



KINGDOM OF LESOTHO

Millennium Development Goals Status Report 2013



ACKNOWLEDGEMENTS

This Millennium Development Goals Report (MDGR) 2013 is a joint effort by the Government of Lesotho and the United Nations in Lesotho. It was developed through the leadership and support of the Department of Monitoring and Evaluation in the Ministry of Development Planning (MDP), and financial and technical support of the United Nations Development Programme (UNDP).

The Government of Lesotho extends its profound gratitude to the ministries, departments, parastatals, agencies, development partners, civic organisations and the private sector who contributed immeasurably in this national exercise. They provided data, comments and feedback, peer review and consistent interaction in a manner that must be commended and recommended to sustain for further processes of this magnitude and nature.

The Government of Lesotho is further grateful to the Drafting Team that wrote this MDGR, namely Mr Potlako Peko - Director of M&E Department and Drafting Team Leader; Ms Lineo Mokitimi - Chief Economic Planner MDP; Mr Thuloane Tsehlo - National Economist UNDP; Mr Rets'elisitsoe Pulumo - Senior Economic Planner MDP; Ms Liako Mofo - Chief Economist MDP; Ms Moipone Lehloara - Economic Planner MDP; with invaluable support of Ms 'Mabereng Mpoosa - Economic Planner MDP; Mr Ts'epo Mosoeunyane - Assistant Economic Planner MGYSR; Mr Bokang Lekau - Assistant Economic Planner MDP; Mr Sentle Monaheng - Economic Planner MDP; Mr Sebothama Moshoeshe - Economic Planner MDP; Ms 'Mahlompho Chaotsane - Economic Planner MDP; Ms Puseletso 'Musi - Senior Economic Planner MDP; Ms 'Mamolitsane Thoothe - Senior Economic Planner MH, Ms Mahali Sekants'I - Principal District Gender Officer - MGYSR.

The Government of Lesotho acknowledges the excellent work of the Lesotho Council of NGOs (LCN) which undertook a country wide intensive consultative process on the Post 2015 Agenda. This consultative process was a first and reflects the voices of the people and mirrors the aspirations of Basotho moving beyond 2015.

The MDG Report would not have been possible without the invaluable oversight provided by the Steering Committee: Mr Lerotholi Pheko - Principal Secretary, MDP; Ms Alka Bhatia - Economic Advisor UNDP; Ms Mothweso Lefosa - Director BoS; and Ms Nthoateng Lebona, Director Department of Policy and Strategic Planning, MDP.

FOREWORD

This MDGR 2013 for the Kingdom of Lesotho shows the status of each of the eight MDGs using the latest available data in 2013. It succeeds the 2008 MDGR, for which an update was done in 2009 and an addendum to the report was prepared in March 2010. Data on some of the indicators was updated in 2011 and 2012, which was also utilized in the development of the National Strategic Development Plan (NSDP) 2012-2017. The purpose remains to use the report as a tool for awareness raising, advocacy, alliance building, and renewal of political commitment at the country level. It is also to build national capacity for monitoring and reporting on progress.

As the formal 2015 deadline for the MDGs draws near, the report structure has been adapted to incorporate elements that provide insight into the country status before the deadline 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; trends and inequalities, including differences in rates of change, and the geographic representation of variations in progress. It also highlights the unfinished business of the MDGs and emerging priorities.

Therefore we deliver this MDGR 2013 for the Kingdom of Lesotho with the hope that it provides a basis for policy discussions, peer learning and advocacy, as well as incentive for policy decisions and actions by the Kingdom of Lesotho's Government, development partners and non-Governmental organizations. It also serves as a policy document for promoting strong and coordinated action towards achieving the national development initiatives.

As succinctly relayed by the Secretary General of the United Nations Mr Ban Ki Moon, 'Achieving the MDGs by 2015 is challenging but possible...Let us build on the successes we have achieved so far, and let us not relent until all the MDGs have been attained'.

Signed in Maseru, Lesotho:

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Honourable Minister
Ministry of Development Planning*

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UN Resident Coordinator and
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____ / ____ / 2013

LIST OF ACRONYMS

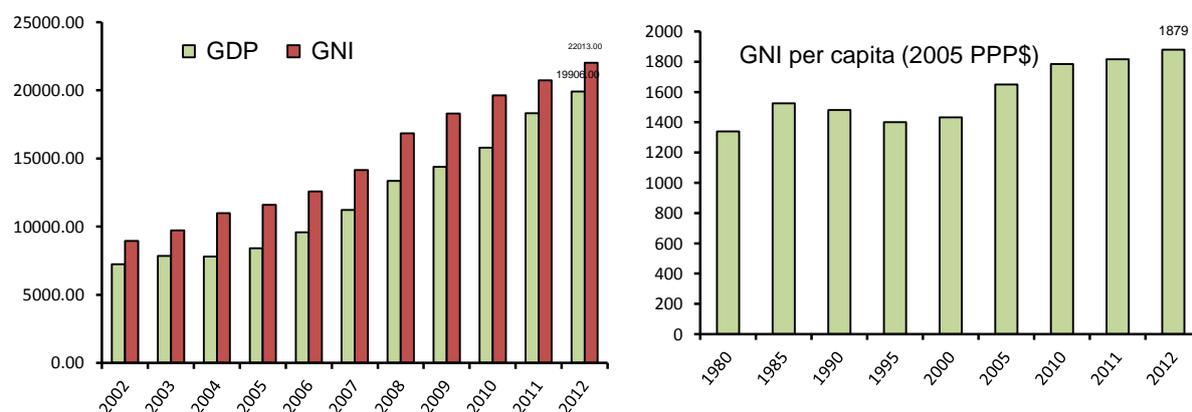
AAP	Africa Adaptation Programme	LMS	Lesotho Meteorological Service
AGOA	African Growth and Opportunity Act	LNDC	Lesotho National Development Corporation
AIDS	Acquired Immune Deficiency Syndrome	LREBRE	Lesotho Renewable Energy Based Rural Electrification Project
AJR	Annual Joint Review of the Health Sector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

KEY DEVELOPMENT INDICATORS

Demographic Indicators

Total population	1.89 million (2011)	Unemployment	25.3% (2009)
Population Growth rate	0.9% (2011)	Poverty Rate	57.3% (2011)
Male population	49%(2011)	Gini Index	0.528 (2011)
Female population	51%(2011)	Labour force participation rate	Males 77.7%(2010)
Literacy rate (15-49)	80.9% (M)		(2009)
	96.9% (F)		
Life expectancy at birth (years)	48.2 (2011)	HDI rank (out of 186)	158 (2013)

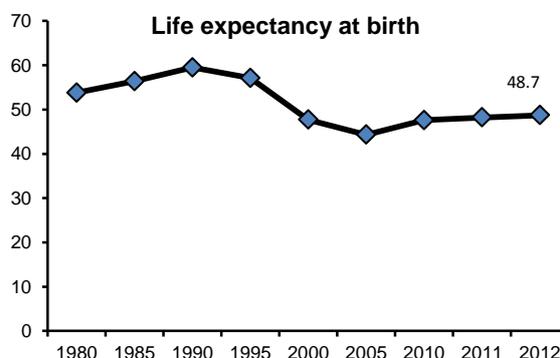
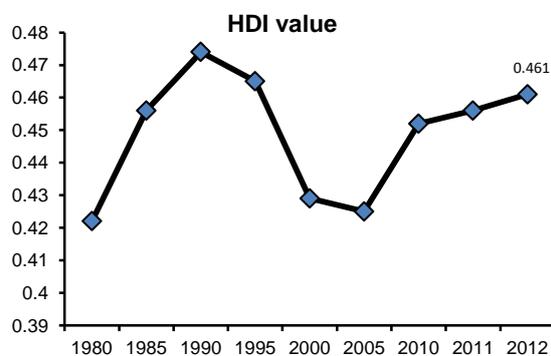
Economic Growth



Key Policy Indicators

Corruption Perceptions Index Transparency International	Rank 77/183 (2011) Score: 3.5/10	Country Policy and Institutional Assessment (CPIA) World Bank	3.44 (2011)
Ease of Doing Business World Bank	Rank 136/189 (2013)	Sovereign credit rating of the country (long-term) Fitch	BB- (2013)
Democracy Index World Economic Forum	Rank 55/166 (2013) Score: 6.33/10	Ibrahim Index of African Governance	9th out of 52 (2013)

Human Development Indicators: Lesotho ranks 158 out of 187 Countries (2013)



LESOTHO'S DEVELOPMENT CONTEXT

The Kingdom of Lesotho is a small (30,355 km²), mountainous country landlocked within South Africa. It is classified among Least Developed Countries with a per capita income of \$1879 (PPP)¹. It ranks 158 out of 186 countries on the UN Human Development ranking, falling into the category of low human development. National poverty figures indicate that 57.3% of the population live below the national poverty line. Income distribution is unequal indicated by a Gini coefficient of 0.53. Due to the devastating impact of the HIV/AIDS pandemic, average life expectancy stands at 48.2 years. Literacy rates are high at 80.9% for men and 96.9% for women in the age group of 15-49 years (women are traditionally more 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 the 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, largely 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 US\$600 by 2010, and is expected to reach an annual GDP growth target of 7% for 2016-20. The economy grew by 5.6% (real GDP) in 2010, but is estimated to have slowed down to 3.1 in 2011 and slightly increased to 4.3% in 2012³.⁴ Excessive dependence on the Southern Africa Customs Union (SACU) receipts, textile imports to the United States and miners' remittances has continued to make the country vulnerable to external shocks and to slow its growth trajectory. Revenues from SACU finance a significant portion of the national budget - 30% in 2011/2012 and 53% in 2012/13. At the same time and overall perspective notes that 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. In 2009/2010 and 2010/2011, the budget deficit was slightly over 6% of GDP. In 2011/2012, the deficit has reached approximately \$300 million USD – 12.3% of the GDP⁵.

A socio-economic perspective on the progress towards the MDGs in 2012 is mixed. Achievements in primary education and gender are strong, with a net enrolment rate of 82% in 2010 and a gender ratio favouring girls. Lesotho is ranked first in Africa and ninth 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. With an HIV prevalence of 23%, Lesotho ranks as the third worst-affected country in the world. 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 involving the Government and all relevant development stakeholders.

¹ World Bank (2012)

² National Census of 2006

³ Central Bank of Lesotho 2012

⁴ World Bank 2012

⁵ Budget speech 2012

EXECUTIVE SUMMARY

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. Consequently, malnutrition is a major challenge with increased prevalence on stunting and underweight children. The country is off-track on this goal.

Lesotho continues to boast one of the highest literacy rates in Sub-Saharan Africa and is one of the highest on primary education. Whilst access to education has improved and many children have enrolled in primary schools, there are pockets of disadvantaged children who are out of school, consisting mainly of herd-boys, learners with disabilities, orphans and other vulnerable children. Enrolment trends show that total enrolments rose until 2003 but started on a steady decline since 2004 mainly due to the high levels of poverty though enrolment in primary education remains above 80%. Dropout rates also pose a significant challenge to country efforts. The country is on-track on this goal.

The society in Lesotho remains patriarchal, with the male as head of the family and in most cases as heir. However, females have progressed intensively in terms of education. In primary education, there are more males than females. The situation becomes different at secondary and tertiary education where there are more females than males making them the more educated. Female participation in formal employment has also increased. In spite of this, women still lag behind in occupying decision making positions and adherence to socio-cultural beliefs and practices still remains a challenge in Lesotho for this goal. Overall, the country is on-track on this goal.

The proportion of children who die before their fifth birthday has remained constantly high. Similarly, infant mortality has been increasing during the same period 2001 to 2009. The major causes of child mortality are pneumonia, malnutrition, diarrhoea, measles and HIV and AIDS. Government efforts Prevention of Mother to Child Transmission (PMTCT), nutrition and treatment of common childhood diseases and immunization against measles are usually hindered by insufficient transportation, inaccessibility of health centres and inadequate skilled personnel. The country is off-track on this goal

Maternal Mortality is one the key challenges in Lesotho, where maternal deaths have been on the rise

since 2001. Most women, especially in the rural areas, die of causes that could be prevented if they had easy access to health services. Though more deliveries have been attended by skilled health personnel, maternal deaths remain high. The Lesotho MDG Accelerated Framework (MAF) has been effected to focus on this MDG since it was the worst performing and yet a priority of the Government. The country is off-track on this goal.

HIV and AIDS have been acknowledged as the foremost constraints to attaining all the other MDGs. Youth prevalence rate has declined slightly yet on the other hand prevalence among adults remains high. The women have a higher infection rate than men, with prevalence in urban areas higher compared to that of rural areas - a prevalence attributed to rural urban migration and transactional sex. There has been a slight improvement with regard to behavioural change by increased condom use and decreased multiple partnerships. The proportion of TB cases that have been successfully treated has increased. Overall the country is off-track on this goal.

Land degradation is an environmental challenge in Lesotho driven by heavy reliance on wood and biomass, poor agricultural practices, and livestock overgrazing. The 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. Overall the country is making slow progress in this goal.

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 multilateral institutions to ease the impact of the global economic crisis. Lesotho has experienced a remarkable growth with teledensity; the success which 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 and 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 still remains a major challenge. Overall, the country is making slow progress on this goal.

REFLECTING ON NATIONAL ENDEAVOURS AROUND THE MDGS

- GOAL 1:** On fighting poverty, easing and providing more access to finance has been viewed as a long-term solution. 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 programme.
- GOAL 2:** The Government has implemented several initiatives to facilitate meeting the target of 100%. Key policies include: the introduction of Free Primary Education (FPE) in 2000; passing of Education Act, 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 material; 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 establishment of learning centres to promote non-formal education for youth and non-enrolled pupils. 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 rights of women, and the Law Reform Commission has worked to repeal or revise all discriminatory laws and policies such as the Companies Act 2011 and other laws concerning economic transactions and property rights. The Sexual Offences Act 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 entrenches 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. Also, 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 the collaborative solutions involving Government and all relevant stakeholders. The framework is designed to address the challenges in the area of maternal health that the country is facing by accelerating the operationalization of 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 completion and launch of 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 have been very beneficial in fortifying efforts by the country to combat HIV and AIDS and their effects.
- GOAL 7:** The completion country enacted the Environment Act of 2008. This is a catalytic law to 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 oversee and 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 in place 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. The country has also increased its efforts to diversify export markets and explore increased South-South trade with China, India, MERCOSUR, and SADC countries. The country has established institutions that have made it easy to improve communication access.

MDGs AT A GLANCE

GOAL	TARGET	INDICATOR	BASELINE	CURRENT	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	66.61 %	57.3%	Off Track
		Unemployment Rate	28.7%	25.3%	Off Track
	Halve the proportion of people who suffer from hunger	Proportion of people vulnerable to food insecurity	29%	39%	Off Track
		Prevalence of underweight children under 5	15.8%	13.2%	Slow Progress
Achieve Universal Primary Education	Ensure that all children are able to complete primary education	Net Enrolment Rate	82%	82.1%	On Track
		Proportion of pupils who reach last grade of primary school	61.2%	65.5%	Slow Progress
		Literacy rate among 15-24 year olds	M: 82.5 F: 96.1	87.4% (M) 98.2% (F)	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	100	On Track
		Secondary education (girls/100 boys)	128	133	Off Track
		Tertiary education (girls/100 boys)	118	146	Slow Progress
		Proportion of seats held by women in the National Assembly	10.6%	25%	Slow Progress
		Share of women in non-agricultural wage employment	34.4%	56.1%	On Track
Reduce Child Mortality	Reduce by two-thirds the under-five mortality rate	Under-five mortality rate (per 1000 live births)	113	117	Off Track
		Infant mortality rate (per 1000 live births)	81	91	Off Track
		Proportion of 1 year olds immunized for measles	71.3%	60%	Slow Progress
Improve Maternal health	Reduce by three-quarters the maternal mortality ratio	Maternal Mortality Rate (per 100,000)	370	1,155	Off Track
		Proportion of births attended by skilled health personnel	60	61.7%	Slow Progress
		Antenatal care coverage (at least 1 visit)	85.2	92%	On Track
		Contraceptive Prevalence Rate among married women (15-49)	36.1	45.6%	Slow Progress
		Unmet need for family planning	30.9	23%	Slow Progress
Combat HIV/AIDS and TB	Halt and begin to reverse spread of HIV/AIDS	Prevalence among adults (15-49)	0.8%	23%	Slow Progress
		Prevalence among youth (15-24)	11.3%	9.3%	Slow Progress
		Condom use at last high-risk sex among adults	M: 48.6 F: 41.9	50.5% (M) 38.5% (F)	Slow Progress
		Proportion of adults who have ever been tested and received results	M: 9.1 F: 12.0	38.5% (M) 65.6% (F)	Slow Progress
		Youth with comprehensive correct knowledge of HIV/AIDS	M: 18.4 F: 25.8	28.7% (M) 38.6% (F)	Slow Progress
		Adult Antiretroviral Coverage Rate	16%	59%	Slow Progress
		ARV Coverage among children (under 15)	22%	24%	Slow Progress
	Halt and begin to reverse incidence of TB	Mother to Child Transmission Rate	6%	8.8%	Slow Progress
		Incidence of TB per 100,000	-	633	Slow Progress
		Prevalence of TB per 100,000	249	402	Slow Progress
Ensure Environmental Sustainability	Halve the proportion of people without access to safe drinking water and basic sanitation	Population without access to safe drinking water	19.4%	21.6%	Slow Progress
		Population without access to basic sanitation	76%	35.6%	Slow Progress
	Reverse loss of environmental resources	Proportion of Arable land	10.1%	9.6%	No Target
		Proportion of land covered by forest	1.30%	4.6%	No Target
		Proportion of Energy Needs met using biomass	66%	57%	Off Track
Develop a Global Partnership for Development	Develop further an environment conducive for beneficial trade and investment	ODA as a proportion of Lesotho GNI	-	10%	No Target
		ODA per capita (current USD)	-	\$136	No Target
		Proportion of ODA that is untied	-	96%	No Target
		Proportion of ODA allocated to social services	60.4%	91.1%	No Target
		Share of Exports in GDP	-	36.6%	No Target
	Make available the benefit of new technology in cooperation with the private sector	Mobile lines per 100	0.35	69.6	On Track
		Internet users per 100	0.22	4.45	Slow Progress
	Average availability of essential medicines at all hospitals	74%	68.6%	Slow progress	



1. Eradicate Extreme Poverty and Hunger

TARGETS

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

b) Achieve full and productive employment for all

Indicators

1.4: Unemployment rate

1.5: Proportion of vulnerable employment in total employment

c) Reduce by half the proportion of people suffering 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

Overview

Over 57.3% of the Kingdom of Lesotho's population lives below the national poverty line of M246.6/person/month⁶. The GINI inequality index increased by 1.4 percentage points between 2002–3 and 2010–11 with further investigation revealing that the most effect occurred in the richer segment of the population. The poverty gap index stands at 29.5. An estimated 38.7% (some 725,000 people) faced food shortages in 2012/13 due to declined agricultural production, which was caused by the 2011/12 droughts and inflationary pressures on food products. Chronic food insecurity is evident in the high rates of underweight and stunted children as well as the food assistance demands. Furthermore, job losses in the textiles sector impacted women employment adversely, and there is a continuing decline in the number of Basotho miners working in RSA. Unemployment has persistently hovered around 25% during the past decade. Finally, the HIV pandemic has exacerbated the situation, as it primarily affects the productive age group, creates vulnerable populations and magnifies the poverty trap. Table 1.1 below depicts the information.

TABLE 1.1: MDG 1 Snapshot

Indicator	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	37.85 (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 below the national poverty line	66.61 (1995)	57.3 (2011)	29%
GINI Index	57 (1995)	53.8 (2011)	N/A

Trend Analysis

Indicator 1.1: Proportion of people below national poverty line

TABLE 1.2: Poverty Trends in Lesotho

	1994/1995	2002/2003	2010/11	2015 (Target)
Very Poor Households	37.8%	29.1%	34.1%	19%
Poor Households	66.61%	56.61%	57.1%	29%
Food Poverty Line (Maloti per month)	M42.92	M84.41	M137	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

⁶ Lesotho Household Budget Survey Report - 2011

⁷ Lesotho Valnerable Assessment Committee (Food Security Monitoring Report 2012)

Poverty and severe poverty are increasing thus showing a worsening economic status for most Basotho⁸. Lesotho is off track on these indicators as shown by Fig. 1.1 and Fig 1.2 below. The percentage of very poor households has increased from 29.1% in 2003 to 34.1% in 2011, while the percentage of poor households increased from 56.61% in 2003 to the current 57.3%. Other complementary indicators like unemployment rate, agricultural productivity, and malnutrition also reveal that there is persistently high poverty situation in Lesotho.

