu	
160	FCT	Sani Agwai	Head of laboratory un
161	FCT	Nafisat Abdulsalam	Nurse
162	FCT	Solomon Ibe	Lab Technician
163	FCT	Ma'azu Kabir .A	Med. Lab. Attendant
164	FCT	Ishaka Sule	Med. Lab. Attendant
165	FCT	M.S Ibrahim	Head of Laboratory un
166	FCT	Mari'am Ta'au	Nurse
167	FCT	Thompson Ifeoma	Assistant to the lab.
168	FCT	Zainab Musa	Person in charge of t
169	FCT	Gwagwalada clinic and	Mohammed Iliasu
170	Plateau	Abdulmumini mohammed	C.H Aide
171	Abia	Okezie Precious Chidin	SCHEW
172	Zamfara	Sa'adatu F. Audu	Secretary

173	Zamfara	Fatima Abubakar Yahaya	I/c
174	Cross River	Mr. Akpan	Security
175	Cross River	S.M Doko	CNO
176	Cross River	Isiya Bala	SMLT
177	Zamfara	Murtala Rabiu	HOD Lab.
178	Zamfara	Barau Abubakar	CMO
179	Zamfara	Muktar Usman	CMO
180	Abia	Dr Abdullahi S.A	P.M.O
181	Zamfara	Shuaibu Uba Abba	SMLS
182	Zamfara	Musa Sani Mada	I / C
183	Zamfara	Garba Umar	2 I / C
184	Zamfara	Haruna Abdullahi	Desk Office
185	Kaduna	Daniel D.	CNO
186	Nasarawa	Joshua Kaya Gbyah	Data Clerk
187	Kebbi	Abubakar Mohammed	Zonal Health Officer
188	Katsina	Usman Umar	Facility Support Staf
189	Katsina	Engr. S. Yusuf	Maintenance Officer
190	Katsina	Adamu Suleiman	HOD, Maintenance
191	FCT	M.K. Mai-Akwai	SEPA
192	FCT	Efenarhua Samson	Med. Lab scientist
193	FCT	Ishaka Sule	Med. Lab. Attendant
194	FCT	M.S Ibrahim	Head of Laboratory un
195	Zamfara	S.M Doko	CNO
196	Zamfara	Isiya Bala	SMLT
197	Zamfara	Murtala Rabiu	HOD Lab.
198	Zamfara	Barau Abubakar	CMO
199	Zamfara	Muktar Usman	CMO
200	Zamfara	Dr Abdullahi S.A	P.M.O
201	Zamfara	Shuaibu Uba Abba	SMLS
202	Zamfara	Musa Sani Mada	I / C

Annex 9: Health Care Waste Management options applicable

(for both primary and secondary healthcare facilities based on Healthcare Waste Management Plan for the Nigeria State Health Programmatic Investment Credit, 2011)

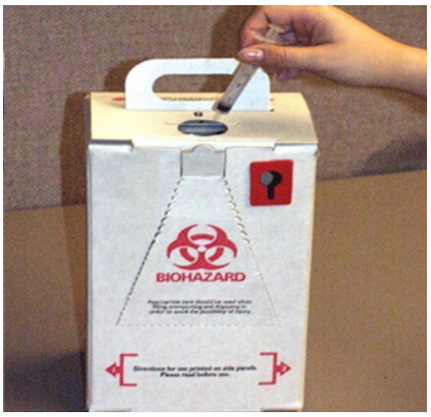
HCWM minimization

To reduce the amount of hazardous HCW generated at Primary and Secondary healthcare facilities in Nigeria;

- The use of recyclable materials and products should be encouraged;
- Encourage a preference for oral alternatives in place of injections in treatment when appropriate;
- ensure good management and control practices especially in the purchase and use of pharmaceuticals; and,
- enforce a rigorous and careful segregation of HCW at source.

Segregation

Correct waste segregation is the fundamental first step for efficiently and effectively managing HCW. Proper segregation of waste at source will also reduce the quantity of waste requiring treatment prior to final disposal.



Infectious and other hazardous waste must be segregated at source and put in appropriate colour–coded containers/bags as recommended by the National HCWM Guidelines. In particular, sharps must be segregated from other HCW at their point of generation.

