



Kingdom of Lesotho

Millennium Development Goals Status Report 2013



ERADICATE EXTREME POVERTY AND HUNGER ACHIEVE UNIVERSAL PRIMARY EDUCATION PROMOTE GENDER EQUALITY AND EMPOWER WOMEN REDUCE CHILD MORTALITY IMPROVE MATERNAL HEALTH COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES ENSURE ENVIRONMENTAL SUSTAINABILITY DEVELOPE GLOBAL PARTNERSHIP FOR DEVELOPMENT



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FOREWORD

At the millennium summit in 2000, 189 nations including the Kingdom of Lesotho committed themselves to a new global partnership to reduce extreme poverty and achieve substantial progress in human development through the realization of eight overarching Millennium Development Goals (MDGs) and targets. This commitment would form the foundation for a better future for people all over the world.

This 2013 Millennium Development Goals Status Report presents information on the status of each of the eight global MDGs using the latest available data. As the formal 2015 deadline for the MDGs draws near, the report incorporates elements that provide insight into the country's status as well as pinpointing issues that remain vital for the country's post 2015 agenda. In particular, the report reflects on national milestones around the MDGs, their influence on the country's development agenda, as well as the unfinished business of the MDGs and emerging priorities. Our performance on the MDGs in the last fourteen years is broadly unsatisfactory and there is now urgent need to act decisively.

It is also notable that the MDGs bear close relationship to the seven pillars of the National Vision 2020. Thus, for those goals we have faltered, we are off the trajectory to accomplish the vision we have set for ourselves. For the goals we will likely achieve, we will make efforts to consolidate achievements including by focussing on quality and human capacity. For those goals for which progress has been slow or absent, we will redouble our efforts going forward to deliver a better future for Basotho and also extend our focus to include consideration for people with disabilities. In the post-2015 period, we will mobilise more development partnerships and exert decisive leadership to ensure traction of our efforts to attain our goals.

The 2013 MDG Status Report for the Kingdom of Lesotho is candid in its assessment of our performance in the last fourteen years. It should provide a basis for equally candid policy discussions and learning from our deficits in implementation as well as stronger policy direction going forward. It calls for a more coordinated and concerted action towards achieving national development goals.



The Right Honourable Motsoahae Thomas Thabane

Prime Minister

PREFACE

As the 2015 test date for the Millennium Development Goals approaches, Lesotho has undertaken an assessment of progress in the attainment of the eight globally agreed MDGs. Interpretation of statistical data and consultations in the last few years underpins the conclusions reached in this assessment. Views have also been canvassed on the aspirations of Basotho for the period beyond 2015 and these are reflected in this report.

The Lesotho 2013 Millennium Development Goals Status Report reveals a mixed picture of success and challenges in the path to attaining the agreed MDGs. Based on available data, Lesotho is on track to achieving the goal on universal primary education (MDG 2) and promoting gender equality and empowering women (MDG 3). The strong commitment to free primary education has contributed positively to the efforts to attain the second MDG. However, like many of its peers, Lesotho has focused heavily on getting the numbers into school, while paying inadequate attention to the quality of education. Our efforts from now and beyond 2015 period will be to increase the quality of education and life skills as well as access to higher levels of education. Policies are being developed and implemented in this regard, but more will need to be done going forward.

Leadership, conducive public opinion and decisive policy action has paved way for improved gender equality and empowerment of women, putting MDG 3 within reach by the target date. However further action to consolidate the gains and to continue to democratize opportunity for all genders will be required.

Slow progress has been observed on ensuring environmental sustainability (MDG 7) and developing global partnerships for development (MDG 8). Very limited progress has been achieved on reversing land degradation, which is the foremost environmental challenge for Lesotho. Fragile soils, degraded rangelands and volatile climate combine to hold back progress on eradicating extreme poverty and hunger (MDG 1), for which Lesotho is off-track. Strong action on MDG 7 will enhance efforts toward the attainment of MDG 1 and others that link closely to the natural resource base.

The health-related MDGs of child health (MDG 4), maternal health (MDG 5) and combating HIV and AIDS, TB and other diseases (MDG 6) are out of reach for 2015, but are critical to accomplishing any level of development and all other MDGs. Inadequate progress in reducing new HIV and AIDS infections has created negative feedback loops to the other MDGs by amplifying vulnerability at the household level and undermining productive activities. Stronger and timely action is needed to reverse trends in these health-related MDGs.

Partnerships are critical to making progress towards attaining all MDGs. Recognition of the positive and complementary roles to be played by the private sector, civil society, development partners, and others has been slow, but has now picked up considerably both at the global and national levels. For its part, government is negotiating with various partners agreements to ensure effective action.

Going forward, the Government of Lesotho is committed to galvanizing momentum for action in the period to and beyond the 2015 MDG deadline.



Honourable Moeketsi Majoro

Minister of Development Planning

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Contributors to the report include government ministries, departments, parastatals, agencies, development partners, civil organizations and members of the private sector, all of which provided valuable data, feedback, and peer review. Furthermore, the Lesotho Council of NGOs (LCN) undertook a countrywide consultative process on the Post 2015 Agenda.

The Government of Lesotho is grateful to the Drafting Team that wrote the report, Mr Potlako Peko, Director of M&E Department and Drafting Team Leader; Ms Lineo Mokitimi, Chief Economic Planner (MDP); Mr Thuloane Tšehlo, National Economist (UNDP); Ms Liako Mofo, Chief Economist (MDP); Mr Retšelisitsoe Pulumo, Senior Economic Planner (MDP); Ms Moipone Lehloara, Senior Economic Planner (MDP); Mr Sebothama Moshoeshe, Senior Economic Planner (MDP); Ms 'Mahlompho Chaotsane, Economic Planner (MDP); Mr Sentele Monaheng, Economic Planner (MDP); Ms 'Mabereng Mpoosa, Economic Planner (MDP); Mr Bokang Lekau, Assistant Economic Planner (MDP); Ms Puseletso 'Musi, Senior Economic Planner (MDP) with invaluable support from Mr Tšepo Mosoeunyane, Assistant Economic Planner (MGYSR); Ms 'Mamolitsane Thoothe, Senior Economic Planner (MOH) and Ms Mahali Sekantši, Principal District Gender Officer (MGYSR).

Finally, the development of Lesotho's MDG Status Report 2013 was overseen by the steering committee: Ms Alka Bhatia, Economic Advisor (UNDP); Ms Mothweselo Lefosa, Director (BOS) and Ms Nthoateng Lebona, Director (PSP).

List of Acronyms

AAP	Africa Adaptation Programme	LHPW	Lesotho Highlands Water Project
AGOA	African Growth and Opportunity Act	LMS	Lesotho Meteorological Service
AIDS	Acquired Immune Deficiency Syndrome	LNDC	Lesotho National Development Corporation
AJR	Annual Joint Review of the Health Sector	LREBRE	Lesotho Renewable Energy Based Rural Electrification Project
ALAFA	Apparel Lesotho Alliance to Fight		
AidsART	Antiretroviral Treatment	LVAC	Lesotho Vulnerability Assessment Committee
ARV	Antiretroviral	MAFS	Ministry of Agriculture and Food Security
BCC	Behaviour Change Communication	MC	Male Circumcision
BOS	Bureau of Statistics	MCA	Millennium Challenge Account
CA	Conservation Agriculture	MCC	Millennium Challenge Corporation
CBL	Central Bank of Lesotho	MCP	Multiple and Concurrent Partnerships
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women	MDG	Millennium Development Goal
		MFLR	Ministry of Forestry and Land Reclamation
CHAL	Christian Hospital Association of Lesotho	MMR	Maternal Mortality Ratio
CMS	Continuous Multi-purpose Household Survey	MNR	Ministry of Natural Resources
CO2	Carbon Dioxide	MOE	Ministry of Education
DAC	Development Assistance Committee of the OECD	MOF	Ministry of Finance
DHMT	District Health Management Team	MOGYS	Ministry of Gender, Youth, Sports, and Recreation
DMA	Disaster Management Authority	MOH	Ministry of Health
DNA-PCR	Deoxyribonucleic Acid-Polymerase Chain Reaction	MSME	Medium, Small, and Micro Enterprises
DOE	Department of the Environment	MTCT	Mother to Child Transmission
DRWS	Department of Rural Water Supply	MTEC	Ministry of Tourism, Environment, and Culture
EIA	Environmental Impact Assessment	MTICM	Ministry of Trade, Industry, Cooperative, and Marketing
EMICS	Strategic Environmental Assessment		
EPA	Economic Partnership Agreement	NAC	National AIDS Commission
EASSy	East African Submarine System	NDSO	National Drug Supply Organization
EU	European Union	NEC	National Environmental Council
FAO	Food and Agriculture Organization of the UN	NGO	Non-Governmental Organization
FDI	Foreign Direct Investment	NSDP	National Strategic Development Plan
FNCO	Food and Nutrition Coordinating Office	ODA	Official Development Assistance
FPE	Free Primary Education	OECD	Organization for Economic Cooperation and Development
GBV	Gender Based Violence		
GDP	Gross Domestic Product	OVC	Orphaned or Vulnerable Children
GNI	Gross National Income	PMTCT	Prevention of Mother to Child Transmission
GOL	Government of Lesotho	RED	Reaching Every District Immunization Initiative
ha	hectare	RSA	Republic of South Africa
HAART	Highly Active Antiretroviral Treatment	SACU	Southern African Customs Union
HIV	Human Immunodeficiency Virus	SADC	Southern Africa Development Community
HTC	HIV Testing and Counselling	SEA	Strategic Environmental Assessment
ICT	Information and Communication Technology	STG	Standard Treatment Guidelines for Pharmaceuticals
IDA	International Development Association of the World Bank	SWAP	Sector-Wipe Approach for Aid Coordination
		SIAPS	Systems for Improved Access to Pharmaceuticals and Services
IMCI	Integrated Management of Childhood Illnesses		
IUCN	International Union for the Conservation of Nature	TB	Tuberculosis
LCA	Lesotho Communications Authority	UAF	Universal Access Fund
LDHS	Lesotho Demographic and Health Survey	UNDP	United Nations Development Programme
LHDA	Lesotho Highlands Development Authority	USD	United States Dollar
LDS	Lesotho Demographic Survey	VIP	Ventilated Improved Pit Latrine
LGNSP	Local Governance and Non-State Actors Support Programme	WASCO	Water and Sanitation Company
		WFP	World Food Programme

Section I Overview



LESOTHO'S DEVELOPMENT CONTEXT

The Kingdom of Lesotho is a small, mountainous country landlocked within South Africa. Its land area measures 30,355 km². It is classified among the Least Developed Countries with a per capita income of \$1879 (PPP)¹. It ranks 158 out of 187 countries on the UN Human Development ranking, falling into the category of low human development. National poverty figures indicate that 57.1% of the population lives below the national poverty line. Income distribution is unequal indicated by a Gini coefficient of 0.54. Due to the devastating impact of the HIV/AIDS epidemic, average life expectancy stands at 48.7 years. Literacy rates are high at 80.9% for men and 96.9% for women in the age group of 15-49 years. The much higher literacy rates for women are because women are better represented in the education system, while men tend to livestock and subsistence farming from an early age.

The population of the country is 1.9 million² with an annual growth rate of 0.9%, an increase of 0.1 percentage points from the 0.8% in the period 1996-2006. The country is very young demographically, with about 40% of the population comprising youth (15 – 35 years). The population is predominantly rural with approximately 77% residing in rural areas. The rural population depends to a large extent on subsistence agriculture for their livelihoods. However, owing to low agricultural productivity and with only 10% of its land surface available for arable agriculture, the country relies heavily upon imports from South Africa. Domestic cereal production only satisfies 30% of Lesotho's needs.

An economic analysis shows that the country exceeded the per capita GNI target of USD 600 by 2010, and is expected to reach an annual GDP growth target of 7% for 2016-20. The economy grew by an estimated 4.3% (real GDP) in 2013.³ Excessive dependence on the Southern Africa Customs Union (SACU) receipts, reliance on miners' remittances and textile exports to the United States continues to make the country vulnerable to external setbacks. Revenues from SACU finance a significant portion of the national budget; 53% in 2012-13, 42% in 2013-14 and an expected 48% in 2014-15. The global economic and financial crisis has led to a considerable decline in import revenues for SACU, which has resulted in reduced revenues for Lesotho.

A socio-economic perspective on the progress towards the MDGs is mixed. Achievements in primary education and gender are strong with a net enrolment rate of 82% in 2010 and a higher rate of female attendance than male attendance at secondary and tertiary schooling. Lesotho is ranked first in Africa and sixteenth⁴ in the world on bridging the gap between the sexes and has adopted several gender-sensitive laws. Nevertheless, women continue to face challenges due to cultural norms that limit their ability to take advantage of newly attained opportunities. The other MDGs are off-track or making slow progress with particular challenges in health, manifested in high maternal and infant/child mortality. The MDG Acceleration Framework (MAF) focusing on MDG 5: Improve Maternal Health, aims at helping the country analyse why it is lagging behind in this area, prioritize the bottlenecks to progress and identify collaborative solutions for the Government and development stakeholders. With an HIV prevalence of 23%, Lesotho ranks as the third country most impacted by HIV/AIDS in the world.

¹ World Bank (2012)

² National Census of 2006

³ World Bank (2012)

⁴World Economic Forum, The Global Gender gap Report, 2013

EXECUTIVE SUMMARY

Lesotho has made uneven progress toward the Millennium Development Goals. While its attendance rates in primary education are among the highest in Africa, Lesotho's progress in other areas, especially in maternal and infant mortality has been hindered by economic, climatic and sometimes cultural factors.

Poverty in Lesotho has increased since the turn of the 21st century. As of 2013, more than half of the population is living below the poverty line. Unemployment has contributed to the high level of poverty, particularly among youth, who constitute almost half of the population. South African mines once provided many jobs for Basotho whose remittances strengthened Lesotho's economy. With the decline of jobs in South African mines, Lesotho's economy has weakened remarkably. Added to this, recurring droughts have caused pronounced food insecurity. Consequently, there is an increased prevalence in underweight children as well as children who have been so severely deprived of nourishment that their development is stunted. As a result of these economic and climatic factors, Lesotho is off-track on Goal 1: Eradicate extreme poverty and hunger.

Education is an area where Lesotho has made strong progress. Lesotho continues to boast one of the highest literacy rates in Sub-Saharan Africa. The country also ranks as one of the highest in primary education attendance. While access to education has improved and most children are enrolled in primary schools, extremely disadvantaged children remain largely outside of the school system. These include herd-boys, learners with disabilities, orphans and other vulnerable children. The goal of educating 100% of children at the primary level cannot be achieved without meeting the educational needs of the most vulnerable children in Lesotho. The country's economic difficulties, which in recent years have included a rise in extreme poverty, pose a threat to its ability to achieve 100% enrolment and attendance in primary school. Indeed, the rise in poverty has already caused a decline in the high

attendance rates achieved in Lesotho. Enrolment in primary education rose until 2003 when it reached its peak. Since 2004, the percentage of children attending primary schools has declined steadily. Dropout rates also pose a significant challenge to the goal of universal education. Nevertheless, enrolment in primary education remains above 80%. Lesotho is on track to achieve Goal 2: Achieve universal primary education.

Achieving gender equality in Lesotho is a complex process given the highly patriarchal nature of Lesotho's society and culture. In Lesotho, the male is head of the family and, in most cases, the heir. However, gender-based patterns of education may challenge this traditional model. Today, females surpass males in Lesotho in terms of secondary and tertiary education. Female participation in formal employment has also increased, although women lag behind men in occupying decision-making positions. Adherence to traditional socio-cultural beliefs and practices present a persistent challenge to achieving gender equality. Nevertheless Lesotho is on track to achieve Goal 3: Promote gender equality and empower women.

Infant mortality in Lesotho has increased between 2001 and 2009. The major causes of infant/child mortality are neonatal causes, pneumonia, malnutrition, diarrhoea, measles and HIV and AIDS. Government programs that provide maternal and neonatal health care, such as Prevention of Mother to Child Transmission (PMTCT), nutrition and treatment of common childhood diseases and immunization against measles are often hindered by transportation issues, inaccessibility of health centres and inadequate skilled personnel. Lesotho is off-track on Goal 4: Reduce child mortality.

Just as infant mortality has increased between 2001 and 2009, so has maternal mortality. Most maternal deaths are preventable and caused by lack of access to health services, particularly in rural areas. Although there has been an increase in skilled personnel attending births since 2004, maternal deaths remain high. The Lesotho MDG

Accelerated Framework (MAF) has focused especially hard on this issue since it is Lesotho's worst performing MDG and a particular priority of the Government. Lesotho is off-track on Goal 5: Improve maternal health.

HIV and AIDS constrain the attainment of all the other MDGs. While the youth prevalence rate has declined slightly, the prevalence of HIV and AIDS among adults remains high. Women have a higher infection rate than men, with higher prevalence in urban areas than in rural areas. This prevalence is likely the result of rural-urban migration and transactional sex. There has been a slight increase in condom use and a decrease in multiple partnerships. Tuberculosis (TB) is also a significant public health challenge. The proportion of TB cases that have been successfully treated has increased. Nevertheless, the country is on Slow Progress on Goal 6: Combat HIV and AIDS, TB, Malaria and other diseases.

Ensuring environmental stability is a challenge in Lesotho. Heavy reliance on wood and biomass, poor agricultural practices and livestock overgrazing all contribute to land degradation. Poor land management practices eventually cause sedimentation and impact river ecosystems and water quality. Lesotho has made little progress in the past decade on clean and safe water and sanitation coverage. Lesotho is not a large emitter of greenhouse gases, but is highly vulnerable to climate change, particularly in the agriculture, energy and water sectors and has already experienced extreme weather shifts. Owing to slow progress on some fronts such as the Environmental Impact Assessment (EIA) system and climate change adaptation initiatives, there is a need to strengthen environmental governance and coordination. The country is making slow progress on Goal 7: Ensure environmental stability.

Official Development Assistance (ODA) to Lesotho grew considerably in the 2000s as a result of increased funding for HIV and AIDS, the Millennium Challenge Corporation (MCC) and direct budget support from a bilateral donor and multilateral institutions to ease the impact of the global economic crisis. Lesotho has experienced a remarkable growth with teledensity; its success continues to be driven by growth in mobile access whilst fixed telephony, in line with global trends, continues to decline. Internet penetration has

been slow but rapid growth in this area is expected in the coming years. The mean availability of essential medicines in hospitals has improved. However, medicine access in health centres remains a major challenge. Overall, the country is making slow progress on Goal 8: Global partnership for development.

Post-2015 Development Agenda

As 2015 approaches, the Government of Lesotho and the United Nations increasingly look to the Post-2015 Development Agenda to accelerate the momentum of development work and ensure the maintenance of the significant progress made thus far. Lesotho participated with other African nations in drafting the position paper on the Post-2015 Development Agenda. The plan commits Lesotho and its neighbours to eradicating poverty and transforming economies through sustainable development. The areas of particular focus are food security, education, health, democracy and effective institutions. African leaders have indicated a particular interest in the promise of innovative technological transfer and structural economic transformation, strategic partnerships and inclusive growth.

The alignment between community-level priorities and national development goals is central to the post-2015 agenda. This involves attending to the practical needs and concerns of communities and anticipating how development work will play out on the ground. As this report has shown, local issues such as access to roads and transportation can greatly hinder the success of development efforts. By aligning more closely the realities of communities with national development policy, the post-2015 agenda addresses the need for infrastructure that will facilitate development efforts. Lesotho and the other nations committed to the post-2015 agenda envision "a world in 2030 that is more equal, more prosperous, more peaceful and more just than that of today. A world where extreme poverty has been eradicated and where the building blocks for sustained prosperity are in place."

The Government of Lesotho and the United Nations are thoroughly committed to this vision and look forward to their continued collaboration to achieve it.

REFLECTING ON NATIONAL ENDEAVOURS AROUND THE MDGS AND THEIR INFLUENCE ON THE COUNTRY'S DEVELOPMENT AGENDA

GOAL 1: Fighting poverty and providing more access to finance is as a long-term goal. The Government has partnered with various development agencies to support financial inclusion in Lesotho to improve and expand access to sustainable financial services in urban and rural areas. There are credit loan schemes set up for commercialising agriculture, 50% subsidies to Lesotho farmers for key agricultural inputs as well as direct farming partnerships with the Government of Lesotho. The Government also promotes youth employment as a long-term strategy for poverty reduction in Lesotho. The Government has developed the Draft National Nutrition Policy, Nutrition Health Strategy, and ECCD Policy to improve feeding for children and implemented the nutrition component of the United Nations Trust Fund for Human Security (UNTFHS) programme.

GOAL 2: The Government has implemented several initiatives to facilitate meeting the target of universal primary education. Key policies include: the introduction of Free Primary Education (FPE) in 2000; passing of the Education Act of 2010, which made education not only free, but also compulsory; School Feeding Programme to ensure that each child gets at least one meal a day at school; the provision of free teaching and learning material; the provision of grants for new and qualified teachers and construction of new schools and additional classrooms in existing schools. Other interventions include integration of children with special educational needs (SEN) into primary schools, the Child Welfare and Protection Act of 2011 and the establishment of learning centres to promote non-formal education for youth and non-enrolled pupils. The Government is continuing the construction of new schools and additional classrooms in already existing schools.

GOAL 3: Parliament has passed numerous pieces of legislation to promote the rights of women, and the Law Reform Commission has worked to repeal or revise all discriminatory laws and policies such as the Companies Act of 2011 and other laws concerning economic transactions and property

rights. The Sexual Offences Act of 2003 combats sexual violence and prescribes strong sentences for offences. The Anti-Trafficking in Person Act of 2011 prohibits all forms of human trafficking and imposes penalties on offenders. Also, the Legal Capacity of Married Persons Act of 2006 removed several restrictions on the legal capacity of a wife and effectively establishes the equality of spouses. In 2011, Lesotho adopted a National Action Plan to end gender-based violence against women and a Domestic Violence bill is in progress. In addition, the National Gender and Development Policy provides a rights-based approach to development to address the challenges of gender inequalities, poverty, increased spread of HIV and AIDS and unemployment.

GOAL 4: The Support of Global Alliance for Vaccine Immunization (GAVI) in the Expanded Program Immunization and the Integrated Management of Childhood Illnesses (IMCI) strategy have enhanced children's health and survival prospects. The country's efforts on Prevention of Mother to Child Transmission (PMTCT) have slightly decreased Mother to Child Transmission (MTCT) from 28% in 2009 to 26%. Implementation of the Children's Protection and Welfare Act has also improved the legal framework

GOAL 5: In 2013, the Government of Lesotho with support from the UN and other stakeholders developed the MDG Acceleration Framework (MAF) on Maternal Health. The Framework identifies and prioritises the main bottlenecks and identifies collaborative solutions involving the Government and all relevant stakeholders. The framework is designed to address the challenges in the area of maternal health by accelerating various initiatives. Importantly, the MAF is to be operationalized through a time-bound action plan, with an accompanying monitoring and evaluation framework to ensure its timely implementation.

GOAL 6: The following initiatives have fortified Lesotho's efforts to halt and reverse the spread of HIV and AIDS: the National HIV Prevention Strategy (2012-2016) and the HIV Prevention

Revitalization Action Plan (2011-2013), the completion and launch of the National Strategic Plan on HIV and AIDS (2011-12-2015-16) and its national M&E framework and the release of new HIV-prevention tools and materials targeting youth.

GOAL 7: The country has enacted the Environment Act of 2008. This law catalyses the country's efforts towards a sustainable environment. It recommends decentralisation of environment management through Environmental Units within the Planning Divisions of all ministries, establishment of a National Environmental Council (NEC) to bring together relevant ministers and other stakeholders to coordinate national

environmental policy-making as well as an Environmental Tribunal to act as a final arbiter on environmental issues.

GOAL 8: The country has continued to reform its Public Financial Management, Treasury, and Procurement systems and improve the coordination of aid via programme and sector-wide approaches and harmonize donor procedures and reporting. A programmatic monitoring and evaluation framework is also used by all Government ministries. Recently, the country has seen improvements in development efforts through increased ODA, budget support and credit facilities from donor countries and agencies.

MDGs AT A GLANCE

GOAL	TARGET	INDICATOR	BASELINE	CURRENT	2015 Target	PROGRESS
Eradicate Extreme Poverty and Hunger	Halve the proportion of people whose income is less than a dollar a day	Proportion of people below the poverty line	66.6 %	57.1%	29%	Off Track
		Unemployment Rate	28.7%	25.3%	15%	Off Track
	Halve the proportion of people who suffer from hunger	Proportion of people vulnerable to food insecurity	29%	39%	No target	No target
		Prevalence of underweight children under 5	15.8%	13.2%	8%	Slow Progress
Achieve Universal Primary Education	Ensure that all children are able to complete primary education	Net Enrolment Rate	82%	82.1%	100	Slow Progress
		Proportion of pupils who reach last grade of primary school	61.2%	65.5%	100	Slow Progress
		Literacy rate among 15-24 year olds	M: 82.5% F: 96.1%	M: 87.4% F: 98.2%	100	On Track
Promote Gender Equality and Empower Women	Eliminate gender disparity in education by 2005 and at all levels no later than 2015	Primary education (girls/100 boys)	101	105	100	On Track
		Secondary education (girls/100 boys)	128	133	100	Off Track
		Tertiary education (girls/100 boys)	118	146	100	Off Track
		Proportion of seats held by women in the National Assembly	10.6%	25%	30%	Slow Progress
		Share of women in non-agricultural wage employment	34.4%	56.1%	50%	On Track

GOAL	TARGET	INDICATOR	BASELINE	CURRENT	2015 Target	PROGRESS
Reduce Child Mortality	Reduce by two-thirds the under-five mortality rate	Under-five mortality rate (per 1000 live births)	113	117	37	Off Track
		Infant mortality rate (per 1000 live births)	81	91	27	Off Track
		Proportion of 1 year olds immunized for measles	71.3%	69.6%	100%	Off Track
Improve Maternal health	Reduce by three-quarters the maternal mortality ratio	Maternal Mortality Rate (per 100,000)	419	1,155	93	Off Track
		Proportion of births attended by skilled health personnel	60%	61.7%	80%	Slow Progress
		Antenatal care coverage (at least 1 visit)	85.2%	92%	100%	Slow Progress
		Contraceptive Prevalence Rate among married women (15-49)	36.1%	47%	80%	Slow Progress
		Unmet need for family planning	30.9%	23%	No target	No target
Combat HIV and AIDS and TB	Halt and begin to reverse spread of HIV and AIDS	Prevalence among adults (15-49)	25%	23%	No target	No target
		Prevalence among youth (15-24)	11.3%	9.3%	No target	No target
		Condom use at last high-risk sex among adults	M: 48.6% F: 41.9%	M: 50.5% F: 38.5%	M: 80% F: 70%	Slow Progress
		Proportion of adults who have ever been tested and received results	M: 9.1% F: 12%	M: 38.5% F: 65.6%	No Target	No target
		Youth with comprehensive correct knowledge of HIV and AIDS	M: 18.4% F: 25.8%	M: 28.7% F: 38.6%	85%	Slow Progress
		Adult Antiretroviral Coverage Rate	16%	59%	80%	Slow Progress
		ARV Coverage among children (under 15)	22%	24%	95%	Slow Progress
		Mother to Child Transmission Rate	6%	8.8%	97%	Slow Progress
	Halt and begin to reverse incidence of TB	Incidence of TB per 100,000	-	633	No target	No target
		Prevalence of TB per 100,000	249	402	No target	No target

GOAL	TARGET	INDICATOR	BASELINE	CURRENT	2015 Target	PROGRESS
Ensure Environmental Sustainability	Halve the proportion of people without access to safe drinking water and basic sanitation	Population with access to safe drinking water	80.6%	82%	91%	Slow Progress
		Population with access to basic sanitation	24%	55%	38%	On track
	Reverse loss of environmental resources	Proportion of Arable land	10.1%	9.6%	No target	No Target
		Proportion of land covered by forest	1.3%	1.6%	5%	Slow Progress
		Proportion of Energy Needs met using biomass	66%	57%	No target	No target
Develop a Global Partnership for Development	Develop further an environment conducive for beneficial trade and investment	ODA as a proportion of Lesotho GNI	3.8%	9%	No Target	No Target
		ODA per capita (current USD)	\$20	\$121	No Target	No Target
		Proportion of ODA that is untied	-	96%	No Target	No Target
		Proportion of ODA allocated to social services	60.4%	91.1%	No Target	No Target
		Share of Exports in GDP	-	36.6%	No Target	No Target
	Make available the benefit of new technology in cooperation with the private sector	Mobile lines per 100	0.4	84	No Target	No Target
		Internet users per 100	0.2	4.5	No Target	No Target
		Average availability of essential medicines at all hospitals	74%	77.7%	No Target	No Target

Section II

Tracking Progress





1 ERADICATE EXTREME POVERTY & HUNGER

TARGETS

1. A. Reduce by half the proportion of people living on less than US \$1.25 a day

Indicators

- 1.1: Proportion of people living below the national poverty line
- 1.2: Poverty gap index
- 1.3: Gini index

1.B. Achieve full and productive employment for all

Indicators

- 1.4: Unemployment rate
- 1.5: Proportion of vulnerable employment in total employment

1.C. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Indicators

- 1.6: Proportion of population that is food insecure
- 1.7: Prevalence of underweight children under 5 years
- 1.8: Proportion of stunted children under 5 years



Overview

Poverty is rife in Lesotho with more than half of the population living below the poverty line. The level of poverty has been increasing since the turn of the 21st century. Recently it has been propagated further by recurring droughts that have caused food insecurity. Unemployment has also been identified as one of the key factors that contribute to the high level of poverty. It is higher among the youth, who constitute almost half of the population, and to this is added the high level of retrenchment of Basotho from South African mines, as well as the high income inequality. Malnutrition is a major challenge with increased prevalence of stunting and underweight children.

TABLE 1.1: Millennium Development Goal 1 At A Glance

	Baseline	Current	2015 (Target)
On Track			
Prevalence of underweight children under 5 years (%)	15.8 (1992)	13.2 (2009)	8
Slow Progress			
Poverty gap index (%)	37.9 (1995)	29.5 (2011)	17
Unemployment rate (%)	28.7 (1995)	25.3 (2008)	15
Proportion of vulnerable employment in total employment (%)	29 (2003)	11.8 (2011)	N/A
Off Track			
Food insecure population (%)	34 (2003)	39 (2012)	N/A
Proportion of stunted children under 5 (%)	45.4 (2000)	39.2 (2009)	N/A
Proportion of people living below the national poverty line (%)	66.6 (1995)	57.1 (2011)	29
Gini Index	57 (1995)	53.8 (2011)	N/A

Trend Analysis

Indicator 1.1: Proportion of People Living Below National Poverty Line

TABLE 1.2: Poverty Trends in Lesotho

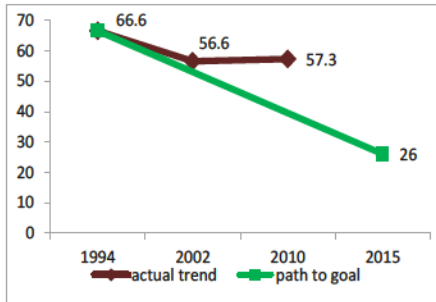
	1994/1995	2002/2003	2010/11	2015 (Target)
Very Poor Household Members (%)	37.8	34	35.1	19
Poor Household Members (%)	66.6	56.6	57.1	29
Food Poverty Line (Maloti per month)	M42.92	M84.41	M138.9	No Target
Total Poverty Line (Maloti per month)	M83.13	M149.91	M246.6	No Target

Source: Household Budget Survey, 2002/2003 and 2010/2011

Poverty in Lesotho is measured primarily through the periodic Lesotho Household Budget Survey (HBS). The most recent HBS was conducted in 2010–11. The poverty line is constructed based on the value of a minimal level of consumption, which was M246.6/person/month in 2011. The food poverty line is the value of the minimal level of food consumption needed to meet standard nutritional requirements (M137/month in 2011). Households whose incomes fall below this line (34.1%) are

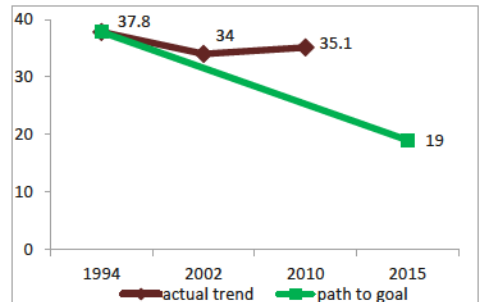
considered very poor. Lesotho is off track on these indicators as shown by Figure 1.1 and Figure 1.2. The percentage of very poor household members has increased from 34% in 2003 to 35.1% in 2011, while the percentage of poor household members increased from 56.6% in 2002 to 57.1% in 2011. Complementary indicators such as unemployment rate, agricultural productivity and malnutrition also reflect persistently high poverty in Lesotho.

Figure 1.1: Poor Household Members



2010/11 Lesotho Household Budget Survey Report

Figure 1.2: Very Poor Household Members



2010/11 Lesotho Household Budget Survey Report

TABLE 1.3: Composition of FGT³ Family of Indices by Geography

	Poverty Headcount Rate	Income Gap Ratio	Poverty Gap	GE(2)	Squared Poverty Gap
Urban	39.0	45.0	17.5	10.9	10.4
Rural	60.9	52.0	31.7	15.4	20.7
Total	56.6	51.0	28.9	14.5	18.7
2010/11					
Urban	39.2	45.2	17.7	11.1	10.6
Rural	59.6	51.9	31.0	15.1	20.3
Total	57.1	51.6	29.5	14.7	19.2
Change					
Urban	0.5	0.3	0.3	0.3	0.2
Rural	-0.5	-0.4	-0.5	-0.3	-0.4
Total	0.5	0.6	0.6	0.2	0.5

Source: 2002/03 and 2010/11 Lesotho Household Budget Survey Report, BoS Technical Note on Lesotho Poverty Measurement 2013

³ Foster, Greer, Thorbecke family of poverty measures

Table 1.3 shows the incidence of poverty has increased by 0.5% from 56.6% in 2002–03 to 57.1% in 2010–11. The increase in severe poverty affects most Basotho. Poverty in the country has a predominantly rural face; the headcount rate is higher in rural areas than in urban areas. This is due to low agricultural sector performance, which is the main source of income in rural areas. The results in this analysis suggest that in 2010–11 the poverty gap for the rural population was 31%, implying that, on average, every poor person would require a 31% increase in income to reach the poverty line.