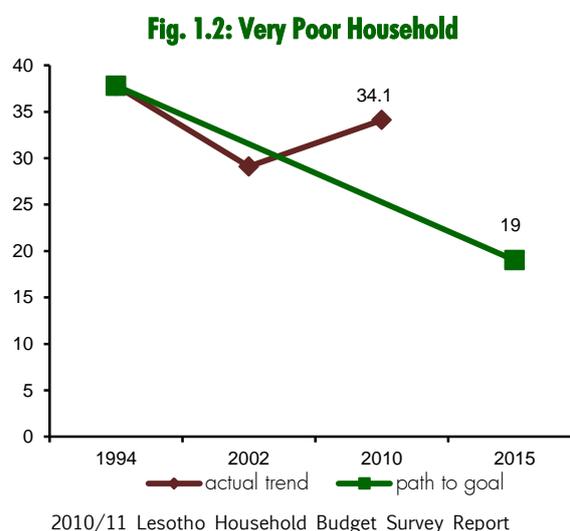
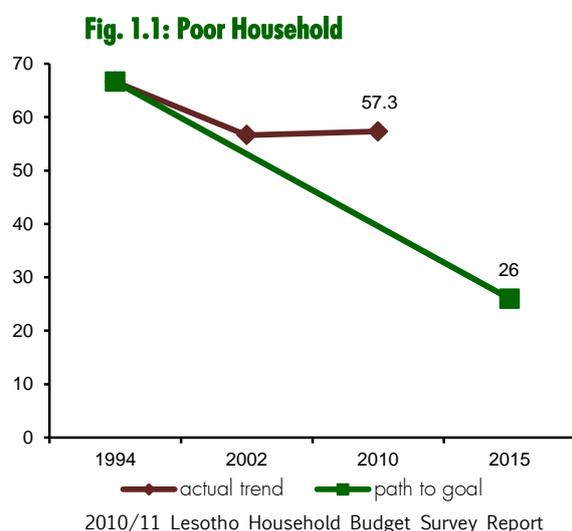


TABLE 1.3: Composition of FGT Family of Indices by Geography

	Poverty Headcount Rate	Income Gap Ratio	Poverty Gap	GE(2)	Squared Poverty Gap
<i>Poverty line = 246.6</i>					
<i>2002/03</i>					
Urban	39.0	45.0	17.5	10.9	10.5
Rural	60.9	52.0	31.7	15.1	20.7
Total	56.6	51.0	28.9	14.5	18.7
<i>2010/11</i>					
Urban	39.6	45.2	17.9	11.3	10.8
Rural	61.2	52.6	32.2	15.2	21.1
Total	57.3	51.6	29.5	14.7	19.2
<i>Change</i>					
Urban	0.6	0.3	0.4	0.4	0.3
Rural	0.2	0.6	0.5	0.1	0.4
Total	0.7	0.6	0.6	0.2	0.5

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

⁸ Poverty in Lesotho is measured primarily through periodic Household Budget Survey (HBS) – the most recent 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), and households whose incomes fall below this line (34.1%) are considered very poor.

From table 1.3 above, the incidence of poverty has increased by 0.7 from 56.6% in 2002/03 to 57.3%. Poverty head-count rate is higher in rural areas than in urban areas. This is attributed to low agricultural sector performance, which is the main source of income in rural areas. The head-count ratio does not show by how far below the poverty line poor households are. The poverty gap has been used to measure the required annual income transfer to all poor households to bring them out of poverty. It captures the average expenditure shortfall, or gap for the poor in a given area to reach the poverty line. The results in this analysis suggest that in 2002 the poverty gap for rural population was 31.7%; implying that, on average, every poor person would require additional 31.7% income per month to reach the poverty line. The squared poverty gap index was found to be high in both rural and urban areas in 2002/03 and 2010/11. However, in rural areas it is more than double that of urban areas.

Indicator 1.2: Poverty Gap Index

Poverty gap index increased by 0.6% between 2003 and 2011. In other words, the income of all poor persons is on average, 29.5% in 2011 below the poverty line as compared to 28.9% in 2003. Furthermore, poverty gap is high in rural areas than in urban areas.

That notwithstanding, the poverty gap does not show inequality among the poor people, i.e. the fact that some people might be a few Maloti short of the poverty line while others might only have a few Maloti to spend. The Gini coefficient is a measure that captures this range in people's expenditures/incomes

Indicator 1.3: GINI coefficient

The most commonly used method for measuring 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 is high. It has increased from 0.514 in 2002/3 to 0.528 in 2010/11. Table 1.4 below shows trends in inequality using different measures of the Gini coefficient. To understand the inequality trend better, generalized entropy (GE) is calculated. The GE can highlight changes in inequality for different levels of consumption expenditures. GE(0) focuses more on inequality among the low-income group, GE(1) focuses on the middle-income level, and GE(2) focuses more on inequality among the wealthy. Table 1.4 shows that inequality increased between the two rounds, but more so in the richer segment of the population.

TABLE 1.4: Trends in Inequality Using Different Measures of the Gini Coefficient

	Gini	GE(0)	GE(1)	GE(2)
2002-3^a	0.514	0.507	0.490	0.853
2010-11	0.528	0.523	0.535	1.065
Ratio	1.03	1.03	1.09	1.25
<i>a. All inequality measures for 2002-3 are calculated after dropping the largest two household expenditures per adult equivalence to make the inequality measures comparable between 2002-3 and 2010-11.</i>				

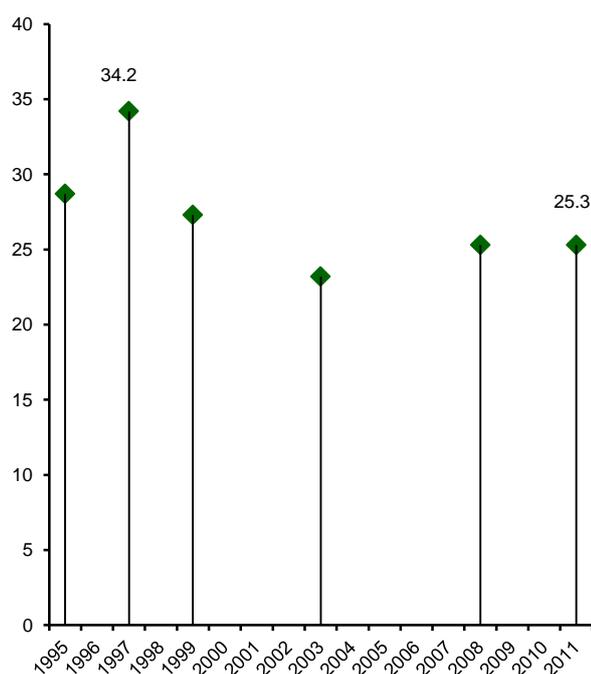
Source: HBS 2002/03 and CMS/HBS 2010/11.

Indicator 1.4: Unemployment Rate⁹

Figure 1.3, below, shows that unemployment rate has declined in the past decade from 34% in 1997 to around 25%. However, no reliable and comprehensive integrated labour force survey has been conducted since the global financial crisis, and, thus, it is unclear how the economic downturn has specifically impacted employment.

⁹ The unemployed comprise all people aged 20 and above who are: (a) without work, (b) currently available for work and (c) seeking work. It does not include the economically inactive population such as students. In other words, the unemployed are those individuals in the labor force without work, and the unemployment rate is calculated by dividing the number of unemployed by the population in the labor force.

Fig 1.3: Unemployment rate



Source: HBS 2003 and 1995, Census 2006, ILFS2008

Variations in Unemployment

Table 1.5, below, presents the percentage distribution of unemployed population by age, sex and urban/rural residence. According to the results, the proportion of unemployed population was 29.8 and 23.2 percent in age-groups 20-24 and 25-29 years respectively. In age-group 20-24 years the proportion of unemployed population was 32.7 percent for females and 28.2 percent for males. In rural areas, the population aged 20-24 years constituting 28.1 percent of males and 31.4 percent for females were unemployed, as compared to 28.5 percent of males and 35.9 percent of females in urban areas. The proportion of unemployed population is high among the youth across the country. The age distribution also reveals that in urban areas, there were females aged 10-14 years that were recorded as job seekers (1.1 percent) and this raises an alarm because these children are expected to be in school since the free education policy had been introduced.

TABLE 1.5: Percentage Distribution of Unemployed Population by Age, Sex and Urban-Rural Residence, 2011 LDS

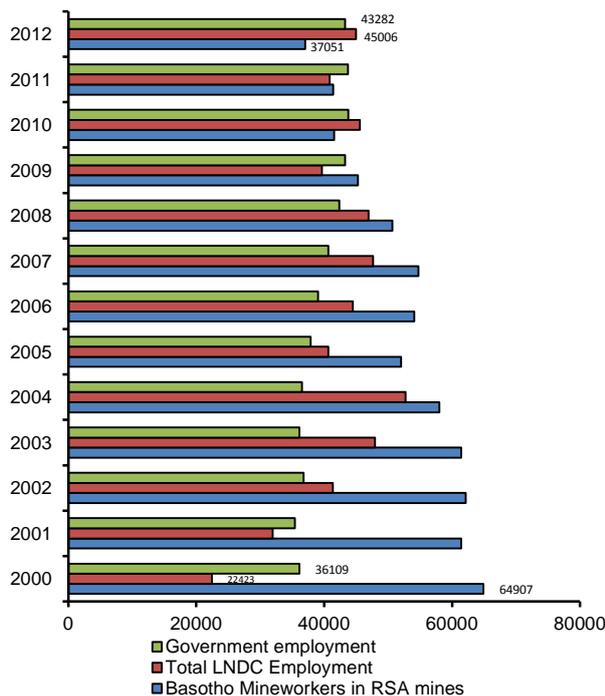
Age	Lesotho			Urban			Rural		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
10-14	0.7	0.5	1.1	0.6	0.0	1.4	0.7	0.7	0.9
15 - 19	9.5	7.6	12.9	7.0	5.9	8.5	10.3	8.1	14.8
20 - 24	29.8	28.2	32.7	31.7	28.5	35.9	29.2	28.1	31.4
25 - 29	23.2	23.0	23.4	22.7	21.8	24.0	23.3	23.4	23.2
30 - 34	15.4	17.1	12.4	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)

As alluded to, above, youth unemployment is a major problem in Lesotho. Many youth enter the job market lacking the requisite level of skills and education demanded by most employers, and, even if they do find jobs, they are usually restricted to work in the informal sector or subsistence agriculture. Moreover, those better-educated youth are often drawn to jobs in more favourable markets, such as RSA, creating a 'brain drain' phenomenon. Finally, youth have less work experience, less knowledge about how/where to search for work, and fewer contacts, and they are subject to the 'last hired, first fired' principle in economic recessions.¹⁰

¹⁰ Setsabi, Setsabi, Lesotho Youth and Development Concept Paper, 2012.

Fig 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 37051. This was a tremendous shift given the numbers have been continuously decreasing from approximately 120,000 in the 1980s. The trend of employment in the sector depends upon factors such as 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 it has been propagated by deliberate measures by South Africa to substitute local for foreign mine workers.

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

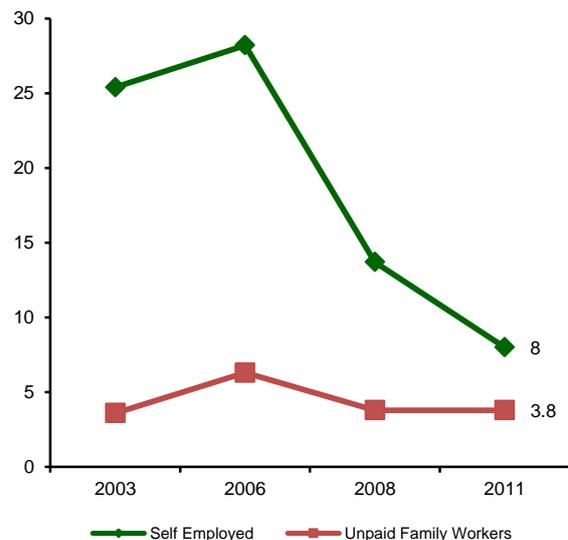
Lastly, the public sector employment declined the least by 1.05% to 43,282 in 2012 from 43,742 employees at the end of December

2011. The fall is mainly attributable to a decrease of 3.7% in the number of daily paid workers, 0.8% teachers and 0.6% in the number of civil servants in line with the Government's fiscal consolidation efforts.

Indicator 1.5: Proportion of Vulnerable Employment in total Employment

Vulnerable workers comprise of unpaid family workers and the self-employed. More specifically, self-employed workers who have no employees and their income is vulnerable and directly dependent on the profits from the goods/services they produce. These workers are considered 'vulnerable' because their employment is often not formal or secure, and their income, productivity and working conditions are more likely to be poor and unstable.

Fig. 1.4: Vulnerable Employment in Lesotho



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

As reflected in Figure 1.4 above, the proportion of self-employed workers in total employment 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

survey appears to exclude them. On the other hand, the proportion of unpaid family workers in total employment has consistently hovered around 5%. Accordingly the proportion of vulnerable employment 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 areas (census 2006) and between 75% and 80% of these rural dwellers depend on agriculture for their livelihoods. Half of all employed men (age 15-49) and 21% of women (aged 15-49) depend on agriculture for their livelihoods. Farming is particularly dominant in the rural areas where most of the population resides – 65% of men in rural areas and 76% in the highlands rely on agriculture.¹¹ Land degradation and climate change – particularly persistent drought, flooding, and early frost – have caused low agricultural productivity in recent years. Lesotho imports over 70% of its annual cereal requirement (99% of commercial cereal) mostly from RSA.¹² Moreover, HIV and AIDS, extreme poverty, unemployment, and inflation exacerbate the problem of food insecurity. Overall, food insecurity and malnourishment are increasing, and Lesotho is off-track in reducing hunger.

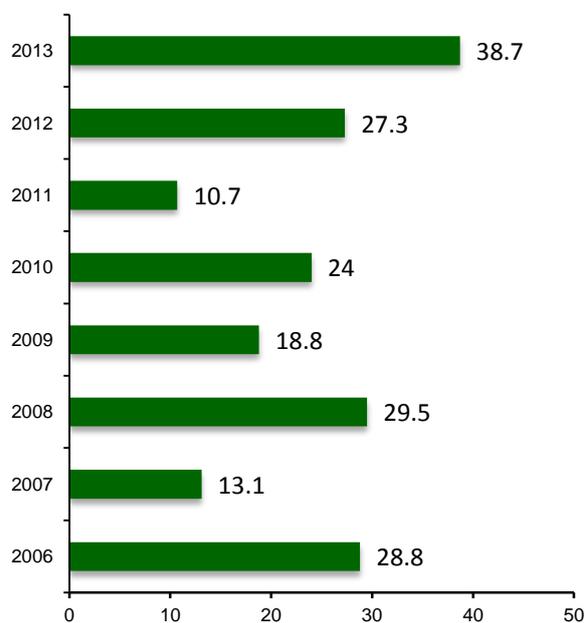
Indicator 1.6: Proportion of population that is food insecure

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 has reliable data for measuring this indicator. Households requiring assistance include those that will not be able to afford the minimum level of food to meet nutrition requirements after accounting for 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.¹³

The 2009/10 season saw bumper harvests, and food insecurity declined substantially to 10.6%. 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. Again, in 2011, drought plagued the planting season (Aug-Oct), and many farmers planted late or not at all. In the lowlands up to 60% of fields were left fallow.¹⁴ The area planted to crops declined from 238,524 ha in 2010 to 144,278 ha in 2011.¹⁵ Thus, 2012 LVAC report estimated that 38.7% of the population – 726,000 people – required food assistance in 2012/2013.

Fig. 1.5: Proportion of Population Requiring Food Assistance



Source: Lesotho Vulnerable Assessment (LVAC) Reports

Indicator 1.7: Proportion of Underweight

¹³Agricultural Situation Report 2009-2010.; USAID FFP-OFDA Food Security Assessment, 2012; LVAC Report

¹⁴USAID FFP-OFDA Food Security Assessment, 2012

¹⁵MAFS/BoS, Lesotho Crop Forecasting Report 2011-2012

¹¹LDHS 2009.

¹²NSDP; USAID FFP-OFDA Food Security Assessment, 2012

The statistics from Lesotho Demographic and Health Surveys shows that percentage of underweight children¹⁶ has declined from nearly 19.8% in 2004 to 13.2 % in 2009 and Lesotho is making slow progress on this indicator. The slight decrease in underweight children can be attributed to the implementation of short and long term food security and nutrition intervention programmes such as encouraging home garden food production, home-based income generating activities and food aid.

Indicator 1.8: Stunted Children Under-Five

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 the proper nutrition over a long period of time.

Prevalence of stunting is one of the most long-term problems in Lesotho. It has increased over the past two decades from 33% in 1992 to 39.2% in 2009, which suggests food security at the household level has slowly deteriorated.¹⁷ Despite efforts made to address the problem, stunting remains one of the bigger challenges facing children hence this indicator is off-track.

Table 1.6 disaggregates child malnutrition rates by region, education, and income. Being underweight or stunted is evidently associated with mother's education level and wealth quintile. Mothers who have at least a secondary education or who fall within the top two wealth quintiles are especially less likely to have malnourished children.

¹⁶ 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.

¹⁷ MAFS/BoS, Lesotho Agricultural Situation Report 2009-2010; 2011 CHS.

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

TABLE 1.8: Underweight and Stunting Prevalence 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/AIDS affects the nutrition, livelihoods, and the viability of institutions in many ways. The epidemic is concentrated on the productive age group, often the breadwinners. It commonly undermines the ability of individuals to feed and care of themselves, while eroding the capacity of communities and institutions to provide basic services to people in need. In Lesotho the extended family system, which has traditionally been the main social safety net is quickly diminishing, leaving the poor and vulnerable to die of destitution. The pandemic directly affects children who are 0 – 17 years old and have lost one or both parents. The 2006 Census indicates there are 221,000 orphans in Lesotho. They often undertake responsibility of caring for siblings, grandparents, and other relatives. The loss of parents sometimes leads to these children

assuming headship responsibility, and sometimes they become heads of household. Moreover, the number of female-headed households has increased to over 36% in 2009¹⁸.

Bottlenecks, Challenges, and Constraints

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

- Environmental degradation and climate change (MDG 7) are 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 linkages with 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.¹⁹ Moreover, textile producers' success is highly contingent on U.S. demand and the continuation of trade preferences under AGOA.

Policy and Planning

- **Poor Investment Climate.** Lesotho ranks 136 out of 189 countries in 2012 on the World Bank 'Ease of Doing Business' ranking. 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 absence of food safety and quality regulations. These standards are still in draft form apart from the 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, poor 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 poor 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.²⁰ Declining remittances have offset GDP growth and, thus, poverty has remained rife.
- **Vulnerable Populations.** Currently, women head 36% of all households.²¹ Female-headed households have a higher incidence of poverty. Moreover, they are less likely to own assets – particularly productive assets and face more difficulty

¹⁸ LDHS, 2009

¹⁹ BoS, Statistical Yearbook 2010

²⁰ NSDP.

²¹ LDHS 2009

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 proper 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, for example, and even educated 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 accumulating 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. Thus, arable land in Lesotho is extremely limited and declining. Lesotho has lost nearly 82, 00 hectares of arable land in the past decade and currently only 9-10% of total land area is arable.

- **Poor Agricultural Practices.** About 90% of all farmers are subsistence farmers who own less than 1 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 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. Moreover, it results in the loss of a crucial assets and source of income for rural households and makes farmers reluctant to invest in more stock.
- **Low inputs.** There is low usage of improved inputs and technology especially in rural areas. Moreover, these inputs are much more costly in Lesotho than RSA and their use would raise costs for local smallholder farmers and make them even less competitive against higher quality, cheaper agricultural imports from RSA.
- **Insufficient institutional support.** Extensions services for farmers in the districts are very poor. Many extension agents have limited capacity and work in isolated areas with poor access. Additionally, infrastructure and market information systems are very poor 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 grain. Thus, farmers who do want to sell surplus 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 sub-sector that plays an important role in supporting rural livelihoods is livestock production. Cattle, goats, and sheep are very important assets, and wool and Mohair are Lesotho's dominant agricultural exports, bringing foreign

earnings for the country and much needed income for rural communities. However, livestock productivity is low due to poor animal health, low conception, 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 Bottlenecks, Challenges, and Constraints

Financing

- **School Feeding Programmes.** Primary school feeding programmes are a particularly important intervention for improving nutritional status of vulnerable groups. GOL was expected to fully take over the programme from WFP at the end of 2010. However inadequate funding delayed this transition. Currently, GOL provides meals in two-thirds of the schools, while WFP provides the rest.
- **Inadequate Nutrition Funding.** Financing of nutrition programmes is skewed to donor support, with less funding from GOL. Currently, nutrition programmes in the key ministries are marginalized because of inadequate Government resources.
- **Inadequate budgetary allocations.** Reduced allocation of funds on some Government programmes/projects has made it difficult for affected ministries/sectors to implement such programmes/projects hence this impacts negatively towards achievement of development objectives of affected ministries/sectors

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 yet these have not been fully

operationalized due to lack of trained nutrition personnel and poor collaboration among key stakeholders such as National Aids Commission (NAC), Food and Nutrition Coordinating Office (FNCO) and HIV/AIDS units in MOH, Ministry of Agriculture and Food Security (MAFS) and NGOs. The HIV epidemic has attracted many resources yet the nutrition component has not been allocated sufficient resources.