Important elements specific to the segregation of sharps include:

1. Sharps boxes, should be used strictly for sharps. Where there is a difficulty in getting sharps boxes, the use of recycled cardboard boxes is acceptable if it is puncture resistant, securely in place, easy to insert sharps, contains sharps without risk of spillage, and is well labelled.

2. No healthcare waste other than sharps should be deposited in sharps containers. When a disposable syringe is used, the packaging should be placed in the general waste bin and the used syringe in the sharps container.

3. Syringes and needles must be discarded of immediately following use without needles being removed from syringe, recapped, bent or broken before disposal (except where the healthcare facility has appropriate needle cutters/removers in place).

4. The whole combination must be inserted into the safety box directly after use. If removal of the needle is required, special care must be taken.

Colour Coding

The colour coding system for HCW as recommended by the Nigeria National Healthcare Wastes Management Guidelines document is black, yellow and red in primary healthcare facilities, and black, yellow, red, and brown in secondary and tertiary healthcare facilities, and is one of the efficient ways of achieving segregation of waste and for sorting out items such as paper, plastic, glass and metal for recycling.

- Colour coding for plastic bags should correspond or match whenever possible the waste containers.

Recommended segregation and colour coding system in Nigeria

It is essential that clinical and related wastes are properly segregated, packaged, labelled, handled and transported to minimize risk to waste handlers and the community, such as needle stick injuries and transmission of infectious diseases.

Recommended colour coding system for primary HCFs in Nigeria

Black Yellow

- non-risk waste of category infectious waste and highly infectious waste
- sharps collected in yellow, puncture-proof containers

Recommended colour coding system for secondary HCF in Nigeria

Black Yellow Red Brown

- non-risk(domestic) waste infectious waste
- sharps collected in yellow, puncture-proof containers highly infectious waste pharmaceutical waste, some chemical waste, heavy metal wastes

Class	**Labelling**	**International symbols**
2	« Danger! Hazardous infectious waste »	
3	« Danger! Contaminated sharps, do not open »	
4	« Danger! Anatomical waste, to be incinerated or deeply buried »	
5	« Danger! To be discarded by authorized staff only »	
6	« Danger! Highly infectious waste, to be pre-treated »	
7	« Danger! Radioactive waste »	

- All waste bags or containers should be labelled with basic information in English and the local language of the area where the HCF is located. Basic label information should include type of waste in the container; name of the ward/facility, date of collection and, warning of hazardous nature.

- Provide Colour-coded refuse bags & bins (Black, yellow and red for the primary healthcare facilities) and (black, yellow, brown and red for the General Hospitals.

- Introduce segregation code of practice to be followed in each hospital.
- Training - Continuous training of staff.
- Reinforce on-job training and supervision.

HCW Collection

After proper segregation is performed, it is important that routine collection of waste is conducted. Health care waste collection must be performed on a regular schedule by designated personnel and carried out along well-defined routes within the HCF.

- When full, all health care waste containers must be sealed to prevent spilling during handling and transportation
- Bins/boxes and collection receptacles must not be overfilled and must be transported in carts well fitted to prevent spillages.

- Sanitary staff and cleaners should always wear Personal Protective Equipment (PPE) including, as a minimum, overalls or industrial aprons, nose mask, heavy duty gloves, and safety boots.
- Regulations and supervisory arrangements must be set in-place to ensure that personnel utilize PPE when on duty.
- No bags should be removed unless they are labelled with their point of production (hospital and ward or department) and contents.
- The bags or containers should be replaced immediately with new ones of the same type.
- A supply of fresh collection bags or containers should be readily available at all locations where waste is produced.
- Containers for waste collection should meet the following requirements:
    - Non-transparent;
    - Impervious to moisture;

- Sufficient strength to prevent easy damage during handling or use;
- Leak resistant;
- Close-fitted lids;
- Fitted with handles for easy manipulation;
- Light weight and convenient;
- Designed to minimize physical contact.

- Nursing and other clinical staff should ensure that waste bags are tightly sealed when three-quarters full by tying the neck or sealing tag. Bags should not be closed by stapling.
- Sealed sharps containers should be placed in a labelled, yellow infectious health-care waste bag before removal from the hospital ward or department.
- Wastes should not be allowed to accumulate at the point of production.
- Routine programmes for waste collection should be established as part of the hospital's waste management plan (daily or as frequently as is necessary) and should be transported to a central storage site or treatment site.
- Collection carts should be easy to load and unload, have no sharp edges that could damage waste bags or containers, and be easy to clean.
- Water and hand-wash materials must be readily available for healthcare waste handlers to wash their hands after handling HCW.

