KINGDOM OF LESOTHO

Millennium Development Goals Status Report

2015

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FOREWORD

It is an honour and a rare privilege to present this Millennium Development Goals Report, which is the fifth and final MDG Report since 2005. The MDGs have influenced development planning and policy formulation around the world. The Kingdom of Lesotho joined 188 countries in 2000 to commit to achieving the eight Millennium Development Goals (MDGs) by 2015.

This MDG Report captures Lesotho's performance for the past 15 years with respect to the goals and targets set at the United Nations Millennium Summit in September 2000. Our performance in those 15 years is not satisfactory in all the goals and the details are elaborated in the relevant chapters of the report. The report also identifies the unfinished business of the MDGs which will coalesce into the Sustainable Development Goals (SDGs) Agenda.

The year 2015 was the final year for the MDGs as well as the year for formulating the Post-2015 Development Agenda. The new Post-2015 Development Agenda "Transforming Our World: the 2030 Agenda for Sustainable Development," was endorsed by the United Nations Member States in New York in September 2015.The Agenda will guide the development process for the world for the coming 15 years and seeks to address the three dimensions of sustainable development- social, economic and environment-in a balanced and integrated manner. The agenda is defined by 17 Sustainable Development Goals and 169 targets designed to improve people's lives and protect the planet for future generations.

The lessons learned from Lesotho's MDG experience will inform a smooth transition from the Millennium Development Goals (MDGs) to the new development agenda and therefore this MDG end-point report will serve as an invaluable resource document as we transition from the MDGs to the SDGs. It will also serve as a useful guide in the smooth implementation of the SDGs. A set of concrete measures will have to be taken, ranging from the localization of the SDGs to accord with national realities, mainstreaming these global goals and targets into the national, regional and continental development plans, as well as tracking and monitoring progress towards the achievement of the SDGs by 2030. As the MDGs monitoring and reporting exercises have shown, the improved availability of data is crucial for sound analysis and decision-making.

The Government of Lesotho will provide the political support and policy guidance in the implementation of the SDGs. The Government, the United Nations, other development partners, the private sector, academia and the civil society will work together to complete the unfinished business of the MDGs and at the same time roll out the SDGs. While committing to our renewed partnership, we present to you the Millennium Development Goals Report for 2015 trusting that it will spur all stakeholders into action for the next 15 years.

The Right Honourable Dr. Pakalitha Mosisili

Prime Minister of the Kingdom of Lesotho

PREFACE

The Lesotho 2015 Millennium Development Goals Report reviews Lesotho's progress in achieving the Millennium Development Goals that guided Lesotho's development efforts between 2000 and 2015. Using the latest available data, the report presents information about the progress achieved so far on each of the eight global MDGs associated to 13 targets and 56 indicators relevant to Lesotho. It assesses the overall trends and progress in achieving various targets and indicators, highlights the policies and strategies that supported the progress on some of the goals and identifies the bottlenecks and challenges that have hindered further progress. The report also highlights emerging priorities for Lesotho, lessons learned and offer recommendations for the way forward.

Since the inception of MDGs in 2000, Lesotho's MDG progress has shown mixed results with some goals showing progress, while others have witnessed very slow progress. The country has made slow progress with regard to universal primary education (Goal 2), promoting gender equality and empowering women (Goal 3) and ensuring environmental sustainability (Goal 7). Substantial progress has been observed in developing global partnership for development (Goal 8); while very slow progress has been observed in reducing child mortality (Goal 4). The country in particular is lagging behind in poverty reduction (Goal 1), reducing Maternal Mortality by ¾ and combating HIV and AIDS and other diseases (Goals 5 and 6). The major unfinished business of MDGs in Lesotho relate to eliminating poverty and hunger, reducing inequalities, improving maternal health, reducing child mortality and tackling HIV and AIDs and TB. Gender inequality (access to economic assets, participation, representation in private sector and public decision-making) and environmental sustainability (owing to degradation of land, low forest coverage and climate change) also still remain challenges.

Although there has been good progress towards achieving several targets, none of the MDGs have been met. Experience from the implementation of the MDGs has demonstrated that significant progress can be made with targeted interventions, sound strategies, adequate resources and political will.

Going forward, the Kingdom of Lesotho needs to redouble its efforts to meet the as-yet unreached MDGs while also meeting its Sustainable Development Goals. A renewed sense of commitment from the Government, Development Partners, private sector, non-state actors and other stakeholders is required if Sustainable Development Goals (SDGs) are to serve as the platform for balanced and inclusive growth, while leaving no one behind.

Honourable Francis Mokoto Hloaele, MP

The Minister of Development Planning

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

The Government of Lesotho is grateful to the Drafting Team that wrote the report; Ms. Malefu Khanyapa (MDP); Ms. Lineo Mokitimi (MDP); Mr. Retšelisitsoe Pulumo (MDP); Ms. Moipone Lehloara, (MDP); Mr. Sebothama Moshoeshoe, (MDP); Ms. 'Mahlompho Chaotsane, (MDP); Mr. Moeketsi Matia (MDP); Ms. 'Mabereng Mpooa (MDP); Mr. Phaello Mosala (MDP); Mr. Maoala Khesa (MAFS); Ms. Mamotšabi Lemeke (MOET) and Ms. Mantšabeng Lifalakane (Ministry of Gender).

Finally, the development of this report was overseen by Mr. Potlako Peko, Ms. Asha Kannan, Senior Economic Advisor (UNDP), Ms Mabulara Tsuene, National Programme Officer – Microfinance (UNDP).

LIST OF ACRONYMS

AAP Africa Adaptation Programme

AGOA African Growth and Opportunity Act

AIDS Acquired Immune Deficiency Syndrome

AJR Annual Joint Review of the Health Sector

ALAFA Apparel Lesotho Alliance to Fight Aids

ART Antiretroviral Treatment

ARV Antiretroviral

BCC Behaviour Change Communication

BOS Bureau of Statistics

CA Conservation Agriculture

CBL Central Bank of Lesotho

CEDAW Convention on the Elimination of all forms of Discrimination Against Women

CHAL Christian Hospital Association of Lesotho

CMS Continuous Multi-purpose Household Survey

CO_2 Carbon Dioxide

DAC Development Assistance Committee of the OECD

DHMT District Health Management Team

DMA Disaster Management Authority

DNA-PCR Deoxyribonucleic Acid-Polymerase Chain Reaction

DOE Department of the Environment

DRWS Department of Rural Water Supply

EIA Environmental Impact Assessment

EASS East African Submarine System

EMICS Strategic Environmental Assessment

EPA Economic Partnership Agreement

EU European Union

FAO Food and Agriculture Organization of the UN

FDI Foreign Direct Investment

FNCO Food and Nutrition Coordinating Office

FPE Free Primary Education

GBV Gender Based Violence

GDP Gross Domestic Product

GGGR Global Gender Gap Report

GNI Gross National Income

GOL Government of Lesotho

ha hectare

HAART Highly Active Antiretroviral Treatment

HIV Human Immunodeficiency Virus

HTC HIV Testing and Counselling

ICT Information and Communication Technology

IDA International Development Association of the World Bank

IMCI Integrated Management of Childhood Illnesses

IUCN International Union for the Conservation of Nature

LCA Lesotho Communications Authority

LDHS Lesotho Demographic and Health Survey

LIST OF ACRONYMS

LHDA Lesotho Highlands Development Authority

LDS Lesotho Demographic Survey

LGNSP Local Governance and Non-State Actors Support Programme

LHWP Lesotho Highlands Water Project

LMS Lesotho Meteorological Service

LNDC Lesotho National Development Corporation

LREBRE Lesotho Renewable Energy Based Rural Electrification Project

LVAC Lesotho Vulnerability Assessment Committee MAFS Ministry of Agriculture and Food Security

MC Male Circumcision

MMC Medical Male Circumcision

MCA Millennium Challenge Account

MCC Millennium Challenge Corporation

MCP Multiple and Concurrent Partnerships

MDG Millennium Development Goal

MDP Ministry of Development Planning

MFLR Ministry of Forestry and Land Reclamation

MMR Maternal Mortality Ratio

MNR Ministry of Natural Resources

MOE Ministry of Education

MOF Ministry of Finance

MOGYS Ministry of Gender, Youth, Sports, and Recreation

MOH Ministry of Health

MSME Medium, Small, and Micro Enterprises

MTCT Mother to Child Transmission

MTEC Ministry of Tourism, Environment, and Culture

MTICM Ministry of Trade, Industry, Cooperative, and Marketing

NAC National AIDS Commission

NDSO National Drug Supply Organization

NEC National Environmental Council

NGO Non-Governmental Organization

NSDP National Strategic Development Plan

ODA Official Development Assistance

OECD Organization for Economic Cooperation and Development

OVC Orphaned and Vulnerable Children

PMTCT Prevention of Mother to Child Transmission

RED Reaching Every District Immunization Initiative

RSA Republic of South Africa

SACU Southern African Customs Union

SADC Southern Africa Development Community

SEA Strategic Environmental Assessment

STG Standard Treatment Guidelines for Pharmaceuticals

SWAP Sector-Wide Approach for Aid Coordination

SIAPS Systems for Improved Access to Pharmaceuticals and Services

TB Tuberculosis

LIST OF ACRONYMS

UAF Universal Access Fund

UNDP United Nations Development Programme

USD United States Dollar

VIP Ventilated Improved Pit Latrine

WASCO Water and Sanitation Company

WFP World Food Programme

SECTION I: OVERVIEW

LESOTHO DEVELOPMENT CONTEXT

The Kingdom of Lesotho is a small, mountainous country landlocked within South Africa. The kingdom's land area measures 30,355 km[2]. It has a population of 1,872,721[1].By several global rankings, Lesotho is a country in need of economic development. With a per capita income of US$1879[2], Lesotho is classified among the world's Least Developed Countries The World Bank ranks Lesotho 114 out of 189 countries in terms of how its business regulatory environment affects the economy's current health and prospects for growth[3]. The United Nations Human Development Index, which ranks countries based on a composite score of their citizens' life expectancy, education and income ranks Lesotho 161 out of 187 countries.[4]This ranking designates Lesotho as a country characterized by low human development.

Complicating its development progress is the fact that the country has been rather slow to urbanize. Three-quarters of Lesotho's citizens live in rural areas and engage in subsistence agriculture. Many households continue to depend on remittances from family members working in South Africa, in mines, on farms and as domestic workers, although mining employment has declined substantially since the 1990s.

Lesotho's Gross Domestic Product witnessed an annual average growth rate of 4.6% since 2004. Lesotho recovered well from the global economic crisis of 2008 and by 2010 boasted a growth rate of 7.9%. Unfortunately, the pace of growth slowed in 2011 due to a decline in agricultural production caused by floods early that year. Although the GDP growth rate picked up in 2012 with an estimated annual growth rate of 5%, it gradually slowed to 3.6% in 2014. The sluggish growth was attributable to slackened performance of agriculture and construction. Certain major construction activities such as Metolong dam were completed in 2014. Agriculture contracted by 4.7% in 2014, from a high of 17.1% in 2013.

Lesotho's economy is projected to recover gradually amid uncertainties and challenges in the manufacturing, particularly textiles and clothing industry, and agricultural sectors. Real Gross Domestic Product (GDP) is expected to accelerate steadily from 2.9 per cent in 2015 to 4.6 per cent in 2018, mainly supported by mining industry as well as services sector. Advance infrastructure development associated with the second phase of the Lesotho Highlands Water Project (LHWP) is also set to boost economic growth starting from 2018. Nevertheless, gradual erosion of the country's competitiveness in the US market is set to restrain growth in textile and clothing industry while regional drought conditions are likely to curtail crop production.
The economy continues to face numerous challenges. These include a lower degree of diversification, low domestic savings leading to over-dependence on foreign capital inflows, high

[1] 2006 Lesotho Population and Housing census

[2] World Bank (2012)

[3]World Bank Doing Business Report (2016)

[4]United Nations Human Development Report (2015)

unemployment, widening inequality and poverty. Added to this is the burden of HIV/AIDS, particularly on the young generation. Together with high inequality[5], these have implications on social spending to protect the vulnerable population. In line with the current trajectory of South African Customs Union (SACU) revenue, government budgetary operations are expected to deteriorate and dip into deficit equivalent to 6.3 per cent GDP in 2016 before improving to a deficit of 1.1 per cent of GDP in 2018. Slow implementation of Southern African Development Community (SADC) protocols on free movement of goods, services, labour and capital impedes regional economic integration as well as the spatial inclusion of Lesotho in regional growth. Together with the expected deterioration of the external sector, gross official reserves are projected to decline from 6.4 months of import cover to approximately 3.9 months in 2018. The main risks to domestic economic outlook include uncertainties surrounding SA growth prospects, adverse weather conditions, possible delays in the implementation of major capital investment projects and recently signed Trans-Pacific Partnership (TPP) agreement. All these may put strains on domestic economic prospects including the country's external position and fiscal outlook.

Poverty in Lesotho has a strong spatial dimension, as the rural areas are home to the majority of the poor. This divide is reflected in a wide range of poverty indicators, including the national poverty, extreme poverty and dollar/day poverty rates. Income distribution in Lesotho remains skewed towards the urban areas, which calls for urgent policies to redress this. Another area of spatial tension is unemployment and inequality. About 75.7% of the unemployed live in rural areas. Unemployment is especially high among the youth. The majority of rural workers employed in private household activities, largely agriculture while in urban areas, manufacturing and services sectors tend to be the main employers. Decline in agriculture over time and concentration of key activities in urban areas have encouraged rural to urban migration with attendant negative socio-economic effects.

[5]Lesotho has a Gini Index of 0.54

EXECUTIVE SUMMARY

At the Millennium Summit in September 2000, 189 countries, including the Kingdom of Lesotho, committed to achieving eight Millennium Development Goals by 2015. This was a groundbreaking moment in history. Never before had most of the world's nations committed to a specific, shared agenda for improving living conditions for all people. The Millennium Development Goals (MDGs) included reducing poverty and hunger, achieving universal primary education, promoting gender equality and the empowerment of women, reducing child mortality, improving maternal health, combating malaria, HIV/AIDS and other diseases and ensuring environmental sustainability. For the next 15 years, from 2000 to 2015, the MDGs established the global framework for development.

As the 15-year MDG period ended on December 31, 2015, the purpose of this report is to reflect on Lesotho's progress towards the MDGs since 2000. As reviewed in the Report, the MDGs provided a highly constructive framework for Lesotho's ongoing development efforts.

Lesotho's success in achieving the MDGs has been mixed. The country has made progress in the areas of education, gender equality, the environment and global partnership for development. These are critical achievements that Lesotho will strive to build on as it begins its work on the Post-2015 Development Agenda.

Lesotho fared less well in health and poverty-related MDGs. According to 2014 LDHS, Lesotho has the second-highest HIV prevalence in the world at 25%. The high prevalence of HIV/AIDS makes poverty alleviation and infant/maternal health efforts more challenging. The high HIV/AIDS prevalence and Tuberculosis and high unemployment have also contributed to Lesotho's extremely slow progress in the areas of eradicating extreme poverty, reducing child mortality and improving maternal health.

MILLENNIUM DEVELOPMENT GOAL 1

As of 2015, more than half of Lesotho's population is living below the poverty line. While unemployment has decreased from 34.2% in 1997 to 28.7% in 2015, it continues to contribute to the high level of poverty. South African mines once provided over 100,000 jobs for Basotho whose remittances strengthened Lesotho's economy. With the decline of jobs in South African mines, Lesotho's economy has weakened considerably. Added to this, recurring droughts have caused pronounced food insecurity. Lesotho's largely rural and very young population are complicating poverty alleviation efforts. Youth comprise about half the country's population. Thirty-percent of the population is food insecure, which means that they do not have regular, daily access to sufficient nutrition. Although the levels of developmental stunting among the 5 year olds, an indicator of extreme nutritional deprivation, is declining, the incidences of malnutrition in children remain high. As a result of these challenges, Lesotho has failed to achieve MDG 1: Eradicate Extreme Poverty and Hunger.

MILLENNIUM DEVELOPMENT GOAL 2

Lesotho has shown decisive leadership in the area of primary education. In a milestone effort to achieve universal primary education, Lesotho enacted the Education Act of 2010, which made primary education not only free, but also compulsory. Primary education enrolment is currently at 76% in Lesotho. This represents a decline. As recently as 2010, primary enrolment was at 80% for boys and 84% for girls. Another significant achievement during the MDG period has been the improvement in the net cohort survival rate, the number of students who graduate from primary education. This figure has risen from 61.5% in 2005 to 71.8% in 2014. Lesotho has achieved and maintained literacy rates of over 90% for women and men since 2005. While Lesotho is a regional leader in education in Sub-Saharan Africa, it failed to meet its target of 100% in the areas of literacy among 15-24 year olds, net enrolment and proportion of pupils who complete primary school. As a result, while Lesotho has made progress, it failed to achieve MDG 2: Achieve Universal Primary Education.

MILLENNIUM DEVELOPMENT GOAL 3

Lesotho has achieved substantial progress in promoting gender equality and female participation in politics. Whereas just 11.2% of Lesotho's National Assembly were females in 1993, 25% of the National Assembly were females in 2014. The country's efforts to empower girls and women are shown by the fact that currently more girls than boys attend secondary and tertiary education. Lesotho now has to address the lower enrolment rates of boys rather than girls, especially in the areas of secondary and tertiary education. Lesotho has succeeded in meeting its target of achieving 50% share of women in non-agricultural wage employment. While Lesotho has either met or made substantial progress toward several indicators for MDG 3, Lesotho has not met all its targets and therefore has not achieved MDG 3: Promote Gender Equality and Empower Women.

MILLENNIUM DEVELOPMENT GOAL 4

The under-5 mortality rate is considered a proxy for a nation's level of development, for it reflects on a wide range of factors that contribute to the death of a child. These factors include poverty, hunger and quality of health services for both mother and child. Lesotho has significantly reduced its under-5 mortality rate from 113 per 1000 live births in 2005 to 85 per 1000 live births in 2015. However, Lesotho's goal was to reduce by two-thirds the under-five mortality rate, which would have produced an under-5 mortality rate of 37 per 1000 live births. Therefore, it did not achieve this target. Similarly, Lesotho achieved important progress in reducing its infant mortality rate from 81 per 1000 live births in 2005 to 59 per 1000 live births in 2015. Nevertheless, Lesotho had set a target of reaching 27 per 1000 live births by 2015. It therefore, failed to meet its target of reducing infant mortality by two-thirds by 2015. Lesotho substantially achieved its target of 100% immunization against measles for one year olds. As of 2015, the country immunizes 90% of its one-year olds against measles, a nearly 20% jump since 2005 when it only immunized 71.3% of its one-year olds. This achievement notwithstanding, Lesotho has failed to meet MDG 4: Reduce Child Mortality.

MILLENNIUM DEVELOPMENT GOAL 5

The maternal mortality situation in Lesotho represents a national crisis. Since 2001, maternal deaths have risen sharply. In 1990, maternal deaths were 370 per 100,000 births. In 2009, maternal deaths had risen to 1,143 per 100,000 births; however, it has slightly decreased to 1,024 in 2014. As of 2015, one out of 32 Basotho women dies of pregnancy and childbirth-related conditions. Most maternal deaths are preventable and caused by lack of access to health services, particularly in rural areas. It is of concern that an 18% increase in skilled personnel attending births since 2001 has not reduced the maternal mortality rate. While access to contraception and family planning facilities has registered a positive trend, Lesotho has not met MDG 5: Improve Maternal Care.

MILLENNIUM DEVELOPMENT GOAL 6

The HIV/AIDS infection rate among adults in Lesotho is 25%, the second highest in the world. Although there is increased awareness and usage of condoms, there is still more to do to ensure ART coverage, adherence as well as prevent new infections. There is also a noted reversal on the progress made on treatment of TB, with increased incidences, linked to HIV and AIDS.

HIV/AIDS constrain the attainment of all the other MDGs. Women have a higher infection rate than men, with higher prevalence in urban areas than in rural areas. This prevalence is likely the result of rural-urban migration and transactional sex. Tuberculosis (TB) is also a significant public health challenge. Although there has been some improvement in ART coverage and treated TB cases, Lesotho has not met its targets for Goal 6: Combating HIV and AIDS, TB, Malaria and other diseases.

MILLENNIUM DEVELOPMENT GOAL 7

Lesotho faces many challenges in the area of environmental stability. In 1990, just 1.3% of the country's arable land was covered by forest. The country set a goal of reaching 5% forestry coverage by 2015, but as of 2015, this percentage has grown by just 0.3% to 1.6%. Adding further stress to the environment is the country's heavy reliance on wood and biomass, poor agricultural practices and livestock overgrazing. Poor land management practices eventually cause sedimentation and impact river ecosystems, while also exacerbating air and water pollution.

Lesotho has made substantial progress in the past decade on improved sanitation, which is critical to environmental sustainability and health. Improved sanitation facilities include flush toilets, ventilated improved pit latrine, pit latrine with slab and composting toilet. In 1990, 24% of Basotho households had access to sanitation facilities. More than 25 years later, in 2015, 50.9% of Basotho households have improved sanitation facilities. The balance of this largely rural population still use open defecation, which greatly increases the spread of disease and infection.

Lesotho has also experienced success in improving access to clean water. According to the World Bank, 77% of rural residents and 95% of urban residents have access to an improved water source such as piped household water, public taps, or protected springs or dug wells. Lesotho is not a large emitter of greenhouse gases, but is 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. Lesotho has made progress; but did not achieve this goal.

MILLENNIUM DEVELOPMENT GOAL 8

Official Development Assistance (ODA) to Lesotho has increased steadily over the last decade to USD $343 million in 2015, the highest on record. ODA to Lesotho grew as a result of several factors such as, increased funding for HIV/ AIDS, the Millennium Challenge Corporation (MCC) and direct budget support from a bilateral donor and multilateral institutions to ease the impact of the global economic crisis. Lesotho has achieved remarkable growth with teledensity, owing to technology transfers under ODA. Teledensity is a critical form of infrastructure, which is likely to promote and facilitate Lesotho's encouragement of Basotho entrepreneurs as well as the country's development as a tech hub and a participant in the 21st Century global information economy.

TRANSITION FROM MDGS TO SDGs

Lesotho has prepared itself for a smooth transition to the new Sustainable Development Goals (SDGs)/ and Post-2015 Development Agenda by drawing upon the lessons learned from its MDG achievement and challenges. The challenge facing Lesotho is that it must continue striving toward completing the unfinished business of MDGs, while simultaneously integrating the Post-2015 Development Agenda within its national development plans and regional plans such as Agenda 2063. Furthermore, Lesotho must mobilize domestic resources and explore new partnerships with the private sector, academia, CSOs and NGOs.

DATA AND MONITORING AND EVALUATION SYSTEMS

The importance of building a modern data collection system for evidence-based policymaking and timely and regular analysis is evident from Lesotho's MDG experience. The lack of up-to-date data has hampered assessment of progress in many MDG targets/indicators. Systematic monitoring and evaluation mechanisms must be established to prevent similar problems in achieving the SDGs.

Given domestic capacity constraints in this area, support from development partners and international agencies will be critical to develop personnel and tools for governmental data recording, analysis and management.

FINANCING FOR DEVELOPMENT

Net ODA has played a critical role in Lesotho's ability to address MDG challenges. Thanks to the commitment of Lesotho's global partners, Net ODA to Lesotho more than doubled during the period of the MDGs. This had the side effect of creating high aid dependency (15.4% of GNI in 2013). The largest share of ODA (78% in 2013) goes to the social sector to mitigate the persistently high impact of HIV /AIDS, amongst other diseases including Tuberculosis.

Given its small size and excessive dependence on South African Customs Union receipts, textile exports to the United States and miner's remittances, Lesotho is highly vulnerable to external economic shocks. Given the country's limited resources, there is a need for greater international donor support and engagement to support Lesotho in addressing its persistent socio-economic challenges.

The financing of the SDGs is going to be increasingly challenging for Lesotho, given its current heavy dependence on ODA for meeting the MDGs. The continued support of the global community is vital to prevent reversals of Lesotho's developmental achievements and ensure the country's success in meeting the SDGs. The Government of Lesotho looks forward to continuing its partnership with the UN system, other development agencies and the private sector in improving conditions for all who call Lesotho home.

MILLENNIUM DEVELOPMENT GOALS AT A GLANCE

Lesotho did not achieve any Millennium Development Goals. Its progress towards each MDG is provided in the table below.

MDG	STATUS
MDG 1: Eradicate Extreme Poverty and Hunger	Very Slow Progress
MDG 2: Achieve Universal Primary Education	Slow Progress
MDG 3: Promote Gender Equality and Empower Women	Slow Progress
MDG 4: Reduce Child Mortality	Very Slow Progress
MDG 5: Improve Maternal Health	Very Slow Progress
MDG 6: Combat HIV and AIDS and TB	Very Slow Progress
MDG 7: Ensure Environmental Sustainability	Slow Progress
MDG 8: Develop a Global Partnership for Development	Substantial Progress

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
Eradicate Extreme Poverty and Hunger	Reduce by half the proportion of people living on less than $1.25 a day	Proportion of people below the national poverty line (%)	66.6% (2003)	29%	57.1% (2010/11)	Not Achieved
		Poverty gap index (%)	37.9% (1995)	17%	29.5% (2011)	Not Achieved
		Gini Index	0.57 (1995)	No Target	0.54(2011)	…
	Achieve full and productive employment for all	Unemployment rate (%)	34.2% (1997)	15 %	28.7 % (2010/11)	Not Achieved
		Proportion of vulnerable employment in totalemployment (%)	29%(2003)	No Target	11.8 % (2011)	….
	Halve, between 1990 and 2015, the proportion of people who suffer	Proportion of population that is food insecure (%)	29.5% (2008)	No target	23.6% (2014)	…
		Prevalence of	15.8%	8%	10%	Substantially

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
	from hunger	underweight children under 5 years (%)			(2014)	Achieved
		Proportion of stuntedchildrenunder 5 (%)	45.4% (2000)	No Target	33% (2014)	…
Achieve Universal Primary Education	Ensure that all children are able to complete primary education	Net enrolment ratio in primary education (%)	82% M: 78.7% F: 85.3% (2000)	100%	76.6% M: 75.1% F: 78.2% (2014)	Not Achieved
		Percentage of pupils starting grade 1 who reach last grade of primary (%)	61.2% (2005)	100%	71.8% (2014)	Not Achieved
		Literacy rate of 15-24 year-olds, women and men (%)	89.3% M: 82.5% F: 96.1% (2004)	100%	94.6% M: 90.6% F: 98.6% (2014)	Substantially Achieved
Promote Gender Equality and Empower Women	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	Girls-boys ratio in primary education	102 (2000)	100	96.1 (2014)	Substantially Achieved
		Girls – boys ratio in secondary education	131 (2000)	100	137.2 (2014)	Not Achieved
		Girls – boys ratio in tertiary education	116 (2000)	100	142 (2014)	Not Achieved
		Percentage of women in non-agricultural wage employment (%)	34.4% (2001)	50%	56.1% (2012)	Achieved
		Percentage of seats held by women in parliament (%)	17% (2003)	30%	25% (2015)	Substantially Achieved
Reduce Child Mortality	Reduce by two-thirds the under-five mortality rate	Infant mortality rate (per 1,000 live births)	81	27	59	Not Achieved
		Under-five mortality rate	113	37	85	Not Achieved

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
		(per 1,000 live births)				
		Percentage of 1 year-olds immunized against measles (%)	71.3%	100%	90%	Substantially Achieved
Improve Maternal health	Reduce by three-quarters the maternal mortality ratio	Maternal mortality ratio (per 100,000 births)	419 (2001)	90 (global) 300 (national)	1024 (2014)	Not achieved
		Proportion of births attended by skilled health personnel (%)	60% (2001)	80%	78% (2014)	Substantially Achieved
		Contraceptive Prevalence Rate	40.6% (2001)	80%	60.2% (2014)	Not Achieved
		Adolescent Birth Rate (%)	13% (2001)	No set target	19.1% (2014)	….
		Antenatal Coverage at least 1 visit	85% (2001)	100%	95% (2014)	Substantially Achieved
		Antenatal Coverage at least 4 visits (%)	66.9% (2004)	100%	77.9% (2014)	Not Achieved
		Unmet need for family planning (%)	30.9%(2004)	No Target	18% (2014)	…
Combat HIV and AIDS and TB	Halt and begin to reverse spread of HIV and AIDS	HIV Prevalence among population aged 15-24(%)	11.3% M: 6% F:15.4% (2004)	No Target	9.6% M:6.0% F:13.1% (2014)	…
		Prevalence among adults (15-49) (%)	23% (2009)	No Target	25% (2014)	…
		Adults (15-49)with multiple partners in the past year(%)	M:30.4% F:11% (2004)	No Target	M:26.5% F: 6.57% (2014)	…

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
		Condom use among adults during last high-risk sex(%)	28% M:38% F:19% (2004)	M:80% F:70%	60% M:65% F: 54%	Not Achieved
		Proportion of population aged 15-24 years(youths) with comprehensive correct knowledge of HIV and AIDS (%)	22% M:18% F:26% (2004)	85%	34% M:31% F: 38% (2014)	Not Achieved
		Adult Antiretroviral coverage (%)	1 (2004)	80	35 (2014)	Not Achieved
		Child Antiretroviral coverage (%)	No Data	80	30 (2014)	Not Achieved
		HIV+ pregnant women receiving ART for preventing MTCT (%)	4 (2004)	95	74 (2014)	Not Achieved
	Halt and begin to reverse incidence of TB	TB Prevalence per100,000 population	No Data	No Target	411 (2011)	…
		TB Deaths per 100,000 population	No Data	No Target	94 (2011)	…
		TB Incidence	No Data	No Target	No Data	…
		Proportion of tuberculosis		85	70	Partially Achieved

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
		cases detected and cured (%)	No Data			
Ensure Environmental Sustainability	Reverse loss of environmental resources	Reliance on Biomass (cooking)%	66%(2001)	No Target	53.9% (2011)	…
		Reliance on Biomass (heating) %	67% (2001)	No Target	No Data	…
		Endangered animal species	No Data	No Target	3 (2011)	…
		Protected Land Area(km^2)	No Data	No Target	0.4 (2012)	…
		CO^2 Emissions, Total (tonnes)	805,000 (2000)	No Target	No Data	…
		CO^2Emissions, per capita (tonnes)	0.43 (2000)	No Target	No Data	…
		Households with Improved Sanitation (%)	24% (2001)	62	50.9% (2014)	Partially Achieved
		Households with Improved Water Sources (%)	80.6% (1995)	91%	82.2% (2014)	Substantially Achieved
		Forestry Coverage (%)	1.3%(200)	5%	1.6% (2013)	Not Achieved
Develop a Global Partnership for Development	Address the special needs for LDCs	Net ODA to Lesotho – total (USD millions)	36.7 (2000)	No Target	343.2 (2013)	…
		Proportion of ODA allocated to social services	60.4 (2002)	No Target	77.9 (2013)	…
	Develop further an open, rule based,	Proportion of exports to developed	11 (2000)	No Target	100 (2013)	…

Goal	TARGET	INDICATOR	BASELINE	2015 TARGET	CURRENT	STATUS
	predictable, non-discriminatory trading and financial system	countries admitted free of duty (%)				
		Proportion of ODA allocated to build trade capacity (%)	6.7 (2002)	No Target	0.3 (2010)	…
		Foreign Direct Investment into Lesotho (Million Maloti)	224.5 (2000)	No Target	1593.7 (2012)	…
	Make available benefits of technologies, especially information and communications (%)	Fixed telephone lines per 100 people	1.1 (2000)	No Target	3 (2014)	…
		Mobile subscribers per 100 people	0.4 (2000)	No Target	93 (2014)	…
		Internet users per 100 people	0.2 (2000)	No Target	11 (2014)	…
	Provide access to affordable essential drugs in developing countries (%)	Availability of essential medicines	74 (2007)	No Target	73.5	…

SECTION II: TRACKING PROGRESS

MDG 1: Eradicate Extreme Poverty and Hunger

MDG 1: Eradicate Extreme Poverty and Hunger

Target 1A: 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

Target 1B: Achieve full and productive employment for all

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

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

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

OVERVIEW

Poverty is rife in Lesotho with more than half of the population living below the poverty line. The percentage of those living in poverty has increased since 2000. In recent years, poverty has been exacerbated by recurring droughts that have caused food insecurity. Unemployment is one of the factors contributing to high poverty rates.

Unemployment rates are higher among the youth, who constitute almost half of the population. A further contributor to high poverty in Lesotho is the lack of jobs in South African mines which in previous decades enabled Basotho mine workers to send remittances home to support their families.


Dry Season in Lesotho


Example of Key-hole gardening

Table 1.1: Millennium Development Goal 1 at a Glance

Indicator	Baseline	Current	2015 (Target)
Prevalence of underweight children under 5 years (%)	15.8% (1992)	10.3% (2014)	8%
Poverty gap index (%)	37.9% (1995)	29.5% (2011)	17%
Unemployment rate (%)	28.7% (1995)	49% (2013/14)	15%
Proportion of vulnerable employment in total employment (%)	29% (2003)	11.8% (2011)	N/A
Food insecure population (%)	34% (2003)	23.6% (2014)	N/A
Proportion of stunted children under 5 (%)	45.4% (2000)	33% (2014)	N/A
Proportion of people living below the national poverty line (%)	66.6% (1995)	57.1% (2011)	29%
Gini Index	.57 (1995)	.54 (2011)	N/A

TRENDS AND ACHIEVEMENTS

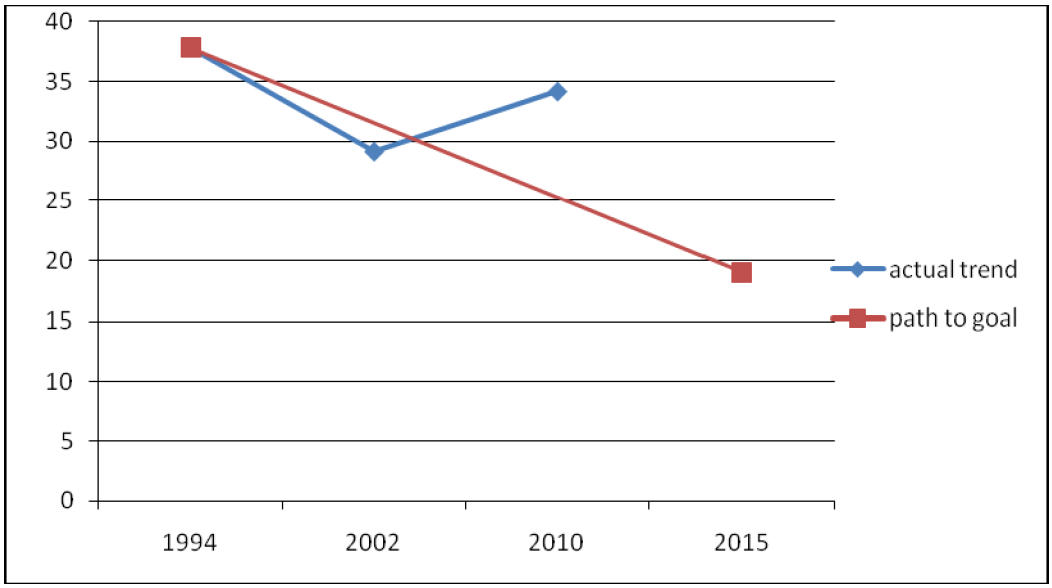
TARGET 1A: REDUCE BY HALF THE PROPORTION OF PEOPLE LIVING ON LESS THAN 1.25 DOLLARS A DAY

Indicator 1.1: Proportion of people living below the national poverty line

As Table 1.1 shows, the incidence of poverty has increased by 0.5% from 56.6% in 2002–03 to 57.1% in 2010–11. The increase in severe poverty affects most Basotho. Poverty in the country has a predominantly rural face; the poverty headcount ratio is far greater in rural areas than in urban areas. This is due to low agricultural sector performance, which is the main source of income in rural areas. The results in this analysis suggest that in 2010–11, the poverty gap for the rural population was 31%, implying that, on average, every poor person would require a 31% increase in income to reach the poverty line.

Although there has been some decline in poverty from 1994 to 2011, Lesotho has not met the targets relating to these indicators. As shown in the Figure 1.1, the percentage of very poor households has increased from 34% in 2003 to 35.1% in 2011. Although no indicative studies have been undertaken, the poverty level is expected to worsen beyond 2015 due to severe drought and poor agricultural output.

Figure 1.1: Percentage of Very Poor Households



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

Indicator 1.2: Poverty Gap Index

The Poverty Gap measures the difference in annual income required to bring all poor households out of poverty. It captures the average expenditure shortfall for the poor in a given area to reach the poverty line. This figure has increased by 0.6% between 2003 and 2011. In other words, in 2011 the average income of poor persons was 29.5% below the poverty line compared to 28.9% in 2003.

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

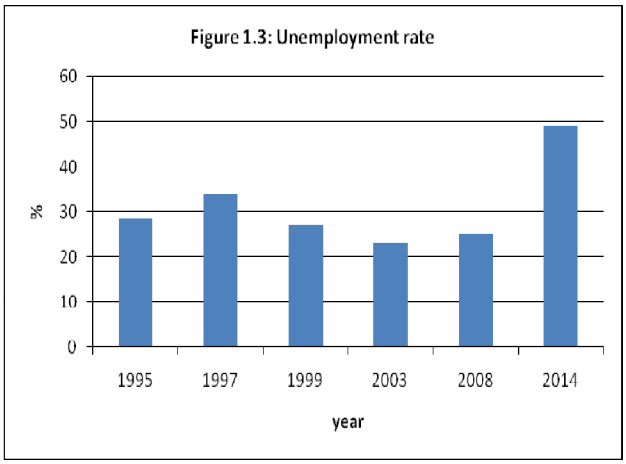
Indicator 1.3: Gini Coefficient

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

TARGET 1B: ACHIEVE FULL AND PRODUCTIVE EMPLOYMENT FOR ALL

Indicator 1.4: Unemployment Rate

The unemployment rate in Lesotho declined from 34% in 1997 to 25.3% in 2008. However, the third quarter 2013/14 CMS estimates undertaken by the Bureau of Statistics showed that Lesotho had a high unemployment rate of 49%,whichpersisted at least through 2014.The high rate of unemployment is, in significant part attributable to inadequate diversification of industries in Lesotho. Specifically, in the manufacturing sector, the textile industry contributes almost 90% of all manufacturing jobs[6]. This overspecialization creates insufficient employment opportunities.