Structural Problems

- **Rising Commodity Prices.** Lesotho is highly vulnerable to external commodity price fluctuations, as 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, and 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 with dry land quickly erode and wash away the soil. Indeed, climate change could shrink arable land coverage to as little as 3%.²²

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

²² European Commission, Country Environmental Profile, July 2012, 35.

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 – 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, consumption, and scale of vegetables – inducing 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 feeding programme, public assistance grants, Child Grants, and OVC bursaries. The programs are currently not well-targeted to those most in need, and there is no integrated framework for providing

these social supports, leading to duplication and inefficiencies.

- Explore the possibility of a Conditional Cash Transfer Program to improve the targeting of the social safety net, provide short-term poverty relief, and reduce long-term, intergenerational poverty by increasing the ability of the programs to advance human capital development of 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/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, transportation.
- Strengthen SACU partnerships, particularly focusing 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 high school levels
- Mobilize and target 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 youths 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.*
- *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 for children*
- *Implementation of nutrition component of the United Nations Trust Fund for Human Security programme*

Key contributing factors

- *Support to Financial Inclusion in Lesotho to improve and expand access to sustainable financial services in urban and rural areas*



2. Achieve Universal Free Primary Education

TARGET

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 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 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 reach a peak at 85% in 2003. Table 2.1, below, illustrates. Since 2004 however, enrolments started to decline and have been falling steadily since then. To curb this problem, in 2010 the Government passed the Education Act of 2010, making primary education not only free, but also compulsory. This notwithstanding, net enrolment rates continued to decline gradually from 81.8% in 2010 to reach the current 82.6%.

TABLE 2.1: Education Trends

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	M: 87.4 F: 98.2 (2009)	100
Slow Progress					
Percentage of pupils starting grade 1 who reach last grade of primary (%)	N/a	61.2 (2005)	62.8	65.5	100
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

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%. The downward 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% for males and 98.2% for females - so is **on track to attain this MDG indicator.**

Net Cohort Survival Rate (NCRS) at primary level has also improved significantly over this period. 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, through repeating 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. Even during the recent global economic crisis, when resources were limited, and when Governments changed in 2012 this high level of budget allocation was sustained. Nevertheless, the progress is too slow and unless the Education Act, 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.**

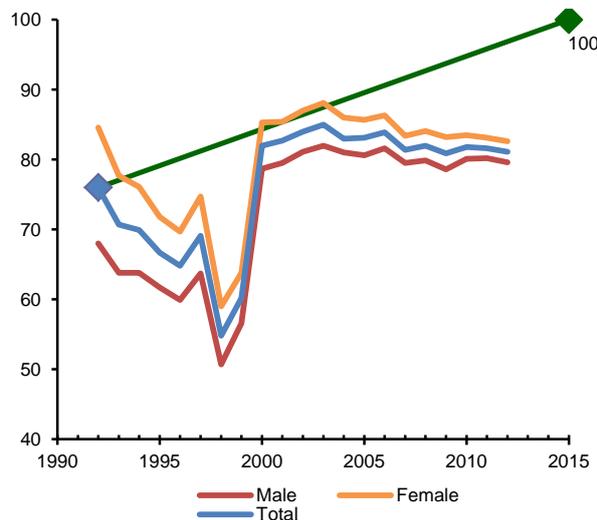
Trend Analysis

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%. Key policies include: the introduction of Free Primary Education (FPE) in 2000; passing of Education Act 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 material; 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 establishment of learning centres to promote non-formal education for youth and non-enrolled pupils.

Fig. 2.1: Net Enrolment Ratio in Primary Education



Source: MOET, Education Statistics Bulletins 2001, 2012

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. Enrolments continued to increase till they reached a peak at 429,794 in 2003 with NER registering 85%. However, from 2004 they started to decline steadily down to 381,690 in 2012, accompanied by a fall in NER to 81.1% in 2012 as illustrated by Fig. 2.1 above.

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.²³ Japan has been one of the major donors in 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 Programme (WFP) covers the remaining one-third.²⁴ 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.²⁵ Moreover, school feeding is proven to contribute to positive behavioural patterns such as increased attentiveness and learning ability.²⁶ 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

²³ MOET; Education Statistics Report, 2010

²⁴ UN WFP Lesotho, Facts and Figures of Lesotho, 2012

²⁵ WFP Lesotho, 2007

²⁶ WFP Lesotho, 2003

search of a means of survival.²⁷ Physical access to schools in the mountain areas, where average walking times 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.²⁸

Completion of Primary Education

Indicator: 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 the rate has been fluctuating thereafter, as there was a decline of 1.6% in 2010, it 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 drop-out 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 1-3.²⁹ 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 boys,³⁰ due to traditional practices of herd-boys and initiation schools. Figure 2.2, below, illustrates the trends in the NCSR against the set target of 100% by 2015.

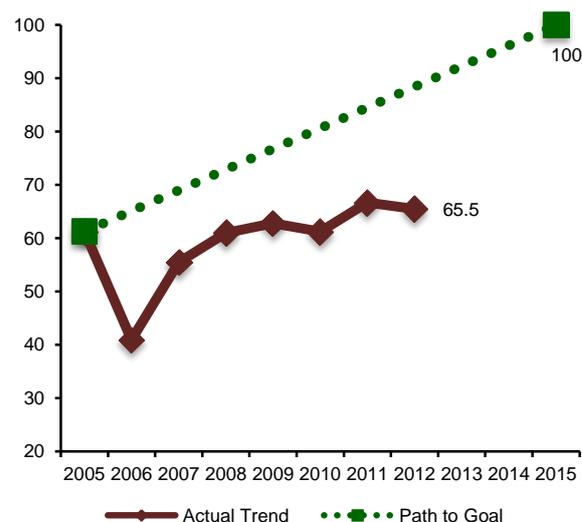
²⁷World Food Program, 2008

²⁸LDHS, 2009

²⁹MOET, Education Statistic Report, 2012

³⁰Ibid

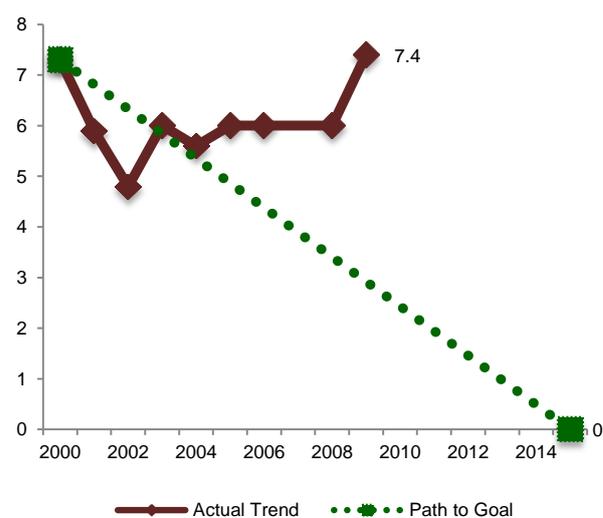
Fig. 2.2: Proportion of Students who reach Grade 7



Sources: MOET, Education Statistics Bulletin 2012

After the Government introduced FPE, many older 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, the fluctuation and generally lower average level in completion rates. Figure 2.3 illustrates.

Fig. 2.3: Dropout Out 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 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 changed since 2005. The 2012 results, portrayed sex 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 the 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: 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 6843, compared with 8878 in 2012, showing an increase of 23%. Out of 8878 non-formal education learners in 2012, 7889 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 male population. For example, in 2012, 6542 (74%) learners were males and 2336 (26%) were females. The districts 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 students³¹. To aid the process of learning, 10749 books were distributed across all levels of education in the 362 learning posts country-wide. **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 a high average of 65% in 2008, against an acceptable standard of 40%. It gradually improved over the years

³¹ MOET, Education Statistics Report, 2012

and stood at 50% in 2012. The percentage of unqualified teachers is particularly high in Mohale's Hoek, Quthing, Qacha's Nek, and Thaba-Tseka³², 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, 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. 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, 2010 provides that those who would 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: 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.

³²ibid

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 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 Botswana³³.

³³World 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 pay – accounting 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.³⁴ The rapid investment in the education sector, to recruit qualified teachers, build schools, provide for FPE, etc. 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.

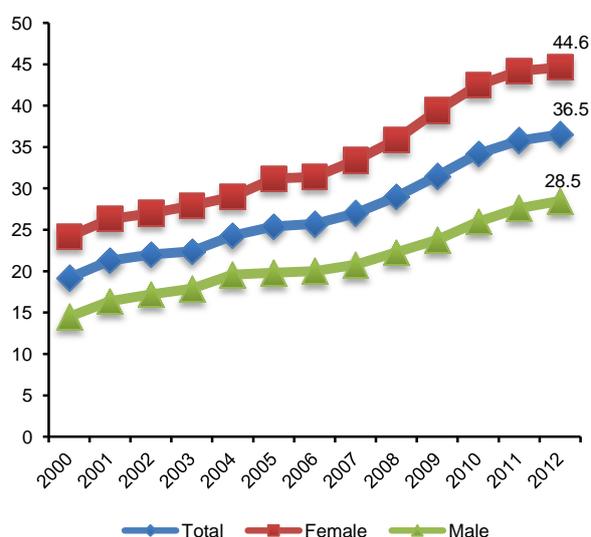
Secondary Education

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 have 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.

Fig. 2.4: Net Enrolment Rates, Secondary School



Source: MOET, Education Statistics Bulletin 2012

Unlike primary schooling, secondary education is not free in Lesotho, which explains the inconsistency between primary and secondary school enrolment. Thus, the

³⁴Ibid

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 quintile³⁵

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

	Lowest	Second	Third	Fourth	Highest
Net Enrolment 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 is therefore investing in construction of science laboratories, but is limited by financial resources towards capital projects. Lesotho is also localizing the curriculum for relevance.

Tertiary Education

Tertiary education has been effectively free due to the fact that there was no effective loan recovery mechanism. However, this is expected to change as the Government has put in place a Student Scholarship Management and Administration System (SSMAS) and is going to implement a mean-testing mechanism for bursary and loan beneficiaries. Lesotho allocates 36.4% of education expenditures to tertiary level, compared to 36% for secondary and only 20.5% for primary education.³⁶ Not only is this policy fiscally unsustainable, but it also makes education expenditure highly regressive. 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.**

³⁵LDHS, 2009

³⁶ World Bank, Lesotho Public Expenditure Review, August 2012.

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.³⁷ 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, Challenges and Constraints

Policy and Planning Framework

- Although 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, quality is adversely affected as existing resources were overstretched by the influx of learners into schools.
- Though Government has adopted inclusive education policy, revised classrooms and latrines designs to cater for learners with disabilities and since 2011/12 constructed school infrastructure is disability friendly, enrolment of learners with special education needs remain 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

³⁷ World Bank, Lesotho: Sharing Growth by Reducing Inequality and Vulnerability: Choices for Change, 2010.

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 impacts the quality of education students receive, test scores and repetition rates. This is particularly so in the mountain 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, limits 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 a 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 aspect 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 started to decline gradually. The Government in turn passed the Education Act, 2010, making education not only free but also compulsory; but the Act was not enforced so 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 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 levels.

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

- Lure 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, 2010 to improve quality of education.
- Scale up attachment of reception classes to primary schools, support other forms of early childhood education such as home and community based pre-schooling, and register pre-schools to reduce high repetition rates for students in early grades and improve learning outcomes at primary level.
- 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 education for their children share the cost. 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 students outside the country and in unregistered schools for a full picture of education issues in Lesotho.
 - Collaborate with other stakeholders to enforce the Education Act 2010 and the Child Protection and Welfare Act 2011 so as to bring disadvantaged children (herd-boys, children with disabilities and orphans) to school.

Key Factors Contributing to Meeting the Target

- 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 Education for All. This will in turn improve progress made towards MDG 2.
- 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.
- Backing up free primary education with School feeding programme has attracted children from poor households to school.



3. Promote gender equality and empower women

TARGET: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015

Indicators

3.1: Ratio 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 Parliament

Overview

Gender equality is the measure of equal representation and participation of women and men in politics and decision-making positions. It means that procedures and processes that led to the occupation of these positions should be cognisant of the presence of these key groups as well as the gender issues that may impact their representation and participation.³⁸ United Nations regards gender equality as a human right. The nations which empower women move towards development advancement and poverty reduction. It also means that there should be equal pay for the same job.³⁹

Lesotho is performing well in its efforts to bridge the gender gap. In 2011 the World Economic Forum's gender equality ratings ranked Lesotho 9th in the world, just behind Denmark and the Philippines. It is one of the few countries in Sub-Saharan Africa ensuring equal access to education for females, as indicated by a consistently higher ratio of girls to boys at all levels. 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 and 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 empowerment.

Women's participation in formal employment and governance has also increased. In 2008 women's share in wage employment in the non-agricultural sector was 42.5%. This figure has since increased to 56%, surpassing the 2015 target. Women now hold a quarter of the seats in the Lesotho parliament. Thus, Lesotho is firmly on-track for these two indicators. According to the Continuous Multi-purpose Survey (CMS) the women share in wage employment in the non-agricultural sector was 54.4% in 2011 as compared to 56.1% in 2012, meaning that it is on track⁴⁰. The country strives to promote equal opportunities for women, men, girls and boys, so that development efforts may exert positive impact on all.

TABLE 3.1 Gender Equality Trends

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

³⁸ <http://www.unfpa.org/gender/>

³⁹ International Planned Parenthood Federation Report, 2012

⁴⁰ CMS 2011

Trend Analysis

Gender Equity in Education

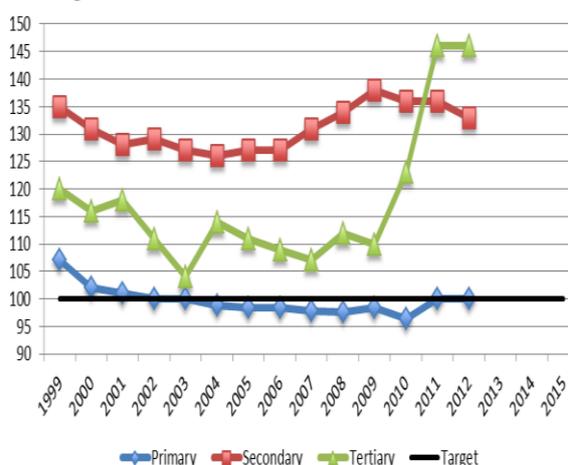
Indicator 3.1: Ratio of boys to girls in primary, secondary, and tertiary education

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 that is, more girls than boys enrolled in primary school. In the year 2004, the situation changed until the year 2011 when results show more girls than boys enrolling in primary school. However, the situation is different in secondary school, where more females still enrol compared to males and this inequality experienced at secondary school level remains a concern for the country.

The Free Primary Education (FPE) Policy passed in 2000 mandates equal access for boys and girls, 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.⁴¹ Moreover, as seen in Figure 3.1, the female-male ratio has on average remained balanced, over the past decade, ranging from 102 to 96.4.⁴² However, trends are very different for secondary and tertiary education. The girl-boy ratio in secondary school initially fell from 149/100 in 1990 to a low of 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.⁴³ The impact of this pattern is evident in long-term literacy and educational outcomes, whereby, 97% of women (age 15-49) are literate compared to only 80% of men.⁴⁴ Moreover, 52% of women have a secondary or higher education, while only 40% of males have achieved that distinction.⁴⁵

Fig. 3.1: Female-Male School Enrolment Ratios



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

It has been discovered that males have had lower educational outcomes for several reasons namely: 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. Also, in recent years, high HIV and AIDS related deaths have often forced adolescent boys to become heads of household as they 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 is still off-track for equitable access to secondary and higher education.**

⁴¹BoS, Education Statistics Report, 2001,

⁴²BoS, Education Statistics Reports 2003, 2003-2007, 2009, 2010, 2011, 2012 and GoL, Education Statistics Bulletin, 2010.

⁴³Ibid.

⁴⁴LDHS: 2009.

⁴⁵ Education Management Information System (EMIS) Results 1999 to 2012

At primary level the target was to get males at par with their female counterparts and that has been achieved. Presently, statistics reflect 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 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 and this implies a gender inequality that needs to be addressed. One reason that is stated in the EMIS is that males struggle to progress to the secondary level. Likewise, in tertiary level, according to the Education Report (2012) the female enrolment is higher than that of the males except for the Lerotholi Polytechnic which has a higher male enrolment. This means that there is a need for advocacy to get females interested in the "male oriented courses".

In Sub-Saharan Africa and Southern Asia for example, only 67 and 76 girls per 100 boys respectively are enrolled in tertiary education. Women seem to be over represented in some courses like Humanities and Social Sciences and significantly underrepresented in science, technology and in particular engineering. Also completion rates tend to be lower among women than men.⁴⁶

Gender Equity in the Economy

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

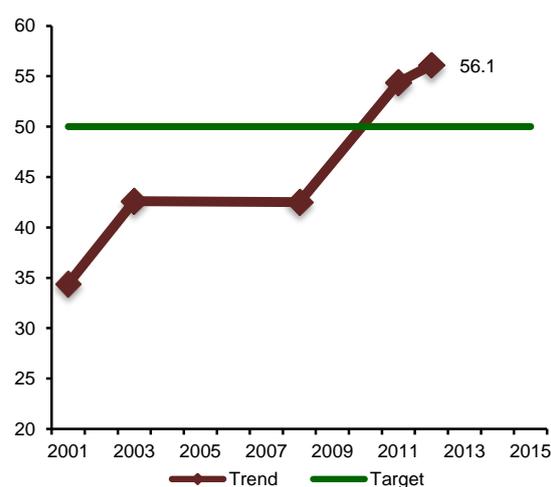
The share of women in paid employment outside the agriculture sector has been high and it shows an increasing trend. The Gender

⁴⁶MDG World Report 2010

equality in the labour market is also a concern in Sub-Saharan Africa, where only one in three paid jobs outside of agriculture are occupied by women even though women represent a large share of employment, it does not mean that they have secured decent jobs. Women are less paid generally and have less employment security than men. Also completion rates tend to be lower among women 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 target in 2011 reaching 54.4% and 56.1% in 2012⁴⁷. 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.

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



Sources: LDS (2001), HBS (2002/03), ILFS (2008), 4th CMS (2010-2011) and 3rd CMS (2011-2012)

⁴⁷Lesotho Demographic Survey, 2001; Household and Budget Survey, 2002/03; Labor Force Survey, 2008.

Several factors help explain this achievement. First, Lesotho has performed well historically on this indicator. Large numbers of men found work in the South African mines, Basotho women then took 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 consistent high female enrolment in secondary and higher education and their high female literacy rates.⁴⁸

In recent years Lesotho Government has created laws to protect women's rights, though they are slow to be implemented. 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 manner, in 2003 the Sexual Offences Act was enacted. This legislation protects women from all forms of sexual violence including rape.⁴⁹ However, the reality is Basotho culture still promotes the discrimination that these laws are designed to change.

Legally, the Constitution of Lesotho allows for discrimination on the basis of culture and tradition according to section 18 (4) (c) in employment and compensation. With the assistance of the Millennium Challenge Account, the Government is reviewing all laws that discriminate against women economically. 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 and revisions to the Bank Savings and Development Order improve credit access for women⁵⁰

The Government and development partners have also 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. Despite the progress achieved, women still face constraints. Men dominate in 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 only 23% of the economic decision-making positions in Government. Moreover, 70% of landowners are male.⁵¹

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. Therefore, as the share of female-headed households rises,

⁴⁸CMS 2010-2011.

