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CHILD POVERTY IN LESOTHO:

UNDERSTANDING THE EXTENT OF MULTIPLE OVERLAPPING DEPRIVATION

2018

Acknowledgements

About 38 per cent of the population of Lesotho are children. They hold the key to the development of the country. Therefore, it is of utmost importance to ensure they grow to their fullest potential to be productive citizens of the country. As about half of the population of Lesotho live below the national poverty line there are reasons to believe that children are disproportionally affected by poverty and deprivation. UNICEF Lesotho, therefore, together with the Ministry of Development Planning (Bureau of Statistics), produced this child poverty study to establish a baseline for monitoring the progress towards achieving the SDG target related to child poverty, and to prepare the relevant policy recommendations that aim at achieving this target by 2030.

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Understanding the extent of multiple overlapping deprivation

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Contents

Figures

Tables

Acronyms and abbreviations

LDHS	Lesotho Demographic and Health Survey 2014
MDG	Millennium Development Goal
MODA	Multiple Overlapping Deprivation Analysis
MOH	Lesotho Ministry of Health
N-MODA	National Multiple Overlapping Deprivation Analysis
PHC	2006 Lesotho Population and Housing Census
SDG	Sustainable Development Goal
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Purpose and aim

Like many countries in Africa, Lesotho faces significant challenges related to persistent poverty and hindered development. Indeed, 57 per cent of all households live below the national poverty line (Government of the Kingdom of Lesotho, 2014) and there are reasons to believe that children are disproportionally affected by deprivations such as malnutrition, HIV/AIDS, school dropout, under-five mortality and orphanhood (MOH and ICF International, 2016). There is an acute need to assess the current situation of children in order to establish the empirical threshold for measuring and monitoring progress towards achieving Sustainable Development Goal (SDG) Target 1.2,[1] and to prepare policy recommendations that aim at achieving this target by 2030.

Lesotho has a relatively young population with nearly half of all inhabitants under the age of 18 (MOH and ICF International, 2016). This study builds on the indication that understanding the complexity of child poverty and children's deprivation is essential to addressing the needs of children through suitable programmes and policies. Therefore, this study aims to analyse the extent and characteristics of child deprivations and the profiles of children suffering from deprivation in Lesotho, and to inform equity-based policy responses to meet SDG Target 1.2.

Approach

This study measures child poverty using UNICEF's Multiple Overlapping Deprivation Analysis (MODA) methodology (Neubourg et al., 2013b). This methodology was explicitly designed to holistically explore and quantify children's vulnerabilities to help identify the multidimensional nature of these and to support the identification of interventions that more suitably meet the needs of children. Understanding the complexities of child poverty is key to developing policy responses that ensure maximum impact on child development and well-being.

The multidimensional child poverty analysis in Lesotho employs empirical evidence from the 2014 Lesotho Demographic and Health Survey (LDHS).

To better capture children's deprivation in relation to their developmental stage, the analysis splits children into four age groups: 0–23 months, 24–59 months, 5–12 years and 13–17 years.

Lesotho has a relatively young population with **nearly half of all inhabitants under the age of 18.**

1 Target 1.2 of SDG 1 states that "By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions". In this study, the focus is only on children.

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.**

Key findings

Child poverty by dimensions of well-being

The selected dimensions, indicators and thresholds for each age group are presented in Annex 1 of this report. The key findings for each dimension of child well-being are as follows:

- Across age groups, between 84 per cent and 88 per cent of all children are deprived with respect to **housing**.
- **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 schoolchildren and 62 per cent of secondary schoolchildren.
- **Water** deprivation rates range between 29 per cent and 32 per cent among children of the four age groups.
- **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 with respect to **information**.

Child poverty is multidimensional

In Lesotho, the deprivation of children is not unidimensional. In fact, 86 per cent of all children in the country are simultaneously deprived in two or more dimensions of well-being. This MODA analysis considers the national context of Lesotho and defines multidimensional poverty when a child is simultaneously deprived in three or more dimensions of well-being.

This report sets 65.4 per cent of all children as the baseline rate of child poverty in Lesotho to allow for future monitoring and progress tracking. According to SDG Target 1.2, this proportion of multidimensionally poor children needs to be reduced by at least half, to 32.7 per cent, by 2030.

Profiling multidimensional child poverty

- Multidimensional child poverty is significantly higher in **rural areas** compared to **urban areas** (72 per cent and 43 per cent, respectively).
- At the **regional** level, Maseru has the lowest proportion of multidimensionally poor children (56 per cent), while and Thaba-Tseka have the highest multidimensional poverty rates among children (85 per cent and 84 per cent, respectively).
- The proportion of multidimensionally poor children is higher in **mountain** locations compared to lowlands (82 per cent and 53 per cent, respectively).
- Differences in child deprivation based on **gender** are relatively small for younger children. For older children, however, the gender disparities are more visible, particularly with respect to education, which affects 72 per cent of boys aged 13–17 compared to 50 per cent of girls in the same age group.
- The multidimensional child poverty rate is lower when the **household head has secondary education** compared to when the household head has no education (42 per cent and 80 per cent, respectively).
- **Orphanhood** is a condition that increases multidimensional child poverty, although by a small margin.
- Girls experiencing an **early pregnancy** are more multidimensionally poor compared to girls who have not been pregnant (92 per cent and 69 per cent, respectively).
- Girls who entered a **marital union** are more multidimensionally poor compared to girls who were not married (95 per cent and 69 per cent, respectively).

Overlap between monetary and multidimensional poverty

The study includes an analysis of the overlap between monetary and multidimensional poverty. Monetary poverty is measured by a Wealth Index based on 33 household assets. The key findings are: (1) 31 per cent of children are multidimensionally poor, but not monetarily poor; (2) 8 per cent of children are monetarily poor, but not multidimensionally poor; (3) 34 per cent of children are both monetarily and multidimensionally poor; and (4) 27 per cent of children are neither monetarily nor multidimensionally poor. This implies that vulnerabilities can still exist despite the availability of assets or monetary resources.

31 per cent

of children are multidimensionally poor but not monetarily poor.

Policy initiatives to reduce child vulnerability

To alleviate multidimensional child poverty, it is necessary to integrate responses from many sectors and involve different government agencies to better target multidimensionally poor children.

This study helps to identify the characteristics of the most vulnerable children in Lesotho. Focusing on the poorest children who suffer from three or more deprivations at one time is key when the national budget is restricted.

Policy actions that target vulnerable segments of the population, as per the profiling characteristics, would do well in alleviating child poverty.

In the longer term, it is important to provide safety nets for all children through social protection programmes in the areas of well-being identified in this study.

Introduction

Lesotho is a small landlocked country entirely surrounded by South Africa. It is classified as a low-human-development country and ranks 161st of 188 countries in the most recent classification of the Human Development Index (UNDP, 2016). Like many countries in sub-Saharan Africa, Lesotho faces significant challenges related to persistent poverty, poor outcomes and hindered development.

Specifically, in 2010 an estimated 57 per cent of households lived below the national poverty line of US$1.08 per day, and an estimated 34 per cent lived below the national food poverty line of US$0.61 per day (Government of the Kingdom of Lesotho, 2014). Life expectancy at birth was 50 years, and the Gini coefficient 54.2 in 2016 indicates a high level of income inequality in the country (UNDP, 2016). Furthermore, more than one in four individuals aged 15–49 years in Lesotho are carriers of HIV, and women and adolescent girls are disproportionately affected (UNICEF, 2016).

Lesotho has a young population with nearly half of all inhabitants under the age of 18 (MOH and ICF International, 2016). These children are at the forefront of vulnerability. Malnutrition is high with 33 per cent of children stunted and 11 per cent severely stunted, while more than half of Basotho children are anaemic (MOH and ICF International, 2016). Furthermore, between 2009 and 2014 the under-five mortality rate dropped from 117 to 85 per 1,000 live births, and birth registration slightly decreased from 49 per cent (2009) to 43 per cent (2014) of births (UNICEF, 2012; MOH and ICF International, 2016). The orphanhood rate among children aged 5–17 hits a staggering 48 per cent, and only 51 per cent of girls and 35 per cent of boys aged 13–17 attend secondary school (MOH and ICF International, 2016).

These profiles suggest complex patterns of vulnerability and it is likely that Basotho children experience several deprivations at a time. Deprivation is more than the lack of income or resources to sustain livelihood. It also comprises malnutrition; limited access to education, health and other basic facilities; discrimination; and violence and lack of protection. The analysis of child poverty must be inclusive of all vulnerability aspects to ensure sustainable policy are targeted and provided.

The Basotho children represent a vulnerable population that deserves special attention. The characteristics of child deprivation and the complexity of child vulnerability in Lesotho have not been empirically examined in detail. In January 2016, the Sustainable Development Goals (SDGs) came into effect to focus on strategic areas of development and to provide support for policymaking in achieving national development plans and policies. One strategic area of development is the alleviation of child poverty, which is reflected in SDG1, Target 1.2, aimed at reducing at least by half, by 2030, the proportion of children, men, and women living in poverty in all its dimensions according to national definitions.

Malnutrition is high with **33 per cent** of children stunted and 11 per cent severely stunted.

Assessing the situation of children supports the agenda of the Government of the Kingdom of Lesotho. The government ratified the Convention on the Rights of the Child in 1992 and has been successful in incorporating the provisions of the Convention in national legislation through initiatives such as the Children's Protection and Welfare Act of 2011. A national policy on orphans and vulnerable children was also installed by the Ministry of Health and Social Welfare, and the government also committed itself to scaling up the national response to HIV and AIDS and its impact on children. Other achievements include the National Multisectoral Child Protection Strategy 2014/5–2018/9 following the completion of the child protection mapping and systems assessment, and the costed plan for implementation; the National Policy and Strategic Plan for Integrated Early Childhood Care and Development, and the start-up of institutional arrangements to facilitate its implementation; and the development of a sector-wide approach to education in partnership with the World Bank through the Global Partnership for Education (UNICEF, 2014).

There is a stringent need to assess the current situation of children in Lesotho.

Yet, the operationalization of these development initiatives constitutes a major challenge. There is an urgent need to assess the current situation of children in Lesotho in order to establish the empirical threshold for measuring and monitoring the progress towards achieving the SDG 1, Target 1.2, and to prepare the relevant policy recommendations that aim at achieving this target by 2030.

This study builds on the assumption that understanding the complexity of child poverty and children's deprivation is essential to addressing the needs of children through suitable programmes and policies. Therefore, this report aims to analyse the extent and characteristics of children's deprivations and the profiles of the children suffering from deprivation in Lesotho, and to inform equity-based policy responses.

The complexity of child poverty in Lesotho is analysed through UNICEF's Multiple Overlapping Deprivation Analysis (MODA) methodology (Neubourg et al., 2013a, 2013b). This methodology was explicitly designed to holistically approach and quantify children's poverty to help identify its multidimensional nature and to support the identification of interventions that more accurately meet the needs of children. Specifically, MODA identifies the type, level and overlaps of deprivations in the areas of nutrition, HIV/AIDS, health, housing, protection against violence, sanitation, water, education, information, and registration. In addition, MODA uses profiling variables to describe the characteristics of the most vulnerable children in Lesotho.

In addition, a Wealth Index is used to map wealth among children living in households in Lesotho as a profiling indicator and to measure the overlap between monetary poverty and multidimensional deprivation in the country. The analysis is based on data from the 2014 Lesotho Demographic and Health Survey (MOH and ICF International, 2016). To improve the capture of children's deprivation in relation to their developmental stage, the analysis splits children into four age groups: 0–23 months, 24–59 months, 5–12 years, and 13–17 years.

A section detailing the methodology of this study is presented next. A section presenting the results follows that. Conclusions and policy recommendations sum up the report.

Methodology

2.1 Multiple Overlapping Deprivation Analysis

This study uses UNICEF's MODA to measure multidimensional poverty among children aged 0–17 years. Understanding the complexity of child poverty is key to developing policy responses that ensure maximum impact on child development and well-being. Analyses on poverty, including child poverty, often focus on monetary wealth, using household income or expenditures as measures to assess relative or absolute poverty status of household members. While income is an important aspect of a child's welfare, evidence shows that not all monetarily poor children are deprived in other dimensions of well-being (e.g. health, education, protection, etc.), and that not all children who are deprived in a specific dimension of well-being are necessarily also monetarily poor. In other words, it is expected that the overlap between monetary and other forms of child deprivation may not always be consistent with each other. This is simply because the availability of financial resources in the household might not directly translate into improvements for children because children are not the decision-makers and they have specific needs that require investments different from those of adults.

The MODA methodology complements traditional income-based measures of poverty, such as UNICEF's Global Study on Child Poverty and Disparities (as described by Gordon et al., 2003) and the Oxford Poverty and Human Development Initiative's Multidimensional Poverty Index (Alkire and Foster, 2011), and adopts a holistic definition of child well-being by concentrating on the access of children to various goods and services that are crucial for their long-term development. The approach to MODA recognizes that child vulnerability is multifaceted, and that multiple overlapping deprivations are interrelated and context specific and likely to occur with greater adversity among certain socio-economically disadvantaged groups.

The MODA methodology adds innovation to existing approaches by concentrating on the following five key elements.

Firstly, MODA brings in the **child as the unit of analysis**, rather than the household, since children may have different needs and often experience poverty differently to the needs and experiences of adults. In doing so, MODA relies to a greater extent on individual-level data so that children can be identified and analysed individually, including those living in the same household. As a result, differences between genders, ages and access to resources can be observed and thoroughly documented.

Secondly, MODA adopts a **life-cycle approach**, following the theoretical and empirical evidence that children of different ages have different needs and developmental paths. In doing so, the analysis selects dimensions and indicators that specifically target the needs of children depending on their developmental stage – early childhood, primary childhood or adolescence.

The approach to MODA recognizes that child vulnerability is multifaceted, and that multiple overlapping deprivations are interrelated.

Thirdly, MODA includes the **prevalence and the depth of child deprivation** by looking at the number of deprivations that a child experiences simultaneously. It thus reveals the most vulnerable children and broadens the scope of targeting child poverty and policy response. Children often experience more than one deprivation at a time and it is important that different policy sectors have evidence-based recommendations that will help them work together in addressing children's needs.

Fourthly, MODA also measures **monetary and material deprivations** for each child. In Lesotho, the analysis includes an asset-based Wealth Index as a proxy for monetary poverty, revealing those children who are deprived in the availability of wealth and the overlap between monetary poverty and multidimensional deprivations.

Fifthly, the child-oriented MODA includes an **equity focus**, which generates profiles of poverty in terms of geographical and socio-economic characteristics, allowing one to concentrate on the most vulnerable children in the society. The profiling of child deprivation enriches sector-based approaches for effective policy design and interventions.

The total number of sampled households was **9,942.**

The step-by-step MODA methodology is described in UNICEF working papers (Neubourg et al., 2013a, 2013b) and has been applied in measuring child deprivation in various countries across the world. In Lesotho, the analysis employs the National MODA (N-MODA) approach, in which the application of the MODA methodology is designed to match the specific national context. It includes the customized use of datasets, age groups, dimensions, indicators and thresholds in agreement with relevant policy stakeholders in the country. The analysis therefore reflects the specificity of child deprivation in Lesotho.

2.2 Data and sample

This study assesses children's multidimensional poverty by using the Lesotho Demographic and Health Survey of 2014 (LDHS; MOH and ICF International, 2016). These data provide the most recent large-scale empirical evidence for Lesotho and has a variety of rich indicators pertaining to children and their vulnerabilities. The survey was carried out by the Lesotho Ministry of Health (MOH) with technical assistance from the Demographic and Health Surveys Program, and from other local and international stakeholders. Data were collected between 22 September and 7 December 2014 on a national representative sample. The 2014 survey follows the previous surveys in the country in 2004 and 2009. The aim of the LDHS is to provide up-to-date estimates of the country's demographic, health and other socio-economic indicators.

The sampling strategy of the LDHS followed that of the 2006 Lesotho Population and Housing Census (PHC) provided by the Lesotho Bureau of Statistics, which employs a two-stage nationally representative sampling design that accounts for the inclusion of sampling units in urban and rural areas, and each of Lesotho's 10 districts. The first stage selected 400 cluster units within the selected sample points delineated by the 2006 PHC, while the second stage involved the random sampling of households from available cluster units' lists. Weighted factors were added to the collected data to account for variations in the sampling design so that results can be representative at the national level. The total number of sampled households was 9,942.

In all households, women aged 15–49 years who were permanent residents or visitors who had stayed in the household the night before the survey were eligible to be interviewed. The same procedure was applied to all men aged 15–59 years, but only in half of the sampled households. This implies that males in the LDHS (aged 15 and above) are under-sampled, which should be kept in mind when reading through the results here. In all households, with the parent's or guardian's consent, information about children was collected. Of all the households surveyed, 6,511 (65 per cent) had at least one child aged 0–17 years. The total number of children in these households is 15,504.

The questionnaires were administered using personal digital assistants and the information was remotely transferred via electronic devices from interviewers to fieldwork supervisors. The household head was asked to provide information for the Household Questionnaire. All eligible men (aged 15–59 years) and women (aged 15–49 years) were asked to provide

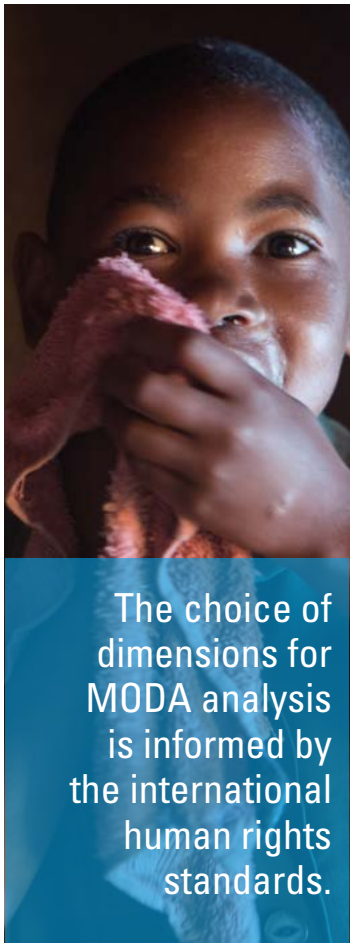
information for the Man's Questionnaire and the Woman's Questionnaire, respectively. The parent(s) or the legal guardian(s) of the children were asked to provide information about children aged 0–14 years. Adults thus reported on younger children, while girls and boys aged 15–17 years filled in the questionnaire themselves. This difference in interviewees for younger and older children might affect the results as recent studies reveal that children and adults are likely to report differently on a child's outcome (Cebotari, Siegel and Mazzucato, 2016).

2.3 Dimensions, indicators and age groups

Following the child-centred approach of MODA and considering the heterogeneity of children's needs according to their age, the analysis of multiple and overlapping deprivation is based on indicators, dimensions, thresholds and age groups based on data-driven feasibility assessments, discourse with national partners, and following the definition of international child-rights standards.

The choice of dimensions for MODA analysis is informed by the international human rights standards. Specifically, the 1989 Convention on the Rights of the Child and the 2016 SDGs emphasize a core set of dimensions that are essential for the well-being of children and their development, worldwide. These include, among others, food, safe drinking water, sanitation facilities, health, shelter, education, protection and access to information.

For this report, the final choice of dimensions was driven by the availability of measurable indicators in the LDHS. A working group, composed of experts from UNICEF Lesotho country office, Ministry of Education, Ministry of Police, Ministry of Health, Ministry of Social Development, Lesotho Bureau of Statistics, Ministry of Labour and Employment, the Economic Policy Research Institute and the Social Policy Research Institute discussed the option of dimensions and indicators during a workshop organized in August 2016. This meeting aimed at contextualizing child poverty in the national realm of Lesotho, with stakeholders having an active role in discussing and advising on age groups and on most relevant dimensions, indicators and thresholds to measure monetary and multidimensional poverty in the country. The final selection of these outputs reflects the common agreement of involved stakeholders in line with data availability. The selected dimensions for each age group are presented in Table 1 below.



The choice of dimensions for MODA analysis is informed by the international human rights standards.

Table 1: Dimensions for each age group for the MODA using the LDHS

0–23 months	24–59 months	5–12 years	13–17 years
Health	Health	Education	Education
HIV/AIDS	HIV/AIDS	Health	Health
Housing	Housing	Housing	Housing
Information	Information	Information	Information
Nutrition	Protection	Protection	Protection
Protection	Sanitation	Sanitation	Sanitation
Sanitation	Water	Water	Water
Water	–	–	–

Source: Authors' own compilation based on LDHS.