Indicator 1.2: Poverty Gap Index

The poverty gap has been used to measure the annual income transfer required to bring all poor households out of poverty. It captures the average expenditure shortfall for the poor in a given area to reach the poverty line. It has increased by 0.6% between 2003 and 2011. In other words, in 2011 the average income of poor persons was 29.5% below the poverty line in 2011 compared to 28.9% in 2003. Furthermore, the poverty gap is much higher (nearly double) in rural areas than in urban areas.

The squared poverty gap index, a measure used to determine the severity of poverty, reveals that the severity of poverty is greater in rural areas (20.3%) compared to urban areas (10.6%). Moreover, it has increased in 2010–11 as compared to 2002–03.

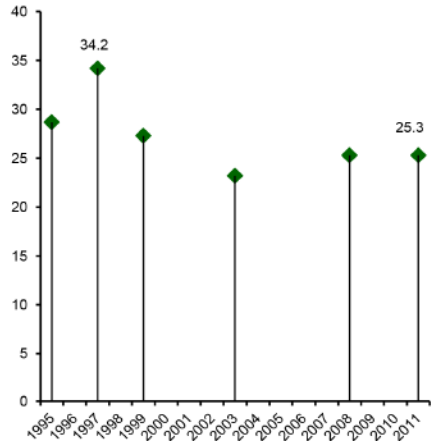
Indicator 1.3: Gini Coefficient

The most commonly used method for measuring income inequality is the Gini coefficient. A Gini value of zero suggests equal distribution of income across the population, and a Gini value of one implies a very unequal distribution. The Gini coefficient in Lesotho is high and has increased slightly from 0.52 in 2002-3 to 0.54 in 2010-11. Another measure of inequality is income distribution which markedly favours the wealthy. The top quintile receives 60% of all income while the bottom 20% of the population receives only 2.8% of the national income. Although the poor comprise almost 57% of all households, they receive only 20.5% of all income in Lesotho.

Indicator 1.4: Unemployment Rate

The unemployment rate has declined in the past decade from 34% in 1997 to approximately 25% in 2008. However, no comprehensive labour force survey has been conducted since the global financial crisis. Therefore, it is unclear how the economic downturn has specifically impacted employment.

Figure 1.3: Unemployment Rate



Source: HBS 2003 and 1995, Census 2006, ILFS2008

Variations in Unemployment

Table 1.4 presents the distribution of the unemployed population by age, sex and urban/rural residence. According to the results, the proportion of the unemployed population was 29.8% in the 20-24 years age group and 23.2% in the 25-29 years age group. In the 20-24 years age group, the proportion of the unemployed population was 32.7% for females and 28.2% for males. In rural areas, 28.1% of males and 31.4% of females in the 20-24 years age group were unemployed, as compared to 28.5% of males and

35.9% of females in the same age group in urban areas. The proportion of unemployed youth is high across the country. The age distribution also reveals that in urban areas, 1.1% of job seekers

were female children aged 10-14 years. This is alarming because children are expected to be in school since primary education is both compulsory and free in Lesotho.

TABLE 1.4: Percentage Distribution of Unemployed Population by Age, Sex and Urban/Rural Residence, 2011 LDS

Age	Lesotho			Urban			Rural		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
10-14	0.7	0.5	1.1	0.6	0.0	1.4	0.7	0.7	0.9
15 - 19	9.5	7.6	12.9	7.0	5.9	8.5	10.3	8.1	14.8
20 - 24	29.8	28.2	32.7	31.7	28.5	35.9	29.2	28.1	31.4
25 - 29	23.2	23.0	23.4	22.7	21.8	24.0	23.3	23.4	23.2
30 - 34	15.4	17.1	12.4	15.7	17.4	13.5	15.3	17.0	12.0
35 - 39	8.5	10.2	5.6	7.7	8.9	6.2	8.8	10.6	5.3
40 - 44	5.0	5.0	4.9	5.6	6.1	4.9	4.7	4.7	4.9
45 - 49	3.6	4.2	2.6	5.1	6.0	3.9	3.1	3.7	2.0
50 - 54	2.0	2.1	1.9	2.1	2.6	1.4	2.0	2.0	2.1
55 - 59	1.1	1.1	1.3	0.7	1.2	0.2	1.3	1.0	1.7
60 - 64	0.6	0.7	0.5	0.5	0.8	0.0	0.7	0.7	0.7
65+	0.4	0.3	0.7	0.5	0.9	0.0	0.4	0.1	1.1
Total (N)	49,756	31,696	18,061	12,479	7,039	5,440	37,277	24,656	12,621

Source: LDS (2011)

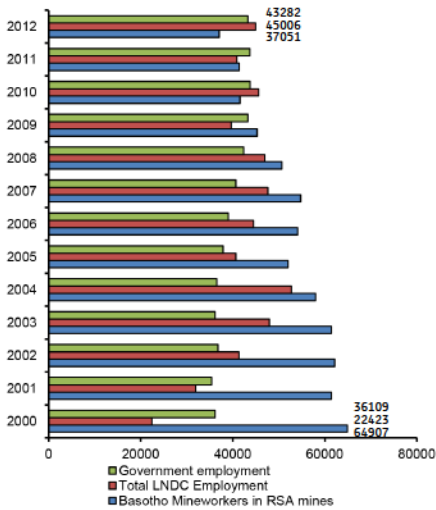
Youth unemployment is a major problem in Lesotho. Many youths enter the job market lacking the

requisite skills and education for employment. Even when they do find jobs, youth workers are usually restricted to work in the informal sector or subsistence agriculture. Well-educated youth are often drawn to jobs in more favourable markets, such as Republic of South Africa (RSA), creating a 'brain drain' phenomenon. Finally, youth have

less work experience, less knowledge about how and where to search for work and fewer contacts, and they are subject to the 'last hired, first fired' principle in economic recessions.⁶

⁶ Lesotho Youth and Development Concept Paper, UNDP, Lesotho 2012.

Figure 1.4: Formal Employment



Source: Central Bank of Lesotho, 2012

Employment numbers have continued to decrease in the three largest formal employment sectors in Lesotho. The number of migrant mineworkers has decreased to about 37,051. This is a dramatic decline from approximately 120,000 mineworkers in the 1980s. The demand for mineworkers depends on the exchange rate of the Loti against major currencies, export earnings and the performance of the mining sector at large. However, during the review period, the decline has been exacerbated by deliberate measures by the RSA to substitute local mineworkers for foreign ones.

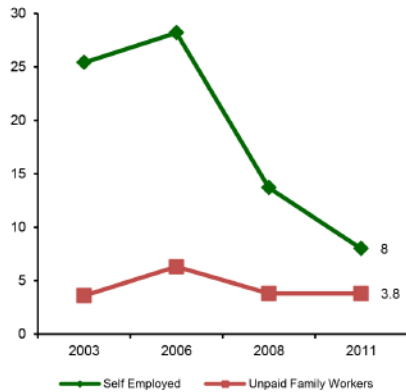
LNDC-assisted companies registered a 10.4% decline in employment. The slow labour market recovery in the U.S. and the slowdown in manufacturing, especially in textile and clothing, were the major causes of the decline.

Lastly, public sector employment declined the least by 1.05% to 43,282 in 2012 from 43,742 employees at the end of December 2011. The decline is mainly attributable to a decrease of 3.7% in the number of daily paid workers, 0.8% of teachers and 0.6% in the number of civil servants as a result of the Government's fiscal consolidation efforts.

Indicator 1.5: Proportion of Vulnerable Employment in Total Employment

Vulnerable workers include unpaid family workers and the self-employed. More specifically, self-employed workers who do not hire others and whose income is directly dependent on the profits from their goods/services are considered 'vulnerable' because their employment is typically informal which makes their income, productivity and working conditions unstable.

Figure 1.5: Vulnerable Employment in Lesotho



Sources: Census Volume IIIB Socio-Economic Data (2006), ILFS (2008) and LDS (2011)

According to Figure 1.5, the proportion of self-employed workers within the total working population declined from 25.4% in 2003 to the current 8%. However, differences in survey methodology render inter-year comparisons difficult for this indicator. The 2003 and 2006 surveys included subsistence farmers in the self-employed population, while the 2008 and 2011 surveys appear to exclude them. On the other hand, the proportion of unpaid family workers in total employment has consistently hovered around 3.8% except for a sharp increase to 6.3% in 2006. The proportion of vulnerable employment currently is 11.8%.

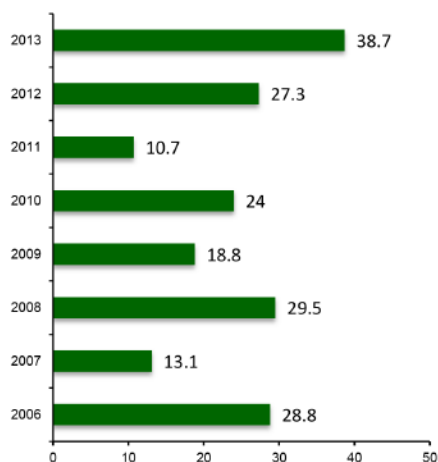
Food Security and Agriculture

Lesotho relies heavily on rain-fed, subsistence production of maize, sorghum and wheat with few improved inputs. 77% of Lesotho's population resides in rural areas⁷. Between 75% and 80% of Lesotho's rural dwellers depend on agriculture for their livelihoods. Half of all employed men (age 15-49) and 21% of employed women (aged 15-49) depend on agriculture for their income. Farming is particularly dominant in the rural areas where most of the population resides. Land degradation and climate change, particularly persistent drought, flooding, and early frost, have caused low agricultural productivity in recent years. As a result, Lesotho imports over 70% of its annual cereal requirement (99% of commercial cereal), mostly from RSA.⁸ Food insecurity has been exacerbated by HIV and AIDS, extreme poverty, unemployment, and inflation. Overall, food insecurity and malnourishment are increasing and Lesotho is off-track in reducing hunger.

Indicator 1.6: Proportion of population that is food insecure

The proportion of the population requiring food assistance is used as a proxy for gauging the level of food insecurity in Lesotho because there is no direct measurement that produces reliable data for measuring this indicator. Households requiring assistance include those that cannot afford to meet nutritional requirements after making other essential expenditures such as health and education. These people often suffer from Protein Energy Malnourishment and cope by reducing the quantity and frequency of meals.⁹

Figure 1.6: Proportion of Population Requiring Food Assistance



Source: Lesotho Vulnerable Assessment (LVAC) Reports

The 2009-10 season saw bumper harvests. As a result, food insecurity declined substantially to 10.7%. Widespread drought followed by flooding destroyed much of the 2010-11 crops, though many households still had stock from the previous year's abundant harvest. In 2011, drought again plagued the planting season (August-October), causing many farmers to plant late or not at all. In the lowlands up to 60% of fields were left fallow.¹⁰ The area planted to crops declined from 238,524 ha in 2010 to 144,278 ha in 2011.¹¹ Thus, the 2012 LVAC report estimated that 38.7% of the population, or 726,000 people, required food assistance in 2012-13.

⁷ Census 2006

⁸ NSDP; USAID FFP-OFDA Food Security Assessment, 2012

⁹ Agricultural Situation Report 2009-2010.; USAID FFP-OFDA Food Security Assessment, 2012; LVAC Report

¹⁰ USAID FFP-OFDA Food Security Assessment, 2012

¹¹ MAFS/BoS, Lesotho Crop Forecasting Report 2011-2012

Indicator 1.7: Proportion of Underweight

The prevalence of underweight children is the percentage under 5 years whose weight for age is two standard deviations or more below the median weight for their age. Child malnutrition increases child mortality risk, inhibits cognitive development and ultimately impacts the quality of human capital. Moreover, it is indicative of poverty, low education levels, and poor access to healthcare – particularly prenatal and neonatal care

The statistics from Lesotho Demographic and Health Surveys show that the percentage of underweight children has declined from nearly 19.8% in 2004 to 13.2% in 2009. Lesotho is making slow progress on this indicator. The slight decrease in underweight children can be attributed to short and long-term food security and nutrition intervention programmes. These programmes encourage home gardens and home-based income generating activities and support food production and food aid.

Indicator 1.8: Stunted Children

Stunted children include those who are more than two standard deviations below the height-for-age median. Stunting is a measure of chronic malnourishment because it reflects the cumulative effect of failing to receive proper nutrition over a long period of time.

The prevalence of stunting is one of the most persistent problems in Lesotho. It has increased over the past two decades from 33% in 1992 to 39.2% in 2009, which suggests that food security at the household level has slowly deteriorated.¹² Despite efforts made to address the problem, stunting remains one of the most significant challenges facing children. Consequently, this indicator is off-track.

Table 1.6 disaggregates child malnutrition rates by region, maternal education, and income. Being underweight or stunted is associated with a low maternal education level and income. Conversely, mothers who have at least a secondary education or who fall within the top two wealth quintiles are much less likely to have malnourished children.

Regionally, child malnutrition is above average in the highlands and Senqu River Valley and below average in urban, lowland regions. The Thaba-Tseka, Mokhotlong, and Mophale's Hoek districts in particular have above-average prevalence in both underweight and stunted children.

TABLE 1.5: Prevalence of Underweight and Stunted Children, Disaggregated

Characteristic		Stunted	Underweight
Residence	Urban	30.2	12.2
	Rural	41.0	13.4
Geographical Zone	Lowlands	34.3	11.5
	Foothills	35.5	14.3
	Mountains	48.3	16.3
	Senqu River valley	44.5	12.3
Mother's Education	Primary incomplete	43.5	16.3
	Primary complete	40.5	12.4
	Secondary+	31.0	9.5
Wealth Quintile	Lowest	45.6	17.8
	Second	46.9	13.5
	Middle	40.3	11.9
	Fourth	28.7	11.5
	Highest	28.3	9.2
National Average		39.2	13.2

Source: 2009 LDHS

Impact of HIV and AIDS

HIV and AIDS affects the nutrition and livelihood of individuals as well as the viability of institutions in many ways. The epidemic is concentrated in the most productive age group, often affecting the breadwinners of families. It undermines the ability of individuals to feed and care for themselves, while eroding the capacity of communities and institutions to provide basic services to people in need. In Lesotho, the extended family, traditionally the main social safety net, is diminishing, leaving

¹² MAFS/BoS, Lesotho Agricultural Situation Report 2009-2010; 2011 CHS.

the poor and vulnerable to die of destitution. The pandemic directly affects children aged 0 – 17 years who have lost one or both parents to HIV and AIDS. The 2006 Census indicates there are 221,000 orphans in Lesotho. The loss of parents sometimes leads to children becoming the heads of households. They often undertake the responsibility of caring for siblings, grandparents, and other relatives. Moreover, in large part due to HIV and AIDS, the number of female-headed households has increased to over 36% in 2009.

Key Implementation Bottlenecks Constraining Progress

Lesotho's challenges with poverty, unemployment and food insecurity cannot be addressed in isolation from other development challenges that include emerging inclusive redefinitions that combine socio-economic, geographic and other deprivations to people's wellbeing. Some of these challenges follow:

- **Environmental degradation** and climate change (MDG 7) is eroding the agricultural livelihoods of most of the population, leading to food insecurity and poverty.
- **HIV and AIDS** (MDG 6) hinder labour force productivity, and in the rural areas many fields lie fallow because the human resources to work them have declined. The number of orphans and female-headed households is rising, and the epidemic is decimating the traditional social safety net of the extended family system.
- **Job-less Growth.** Capital-intensive activities, especially in mining, have driven growth in the past decade and the recent past. However, these sectors have limited impact on the rest of the economy and create few permanent jobs.
- **Inadequate Diversification.** Manufacturing has the greatest potential for new job creation, but the sector suffers from low diversification. The textile industry dominates the economy – contributing almost 90% of manufacturing jobs and over half of all exports. Moreover, textile producers' success is highly contingent on U.S. demand and the continuation of trade preferences under Africa Growth and Opportunity Act (AGOA).

Policy and Planning

- **Poor Investment Climate.** Lesotho ranks 136 out of 189 countries in the World Bank 'Ease of Doing Business' ranking, benchmarked to June 2013. High start-up costs, complex regulatory impediments and an underdeveloped legal framework for the private sector discourage potential entrepreneurs from starting new enterprises and creating jobs.
- **No Food Standards.** Food fortification interventions to combat micronutrient deficiencies improve long-term nutritional intake, especially where access to a variety of foods is constrained. However, these interventions do not exist in Lesotho due to an absence of food safety and quality regulations. These standards are still in draft form apart from legislation on Iodine levels in salt. Food fortification is more cost effective as a medium-term solution, while food diversification is a better long-term solution.
- **Food Security Policy Implementation.** GOL has established policies such as the Food Security Policy and Action Plans to address food insecurity. Potential implementation problems include low programme ownership, weak collaboration among implementing ministries and agencies, inadequate staff skills and extension services, poor linkages between national and district level staff, inadequate supervision at implementation level and insufficient documentation of progress.

Structural Problems

- **Decreased Remittances.** The number of Basotho workers in RSA mines has fallen from around 120,000 in the 1980s to less than 40,000, which has eroded one of the primary sources of household income. Declining remittances have offset GDP growth and thus, poverty continues unabated.
- **Vulnerable Populations.** Currently, women head 36% of all households. Female-headed households have a higher incidence of poverty. As heads of households,

women are less likely to own assets, particularly productive assets, and face more difficulty in securing stable employment. Moreover, there are 221,000 orphans (28.5% of all children) largely due to HIV and AIDS deaths. These children are particularly vulnerable to poverty and food insecurity.

- **Insecure Income Sources.** Many poor households and subsistence farmers rely heavily on insecure work such as casual labour and home brewing for local sale. The average wage for a casual labourer is 20M/day. Alternatively, poultry farming, vegetable production or micro enterprise would be better ways for generating income. However, farmers lack appropriate training, capital and inputs. The Micro, Small and Medium Enterprise sector (MSMEs) is hindered by inadequate management and entrepreneurial capacity, a poor regulatory framework and low access to finance and markets.
- **Skills.** Currently, the skills and training provided by the education system are misaligned with the skills demanded by the economy in technology and entrepreneurship. Even University graduates struggle to find gainful employment.
- **Rural isolation.** Households in the highlands are particularly disadvantaged because of their remote location. They are distant from markets and urban centres of employment, where they could find supplementary work opportunities.
- **Youth unemployment** rate is rising at a geometric rate and will be a threat to law and order if aggressive policies to combat this trend are not implemented.

Agriculture and Food Security

- **Environmental Degradation** is slowly destroying agricultural productivity and the livelihood of the vast majority of the population. Poor agricultural practices such as single cropping, overgrazing, heavy reliance on biomass for energy, deforestation, road drainage and extreme climatic events are all driving rapid soil erosion. Consequently, arable land in Lesotho is extremely limited and declining.

Lesotho has lost nearly 82, 000 hectares of arable land in the past decade and currently only 9-10% of the total land area is arable.

- **Poor Agricultural Practices.** About 90% of all farmers are subsistence farmers who own less than one hectare and produce little or no surplus. Most lack proper training in improved agricultural practices or conservation. Despite abundant water resources and potential for irrigation, crop production is largely rain-fed with low yields of usually less than 1 tonne/ha. Moreover, these farmers have little to no capacity to absorb major shocks.
- **Stock Theft** is widespread, particularly on the border areas between Lesotho and RSA. It results in the loss of crucial assets and income for rural households and makes farmers reluctant to invest in more stock.
- **Low Inputs.** Resistance to improved inputs and technology are due to cost. These inputs are much more costly in Lesotho than in RSA and their use would raise costs for local smallholder farmers and make their goods even less competitive in the immediate term against higher quality, cheaper agricultural imports from RSA.
- **Insufficient Institutional Support.** Extension services for farmers in the districts are very inadequate. Many extension agents have limited capacity and work in isolated areas. Additionally, there is weak infrastructure and market information systems in rural areas and the highlands, with underdeveloped supply chains, regional market centres and access roads. For example, the two commercial mills in Lesotho do not operate regional collection centres due to the small amounts of grain produced by subsistence farmers for commercial markets and the relatively low quality of that grain. As a result, farmers who want to sell surplus grain face high transport and marketing costs. Finally, the land tenure system provides little incentive for farmers to increase productivity and adopt conservation practices.
- **Poor Livestock Support.** The other agricultural subsector that plays an important role in supporting rural livelihoods is livestock production. Cattle, goats and

sheep are very important assets while wool and mohair are Lesotho's dominant agricultural exports, bringing foreign earnings into the country and much-needed income for rural communities. However, livestock productivity is low due to poor animal health, low reproduction and disease outbreaks. Sheep scabies is common and severely reduces wool and mohair production. Other diseases reduce the marketability of livestock products in the international market. No vaccination campaigns exist for the control of infectious diseases and veterinary services are limited.

New Challenges for Meeting Millennium Development Goal 1

Financing

- **School Feeding Programmes.** Primary school feeding programmes are a particularly important intervention for improving nutritional status of vulnerable groups. Since 2011, the Government has provided funding for the feeding of 30,000 beneficiaries in schools assisted by WFP, a clear message that the country is willing to take ownership of its assistance schemes.
- While the Government pledged its willingness to take over the WFP school meals programme by the end of 2012, the Government felt that it did not yet have the necessary logistical capacity to do so especially in the hard to reach mountain areas. Currently, GoL provides meals to 660 schools in the lowlands and foothills while WFP provides meals to 740 schools in the mountain areas and some hard to reach foothills areas.
- WFP is expected to continue with its technical support to the Food Management Unit (FMU) in procurement, logistics, monitoring and reporting. FMU is the identified institution to take over from WFP once capacity-building exercises have been completed by the Government of Lesotho.
- Inadequate Nutrition Funding. The financing of nutrition programmes tends to rely on

donor support with less funding from GoL. Currently, nutrition programmes in the key ministries are marginalized because of inadequate government resources.

Service Delivery

- **Poor Nutrition Delivery to HIV and AIDS Patients.** Good nutrition prolongs and improves the quality of life for people living with HIV and AIDS. The Ministry of Health (MOH) has established Guidelines on Nutrition and HIV, but these have not been fully operationalized due to a lack of trained nutrition personnel and weak collaboration among key stakeholders such as National Aids Commission (NAC), Food and Nutrition Coordinating Office (FNCO) and HIV and AIDS units in MOH, Ministry of Agriculture and Food Security (MAFS) and NGOs. While the HIV and AIDS epidemic has attracted many resources, the nutrition component has been inadequately supported.

Structural Problems

Rising Commodity Prices. Lesotho is highly vulnerable to external commodity price fluctuations because most of its grain is imported from RSA. Commodity prices have recently been increasing due to poor harvests in RSA and rising fuel/transport prices. In May 2012 maize meal prices were approximately 26% higher than May 2011 prices.

- **Climate change** has also exacerbated the decline in agricultural yields. Drought has been more frequent in recent years, particularly at critical stages of plant growth. In 2006-2007 Lesotho experienced its most severe drought in the past 30 years. Drought followed by substantial flooding plagued the 2011 harvest. In 2012 widespread drought and early frost is causing a severe food crisis with a 77% decline in crop production. Moreover, extreme weather events and heavy rain in the wake of a long dry spell quickly erode and wash away the soil. Indeed, climate change could shrink arable land coverage to as little as 3%.

Recommendations

- Promoting Conservation Agriculture (CA): This is a method of sustainable agriculture and land management based on the principles of minimal soil disturbance, permanent soil cover and crop rotations. When implemented correctly, CA should increase the efficiency of nutrient and water use and generate higher yields. It should be noted that CA requires intensive training and support for local farmers.
- Promote Commercial Block Farming Initiatives, whereby farmers cultivate their fields as a group to create economies of scale, thereby reducing overall costs, facilitating access to inputs/equipment, and enabling more sustainable land use.
- Increase smallholder access to improved inputs through subsidies, input trade fairs, training in input use and credit schemes such as revolving loan funds.
- Encourage domestic production of improved seed varieties.
- Scale-up water harvesting and small-scale irrigation development, particularly gravity-fed irrigation and pass the draft Irrigation Policy.
- Improve agricultural extension and support services, particularly for smallholder farmers in rural and highland areas. Improve domestic agricultural research and training for farmers and improve rural market infrastructure for farmers.
- Scale-up production and consumption of vegetables, including in home and community gardens, by providing access to necessary training and inputs.
- Scale up veterinary services, vaccinations and disease prevention for livestock.
- Improve quality and timeliness of data collection and reporting for crop forecasts, agricultural production surveys and regular price monitoring of food staples.
- Improve the efficiency and targeting of the social safety net system and transfer programs, including Old Age Pension, school meal programme, public assistance grants, Child Grants and OVC bursaries. These programs are currently not reaching those most in need and there is no integrated framework for providing these supports, leading to duplication and inefficiencies.
- Invest in human capital development by exploring a Conditional Cash Transfer Program to improve the reach of the social safety net, provide short-term poverty relief and reduce long-term, inter-generational poverty by increasing social safety programmes for poor children.
- Pursue cash-for-work programmes focusing on construction of small-scale irrigation, rural infrastructure and projects mitigating environmental degradation.
- Ensure continuation of primary school feeding programmes. Explore possibility of school feeding for eligible secondary students (e.g., OVCs), and a programme of take-home food rations for children visiting post-natal clinics.
- Operationalize guidelines for nutrition support to people living with HIV and AIDS.
- Further diversify the manufacturing sector and export markets. Identify areas of competitive advantage and growth strategies that will create new employment.
- Develop adequate industrial infrastructure and ready-use industrial facilities with access to water, waste management, ICT and transportation.
- Strengthen SACU partnerships, with a particular focus on reducing the barriers for cereal transport from RSA to Lesotho and opportunities for increased exports to RSA.
- Increase support for the MSME sector with entrepreneurship training, business incubators, credit and technology access and a proper regulatory framework.
- Introduce a compulsory practical farming and vocational curriculum for secondary and tertiary levels

- Mobilize the severely unemployed youth brackets (20-34 age groups) by forming regional associations that will utilize free-flowing rivers, energy resources and unused land for implementing various projects.
- Initiate and strengthen integrated sector monitoring programmes that link district to regional youth associations
- Develop coordinated cross-ministerial efforts under a credible national nutrition plan with strong accountability measures at the local, district and national levels.
- Increase health promotions and education, particularly related to infant and young child feeding.

Key factors contributing to meeting the targets

- Support Financial Inclusion in Lesotho to improve and expand access to sustainable financial services in urban and rural areas
- Joint Programme on Economic Growth and Development to accelerate shared and sustainable economic growth
- Promotion of Youth Employment Towards Poverty Reduction in Lesotho
- 50% subsidies to Lesotho farmers for key agricultural inputs
- Government of Lesotho has initiated partnership with farmers
- Availability of Credit Loan schemes for commercialising agriculture
- Draft National Nutrition Policy developed
- Nutrition Health Strategy
- Development of ECCD Policy to improve feeding of children
- Implementation of nutrition component of the United Nations Trust Fund for Human Security (UNTFHS) programme



2 ACHIEVE UNIVERSAL PRIMARY EDUCATION

TARGETS

2A. Ensure that by 2015, children everywhere, boys and girls alike, are able to complete a full course of primary schooling.

Indicators

- 2.1: Net enrolment ratio in primary education
- 2.2: Proportion of pupils starting grade 1 who reach last grade of primary
- 2.3: Literacy rate of 15-24 year-olds, women and men



Overview

In 2000, the Government of Lesotho introduced Free Primary Education (FPE), which greatly improved access to primary education. This led to a significant increase in the number of children enrolling in primary schools, as indicated by an increase in the Net Enrolment Rate (NER) from 60.2% in 1999 to 82% in 2000. Total enrolments continued to rise until 2003, indicated by a growth of NER from 82% in 2000 to 85% in 2003, as Table 2.1 illustrates. However, in 2004 enrolments started to decline and have been falling steadily since. To curb this problem, in 2010 the Government passed the Education Act of 2010, making primary education not only free, but also compulsory. Net enrolment rates have continued to increase gradually from 81.8% in 2010 to reach the current 82.6%, denoting slow progress.

TABLE 2.1: Millennium Development Goal 2 At A Glance

Indicator	2000	2004	2009	2012	2015 (Target)
On-Track					
Literacy rate of 15-24 year-olds, women and men (%)	N/a	M: 82.5 F: 96.1	M: 87.4 F: 98.2	N/a	100
Slow Progress					
Net enrolment ratio in primary education (%)	82 M: 78.7 F: 85.3	83 M: 81 F: 86	80.9 M: 78.6 F: 83.2	82.1 M: 79.6 F: 82.6	100
Percentage of pupils starting grade 1 who reach last grade of primary (%)	N/a	61.2 (2005)	62.8	65.5	100

Whilst access to education has improved and many children have enrolled in primary schools in Lesotho, as indicated by a NER that is sustained above 80%, there are pockets of disadvantaged children who are out of school, consisting mainly of herd-boys, learners with disabilities, orphans and other vulnerable children, who constitute around 20% of the child population. The trend in NER indicates slow progress towards the attainment of 100% NER goal in 2015.

Lesotho has one of the highest literacy rates in sub-Saharan Africa; 87.4% of males and 98.2% of females are literate. Lesotho is on track to attain this MDG indicator.

The Net Cohort Survival Rate (NCRS) at primary level has also improved significantly. In 2006, it stood at 40.9%, indicating that only about 4 in 10 children enrolled in Grade 1 in 2000 reached Grade 7 in 2006.

Although this rate has been fluctuating, overall it has been improving and it increased to 65.5% in 2012, implying that two-thirds of children enrolled in Grade 1 in 2006 reached Grade 7 in 2012. It is worrisome though, that one third did not reach Grade 7, either through repeating grades or dropping out along the way.

Lesotho has made significant progress in access

indicators at primary level. High political support has meant that the Education Sector has continued to get around 20% of the annual budget. Nevertheless, the progress is slow and unless the Education Act of 2010 is enforced to address the herd-boys and bring all disadvantaged children into school, Lesotho is unlikely to meet MDG Goal 2 in 2015.

Trend Analysis

Indicator 2.1: Net enrolment ratio in primary education

The NER for primary school measures the proportion of children of primary school age (age 6-12) who are attending primary school.

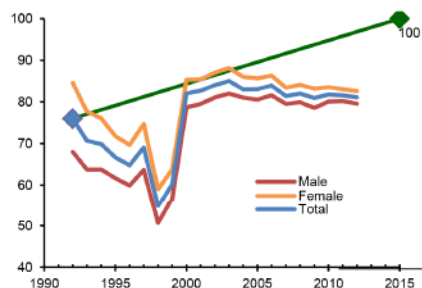
The Government has implemented several initiatives to facilitate meeting the target of 100% primary school attendance. Key policies include: the introduction of Free Primary Education (FPE) in 2000; passing of the Education Act of 2010, making education not only free, but also compulsory; School Feeding Programme to ensure that each child gets at least one meal a day at school; provision of free teaching and learning materials; provision of grants for new and qualified teachers and construction of new schools and additional classrooms in existing schools. Other interventions include integration of children with special educational needs (SEN) into primary schools, the Child Welfare and Protection Act of 2011 and the establishment of learning centres to promote non-formal education for youth and non-enrolled pupils.

With the introduction of FPE, total enrolment increased from 364,951 pupils in 1999 to 410,745 in 2000, as NER rose from 60.2% to 82% in the same period. Enrolment continued to increase till it reached a peak at 429,794 in 2003 with NER registering 85%. However, from 2004 it started to decline steadily down

to 381,690 in 2012, accompanied by a fall in NER to 81.1% in 2012 as illustrated by Figure 2.1.

To accommodate the influx of learners, the Government, supported by development partners, invested heavily in the construction of new schools and hiring of teachers in the past decade.¹³ The Government of Japan has been one of the major donors in the construction of schools. Given the prevailing high levels of poverty and food insecurity, the school feeding programme plays an important role in attracting and retaining pupils. The Government provides school meals to two-thirds of the schools, while World Food

Figure 2.1: Net Enrolment Ratio in Primary Education



Source: MOET, Education Statistics Bulletins 2001, 2012

¹³ MOET; Education Statistics Report, 2010

Programme (WFP) covers the remaining one-third.¹⁴ In 53% of primary schools in the mountain regions, 70-100% of pupils received their only meal of the day from school, particularly during lean periods.¹⁵ Moreover, school meals are proven to contribute to positive behavioural patterns such as increased attentiveness and learning ability.¹⁶ Notwithstanding this progress, the proportion of children who still have not enrolled in primary schools is high; stagnating around 15-20% annually. Anecdotal evidence suggests that poor households often do not send their children to school mainly because of high levels of poverty, large numbers of orphans and child-headed

families, traditional practices and attitudes. Girls frequently provide care for younger siblings or sick relatives, while boys tend to livestock. Others simply stay out of school in search of a means of survival.¹⁷ Physical access to schools in the mountain areas, where average walking times to school sometimes exceed an hour, are a major challenge, particularly for malnourished children. Indeed, results from the 2009 LDHS confirm this analysis; attendance ratios are much lower for students living in the mountain districts and in the lowest wealth quintile.¹⁸

Completion of Primary Education

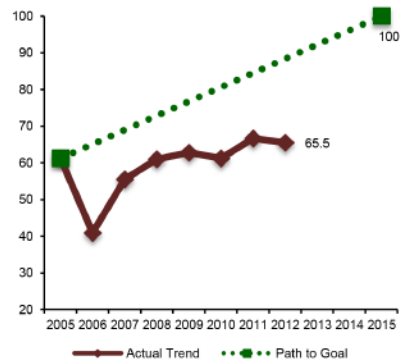
Indicator 2.2: Proportion of pupils starting Grade 1 who reach last grade of primary school

The proportion of pupils beginning primary school who reach Grade 7 - Net Cohort Survival Rate (NCSR) - increased by 15% from 40.9% in 2006 to 55.5% in 2007, and by a further 6.7% to reach 62.8% in 2009. Although there was a decline of 1.6% in 2010, the rate recovered to reach 66.7% in 2011. A fall of 1.2% was observed from 2011 to 2012 implying a decline in NCSR in 2012. On the whole, NCSR has improved from 40.9% in 2006 to 65.5% in 2012. This implies that two thirds of children who enrolled in Grade 1 in 2006 reached Grade 7 in 2012, and one third did not, as they either repeated a grade or dropped out. Despite improvement in this indicator, progress is too slow to reach the MDG target of 100% in 2015. Moreover, the dropout rate has averaged 6.1% in the past decade.