Source: HBS 2003 and 1995, Census 2006, ILFS 2008

Variations in Unemployment

Unemployment is very severe among youth[7]. Only 45.1% of 15-24 year olds are employed. The third quarter of 2012/13 CMS data indicated that the youth (15–35years) unemployment rate is 50.8%. The causes for high youth unemployment are several. Many youths enter the job market lacking the requisite skills and education for employment. Even when they do find jobs, youth workers are usually restricted to working in the informal sector or subsistence agriculture. Well-educated youth are often drawn to jobs in more favourable markets, such as the Republic of South Africa (RSA), creating a brain drain phenomenon. Finally, youth have less work experience, less knowledge about how and where to search for work and fewer contacts, and they are subject to the 'last hired, first fired' principle in economic recessions.[8]

[6]Bos, Statistical Book Year, 2010
[7]See Table 5.55 of 2010/11 HBS Report
[8]Lesotho Youth and Development Concept Paper , UNDP 2012

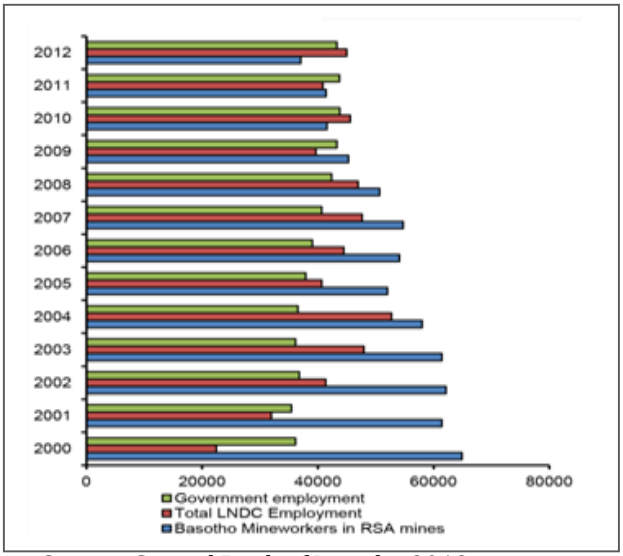
Table 1.2: The Unemployed in Lesotho by Age, Sex and Urban/Rural Residence

Age Group	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

According to Figure 1.4, employment numbers of Basotho mineworkers in RSA have continued to decline consistently. The number of migrant mineworkers has decreased from over 64,000 in 2000 to 37,051 in 2012. This is mainly associated with the decreasing production in the South African mining sector. Consequently, RSA resolved to give preference to their nationals.

Figure 1.4: Formal Employment



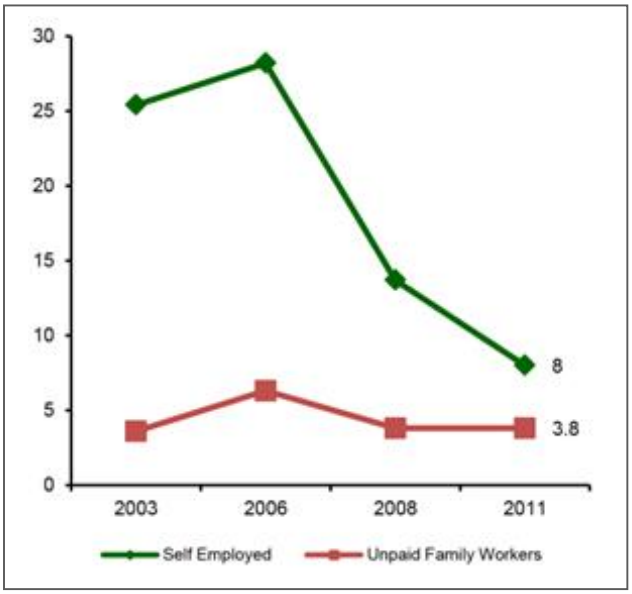
Source: Central Bank of Lesotho 2012

Declining employment figures were also experienced locally. The slow labour market recovery in the U.S. and the slowdown in manufacturing, especially in textile and clothing, were the major causes of the decline. Furthermore, unemployment in the public sector declined by 1.05% to 43,282 in 2012 from 43,742 employees at the end of December 2011. The decline is mainly due to the Government's fiscal consolidation efforts which produced a decrease of 3.7% in the number of daily paid workers, 0.8% of teachers and 0.6% in the number of civil servants. However, LNDC-assisted companies registered a 10.4% increase in unemployment in the period 2007-2012.

Indicator 1.5: Proportion of Vulnerable Employment in Total Employment

Vulnerable workers include self-employed workers who participate in the informal labour market. These workers do not have permanent employment and their income is directly dependent on profits from their goods/services. These workers are considered 'vulnerable' because their income, productivity and working conditions are temporary and therefore, unstable. Family members who work as caregivers for little or no pay are also vulnerable workers.

Figure 1.5: Vulnerable Employment



2006, ILFS 2008 and LDS 2011

According to Figure 1.5, the proportion of self-employed workers within the total working population declined from 25.4% in 2003 to the current 8% in 2011. However, differences in survey methodology render inter-year comparisons difficult for this indicator. The 2003 and 2006 surveys include subsistence farmers in the self-employed population, while the 2008 and 2011 surveys appear to exclude them. On the other hand, the proportion of unpaid family workers in total employment has consistently hovered around 3.8% except for a sharp increase to 6.3% in 2006. The proportion of vulnerable employment declined to 8% in 2011 from around 29% in

2003. This reflects worsening social hardships as this has resulted in higher dependency ratios.

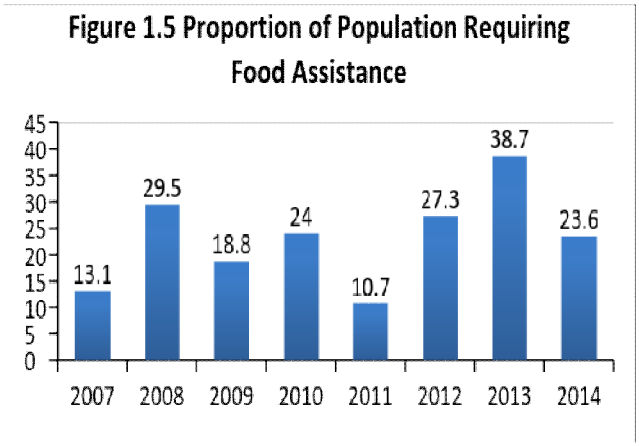
TARGET 1C: REDUCE BY HALF THE PROPORTION OF PEOPLE SUFFERING FROM HUNGER

Indicator 1.6: Proportion of Population that is Food Insecure

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

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

According to Figure 1.5, it was estimated that 38.7% of the population, or 726,000 people, required food assistance during 2012-13. Moreover, the 2014 LVAC report showed that 23.6% of the population required humanitarian assistance for a period of 4-5 months between October/November 2014 and February/March 2015. The estimated requirement for intervention for the 4-5 months period was 32,108 metric tonnes of maize, amounting to M257, 861,320. It should also be noted that assessment was conducted in the rural areas; therefore food insecurity figures are for rural areas only.[9]



Source: Lesotho Vulnerability Assessment Committee (LVAC) Reports 2014

Indicator 1.7: Prevalence of Underweight Children Under 5 years

Weight-for-age is an overall indicator of a population's nutritional health. Children under the age of 5 are classified as underweight if their weight 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.

The results of the Weight-For-Age Survey[10] showed that 10.3% of Lesotho's children are underweight and 2% are severely

[9]Lesotho Vulnerability Assessment Committee (LVAC) Results, 2014

[10] Lesotho Demographic and Health Survey 2014

underweight in 2014. A higher percentage of male than female children are underweight (13% and 8% respectively).

Lesotho had set a target of decreasing the prevalence of underweight children to 8% by 2015, a target that it has missed by 2 percentage points. In addition, 51% of children under 5 years of age suffer from anaemia (an iron deficiency typically caused by a lack of micronutrients in the diet). The primary causes of chronic malnutrition are inadequate dietary intake from 6 months of birth onward and poor health care, which is especially endemic in rural areas.

Indicator 1.8: Prevalence of Stunted Children under 5 years

Stunting (low height for age) is a result of a variety of factors reflecting; public health system, food security, feeding and caring practises, environment, capacity of social welfare systems as well as social and economic policies.

The prevalence of stunting is one of the most serious problems facing Lesotho. The 2014 LDHS Key Indicators Report shows that 33% of Basotho children are stunted, and 11% are severely stunted. While stunting in children has decreased from 39% in 2009 to 33% in 2014.Being underweight or stunted is associated with low maternal education and income. Conversely, mothers who have at least a secondary education or who fall within the top two wealth quintiles are much less likely to have malnourished children.[11] To prevent underweight and stunted development, food and nutrition security intervention programmes in the short, medium and long-term must be strengthened. In addition to providing much-needed food aid, all stakeholders in the food and nutrition sector should work together to encourage the development of home gardens and home-based income generating activities that support food production. Just as importantly, breast-feeding should be encouraged to prevent children from being underweight and stunted. However, clear policies, frameworks and strategies to address stunting coupled with strong coordination are required as food alone cannot reverse stunting.Despite efforts to address the problem, stunting remains one of the most serious challenges facing children. Consequently, the associated target has not been achieved.

POLICIES AND STRATEGIES

The Government of Lesotho has developed myriad strategies to address poverty. It has partnered with development agencies to improve and expand access to sustainable financial services in urban and rural areas. Credit loan schemes have been introduced for commercialising agriculture and providing subsidies to Lesotho farmers for key agricultural inputs as well as direct farming partnerships with the Government of Lesotho. In order to boost food production, the Government of Lesotho has invested in programs aimed at building capacities for smallholder farming and homestead gardening. The Government further introduced a block-farming program for large scale grain production. These initiatives have yielded mixed results, due to unpredictable weather patterns and management capabilities.

The Government also promotes youth employment as a long-term strategy for

[11]Lesotho Demographic and Health Survey 2014

poverty reduction in Lesotho. The Government has developed the Draft National Nutrition Policy, Nutrition Health Strategy, and Early Childhood Care and Development to improve feeding of children and has implemented the nutrition component of the United Nations Trust Fund for Human Security programme.

BOTTLENECKS AND CHALLENGES

- **Decreased remittances**: The number of Basotho workers in mines in the Republic of South Africa has fallen from around 120,000 in the 1980s to less than 40,000 in 2013, which has eroded one of the primary sources of household income. Declining remittances have offset GDP growth and thus, poverty continues unabated.

- **Youth unemployment** rate is rising at an alarming rate and is a threat to the country if aggressive economic and social welfare policies to combat this trend are not implemented.

- **Jobless Growth:** While Lesotho's economy has grown in the past decade through capital-intensive activities such as mining, these activities create few permanent jobs for Basotho. Consequently, these capital-intensive activities have little impact on poverty alleviation.

- **Climate change** has exacerbated the decline in agricultural yields. Drought and erratic rainfall have been unusually frequent in recent years, particularly at critical stages of plant growth. Extreme weather events and heavy rains in the wake of a long dry spell quickly erode and wash away the topsoil. In 2006-2007, Lesotho experienced its most severe drought in the past 30 years. Drought followed by substantial flooding plagued the 2011 harvest. In 2012, widespread drought and early frost led to a 77% decline in crop production which led to a severe food crisis.

- **Inadequate Nutrition Funding**. The financing of nutrition programmes tend to rely on donor support with less funding from the Government of Lesotho. Currently, government-funded nutrition programmes are constrained because of inadequate government resources.

- **Weak Coordination.** There is weak coordination, no multispectral framework for prevention of stunting, monitoring and evaluation is non-existence for nutrition interventions.

- **Inadequate Integrated Planning**: The implementation of the NSDP and its predecessors has failed to promote cooperation and interaction between the Government, the private sector and the general public in the rural areas where the majority of the population reside. This lack of integration threatens the success of the NSDP implementation.

LESSONS LEARNED AND WAY FORWARD

- The creation of an enabling socio-economic and political environment is necessary to address the causes of poverty among the rural population.

- A complex set of factors deter sustainable poverty reduction. To address these factors, the social protection system must be able to provide immediate famine relief while longer-term poverty eradication and agriculture production programmes are implemented.

- High dependency on rain-fed subsistence farming by large numbers of Lesotho residents necessitates promotion of sustainable agriculture strategies together with climate-smart technologies to address unreliable climate conditions.

- Services for crop and animal production should be scaled up. There should be an enabling environment to reduce poverty and ensure sustainable food and nutrition security for Basotho at household and national levels by improving production, productivity, diversification and commercialisation of food production. The development of high-value chains and high-functioning markets, as well as improved access to rural finance and infrastructure are good targets.

- There is a need to strengthen systems to monitor and evaluate poverty alleviation programmes and to provide relevant information for formulating policy and strategies.

- Available opportunities to address under-nutrition in the country are not utilised. Nutrition sector should review and revise its leadership for effective and efficient nutrition programming in the country. Nutrition should get the recognition it deserves like other developmental challenges in the country in terms of funding.

- A Poverty Observatory Roadmap has been developed in all Southern African Development Community (SADC) member countries. It serves as a permanent platform for all stakeholders to sustainably address poverty in all its manifestations and to share information and best practices with the SADC Regional Poverty Observatory.

- Being a cross-cutting issue by nature, poverty alleviation requires integrated planning among all sectors in order to maximize positive economic outcomes.

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

MDG 2: ACHIEVE UNIVERSAL 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

To ensure universal access to primary education, the Government of Lesotho introduced Free Primary Education (FPE) in 2000. This was phased in gradually, adding one grade per year. In addition to this, the Education Act of 1995 was repealed to make primary education not only free, but also compulsory. This coincided with FPE being fully functional across all primary grades. During its inception, FPE had a major impact that put Lesotho on track to achieve MDG 2 by 2015. The Net Enrolment Rate (NER) increased by 32%[12] between 1999 and 2000 (from 60.2% to 82% respectively).[13]

This growth rate is far higher than rates recorded during preceding years, which in most cases had shown a declining trend, as can be noted from Figure 2.1. The NER figures were, however, hampered by other socio-economic issues[14] which have led to a gradual decline in enrolment since 2004. In 2014, NER declined to 76.6%[15], its lowest performance since the introduction of FPE. This suggests that the Education Act of 2010 has not been effectively implemented. Given the downward trend shown by NER performance over the years, it is unlikely to achieve this indicator by the end of 2015.


Local Primary School Facilities


Learning materials in one of local schools

[12] MOET, Education Statistics Bulletin, 2014
[13] Ibid

[14] Discussed under Trend Analysis section (indicator 2.1)
[15] MOET, Education Statistics Bulletin, 2014

Table 2.1: Millennium Development Goal 2 at a Glance

Indicator	2000	2004	2009	2014	2015 (Goal)
Literacy rate of 15-24 year-olds, women and men (%)	No Data	89.3% M: 82.5% F: 96.1%	92.8% M: 87.4% F: 98.2%	94.6% M: 90.6% F: 98.6%	100%
Percentage of pupils starting grade 1 who reach last grade of primary (%)	No Data	61.2% (2005)	62.8%	71.8%	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*	76.6% M: 75.1 F: 78.2	100%

Whilst NER reached its lowest point in 2014, the percentage of children who completed primary school reached its highest completion rate since the first seven-year cohort under FPE. Seventy-one percent of students who began first grade in 2008 graduated from seventh grade in 2014.[16] This is a significant achievement, especially since NCSR had mostly fluctuated between 61% and 66.7% except in 2006 and 2007 when it plummeted to 40.9% and 55.5% respectively. Nevertheless, the net cohort survival rate remains low considering the 28.2% of pupils who did not even complete their primary education.

While the 2014 literacy rate performance is only 5.4 percentage points short of the 100% MDG target, a 1.8 percentage points' increase between 2009 and 2014 demonstrates that the 2015 target is unlikely to be fully met. There is a gender equity issue with literacy attainment, just as there is in secondary and tertiary educational enrolment. Females are eight percentage points literate more than males. This is undoubtedly a by-product of the lower educational attainment of males relative to females.

According to Education International,[17] as of 2013, Lesotho offered only two schools for students with visual disabilities, two schools for students with hearing or speech disabilities, and one school for children with intellectual disabilities. As a direct result of inadequate planning for disabled children, nearly 40% of disabled children between the ages of 5 and 10 do not attend primary school, and an estimated 23% of disabled

[16]The exact percentage was 71.8% as measured by the Net Cohort Survival Rate (NCSR) in 2014.

[17]http://www.ei-ie.org/barometer/en/profiles_detail.php?country=lesotho – Accessed 19 August 015

students between the ages of 10 and 20 do not attend secondary school.[18]

While Lesotho can take justifiable pride in its progress in education, it must provide greater educational access to children with special needs. Another pressing area for Lesotho's education policy is to address the growing gap in educational attainment between males and females.

Overall, Lesotho's educational policies and budgetary allocations have resulted in the country's successful performance on most MDG 2 indicators. Now that the country has created the infrastructure to make primary education for all viable and compulsory, it must improve the quality and relevance of its curriculum at all levels so that investments in education result in a highly prepared workforce that can contribute to today's complex global economy. Indeed, this is the key to Lesotho's future.

TRENDS AND ACHIEVEMENTS

Indicator 2.1: Net Enrolment Ratio in Primary Education

The success of Free Primary Education, the legalization of compulsory primary education and the Child Welfare and Protection Act (2011) together with other initiatives have been hampered by challenges facing children such as poverty and opharnhood. Major programmes designed to facilitate access to primary education include

- School feeding programme,
- Construction of schools to reduce walking distance to school,
- Provision of learning materials,
- Integration of children with special educational needs into primary schools,
- Establishment of learning centres to promote non-formal education for youth and out-of-school pupils.

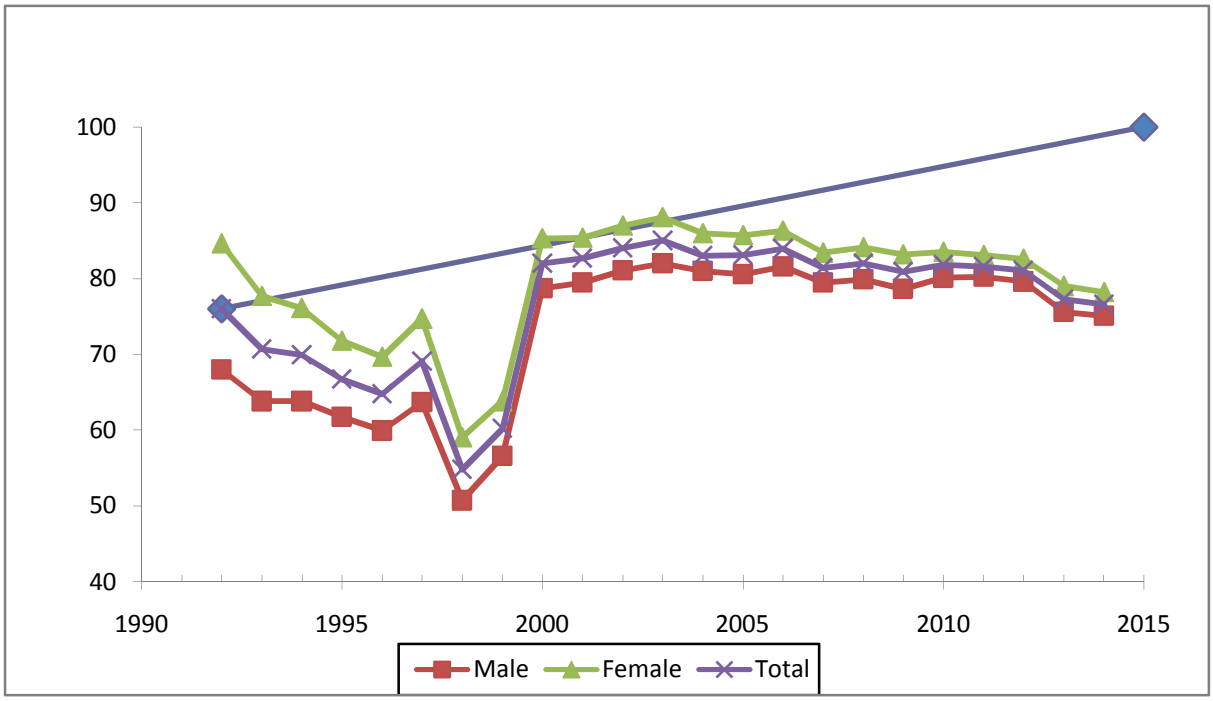
Further support has been provided by the Child Grants Programme under the Ministry of Social Development which covers the cost of school uniforms and transportation to and from school for orphaned and vulnerable children (OVC).

Not surprisingly, given the strong governmental support for Free Primary Education in its inaugural year of 2000, primary school enrolment increased dramatically during that year. It jumped 12.5% from 364,952 in 1999 to 410, 475 in 2000. The positive effect of this inaugural year was further reflected by a Net Enrolment Ratio increase from 60.2% to 82% during the same period. However, this climb began to deteriorate in 2004. NER fell from a peak of 85% in 2003 to 83% in 2004. Between 2004 and 2012, NER fluctuated between 80.9% and 83.9% with a negative average growth. Since 2013, NER has fallen below 80% and has since declined to 77.3% in 2013 and then to 76.6% in 2014.


School Feeding Programme

[18] Ibid

Figure 2.1: Net Enrolment Ratio in Primary Education



Source: Ministry of Education Planning Unit, Education Statistics Bulletin 2001 and 2014

The negative trend in enrolment figures is especially worrisome given the size of budget allocated towards education in Lesotho. These vulnerabilities frequently lead to children heading households, a responsibility that precludes school attendance. In the case of boys, research[19] has shown that boys' traditional roles of herding animals often make school attendance impossible. Having unemployed parents who need the support of working children is another reason for nonattendance for both boys and girls. In the case of girls, they are often made responsible for taking care of siblings and their sick parents and relatives. These duties normally oblige OVCs to fend for themselves out of school. Finally, orphans are sometimes deterred from attending school due to child marriage. While the age 15 falls outside the official primary school age, it is estimated that 2.3% of orphaned girls who were married before they turned 15 did not attend primary school due to marital commitments.[20]

Indicator 2.2: Proportion of Pupils Starting Grade 1 who reach Grade 7, the Final Grade of Primary School

Figure 2.2 shows that, the net cohort survival rate was 71.8%in 2014. This indicates a percentage increase in net cohort survival of 6.5%. Despite improvement in this indicator, progress is too slow to reach 100% MDG target.

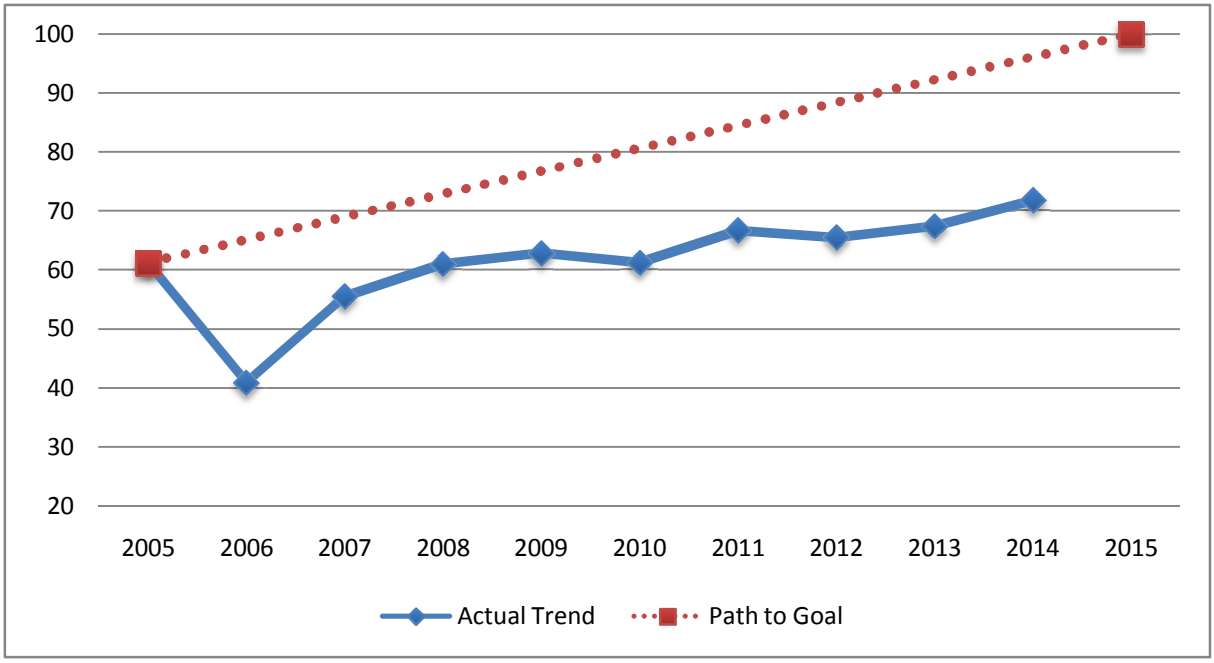
[19]Lefoka, J. (2007) - http://www.ungei.org/resources/files/Lesotho.pdf - Accessed 20 August 2015

[20]Tamasane, T, 2011. Analysis of Services for Orphans and Vulnerable Children in Lesotho ï A Desktop Review. Pretoria: Human Sciences Research Council (HSRC).

A related indicator is the repetition rate, the percentage of students who repeat a grade. Grade repetition is consistently higher among boys due to traditional practices of herd-boys and initiation schools. In 2011, 19.2% of boys repeated a grade, compared with 13.6% of girls. These statistics improved in 2013 with just 9.6% of boys having repeated and 7.4% of girls having repeated a grade.[21]

In the past, most repetition occurred in lower grades, mainly in Grades 1-3.[22] However, this pattern changed between 2011 and 2013. Starting in 2011, grade repetition occurred most frequently in the 4th grade with as many as 14.5% of enrolled children not continuing to grade 5 and 5.7% dropping out. Being an orphan was not a predictor of school retention. However, orphans had a higher likelihood of dropping out and not continuing in school once enrolled.[23]

Figure 2.2: Proportion of Students Who Reach Standard 7



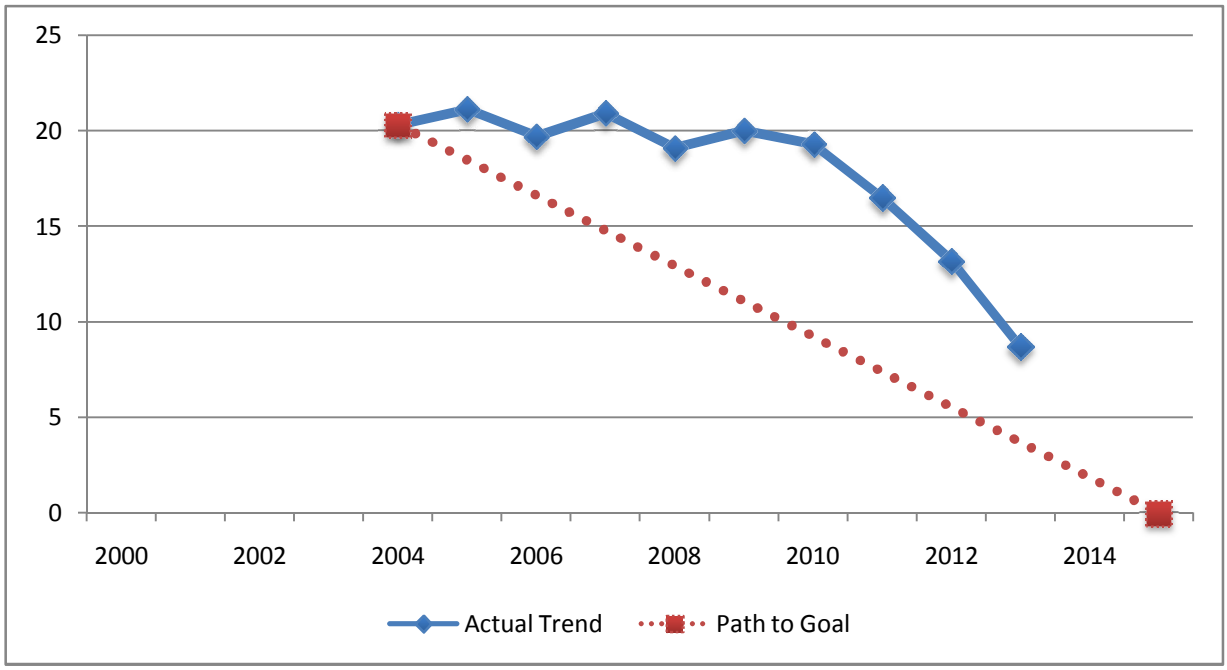
Sources: MoET 2012, Education Statistics Bulletin 2014

After the Government introduced FPE, many older children/youth and even adults enrolled in the first grade. However, most of these over-age students 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, as well as the fluctuation in completion rates.

[21]MoET, 2012, Education Statistics Bulletin

[22]MoET, 2012, Education Statistics Bulletin
[23] World Bank 2005

Figure 2.3: Dropout Rate, 2004 – 2014



Sources: MoET, Education Statistics Bulletin 2014

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.[24] It ranks 16 in the world in gender equity with regard to primary education in the 2013 World Economic Forum Global Gender Gap report.

Historically, more females than males were enrolled in primary schools. Since 2000 there was a marginal gender imbalance in favour of females, implying there were slightly more females than males with a female to male ratio of 104:100 as reflected in Table 2.2. However, this situation has changed since 2005. The 2014 results portrayed a gender ratio of approximately 98 females to 100 males, showing a gender imbalance in favour of males (more boys than girls in primary schools).


Looking after family stock is one of the factors leading to non – school attendance by male children

[24] The Global Gender Gap Report 2014

Table 2.2: Primary School Enrolment Rates and Gender Parity Indices

	Gross Enrolment				Net Enrolment			
	Males	**Females**	**Total**	**GPI**	**Males**	**Females**	**Total**	**GPI**
2000	118.1	122.6	120.3	1.04	78	85.3	82	1.08
2004	126	127	126.6	1.01	81	86	83	1.06
2005	126	126.3	126.1	1.00	80.6	85.7	83.1	1.06
2009	116.2	116.2	116.2	1.00	78	83.2	80.9	1.06
2012	111.6	108.8	110.2	0.97	79	82.6	81.1	1.04
2013	105.8	103.9	104.9	0.98	75.6	79.0	77.3	1.04
2014	103.4	101.1	102.3	0.98	75.1	78.2	76.6	1.04

Sources: Annual Educational Statistical Bulletin 2012 and 2014

Literacy Rate

Indicator 2.3: Literacy Rate of 15-24 year-olds, Women and Men

Lesotho's literacy rates are among the highest on the continent, with the literacy rate among youth (age 15-24) standing at 94.6% in 2014, up from 92.8% in 2009. The literacy rate is higher among women: in 2014 almost 100% of women were considered literate as compared to only 90% of men. The literacy rate has been improving in the past decade. 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, which helped strengthen the literacy rates.

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

	2004	**2009**	**2014**	Target 2015
Males	82.5%	87.4%	90.6 %	100%
Females	96.1%	98.2%	98.6%	100%
Total	**89.3%**	**92.8%**	**94.6%**	**100%**

Sources: LDHS 2004, 2009 and 2014

Increasing enrolment in Non-Formal Education (NFE) also contributes to high literacy rates in Lesotho. In rural and mountainous areas, there are learning posts or centres where people can develop their skills. Of the 369 learning posts or centres, literacy and numeracy accounted for 350 (94.9%) while continuing education accounted for only 19 (5.1%). The majority of literacy and numeracy learning posts are in the mountainous districts of Mokhotlong and Thaba-Tseka.

Quality of Education

Primary Education

The overall quality of the education provided in Lesotho is low. A shortage of qualified teachers is one of the main reasons for this, along with overcrowding in primary schools due to the introduction of FPE. The influx of learners overstretched some of the education resources. It created a demand for an increase in the number of qualified teachers, classrooms, teaching and learning materials.

The pupil: qualified-teacher ratio (PQTR) deteriorated, and stood at 65 students to one teacher against an acceptable 40 students to 1. It gradually improved and by 2014, there were 43 pupils per qualified teacher. This is lower than the Education for All (EFA) target of 45:1 for primary schools. During the same year the percentage of unqualified teachers was particularly high in Botha Bothe and Leribe with the lowest PQTRs of 37 and 38 respectively. PQTR was highest in ThabaTseka and Mokhotlong with 63 and 53 students to each teacher respectively. This is probably because ThabaTseka and Mokhotlong have hard-to-reach schools which have difficulty employing qualified teachers.

The Government has introduced incentives for teachers willing to serve in rural areas. A well-structured teacher-development and teacher-management system is being developed in order to improve rural/urban equality in the performance of learners. Teachers' salaries were brought in line with those of the civil service, a move which has resulted in graduate-level teachers now teaching at the primary-school level. MoET is strengthening teacher-development governance and increasing efficiency.

Interventions such as rewarding good performance and the establishment of a database for teacher management (dealing with teacher registration, appointments, promotions, leave, transfers, termination, and retirement) have been developed. Unqualified teachers are given an opportunity to further their studies through a Distance Teacher Education Programme (DTEP). About 1,300 teachers have benefited from the programme. Furthermore, the Government has reviewed the curriculum, strengthened school inspection and provided free teaching and learning materials.

The Government has also embarked on classroom construction to reduce overcrowding in schools. As a result, the pupil-classroom ratio has improved substantially from 67:1 in 2003 to 47:1 in 2013. MoET has started a policy of transferring teachers from schools with excess grants to schools with a shortage of teachers. A Teachers' Establishment List is also being developed as a strategy to control and manage teachers' establishment per school.

Table 2.4: Quality Indicators

	2001	2003	2005	2007	2009	2011	2012	2013	2014
Number of Primary Teachers	8762	9294	10154	10778	11536	11378	11200	11324	11167
Number of Primary Schools	1295	1355	1419	1455	1479	1468	1469	1472	1477
Primary Pupil-Teacher Ratio	47	46	42	37	34	34	34	33	33
Pupil Qualified Teacher ratio	-	-	-	-	56	51	50	45	43

Sources: Education Statistical Bulletin 2003, 2007, 2009, 2012, and 2014

Thus MoET reviewed the old curriculum and produced a new Curriculum and Assessment Policy Framework in 2008. 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 integrates continuous assessment of learners throughout the year. The new integrated curriculum was rolled out in all primary schools in 2013, starting with Grades 1-3 and will be introduced to each additional grade with every year.

Efficiency in Use of Financial Resources for Education

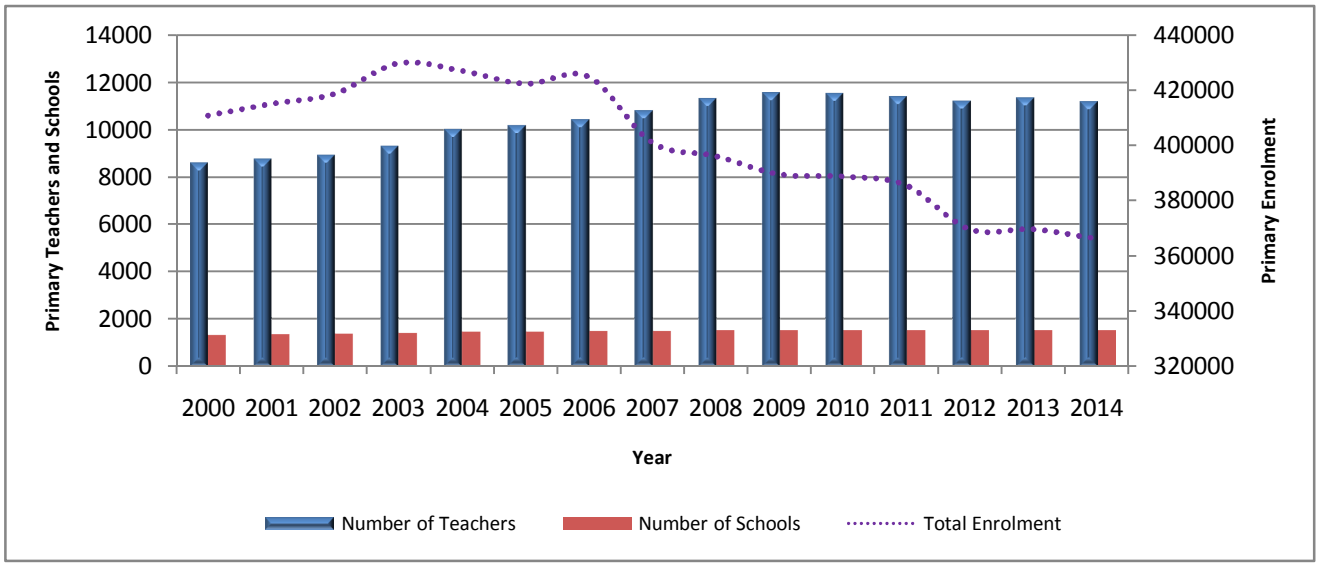
Apart from international support towards improving education, the highest percentage (18.4%)[25] of the total recurrent budget was allocated to MOET during the 2015/16 FY. This amount does not include bursary expenditure for tertiary education nor does it cover OVC's bursaries in secondary education. Unlike OVC bursaries for secondary education, tertiary bursaries are allocated to the first batch of best qualifiers admitted at tertiary institutions regardless of the wealth of such recipients.

[25] Government of Lesotho, Ministry of Finance (2015) Budget Speech

During the FY 2010/11 – 2013/14 period, an average 16% of the total government budget was allocated to the Ministry of Education alone. Since MOET is not responsible for providing tertiary bursaries, that takes an additional chunk of the Government budget. The main driver of education costs is teacher pay. This accounts for 69% of recurrent spending in 2010/11. Owing to the increasing numbers of qualified teachers, this amount is expected to increase in future years. Notwithstanding this, the mismatch between funds allocated towards education and relative education outcomes remains a challenge.