The analysis includes four age groups (0–23 months, 24–59 months, 5–12 years and 13–17 years). The choice of the age groups is based on a life-cycle approach, which is embedded in the MODA methodology and based on the rationale that children in different stages of their childhood have different needs. For this reason, different indicators are used to capture children's well-being at different ages. Education, for example, includes children who are 5 years or older, while birth registration applies chiefly to children in their first years of life. Some other dimensions of well-being, such as health, sanitation, water, housing and information,

cut across all age groups. The age group is defined in such a way that it identifies the most relevant dimensions for children of a certain age. In the context of Lesotho, the school cycle was also accounted for when clustering children. Specifically, children of primary-school age (5–12 years) were grouped together and children of secondary-school age (13–17 years) were put in the same category to better target policy recommendations that aim at children's educational needs.

The selection of age groups was also based on the availability of data. For consistency, all indicators that are selected for a specific age group must cover the whole population of children in that age group. This is important when measuring multiple deprivations, as each child in the age group must be identified as deprived or not deprived in all dimensions of well-being. When data are not available for all children of a certain age group, there is a high proportion of missing observations, which distort the results. For this reason, the decision was taken to divide children under the age of 5 years into two categories – children aged 0–23 months and children aged 24–59 months – because data on meal frequency and meal diversity were only collected for children aged 0–23 months. Due to data limitations, the dimension HIV/AIDS is included only for children under 5 years old.[2]

The rate of monetary poverty in Lesotho is high, measured at **57 per cent** in 2010.

There are three types of indicators included across dimensions and age groups. The first type comprises information related directly to the child, i.e. nutrition, health (vaccinations), registration, education and sanitation (disposal of child's faeces). The second type of indicators comprises those based on household-level information, i.e. health (distance to health facility), water, sanitation, housing and information. Finally, the third type of indicators relies on information reflecting adult perceptions and knowledge, i.e. health (knowledge of tuberculosis), HIV/AIDS and protection against violence. Because of data constraints, some dimensions and indicators do not provide the information for the whole population of children. All indicators used national insights to define the thresholds for inclusion in the dimension. Where meaningful, the thresholds for each indicator were defined according to international standards, mainly in line with definitions of the United Nations, UNICEF and the World Health Organization (WHO).

Table 2 presents the list of indicators for each dimension, and indicates in which age groups they were included. A detailed description of indicators and thresholds is included in Annex 1.

The rate of monetary poverty in Lesotho is high, measured at 57 per cent in 2010 (Government of the Kingdom of Lesotho, 2014). The LDHS does not provide reliable measurements of monetary income at the household or individual levels. Rather, data provide indicators of wealth, which can be used to proxy monetary poverty in the country. Thus, this report includes a Wealth Index. The Wealth Index sums up 33 assets measured at the household level on a continuous scale. Asset indicators that are part of the Wealth Index in Lesotho are presented in Table 3. The Wealth Index is used to map the wealth among children living in households in Lesotho, as a profiling indicator, and to measure the overlap between monetary poverty and multidimensional deprivation in the country.

2 Information on knowledge of HIV/AIDS was collected in the women's and men's questionnaires for women aged 15–49 years and men aged 15–59 years. Given that 24 per cent of children aged 5–12 years and 13 per cent of children aged 15–17 years live in a household where there is no eligible women and men for those questionnaires, the indicator "Knowledge on HIV/AIDS" could not be used for children aged 5 years and above because of the high prevalence of missing values.

Table 2: Selection of dimensions and indicators for each age group

Dimension	Indicator	Age group			
		0–23 months	24–59 months	5–12 years	13–17 years
Nutrition	Exclusive breastfeeding	✓ 0–5 months	✓	✓	✓
	Food frequency and diversity	✓ 6–23 months	✓	✓	✓
Health	Vaccinations	✓	✓	✓	✓
	Distance to health facility	✓	✓	✓	✓
	Knowledge on tuberculosis	✓	✓	✓	✓
HIV/AIDS	Mother's HIV testing and HIV counselling during antenatal care	✓	✓	✓	✓
	Mother's knowledge on HIV/AIDS	✓	✓	✓	✓
Protection	Birth registration	✓	✓	✓	✓
	Attitudes to domestic violence	✓	✓	✓	✓
Education	School attendance	✓	✓	✓ 6–17 years	✓ 6–17 years
	Grade-for-age	✓	✓	✓ 6–17 years	✓ 6–17 years
Water	Drinking water source	✓	✓	✓	✓
	Distance to drinking water source	✓	✓	✓	✓
Sanitation	Toilet type	✓	✓	✓	✓
	Shared toilet	✓	✓	✓	✓
	Disposal of youngest child's faeces	✓	✓	✓	✓
Housing	Overcrowding	✓	✓	✓	✓
	Electricity	✓	✓	✓	✓
	Cooking fuel	✓	✓	✓	✓
Information	Access to a radio or television	✓	✓	✓	✓

Source: Authors' own compilation based on LDHS.

Note: The aggregation of indicators for each dimension is based on MODA's union approach; i.e., a child is identified as deprived in the dimension if she/he is deprived in at least one of the indicators of that dimension. All indicators in the dimension have an equal weight, following the approach of the Convention on the Rights of the Child that assumes that children's needs are equally important for children's well-being and development. Similarly, each dimension is considered as being equally important for children because they each reflect a basic human right.

Table 3: Assets identified as indicators of wealth

Electricity	Cattle	Solar panel (only rural areas)
Radio	Cows/bulls	Bed/mattress
Television	Horses/donkeys/mules	Computer
Refrigerator	Goats	Internet access
Bicycle	Sheep	Floor
Car/truck	Chickens	Roof
Telephone (land line)	Bulls	Walls
Mobile phone	Cows	–
Watch	Improved chickens	–
Animal-drawn cart (only rural areas)	Ordinary pigs/Improved pigs	–
Owns land used for agriculture (hectares)	Battery or generator	–

Source: Authors' own compilation based on LDHS.

This analytical step reveals the extent to which children live at the intersection between monetary and multidimensional poverty.

2.4 Analytical approach

The analysis was conducted in five steps, as follows:

1. The **single deprivation** (sector-specific) analysis is carried out for children in each age group. This analysis presents the proportion of children deprived in each indicator and in each dimension. It gives a first perspective on how child deprivation unfolds in Lesotho and which deprivations drive child vulnerability across the four age groups. Additionally, it enables to profile the children deprived in the dimensions of well-being used in the study based on their characteristics, including child gender and the Wealth Index.
2. A **deprivation count** is then performed, reflecting the distribution of the number of dimensions in which children are deprived. The deprivation count is important as it mirrors the depth of multidimensional deprivation among children of different ages in Lesotho. The deprivation count is also conducted in relation to the profiling variables, i.e. child gender, orphanhood and the country's geographical regions.
3. The **multidimensional deprivation overlap** is then analysed by looking at the different deprivations that are experienced simultaneously by children of specific age groups. Depending on the age group, combinations of deprivations are observed ranging from zero to nine deprivations (0–23 months), from zero to eight deprivations (24–59 months), and from zero to seven deprivations (5–12 years and 13–17 years).
4. Next, an analysis of **multiple deprivation indices** provides summary statistics for the following items:
   a) The *headcount ratio*, which looks at the incidence of multiple deprivation in various dimensions.
   b) The *average intensity*, which counts the number of deprivations that a deprived child has as a percentage of all measured deprivations.
   c) The *adjusted deprivation headcount*, which calculates both the incidence and the depth of deprivation.
5. Finally, an analysis of the **overlap between monetary poverty, measured through the Wealth Index, and the multidimensional deprivation** is carried out. This analytical step reveals the extent to which children live at the intersection between monetary and multidimensional poverty. This is important because the differences and the overlap between monetary and multidimensional deprivation may capture change, in that that households with higher living standards but lower wealth might be temporarily vulnerable and those with low living standards but high wealth might be rising out of poverty (Neubourg, et al., 2012). Nevertheless, income wealth and material deprivation reveal different types of relevant information for policymaking and the overlap approach provides a reliable instrument for revealing the core vulnerabilities among children.

Results and findings

This chapter presents the results of the study on multidimensional child poverty in Lesotho using the MODA methodology. The analysis employs the LDHS data. The presentation of results proceeds in two steps. Firstly, an overview is provided as to how the current study on child poverty in Lesotho is embedded in the rationale of SDG 1, Target 1.2. Secondly, the results of the MODA analyses are presented by different age groups (0–23 months, 24–59 months, 5–12 years and 13–17 years) as per the steps in the analysis: single deprivation (sector-specific) analysis, deprivation count, multidimensional deprivation overlap and the multiple deprivation indices.

3.1 Embedding the measurement of child poverty in SDG1, Target 1.2

The SDGs came into effect in 2016 as part of a new sustainable development agenda that aims at improving the lives of billions of people worldwide by the year of 2030. The SDGs build on the Millennium Development Goals (MDGs), which guided the development agenda worldwide between 2000 and 2015. The Kingdom of Lesotho's progress in achieving the developmental goals for children was below expectations. Specifically, a recent report by the Government of the Kingdom of Lesotho (2016), on the MDGs status and impact, found that although there has been some progress towards achieving several targets, none of the MDGs related to child well-being have been fully met.

The SDGs set up the new development agenda and aim to eradicate poverty, reduce inequalities and extend the benefits of sustainable economic development to all, particularly the poorest and most vulnerable populations, including children. There are 17 SDGs elaborated into 169 targets and 230 indicators. The first SDG aims at ending poverty in all its forms everywhere (Table 4). Particularly relevant for this study is Target 1.2 of SDG 1, which aims at reducing, at least by half, the proportion of men, women and children living in poverty in all its dimensions according to national definitions. There is therefore a need to empirically measure the baseline status of child poverty, in all its forms, to inform policy actions aiming at reducing child deprivation. The main objective of this study is to set the baseline figure for multidimensional poverty among Basotho children, which will allow for policy implementation and future monitoring of progress in achieving the development agenda for children as per SDG Target 1.2. In this study, children are defined as individuals aged 0–17 years.

Multidimensional child poverty in Lesotho was analysed within the framework of MODA, a methodological tool described in the previous chapter. Designed to account for the local context, child vulnerabilities, indicators and dimensions of well-being that best fit the context of Lesotho were selected. Following the methodological rationale, a child in Lesotho is defined

The SDGs set up the new development agenda and aim to eradicate poverty, reduce inequalities and extend the benefits of sustainable economic development to all.

as multidimensionally poor if she/he is deprived in at least three dimensions of well-being.

The baseline figure for multidimensional child poverty in the Kingdom of Lesotho is based on LDHS data (MOH and ICF International, 2016) and affects 65.4 per cent of all children aged 0–17 years in the country (Table 4). In line with SDG 1, Target 1.2, the aim is to progressively reduce this proportion of multidimensionally poor children by at least half (32.7 per cent) by 2030; the progress towards this target should be monitored over the next 13 years.

Table 4: Baseline and target poverty rates of children in Lesotho, in line with Target 1.2 of SDG 1

Description of target		By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
Description of baseline situation		The percentage of children of all ages living in poverty in all its dimensions according to national definitions
Poverty threshold		A child is defined as poor if she/he is deprived in at least three dimensions used to measure well-being (see Table 1 for list of dimensions used)
Poverty rate of children:	Baseline (2014)	65.4%
	Target (2030)	32.7%

Source: LDHS (MOH and ICF International, 2016).

The percentage of 65.4 per cent offers a general overview of multidimensional child poverty in the country. The next set of results disaggregates and presents data on child poverty for different age groups of children in order to determine the profile of multidimensionally poor children in Lesotho.

3.2 The profile of multidimensionally poor children (0–17 years) in Lesotho

In this chapter, the profile of the multidimensionally poor children will be analysed in order to identify the most vulnerable children in Lesotho. The aim is to know the characteristics of multidimensionally poor children in order to guide the design of policies and reduce targeting errors.

In Lesotho, the deprivation of children is not unidimensional. In fact, more than eight out of ten children in the country are simultaneously deprived in two or more dimensions of well-being (Figure 1). MODA considers the national context of Lesotho and defines multidimensional poverty when a child is simultaneously deprived in three or more dimensions of well-being.

Results of the rates of multidimensional poverty according to a number of profiling characteristics of the child follow below. These include geographical location; gender; education levels of household head, mother and/or father; household size; number of children in the household; orphanhood; early pregnancy; early marriage; and decision-making in the household.

3.2.1 Geographical location

There are notable disparities between deprivation rates based on geographical location.

Deprivation rates are significantly higher in rural areas compared to urban areas (72.3 per cent and 42.7 per cent, respectively) (Figure 2). The Multidimensional Child Poverty Index is also higher for children living in rural areas, implying that the overall rate, depth and intensity of deprivation is higher in rural areas. However, although percentages are low, the prevalence of deprivation in urban areas is inherent. At district level, Maseru has the lowest proportion of poor children (55.9 per cent) while Mokhotlong and Thaba-Tseka are the worst off with 84.7 per cent and 83.5 per cent of poor children, respectively. It was also found that there is higher percentage of poor children living in mountainous areas (82 per cent), and a relatively lower percentage living in the lowlands (52.7 per cent).

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

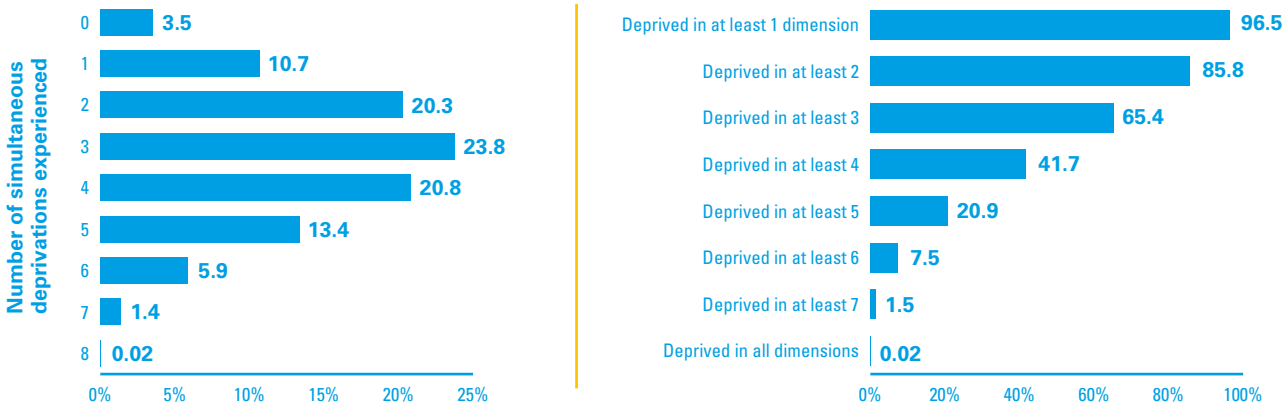


Figure 2: Rates of multidimensional child poverty by geographical location of children aged 0–17 years

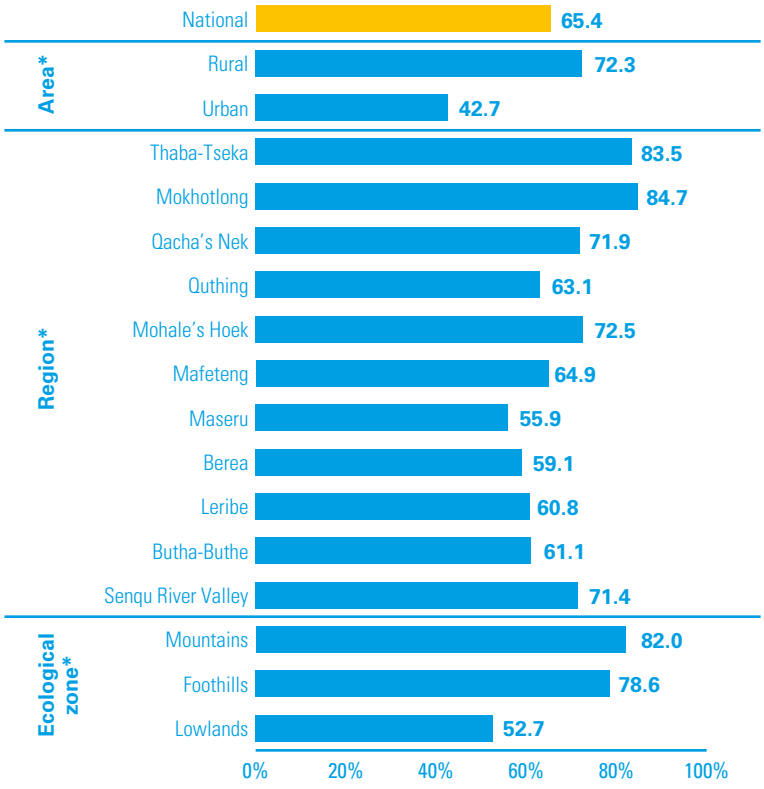
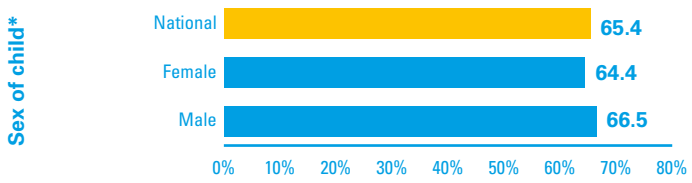


Figure 3: Multidimensional child poverty rates of boys and girls aged 0–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

3.2.2 Gender of the child

There are no large differences in multidimensional poverty for boys and girls below the age of 5, but gender disparities set in as children grow older, most notably in education.

Overall, 66.5 per cent of boys are multidimensionally poor compared to 64.4 per cent of girls (Figure 3). Further investigations (see next section) reveal that there is not much difference by gender for children under the age of 5. Boys and girls are almost equally poor at a very young age, but as they grow older, gender disparity sets in in the field of education. There is a significantly higher proportion of boys compared to girls who are deprived in the dimension of education (see results below for children aged 5–12 and 13–17 years). More attention should be given to boys, especially in ensuring that they complete primary education and continue with secondary education. Often, for boys, the opportunity cost of education in terms of child labour is very high and this might be the reason behind high dropout rates from school.

3.2.3 Education level of the household head, mother and/or father

The education level of the household head, the mother and/or the father matters when accounting for the multidimensional poverty of children.

The less educated the household head, the mother and/or the father, the higher the proportion of multidimensionally poor children (Figure 4). For example, the multidimensional poverty rate of children living in a household whose head has secondary or higher education is 42 per cent, compared to 80 per cent when the household head has no education. Similarly, when mothers have secondary or higher education, multidimensional child poverty is lower compared to those whose mothers have no education (77 per cent and 94 per cent, respectively). Promoting at least secondary education for everyone in Lesotho will contribute to breaking the intergenerational transmission of poverty.

In households with seven or more members the child poverty rate is as high as **70.9 per cent.**

3.2.4 Household size

Children living in households with more members have higher rates of multidimensional poverty.

In households with seven or more members the child poverty rate is as high as 70.9 per cent. In comparison, the multidimensional poverty rate of children living in households with 1–3 members is 58.6 per cent (Figure 5).

3.2.5 Number of children in the household

The higher the number of children in the household, the more multidimensionally deprived the children are.

Children living in households with five or more children have a multidimensional poverty rate of 77.4 per cent, compared to 58.4 per cent for children living with 1–2 children in the household (Figure 6).

3.2.6 Orphanhood

Orphaned children are more multidimensionally poor compared to non-orphan children.

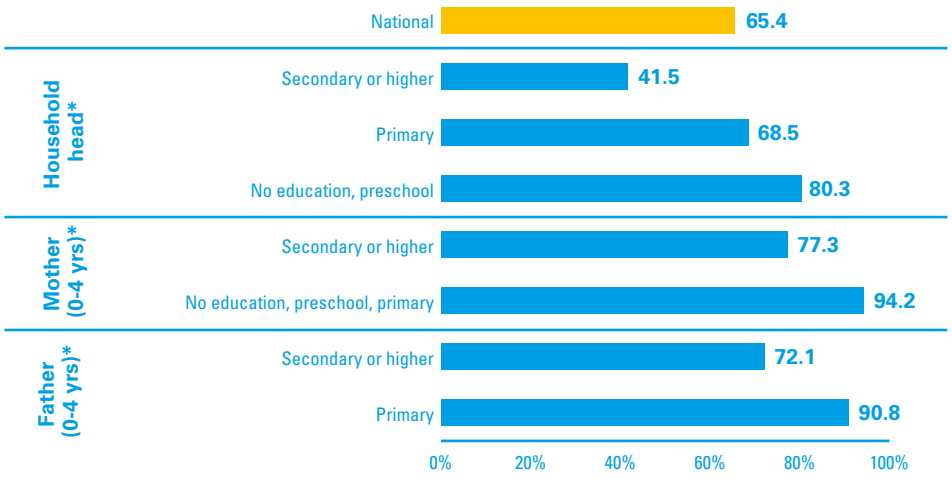
Multidimensional child poverty is more prevalent among double orphans (whose mother and father are both not present), having a 69.9 per cent deprivation rate (Figure 7). Children living without their biological mother are better off than those living without their biological father (60.5 per cent and 68.9 per cent, respectively). This implies that the absence of fathers, who often fulfil the role of breadwinner, poses a greater vulnerability for children than maternal absence.