A related indicator is the repetition rate, which influences retention and completion. Most repetition occurs in lower grades, mainly Grades

1-3.¹⁹ Repeaters constituted 19% of enrolment in 2010, similar to rates in the past decade, with an improvement to 16.5% in 2011. Repetition is consistently higher among boys²⁰ due to traditional practices of herd-boys and initiation schools. Figure 2.2 illustrates the trends in the NCSR against the set target of 100% by 2015.

Figure 2.2: Proportion of Students who Reach Grade 7



Sources: MOET, Education Statistics Bulletin 2012

¹⁴ UN WFP Lesotho, Facts and Figures of Lesotho, 2012

¹⁵ WFP Lesotho, 2007

¹⁶ WFP Lesotho, 2003

¹⁷ World Food Program, 2008

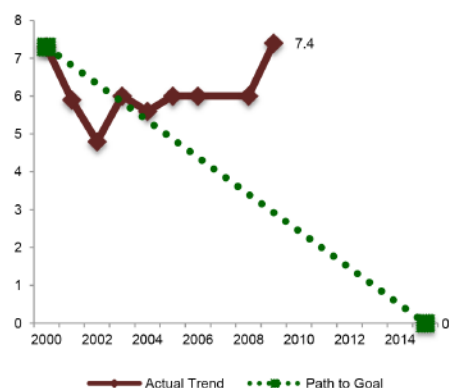
¹⁸ LDHS, 2009

¹⁹ MOET, Education Statistic Report, 2012

²⁰ Ibid

After the Government introduced FPE, many over-aged children, youth and even adults enrolled in the first grade. However, most of these over-age enrollees did not complete a full course of primary education. Rather, they left school after acquiring some basic reading and writing skills. This phenomenon may help explain high literacy rates, increasing total enrolments, fluctuation and generally lower average level in completion rates. Figure 2.3 illustrates.

Figure 2.3: Dropout Rate



Sources: UNICEF Division of Policy and Practice, May 2008 and UNESCO Institute for Statistics, 2010

Lesotho has attained gender balance in primary education, recording an almost equal number of males and females as indicated by the Gender Parity Index (GPI) of around 1. Historically more females than males were enrolled in primary schools. Between 2000 and 2004 there was a marginal gender imbalance in favour of females, indicating there were slightly more females than males. However, this situation has changed since 2005.

The 2012 results portrayed a ratio of approximately 104 males to 100 females, showing a gender imbalance in favour of males (more boys than girls in primary schools). It is noteworthy though that NER remains higher for females than males, as Table 2.2 shows.

TABLE 2.2: Primary School Enrolment Rates and Gender Parity Indices

Year	Gross Enrolment			GPI
	Males	Females	Total	
2000	118.1	122.6	120.3	1.04
2004	126.2	127	126.6	1.01
2005	126	126.3	126.1	1.00
2009	116.2	116.2	116.2	1.00
2012	111.6	108.8	110.2	0.97
Year	Net Enrolment			GPI
	Males	Females	Total	
2000	78	85.3	82	1.08
2004	81	86	83	1.06
2005	80.6	85.7	83.1	1.06
2009	78	83.2	80.9	1.06
2012	79	82.6	81.1	1.04

Source: MOET, Education Statistics Bulletin 2012

Literacy Rate

Indicator 2.3: Literacy rate of 15-24 year-olds, women and men

Lesotho's literacy rate among 15-24 year-olds is among the highest in Africa. In 2009, 87% of men and 98% of women were literate, compared to 83% and 96% in 2004. The introduction of FPE brought many adults and older youth to school in order to improve basic skills in reading and writing, which helped strengthen the literacy rates.

TABLE 2.3: Literacy Rates among 15-24 year-olds

	2004	2009	Target 2015
Males	82.5	87.4	100
Females	96.1	98.2	100

Source: LDHS 2004 and 2009

Increasing enrolments in non-formal education (NFE) also contribute to high literacy rates in Lesotho. In 2011 enrolment in NFE was 6,843, compared to 8,878 in 2012, showing an increase of 23%. Out of 8,878 non-formal education learners in 2012, 7,889 were in primary school, while 456 were in lower secondary and 533 were in higher secondary. Under non-formal education there was significant gender imbalance in favour of the male population. For example, in 2012, 6,542 (74%) learners were males and 2,336 (26%) were females. The district of Thaba-Tseka had the highest concentration of learning posts with 64, followed by Mokhotlong with 62 learning posts. Consistently, Mokhotlong and Thaba-Tseka learner enrolments were highest at 1900 and 1434 learners, respectively and Butha-Buthe had the lowest enrolment of 96 students²¹. To aid the process of learning, 10,749 books were distributed across all levels of education in the 362 learning posts countrywide. Progress on meeting the MDG target of 100% literacy rate is on-track.

Quality of Education

Primary Education

The influx of learners as a result of the introduction of FPE overstretched some education resources, adversely affecting the quality of education. It created a demand for an increase in the number of qualified teachers, classrooms, teaching and learning materials. The pupil: qualified-teacher ratio deteriorated, and stood at 65 pupils per teacher in 2008, against an acceptable standard of 40 pupils per teacher. It gradually improved over the years and stood at 50 pupils per teacher

²¹MOET, Education Statistics Report, 2012

in 2012. The percentage of unqualified teachers is particularly high in Mohale'sHoek, Quthing, Qacha's Nek, and Thaba-Tseka²², especially in the remote and difficult-to-reach schools. The reason is that qualified teachers opt for jobs in the lowlands, leaving unqualified teachers predominantly in the mountain and difficult-to-reach schools, leading to low learning outcomes in these areas.

To address the eroded quality of education, the Government reviewed teacher's career and salary structure; established a distance teacher education programme (DTEP); reviewed the curriculum; strengthened school inspection and provided free teaching and learning materials. The Government increased teachers' salaries in 2009 to attract and retain qualified teachers and to make teaching profession a career of choice instead of a last resort for those who did not meet the requirements to go to universities to pursue other careers. Unqualified teachers were given an opportunity to further their studies through distance education. The Education Act of 2010 provides that those who have not acquired teaching qualifications in 2014 (after five years) will be retired and replaced by qualified teachers.

MOET has invested substantial resources in building new classrooms to accommodate the growing enrolment numbers since FPE in 2000. As a result, the pupil-classroom ratio has also improved substantially from 67: 1 in 2003 to 55: 1 in 2007.

TABLE 2.4: Education Quality Indicators

	2005	2007	2009	2011	2012
Number of Primary Teachers	10154	10778	11536	11378	11200
Number of Primary Schools	1419	1455	1479	1468	1469
Primary Pupil-Teacher Ratio	42	37	34	34	34
Pupil Qualified Teacher ratio	-	-	56	51	50

Sources: MOET, Education Statistics Bulletins 2003, 2007, 2009, 2012.

²² Ibid

MOET reviewed the old curriculum and produced a new Curriculum and Assessment Policy Framework in 2008. The new integrated curriculum was rolled out in all primary schools in 2013, starting with Grades 1-3 and will be rolled upwards to the next Grade each year. The new curriculum is more relevant to the needs of the country as it

is aimed at ensuring that the children not only acquire knowledge and competencies, but also are able to apply them in their environment. It builds stronger literacy and numeracy skills and includes integrated continuous assessment of learners throughout the year.

Efficiency in Use of Financial Education Resources

Annual budget allocations to MOET constitute on average about 17% of the total budget. Moreover, accounting for student bursary expenditures from the Ministry of Finance, education absorbs a third of the recurrent spending, and overall, the Government spent an average of 13.5% of GDP on education between 2008 and 2010.

International comparisons reveal that Lesotho spends far more on education than its peers. Other

African countries with similar income levels have achieved comparable education outcomes while spending only about 4% of GDP on the sector. Lesotho also spends much more than other SACU countries. For example, in 2008 Lesotho spent 24% of GDP per capita on each student, compared to 14% for South Africa and 12% for Botswana²³.

²³ World Bank, Lesotho Public Expenditure Review, August 2012

TABLE 2.5: Approved Budget Allocation For Ministry Of Education And Training, 2010/11-2012/13

Financial Year	MOET Total Recurrent Budget	Total Gov. Recurrent Budget	MOET Recurrent as % of Total Recurrent Budget	MOET Total Capital Budget	Total Gov. Capital Budget	MOET Capital as % of Total Capital Budget	Total MOET Budget	Total Gov. Budget	MOET Total Budget As % Of Gov. Budget
2010/11	1,600	6,906	23	181.6	3,571	5	1,781	10,476	17
2011/12	1,914	8,277	23	130.7	5,116	3	2,045	13,394	15
2012/13	1,986	8,421	24	116.0	3,491	3	2,102	11,913	18
2013/14	*1,813	9,405	19	153.3	4,828	3	*1,966	14,233	*14

Source: Ministry of Finance

* Figure excludes OVCs Bursaries which were transferred to social Development

All figures exclude the NMDS loan bursaries

The main driver of high education costs is teacher salaries which account for 69% of recurrent spending in 2010-11. The Government doubled primary school teacher salaries and boosted pay by 50% at the secondary level in 2009. An analysis by the World Bank revealed that salaries in Lesotho are far higher than in comparable countries. For example, in Tanzania and Ghana, teacher salaries are less than half the average salary in Lesotho, even though they achieve similar educational outcomes. Another problem is inadequate resources for inspection, teacher development and advisory support.

In 2010-11 the MOET spent only 2% of the recurrent budget on teacher development and management and 0.3% on support and advisory services.²⁴ The rapid investment in the education sector, to recruit qualified teachers, build schools, and provide FPE has resulted in significant increases in enrolments, net cohort survival rates and completion rates at primary level. This notwithstanding, the pace is too slow to reach the MDGs by 2015.

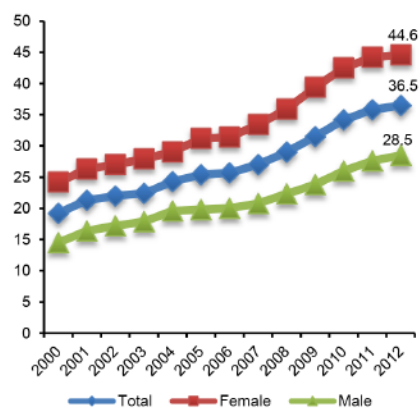
Secondary Education

The introduction of FPE has rapidly increased enrolments at secondary level as well. The first cohort of FPE graduates reached Form A at secondary level in 2007. NER at secondary level has almost doubled, rising from a low level

of 19.2% in 2000 to 36.5% in 2012. This figure excludes learners studying outside Lesotho and those in unregistered schools in the country.

Transition rates have also increased from 66.8% in 2001 to 75% in 2012, meaning 75% of those who completed primary transitioned to secondary schools. The major constraints to increased access and transition to secondary education are limited classrooms and school fees given the high levels of poverty in Lesotho.

Figure 2.4: Net Enrolment Rates, Secondary School



Source: MOET, Education Statistics Bulletin 2012

²⁴ Ibid

Unlike primary schooling, secondary education is not free in Lesotho, which explains the inconsistency between primary and secondary school enrolment. Thus, the poor have low access to secondary education. Only 10.7% of youth in the lowest wealth quintile are enrolled in secondary school compared to 61% of those in the highest quintile.²⁵

TABLE 2.6: Net Enrolment in Secondary School by Wealth Quintile, 2009

	Lowest	Second	Third	Fourth	Highest
Net Enrol-ment in Secondary School (%)	10.7	21	31.2	44.4	61

Source: LDHS 2009

In terms of quality, performance in mathematics and sciences has not been satisfactory, mainly due to shortage of qualified mathematics and science teachers and science laboratories. Lesotho's efforts to invest in science laboratories is hampered by limited resources. Localization of curriculum has been adopted as one of strategies to improve relevance.

Tertiary Education

Tertiary education in Lesotho has over the years been fully subsidized by government, beneficiaries are expected to pay back only 50% of the loan bursary. However, recovery rate has not been commensurate with loan bursary amount, as such a revolving nature of the loan bursary has been undermined. Lesotho allocates 36.4% of education expenditures to tertiary level, compared to 36% for secondary, 20.5% for primary education and less than one % for ECD. Since only higher income students can afford to attend secondary school, these same students necessarily dominate tertiary enrolment. Thus, the benefits of government spending on education

predominantly accrue to the wealthy.

Redirecting resources from tertiary to secondary education would create better, more equal educational outcomes for society and would be more efficient. The cost of one student's tertiary education in Lesotho could fund 18 students at the secondary level.

The Government could use these resources to instead subsidize secondary education for the poorest students, reduce fees and increase the quantity and quality of secondary schools and teachers. The Government through NMDS is considering how best to introduce means testing and cost sharing in tertiary education to ensure that parents with means partially cover the cost of educating their children, whilst full subsidy is directed only to the neediest.

Key Implementation Bottlenecks Constraining Progress

Policy and Planning Framework

- Although Lesotho Government has realized commendable success in increasing enrolment rates at almost all levels of education, gender equality at primary level and the quantity of education inputs (teachers, classrooms) following the 2000 FPE policy, the quality of instruction has been adversely affected as existing resources were overstretched by the influx of learners into schools.
- Though the Government has adopted inclusive education policy, revised the designs of classrooms and latrines to cater for learners with disabilities and since 2011-12, constructed school infrastructure that is disability-friendly, the enrolment of learners with special education needs remains low due to limited resources for procurement of adequate teaching and learning facilities/materials.
- Despite strong progress in improving overall pupil-teacher ratio (34:1), average pupil-qualified teacher ratio has been reduced to 50: 1 in 2012, which is still considerably higher than the internationally accepted rate of 40: 1. High pupil-qualified teacher ratio

²⁵ LDHS, 2009

impacts the quality of education students receive, test scores and repetition rates. This is particularly so in the mountainous areas.

- Spending on inspection, teacher training, support and supervision is low, accounting for only 2.3% of the recurrent budget in 2010.
- Inadequate human and financial resources for curriculum development and assessment limit the pace of curriculum reforms.

Financing and Budgeting

- Teacher salaries consume most of the recurrent budget, thus limiting the budget for other crucial measures to improve educational quality at all levels of education.
- The current policy for subsidizing tertiary education is fiscally unsustainable. Moreover, it diminishes the resources available for funding fees at secondary education, which would yield stronger, more equitable education outcomes. The Education Sector Strategic Plan (2005–2015) calls for proper cost sharing between the Government, parents, and donors. National Manpower Development Secretariat (NMDS) is considering how best to implement the means testing and cost sharing aspects of the plan with respect to bursaries.

Service Delivery

- FPE, school feeding and OVC bursaries have significantly increased enrolment rates. However, since 2004, enrolment rates have gradually declined. The Government in turn passed the Education Act of 2010, making education not only free but also compulsory. However, because the Act was not enforced, enrolment continued to decline.
- Repetition and dropout rates remain high, which reduces the proportion of students who finish primary school, leading to wastage of resources. Repetition is highest in the early grades of 1-3, which probably discourages children from pursuing their education. Moreover, most children do not have access to preschool education, which partly explains high repetition in early elementary grades.

Data Challenges

- Overall, basic data on educational indicators is consistently available on an annual basis and is disaggregated by districts, ecological zones and schools. However, it is not sufficiently disaggregated by region (sub-districts), which would allow for better planning and allocation of resources.

Recommendations

Attract qualified teachers from over-staffed schools in the lowlands to under-staffed schools in mountainous and difficult-to-reach areas through hardship allowances.

Implement the replacement of unqualified teachers in 2014 in accordance with the Education Act of 2010 to improve the quality of education.

Scale up the attachment of reception classes to primary schools, support other forms of early childhood education such as home and community based pre-schooling. Register pre-schools to

reduce high repetition rates in early grades and improve learning outcomes at primary level by increasing the budget for ECD.

Establish a robust mechanism to recover loans for tertiary graduates and introduce means testing to ensure that parents who have the capacity to pay for their children's education do so. Use the savings to reduce fees for secondary schooling and provide full bursaries for students from families without means.

Expand non-formal education such as distance-

learning to increase access to primary education for older youth and adults, as well as non-enrolled children.

Establish stronger links between non-formal and formal education, particularly in the area of basic literacy and numeracy and improve quality of education to allow for progression from non-formal to formal education.

Improve data collection for disaggregated regional data for all levels of education including early childhood development, tertiary education,

TVET, non-formal education and adult literacy education.

Collect data on children who attend school outside the country and in unregistered schools in order to ascertain accurate estimates of school enrolments in Lesotho.

Collaborate with other stakeholders to enforce the Education Act of 2010 and the Child Protection and Welfare Act of 2011 so as to bring disadvantaged children (herd-boys, children with disabilities and orphans) to school.

Key factors contributing to meeting the targets

Though enrolments have lately become stagnant, most children from poor households continue to benefit from free primary education.

To address the falling enrolment rate, in 2009, Lesotho passed the Education Law, which makes primary education compulsory for all children of school age. It is as yet unknown about the impact of this law and whether it has improved net enrolment statistics.

Lesotho is a signatory of the Fast Track Initiative, which seeks to speed up progress towards achieving the targets of Education For All (EFA). This will in turn improve progress made towards MDG 2.

The government is continuing the construction of new schools and additional classrooms in already existing schools.

In the 2008-09 Budget, qualified teachers were rewarded with a 32% pay rise to ensure the retention of existing staff and the attraction of new ones and to provide an incentive for teachers to gain qualifications. This has resulted in some improvement till date as the Pupil Qualified Teacher ratio has declined from 1:56 in 2009 to 1:50 in 2012.

Backing up free primary education with a School Feeding Programme has attracted children from poor households to school.



3 PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

TARGETS

3A. Eliminate gender disparity in primary and secondary education preferably by 2005, and in all levels of education no later than by 2015

Indicators

- 3.1: Ratios of girls to boys in primary, secondary and tertiary education
- 3.2: Share of women in wage employment in the non-agricultural sector
- 3.3: Proportion of seats held by women in national parliament



Overview

Equal representation and participation of women and men in politics and decision-making positions is a strong measure of gender equality in a nation. Processes that lead to the occupation of these positions should reflect an understanding of issues that impact equal representation and participation.²⁶ Gender equality also means that there should be equal pay for the same job.²⁷ The United Nations regards gender equality as a human right. Nations that empower women move more rapidly towards development advancement and poverty reduction.

The country has performed well in ensuring equal access to education for females, as indicated by a consistently higher ratio of girls to boys at most levels of education. Indeed, the ratio of females to males, particularly in secondary and higher education, is too high, and Lesotho must develop measures to improve access to education for boys in order to achieve a balanced human development outcome. Thus, while the country is on track for the indicator on equitable primary education, it is off track on the indicators for balanced access to secondary and tertiary education. This however also indicates a greater degree of women's empowerment.

Women's participation in formal employment and governance has also increased. The country strives to promote equal opportunities for women, men, girls and boys, so that development efforts may exert positive impact on all. Thus, Lesotho is firmly on track for these two indicators.

TABLE 3.1 Millennium Development Goal 3 At A Glance

Indicator	Baseline (2001)	2003	2007	2008	2010	2011	2012	2015 (Goal)
On-Track								
Female-male ratio in primary education	101	100	97.8	97.6	96.4	104	105	100
Share of women in non-agricultural wage employment (%)	34.4	42.6	-	42.5	-	54.4	56.1	50
Percentage of seats held by women in parliament (%)	10.6 (2002)	17	22.9	22.9	22.9	22.9	25.3	30
Off-Track								
Female-male ratio in secondary education	128	127	131	134	136	136	133	100
Female-male ratio in tertiary education	118	104	107	112	123	146	146 (2011)	100

²⁶ <http://www.unfpa.org/gender/>

²⁷ International Planned Parenthood Federation Report, 2012

Trend Analysis

Gender Equity in Education

Indicator 3.1: Ratio of girls to boys in primary, secondary and tertiary education

Lesotho has attained gender balance in primary education; indicating almost equal numbers of males and females in school. The statistics reflect that between the years 2000 and 2003 there was a marginal gender imbalance in favour of females. In the year 2004, the situation changed until the year 2011 when results show more males than females enrolling in primary school. However, the situation is different in secondary school where more females enrol compared to males. The gender inequality in secondary school enrolment remains a concern for the country.

The Free Primary Education (FPE) Policy passed in 2000 mandates equal access to primary school for males and females, and Lesotho has progressed considerably on this front. Historically, Lesotho has been one of the few countries in Africa where female enrolment has exceeded male enrolment in primary school. However, this ratio drastically

declined between 1990 and 2000 from 121 to 102 girls per 100 boys.²⁸ Moreover, as seen in Figure 3.1, the female-male ratio has on average remained balanced over the past decade, ranging from 102 to 96.4.²⁹ Nevertheless, the trend is very different for secondary and tertiary education. The female-male ratio in secondary school initially fell from 149/100 in 1990 to 126 in 2004, but it has now crept back up to 136. Furthermore, the female-male ratio for tertiary education has hovered around 110 females

per 100 males during the past decade.³⁰ The impact of this pattern is evident in long-term literacy and educational outcomes. For example 97% of women (age 15-49) are literate compared to only 80% of men.³¹ Additionally, 52% of women have a secondary or higher education, while only 40% of males have achieved that distinction.³²

²⁸ BoS, Education Statistics Report, 2001,

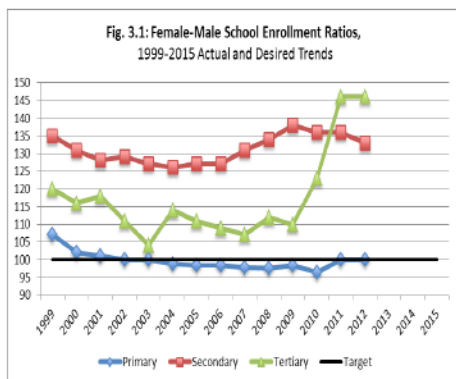
²⁹ BoS, Education Statistics Reports 2003, 2003-2007, 2009, 2010, 2011, 2012 and GoL, Education Statistics Bulletin, 2010.

³⁰ Ibid.

³¹ LDHS: 2009.

³² Education Management Information System (EMIS) Results 1999 to 2012

Figure 3.1: Female-Male School Enrolment Ratio



Source: Education Statistics Reports 2001, 2003, 2003-2007, 2009, 2010, 2011, 2012

It is observed that males have had lower educational outcomes for several reasons. Boys often herd livestock, which increases absenteeism rates. Those who do finish primary school often migrate to cities for job opportunities or drop out to work in South African mines. In recent years, high numbers of HIV and AIDS-related deaths have forced many adolescent boys to become heads of households and seek employment to support younger siblings. In sum, Lesotho is on track for achieving a balanced ratio of girls to boys in primary education, but it is still off track for equitable access to secondary and higher education.

At the primary level, the target was to achieve parity between the genders. That has been achieved. Statistics indicate that between 2010 and 2012 more males have enrolled than females. In 2010, 104 males to 100 females, in 2011, 105 males to 100 females and in 2012, 104 males to 100 females enrolled. However, at the secondary level, the trend changed drastically. The female enrolment rate is much higher than the male enrolment according to the Education Management Information Systems (EMIS), (1999-

2012). It reflects the enrolment ratio of 133 females to 75 males in 2012. One reason for the lack of parity according to the EMIS is that males struggle to progress to the secondary level.

At the tertiary level, female enrolment is higher than that of their male counterparts (Lesotho Education Report 2012) unlike in Sub-Saharan Africa where female enrolment is lower than that of males (67:100).³³

Gender Equity in the Economy

Indicator 3.2: Share of women in wage employment in the non-agricultural sector

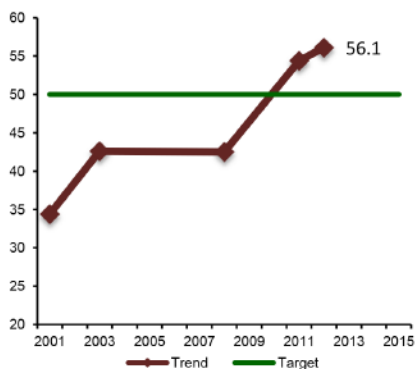
The number of women in paid employment outside the agriculture sector has been high and is on the rise. Gender equality in the labour market is also a concern in Sub-Saharan Africa, where women occupy only one in three jobs outside of agriculture. While women represent a large share of the employed, that does not mean that they have necessarily all secured stable, well-paying jobs. Generally-speaking, women earn less and enjoy less employment security than men.

The share of women in formal wage employment in the non-agricultural sector is the share of women employed in the sector expressed as a percentage of the total wage employment in the sector. In Lesotho this figure has slowly risen from 34% (2001) to 43% between 2003 and 2008. The percentage continued to rise until it exceeded the target in 2011 reaching 54.4% and 56.1% in 2012³⁴. It should be noted that these figures come from three surveys using dissimilar methodologies. Nevertheless, the general trend for achieving balanced employment appears to be on track.

³³ MDG World Report 2010

³⁴ Lesotho Demographic Survey, 2011; Household and Budget Survey, 2002/03; Labor Force Survey, 2008.

Figure 3.2: Share of Women in Wage Employment in the Non-agricultural Sector



Sources: LDS (2001), HBS (2002/03), ILFS (2008), CMS (2010/11 & 2011/12)

Several factors help explain this achievement. First, Lesotho has performed well historically on this indicator. One reason for this is because large numbers of men found work in the South African mines, allowing Basotho women to take their places in education, employment and household management. For example, female employment dominated the booming textile industry of the 2000s. Another key factor is the consistently high female enrolment in secondary and higher education and associated high female literacy rates.³⁵

In recent years, the Government has enacted laws that protect women's rights, though the impact of implementation is yet to be realised. The status of married women in Lesotho was equalized to that of men in 2006 under the Legal Capacity of Married Persons Act. Legally, any woman can now own land and receive inheritance. Prior to 2006, women in Lesotho were considered legal minors. In the same spirit of protecting women's rights, in 2003 the Sexual Offences Act was enacted. This legislation protects women from all forms of sexual violence.³⁶ Nevertheless, Basotho culture continues to promote gender-based discrimination that these laws are designed to alleviate.

³⁵ CMS 2010-2011.

³⁶ Discovering the Mountain Kingdom, July 2008, 2010

Legally, the Constitution of Lesotho enabled discrimination of women on the basis of culture and tradition according to section 18 (4) (c) ; however these laws were reviewed. The Legal Capacity of Married Persons Act of 2006 gives men and women equal status and ensures more equitable access to productive resources. The Land Act of 2010 was also a breakthrough for women's property rights, as it provides for inheritance of immovable property, joint land ownership, equal security of tenure for women, inclusion of women on land titles and representation of women in land allocation structures. Furthermore, the Companies Act of 2008 repealed the provision that denied women the right to be directors of companies without their husbands' approval. Revisions to the Bank Savings and Development Order have improved credit access for women.³⁷

The Government and development partners have established initiatives to facilitate financial credit for businesswomen. Credit is still not fully available to women, especially in rural areas, as most women do not meet financial institutions' criteria and do not possess property to use as collateral. However, there are new reforms and microcredit schemes in the pipeline to combat these challenges. Men dominate the sectors of industry, mining, public administration, electricity, private enterprise, construction, transportation, and communication – sectors where economic and political power is concentrated. Female CEOs and managers are still rare. Only 24% of employers are female. Women occupy just 23% of the economic decision-making positions in Government. Moreover, 70% of landowners are male.³⁸

Finally, gender imbalances in the economy impede development and exacerbate endemic poverty. In 1996, women headed an estimated 30% of households, rising to 35.1% in 2006 and 36.3% in 2009. Female-headed households are vulnerable because they face difficulties in securing incomes and are less likely to own major assets such as livestock (35% for female versus 55% for male-headed households). In 2006 female-headed households owned only 18.5% of cars and 28.2% of refrigerators. As the share of female-headed households rises, securing equal economic rights for women is an urgent priority.³⁹

³⁷ www.gov.ls

³⁸ Labor Force Survey 2008

³⁹ CMS 2012

Gender Equity in Government and Politics

Indicator 3.3: Proportion of seats held by women in the national parliament

Women in Parliament

The key indicator of women's political empowerment is female representation in parliament. However, parliament is only one of several realms of political power. It is important to also include women's participation in the cabinet, judiciary, public service and local government. The share of women in parliament shows a slow increase and a high of 19% in 2010. There are still four men for every one woman in the Lesotho Parliament. Greater efforts and political will are needed in order to meet the 30% target.⁴⁰

Lesotho's Parliament statutorily includes the (a) King of Lesotho, (b) Senate, and (c) National Assembly. The Senate comprises 33 members – of whom 22 are principal chiefs and 11 are appointees of the King on advice of the Prime Minister. According to the Chieftainship Act of 1968, only males are entitled to inherit the office of principal chief, but occasionally women may occupy the senate seat of a principal chief in the place of a husband or son. The National Assembly currently has 120 seats. Section 47 of the National Assembly Electoral Act 2011 introduced a limited gender quota system for national assembly elections. The new provision applies to the 40 seats allocated through proportional representation party lists and requires political parties to put forward equal numbers of male and female candidates ("zebra" party list). Lesotho has achieved slow but progressive improvement with respect to gender equality in Parliament as indicated in Table 3.2.

Local government in Lesotho was reintroduced in 2005 and two local government elections have since occurred in 2005 and 2011. In 2005, the Government made a proactive effort to ensure

female representation by reserving 30% of all constituencies exclusively for women candidates. The remaining 70% of constituencies were open to men and women. Ultimately, women were elected to 58% of contested positions in local government in 2005. In 2011, the Tanzanian model was adopted and the First Past The Post (FPTP) system was adopted abandoning the 30% quota system.⁴¹ According to the SADC Protocol on Gender and Development, it was agreed that women should hold 50% of decision-making positions in the private and public sector. In addition to this, the Beijing Platform for Action states that women will participate without any discrimination in all elections and should be treated as equal partners with men at all levels of development.

As a result, the Independent Electoral Commission amended the system for 2011 by opening up all constituency seats to both men and women. Yet, an additional 30% of seats were allocated to women on a proportional representation basis. Consequently, female representation in local government dropped to 49.1%. Nevertheless, the quota and local government bodies were seen as much more legitimate and Lesotho still has the highest representation of women in local government in the region.

The proportion of women in Lesotho's Senate has fluctuated around the 30% target since 1998, while female representation in the lower house has steadily increased. The total representation of women in Parliament is also on track, increasing from 10.6% in the 1998 elections to 25.4% in 2012. Lesotho is within reach of the MDG target of 30% representation.

⁴⁰ Gender Links, SADC Gender Protocol 2011 Barometer, Chapter 4, Economic Justice.

⁴¹ Parliamentary representations include women in both the National Assembly and the Senate. Election Years are 1993, 1998, 2002, 2007, and 2012. Figures provided by Inter-Parliamentary Union, Statistical Archive on Women in Parliament (<http://www.ipu.org/wmn-e/world-arc.htm>) and Gender Links, SADC Gender Protocol Barometer 2011, Chapter 2, "Gender and Governance."

TABLE 3.2: Female Representation in Parliament

	1993	2007	2012
Seats in Senate	33	33	33
Number of Women in Senate	8	10	9
Percentage of Women in Senate (%)	24.2	30.3	27.3
Seats in National Assembly	65	120	120
Number of women in National Assembly	3	29	30
Percentage of women in National Assembly (%)	4.6	24	25
Total Percentage of Women in Parliament (%)	11.2	25.4	25.4

Women in the Executive

At the helm of the executive branch are the Prime Minister and Cabinet of Ministers. Lesotho's cabinet comprises 23 ministers (including the PM), and, following the 2012 elections, five ministers (21.7%) are women. Three of the seven deputy ministers are also women. Latest estimates show that women comprise 40% of public servants.

Women in the Judiciary

The courts in Lesotho are organized in a three tier structure comprising (a) the Court of Appeals; (b) the High Court of Lesotho and (c) Subordinate Courts. The Court of Appeals has 5 judges, all of whom are men. The High Court of Lesotho has 12 judges and half are women. There is no data readily available concerning the gender balance in the subordinate courts.

Key factors contributing to meeting the targets

Policy and Legislative framework

Lesotho has ratified most regional and international agreements promoting the rights of women, including the Convention on the Elimination of all forms of Discrimination against Women (CEDAW1979) with reservations; the Beijing Declaration and the Platform for Action (1995); the SADC Declaration on Gender and Development (1997); and the SADC Protocol on Gender and Development (2008). Many of the key elements of these agreements have been domesticated in Lesotho in the Gender Policy, which was adopted in 2003 and is currently under review.