Figure 2.4 shows that primary schooling inputs in terms of teachers and schools have increased steadily since the introduction of FPE in 2000. While enrolments have increased during the introduction of FPE, the continual investments in primary education eventually showed no impact on enrolment figures a few years later. Other indicators, including the Pupil:Teacher and the Pupil: Classroom ratios improved, but caution should be drawn as such ratios are also symptomatic of a detrimental decline in student enrolments. As already noted, there have been some improvements in NCSR and dropout rates.

Figure 2.4: Number of Primary Schools and Teachers against Enrolments, 2000 - 2014



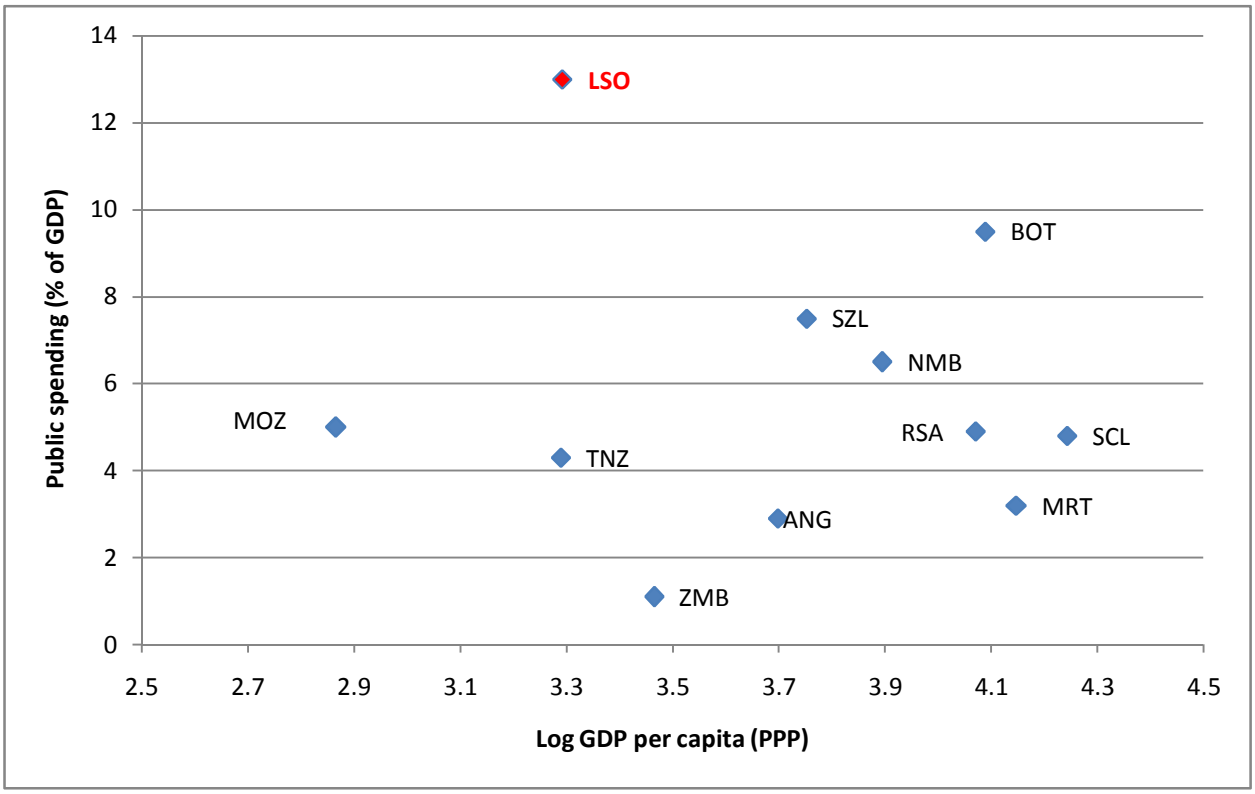
Sources: MoET Education Statistics Bulletin 2009 and 2014

Lesotho spends significantly more on education than its regional neighbours do. Figure 2.5 illustrates this point. Despite Lesotho's high spending on education, the country's primary school gross enrolment rates (GER) and net enrolment rates (NER) are not very different to those of its neighbours. The situation is similar for secondary education. Lesotho's secondary GER and NER are similar to the average of similar countries.[26] Lesotho also spends much more on secondary and tertiary

[26] WB Public Expenditure Review, 2012

education 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 Botswana.[27]

Figure 2.5: Public Expenditure on Education, 2006 – 2009



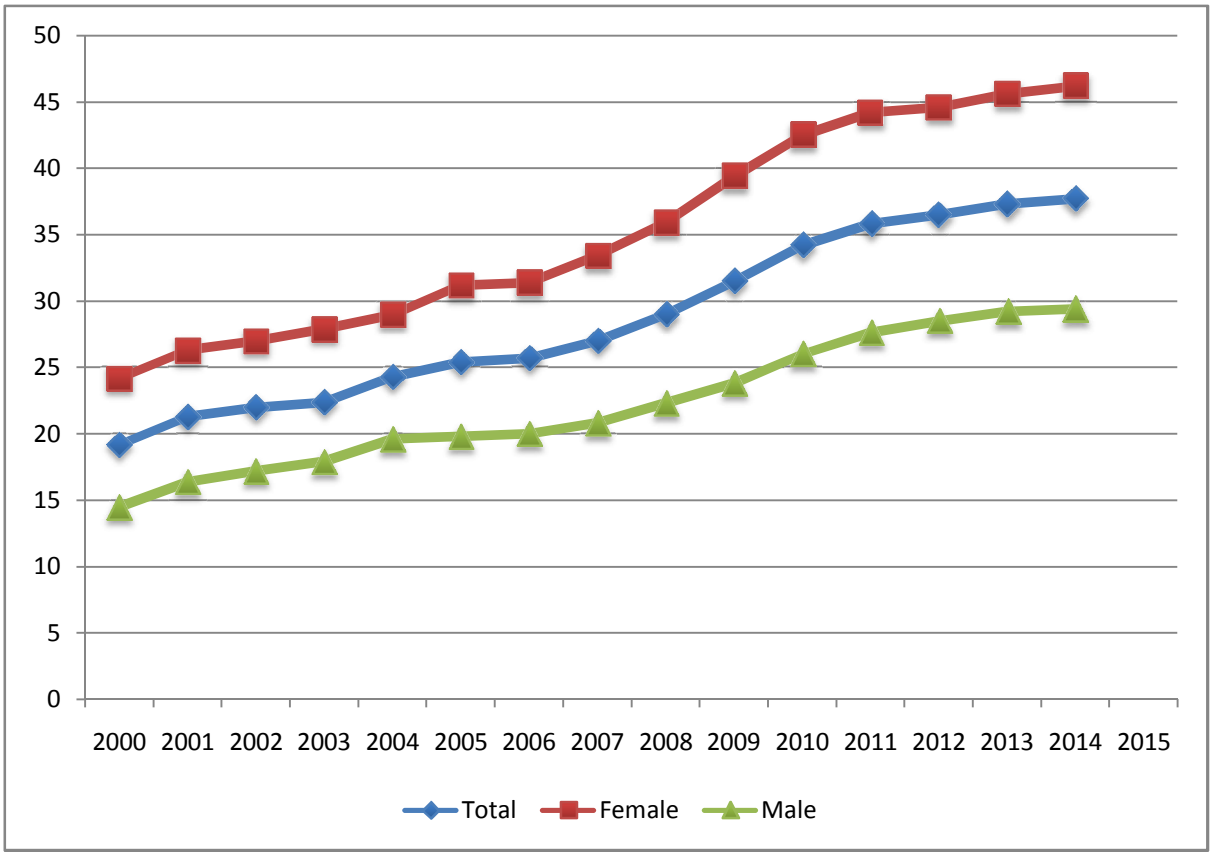
Source: World Development Indicators

Secondary Education

Notwithstanding the importance of basic education, there are fewer employment opportunities for individuals who have only a primary-level education. Where there are such opportunities, they are normally in poor conditions and pay very little. In this regard, information regarding secondary education is included under MDG 2 even though it does not necessarily fall under basic education. Figure 2.6 shows the secondary NER by gender during the FPE inception period of 2000 to the year 2014.

[27] World Bank Development Indicators

Figure 2.6: Net Enrolment Rates in Secondary School, 2000 – 2014

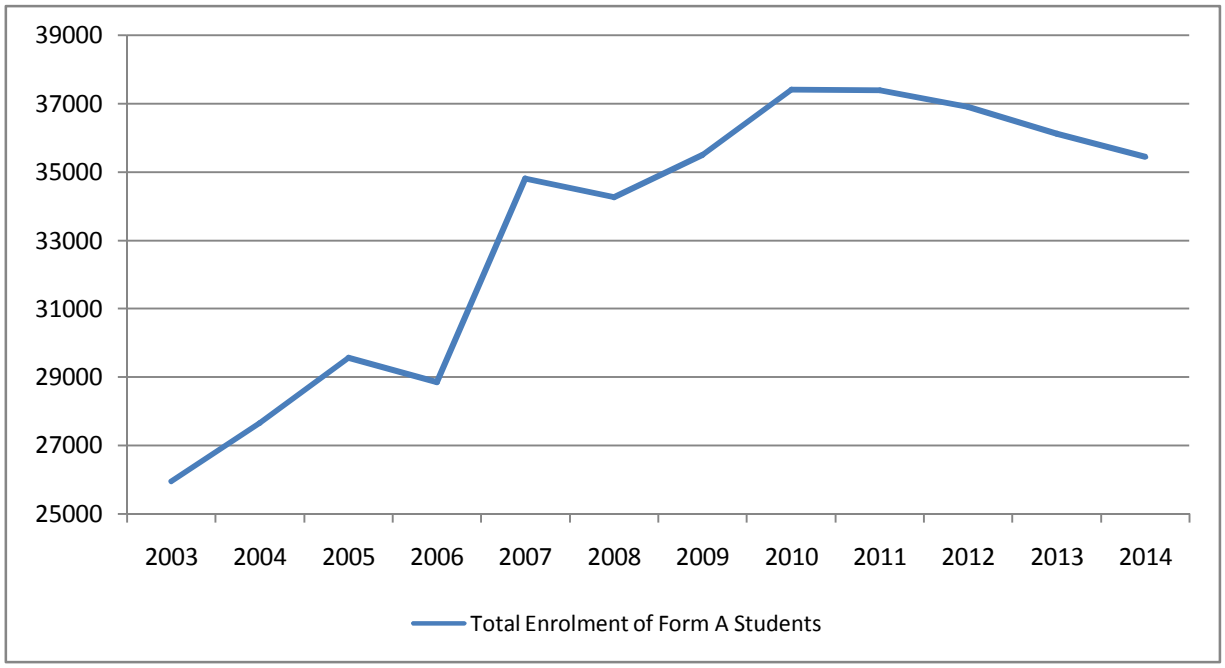


Source: MoET, Education Statistics Bulletin 2014

Contrary to a declining NER in primary education, secondary education NER has been increasing steadily over the years since the introduction of FPE, as reflected in Figure 2.6. However, the increased NER in secondary education, which is still far below that of primary, cannot solely be linked with the introduction of FPE given the fact that secondary education is not free. The total enrolment of Form A students increased in 2007 when the first cohort of FPE was admitted to secondary, as reflected in Figure 2.7. Nevertheless, lack of sector capacity to construct sufficient secondary schools; together with tuition fees, remains the key barrier for young people wanting to attend secondary school.[28]

[28]Open Society Initiative for Africa (2013) - http://www.osisa.org/open-learning/lesotho/lesotho-education-system - Accessed 21 August 2015

Figure2.7: Total Enrolment of Form A Students



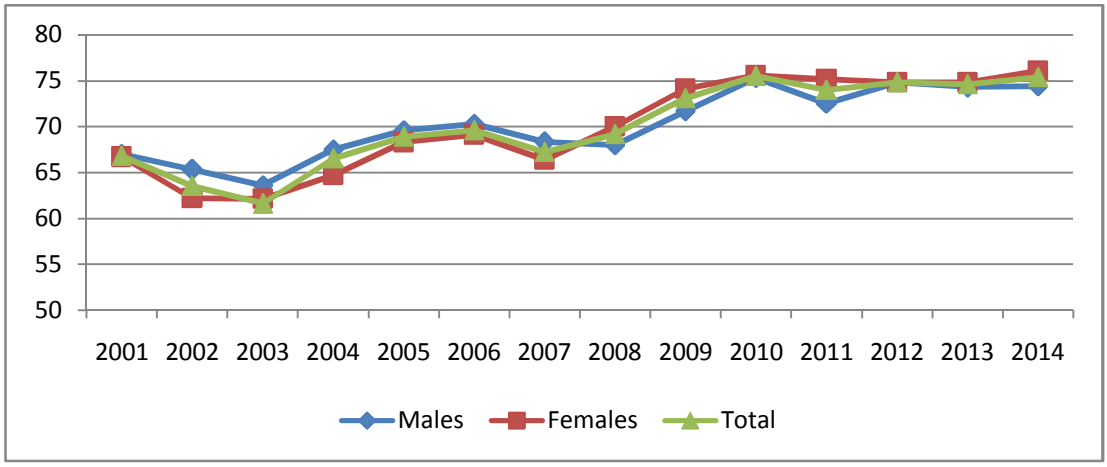
Source: MoET, Education Statistics Bulletin 2014

The obstacles to secondary education together with issues around quality of primary education, have resulted in around 25% of pupils who completed Standard 7 failing to continue on to secondary schools in 2014.This figure remains lower than the 33% of Standard 7 graduates who failed to proceed to Form A in 2001. The transition rate from primary to secondary school was 67% in 2001 and 75% in 2014.

Figure 2.8 shows that transition rates have been fluctuating. The lowest transition rate was 61.6% in 2003 while the highest transition rate was 75.5% in 2010.[29] It should be noted that when the first FPE cohort reached secondary school in 2007, the transition rate declined to 67.2% from 69.6% in the previous year. This can partly be associated with poor quality FPE together with an inadequate number of secondary schools despite notable efforts to absorb the influx of FPE graduates into secondary education.

[29] MOET Education Statistics Bulletin 2014

Figure 2.8: Transition Rates from Standard 7 to Form A, 2001 – 2007



Source: MoET, Education Statistics Bulletin 2014

To absorb the influx of the first FPE graduates into secondary schools, the Government increased the number of registered secondary schools from 240 in 2006 to 291 in 2007.[30] This represents a 21% increase between 2006 and 2007, far above the 6.5% increase of registered secondary schools in 1999 and 2003[31]. To address challenges around payment of fees, MOET continued to implement the bursary scheme for orphaned children, which now fall under the Ministry of Social Development and caters for OVC. Studies have revealed that vulnerability has contributed adversely towards access to education as whole, being primary or secondary. Challenges around access to secondary school are further exacerbated by school fees which most poor families cannot afford to pay. This is evidenced by a mere 10.7% of youth in the lowest quintile attending secondary schools against 61% of those in the highest quintile[32] as illustrated in Table 2.5.

Table 2.5: 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

There are undoubtedly more job

[30]MOET Education Statistics Bulletin 2007
[31]MOET Education Statistics Bullein 2003

[32]LDHS, 2009.

opportunities for post-primary graduates than for those with basic education. Nonetheless, even just a high-quality primary education offers skills necessary to search for and obtain a livelihood.

The quality of Lesotho's education at primary level in Science and Mathematics subjects is unsatisfactory. An assessment of internationally standardised scores used by the Southern and Eastern African Consortium Monitoring Education Quality (SACMEQ) reveals that Lesotho's Mathematics scores for both SACMEQ II and III[33] are below most of its regional counterparts.

BOTTLENECKS AND CHALLENGES

- Despite legal obligations and the abolishment of school fees, there is insufficient support to ensure that all children are attending primary school. Children who do not attend primary school are victims of factors beyond their control such as poverty, supporting a family through employment or childcare, child marriage, intellectual or physical disability, orphanhood, or health-related factors such as Tuberculosis, HIV and AIDS.

- The enrolment of learners with special education needs remains low due to limited availability of learning facilities.

- Even though quality of education indicators (e.g. pupil-teacher ratio) seems to be improving, the quality of Lesotho's education is below that of its neighbours in SACU. This is in spite of the fact that Lesotho invests much more in education than its neighbours.

- The enrolment of children in Early Childhood Care Development (ECCD) classes is relatively low at less than 40%. This is problematic because it is recognised that children who have undergone ECCD have better learning outcomes in primary schools and a much lower dropout rate.

- Even though overall dropout rates have declined, there was a reversal of trend in 2014, to the 1992 rate. There is need to establish causality for this reversal, especially in the early grades, and develop management strategies.

LESSONS LEARNED AND WAY FORWARD

- Inadequate support for disabled and vulnerable children has hindered Lesotho's progress towards attaining MDG 2. To ensure universal primary education, it is critical to provide adequate support for persons with disabilities (PWDs) and vulnerable children. This will enable access to education for all.

- MDG 2 focuses mainly on access and overlooks issues around quality which has been proven to be a major challenge in Lesotho. It is critical to prioritise and expand ECCD education as an important basis for primary education, while also revising the current curriculum to be more effective.

- The very close relationship among MDGs in Lesotho (especially between the education goal MDG 2 and poverty and

[33] http://www.sacmeq.org/?q=sacmeq-projects/sacmeq-ii/readingmathlevels and http://www.sacmeq.org/?q=sacmeq-projects/sacmeq-iii/readingmathscores

hunger MDG 1 and HIV/AIDS and Tuberculosis MDG 6) has negatively affected the attainment of MDG 2 even though it has initially shown some positive progress. To facilitate achievement of MDG 2, it is critical to have a holistic and comprehensive education strategy which factors in the issues of poverty and health.

- Transfer of qualified teachers from overstaffed schools in the lowlands to under-staffed schools in mountainous and difficult to reach areas will ameliorate both the quality and access to education in rural areas.
- 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 the primary level.
- 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 informal to formal education.
- Analyse causes of high dropout rates for boys at secondary and tertiary levels. Although there are more boys than girls at primary school level, these numbers are drastically reversed at secondary and tertiary levels (MDG 3).

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

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

Indicators

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

Overview

Gender equality in a nation is achieved by ensuring equal representation and participation of women and men in politics and decision-making positions. There are procedures to follow that lead to the occupation of these positions which should reflect an understanding of issues that impact equal representation and participation.[34] Gender equality also means that there should be equal pay for the same job.[35] The United Nations regards gender equality as a human right. Nations that empower women move more rapidly towards development, advancement and poverty reduction. Gender equality is the notion that all parties in a nation should be treated equally.

Lesotho has performed well in ensuring equal access to education for females, as indicated by a consistently higher ratio of girls to boys at most levels of education. Indeed, the ratio of females to males, particularly in secondary and higher education, remained high. The Kingdom of Lesotho has developed measures to improve access to education for boys in order to achieve a balanced human development outcome beyond 2015.

In spite of Lesotho's progress, the country did not meet all its targets in gender equity. In education, from primary, secondary and tertiary, women outnumber men. This indicates a greater degree of women's empowerment. Nevertheless, Lesotho outperformed one of its targets: the share of women in non-agricultural wage employment which is, at 56.1%, above its 2015 target of 50%.

Women's participation in formal employment and governance has also increased even though the target was not achieved. As of 2014, 25 seats in the parliament were held by women, up from just 10 in 2001.

[34] United Nations Division for the Advancement of Women (2005)
[35] International Planned Parenthood Federation Report, 2012

Table 3.1: Millennium Development Goal 3 At A Glance

Indicator	Baseline (2001)	2003	2007	2008	2010	2011	2012	2014	2015 (Goal)
Girls - Boys ratio in primary education	101	100	97.8	97.6	96.4	104	105	96.1	100
Share of women in non-agricultural wage employment (%)	34.4%	42.6%	-	42.5%	-	54.4%	56.1%	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%	25%	30%
Female-male ratio in secondary education	128	127	131	134	136	136	133	137.18	100
Female-male ratio in tertiary education	118	104	107	112	123	146	146 (2011)	142	100

TRENDS AND ACHIEVEMENTS

Gender Equity in Education

Indicator 3.1: Ratio of Girls to Boys in Primary, Secondary and Tertiary Education

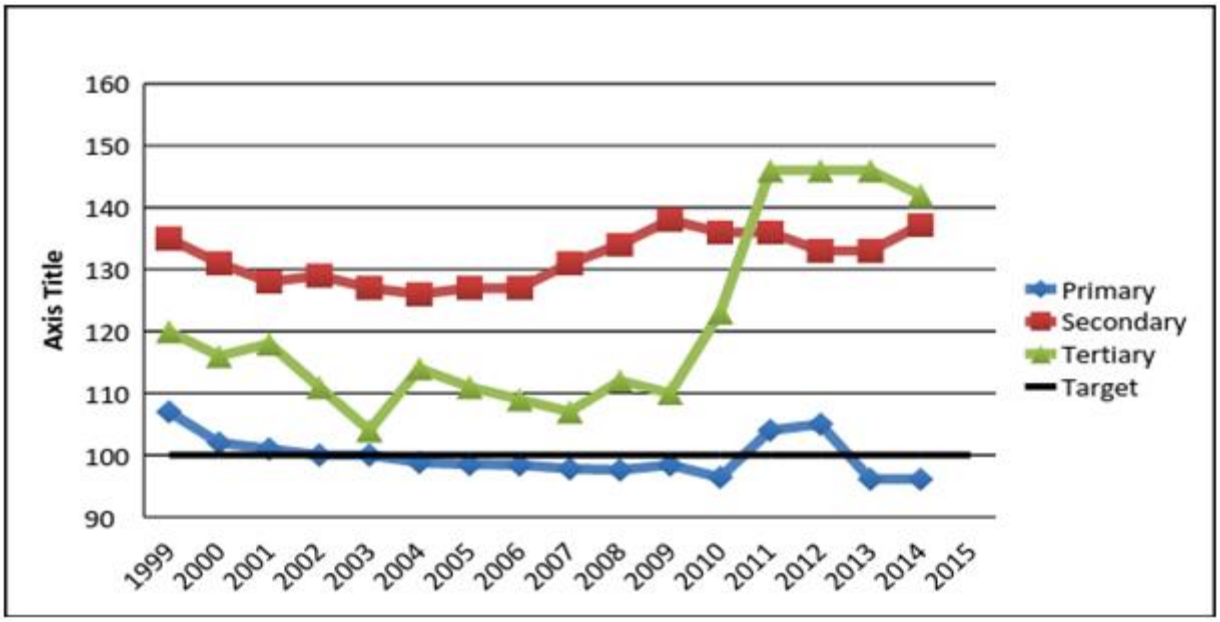
The gender balance in primary school enrolment has fluctuated over the past 15 years. Between 2000 and 2003 there was a marginal gender imbalance in favour of females. This gender imbalance continued until 2010 when results show more males than females enrolled in primary school, an imbalance that continued through 2015.

The situation is different in secondary school where more females enrol than males. The gender inequality in secondary school enrolment remains a concern for the country.

The Free Primary Education (FPE) Policy passed in 2000 mandates equal access in primary school for males and females. Lesotho has progressed considerably and has been one of the few countries in Africa where female enrolment has exceeded male enrolment in primary school.[36] Moreover, as seen in Figure 3.1, the female-male ratio may fluctuate, but it has remained quite balanced.

[36] BoS, Education Statistics Bulletin, 2001

Figure 3.1: Enrolment Ratios in Primary, Secondary and Tertiary Education



Sources: Education Statistics Bulletin 2001, 2003, 2003-2007, 2009, 2010, 2011, 2012 and 2014

Males have had lower educational outcomes for several reasons. Boys and young men herd livestock during the day which increases absenteeism rates. Those who do finish primary school often migrate to cities for job opportunities or leave Lesotho to work in South African mines. In recent years, high numbers of HIV and AIDS-related deaths have forced many adolescent boys to become heads of households and seek employment to support younger siblings. In this regard, Lesotho has not achieved a balanced ratio of girls to boys in primary education. The primary school target was to achieve parity between the genders, which has not been achieved. Statistics indicate that between 2010 and 2012 more males have enrolled than females. This is reflected by an upward growth above the target line in Figure 3.1 above.

[37]BoS, Education Statistics Bulletin 2003, 2003-2007, 2009, 2010, 2011, 2012 and GoL, Education Statistics Bulletin, 2010

Table 3.2: Ratio of Girls to Boys Attending Primary School (2010-2014)

Year	Girls attending Primary School	Boys attending Primary School
2010	100 (49%)	104 (51%)
2011	100 (48.78%)	105 (51.22%)
2012	100 (49%)	104 (51%)
2014	96.1 (49%)	100 (51%)

Sources: Education Statistics Bulletin 2001, 2003, 2003-2007, 2009, 2010, 2011, 2012 and 2014

The ratio of girls to boys attending primary school over the years 2010-2015 is presented in the table. It compares the number of boys per 100 girls.

In 2010, there were 104 boys attending primary school for every 100 girls. In 2011, the ratio of boys rose to 105 for every100 girls. In 2012, the ratio dropped to 104 boys for every100 girls who enrolled in primary school. The primary school enrolment in 2014 reflected that the girls-boys ratio was 96.1 girls per 100 boys which declined from 105 to 100 in 2012. This is an indication that the country is progressing slowly towards meeting the 2015 target of 100 (1:1).

For the period under review, there were more girls than boys that had access to primary schooling in the years 2000 to 2002. Table 3.2 reflects that more boys than girls attended primary school. From 2010 to 2014 results indicate that there were more boys than girls who enrolled for primary schooling since there were 49% of girls and 51% of boys.

At the secondary school level, the trend changed drastically. The female enrolment rate is much higher than the male enrolment rate according to the Education Management Information Systems (1999-2012). It reflects the enrolment ratio of 133 females to 75 males in 2012. One reason for the lack of parity is that males struggle to progress to the secondary level, as reflected in Table 3.3.

At tertiary level, female enrolment is also higher than that of males[38] unlike in Sub-Saharan Africa where female enrolment is lower than that of males.[39] The tertiary enrolment is indicated by ratios elaborated in Table 3.4.

[38]Lesotho Education Report, 2012

[39]BoS, Education Statistics Bulletin 2003, 2003-2007, 2009, 2010, 2011, 2012 and GoL, Education Statistics Bulletin, 2010

Table 3.3: Ratio of Females to Males Attending Secondary School, 2001-2014

Year	Females attending Secondary School	Males attending Secondary School
2001	128	100
2003	127	100
2007	131	100
2008	134	100
2010	136	100
2011	136	100
2012	133 (64%)	75 (36%)

Sources: Education Statistics Bulletin 2001, 2003, 2003-2007, 2009, 2010, 2011, 2012 and 2014

Table 3.4: Ratio of Females to Males Attending Tertiary Education, 2001-2014

Year	Females attending Tertiary Education	Males attending Tertiary Education
2001	118 (54%)	100 (46%)
2003	104 (51%)	100 (49%)
2007	107 (52%)	100 (48%)
2008	112 (53%)	100 (47%)
2010	123 (55%)	100 (45%)
2011	146 (59%)	100 (41%)
2014	142 (59%)	100 (41%)

Sources: Education Statistics Bulletin 2001, 2003, 2003-2007, 2009, 2 2012 and 2014

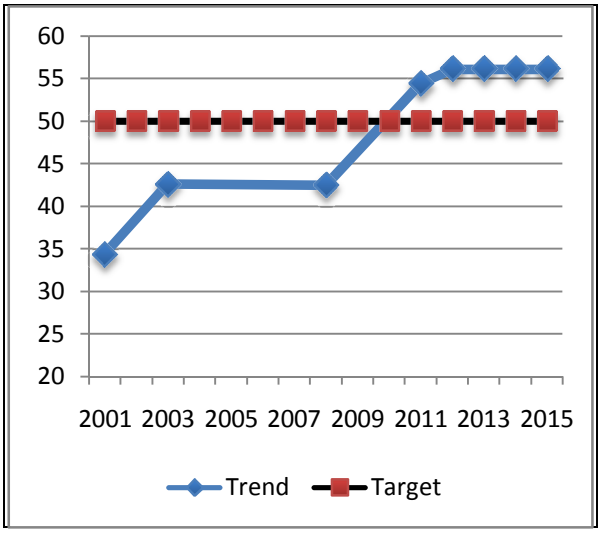
Gender Equity in the Economy

Indicator 3.2: Percentage of Women in Wage Employment in the Non-Agricultural Sector

Gender equality in the labour market has been a concern in Sub-Saharan Africa, where women occupy only one in three jobs outside of agriculture. In Lesotho, however, the number of women in paid employment outside the agricultural sector is high and above target. While women in Lesotho represent a large share of the employed, that does not mean that all employed women have secure, well-paying jobs. Generally-speaking, women earn less than men and have jobs that are less secure. Majority of women working in non-agricultural employment are in the informal small enterprises working from their homes or on the streets.

As Table 3.1 shows, the percentage of women with paying jobs in the non-agricultural sector has increased substantially between 2001 and 2015. In 2001, the percentage of women working in the non-agricultural sector was 34.4%. By 2003, this figure grew to 42.6%. In 2011 and 2012, the percentage of women working in the non-agricultural sector was 54.4% and 56.1% respectively. It remained above 50% between the years 2013 and 2015 as highlighted by the trend line moving above the target in Figure 3.2. Clearly, Lesotho has met the target of 50% of non-agricultural jobs being carried out by women by 2015.

Figure 3.2: Percentage of Women in Non-Agricultural Wage Employment



Sources: LDS 2001, HBS 2002/03, ILFS 2008, CMS 2010/11 & 2011/12 & Global Gender Gap Report (GGGR) 2014

Lesotho has performed well historically on this indicator. One reason for this is the large numbers of Basotho men who found work in the South African mines which allowed Basotho women to assume traditionally male jobs in education, employment and household management. Female employment dominated the booming textile industry in the 2000s. Another contributing factor is high female enrolment in secondary and higher education and associated high female literacy rates which give women the skills and confidence to open businesses. [40]

At the same time, men still dominate the sectors of industry, mining, public administration, electricity, private enterprise, construction, transportation and communication where economic and political power is concentrated. Female CEOs and managers are still rare.[41]Women are held back from leadership roles for largely cultural reasons. The Government of Lesotho has enacted laws that assert equal rights for women. Many of these laws have been introduced in the past decade and their introduction is too recent for their impact to be fully realized. It was only in 2006 that the status of married women in Lesotho was declared equal to that of their husbands in the eyes of the law under the Legal Capacity of Married Persons Act of 2006. As a result, women now have the right to own land and inherit property. Prior to 2006, women in Lesotho were considered legal minors.

The Land Act of 2010 also recognized women's property rights, as it ensures woman's right to inheritance of immovable property, joint land ownership, equal security of tenure, and inclusion of women on land titles and representation of women in land allocation structures. This empowered women into owning property and land. The Companies Act of 2008 asserted women's legal right to become directors of companies without their husbands' approval. Revisions to the Bank Savings and Development Order have improved credit access for women.[42]

The Government and development partners have established initiatives to facilitate financial credit for businesswomen. Credit is still exceptionally difficult to obtain for women, especially in rural areas, as most women do not meet financial institutions' criteria and do not possess property to use as

[40] CMS 2010-2011

[41] Integrated Labour Force Survey 2008

[42] www.gov.ls

collateral. However, reforms and microcredit schemes have contributed to overcoming these barriers for female entrepreneurs.

Gender imbalances in the economy impede development and exacerbate endemic poverty. Female-headed households are vulnerable because they face difficulties in securing incomes and are less likely to own major assets such as livestock. In 2006, female-headed households owned only 18.5% of cars and 28.2% of refrigerators. As the share of female-headed households rises, securing equal economic rights for women is an urgent priority. Only 24% of employees and 30% of landowners are female.[11]

Indicator 3.3: Proportion of Seats Held by Women in National Parliament

The key indicator of women's political empowerment is female representation in parliament. However, parliament is only one of several realms of political power. It is important to also include women's participation in the cabinet, judiciary, public service and local government. There is still a large number of men as compared to women. As of 2015, women occupy only 23% of the economic decision-making positions in the Government of Lesotho. Therefore, Lesotho underperformed on the 30% target by seven[43].

The Kingdom of Lesotho is led by the King as Head of State, as well as by the Senate and National Assembly. 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. Out of 32 members of Senate, eight were women in 2015. Thus, female members account for 25% of the Senators. This represents a decline in female senators. In 2007, 10 Senators (30.3% of the Senate) were female. In both 2012 and 2014, nine Senators (27.3% of the Senate) were women.

The National Assembly currently has 152 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). The Kingdom of Lesotho has showed improvement in increasing female members of the National Assembly from 3 in 1993 to 29 in 2007 to 30 in 2012 to 34 in 2014. As of 2015, this figure has declined to 30.

The Government of Lesotho introduced local governance in 2005 and two local government elections were held in 2005 and 2011. In 2005, the Government made a proactive effort reserving 30% of all constituencies exclusively for women candidates. The remaining 70% of constituencies were open to men and women. Ultimately, women were elected to 58% of contested positions in local government in 2005. In 2011, the Tanzanian model was adopted and the First Past the Post (FPTP) system was adopted. This represented an abandonment of the 30%

[43] Gender Links, SADC Gender Protocol 2011 Barometer, Chapter 4,Economic Justice

quota system.[44]

According to the SADC Protocol on Gender and Development, women should hold 50% of decision-making positions in the private and public sector. In addition to this, the Beijing Platform for Action states that women have the right to participate without any discrimination in all elections and should be treated as equal partners with men at all levels of development.

to both men and women. The additional 30% of seats were allocated to women on a proportional representation basis. Consequently, female representation in local government dropped to 49.1% in 2011 from 58% in 2005. 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.

Table 3.5: Female Representation in Parliament

	1993	2007	2012	2014	2015
Seats in Senate	33	33	33	33	32
Number of Women in Senate	8	10	9	9	8
Percentage of Women in Senate (%)	24.2	30.3	27.3	27	25
Number of women in National Assembly	3	29	30	34	30
Percentage of women in National Assembly (%)	4.6	24	25	28	25
Total Percentage of Women in Parliament (%)	11.2	25.4	25.4	28	25

Source: www.gov.ls/senate

The proportion of women in Lesotho's Senate has fluctuated below the 30% target since 1998. The representation of women increased from 24.2% in 1993 to 30.3% in 2007 before declining to 27.3% in both 2012

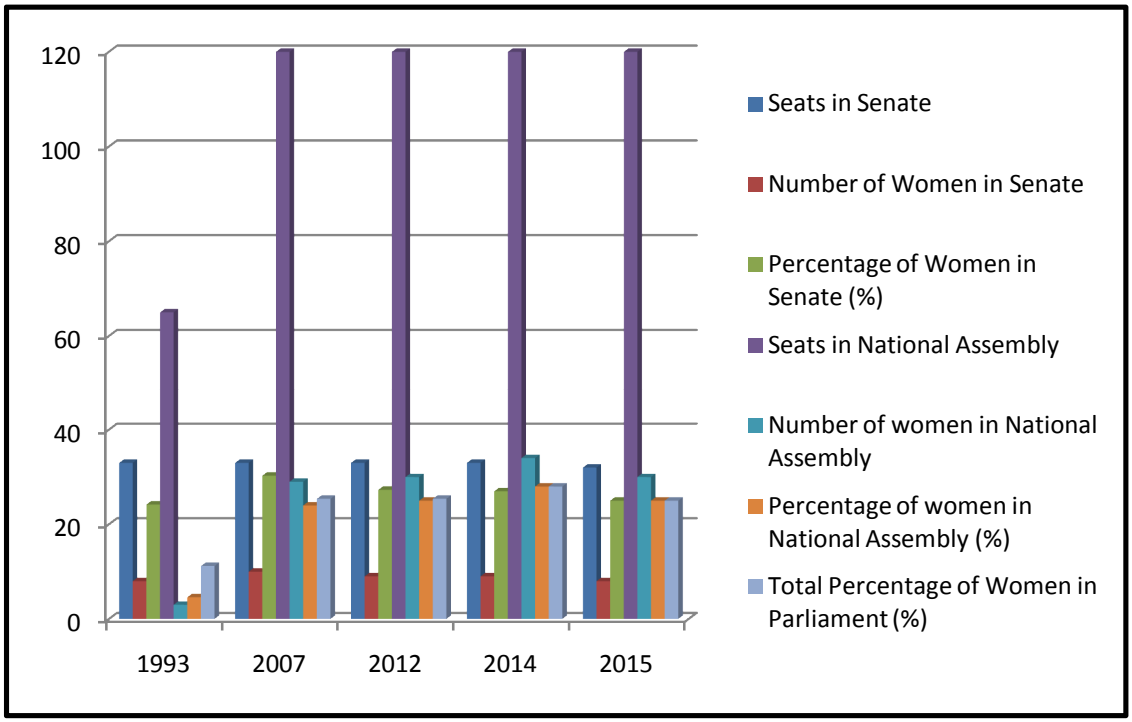
In 2011, the Independent Electoral Commission opened up all constituency seats

and 2014. The proportion of women representation further declined to 25% in 2015. The total number of women in Parliament is also on target, even though it declined from 34 in 2014 to 30 in 2015.


Lesotho National Assembly

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

Figure 3.3: Representation of Women in Parliament



Source: Lesotho National Assembly Report 2015, Senate Registry 2015

Women in the Executive Branch

At the helm of the executive branch of government is the Prime Minister and Cabinet of Ministers. Lesotho's Cabinet comprised of 23 ministers (including the PM) in 2007. Following the 2012 elections, five ministers (21.7%) were women. Three of the seven deputy ministers were also women. In the year 2015, the number of cabinet members grew to 34. This number was made up of 22 male ministers, five female ministers, four male deputy ministers and three female deputy ministers.[45]

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 High Court of

Lesotho has 12 judges, six of whom are women. The Court of Appeals has 5 judges, all of whom are men. Lesotho's Court of Appeals is responsible for the section in the Chieftainship Act that denies first-born daughters the right to inherit chieftainship. While it is noteworthy that such a decision was made by an all-male court, it is even more important to recognize how such laws can taint the progress made by Lesotho towards gender equality and female empowerment.