3.2.7 Early pregnancy

Girls who experienced an early pregnancy are more multidimensionally deprived.

In the age group 15–17 years, more than nine out of ten girls (92.2 per cent) who are, or have been, pregnant are multidimensionally poor (Figure 8). The multidimensional poverty rate of girls who have not experienced a pregnancy is 68.5 per cent. Early pregnancy is a vulnerability that deserves more attention.

Figure 4: Multidimensional child poverty rates by level of education of the household head (children aged 0–17 years), and the education level of the mother and the father (children aged 0–4 years)



Note: The education level of the mother could not be disaggregated into three categories (no education or preschool, primary education and secondary or higher education) because of the low prevalence of mothers with no education.

Figure 5: Multidimensional child poverty rates by household size for children aged 0–17 years

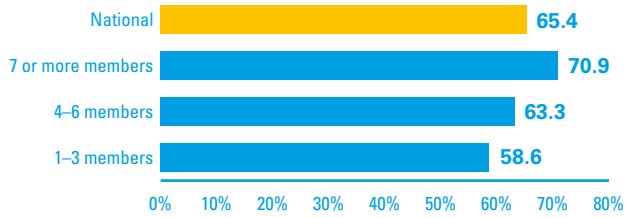
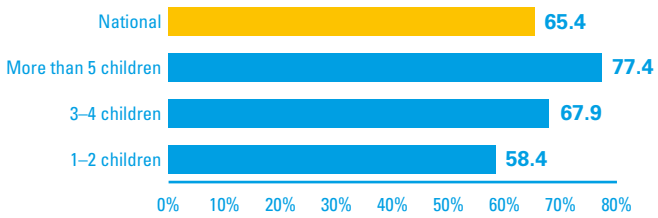


Figure 6: Multidimensional child poverty rates by the number of children (aged 0–17 years) in the household



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

3.2.8 Early marriage

Girls who are married before the age of 18 years face higher multidimensional poverty rates.

Almost all girls (95.2 per cent) in the age group 15–17 years who were or had been in a marital union at the time of the survey were also multidimensionally poor (Figure 9). Comparatively, the multidimensional poverty rate of girls who were not married was 68.7 per cent. The high deprivation rate of girls in an early marriage suggests that child marriage affects most dimensions of a child's life. This must be an area of utmost priority in policymaking when designing actions aimed at alleviating child poverty.

3.2.9 Mother's participation in household decisions

A lower rate of child poverty is observed when the mother participates in household decisions.

The child poverty rate decreases from 96.9 per cent to 84.8 per cent when the mother participates in the household's decisions (Figure 10). More attention must be given to design policies that give mothers increased control on decisions related to the well-being of children.

The high deprivation rate of girls in an early marriage suggests that child marriage affects most dimensions of a child's life.

3.3 Results by age group

This section presents the results for children in age groups 0–23 months, 24–59 months, 5–12 years and 13–17 years. The results for each age group are divided into two sections: the single (sectoral) deprivation analysis and the multidimensional deprivation analysis.

The sectoral deprivation analysis examines the proportion of children deprived in each dimension as a percentage of all the children in that age group. In doing so, it allows policymakers to identify the sectors that need particular attention in each age group.

The multidimensional deprivation analysis, on the other hand, measures the depth of deprivation that children face. It examines the extent to which deprivations are experienced simultaneously by the child, the overlap between deprivations, the headcount rate of multidimensionally poor children and the profile of children affected by multidimensional poverty in Lesotho.

3.3.1 Children aged 0–23 months

Main trends for children aged 0–23 months

- Of children aged 0–23 months, 94.1 per cent are multidimensionally poor, being deprived in at least three dimensions of well-being.
- Almost all (99.8 per cent) children in this age group are deprived in at least one dimension of well-being.
- Multidimensionally poor children in this age group have on average 5.1 (out of 8) deprivations.
- The highest rates of deprivation experienced by children aged 0–23 months are in the dimensions of housing, nutrition and protection (88.4 per cent, 79.2 per cent and 77.4 per cent, respectively).
- 78.3 per cent of children live in households without access to electricity.
- 76.5 per cent of children fail to meet the requirements for food diversity set by WHO.
- Children whose parents are more educated, experience less deprivation compared to children whose parents are less educated.
- Children in rural areas experience a higher number of simultaneous deprivations compared to children in urban areas.
- Of 10 districts in Lesotho, children in Thaba-Tseka and Mokhotlong are the most deprived. Children in Maseru are relatively less deprived.

Figure 7: Multidimensional child poverty rates by orphanhood of children aged 0–17 years

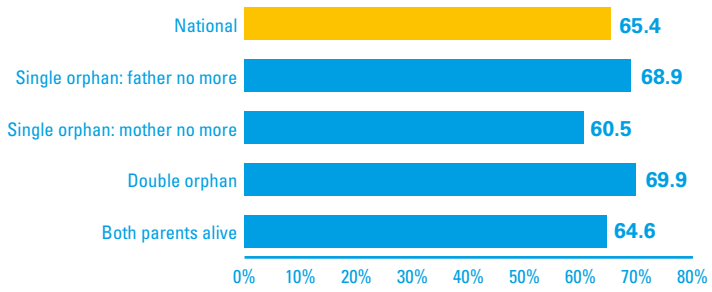


Figure 8: Multidimensional child poverty rate at national level (children aged 0–17 years) and by the pregnancy status of girls aged 15–17 years

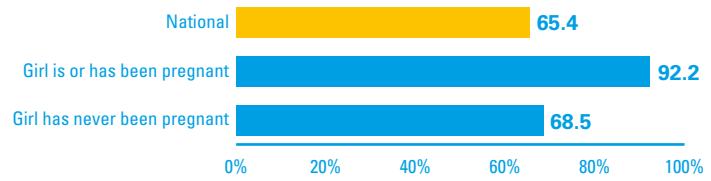


Figure 9: Multidimensional child poverty rates at national level (children aged 0–17 years) and by marriage status of girls aged 15–17 years

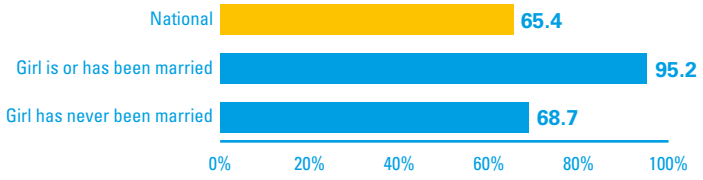
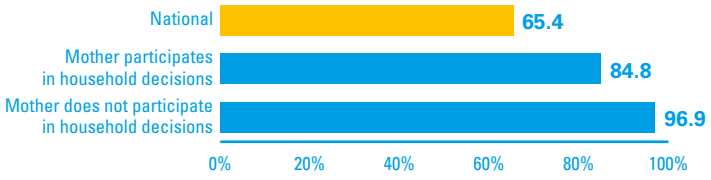


Figure 10: Multidimensional poverty rates of children aged 0–17 years related to the participation of mothers in household decisions



3.3.1.a Sectoral deprivation analysis

In Lesotho, eight dimensions were used to proxy the well-being of children aged 0–23 months, namely nutrition, health, HIV/AIDS, protection, water, sanitation, housing and information. Figure 11 shows the deprivation rates for each indicator, according to the dimension it measures. In line with MODA methodology, indicators are aggregated to measure the deprivation rate for each dimension using the union approach (Figure 12). The union approach states that a child is deprived in a dimension if that child is deprived in at least one of the indicators measuring that dimension. The findings show that deprivation rates are high in all dimensions, with the notable exception of information. The dimensions of housing (88.4 per cent), protection (79.2 per cent), nutrition (77.4 per cent) and HIV/AIDS (74.1 per cent) record the highest proportions of deprived children. These rates are detailed below.

In the age group 0–23 months, 77.4 per cent of all children are deprived in the *nutrition* dimension. Nutrition is measured by exclusive breastfeeding for children under 6 months, and meal frequency[3] and dietary diversity[4] for children aged 6–23 months. Results in Figure 11 show that it is mainly dietary diversity (76.5 per cent) that is driving the high deprivation rate in the nutrition dimension, followed by meal frequency with 56.6 per cent of children having meals at a lower frequency than that recommended by WHO. More than one third of children (35.1 per cent) aged 0–6 months are not exclusively breastfed in Lesotho. WHO highlights the benefits of exclusive breastfeeding during the first six months of a child's life, including a lower risk of gastrointestinal infection, optimal growth, development and health condition, as well as important benefits for the mother (WHO, 2011).

Of Basotho children in the 0–23 months age group, **65.5 per cent** are deprived in the *health* dimension.

Of Basotho children in the 0–23 months age group, 65.5 per cent are deprived in the *health* dimension. Three indicators define this dimension, namely vaccination, distance to a health centre and caretakers' knowledge on tuberculosis. More than a quarter (25.9 per cent) of all children in this age group did not receive all the recommended vaccinations. Furthermore, 43.5 per cent of children live in a household far away from a health care centre.[5] The distance of health care facilities from households is problematic in Lesotho, especially for children; people have to travel long distances through difficult terrain to seek care and emergency treatment when in need. The knowledge of caretakers on tuberculosis is also contributing to children's deprivation in Lesotho – up to 28.5 per cent of caretakers of children (aged 0–23 months) are not sufficiently informed about this disease.

Lesotho comes second, after Swaziland, in the most recent world's ranking of the HIV/AIDS prevalence rate (WHO, 2016). The *HIV/AIDS* dimension employed by this study measures the counselling of the mother of the child on HIV/AIDS during the antenatal care, and the knowledge of the caretaker of the child on this transmissible disease. Overall, 74.1 per cent of Basotho children aged 0–23 months are deprived in this dimension. The mothers of 29 per cent of children were not given counselling on HIV/AIDS during antenatal care, while 63.7 per cent of the mothers (or caretakers) of children in this age group did not have adequate knowledge of HIV/AIDS.

The *protection* dimension has a high deprivation rate among children aged 0–23 months, at 79.2 per cent. The high deprivation rate is mainly driven by the absence of a birth certificate (60.4 per cent) and the fact that children live in a violent environment, where domestic violence is accepted or condoned (46.8 per cent).

The study found that 30.7 per cent of the children are deprived in the *water* dimension, for which the source of drinking water and the distance to the water source were used

3 Meal frequency per day is defined using WHO standards: twice for breastfed infants aged 6–8 months; three times for breastfed children aged 9–23 months; and four times for non-breastfed children aged 6–23 months.

4 Dietary diversity is based on WHO standards, which refer to the child receiving four or more of the following food groups per day: (i) grains, roots and tubers; (ii) legumes and nuts; (iii) dairy products (milk, yogurt, cheese); (iv) flesh foods (meat, fish, poultry and liver/organ meats); (v) eggs; (vi) vitamin-A-rich fruits and vegetables; and (vii) other fruits and vegetables.

5 A household is considered to be located far away from a health care centre when it takes more than 30 minutes to reach the facility with any means of transportation in urban areas, and more than 60 minutes with a vehicle, or 120 minutes by foot in rural areas.

Figure 11: Deprivation headcount ratio (%) by each indicator at the national level, 0–23 months

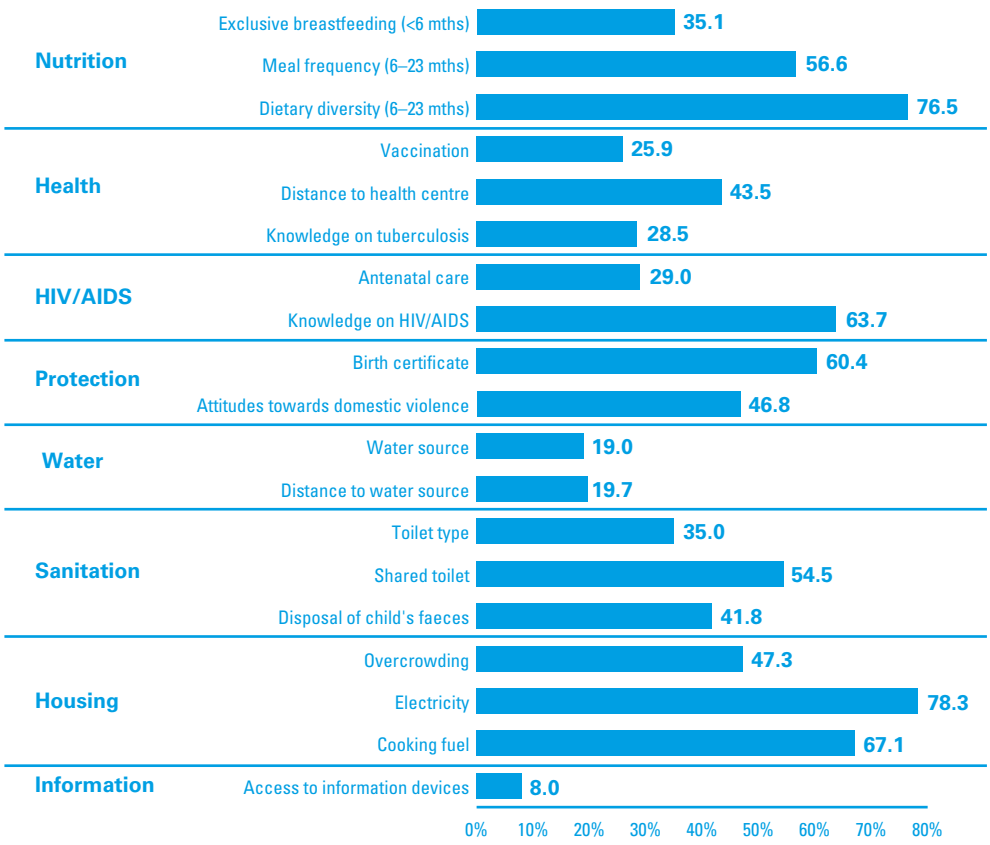
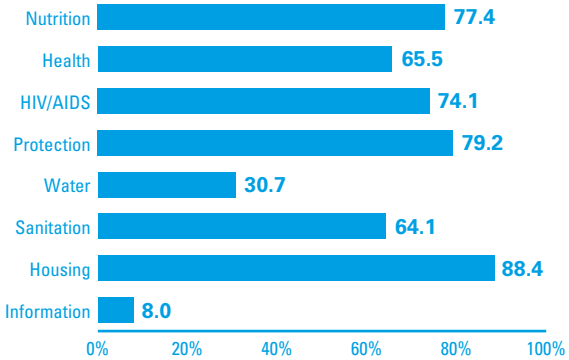


Figure 12: Deprivation headcount ratio (%) by each dimension at the national level, 0–23 months



The distance to the water source plays an important role for children.

as indicators. Up to 19 per cent of children in this age group live in households that use unimproved sources of drinking water.[6] In addition, 19.7 per cent of children live in households that are more than 30 minutes away from the water source.

The distance to the water source plays an important role for children. A recent study of 26 countries sub-Saharan Africa, including Lesotho, found that a decrease in the walk time to a water source is associated with a reduction in diarrhoea prevalence, improved anthropometrics and an overall reduction in under-five child mortality (Pickering and Davis, 2012). The authors hypothesize that the association between healthier children and a closer water source was due to mothers having more time available for other activities, such as caring for their children, seeking health care services and generating income.

The dimension of *sanitation* has a deprivation rate of 64.1 per cent among Basotho children aged 0–23 months. This was measured according to the type of toilet facilities, whether toilet facilities are shared or not and the disposal of the young child's faeces. Unimproved toilet facilities[7] affect 35 per cent of children aged 0–23 months in Lesotho, while 54.5 per cent of them live in households with shared toilet facilities and 41.8 per cent of them live in households where children's faeces are disposed of in an unsafe manner.[8] Unimproved sanitation hinders child development in many ways. Unimproved sanitation is a leading cause of infant diarrhoea, as demonstrated by Roushdy et al. (2012) in the context of Egypt. Similarly, Ezeh et al. (2014) found that improved sanitation reduces neonatal, post-neonatal and child mortality significantly in Nigeria. Finally, a global study in 70 low- and middle-income countries, by Fink, Günther and Hill (2011), demonstrated that access to improved sanitation was associated with lower mortality, and a lower risk of mild or severe stunting.

The *housing* dimension has the highest deprivation rate for children aged 0–23 months in Lesotho, affecting 88.4 per cent. This is mainly driven by the indicator measuring the absence of electricity in the household, which affects 78.3 per cent of children aged 0–23 months in Lesotho. The use of unimproved cooking fuel[9] is also high, standing at a rate of 67.1 per cent. Furthermore, 47.3 per cent of children in this age group lives in overcrowded houses with more than three people per sleeping room.

The *information* dimension, measured by access to either a radio, a television or a mobile phone, yields a deprivation rate of 8 per cent among Basotho children aged 0–23 months. This shows widespread use of media and communication technology in Lesotho.

Profiling deprived children aged 0–23 months

The results above reflect aggregated percentages for all children aged 0–23 months in the country. In an attempt to facilitate the identification of the most vulnerable children aged 0–23 months, and to ease policymaking, this section further profiles children deprived in dimensions based on their geographical location, individual characteristics, household characteristics and the characteristics of the mother.

Geographical location

Figure 13 shows the deprivation rates among Basotho children aged 0–23 months according to their **geographical location**. The asterisk (*) indicates that the difference between the categories is significant at a 5-per-cent level of significance.

The deprivation levels in all dimensions are higher for children living in rural areas compared

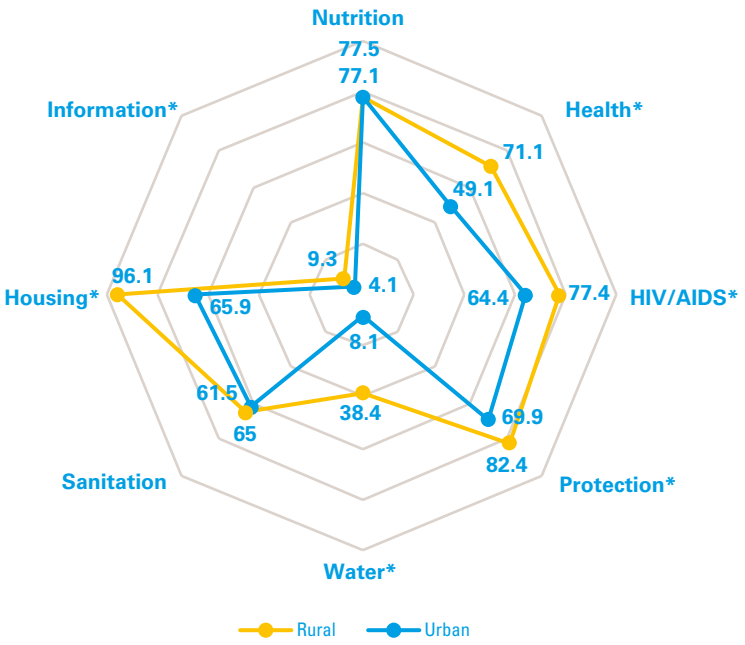
6 In this study, WHO's definition of unimproved drinking water sources has been used. These include unprotected wells, unprotected springs, surface waters (rivers, dams, lakes, ponds, streams, canals and irrigation channels) and tanker trucks.

7 In the context of Lesotho, unimproved toilet facilities are defined as those which are flushed to 'somewhere else' or flushed to 'don't know where', pit latrines without a slab (open pit), and where there is no facility and the bush or field is used.

8 Unsafe methods of disposing the child's faeces in Lesotho include burying; putting or rinsing into a drain or ditch; and left in the open or not disposed of. 'Throwing into garbage' is also considered unsafe in rural areas because of no removal services, which causes stray dogs to scatter faeces in the yard and on the streets, which is unhygienic and detrimental to the health of children.

9 In the context of Lesotho, unimproved cooking fuel includes coal or lignite; wood; straw, shrubs or grass; agricultural crops; and animal dung.