7.3 HCW Waste Storage

Storage is the time lapse between the productions of the waste until collection for final disposal. Consideration for storage must be based on the classification or type of waste being dealt with and the potential risk of infection to health-care workers, waste disposal staff, and the public.

The following rules should be observed for proper storage of HCW in Nigeria:

- Initial packaging should take place where HCW is generated.
- Non-risk HCW should always be stored in a separate location from the infectious / hazardous HCW in order to avoid cross-contamination.

The Nigeria National Guidelines for HCWM recommends the under-listed characteristics for infectious and hazardous waste storage facilities for health-care waste:

- Impermeable, hard-standing floor with good drainage;
- easy to clean and disinfect, with a water supply;
- easy access for staff in charge of handling the waste;
- locked to prevent access by unauthorized persons;
- easy access for waste-collection vehicles;
- protected from the sun;
- for storage periods more than 24 hours, temperature must not exceed +10 degrees Celsius. (The storage of biological waste might require much lower temperatures);

- inaccessible for animals, insects, and birds;
- good lighting and at least passive ventilation;
- outside the proximity of fresh food stores or food preparation areas; and,
- Convenient to a supply of cleaning equipment, protective clothing, and waste bags or containers.
- Provide secured storage with adequate chambers for infectious, non-infectious, and food waste

7.4 HCW Waste Handling/Internal Transport

Health-care waste should be transported by the quickest possible route, which should be planned before the journey begins.

- Every effort should be made to avoid unnecessary handling of HCW;
- Hazardous HCW must be packaged in a closed yellow or red bag, tied and placed into sturdy container
- Waste that has the potential to leak must be double bagged
- all waste bags should be in-place and intact at the end of transportation;
- Provide dedicated trolleys/ trolley bins for on-site transport.
- Personnel handling/transporting HCW must wear PPE (i.e. gloves, lab coat, etc.)
- Have spill clean-up material available or, at minimum, know where it is (i.e. absorbent pads, bleach solution, etc.)

Off-site Transport

When transporting waste off-site, it is important that:

- Vehicles should be kept locked at all times, except when loading or unloading;
- when transporting hazardous waste, vehicles and containers must be cleaned and disinfected daily with an appropriate disinfectant;
- waste bags should be placed in containers (e.g. cardboard boxes or wheeled, rigid, lidded plastic or galvanized bins), before being placed directly into the transportation vehicle;
- any vehicle used to transport health care waste should fulfil the following design criteria:
- Suitable size for the amount of waste;
- designed such that the load is retained even if the vehicle is involved in a collision;
- include a system for securing the load during transport;
- possess a separate compartment in the vehicle for spare plastic bags, suitable protective clothing, cleaning equipment, tools, disinfectant, and “spill,” and,
- able to be easily cleaned and have no sharp edges to damage waste containers.
- Provide securely designed transport vessel for off-site transport

7.5 HCW Waste Treatment

Proper treatment and disposal of healthcare waste is necessary to ensure that its impact on the environment and human health is minimized or eliminated. Unfortunately, environmental-friendly, safe and affordable options for treatment and disposal are not readily available for every situation in Nigeria.

The first step in HCWM is to ensure that all non-risk (general) waste is safely sent to the municipal waste management system. The remaining fraction of hazardous and highly hazardous health care waste should be treated and disposed appropriately to meet the following objectives:

- destruction of viable infectious organisms
- destruction/transformation of used or expired pharmaceuticals and chemicals
- destruction of sharps and other materials capable of causing physical injuries
- decomposition of radioactive waste materials
- final disposal / destruction of body parts, tissues, blood and other organic material
- avoidance or minimisation of secondary impacts from the disposal system

Decisions regarding treatment technology should be made at hospital level; however responsible personnel for waste management in the hospital should be in close contact with the regulatory/ supervisory authority.

– All non-hazardous HCW not designated for recycling should be collected and managed with the general municipal waste.

– Burning in low temperature incinerators, preferably a well designed, constructed and managed De-Montfort Waste Disposal Unit (DWDU) –is satisfactory whenever this can be made available for a primary health centre and even for some secondary healthcare facilities. However, this option is not satisfactory environmentally, and should only be considered a short-term solution to HCW treatment.