Parliament has passed numerous pieces of legislation to promote rights of women, and the Law Reform Commission has worked to repeal or revise all discriminatory laws and policies such as the Companies Act of 2011 and other laws concerning economic transactions and property rights. The Sexual Offences Act of 2003 combats sexual violence and prescribes strong sentences for offenders. The Anti-Trafficking in Person Act of 2011 prohibits all forms of human trafficking and imposes penalties on offenders. Also, the Legal Capacity of Married Persons Act of 2006 removed several restrictions on the legal capacity of a wife and effectively establishes the equality of spouses. In 2011, Lesotho adopted a National Action Plan to end gender-based violence against women and a domestic violence bill is in progress. Furthermore, the National Gender and Development Policy observes a rights-based approach to development in addressing the challenges of gender inequalities, poverty, increased spread of HIV and AIDS and unemployment.

Institutional Developments

Among other initiatives, the Child and Gender Protection Units (CGPU) were established throughout the country in the Lesotho Mounted Police Service. The core activities of this unit include investigating cases of children needing care and sexual offence cases. The unit also provides services to gender-based violence survivors and maintains a database on all reported cases.

Key Implementation Bottlenecks Constraining Progress

Policy and Planning Framework

- Basotho have traditionally been patriarchal with decision-making powers and rights vested in males. Traditional practices were enshrined in the Laws of Leretholi (1903), and they largely designated women as minors and constrained them from decision-making, ownership of property and inheritance. An Africa Peer Review Mechanism Report notes that the primacy accorded to cultural beliefs and practices as articulated in Section 18(4)(c) of the Constitution establishes gender-based discrimination and inhibits full development of human rights regardless of gender. One example is that Lesotho has ratified CEDAW with reservations on issues of culture and chieftainship.
- A key task is to ensure that both men and women understand the Legal Capacity of Married Persons Act, 2006 and how gender equality contributes to development for all members of society.

Service Delivery

- The growing gap between males and females in secondary and tertiary education is alarming. Interventions are needed in the education sector to ensure more males continue their education from primary school into higher levels rather than immediately assuming occupations in agriculture, unskilled labour or mining.
- Despite strong education and literacy levels, women are still constrained in their access to credit, land and productive resources. They also face barriers in securing equal wages, and gaining professional and management positions in the workforce.

Gender-Based Violence (GBV)

- Curbing violence against women remains a major challenge as it adversely impacts women's health, productivity and wellbeing. Sexual violence is a particular concern in a country where HIV and AIDS is so prevalent.
- Large proportions of both men and women still agree that gender-based violence is justifiable under some circumstances. For instance, 27% of women and 34% of men believe that a husband is justified in beating his wife if she argues with him. 37% of women and nearly half of all men agree that wife beating is acceptable under certain circumstances.
- Moreover, in the case where a woman refuses sexual intercourse, 63% of men have indicated their belief that they have a right to get angry and reprimand her, while 26% believe it is appropriate to refuse her financial support and 16% agree that it is justifiable to use force.

Recommendations

- Encourage political parties to establish strategies for empowering female members.
- Mainstream gender in all sectoral programs and national policies.
- Provide more advocacy and knowledge dissemination on the constitution and child protection bill.
- Train media in appropriate, gender-sensitive reporting.
- Strengthen the voice of vulnerable groups by creating seats for their representatives in Parliament.
- Continue reforming laws and customs that hinder female economic mobility (e.g., laws and policies on credit, property rights, inheritance, land, etc.) and scale-up programs to provide financial credit to women for operating micro, small, and medium enterprises.
- Strengthen support to the one-stop centre for GBV survivors, the gender and child protection units and other mechanisms to increase awareness and curb GBV.
- Scale up funding and initiatives for raising awareness about and preventing GBV, such as the Sixteen Days of Activism against GBV. Work through churches, civil society, schools/education curriculum, community leaders and the media to change harmful social beliefs that sustain GBV.
- Create M&E tools for monitoring GBV levels. Specifically, develop indicators of GBV and measure the indicators regularly through household attitudes surveys, administrative data (e.g., police records, court and health records), GBV content in the media, and political correspondence/discourse/speeches.
- Create M&E tools for monitoring the participation and representation of women in politics and decision-making positions.
- Create M&E tools for monitoring the participation and representation of women employment in the non-agricultural sector.
- Review and amend customary law to allow for gender equality
- Enact Domestic Violence legislation.



4 REDUCE CHILD MORTALITY

TARGETS

4. A. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicators

4.1: Under-five mortality rate

4.2: Infant mortality rate

4.3: Percentage of 1 year-old children immunized against measles



Overview

One in every nine children born in Lesotho dies before reaching a fifth birthday. For the five-year period 2005-2009, the infant mortality rate was 91 deaths per 1,000 live births, and the under-5 mortality rate: 117 deaths per 1,000 live births. Deaths occurring in the neonatal period (1-28 days) account for 40% of under-five mortality and deaths during the postnatal period (child birth to 6 weeks) account for 38%. Increasing poverty, malnutrition and high prevalence of HIV/AIDS make children vulnerable to ill health, abuse, violence and abandonment. The health sector programmes aim to ensure the survival and development of children through basic health services, specifically immunization, nutrition and treatment of common childhood diseases.

TABLE 4.1: Millennium Development Goal 4 At A Glance

Indicator	2001	2004	2009	2015 (goal)
Off Track				
Infant mortality rate (per 1,000 live births)	81	91	91	27
Percentage of 1 year-olds immunized against measles	71.3	74.7	69.6	100
Under-five mortality rate (per 1,000 live births)	113	113	117	37

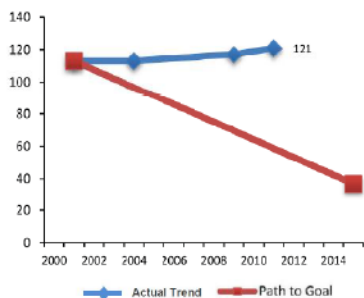
Trend Analysis

Under-Five Mortality Rate

Indicator 4.1: Under-five Mortality Rate

The Lesotho Demographic and Health Survey of 2009 show an increase in the under-five mortality rate between 2004 and 2009. From 2001 to 2004, the under-five mortality rate was 113 deaths per 1,000 live births, but in the period from 2005-2009, the rate increased to 117 deaths per 1,000 live births. However, a different source of data (Lesotho Demographic Survey of 2011) noted that under-five mortality rate was 121 per 1,000 live births.

Figure 4.1: Under-Five Mortality Rate



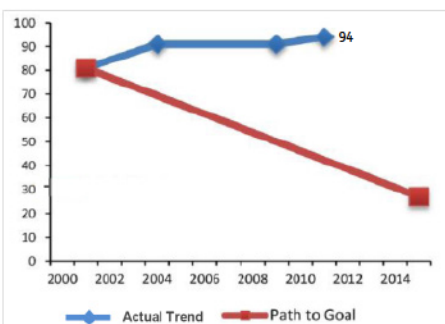
Source: (LDHS 2009, 200 and LDS (2001, 2011))

Indicator 4.2: Infant Mortality Rate

Lesotho has set a goal to reduce infant mortality rate to 27 deaths per 1,000 live births. In 2001, 74 infants per 1,000 live births died within their first year. Four years later (2004), the number had increased to 91 infant deaths per 1,000 live births and remained the same in 2009. One of the major

reasons for this increase was the transmission of HIV and AIDS from mother to child. Other causes of death were diarrhoea and pneumonia, which are also frequently linked to HIV infection. According to LDHS 2004 and 2009, about 40% of under-five deaths occur during the neonatal period. Neonatal causes of child death include asphyxia, preterm births, and sepsis related to childbirth. Furthermore, poor sanitation and unsafe drinking water are associated with a high prevalence of diarrhoea among children. Diarrhoea is one of the major causes of death, according to the 2004 Lesotho Demographic Health Survey (2004, LDHS). The LDS of 2011 notes an increase in the infant mortality rate at 94 per 1,000 live births, a significant increase over 2001. At the present rate, the country is not likely to achieve its MDG target of 27 infant deaths per 1,000 live births.

Figure 4.2: Infant Mortality Rate



Source: (LDHS 2009, 2004) and LDS (2001, 2011)

Socioeconomic Variations in Rates and Causes of Mortality

Child mortality rate is a key indicator of a nation's level of development, particularly because it reveals the quality of health services. High child-mortality rate is usually indicative of inadequate healthcare systems, inappropriate hygienic conditions, and unfavourable socio-economic factors. The Ministry of Health and Social Welfare (MOHSW) 2011 Annual Joint Review revealed that in Lesotho, the five major causes of child

mortality are pneumonia, malnutrition, HIV and AIDS, diarrhoea and measles. Poor sanitation and drinking water are also major causes of child illnesses.⁴²

Mortality rates vary by place of residence, maternal education, and income level. The infant and under-five mortality rates are higher in rural areas and in mountainous regions.⁴³

⁴² MOHSW, Annual Joint Review, 2011.

⁴³ LDHS, 2009

TABLE 4.2: Mortality Rates by Socioeconomic Characteristics for 10-year Period (1999-2009) Preceding the Survey

Characteristic		Infant mortality	Under five mortality
Residence	Urban	74	89
	Rural	86	110
Geographical Zone	Lowlands	79	98
	Foothills	82	117
	Mountains	89	114
	Senqu River valley	88	103
Mother's Education	No education	(55)	76
	Primary incomplete	95	124
	Primary complete	88	108
	Secondary+	71	88
Wealth Quintile	Lowest	88	107
	Second	93	125
	Middle	76	96
	Fourth	91	115
	Highest	65	80

Source: LDHS 2009

Child mortality rates are clearly linked with the mother's education level: more education is associated with lower child mortality rates because the mother is better educated about nutrition, family planning, illness prevention and treatment, hygiene and immunization. The LDHS 2009 indicates that infant and under-five mortality rates drop as maternal education levels increase, but contrary to expectations, mortality rates are lowest when the mother has "no education." However, the number of mothers

reporting "no education" is very low compared to the other categories and, thus, this category is likely an insignificant statistical aberration from the general trend.

The correlation between mortality rates and family wealth does not follow expected patterns. The second and fourth quintiles report the highest mortality rates, contrary to expectations that mortality rates will decrease progressively as the wealth of the mother increases.

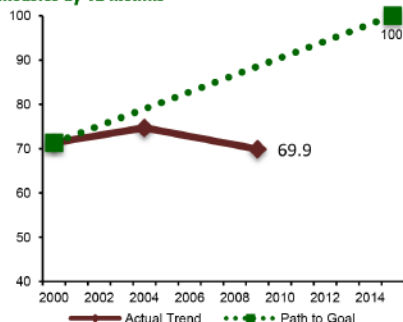
Immunization against Measles

Indicator 4.3: Proportion Of 1 Year-Old Children Immunized Against Measles.

This indicator provides a measure of the coverage and quality of child healthcare and is a critical component of reducing under-five mortality. Immunization against measles is especially important, as measles is the leading cause of mortality among vaccine-preventable childhood diseases. Lesotho has implemented the Expanded Programme on Immunizations as a cost-effective public health intervention to reduce child morbidity and mortality from preventable diseases such as tuberculosis, polio, diphtheria, whooping cough, tetanus, influenza and measles.

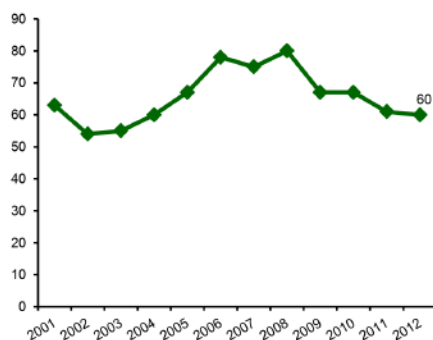
There is slow progress in scaling up immunization, especially against measles, which is characterized by frequent fluctuations. Figure 4.4 provides a good picture of the inter-year variation in measles immunisation coverage among all children since 2001. Immunization against measles among children younger than one year has consistently been less than the recommended 90% national coverage (80% for rural districts) and MDG target of 100%.

Figure 4.3: Proportion of Children Immunized Against Measles by 12 months



Source: LDHS (2009, 2004) and EMICS 2000

Figure 4.4: Measles Coverage



Source: MOH Annual Joint Review 2010, 2011, 2012

The cause of low coverage is inadequate provision of immunization through health centres. Inadequate transportation, lack of skilled personnel, frequent staff turnover and reliance on fluctuating donor support have contributed to low coverage

performance. Moreover, the decentralization of health services is not yet fully functioning and districts still depend on the central level for planning and resource mobilization.

These factors help explain the large year-to-year fluctuations in coverage. Most children are vaccinated through fixed or static services because numerous obstacles prevent families from vaccinating infants through outreaches. The 2007 and 2010 post-campaign evaluation report indicated that 75% and 78% of children were vaccinated through outreach services respectively. When financial and personnel resources are robust, outreach services can be

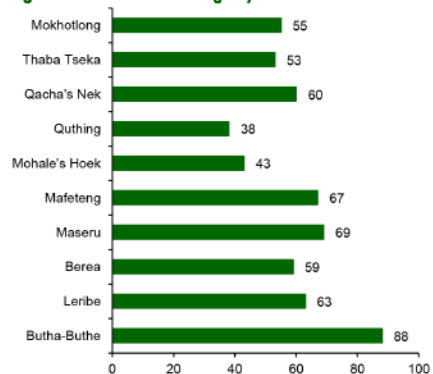
provided using the Reaching Every District/Child (RED/C) strategy. In an attempt to address the disparity in immunization, Lesotho introduced the strategy in 2012 in the four districts with high numbers of children with DTP3 and measles. Even so, the strategy is not well implemented due to constraints such as inadequate transportation to reach the target communities. When outreach services decline, immunization coverage decreases. Scaling up sustained outreach services has been proposed and discussion is on going for partners to fully dedicate themselves to this effort.

VARIATIONS IN IMMUNIZATION COVERAGE

The national routine immunization by vaccine as depicted in Table 4.3 shows that the immunization coverage is on an average of 60%. This poses a great concern related to achieving the MDG target on immunization. The efforts have not yet realized the intended target of 80%. There are wide disparities and fluctuations among the districts. Butha-Buthe and Maseru districts have relatively better coverage than the other districts while Quthing is the worst performing district.

Lowland and foothills areas have the highest immunization coverage, while the highlands and Senqu River Valley have the lowest. The coverage differential between urban (90%) and rural (77.5%) is particularly sharp. Coverage is also positively correlated with maternal education level.

Figure 4.5: Measles Coverage by Districts - 2012



Source: Ministry of Health Annual Joint Review (2012)

TABLE 4.3: Immunization Coverage among Children aged 12-23 months

Characteristic		Measles Immunization Coverage
Residence	Urban	90
	Rural	77.5
Geographical Zone	Lowlands	85.1
	Foothills	80.4
	Mountains	73.8
	Senqu River valley	71.3
Mother's Education	No education	n/a
	Primary incomplete	71.1
	Primary complete	79.2
	Secondary+	86.3

Source: LHDS (2009)

Key Implementation Bottlenecks, Challenges and Constraints

The greatest challenge in reducing child and infant mortality is a weak health care system coupled with poor family and community health practices.

Institutional Capacities

- **Inadequate health worker skills.** The 2009 Community Integrated Management of Childhood Illness (IMCI) Survey revealed a lack of skilled health professionals and community knowledge, especially in recognizing danger signs of illnesses in children. Even though the IMCI strategy works to improve health worker skills, health sector efficiency, and community practices, it has not produced a substantial change in knowledge and behaviour. Guidelines have been developed but there are no national or district strategies for implementation. Some strategies like community IMCI are yet to be adopted.
- **Infrastructure and human resources:** Health services are largely inaccessible, especially for people living in the mountainous areas, due to (a) a shortage of skilled staff at all levels of the health system, (b) insufficient health promotion and (c) poor infrastructure (inadequate road networks, lack of ambulances and insufficient two-way communication).

Service Delivery

- **Poor health-seeking behaviour when children are ill.** Only 54% of children with symptoms of fever and respiratory illnesses were brought to a health facility in 2004. Lack of awareness among parents and communities to identify danger signs of childhood illnesses is among the causes.
- **HIV.** The high prevalence of HIV exacerbates health system problems. Health workers, especially those providing maternal care, are working beyond their capacity with the number of people living with HIV and often give less attention to the quality of care.

Policy and Planning Framework

- **Weak decentralization.** A decentralized health system is underway but implementation is slow. Thus, at the district level, inadequate capacity to plan, mobilize resources and manage programmes hinders progress. There is an urgent need to build capacities of the district health management teams to rapidly take up their roles.
- **Weak policy implementation and integration.** Major policy responses include the IMCI strategy and the Infant and Young Child Nutrition programmes, and Expanded Programme on Immunization and the 'Reaching Every District (RED)' initiative. Through the IMCI, Lesotho intends to prevent and manage childhood illnesses such as acute respiratory illnesses, diarrhoea and gastrointestinal diseases like intestinal worms. However, these programmes require separate operational plans with weak integration.

Data Challenges

- Insufficient data collection on health and mortality among children is a serious constraint. In addition, long intervals (5 years) between the demographic health surveys limit the capacity to evaluate changes on the ground. Many uncoordinated data collection tools from different programmes create problems in the collection, analysis and use of data/information to formulate quality policies and plans.

Recommendations

Integrate health services for children and mothers. In the absence of integration, available resources to improve health for both child and mother are not efficiently used. It is a priority to implement an integrated and meaningful approach to service delivery.

Operationalize existing strategies. There is an urgent need for the government to mobilize resources and strengthen partnerships with the private sector and Development Partners in order to operationalize strategies such as the Reaching Every District (RED) initiative, maternal/child health weeks, family health days and African Vaccination Week.

Develop a child survival policy and operational plan for national, district and community levels. The Government and partners should channel adequate resources for accelerated implementation.

Review the Integrated Management of Childhood (IMCI) strategy. Adequately address the child survival interventions.

Develop strong cross-border collaboration between Lesotho and South Africa. This partnership, especially at the community level, will help, for example, tackle the measles outbreak and sustain the elimination efforts. This issue should be addressed at the SADC forum.

Key factors contributing to meeting the targets

- Support of Global Alliance for Vaccine Immunization (GAVI) in the Expanded Program Immunization.
- Integrated Management of Childhood Illnesses (IMCI) strategy has the potential to enhance children's health and survival prospects.
- Prevention of Mother to Child Transmission (PMTCT): Recent surveys indicate that the Mother to Child Transmission (MTCT) rate has slightly declined from 28% in 2009 to 26% in 2010.
- Children's Protection and Welfare Act.



5 IMPROVE MATERNAL HEALTH

TARGETS

5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators

5.1: Maternal mortality ratio (MMR)

5.2: Proportion of births attended by skilled health personnel

5.B. Achieve, by 2015, universal access to reproductive health

Indicators

5.3: Contraceptive prevalence rate

5.4: Adolescent birth rate

5.5: Antenatal care coverage (at least one visit and at least four visits)

5.6: Unmet need for family planning



Overview

As of 2013, one out of 32 women in Lesotho dies of pregnancy and birth complications. The Maternal Mortality Ratio (MMR) has increased steadily since 1990. While supportive policies and strategic programs help ensure universal access to reproductive health, most of the secondary indicators show slow improvement. Lesotho remains off-track on the target of reducing maternal mortality ratio, but is registering some progress on improving access to reproductive health.

TABLE 5.1: Millennium Development Goal 5 At A Glance

	2001	2004	2009	2015
Off-track				
Maternal mortality ratio (per 100,000 births)	419	762	1,155	93
Slow Progress				
Proportion of births attended by skilled health personnel (%)	60.0	55.0	61.5	80
Contraceptive prevalence rate, married women, 15-49 (%)	36.1	37	47	80
Adolescent (15-19) birth rate (%)	-	20.2	19.6	
Antenatal care coverage (at least 1 visit) (%)	85.2	90.0	92.0	100
Antenatal care coverage (at least 4 visits) (%)	-	69.6	70.4	
Unmet need for family planning (%)	-	30.9	23.0	

Trend Analysis

Target 5.A: Reduce by 3/4 the maternal mortality ratio between 2000 and 2015,

Indicator 5.1: Maternal Mortality Ratio

Lesotho's maternal mortality ratio (MMR) is the highest in the region.

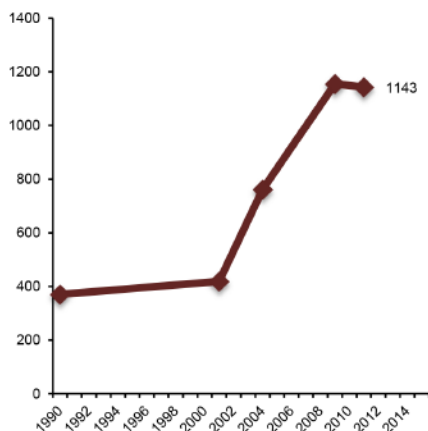
TABLE 5.2: Regional Maternal Mortality Trends

Country	MMR	Survey Year
Botswana	190	2009
Namibia	448	2007
Swaziland	589	2007
South Africa	625	2007
Lesotho	1155	2009

Sources: LDHS 2009, UNDP Botswana, Namibia, Swaziland, and South Africa

According to the End of Decade Multiple Indicator Cluster Survey (EMICS) of 2000 and the Demographic and Health Surveys of 2004 and 2009, MMR increased from 419 per 100,000 live births in 2000 to 762 per 100,000 in 2004 and 1,155 per 100,000 in 2009.⁴⁴ Using the 2004 baseline (762 deaths per 100,000 live births), the Government of Lesotho has set a target to reduce maternal deaths to 300 deaths per 100,000 live births by 2015⁴⁵. This was increased from the initial target of 93 deaths derived from the baseline of 370⁴⁶ deaths per 100,000 live births. According to the Lesotho Demographic Survey (LDS) of 2011, there has been a slight decline from 1,155 in 2009 to 1,143 in 2011. As illustrated in Figure 5.1, the 2015 target is unlikely to be achieved, unless accelerated measures are taken.

Figure 5.1: Maternal Mortality Rate



Source: LDHS(2004, 2009), LDS(2001, 2011) and WHO/UNICEF/UNFPA/World Bank, Trends in Maternal Mortality: 1990-2008.

⁴⁴ EMICS and LDHS used slightly different survey methodologies. The EMICS includes women who had a birth in the year preceding the survey, whereas LDHS surveyed trends in the 5-year period preceding the survey.

⁴⁵ GoL, Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Lesotho, (2007-2015)

⁴⁶ WHO/UNICEF/UNFPA/World Bank, Trends in Maternal Mortality: 1990-2008.

The high levels of maternal mortality in Lesotho are attributed to the “3 delays”⁴⁷:

Delays in making decisions on the part of pregnant women to access health care services, mainly as a result of socio-cultural barriers. These include women’s constrained decision-making power, their low ability to command resources and their low societal status, as well as their failure to recognise complications;

Delays in reaching health care services on the part of women experiencing complications, poor accessibility of maternity homes in large part due to Lesotho’s mountainous terrain; the lack of sufficient community and formal ambulatory transport, the limited hours of health facilities and the weakness of the health referral system; and

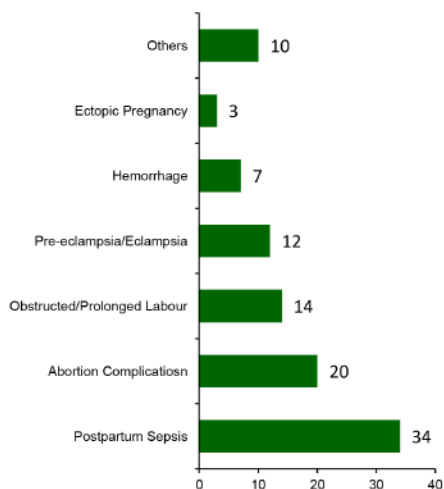
Delays in receiving adequate health care services due to insufficient human resources, particularly in hard-to-reach health facilities, inadequate equipment and supplies and infrastructure including water and electricity.

Immediate and direct causes are post-partum sepsis (34%), abortion complications (20%), obstructed or prolonged labour (ruptured uterus) (14%), pre-eclampsia/eclampsia (12%), haemorrhage (7%) and ectopic pregnancy (3%). Indirect causes include tuberculosis, anaemia, and HIV (10%).⁴⁸

⁴⁷ MDG Acceleration Framework, 2013

⁴⁸ LDHS 2009

Figure 5.2: Causes of Maternal Deaths



Source: EmOC 2005

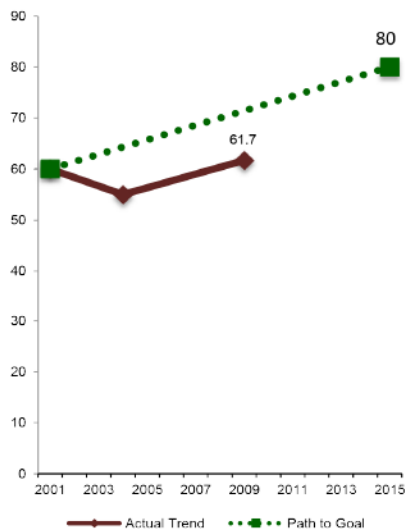
Indicator 5.2: Proportion of Births Attended by Skilled Health Personnel

Lesotho has set a goal of increasing the percentage of live births to 80%. Trends in deliveries with help from health professionals have been mixed in recent years. While in 2000, 60% of women gave birth with the assistance of a skilled health worker (doctor, midwife), the proportion decreased to 55% in 2004.⁴⁹ The 2009 LDHS shows an improvement to 61.5%. Although there is an increase in the number of deliveries attended by health professionals, the quality of care is a concern. Immediate postnatal care is very low (15%),⁵⁰ and is particularly undesirable because most deaths occur within two days of childbirth.

⁴⁹ End of Decade Multiple Indicator Survey, 2000 and LDHS 2004.

⁵⁰ LDHS 2009

Figure 5.3: Proportion of Births Attended by Skilled Health Personnel



Source: LDHS (2009, 2004) and EMICS 2000

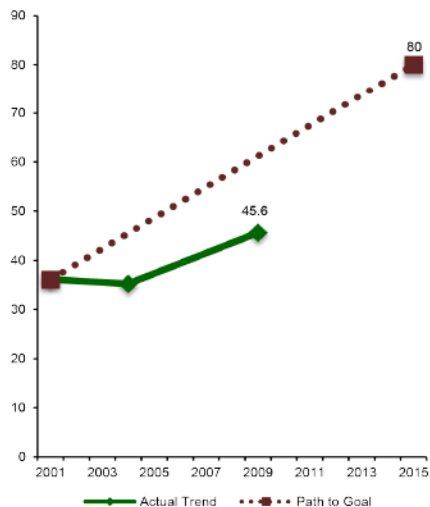
Target 5.B: Achieve, by 2015, universal access to reproductive health

Indicator 5.3: Contraceptive Prevalence Rate

The contraceptive prevalence rate (CPR) of modern methods is the percentage of married women aged 15-49 using a modern method of family planning. High access to contraception helps reduce maternal mortality. Fortunately, the CPR has been increasing, from 36.1% in 2001, to 35% in 2004 and 46% in 2009. Moreover, knowledge of family planning is almost universal with over 98% of women aged 15 - 49 knowing at least one method of modern Family Planning⁵¹. This increase, however, has not been high enough to decrease the maternal mortality rate.

⁵¹ LDHS 2009

Figure 5.4: Contraceptive Prevalence Rate Among Married Women, 15-49

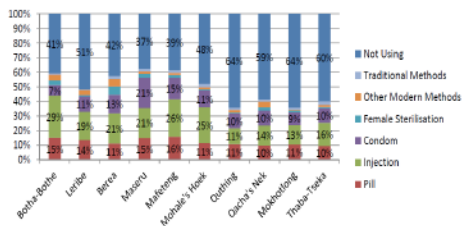


Source: LDHS: 2009, 2004, 2001

Variations in Contraceptive Usage

As reflected in Figure 5.5, Quthing and Mokhotlong districts have the lowest use of contraceptives among the mountain districts. Maseru and Mafeteng have the highest use of contraceptives among sexually active women (63% and 61% respectively).

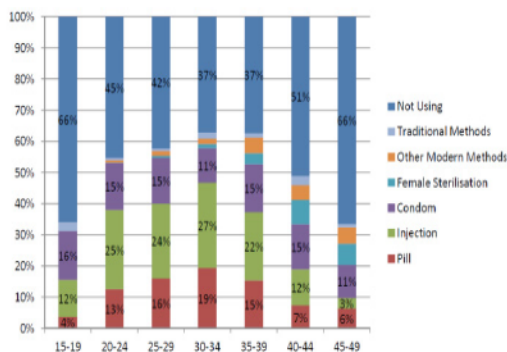
Figure 5.5: Contraceptive Use by District - 2012



Source: MOH Annual Joint Review (2012)

According to UNFPA⁵², more than one quarter of unwanted pregnancies worldwide end in abortion. In Lesotho where abortion is illegal unless recommended by a qualified health personnel, some of these abortion procedures are performed under unsafe conditions and have led to maternal deaths. As reflected in the chart, 66% of women in the youngest and oldest age groups are not using methods of contraception. This figure is worrisome, especially in the youngest age group, as it is likely to increase the unplanned adolescent pregnancy and birth rate that could in turn lead to unsafe abortions. Injection is the most common method of contraception in age group 30-34 (27%). The long-term contraceptive methods (IUD and implants) are common in age groups 35-49. Though it's not common, long-term contraceptive methods are used by every group, except the 15-19 age group. The contraceptive pill is the second most-used method in age groups 25-39.

Figure 5.6: Contraceptive Use by Age - 2012



Source: MOH Annual Joint Review (2012)

Indicator 5.4: Adolescent Birth Rate

In Lesotho, the adolescent birth rate is the percentage of women aged 15-19 who have had a live birth or who are pregnant with their first child. Teenage pregnancy is a major health concern because it is associated with higher maternal child mortality and morbidity and carries high risks, such as pregnancy-induced hypertension, obstructed or prolonged labour, and unsafe abortion. Younger mothers are much less likely to receive antenatal care. Moreover, teen pregnancy

⁵² www.unfpa.org/public/home/mothers/pid/4382

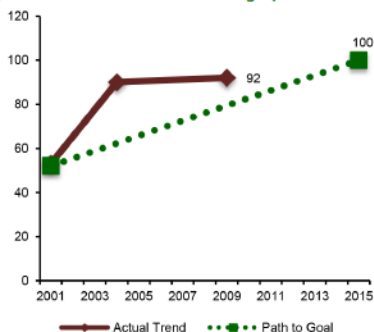
adversely impacts long-term wellbeing, as young mothers are less likely to continue their education and find decent employment.⁵³

In 2004, the teen birth rate was 20.2%, and it dropped slightly to 19.6% in 2009. Also, the CPR among married adolescent girls has improved from 14.7% in 2004 to 26.8% in 2009.⁵⁴

Indicator 5.5: Antenatal Care Coverage

Antenatal care (ANC) coverage is the percentage of pregnant women (age 15-49) who receive ANC from a skilled provider (doctors, midwives). Antenatal coverage has improved from 53% in 2001 to 90% in 2004 and to 92% in 2009. The proportion of women who have at least four antenatal care visits has also slightly increased from 69.6% in 2004 to 70.4% in 2009.⁵⁵

Figure 5.6: Antenatal Care Coverage (at least one visit)



Source: LDHS (2004, 2000) and EMICS 2000

The geographic differences in ANC utilization are also apparent where fewer women in the rural areas (28.4% in 2004 and 29.2% in 2009) initiated ANC during the first trimester, compared to 40.2% (2004) and 42.3% (2009) from the urban residences. With regard to number of ANC visits, it is recommended that women should at least have a minimum of four visits, provided there are no complications. LDHS 2009 shows that while the majority of women do have a minimum of four

⁵³ Ibid.

⁵⁴ LDHS, 2004 and LDHS, 2009

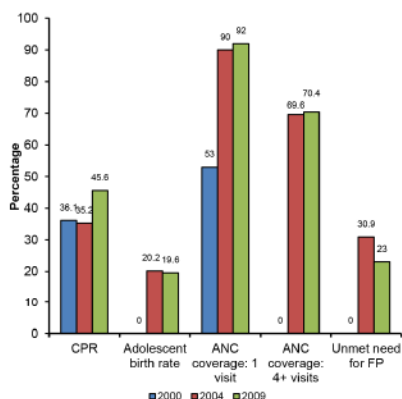
⁵⁵ Ibid.

visits, there is a sizeable number of women who do not achieve the recommended number of visits (18% in 2004, 19.4% in 2009). When disaggregated geographically, the data reveals that more women in the urban areas (85.5% in 2004 and 82.5% in 2009) are likely to have had four or more visits as compared to those in the rural residences (67% in 2004 and 66.3% in 2009).

Indicator 5.6: Unmet Need for Family Planning

The unmet need for family planning services by married women aged 15-49 for the purposes of both spacing and limiting childbirth has been high but declining from 30.9% in 2004 to 23% in 2009.⁵⁶ The 2009 LDHS reveals that the unmet need is higher among rural women (26%) than the urban women (15%). The need is also higher among women in mountainous areas (33%) compared to those who live in lowlands (18%). This indicator reveals that more investment should be channelled towards improving family planning services as opposed to demand creation.

Figure 5.8: Performance of All Indicators for Target 5B



⁵⁶ Ibid.

Key Implementation Bottlenecks Constraining Progress

Limited Skilled Human Resources and Infrastructure

Shortage of skilled staff is a problem at all levels of the health system. For maternal, newborn and reproductive services, the major problem is a shortage of midwives. Nearly 40% of women deliver without the assistance of any skilled personnel (doctors and midwives). Registered nurse midwives have both general nursing and midwifery certificates – serving a dual role. However, the deployment of nurse/midwives does not favour allocation to provision of maternal health care services. Moreover, health workers, especially those providing maternal care, are stretched beyond their capacity by caring for large numbers of HIV and AIDS patients.