Figure 13: Deprivation headcount ratio (%) by area, 0–23 months



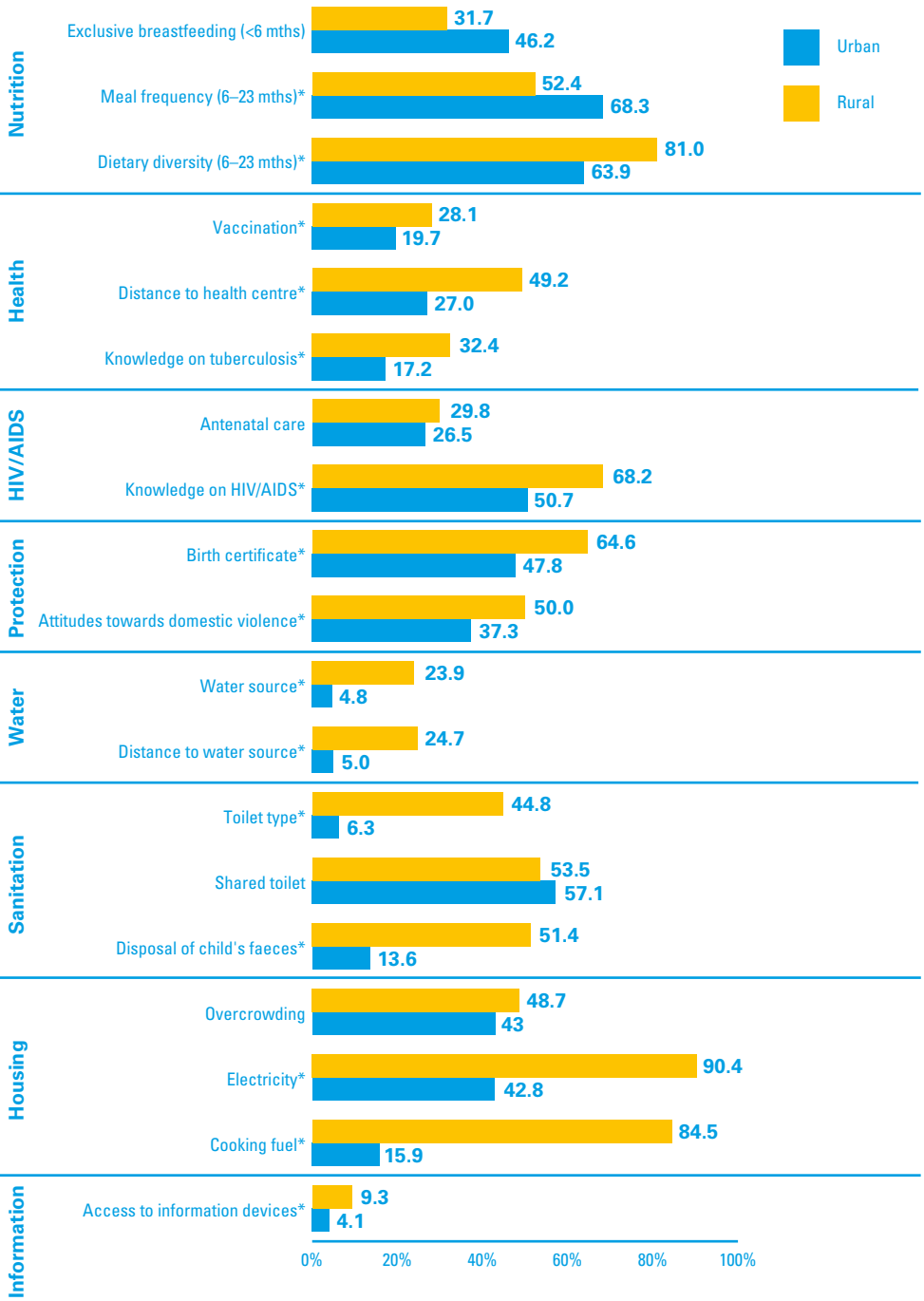
Note: The '' denotes statistical significant correlation between categories at p< 0.05*

to children in urban locations. Higher disparities between rural and urban areas are observed for the dimensions of water (38.4 per cent and 8.1 per cent, respectively), housing (96.1 per cent and 65.9 per cent, respectively), and health (71.1 per cent and 49.1 per cent, respectively). The differences between rural and urban are statistically significant for all dimensions, with the exception of nutrition and sanitation.

All indicators measuring dimensions are further decomposed by urban and rural areas in Figure 14. Although deprivation in rural areas is more pronounced compared to urban locations, there are some indicators that show the opposite. For instance, the deprivation of children aged 0–23 months in meal frequency and exclusive breastfeeding (both indicators of nutrition) is higher in urban areas than in rural locations. Similarly, the proportion of children sharing toilet facilities (sanitation) is higher in urban areas than in rural locations, although this difference is small and not statistically significant. The largest differences in deprivation between rural and urban children (0–23 months) is observed for the following indicators: distance to health centre (health dimension, 49.2 per cent and 27 per cent, respectively); water source (water dimension, 23.9 per cent and 4.8 per cent, respectively); distance to water source (water dimension, 24.7 per cent and 5 per cent, respectively); disposal of child's faeces (sanitation dimension, 51.4 per cent and 13.6 per cent, respectively); access to electricity (housing dimension, 90.4 per cent and 42.8 per cent, respectively); and cooking fuel (housing dimension, 84.5 per cent and 15.9 per cent, respectively). These differences point to areas of vulnerability across the rural–urban divide and may help prioritize policy actions as per the evidence in the measured indicators.

Table 5 shows the deprivation rates by dimension in each of the country's ten districts. Of all the districts, Maseru records relatively lower deprivation rates in four out of the eight dimensions, namely health, HIV/AIDS, water and housing. The Thaba-Tseka and Mokhotlong districts have high deprivation rates in four and five of the eight dimensions, respectively, as shown in Table 5.

Figure 14: Deprivation headcount ratio (%) by each indicator and by rural and urban area, 0–23 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Table 5: Deprivation rates (%) by dimension and by district, 0–23 months

	Nutrition*	Health*	HIV/AIDS	Protection*	Water*	Sanitation*	Housing*	Information*
Thaba-Tseka	69.5	77.9	77.8	81.2	48.9	80.2	98.1	15.4
Mokhotlong	82.5	81.5	74.9	84.5	47.4	89.6	99.0	22.2
Qacha's Nek	83.2	75.9	76.2	94.2	23.5	64.3	94.2	12.8
Quthing	68.6	71	77.5	88.8	28.2	64.4	94.4	6.0
Mohale's Hoek	91.4	75.3	81.0	84.9	40.1	75.1	93.5	6.0
Mafeteng	78.2	62.9	73.7	74.6	30.1	50.0	78.5	1.7
Maseru	77.9	52.5	71.5	73.8	17.0	59.2	78.4	5.7
Berea	76.4	62.1	72.1	77.1	27.6	61.6	85.9	5.3
Leribe	74.4	68.6	72.0	71.6	38.6	59.0	89.6	6.7
Butha-Buthe	73.6	59.4	71.5	90.0	21.0	49.6	97.4	8.7

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Table 6 shows the disaggregation of deprivation rates by ecological zones. In general, the children living in the lowlands have lower deprivation rates across dimensions, while those in the mountains have higher deprivation rates. These differences are statistically significant for all the dimensions with the exception of nutrition.

Table 6: Deprivation rates (%) by dimension and ecological zone, 0–23 months

	Nutrition	Health*	HIV/AIDS*	Protection*	Water*	Sanitation*	Housing*	Information*
Senqu River valley	78.8	77.6	76.8	88.1	31.9	70	96.2	7.5
Mountains	75.9	80.2	80.8	83.6	46.3	80.1	98.4	15.1
Foothills	71.8	77.3	76.6	88.1	33.7	66	99.5	10.4
Lowlands	79.3	53.8	69.8	73.6	22.3	55.1	79.8	4.0

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Number of children in the household

Figure 15 shows the disaggregation of deprivation rates by the number of children in the household. Children living in households with more than five children are generally more deprived, compared to those living in households with 1–2 children (Figure 15). This deprivation is particularly visible in the dimensions of health, HIV/AIDS, protection, water and housing – the greater the number of children in the household, the higher the deprivation rate in these dimensions. One notable exception is nutrition, where children living in households with 1–2 children or 3–4 children are generally more deprived in this dimension compared to children living in households with more than five children.

Education levels of the household head, and mother and father

The education levels of the household head (Figure 16), the mother (Figure 17) and the father (Figure 18) are important profiling indicators for the deprivation rates in Lesotho. The more educated the household head, the mother or the father, the lower the deprivation rates in almost all the dimensions. One notable exception is the dimension of nutrition in relation to the education of the mother and the household head. Auxiliary analysis reveals that this is due to exclusive breastfeeding, in that more educated mothers, for instance, do not exclusively breastfeed their children.

Child's stunting status

Children aged 0–23 months who are stunted are, overall, more deprived in the dimensions of health, HIV/AIDS, protection, sanitation, housing, and information, compared to their non-stunted counterparts (Figure 19). For health and water dimensions, however, the opposite is true; that is, children who are not stunted are more deprived compared to stunted children.

Additional analyses were conducted to profile the dimensions of deprivation by the gender of the child and by the gender of the household head. The findings show that these measurements do not vary much across dimensions of deprivation for children aged 0–23 months. For brevity, these analyses are not graphically displayed here.

Figure 15: Deprivation headcount ratio (%) by dimension and by number of children in the household, 0–23 months

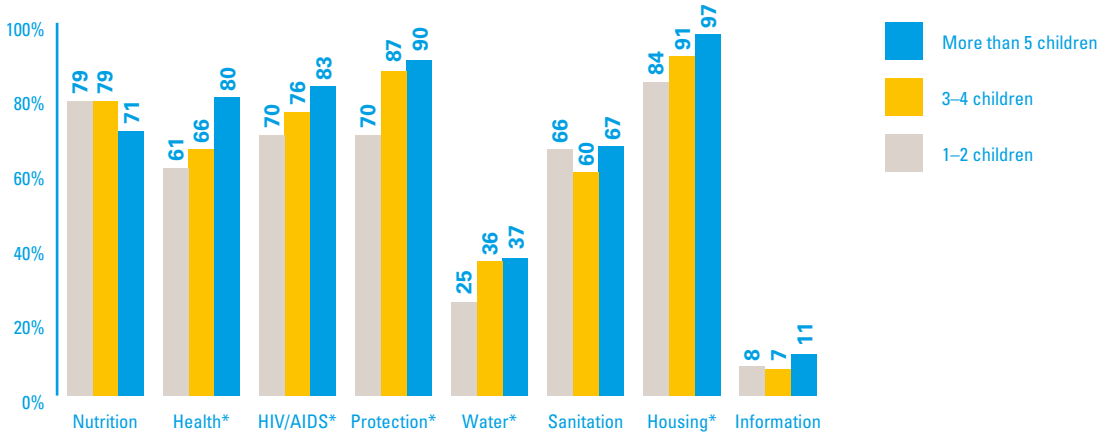
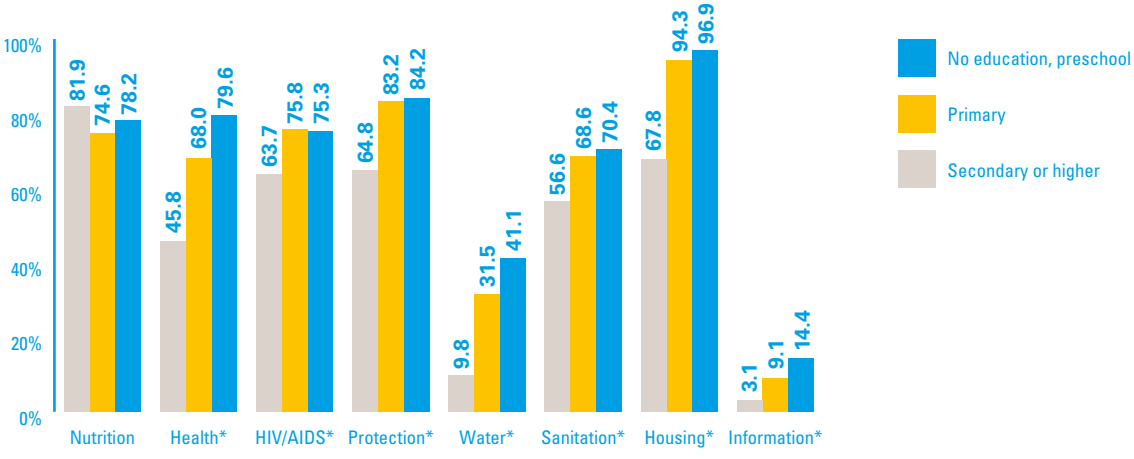
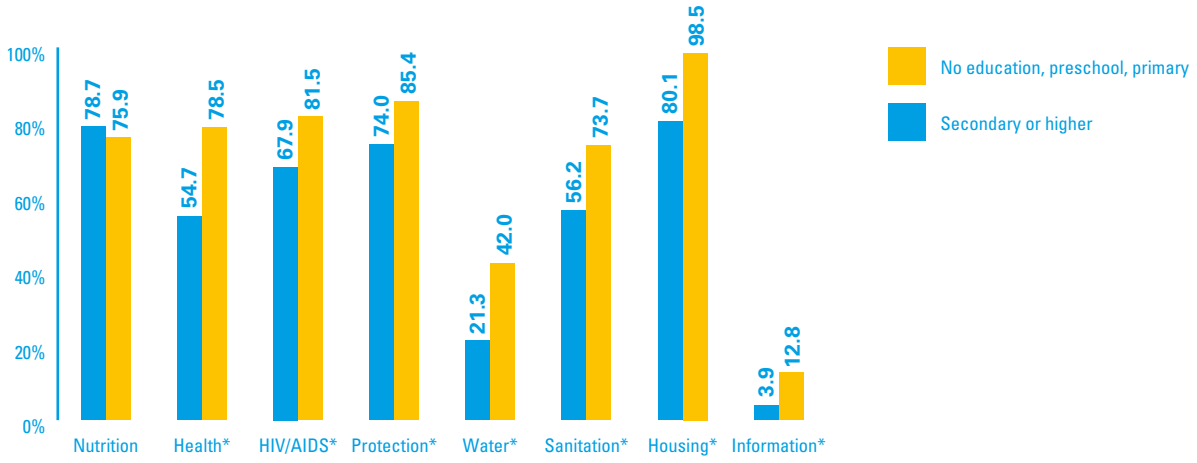


Figure 16: Deprivation headcount ratio (%) by dimension and by education level of household head, 0–23 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 17: Deprivation headcount ratio (%) by dimension and by education level of the mother, 0–23 months



**Note: The education level of the mother could not be disaggregated into three categories (no education or preschool; primary; and secondary or higher education) because of a limited number of mothers with no education.*

Figure 18: Deprivation headcount ratio (%) by dimension and by education level of the father, 0–23 months

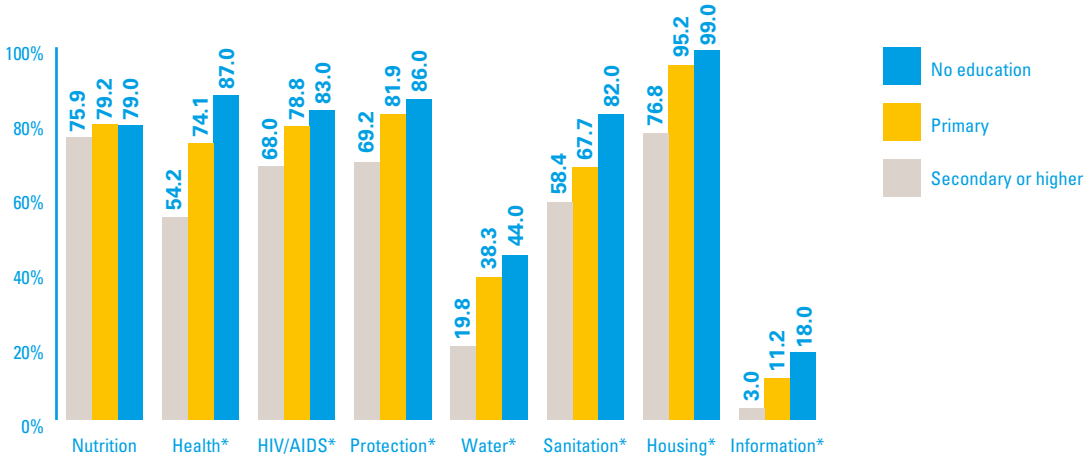
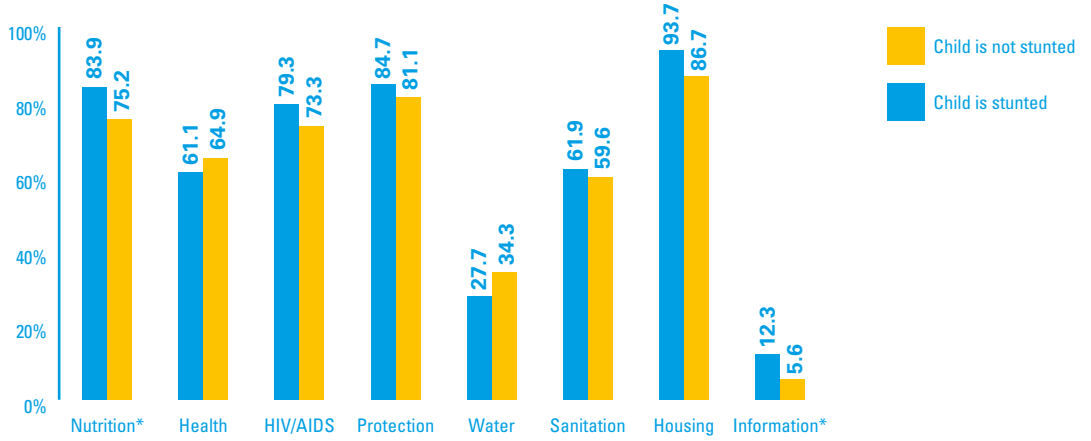


Figure 19: Deprivation level by stunting status, 0–23 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

3.3.1.b Multidimensional deprivation analysis

Number of deprivations faced by children aged 0–23 months

The crux of the MODA methodology is the ability to observe the overlap of deprivations in different dimensions. Children deprived in several dimensions at a time are more vulnerable. This section presents the number of simultaneous deprivations that a child experiences in the context of Lesotho. Figure 20 presents the distribution of simultaneous deprivations at the national level and by rural–urban location.

The distribution of simultaneous deprivations is skewed to the right (Figure 20a), meaning that the majority of Basotho children experience several deprivations at the same time. In fact, only 0.2 per cent of the children aged 0–23 months are not deprived in any of the dimensions of this study. A small proportion of children (5.8 per cent) experience one or two deprivations at a time. The majority of children in this age group, however, are deprived in four or more dimensions simultaneously, and peaks at five and six simultaneous deprivations (27.7 per cent and 24.1 per cent, respectively). Up to 11.7 per cent of the children are deprived in seven or eight dimensions of well-being simultaneously.

By disaggregating the distribution by area of residence (Figure 20b), results show that children in urban areas are, overall, less deprived in several dimensions at a time compared to children in rural areas, although the number of deprivations facing children remains high in both areas.

The distribution of the simultaneous deprivation, by district, is presented in Table 7. Out of Lesotho's 10 districts, only Maseru and Thaba-Tseka have a very small proportion of children aged 0–23 who are not deprived in any of the dimensions (0.5 per cent each). Overall, Maseru is also the district with the lowest proportion of children deprived in six or more dimensions, albeit by a relative margin compared to other districts. The distribution of overlapping deprivations is more pronounced in the remote or mountainous districts of the country. For instance, Mokhotlong has the highest proportions of children aged 0–23 months who are simultaneously deprived in seven and eight dimensions (23.4 per cent and 9.2 per cent, respectively).

Table 7: Distribution of simultaneous deprivations by district, 0–23 months

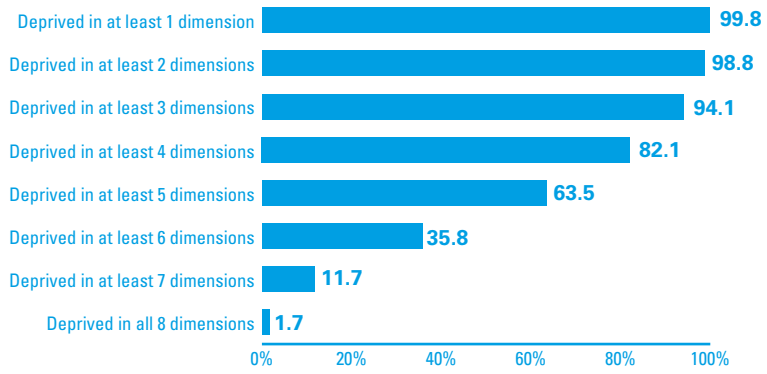
Districts	Number of simultaneous deprivations experienced by the child								
	0	1	2	3	4	5	6	7	8
Thaba-Tseka	0.5	0.0	1.4	4.5	14.8	28.5	26.6	18.8	5.0
Mokhotlong	0.0	0.0	0.7	3.6	13.0	20.6	29.5	23.4	9.2
Qacha's Nek	0.0	0.0	3.6	7.1	15.9	23.9	34.8	13.6	1.1
Quthing	0.0	1.5	1.6	11.4	19.7	27.8	27.0	8.0	3.0
Mohale's Hoek	0.0	0.0	2.6	6.2	9.4	26.6	35.0	19.1	1.2
Mafeteng	0.0	4.9	3.9	22.0	16.4	23.2	18.2	11.5	0.0
Maseru	0.5	0.6	6.8	19.2	23.2	31.6	14.1	3.8	0.3
Berea	0.0	2.3	6.4	13.2	19.1	24.6	26.6	7.8	0.0
Leribe	0.0	1.5	6.9	9.3	19.7	25.1	30.6	5.6	1.3
Butha-Buthe	0.0	0.0	5.0	9.1	25.1	37.4	17.9	5.1	0.5

Figure 20: Distribution of the number of deprivations that children aged 0–23 months experience at a time at the national level (a) and by rural–urban location (b)

Multidimensional deprivation indices

In order to calculate the multidimensional deprivation indices, it is important to define who is a poor child in the context of Lesotho. After discussions with local stakeholders,[10] it has been agreed that a child is considered multidimensionally poor if she/he is deprived in at least three dimensions at a time.