[45] www.gov.ls

POLICIES AND STRATEGIES

The Lesotho Parliament has passed numerous pieces of legislation to promote rights of women, and the Law Reform Commission has worked to repeal or revise all discriminatory laws and policies such as the Companies Act of 2011 and other laws concerning economic transactions and property rights. The Sexual Offences Act of 2003 combats sexual violence and prescribes strong sentences for offences. The Anti-Trafficking in Person Act of 2011 prohibits all forms of human trafficking and imposes penalties on offenders. The Legal Capacity of Married Persons Act of 2006 removed several restrictions on the legal capacity of a wife and effectively asserts the equality of spouses. In 2011, Lesotho adopted a National Action Plan to end gender-based violence against women and thereafter a domestic violence bill was enacted. 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.

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 translated into legal practice in Lesotho to help achieve female empowerment.

Among other initiatives, the Child and Gender Protection Units (CGPU) were established throughout the country in the Lesotho Mounted Police Service. The core activities of this unit include investigating cases of children needing care and sexual offence cases. The unit also provides services to gender-based violence survivors and maintains a database on all reported cases. In 2003, the Sexual Offenses Act was enacted. This legislation makes all forms of sexual violence illegal.[46] In spite of these critical changes to Lesotho's legal framework, Basotho culture continues to promote gender-based discrimination.

BOTTLENECKS AND CHALLENGES

- Basotho culture is highly patriarchal. Traditionally, decision-making powers have been vested in males. Traditional practices are enshrined in the Laws of Lerotholi (1903), which designated women as minors and constrained them from decision-making, ownership of property and inheritance. An African Peer Review Mechanism Report notes that the primacy accorded to cultural beliefs and practices as articulated in Section 18(4)(c) of the Constitution establishes gender-based discrimination and inhibits full development of human rights regardless of gender.

- The data on the share of women in non-agricultural sector is collected only through a survey which is conducted outside the country. There are no records

[46] Discovering the Mountain Kingdom, July 2008, 2010

of a share of women in Lesotho's statistical records. Women's representation in politics is still below target.

- Boys 'enrolment in school has been lower compared to that of girls which reflects inequality in educational attainments in the country.

- Curbing violence against women remains a major challenge as it adversely impacts women's health, productivity and wellbeing. Sexual violence is a particular concern in a country where HIV and AIDS is so prevalent.

- Large proportions of both men and women still agree that gender-based violence is justifiable under some circumstances. For instance, 27% of women and 34% of men believe that a husband is justified in beating his wife if she argues with him. About 37% of women and nearly half of all men agree that wife beating is acceptable under certain circumstances.

LESSONS LEARNED AND WAY FORWARD

- Inequality is shaped by politics and policies. Laws can protect women and girls from customs which discriminate against them. There is a need to introduce legislation that advocates for

- Gender and Development (GAD), reform laws and customs that hinder female economic development.

- Gender equality is vital for economic growth. A key task is to ensure that both men and women understand the Legal Capacity of Married Persons Act of 2006 and how gender equality contributes to development for all members of society.

- In Lesotho, cultural norms are still highly observed and mostly biased in favour of males. The nation must engage in a dialogue aimed at reforming the Laws of Lerotholi (1903) to accommodate women in all spheres of life.

- The principle of gender equality must be embedded in all development plans with involvement of all groups in the community during the development of such plans. 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.

MDG4: REDUCE CHILD MORTALITY

MDG4: REDUCE CHILD MORTALITY

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

Indicators

4.1: Under-five mortality rate

4.2: Infant mortality rate

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

OVERVIEW

Selected impact indicators show a stalemate in the improvement of health of the people of Lesotho. In recent years, the country has lost ground on important measures of child health. Between 2000 and 2010, the under-5 mortality rate climbed from 113 to 117 per 100,000 live births. However, the 2014 LDHS Key Indicators Report shows a great improvement in the under-five mortality rate which has declined to 85, but is still far from the 2015 MDG target of 37.

For the years 2004 and 2009, infant mortality rate was 91 deaths per 1,000 live births and decreased drastically to 59 deaths per 1,000 live births in 2014. During the same period, child mortality rate was 24 deaths per 1,000 children surviving to age 12 months in 2004, rising to 28 in 2009 and slightly dropping to 27 in 2014. Child mortality rate is a key indicator of a nation's level of development, particularly because it reveals the quality of health services. A high child-mortality rate is usually indicative of inadequate health care systems, unhygienic conditions, and unfavourable socio-economic factors. The Ministry of Health and Social Welfare (MOHSW) 2011 Annual Joint Review revealed that in Lesotho, the five major causes of child mortality are pneumonia, malnutrition, HIV and AIDS, diarrhoea and measles. Poor sanitation and drinking water are also major causes of child illnesses.

Forty percent of under-five mortality are deaths during the first 28 days of life, known as the neonatal period. A further 38% of under-five mortality occurs during the first 6 weeks of life, known as the post-natal period. Increasing poverty, malnutrition and high prevalence of HIV\AIDS make children vulnerable to ill health, abuse, violence and abandonment. The health sector programmes aim to ensure the survival and development of children through basic health services, specifically immunization, nutrition and treatment of common childhood diseases.

Table 4.1: Millennium Development Goal 4 At A Glance

Indicator	2001	2004	2009	2014	2015 Target
Infant mortality rate (per 1,000 live births)	81	91	91	59	27
Under-five mortality rate (per 1,000 live births)	113	113	117	85	37
Percentage of 1 year-olds immunized against measles	71.3	85	80	90	100

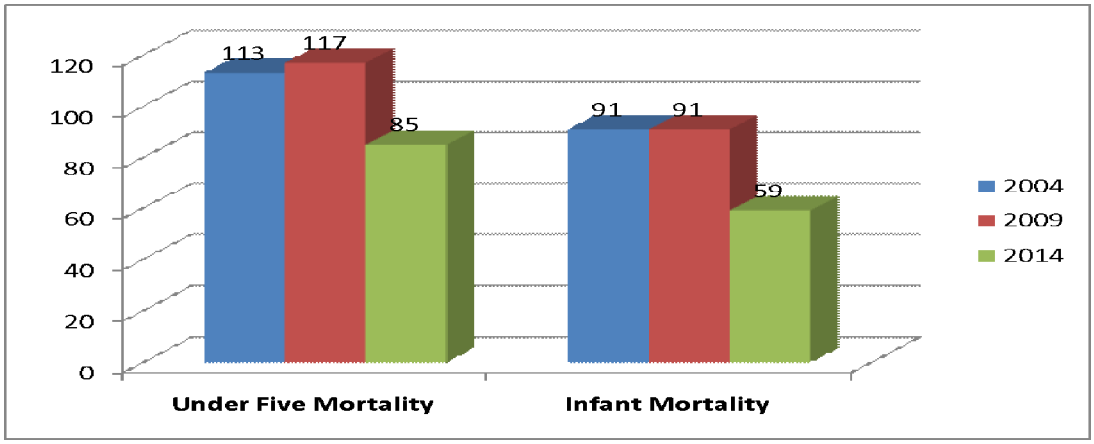
Sources: LDHS 2014, 2009, 2004 and LDS 2001

TRENDS AND ACHIEVEMENTS

Indicator 4.1: Under-five Mortality Rate

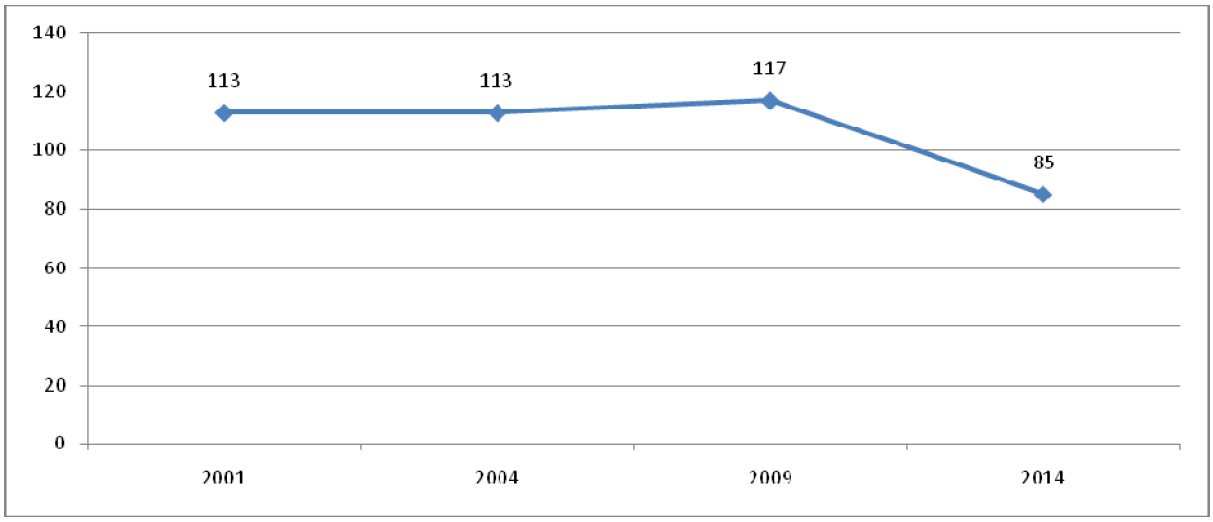
Table 4.1 and Figure 4.1 present trends in childhood mortality, as assessed through the 2004 and 2009 LDHS together with the 2014 LDHS Key Indicators Report. While there was little change in mortality rates between the 2004 and 2009 surveys, the changes between the 2009 and 2014 surveys are striking, with the under-5 mortality rate decreasing from 117 to 85 deaths per 1,000 live births and infant mortality dropping substantially from 91 deaths per 1,000 live births to 59 deaths per 1,000 live births. In Lesotho, 69% of all deaths among children under age 5 take place before a child's first birthday, with 40% occurring during the first month of life. The Lesotho Demographic and Health Survey of 2009 shows an increase in the under-five mortality rate between 2004 and 2009. From 2001 to 2004, the under-five mortality rate was 113 deaths per 1,000 live births, but in the period 2005-2009, the rate increased to 117 deaths per 1,000 live births. It should be noted that the Lesotho Demographic Survey of 2011 measured under-five mortality rate at 121 per 1,000 live births.

Figure 4.1 Trends in Childhood Mortality (deaths per 1,000 live births), 2004-2014



Sources: LDHS 2004, 2009 and 2014

Figure 4.2Trends in Under-5Mortality, 2000-2014



Sources: LDHS 2014, 2009, 2004 and LDS 2001

As Figure 4.2 shows, the under-5 mortality rate has greatly declined from 117 per 1000 live births in 2001 to 85 per 1000 live births in 2014[47]. This exceeds the national target of 115 for 1000 live births by 2015. The MDG target of lowering under-5 mortality to 37 per 1000 live births by 2015 was not achieved.

Infant mortality has dropped from 91 per 1000 live births in 2009 to 59 deaths per 1,000 live births in 2014. Factors that contributed to these outcomes are an improvement in child nutrition evidenced by a decline in stunting from 39.2% in 2009 to 33.2% in 2014 and an increase in the proportion of infant immunizations against measles from 88% in 2012 to 90.1% in 2014. Improvements in care before, during and after childbirth contributed towards Lesotho's success in reducing its under-5 mortality rate by 2015.

Indicator 4.2: Infant Mortality Rate

Lesotho has set a goal to reduce the infant mortality rate to 27 deaths per 1,000 live births. In 2001, 74 infants died within their first year per 1,000 live births. In 2004, infant mortality had increased to 91 per 1,000 live births and remained at 91:1000 in 2009.

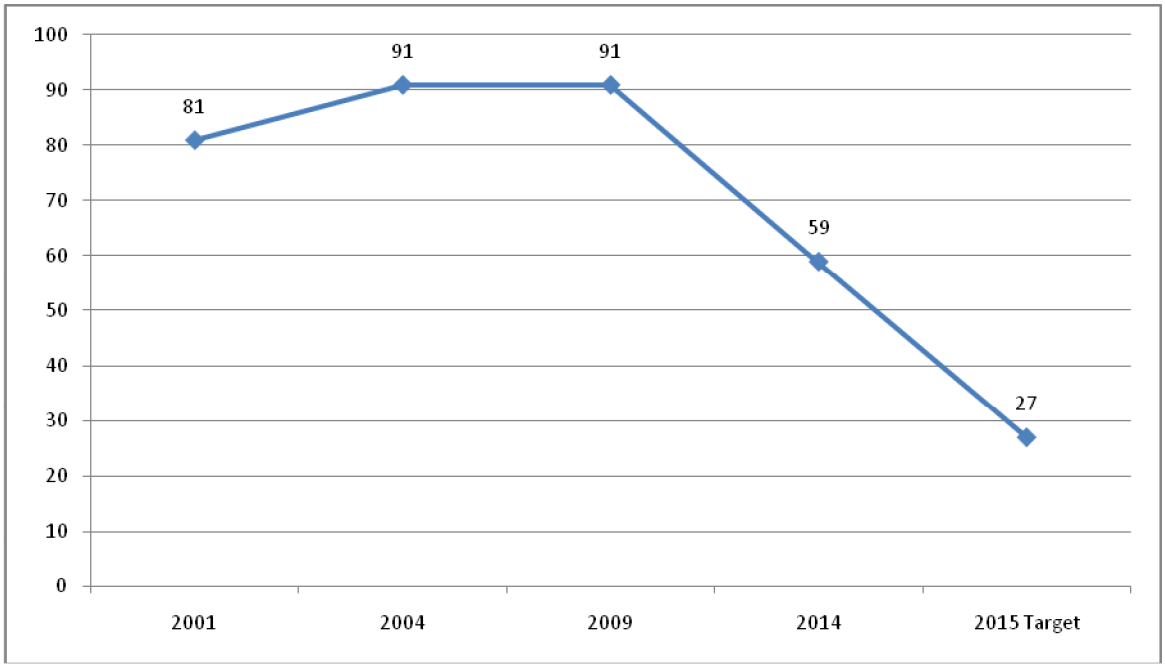
The transmission of HIV and AIDS from mother to child was a significant driver of this increase. Two percent of infant deaths were directly caused by HIV and AIDS.[48]Additional causes of death such as diarrhoea and pneumonia are also frequently linked to HIV infection and AIDS. According to LDHS 2004 and 2009, about 40% of under-five deaths occur in the months immediately following birth, the neonatal period. Common causes of neonatal death include asphyxia, preterm births, and sepsis related to childbirth. Clearly, poor hygiene is a major risk factor for these conditions. Furthermore, poor sanitation and unsafe drinking water are associated with a high prevalence of diarrhoea among children. According to the 2004 Lesotho Demographic Health Survey,

[47] LDHS Preliminary Report (2014)

[48] LDHS Preliminary Report (2014)

diarrhoea is one of the major causes of infant deaths. With a 2014 infant mortality rate of 59 per 1000 live births, Lesotho was unable to achieve its MDG target of 27 infant deaths per 1,000 live births by 2015.

Figure 4.3: Trends in Infant Mortality, 2000-2014

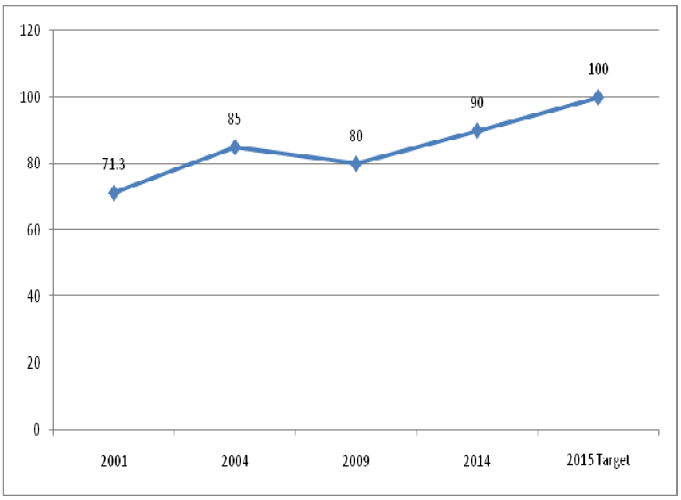


Source: LDHS 2014, 2009, 2004 and LDS 2001

Indicator 4.3: Percentage of 1 Year-Old Children Immunized Against Measles.

Measles is the leading cause of mortality among vaccine-preventable childhood diseases. Lesotho has implemented the Expanded Programme on Immunizations as a cost-effective public health intervention to reduce child morbidity and mortality from preventable diseases such as tuberculosis, polio, diphtheria, whooping cough, tetanus, influenza and measles.

Figure 4.4: Trends in Measles Coverage, 2000-2014



Source: LDHS 2014, 2009, 2004 and EMICS 2000

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

The cause of low coverage is inadequate provision of immunization through health centres. Inadequate transportation, lack of skilled personnel, frequent staff turnover and reliance on fluctuating donor support have contributed to low coverage. Moreover, the decentralization of health services is not yet fully functioning and districts still depend on the central level for planning and resource mobilization. These factors help explain the large year-to-year fluctuations in coverage. Most children are vaccinated through fixed or static services because numerous obstacles prevent families from vaccinating infants through outreaches.

The 2007 and 2010 post-campaign evaluation report indicated that 75% and 78% of children were vaccinated through outreach services respectively. When financial and personnel resources are robust, outreach services can be provided using the Reaching Every District/Child (RED/C) strategy. In an attempt to address the disparity in immunization, Lesotho introduced the strategy in 2012 in the four districts with high numbers of children with DTP3 and measles. Even so, the strategy is not well implemented due to constraints such as inadequate transportation to reach the target communities. When outreach services decline, immunization coverage decreases. Scaling up sustained outreach services has been proposed and discussion is ongoing for partners to fully dedicate themselves to this effort.

Variations in Measles Immunization Coverage

Table 4.3 provides information on variations in measles immunization coverage by socio-economicstatuslookingatthefollowingcharacteristics–urban/ruralresidence, geographical/ecological zones, districts, mother's education and wealth quintiles. There has been a general increase in coverage for all the socio-economic characteristics from 2009 to 2014 reporting periods with the exception of Mokhotlong where coverage decreased from 84.3% to 76.4% during the same periods.

Table 4.3: Socio-economic Variations in Measles Immunization Coverage

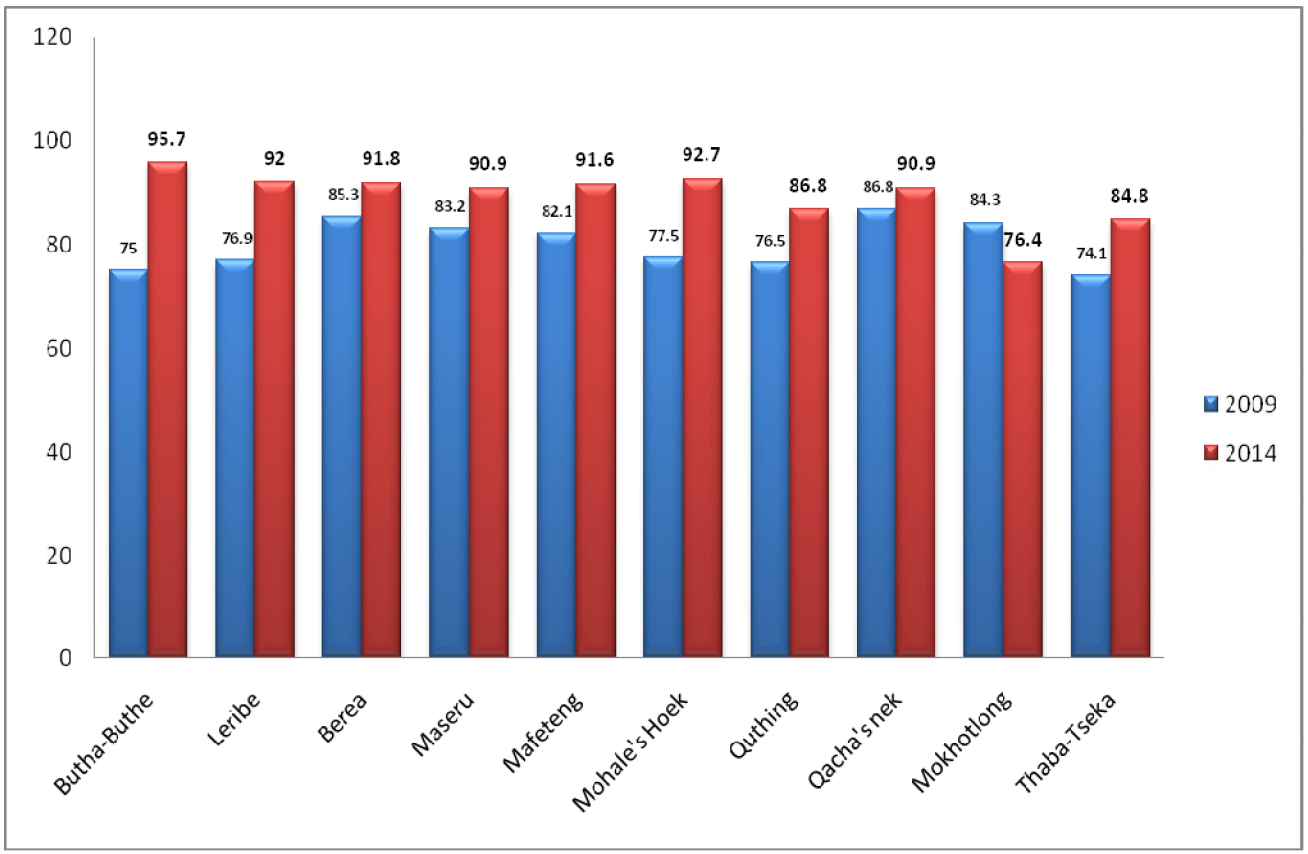
Characteristics		Measles Immunization Coverage	
		2009	2014
Residence	Urban	90.0	92.8
	Rural	77.5	89.1
Geographical Zone	Lowlands	85.1	91.9
	Foothills	80.4	93.6
	Mountains	73.8	83.4
	Senqu River Valley	71.3	96.2
District	Butha-Buthe	75.0	95.7
	Leribe	76.9	92.0
	Berea	85.3	91.8
	Maseru	83.2	90.9
	Mafeteng	82.1	91.6
	Mohale's Hoek	77.5	92.7
	Quthing	76.5	86.8
	Qacha's nek	86.8	90.9
	Mokhotlong	84.3	76.4
	Thaba-Tseka	74.1	84.8
Mother's Education	No education	n/a	n/a
	Primary incomplete	71.1	87.3
	Primary complete	79.2	87.2
	Secondary+	86.3	92.4
Wealth	Lowest	67.8	87.6
	Second	77.5	85.3
	Middle	82.8	97.1
	Fourth	83.8	91.0
	Highest	91.7	89.7

Sources: LHDS 2009 and 2014

Measles Immunization Coverage by District

Figure 4.5 shows that immunization coverage varies by district with Butha-Buthe leading by 95.7%, followed by Mohale'sHoek (92.7%) and Leribe (92%). Mokhotlong is the lowest-performing district with 76.4% immunization coverage. The 2014 picture is different from the 2009 situation where some of the districts which did not perform well have shown a great improvement even exceeding the leaders in 2009, i.e. Butha-Buthe which is now at the top was second from the bottom in 2009.

Figure 4.5: Measles Immunization Coverage by District

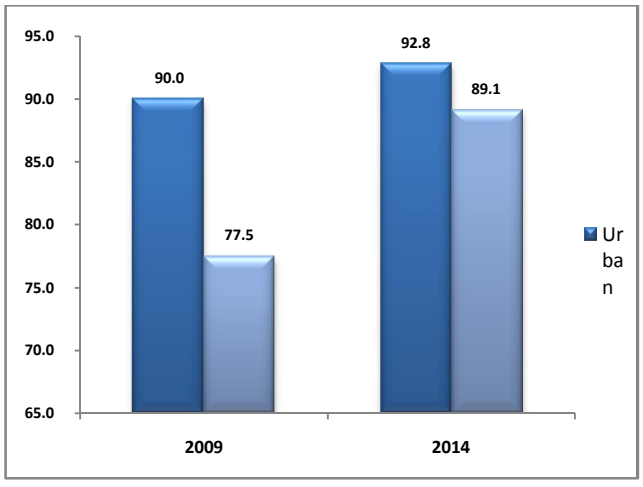


Sources: LHDS 2009 and 2014

Measles Immunization Coverage by Urban/Rural Residence

As Figure 4.6 shows, urban areas perform better than rural areas in immunizing children against measles. However, rural areas show a great improvement from 2009 to 2014 than urban areas. The gap between urban and rural has greatly decreased from 12.5% points in 2009 to just 3.7% points in 2014.

Figure 4.6: Measles Immunization Coverage by Urban/Rural

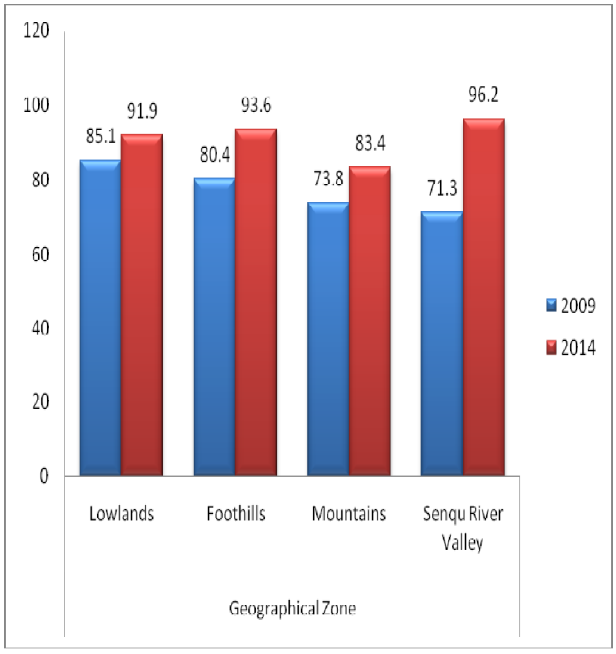


Sources: LHDS 2009 and 2014

Measles Immunization Coverage by Ecological Zones

Senqu River Valley shows the highest coverage (96.2%), followed by the Foothills (93.6%) then the Lowlands (91.9%), while the Mountains have the lowest coverage (83.4%). Topography plays a major role because mountainous areas are hard to reach and therefore hinder service delivery.

Figure 4.7: Measles Immunization Coverage by Ecological Zones

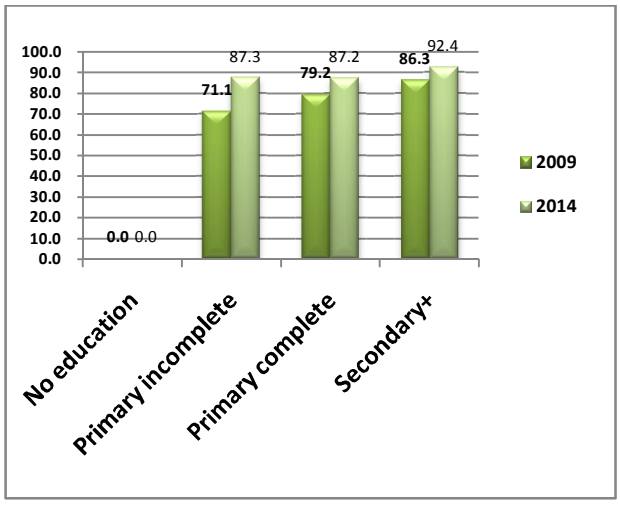


Sources: LHDS 2009 and 2014

Measles Immunization Coverage by Mother's Education Level

As depicted by Figure 4.8, there is a correlation between the level of a mother's education and a child's immunization coverage. Better-educated mothers are more likely to ensure that their children are vaccinated.

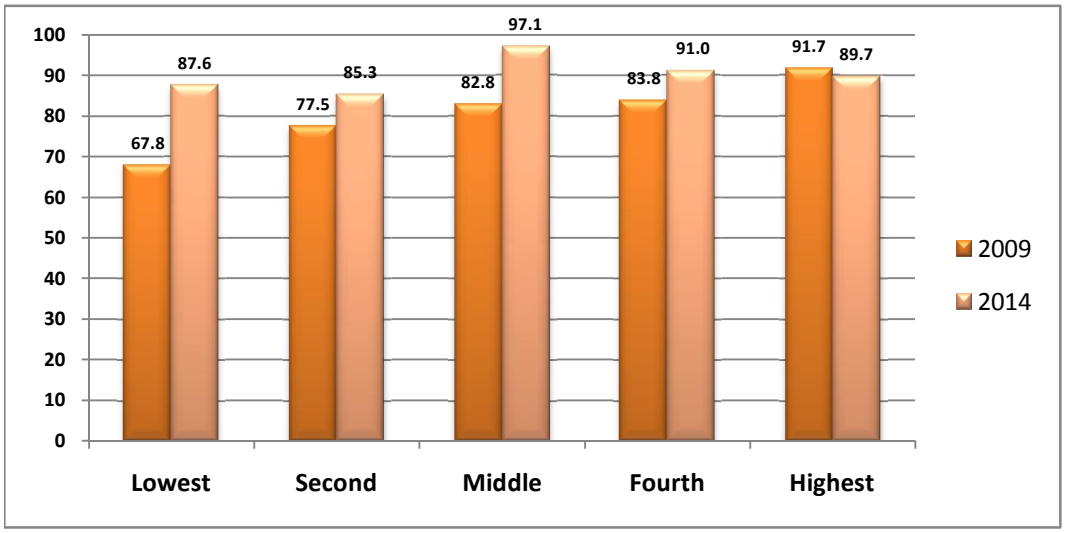
Figure 4.8: Measles Immunization Coverage by Mother's Education Level



Sources: LHDS 2009 and 2014

Figure 4.9 presents levels of measles immunization coverage by wealth quintiles. Coverage has generally increased between 2009 and 2014 for the four lowest wealth quintiles and has surprisingly decreased for the highest quintile. As shown in the Figure 4.9, in 2009 immunization coverage was lowest among the poorest at 67%, increasing with each wealth quintile ladder with and the richest quintile registering coverage of 91%. However, in 2014 things took a different turn as there were sharp increases in the lowest quintile and middle quintiles, while the second and fourth quintiles showed moderate improvements.

Figure 4.9: Measles Immunization Coverage by Wealth Quintile



Sources: LHDS 2009 and 2014 LDHS Key Indicators Report

POLICIES AND STRATEGIES

In order to realize the Government's commitment to improving child health, a number of policy interventions aimed at improving access to and quality of child and maternal health services have been implemented by the Ministry of Health. The Ministry was involved in the revitalization of Primary Health Care exercise and responsible for the aggressive implementation of a program to eliminate mother-to-child transmission of HIV strategy as well as the development of the MDG Acceleration Framework (MAF) in 2013.

In late 2013, Partners in Health (PIH/L) and the Ministry of Health began collaborating on a plan to scale up the maternal mortality program so that all health clinics would be able to deliver a comparable level of care to what PIH/L had been delivering for years. While PIH/L will be intimately involved in training staff and providing technical assistance, the health centres will remain under the purview of the Ministry of Health.

The national reform will occur in three phases over five years.

In an effort to improve declining health outcomes, the ministry is pursuing innovative methods of financing health care, such as Performance-Based-Financing (PBF). The MOH, with the assistance of the World Bank, is implementing a Performance-Based Financing Project designed to improve the utilization and quality of health care services, particularly maternal and newborn health services, and hence improve overall health outcomes.

On the advocacy side, the parliamentarians, senators and media personnel have been educated on issues relating to Maternal, Neonatal and Child Health (MNCH) through a workshop. The main purpose of the workshop was to facilitate the rapid implementation of cost-effective interventions in order to attain the target by 2015. While the target was unmet, the

workshop renewed the sense of urgency in working toward this goal.

There is no doubt that immunizations and other health care interventions save lives and deserve prioritization. Immunization is one of the most efficient, powerful and cost-effective health interventions for children and their mothers. When vaccination of children is combined with other health interventions such as Vitamin A and de-worming tablets (Albendazole), it becomes a major force for child survival.

BOTTLENECKS AND CHALLENGES

The greatest challenges in scaling up health services to reduce child mortality are weaknesses in the health care system coupled with poor family and community health practices.

Specific health system constraints are:

- Inadequate health worker skills: Implementation of the Integrated Management of Childhood Illness (IMCI) suffered from lack of skilled health professionals, inadequate capacity to carry out post-training supervision and mentoring that support trainees and build their confidence in caring for sick children. The PMTCT programme faced similar challenges.

- Inadequate provisions of services through health centres caused by inadequate transportation, lack of skilled personnel, frequent staff turnover and reliance on fluctuating donor support have contributed to poor service delivery.

- The decentralization of health services is not yet fully functioning. As a result, districts still depend on the central level. The lack of district-level autonomy hinders districts' ability to adequately plan, mobilize resources and manage programmes. All of this hinders progress.

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

- Weak policy implementation and integration: Major policy responses such as IMCI, Reaching Every District, PMTCT, ART for children, Emergency Obstetric and Neonatal Care; Integrated management of acute malnutrition strategy have seen slow implementation.

LESSONS LEARNED AND WAY FORWARD

- Even though the health sector has received increased financing and other support, its performance in some of the critical indicators has deteriorated. There is a demand-supply side mismatch. Furthermore, a significant portion of the population does not fully utilize health services due to a number of reasons, such as cultural practices and lack of awareness of services available.

- While the Government is implementing several policies and programmes, most of them, such as the Reaching Every District (RED) Strategy and Performance-Based Funding, have not been fully rolled out to the entire country. There are only two Performance-Based Funding-implementing districts.

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

- Sufficient supply of vaccine and vaccine devices is one of the factors contributing to low immunization rates. The importance of maintaining the required stock levels cannot be overemphasized.

- There is an urgent need to train health workers on the management of EPI activities, including having dedicated personnel who will implement recommendations from surveys. There is a dire need to roll-out RED/REC Strategy countrywide. Furthermore, the program should implement Enhanced Routine Immunisation Activities (ERIA) in all districts and strengthen supportive supervision at all levels.

MDG 5: IMPROVE MATERNAL HEALTH

MDG 5: IMPROVE MATERNAL HEALTH

Target 5.A: Reduce by 75% the maternal mortality ratio, between 1990 and 2015.

Indicators

5.1: Maternal mortality ratio (MMR)

5.2: Proportion of births attended by skilled health personnel

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

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

Maternal health is a useful indicator in assessing not only women's health status, but also the accessibility, sufficiency, and effectiveness of a country's health service system. Maternal Mortality Ratio (MMR) has been increasing steadily since 2001. Nevertheless, most secondary indicators have shown some improvements.

According to 2014 LHDS Key Indicators Report, the proportion of women who received ANC services from skilled providers increased from 90% in 2004 to 95% in 2014. The report also reported a notable increase of births attended by skilled providers from 55% in 2004 to 78% in 2014. The proportion of births that occurred in health facilities also increased significantly over the years, recording 52% in 2004, 59% in 2009 and 77% in 2014.

TABLE 5.1: Millennium Development Goal 5 At A Glance

Indicators	2001	2004	2009	2011	2014	2015 (Target)
Maternal Mortality rate (per 100,000 live births)	419	762	1155	1143	1024	90 (global target) 300 (national)
Proportion of births attended by skilled health personnel %	60	55	62	62	78	80
Contraceptive Prevalence Rate (15-49 years, married women) %	40.6	37	47	47	60.2	80
Adolescent birth rate (15-19 years) %	-	20.2	19.6			No set target
Antenatal Coverage (at least 1 visit) %	85.2	90	92	92	95.2	100
Antenatal Coverage (at least 4 visits) %	-	69.6	70.4	70.4	77.9	100
Unmet Need for Family Planning (%)	-	30.9	23	23	18.4	No set target

Sources: LDS 2001 and, 2011, LDHS 2004, 2009 and 2014

TRENDS AND ACHIEVEMENTS

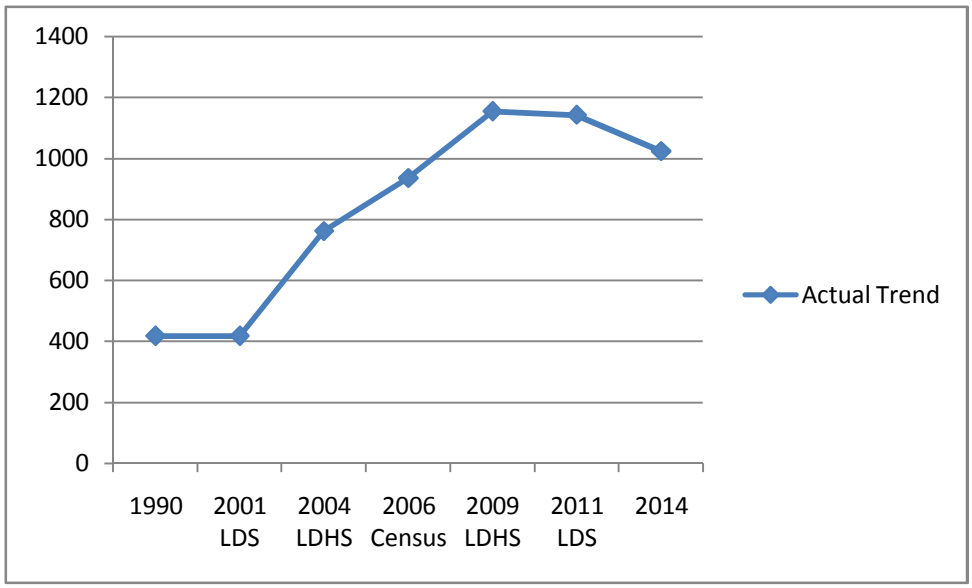
Target 5A: Reduce by 75% the Maternal Mortality Ratio between 2000 and 2015

Indicator 5.1: Maternal Mortality Ratio

The Maternal Mortality Ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births. Such deaths are affected by various factors, including general health status, education and services during pregnancy and childbirth. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth will reduce maternal deaths significantly. The global MDG 5 target for maternal health was to reduce the number of women who die in pregnancy and childbirth by 75% between 1990 and 2015. When applying this target to Lesotho, the goal was to reduce maternal mortality to 90 cases per 100,000 live births. Using the 2004 baseline (762 deaths per 100,000 live births), the Government of Lesotho set a target to reduce maternal deaths to 300 per 100,000 live births by 2015.