Personnel shortages result in specific problems for maternal care. For example, only 53% of women who received antenatal care were informed of warning signs of pregnancy complications. Only 3% of new mothers received a postnatal check-up within the recommended time period (within the first 2 days after child birth), while only 58% had any postnatal check-up at all.⁵⁷ Furthermore, community health education receives little attention.

Finally, poor infrastructure, (poor roads, lack of ambulance services, lack of communication including breakdown of two-way radio communication) limits access to health services especially for the population living in mountainous areas.

Institutional Capacity Gaps

The weak health care system poses the greatest challenge to the reduction of maternal mortality. Specific institutional capacity challenges include:

- Implementation of the Decentralized Health Service System is slow, resulting in inadequate capacity at the district level to effectively plan, mobilize resources and implement programmes.

⁵⁷ Ibid.

- The health information system is weak, and there are many uncoordinated data collection tools serving different programmes, creating problems in the collection, analysis and use of data to improve services.
- Delays in implementing the health sector human resource retention strategy impacts negatively on maternal health indicators.

Limited Financing for Reproductive Health Services

- In 2008 MOHSW started providing some services in health centres for free because the prevalence of poverty has been a major impediment for healthcare – especially reproductive and maternal care. However, 73% of women still report access problems, including concerns about the availability of drugs, lack of money for advanced treatment, distance to health centres and transportation.⁵⁸ Fees are still levied in both government and CHAL hospitals for normal and surgical deliveries, and emergency obstetric care is not included among the free services offered in health facilities.
- Women in rural and remote areas underutilize waiting mothers' homes attached to health centres because of poverty and lack of a feeding programme in these facilities.
- The 2009 LDHS indicated that many people do not attend antenatal care services due to inadequate funds, difficult topography and cultural practices, resulting in dangerous delays, which increase the risk of death to mother and child.
- Continuous availability of essential obstetric equipment, medicine and medical supplies is a challenge. There are frequent reports of stock-outs due to the inability to forecast requirements coupled with procurement problems.
- The health facility accreditation survey conducted for quality assurance in 2009 indicated that only 47 health centres and none of the 16 hospitals passed the accreditation standards for quality assurance, meaning that the chances of receiving appropriate maternal health care services are minimal.

⁵⁸ Ibid.

Data challenges

While the Road Map for Accelerated Reduction of Maternal and Newborn Mortality was developed in 2007 as a strategy, the operational plan and the M&E framework were just developed in the last quarter of 2011. Still, progress has been made with the data collection tools such as the ANC, delivery and postnatal registers.

Furthermore, Lesotho has institutionalized

maternal death reviews and adopted maternal death surveillance and response as procedures of reporting maternal deaths. However, the country has not yet started community-based maternal review or verbal autopsy. The Health Information Management System (HIMS) regularly generates data, which informs the Annual Joint Review of the health sector, but there is no forum to effectively apply the result and develop better evidence-informed policy in maternal and child health.

Recommendations

- Improve the human resource base of the health sector, particularly frontline and community health workers and implement a retention strategy.
- Fast-track implementation of the Nursing Education Partnership Initiative (NEPI)⁵⁹ or enhanced midwifery course in the training curricula for nurses, as in many African countries.
- Introduce feeding programmes in health centres and waiting mothers' homes.
- Increase efforts to decentralize the healthcare system and build district-level capacity.
- Improve the referral system for emergency obstetrics, taking into account communication and transport needs.
- Strengthen integration of HIV/ AIDS patient care and reproductive, maternal and neonatal health services
- Strengthen the supply chain and distribution of obstetric equipment, medicines, medical supplies and contraceptives.
- Develop a forum to apply the results of the Annual Joint Review of the health sector.
- Improve the health information system and integrate data collection and analysis.
- Scale up IEC (Information, Education, and Communication) interventions in order to promote maximum utilization of services.
- Integrate outreach services through appropriate transport.
- Fast-track decentralization of health services and revitalization of primary health services.
- Strengthen capacity of Riders for Health to improve EMOC and blood services.

⁵⁹ Given the critical shortage of nurse midwife professionals, the Government of Lesotho (GoL) and the U.S. Government are collaborating on the Nursing Education Partnership Initiative (NEPI) It aims to help Lesotho address this existing nurse midwife gap within the health workforce and focuses also on improved quality of nursing and midwifery education

Key factors contributing to meeting the targets

MDG Acceleration Framework (MAF):

In 2013, the Government of Lesotho with support from the UN and other stakeholders developed the MDG Acceleration Framework (MAF) for Maternal Health. The Framework identifies and prioritises the main bottlenecks and proposes collaborative solutions involving the government and other stakeholders. The framework is designed to accelerate the operationalization of various maternal health initiatives. In view of the challenges facing maternal health that go beyond the MOH and health care professionals alone, the MAF prioritizes four key intervention areas to address the three delays:

- Improvements in skilled delivery through investments in infrastructure and road access to health facilities; by availing community-based transport systems; by providing food in maternity waiting homes; by incentivising health care workers, particularly in hard-to-reach facilities; and by improving communications, including through the enhanced use of cellular technology
- Strengthening the Provision of Emergency Obstetric and Neonatal Care by providing ambulances for all District Health Management Teams (and some health centres); by ensuring the supply and retention of the essential human resources

for health; by empowering health workers in Emergency Obstetric Care skills; by ensuring adequate Emergency Obstetric Care (Emoc) equipment and supplies, including blood supplies; by ensuring the improved monitoring of pregnant women during labour and delivery; and by exploring the use of low-cost technologies in Maternal and Neonatal Health

- Improvements in the Quality of Antenatal and Neonatal Care by making available postnatal wards at the health centre level; by exploring the possibility of instituting free user fees at the hospital level; by enhancing community outreach and the use of village health workers in support of maternal and neonatal care
- Increasing access to family planning services through increased community outreach to advocate for the establishment of male support groups and to change socio-cultural attitudes to family planning; and by training health workers, including community-based distributors of family-planning commodities on customer care and on the logistical management of commodities.

Importantly, the MAF is to be operationalized through a time-bound action plan, with an accompanying monitoring and evaluation framework to ensure its timely implementation. The advantage of the MAF is that it will coordinate the work of various agencies and stakeholders for maximum impact and sustainability.



6 COMBAT HIV AND AIDS AND TUBERCULOSIS

TARGETS

6A. Halt and begin to reverse the spread of HIV and AIDS by 2015

Indicators

- 6.1: HIV Prevalence among population aged 15-24 years
- 6.2: Condom use at last high-risk sex
- 6.3: Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV and AIDS
- 6.4: Adults (15-49) with multiple partners in the past year

6B. Achieve, by 2015, universal access to treatment for HIV and AIDS for all those who need it

Indicators

- 6.5: Proportion of population with advanced HIV infection with access to antiretroviral drugs

6C. Halt and begin to reverse the incidence of tuberculosis and other diseases by 2015

Indicators

- 6.6: Incidence, prevalence and death rates associated with tuberculosis
- 6.7: Proportion of tuberculosis cases detected and cured under directly observed treatment, short course



Overview

HIV and AIDS is an extraordinary threat to Lesotho's development, and it affects progress toward every MDG. The epidemic hinders child and maternal health, undermines economic productivity and impacts educational outcomes of Orphans and Vulnerable Children (OVCs). Lesotho currently has the third highest HIV prevalence rate in the world. However, key indicators suggest that it is making slow progress in reversing the spread of HIV. Both the prevalence rate among youth (15-24 years) and the incidence rate have declined since 2004, driving a modest decrease in new infections. Comprehensive studies have allowed GOL and partners to identify the primary drivers of new infection and scale up more effective prevention strategies. The current challenge is scaling up and implementing evidence-informed, targeted prevention strategies focusing on multiple partnerships, correct and consistent condom use, youth sex education, circumcision, gender discrimination, key populations and migrant labourers.

Lesotho has made particularly strong progress in testing, treatment and prevention of mother-to-child transmission (PMTCT). Testing among adults and youth increased rapidly from 2004 to 2009 though the remaining challenge is to engage people who do not know their HIV status and retention into care for HIV-positive individuals. Antiretroviral Treatment (ART) coverage has also spread substantially from 13% in 2005 to 59% in 2012. Finally, innovations such as the "mother-baby pack" and new PMTCT guidelines are employed to accelerate scale-up of PMTCT services to a greater proportion of pregnant women and newborns who would otherwise not receive antiretroviral to prevent mother-to-child transmission. The proportion of HIV pregnant women receiving antiretroviral treatment for preventing Mother-to-Child Transmission (MTCT) increased from an estimated 6% in 2004 to 51% in 2011 and then increased slightly to 52 % in 2012.

This section comprises five parts: (1) epidemiological trends, (2) key transmission routes and prevention efforts, (3) testing and treatment, (4) PMTCT and impact on children and (5) tuberculosis/HIV co-infection.

TABLE 6.1: Millennium Development Goal 6 At A Glance

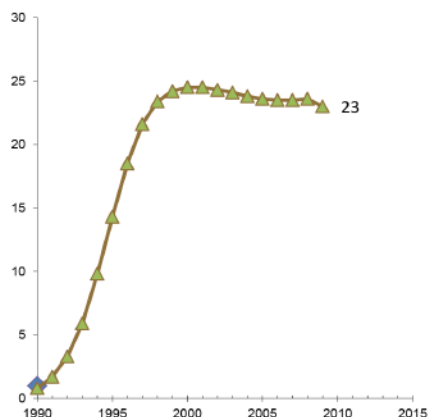
Indicators	2004	2005	2007	2009	2010	2011	2012	Target 2015
Slow Progress								
HIV Prevalence among population aged 15-24(%)	11.3 M: 6.0 F: 15.4	-	-	9.3 M: 4.2 F: 13.6	-	-	-	-
Adults (15-49) with multiple partners in the past year	M: 30.4 F: 11.0	-	-	M: 21.9 F: 6.4	-	-	-	-
Condom use among adults during last high-risk sex	M: 38 F: 18.7	-	-	M: 50.5 F: 38.5	-	-	-	M: 80 F: 70
Proportion of population aged 15-24 years (youths) with comprehensive correct knowledge of HIV and AIDS (%)	M: 18.4 F: 25.8	-	-	M: 28.7 F: 38.6	-	-	-	85
Adult Antiretroviral coverage	4	13	24	48	59	58	59	80
Child Antiretroviral coverage	-	1	11	24	19	22	24	80
Infants born to HIV+ women who receive preventative ART	-	-	22	31	35	31	38	95
HIV+ pregnant women receiving ART for preventing MTCT	2	5	25	40	43	51	52	97
TB Prevalence/100 000 pop	-	-	421	410	408	411	-	-
TB Deaths/100 000pop	-	-	83	90	85	94	-	--
Proportion of tuberculosis cases detected and cured	-	-	53	64	59	58	63	85

Trend Analysis

Indicator 6.1: HIV Prevalence among population aged 15-24 years

Lesotho's HIV prevalence is a measure of the proportion of the population that is HIV-positive. The prevalence among adults naturally stabilized around the year 2000 and is currently at 23%⁶⁰. Although HIV infection is pronounced in nearly every socio-demographic and geographic subpopulation, its impact is not homogenous. Women have a higher infection rate than men; 27% versus 18%⁶¹. HIV prevalence in urban areas is 27.2%, compared to 21.1% in rural areas. The increased urban prevalence is due to a number of factors including rural-to-urban migrations which often result in informal living arrangements. These contexts tend to increase vulnerability to HIV because people in unstable living contexts often exhibit higher risk-taking behaviours such as transactional sex.

Figure 6.1: HIV Prevalence among Adults (15 - 49 years) 1990-2015 Trend



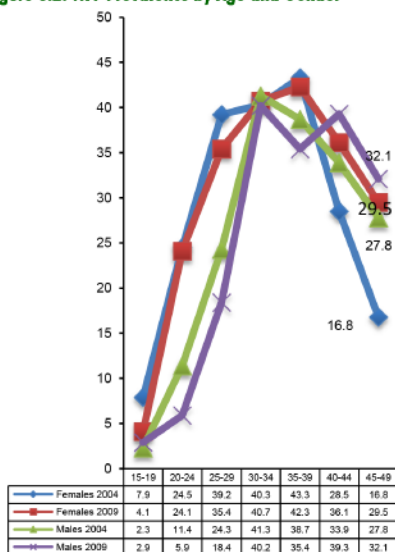
Sources: WHO and LDHS (2009)

⁶⁰ LDHS, 2009

⁶¹ Ibid.

Figure 6.2 disaggregates prevalence by age and gender for 2004 and 2009. Young women are particularly at risk. For females between 20 to 24 years, HIV prevalence is 24% compared to just 6% for their male counterparts. At 25 to 29 years, the difference is substantial with 35.4% prevalence for females and 18.4% for males. However, prevalence converges at around 40% for both men and women after age 30.

Figure 6.2: HIV Prevalence by Age and Gender



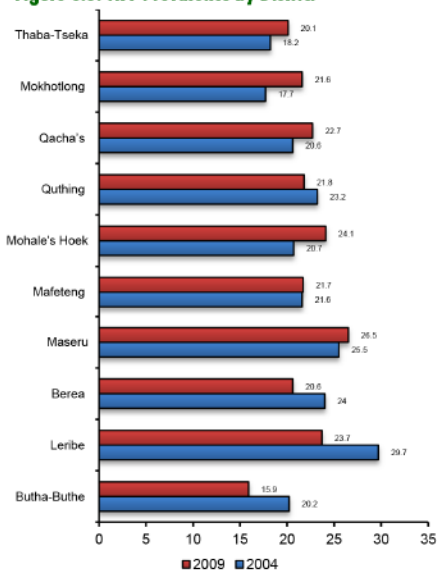
Sources: LDHS (2004,2009)

Lower education levels are also associated with higher HIV prevalence. In 2009, prevalence was 26.6% among those with "no education" compared to 20.9% of those with secondary education or higher.⁶² A 2007 multivariate analysis of LDHS data indicates that as education increases (controlling for other factors), the likelihood of being HIV-positive decreases. Moreover, education is positively correlated with preventative

⁶² Ibid.

behaviours such as condom use, avoidance of extra-marital sex, delayed sexual debut, testing and comprehensive knowledge about HIV and AIDS.⁶³ Income level is also a predictor of HIV status. The prevalence rate steadily rises for each wealth quintile from 18.5% for the lowest to 26.4% to the 4th quintile, before dipping back to 23.3% for the highest. Prevalence is also much higher among the employed than the unemployed – 27.2% compared to 17.6%, primarily because many employed adults are migrant labourers engaged in extramarital or multiple sexual partnerships.⁶⁴ Finally, variation across districts is not wide. All districts have prevalence rates above 20% except Butha-Buthe (16.9%). Urban areas have a significantly higher prevalence rate than rural areas – 27.2% compared to 21.1%.

Figure 6.3: HIV Prevalence by District



Source: LDHS (2009)

⁶³ Lucia Corno and Damien de Walque, World Bank Development Research Group, Determinants of HIV Infection and Related Sexual Behaviors: Evidence from Lesotho, December 2007.

⁶⁴ LDHS, 2009

Though much of Lesotho's data on HIV concerns prevalence, it is not the best measure for understanding current trends and designing policy responses because changes in prevalence lag behind changes in current risk. Prevalence continues to rise even after incidence begins to fall because of the extended time between infection and death, which has been prolonged by the availability of ART. Thus, prevalence data is increasingly difficult to interpret.

Information on incidence – the number of new infections in a given time period – is a much better indicator of the spread of HIV, but measured data on incidence in Lesotho is unavailable. UNAIDS estimates that the incidence rate among adults has stabilized at 2.32%, down from a peak of 4.99% in 1996⁶⁵. Numbers of new infections among adults have also declined from 26,000 in 2005 to 23,000 in 2012. Meanwhile, adult AIDS-related deaths have declined from 23,000 in 2005 to 14,000 in 2012⁶⁶. Table 6.2 provides the new HIV infection estimates together with the projections. According to these projections, cases of new infections are expected to decline over the next five years until it reaches around 19,000.

TABLE 6.2: Lesotho New HIV-Positive Cases by Sex, 1970 - 2020

New HIV Infections			
Year	Total New Infections	Male New Infections	Female New Infections
2009	29,797	13,316	16,480
2010	26,799	12,015	14,784
2011	25,922	11,615	14,307
2012	27,618	12,437	15,181
2013	25,413	11,376	14,038
2014	24,541	11,004	13,537
2015	23,471	10,540	12,931
2016	22,382	10,073	12,309
2017	20,951	9,447	11,504
2018	20,017	9,038	10,979
2019	19,917	8,998	10,918
2020	19,737	8,921	10,815

Source: Annual Joint Review report 2012

⁶⁵ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009.

⁶⁶ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

An alternative indicator is HIV prevalence among youth (15-24), which reveals trends in new infections and can serve as a proxy for incidence. HIV prevalence has declined among youth from 11.3% in 2004 to 9.3% in 2009. This progress is evident for both genders. However, elevated rates of HIV in young women persist, especially among 20-24 year olds. Not only are women biologically more vulnerable to HIV infection, they are more likely to have intergenerational sex and less power to negotiate condom use due to traditional gender roles.

TABLE 6.3: Youth HIV Prevalence Rate (15-24)

	2004	2009
Total (%)	11.3	9.3
Male (%)	6.0	4.2
Female (%)	15.4	13.6

Sources: LDHS (2004, 2009)

Analysis of HIV Modes of Transmission and Prevention Efforts

Multiple and Concurrent Partnerships (MCP)

Multiple and concurrent sexual relationships both before and during marriage are the primary driver of HIV transmission in Lesotho – exacerbated by a culture of relaxed social norms regarding MCP and low risk perception.⁶⁷

According to the WHO, unprotected sex with multiple partners is one of the primary risk factors for HIV in sub-Saharan Africa.⁶⁸ Indeed, the 2009 LDHS confirms that HIV prevalence is strongly correlated with the number of partners. Only 16.5% of adults report one lifetime partner with HIV, compared to 25.7% for two partners, 30% for three to nine partners, and 36% for 10 or more partners.⁶⁹

⁶⁷ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

⁶⁸ WHO, Global HIV and AIDS Response, Progress Report, 2011

⁶⁹ LDHS, 2009

MCP in Lesotho is much higher than the regional average, but appears to be declining. In 2009, 21.9% of men (age 15-49) reported more than one sexual partner in the past year – including almost a quarter of married men. Among women, the rate of multiple partnerships is lower at 6.4%, including 7.5% of married women. It is notable that MCP is even more common among married people than single adults.⁷⁰

TABLE 6.4: Summary of Research on Multiple and Concurrent Partnerships in Lesotho

Year	Indicator	Sample	Result
1989/1990	More than 1 partner, past 12 months	n/a	55% (M) 39% (F)
2002/2003	More than 1 partner, past 12 months	Adults (16-60) with at least 1 partner	44%
2004	More than 1 partner, past 12 months	Sexually active adults (15-49)	29% (M) 11% (F)
2007	More than 1 partner, past 12 months	Adults (16-60) with at least 1 partner	48% (M) 21% (F)
2009	More than 1 partner, past 12 months	All adults (15-49)	21.9% (M) 6.4% (F)

Source: Adapted from UNAIDS/MOHSW 2009 Modes of Transmission Analysis

Table 6.4 suggests that MCP frequency has fallen in the past two decades, but this trend is inconclusive because of variations in how sample populations are defined in each survey. The 2009 LDHS is particularly problematic because it samples all adults, rather than just sexually active adults.

One problematic facet of MCP is concurrency, or having multiple partners at the same time. The viral load (HIV concentration in the blood and

⁷⁰ Ibid.

bodily fluids) of an HIV positive adult is particularly high in the first 6-8 weeks after infection.⁷¹ Thus, concurrency exacerbates HIV transmission because HIV positive adults are much more likely to infect their partners during this initial stage. A 2007 survey revealed that, among sexually active adults, 36% of men and 16% of women had more than one current sexual partner. Moreover, 38% of male workers and 17% of females in a 2007 Apparel Lesotho Alliance to Fight Aids (ALAFA) survey acknowledged having more than one current partner. Interviews also suggest that adults with multiple partners usually have concurrent rather than sequential relationships.⁷²

Entrenched, supportive social norms sustain widespread MCP. For males, it is a measure of masculinity and virility. For women, MCP is an important means for gaining economic and social assistance.⁷³ Other factors contributing to MCP include the influence of family and friends and labour force mobility (eg, men working in RSA mines and internal migration of women to work in garment factories). Moreover, it is often socially acceptable for a married person to retain multiple partners as long as he/she is supportive and respectful toward each partner.⁷⁴

Prevention

In Lesotho the health sector implemented initiatives towards expanding coverage and improving the quality of HIV prevention, diagnosis, treatment and care. In 2012 the Ministry of Health sought to revitalize HIV prevention through intensive efforts that included requiring district-level HIV symposiums to strengthen HIV prevention and ART services. The programme also coordinated development and costing of the Condom Strategy. There was implementation of Family Health Day campaigns, which sought to augment HTC and enrolment to treatment. Moreover, technology such as Point of Care CD4 count machine was used for the first time in campaigns. There were also male-targeted testing initiatives through soccer matches and Voluntary

Medical Male Circumcision. The Provider Initiated Counselling and Testing (PITCT) was intensified in all facilities.

Indicator 6.2: Condom Use At Last High-Risk Sex

While enough condoms are procured for Lesotho, they are not readily available for use by people at the community level, especially after hours. In an effort to improve accessibility of condoms in 2012-2013, 240 condom dispensers were installed in the 10 districts of Lesotho and 100 condom baskets distributed to Lesotho Government Ministries.

There has been an overall improvement in the provision of condoms at district level, except for a few districts like Quthing where condoms are stored in the veranda of the pharmacy store. There is also improvement in recording when condoms reach pharmacy stores. However, there is weaker recording of the dispersal of condoms from the pharmacy stores to different departments of hospitals or from the DHMT store to the health centres.

Condom usage has not yet become a routine aspect of sexual relations in Lesotho; a situation caused at least in part by weak distribution and availability of condoms. Issues around knowledge, use and attitudes towards female condoms are still negative, thereby rendering the uptake of female condoms very low. Low condom use by both men and women calls for intensive education, promotion and advocacy at the community level.

Despite increasingly widespread promotion and distribution of condoms, their positive impact has not been significant because consistent, correct condom use remains low. People use condoms in sexual encounters where they perceive an increased risk (commercial and casual sex) but tend not to use them in sexual acts that are perceived as low-risk including among multiple/concurrent partners.⁷⁵ Also, though almost all condoms are provided free of charge by GOL or NGOs, widespread, consistent distribution remains a challenge. According to a 2010 study, condom coverage was 69% in urban areas, but only 33% in rural areas due to frequent stock-outs in local health centres.⁷⁶

⁷¹ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009.

⁷² Ibid.

⁷³ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

⁷⁴ NAC/UNAIDS, Gender and MCP in Lesotho, 2008.

⁷⁵ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁷⁶ PSI Lesotho, HIV and AIDS TRAC Study, Third Round,

One informal indicator of the rate of condom use is its use as a contraceptive among married women. The rate fluctuated slightly from 16% in 2001 to 13% in 2004 and then increased significantly to 20% in 2009. Similarly, ALAFA has measured usage among married people and found that 12% in 2002 and 20% in 2007 used condoms with spouses.⁷⁷

Though increasing, the frequency of condom use among married couples is still low because the risk of transmission from a spouse is perceived to be low. However, high rates of multiple partnerships, many of which may occur in secret, create a dangerous risk for married people. Indeed, WHO reports that increasing numbers of new HIV cases involve HIV-discordant cohabitating couples (in which only one person is living with HIV), and many of these discordant couples are unaware of their partner's HIV status⁷⁸. Figures from Lesotho confirm this trend; from 2004 to 2009 the percentage of HIV sero-discordant couples increased from 13% to 17%⁷⁹.

A more important indicator is condom usage among adults engaging in "higher-risk" sex, which has remained static. 48.6% of males and 41.9% of females report condom usage in 2004, compared to 50.5% and 38.5%, respectively, in 2009⁸⁰. These figures are still far below the target rates of 80% for males and 70% for females. However, it is important to note that the definition of "high-risk" is slightly different between the survey years. The 2004 LDHS measures condom usage during sex with a partner who is neither a spouse nor cohabitating partner, while the 2009 survey considers condom usage and MCPs.

TABLE 6.5: Condom Usage Among Adults with Multiple Partners

	Women	Men
Urban	52.3	67.2
Rural	31.1	46.1
Education		
No Education	n/a	25.3
Some Primary Education	24.9	41.4
Primary Complete	30.2	50.4
Secondary +	52.1	68.1
Wealth		
Lowest Wealth Quintile	13.4	29.8
Second Quintile	32.6	45.1
Middle Quintile	31.7	47.3
Fourth Quintile	51.7	56.6
Highest	49.0	70.8

Source: 2009 LDHS

Condom usage among adults with multiple partners is positively correlated with residence, education level and income. These figures suggest that GOL and partners should particularly target uneducated, low-income and rural populations with condom distribution and education programs.

Moreover, condom use among married adults with multiple partners is much lower than average: 35.5% for married men and only 24% for married women⁸¹. Therefore, married adults with multiple partners not only have a higher risk for contracting HIV, but are also much more likely to infect their spouses and sexual partners.

Furthermore, social norms regarding condoms inhibit consistent and correct usage. For example, the use of condoms is often interpreted as signs of sexual infidelity or a lack of trust, particularly among spouses. Many men still have negative attitudes about condoms, believing they diminish sexual pleasure (45%), are inconvenient (37%), are

⁸¹ LDHS 2009

2010.

⁷⁷ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁷⁸ WHO, Global HIV and AIDS Response, Progress Report, 2011

⁷⁹ LDHS, 2009

⁸⁰ LDHS, 2004 and LDHS, 2009

embarrassing to obtain (34%) and that people who use condoms are unfaithful (33%).⁸² A 2008 CIET study revealed that attitudes toward demanding condom use might even be deteriorating. In 2002, 48% of adults said they would not have sex if their partner refused to use a condom. In 2007, this percentage dropped to 39%.⁸³

Low Demand for Medical Male Circumcision (MC)

Studies in Africa indicate that MC reduces the risk of acquiring HIV by 60% and provides indirect benefits for women, reducing the long-term transmission rate from males to females by nearly half.⁸⁴

Traditional MC has long been practiced in Lesotho as a rite of passage into adulthood – particularly in rural areas. 51.6% of adult males are circumcised.⁸⁵ Currently, however, traditional MC does not confer a protective effect because it is most likely incomplete by bio-medical standards – involving only an incision into the foreskin by a traditional “surgeon” rather than a complete removal. The most recent estimates suggest that only about one-third of all circumcisions occur in the health sector and scale-up of safe, medical MC is essential.⁸⁶ Still, the issue must be treated sensitively, with strong public awareness campaigns, as it touches on important cultural and religious beliefs for many Basotho.⁸⁷

Trends among Youth: Delayed Marriage and Early Sexual Debut

The level of comprehensive correct knowledge of HIV and AIDS among youth (age 15-24) is an important indicator of national prevention efforts because it reflects the success of education and communication efforts to increase prevention

⁸² UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁸³ Ibid.

⁸⁴ WHO, Global HIV and AIDS Response, Progress Report, 2011

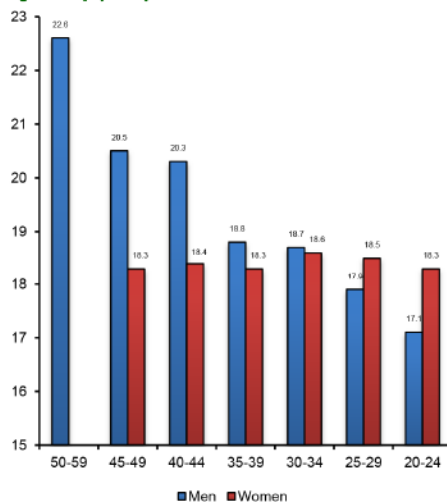
⁸⁵ LDHS, 2009

⁸⁶ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁸⁷ USAID, Lesotho Health System Assessment, 2009

knowledge and reduce misconceptions. This figure has been slowly increasing and is currently 39% for females and 29% for males (the rates among adults age 15-49 are nearly identical). Given the pervasiveness of sexual activity among youth, this level of knowledge is still unacceptably low and far from the 85% target.

Figure 6.4: Age at First Sexual Intercourse by Current Age Group (2009)



Source: LDHS, 2009

Overall, the median age for marriage is rising, with earlier sexual debut for men. Figure 6.5 presents data on sexual debut by age group and reveals that young males today have their first intercourse around age 17, about 3-5 years earlier than their parents' generation. While the prevalence of sexual activity among the very young (before age 15) has fallen, overall youth sexual activity appears to be increasing – with higher rates of sex before age 18 and rising percentages of sexually active youth (within the past 12 months). On the other hand, condom usage (65%) is relatively high and increasing. For females, age at first sexual intercourse is correlated with income and education level. Among girls with an incomplete primary education, 66% had sex before the age of 18, compared to only 39% of girls with a secondary education or higher.

TABLE 6.6: Sexual Activity Among Youth

Indicator	2004	2009
Sexual intercourse before age 15 (%)	13.1 (M)	22.1 (M)
	6.4 (F)	7.8 (F)
Sexual intercourse before age 18 (%)	48.9 (M)	61 (M)
	38 (F)	45.4 (F)
Sexual intercourse in past 12 months (%)	47.7 (M)	57.2 (M)
	28.2 (F)	35.1 (F)
Condom use during last sexual intercourse (%)	50.7 (M)	65 (M)
	55.7 (F)	65.8 (F)
Multiple sexual partners in the past 12 months (%)	35.5 (M)	33.5 (M)
	8.8 (F)	7 (F)
Condom use among youth with multiple sexual partners (%)	47.9 (M)	64.4 (M)
	50.1 (F)	64 (F)

Source: LDHS 2009

These trends suggest the need for prevention programmes among youth, including evidence-informed, life skills-based sexual education. Progress in recent years includes a specific youth component of the Behavioural Change Communication (BCC) strategy, a Minimum Package Guide on HIV Prevention released by Ministry of Gender, Youth, Sports and Recreation (MoGYSR) specifically for youth, and Lesotho Youth Federation's 40 "Youth Ambassadors," which reached 25,000 of their peers.⁸⁸ Still, intensified, targeted prevention efforts are needed to change harmful social norms (MCP, gender discrimination, etc.) among youth, make health services youth-friendly, expand sex education and substantively involve youth in leading HIV programming. Specifically, GOL and partners should target uneducated and unskilled young males, who are beyond the reach of many

⁸⁸ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

prevention programmes and exhibit multiple risk factors including early sexual debut, low testing rates, and low condom usage.⁸⁹

Gender Discrimination and Sexual Violence

Lesotho is a patriarchal society with distinct gender roles. This dynamic persists in marriage with male sexual entitlements and it has major implications for sexual health and HIV transmission. Table 6.7 indicates mixed progress. While most Basotho report that they reject the idea of beating wives for refusing sex, significant proportions of the population insist that it is unacceptable for women to refuse sex on the basis of their husband's multiple partnerships or STIs. Moreover, small but increasing percentages of men believe that husbands have the right to force sex on their wives. This discrimination is strongly associated with income, education level and rural residence.⁹⁰

The outcomes of these entrenched beliefs include high levels of sexual violence. 60% of women have suffered sexual violence, while 22% report being forced to have intercourse and most of these incidents go unreported.⁹¹ Research has indicated that victims of intimate partner violence are 1.4 times more likely to be HIV positive.⁹² The key problem is that the very behaviours that help prevent HIV transmission – refusing sex, insisting on the use of a condom and inquiring about other partners – often trigger sexual violence. In this environment, women have little ability to negotiate condom use and face increased risks for contracting HIV or other STIs.

⁸⁹ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁹⁰ LDHS, 2009

⁹¹ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁹² Dunkle et al, Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363 (May1), 2004.

TABLE 6.7: Gender Discrimination and Sexual Violence

Indicator	2004	2009
Husband is justified in beating wife if she refuses sex (%)	M: 19.6 F: 20.1	M: 15.4 F: 12.6
Wife is justified in refusing sex if she knows husband has an STI (%)	M: 71.6 F: 81.9	M: 52.5 F: 52.4
Wife is justified in refusing sex if she knows the husband has sex with other women (%)	M: 62.5 F: 79.7	M: 63.8 F: 73.5
Husband has the right to use force to have sex if wife refuses (%)	M: 12.4	M: 16.5
Husband has the right to deny financial support if wife refuses sex (%)	M: 17.5	M: 26.3

Source: LDHS 2009

Lesotho has taken steps to address these problems with new national policies and stronger, more equal legal rights for women, including the Anti-Trafficking in Persons Act of 2010, the Gender and Development Policy of 2003 (which guarantees sexual and reproductive care and family planning services), the Legal Capacity of Married Persons Act of 2006 (which removes the minority status of married women) and the Sexual Offences Act of 2003. These are commendable and progressive efforts, but discriminatory social and cultural practices at the community and family level persist.

Age-Disparate Relationships

HIV prevalence in young women is significantly higher than in young men. Age-disparate relationships have been cited in Southern Africa as an explanation for the high rates of infection among young females. The 2002 Reproductive Health Survey revealed that in 19% of relationships the man was at least 10 years older than his female partner (among females aged 12-24).⁹³ In 2009,

⁹³ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention

roughly 7% of girls 15-19 reported sex with a man at least 10 years older.⁹⁴ Age mixing for females 15-19 was 7.3% in 2004 and reduced to 2.3% in 2009

These relationships involve imbalanced power dynamics in which young girls may not be able to ensure safe sex practices. Furthermore, age-disparate relationships may exacerbate HIV transmission if younger girls have sex with an older, HIV-positive partner and then introduce the virus into their younger peer group.