Figure 21: Multidimensional deprivation headcount ratio (%) at the national level, 0–23 months



10 Representatives from the following institutions in Lesotho were consulted: Ministry of Education, Ministry of Police, Ministry of Health, Ministry of Social Development, Lesotho Bureau of Statistics, and Ministry of Labour and Employment.

The gap in the ratio between rural and urban children widens with the number of deprivations they are facing.

The *multidimensional deprivation headcount ratio* expresses the proportion of children aged 0–23 months experiencing at least one, and more, deprivations at a time (Figure 21). Almost all (99.8 per cent) are deprived in at least one dimension at a time. Moreover, 94.1 per cent of them are multidimensionally poor, experiencing between three and eight simultaneous deprivations at a time. A proportion of 1.7 per cent of all Basotho children aged 0–23 months face deprivation in all eight dimensions.

Figure 22 shows how the deprivation headcount ratio disaggregates when comparing children aged 0–23 months in rural and urban areas. In general, the ratio is higher in rural areas than in urban locations. Not surprisingly, the gap in the ratio between rural and urban children widens with the number of deprivations they are facing. For example, the proportion of children who are deprived in three or more dimensions in rural and urban areas is 94.1 per cent and 87.1 per cent, respectively. When the number of deprivations is five or more, the gap between rural and urban widens (71.8 per cent and 39.1 per cent, respectively). This implies that children aged 0–23 months in rural areas are more severely affected by multidimensional deprivation than children in urban locations.

The *intensity of deprivation* is the average number of dimensions that multidimensionally poor children (deprived in at least three dimensions) experience. This index provides additional information on how poor the poor children are by measuring the intensity of deprivation. Multidimensionally poor children aged 0–23 months have on average 5.1 deprivations, out of a total of 8 deprivations. It implies that Basotho children aged 0–23 months are deprived in 63.4 per cent of the total number of dimensions.

The *Multidimensional Child Poverty Index* is a combination of both the headcount and the intensity of deprivation. It is calculated as the product of the headcount and the average intensity and is therefore sensitive to changes in either. The index can be used to compare children with different profiles. The higher the index, the more vulnerable the children are. Figure 23 shows the Multidimensional Child Poverty Index, deprivation headcount ratio and intensity of deprivation at the national level, for children in rural–urban locations and further disaggregated into districts. Overall, children aged 0–23 months living in urban areas (Multidimensional Child Poverty Index of 0.47) are doing better than children in rural areas (Multidimensional Child Poverty Index of 0.64). Mokhotlong has the highest index (0.73) implying greater vulnerability amongst children aged 0–23 months in that district. Maseru, on the other hand, has the lowest index, at 0.53.

Although the intensity of deprivation (i.e. how poor the poor children are) shows better scores in urban than in rural areas, it is interesting to observe that it does not vary much across districts. This implies that multidimensionally poor children aged 0–23 months face the same level of deprivation, irrespective of their district location.

How does each dimension contribute to the Multidimensional Child Poverty Index?

The analysis can be further decomposed to identify which of the dimensions is contributing more to the overall deprivation level in Lesotho. As mentioned above, the overall deprivation level is measured by the Multidimensional Child Poverty Index, which captures both the headcount and the intensity of deprivation. Figure 24 shows the index decomposed at national level and by urban and rural locations. Of all dimensions, housing, protection and nutrition contribute the most to deprivation, overall, at the national level. The contribution of these dimensions is however different for the rural–urban divide. In rural locations, housing contributes most to child deprivation (18.5 per cent), followed by protection (15.9 per cent), HIV/AIDS (14.9 per cent) and nutrition (14.7 per cent). In urban areas, however, nutrition contributes most to child deprivation (19.0 per cent), followed by housing (16.6 per cent), protection (16.9 per cent), and HIV/AIDS (16.5 per cent).

Deprivation overlap analysis

Deprivation overlap analysis presents the proportion of children who are deprived in only the specific dimension analysed, or one, two or more additional dimensions. Analysing these overlaps allows for a better insight into the nature and severity of a child's multidimensional deprivation. It shows the extent to which sectoral deprivations are singular problems and whether they overlap with other deprivations. For policymaking, the deprivation overlap analysis reveals which dimensions of deprivation need to be addressed in combination.

Figure 22: Multidimensional deprivation headcount ratio (%) at the national level and for rural and urban children, 0–23 months

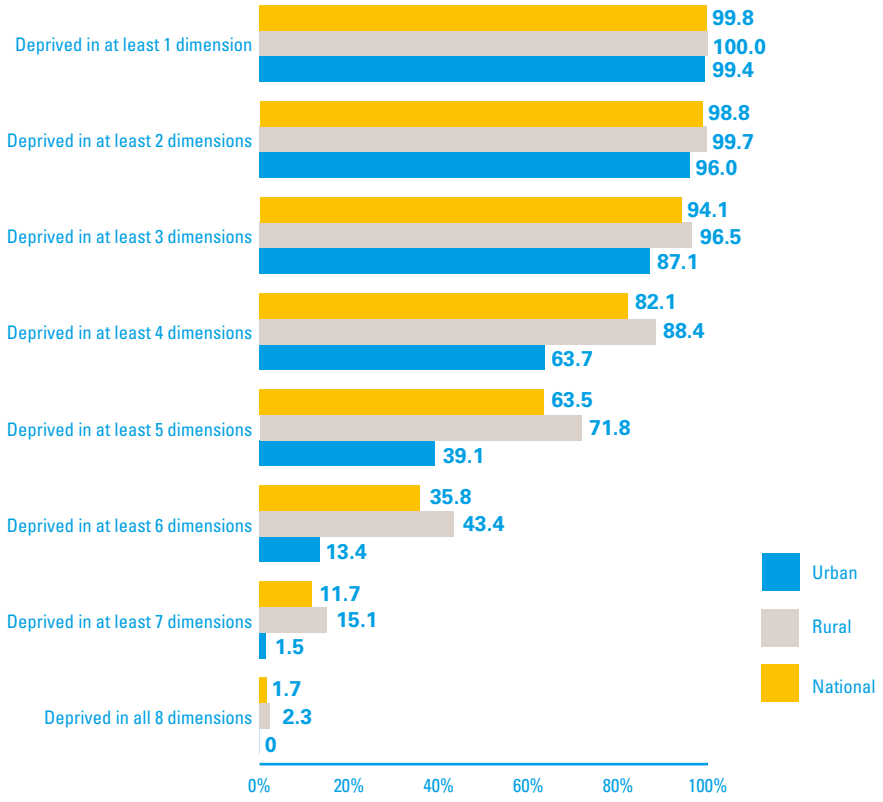


Figure 23: Multidimensional Child Poverty Indices at the national level and by rural–urban location and district, children aged 0–23 months deprived in at least three dimensions

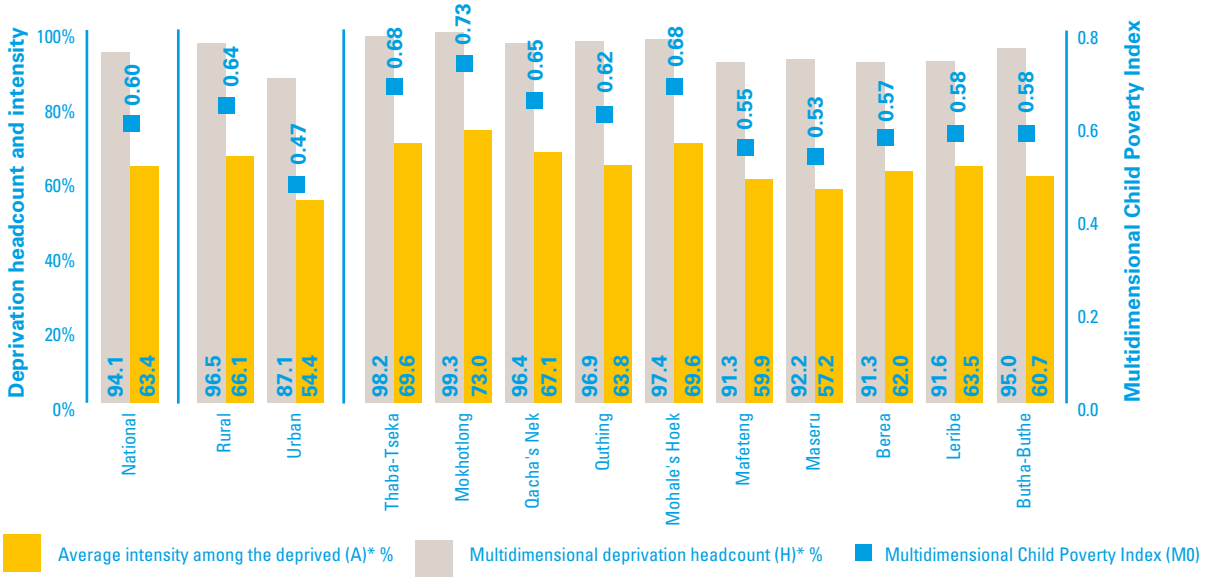


Figure 25 shows the deprivation overlap for each dimension for children aged 0–23 months. It shows that almost no children in this age group are deprived in only the given dimension (represented by the blue area in the graph). In fact, the majority of children are deprived in the given dimension, plus three or more other dimensions at a time. This is particularly true for the overlapping dimensions related to housing, nutrition, protection and HIV/AIDS. A strategy to reduce multidimensional child poverty in Lesotho would require an inter-sectoral response that targets those deprivations that children face concurrently.

Example of deprivation overlap of three dimensions

This section provides a summary of results of a deprivation overlap for any of the three dimensions that children may experience at a time. While all combinations of dimensions were analysed (see Annex 2), only an example of a deprivation overlap of three dimensions is presented here. The deprivation overlaps between dimensions are best represented using Venn diagrams. A Venn diagram that combines a number of dimensions provides the following information: (1) deprivation rates for each dimension separately; (2) deprivation overlap between any two dimensions; (3) deprivation overlap between all three dimensions; and (4) the proportion of children that are not deprived in any of the included dimensions.

Figure 26 provides an example of deprivation overlap of three dimensions – nutrition, health and HIV/AIDS – among Basotho children aged 0–23 months. The Venn diagram reveals that 40.2 per cent of all children of this age group are simultaneously deprived in these three dimensions. For policymaking, this implies that targeting these three areas of vulnerability concurrently would impact a large share of the child population aged 0–23 months.

Data in Figure 26 also show that out of 65.6 per cent of children who are deprived in health, only 4.3 per cent are deprived in health only – the remaining 61.3 per cent are also simultaneously deprived in nutrition and/or HIV/AIDS. Similar overlap can be observed for all other dimensions in the Venn diagram, making it clear that very few Basotho children aged 0–23 months are deprived in only one dimension at a time. In fact, the majority of children in

Figure 24: Decomposition of the Multidimensional Child Poverty Index at the national level and by rural–urban location, 0–23 months

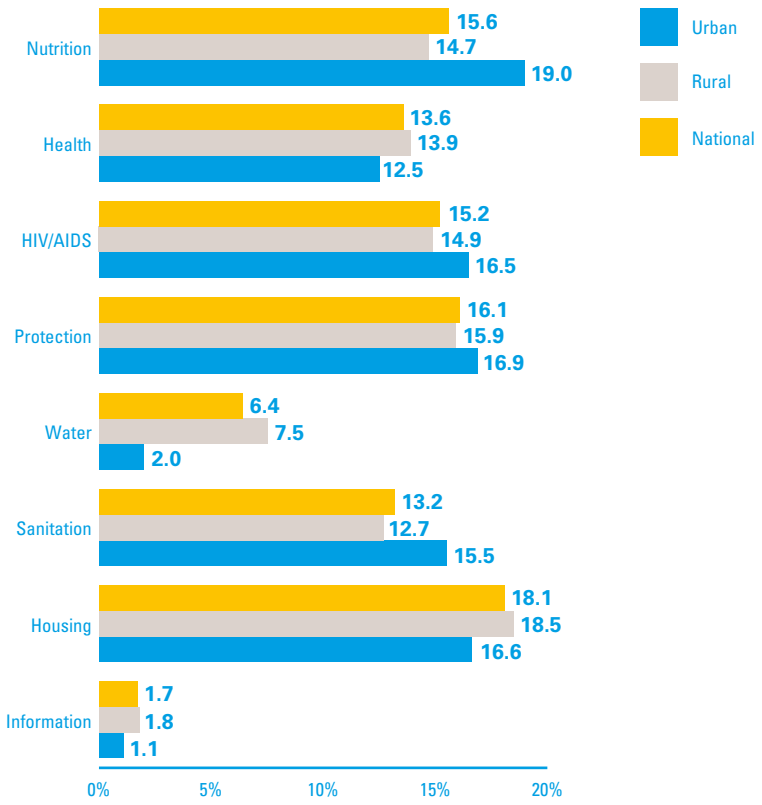


Figure 25: Deprivation overlap for each dimension, 0–23 months

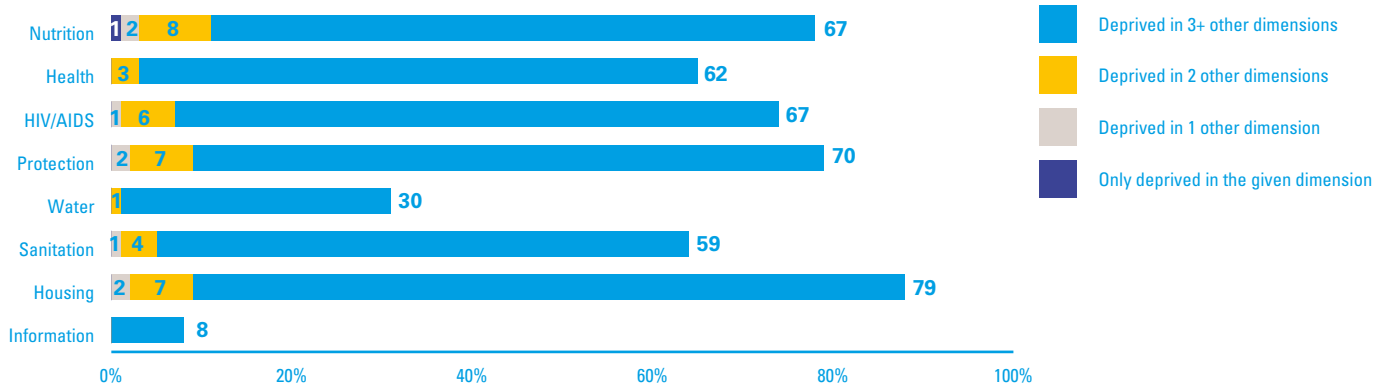
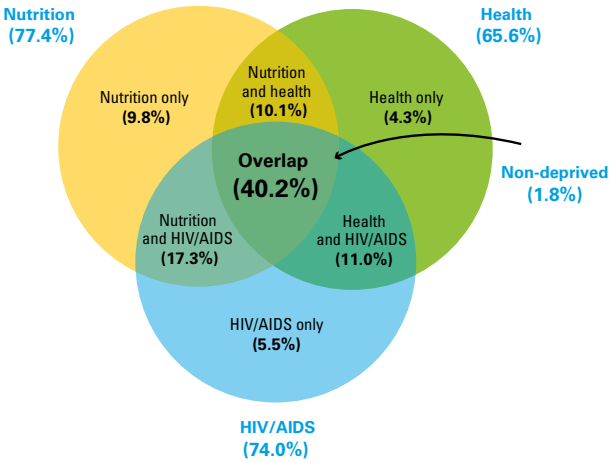
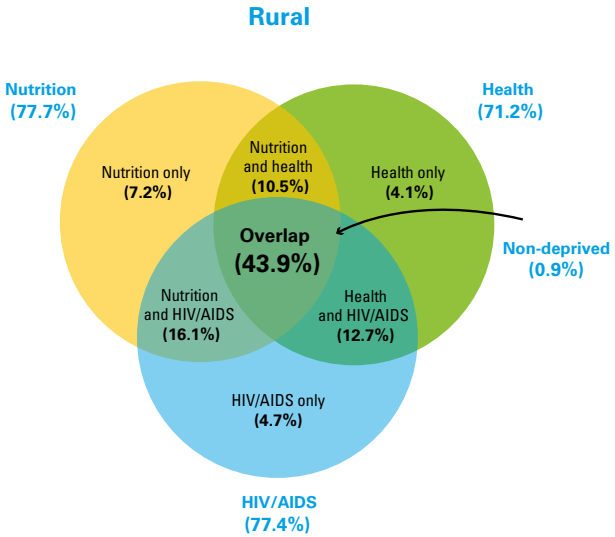
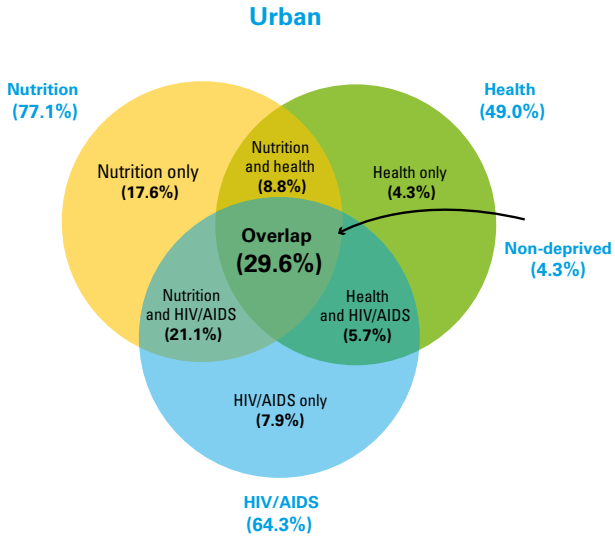


Figure 26: Deprivation overlap between the dimensions nutrition, health and HIV/AIDS at the national level and by rural–urban location, 0–23 months







this age group are deprived in a combination of two or three dimensions. For instance, the overlap between nutrition and HIV/AIDS affects 17.3 per cent of children aged 0–23 months. Only 1.8 per cent of children in this age group are not deprived in any of the three dimensions of health, nutrition or HIV/AIDS.

The overlap between deprivations can also be differentiated by rural–urban location, as displayed in Figure 26. A much larger proportion of children living in rural areas are deprived simultaneously in the three dimensions (43.9 per cent) than those living in urban areas (29.6 per cent). Children in rural areas are also more prone to an overlap of any two of the dimensions than children in urban locations. Such analyses can lead to more specific and efficient policy actions according to specific vulnerabilities occurring simultaneously.

3.3.2 Children aged 24–59 months

Main trends for children aged 24–59 months

- Almost 8 out of 10 children aged 24–59 months are multidimensionally poor, being deprived in at least three dimensions of well-being.
- The multidimensionally poor children face, on average, of 4.3 out of 7 deprivations.
- Of all children aged 24–59 months, 97.8 per cent are deprived in at least one dimension of well-being; about 2 per cent are deprived in all seven dimensions of well-being.
- The highest rates of deprivation experienced by children aged 24–59 months are in the dimensions of housing, protection and HIV/AIDS (86.6 per cent, 72.1 per cent and 63.3 per cent, respectively).
- Urban children experience lower deprivation rates in all dimensions and less multiple deprivations at a time compared to rural children.
- In all 10 districts, more than half of the children in this age group experience three or more deprivations simultaneously. However, children living in Maseru, Berea and Leribe are slightly better off than those from elsewhere, and children living in Thaba-Tseka, Mokhotlong and Mohale's Hoek are the worst off.

3.3.2.a Sectoral deprivation analysis

In measuring the multidimensional poverty of children aged 24–59 months, seven dimensions are used, namely health, HIV/AIDS, protection, water, sanitation, housing and information.

Figure 27 shows the deprivation headcount ratio for all indicators used to measure child vulnerabilities within each dimension. Subsequently, Figure 28 presents the deprivation headcount ratio for each dimension.