Figure 5.1 shows that Maternal Mortality Ratio (MMR) has been increasing steadily since 2001. In the period 2007-2010, Lesotho reported maternal mortality ratio of 1,155 deaths per 100,000 live births. According to Lesotho Demographic Health Survey of 2014, the MMR has slightly decreased to 1,024 deaths per 100,000 live births.

Figure 5.1: Trends in Maternal Mortality Rate



Source: LDS 2001, 2011 and LDHS 2004, 2009 and 2014

The maternal health situation is grave in Lesotho. The number of women who die from pregnancy and childbirth-related causes has increased rapidly since 2001. As of 2015, one out of 32 Basotho women dies of pregnancy and childbirth-related conditions. Maternal mortality in Lesotho has been largely associated with three delays in maternal care:

- Delay in decision making to seek health care,
- Delay in reaching care and,
- Delay in receiving care.

Ensuring that the country reduced the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 has proved a challenge. Lesotho did not reach the national target of 300 or the global target of 90 maternal deaths by 2015.

It should be noted however that assessing progress towards this indicator has presented a major challenge due to the paucity of data.

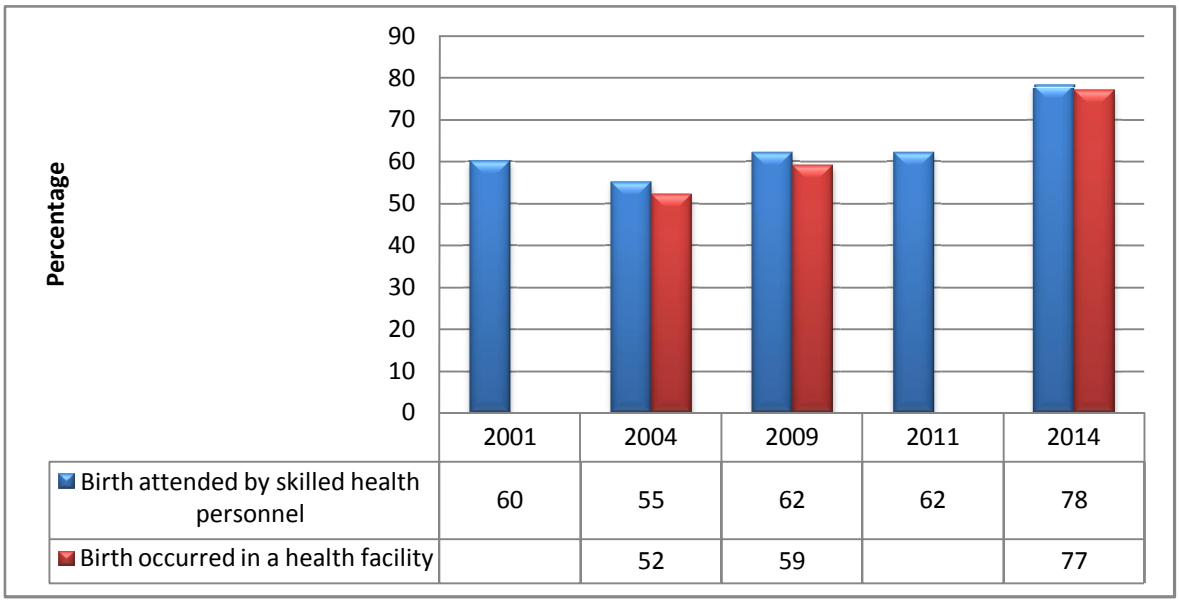
Indicator 5.2: Proportion of Births Attended by Skilled Health Personnel

The presence of skilled health personnel during active labour and delivery is one of the best ways to ensure the survival of mother and child. In order to reduce maternal mortality and infant mortality, it is extremely important that all births be attended by skilled health personnel, as

timely management and treatment can make the difference between life and death.

The target for this indicator stipulated that at least 80% of births must be attended by a skilled health professional. In 2001, 60% of women gave birth with the assistance of a skilled health worker, as indicated by Figure 5. 2. Four years later, the proportion decreased to 55%.[49]

Figure 5.2: Births Attended by Skilled Health Personnel and Births Occurred in a Health Facility



	2001	2004	2009	2011	2014
Birth attended by skilled health personnel	60	55	62	62	78
Birth occurred in a health facility		52	59		77

Sources: LDS 2001, LHDS 2004, 2009, LDS 2011 and Preliminary Results LDHS 2014

The results from 2009 LDHS and 2014 LDHS Key Indicators Report show an improvement from 62% in 2009 to 78% in 2014. Although considerable progress has been achieved over the years in improving the proportion of births attended by skilled personnel, the quality of care and accessibility to health care facilities remain a concern. Moreover, immediate postnatal care is very low, a particularly undesirable state of affairs because most deaths occur within two days of childbirth. While births in a health facility have been increasing, the target was not achieved by end of 2015.

Target 5.B: Achieve Universal Access to Reproductive Health by 2015

Indicator 5.3: Contraceptive Prevalence Rate (CPR)

Contraceptive use supports maternal and reproductive health by avoiding unintended and closely-spaced pregnancies. This, in turn, reduces the need for unsafe abortions. The contraceptive prevalence rate (CPR) of modern methods is the percentage of married women aged 15-49 using a modern method of family planning. Figure 5.3 shows that according to LDS 2001, the CPR was

[49]LDHS, 2014

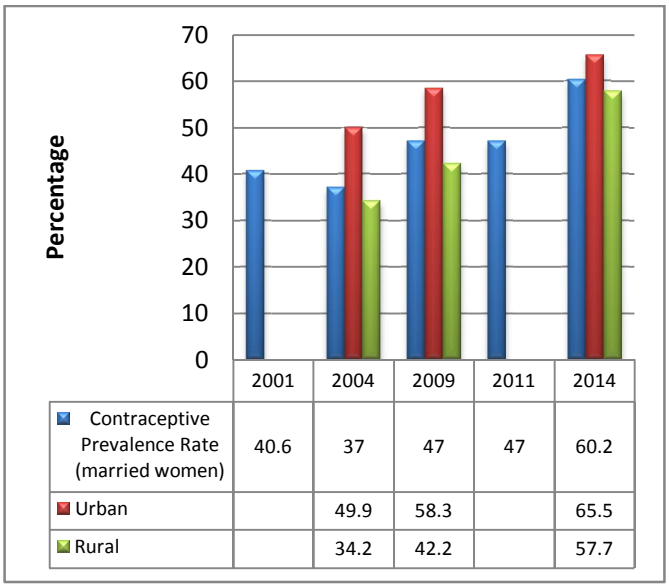
40.6% which was quite high by African standards. In 2004, the CPR was 37% which showed a decline of 3.6%.

Between 2004 and 2009, the contraceptive prevalence rate increased from 37% to 47%. As set out in Lesotho's population policy, contraceptive prevalence increased to 75% by 2011 so that levels of fertility could be reduced to desired levels. According to 2014 LDHS Key Indicators Report, CPR only increased to 60.2% which shows that the use of contraceptive methods among currently married females of reproductive age is increasing. Similarly, the CPR among sexually active unmarried women has steadily risen from 48% in 2004 to 58% in 2009 and 73% in 2014.

This increase can be attributed to easily available contraceptive methods in all Government health centres and Christian Health Association of Lesotho (CHAL) private health centres where they are offered freely. Moreover, knowledge of family planning is almost universal with over 98% of women aged 15 – 49 knowing at least one method of modern family planning. Although high access to contraception helps reduce maternal mortality; it has not been high enough to decrease the maternal mortality rate.


Offices of Lesotho Planned Parenthood Association

Figure 5.3: Contraceptive Prevalence Rate Among Married Women



	2001	2004	2009	2011	2014
Contraceptive Prevalence Rate (married women)	40.6	37	47	47	60.2
Urban		49.9	58.3		65.5
Rural		34.2	42.2		57.7

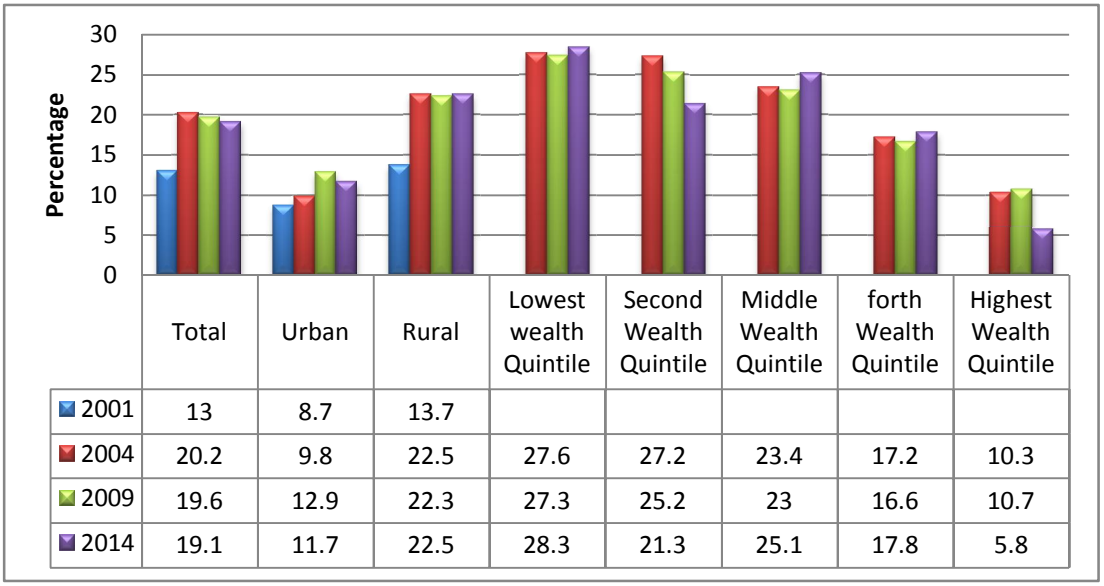
Sources: LDS 2001, LHDS 2004, 2009 and 2014

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 of its association with higher morbidity and mortality for the mother and child. Childbearing during the teenage years also frequently has adverse social consequences, particularly on female educational attainment. Women who become mothers in their teens are more likely to curtail their education and have limited access to job opportunities.

Globally, most regions are witnessing a decline in adolescent birth rates among women aged 15 to 19 years and Lesotho is not an exception.

Figure5.4: Adolescent Birth Rate



	Total	Urban	Rural	Lowest wealth Quintile	Second Wealth Quintile	Middle Wealth Quintile	forth Wealth Quintile	Highest Wealth Quintile
2001	13	8.7	13.7					
2004	20.2	9.8	22.5	27.6	27.2	23.4	17.2	10.3
2009	19.6	12.9	22.3	27.3	25.2	23	16.6	10.7
2014	19.1	11.7	22.5	28.3	21.3	25.1	17.8	5.8

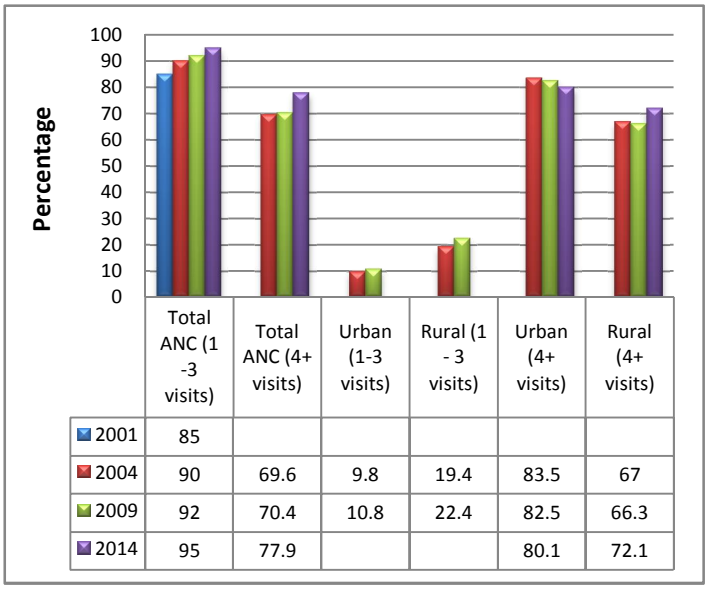
Sources: LDS 2001 and LHDS 2004, 2009 and 2014

Figure 5.4 shows that total adolescent births rates have trended downward since 2004, though there have been fluctuations among teens of varying wealth levels. Rural teenagers and those from the lowest wealth quintile to middle wealth quintile tend to start bearing children earlier than urban teenagers and those in the fourth and highest wealth quintiles. The proportion of teenagers who have begun childbearing rises rapidly with age, from 3% at age 15 to 40% at age 19.[50]

Indicator 5.5: Antenatal Care Coverage

High-quality care during pregnancy is fundamental to the health, well-being and survival of mothers and their babies. Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, delivery, and the postnatal period (within 42 days after delivery). Pregnant women should also be tested for HIV. If HIV positive, pregnant women can receive guidance both on living with the virus, and in avoiding transmission to their babies.

Figure 5.5: Antenatal Care



	Total ANC (1 -3 visits)	Total ANC (4+ visits)	Urban (1-3 visits)	Rural (1 - 3 visits)	Urban (4+ visits)	Rural (4+ visits)
2001	85					
2004	90	69.6	9.8	19.4	83.5	67
2009	92	70.4	10.8	22.4	82.5	66.3
2014	95	77.9			80.1	72.1

Sources: LDS 2001 and LDHS 2004, 2009 and 2014

[50] 2014 LDHS- Key indicators report

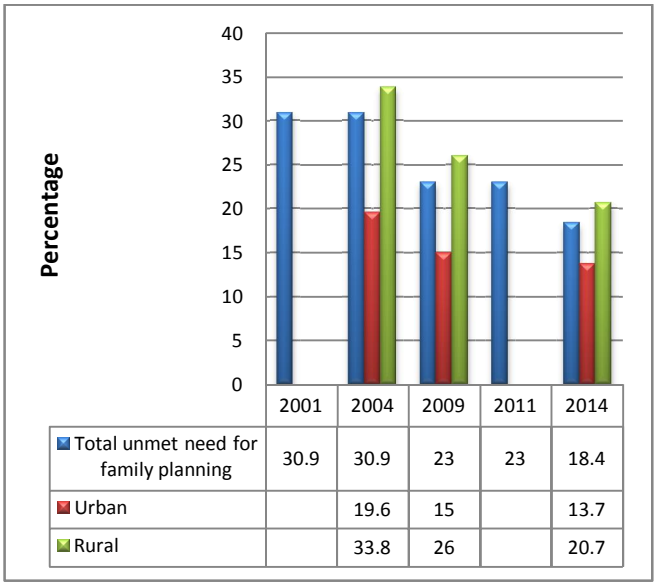
As Figure 5.5 shows, the percentage of women receiving antenatal care from a skilled provider has increased slightly from 90% in 2004 to 92% in 2009.The 2014 LDHS Key Indicators Report results show that 95% of women who gave birth received antenatal care from a skilled provider at least once prior to their last birth.

The World Health Organization has recommended a minimum of four antenatal care visits to ensure the wellbeing of mothers and newborns. These visits should include tetanus toxoid vaccination, screening and treatment for infections, and the identification of warning signs during pregnancy. Although Lesotho has made good progress on antenatal care, the target of achieving 100% of at least four antenatal visits was not met.

Indicator 5.6: Unmet Need for Family Planning

The unmet need for family planning is defined as the percentage of women aged 15 to 49, whether married or in a relationship, who wish to delay or avoid pregnancy, but are not using any form of contraception. Figure 5.6 shows that unmet needs for family planning have gradually decreased. In 2014, 18% of married women had an unmet need for family planning services. At present, 77% of the potential demand for family planning is being met. Thus, if all married women who want to delay or avoid pregnancy were to use family planning methods, the Contraceptive Prevalence Rate (CPR) would increase from 60% to 79%.Currently, 18% of married women have unmet needs for family planning and 77% of the potential demand for family planning is being met.

Figure 5.6: Unmet Need for Family Planning



	2001	2004	2009	2011	2014
Total unmet need for family planning	30.9	30.9	23	23	18.4
Urban		19.6	15		13.7
Rural		33.8	26		20.7

Sources: LDS 2001, 2011 and LDHS 2004, 2009 and 2014 LDHS Key Indicators Report

POLICIES AND STRATEGIES

The Government of Lesotho has formulated a number of policies, guidelines and other frameworks that foster reproductive health. These include:

- The National Adolescent Health Policy (2006); PMTCT Guidelines (2007); Emergency Obstetric Care Training Manual for Health Professionals (2009); Reproductive Health Policy (2009); the National AIDS Policy, the National HIV/AIDS Strategic Plan for 2006-2011; the National HIV/AIDS Monitoring and Evaluation Plan; the National OVC Policy, the Blood Transfusion Policy and HIV Testing and Counselling Policy.
- In 2013, the Government of Lesotho, with support from the UN and other stakeholders, developed the Roadmap for Accelerated Reduction of Maternal and

Newborn Morbidity and Mortality in Lesotho. The roadmap identified and prioritised the main bottlenecks and highlighted collaborative solutions involving the Government and all other stakeholders. The framework was designed to address challenges in the area of maternal health by accelerating the operationalization of various initiatives. Importantly, the MAF was to be operationalized through a time-bound action plan, with an accompanying monitoring and evaluation framework to ensure its timely implementation.

BOTTLENECKS AND CHALLENGES

- Lesotho has made significant progress in increasing access to sexual and reproductive health services, however there is still limited financing for reproductive health services.

- Insufficient infrastructure and skilled health personnel across the country, especially in the rural areas are threats to reproductive health.

- Fees are levied in both government and CHAL hospitals for normal and surgical deliveries, which creates a disincentive for pregnant women to seek care. Health centres offer free services but not for emergency obstetric care.

- 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.

- Data challenges: Insufficient data/information has hindered frequent monitoring of maternal health outcomes and development of better actions for addressing maternal health issues.

- Although considerable progress has been achieved over the years in the proportion of births attended by skilled personnel, the quality of care and accessibility to health facilities remain a concern.

LESSONS LEARNED AND WAY FORWARD

- Investing in better maternal health not only improves a mother's health, but also increases the number of women in the workforce and promotes the economic wellbeing of families and communities.

- There has been a significant increase in services for preventing mother-to-child transmission of HIV.

- Reducing teenage pregnancies and empowering women to space out births and choose family size are critical.

- More work needs to be done to promote the health and safety benefits of delivering babies at a health facility. During antenatal care, pregnant women should be educated about the importance of delivering under the care of a skilled health personnel and getting timely postnatal check-ups.

- Empower and motivate community (VHWs and Local authorities) to provide basic healthcare services earliest possible.

- Remove obstacles to delivery at healthcare facilities by providing vouchers to low-income women in hard-to-reach areas for transport and/or to cover cost of delivery services.

- Target low-income women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).

- Address the inadequate human resources for health care by training more midwives and deploying them to the poorest and/or hardest-to-reach districts.

- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery .

- Implement the MDG Acceleration Framework (MAF) for Maternal Health.

MDG 6: COMBAT HIV AND AIDS AND TUBERCULOSIS

MDG 6: COMBAT HIV AND AIDS AND TUBERCULOSIS

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

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

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

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

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

Indicators
6.6: Incidence, prevalence and death rates associated with tuberculosis

OVERVIEW

Lesotho has the second-highest HIV prevalence in the world amongst people aged 15-49 years. An estimated 25% of Lesotho's population aged 15-49 has HIV or AIDS. The effect is devastating on the socio-economic development of the country. The prevalence has remained high despite government initiatives in partnership with development partners to lower it. This increase in the prevalence rate from 23% in 2009 to 25% in 2014 calls for concerted efforts by GoL and its development partners to identify the root causes for new infections, which will enable them to scale up strategies that are more effective.

IV/AIDS is a constant threat to the economic growth of the country. It undermines the economic productivity of the labour force. In devastating child and maternal health, it negatively impacts the educational outcomes of orphans and vulnerable children (OVC). It also hinders the attainment of other MDGs as it compromises the health of the human capital of the country.

Lesotho has made particularly considerable progress in testing, treatment and prevention of mother-to-child transmission (PMTCT) even though coverage has been declining from 95% in 2011 to 74% in 2014. According to the 2014 national HIV estimates, the HIV transmission from mother to child in 2012 was 3.5%. However, the HIV transmission

rate from mother to child has slowly been increasing to 5.8% and 5.9% in 2013 and 2014 respectively. Testing among adults and youth increased rapidly from 2004 to 2014 though the remaining challenge is to engage people who do not know their HIV status and retain those who are in treatment and care.

Antiretroviral Treatment (ART) coverage has also increased substantially from 3% in 2005 amongst adults to 35% in 2014, while for children it increased from 1% in 2005 to 30% in 2014.[51] Finally, innovations such as the "mother-baby pack" and new PMTCT guidelines have been employed to scale-up pregnant women and newborns who would otherwise not receive antiretroviral PMTCT services to a greater proportion of treatments to prevent mother-to-child transmission. The proportion of HIV-positive pregnant women receiving antiretroviral treatment for preventing Mother-to-Child Transmission (MTCT) increased from an estimated 6% in 2004 to 51% in 2011 and then increased slightly to 52% in 2012.

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

Table 6.1: Millennium Development Goal6 at a Glance

Indicators	2004	2007	2009	2010	2011	2012	2014	Target 2015
HIV Prevalence among population aged 15-24(%)	11.3 M: 6.0 F: 15.4		9.3 M: 4.2 F: 13.6				9.6 M:6.0 F: 13.1	-
HIV Prevalence among population aged 15-49(%)	23.4 M: 19.0 F: 26.3	-	23 M:18 F:26.7	-	-	-	24.6 M: 18.6 F: 29.7	-
Condom use among adults during last high-risk sex (%)	M:38 F18.7		M:50.5 F:38.5	-	-	-	M:65.34 F: 53.94	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	-	-	-	M: 30.87 F: 37.58	85
Adult Antiretroviral coverage (%)	4(1)	24 (13)	48 (23)	59(28)	58(28)	59(30)	(35)	80
Child Antiretroviral coverage (%)	-	11	24	19	22 (24)	24	30	80
HIV+ pregnant women receiving ART for preventing MTCT (%)	4	37	58	72	95	89	74	97
TB Prevalence/100,000 pop	-	421	410	408	411	-		-
TB Deaths/100,000 pop	-	83	90	85	94	-		--
Proportion of Tuberculosis cases detected and cured	-	53	64	59	58	63	70	85

[51] MOH, Annual Joint Review, 2015

TRENDS AND ACHIEVEMENTS

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

HIV prevalence among youth (15-24) reveals trends in new infections and can serve as a proxy for incidence. HIV prevalence has declined among youth from 11.3% in 2004 to 9.3% in 2009 and it slightly increased to 9.6% in 2014. This progress is evident for both genders. However, elevated rates of HIV prevalence in young women persist, especially among 20-24 year olds. Not only are women biologically more vulnerable to HIV infection, they are more likely to have intergenerational sex and less power to negotiate condom use due to traditional gender roles.

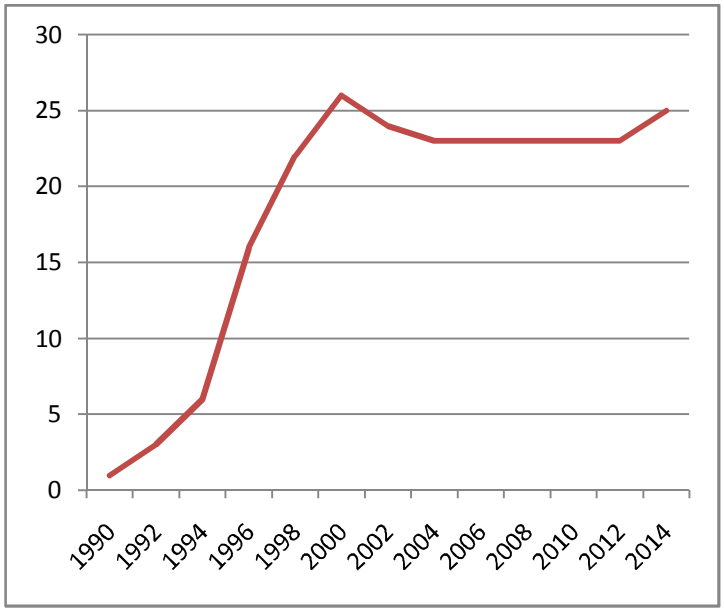
Table 6.2: Youth HIV Prevalence Rate (15-24)

	2004	2009	2014
Total (%)	11.3	9.3	9.6
Male (%)	6.0	4.2	6.0
Female (%)	15.4	13.6	13.1

Sources: LDHS 2004, 2009, 2014

As Figure 6.1 shows that, HIV prevalence, as measured by the proportion of the population that has tested positive for HIV, has hovered at around 23% for the past 10 years. The prevalence of HIV infection spans all socioeconomic groups, but it affects the genders differently. Women are more vulnerable to HIV infection, with the prevalence rate of 30% versus 19% in men.[52] Studies have shown that HIV prevalence is more pronounced in urban areas at 30.0% versus 21.8% in rural areas. Rural-urban migration often leads to insecure housing and income which, in turn, increases vulnerability to HIV as people in these contexts often exhibit higher risk-taking behaviours, including transactional sex.

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

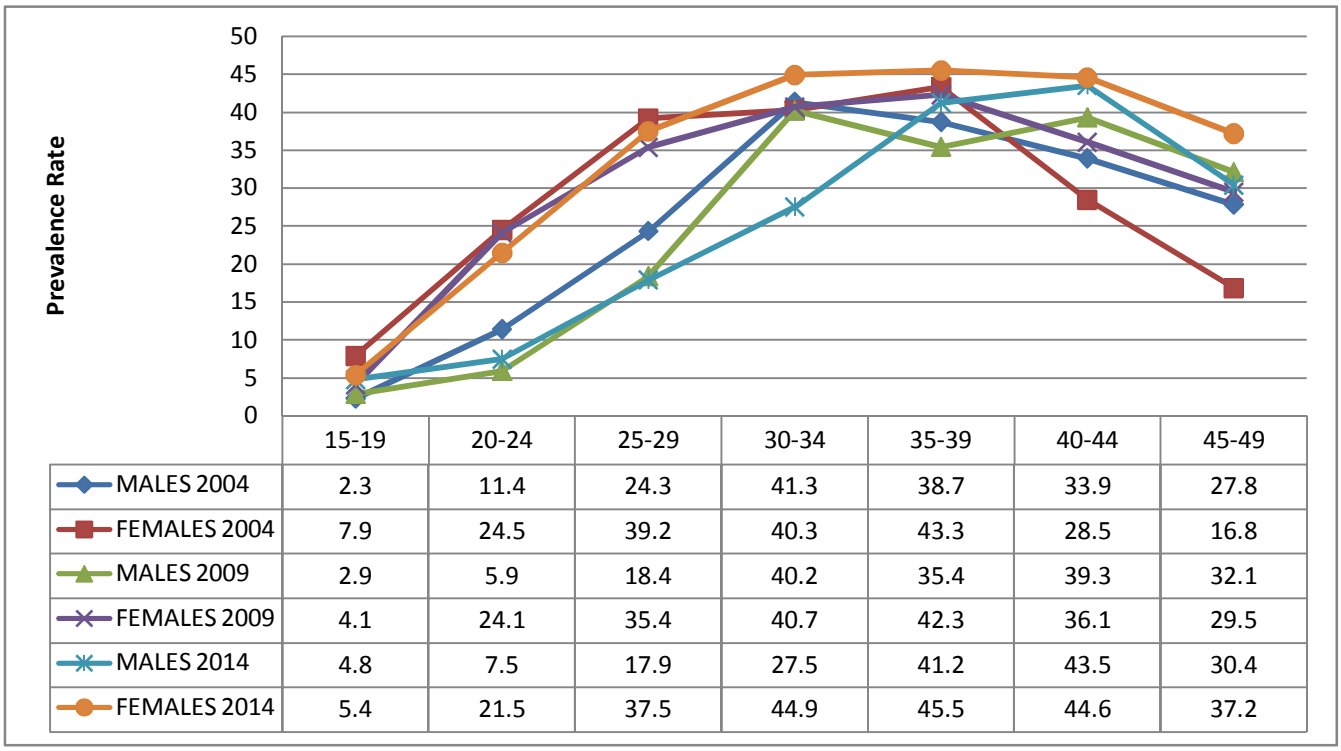


Sources: WHO and LHDS 2009 and MOHSW, AJR 2014

Figure 6.2 disaggregates HIV prevalence by age and gender for 2004, 2009 and 2014. Young women are particularly at risk. For females between ages 20 to 24, HIV prevalence is 21.5% compared to just 7.5% for their male counterparts in 2014. The difference is even more acute for age group 25-29.Women in this age band have an HIV prevalence rate of 37.5% versus 17.9% for males. However, prevalence converges at around 40% for both men and women after age 30. While the prevalence rate for males and females aged 15-29 is declining, it is increasing for older age groups.

[52] LDHS 2014

Figure 6.2: HIV Prevalence by Age and Gender



	15-19	20-24	25-29	30-34	35-39	40-44	45-49
MALES 2004	2.3	11.4	24.3	41.3	38.7	33.9	27.8
FEMALES 2004	7.9	24.5	39.2	40.3	43.3	28.5	16.8
MALES 2009	2.9	5.9	18.4	40.2	35.4	39.3	32.1
FEMALES 2009	4.1	24.1	35.4	40.7	42.3	36.1	29.5
MALES 2014	4.8	7.5	17.9	27.5	41.2	43.5	30.4
FEMALES 2014	5.4	21.5	37.5	44.9	45.5	44.6	37.2

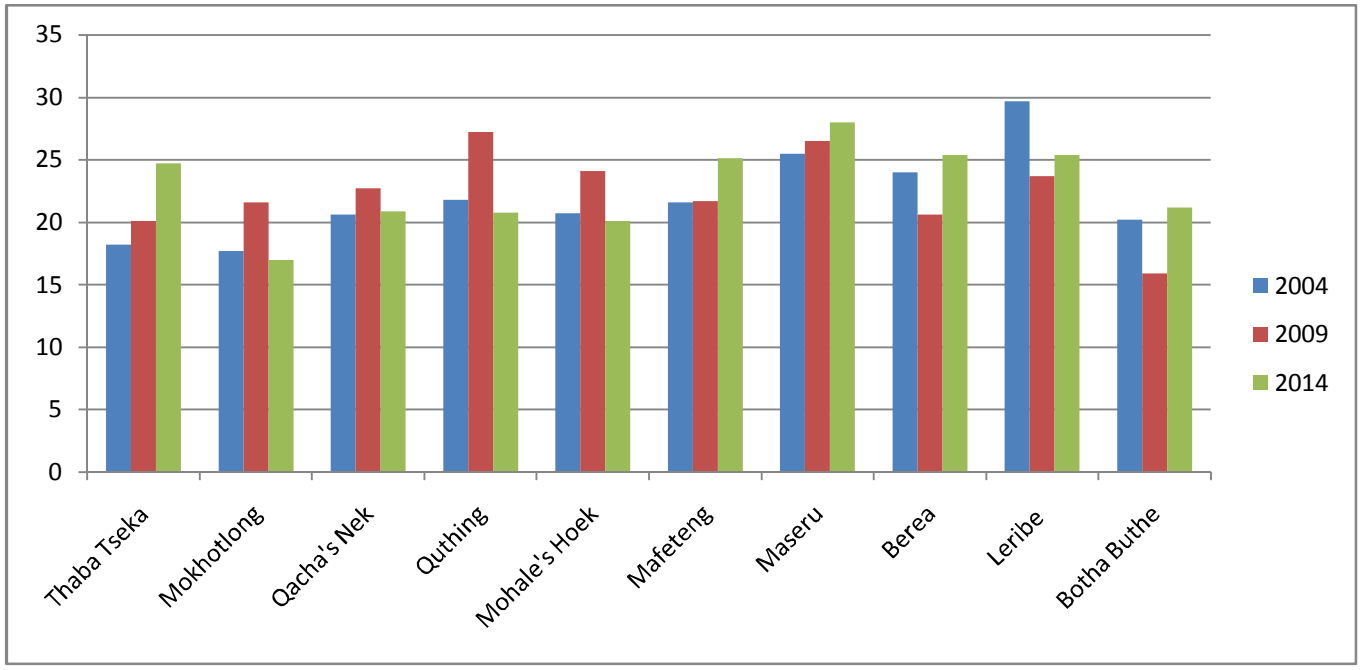
Sources: LDHS 2004 and 2009

Lower education levels are associated with higher HIV prevalence. In 2009, 26.6% among those with "no education" were HIV-positive and it further increased in 2014 to 29.0% compared to 20.9% in 2009 and 24.7% in 2014 of those with secondary education or higher . 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 preventive behaviours such as condom use, avoidance of extra-marital sex, delayed sexual debut, testing and comprehensive knowledge about HIV and AIDS. Income level is also a predictor of HIV status. The prevalence rate steadily rises for each wealth quintile from 22.4% for the lowest to 29.0% to the 4th quintile, before dipping back to 25.4% for the highest in 2014. Prevalence is also much higher among the employed than the unemployed. Of the employed, 27.2% are HIV-positive compared to 17.6% of the unemployed. This can be explained to some degree because many employed adults in Lesotho are migrant labourers who, due to their migrant status, are more often engaged in high-risk sexual encounters such as extramarital or multiple sexual partnerships.[53]

Finally, as illustrated in Figure 6.3, there is little variation in prevalence among districts. All districts have prevalence rates above 20% except Mokhotlong (17%) in 2014. Urban areas have a significantly higher prevalence rate than rural areas.

[53]LDHS 2009

Figure 6.3: HIV Prevalence by District



Source: LDHS 2009

Though much of Lesotho's data on HIV concerns prevalence, prevalence alone is not the best measure for understanding current sexual health trends and designing policy responses. This is because changes in prevalence lag behind changes in current risk behaviours. Prevalence may continue to rise even after incidence begins to fall because of the extended time between contraction of HIV and testing/diagnosis, which has been prolonged by the availability of ART. Thus, prevalence data is increasingly difficult to interpret.

Information on incidence, defined as the number of new infections in a given time period, is a much better indicator of the spread of HIV. HIV incidence among women and men age 15-49 is 1.9 new infections per 100 person-years (PY) of exposure in 2014.

Meanwhile, adult AIDS-related deaths have declined from 23,000 in 2005 to 14,000 in 2012. Table 6.2 provides the new HIV infection estimates together with the projections of incidence. According to these projections, the number of new infections is expected to decline over the period 2015-2020 until it reaches around 19,000 in 2020.

His Majesty King Letsie III Commemorating World AIDS Day

Table 6.3: Estimates of New HIV Infections by Gender, 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: MOHSW Annual Joint Review Report 2014

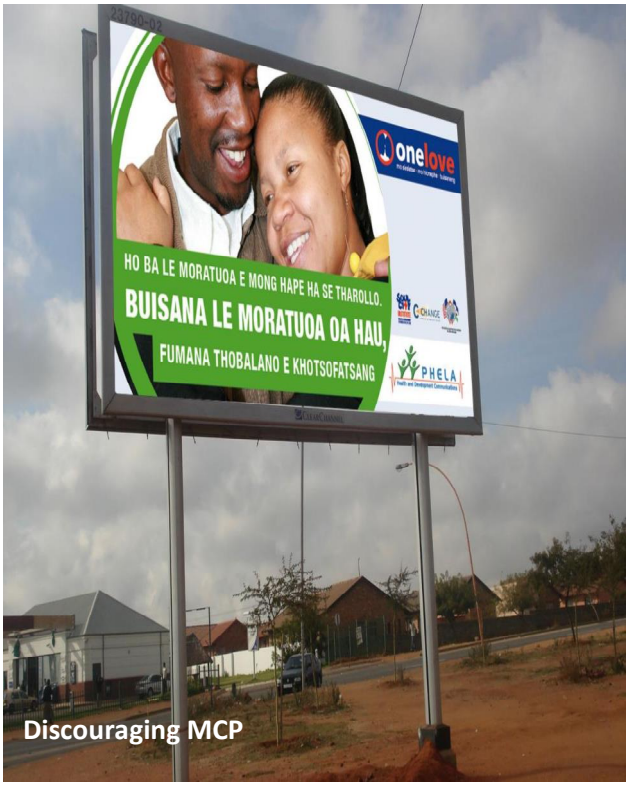
Analysis of HIV Modes of Transmission and Prevention Efforts

Multiple and Concurrent Partnerships (MCP)

A major contributing factor to the high prevalence rate in Lesotho is multiple and concurrent sexual relations either before or after marriage. A study by WHO, found unprotected sex with multiple partners to be the primary risk factor for HIV infection in sub-Saharan Africa. In Lesotho, this is further exacerbated by relaxed cultural norms regarding MCP and low HIV risk perception. High frequency of concurrent sexual partners leads to interrelated sexual networks which increase the chances of contracting HIV.

Of adults who report having had one lifetime sexual partner, 16.5% contracted HIV. In contrast, among adults who report having had two lifetime sexual partners, the HIV prevalence rate jumped to 25.7%, The prevalence rate was 30% among those who reported three to nine lifetime sexual partners, and 36 % for those who reported having had 10 or more sexual partners. These statistics puts an emphasis on the strong correlation between HIV contraction and the number of sexual partners a person has had.

MCP in Lesotho is much higher than the regional average. In 2009, 21.9% of men aged 15-49 reported having had more than one sexual partner in the past year. In 2014, this number increased to 26.75%. Among women, the rate of multiple partnerships has declined from 11% in 2004 to 6.57% in 2014. It is notable that MCP is more common among married people than among single adults.