Labour and Migration

The two largest sources of employment for Basotho are the mining industry in RSA and the textile sector, both of which involve large numbers of migrant workers. Unskilled men dominate labour migration to South Africa, though their number has fallen tremendously in the past 15 years. Young women comprise most of the textile workforce in urban areas and two-thirds of apparel workers are internal migrants. These jobs require constant commuting between the factories and their homes and families.⁹⁵

Working away from families for extended periods of time interferes with the normal ways of family life. Moreover, women in particular (both those who migrate and those who stay behind) often need extra social and economic support. Thus, migration encourages MCP, extra-marital relations, casual sex, transactional sex and unprotected sex, exacerbating HIV transmission. Among married couples, migration heightens the risk for both partners because both may have extra-marital sex while apart, increasing the chance that one of them will acquire HIV and infect the other upon reuniting.

Though data on HIV trends among mine workers is unavailable, a 2007 ALAFA study indicated that 44% of female textile workers are HIV positive, though this is partly due to the age distribution of the workforce. Single female workers in garment factories are especially at risk. The 2009 LDHS also revealed that HIV prevalence is higher among migrants and the employed.

Response and Modes of Transmission Analysis, 2009

⁹⁴ LDHS, 2009

⁹⁵ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

TABLE 6.8: HIV Prevalence by Migration Status in the Past 12 Months (2009)

	Men	Women	Total
1-2 times away from home (%)	17	25.5	21.8
3-4 times away from home (%)	18.9	27.3	23.3
5+ times away from home (%)	22	30.9	26.8
Away from home (%)			
Away more than 1 month (%)	17.8	28.2	23.3
Away less than 1 month (%)	20.4	27.7	24.5
Not Away (%)	16.4	25.7	21.9
Employment Status (%)			
Employed (%)	21.8	33.3	27.2
Not Employed (%)	9.4	21.1	17.6

Source: LDHS 2009

HIV Testing and Counselling (HTC) and Treatment

An estimated 31% of Basotho living with AIDS do not know their HIV and AIDS status.⁹⁶ Nevertheless, Lesotho has made dramatic progress in HTC. Between 2004 and 2009, the percentage of adults who have tested for HIV has increased from 9% to 39% for men and from 12% to 66% for women. However, in a generalized epidemic as in Lesotho, annual testing is recommended. Table 6.9 indicates rates of people tested have increased drastically, but the percentage of adults tested in the past 12 months is still far below the target of 80%. The gender disparity is particularly striking. Testing is twice as high for females because females have more contact with the health care system and provider-initiated testing, for instance, during pregnancy or when seeking health services for children. Therefore, more targeted interventions are needed to increase the entry points for males for testing, care and treatment.

⁹⁶ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

TABLE 6.9: Trends in HIV Testing

	2004	2009
Adults (age 15-49) who have ever been tested and received results (%)	M: 9.1 F: 12	M: 38.5 F: 65.6
Youth (age 15-24) who have ever been tested and received results (%)	M: 3.4 F: 8.6	M: 25 F: 57.5
Adults tested and received results in the past 12 months (%)	M: 4.8 F: 6.3	M: 24.7 F: 42
Youth tested and received results in the past 12 months (%)	M: 2.2 F: 4.9	M: 17.1 F: 40.4

Source: LDHS, 2009

Mutual testing and disclosure for couples is one promising intervention to increase male testing rates and address the high percentage of sero-discordant marriages in Lesotho (17%). Couples who test together and find they are sero-discordant are more likely to adopt preventive behaviours, pursue and adhere to treatment and take steps to prevent MTCT. Moreover, providing ART to the partner living with HIV reduces viral load and significantly decreases transmission risk to the other partner. Home-based testing is a particularly effective way to implement this intervention.⁹⁷

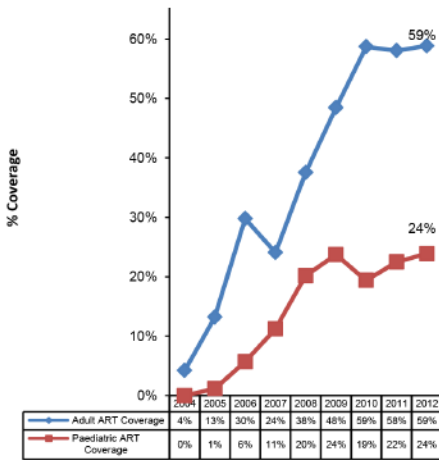
⁹⁷ WHO, Global HIV and AIDS Response, Progress Report, 2011

Indicator 6.5: Proportion of population with advanced HIV infection with access to antiretroviral drugs.

There has been a tremendous increase in adult ART coverage during the 2004-2006 period. The coverage declined to 24% in 2007 from 30% in 2006. As reflected in Figure 6.5, it grew constantly between 2007 and 2010 until it declined to 58% in 2011. It increased slightly to 59% in the subsequent year. Additionally, ART coverage for children has been increasing slowly relative to adult coverage. At 24%, the 2012 ART coverage for children was similar to figures recorded three years earlier (2009). This represents a small increase from the declines that were recorded in 2010.

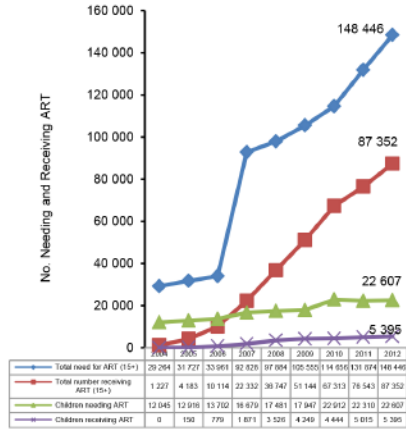
Figure 6.5: Adult & Paediatric ART Coverage, 2004-2012

Figure 6.5: Adult & Paediatric ART Coverage, 2004-2012



Source: MOH, Annual Joint Review 2012

Figure 6.6: ART Coverage by Adult and Paediatric, 2004-2012



Source: Ministry of Health (2013)

Lesotho appears to be slow to achieve the 80% target. However, retention rates remain at 72% and near the 80% target. An estimated 42,000 deaths have been averted since the ART rollout⁹⁸. Figure 6.7 reflects the gap between need for ART and the numbers already receiving treatment. There is still a large number of people, both adults and children, who need treatment.

At the policy level, Lesotho implemented new international ART guidelines in 2010. The policy requires monthly ARV collection and continues to decentralize treatment to health centres, with teams of mentors in each district to support health care professionals.⁹⁹ As ART coverage grows, decentralization must continue and capacity must grow at treatment sites to ensure adequate care and retention. Task-shifting in service delivery, expanding the role of communities, home-based care, networks of people living with HIV, and warehousing ARVs locally may all be part of the solution.¹⁰⁰

⁹⁸ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

⁹⁹ Ibid

¹⁰⁰ WHO, Global HIV and AIDS Response, Progress Report, 2011

Variations by Districts

According to Figure 6.7, Butha-Butha has the highest proportion of people enrolled on ART with Maseru, Mafeteng and Qacha's Nek directly following. The scenario is interesting and would require the districts to learn from each other because even a hard-to-reach district like Qacha's Nek performed better than accessible districts like Berea and Leribe. It is a concern that most districts performed way below the 80 percent target.

Figure 6.7: Proportion of ART Coverage by Districts- 2012



Source: Ministry of Health Annual Joint Review 2012

Pre-ART Retention

Usually, a period of up to 8 years exists between diagnosis and ART initiation (after CD4 counts drop to 350) Follow-up and care during this interim is almost non-existent.¹⁰¹ Pre-ART retention is poorly documented, but the WHO estimates that only 18% of people diagnosed with HIV remain in care until they became eligible for ART. Furthermore, a study in neighbouring South Africa estimated a 33% retention rate between provision of first CD4 count and therapy initiation.¹⁰²

Indeed, MOH acknowledges that full ART coverage will be a major challenge because many eligible for ART may not know it or feel sick enough to seek medical attention.¹⁰³ In order to improve treatment, Lesotho must link the services a person must navigate after diagnosis and improve follow-up by strengthening patient tracking systems, providing decentralized and regular CD4 monitoring and strengthening laboratory services to minimize the delay of test results.

Prevention of Mother to Child Transmission (PMTCT) and Impact on Children

HIV is transmitted from HIV-positive mothers to newborns by either crossing the placenta during birth or through the breast milk. The risk of transmission is around 23.4%, and, given that HIV prevalence among women of childbearing age is much higher than average, MTCT is a major child health concern. The 2013 estimates indicate that the MTCT rate has slightly declined from 27.6% in 2009 to 23.4% in 2012 though it is still much higher than the goal of 2%. Estimated MTCT rate at 6 weeks declined from 12.4% in 2009 to 8.8% in 2012.

MTCT is preventable by providing ART to mothers and children, beginning early in pregnancy. Lesotho has made strong progress in PMTCT uptake since 2004. In 2010, it adopted revised PMTCT guidelines consistent with new WHO standards, which calls for HIV positive pregnant women to begin prophylaxis at week 14 of their pregnancy. Also, infants born to HIV positive mothers must receive preventative therapy until one week after breastfeeding ends, with exclusive breastfeeding for 6 months.¹⁰⁴

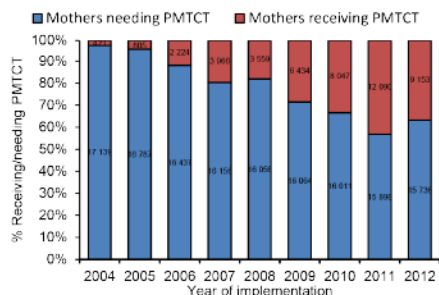
¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ MOHSW, Annual Joint Review, 2011.

¹⁰⁴ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

Figure 6.8: PMTCT Coverage, 2004-2012



Source: Ministry of Health (2013)

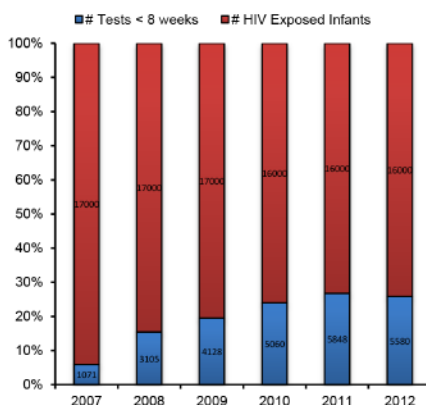
Facility-based uptake of ART among pregnant women to prevent MTCT has increased from 6% in 2004 to 96% in 2012. However, population-based PMTCT coverage was 43% in 2010 and 58% in 2012. This calls for a massive service demand creation exercise. The introduction of PMTCT guidelines with the option B+ approach of providing lifelong ART to all HIV-positive pregnant women will attract more women into the programme.

Moreover, preventive coverage among infants born to HIV-positive mothers increased from 28% in 2007 to 38% in 2012.¹⁰⁵ This success is partly due to the Mother-Baby Pack, created by MOH and UNICEF to address the challenge many women face in repeatedly accessing health centres during pregnancy. Recognizing that 90% of pregnant women attend ANC services at least once, health workers began providing a package of ARV medications and/or antibiotics to all pregnant women during their first ANC visit for use during pregnancy and the early post-natal period. Six weeks after birth, mothers are expected to return for immunizations, check-ups, HIV testing and further ARVs, if needed. Three types of standardized packages are available, depending on the mother's HIV status and treatment regimen.¹⁰⁶

Testing and Treatment among Children

According to the Ministry of Health Annual Joint Review Report, WHO recommends that infants known to be exposed to HIV should have a virological test (HIV nucleic acid test) at 4-6 weeks of age or at the earliest opportunity. Testing at this time (4-6 weeks of age) will identify over 95 percent of infants who are HIV-positive intra- and peri-partum. Delaying testing beyond this time will delay diagnosis and put HIV-positive infants at risk of disease progression and death. Early diagnosis through Deoxyribonucleic Acid-Polymerase Chain Reaction DNA-PCR assists in the treatment and care as well as on decision-making regarding child feeding. As portrayed in Figure 6.9, the numbers of HIV exposed infants are at least 16,000 but the number of infants below eight weeks old who have been tested have remained very low. Although the number of infants tested grew steadily from 2007 to 2011 when it reached a peak 5,848, it has since declined to 5,580 infants in 2012.

Figure 6.9: Proportion of Exposed Infants Receiving DNA PCR Test by 8 weeks (2007-2012)



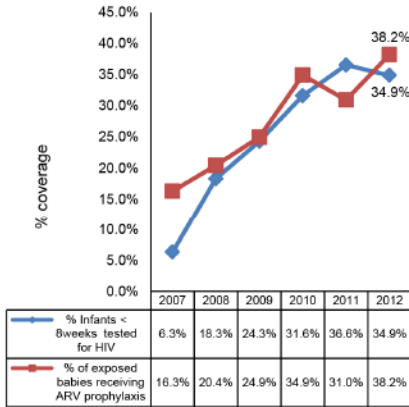
Source: Ministry of Health 2013

¹⁰⁵ WHO, Global HIV and AIDS Response, Progress Report, 2011

¹⁰⁶ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

Due to the increasing availability of pediatric anti-retroviral treatment, the percentage of babies exposed to HIV who are receiving treatment and the number of babies tested are trending upward (see Figure 6.10). The minor difference between the number of children tested and those receiving treatment are encouraging, but these figures are still very low and require further intervention if the effects of HIV on children are to be curbed.

Figure 6.10: HIV Testing and ARV Prophylaxis Among Infants < 8 Weeks

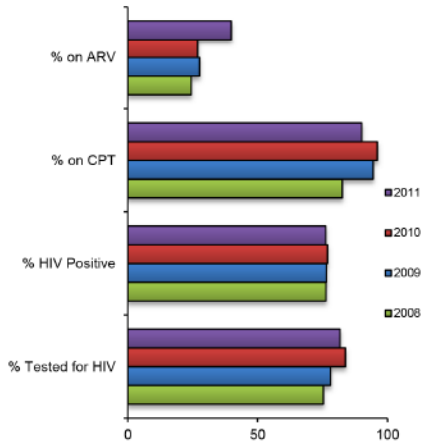


Source: Ministry of Health 2013

HIV/TB Co-infection

Identification and management of TB/HIV co-infection is improving. The co-infection rate remained stable at 76%, with approximately 80% of new TB patients tested for HIV. While the percentage of patients with both HIV and TB enrolled in ART has increased substantially from 24% in 2008 to 40% in 2012 access to ART for clients with both HIV and TB remains low compared to the general population (40% vs. 60%).

Figure 6.11: TB/HIV Co-infection Trends



Source: NAC/UNAIDS 2012

Halting and reversing the incidence of Tuberculosis and other diseases

The GOL has adopted the global targets for reducing the burden of diseases attributed to TB. There is high political commitment to the achievement of the MDG targets for 2015 as well as the Stop TB target for 2015 and 2050. Lesotho is one of the fifteen countries with the highest per capita case incidence 632/100,000¹⁰⁷ as well as the Stop TB Strategy target for 2015 and 2050. The country also adopted the WHO-recommended DOTS strategy to control the spread of TB through prompt detection and provision of anti-TB drugs under standard case management conditions.

Although the TB notification rate remains high; in the past five years there has been a noticeably steady stabilization and slight decline. A total of 11,971 patients were notified in 2004 compared to 13,520 recorded four years ago (2009). Stabilization can be expected if both ART and TB programs are performing well and other factors; this is not true of both programs, we therefore need to study notification decline carefully.

¹⁰⁷ WHO, Global Tuberculosis Report 2012

TABLE 6.10: Performance against the Millennium Development Goal Indicators

Indicator	Baseline in 1990	Performance			
		2009	2010	2011	2012
TB Prevalence	249/100 000	410/100 000	408/100 000	411/100 000	
TB Deaths	31/100 000	90/100 000	85/100 000	94/100 000	
TB Treatment Success (%)	47 (1995)	70	69	74	74

Source: MOH Annual Joint Review 2012

General TB indicators have also improved. Incidence has declined from 13,520 new cases in 2009 to 12,616 in 2011. Moreover, Lesotho has maintained a high TB detection rate of 82% in 2011, up from 80% in 2008 and well above the WHO standard of 70%. A 74% success rate in cure of TB was reported in 2012, still well below the set target of 85%.

Key Implementation Bottlenecks Constraining Progress

Policy and Planning Framework

Prevention Strategies: Despite some gains in the national response, as reflected in the stabilization of HIV prevalence at 23%, the number of new infections is still high at 23,000 annually. In response, a national HIV prevention strategy (2011– 2016) has been developed. However, for effective implementation of the strategy, there is a need for leadership commitment at all levels and in all sectors and accountability mechanisms for HIV Prevention.

Coordination of the national multi-sectoral HIV and AIDS response: The primary role and responsibility of the MOH is to coordinate the HIV and AIDS response in the health sector, (while NAC had the overall responsibility for the coordination of the national response). The separation of these roles and responsibilities is unclear. Moreover, the closure of the National

AIDS Commission Secretariat resulted in the loss of national coordination, monitoring, evaluation and institutional memory for leadership.

Macro-Level Drivers: The Government has inadequately addressed major structural drivers of the HIV epidemic in its policies and programmes, including labour migration, sexual violence and income inequality.

MCP: Despite evidence that MCP is the main driver of HIV, policies, programmes and prevention messages, such as the Behavioural Change Communication Strategy (BCC), do not explicitly address this problem.

Inadequate Prevention Targeting: The current prevention strategy is not sufficiently targeted to priority sub-populations using evidence-based guidance, such as OVCs, herd boys, sero-discordant partners, uneducated people and migrant labourers.

HIV/TB challenges: These include universalizing TB/HIV collaboration across the health sector, increasing the number of health care workers providing combined TB/HIV care, improving infection control standards and addressing cross-border migration particularly as it impacts on prevention, diagnosis and treatment. In response, Lesotho will train more health workers on collaborative TB/HIV care, support the district-level TB/HIV technical working groups and work towards response harmonization with other SADC countries. It will also engage more private practitioners as partners in implementing the TB/HIV strategy.

Service Delivery

Increasing Health Care Demand. As ART coverage has expanded, one resulting challenge is increased volume of patients at health centres where a registered nurse or nurse clinician is often the only clinical provider on staff. In response, supervising medical officers have been deployed in each district and a national mentorship programme is underway to ensure that health providers involved in ART receive support and maintain national ART standards.

In some cases, health centres have reduced service times in order to keep up with filling registers and monitoring cohorts for timely follow-up and

proper adherence to the treatment regimens. Logistical problems still occur, however, but less frequently at district and health centre levels. At the community level, village health workers, community health workers, expert patients, traditional healers and others have been trained to provide adherence support.

Human Resource Capacity. Lesotho has the lowest ratio of healthcare workers to population in the region, with just one health care professional per 1,000 people. Retention is a major challenge. The sector operates with high vacancies, particularly among front-line workers. Many health care workers migrate to other countries because the compensation in Lesotho is uncompetitive, particularly in rural, hardship areas. To address the shortage of health care providers, implementation of the Health Sector Human Resource Retention Strategy is key, including the possibility of establishing a Medical School in Lesotho.

Low Integration of SRH and HIV and AIDS care. The lack of integration of HIV and reproductive health services is also a major problem. Women with HIV are much more likely to experience pregnancy complications and around 35% of women do not even know their status. Moreover, this lack of integration means that opportunities to more efficiently use resources are missed.

Decentralisation. Implementation of the Decentralized Health Service System is slow, resulting in inadequate capacity in the districts to effectively plan, mobilize resources and implement programmes.

Drug Supply Problems. Health centres experience ARV stock-outs. In 2010, stock outages averaged 56 days in the North, 73 days in the South and 194 days in central districts. It is worth noting that 2012 has been a difficult year for the program. There was a delay in government funding, and the programme consequently struggled with regard to retention of counsellors, stock outs for both test kits and CD4 count reagents.

Financing

Poor Budget Execution. GOL has poured substantial resources into the health sector. MOH budget allocations have doubled from 4% of GDP in 2004 to 8% in 2010. In 2011/12, MOHSW was allocated 1,042 million Maloti or 12.7% of the total budget, second only to the Ministry of Education.

However, poor budget management prevented full deployment of resources and rapid increases in MOHSW's budget allocations have strained the ministry's capacity. Average absorptive capacity for 2007 through to 2010 was 86% for the recurrent budget and only 69% for the capital budget. The lack of sustainable financing strategies, coupled with inadequate financial tracking is also a challenge for the sector.

Recommendations

- Determine the appropriate role for the NAC secretariat, its coordination function and its broad composition. Revise the 2005 NAC Act.
- Focus specifically on raising awareness about the risks of MCP in prevention strategies and in messaging efforts, such as BCC. Specifically promote "partner reduction."
- Target evidence-informed prevention and BCC activities to underserved, vulnerable and key populations, like uneducated young males, MSM, migrant labourers, university students and sero-discordant couples.
- Develop research-based sex education curriculum that begins at age 12 and continues to end of secondary school.
- Increase condom distribution and education programs, with a focus on raising awareness about proper, consistent use. Target uneducated, low-income and rural populations. This will be addressed by installing more condom dispensers in communities to ensure that all individuals including youth can access condoms easily.

- Encourage full, medical male circumcision as part of free primary health care. Increasing voluntary medical male circumcision among 15-49 year old men in Sub-Saharan Africa could prevent up to 3.5 million people from being newly HIV-positive, with a cost savings of nearly \$17 billion over the next 15 years.
- Increase the entry points for males for HIV testing, care and treatment. For example, provide family-centred approaches to PMTCT care by involving male partners in testing and ANC services. Also, increase mutual testing and disclosure for couples, particularly through home-based testing.
- Promote task shifting in service delivery among doctors, nurses, health assistants, export patients, and community health workers.
- Increase HIV testing among pregnant women, at least twice in pregnancy and again at delivery.
- Expand the role of the community and community health workers, home-based care, networks of people living with HIV and increase decentralization, such as warehousing of ARVs in the districts.
- Expand family-planning services among women and strengthen the integration between Sexual and Reproductive Health Services and HIV and AIDS care.
- Improve care and retention during the interim period between diagnosis and treatment. Improve regular follow-up by strengthening patient tracking systems, providing decentralized, regular CD4 monitoring and strengthening laboratory services to minimize the delay of test results.
- Improve the logistics chain management for HIV and AIDS commodities and supplies (forecasting, coordinated procurement, storage and distribution)
- Strengthen coordination between health centres and the National Drug Service Organization. Train personnel in each NDSO branch in recording of payments payments (to NDSO), order preparation and scheduling, proper monitoring of ARV stocks and maintenance of a buffer stock.
- Improve cross-border coordination with South Africa and other SACU countries on HIV prevention, treatment and monitoring mechanisms.
- Ensure an enabling protective legal and policy environment, which will improve the lives of people living with HIV and reduce vulnerability to infection.
- Ensure visibility of leadership commitment to help change public opinion regarding the prevention of HIV, etc.

New Challenges for Meeting MDGs

- Frequent stock-outs of HIV test kits and CD4 reagents as a result of a poor procurement and supply chain management of laboratory reagents and consumables.

Key factors contributing to meeting the targets

- The completion and launch of the National HIV Prevention Strategy 2012-2016 and the HIV Prevention Revitalization Action Plan 2011-213.
- The completion and launch of the National Strategic Plan on HIV and AIDS 2011/12-2015/16 and its national M&E framework.
- The release of new HIV prevention tools and materials targeting youth.
- The convening of a National Symposium on HIV Prevention and the subsequent launch of a Commitment Statement to end HIV transmission to be signed by all Basotho;
- The integration of HIV and AIDS prevention, treatment and care within a Primary Health Care Revitalization Strategy.
- Release of the revised PMTCT guidelines and the launch of Mother-baby Pack in all the districts;
- Revised ART guidelines, which recommend that all HIV-positive individuals with active TB infection start on ART immediately.



7 ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGETS

7A. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicators

- 7.1: Proportion of households relying on biomass as primary fuel
- 7.2: Proportion of land area covered by forest
- 7.3: Number of endangered animal species
- 7.4: Proportion of land area protected
- 7.5: CO2 emissions, total, per capita and per \$1 GDP (PPP)

7B. Halve, by 2015, the proportion of people without sustainable access to improved drinking water and sanitation

Indicators

- 7.6: Proportion of population using an improved water source.
- 7.7: Proportion of population using an improved sanitation facility.



Overview

Strong environmental management is essential for long-term sustainable development and poverty reduction. Environmental degradation and climate change issues are particularly critical for Lesotho because its economy is dependent on subsistence, rain-fed agriculture and natural resource exports. Moreover, the Government's growth strategy comprises environmentally sensitive activities such as mining, large infrastructure, the garment industry and agriculture. Key areas of concern include land degradation, solid waste management, slow progress on access to water and sanitation, biodiversity, climate change, energy and environmental governance.

Lesotho's most serious environmental challenge is land degradation, driven by heavy reliance on wood and biomass, poor agricultural practices and livestock overgrazing. As land and water are integrated systems, these poor land management practices eventually cause sedimentation and impact river ecosystems and water quality. Concerning improved water and sanitation coverage, it is expected that Lesotho will make progress through projects such as the Metolong Dam and Millennium Challenge Corporation (MCC) initiatives. Though Lesotho is not a large emitter of greenhouse gases, it is highly vulnerable to climate change, particularly in the agriculture, energy and water sectors and has already experienced extreme weather shifts. Despite slow progress on some fronts such as the Environmental Impact Assessment (EIA) system and climate change adaptation initiatives, there is a need to strengthen environmental governance and coordination.

TABLE 7.1: Millennium Development Goal 7 At A Glance

Indicator	Baseline	Latest Available	2015 (Target)
Reliance on Biomass (cooking) %	66 (2001)	53.9(2011)	-
Reliance on Biomass (heating) %	67 (2001)	51.7(2011)	-
Endangered animal species	-	3 (2011)	-
Protected Land Area (km ²)	-	0.4 (2012)	-
CO ₂ Emissions, Total (tonnes)	636000 (1994)	805000 (2000)	-
CO ₂ Emissions, Per Capita (tonnes)	0.35 (1994)	0.43 (2000)	-
Slow Progress			
HHs with Improved Sanitation (%)	24 (2001)	55 (2011)	62
HHs with Improved Water (%)	80.6 (1995)	82 (2011)	91
Forestry Coverage (%)	1.3 (1990)	1.6 (2013)	5

Land Degradation

Basotho originally occupied a much larger region of flat, arable land expanding into South Africa's Free State. As they gradually lost this territory and were pushed into the mountainous modern-day Lesotho, they maintained their agricultural and animal husbandry livelihoods without adapting to less hospitable terrain.¹⁰⁸ Moreover, a growing population over decades has used wood, land and other natural resources from an already sparse landscape in an unsustainable manner. Today, rangeland degradation, erosion and deforestation all threaten Lesotho's environment and economy.

TABLE 7.2: Proportion of Households Relying on Biomass as Primary Fuel

	2006	2009	2011
Wood for Cooking	52.5	44.1	52.2
Dung and Crop Waste for Cooking	3.9	7.2	1.7
Total Biomass For Cooking	56.4	51.3	53.9
Wood for Heating	51.7	-	48.9
Dung and Crop Waste for Heating	6	-	2.8
Total Biomass For Heating	57.5	-	51.7

Sources: LDHS 2009 and 2011 Lesotho Environment and Energy Statistics Report

Indicator 7.1: Proportion of households relying on biomass as a fuel

One comprehensive indicator of unsustainable land use is reliance on biomass (wood, crop residue, shrubs and animal dung). Biomass extraction contributes to deforestation, deprives the soil of nutrients and removes sources of land stability that prevent erosion. Biomass is the dominant form of energy in Lesotho being used by 53.93% of households for cooking needs and 51.7% of households for heating needs. As shown

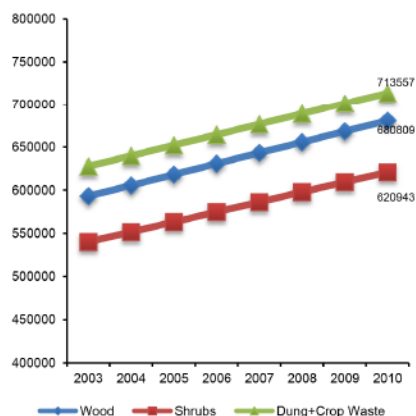
¹⁰⁸ USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

in Table 7.2, wood, dung and crop waste are the primary forms of biomass used in Lesotho.

Further analysis shows that consumption of biomass is higher in rural areas.¹⁰⁹ In 2011, 71.3% of rural households used wood as the primary fuel for cooking compared to 8% in urban areas and the disparity is similar for cooking.¹¹⁰

Although Table 7.2 indicates that reliance on biomass for energy needs has been declining between 2006 and 2009 before a slight increase in 2011, aggregate biomass consumption in tonnes increased from 1.76 million in 2003 to 1.98 million in 2009 - a 12.5% jump in 6 years.¹¹¹ This suggests increasing unavailability of biomass and use of other sources as a substitute, such as paraffin, which is expensive and unhealthy. This unsustainable reliance on biomass exacerbates deforestation and depletes the resources that replenish and sustain the land, leading to degradation of rangelands, soils and forests as shown in Figure 7.1.

Figure 7.1: Biomass Consumed in Tonnes



Source: 2011 Lesotho Environment and Energy Statistics Report, Department of Energy 2013

¹⁰⁹ Department of Energy, Assessment of Energy for Rural Development in Lesotho, May 2012.

¹¹⁰ LDHS, 2009 and BoS, Environment and Energy Statistics Report, 2011.

¹¹¹ BoS, Environment and Energy Statistics Report, 2011

Rangelands

Rangelands constitute about 65% of total land area and are a crucial resource because they serve as grazing areas for livestock.¹¹² Most rural families rely heavily on livestock for meat, milk, labour, transport and wool/mohair for export, and thus, land degradation threatens Basotho livelihoods. Moreover, rangelands support biodiversity, soil stability, erosion mitigation and water filtration. The most recent estimates from the 1980s suggest that degradation is occurring at an annual rate of 40 tonnes/ha. The major cause is overstocking which averages 40-80%.¹¹³ Other drivers include encroachment for cultivation, urban sprawl, poor land use management, Lesotho Highlands Water Project (LHWP) dams and fires.¹¹⁴

Soil Erosion

Only 9-10% of land is arable in Lesotho and 54% of it is exposed to sheet erosion, the uniform removal of a thin layer of soil usually caused by water run-off.¹¹⁵ Moreover, up to 13 tonnes/ha of soil and 0.2-1.0% of arable land are lost to soil erosion annually.¹¹⁶ This erosion not only weakens soil fertility and agricultural yields (currently less than 1 tonne/ha), but it also drains to rivers and damages river ecosystems via eutrophication. Eventually, this sediment load ends up in Lesotho's dams, diminishing hydropower potential and water exports. In sum, erosion could restrict Lesotho's main source of foreign exchange, as well as its efforts to provide domestic energy and improved access to water.¹¹⁷

The primary drivers exacerbating erosion include poor agricultural practices such as single cropping, overgrazing, vegetation removal, drainage from roads and the flooding of lands by the LHWP.¹¹⁸ Lesotho also contains large areas of duplex soils, with distinct upper and lower layers, which are particularly vulnerable to erosion. In other places these soils are left fallow, but they have been cultivated in Lesotho due to limited arable land.¹¹⁹ Basotho have adopted several structural measures to combat erosion such as terracing, water diversion furrows and contour ploughing. However, they are inconsistently applied and poorly maintained. Only half of households in the mountains use an erosion control method and one-third of all farmers reported that these structures are not maintained. Moreover, these conventional methods are merely stopgaps that cannot avert long-term erosion without substantial changes in water catchment and land management such as conservation agriculture, reduced tillage and crop rotation.¹²⁰

Forests

Indicator 7.2: Proportion of Land Area Covered by Forest

Land covered by forests includes land spanning more than 0.5 hectares with trees higher than 5 meters and a canopy cover of more than 10%. Forest area is an important environmental indicator because forests protect against flooding, help conserve watersheds and soil, offer a habitat for biodiversity, serve as carbon sinks and provide many resources.

¹¹² BoS, Environment and Energy Statistics Report, 2011

¹¹³ Ministry of Forestry and Land Reclamation (MFLR), National Range Resources Draft Policy, 2011

¹¹⁴ European Union (EU), Lesotho Country Environmental Profile, June 2012

¹¹⁵ NSDP, 2012

¹¹⁶ EU, Lesotho Country Environmental Profile, June 2012

¹¹⁷ Ibid

¹¹⁸ UNDP, Project Document, Capacity Building and Knowledge Management for Sustainable Land Management

¹¹⁹ EU, Lesotho Country Environmental Profile, June 2012

¹²⁰ FAO, Strengthening Capacity for Climate Change Adaptation in Agriculture, 2011

TABLE 7.3: Forest Coverage

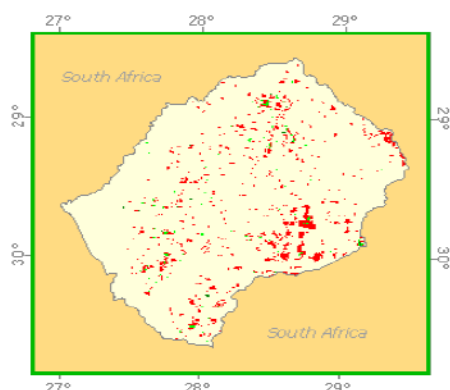
	1990	2000	2005	2010	2013
Forest in Hectares	39315	41515	42615	43715	49450
Other Wooded Land in Hectares	142115	119615	108365	97115	-
Total Land Area in Hectares	3035500	3035500	3035500	3035500	3035500
Proportion of Land Area Covered by Forest (%)	1.30	1.37	1.40	1.44	1.63
Proportion of Wooded Land (%)	5.98	5.31	4.97	4.64	-

Source: FAO, Lesotho Forest Resource Assessment 2010

Forest area is very small but has steadily increased from 1.3% to 1.63% of total land area since 1990.¹²¹ In recent years, GOL has led major initiatives to increase forest cover with a target of 5% total land area by 2020. The most successful of these initiatives was the Lesotho Woodland Project of the 1970s and 1980s which established 485 forest reserves and the Social Forestry and Conservation Project.¹²² Around 6000 hectares are government-owned plantations while 37,000 ha are held as community land presided over by village chiefs with delegated power from the King.¹²³ Nevertheless, Lesotho has increased coverage by just 0.33% since 1990.

