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# CHILD POVERTY IN LESOTHO:

## THE CHALLENGE AND POSSIBLE RESPONSES


# Introduction



Like many countries in Africa, Lesotho faces significant challenges related to persistent poverty and development. The most recent estimates indicate that 57 per cent of all households live below the national poverty line. There are also reasons to believe that children in Lesotho are disproportionally affected by occurring deprivations like malnutrition, HIV/AIDS, school dropout, under-five mortality and orphanhood.[1] With nearly half of Lesotho's inhabitants under the age of 18,[2] it is important to understand the complexity of child poverty in the country and to address child-specific vulnerabilities through appropriate policy actions.

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of all households live below the national poverty line.

This objective complements the global development agenda enshrined in Sustainable Development Goal (SDG) Target 1.2, which aims to halve the proportion of children, men and women living in poverty in all its dimensions by 2030. To support the government's efforts in this area, UNICEF Lesotho commissioned a study on child poverty, which employs UNICEF's Multiple Overlapping Deprivation Analysis (MODA) methodology,[3] and the 2014 Lesotho Demographic and Health Survey (LDHS) data. The 2014 LDHS provides the most recent nationally representative data to quantify child poverty and its multidimensional nature. This brief has been prepared based on the study findings.

Multidimensional child poverty is analysed using a set of dimensions that measure child well-being.[4] A child in Lesotho is defined as multidimensionally poor if she/he is deprived in at least three dimensions of well-being. To assess child poverty in relation to key developmental stages, the study divides children into four age groups: (i) 0–23 months; (ii) 24–59 months; (iii) 5–12 years; and (iv) 13–17 years.

The remainder of this policy note summarizes the key findings and policy recommendations from the MODA exercise.

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1 Government of the Kingdom of Lesotho. (2014). National Social Protection Strategy 2014/15–2018/19. Retrieved from Maseru, Lesotho http://www.social-protection.org/gimi/gess/ShowRessource.action?ressource.ressourceId=50699

2 *Lesotho Demographic and Health Survey (LDHS) 2014*. Retrieved from Maseru, Lesotho: https://dhsprogram.com/pubs/pdf/FR309/FR309.pdf

3 Neubourg, C. D., Chai, J., Milliano, M. d., & Plavgo, I. (2013). Step by step guidelines to the Multiple Overlapping Deprivation Analysis (MODA). *Innocenti Working Papers*. Retrieved from https://www.unicef-irc.org/publications/695/https://www.unicef-irc.org/publications/695/

4 The dimensions of well-being used to measure multidimensional poverty differ by age group. For children aged 0–23 months, the dimensions *nutrition, health, HIV/AIDS, protection, water, sanitation, housing* and *information* are used. For children aged 24–59 months, the dimensions *health, HIV/AIDS, protection, water, sanitation, housing* and *information* are used. For children aged 5–12 years, the dimensions *education, health, protection, water, sanitation, housing* and *information* are used. For children aged 13–17 years, the dimensions *education, health, protection, water, sanitation, housing* and *information* are used.

# Key findings

## The overall situation of child poverty

In Lesotho, 65.4 per cent of all children (aged 0–17 years) are multidimensionally poor, that is they are simultaneously deprived in three or more dimensions of well-being. In fact, 86 per cent of all children in the country are simultaneously deprived in two or more dimensions of well-being.

- Across age groups, between 84 per cent and 88 per cent of all children are deprived in the housing dimension.
- HIV/AIDS affects 74 per cent of children aged 0–23 months, and 63 per cent of children aged 24–59 months.
- Nutrition intakes are not adequate for 77 per cent of children aged 0–23 months.
- Child protection has higher deprivation rates for children aged 0–23 months and 24–59 months (79 per cent and 72 per cent, respectively) compared to children aged 5–12 years and 13–17 years (36 per cent and 42 per cent, respectively).
- Education is a vulnerability for 17 per cent of primary school children and for 62 per cent of secondary school children.
- Water deprivation rates range between 29 per cent and 32 per cent among children of the four age groups.
- The sanitation deprivation rate is 64 per cent for children aged 0–23 months. For children aged 2–17 years, the deprivation rate ranges between 48 per cent and 54 per cent.
- Between 7 per cent and 10 per cent of all children are deprived in the information dimension.