Discouraging MCP

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

Year	Indicator	Sample	Result
1989/1990	More than 1 partner, past 12 months	N/A	55% (M) 39%(F)
2002/2003	More than 1 partner, past 12 months	Adults (16-60) with at least one 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 one partner	48% (M) 21%(F)
2009	More than 1 partner, past 12 months	All adults (15-49)	21.9% (M) 6.4% (F)
2014	More than 1 partner, past 12 months	All adults (15-49)	26.75% (M) 6.57(F)

Sources: UNAIDS/MOHSW 2009 Modes of Transmission Analysis and MOHSW, AJR Report 2014

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 because 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. Thus, concurrent sexual relationships exacerbate HIV transmission because HIV-positive adults are much more likely to infect their partners during this initial stage. A 2007 survey revealed that, among sexually active adults, 36% of men and 16% of women had more than one current sexual partner. Moreover, 38% of male workers and 17% of females in a 2007 survey organized by Apparel Lesotho Alliance to Fight Aids (ALAFA) acknowledged having more than one current sexual partner. Social norms sustain widespread MCP. 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. Other factors contributing to MCP include the influence of family and friends and labour force mobility (eg, men working in RSA mines and internal migration of women to work in garment factories).

Prevention

The Ministry of Health has implemented several initiatives to increase the coverage and quality of HIV diagnosis, prevention, treatment and care. In 2012, the Ministry of Health revitalized HIV prevention measures

through requiring district-level HIV symposia to strengthen HIV prevention and ART services. The programme also coordinated the development and financing of the Condom Distribution Strategy. There was implementation of Family Health Day campaigns, which sought to augment HIV Testing and Counselling (HTC) and enrolment for treatment. Moreover, technology such as Point of Care CD4 count machine was used for the first time in campaigns. There were also male-targeted testing initiatives marketed through soccer matches and Voluntary Medical Male Circumcision initiatives. Provider-Initiated Counselling and Testing (PITCT) were intensified in all health facilities.

Indicator 6.2: Condom Use at Last High-Risk Sex

The Ministry of Health realized that despite its ability to procure enough condoms, the problem of accessibility still existed, especially after working hours. To mitigate this problem, the ministry installed about 240 condom dispensers in all the districts of Lesotho and 100 condom baskets were distributed to Lesotho government ministries during 2013-2014.

The overall assessment indicates improvement in distribution of condoms especially at the district level. There is also improvement in recording when condoms reach pharmacy stores. However, there is weaker recording of the dispersal of condoms from the pharmacy stores to different departments of hospitals or from the District Health Management Team (DHMT) store to the health centres.

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

Despite increasingly widespread promotion and distribution of condoms, their impact has not been significant because consistent condom use remains low. People use condoms in sexual encounters such as commercial and casual sex in which they perceive an increased risk of Sexually Transmitted Diseases (STDs). They tend to forgo them in sexual acts which they perceive as low-risk, including sex with multiple/ concurrent partners. Although almost all condoms are provided free of charge by GOL or NGOs, widespread 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.

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

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

occur in secret, create a dangerous risk factor for married people. Indeed, WHO reports increasing numbers of new HIV cases among HIV serodiscordant cohabiting couples (in which only one person is HIV-positive), Many of these serodiscordant couples are unaware of their partner's HIV status. Figures from Lesotho confirm this trend; from 2004 to 2009, the percentage of HIV serodiscordant[54] couples increased from 13% to 17%.

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 2009. 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 in each survey year. The 2004 LDHS measures condom usage with a partner who is neither a spouse nor cohabiting partner, while the 2009 survey considers condom usage in the context of MCPs.

Table 6.5: Condom Usage among Adults with Multiple Partners

	2009		2014	
	Women	**Men**	**Women**	**Men**
Urban	52.3	67.2	68.7	70.6
Rural	31.1	46.1	45.3	61.6
No Education	n/a	25.3	n/a	34.0
Some Primary Education	24.9	41.4	36.4	58.6
Primary Complete	30.2	50.4	45.8	63.4
Secondary and Above	52.1	68.1	69.7	71.3
Lowest Wealth Quintile	13.4	29.8	26.6	50.4
Second Quintile	32.6	45.1	47.1	62.8
Middle Quintile	31.7	47.3	54.4	58.6
Fourth Quintile	51.7	56.6	54.4	71.1
Highest Wealth Quintile	49.0	70.8	66.5	71.3

Sources: LDHS 2009 and 2014

Low condom usage among adults with multiple partners is rarest among rural citizens with low education level and low income. This suggests that the Government of Lesotho and its partners should prioritise sexual health outreach to low-income, 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 women. Therefore, married adults with multiple partners not only have a higher risk

[54] A serodiscordant relationship is one in which one partner is HIV positive and the other is not.

of contracting HIV themselves, but are also much likelier to spread the illness to their spouses and sexual partners.

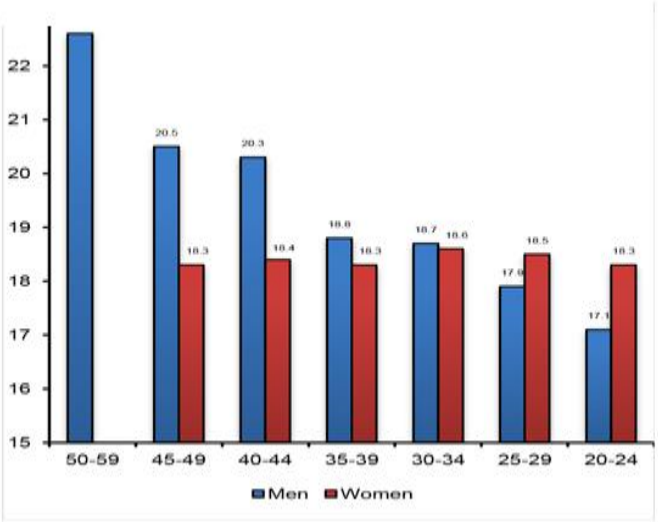
Furthermore, social norms regarding condoms inhibit consistent and correct usage. There is a sexual politics around the use of condoms. For example, condom initiation is often interpreted as a sign of sexual infidelity or a lack of trust, particularly among spouses. Many men still have negative attitudes about condoms, believing they diminish sexual pleasure (45%), are inconvenient (37%), are embarrassing to obtain (34%) and that people who use condoms are unfaithful (33%). A 2008 CIET study revealed that attitudes toward condom use might be worsening. In 2002, 48% of adults said they would not have sex if their partner refused to use a condom. By 2007, this percentage dropped to 39%.

Low Demand for Medical Male Circumcision (MMC)

Studies in Africa indicate that medical male circumcision reduces the risk of acquiring HIV by 60%. It also benefits women by reducing the HIV transmission rate from males to females by nearly half. Traditional MMC has long been practiced in Lesotho as a rite of passage into adulthood, particularly in rural areas. In Lesotho, 51.6% of adult males have been circumcised; but the form of traditional MMC they receive does not confer a protective effect from HIV because it is typically incomplete by bio-medical standards. The most recent estimates suggest that only about one-third of all circumcisions occur under professional medical care. Therefore, the availability of safe MMC is essential. The encouragement of MMC must be communicated with care as it relates to important cultural and religious beliefs for many Basotho. Public awareness campaigns must use tact in disseminating information about MMC and explaining the importance of undergoing the surgery under medical care.

The level of comprehensive knowledge about HIV and AIDS among youth (age 15-24) is an 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 among youth. Given the pervasiveness of sexual activity among youth, this level of knowledge is still unacceptably low and far from the 85% target.

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



Source: LDHS 2009

Overall, the median age for marriage is rising while the age of sexual debut for men is

getting younger. Figure 6.5 presents data on sexual debut by age group and reveals that the majority of young males today have their first intercourse around age 17, which is about 3-5 years earlier than their parents' generation. While the prevalence of sexual activity among the very young (before age 15) has fallen, youth sexual activity appears to be increasing with higher rates of sex before age 18 and rising percentages of sexually active youth. On the other hand, condom usage at 65% is relatively high and growing higher. For females, age of sexual debut is correlated with income and education level. On average, the less education a girl has, the younger she is when she begins having sex. Among girls with an incomplete primary education, 66% had sex before the age of 18. In contrast, only 39% of girls with a secondary education or higher had sex before the age of 18.

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- informed sexual education in the broader context of life skills. Progress in recent years has included a specific youth component of the Behavioural Change Communication (BCC) strategy, a Minimum Package Guide on HIV Prevention released by the 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. Nevertheless, intensified prevention efforts are needed to change harmful social norms 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 young males who are beyond the reach of many school-based prevention programmes and exhibit multiple risk factors including early sexual debut, low HIV testing rates and low condom usage.

Gender Discrimination and Sexual Violence

Lesotho is a patriarchal society with traditional gender roles. This dynamic persists in marriage and has major implications for sexual health and HIV transmission. While most Basotho report that they reject the idea of beating wives for refusing sex, significant proportions of the population insist that it is unacceptable for women to refuse sex on the basis of their husband's multiple partnerships or STIs. Moreover, small but increasing percentages of men believe that husbands have the right to force sex on their wives. Tolerance for sexual violence towards women is strongly correlated with low income, low educational level and rural residence.

The outcomes of these beliefs include high levels of sexual violence. Sixty percent of women have suffered sexual violence, while 22% report being forced to have intercourse by their husbands. Most of these incidents go unreported to the police. Research has indicated that victims of intimate partner violence are 1.4 times more likely to be HIV-positive than those who have not been victimized. The tragedy is that the very behaviours that help prevent HIV transmission such as refusing sex, insisting on the use of a condom and inquiring about sexual history, are practices that often trigger sexual violence. In this environment, women have little ability to negotiate condom use or refuse sex. They face increased risks for contracting HIV or other STIs.

Age-Disparate Relationships

Age-disparate relationships are sexual relationships in which one partner is 10 years older than the other. Age-disparate relationships have been cited in Southern Africa as a factor in the high rates of infection among young females. By their very nature, age-disparate relationships involve imbalanced power dynamics in which young girls may not be able to insist on safe-sex practices. Furthermore, age-disparate relationships may spread HIV transmission if younger girls have sex with an older, HIV-positive partner and then introduce the virus into their younger peer group. The 2002 Reproductive Health Survey revealed that among females aged 12-24 in Lesotho, 19% of sexual relationships were with a man who was at least 10 years older. In 2009, roughly 7% of girls aged 15-19 reported having had sex with a man at least 10 years older. Age-disparate relationships for females aged 15-19 was 7.3% in 2004 and reduced to 2.3% in 2009.

Labour and Migration

The 2009 LDHS revealed that HIV prevalence is higher among migrants and the employed, as indicated in Table 6.8. In a country with massive unemployment, the employed have often had to move from home to find work, becoming migrants.

The two largest sources of employment for Basotho are the mining industry in RSA and the textile sector, both of which involve large numbers of migrant workers. Unskilled men dominate labour migration to South Africa, though their number has fallen significantly 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.

Living and working far from home for extended periods can alter an individual's habits and values. Migration impacts negatively on women whether they are the ones who have migrated or are the ones who have been left behind. Women on either end of migration are often deprived of social and economic support. In this context, migration can encourage extra-marital relations, casual sex, transactional sex and unprotected sex, all of which are risk factors for HIV transmission. Among married couples, migration heightens the risk for both partners because both may have had extramarital sex while apart, increasing the chance that one of them will acquire HIV and infect the other upon reuniting.

Though data on HIV trends among mine workers is unavailable, a 2007 ALAFA study indicated that 44% of female textile workers are HIV-positive, though this is partly due to

the age distribution of the workforce. Single female workers in garment factories are especially at risk due to the fact that their low salaries compel many of them to earn extra money by having transactional sex.

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

An estimated 31% of Basotho living with HIV and AIDS are unaware of their HIV and AIDS status.[55]Nevertheless, Lesotho has made dramatic progress in HIV Testing and Counselling (HTC) as indicated in Table 6.9. Between 2004 and 2014, the percentage of adults who have tested for HIV has increased tremendously from 9% to 63% for men and from 12% to 84% for women.

In a generalized HIV epidemic, annual HIV testing for all sexually active citizens is recommended. Table 6.9 indicates that thepercentageof people tested has increased drastically, but the percentage of adults tested in the past 12 months is still far below the target of 80%. The gender disparity is particularly striking. Testing is twice as high for females as for males. This is because females have more contact with the health care system, for example, during pregnancy or when seeking health services for children. Therefore, more targeted interventions are needed to increase the entry points for males for HIV testing, care and treatment.

TABLE 6.9: Trends in HIV Testing

	2004	2009	2014
Adults (age 15-49) who have ever been tested and received results (%)	M; 9.1 F: 12	M:38.5 F: 65.6	M:63 F: 84
Youth (age 15-24) who have ever been tested and received results (%)	M: 3.4 F: 8.6	M: 25 F: 57.5	M: 51.2 F: 71
Adults tested and received results in the past 12 months (%)	M: 4.8 F: 6.3	M: 24.7 F: 42	M: 36 F: 58
Youth tested and received results in the past 12 months (%)	M: 2.2 F: 4.9	M: 17.1 F: 40.4	M: 28.6 F: 54

Sources: LDHS 2004, 2009 and 2014 LDHS Key Indicators Report

A serodiscordant relationship is one in which one partner is HIV positive and the other is not. Mutual testing and disclosure for couples is one promising intervention to

[55]Lesotho Global AIDS Response Country Progress Report (2012)

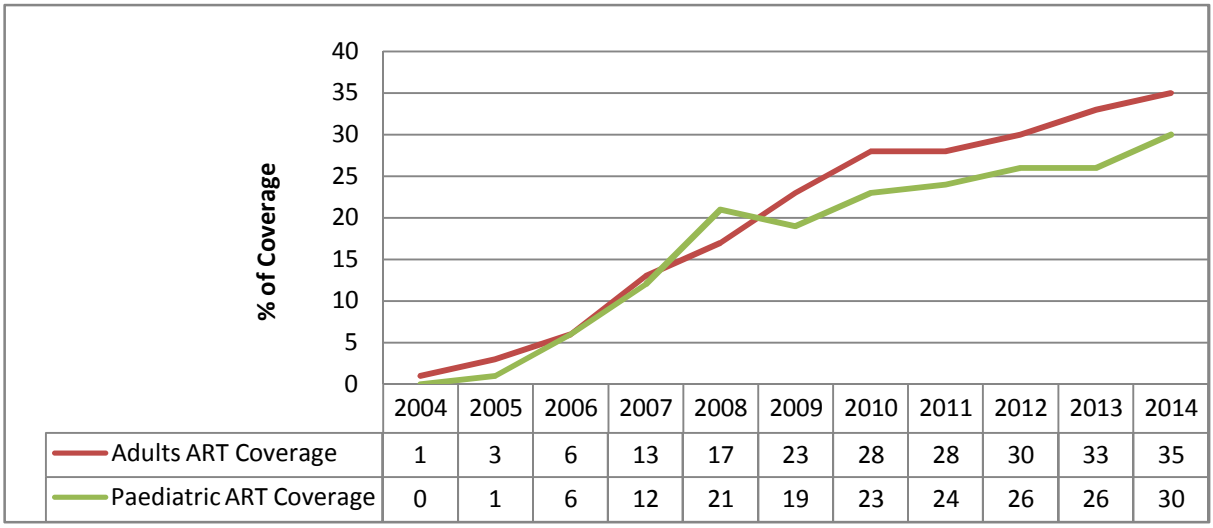
increase male testing rates and address the 17% of marriages in Lesotho that are serodiscordant. Couples who test together and find they are serodiscordant are more likely to adopt behaviours to protect the partner who is not HIV-positive. They are also more likely to, pursue and adhere to treatment and take steps to PMTCT. 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.

policy requires monthly ARV collection and continues to decentralize treatment to health

Indicator 6.5: Proportion of Population with Advanced HIV Infection with Access to Antiretroviral Drugs

There has been a tremendous increase in adult ART coverage during the 2004-2014 periods. The adult coverage increased from 1% in 2004 to 35% in 2014. On the other hand, ART for children increased from 1% in 2005 to 30% in 2015, as reflected in Figure 6.5.

Figure 6.5: Adult and Pediatric ART Coverage



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Adults ART Coverage	1	3	6	13	17	23	28	28	30	33	35
Paediatric ART Coverage	0	1	6	12	21	19	23	24	26	26	30

Sources: MOH, AJR report 2012 and 2014

Lesotho appears to be slow to achieve the 80% target. However, retention rates remain at 72%. An estimated 42,000 deaths have been averted since the ART rollout. At the policy level, Lesotho implemented new international ART guidelines in 2010. This

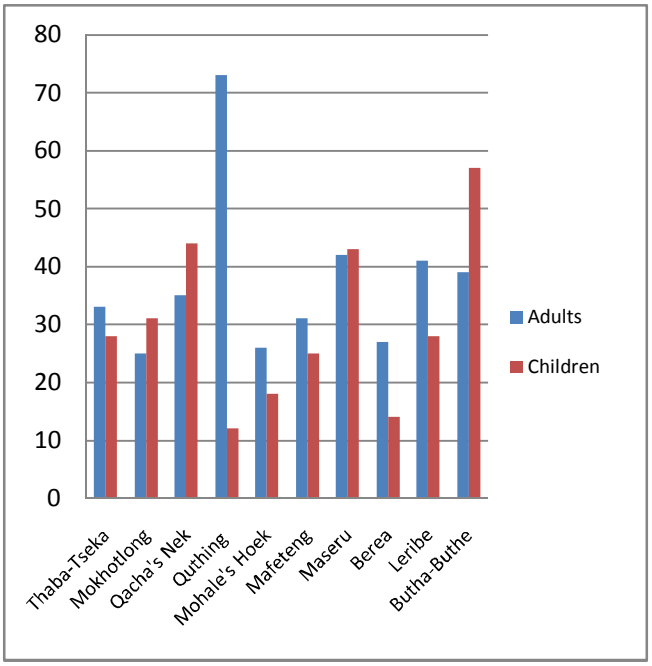
centres, with teams of mentors in each district to support health care professionals. As ART coverage grows, decentralization must continue and capacity must grow at treatment sites to ensure adequate care and retention. Task-shifting in service delivery, expanding the role of communities, home-

based care, networks of people living with HIV, and warehousing ARVs locally are all part of the solution.

Variations by Districts

According to Figure 6.7, Butha-Buthe has the highest proportion of people enrolled on ART, closely followed by Maseru, Mafeteng and Qacha's Nek. The scenario is interesting 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 below the 80 percent target.

Figure 6.7: Proportion of ART coverage by Districts, 2014



Source: Ministry of Health Annual Joint Review 2012 and 2014

Pre-ART Retention

Usually, a period of up to 8 years exists between diagnosis of HIV and ART initiation (after CD4 counts drop to 350). Follow-up and care during this interim is almost non-existent. While pre-ART retention is poorly documented, the WHO estimates that only 18% of people diagnosed with HIV remain in care until they became eligible for ART. The Ministry of Health acknowledges that full ART coverage will be a major challenge because many eligible for it may not feel sick enough to seek medical attention. In order to improve treatment, Lesotho must link the services a person uses after diagnosis and improve follow-up by strengthening patient tracking systems, providing decentralized and regular CD4 monitoring and scaling up laboratory services to minimize the delay of test results.

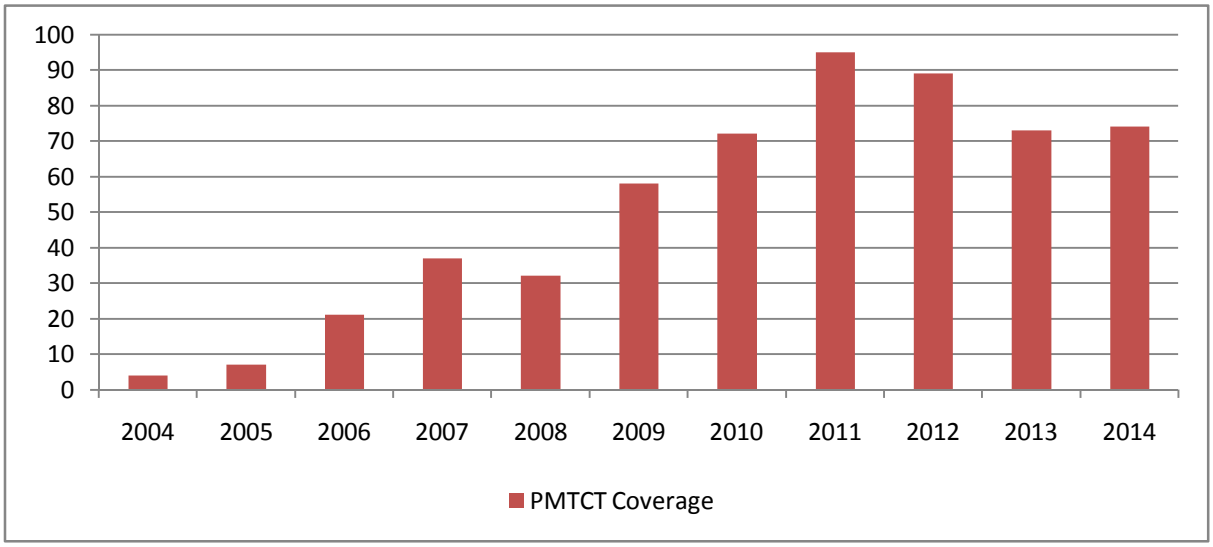
Prevention of Mother to Child Transmission (PMTCT) and Impact on Children

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

Mother-to-child transmission is preventable by providing ART to mothers and children, beginning early in pregnancy. Lesotho has made strong progress in PMTCT 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. The policy also calls for infants born to HIV-positive mothers to receive antibiotics to all pregnant women during preventive therapy from birth until one week after breastfeeding ends.

Figure 6.8: PMTCT Coverage, 2004-2014



Source: MOHSW, AJR Report 2014

Facility-based uptake of ART among pregnant women to prevent MTCT increased dramatically from 6% in 2004 to 96% in 2012. It then decreased to 76% in 2014. However, PMTCT coverage nationwide was 43% in 2010 and 58% in 2012. This calls for a massive service /demand creation exercise. The introduction of PMTCT guidelines with the option B+ approach of providing lifelong ART to all HIV-positive pregnant women will attract more women into the programme.

Preventive coverage for infants born to HIV-positive mothers increased from 28% in 2007 to 38% in 2012. This 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 their first antenatal care (ANC) visit for use during pregnancy and the early post-natal period. Six weeks after birth, mothers are expected to return for immunizations, check-ups, HIV testing and further ARVs, if needed. Three types of standardized packages are available, depending on the mother's HIV status and treatment regimen.

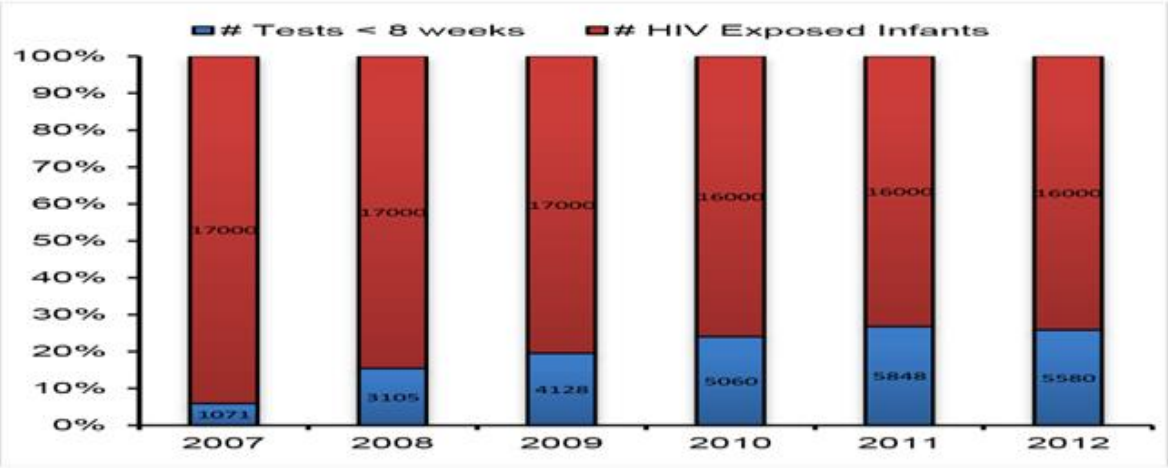
Testing and Treatment among Children

According to the Ministry of Health Annual Joint Review Report, WHO recommends that infants 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% of infants who are HIV-positive intra- and peri-partum. Delaying testing beyond this time will stall diagnosis and put HIV-positive infants at risk of disease

progression and death. Early diagnosis through Deoxyribonucleic Acid-Polymerase Chain Reaction DNA-PCR assists in the treatment and care as well as on decision-making regarding child feeding.

As portrayed in Figure 6.9, the numbers of HIV- exposed infants are at least 16,000. The real number of HIV-exposed infants is probably much higher because relatively few infants younger than eight weeks have been tested. Although the number of infants tested for HIV grew steadily from 2007 to 2011, it reached a peak of 5,880 infants in 2012.

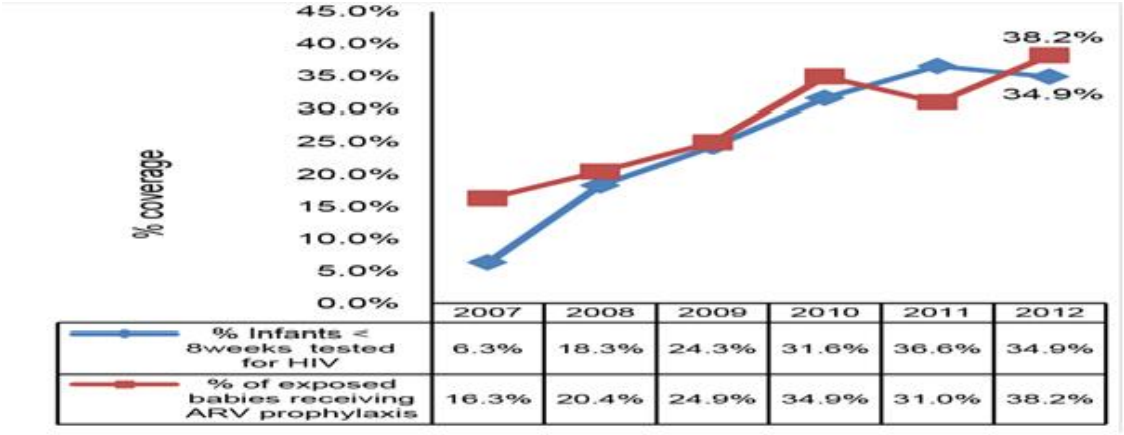
Figure 6.9: Proportion of Exposed Infants DNA PCR Test by 8 Weeks, 2007 – 2012



Source: MOH AJR 2013

Due to the increasing availability of paediatric antiretroviral treatment, the percentage of babies exposed to HIV who are receiving treatment and the number of babies tested are trending upward (see Figure 6.10). The difference between the number of children tested and those receiving treatment is minor. Nevertheless, the numbers of children being tested remain very low and require further intervention if the effects of HIV on children are to be curbed.

Figure 6.10: HIV Testing and Prophylaxis among Infants < 8 Weeks



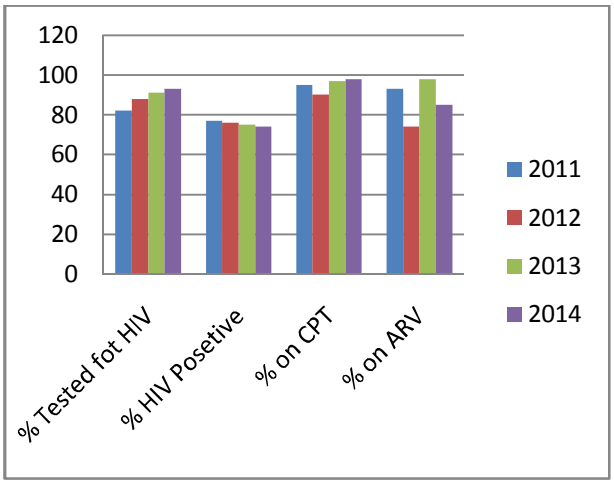
	2007	2008	2009	2010	2011	2012
% Infants < 8weeks tested for HIV	6.3%	18.3%	24.3%	31.6%	36.6%	34.9%
% of exposed babies receiving ARV prophylaxis	16.3%	20.4%	24.9%	34.9%	31.0%	38.2%

Source: MOH AJR 2013

HIV/TB Co-infection

Identification and management of TB/HIV co-infection is improving. The co-infection rate remained stable at 76%, with approximately 80% of new TB patients tested for HIV. While the percentage of patients with both HIV and TB enrolled in ART has increased substantially from 24% in 2008 to 83% in 2014, access to ART for clients with both HIV and TB remains low compared to the general population (40% vs. 60%).

Figure 6.11: TB/HIV Co-infection Trends



Source: MOH, AJR Report 2014

Halting and Reversing the Incidence of Tuberculosis and Other Diseases

The GoL adopted the global targets for reducing the burden of diseases attributed to TB. Although Lesotho demonstrated high political commitment to the achievement of the MDG targets for 2015; the target for 2015 has not been achieved. The country will be embarking on the strategy for the 'Stop TB' target beyond 2015 to 2050. Lesotho is one of the fifteen countries with the highest per capita incidence of Tuberculosis with 632 cases for every 100,000 citizens. The country also adopted the WHO-recommended DOTS strategy to control the spread of TB through prompt detection and provision of anti-TB drugs under standard case management conditions.

Although the TB notification rate remains high, in the past five years there has been a steady stabilization; a total of 11,971 patients were notified in 2004 that they had TB compared to 13,520 in 2009. Stabilization can be expected if both ART and TB programs are performing well.

TABLE 6.10: Performance of TB Indicators

Indicator	Baseline in 1990	Performance			
		2009	2010	2011	2012
TB Prevalence	249/100,000	410/100,000	408/100,000	411/100,000	Data not available
TB Deaths	31/100,000	90/100,000	85/100,000	94/100,000	Data not available
TB Treatment Success (%)	47(1995)	70	69	74	74

Sources: MOH, AJR Report 2013

Indicator 6.6: Incidence, Prevalence and Death Rates Associated with Tuberculosis

Incidences of TB have declined from 13,520 new cases in 2009 to12, 616 in 2011. Moreover, Lesotho maintained a high TB detection rate of 82% in 2011, up from 80% in 2008 and well above the WHO standard of 70%.

Indicator 6.7: Proportion of Tuberculosis Cases Detected and Cured Under Directly Observed Short Course

Lesotho reported a 74% success rate in the cure of TB in 2012. Nevertheless, this was still below the 2015 target of 85%.

POLICIES AND STRATEGIES

Lesotho has embarked on a number of campaigns that have fortified efforts to combat AIDS and HIV. These include:

- The completion and launch of the National HIV Prevention Strategy for 2012-2016.
- The HIV Prevention Revitalization Action Plan for 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.
- The release of new HIV prevention tools and materials targeting youth.

BOTTLENECKS AND CHALLENGES

ǒ The alarmingly high HIV prevalence in Lesotho remains at around 23%, and the number of new infections remains high. The National HIV Prevention Strategy (2011-2016) has been developed, but in order to achieve desired results there is a need for strong leadership commitment at all levels and sectors as well as accountability mechanisms for HIV prevention.

ǒ Evidence shows that multiple and concurrent sexual partnerships and relatively low condom use are major

drivers of the high prevalence of HIV in Lesotho.

- HIV policies, programmes and prevention messages are not yielding maximum returns, despite huge investments.

- While the TB treatment success rate has improved, TB-HIV co-infection has contributed to growing numbers of Multi-Drug Resistance (MDR).

- There is an urgent need to strengthen the procurement and supply chain management systems for HIV test kits and CD4 reagents; as stock outs are extremely common.

- The absence of a national, multi-sectoral coordination body for HIV prevention and treatment has contributed to the misalignment of health sector and non-health sector responses to this health crisis.

- Stigma and discrimination towards People Living with HIV (PLHIV) continue to undermine effective responses and deters service scale-up.

LESSONS LEARNED AND WAY FORWARD

- Implement the *Fast-Track strategy* in order for 90% of the general population to know their HIV status; 90% of PLHIV to be put on treatment, and of which 90% should have viral suppression of HIV by 2020.

- There is a need to apply *strategic investment approaches* to planning, resource allocation and programming, ensuring that investments are focused and evidence-informed.

- The country should pursue Universal Health Coverage through implementation of the Primary Health Care Revitalisation strategy in order to have improved and increased *equitable access to health services.* These services include HIV testing and treatment. To accomplish this will require revitalizing the National Aids Commission (NAC), focusing on key locations at the regional level, scaling-up prevention, treatment, care and accompanying systems.

- Effective programmatic and scientific innovations such as medical male circumcision, early detection and treatment of TB and HIV, including viral load testing, should be scaled up. This will help lower treatment costs, making it easier to identify early treatment failure and intervene to support patients who are having difficulty adhering to prescribed regimens.

- Lesotho will train more health workers on collaborative TB/HIV care, support the district level TB/HIV technical working groups, and work towards response harmonization with other SADC countries. It will also engage more private practitioners as partners in implementing the TB/HIV strategy.

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

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

Indicators
7.1: Proportion of households relying on biomass as primary fuel
7.2: Proportion of land area covered by forest
7.3: Number of endangered animal species
7.4: Proportion of land area protected
7.5: CO_2 emissions, total, per capita and per $1 GDP (PPP)

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

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

OVERVIEW

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

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

TABLE 7.1: Millennium Development Goal 7 at a Glance

Indicator	Baseline	1996	1997	2009	2013	2015	2015 (Target)
Reliance on Biomass (cooking) %	66% (2001)	-	-	51.3% (2009)	53.9% (2011)	53.9% (2011)	-
Reliance on Biomass (heating) %	67% (2001)	-	-	57.5% (2006)	51.7% (2011)	51.7% (2011)	-
Endangered animal species	-	-	-	-	3 (2011)	3 (2011)	-
Protected Land Area (km^2)	-	-	-	-	0.4 (2012)	0.4 (2012)	-
CO_2 Emissions, Total (tonnes)	636,000 (1994)	681,000 (1996)	700,000 (1997)	805,000 (2000)	805,000 (2000)	805,000 (2000)	-
CO_2 Emissions, Per Capita (tonnes)	0.35 (1994)	0.37 (1996)	0.38 (1997)	0.43 (2000)	0.43 (2000)	0.43 (2000)	-
HHs with Improved Sanitation (%)	24% (2001)	-	-	24% (2009)	-	50.9% (2014)	62%
HHs with Improved Water (%)	80.6 % (1995)	-	-	78.9% (2009)	-	82.2% (2014)	91%
Forestry Coverage (%)	1.3% (1990)	-	-	1.4% (2005)	1.6% (2013)	1.6% (2013)	5%

Land Degradation

The Kingdom of Lesotho has suffered severe land degradation in both cultivated lands and the rangelands for many decades. Cultivated lands are threatened by water and wind erosion; declining soil fertility; sediment deposition; increasing variability in stream flow and lower water tables. Similarly, the range complex is threatened by reduced ground cover due to grazing and fuel collection; wind and water erosion; declining soil fertility, woody biomass and biodiversity that leads to variable stream flows and off-site sediment deposition within and beyond Lesotho.

Despite numerous attempts and intensive technical knowledge, efforts to implement effective sustainable land management (SLM) models have failed. As a result, land degradation continues to jeopardize local livelihoods. Lesotho is the source of rivers that reach the Atlantic Ocean in the west; its catchments supply an increasing proportion of the water consumed in South Africa's industrial heartland. Fully functioning ecosystems are vital not only to the livelihoods and welfare of the people of Lesotho, but also to environmental benefits on a much larger scale. Sustainable Land Management is therefore a vital ingredient of broader environmental wellbeing.

TRENDS AND ACHIEVEMENTS

TARGET 7A: Integrate the Principles of Sustainable Development into Lesotho's Policies and Programmes and Reverse the Loss of Environmental Resources

Indicator 7.1: Proportion of Households Relying on Biomass as a Fuel

Biomass extraction contributes to deforestation because it deprives the soil of nutrients and removes sources of land stability that prevent erosion. As Table 7.2 shows, wood, dung and crop waste are the primary forms of biomass used in Lesotho. Consumption of biomass is higher in rural areas.[56] In 2011, 71.3% of rural households used wood as the primary fuel for cooking compared to 8% in urban areas. This disparity is similar for cooking.[57]

As Table 7.2 indicates, reliance on biomass for energy needs declined between 2006 and 2009 before a slight increase in 2011. Aggregate biomass consumption saw a 12.5% jump in 6 years from 1.76 million in 2003 to 1.98 million in 2009.[58] This suggests increasing unavailability of biomass and use of other sources as a substitute, such as paraffin, which is expensive and unhealthy.

[56] Department of Energy, Assessment of Energy for Rural Development in Lesotho, May 2012.
[57] LDHS, 2009 and BoS, Environment and Energy Statistics Report, 2012
[58] BoS, Environment and Energy Statistics Report, 2012

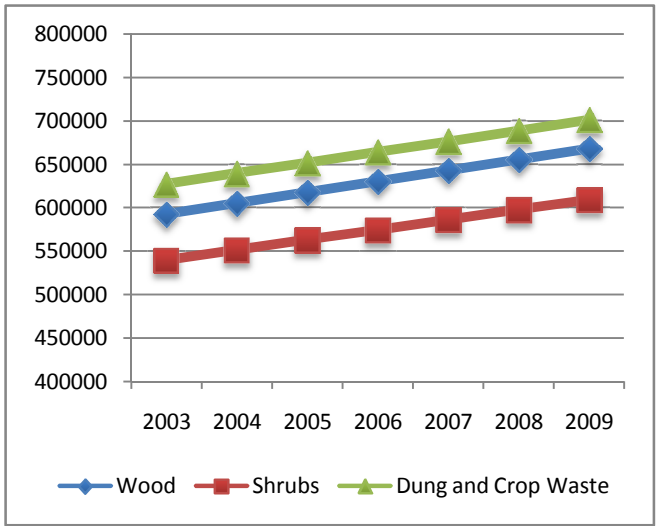
TABLE 7.2: Proportion of Households Relying on Biomass as Primary Fuel

	2006	2009	2011
Wood for Cooking (%)	52.5%	44.1%	52.2%
Dung and Crop Waste for Cooking (%)	3.9%	7.2%	1.7%
Total Biomass For Cooking	**56.4**	**51.3**	**53.9**
Wood for Heating %	51.4%	-	48.9%
Dung and Crop Waste for Heating (%)	6%	-	2.8%
Total Biomass For Heating	**57.5**	-	**51.7**

Sources: Lesotho Population and Housing Census 2006, LDHS 2009 and 2011 Lesotho Environment and Energy Statistics Report 2012.