In Lesotho, the highest deprivation rates among children aged 24–59 months are in the dimensions of housing (86.6 per cent), protection (72.1 per cent) and HIV/AIDS (63.3 per cent).

More than half (55.6 per cent) of children aged 24–59 months are deprived in the *health* dimension. This deprivation rate is determined from the indicators measuring the proximity of the household to the closest health care centre and the caregiver's knowledge on tuberculosis. Specifically, 46.1 per cent of children aged 24–59 live in a household that is considered far away from a health care facility;[5] while 26.0 per cent of children in this age group live in households in which caregivers do not have sufficient knowledge on tuberculosis.

The *HIV/AIDS* dimension measures the caretaker's knowledge of the disease and has a deprivation rate of 63.3 per cent. Notable is that this figure is lower than in the youngest age group of 0–23 months (74.1 per cent).

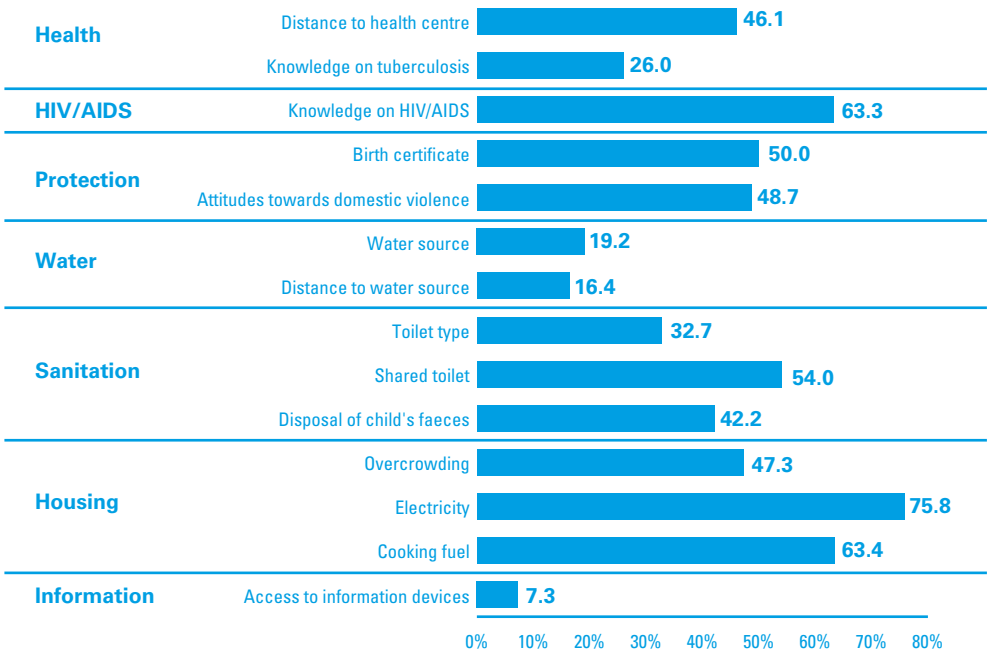
Almost two-thirds of children (72.1 per cent) aged 24–59 months are deprived in the dimension of *protection*. This dimension comprises indicators for birth certificate (registration) and attitudes towards domestic violence. Half (50.0 per cent) of Basotho children aged 24–59 months do not have a birth certificate. The absence of a birth certificate creates administrative difficulties for authorities and hurdles for children to access services, care and social benefits (Dietrich et al., 2016). The indicator assessing the attitudes toward domestic violence reveals that 48.7 per cent of children aged 24–59 months live in households where domestic violence is accepted. Living in a violent environment is harmful for children, affecting their psychological well-being and overall development. More attention needs to be given to actions that prevent domestic violence, as this may affect children and their life chances in the future.

The dimension of *water* has a deprivation rate of 28.6 per cent. Two indicators measure this dimension: the type of water source and the distance to the water source. About 19.2 per cent of children live in a household that relies on unimproved drinking water sources.[11] Of all children aged 24–59 months, 16.4 per cent live in households where it takes more than 30 minutes to get to a water source.

The dimension of *sanitation* has a deprivation rate of 54.4 per cent. This dimension is measured by indicators that look at the type of toilet facility, sharing of the toilet facility and the method of disposal of the child's faeces. In Lesotho, 32.7 per cent of children aged 24–59 months live in households with unimproved toilet facilities.[12] Furthermore, 54.0 per cent of them live in households that share toilet facilities with other households, while 42.2 per cent live in households that dispose of children's faeces in an unsafe manner.[13]

50.0 per cent of Basotho children aged 24–59 months do not have a birth certificate.

Figure 27: Deprivation headcount ratio (%) of each indicator at the national level, 24–59 months

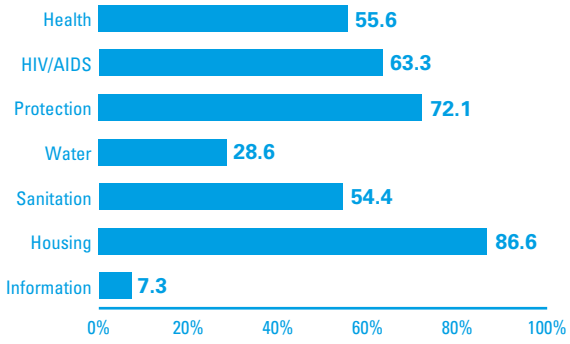


11 The WHO definition of unimproved drinking water sources has been used. Based on this definition, unimproved water sources include unprotected well, unprotected spring, surface water (river, dam lake ponds, stream, canal, and irrigation channel) and tanker truck.

12 In the context of Lesotho, the unimproved toilet facilities are defined as those which are flushed to somewhere else, flushed to don't know where, pit latrine without slab/open pit, and no facility/bush/field.

13 Unsafe methods of disposing a child's faeces in Lesotho are buried, put/rinsed into drain/ditch, and left in the open/not disposed of. "Throwing into garbage" is also considered as unsafe in rural areas because of the lack of removal services which causes stray dogs to scatter the faeces in the yard and on the streets. This is unhygienic and detrimental to the health of children.

Figure 28: Deprivation headcount ratio (%) of each dimension at the national level, 24–59 months



Research points to the negative effects of poor housing facilities on children's well-being, including their education, behaviour and health.

Of all measurements, the highest deprivation rate among children aged 24–59 is observed in the dimension of *housing*, which stands at 86.6 per cent. This is mostly driven by the indicator measuring access to electricity, which affects 75.8 per cent of children in this age group. In addition, 63.4 per cent of children in this age group live in a household that uses unimproved cooking fuel,[14] and 47.3 per cent of them live in a household where there are more than three people per sleeping room. Research points to the negative effects of poor housing facilities on children's well-being, including their education, behaviour and health (Solari and Mari, 2012).

The lowest deprivation rate, of 7.3 per cent, is found in the dimension of *information*, measured by access to a radio, a television or a mobile phone. This is encouraging as recent evidence points to the use of information and communication technologies as efficient contributors to efforts towards meeting child-focused development goals (UNICEF, 2013).

Profiling deprived children aged 24–59 months

This section presents the profile of poor children aged 24–59 months in Lesotho.

Geographical location

There is a significantly higher proportion of deprived children aged 24–59 months in rural areas compared to urban areas for all the analysed dimensions with the exception of sanitation (Figure 29). The 'shared toilet' indicator under the dimension of sanitation, on the other hand, shows a higher deprivation rate in urban areas (Figure 30), due to the greater numbers of urban people living in shared buildings with limited sanitation facilities. Additionally, the 'overcrowding' indicator shows only a slightly higher proportion of deprived children in rural areas, which is not statistically significant.

Table 8 presents the percentage of deprived children for each dimension and in each district. The dimension of housing has high deprivation rates across all districts, with the lowest being in Maseru (74.4 per cent). Children living in Berea face the lowest deprivation rates in the dimensions of health (43.0 per cent), protection (59.9 per cent) and information (1.6 per cent). Apart from having the lowest proportion of deprived children in the dimension of housing (74.4 per cent), Maseru also has the lowest in the dimension of water (12.3 per cent). Children aged 24–59 months in the district of Thaba-Tseka are worst off in nearly all the dimensions of well-being studied. In addition, children living in lowlands are better off than those living in the mountains in all dimensions, and no children living in the foothills meet their basic housing conditions (Table 9).

14 In the context of Lesotho, unimproved cooking fuel includes coal/lignite, wood, straw/shrubs/grass, agricultural crop, and animal dung.

Figure 29: Deprivation headcount ratio (%) by dimension in rural and urban locations, 24–59 months

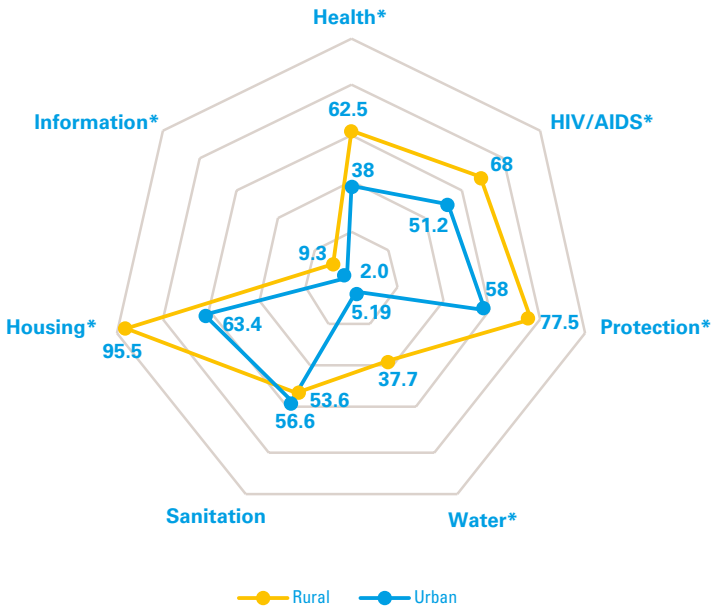
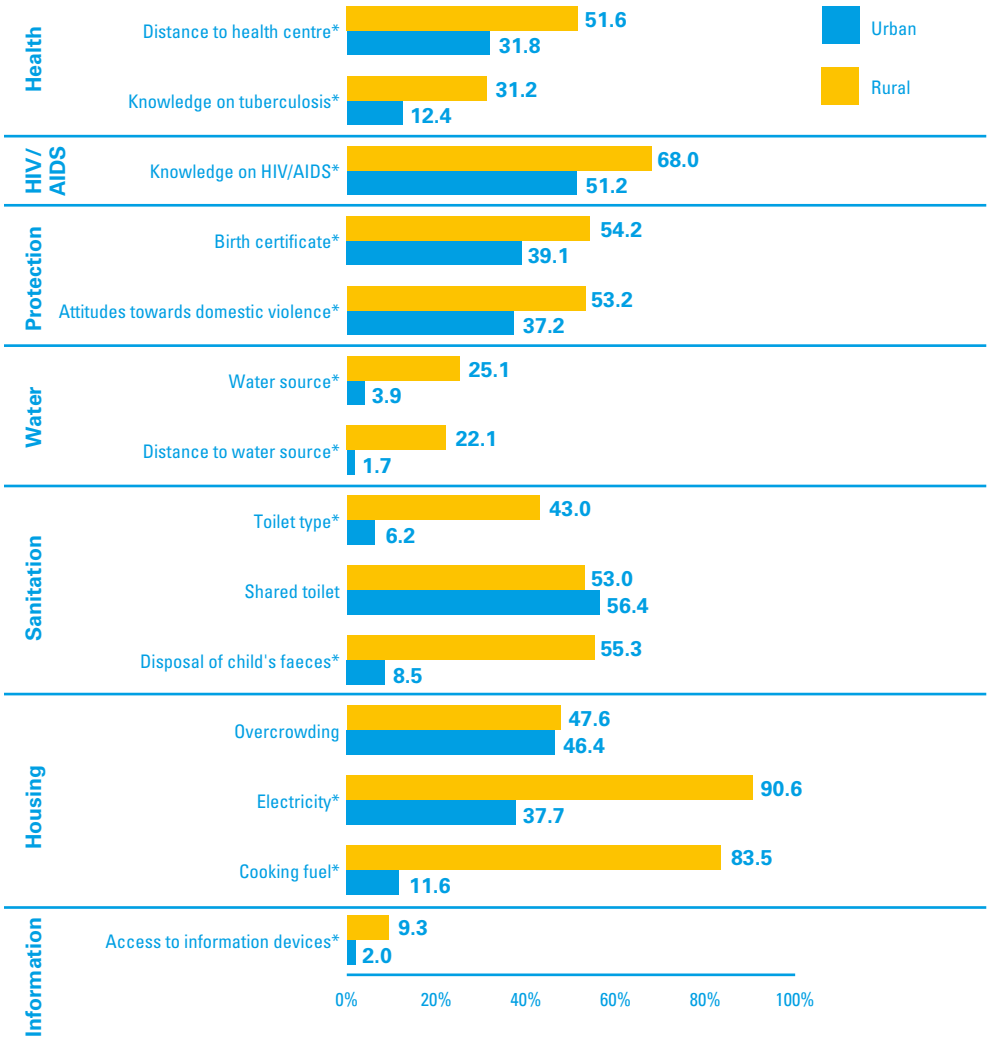


Figure 30: Deprivation headcount ratio (%) by indicator in rural and urban locations, 24–59 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Table 8: Deprivation rates (%) by dimension and by district, 24–59 months

	Health*	HIV/AIDS*	Protection*	Water*	Sanitation*	Housing*	Information*
Thaba-Tseka	78.3	72.1	76.1	58.0	68.5	99.4	21.5
Mokhotlong	66.3	70.5	82.3	47.4	75.0	96.9	13.0
Qacha's Nek	68.3	65.7	80.9	18.5	54.0	95.6	12.3
Quthing	61.9	67.7	79.6	31.5	45.0	90.3	7.7
Mohale's Hoek	69.2	69.4	82.1	33.1	65.1	95.5	9.6
Mafeteng	53.9	70.7	69.0	25.7	53.1	81.3	4.7
Maseru	48.1	57.8	69.0	12.3	51.6	74.4	4.2
Berea	43.0	55.8	59.9	24.0	45.2	80.9	1.6
Leribe	47.3	59.5	66.6	35.8	53.5	89.5	3.9
Butha-Buthe	53.6	64.9	82.0	24.3	37.2	98.1	8.1

Table 9: Deprivation rates (%) by dimension and ecological zone, 24–59 months

	Health*	HIV/AIDS*	Protection*	Water*	Sanitation	Housing*	Information*
Senqu River valley	72.7	72.3	78.0	30.5	53.2	94.4	11.0
Mountains	74.8	71.3	81.7	49.9	63.1	98.1	15.5
Foothills	71.4	69.8	80.3	30.7	59.3	100.0	9.46
Lowlands	40.7	56.9	64.9	18.1	49.5	77.1	2.5

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figures 31–37 show a number of profiling characteristics related to dimensions of well-being for children aged 24–59 months.

Number of children in the household

Households with more children have higher deprivation rates in most of the analysed dimensions. For example, 82 per cent of children living in a household with more than five children are deprived in the protection dimension. In comparison, the deprivation rate for children in a household of 1–2 children is 67 per cent in protection (Figure 31).

Education levels of the household head, and mother and father

The more educated the household head, the mother and/or the father of a child, the lower the deprivation rate (Figure 32–34). The distinction is particularly visible in the dimension of health, with a difference of 51 per cent in deprivation when household heads have no education or preschool, and those that attained levels of secondary or higher education (Figure 32).

Mother's participation in household decisions

Deprivation rates in the dimensions of health, HIV/AIDS, protection, water and housing are lower for children whose mothers participate in household decisions. This is particularly so in the water dimension, which shows a difference in deprivation of 33 per cent between children whose mothers are involved in decisions and those whose mothers are not (Figure 36).

Figure 31: Deprivation headcount ratio (%) by dimension and number of children in the household, 24–59 months

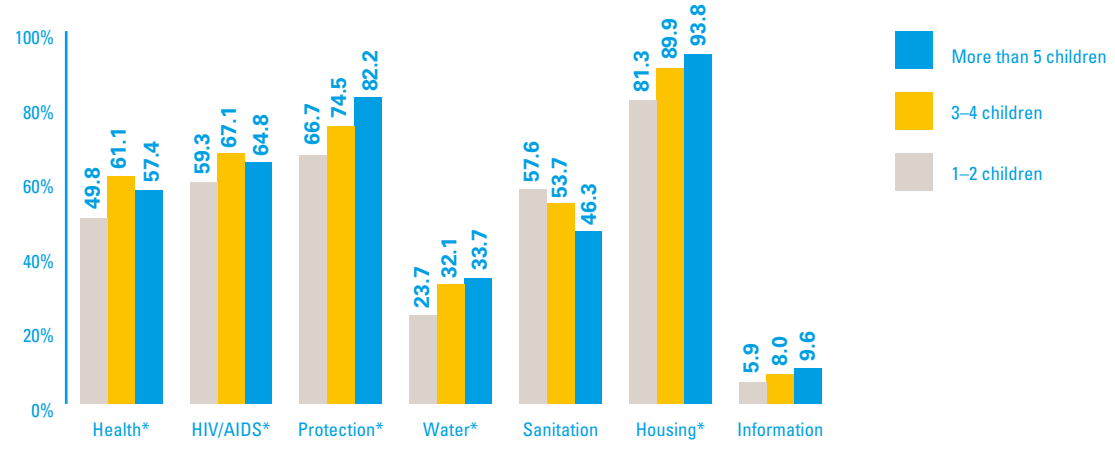


Figure 32: Deprivation headcount ratio (%) by dimension and education level of the household head, 24–59 months

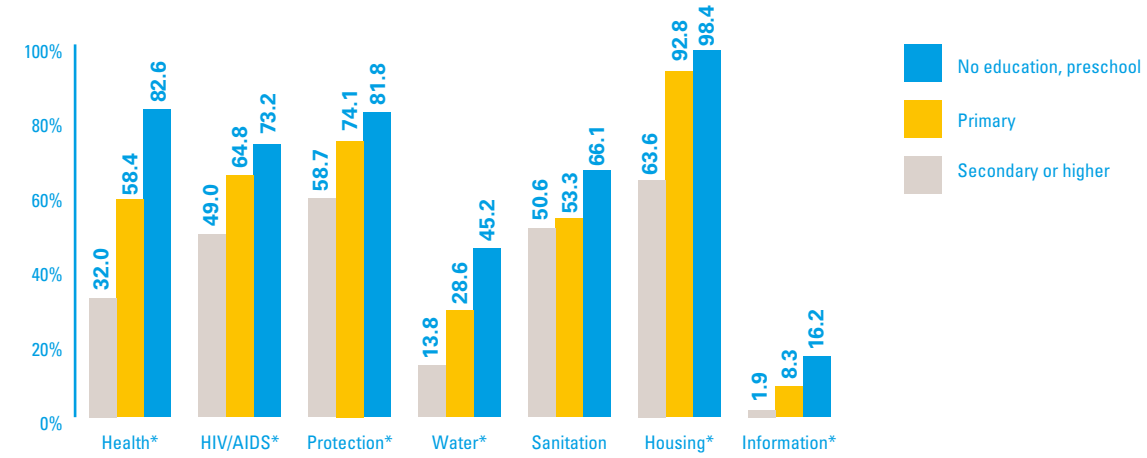
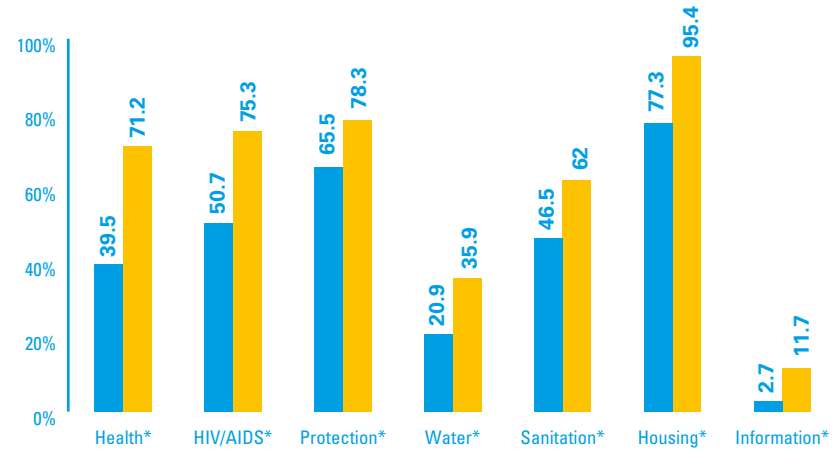


Figure 33: Deprivation headcount ratio (%) by dimension and education level of the mother, 24–59 months



**Note: The education level of the mother could not be disaggregated into three categories (no education or preschool, primary education, and secondary or higher education) because of a limited number of mothers with no education.*

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Child's stunting status

Children who are stunted are more likely to be deprived in dimensions of well-being, particularly in health, HIV/AIDS and housing. Notably, up to seven out of ten children aged 24–59 months who are stunted, are deprived in the dimension of health. In comparison, only half of children not stunted are deprived in health (Figure 35).