⁴⁹Discovering the Mountain Kingdom, July 2008, 2010

⁵⁰www.gov.ls

⁵¹ Labor Force Survey 2008

securing equal economic rights for women is an imminent dispensation.⁵²

Gender Equity in the Government and Politics

Indicator 3.3: Proportion of seats held by women in the 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 and 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 an all-time high of 19 per cent in 2010. There are still four men for every one woman in parliament. Greater efforts and political intervention will be needed in order to meet the 30% target.⁵³

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 below.

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.

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 currently women. Also, three of the seven deputy ministers are women. Latest estimates show that, women comprise 40% of public servants.⁵⁴

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. Local Government in Lesotho was reintroduced in 2005 and two local Government elections have since occurred – in 2005 and in 2011. In 2005 the Government made a proactive effort to ensure female representation by reserving 30% of all constituencies – in other words, only women could contest these constituencies. The remaining 70% were open to men and

⁵²CMS 2012

⁵³Gender Links, SADC Gender Protocol 2011 Barometer, Chapter 4, Economic Justice.

women. Ultimately, women were elected to 58% of contested positions in local Government in 2005, but the system was extremely controversial. In 2011, the Tanzanian model was adopted and the First Past The Post (FPTP) system was adopted abandoning the 30% quota system.⁵⁵ According to SADC protocol on gender and development it was agreed that women will 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.

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%

Thus, 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. As a result, female

⁵⁵Parliamentary 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."

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.¹⁹

Factors Contributing to Meeting the Target

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 (CEDAW/1979) 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.⁵⁶

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 2011 and other laws concerning economic transactions and property rights. The Sexual Offences Act 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 entrenches 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. Also, 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.⁵⁷

Institutional Developments

Amongst 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 Bottlenecks, Challenges and Constraints

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 Lerotoli (1903), and they largely designated women as minors and constrained them in decision-making, ownership of property, and inheritance. An Africa Peer Review Mechanism Report notes that the primacy accorded cultural beliefs and practices as articulated in Section 18(4) (c) of the Constitution entrenches gender-based discrimination and inhibits full development of human rights culture regardless of gender. One example is that Lesotho has ratified CEDAW with reservations on issues of culture and chieftainship.⁵⁸

- The other 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, gaining higher level of professional and management positions in the workforce.

Gender-Based Violence (GBV)

- Curbing violence against women remains a major challenge as it adversely impacts their health, productivity and wellbeing. Sexual violence is particularly a concern in a country where HIV and AIDS is so prevalent.
- Large proportions of both men and women still agree with the notion that gender-based violence is justifiable under some circumstances. For instance, 27% of women and 34% of men believe a husband is justified in beating the wife if she argues with him. Thirty seven percent of women and nearly half of all men agree that wife-beating is acceptable under certain reasons.⁵⁹
- Moreover, in the case where a woman refuses sexual intercourse, 63% of men indicate they have a right to get angry and reprimand her, while 26% believe it is

⁵⁷www.gov.ls/Cabinet

⁵⁸ Lesotho Africa Peer Review Mechanism Report: 2009 Gender Links, SADC Gender Protocol 2011 Barometer, Chapter 2, Governance.

⁵⁹ Reasons include burning the food, arguing with the husband, leaving the home without telling the husband, neglecting the children, or refusing sexual intercourse, 2009 Lesotho Demographic Health Survey.

appropriate to refuse her financial support and 16% agree that it is justifiable to use force.⁶⁰

Recommendations

- Encourage political parties to establish strategies for empowering female members.
- Mainstream gender in all sectoral programs and national policies.
- 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; (men, women, boys, girls, disabled and orphans).
- 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 survey, 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 non-agricultural sector.
- Customary law should be reviewed and amended to allow for gender equality
- Enact Domestic Violence Legislation.

⁶⁰ Gender Links, SADC Gender Protocol Barometer 2011, Chapter 5, Gender Based Violence.



4. Reduce child mortality

TARGET: Reduce the under-five mortality rate by two-thirds

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 is 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%.⁶¹ Increasing poverty, malnutrition and high prevalence of HIV 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. According to the Lesotho Demographic Survey (LDS) of 2011, there has been some notable progress on infant mortality rate decrease; however, this progress is still too slow to achieve the 2015 target of 27 deaths per 1,000 live births.

TABLE 4.1: Child Mortality Trends

Indicator	2001	2004	2009	2015 (goal)
Slow Progress				
Infant mortality Rate(per 1,000 live births)	81	91	91	27
Off Track				
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

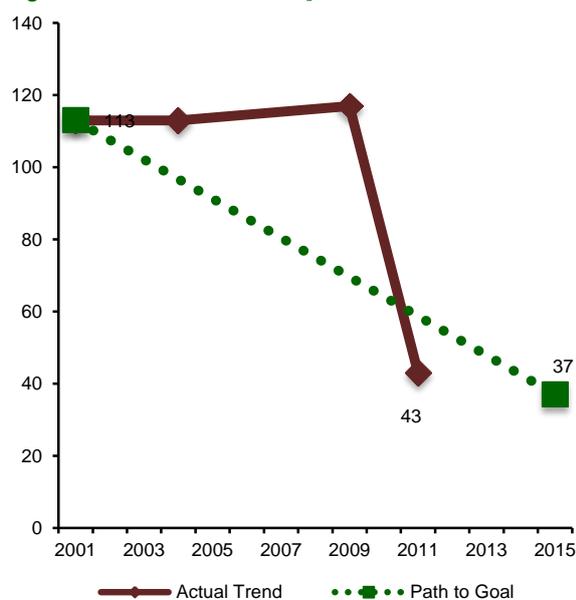
⁶¹LDHS, 2009

Under-Five Mortality

Indicator: Reduce under-five mortality to 37/1,000 live births

In 2001 the under-five mortality rate was at 113 deaths per 1000 births and in the following years to 2004 it held steady at 113 deaths per 1000 births and in the most recent period from 2005-2009 it increased to 117 deaths per 1000 live births. The Lesotho Demographic and Health Survey of 2009 shows that there has been an increase in under-five mortality rate between 2004 and 2009. However, a different source of data (Lesotho Demographic survey of 2011) recorded a decrease to 43 births in 2011

Fig. 4.1: Under-Five Mortality Rate



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

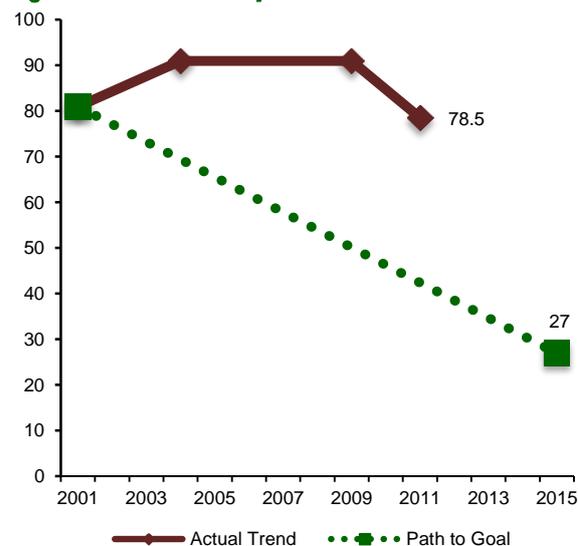
Infant Mortality

Indicator: Reduce infant mortality rate to 27/1,000 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 most likely are also linked to HIV-infection. Poor sanitation and unsafe drinking water was also found to be major causes of death in the 2004 Lesotho Demographic Health Survey (2004, LDHS). According to the LDS of 2011, the infant mortality seems to be moving closer towards the 2015 target. However, this rate of change is still very low. The decline in infant deaths might be associated with the improvement in maternal health services. The impact of these improvements has however been very slow and the quality still remains low. At the present rate, the country is less likely to achieve its MDG target of 27 infant deaths per 1000 live births.

Fig. 4.2: Infant Mortality Rate



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

Socioeconomic Variations in Mortality 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. Specifically for Lesotho, the then Ministry of Health and Social Welfare (MOHSW) 2011 Annual Joint Review reveals that the four

major causes of child mortality are pneumonia, malnutrition, HIV/AIDS, diarrhoea, and measles. Poor sanitation and drinking water are also major causes of child illnesses.⁶²

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 in the period⁶³

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 do indeed 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

⁶² MOHSW, Annual Joint Review, 2011.

⁶³LDHS, 2009

likely an insignificant statistical aberration from the general trend.

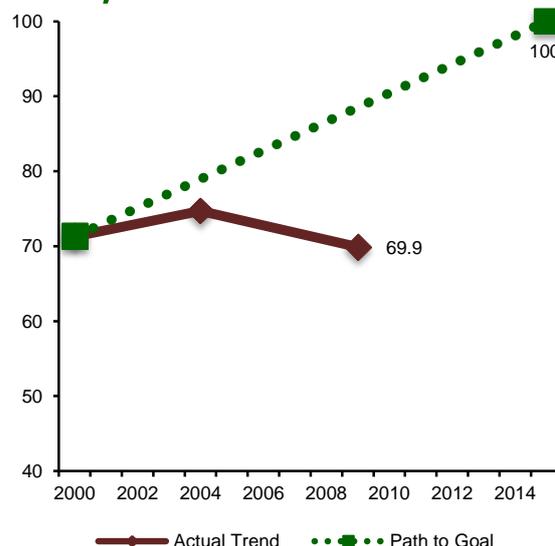
The correlation between mortality rates and family wealth does not follow expected patterns. The second and fourth quintiles report the highest rates, contrary to expectations that mortality rates will decrease progressively as the wealth status of the mother increases.

Immunization against Measles

Indicator: Proportion of 1 year-olds 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 it 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.

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

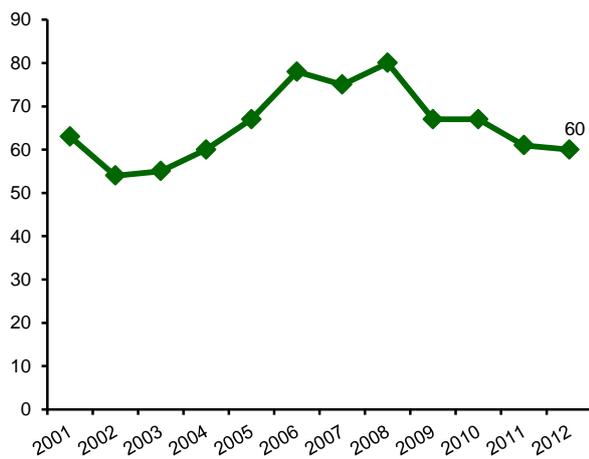


Source: LDHS (2009, 2004) and EMICS 2000

There is slow progress in scaling up immunization, especially against measles, which is characterized by frequent fluctuations. The

graph below 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 **constantly been less than the recommended 90% national coverage (80% for rural districts) and MDG target of 100%**.

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 transport, insufficient 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.

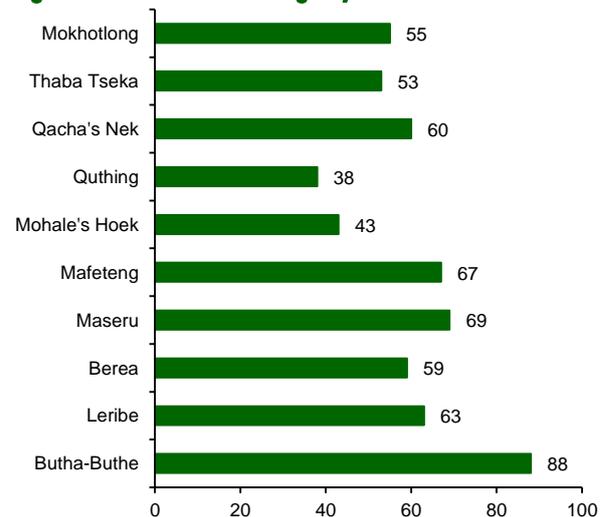
These factors help explain the large year-to-year fluctuations in coverage described above. Most children are vaccinated through fixed or static services because numerous obstacles prevent families from vaccinating infants through outreaches. The 2007 and 2010 post campaign evaluation report indicated 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 transport to reach the communities. Therefore when outreach services decline, immunization coverage decreases. Scaling up sustained outreach services has been proposed and discussion is on-going for partners to buy in.

Variations in immunization coverage

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

Figure 4.5: Measles Coverage by Districts - 2012



Source: Ministry of Health Annual Joint Review (2012)

Lowland and foothills areas have the highest coverage, while the highlands and Senqu River Valley have the lowest. The coverage differential between urban (90%) and rural (77.5%) is particularly sharp. Moreover,

coverage is also seen to be positively correlated with the mother's education level.

TABLE 4.3: Immunization Coverage among children age 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 constraining progress

The greatest challenge to 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 there is 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 been translated into a real 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 network, lack of ambulances and insufficient 2-way communication).

Service Delivery

- **Poor health seeking behaviour when children are ill.** Only 54% of children with symptoms of fever and respiratory illnesses sought care from a health facility in 2004. Lack of knowledge among parents and communities to identify danger signs of childhood illnesses are among the causes.⁶⁴
- **HIV.** The high prevalence of HIV further aggravates health system problems. Health workers, especially those providing maternal care, are overburdened with the care 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 effectively plan, mobilize resources and manage the 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

⁶⁴LDHS, 2004

such as acute respiratory illnesses, diarrhoea and gastrointestinal diseases like intestinal worms. However, these programmes implement separate operational plans with weak integration.

Data Challenges

- *Insufficient data collection on health and mortality among children is a serious constraint. 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 and Development Partners to fully 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. 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 accelerated progress on MDG 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

a) *Reduce by three quarters the maternal mortality ratio*

Indicators

5.1: Maternal Mortality Ratio (MMR)

5.2: Proportion of births attended by skilled health personnel

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

Presently, 1 out of 32 women in Lesotho dies of pregnancy and birth complications. The 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: General Maternal Health Trends

	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 a: Reduce by three quarters, between 2000 and 2015, the maternal mortality ratio

Indicator 5.1: Maternal mortality ratio
Lesotho's maternal mortality ratio (MMR) is the highest in the region, as seen below in Table 5.2.

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

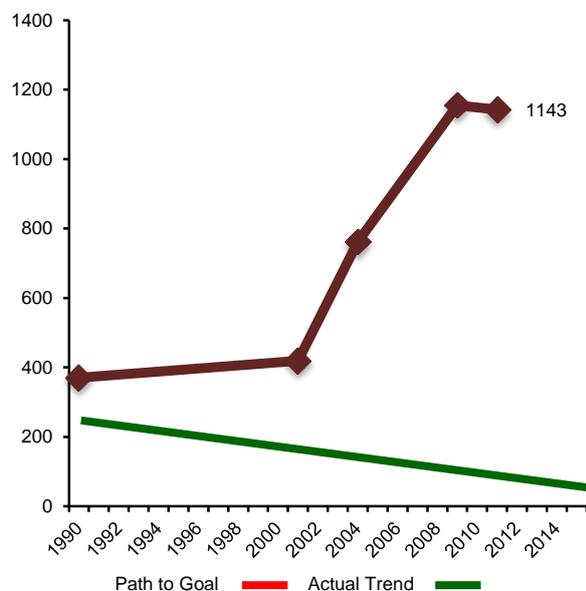
According to the End of Decade Multiple Indicator Cluster Survey (EMICS) of 2000 and the Demographic and Health Surveys of 2004 and 2009, the MMR increased from 419 per 100,000 live births in 2000 to 762 per 100,000 in 2004 and 1,155 per 100,000 in 2009.⁶⁵ Using the 2004 baseline (762 deaths per 100,000 live births), the Government of Lesotho (GOL) has set a target to reduce maternal deaths to 300 deaths per 100,000 live births by 2015⁶⁶. This was increased from the initial target of 93 deaths derived from the baseline of 370⁶⁷ deaths per 100,000 live births. According to the

⁶⁵ 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.

⁶⁶GoL, Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Lesotho, (2007-2015)
⁶⁷ WHO/UNICEF/UNFPA/World Bank, Trends in Maternal Mortality: 1990-2008.

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 below, the 2015 target is highly unlikely to be achieved, unless accelerated measures are undertaken.

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.

The high levels of maternal mortality in Lesotho are attributed to the "3 delays"⁶⁸:

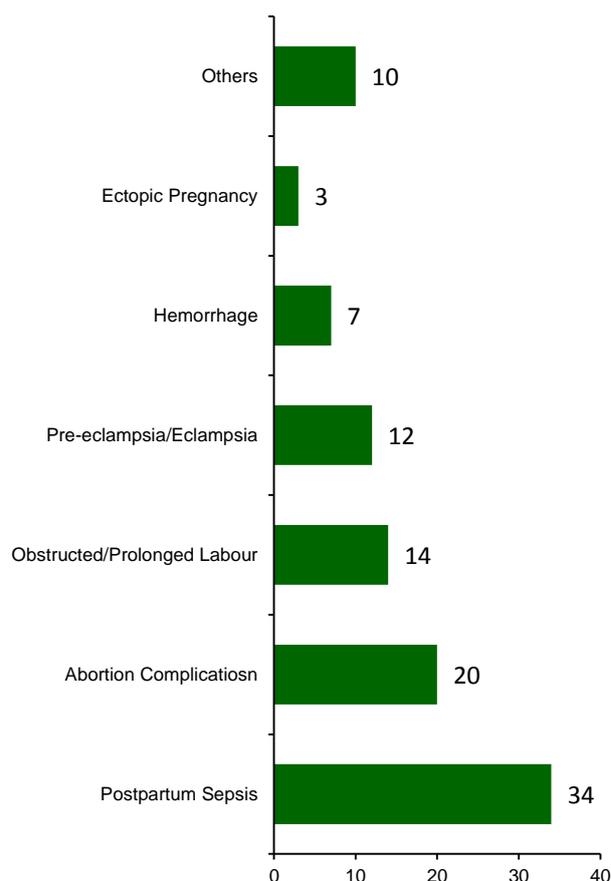
1. **Delays in making decisions** on the part of pregnant women to access health care services, mainly as a result of socio-cultural barriers. These include women's constrained decision-making power, their low ability to command resources and their low societal status as well as their failure to recognise complications;
2. **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 difficult and mountainous terrain; the lack of sufficient community and formal ambulatory

transport, the limited hours of operation of health facilities and the weakness of the health referral system; and

3. **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, HIV/AIDS (10%).⁶⁹

Fig. 5.2: Causes of Maternal Deaths



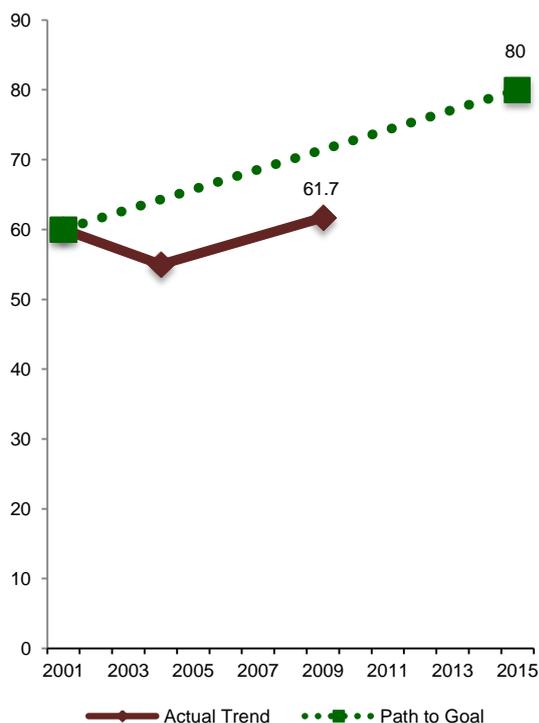
Source: EmOC 2005

⁶⁸MDG Acceleration framework, 2013

⁶⁹LDHS 2009

Indicator 5.2: Increase proportion of births attended by skilled health personnel to 80%
Trends in deliveries with help from health professionals have been mixed in recent years. While in 2000 60% of the women were delivering with assistance of a skilled health worker (doctor, midwife), the proportion decreased to 55% in 2004.⁷⁰ The 2009 LDHS shows an improvement to 61.5%. However although there is an increase in the number of deliveries attended by health professionals, this leaves a question on the quality of service provided. Immediate post natal care is very low (15%)⁷¹ yet most deaths occur during the first two days of child birth.