This poverty rate is the baseline figure for child poverty in Lesotho and allows for future monitoring and progress tracking. According to SDG Target 1.2, the proportion of multidimensionally poor children needs to be reduced by at least half to 33 per cent by 2030 (Figure 2). Over the next years, the progress towards this target should be monitored based on new survey data.

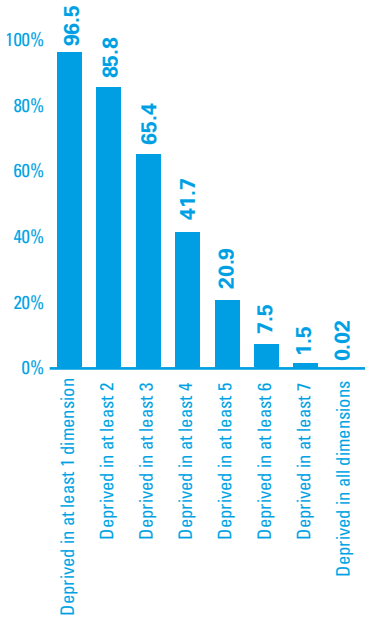



Figure 1: Percentage of children (0–17 years) deprived in various numbers of dimensions simultaneously

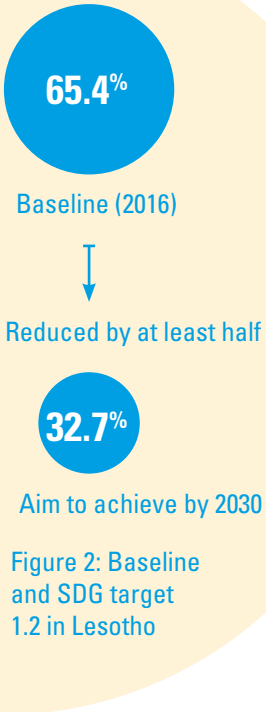



Figure 2: Baseline and SDG target 1.2 in Lesotho

## Specific characteristics of child poverty

When considering **urban–rural location**, multidimensional child poverty is significantly higher in rural than in urban areas (72 per cent and 43 per cent, respectively).

At the **regional** level, Maseru and Berea have the lowest proportion of multidimensionally poor children (56 per cent and 59 per cent, respectively) while Mokhotlong and Thaba-Tseka have the highest poverty rates among children (85 per cent and 84 per cent, respectively) (Figure 3). The proportion of multidimensionally poor children is also higher in **mountain locations** compared to **lowlands** (82 per cent and 53 per cent, respectively).