Gender of the child

Overall, girls are slightly more deprived in the dimensions of health, HIV/AIDS, water, sanitation, housing and information than boys. Notably, there are no differences in deprivation rates between girls and boys in the protection dimension (Figure 37).

3.3.2.b Multidimensional deprivation analysis

Number of deprivations faced by children aged 24–59 months

Figure 38 shows the number of deprivations experienced by children aged 24–59 months, at the national level and by rural–urban location. At the national level, the distribution of deprivations is skewed to the right, revealing that children in this age group experience multiple deprivations at a given time (Figure 38a). The vast majority of children aged 24–59 months face three or more deprivations (78 per cent), while only 2.2 per cent of children are not deprived in any of the seven dimensions. Notably, just 1.5 per cent of children in this age group are deprived in all seven dimensions.

When desegregating the results by area of residence, it can be observed that the distribution of deprivations for children living in rural areas is skewed to the right, whereas the distribution for children living in urban areas is slightly skewed to the left (Figure 38b). This means that children in rural areas experience more multiple deprivations simultaneously than urban children.

Table 10 shows the distribution of simultaneous deprivations for children aged 24–59 months in the 10 districts. Although the combined deprivation rates are high across all districts, children living in Maseru, Berea and Leribe are slightly better off as they face a relatively lower number of simultaneous deprivations. On the other hand, children living in Thaba-Tseka, Mokhotlong and Mohale's Hoek are worse off, as they experience a higher number of deprivations at a time.

Table 10: Distribution of simultaneous deprivations by district, 24–59 months

Districts	Number of simultaneous deprivations experienced by the child							
	0	1	2	3	4	5	6	7
Thaba-Tseka	0.1	1.9	5.2	10.9	19.6	29.6	26.5	6.2
Mokhotlong	0.2	1.9	4.7	11.0	29.4	31.4	17.8	3.6
Qacha's Nek	0.6	4.5	7.3	23.2	28.7	24.8	8.5	2.4
Quthing	1.7	4.9	13.3	21.9	23.2	19.9	13.0	2.2
Mohale's Hoek	0.0	2.9	10.4	15.2	24.3	28.6	15.8	2.8
Mafeteng	3.3	8.3	14.7	18.8	22.3	21.6	9.9	1.1
Maseru	4.3	8.3	18.7	27.3	23.6	11.9	6.0	0.0
Berea	3.1	14.9	19.6	19.1	24.3	15.6	3.4	0.0
Leribe	2.0	4.0	11.2	31.6	28.3	17.8	4.3	0.8
Butha-Buthe	0.0	1.5	17.8	21.4	38.7	13.2	6.7	0.6

Figure 34: Deprivation headcount ratio (%) by dimension and education level of the father, 24–59 months

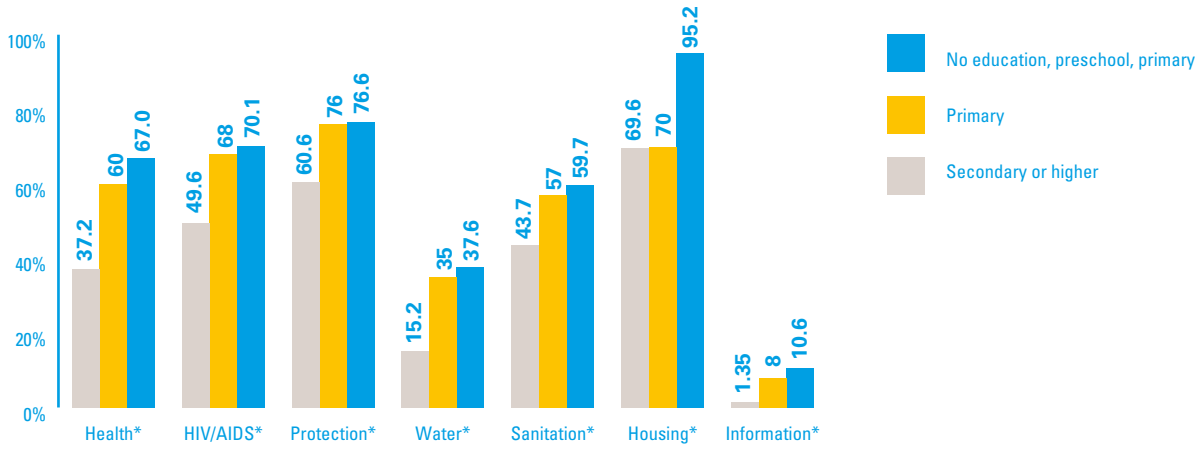


Figure 35: Deprivation headcount ratio (%) by dimension and a child's stunting status, 24–59 months

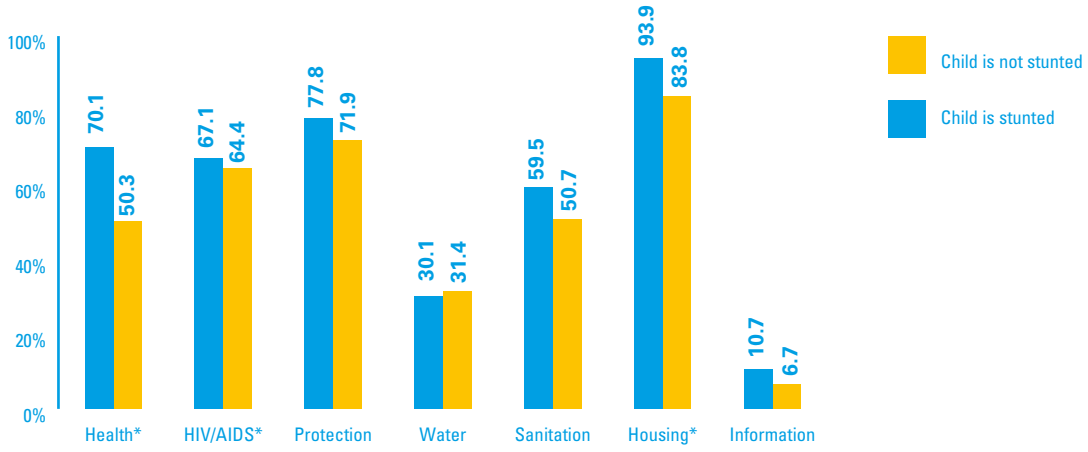
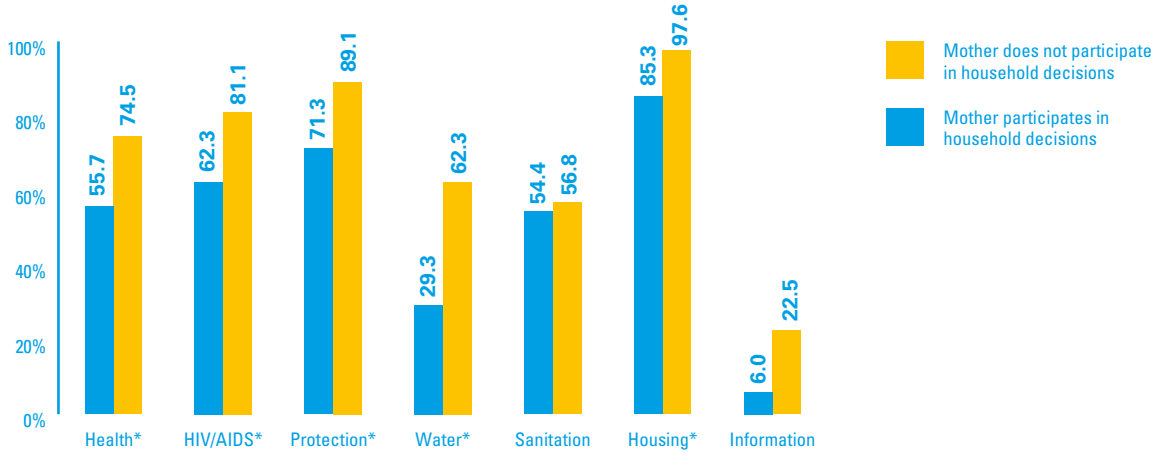


Figure 36: Deprivation headcount ratio (%) by dimension and the mother's participation in household decisions, 24–59 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Multidimensional deprivation indices

Figure 39 shows the *multidimensional deprivation headcount ratio* of children aged 24–59 months. Data show that almost all children of this age are deprived in at least one dimension, with only 2.2 per cent not deprived in any of the analysed dimensions. If children are considered multidimensionally poor if they are deprived in three or more dimensions at a time, then 78 per cent of children aged 24–59 months are multidimensionally deprived. This underlines the need to address child poverty through multi-sectoral policies, especially since more than 9 out of 10 children aged 24–59 months are simultaneously deprived in at least two dimensions.

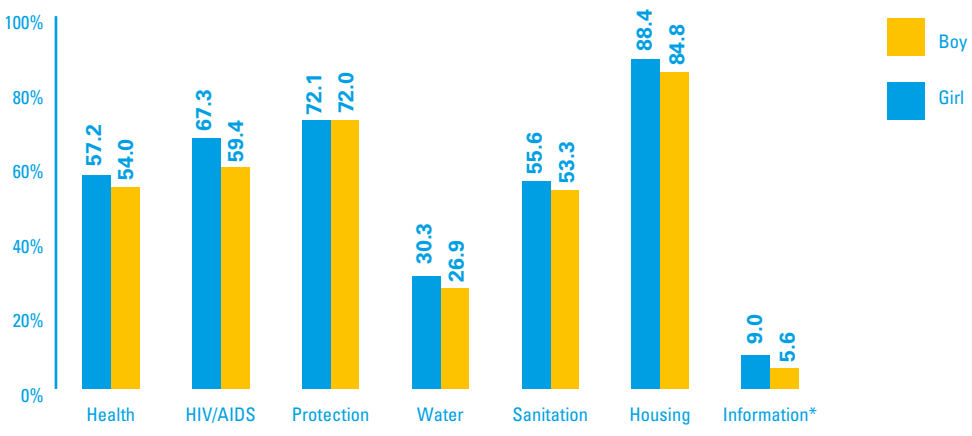
Figure 40 shows the deprivation headcount ratio at the national level and for children in rural and urban areas. Overall, children living in urban areas are better off than children living in rural areas. Specifically, 86.2 per cent of children aged 24–59 months living in rural areas face three or more deprivations simultaneously, compared to 56.7 per cent of those in urban areas. However, a high proportion of all children experience deprivation in at least one or two dimensions, regardless of the area of residence (96.4 per cent for rural children and 79.4 per cent for urban children). It is therefore important to focus on rural and urban areas, and target those children who are multidimensionally poor.

The *intensity of deprivation* is the average number of dimensions that multidimensionally poor children (i.e. deprived in at least three dimensions simultaneously) experience. The intensity of deprivation provides valuable information on how poor the poor children are. Data on multidimensional poor children aged 24–59 months show that they are deprived, on average, in 4.3 dimensions (out of a total of 7 dimensions). In other words, multidimensionally poor children are deprived in 61.1 per cent of the total number of dimensions.

The *Multidimensional Child Poverty Index* combines the multidimensional deprivation headcount and the average intensity. It is used to compare different profiles to each other, with a higher index value indicating higher vulnerability. As shown in Figure 41, urban areas with an Multidimensional Child Poverty Index of 0.31 are doing better than rural areas with an Multidimensional Child Poverty Index of 0.54 with respect to multidimensional poverty of children aged 24–59 months. Figure 41 also shows the deprivation headcount ratio, deprivation intensity and Multidimensional Child Poverty Index of children aged 24–59 months in Lesotho's districts. Thaba-Tseka and Mokhotlong have the highest proportions of multidimensionally poor children in the country (92.8 per cent and 93.3 per cent, respectively). Not surprisingly, both districts also have the highest Multidimensional Child Poverty Index values (0.66 and 0.63, respectively). Children living in Berea and Maseru are doing better, although a significant proportion of them still face multiple deprivations.

Notably, the deprivation intensity (i.e. how poor are the poor children) is uniformly distributed across districts in Lesotho, meaning that all multidimensionally poor children aged 24–59 months face similar levels of deprivation, regardless of their rural–urban or district location (Figure 41).

Figure 37: Deprivation headcount ratio (%) by dimension of girls and boys, 24–59 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 38: Distribution of the number of deprivations that children aged 24–59 months experience at a time at the national level (a) and by rural–urban location (b)

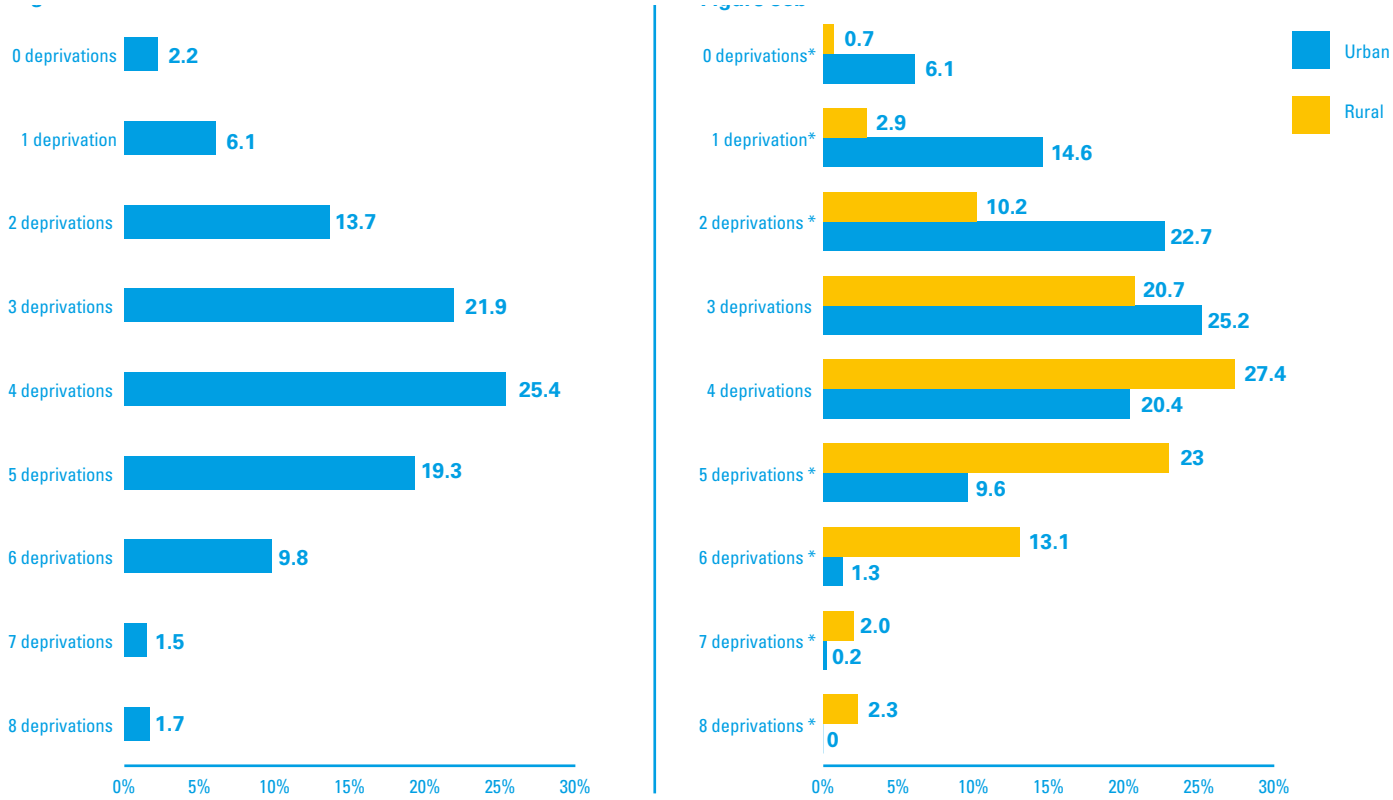
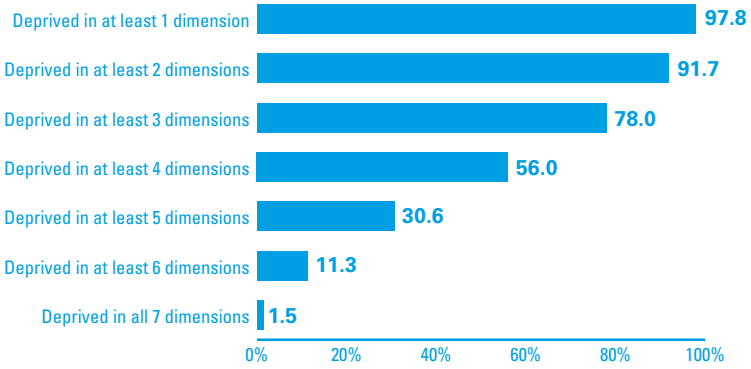


Figure 39: Multidimensional deprivation headcount ratio (%) at the national level, 24–59 months



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 40: Multidimensional deprivation headcount ratio (%) at the national level and for rural and urban children, 24–59 months

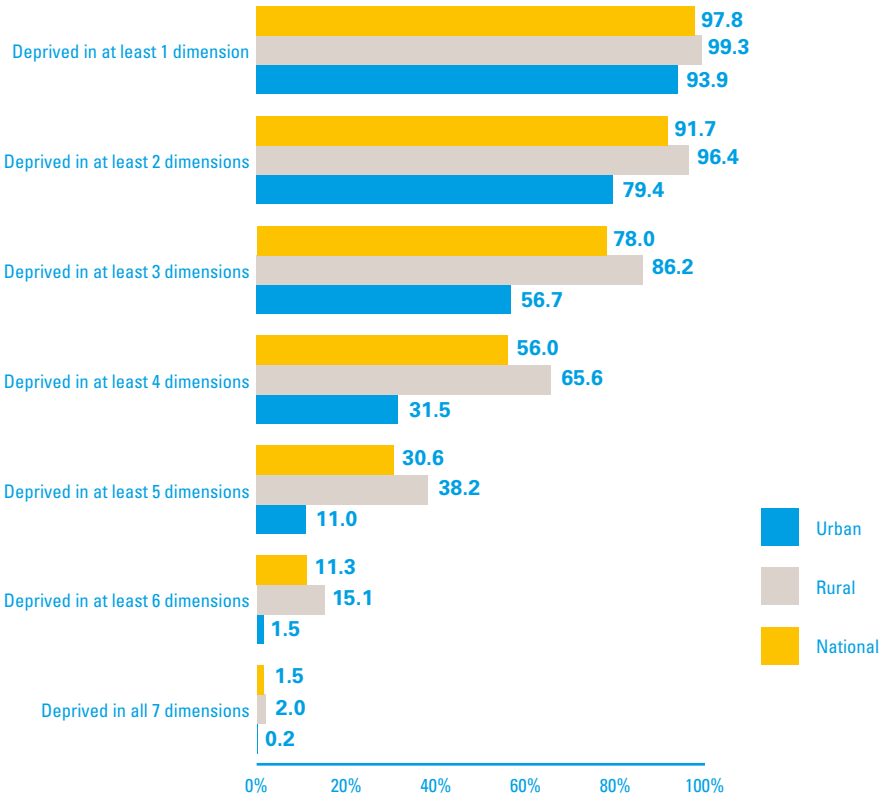
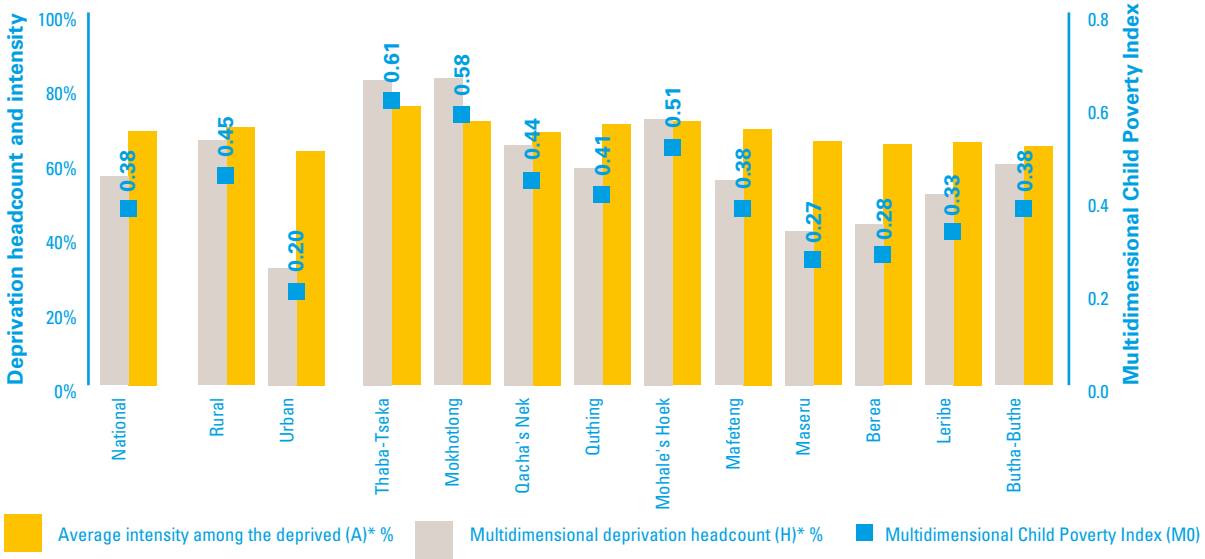
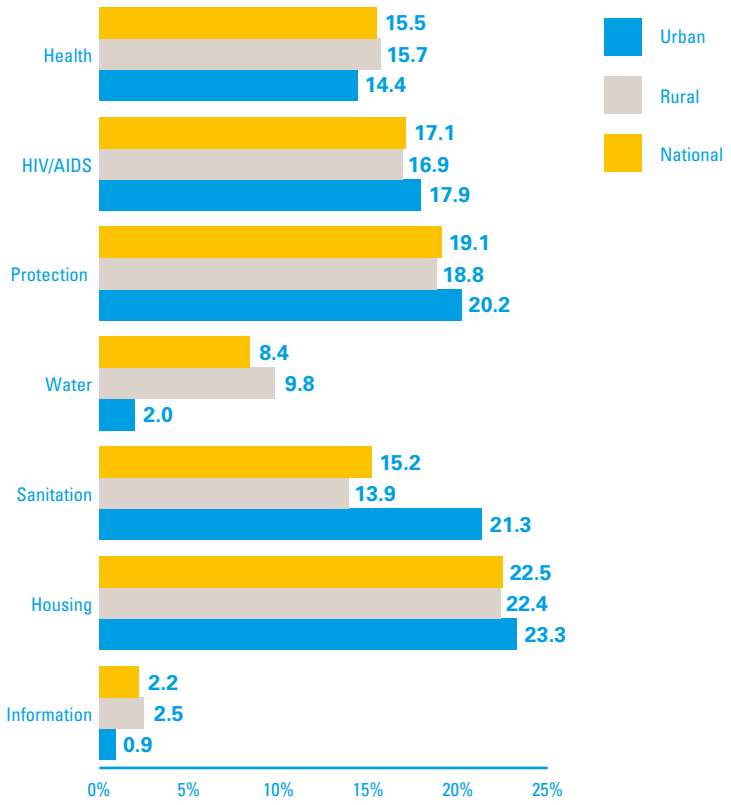


Figure 41: Multidimensional Child Poverty Indices at the national level and by rural–urban location and district, children aged 24–59 months deprived in at least three dimensions



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 42: Decomposition of the Multidimensional Child Poverty Index at the national level and by rural–urban location, 24–59 months



How does each dimension contribute to the Multidimensional Child Poverty Index?