Fig. 5.3: Proportion of Births Attended by Skilled Health Personnel



Source: LDHS (2009, 2004) and EMICS 2000

Target b: Achieve, by 2015, universal access to reproductive health

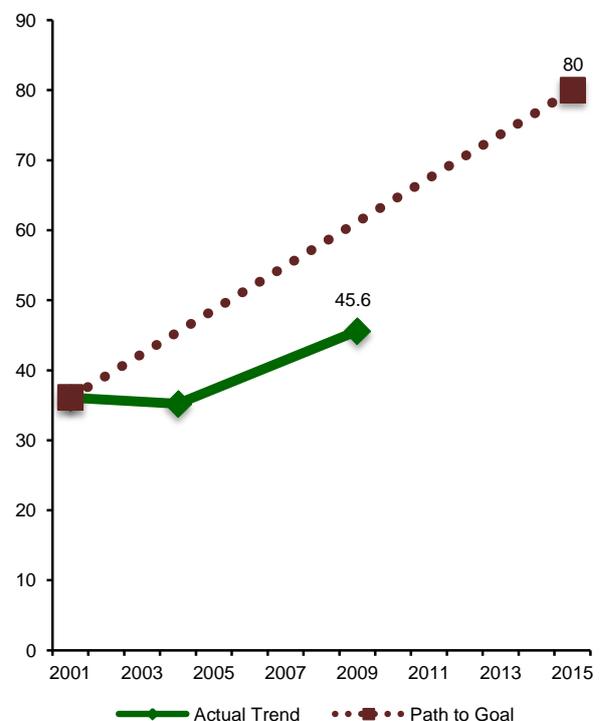
Indicator 5.3: Contraceptive Prevalence Rates
The contraceptive prevalence rate (CPR) of

⁷⁰End of Decade Multiple Indicator Survey, 2000 and LDHS 2004.

⁷¹LDHS 2009

modern methods is the percentage of married women age 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 years knowing at least one method of modern Family Planning⁷². This increase however has not been high enough to cause a dent in the maternal mortality rate.

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



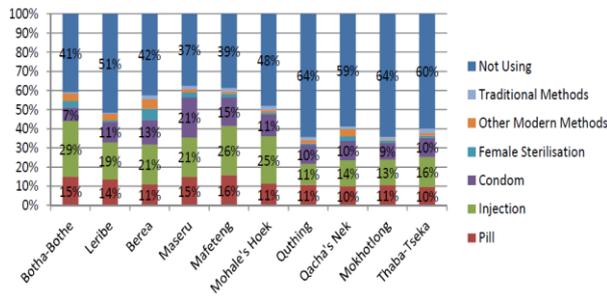
Source: LDHS: 2009, 2004, 2001

Variations in Contraceptive Usage

As reflected in Figure 5.5 below, 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).

⁷²LDHS 2009

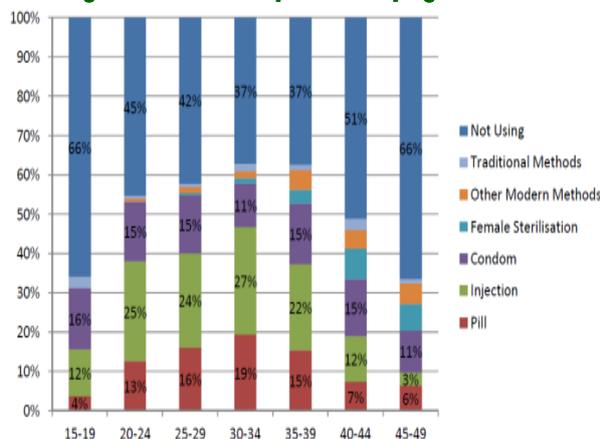
Fig. 5.5: Contraceptive Use by District - 2012



Source: MOH Annual Joint Review (2012)

According to UNFPA⁷³, 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 has led to maternal deaths. As reflected in the chart below, 66% of youngest and oldest age groups are not using methods of contraceptives. This figure is worrisome, more especially on the youngest age group, as it is likely to increase the unplanned adolescent pregnancy and birth rate which could in turn lead to unsafe abortions. Injection is the common method in age group 30-34 (27%). The long term methods (IUD and implants) are common in age groups 35-49. Though it's not common, long term methods are used by all the groups except age group 15-19. 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)

⁷³ www.unfpa.org/public/home/mothers/pid/4382

Indicator 5.4: Adolescent Birth Rate

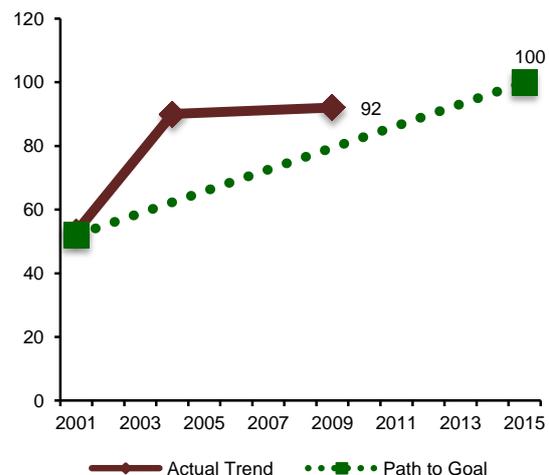
In Lesotho the adolescent birth rate is the percentage of women aged 15-19 who have had a live birth or who are pregnant with their first child. Teenage pregnancy is a major health concern because it is associated with higher maternal child mortality and morbidity and carries high risks, such as pregnancy induced hypertension, obstructed or prolonged labour, and unsafe abortion. Younger mothers are much less likely to receive antenatal care. Moreover, teen pregnancy adversely impacts long-term wellbeing, as young mothers are less likely to continue their education and find decent employment⁷⁴

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 2009.⁷⁵

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 4 antenatal care visits has also slightly increased from 69.6% in 2004 to 70.4% in 2009⁷⁶

Fig. 5.7: Antenatal Care Coverage (at least one visit)



Source: LDHS (2004, 2000) and EMICS 2000

⁷⁴Ibid.

⁷⁵LDHS, 2004 and LDHS, 2009

⁷⁶Ibid.

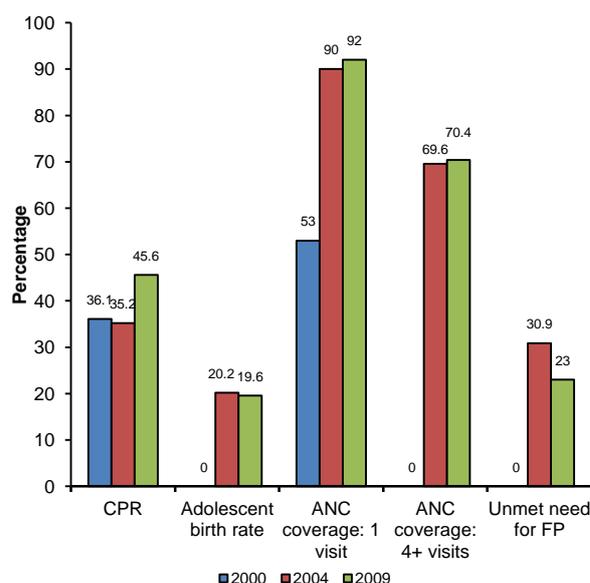
The geographic differences in ANC utilization are also apparent where fewer women in the rural areas (28.4% in 2004 and 29.2% in 2009) initiated ANC during the first trimester, compared to 40.2% (2004) and 42.3% (2009) from the urban residences. With regard to number of ANC visits, it is recommended that women should at least have a minimum of four visits, provided there are no complications. DHS 2009 shows that while the majority of women do have a minimum of four visits or more, there is still 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 child birth has been high but declining from 30.9% in 2004 to 23% in 2009.⁷⁷ The 2009 DHS 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.

⁷⁷Ibid.

Fig 5.8 Performance of All Indicators for Target 5b



Key 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, new born and reproductive services, specifically, the 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 overburdened with caring for HIV 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.⁷⁸ Furthermore, community health education and awareness receives little attention.

Finally, poor infrastructure, (poor roads, lack of ambulance services, lack of communication including breakdown of the two-way radio communication) limits access to health services especially for the population living in the 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.
- 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 free services in health centres 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.⁷⁹Fees 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 DHS indicated that many people do not attend antenatal care services due to lack of money, difficult topography and cultural practices - resulting in dangerous delays which increases the risk of death.
- Continuous availability of essential obstetric equipment, medicines and medical supplies is a challenge. There are frequent reports of stock-outs due to inability to make appropriate forecasts of 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.

Data challenges

While the Road Map for Accelerated Reduction of Maternal and New Born 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.

Also, Lesotho has institutionalized maternal death reviews and adopted maternal death surveillance and response as form of reporting maternal deaths. However the country has not yet started community based maternal review/verbal autopsy. The Health Information

⁷⁸Ibid.

⁷⁹Ibid.

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-based 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),⁸⁰ 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 and AIDS and reproductive, maternal and newly born child health services
- Strengthen the supply chain and distribution of obstetric equipment, medicines, medical supplies, and contraceptives.

⁸⁰ 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 and the relevance of such education to the country health context.

- 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 health primary health services.
- Strengthen capacity of Rider for Health to improve Emoc and blood services.

Key Initiatives to Accelerate Progress

MDG Acceleration Framework (MAF):

In 2013, the Government of Lesotho with support from the UN and other stakeholders developed the f the MDG Acceleration Framework (MAF) for Maternal Health. The Framework identifies and prioritises the main bottlenecks and identifies the collaborative solutions involving Government and all relevant stakeholders. The framework is designed to address the challenges in the area of maternal health that the country is facing by accelerating the operationalization of various initiatives. Given that the challenges facing the area of maternal health go beyond the Ministry of Health and health care professionals alone, the MAF brings together all key stakeholders by prioritising 4 key intervention areas to address the 3 delays:

- Improvements in skilled delivery through improvements in infrastructure and road access to health facilities; by availing of

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 complement of human resources for health; by empowering health workers in Emergency Obstetric Care skills; by ensuring the availability of 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 use of village health workers in support of maternal and neonatal care

- *Increasing access to family planning services* by engaging in increased community outreach to advocate 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

a) Halt and begin to reverse spread of HIV and AIDS

Indicators

6.1: HIV Prevalence among population aged 15-24

6.2: Condom use among adults during last high-risk sex

6.3: Proportion of population aged 15-24 years (youths) with comprehensive correct knowledge of HIV and AIDS

6.4: Adults (15-49) with multiple partners in the past year

b) 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

c) Halt and begin to reverse the incidence of Tuberculosis and other diseases

Indicators

6.6: Prevalence and death rates associated with tuberculosis

6.7: Proportion of tuberculosis cases detected and cured

Overview

HIV and AIDS is an extraordinary threat to Lesotho's development, and it affects every other MDG. The epidemic hinders child and maternal health, undermines economic productivity, and impacts educational outcomes of 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-based, 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 new-borns 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, (5) tuberculosis/HIV co-infection.

TABLE 6.1: MDG 6 Snapshot

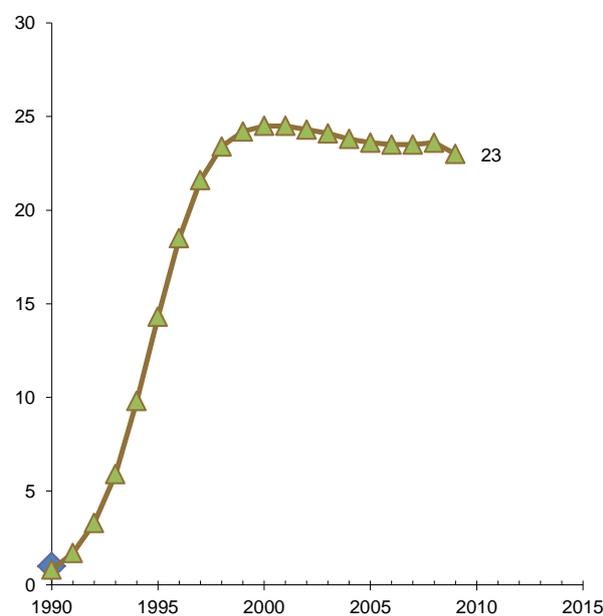
Indicators	2004	2005	2007	2009	2010	2011	2012	Target 2015
Slow Progress								
HIV Prevalence among population aged 15-24	11.3% M: 6.0 F: 15.4	-	-	9.3 M: 4.2 F: 13.6	-	-	-	-
Adults (15-49) with multiple partners in the past year	M: 30.4 F: 11.0	-	-	M: 21.9 F: 6.4	-	-	-	-
Condom use among adults during 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: Prevalence and incidence among adults (15-49) and youth (15-24)

Lesotho's HIV prevalence is a measure of the proportion of the population infected with HIV. Prevalence among adults naturally stabilized around the year 2000 and is currently at 23%⁸¹. 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%⁸². HIV prevalence in urban areas is 27.2%, when compared to that of rural areas at 21.1%. The increased urban prevalence may be attributed to a number of factors including rural urban migrations where most people settle in informal settlements where vulnerability to HIV is increased when they exhibit higher risk taking behaviours such as transactional sex.

Fig. 6.1: HIV prevalence among adults (15 - 49 years) 1990-2015 Trend



Sources: WHO and LDHS (2009)

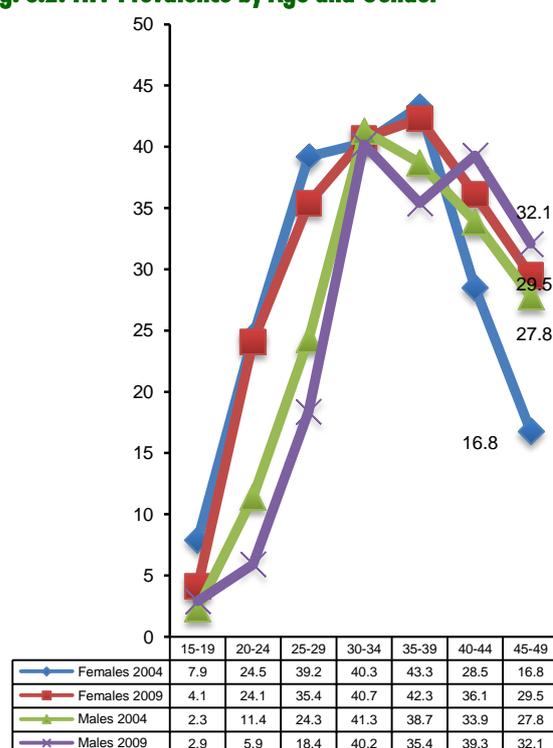
Figure 6.2 below disaggregates prevalence by age and gender for 2004 and 2009. Young

⁸¹LDHS, 2009

⁸²ibid.

women are particularly at risk. For females between 20 to 24 years, 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.

Fig. 6.2: HIV Prevalence by Age and Gender



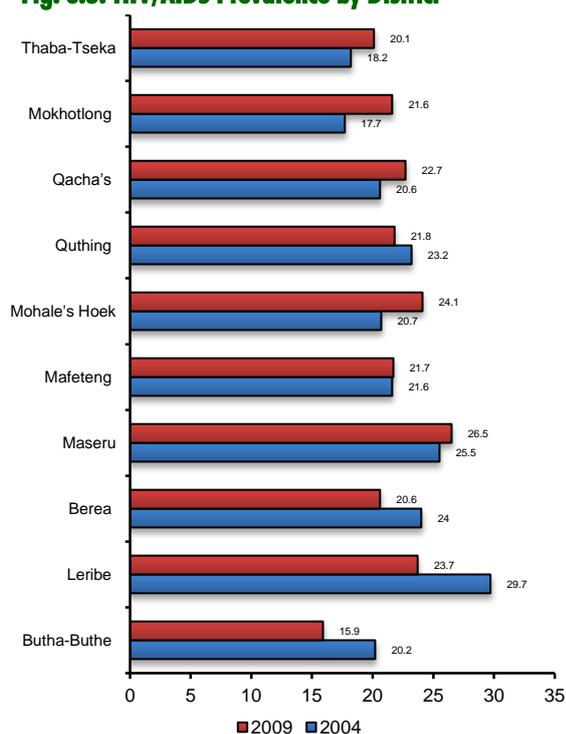
Sources: LDHS (2004,2009)

Lower education levels are also associated with higher prevalence. In 2009, prevalence was 26.6% among those with "no education" compared to 20.9% of those with secondary or higher.⁸³ 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 behaviours such as condom use, avoidance of extra-marital sex, delayed

⁸³ibid.

sexual debut, testing, and comprehensive knowledge about HIV and AIDS.⁸⁴ 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.⁸⁵ Finally, variation across districts is not wide – all 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%.

Fig. 6.3: HIV/AIDS Prevalence by District



Source: 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 1996⁸⁶. 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 2012⁸⁷. Table 6.2 below provides a highlight the new HIV infection estimates together with the projections. According to these projections, cases of new infections are expected to decline over the years until it reaches around 19,000.

TABLE 6.2: Lesotho New Infections 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

⁸⁴ Lucia Corno and Damien de Walque, World Bank Development Research Group, Determinants of HIV Infection and Related Sexual Behaviors: Evidence from Lesotho, December 2007.

⁸⁵LDHS, 2009

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

⁸⁷NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

An alternative indicator is HIV prevalence among youth (15-24), which reveals recent 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 for young women persist – especially 20-24 year olds. Not only are women biologically more vulnerable to HIV infection, they are more likely to have intergenerational sex and have less power to negotiate condom use due to traditional gender roles, dominated by their male counterparts.

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.⁸⁸

According to the WHO, unprotected sex with multiple partners is one of the primary risk factors for HIV in sub-Saharan Africa.⁸⁹ Indeed, the 2009 LDHS confirms that HIV prevalence is strongly correlated with the number of partners. Only 16.5% of adults reporting one lifetime partner are infected with HIV, compared to 25.7% for 2 partners, 30% for 3-9 partners, and 36% for 10 or more partners.⁹⁰

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.⁹¹

TABLE 6.4: Summary of Research on MCP 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 (15-64)	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 – having multiple partners at the same time. The viral load (HIV concentration in the blood and bodily fluids) of an HIV positive adult is particularly high in the first 6-8 weeks after infection.⁹² 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

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

⁸⁹WHO, Global HIV/AIDS Response, Progress Report, 2011

⁹⁰LDHS, 2009

⁹¹ Ibid.

⁹² UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009.

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.⁹³

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.⁹⁴ Other factors contributing to MCP include the influence of family and friends and labour force mobility (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.⁹⁵

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 undertook to revitalize HIV prevention through intensive efforts which included the district HIV symposiums that were conducted in all districts to revitalize HIV prevention and strengthen 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; 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.

Condom Use

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

There has been an overall improvement in the management of condoms at district level, except for a few districts like Quthing where condoms are stored in the veranda of the pharmacy store. Also evident is an improvement in recording of condoms by Pharmacy as they reach the pharmacy stores, it is however also apparent that there is less recording as condoms move out of the pharmacy store to different departments of the hospitals or from the DHMT store to the health centres.

There is an obviously low uptake of condoms; this is shown by the low level of condoms distribution - and in particular female condoms. Issues around knowledge, use and attitudes towards female condoms are still negative; thereby rendering the uptake of female condoms very low. This calls for intensive education, promotion and advocacy at community level. The program in collaboration with other programs is the process of supporting the districts to implement this initiative.

Despite increasingly widespread promotion and distribution of condoms, their positive impact has not been significant because consistent, correct use is not sufficiently high. People use condoms in sexual encounters where they perceive an increased risk (commercial and casual sexual) but tend not to use them in perceived low-risk relationships - including among multiple/concurrent

⁹³ Ibid.

⁹⁴NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

⁹⁵ NAC/UNAIDS, Gender and MCP in Lesotho, 2008.

partners.⁹⁶ 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.⁹⁷

One informal indicator is the condom use rate of the contraceptive prevalence rate 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 also measured usage among married people and found that 12% in 2002 and 20% in 2007 used condoms with spouses.⁹⁸

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 proportions 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 one another's HIV status⁹⁹. Figures from Lesotho confirm this trend – from 2004 to 2009 the proportion of HIV sero-discordant couples increased from 13 to 17%¹⁰⁰.

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 2009¹⁰¹. 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 women¹⁰². Thus, not only do these adults have a higher risk for contracting HIV, but they also are much more likely to subsequently infect their spouses.

Social norms surrounding condoms also inhibit consistent, correct usage. For example,

⁹⁶ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁹⁷ PSI Lesotho, HIV/AIDS TRAC Study, Third Round, 2010.

⁹⁸ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

⁹⁹WHO, Global HIV/AIDS Response, Progress Report, 2011

¹⁰⁰LDHS, 2009

¹⁰¹LDHS, 2004 and LDHS, 2009

¹⁰²LDHS 2009

condoms often signify potential 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 embarrassing to obtain (34%), and that people who use condoms are unfaithful (33%).¹⁰³ A 2008 CIET study revealed that attitudes toward demanding condom use may even be deteriorating. In 2002, 48% of adults said they would not have sex if their partner refused to use a condom, and this percentage dropped to 39% in 2007.¹⁰⁴

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.¹⁰⁵

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.¹⁰⁶ 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.¹⁰⁷ Still, the issue must be treated sensitively, with strong public awareness campaigns, as it touches on important cultural and religious beliefs for many Basotho.¹⁰⁸

¹⁰³ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

¹⁰⁴ Ibid.