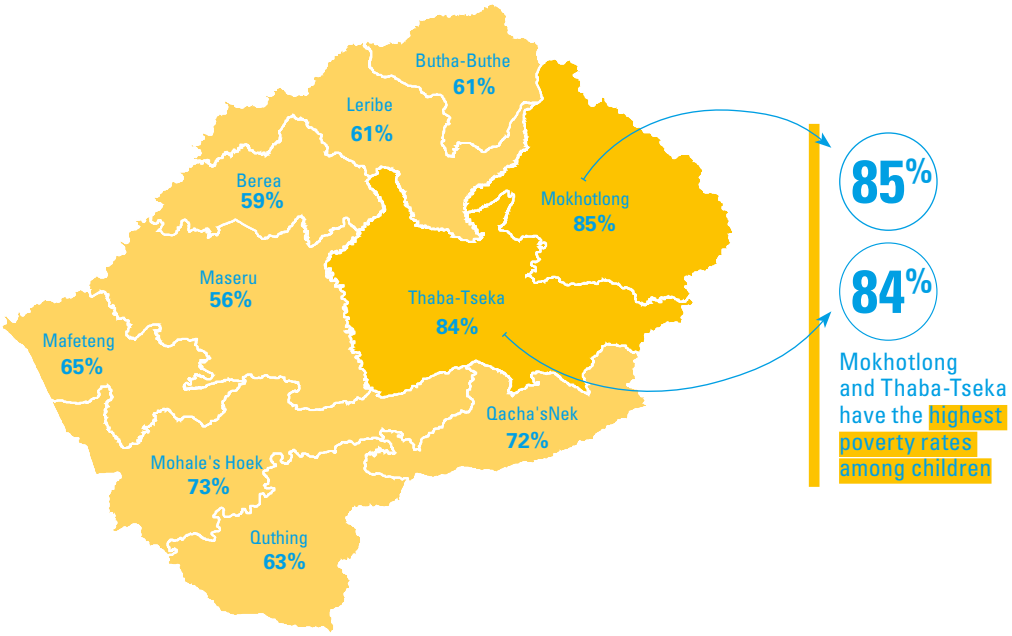



Figure 3: Multidimensional poverty amongst children by region

Differences in child poverty based on **gender** are relatively small. Specifically, 67 per cent of boys and 64 per cent of girls are multidimensionally poor. For older children, however, the gender disparities are more visible, particularly in the education dimension where 72 per cent of boys aged 13–17 are out of school or lag behind in education compared to 50 per cent of girls in the same age group.

One of the main drivers of multidimensional child poverty is the **education level of parents**. For instance, the multidimensional poverty rate among children living in a household whose head has secondary education or more stands at 42 per cent compared to 80 per cent when the household head has no education. Similarly, when mothers have achieved at least a secondary education, multidimensional child poverty is lower than when mothers have no education (77 per cent versus 94 per cent, respectively).

One of the main drivers of multidimensional child poverty is the **education level of parents**.

**Orphanhood** is another condition that enhances multidimensional child poverty in Lesotho, although only minimally. Specifically, children whose parents are deceased have a slightly higher poverty rate than children living with both parents (70 per cent and 65 per cent, respectively). Notably, children that have a deceased mother are less multidimensionally poor than those that have a deceased father (61 per cent versus 69 per cent, respectively).

Perhaps two of the biggest predictors of child poverty are **early pregnancy** in girls or **marriage before the age of 18** of girls. More than 90 per cent of girls who get pregnant before the age of 18 are multidimensionally poor compared to less than 70 per cent for those who do not. At the same time, nearly all girls (95 per cent) who entered a marital union before the age of 18 are multidimensionally poor.

## A comparison of multidimensional and monetary child poverty

Children who are multidimensionally deprived are not always monetarily poor and vice versa. It is, therefore, important to distinguish between these different types of poverty when assessing the vulnerability of children.

To measure monetary poverty, the analysis constructed a wealth index consisting of 33 household assets, which classifies households into five wealth quintiles. Children living in households belonging to the two lowest wealth quintiles are considered monetarily poor. Multidimensional poverty remains consistent with the earlier analysis: a child is poor if she/he is simultaneously deprived in three or more dimensions of well-being.

Several key findings emerge when looking at the overlap between monetary and multidimensional poverty among Basotho children aged 0–17 years (Figure 4). First, 31 per cent of children experience multidimensional but not monetary poverty. Second, 8 per cent of children experience monetary but not multidimensional poverty. Third, just over one third of children are considered poor in both monetary and multidimensional terms. And fourth, around one in four children is not affected by either type of poverty. This evidence implies that a large proportion of Basotho children are vulnerable in different dimensions of well-being despite the availability of assets or monetary resources.