Reliance on biomass is unsustainable and leads to degradation of rangelands, soils and forests as shown in Figure 7.1. Local communities continue to overexploit indigenous forests rather than pursuing renewable energy sources such as hydropower, solar and wind energy. It is observed from Figure 7.1 that the quantity of biomass (wood, shrubs, dung, crop) consumed increased from 2003 to 2009. The quantity of crop waste and dung used has been higher than the quantity of wood and shrubs used for the period 2003 to 2009.

Figure 7.1: Biomass Consumed in Tonnes



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

Rangelands

Rangelands constitute about 65% of Lesotho's total land area and are a crucial resource because they serve as grazing areas for livestock.[59] Most rural families rely heavily on livestock for meat, milk, labour, transport and wool/mohair for export. Therefore, land degradation threatens Basotho livelihoods. Moreover, rangelands support biodiversity, soil stability, erosion mitigation and water filtration. It is estimated that the country loses (per annum) 15 million tonnes of cropland soil, 23 million tonnes of soil from rangelands through sheet and rill erosion and 0.7 million tonnes as gully erosion. Based on the carrying capacity of 8 hectares/animal unit (AU), the study concluded that the overstocking rate ranges between 40-80%. Overstocking is therefore recognised as one of the contributing factors

[59]BoS, Environment and Energy Statistics Report, 2012

towards land degradation resulting in overgrazing.[60] Other drivers include encroachment of land for cultivation, urban sprawl, poor land use management, the Lesotho Highlands Water Project (LHWP) dams and fires.[61]

Soil Erosion

Soil is a vital resource in Lesotho. The majority of the population base their livelihoods (or part of their livelihoods) on soil by means of agricultural activities. The suitability of soil is highly variable, being influenced by topography and rainfall (including severe flood and drought events) in conjunction with human-made pressures such as cultivation, grazing and poor management practices.[62]The susceptibility of the soil to damage is partly due to the fragile mountainous terrain in Lesotho. Currently, just less than 40 million tonnes of soil is lost per year by means of gully, sheet and rill erosion. As a result, more than 2% of the topsoil of Lesotho's land is lost per year.[63]

Indicator 7.2: Proportion of Land Area Covered by Forest

Land covered by forests include land spanning more than 0.005km^2 (0.5 hectares) with trees higher than 5 meters and a canopy cover of more than 10%.The destruction of this land not only poses a serious threat to environmental sustainability, but also hinders the eradication of extreme poverty and hunger.

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 (%)	1.3%	1.37%	1.4%	1.44%	1.63%
Proportion of Wooded Land (%)	5.98%	5.31%	4.97%	4.64%	-

Source: FAO, Lesotho Forest Resource Assessment 2010

[60] Ministry of Forestry and Land Reclamation (MFLR), National Range Resources Management Policy, 2014

[61] European Union (EU), Lesotho Country Environmental Profile, June 2012

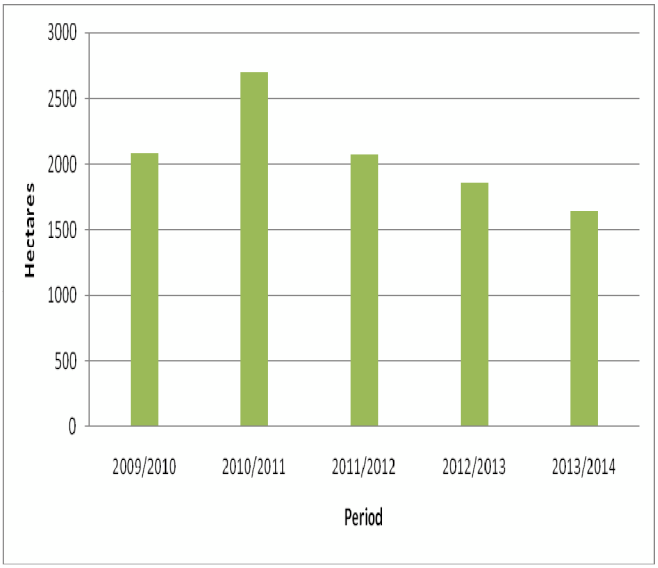
[62] LMS (2000)

[63] LMS, (2007); GEF, (2013)

Forest area in Lesotho is very small, but has increased steadily from 1.3% to 1.63% of total land area since 1990.[64] In recent years, GoL has led major initiatives to increase forest cover with a target of 5% total land area by 2020. The most successful of these initiatives was the Lesotho Woodland Project of the 1970s and 1980s which established 485 forest reserves. The Social Forestry and Conservation Project was also a success.[65] Around 6,000 ha are government-owned plantations while 37,000 ha are held as community land presided over by village chiefs to whom power has been delegated by the King.[66]

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 due to heavy reliance on biomass. 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, grazing in protected areas, fires, drought and commercial exploitation.[67]

Figure 7.2: Planted Forest Trees in Hectares by Period (2009/2010-2013/2014)



Source; Ministry of Forestry and Land Reclamation Annual Report 2015

Indicator 7.3: Number of Endangered Animal Species

Endangered animal species are moving towards extinction very fast, with declines in both populations and distribution. In spite of the country's small size, Lesotho is rich in biodiversity with a number of endemic flora and fauna, especially in the Maluti-Drakensburg area. There are 3,093 species of plants, 63 species of mammals, 318 species of birds, 40 species of reptiles, 19 species of amphibians, and 14 species of fish.[68]However, the most recent findings show that the number of animals in certain endangered species is declining very fast. 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, the white-tailed mouse and long- toed tree frog are endangered and 11 other species

[64] Ministry of Forestry and Land Reclamation, forthcoming
[65] MFLR, National Forestry Policy, 2008.
[66] FAO, Lesotho Forest Resource Assessment, 2010
[67] USAID, Biodiversity and Tropical Assessment for Lesotho, 2007

[68]BoS, Environment and Energy Statistics Report, 2012

are vulnerable. The primary threats to these species include animal trampling, overgrazing, fires, urban encroachment, agricultural encroachment, invasive alien species, pollution and unsustainable plant harvesting.

Indicator 7.4: Proportion of Land Area Protected

There are only two nature reserve areas in Lesotho established specifically to protect biodiversity. These are Sehlaba-Thebe National Park and the Masetise Nature Reserve. Four other nature reserves were established within the LHWP Phase 1 Area at Bokong, Tsehlanyane, Muela and Liphofung. Sehlabathebe has the largest area of 6, 475 ha while N.U.L (botanical garden) has the smallest area with 1.5 ha.

Table 7.4: Lesotho's Protected Regions by Area (ha) for the Year 2000

Protected Area	Area (ha)
Sehlabathebe National Park	6,475
Masitise Nature Reserve	20
National University of Lesotho (Botanical Garden)	1.5
Bokong Nature Reserve	1,972
Muela Nature Reserve	45
Ts'ehlanyane Nature Reserve	5,300
Liphofung National Monument and Reserve	4

Source: BOS, 2014 Biodiversity and Land Use Statistical Report No.15: 2015

Wetlands cover only 1.36% of land area in Lesotho. Most of the wetlands are found in the mountain region and are known to be of high significance. Eco-hydrologically, they provide a range of goods and services, particularly water, livestock pasture, medicinal plants and thatch grass for local communities.

Indicator 7.5: CO_2 Emissions: Total Per Capita, and Per $1 GDP (PPP)

The UN MDG Report 2015 states that between 1990 and 2012, global emissions of carbon dioxide increased by over 50%. Data collected over two decades show that the growth in global emissions has accelerated, rising from 10% in 1990 to 2000 to 38% during the period 2000 to 2012, driven mostly by growth in the developing regions. A continual rise in greenhouse gas emissions is projected to further warm the planet and cause long-lasting changes in the climate system, threatening severe and irreversible consequences for people and ecosystems. Impacts on natural and human systems are projected to span the globe, with varying effects from region to region. They include altered ecosystems and habitats; detrimental impacts on agriculture, potential food shortages; weather extremes and natural disasters.

Lesotho is not a large CO_2emitter. Lesotho's first national communication to the UN Framework Convention on Climate Change reported 636,000 metric tonnes of emissions (not including land use change and forestry) for 1994, all from the energy sector.[69] This figure steadily increased to 805,000 in

[69] Ministry of Natural Resources, National Report on Climate Change, April 2000.

2000.[70] However, Lesotho contributes less than 0.01% of global emissions and its carbon footprint is the lowest in the Sub-Saharan Africa region.

TABLE 7.6: CO_2 Emissions in Lesotho

	1996	1997	1998	1999	2000
CO_2 Emissions (metric tonnes)	681,000	700,000	750,000	772,000	805,000
Emissions Per Capita (tonnes)	0.37	0.38	0.40	0.41	0.43

Source: LMS Greenhouse Gas Inventory Base Year 2000 Report; unpublished, May 2012

Summary of Greenhouse Gas Emissions Inventory for All Subsectors in 2000

The summary of the National Greenhouse Gas(GHG) Inventory for 2000 is presented in Table 7.6. Lesotho emitted a total of 3512.89 Gg of CO_2 equivalent (CO_2eq) emissions without Land Use Change and Forestry (LUCF). The LUCF sector provided a net sink of 2134.91 Gg of $C0_2$ eq. This shows that Lesotho remains a net emitter of GHG. The highest emissions without LUCF are from the agricultural sector. Lesotho is vulnerable to climate change due to its reliance on rain-fed subsistence agriculture and on water resources for export earnings and hydroelectricity.

Dry conditions brought by climate change 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%.

Furthermore, climate change exacerbates deforestation, and chronic drought hinders the recovery of rangelands and wetlands. Climate change mainstreaming has not occurred across all vulnerable sectors. There are particular weaknesses in the water sector and in climate-proofing infrastructure. However, progress is accelerating in climate change mitigation and adaptation. The institutionalization of climate change issues and processes is mandated to the Lesotho Meteorological Services (LMS) under the Ministry of Energy and Meteorology through the Climate Unit established within the LMS. The Unit carries out climatic monitoring, research and assessment. It is supported by an ad-hoc interdisciplinary and intersectoral National Climate Change Committee (NCCC) comprising of government agencies, academia, the private sector and non-governmental organizations.

[70]BoS, Environment and Energy Statistics Report, 2012.

In accordance with its responsibilities, the LMS carries out regular collection, processing, formatting, and recording of data related to weather, climate and climate change for the government. It serves as the Designated National Authority (DNA) for reporting on climate change at the UNFCCC and for managing applications for carbon trading through clean development mechanisms. It is a key government institution responsible for overseeing coordination of climate change issues in Lesotho.

For the implementation of mitigation measures contained in the Initial National Communication (INC) for the energy sector, the GoL developed and implemented the Lesotho Renewable Energy Based Rural Electrification (LREBRE) project with the technical and financial support of Global

Environment Facility (GEF). LREBRE aims at reducing Lesotho energy usage related to CO_2 emissions by promoting renewable and low GHG emissions technologies as a substitute for fossil fuels utilised in rural areas for the country.

Since the start of the project, a total of 1537 Solar Home Systems (SHS) with a capacity of 65 watts have been installed and an estimated 500 SHS have also been independently installed. In addition, GoL is implementing the Rural Electrification Project with the objective of supporting investments in the electricity supply to enhance the electricity access rate and to ensure improved efficiency.

Table 7.7: Summary of GHG Emissions Inventory for All Sub-Sectors in 2000 (Gg)

Sources	CO_2	CH_4	N_2O	Total Sinks/ Removals
Energy	805,03	11	0,14	
Industrial Processes	0	0	0	
Agriculture		40,83	4,44	
Land use change and forestry (LUCF)	200,58	0	0	-1578,56
Waste		8,03	0,1	
Total GHG Emissions by Gases	805,03	59,86	4,68	
GWP	1	21	310	
Total CO_2 Equivalent	805,03	1257,06	1450,8	

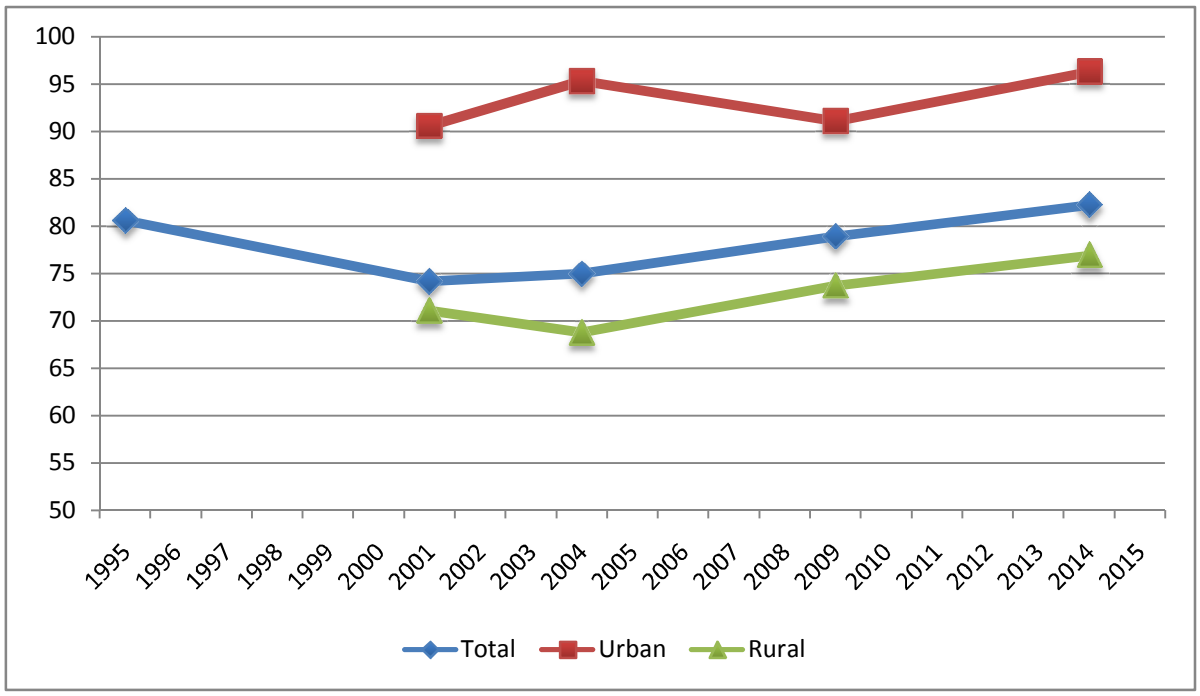
Source: Second National Report on Climate Change, November 2013

Indicator: 7.6: Proportion of Population Using an Improved Water Source

The water sector is especially vulnerable because decreased rainfall diminishes renewable water sources. While water is currently abundant, it is estimated that Lesotho will enter a water stress period of less than 1,700m^3 per capita per year by 2019 and a water scarcity period of less than 1,000m^3 per capita per year by 2062. These projections are based on current population growth and climate patterns. The

Department of Water Affairs and the Lesotho Highlands Water Project (LHWP) engage in water quality and testing. According to the 2012 Environment and Energy Statistics Report, the water temperature complies with RSA standards and the water pH complies with WHO standards except for the Mohokare River which receives industrial waste.[71] As shown in Figure 7.3 and Table 7.8, most urban households use piped water to yard or plot (55.2%) followed by those who use boreholes in yards (16.8%). However, in rural residences, the majority of households use public tap/standpipe as their source of drinking water (51.9%). Of the 82.2% of households that use improved water sources, 96.3% are from urban areas while 76.9% live in rural areas.[72]

Figure 7.3: Proportion of Households with Improved Water



Source: LDS 2001, LDHS 2004, 2009, CMS 2011, LDHS Preliminary Report 2014

It can also be observed from Table 7.8 overleaf that 18.2% of rural households still use water from unprotected springs that could result in water borne diseases; therefore, efforts should be made to supply the rural population with improved water sources. In general, the majority of Lesotho households use public tap/ standpipe (31.8%) followed by fixed water to yard/ plot (27.4%).

[71] BOS, Environment and Energy Statistics Report, August 2012

[72] CMS 2011/2012

Table 7.8: Percentage of Urban and Rural Households by Source of Water and Urban- Rural Residence

Source of Water	Urban	Rural	Total
Piped into dwelling	8.5	0.7	4.3
Piped water to yard/plot	55.2	3.4	27.4
Piped to someone else's yard/plot	1.2	1	1.1
Borehole at home	16.8	1.9	8.8
Rainwater harvesting at home	0.7	9.3	5.3
Rainwater harvesting neighbour	0.1	0.2	0.2
Public tap/standpipe	8.4	51.9	31.8
Public borehole	1.2	7.3	4.5
Protected spring	4	5.6	4.8
Unprotected spring	3.5	18.2	11.4
Surface water	0	0.1	0
Cart with small tank/drum	0.2	0.5	0.4
Tanker truck	0.1	0	0
Total	**100**	**100**	**100**

Source: CMS 2011/2012

Water and Sanitation

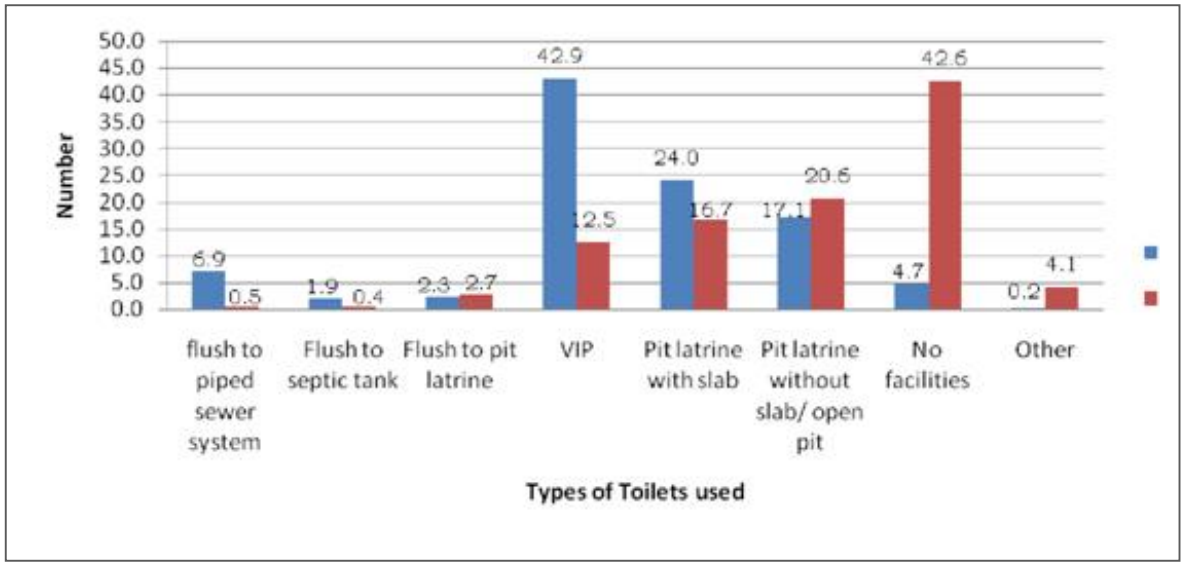
Lesotho Highlands Water Project (LHWP) exports water to RSA and provides domestic hydroelectric power with a series of three dams and one 72 Mega Watts (MW) hydropower station. Hence, sustainable management of water resources is critical. Upstream, large dams inundate arable farming land, rangelands and forests. For example, combined phases 1 and 2 of the LHWP anticipate flooding 4,000 ha of arable land. Dams also disrupt water flow downstream, which damages river ecosystems, increases sedimentation and reduces water quality.

Water is Lesotho's most valuable and abundant natural resource. As a water-rich country in the middle of water-stressed Southern Africa, Lesotho must carefully manage this resource so that it acts as a key economic determinant for Lesotho within a framework of sustainable development.

Domestic Water Supply and Sanitation

As Figure 7.4 shows, households in Lesotho use a range of sanitation mechanisms. From the table, it can be observed that in urban areas, the majority of households report using Ventilated Improved Pit latrine (VIP) (42.9%) and the Pit latrine with slab (24%). In rural areas, the majority of households did not have toilets (42.6%). Of the rural households that did have toilets, the Pit latrine without a slab/open was most common (20.6 %).

Figure 7.4: Types of Toilets Used



Source: CMS Statistics Report 3rd Quarter 2011/2012

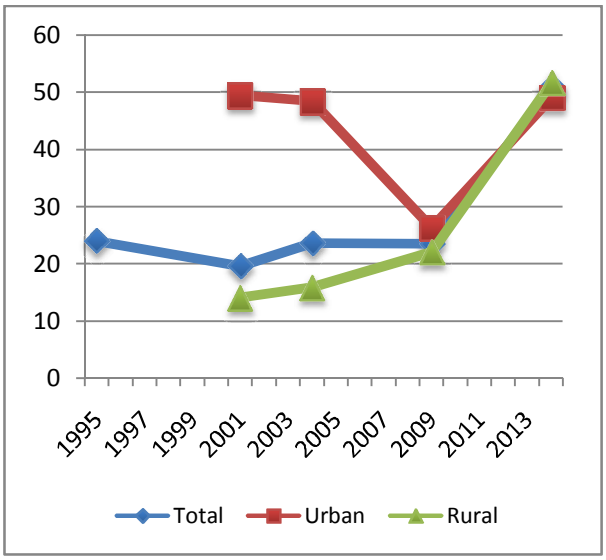
Indicator 7.7: Proportion of Population Using an Improved Sanitation Facility

The category of improved sanitation facilities includes

- Flush toilet,
- Ventilated Improved Pit (VIP) latrine,
- Ordinary pit latrine/pit latrine with a slab, or
- Composting toilet that is used by one household and not shared with other households.

According to the LDHS 2014 Key Indicators Report, about 50.9% of Lesotho's households are using an improved sanitation facility with 49% and 51.6 % for urban and rural areas, respectively. Figure 7.4 shows that the total coverage has risen since the last survey in 2009. This increase can be attributed to increases in donor funding for sanitation projects. The Millennium Challenge Corporation (MCC) has provided funding for VIP latrine construction, while the EU is providing around 43 million Euros for water and sanitation projects. The overall trend after 2009 suggests that sanitation coverage in urban areas remained sluggish with rural coverage higher than urban coverage since the statistics cover households that do not share this facility with other households. Shared latrines are not regarded as adequate hygienic sanitation facilities by WHO and the Ministry of Health. MCC and EU funding mostly targets improving water and sanitation projects in rural areas.

Figure 7.5: Proportion of Households with Improved sanitation



Source: LDS 2001, LDHS 2004, 2009, CMS 2011, LDHS Key Indicators Report 2014

POLICIES AND STRATEGIES

The country enacted the Environment Act of 2008, a law that catalyzed the country's efforts towards a sustainable environment. It recommends

- Decentralisation of environmental management through environmental units within the planning divisions of all ministries,
- Establishment of an Environmental Tribunal to act as a final arbitrator on environmental issues.
- Establishment of a National Environmental Council (NEC) to bring together relevant ministers and other stakeholders to oversee and coordinate national environmental policy-making.
- The Water Act of 2008 was also enacted to provide for the management, protection, conservation, development and sustainable utilisation of water resources.

BOTTLENECKS AND CHALLENGES

ð Lack of data is a major challenge and hinders measuring environmental issues.

ð Lesotho faces environmental degradation due to overgrazing, heavy reliance on the environment for non-renewable energy sources and poor land management including agricultural practices.

ð Despite government efforts to provide electricity, biomass such as wood, shrubs, field residue and stock dung is the dominant form of energy used in Lesotho with 53.9% of households using it for cooking needs and 51.7% of the population relying on it for heating.

ð Due to a fragmented compliance regime, soil erosion and other environmental challenges are not being effectively addressed despite several laws and policies such as the Lesotho Water Act of 2008, the Lesotho Environmental Act of 2008 and the Lesotho National Forestry Act of 1998.

ð Although local government community councils are legally mandated to play a basic role in environmental protection, they either lack the capacity to carry out their responsibilities or are undermined by the line ministries.

LESSONS LEARNED AND WAY FORWARD

- Environmental governance is weak. Responsibilities are fragmented across a number of ministries and departments. These actors often operate independently without adequate communication and coordination.
- There is a need to establish inter-governmental coordination mechanisms specifically for land degradation and land management issues and for the water sector so that the policies and programmes of the stakeholders in these sectors can uniform.
- Environmental sector evidence, particularly the use of GIS and remote sensing, is critical for informed decision-making and awareness raising among stakeholders.
- The role to be played by local representatives and traditional chiefs in the enforcement of rules and regulations related to natural resource management is critical. Appropriate support should be provided to local and district governance structures.
- In MTEC, the tourism industry is the predominant focus and environmental matters are a secondary priority.
- Wood harvested and sold by the Government is rarely reported to forestry authorities, and wood felled by communities and individuals is never documented. This must be changed to ensure accurate measurement of deforestation and compliance with environmental laws.
- The EIA system should be strengthened 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.

MDG 8: A GLOBAL PARTNERSHIP FOR DEVELOPMENT

MDG 8: A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target 8A: 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

Target 8B: 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

Target 8C: Make new technologies available, especially information and communications

Indicators
8.6: Mobile subscribers per 100 people
8.7: Internet users per 100 people

Target 8D: Provide affordable access to essential drugs in developing countries
Indicator 8.8: Average availability of essential medicines

OVERVIEW

The global partnership for development has seen mixed results throughout the last 15 years in Lesotho. The net ODA more than doubled during the period of the Millennium Development Goals (MDG) to reach $343 million in 2013. The biggest share of ODA is dedicated to the social sector (78% in 2013) to mitigate the persistently high impact of HIV and AIDS, amongst other diseases.

More positive conclusions can be drawn from improved access to telecommunication and trade capacity. Lesotho's products are able to enter European and American markets duty-free. However, only a small percentage of ODA is allocated to enhance trade capacities.

Greater investment in building trade capacity could generate inclusive growth and lift Basotho out of poverty.

Even though the ICT sector registered steady growth in terms of users and geographic coverage of services, internet penetration has

been very slow. There has also been slow growth in providing affordable access to essential drugs in the country.

on budgets in some OECD member nations since the global economic crisis. The 2013

Table 8.1: Millennium Development Goal 8 At A Glance

Indicator	Baseline (2000)	2005	2008	2010	Current
Net ODA to Lesotho (USD millions)	37	67.5	143.8	275.7	343.2 (2013)
Proportion of ODA Allocated to Social Services	60.4 (2002)	81.8	87.6	91.1	77.8 (2013)
Proportion of exports to developed countries Admitted Free of Duty	11	100	100	100	100 (2014)
Proportion of ODA allocated to build Trade Capacity	6.7 (2002)	3.2	1.05%	0.3	
Foreign Direct Investment (million maloti)	224.5	482.2	1583. 5	274.64	1593.69(2012)
Mobile Subscribers per 100 people(%)	0.4	11.2	25.7	84 (2013)	93 (2014)
Internet Users per 100 people(%)	0.2	2.8	4.1	4.5	11 (2014)
Average Availability of Essential Medicines (%)	74 (2007)			77.7	73.5(2015)

TRENDS AND ACHIEVEMENTS

TARGET 8A: Address the Special Needs of Least Developed Countries

Indicator 8.1: Net Official Development Assistance (ODA) to Lesotho

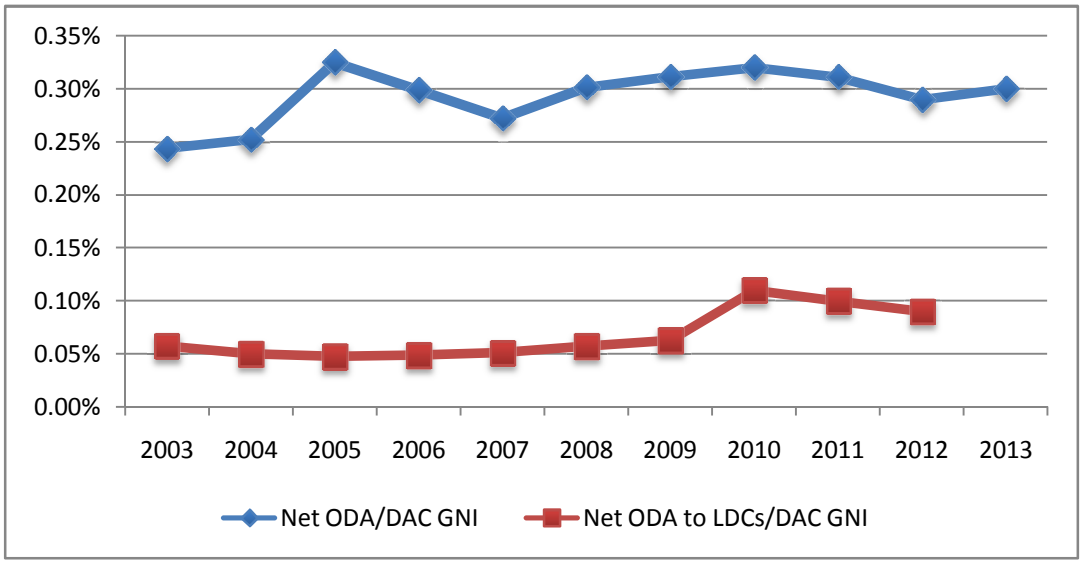
Total net ODA comprises grants or loans to developing countries for economic and social development from Organization for Economic Cooperation and Development (OECD) and Development Assistance Committee (DAC) members. According to the MDG Gap Task Force Report 2014, total net ODA reached a record $135 billion in 2013, helping to alleviate concerns about two consecutive years of falling volumes. This increase was despite the continuing pressure

ODA represents 0.3% of the combined OECD and DAC donors' gross national income (GNI), a marginal improvement in meeting the United Nations target of disbursing 0.7% of donor GNI.

Aid to least developed countries (LDCs) increased by 12.3% in 2013 compared with the previous year. While the increase in aid to LDCs surpassed the overall increase in global aid up to 2010, this trend has begun to reverse. Recent figures indicate an overall decline in aid to LDCs – from USD 46 billion

in 2010 to USD 38 billion in 2014. The drop is mainly due to decreases in bilateral aid, in part because of overall budget pressures in a few OECD and DAC countries and changed priorities in OECD and DAC countries' overall aid allocations. In 2013, ODA to LDCs represented 0.10% of OECD and DAC countries' combined GNI, well below the UN target of providing at least 0.15% of their GNI as ODA to LDCs.

Figure 8.1: ODA as a Proportion of Donor's Gross National Income, 2003 - 2013



Source: OECD

Net Official Development Assistance (ODA) to Lesotho

Lesotho is among the largest recipients of ODA in Africa: aid per capita in Lesotho reached US$183[73]in 2013, totalling US$343 million. Although Lesotho is supported by a large number of bilateral and multilateral development partners, the largest bilateral donor is the USA. The total disbursements from the USA amounted to US$170 million in 2013, and totalled US$457million in the period 2010-2013. The European Union is the second largest donor to Lesotho which in 2013 disbursed US$62 million, with total European Union disbursements of US$316.5 million in the 2010-2013 period. Contributions from other bilateral and multilateral agencies have also been significant and amounted to US$425.62 million in the same period.

In 2010, net ODA to Lesotho from all donors (including multilateral institutions) more than doubled to US $256 million[74] which is 10% of GNI.[75]This substantial increase occurred because of direct budget support provided by 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

[73]15.4% of per capita GDP

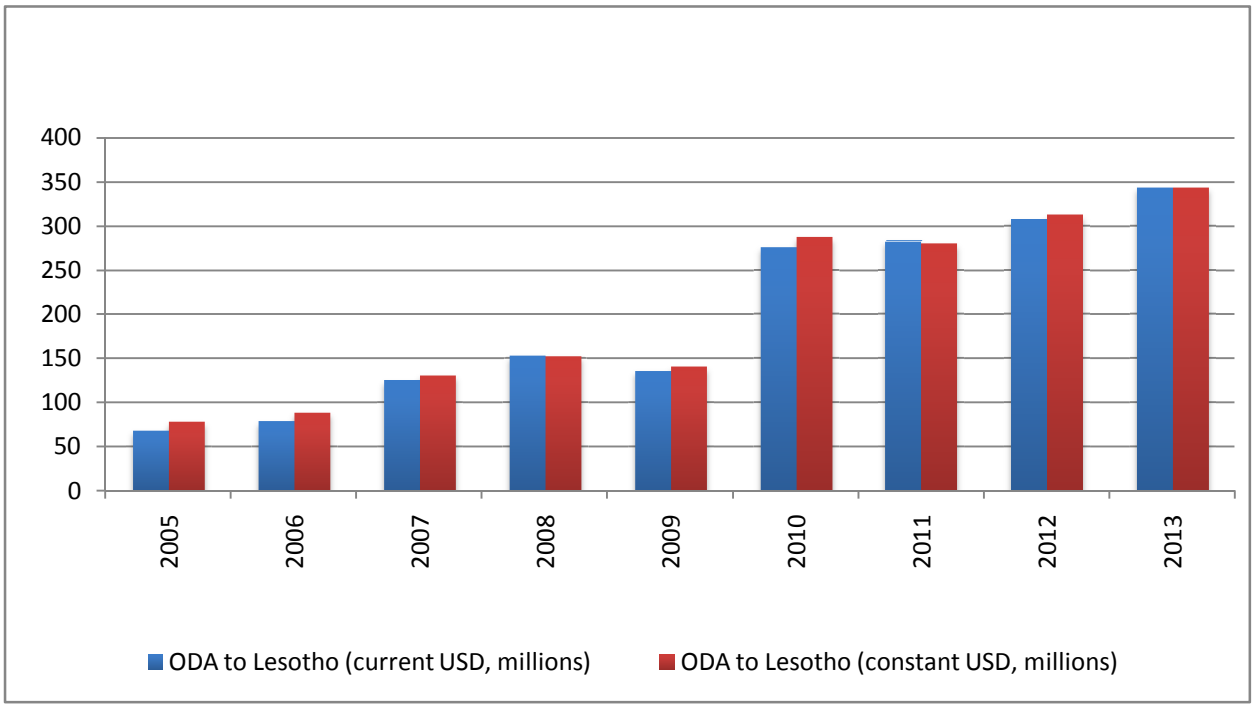
[74]US $118.01 per capita

[75]OECD Aid Databases

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. Figures 8.2 and 8.3 show that in 2011 net ODA to Lesotho only increased to US $307.44million which is 10% of GNI.[76]

Another important indicator of support to LDCs is the proportion of bilateral ODA from DAC donors that is unrestricted. Restricted 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 unrestricted in 2005, which decreased to 73% in 2007 and then rebounded to 96% in 2009.