If “other wooded land” (forest area with only 5-10% canopy coverage) is included, forestry coverage is wider, but rapidly decreasing. Most wooded land comprises indigenous trees and shrubs in lowland valleys, which suffer from unsustainable extraction. Government plantations are somewhat shielded from overuse but are not sustainably managed and protected. The primary drivers of deforestation include land clearance for agriculture, use of wood/biomass for domestic energy needs, grazing in protected areas, fires, drought and commercial exploitation.¹²⁴ Figure 7.2 maps forest cover in Lesotho.

Figure 7.2: Forest Cover in Lesotho



Source: FAO (2010)



¹²¹ Ministry of Forestry and Land Reclamation, forthcoming

¹²² MFLR, National Forestry Policy, 2008.

¹²³ FAO, Lesotho Forest Resource Assessment 2010

¹²⁴ USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

Biodiversity Loss

Endangered Animal Species

Indicator 7.3: Number of Endangered Animal Species

Given the country's small size, biodiversity in Lesotho is rich with a number of endemic flora and fauna, especially in the Maloti-Drakensburg area. There are 3,093 species of plants, 63 of mammals, 318 of birds, 40 of reptiles, 19 of amphibians, and 14 of fish.¹²⁵ The International Union for Conservation of Nature (IUCN) Red List specifies only one animal species in Lesotho as critically endangered, the Maluti minnow, while two are endangered (white-tailed mouse and long-toed tree frog) and 11 others are vulnerable.¹²⁶ The primary threats to these species include animal treplings, overgrazing, fires, urban encroachment, agricultural encroachment, invasive alien species, pollution and unsustainable plant harvesting.¹²⁷

Protected Areas and Wetlands

Indicator 7.4: Proportion of Land Area Protected

Lesotho has the smallest amount of protected land in Africa, with less than 0.4% of the land area under protection.¹²⁸ Protected areas conserve ecosystems that support plant and animal biodiversity, harbour scientific resources, support local livelihoods and help stem land degradation. Lesotho has made great strides in increasing the coverage of protected areas. RSA and Lesotho partnered in 2001 to create the Maloti-Drakensberg Trans-frontier Conservation and Development Program, which incorporated 5170 km² on the Lesotho side, including Sehlabathebe National Park. Other areas include Ts'ehlanyane National Park (56 km²) in the north, the Bokong Reserve (19.7 km²) and Lets'eng-la-Letsie (4.34km²) following its recognition by the Ramsar

Convention in 2004. Nevertheless, several factors threaten to undermine good intentions to preserve these areas. In order to conserve large animals like the lion or baboon, large areas are needed, but fragmentation and transboundary issues weaken the current protected areas. Moreover, the adjacent communities still consider these areas as part of their communal land and illegally exploit them for wood, livestock grazing and other resources.¹²⁹

Wetlands, which cover 1.36% of land area, are in particular need of protection. Lesotho's wetlands are located primarily in the highlands and are the main source of water for the Orange-Senqu River Basin. As diverse ecosystems, they also provide livestock pasture, medicinal plants, thatch grass, carbon sequestration, erosion control and habitats for numerous species. By 2013, 29 wetlands covering an area of 23,831 hectares had been fenced by the Ministry of Forestry and Land Reclamation.¹³⁰ Some wetlands have come under the protection of Sehlabathebe National Park and Bokong Nature Reserve. However, climate change and land degradation are threatening these limited lands, along with livestock overgrazing, agricultural encroachment, siltation from rangelands, invasive species, infrastructure construction and mining¹³¹.

Climate Change

Indicator 7.5: CO2 Emissions, Total, Per Capita, and per \$1 GDP (PPP)

Lesotho is not a large CO2 emitter. The First National Communication to the UN Framework Convention on Climate Change reports 636,000 metric tonnes of emissions (not including land use change and forestry) for 1994, all from the energy sector.¹³² This figure steadily increased to 805,000 in 2000.¹³³ However, Lesotho contributes less than 0.01% of global emissions and its carbon footprint is the lowest in the region. For example, Botswana emits 2.4 metric tonnes per capita, while total emissions in RSA exceed 433 million.¹³⁴

¹²⁵ BoS, Environment and Energy Statistics Report, 2011

¹²⁶ International Union for Conservation of Nature, Red List of Threatened Species, www.iucnredlist.org

¹²⁷ Department of Environment, Lesotho Fourth National Report on Implementation of Convention on Biological Diversity, 2009

¹²⁸ USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

¹²⁹ *Ibid.*

¹³⁰ Ministry of Forestry and Land Reclamation, 2013

¹³¹ European Union (EU), Lesotho Country Environmental Profile, June 2012.

¹³² Ministry of Natural Resources, National Report on Climate Change, April 2000.

¹³³ BoS, Environment and Energy Statistics Report, 2011.

¹³⁴ Botswana and South Africa MDG Reports, 2010.

TABLE 7.4: CO2 Emissions in Lesotho

	1996	1997	1998	1999	2000
CO2 Emissions (metric tonnes)	681,000	700,000	750,000	772,000	805,000
Emissions Per Capita (tonnes)	0.37	0.38	0.40	0.41	0.43

Sources: LMS Greenhouse Gas Inventory Base year 2000 report; unpublished May 2012

Nevertheless, Lesotho is vulnerable to climate change due to its reliance on rain-fed subsistence agriculture and on water resources for export earnings and hydroelectricity. Recent estimates indicate temperatures will rise 0.7°C by 2030 and 2.5-3.5°C by 2080. Shifting precipitation patterns will have serious agricultural and ecological implications, with shorter growing seasons, and an increase in extreme weather events such as floods and droughts is also anticipated. Already, Lesotho has experienced the onset of climate change, with a higher incidence of drought, delayed rainy seasons, heavy rains and floods in the early summer, strong winds and summer cold snaps.

The water sector is especially vulnerable because decreased rainfall diminishes renewable water sources. Water is currently abundant, however given current population growth and climate patterns, it is estimated that Lesotho will enter a water stress period of less than 1,700m³ per capita per year by 2019 and a water scarcity period of less than 1,000m³ per capita per year by 2062. Dry conditions brought by climate change will also reduce agricultural yields and exacerbate food insecurity, particularly among small subsistence farmers in rural areas. Extreme weather events such as long dry spells with dry lands followed by heavy rains will quickly erode and wash away the soil. Indeed, climate change could shrink arable land coverage to as little as 3%.

Finally, climate change exacerbates deforestation, and chronic drought hinders the recovery of

rangelands and wetlands.

Climate change mainstreaming has not occurred across all vulnerable sectors. There are particular weaknesses in the water sector and in climate-proofing infrastructure. However, progress is accelerating in climate change mitigation and adaptation. The 2007 National Adaptation Programme of Action on climate change analysed all vulnerable sectors and identified adaptation options. The key institution responsible for measuring climate change is the Lesotho Meteorological Services (LMS), which collects and processes climate data and feeds it to public and national institutions such as the Disaster Management Authority (DMA) for use in the Early Warning System. DMA prepares regular early warning bulletins and community-level vulnerability assessments. The Government of Japan has also contributed to disaster preparedness by providing grants for disaster response equipment, services and weather stations. These efforts represent a major step forward in preparedness.

Concerning mitigation, there is slow progress on the proliferation of green energy and reduced reliance on carbon-based sources. The draft Energy Policy (2003) and the Renewable Energy Policy (under development as part of the Africa Adaptation Programme (AAP)) seek to expand affordable renewables, particularly solar, hydroelectric, and wind, though no official plans or strategies exist due to the draft status of the policy. The electrification rate stands at 24%, with vast disparity between urban and rural

households. Electrical supply reaches 65% of urban households compared to only 5% in rural areas. Moreover, only 6% of the country's total energy consumption is supplied by electricity, while biomass (wood) and petroleum provide nearly 90% of fuel needs. The targets for electrification are 35% by 2015 and 40% by 2020, though financing problems will likely hinder these goals.

One promising avenue for green energy is hydropower. The Muela Hydropower Plant provides 72MW of power, while the rest is imported from Mozambique and RSA. The LHWP also developed four mini-hydro plants, though three are non-functioning due to poor maintenance, siltation and flooding. Another 83MW hydropower plant is planned for the next phase of LHWP.

The Department of Energy in partnership with UNDP and GEF has also worked to develop the market for solar energy in the rural districts of Qacha's Nek, Mokhotlong and Thabo Tseka and promoted renewable energy in selected rural communities under the Lesotho Renewable Energy-Based Rural Electrification Project (LREBRE) and the AAP. In Phase One of LREBRE, UNDP/GEF provided USD 2.5 million over 5 years to remove the financial, technical and institutional barriers for renewable technology. The project facilitated the setting up of over 1,500 solar powered systems and also helped in the training of communities for setting up of other solar systems countrywide after 2008.

Water Quality

Indicator: 7.6: Proportion of population using an improved water source

The Department of Water Affairs and the Lesotho Highlands Water Project (LHWP) engage in water-quality testing and quality is generally acceptable. However, according to LHWP tests, water quality is better in the highlands than in the lowlands. The major exception to water quality is the Caledon River, which receives industrial pollutants.

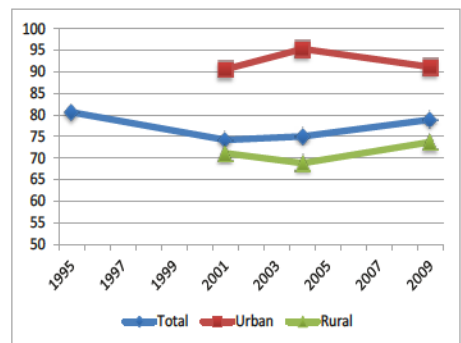
Water supply for Maseru is particularly important because of rapid urbanization

and the demands of the growing industrial sector. The Metolong Dam and Water Supply Programme financed by MCC, the World Bank and bilateral donors is the Government's key response to this need. Metolong will provide 75,000 m³/day to Maseru and surrounding areas by 2014, enabling it to meet domestic and industrial requirements for the next 40 years.

Improved water sources include piped water into dwellings or yards, public taps, protected wells or springs. In 2011, 82% of households were using an improved drinking water source, with major regional disparities. Roughly 91% of urban households versus 74% of rural households use safe water sources. 32% of rural households must travel more than 30 minutes to access safe water compared to 11% for urban families.

Overall, progress on this indicator stagnated from 2001 to 2009 and then decreased dramatically. Lesotho is making slow progress on access to safe water.

Figure 7.3: Proportion of Households with Improved Water



Water and Sanitation

Indicator 7.7: Proportion of population using an improved sanitation facility

Water is Lesotho's most important natural resource and forms the basis of a large part of its economy through the LHWP. Water supply is currently abundant. FAO estimates that Lesotho extracts 0.96% of 5.23 billion m³ in renewable water resources annually. Accounting for surface water committed to LHWP treaties for export, Lesotho has 3 billion m³/year for domestic use and consumes 1.7%. Nevertheless, the coverage is still low.

Lesotho Highlands Water Project (LHWP)

LHWP exports water to RSA and provides domestic hydroelectric power with a series of three dams and one 72MW hydropower station. Four more dams and another 100MW hydropower plant are in the pipeline. Water exports are Lesotho's primary source of foreign exchange and a foundation for economic development. Hence, sustainable management of water resources is critical. Moreover, GOL and partners must take great care to mitigate the negative social and environmental impact of LHWP. Upstream, large dams inundate arable farming land, rangelands and forests. For example, phases 1 and 2 combined of the LHWP anticipate flooding 4,000 ha of arable land. Dams also disrupt water flow downstream, which damages river ecosystems, increases sedimentation and reduces water quality.

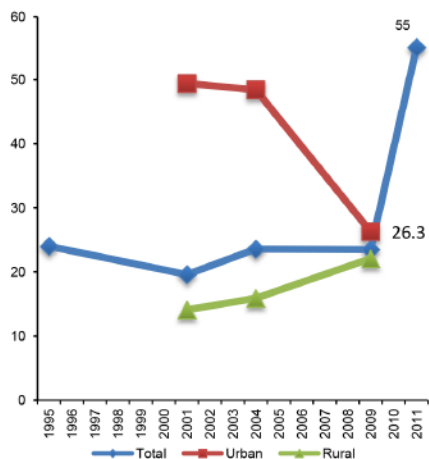
Domestic Water Supply and Sanitation

A key MDG target is a 50% reduction in the proportion of the population without sustainable access to water and sanitation. The Department of Rural Water Supply (DRWS) and community councils are responsible for rural water supply and sanitation and the Water and Sewerage Company (WASCO) manages the sector in urban areas.

Improved sanitation facilities include toilets or latrines connected to the sewer system, septic tanks, ventilated improved pit (VIP) latrines and pit latrines with a concrete slab. About 55% of households are using an improved sanitation facility, 26% and 22% for urban and rural areas, respectively.

Figure 7.4 shows that urban sanitation coverage drastically declined up to 2009, which could be explained both by inter-year differences in data collection and rural-urban migration. However, total coverage has risen since the last survey in 2009 due to significant increases in donor funding for sanitation projects. MCC has provided funding for VIP latrine construction, while the EU is providing around 43 million Euro for various water and sanitation projects. The overall trend for the past two decades suggests that sanitation coverage remained sluggish but notably increased from 2009 onwards (although no disaggregated data is currently available for the rural and urban areas). Thus Lesotho is making slow progress on this indicator.

Figure 7.4: Proportion of Households with Improved Sanitation



Sources: 2009 LDHS, 2004 LDHS, 2001 LDS, CMS 2011

Environmental Governance

Lesotho's economic development strategy rests heavily on environmentally sensitive activities such as garment manufacturing, mining and large-scale infrastructure. The NSDP places particular emphasis on LHWP and the mining industry in discussing Lesotho's growth strategy. To mitigate the potentially harmful impacts of this growth strategy, Lesotho must improve its environmental governance system.

Though high-level policies such as the NSDP recognize the need to reverse environmental degradation and adapt to climate change, environmental governance is fragmented, inconsistent and uncoordinated among the various stakeholders. Wide-ranging provisions in the Environment Act (2008) established a broad framework for environmental management to be overseen by the Ministry of Tourism, Environment and Culture (MTEC), but implementation is a challenge.

Nevertheless, Lesotho has made progress by beginning to mainstream environmental considerations into national planning. First, the Environment Act requires qualifying projects in both public and private sectors to undergo an Environmental Impact Assessment (EIA)

by the Department of Environment (DoE) within MTEC. DoE then can reject projects on environmental grounds or establish conditions to mitigate environmental impact. Second, a Strategic Environmental Assessment (SEA) is now technically required for any government bill, policy, regulation or plan that could impact the environment. However, the process has not been fully developed and no SEA has been conducted. Third, the Environment Act of 2008 requires all ministries to establish Environment Units within their Planning Divisions to ensure compliance with the Act and coordinate with DoE. However, these Environmental Units have yet to materialize in most ministries.

Key Implementation Bottlenecks Constraining Progress

Policy and Planning

Fragmented and Uncoordinated Environmental Management: In general, environmental governance is weak with responsibilities fragmented across a number of ministries and departments. These actors often operate independently without adequate communication and coordination. Lesotho also has a large body of environmental legislation and policy documents and is signatory to numerous international conventions, none of which are well implemented.

Low Capacity within MTEC. In MTEC, the tourism industry is the predominant focus, and environmental matters are a secondary priority. In the 2000s, the National Environment Secretariat was transferred to MTEC and renamed Department of Environment (DoE), which is responsible for setting guidelines, monitoring compliance, producing environmental reports and managing the overall implementation of the Environment Act of 2008. But the department is unable to carry out its mandate effectively due to low capacity and understaffing.

Poor Environmental Mainstreaming within GOL The Environment Act of 2008 mandated the establishment of Environment Units within the Planning Division of each ministry, which should ensure compliance with the Act, liaise with the DoE and oversee the EIA process for

ministry projects. However, only two ministries have so far established these units; Public Works and Transportation and Natural Resources. Moreover, the Act requires the Government to undertake Strategic Environmental Assessments (SEA) for any legislation, policy, regulation or plan that may have an environmental impact. As of March 2014, GOL has not yet implemented one SEA or developed the procedures for doing so.

Ambiguous Authority Structures for Local Land and Resource Management The Decentralization Policy rearranges the powers of chiefs who traditionally served as the stewards of the local environment. Chiefs no longer have the authority to allocate lands and most natural resource management responsibilities have been transferred to the Community Councils created in 1996. Under the 1996 Local Government Act, local authorities are responsible for environmental policy, resource management, planning, land allocation, rangeland management, water resources and forestry. Local communities must also approve the establishment of new protected areas. However, decentralization is incomplete, Ministries have not devolved responsibilities, capacity and resources to local authorities. Meanwhile, traditional chiefs have substantially reduced authority, resulting in a vacuum of strong land and resource management and confusion concerning the institutional arrangements. Moreover, Community Councils are responsible for

large areas of several hundred square kilometres with many villages, and thus, cannot adequately oversee the environment as effectively as the traditional system of chiefs.

Inadequate Forestry Regulations and Data Wood harvested and sold by the Government is rarely reported to forestry authorities, and wood felled by communities and individuals is never documented. Thus, it is impossible to fully understand the rate of deforestation and sustainably manage forest use. Moreover, the Chief Forestry Officer is supposed to issue licenses for removal of any forest resources, but this system is not operational.

Poor Water Quality Management – DoE is tasked with monitoring and enforcing water quality standards, though its limited capacity inhibits this function. It has produced standards for drinking water quality and effluent discharge into bodies of water, but they remain in draft form. Moreover, industrial and commercial discharge into the sewer system is subject to DoE regulation and emitters must possess an Effluent Discharge License or a Pollution License. However, to date, DoE has issued no licenses.

Poor Data – Lack of baseline data on land degradation, forestry, and water use hinders effective environmental policy-making. Gathering environmental statistics is a huge challenge because the task is detailed, time-consuming, costly and requires expertise. Thus, overlapping, inefficient environmental statistics-gathering exercises by the various ministries are currently fragmented and sporadic.

Land Tenure Insecurity – In 2000 GOL undertook a review of the old land tenure system, which stated that land is owned by all citizens and held in trust by the King. The system used no written titles and local chiefs were responsible for allocation to male farmers. The Land Act of 2010 enacted significant changes to this system, particularly by providing for the possibility of long-term formal land allocations with written titles. However, the maximum lease is only 90 years for agricultural land. Farmers still do not have any long-term rights to leased land, and grazing lands are still held in common. Therefore, they have no incentive to use the land sustainably.

Structural Problems

Unsustainable Rangeland Usage – Rangelands can only support a limited amount of livestock grazing. However, current livestock levels exceed the capacity of these lands. Moreover, the traditional practice of letting lands lie dormant for a period of time to regenerate has failed recently because of the scarcity of land.

Overreliance on Biomass – The unsustainable use of biomass, particularly wood, crop residue and dung, will continue to drive rangeland degradation, deforestation and soil erosion, which eventually impacts Lesotho's water resources, dams, agricultural productivity and its economic foundations.

Solar Feasibility – Scale-up of solar will be difficult because it is an expensive alternative due to the need for an international supply of equipment and it is not financially feasible for the targeted rural communities. Subsidies are required but might strain the GOL and donor budgets. Moreover, there are no concise regulations on disposal of batteries, bulbs and used-up panels. Nevertheless, initiatives such as the LREBRE project and AAP continue to expand the availability of solar.

Service Delivery

Inadequate Urban Sewage Treatment – Sewage collection and treatment has recently been installed in Maseru. The system transmits industrial, domestic, commercial and health care sewage to treatment plants which then discharge it into stabilization ponds and finally the Caledon River. Currently, waste water treatment plants are overloaded, but the EU is working with WASCO to improve capacity.

No Solid Waste Management – Although Maseru has a few waste recovery centers, only a small proportion of solid waste is properly discarded. A 2006 study revealed that 56% of households burn their waste, 51% dump it at the Ts'osane dumpsite and 41% dump it in gullies and open spaces, while only 27% make compost, 13% bury it and only 5% recycle.

Recommendations

- Establish inter-governmental coordination mechanisms specifically for land degradation/land management issues and for the water sector and harmonize the policies and programmes of the stakeholders in these sectors.
- Consider pursuing an integrated land and water catchment management approach, as envisioned in the 2007 Water and Sanitation Policy, which is a holistic approach for addressing land degradation, soil erosion, forestry use and water resource management, recognizing that these issues cannot be effectively addressed independently.
- Strengthen the EIA system by issuing specific regulations and guidelines, providing more resources to DoE for assessments and supporting the authority of DoE to reject projects on environmental grounds or establish impact mitigation conditions. Ensure that efforts to facilitate industrial development and investment do not undermine the EIA process.
- Develop procedures and begin implementing Strategic Environmental Assessments for GOL legislation, policies, regulations and plans, per the 2008 Environment Act.
- DoE should produce the National Environmental Action Plan, districts should prepare District Environmental Action Plans and State of the Environment reports and ministries should develop Environmental Management Plans, per the requirements of the 2008 Environment Act.
- MFLR should produce maps of soils and degraded land and undertake comprehensive monitoring of soil erosion.
- Expand and maintain use of traditional soil erosion control mechanisms such as terracing, water diversion furrows and contour ploughing and gradually introduce long-term changes in production practices such as conservation agriculture, crop rotation and reduced tillage.
- Improve water-quality management by developing the regulations for water quality and effluent discharge, implementing the system of Effluent Discharge and Pollution Licenses and providing adequate resources for DoE to monitor and enforce water quality standards.
- Operationalize Environmental Units within the Planning Divisions of all ministries, per the Environment Act of 2008. Alternatively, in case there are staff and capacity constraints for setting up full units, it may be appropriate for existing planning units to be educated and capacitated so that environmental issues are mainstreamed into their planning activities.
- Establish the National Environmental Council (NEC), as mandated by the Environment Act of 2008, to bring together relevant ministers and other stakeholders to oversee and coordinate national environmental policy-making.
- Form the Environmental Tribunal, per the Environment Act of 2008, to act as a final arbiter on environmental issues.
- Strengthen the mandate and resources of the National Climate Change Coordinating Institution to coordinate GOL policy on climate change adaptation and mitigation.
- Mainstream climate change programming across all sectors with a particular focus on scaling up adaptation in the water sector and in transportation infrastructure.
- Undertake the energy survey to inform the energy policy draft of 2003.
- Develop catchment management plans in partnership with local communities and

councils and devolve some responsibility and resources for catchment management from MNR to local areas, while continuing to provide centralized oversight and support.

- Operationalize the licensing system from the Forestry Officer for forest resource extraction.
- Empower local Grazing Associations.
- Improve integrated environmental data collection and management for soil, land,

water, forestry, energy, and biodiversity statistics in the Bureau of Statistics.

- Establish clear, specific performance indicators to measure progress in reversing rangeland degradation, soil erosion and deforestation.
- Improve public awareness of environmental issues by mainstreaming environmental concerns into the educational curriculum, engaging NGOs and civil society and increasing media coverage.



8 DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGETS

8.A Address the special needs of least developed countries

Indicators

8.1: Net Official Development Assistance (ODA) to Lesotho

8.2: Proportion of ODA allocated to social services

8.B Develop further an open, rule-based, non-discriminatory trading and financial system

Indicators

8.3: Proportion of exports to developed countries admitted free of duty

8.4: Proportion of ODA allocated to build trade capacity

8.5: Foreign Direct Investment into Lesotho

8.C Make new technologies available, especially information and communications

Indicators

8.6: Mobile subscribers per 100 people

8.7: Internet users per 100 people

8.D Provide affordable access to essential drugs in developing countries

Indicators

8.8: Average availability of essential medicines



Overview

Goal 8 addresses the way developed countries can assist developing countries in achieving the MDGs through development assistance, market access, foreign investment and access to critical technologies and innovation. Official Development Assistance (ODA) to Lesotho grew considerably in the 2000s as a result of increased funding for HIV and AIDS and the Millennium Challenge Corporation (MCC) and ODA more than doubled from 2009 to 2010 largely because of direct budget support from multilateral institutions to ease the impact of the recent economic crisis. The proportion of aid that is untied and the percentage of ODA allocated to social services have also increased with most assistance provided to the health, water and sanitation, and governance sectors.

Due to duty-free and quota-free access to the U.S. through AGOA and free trade agreements with the EU, SACU and SADC, 100% of exports to developed economies have been admitted free of duty since 2002. However, exports and foreign direct investment are heavily concentrated in the garment sector with insufficient diversification and ODA to Lesotho to build trade capacity and infrastructure has declined substantially during the past decade. Information and Communication Technology (ICT) access has grown exponentially in the form of mobile phones, but Internet use remains very low due to unreliable connectivity and exorbitant prices.

TABLE 8.1: Millennium Development Goal 8 At A Glance

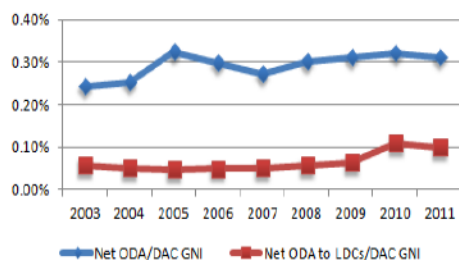
Indicator	Baseline (2000)	2005	2008	Current
Net ODA to Lesotho (USD millions)	37	67.5	143.8	264.6 (2011)
Proportion of ODA Allocated to Social Services (%)	60.4 (2002)	81.8	87.6	91.1 (2010)
Proportion of Exports to Developed Countries Admitted Free of Duty (%)	11	100	100	100 (2012)
Proportion of ODA allocated to build Trade Capacity (%)	6.7 (2002)	3.2	1.1	0.3 (2010)
Foreign Direct Investment (million maloti)	224.5	482.2	1583.5	1593.7 (2012)
On track				
Mobile Subscribers per 100 people	0.4	11.2	25.7	84 (2013)
Slow Progress				
Internet Users per 100 people	0.2	2.8	4.1	4.5 (2010)
Average Availability of Essential Medicines (%)	74 (2007)			77.7 (2010)

Trend Analysis

Indicator 8.1: Net Official Development Assistance (ODA)

Total net ODA comprises grants or loans to developing countries for economic and social development from Organization for Economic Cooperation and Development (OECD) and Development Assistance Committee (DAC) members.¹³⁵ In 2011, Net total ODA was \$134 billion, or 0.31% of donors' combined GNI of which \$32.6 billion was allocated to Africa. By 2012, it had shrunk to \$125.6 billion, or 0.29% of donors' combined GNI. The decline in 2012 followed a similar trend in 2011, when development aid from major donors fell in real terms for the first time in nearly 15 years, dropping 3%. This is the first time since 1996-1997 that ODA has fallen in two consecutive years. Assistance is still far below the commitment of 0.7% of GNI made by development partners at the 2005 Gleneagles Summit reflecting that donors are regressing on their ODA commitments to least-developed countries. Net ODA to Least Developed Countries (which includes Lesotho) fell from 0.11% of GNI in 2010 to 0.10% in 2011. DAC members contributed 0.10% of GNI in net ODA to least-developed countries in 2011, short 0.05% points of the minimum threshold¹³⁶ (Figure 8.1)

Figure 8.1: ODA as a Proportion of Donor's Gross National Income



Source: OECD (2012)

¹³⁵ Net ODA figures subtract principal repayments on loans. DAC members include Western Europe, the United States, Canada, Japan, South Korea, Australia, and New Zealand.

¹³⁶ ECD Aid Databases.

Net Official Development Assistance (ODA) to Lesotho

Net ODA to Lesotho from all donors (including multilateral institutions) more than doubled in 2010 to \$256 million (\$118.01 per capita), which is 10% of GNI¹³⁷. This substantial increase occurred because of direct budget support provided by some bilateral and multilateral institutions to ease the impact of declining SACU revenues, textile exports and miners' remittances during the global economic crisis. The largest contributor to this increase was the EU in the form of grants for budget support and infrastructure, followed by budget support loans and grants from the World Bank (IDA) and the African Development Fund. Other large contributors to the increase include the Global Fund and PEPFAR for HIV programming and MCC for infrastructure. Finally, in 2010 the IMF approved a 3-year Extended Credit Facility of \$61.4 million for Lesotho, a portion of which was disbursed in 2010.

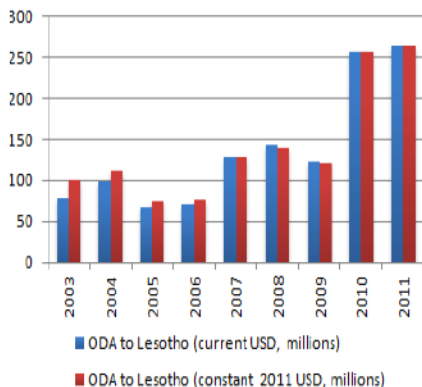
Figure 8.2 and Figure 8.3 show that in 2011, net ODA to Lesotho increased to \$265 million (\$120.6 per capita), which is 9% of GNI.¹³⁸ However, ODA will likely decrease and stabilize at normal levels in subsequent years due to the on-going Eurozone and financial crises.

Another important indicator is the proportion of bilateral ODA from DAC donors that is untied. Tied aid is much less cost-effective because the aid contracts stipulate that recipients must buy from suppliers in the donor country. In Lesotho, 95% of ODA was untied in 2005, which decreased to 73% in 2007 and then rebounded to 96% in 2009.

¹³⁷ OECD Aid Databases

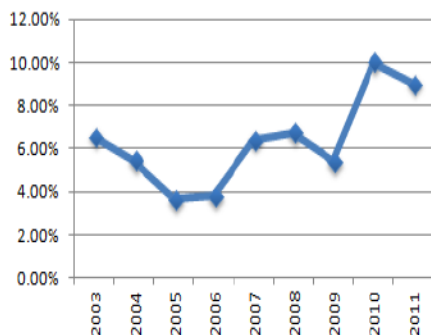
¹³⁸ Ibid

Figure 8.2: Net Official Development Assistance to Lesotho



Source: OECD

Figure 8.3: ODA as a Proportion of Lesotho GNI

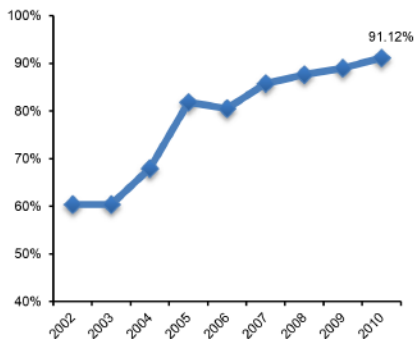


Source: OECD

Indicator 8.2: Proportion of ODA Allocated to Social Services

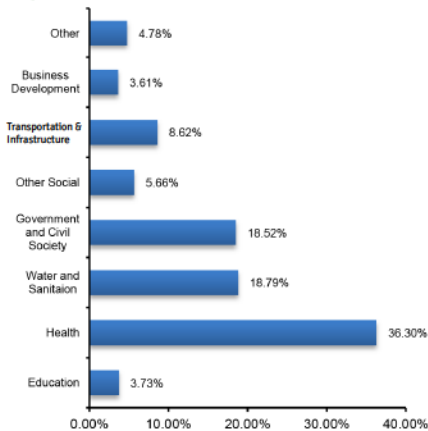
Figure 8.4 indicates that the proportion of bilateral, sector-allocable ODA from DAC donors to basic social services has steadily increased over the past decade from 60% in 2002 to over 90% in 2010. The distribution of sector-allocable ODA from all donors by sector for 2010 is shown in Figure 8.5. The health, water and sanitation, education and governance sectors receive the vast majority of ODA. A high proportion allocated to social services is indicative of the inclusiveness of ODA for all segments of the population and ensures the use of donor funding for basic human development in education, primary health care, nutrition and water and sanitation.

Figure 8.4: Proportion of ODA Allocated to Social Services in Lesotho



Source: OECD

Figure 8.5: ODA by Sector 2010



Source: OECD

Trade and Market Access

Indicator 8.3: Proportion of Exports to Developed Countries Admitted Free of Duty

The manufacturing sector, particularly through the clothing and textile subsector, has been a key driver of Lesotho's economy. Therefore, trade-related indicators are particularly important in monitoring international efforts to remove trade barriers for developing countries, increase productive capacity and volume of exports, thereby fuelling economic growth.

Trade policy is particularly important for Lesotho, a small open economy extremely vulnerable to external shocks, and given its small domestic market, pursuing an outward-oriented development strategy is essential. Trade was the engine of growth for most of the past decade, with an annual average growth in exports of 13.6% between 2001 and 2007, although it fell dramatically after the onset of the global financial crisis in 2008¹³⁹. Exports constituted 43% and 46.8% of the GDP in real prices in 2010 and 2011 respectively.

¹³⁹ World Bank, Lesotho Public Expenditure Review, August 2012.

Lesotho's largest trading partner is SACU, which purchased 39% of its exported goods in 2010¹⁴⁰. Lesotho views the RSA market and the SACU market as a potential regional market for expansion in export volumes. Strategic relations with RSA are especially important as South Africa buys around one-fourth of Lesotho's exports (e.g. water, sand stone, wool and mohair) and provides 80% of its imported goods¹⁴¹. SACU allows for free interchange of goods between member countries and negotiates external free trade agreements with other trading blocs on behalf of the 5-member region. Though exports to the 15-member Southern African Development Community (SADC) outside of SACU are low (1.4%), Lesotho also benefits from membership in the SADC Free Trade Area. Nevertheless, communication and transportation barriers continue to inhibit intraregional trade in Southern Africa.

After SACU, Lesotho's largest trading partner is the United States where 37.5% of exports went to North America in 2010¹⁴². Textiles, in particular, are significant, constituting 82% of exports to the U.S. in 2011¹⁴³. In 2012, Lesotho was the top exporter of garment products to the US in value terms. However, the value of exports for Lesotho has decreased from \$315.323 in 2011 to \$300.930 in 2012, marking a decrease of 4.56% in the value of exports¹⁴⁴.