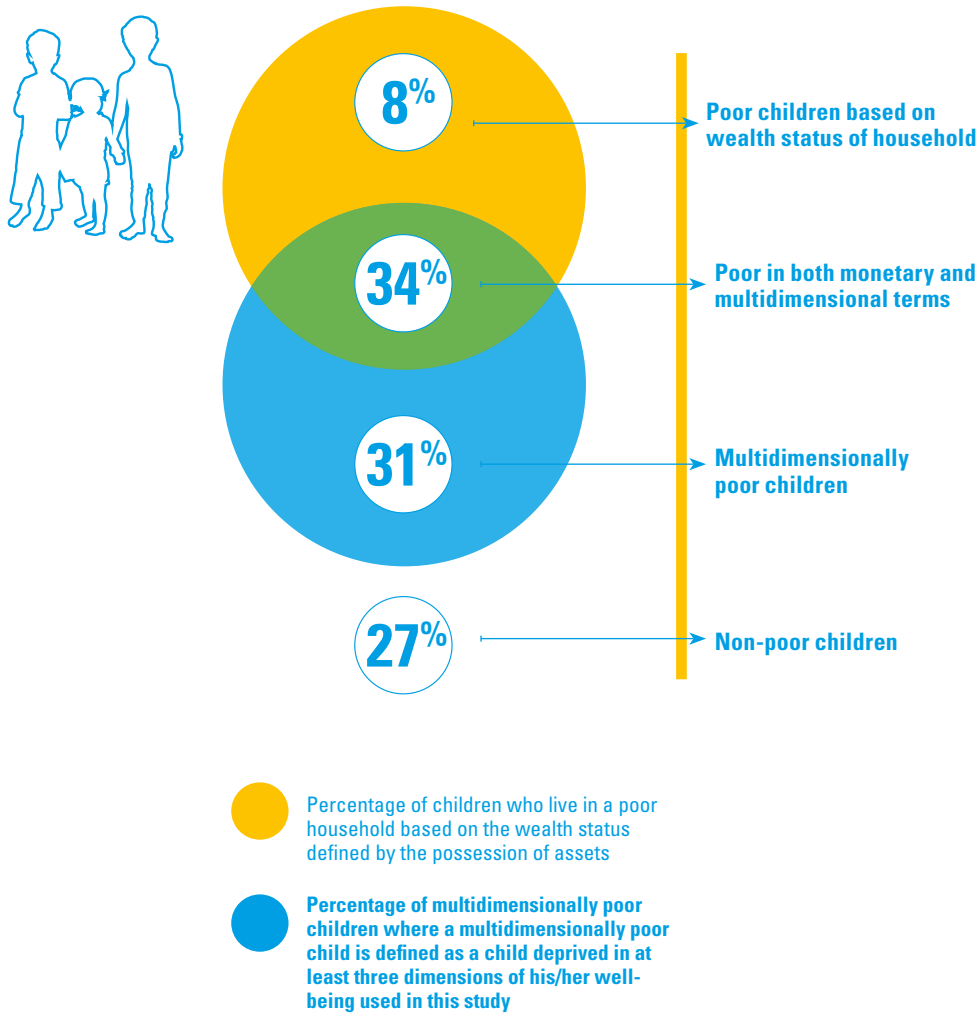
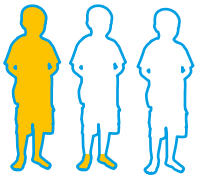



Figure 4: Overlap between monetary poverty and multidimensional poverty, children 0–17 years



Just over one third of children are considered **poor in both monetary and multidimensional terms**

**31%**

of children are multidimensionally poor but not monetarily poor.

# Recommendations

Monetary and material deprivations have wide implications for children. In addition to hindering physical and emotional development, past and ongoing deprivations affect children as they transition into adulthood and increase the likelihood that vulnerabilities are perpetuated across generations. Efforts to reduce child poverty in Lesotho will therefore ensure that child well-being is improved in line with national and international agendas for sustainable and equitable development.

To more effectively alleviate the multidimensional components of child poverty in Lesotho, the government needs to strengthen multi-sectoral responses and better target the most vulnerable children. In practise, this means simultaneously addressing the sector-based policy recommendations to the fullest possible extent. A number of actions should be adopted in sectors that affect the well-being of children. These are discussed below.