Disposal in Burial Pit

100. Burying HCW in specially constructed pits (lined with impermeable materials such as clay) is for the present moment probably the most affordable and acceptable options for Primary HC facilities. This option has the advantage that it can be made available immediately, is cheap to provide, and the personnel can be easily trained on how to manage it in an environmentally sound manner. Of course it has its drawbacks – pollution of air, soil and water; spread of diseases by rodents and insect vectors (when soil-cover is not appropriately utilised); trespass by human beings and animals. A guideline on the safe construction and operation of a HCW burial pit (as designed by the consultant) has been added as an appendix to this HCWM plan document.

Centralized Incineration

– Treatment in a centralized Rotary Kiln Incinerator with good emissions management system, situate in a Tertiary or big secondary healthcare facility (or run by a private waste management firm/ Public-Private partnership arrangement) in the region; with HCW collection by a HCWM contractor or public collection system in the opinion of the Consultant, would be the ideal option for the management of HCW from primary and secondary healthcare facilities in Nigeria. This approach would reduce health and environmental pollution risks that would arise from several inefficiently managed and run incinerators or burning pits/burials pits. The major drawback of this approach is that it will take some time to put in place, is expensive to set-up, and will require a transportation infrastructure that is well organized. But once the initial problems associated with setting up the system are overcome, it should run smoothly, especially if a public-private arrangement for the management of the incinerator is achieved

Waste Treatment in Secondary Healthcare Facilities:

Treatment in a Centralized Incinerator

– As with primary healthcare facilities above, sending the HCW from a secondary healthcare facility for treatment in a centralized dual chamber, semi-pyrolytic (preferably a rotary kiln) incinerator, operating at temperatures above 1000°C in the primary chamber and 1200°C in the secondary chamber and incorporating a good emissions management system, situate in a Tertiary or big secondary healthcare facility (or run by a private waste management firm/Public-Private partnership arrangement) in the region would be the ideal option.

The advantages in choosing off-site centralized HCW treatment solutions are:

a) financial: greater cost-effectiveness can be achieved in larger units unless the running costs for waste collection and transportation remain too expensive;

b) technical: efficient operation and maintenance of units is easier to ensure in a centralized facility than in several plants where financial and human resources may not be readily available;

c) legal compliance: conformance to environmental norms are easier to achieve, thanks to the use of more sophisticated/ expensive technology and by the reduced number of facilities that need to be monitored by environmental surveillance authorities.

Treatment in an On-site Incinerator

– Waste treatment in an on-site, high temperature, dual chamber, semi-pyrolytic incinerator– (which operate at temperatures of over 800°C in the primary chamber, and 1000°C in the secondary chamber), with a good emissions management system is recommended for lager secondary healthcare facilities that is in a region where there is no secondary or tertiary healthcare facility with a good quality incinerator installed. This incinerator should be used to manage HCW from other healthcare facilities in the region, especially by utilizing specialized private HCW managers for waste collection, and whose standards of operation would be supervised by the relevant environmental regulatory authorities.

Note: An Environmental & Social Impact Assessment (ESIA) would be carried out prior to the installation of incinerators in line with the existing laws in Nigeria and World Bank safeguards Policies.

Treatment in a De-Montfort WDU

– As with the primary healthcare facilities, burning in low temperature incinerators, such as a well designed, constructed and managed De-Montfort Waste Disposal Unit (DWDU) –would be satisfactory. However, as noted above, this option is not satisfactory environmentally, and should only be considered a short-term solution to HCW treatment in a secondary healthcare facility.

Treatment in a Burial Pit

– Burying of the HCW in specially constructed pits (lined with impermeable materials such as clay) as described above for treatment of HCW in primary healthcare facilities would be acceptable for use in secondary healthcare facilities where incinerators are unavailable.

Final Disposal of HCW

To fulfil Best Environmental Practices (BEP), an Environmental and Social Impact Assessment (ESIA) will precede commencement of any civil works aimed at installation of incinerators in both primary and secondary healthcare facilities.

7.6 Disposal Procedural Steps

- Provide secured appropriately lined pits for final disposal of incineration ash.
- Transportation of incineration ash and non-hazardous and treated hazardous waste (that has been rendered non-infectious) to engineered designated (sanitary) land fill sites.