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

¹⁰⁶ LDHS, 2009

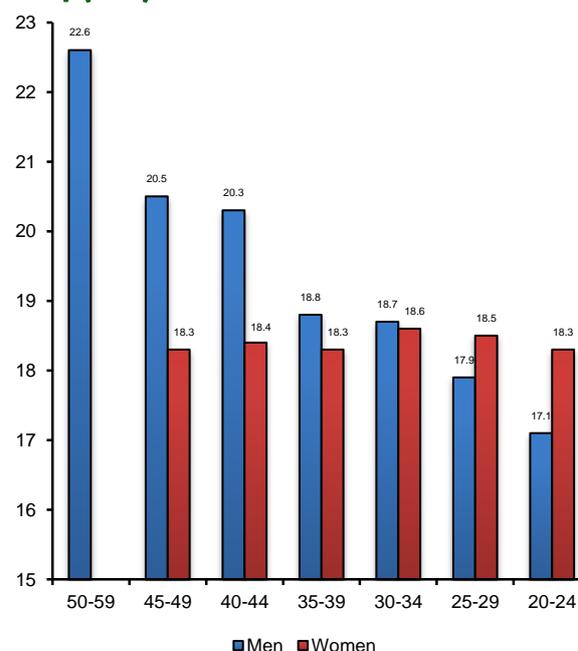
¹⁰⁷ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

¹⁰⁸ USAID, Lesotho Health System Assessment, 2009

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 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). Yet, given the pervasiveness of sexual activity among youth, this level of knowledge is still unacceptably low and far from the 85% target.

Fig. 6.4: Age at 1st 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 analyses age of sexual debut by current age groups and reveals that young males today have their first intercourse around age 17 – about 3-5 years earlier than their parents’ generation. While sex among the very young (before age 15) is down, 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) 6.4% (F)	22.1% (M) 7.8% (F)
Sexual intercourse before age 18	48.9 (M) 38% (F)	61% (M) 45.4% (F)
Sexual intercourse in past 12 months	47.7% (M) 28.2% (F)	57.2% (M) 35.1% (F)
Condom use during last sexual intercourse	50.7% (M) 55.7% (F)	65% (M) 65.8% (F)
Multiple sexual partners in the past 12 months	35.5% (M) 8.8% (F)	33.5% (M) 7% (F)
Condom use among youth with multiple sexual partners	47.9% (M) 50.1% (F)	64.4% (M) 64% (F)

Source: LDHS 2009

These trends suggest the need for prevention programmes among youth, including evidence-based, skills-based sex 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.¹⁰⁹ 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 prevention programmes and exhibit multiple risk factors including early sexual debut, low testing rates, and low condom usage¹¹⁰

Gender Discrimination and Sexual Violence

Lesotho is traditionally 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 not acceptable 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.¹¹¹

Unfortunately, such entrenched discrimination is manifested in higher levels of sexual violence. 60% of women have experienced sexual violence, while 22% report being physically forced to have intercourse, and most of these incidents go unreported.¹¹² Research has indicated that victims of intimate partner violence are 1.4 times more likely to be HIV positive.¹¹³ The key problem is that the primary behaviours that help prevent HIV transmission – refusing sex for various reasons, insisting on the use of a condom, and inquiring about other partners – are the same actions that often trigger sexual

¹⁰⁹NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

¹¹⁰ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

¹¹¹LDHS, 2009

¹¹² UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

¹¹³Dunkle et al, Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet, 363 (May1), 2004.

violence. In this environment women have little ability to negotiate condom use and safe sex and face increased risks for contracting HIV or other STIs.

TABLE 6.7: Gender Discrimination and Sexual Violence

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

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

As indicated above, HIV prevalence for young women is significantly higher than for young men, and 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 (among females aged 12-24).¹¹⁴ In 2009, roughly 7% of girls 15-19 reported sex with a man at least 10 years older.¹¹⁵ Age mixing for females 15-19 was 7.3% in 2004 and reduced to 2.3% in 2009

These relationships involve an imbalanced power dynamic in which young girls may not be able to ensure safe sex practices. Also, this custom may exacerbate HIV transmission if younger, uninfected girls have sex with an older, infected 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 migratory workers. Uneducated 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 – constantly commuting between the factories and their homes and families.¹¹⁶

Workers are away from families for extended periods - outside the bounds of traditional communal restraints. 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 re-uniting.

¹¹⁴ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

¹¹⁵ LDHS, 2009

¹¹⁶ UNAIDS/MOHSW/World Bank, Lesotho HIV Prevention Response and Modes of Transmission Analysis, 2009

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. Also, the 2009 LDHS revealed that prevalence is higher among migrants and the employed.

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 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%
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

Testing

An estimated 31% of Basotho living with AIDS do not know their status.¹¹⁷ Nevertheless, Lesotho has made dramatic progress in HTC. The proportion of adults who have ever been tested and received the results increased from 9% to 39% for men and from 12% to 66% for women between 2004 and 2009. However, in a generalized epidemic like Lesotho, annual testing is recommended. Table 6.9 indicates these rates have also increased drastically, but the proportion 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

¹¹⁷NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

have more contact with the health care system and provider-initiated testing – for instance, during pregnancy or when seeking health services for children. Thus, more targeted interventions are needed to increase the entry points for males for testing, care and treatment.

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: 12.0%	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: 25.0% 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.¹¹⁸

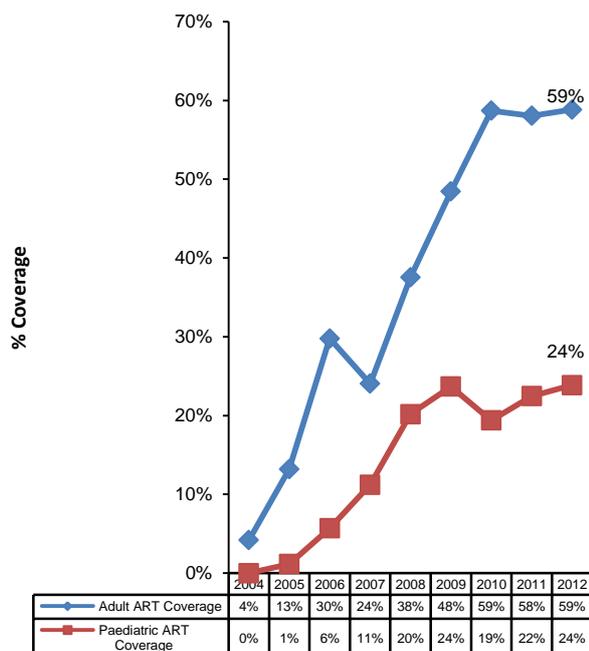
Treatment

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 below, it grew constantly between 2007 and 2010 until it declined to 58% in 2011. It increased slightly to 59% in the

¹¹⁸ WHO, Global HIV/AIDS Response, Progress Report, 2011

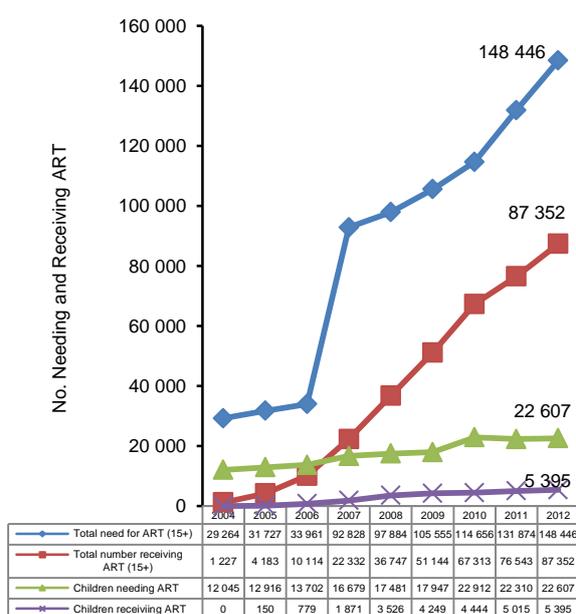
subsequent year. Additionally, ART coverage for children has been increasing slowly relative to adult coverage. At 24%, the 2012 ART coverage for children was similar to figures recorded three years earlier (2009). This represents a small increase from the declines that were recorded in 2010.

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



Source: MOH, Annual Joint Review 2012

Fig 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 ART roll-out¹¹⁹. Figure 6.7 below 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. Also, 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.¹²⁰ 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.¹²¹

Variations by Districts

In the graph below, Butha-Buthe seems to have 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.

¹¹⁹NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

¹²⁰ Ibid

¹²¹ WHO, Global HIV/AIDS Response, Progress Report, 2011

Fig 6.7: Proportion of ART Coverage by Districts- 2012



Source: Ministry of Health Annual Joint Review 2012

Pre-ART Retention

Usually, a long interlude of up to 8 years exists between diagnosis and ART initiation (after CD4 counts drop to 350), and follow-up and care during this lull is almost non-existent.¹²² Pre-ART retention is poorly documented, but the WHO estimates that only 18% of people diagnosed with HIV but not immediately eligible for ART remain in care until they became eligible. Furthermore, a study in neighbouring South Africa estimated a 33% retention rate between provision of first CD4 count and therapy initiation.¹²³

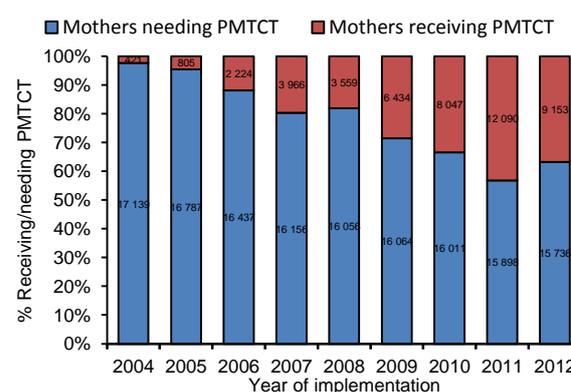
Indeed, the MOH acknowledges that full ART coverage will be a major challenge because many people eligible for ART may not know it or may not feel sick enough yet to seek medical attention.¹²⁴ In order to improve treatment, Lesotho must link the services a person must navigate after diagnosis and improve 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 infected mothers to new borns 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 child-bearing 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.¹²⁵

Fig 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 the population based PMTCT coverage was 43% in 2010 and 58% in 2012 which calls for a

¹²² Ibid.

¹²³ Ibid.

¹²⁴ MOHSW, Annual Joint Review, 2011.

¹²⁵ NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

massive service demand creation exercise. The introduction of reviewed PMTCT guidelines adopting the option B+ approach where a lifelong ART is provided to all HIV infected pregnant women is a key strategy to attract more women into the programme.

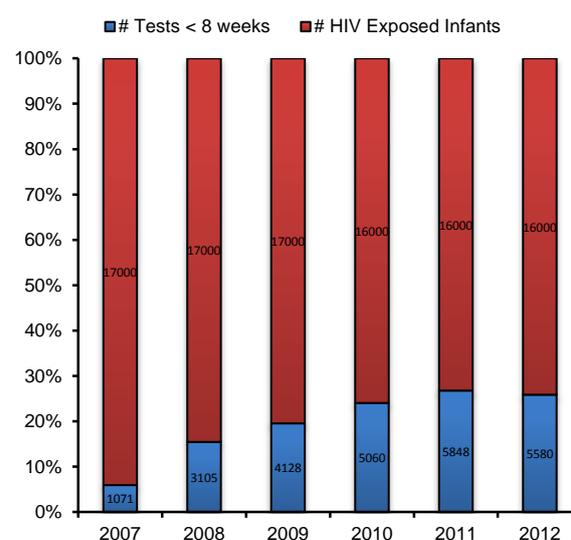
Moreover, preventative coverage among infants born to HIV positive mothers increased from 28% in 2007 to 38% in 2012.¹²⁶ This success is partly due to the Mother-Baby Pack, created by MOH and UNICEF to address the challenge many women face in repeatedly accessing health centres during pregnancy. Recognizing 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 the first ANC visit for use during pregnancy and the early post-natal period. Six weeks after birth, mothers are expected to return for immunizations, checkups, HIV testing, and further ARVs, if needed. Three types of standardized packages are available, depending on the mother's HIV status and treatment regimen.¹²⁷

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 infected intra- and peri-partum. Delaying testing beyond this time will delay diagnosis and put HIV infected 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 below, the numbers of HIV exposed infants are at least 16,000 but the number of infants below 8 weeks old who have been tested have remained very low. Though the number of infants tested has been growing steadily since 2007 to 2011, the number declined to 5,580 infants in 2012 from 5,848 in 2011.

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



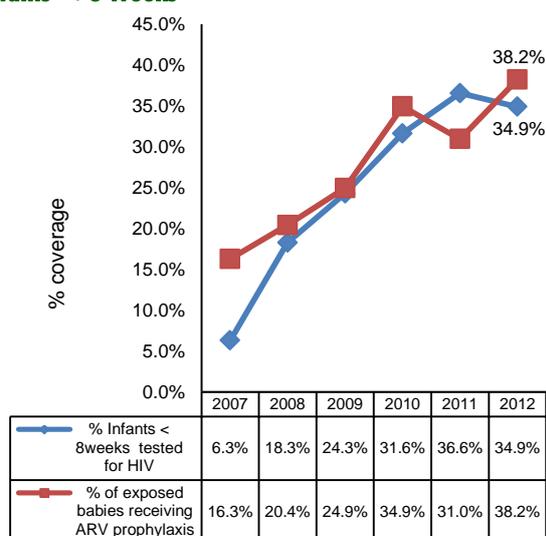
Source: Ministry of Health 2013

Given the increasing availability of paediatric antiretroviral treatment, the trends on the percentage of babies exposed to HIV who are receiving treatment and the number of babies tested are moving in an upward trend (see Figure 6.10). The minor difference between the numbers tested and receiving treatment are encouraging but these figures are still very low and require a lot of effort if the direct effects of HIV on children are to be curbed.

¹²⁶WHO, Global HIV/AIDS Response, Progress Report, 2011

¹²⁷NAC/MOHSW, Lesotho Global Aids Response Country Progress Report, 2012

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

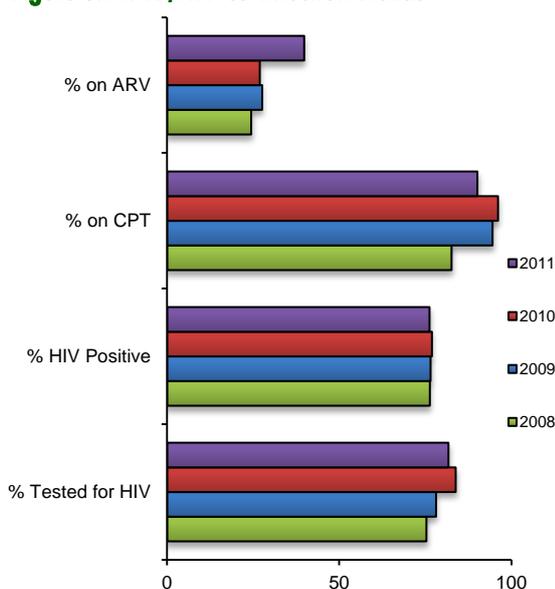


Source: Ministry of Health 2013

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 now tested for HIV. However, although the proportion of co-infected patients enrolled in ART has increased substantially, from 24% in 2008 to 40% in 2012, access to ART for co-infected clients remain low compared to the general population (40% vs. at 60%).

Figure 6.11: TB/HIV Co-infection Trends



Source: NAC/UNAIDS 2012

Target: Halt and begin to reverse the incidence of Tuberculosis and other diseases

The Government of Lesotho 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 highest per capita case incidence 632/100,000 (WHO, GLOBAL TUBERCULOSIS REPORT 2012) for 2015 as well as the Stop TB Strategy target for 2015 and 2050. The country also adopted the WHO recommended DOTS strategy as the approach to control the spread of TB through prompt detection of infectious cases and providing effective therapy with quality-assured anti-TB drugs under standard case management conditions.

Although TB notification rate remained high; in the past five years trends there is a noticeable steady stabilization and slight decline. A total of 11,971 patients were notified compared to 13,520 recorded four years ago (2009). Stabilization may be expected if both ART and TB programs are performing well in coverage as well as minimum loss to follow and other factors; this is not true of both programs, we therefore need to study notification decline carefully.

TABLE 6.10: Performance against the MDG 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 declined from 13,520 new cases in 2009 to 12,616 in 2011. Moreover, Lesotho maintained a high TB detection rate of 82 percent in 2011- up from 80% in 2008 and

well above the WHO standard of 70%. Regarding the successful treatment rate, a 74% success rate was reported in 2012 still well below the set target of 85%.¹²⁸

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 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 would have 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 and evaluation, and institutional memory for leadership.

Macro Level Drivers – The Government has not adequately addressed major structural drivers of HIV in their 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 BCC strategy, do not explicitly address this problem (MCP)

¹²⁸ibid.

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 and its 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 of the TB/HIV strategy.

Service Delivery

Increasing Health Care Demand. As ART coverage has expanded; one resulting challenge is increased volumes at health centres where a registered nurse or nurse clinician is 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 worst ratio of health care workers to population in the region, with just one worker per 1,000 people.¹²⁹ The sector operates with high vacancies, particularly among front-line workers, and retention is a major challenge. Many health workers migrate to other countries, and the compensation is uncompetitive, particularly for rural, hardship areas. The health human resources shortage is a major concern and implementation of the Health Sector Human Resource Retention strategy is key - including consideration for 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.¹³⁰ 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 for the central districts.¹³¹ It is worth noting that 2012 has been a difficult year for the program whereby there was a delay in Government funding, the programme experienced ambivalence with respect to retention of counsellors, stock outs for both test kits and CD4 count reagents.

Financing

¹²⁹World Bank, Lesotho Health Expenditure Review, 2009

¹³⁰LDHS, 2009

¹³¹MOHSW, Medicine Access Survey, 2010

Poor Budget Execution - GOL has poured substantial resources into the sector. MOH budget allocations have doubled from 4% of GDP in 2004 to 8% in 2010.¹³² In 2011/12, MOHSW was allocated 1,042 million Maloti or 12.7% of the total budget – second only to the Ministry of Education.¹³³ 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.¹³⁴ The lack of sustainable financing strategies, coupled with inadequate financial tracking is also a challenge for the sector.

Recommendations

- Agree with all stakeholders on the appropriate role for the NAC secretariat, its coordination function, and its broad composition. Also, 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-based prevention and BCC activities to underserved, vulnerable and key populations, like uneducated young males, MSM, migrant labourers, university students, and sero-discordant couples.
- Scale up evidence-based, skills-based sex education among children and youth, beginning by age 12.
- Scale up condom distribution and education programs, with a focus on raising awareness about proper, consistent use. Target uneducated, low-income, and

¹³²World Bank, Lesotho Public Expenditure Review, August 2012

¹³³Ministry of Finance and Development Planning, 2012/13

Background to the Budget Speech, 2012

¹³⁴MOHSW, Annual Joint Review of the Health Sector, 2010

rural populations. This will be addressed by installing more condom dispensers at communities to ensure that all individuals including youth access condoms when need arises.

- Scale up 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 could prevent up to 3.5 million people from being newly infected, with a cost savings of nearly \$17 billion over the next 15 years.¹³⁵
- 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 logistics chain management for HIV and AIDS commodities and supplies (forecasting, coordinated procurement, storage and distribution)
- Strengthen coordination between health centres and National Drug Service Organization. Train personnel in each facility in 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.
- Leadership commitment in the advocacy for key messages in the prevention of HIV e.g. political, religious, traditional leaders, 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.

¹³⁵Njeuhmeli E et al, Voluntary medical male circumcision: Modelling the impact and cost of expanding male circumcision for HIV prevention in Eastern and Southern Africa, PLoS Medicine, in press.