## Housing

- Enhance existing housing conditions;
- Provide subsidies to purchase generators or solar panels for electricity that target households with children, especially in rural areas and remote locations; and
- Provide alternatives to solid cooking fuels and advise households to practise cooking outside the house to minimize smoke inhalation among children and the ill health impacts.

## Nutrition

- Carry out communication campaigns that inform families on appropriate nutrition practices, food diversity and meal frequency;
- Strengthen food subsidies and micronutrient supplementation to ensure adequate nutrient intake for children in their first 1,000 days of life;
- Ensure that all mothers and caregivers, including those living with HIV/AIDS, are aware of the long-term benefits of exclusive breastfeeding of children;
- Advocate for the enactment of maternity protection laws that allow flexible working hours for mothers and paid maternal leave in all sectors; and
- Lobby for the enactment of the legal code of marketing breastmilk substitutes for breastfeeding protection.

## Health

- Enforce age-appropriate vaccinations in all settings following national procedures and standards;
- Put in place quality of care systems that prevent maternal and child morbidity and mortality, including the provision of free maternal health services by skilled providers at all levels;
- Establish communication emergency reporting mechanisms at all levels of service delivery;
- Expand health management information systems so that they capture age- and sex-disaggregated data to help inform more effective policies, programming and services; and
- Decentralize health services to better reach populations, especially in rural and remote locations.

## HIV/AIDS

- Ensure quality adolescent friendly health services including sexual reproductive health and HIV services;
- Improve links between health facilities and communities to save lives and increase the use of all reproductive, maternal, newborn and child health (RMNCH) services, including HIV through community mobilization;
- Generate age- and sex-disaggregated data to inform effective policies, programming and service delivery; and
- Ensure progressive increases in budget allocations to HIV prevention activities to reach 25 per cent of total budget allocations to HIV/AIDS by fiscal year 2020/21, in line with the 2016 Political Declaration on HIV/AIDS and the 2018/19–2022/23 National Strategic Plan for HIV.

## Child protection

- Put in place a policy framework to address child protection abuses, including enacting the "End Child Marriage law" and updating the 2011 Children's Protection and Welfare Act;
- Strengthen the child protection system, including updating the information management system and carrying out evidence-generation activities to increase public investments;
- Ensure that birth registration services are provided in all public health facilities, and introduce remote options for births that take place outside of the health system;
- Scale up community sensitization campaigns and support on violence against children, child birth registration and child marriage;
- Strengthen the capacity of law enforcement officials to implement child-friendly justice services'; and
- Organize sensitivity campaigns that target domestic violence in order to inform parents on the negative impacts on children's well-being.

## Education

- Provide secondary education services to all children, including by making it compulsory, removing all formal and informal fees, and constructing more schools and boarding units, especially in remote areas;
- Address gender disparities in education by improving monitoring and programming and ensuring that boys complete primary education and continue on to secondary education; and
- Adopt appropriate measures so that boy herders have access to alternative pathways to education and that the most disadvantaged children, including orphans and children with disabilities, receive education subsidies.

## Water

- Invest in infrastructure and facilities to collect and deliver improved water sources to deprived communities, particularly in remote areas; and
- Invest and promote WASH education and appropriate practices at all levels of service delivery, including schools.

## Sanitation

- Update the way that sanitation subsidies are assigned, including improved targeting of the poorest households;
- Increase annual budget for sanitation facilities, including latrines; and
- Explore innovative community-led sanitation initiatives to speed up the process toward achieving open defecation free status.

## Social protection

- Expand child-sensitive social protection programmes to cover all vulnerable children. For instance, child grant programmes only cover around a third of multidimensionally poor children;
- Integrate and harmonize social protection programmes to improve spending efficiencies and the coverage of multidimensionally poor children. This process can begin even as the National Information System for Social Assistance (NISSA) is being expanded;
- Include a life-cycle approach when strengthening multi-sectoral coordination. This is fundamental to address the multiple and compounding risks and vulnerabilities that children face at different stages of their development; and
- While assisting the most vulnerable with social protection services or the short term, aim to make services accessible to all children in the country by 2023.

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