7.7 Resources & Human Capacity Development

- Ensuring mandatory budgeting for HCWM by Healthcare Facilities
- Development of the capacity of healthcare personnel, HCW waste handlers, and HCW waste treatment personnel to appropriately manage HCWM
- Regular trainings and re-trainings of personnel on HCWM techniques
- Provision of awareness materials on HCWM in healthcare facilities and ensuring that they are put in strategic locations in the healthcare facility, and at the points of HCW generation.
- Ensuring that HCWM Committees are setup in healthcare facilities and that they carry out their functions effectively (the Chief Medical Officer of the facility must be the leader of this committee)
- Ensuring that all healthcare facilities appoint/designate a specific officer to be in-charge of HCWM
- Development of supervisory capacity and monitoring mechanism for the implementation of a well developed HCWM Plan for healthcare facilities (including records keeping mechanisms)
- Awareness creation and capacity development in the communities on the dangers associated with improper HCW handling and disposal
- Support and development of mechanisms for private institutions to be involved in HCW collection, transport, treatment and disposal process
- Standardization of transport facilities for the management of HCW

Recordkeeping

o The HCWM Officer must have a fully completed internal HCW manifest ready before transporting the waste to the designated disposal location.

- All details (type, weight, quantity, etc) of the HCW must be filled prior to movement of the wastes for disposal
- A copy of the HCW manifest must be kept at the HCF a copy by the HCW Officer.
- Spillages

Spills should be cleaned-up if:

- The supplies to absorb and bag the spilled material is available
- Use Bleach, diluted to 1:10 with water: to decontaminate the spill area and to clean/decontaminate equipment used in spill response. Cover the spilled area with absorbent pad or paper towels and then pour diluted bleach over the towels; let to stand for 30 minutes and the clean-off
- To reduce the number of employees at risk of exposure: Restrict access to the area of the spill; Provide warnings of hazards and advice about special requirements
- Proper PPE must be worn whilst cleaning spills

Procedures for Clean-up of Mercury Spillages

- Contain the area to prevent spreading the mercury.
- Evacuate the room or affected area immediately. Open exterior windows to ventilate the room. Keep people and animals away to prevent tracking.
- Shut down any ventilation system that would spread mercury vapor to other areas. Lower the temperature if possible because this lowers the amount of mercury that can vaporize. Cover the mercury with plastic to reduce evaporation into indoor air if the mercury is not going to be cleaned up immediately and is confined to a small area.
- Keep anyone who may have been contaminated in a separate room until they can change their clothing and shoes, and remove other articles such as watches or jewelry. If possible, have people shower or at least wash thoroughly before changing into fresh clothes. This protects other people from mercury contamination and prevents the mercury from spreading further.
- Double bag, label and secure these broken containers or items as hazardous waste until proper cleaning or disposal/recycling can be arranged.
- Close the doors and ventilate to the outside by opening windows and activating any existing exhaust fan that vents to the outside.
- Never use a vacuum cleaner, mop or broom to clean up a mercury spill! Heat from the vacuum's motor will increase the amount of mercury vapor in the air. Mops and brooms will spread the mercury, making proper cleanup more difficult and costly. The vacuum cleaner, mop or broom will become contaminated and require disposal as hazardous waste.
- Never pour mercury down a floor drain or any other drain because the mercury may get trapped in the plumbing and continue to vaporize.

Procedures for Reporting and Tracking Spillages

- Inform the immediate supervisor of the unit if any personnel are involved in a spill or cleanup.
- The supervisor must immediately maintain restriction to the area of the accident.
- Information of the spill should be passed to all personnel in a calm and organized manner.

- Personnel of the unit in which the accident occurred should implement appropriate clean-up. It is recommended that health care facilities be provided with US EPA Mercury Clean-up Kits (one of the most effective mercury clean-up kits; containing procedures for best handling of spills and environmentally sound disposal of broken chemical containers).

- The incident should be finally communicated to the records department of the health facility for documentation and lessons learned.

Note: If it is a larger chemical or non-chemical spill there will be a required increase in personnel assistance for clean-up and a more organized clean-up approach.

Prevention of Spillage

Containers and items should be placed in secure areas and marked “breakable handle with care” behavioural patterns are a factor of good or ineffective safety practices. Personnel need hospital chemical safety trainings and educated on the use of material safety data sheets (MSDS) for the identification of chemical in their facilities.