Key factors contributing to accelerated progress on MDG 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 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

a) Integrate the principles of sustainable development into policies and programmes and reduce loss of environmental resources and biodiversity

Indicators

7.1: Proportion of households relying on biomass as primary fuel

7.2: Forestry coverage

7.3: Number of endangered animal species

7.4: Proportion of land area protected

7.5: CO₂ Emissions, total and per capita

b) Halve the proportion of households without sustainable access to improved drinking water and sanitation

7.6: Proportion of households with improved water

7.7 Proportion of households with improved sanitation

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, water, 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, Lesotho has made a significant 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: MDG 7 Snapshot

Indicator	Baseline	Latest Available	2015 (Target)
Reliance on Biomass (cooking) %	66 (2001)	53.93(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)	-
On Track			
HHs with Improved Sanitation %	24 (2001)	55 (2011)	62
Slow Progress			
HHs with Improved Water %	80.6 (1995)	82 (2011)	91
Forestry Coverage %	1.30 (1990)	1.63 (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 the less hospitable terrain.¹³⁶ 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.

¹³⁶USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

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	1.73
TOTAL BIOMASS FOR COOKING	56.4	51.3	53.93
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

One comprehensive indicator of unsustainable land use is reliance on biomass (wood, crop residue, shrubs, 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 in table 7.2, above, 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 areas¹³⁷. 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.¹³⁸

Although table 7.2 indicates that reliance on biomass for energy needs has been declining with a slight increase in 2011, aggregate biomass consumption in tonnes had increased from 1.76 million in 2003 to 1.98 million in 2009 - a 12.5% jump in 6 years.¹³⁹ This suggests increasing unavailability of biomass and use of other sources as a substitute, such

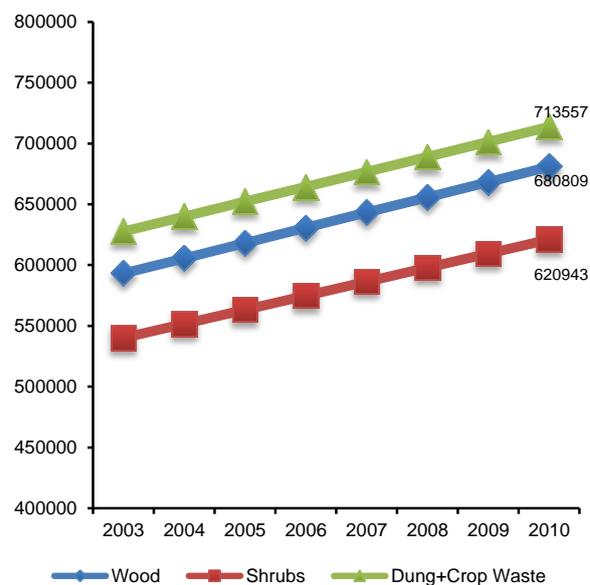
¹³⁷ Thuloane Tsehlo, Department of Energy, Assessment of Energy for Rural Development in Lesotho, May 2012.

¹³⁸ LDHS, 2009 and BoS, Environment and Energy Statistics Report, 2011.

¹³⁹ BoS, Environment and Energy Statistics Report, 2011

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 below.

Figure 7.1: Biomass Consumed in Tonnes



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

Rangelands

Rangelands constitute about 65% of total land area and are a crucial resource because they serve as grazing areas for livestock.¹⁴⁰ 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%.¹⁴¹ Other drivers include encroachment

¹⁴⁰ BoS, Environment and Energy Statistics Report, 2011

¹⁴¹ Ministry of Forestry and Land Reclamation (MFLR), National Range Resources Draft Policy, 2011

for cultivation, urban sprawl, poor land use management, LHWP dams, and fires.¹⁴²

Soil Erosion

Only 9-10% of land is arable in Lesotho, and 54% of this cropland is exposed to sheet erosion - which is the uniform removal of a thin layer of soil usually caused by water run-off.¹⁴³ Moreover, up to 13 tonnes/ha of soil and 0.2-1.0% of arable land are lost to soil erosion annually.¹⁴⁴ 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. Thus, erosion could restrict Lesotho's main source of foreign exchange, as well as its efforts to provide domestic energy and improved access to water.¹⁴⁵

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.¹⁴⁶ 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.¹⁴⁷ 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 these structures are not maintained.

¹⁴² European Union (EU), Lesotho Country Environmental Profile, June 2012

¹⁴³ NSDP, 2012

¹⁴⁴ EU, Lesotho Country Environmental Profile, June 2012

¹⁴⁵ Ibid

¹⁴⁶ UNDP, Project Document, Capacity Building and Knowledge Management for Sustainable Land Management

¹⁴⁷ EU, Lesotho Country Environmental Profile, June 2012

Moreover, these conventional methods are merely temporary stop-gaps that cannot avert long-term erosion without substantial changes in water catchment and land management, such as conservation agriculture, reduced tillage, and crop rotation.¹⁴⁸

Forests

Indicator: Proportion of Land Area Covered by Forests

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.

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 1990.¹⁴⁹ In recent years GOL has led major initiatives to increase forest cover with a target of 5% by 2020. The most successful was the Lesotho Woodland Project of the 1970s and 1980s, which established 485 forest reserves, and the Social Forestry

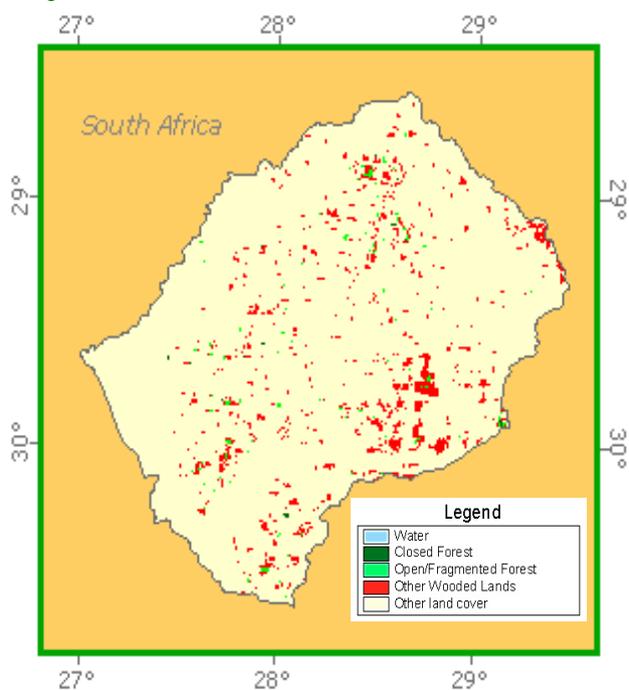
¹⁴⁸ FAO, Strengthening Capacity for Climate Change Adaptation in Agriculture, 2011

¹⁴⁹ Ministry of Forestry and Land Reclamation, forthcoming

and Conservation Project.¹⁵⁰ Around 6000 hectares are Government-owned plantations, while 37,000 ha are held in common.¹⁵¹ That notwithstanding, Lesotho has only increased coverage by 0.33% in the past 23 years from 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.¹⁵² Figure 7.2, below, maps forest cover in Lesotho.

Figure 7.2: Forest Cover in Lesotho



Source: FAO (2010)

¹⁵⁰MFLR, National Forestry Policy, 2008.

¹⁵¹FAO, Lesotho Forest Resource Assessment 2010

¹⁵²USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

Water and Sanitation

Water is Lesotho's most important natural resource and forms the basis of a large part of its economy through the Lesotho Highlands Water Project (LHWP). Water supply is currently abundant, and 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%. notwithstanding this, the coverage is still low.

Lesotho Highlands Water Project (LHWP)

LHWP exports water to RSA and provides domestic hydroelectric power with a series of 3 dams and one 72MW hydropower station. Four more dams and another 83MW hydropower plant are planned. 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.¹⁵³ Dams also disrupt water flow downstream, which damages river ecosystems, increases sedimentation, and reduces water quality.

Domestic Water Supply and Sanitation

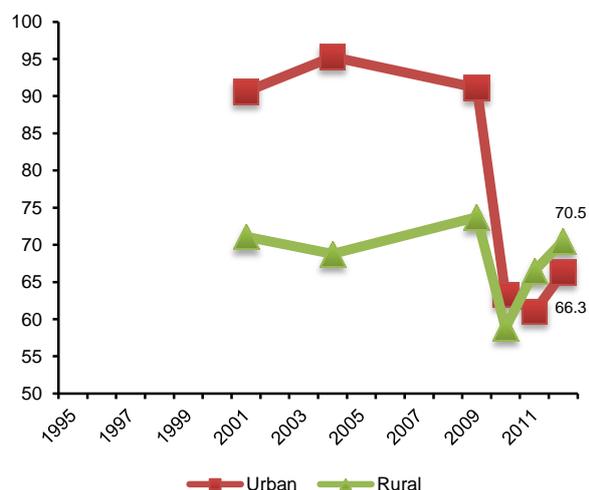
Indicator: Proportion of households with improved sanitation and improved water
A key MDG target is a 50% reduction in the proportion of the population without sustainable access to water and sanitation. The Department of Rural Water Supply (DRWS) and community councils are responsible for rural water supply and sanitation, and the Water and Sewerage

¹⁵³ European Union (EU), Lesotho Country Environmental Profile, June 2012.

Company (WASCO) manages the sector in urban areas. 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. Also, 32% of rural households must travel more than 30 minutes to access safe water – compared to 11% for urban families.¹⁵⁴ Overall, progress on this indicator has stagnated from 2001 to 2009 and then decreased dramatically, and thus, Lesotho is making slow progress on access to safe water.¹⁵⁵

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.¹⁵⁶

Fig. 7.3 Proportion of Households with Improved Water



Source: CMS 2011/12, LDHS 2009, LDHS 2004, LDS 2001

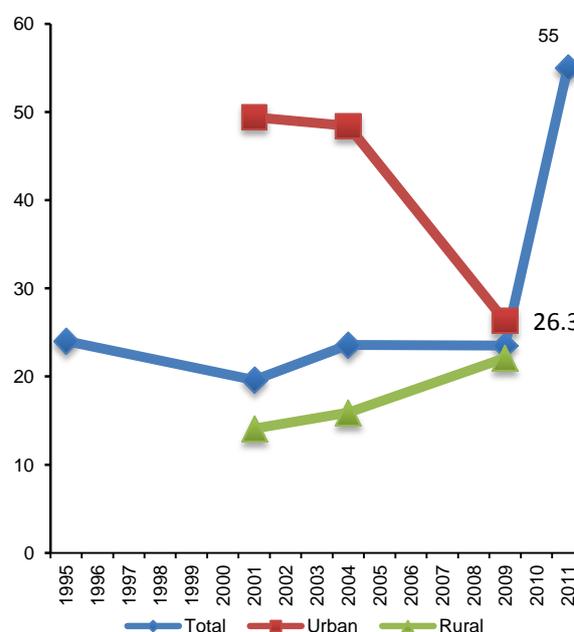
¹⁵⁴LDHS, 2009

¹⁵⁵ Methodological differences between the DHS surveys conducted in different years and differences in the definition of "improved water" and "improved sanitation" make inter-year comparisons difficult. Yet, a thorough review of BoS surveys suggests that water and sanitation access has remained stagnant in the previous decade.

¹⁵⁶NSDP, 2012

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.¹⁵⁷ Figure 7.4, below, shows that urban sanitation coverage had 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 recent 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.¹⁵⁸ The overall trend for the past two decades suggests that sanitation coverage had remained sluggish but notably increased from 2009 onwards (although no disaggregated data is currently available for the rural and urban areas), and thus Lesotho is making slow progress on this indicator.

Fig. 7.4 Proportion of Households with Improved Sanitation



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

¹⁵⁷LDHS, 2009

¹⁵⁸ European Union (EU), Lesotho Country Environmental Profile, June 2012

Water Quality

The Department of Water Affairs and the LHWP engage in water quality testing, and quality is generally acceptable. However, water quality is better in the highlands than in the lowlands, according to LHWP tests. The major exception to water quality is the Caledon River, which receives industrial pollutants.¹⁵⁹

Biodiversity Loss

Endangered animal species

Indicator: 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 or reptiles, 19 of amphibians, and 14 of fish.¹⁶⁰ 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.¹⁶¹ The primary threats to these species include overgrazing, fires, urban encroachment, agricultural encroachment, invasive alien species, pollution, and unsustainable plant harvesting.¹⁶²

Protected Areas and Wetlands

Indicator: 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.¹⁶³ Protected areas conserve ecosystems that support plant and animal biodiversity, harbor 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 the good intentions to preserve these areas. In order to conserve large animals like the lion or baboon, large areas are needed, but fragmentation and trans boundary 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.¹⁶⁴

Wetlands, which cover 1.36% of land area, particularly need protection¹⁶⁵. 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 efforts¹⁶⁶. Some wetlands have come under the protection of Sehlabathebe National Park and Bokong

¹⁵⁹ Ibid.

¹⁶⁰BoS, Environment and Energy Statistics Report, 2011

¹⁶¹International Union for Conservation of Nature, Red List of Threatened Species, www.iucnredlist.org

¹⁶²Department of Environment, Lesotho Fourth National Report on Implementation of Convention on Biological Diversity, 2009

¹⁶³USAID, Biodiversity and Tropical Assessment for Lesotho, 2009

¹⁶⁴ Ibid.

¹⁶⁵

¹⁶⁶ Ministry of Forestry and Land Reclamation, 2013

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 mining¹⁶⁷.

Climate Change

Indicator: CO2 Emissions, Total and Per Capita

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.¹⁶⁸ This figure steadily increased to 805,000 in 2000.¹⁶⁹ 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.¹⁷⁰

TABLE 7.4: CO2 Emissions in Lesotho

	1996	1997	1998	1999	2000
CO2 Emissions (metric tonnes)	681000	700000	750000	772000	805000
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 2080.¹⁷¹ 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.¹⁷²

The water sector is especially vulnerable because decreased rainfall will diminish 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 1700m³ per capita per year by 2019, and a water scarcity period of less than 1000m³ per capita per year by 2062.¹⁷³ 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%.¹⁷⁴ Finally, climate change will exacerbate deforestation, and chronic drought will hinder the recovery of rangelands and wetlands.

Climate change mainstreaming has not occurred across all vulnerable sectors – with particular weaknesses in the water sector and in climate-proofing infrastructure. However, progress is accelerating in climate change

¹⁶⁷European Union (EU), Lesotho Country Environmental Profile, June 2012.

¹⁶⁸ Ministry of Natural Resources, National Report on Climate Change, April 2000.

¹⁶⁹BoS, Environment and Energy Statistics Report, 2011.

¹⁷⁰Botswana and South Africa MDG Reports, 2010.

¹⁷¹FAO, Strengthening Capacity for Climate Change Adaptation in Agriculture, 2011.

¹⁷²FAO, Strengthening Capacity for Climate Change Adaptation in Agriculture, 2011.

¹⁷³Ministry of Natural Resources, National Report on Climate Change, April 2000.

¹⁷⁴ European Union (EU), Lesotho Country Environmental Profile, June 2012.

mitigation and adaptation. The 2007 National Adaptation Programme of Action on climate change analyzed all vulnerable sectors and identified adaptation options. The key institution responsible for 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 and services and weather stations.¹⁷⁵ 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.¹⁷⁶

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.¹⁷⁷ 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 Africa Adaptation Programme (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, and the project helped facilitate the proliferation of over 5,000 solar power systems country-wide after 2008.¹⁷⁸

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

¹⁷⁵ European Union (EU), Lesotho Country Environmental Profile, June 2012.

¹⁷⁶ Thuloane Tsehlo, Department of Energy, Assessment of Energy for Rural Development in Lesotho, May 2012.

¹⁷⁷ Ibid.

¹⁷⁸ Department of Energy/UNDP, LREBRE Report 2012, Promoting Green Energy in Lesotho.

Tourism, Environment, and Culture (MTEC), but implementation is a challenge. MTEC is one of the weakest ministries – with 0.76% of the recurrent budget for 2012/13 – and it is primarily focused on tourism.¹⁷⁹

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.

Bottlenecks, Challenges, and Constraints

Policy and Planning

Fragmented and Uncoordinated Environmental Management - In general, environmental governance is weak with responsibilities fragmented among a number of different 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 implemented well.

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 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.¹⁸⁰ 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. However, GOL has not implemented one SEA or even developed the procedures for doing so.

Ambiguous Authority Structures for Local Land and Resource Management – The Decentralization Policy rearranges the powers of chiefs, who served as the traditional 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

¹⁷⁹Ministry of Finance and Development Planning, Background to the Budget Speech, 2012/13.

¹⁸⁰European Union (EU), Lesotho Country Environmental Profile, June 2012.

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.¹⁸¹

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.¹⁸²

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, held in trust by the King. Thus, 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.¹⁸³ Farmers still do not have any long-term rights to leased land, and grazing lands are still held in common. Thus, they have no incentive to sustainably use the land.

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

¹⁸¹USAID, Biodiversity and Tropical Assessment for Lesotho, 2009.

¹⁸²European Union (EU), Lesotho Country Environmental Profile, June 2012.

¹⁸³ GoL, Land Act, 2012.

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. Also, 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.¹⁸⁴

No Solid Waste Management – Though Maseru has a few waste recovery centres, 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.¹⁸⁵

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.¹⁸⁶*
- *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*

¹⁸⁴European Union (EU), Lesotho Country Environmental Profile, June 2012.

¹⁸⁵Envirotech Services, Baseline Assessment for an Integrated Solid Waste Management System, 2006.

¹⁸⁶ MNR, Lesotho Water and Sanitation Policy, 2007.

- 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 2008 Environment Act, to bring together relevant ministers and other stakeholders to oversee and coordinate national environmental policy-making.
 - Form the Environmental Tribunal, per the 2008 Environment Act, 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.
 - Pass an official Energy Policy (2003 policy remains in draft form) and redouble efforts to replace biomass use with renewable fuel sources, particularly hydroelectric power.
 - 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. A Global Partnership for Development

TARGETS

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

b) *Develop 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

c) *Make new technologies available, especially information and communications*

Indicators

8.6: Mobile subscribers per 100 people

8.7: Internet users per 100 people

d) *Provide affordable access to essential drugs in developing countries*

Indicator

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 MDG 8 Snapshot

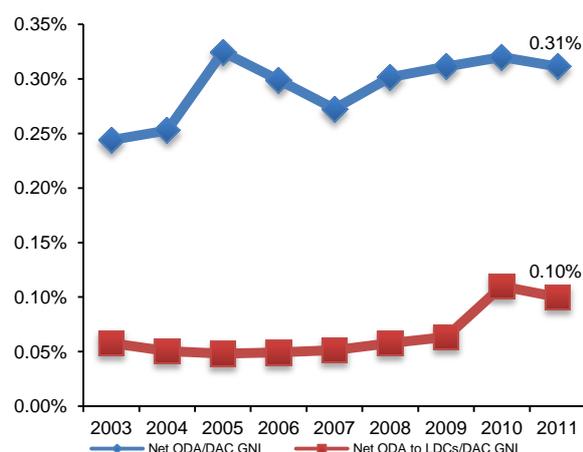
Indicator	Baseline (2000)	2005	2008	Current
Net ODA to Lesotho (USD millions)	37	67.49	143.8	264.58 (2011)
Proportion of ODA Allocated to Social Services	60.4% (2002)	81.8%	87.64%	91.1% (2010)
Proportion of exports to developed countries Admitted Free of Duty	11%	100%	100%	100% (2012)
Proportion of ODA allocated to build Trade Capacity	6.66% (2002)	3.16%	1.05%	0.32% (2010)
Foreign Direct Investment (million maloti)	224.47	482.2	1583.53	1593.69 (2012)
<i>On track</i>				
Mobile Subscribers per 100 people	0.35	11.19	25.67	84 (2013)
<i>Slow Progress</i>				
Internet Users per 100 people	0.22	2.84	4.05	13 (2013)
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), Development Assistance Committee (DAC) members.¹⁸⁷ 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 donor's 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 and the UN 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 threshold¹⁸⁸ (figure 8.1)

Fig. 8.1 ODA as a Proportion of Donor's Gross National Income



Source: OECD (2012)

¹⁸⁷ Net ODA figures subtract principal repayments on loans. DAC members include Western Europe, the United States, Canada, Japan, South Korea, Australia, and New Zealand.

¹⁸⁸ OECD 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 GNI¹⁸⁹. 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/AIDS 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.