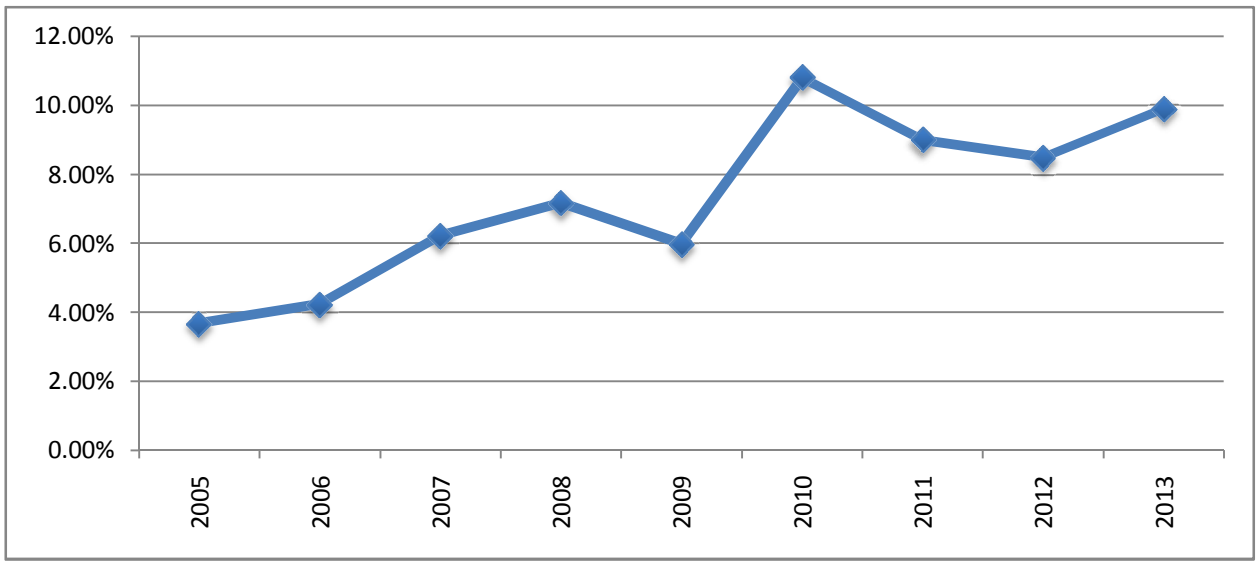
Figure 8.2: Net Official Development Assistance to Lesotho, 2005-2013



Source: OECD

[76] Ibid

Figure 8.3: ODA as a Proportion of Lesotho GNI, 2005-2013

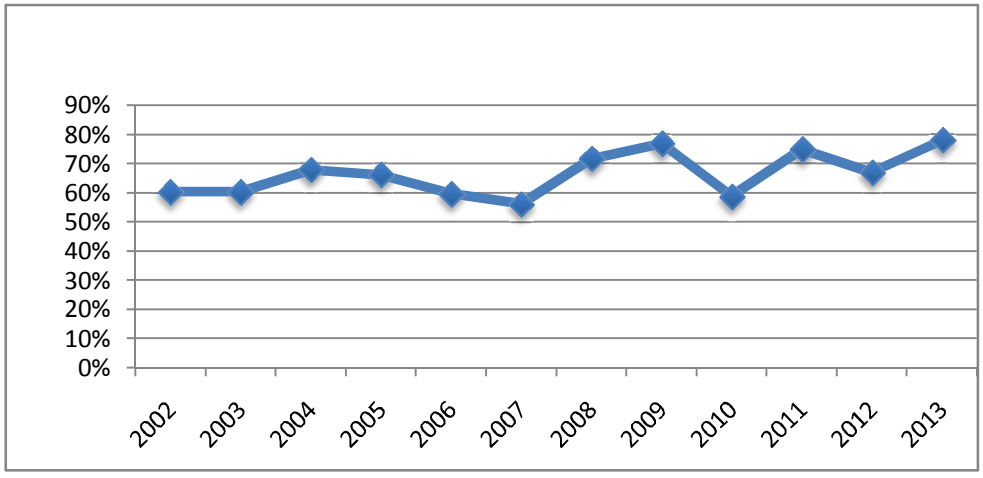


Source: OECD

Indicator 8.2: Proportion of ODA Allocated to Social Services

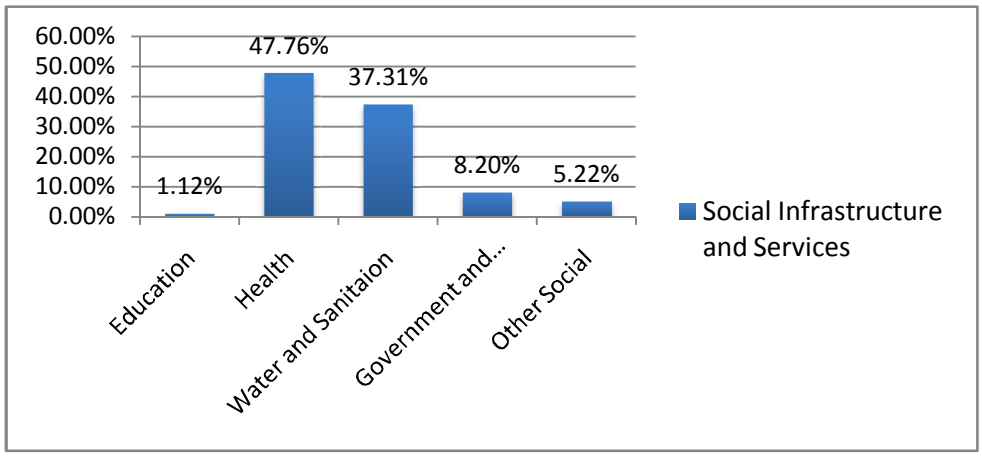
The sectoral distribution of ODA as reported under the OECD sector classification is represented in Figure 8.4. It indicates that the sectoral distribution of ODA to Lesotho is skewed towards the social sectors which attracted over 70% of the total ODA in 2013. The distribution of sector-allocable ODA from all donors for 2013 is shown in Figure 8.5. The largest share of external resources is disbursed as health-related support, which on its own absorbed as much as US$130million in 2013, constituting about 40% of overall aid disbursed to Lesotho in that year. The second largest support was towards Water and Sanitation which constituted 37.3% of the total. While the government and education sectors are considered key drivers for employment creation, poverty reduction and governance, aid to these sectors was recorded at only 8.2% and 1.1% respectively.

Figure 8.4: Proportion of Lesotho ODA Allocated to Social Infrastructure and Services, 2002-2013



Source: OECD

Fig 8.5: ODA by Social Infrastructure and Services Sector, 2013



Source: Overview of Aid Flows to Lesotho, 2010-2013

TARGET 8B: Develop an open, rule-based non-discriminatory trading and financial system

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

The US market under the African Growth and Opportunity Act (AGOA), as well as Southern African Customs Union (SACU) and the European Union (EU) markets continue to be major markets for Lesotho apparel products. The textile and apparel industry products are mostly exported to the US under the AGOA because the preferential trade agreement allows qualifying Sub-Saharan African countries to export goods to the US quota-free and tax-free Lesotho is the second largest Sub-Saharan African exporter of apparel to the US in value and volume terms after Kenya.

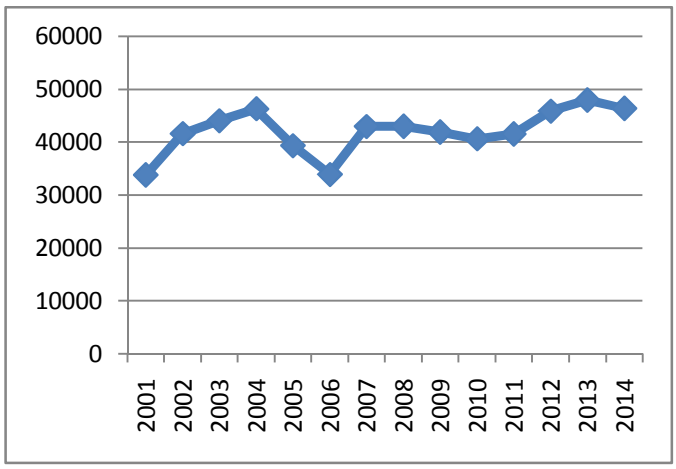
The SACU market is becoming an increasingly important market for Lesotho. Lesotho's location within the Republic of South Africa (RSA) allows it to benefit from RSA's developed economic status. As a result, the largest portion of Lesotho's exports is sold to the South African market. More efforts are being made to ensure that the SADC market is fully exploited in order to diversify demand for Lesotho's textiles and apparel and reduce Lesotho's reliance on the US market. In the period January-July, 2014, the value of exports for Lesotho decreased by 7.68% from US $168,828 million to US $155, 868 million. Lesotho decreased its exports to the US by 1.58% in volume terms from 39,042 MSME in January-July, 2014 to 36,569 MSME in January-July, 2015. These negative growth trends in both the volume and value of exports suggest that Lesotho lost orders to other regions due to the delay in the renewal of AGOA.

The narrowing of the trade deficit reflected a rise in exports which grew by 2.3% in 2013 following a decline of 5.4% in 2012. Export growth was mostly driven by a 6.4% increase in textile and clothing exports against a decline of 3.1% in the previous year. Textile and clothing exports benefited from a recovery in orders by US-based buyers following the extension of the Third Country Fabric Provision (TCPF) in 2012 and a favourable Loti/US dollar exchange rate.

Exports of diamonds fell marginally due to electricity supply problems, which negatively impacted the operations of mines. Despite these challenges, the discovery of exceptional diamonds at Letšeng diamond mines continued to support the sector. As a result, the impact of the electricity problems in mines was only mildly felt by the sector. The sector was also cushioned by the favourable exchange rate of the Loti against major currencies.

As Figure 8.6 shows, employment in the textile sector increased sharply between 2000 and 2003. This was largely due to the introduction of the Multi-Fibre Agreement which imposed quotas on the exports of large economies. Without these quotas, LDCs would be hard-pressed to compete in the global textile market. The Multi-Fibre Agreement improved Lesotho's access to the US market. In 2004, the Multi-Fibre Arrangement came to an end and the quotas were removed. This eroded access some of the markets that Lesotho and other LDCs had traded with and led to a corresponding reduction in employment. In 2007, employment rose when AGOA's Third-Country Fabric Provision was extended. As a result, US buyers placed more orders with African suppliers. However, in 2008, employment decreased following the global financial crisis which negatively impacted the global textile and apparel industry. By 2009, stability was re-established and maintained until 2013 following the renewal of the Third-Country Fabric Provision in 2012.

Figure 8.6: Employment in the Textile Sector, 2000-2014



Source: Central Bank of Lesotho Annual Reports, BOS Manufacturing Reports

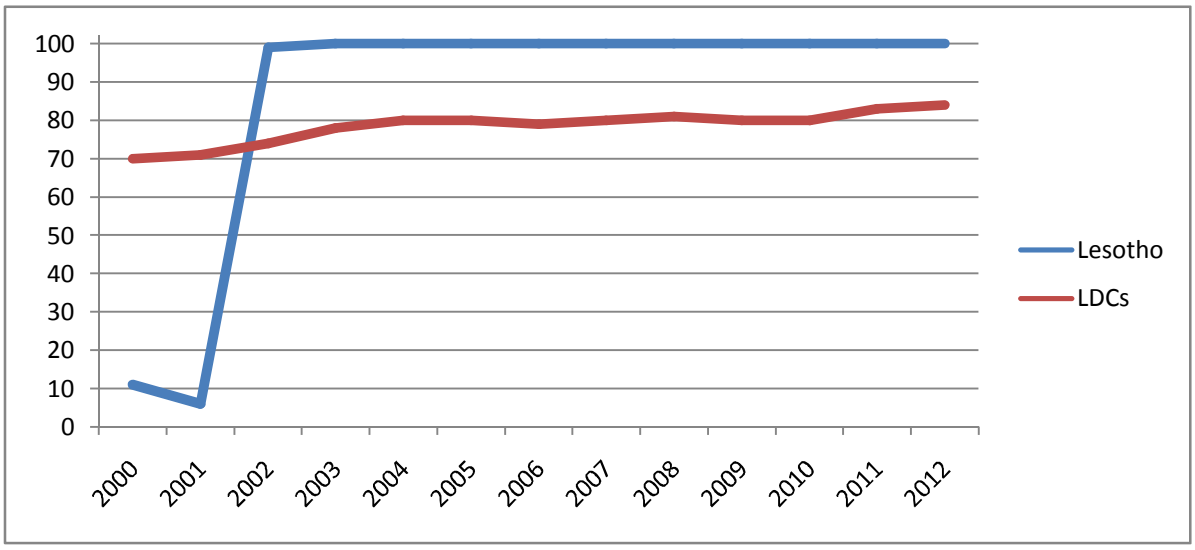
In December 2014 employment in the textile and clothing industry fell to 46, 424 employees from 47, 971 employees in December 2013 due to relatively low order status for firms exporting to the US, as a result of prolonged competitiveness challenges faced by the industry.

The AGOA which permits Lesotho to use foreign third-country fabric for garment exports and provides quota and duty-free entry into the U.S. markets for certain goods, most notably textiles and apparel, was extended on 29 June 2015 by a further ten years, to 2025. The ten-year renewal of AGOA will strengthen the environment for trade and investment between the United States and Lesotho. The extension will also ignite industrial growth in Lesotho. The passing of AGOA is vital for Lesotho's economy and development and has spurred a booming textile sector in Lesotho, creating thousands of jobs.

Trade agreements such as AGOA with the US and the Economic Partnership Agreement

(EPA) with the European Union have benefited Lesotho tremendously over the past decade. The country's exports face a trade-weighted average tariff from the rest of the world of 0.04%, which is much lower than the average for Sub-Saharan Africa (3.5%) and low-middle income countries (2.9%). Moreover, 100% of exports to developed economies have been admitted duty-free since 2002, as shown in Figure 8.7. Lesotho also has concessional market access to other developed and developing countries' markets under the Generalized System of Tariff Preferences (GSP) applicable to each country. These countries include Australia, Canada, Japan, New Zealand and Turkey. Lesotho also finalized an interim Economic Partnership Agreement (EPA) with the EU in June 2009 that offers strong trade preferences, particularly for textiles. In June 2014, Lesotho concluded negotiations for a full EPA with the EU which will further bolster the development of trade within Lesotho.

Figure 8.7: Proportion of Developed Economies' Imports Admitted Free of Duty, 2000-2012

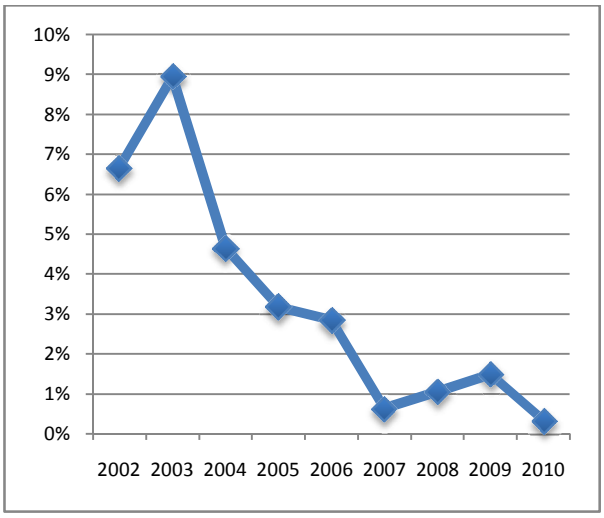


Source: ITC, WTO, UNCTAD

Indicator 8.4: Proportion of ODA Allocated to Build Trade Capacity

Aid for trade aims to help developing countries strengthen productive capacity, regulatory and policy frameworks and trade-related infrastructure. Trade agreements enable Lesotho to better integrate into world markets. In Lesotho, ODA for trade has focused on trade-related infrastructure, agriculture, trade policy and regulation, industrial development and tourism. As shown in Figure 8.8, the proportion of ODA allocated for trade capacity has fallen considerably from 9% in 2003 to less than 1% in 2010 due largely to increased funding towards HIV/ AIDS programmes. However, aid for trade has also declined in absolute terms from nearly US $7 million in 2003 to less than US $1 million in 2010.

Figure 8.8: Proportion of Lesotho ODA for Trade Capacity, 2002-2010

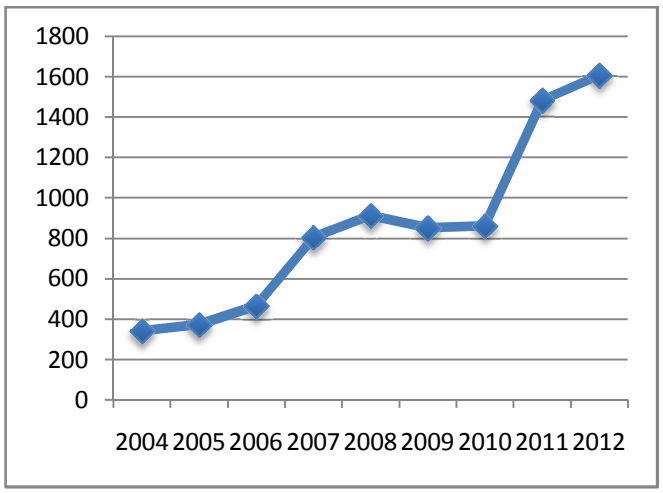


Source: OECD

Indicator 8.5: Foreign Direct Investment into Lesotho

Foreign Direct Investment (FDI) is capital invested directly into production or industry by a foreign company. FDI is an important source of investment, foreign capital and productivity growth for developing countries. It facilitates technology and skills transfer and, most importantly, new job creation in the host country. Figure 8.9 indicates nominal FDI trends for Lesotho over the past decade. FDI has grown considerably from 2006 to 2008 as a result of the efforts of the Lesotho National Development Corporation (LNDC), the development of industrial infrastructure such as factory shells and AGOA. However, the global financial crisis and increased competition from China for the U.S. garment market triggered a decline in FDI after 2008. In 2009-10, five companies closed resulting in 3,755 job losses. As a result of a number of initiatives such as the development of industrial infrastructure, FDI increased from 1,422.24 million Maloti in 2011 to 1,593.69 million Maloti in 2012.

Figure 8.9: Net Foreign Direct Investment (Million Maloti)



Source: Central Bank of Lesotho

TARGET 8C: Make new technologies available, especially information and communications

Indicator 8.6: Mobile Subscribers Per 100 people

Access to ICTs continues to grow, allowing an increasing number of people to join the global information society. This, in turn, enables a wide range of opportunities for investment and facilitates 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 paying bills, and completing banking transactions all from a mobile phone. Medical and government services may also be revolutionized through the internet.

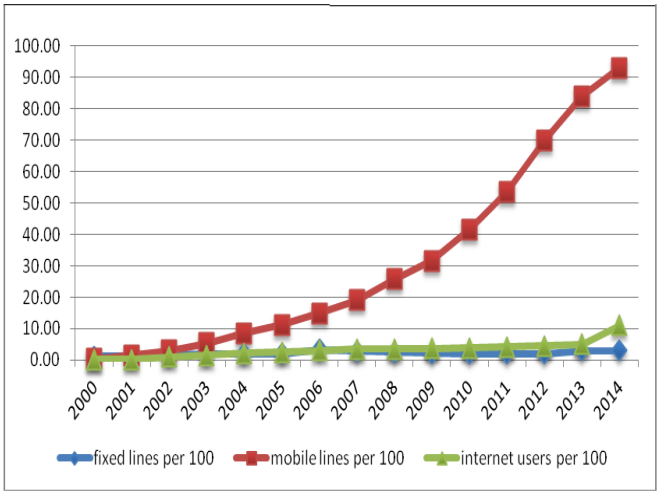
One of Lesotho's strongest ICT achievements is the Lesotho Communications Authority (LCA), which was established in 2000 to

- advance universality of ICT access and services,
- ensure robust competition,
- promote investment in the sector,
- protect consumers and
- manage emerging technology.

The communications sector is dominated by two public communications service providers: Econet Telecom Lesotho and Vodacom Lesotho, which are licensed to provide both voice and data services.

While some areas in Lesotho remain without access to ICT services, there has been a significant penetration of communication services, particularly with respect to mobile networks. The sector has realized increased subscription for both voice and Internet services, increased coverage and wider choice of communication services, all of which contribute to bridging the digital divide. Figure 8.10 shows that teledensity for mobile telephony has increased exponentially from around 1% in 2000 to 93% in 2014. In contrast, the growth of fixed telephony has remained stagnant with teledensity at 3% in 2014 compared to 1% in 2000. This stagnation in fixed telephony is characteristic of most developing countries. Overall sector teledensity for both fixed and mobile subscribers increased from 87% to 96% based on the 2006 population census figure of 1,880,661. The observed growth of the telecommunications sub-sector is due to improved technology and the introduction of promotional products on mobile and fixed lines by the service providers. The geographic coverage area with access to communications service has also increased. The Global MDG Report 2015 shows that as of 2015, 95% of the world's population is covered by a mobile-cellular signal.

Figure 8.10: Information and Communication Technology Access, 2000-2014



Sources: Lesotho Communications Authority; International Telecommunications Union

Indicator 8.7: Internet Users per 100 people

As in most African countries, penetration of internet access and services in Lesotho has progressed very slowly. Exorbitant prices together with slow and unreliable connectivity have been the key factors that have hindered Internet penetration. However, this is likely to change now that Lesotho sources international bandwidth through the East African Submarine System (EASSy) project. Participation in this project is intended to bridge the digital divide through introduction of cheaper and high capacity bandwidth connectivity. Network operators in Lesotho started leasing capacity from EASSy in 2012 and the expected net effect is to see large reductions in broadband prices, but so far these have not been at the scale expected.

In 2000, less than one percent (0.22%) of Lesotho's inhabitants used the Internet, increasing to 4.45% in 2010. While there is a gradual increase in Internet users through different technologies and equipment, the most prominent usage has been on mobile devices, including handsets, following the introduction of mobile Internet services and their promotion. Internet users on mobile services, mainly 3G and Wi-Max, realised a 132% increase from 238,008 in 2012/13 to 551,425 in 2013/14 due to rising popularity and penetration of smart mobile handsets. These users make up 99% of internet users in Lesotho. The introduction of smaller recharge denominations and somewhat affordable data bundles by the operators has also spawned an increase in internet users.

Internet cafes continue to provide important public outlets for internet access. As of 2015, there were 69 operating internet cafés in Lesotho. This figure is down from 77 in 2012. The number of Internet cafes has declined in five of the ten districts, including Maseru, Leribe, Mokhotlong, Mohale'sHoek and Thaba-Tseka. Factors that have contributed to the decline include perpetually high costs of bandwidth as well as increasing use of tablets and smart phones. Table 8.2 shows the distribution of Internet cafes from 2009 to 2013.

Table 8.2: Number of Internet Cafes in Lesotho, 2009 -2013

Table 8.2: Number of Internet Cafes in Lesotho 2009 -2013					
DISTRICT	**2009**	**2010**	**2011**	**2012**	**2013**
BUTHA-BUTHE	2	4	6	5	5
LERIBE	5	5	9	12	11
BEREA	2	2	3	4	6
MASERU	11	15	23	34	29
MAFETENG	3	3	3	6	6
MOHALE'S HOEK	2	3	3	3	2
QUTHING	0	2	2	2	2
QACHA'S NEK	2	2	5	2	3
MOKHOTLONG	1	1	2	6	4
THABA-TSEKA	0	1	2	2	1
TOTAL	28	38	58	77	69

Source: Lesotho Communications Authority Annual Report 2013/14

In its continued effort to improve access to communication services in 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 establishment, the USF has subsidized 20 GSM projects, which have benefited at least 63,400 people in some 320 villages in the rural areas of the country.

The USF has also continued to support the Lesotho Internet Exchange Point (LIXP) in addressing the high costs of Internet connectivity. The LIXP was intended to improve domestic speeds, efficient use of

international bandwidth, and reduce costs on foreign exchange. The USF faced the challenge of inadequate funding; the demand for its services was high in unserved areas relative to the financial resources available. As a result of this situation, six projects for mobile network expansion had to be deferred to 2014/15. The USF continued developing mobile network expansion in unserved areas, setting up the top-level country code domain (ccTLD) name infrastructure elements and establishing a broadband wireless network in partnership with the ITU. The USF also continued with the process of profiling unserved and underserved areas.

The proportion of the population covered by a 2G mobile-cellular network grew from 58% in 2001 to 95% in 2015. Since 2002, the number of mobile-cellular subscriptions has exceeded the number of fixed telephone subscriptions. Increased access to a mobile-cellular network connects Basotho to the global online community. Globally, the number of mobile-cellular subscriptions has grown almost tenfold in the last 15 years, from 738 million in 2000 to over 7 billion in 2015.

Finally, the country is working towards migrating from analogue to digital terrestrial television broadcasting as per agreement under the International Telecommunication Union (ITU).

TARGET 8D: Provide Affordable Access to Essential Drugs in Developing Countries.

Indicator 8.8: Average Availability of Essential Medicines

Access to medicine encompasses the availability of essential medicines, their storage, record-keeping, prescribing, dispensing, all with reference to national laws, established norms and standards. To this end, the National Drug Service Organisation (NDSO) procures, stores and distributes medicine and medical supplies to all public health institutions in the country. Some private sector facilities also purchase commodities from NDSO. Due to the role the Christian Health Association of Lesotho (CHAL) plays in the delivery of health care, the Government of Lesotho (GOL) allocates an annual grant of money to CHAL for administering its services.

In order to assess the availability of essential medicine in Lesotho, a nationwide study was conducted in February and March 2015. The main objective of the survey was to determine availability and accessibility of Essential Medicine, ARVs, TB medicines, Family Planning (FP) medicines and Emergency Medicines in Obstetric Care (EMOC), EPI Emergency/Emergency medicines and drugs for Sexually Transmitted Infections (STI) in public and private health facilities using indicator medicines as proxy. The baseline survey, undertaken in 2007, documented 74% average availability. The 2010 survey results documented 77.7% average availability. This represents an increase of about 3% in availability of essential medicines. The 2015 results, however, reveal that the average availability of medicines at hospitals, was 73.5%.

The 2015 survey further revealed that, the average availability of essential medicines was 74%in government hospitals and 73% in CHAL hospitals. As shown in Table 8.3, there was low availability of TB medicines in both CHAL and government hospitals while there was higher availability of PMTCTs and adult ARVs in both sectors. The categories of medicines that were above 80% were EMOC, STI and adult ARVs in CHAL hospitals and EMOC and adult ARVs in government hospitals. The categories that were below 60% in both CHAL and government were PMTCT and TB medicines. CHAL facilities had higher availability in most of the selected categories of medicines with the exception of essential medicines and TB medicines.

The rational use of medicine refers to patients receiving medications appropriate to their clinical needs, in doses that meet their individual requirements for the period recommended by a medical professional. The 2015 study indicated that, on average, for everyfour medicines prescibed in both government and CHAL hospitals, three are dispensed.Lesotho's hospitals have, on average, one pharmacist and two pharmacy technicians while health centres do not have pharmacy personnel at all. Therefore, recruitment of pharmacy personnel at the health centres and hospitals is crucial.

Table. 8.3: Medicine Access in Lesotho

Table. 8.3: Medicine Access in Lesotho			
HOSPITALS	**2007**	**2010**	**2015**
Availability of Indicator Medicines (All)	74%	77.7%	73.4%
Availability of Indicator Medicines (GoL)	74.5%	80.3%	74%
Availability of Indicator Medicines (CHAL)	74.7%	74.7%	73%
Overall Availability of TB medicines	78%	80.7%	59.5%
Overall Availability of STI medicines	78%	79%	77%
Overall Availability of ARVs		69.6%	78.3%
Overall Availability of PMCTC medicines			48%
HEALTH CENTERS			
Availability of Indicator Medicines	40%	57.7%	61.6%

Source: MOHSW Medicine Access Survey 2010 and 2015

In spite of many initiatives since 2007, little progress has been made in improving access to essential medicine. During the 2014/15 financial year, the Ministry of Health established a supply chain coordinating unit in its pharmacy department to systematize supply delivery. Also, the NDSO extended its services to health facilities in 5 districts. This initiative was introduced in order to respond to the long-standing problem of delivering pharmaceuticals efficiently within the District Health Management Teams (DHMTs). Furthermore, in 2014/2015, dispensing of chemotherapy initiated for the first time at Queen Elizabeth II Clinic in Maseru. This was the first time that chemotherapy was available in a clinic in Lesotho.[77]

[77] AJR 2014/15

A bill to control medicine and medical devices is in the draft stage awaiting presentation before cabinet. Approval of the bill will assist towards controlling and regulating retail pharmacies in terms of prices and quality of essential medicines. Further research is required to obtain a deeper understanding of the causes and consequences of low availability of TB medicines and other essential medicines, which can lead to resistance. As a way forward, the unit will establish a Medicine Regulation Technical Working Group to establish a clear direction for all regulatory activities. To reduce stock-outs of medicines within health facilities, the unit will review Lesotho Standard Operating Procedures (LESOPs), Standard Treatment Guidelines (STG) and Essential Medicines List (EML), Drug Supply Manual, Health Centre Manual and Community Health Manual.

POLICIES AND STRATEGIES

- The Government, through the Ministry of Development Planning, has produced the Lesotho Partnership Policy. Its objectives are to improve the effectiveness of development cooperation through greater government ownership and leadership, as well as increasing transparency and accountability between the government and development partners in the management of development cooperation.

- The Companies Act together with other initiatives, including streamlining the services provided by the One Stop Business Facilitation Centre, has improved Lesotho's 2015 Doing Business ranking from 136 in 2013 out of 189 countries to 110 out of 185 countries.[78].

- In 2007, Lesotho received funds from the Millennium Challenge Corporation of the government of the United States of America. These funds were earmarked for the improvement of the investment climate as well as to finance projects in the health sector, including improvement of the water supply,

BOTTLENECKS AND CHALLENGES

- While the ODA to Lesotho has increased since 2000, the volatility in donors' commitments make budget forecasting and long-term development planning difficult for the government. Lesotho has a high dependence on ODA. Aid per capita in Lesotho reached as high as 15.4% of per capita GDP in 2013. Nevertheless, according to the 2010-13 report on TOAidFto Lesotho, only 1% of the ODA was allocated to support trade capacity, which is essential to facilitate economic growth and diminish aid dependency.

- Despite the progress in the mobile communication sector, there has been slow growth in internet penetration due to very expensive, slow and unreliable connectivity. Development of communications infrastructure in Lesotho is constrained by difficult terrain, lack of financial resources, lack of roads and access to the national electricity grid. With the adoption of

[78]The World Bank Doing Business Report 2016

smart devices, reliable electricity supply has become more critical.

- Lesotho's largest trading partner is the SACU block, especially RSA. However, intra-African trade is low. These Southern African markets have tremendous potential, but communication, infrastructure, as well as bureaucratic and political barriers inhibit the intra-African exchange of goods and services.

- Though access to global markets is favourable, trade diversification is low both in terms of the goods produced for export and trading partners. Without diversification in export markets and goods, Lesotho remains extremely vulnerable to external shocks.

- Although social services including health care represented 78% of ODA to Lesotho in 2013, there has been stagnation in terms of access to essential medicine. The availability of medicines at health facilities, their affordability, as well as the distance to the facility are all obstacles to medicinal access.

- A medicine and medical device control bill has been in the draft stage for more than 20 years. Its delay in authorization hinders progress towards regulating the growing prices of pharmacies, as well as their reliability.

LESSONS LEARNED AND WAY FORWARD

- There is a need to lower Lesotho's aid dependency and to diversify aid, especially with regard to building trade capacities. Moreover, it is critical for the Government to explore new revenue sources through domestic resource mobilisation and strengthen the private sector to create jobs.

- Support telecommunication infrastructures all around the country and expand the prevalence of commercial and public facilities for internet access. Moreover, GoL and donors should partner with the private sector to expand the prevalence of internet centres outside Maseru by absorbing some of the high start-up costs through initiatives such as UAF.

- Lesotho has to expand initiatives to diversify export markets and explore increased intra-African trading.

- Develop a pharmaceutical quality assurance system and regulatory framework for the manufacturing, distribution, sale, and prescription of medicines. Recruitment of more pharmacy personnel at health centres and hospitals is also crucial.

- There is a need to train the District Health Management Teams (DHMTs) to implement monitoring, evaluation and reporting for increased adherence to Standard Treatment Guidelines (STGs) and Standard Operating Procedures (SOPs) to improve prescribing, dispensing and labelling practices.

Section III:

Transition from MDGs to SDGs

Transition from MDGs to SDGs

Lesotho's experience with the Millennium Development Goals (MDGs) has generated invaluable lessons that can guide policymakers in implementing the Post-2015 Development Agenda and support the formulation of future policies and strategies.

CROSS-CUTTING LESSONS LEARNED IN IMPLEMENTING THE MILLENNIUM DEVELOPMENT GOALS

- Effective communication and follow-up are critical for the success of global agendas. An important lesson drawn is that although the commitments were not binding, some success was generated. This outcome was partly due to the continuous follow-up processes at the national level through country reporting.
- MDGs induced demand for more comprehensive and timely data. The MDGs underlined the importance of current and disaggregated data as an important ingredient for monitoring results and holding relevant stakeholders accountable. As a result, the country developed the National Strategy for Development of Statistics.
- MDGs have also revealed that improvements in access to basic services have not been associated with improvements in the quality of service delivery. In spite of substantial resources channelled towards health and education, the quality of service has not reached the desired impact.
- Sustainability requires adopting an integrated approach to development. Measures undertaken towards poverty reduction did not draw particular attention to the underlying causes of poverty. As a result, the country did not meet its target for poverty reduction.

CHALLENGES IN ACHIEVING THE MDGS

Some of the challenges encountered in the process of MDG implementation in Lesotho can help inform the implementation of the SDGs and Post-2015 Development Agenda. These include:

- Insufficient integration of MDGs in policy development and implementation;
- Absence of a coordinated and integrated multi-sectoral approach to development,
- Limited decentralization,
- Weak monitoring and evaluation systems for establishing baselines and tracking progress coupled with outdated data.
- Low sectoral capacity for implementation and limited awareness and participation of stakeholders in the development agenda.
- Unrealistic annual targets considering available resources.
- Weak government ownership and leadership of the MDG implementation process

PRIORITIES FOR COMPLETING THE UNFINISHED BUSINESS OF MDGS

Lesotho has had a mixed experience with respect to MDG achievement during the past 15 years. While the country has made progress in achieving some of the MDG targets and indicators, the progress has been relatively slow overall. The country has been particularly delayed in the case of meeting its poverty, nutrition and health-related targets and indicators.

The country has made progress with regard to universal primary education (Goal 2), promoting gender equality and empowering women (Goal 3), ensuring environmental sustainability (Goal 7) and developing global partnership for development (Goal 8).

The country has been much less successful on achieving goals relating to

- the eradication of extreme poverty and hunger (Goal 1)
- reducing child mortality (Goal 4),
- improving maternal health (Goal 5) and
- Combating HIV and AIDS and Tuberculosis (Goal 6).

Henceforth, the country needs to address the various bottlenecks and challenges that constrained the MDG achievements and redouble its efforts to meet the unfinished business of MDGs, along with the SDGs.

TRANSITION FROM MDGS TO THE SDGS

As2015 marked the end of the MDGs, Lesotho is in the process of a transition to a new global development goals defined by 17 Sustainable Development Goals. The country has to prepare for a smooth transition from MDGs to SDGs by drawing upon the experience from its MDG achievements, challenges and lessons learned.

The new development agenda "*Transforming Our World: The 2030 Agenda for Sustainable Development*," has been approved by the United Nations. The agenda, which will guide the development process for the world from 2015-2030, seeks to address the three dimensions of sustainable development - economic, social and environmental - in a balanced and integrated manner.

The 2030Agenda emphasizes poverty eradication as the biggest global challenge and an indispensable requirement for sustainable development. To ensure the country's success in meeting the SDGs, Lesotho has to address the unfinished business of MDGs, and simultaneously put in place robust data gathering and monitoring systems to track progress toward the SDGs. Lesotho must also:

- Promote countrywide buy-in for the SDGs,
- Integrate the unfinished business of MDGs/SDGs in its national development plans and sector strategies
- Gear up its domestic resource mobilization and
- Explore alternative modes of resource mobilization in the face of shrinking global resources.

The following areas are essential prerequisites for effective and efficient implementation of the SDGs.

DATA AND M&E SYSTEMS

The importance of building a robust data collection system for evidence-based policymaking is clear from Lesotho's MDG experience. The problem of outdated and/or insufficient data has hampered assessment of progress in many MDG targets/indicators. Systematic monitoring and evaluation mechanisms need to be implemented to address some of the challenges faced in the MDG context.

Proper monitoring and evaluation facilitates deliberations and decision making by stakeholders and enhances their ability to make necessary improvements in the realization of the goals.

Given the domestic capacity constraints, there is a need to increasingly garner support from development partners and international agencies to build Lesotho's capacities in the areas of monitoring and evaluation.

FINANCING FOR DEVELOPMENT

The proposed Post-2015 Development Agenda recognizes that each country faces specific challenges in its pursuit of sustainable development. It particularly acknowledges the vulnerabilities of landlocked developing countries, which amongst others, need special attention. The financing of the SDGs is going to be a particular challenge for Lesotho, given its simultaneous dependence on ODA for meeting the MDGs. If Lesotho is going to maintain its development achievements to date, while also confronting the unfinished business of MDGs and the new SDGs, it will require the ongoing support of the global community in the form of aid.

Net ODA has played a critical role in Lesotho in addressing MDG challenges with support more than doubling during the period of the MDGs. The largest share of ODA (78% in 2013) is now going to the social sector, primarily to mitigate the persistently high impact of HIV and AIDS.

Given its small size and excessive dependence on South African Customs Union Receipts, textile exports to the United States and miner's remittances, Lesotho is highly vulnerable to external shocks. With its limited capacity for domestic resource mobilization, Lesotho continues to require international donor support and engagement to support the country in addressing its persistent socio-economic challenges.

It is only with technical and funding support from the global community that Lesotho can supplement its domestic efforts in addressing the chronic problems of poverty and inequality, health-related challenges and ensuring sustainable improvements in living conditions and human development.

PARTNERSHIPS

The importance of promoting partnerships among stakeholders for achieving the SDGs is now well-recognized. Besides the Government and international donors, other stakeholders such as the private sector and civil society have a critical role to play in helping countries achieve the SDGs. Lesotho plans to explore opportunities for strengthening such partnerships to achieve the Post-2015 Development Agenda.

ENVIRONMENTAL CHALLENGES

Land degradation is one of the major environmental challenges confronting Lesotho. Fragile soils, degraded rangelands and climate variability have far-reaching impact and affect the livelihood and incomes of the vulnerable and the poor. Environmental degradation thus exacerbates extreme poverty and hunger as a major portion of the country's population (around 77 %) reside in rural areas and depend on subsistence farming for their livelihoods. In addressing its environmental health, Lesotho will be contributing to the alleviation of widespread poverty among its people.

TECHNOLOGY TRANSFER

The importance of North-South, South-South and other forms of international cooperation for help in realizing the Post-2015 Agenda is recognized. South-South cooperation in supporting transfer of knowledge and best practices to address development challenges is gaining ground. Lesotho can gain and contribute much from such initiatives.

Technology transfer is a particularly innovative and promising area. Investment is needed to enable countries like Lesotho to develop technologically so that it may benefit from and contribute to global technological developments. In so doing, Lesotho will diversify its economy and accelerate its economic growth.

ANNEXES

ANNEX 1: OFFICIAL LIST OF TARGETS AND INDICATORS

MDG 1: Eradicate Extreme Poverty and Hunger

Target 1A: 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

Target 1B: Achieve full and productive employment for all

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

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

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

GOAL 2: Achieve Universal 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

GOAL 3: Promote Gender Equality and Empower Women

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

Indicators

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

GOAL 4: Reduce Child Mortality

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

Indicators

4.1: Under-five mortality rate

4.2: Infant mortality rate

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

GOAL 5: Improve Maternal Mortality

Target 5.A: Reduce by 75% the maternal mortality ratio, between 1990 and 2015.

Indicators

5.1: Maternal mortality ratio (MMR)
5.2: Proportion of births attended by skilled health personnel

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

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

GOAL 6: Combat HIV and Aids Pandemic, TB, Malaria and Other Diseases

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

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

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

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

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

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

GOAL 7: Ensure Environmental Sustainability

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

Indicators
7.1: Proportion of households relying on biomass as primary fuel
7.2: Proportion of land area covered by forest
7.3: Number of endangered animal species
7.4: Proportion of land area protected
7.5: CO_2 emissions, total, per capita and per $1 GDP (PPP)

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

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

GOAL 8: Develop a Global Partnership for Development

Target 8A: 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

Target 8B: 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

Target 8C: Make new technologies available, especially information and communications

Indicators
8.6: Mobile subscribers per 100 people
8.7: Internet users per 100 people

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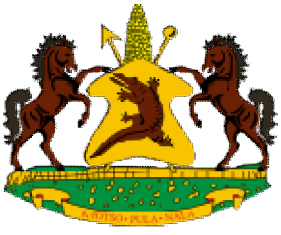

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