In August 2012, the U.S. Congress renewed a key provision of AGOA), which permits Lesotho to use foreign third-country fabric for garment exports and provides quota and duty-free entry into the U.S. for certain goods, most notably textiles and apparel. Both the third-country fabric provision and the overall act are valid through September 2015. AGOA's continuation is vital for Lesotho's economy and development in the medium term. This key economic relationship relies entirely on the (AGOA), originally passed by the U.S. Congress in 2000. The passing of AGOA has spurred a booming textile sector in Lesotho, creating thousands of jobs.

¹⁴⁰ Central Bank of Lesotho (CBL), Annual Report 2010.

SACU is the Southern African Customs Union

¹⁴¹ Bureau of Statistics (BoS), 2010 Statistical Yearbook.

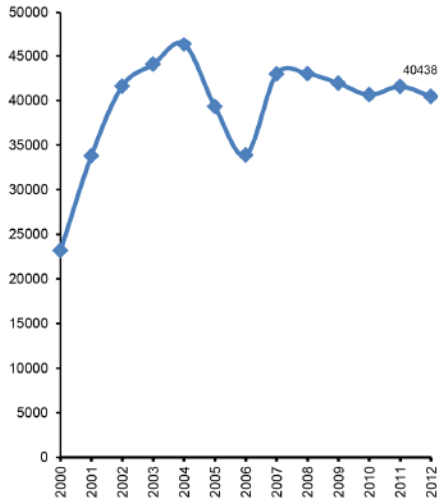
¹⁴² CBL Annual Report, 2010;

¹⁴³ U.S. International Trade Administration, Trade Stats Express Database, 2012.

¹⁴⁴ LNDC Status Report Jan-March 2013

Figure 8.6 shows that employment in the textile sector increased sharply from 2000 to 2003, due to the introduction of the multi-fibre agreement which imposed quotas on the exports of big economies that would otherwise outcompete the least-developed countries, giving Lesotho the advantage of getting better market access in the US. In 2004, the Multi-Fibre Arrangement came to an end and the quotas had to be removed. This eroded some of the markets that Lesotho and other least-developed countries had access to and led to a reduction in employment as well. In 2007, employment rose when AGOA's Third-Country Fabric Provision was extended and US buyers placed more orders from Africa. However, in 2008, employment decreased following the global financial crisis that affected sector activity leading to retrenchments and firm closures. In 2009, firm stability was re-established until 2012 when the employment level declined from 41,558 in 2011 to 40,438 in 2012 following the delay in renewal of the Third-Country Fabric Provision, which prompted US buyers to shift some of their orders to other regions.

Figure 8.6: Employment in the Textile Sector



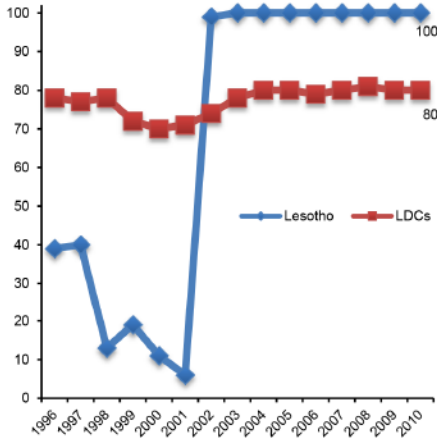
Source: Central Bank of Lesotho

Lesotho also exports about 20% of its goods to the EU market although it has not yet fully exploited this opportunity due to the stringent Rule of Origin (ROO), low labour skills and inflexible firm operations that have been structured to target traditional markets such as the U.S. As a member of the SADC block, Lesotho finalised an interim Economic Partnership Agreement (EPA) with the EU in June 2009 that offers strong trade preferences, particularly for textiles. Currently Lesotho along with other SADC countries is in the final stages of negotiations for concluding a full EPA. These trade agreements including the AGOA have benefited Lesotho tremendously over the past decade. The country's exports face a trade-weighted average tariff from the rest of the world of 0.04%, which is much lower than the average for sub-Saharan Africa (3.5%) and low-middle income countries (2.9%).¹⁴⁵ Moreover, 100% of exports to developed economies have been admitted duty-free since 2002 as shown in Figure 8.7. Lesotho also has concessional market access to other developed and developing countries' markets under the Generalized System of Tariff Preferences (GSP) applicable to each country. These countries include among others Australia, Canada, Japan, New Zealand and Turkey. As in the case with the EU, the challenge to exploit these markets still remains, given stringent ROO.¹⁴⁶

¹⁴⁵ BoS, Statistical Yearbook 2010.

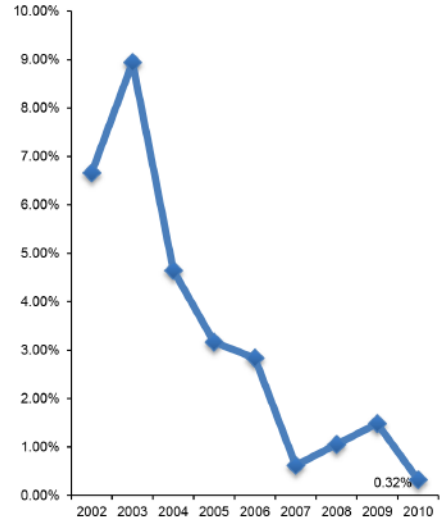
¹⁴⁶ LNDC Status Report Jan-March 2013.

Figure 8.7: Proportion of Developed Economies' Imports Admitted Free of Duty



Source: ITC, WTO, UNCTAD

Figure 8.8: Proportion of Lesotho ODA for Trade Capacity



Source: OECD

Indicator 8.4: Proportion of ODA Provided to Build Trade Capacity

Aid for trade aims to help developing countries strengthen productive capacity, regulatory and policy frameworks and infrastructure. Trade agreements enable Lesotho to better integrate into world markets. In Lesotho, ODA for trade has focused on infrastructure, agriculture, trade policy and regulation, industrial development and tourism. The proportion of ODA allocated for trade capacity has fallen considerably from 9% in 2003 to less than 1% in 2010 due to increased funding towards HIV and AIDS programmes amongst other reasons (8.8). However, aid for trade has also declined in absolute terms from nearly \$7 million (USD) in 2003 to less than \$1 million in 2010¹⁴⁷.

¹⁴⁷ OECD Aid Data Bases.

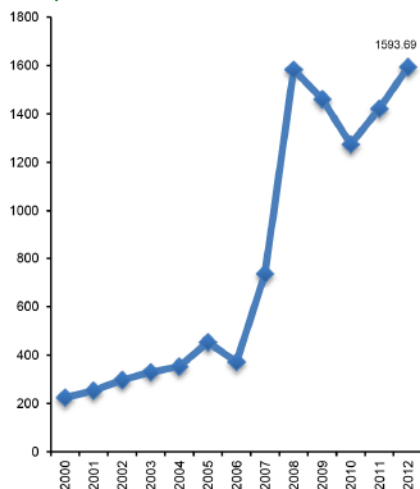
Indicator 8.5: Foreign Direct Investment in Lesotho

Foreign Direct Investment (FDI) is capital invested directly into production or industry by a foreign company. FDI is an important source of investment, foreign capital and productivity growth for developing countries. It facilitates technology and skills transfer and, most importantly, new job creation in the host country. Figure 8.9 indicates nominal FDI trends for Lesotho over the past decade. FDI has grown considerably from 2006 to 2008 as a result of the efforts of the Lesotho National Development Corporation (LNDC), the development of industrial infrastructure such as factory shells and AGOA. However, the global financial crisis and increased competition from China for the U.S. garment market triggered a decline in FDI after 2008 and in 2009-10, five companies closed resulting in 3,755 job losses. FDI increased from 1,422.24 million Maloti in 2011 to 1,593.69 million Maloti in 2012¹⁴⁸ as a result of a number of initiatives such as the development of industrial infrastructure. To attract FDI, efforts are

¹⁴⁸ Central Bank of Lesotho

already being taken by LNDC with support of the Southern Africa Trade Hub to diversify markets. Continued investment in industrial infrastructure, the mining sector, the communication sector and the Motolong water project should also attract further FDI.

Figure 8.9: Net Foreign Direct Investment (million maloti)



Source: Central Bank of Lesotho

Access to Information and Communication Technology (ICT)

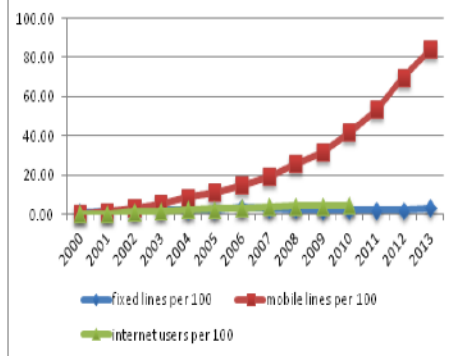
Indicator 8.6: Mobile Subscriptions per 100 people

The level of access to communication services is an important indicator for MDG 8. This is because ICTs continue to create opportunities for investment and facilitate development and growth in all spheres of the economy. For instance, it is now possible to advance financial access by sending money to remote areas via mobile handsets, pay bills, complete banking transactions through Internet services; read and/or watch news over mobile handsets; and to provide e-medical and e-government services.

One of Lesotho's strongest ICT achievements is the Lesotho Communications Authority (LCA), which was established in 2000 to advance universality of ICT access and services, ensure robust competition, promote investment in the sector, protect consumers and manage emerging technology. To date, the communications sector is characterized by two Public Communications Service Providers: Econet Telecom Lesotho and Vodacom Lesotho, which are licensed to provide both voice and data services. Internet services are also provided by six other licensed Internet Service Providers.

While some areas remain without access to ICT services, there has been a significant penetration of communication services in Lesotho, particularly with respect to mobile networks. The sector has realized increased subscription for both voice and Internet services, increased coverage and wider choice of communication services, all of which contribute towards bridging the digital divide. Figure 8.10 shows that teledensity for mobile telephony has increased exponentially from around 1% in 2000 to 84% in March 2013. In contrast, the growth of fixed telephony has remained stagnant with teledensity at 3% in March 2013 compared to 1% in 2000. This stagnation in fixed telephony is characteristic of most developing countries.

Figure 8.10: Information and Communication Technology Access 2000-2013



Sources: Lesotho Communications Authority; International Telecommunications Union

Indicator 8.7: Internet Users per 100 people

As in most African countries, penetration of Internet access and services in Lesotho has progressed very slowly. Exorbitant prices together with slow and unreliable connectivity have been the key factors that have hindered Internet penetration. However, this is likely to change now that Lesotho sources international bandwidth through the East African Submarine System (EASSy) project. Participation in this project is intended to bridge the digital divide through introduction of cheaper and high capacity bandwidth connectivity. Network operators in Lesotho started leasing capacity from EASSy in 2012 and the expected net effect is to see large reductions in broadband prices, but so far these

have not been at the scale expected. In 2000, less than one percent (0.22%) of Lesotho's inhabitants used Internet, increasing to 4.45% in 2010¹⁴⁹. While there is a gradual increase in Internet users through different technologies and customer premises equipment, the most prominent usage has been on the mobile devices, including handsets, following the introduction of mobile Internet services and their promotion¹⁵⁰. Internet cafes continue to provide important public outlets for Internet access. However, their number is also growing at a slow pace and they are concentrated mostly in urban areas and in the capital city, Maseru (40%). Table 8.2 shows the distribution of Internet cafes from 2009 to 2012.

TABLE 8.2: Number of Internet Cafes in Lesotho 2009 -2012

DISTRICT	2009	2010	2011	2012
Butha-Buthe	2	4	6	5
Leribe	5	5	9	12
Berea	2	2	3	4
Maseru	11	15	23	34
Mafeteng	3	3	3	6
Mohale's Hoek	2	3	3	3
Quthing	0	2	2	2
Qacha's Nek	2	2	5	2
Mokhotlong	1	1	2	6
Thaba-Tseka	0	1	2	2
Total	28	38	58	77

Source: Lesotho Communications Authority

In its continued initiatives to improve access to communication services in the rural areas of Lesotho, LCA established the Universal Access Fund (UAF) in May 2009, later renamed Universal Service Fund (USF). The fund was aimed at providing subsidies to licensed network operators for developing and expanding communications infrastructure to the unserved and underserved areas that are predominantly rural. Since its inception, the Fund has changed the lives of many people who live in the remote parts of Lesotho by extending coverage to about 58,000 people from more than 300 villages in all the ten districts

of the country. The USF also provided funding for the establishment of the Lesotho Internet Exchange Point (LIXP) to address the high costs of Internet connectivity. The facility is intended to enable improved domestic speeds, efficient use of international bandwidth, reduced costs and savings on foreign exchange. Finally, the country is working towards migrating from analogue to digital terrestrial television broadcasting as per agreement under the International Telecommunication Union (ITU).

¹⁴⁹ International Telecommunication Union

¹⁵⁰ Ninety nine percent of the users rely on 3G.

Access to Medicine

Indicator 8.8: Proportion of People with Sustainable Access to Affordable, Essential Drugs

Lesotho is committed to making available to its population safe, effective and affordable medicines in both public and private sector. To this end, the National Drug Service Organization (NDSO) procures medicines in bulk and distributes them to the Government Health Facilities and the Christian Health Association of Lesotho (CHAL). ARVs account for roughly half of the total procurement. District Health Management Teams (DHMT) are responsible for managing the drug supply locally, and each DHMT includes a pharmacist and a pharmacy technician to direct district pharmaceutical services. Medicines are provided free of charge at health centres while at hospitals they are provided for free to those who cannot afford them. In 2007, a nationwide study was conducted in order to measure the availability, procurement, distribution and use of a selection of medicines in Lesotho at health facilities. The results of the survey revealed 74% average availability of essential medicines at

hospitals. The 2010 survey results revealed that the mean availability of essential medicines at hospitals increased to 77.7%. Availability is slightly higher at GOL hospitals (80%) compared to CHAL hospitals (75%). In the health centres, drug access is still a major challenge, though availability improved significantly from 40% to 58% between the survey years.¹⁵¹

Although the average out-of-stock days for essential medicines at hospitals climbed from 7 in 2007 to 17 in 2010, Lesotho still performs better in supply management than other regional countries. For instance, in Uganda and Tanzania, the average number of days key medicines were out of stock was 73 and 136 days, respectively, in 2008. However, the situation at the health centre level in Lesotho is still very bleak, as key medicines were out of stock an average of 144 days in 2010 as shown in Table 8.3. Stock outages are much worse in the central districts because pharmaceutical personnel are not adequately distributed between urban and rural areas. ARV stock outages are worse, averaging 56 days for the North, 73 days for the South and 194 days for central districts.¹⁵²

¹⁵¹ MOHSW, Medicines Access Survey, 2010

¹⁵² Ibid

TABLE 8.3: Medicine Access in Lesotho

	2007	2010
HOSPITALS		
Availability of Indicator Medicines (All) ¹ (%)	74	77.7
Availability of Indicator Medicines (GOL) (%)	74.5	80.3
Availability of Indicator Medicines (CHAL) (%)	74.7	74.7
Overall Availability of TB medicines (%)	78	80.7
Overall Availability of STI medicines (%)	78	79
Overall Availability of ARVs (%)	-	69.6
Average Out-of-Stock days for Indicator Medicines (All Hospitals)	7	17
Average Out-of-Stock days for Indicator Medicines (GOL Hospitals)	-	13
Average Out-of-Stock days for Indicator Medicines (CHAL Hospitals)	-	23
HEALTH CENTRES		
Availability of Indicator Medicines (%)	40	57.7
Average Out-of-Stock days for Indicator Medicines	-	143.7

Source: MOHSW Medicine Access Survey (2010)

In preparation to review the National Medicines Policy (NMP), Standard Treatment Guidelines (STG) and Essential Medicines List (EML), the Ministry engaged the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) to facilitate the process, which is now at an advanced stage. Completion of this process will yield the reviewed NMP, STGs and EML to keep up the pace with the complexity of the treatment modalities

of diseases. Lack of legislation and proper drug regulation measures has resulted in a large number of substandard and counterfeit medicines circulating in the country. Due to the increasing production of traditional medicines with medical claims and their unregulated distribution, a medicine safety programme is needed to monitor the pharmacy dynamic of these medicines as well as their long term effect.

Key Implementation Bottlenecks Constraining Progress

Policy and Planning

Aid Alignment Problems. In 2011, Lesotho participated for the first time in the Monitoring Survey for the Paris Declaration on Aid Effectiveness targets and performed poorly on several indicators. Both GOL and donors are responsible for the deficiencies. In particular, ODA is not fully aligned with national development priorities or captured in the Government's budget process. Donor disbursements are often below commitments or delayed. Moreover, OECD found weaknesses in procurement and public financial management systems, which includes budgeting, accounting and auditing, although budgeting and Treasury reforms have yielded some recent improvements. As a result, only 38% of aid in 2010 was disbursed through public financial systems and only 42% used public procurement systems¹⁵³. The survey results also indicated that the manner in which the Government records estimates is unclear and therefore, it is difficult to determine where the discrepancies originate. Hence there is a need for the Government to set realistic budget estimates and for donors to provide timely and accurate information about planned disbursements. However, the challenge for both the Government and donors is that budget cycles for donors do not match that of the Government. In addition, disbursements rely on the level of implementation, which is normally low for Lesotho.

Uncoordinated and Fragmented Aid. The OECD survey also noted problems with aid harmonization and fragmentation. Only 43% of aid in 2010 was channelled through programme-

¹⁵³ OECD, Aid Effectiveness 2005-10: Progress in Implementing the Paris Declaration, V.2 (country chapters)

based approaches, whereby the Government coordinates policy and strategy for projects in each sector. In the case where a Sector-Wide Approach (SWAP) exists, such as in the water sector, donors often do not use it and still conduct aid missions separately. Moreover, fragmented aid, which is disbursed in small pieces from many donors, is increasing. The average number of donors per sector increased from 6.2% in 2005 to 8.8% in 2009. This fragmentation creates an enormous administrative burden because each donor has its own procedures and reporting demands.

No Long-Term Focus. Some donors have a multi-year funding cycle such as the EU and Irish Aid, but other major donors like the World Bank renew support annually, which makes budget forecasting and long-term development planning difficult for the Government. Moreover, there is tremendous volatility in donors' inter-year aid disbursements and in sectoral focus¹⁵⁴.

Insufficient Monitoring and Evaluation. The Project Appraisals Committee currently does not function to its optimal level and inadequate frameworks exist for evaluating the feasibility of proposed projects and measuring results of current projects. Moreover, there is no system of mutual accountability between donors and the Government for joint reviews of aid effectiveness. The level of donor technical cooperation in aid projects is strong, although it often occurs without taking into account the actual needs and absorptive capacity and would benefit from participation of local experts.¹⁵⁵

¹⁵⁴ Personal Interviews, Aid Coordination Unit, Ministry of Finance and Development Planning, August 2012.

¹⁵⁵ OECD, Aid Effectiveness 2005-10: Progress in Implementing the Paris Declaration, V.2 (country chapters)

Low Diversification. Though access to global markets is favourable, trade diversification is low both in terms of production and trading partners. The garment sector accounts for over half of all exports and its fortunes have fluctuated with the health of the global economy in the past decade. Diamonds, which constitute a quarter of exports, are vulnerable to economic shocks and shifts in demand. Moreover, Lesotho's manufacturing sector is contingent on the U.S. and favourable trade provisions under AGOA. Without diversification in export markets and goods, Lesotho remains extremely vulnerable to external shocks.

Lack of Competitiveness. Lesotho competes with countries like Bangladesh, Vietnam and Cambodia in textiles and clothing. Evidence shows that these countries have been gaining competitiveness while Lesotho has been losing the same over time. The textile and apparel manufacturers in Lesotho have become less competitive compared to their competitors in Asia and Africa, owing to burgeoning operational costs among other factors. In 2010, the minimum wage was USD 125 compared with approximately USD 50 in other countries¹⁵⁶. Textile exporters are also subjected to import and export charges while in other countries such charges are non-existent. This places Lesotho at a disadvantage in terms of product pricing and receipt of orders.

No Pharmaceutical Regulations. Though medicine access is improving, there is a great challenge in regulation of the pharmaceutical industry due to lack of legislation. This has resulted in the mushrooming of chemists and pharmacies in the country. Lesotho lacks a medicines regulatory body, any criteria for marketing medicines and standards for licensing manufacturers, wholesalers, distributors and pharmacists. Moreover, there is no quality assurance system¹⁵⁷. Without these mechanisms, it is difficult to ensure safe, efficient use of quality pharmaceuticals.

Structural Problems

Barriers to Intra-African Trade. Lesotho's largest trading partner is the SACU bloc, especially RSA. However, intra-African trade is still low and Lesotho's economic relationships with SADC are weak. These Southern African markets have tremendous potential, but communication, infrastructure, bureaucratic and political barriers inhibit the exchange of goods. Furthermore, internal trade infrastructure is weak, thereby compromising efficiency.

Poor Investment Climate. Despite progress made in the 2012 towards enhancing Lesotho's investment climate, Lesotho still lags behind its peers in SADC and SACU according to rankings by the World Economic Forum Competitiveness Report and the International Finance Corporation Doing Business 2013 Report. Prospective investors look at these rankings as one input before making investment location decisions. Furthermore, high start-up and compliance costs and the lack of a coherent regulatory framework may discourage FDI and growth in manufacturing for exports.

Service Delivery

High Internet Costs. Though improvements are on the horizon, exorbitant prices, slow and unreliable connectivity suppress internet use.

Inaccessibility of Health Centres. Only 10% of health centres have 100% of their coverage population within 8 km, the maximum acceptable distance under MOHSW guidelines¹⁵⁸.

Poor Inventory Management. The average adherence to inventory management Standard Operating Procedures (SOPs) is only 53% at hospitals and 28% at health centres and at many facilities the SOPs are not even available. Only 44% of GOL facilities prepared their orders according to schedule. Moreover, less than half of health facilities knew their pharmaceutical budgets and many had problems processing payments to NSDO¹⁵⁹.

¹⁵⁶ CBL Annual Report 2012

¹⁵⁷ MOHSW, Medicines Access Survey, 2010.

¹⁵⁸ Ibid

¹⁵⁹ Ibid

Inefficient Use of Medicines. Lesotho has been transitioning from inefficient prescription practices to a set of Standard Treatment Guidelines (STGs) developed by MOHSW. However, availability of critical guidelines is still inadequate, 53% at hospitals and 63% at health centres. The decreasing availability of treatment guidelines for ARVs and TB medication is particularly concerning.

Pharmaceutical Personnel. Attracting and retaining a high calibre of personnel to manage inventory and properly distribute medicines under treatment guidelines is a major barrier. Moreover, these personnel are not equitably distributed between urban and rural areas.

Key factors contributing to meeting the targets

- The Government through the Ministry of Development Planning has produced the Lesotho Partnership Policy. Its objectives are to improve the effectiveness of development cooperation through greater government ownership and leadership, as well as increasing transparency and accountability between the Government and development partners in the management of development cooperation.
- Implementation of the New Companies Act together with other initiatives, notably, streamlining of the services provided by the One Stop Business Facilitation Centre, has improved Lesotho's Doing Business ranking from 143 in 2011 to 136 in 2013 out of 185 countries¹⁶⁰.
- Lesotho received funds from the Millennium Challenge Corporation of the Government of the United States of America in 2007. These resources were earmarked for the improvement of the investment climate as well as to finance projects in the health sector and water supply, notably the Metolong Dam project.
- Lesotho is now connected to the Eastern Africa Submarine Cable System (EASSy), which is intended to bridge the digital divide through introducing cheaper and high-capacity bandwidth connectivity.

New challenges for meeting Millennium Development Goal 8

- The eventual (now impending) expiry of AGOA: with AGOA's arrangement programmed to expire by September 2015, there is a high likelihood of further decline in exports to the US by Africa's textile and apparel.

¹⁶⁰ The World Bank Doing Business Report 2013

Recommendations

Development Assistance

- Continue reform of Public Financial Management, Treasury and Procurement systems and work with donors to ensure that aid is captured in the budget process and financial management systems and aligned with national development strategies.
- Improve the coordination of aid via programme and sector-wide approaches and harmonize donor procedures and reporting.
- Develop stronger monitoring and evaluation frameworks and a system of mutual accountability for aid effectiveness with donors.
- Strengthen inter-governmental coordination between the Ministries of Foreign Affairs, Finance and Development Planning.
- Finalize the Aid Policy, which will strengthen the Government's control of aid and centralize coordination and solicitation of donors in the Ministry of Development Planning.

Trade

- Develop an integrated trade and export policy, identify industrial clusters with the most potential for export growth and target resources toward those industries.
- Increase amounts of ODA for Trade Capacity with a focus on trade infrastructure and finance, productive capacity, diversification and trade in the tourism and service industries.
- Develop support institutions for companies beginning or expanding exports and explore mechanisms for trade finance, such as working capital credit for exporters.

- Continue efforts to diversify industry and goods manufactured for export.
- Expand initiatives to diversify export markets and explore increased South-South trade with China, India, MERCOSUR and SADC countries.
- Improve trade infrastructure and transit, particularly national highways and access roads to production zones, and establish a dry port at the border.
- Engage with RSA to increase efficiency and speed of the transit of goods between the two countries through improved export/import permit processing and customs clearance systems at the border. Also, work to improve the transit speed of exports from Lesotho to Durban and other RSA ports.

ICT and Medicines Access

- Expand the prevalence of commercial and public facilities for internet access. Prioritize enhancing internet access in secondary and tertiary schools and health centres. Moreover, GOL and donors should partner with the private sector to expand the prevalence of Internet cafes/centres outside Maseru by absorbing some of the high start-up costs through initiatives such as UAF.
- Improve coordination between health facilities and NDSO. Train at least 2 personnel in each facility in payment to NSDO, preparing orders on schedule, proper monitoring and management of supplies and maintaining a buffer stock.
- Develop a pharmaceutical quality assurance system and regulatory framework for the manufacturing, distribution, sale and prescription of medicines.
- Ensure the availability of SOPs and STGs in all health facilities and train all pharmaceutical personnel in their use.

Section III:

Conclusions and Policy Perspectives



Conclusion: The Way Forward

It is in the nature of the MDGs that they mutually reinforce one another. Success in education, for example, is likely to result in gains in other MDGs, too. Conversely, failure to achieve one MDG, such as the elimination of hunger and extreme poverty, is likely to threaten the achievement of several other MDGs.

It is therefore essential that political will and policy commit itself to key strategies that through close coordination will ensure progress toward each MDG. The policy recommendations below offer an “at a glance” view of these policies.

Certain policies such as the integration of maternal/neonatal care with HIV and AIDS care appear more than once because this policy is as relevant to MDG 5 as it is to MDG 6. Similarly, the importance of training medical and educational professionals to serve at the local level in remote areas is also repeated as a policy recommendation for more than one MDG. These repetitions bear out the synergies that exist among MDGs and the promise that their successful attainment offers Lesotho.

Each section in this report provides detailed recommendations for successfully reaching each Millennium Development Goal. For those interested in a more abbreviated view of these recommendations, the section contains the most “top-level” items. The authors of Lesotho’s MDG Report encourage readers to also review the recommendations in each section for a fuller view of each proposal.

Public Policy Recommendations for MDG 1

- Invest in intensive training and support for farmers in the areas of Conservation Agriculture and Commercial Block Farming.
- Scale up water harvesting and small-scale irrigation development.
- Encourage home and community gardens by providing access and training.
- Improve the targeting of services for the most vulnerable members of society.
- Involve unemployed youth in environmental conservation efforts.
- Develop cross-ministerial efforts at local, district and national levels to address the nutritional needs of infants and children.

Public Policy Recommendations for MDG 2

- Create incentives for qualified teachers to teach in remote areas that are underserved.
- Provide early childhood education (pre-schools) to ensure later academic success.
- Use distance-learning to provide educational opportunities for older youth, adults and non-enrolled children who may be physically prevented from attending school.
- Address the educational needs of the 20% of Lesotho children who are not currently attending school, especially disadvantaged groups.
- Replace unqualified teachers with qualified teachers.

Public Policy Recommendations for MDG 3

- Train media in appropriate, gender-sensitive reporting.
- Encourage political parties to establish strategies for empowering female members.
- Reform laws and customs that prevent women from achieving equality.
- Change harmful social beliefs that sustain gender-based violence.
- Monitor the prevalence of gender-based violence.
- Enact Domestic Violence legislation.
- Monitor and evaluate the participation and representation of women in all areas of government and public life.

Public Policy Recommendations for MDG 4

- Integrate health services for children and mothers.
- Develop and operationalize a child survival policy at the community, district and national level.
- Develop strong cross-border collaboration with South Africa to address the outbreak of illnesses such as the measles.

Public Policy Recommendations for MDG 5

- Improve the training of frontline and community health workers.
- Fast-track the National Education Partnership or enhanced midwifery course in the training curricula for nurses.
- Build district-level healthcare capacity.
- Integrate further maternal/neonatal care and HIV and AIDS patient care.
- Strengthen the supply and distribution chains for medical equipment and supplies.
- Address the transportation needs to execute outreach services.

Public Policy Recommendations for MDG 6

- Promote “partner reduction” messages and ensure leadership commitment to key messages that prevent HIV.
- Provide sex education to children aged 12 and above.
- Increase condom distribution programs and education.
- Encourage full, medical male circumcision as part of free primary care.
- Make HIV testing and treatment more accessible.
- Further integrate Reproductive/Sexual Health Services with HIV and AIDS testing and care.
- Expand family planning services for women.
- Improve forecasting, supply and distribution of supplies for HIV and AIDS care.

Public Policy Recommendations for MDG 7

- Improve public awareness of environmental issues.
- Establish inter-governmental coordination for land and water management issues.
- Expand soil erosion control mechanisms.
- Improve water quality management.
- Improve coordination of national environmental policies via the establishment of a National Environmental Council.
- Pass an official energy policy and redouble efforts to use renewable fuel sources.
- Improve environmental data collection and management.
- Establish indicators to measure progress in reversing soil erosion, rangeland degradation and deforestation.

Public Policy Recommendations for MDG 8

- Improve coordination of aid and develop stronger monitoring and evaluation frameworks.
- Strengthen intergovernmental coordination and finalize the Aid Policy to centralize coordination and solicitation of aid.
- Identify industries with export growth potential and target resources toward them.
- Expand initiatives to diversify export markets.
- Improve trade infrastructure and transit particularly between Lesotho and RSA.
- Expand internet access in commercial and public areas.
- Develop a regulatory framework for the manufacturing, distribution and sale of prescription medicines.

Looking Beyond 2015

The Government of Lesotho is committed to the continuation of momentum for its development goals beyond the 2015 MDG deadline. The country's National Strategic Development Plan is its key implementation strategy for the period 2012-2013 to 2016-2017.

The NSDP seeks to achieve the following strategic objectives:

- Creation of high, shared and employment generating growth;
- Development for key infrastructure;
- Enhancement of skill base, technology adoption and foundation for innovation;
- Improve health, combat HIV and AIDS, and reduce vulnerability;
- Reverse environmental degradation and adapt to climate change;
- Promote peace, democratic governance, and effective institutions;
- Cross cutting issues: Gender, children, youth, disability and elderly¹⁶¹.

These strategic objectives provide a comprehensive framework that covers and exceeds the MDGs.

Post-2015 Development Agenda

Lesotho is engaged in defining its priorities for the Global Post-2015 Sustainable Development Agenda. The Lesotho Chapter has been pro-active in ensuring that the voices of individuals in small communities are heard in the selection of development priorities. Accordingly, Lesotho's post-2015 development agenda highlights the need for stronger alignment between the national development policy framework and the concrete "on the ground" realities of communities at the local level. This participatory process is the most significant ingredient in Lesotho's Post-2015 Development Agenda as it demystifies development and facilitates active involvement in realizing a collectively defined destiny.

The Consolidation of Community Priorities

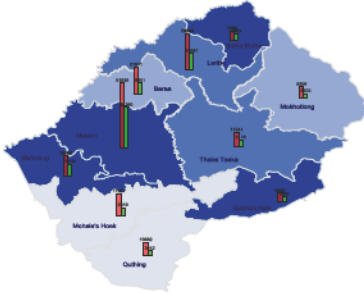
- The community priorities can be consolidated into the following broad themes:
- Infrastructural development and sustainable environment
- Improvement of health services and fight against HIV and AIDS
- Improvement in agriculture
- Public participation & decentralization
- Education and other types of support for the people with disabilities and other vulnerable sectors of society
- The role of science, research and development

¹⁶¹ See National Strategic Development Plan. 2012.Pp75-107

The themes of Lesotho's Post-2015 Development Agenda echo the MDG's priorities of food security, education, health, democracy and effective institutions. The United Nations is committed to supporting Lesotho's development efforts in these areas. Lesotho's participation in the Post-2015 Development Agenda is evidence of the kingdom's continued role as a global partner with other member nations in the eradication of poverty through sustainable development.

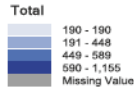
Annex: Geographical Coverage Maps on Selected Health Indicators

ART Coverage
Percent Total



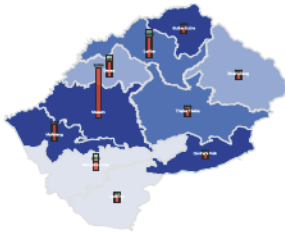
Sources
MoH_Ministry of Health Annual Joint Review _2012

Maternal mortality ratio
Ratio Total



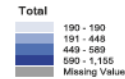
Sources
bos_LDHS_2009

ART Coverage
Percent Total



Sources
MoH_Ministry of Health Annual Joint Review _2012

Maternal mortality ratio
Ratio Total



Sources
bos_LDHS_2009



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