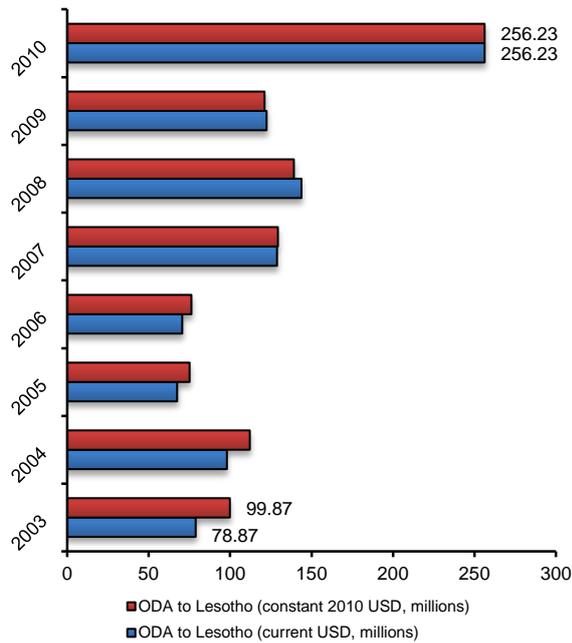
Figure 8.2 and figure 8.3 show that in 2011, net ODA to Lesotho only increased to \$265 million (\$120.6 per capita) which is 9% of GNI.¹⁹⁰ However, ODA will likely decrease and stabilize at normal levels in subsequent years due to the on-going Eurozone and financial crises.

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.

¹⁸⁹ OECD Aid Databases

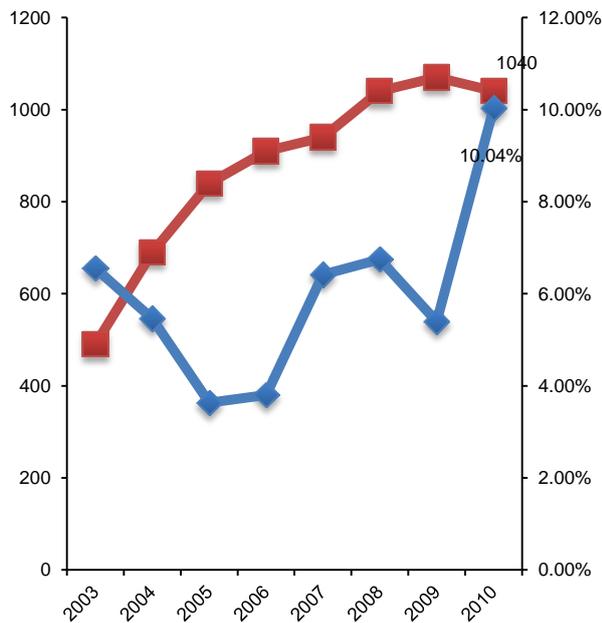
¹⁹⁰ Ibid

Fig. 8.2: Net Official Development Assistance to Lesotho



Source: OECD

Fig. 8.3: ODA as a Proportion of Lesotho GNI



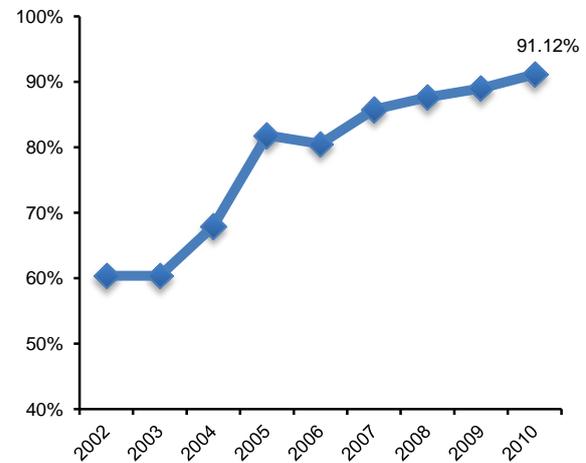
Source: OECD

Indicator 8.2: Proportion of ODA allocated to social services

Figure 8.4 below 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

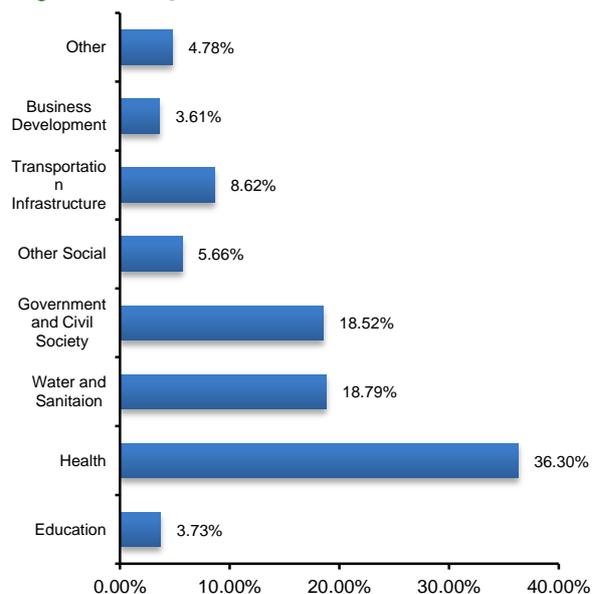
2002 to over 90% in 2010. The distribution of sector-allocable ODA from all donors by sector for 2010 is shown in figure 8.5. The health, water and sanitation, education, and governance sectors receive the vast majority of ODA. A high proportion allocated to social services is indicative of the inclusiveness 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.

Fig. 8.4: Proportion of ODA Allocated to Social Services in Lesotho



Source: OECD

Fig 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 sub-sector, has over the years been a key driver of the Lesotho's economy. Therefore the 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 the 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 2008¹⁹¹. Exports constituted 43% and 46.8% of the GDP in real prices in 2010 and 2011 respectively.

Lesotho's largest trading partner is SACU, which purchased 39% of its exported goods in 2010¹⁹². Lesotho views the RSA market and the SACU market as a whole 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 goods¹⁹³. 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 intra-regional 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 2010¹⁹⁴. Textiles, in particular, are significant, constituting 82% of exports to the U.S. in 2011¹⁹⁵. In 2012, Lesotho was the number one 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 exports¹⁹⁶.

In August 2012 the U.S. Congress renewed a key provision of Africa Growth and Opportunity Act (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 now valid through September 2015, and AGOA's continuation is vital for Lesotho's economy and development in the medium term. Key economic relationship relies entirely on the (AGOA), originally passed by the U.S. Congress in 2000. Passing of AGOA has spurred a booming textile sector in Lesotho, creating thousands of jobs.

Figure 8.6 shows that employment in the textile sector increased gradually 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 out-compete the least developed countries,

¹⁹¹World Bank, Lesotho Public Expenditure Review, August 2012.

¹⁹²Central Bank of Lesotho (CBL), Annual Report 2010. SACU is the Southern African Customs Union

¹⁹³Bureau of Statistics (BoS), 2010 Statistical Yearbook.

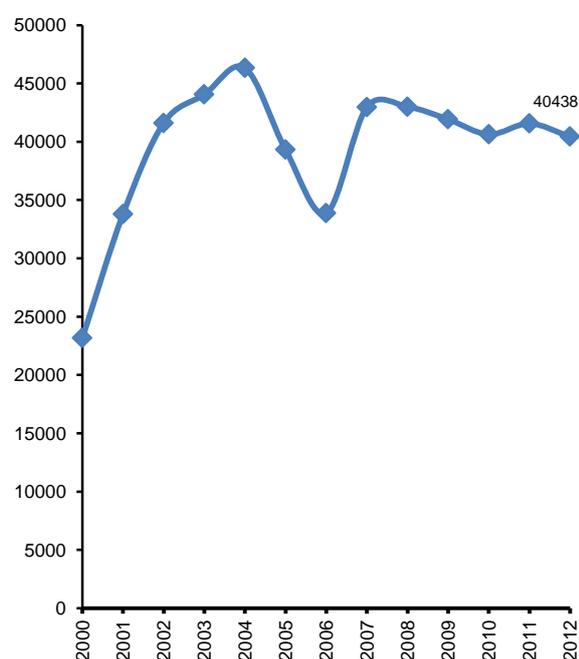
¹⁹⁴CBL Annual Report, 2010;

¹⁹⁵U.S. International Trade Administration, Trade Stats Express Database, 2012.

¹⁹⁶LNDC Status Report Jan-March 2013

giving Lesotho the advantage of getting better market access in the US. In 2004, the multi-fibre agreement came to an end, and the quotas had to be removed. This eroded some of the market that Lesotho and other least developed countries had access to and led to reduction in employment as well. In 2007, employment picked up when the third country fabric provision was extended and the US buyers placed more orders in 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 regained until 2012 and the employment level went slightly down 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.

Fig.8.6 Employment in the Textile sector

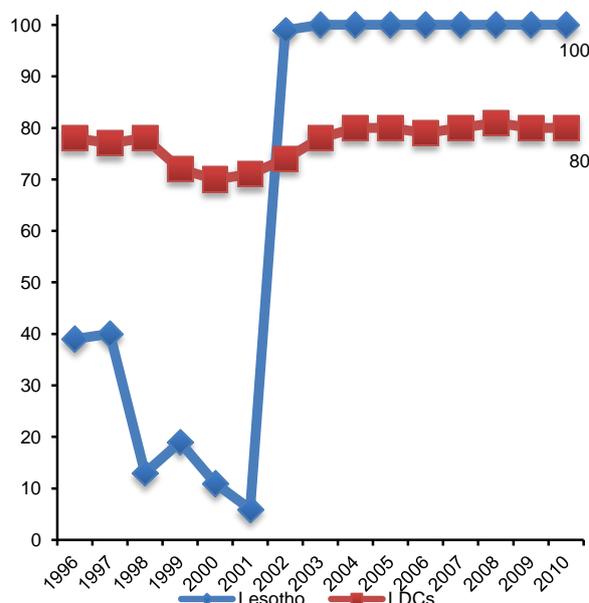


Source: Central Bank of Lesotho

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 rules of origin (ROO), low labour skills and inflexible firm operations that have been

structured to target the traditional markets such as the U.S. As a member of the SADC block, Lesotho is seeking to finalize an Economic Partnership Agreement (EPA) with the EU, and in June 2009 it negotiated an interim EPA with the EU that offers strong trade preferences, particularly for textiles. These trade agreements including the AGOA have benefited Lesotho tremendously over the past decade. The country's exports face a 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%)¹⁹⁷. Moreover, 100% of exports to developed economies have been admitted free of duty since 2002 as shown in figure 8.7. Lesotho also has concessional market access to other developed and developing countries markets under 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 ROO¹⁹⁸.

Fig.8.7 Proportion of Developed Economies' Imports Admitted Free of Duty



Source: ITC, WTO, UNCTAD

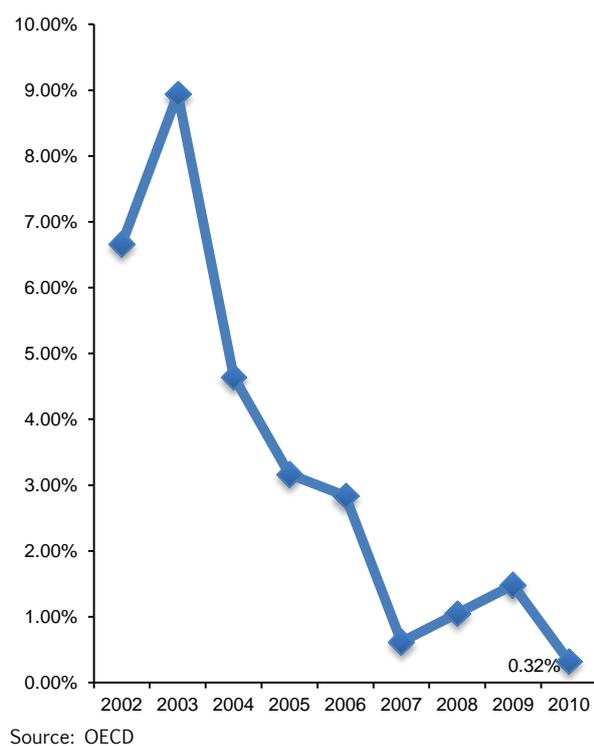
¹⁹⁷BoS, Statistical Yearbook 2010.

¹⁹⁸LNDC Status Report Jan-March 2013.

Indicator 8.4: Proportion of ODA for Trade Capacity

Aid for trade aims to help developing countries strengthen productive capacity, regulatory and policy frameworks, and infrastructure to benefit from trade agreements and 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 (figure 8.8). However, aid for trade has also declined in absolute terms from nearly \$7million (USD) in 2003 to less than \$1 million in 2010¹⁹⁹.

Fig. 8.8 Proportion of Lesotho ODA for Trade Capacity

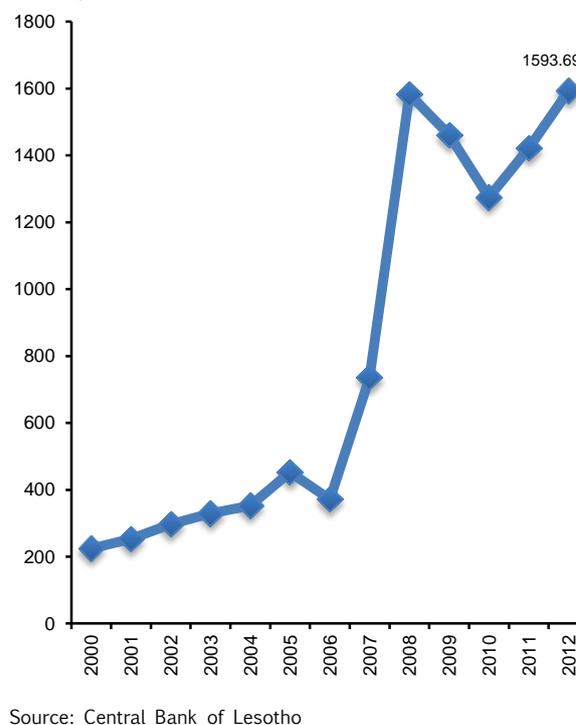


Indicator 8.5: Foreign Direct Investment into Lesotho

Foreign Direct Investment (FDI) is capital investment directly into production or industry by a foreign company – for example, building a factory in another country. FDI is an important source of investment, foreign

capital, and productivity growth for developing countries, and it facilitates technology and skills transfer, and, most importantly, new job creation in the host country. Figure 8.9 below 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 3755 job losses. FDI increased from M1422.24m in 2011 to M1593.69m in 2012²⁰⁰ as a result of a number of initiatives such as the development of industrial infrastructure. To attract FDI, efforts are already being taken by LNDC with support of the Southern Africa Trade Hub to diversify markets. Continued investment in industrial infrastructure, mining sector, communication sector and the Metolong water project should also attract further FDI.

Fig. 8.9: Net Foreign Direct Investment (million maloti)



¹⁹⁹OECD Aid Data Bases.

²⁰⁰Central Bank of Lesotho

Access to Information and Communication Technology (ICT)

Indicator 8.6: Fixed Telephone and Mobile Lines per 100 people

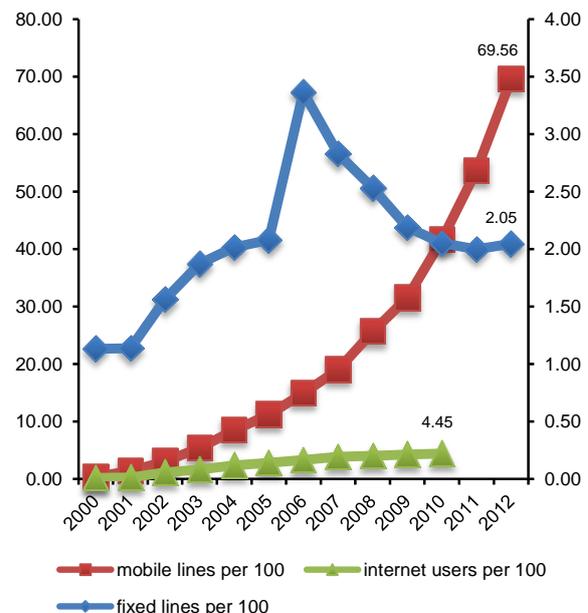
The level of access to communication services is an important indicator for MDG 8. Amongst others, this is because ICTs continue to create unimaginable opportunities for investment and facilitate development and growth in all spheres of the economy. For instance, it is now possible to advance financial inclusivity by sending money to remote areas via mobile handsets, pay bills, complete banking transactions through internet services; read and/or watch news over the mobile handsets; and to provide 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 - namely, Econet Telecom Lesotho and Vodacom Lesotho, which are licensed to provide both voice and data services. In addition to the two, Internet services are also provided by the other six licensed Internet Service Providers.

While some areas remain without access to ICT services, there has been a significant penetration of communication services in the country, 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 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. On the contrary, the growth of fixed telephony has largely 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.

Fig.8.10: Information and Communication Technology Access



Sources: Lesotho Communications Authority; International Telecommunications Union

Indicator 8.7: Internet Users per 100 people

As in most African countries, penetration on Internet access and services in Lesotho has progressed very slowly. Exorbitant prices, slow and unreliable connectivity have been the key factors that hindered Internet penetration. However, this is bound to change now that Lesotho sources international bandwidth through the East African Submarine System (EASSy) project. Participation in this project was 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 was to see large reductions in broadband prices, but these have not been at the scale expected.

In 2000, less than one percent (0.22%) of the inhabitants used Internet, increasing to 4.45% in 2010²⁰¹. The most recent status shows that 13% of the inhabitants use Internet²⁰². 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 promotion²⁰³. Internet cafes continue to provide important public outlets for internet access and usage. 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 living in the remote places 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 high costs of internet connectivity. The facility is intended to enable improved domestic speeds, efficient use of international bandwidth, reduced costs and make savings on foreign exchange. Finally, the county is working towards migrating from analogue to digital terrestrial television broadcasting as per the agreement under the International Telecommunication Union (ITU).

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, good quality, 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

²⁰¹International Telecommunication Union

²⁰²Lesotho Communications Authority

²⁰³Ninety nine percent of the users rely on 3G.

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 however 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 significantly improved from 40% to 58% between the survey years²⁰⁴.

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 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 districts²⁰⁵.

TABLE 8.3: Medicine Access in Lesotho

	2007	2010
HOSPITALS		
Availability of Indicator Medicines (All)206	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)

²⁰⁴ MOHSW, Medicines Access Survey, 2010

²⁰⁵ Ibid

²⁰⁶ MOHSW, Medicines Access Survey, 2010

In view of the need 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 increasing production of traditional medicines with medical claims and their unregulated distribution, medicine safety programme is needed to monitor the pharmacy dynamic of these medicines as well as their long term effect.

Bottlenecks, Challenges, and Constraints

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 systems²⁰⁷. The

²⁰⁷ OECD, *Aid Effectiveness 2005-10: Progress in Implementing the Paris Declaration*, V.2 (country chapters)

survey results also indicated that the manner in which Government records estimates is unclear and therefore difficult to determine where the discrepancies originate. This, therefore points to 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 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-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, aid that 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. Also, there is tremendous volatility in donors' inter-year aid disbursements and in sectoral focus²⁰⁸.

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 relies too much on foreign experts²⁰⁹.

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.

Loss of competitiveness. Lesotho competes with countries like Bangladesh, Vietnam and Cambodia. Scientific 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 amongst others burgeoning operational costs. In 2010, the minimum wage was \$125 compared with approximately \$50 in other countries²¹⁰.

²⁰⁸Personal Interviews, Aid Coordination Unit, Ministry of Finance and Development Planning, August 2012.

²⁰⁹OECD, Aid Effectiveness 2005-10: Progress in Implementing the Paris Declaration, V.2 (country chapters)

²¹⁰CBL Annual Report 2012

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 ultimately receipt of orders.

No Pharmaceutical Regulations. Though medicine access is improving, there is great challenge in regulation of the pharmaceutical industry due to lack of legislation and this has resulted in mushrooming of chemist and pharmacies in the country. Lesotho lacks a medicines regulatory body, criteria for marketing medicines, and standards for licensing manufacturers, wholesalers, distributors, and pharmacists. Moreover, there is no quality assurance system²¹¹. 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 block, 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 international Finance Corporation Doing Business Report 2013. Prospective investors look at these rankings among other things before they make investment location decisions. Also, high start-up and compliance costs and the lack of a coherent regulatory framework may discourage FDI and growth in manufacturing for export.

²¹¹MOHSW, Medicines Access Survey, 2010.

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 guidelines²¹².

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 payment to NSDO²¹³.

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.

²¹²bid

²¹³bid

Key factors contributing to accelerated progress.

- The Government through the Ministry of Development Planning has produced a draft aid 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 2013 Doing Business ranking from 153 to 136 out of 185 countries²¹⁴.
- 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, water supply, notably the Metolong Dam sanitation.
- The country is now connected to the Eastern Africa Submarine Cable System (EASSy) which was intended to bridge the digital divide through introduction of cheaper and high capacity bandwidth connectivity.

• **New challenges for meeting the MDGs**

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

²¹⁴The 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 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 increased 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 secondary and tertiary schools and health centres for enhancing internet access. 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 NSDO. 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.*
- *Ensure the availability of SOPs and STGs in all health facilities and train all pharmaceutical personnel in their use.*

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