Figure 42 shows the decomposition of the Multidimensional Child Poverty Index, revealing the contribution of each dimension to the multidimensional profile of child poverty. At the national level, housing (22.5 per cent), protection (19.1 per cent) and HIV/AIDS (17.1 per cent) are the main contributors to the index among children aged 24–59 months. Although the distribution of dimensions is largely similar for rural and urban areas, there are some differences in decomposition between these areas, which are worth mentioning. Specifically, sanitation plays a more important role in child deprivation in urban than in rural areas (21.3 per cent and 13.9 per cent, respectively). The dimension of water, however, contributes more to deprivation in rural than in urban areas (9.8 per cent and 2.0 per cent, respectively). Notably, children are more deprived in the information dimension in rural than in urban locations (2.5 per cent and 0.9 per cent, respectively).

Deprivation overlap analysis

Figure 43 presents the deprivation overlap for each dimension for children aged 24–59 months. From a multidimensional perspective, it is important to conceptualize how children in each of the measured dimensions are also deprived in any other given dimensions. As Figure 43 shows, very few children in this age group are deprived in just one dimension. In fact, most children aged 24–59 months are deprived in three or four dimensions, in addition to the given dimension. This pattern of vulnerability is important for policymaking as it shows which combinations of policies should be addressed together to efficiently target multidimensional child poverty.

Example of deprivation overlap of three dimensions

The analysis of the deprivation overlap can also be graphically displayed in the form of a Venn diagram. Figure 44 presents the deprivation overlap of three dimensions – HIV/AIDS,

protection and housing – for children aged 24–59 months. For brevity, only this example is included here. The deprivation overlap of other combination of dimensions is included in Annex 2. Figure 44 shows that among children aged 24–59 months, there is a large deprivation overlap between HIV/AIDS, protection and housing. Specifically, it reveals that 44 per cent of children in this age group are simultaneously deprived in all three dimensions. Moreover, one in five children are also deprived in the overlap between protection and housing (20.7%). Notably, only 3.5 per cent of children in the age group 24–59 months are simultaneously deprived in HIV/AIDS and protection.

The differences between rural and urban areas are also worth noting. The proportion of children living in rural areas that are simultaneously deprived in HIV/AIDS, protection and housing is more than double that of children living in urban locations (52.5 per cent and 22.1 per cent, respectively). Moreover, 10.2 per cent of urban children aged 24–59 months are not deprived in any of the three dimensions, compared to only 1.0 per cent of children living in rural areas. Interestingly, there is a similar proportion of children in rural and in urban locations who are deprived in the overlap between HIV/AIDS and housing (13.2 per cent and 13.8 per cent, respectively). This analysis provides evidence in identifying the most vulnerable children, which can subsequently be used to design policy actions that tackle overlapping vulnerabilities together.

3.3.3 Children aged 5–12 years

Main trends for children aged 5–12 years

- Of children aged 5–12 years, 57.2 per cent are multidimensionally poor, being deprived in three or more dimensions of their well-being.
- The multidimensionally poor children are deprived, on average, in 3.8 out of a total of 7 dimensions.
- Almost all (95.8 per cent) of children experience deprivation in at least one dimension of well-being.
- The highest rates of deprivation experienced by children aged 5–12 years are in the dimensions of housing, sanitation and health (88.1 per cent, 50.7 per cent and 49.4 per cent, respectively).
- Overall, children living in rural areas have higher deprivation rates than children living in urban areas.
- Boys face higher deprivation rates in education compared to girls (22 per cent and 12.8 per cent, respectively).
- Of all districts, Maseru and Berea have the lowest proportions of deprived children. Comparatively, children living in Thaba-Tseka and Mokhotlong experience the highest number of deprivations in the country.

3.3.3.a Sectoral deprivation analysis

This section presents the sectoral analysis of children aged 5–12 years. The deprivation analysis for children in this age group uses seven dimensions of well-being, namely health,

Figure 43: Deprivation overlap for each dimension, 24–59 months

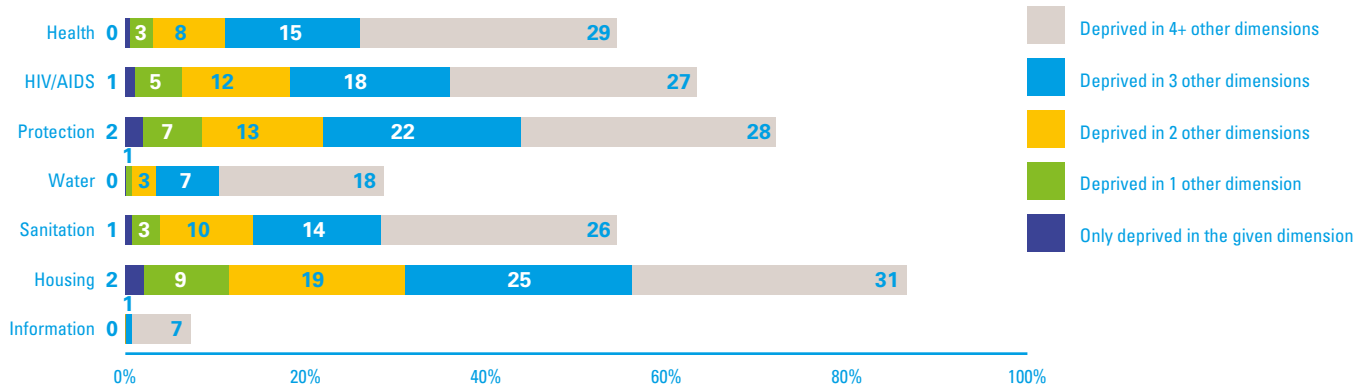
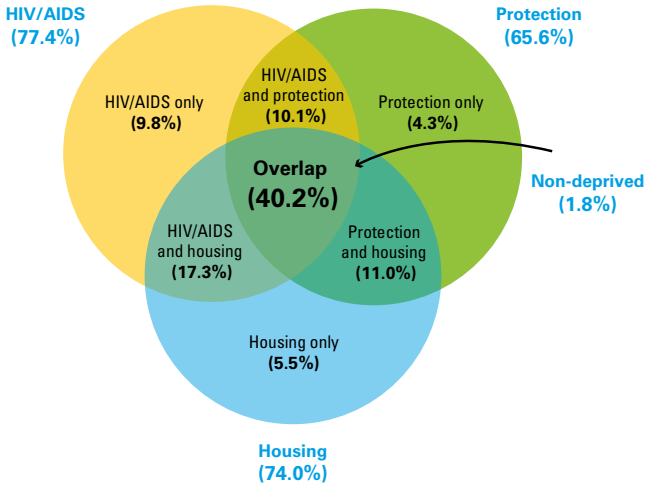
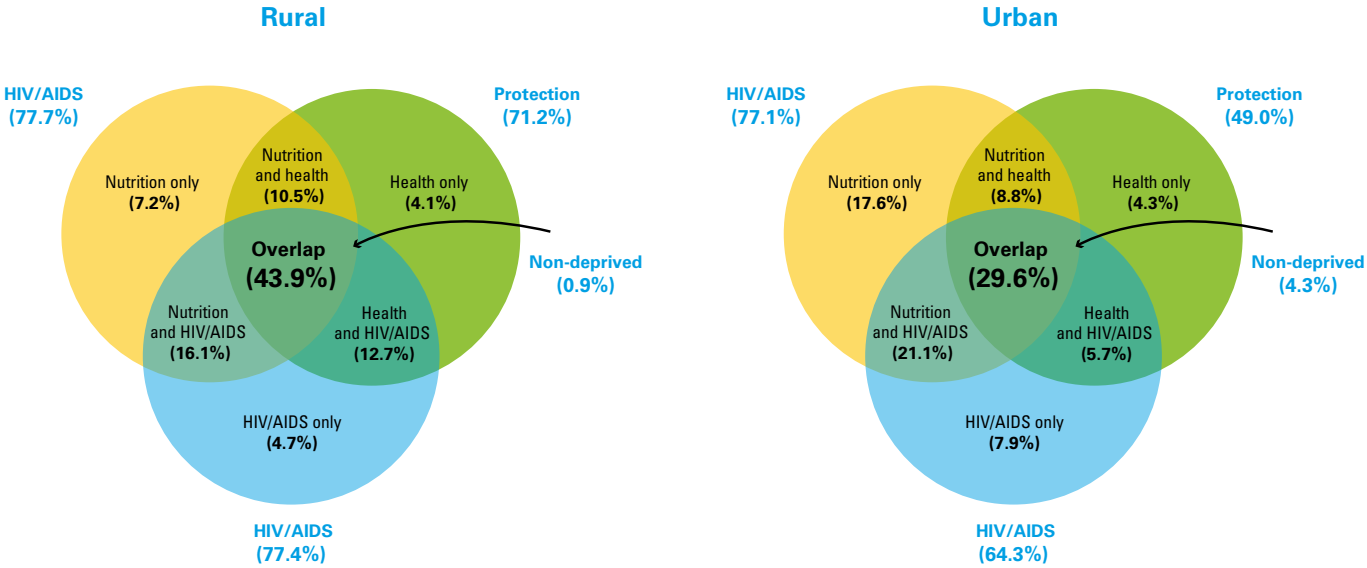


Figure 44: Deprivation overlap between the dimensions HIV/AIDS, protection and housing at the national level and by rural–urban location, 24–59 months





protection, education, water, sanitation, housing and information.[15] The indicators for each of these dimensions, and their deprivation levels are presented in Figures 45 and 46.

Similar to the younger age groups, the dimension of housing yields the highest deprivation rate among children aged 5–12 years, at 88.1 per cent. The dimensions with the next highest deprivation rates among children in this age group are sanitation (50.7 per cent) and health (49.4 per cent). The deprivation rates of all dimensions and their indicators are presented below.

The dimension of *health* is measured using the distance to the closest health care facility as an indicator. About half (49.4 per cent) of the children in this age group live in a household located more than 30 minutes away from the closest health care centre.

Attitude towards domestic violence was used to measure the dimension of *protection*. A deprivation rate of 35.9 per cent was recorded. In other words, more than one third of all children aged 5–12 years live in households that tolerate domestic violence.

The dimension of *education* is only measured for children aged 6 years and older, following the official age of compulsory primary-school enrolment in Lesotho. Data were not available for early childhood development, but this information is expected to be included in future demographic and health surveys of Lesotho.

Education outcomes are paramount to a child's development and success in later life. This study employs two indicators to measure the education of children aged 6–12 years: school attendance (the child is deprived if she/he does not attend school); and grade-for-age (the child is deprived if she/he lags two or more years in education). Results show that 9.5 per cent of children aged 6–12 years do not attend school, while 8.6 per cent of children lag behind in school by at least two years, resulting in a total deprivation rate of 17.3 per cent in the dimension of education.

The dimension of *water* is measured using two indicators: the water source and the distance to the water source. Data show that 20.5 per cent of Basotho children aged 5–12 years live in a household with an unimproved drinking water source, and 20.3 per cent of them live in a household where it takes more than 30 minutes to reach the nearest water source. The resulting deprivation rate for the dimension of water is 32.3 per cent.

The dimension of *sanitation* has a deprivation rate of 50.7 per cent, driven by indicators measuring the type of toilet facility, and the sharing of it. Among children aged 5–12 years, 35.2 per cent of them live in a household with unimproved toilet facilities, while 49.6 per cent of them live in a household with shared toilets. For children of this age, using unimproved toilets, or shared facilities, can be unhygienic, as well as dangerous, especially for girls.

The highest deprivation rate experienced by children aged 5–12 years is in the dimension of *housing* (88.1 per cent). This deprivation is mostly driven by a lack of access to electricity, which affects 79 per cent of children in this age group. Electricity is an important commodity for children of this age group, as it allows school-going children to study and do homework after nightfall. In the absence of electricity, children may use lighting sources that are detrimental to health (e.g. wood or coal fires) or are dangerous (e.g. petroleum lanterns). Unimproved cooking fuel is used in households of 71.2 per cent of children aged 5–12 years. In addition, 41.4 per cent of children in this age group live in an overcrowded house (i.e. where there are more than three people per sleeping room). Overcrowding is particularly harmful for children of school-going age because sharing rooms does not allow for private space or the opportunity to study and do homework in a calm environment.

The dimension of *information* has the lowest deprivation rate among children aged 5–12 years. Specifically, 10.3 per cent of children in this age group live in a household that does not use or own a radio, a television or a mobile phone.

15 For age groups 5–12 years and 13–17 years, it was not possible to include an HIV/AIDS dimension due to data limitations. Specifically, many older children did not have an adult in the household who was eligible for the questionnaire related to knowledge on HIV/AIDS. The sampling strategy of the LDHS targeted women aged 15–49 years in all sampled households, while men aged 15–59 were sampled in only half of the sampled households. To avoid issues related to missing data, a decision was made to omit the HIV/AIDS dimension from the analyses involving older children.

Figure 45: Deprivation headcount ratio (%) of each indicator at the national level, 5–12 years

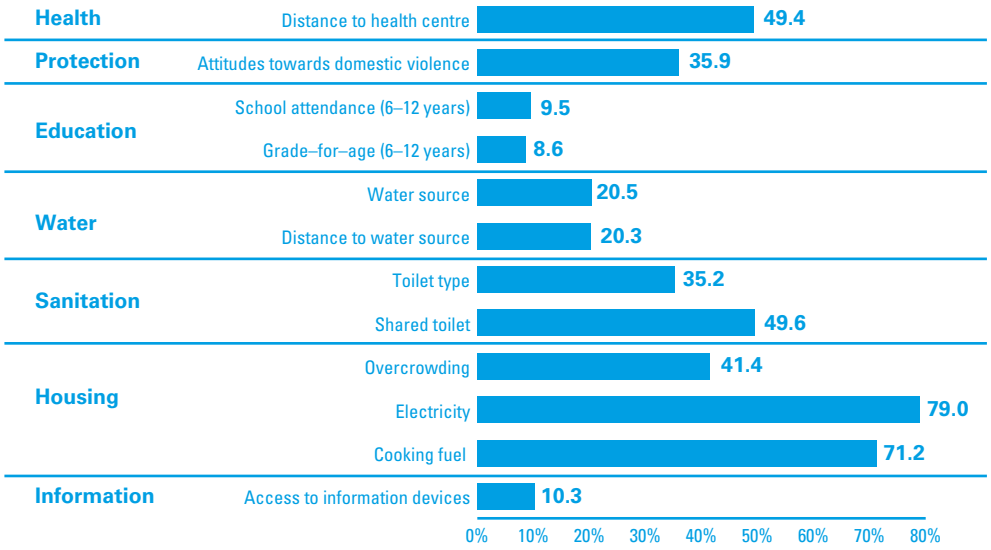
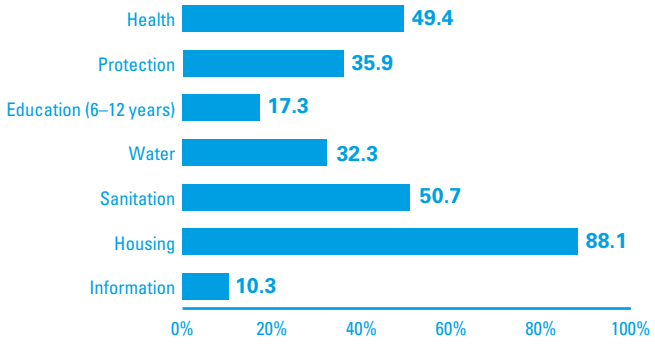


Figure 46: Deprivation headcount ratio (%) of each dimension at the national level, 5–12 years



Profiling deprived children aged 5–12 years

The dimensions of well-being are further analysed by including a set of profiling characteristics. These are discussed below in terms of deprivation rates of children aged 5–12 years.

Geographical location

With the exception of the sanitation dimension, there is a significantly higher proportion of rural children deprived in all the dimensions of well-being in contrast to urban children (Figure 47). The greatest difference between the rural–urban deprivation of children is observed for the dimensions of water (38.9 per cent and 8.2 per cent, respectively) and housing (95.5 per cent and 60.6 per cent, respectively).

Table 11 presents the deprivation rates of children aged 5–12 years for each dimension of well-being in the ten districts of Lesotho. Thaba-Tseka has the highest proportion of deprived children in four out of seven dimensions – education (26.2 per cent), water (50.6 per cent),

housing (98.1 per cent) and information (23.4 per cent). At the same time, Mokholong children have high deprivation rates in the dimensions of protection (41.5 per cent), education (25.7 per cent) and sanitation (76.2 per cent). On the other hand, Leribe, Berea and Maseru have relatively low deprivation rates for all the dimensions studied.

When disaggregated by ecological zones (Table 12), it is found that children living in the mountains have higher deprivation rates across most dimensions of well-being, while children living in the lowlands are least deprived.

Table 11: Deprivation rates by dimension and district, 5–12 years

Region	Health*	Protection*	Education*	Water*	Sanitation*	Housing*	Information*
Thaba-Tseka	66.8	35.7	26.2	50.6	63.6	98.1	23.4
Mokhotlong	58.4	41.5	25.7	43.8	76.2	96.8	15.9
Qacha's Nek	59.4	40.1	19.6	22.8	54.2	95.2	16.5
Quthing	45.0	41.0	15.7	29.1	46.4	94.3	9.4
Mohale's Hoek	65.3	25.5	23.2	34.6	61.1	93.8	7.9
Mafeteng	42.6	36.5	15.3	35.3	50.4	83.5	8.8
Maseru	45.5	41.6	14.9	14.9	46.9	75.4	7.2
Berea	42.2	35.2	12.2	35.6	50.0	84.7	5.3
Leribe	39.8	30.1	12.0	42.8	34.9	89.8	6.5
Butha-Buthe	41.1	32.9	15.8	23.1	37.8	93.7	15.1

Table 12: Deprivation rates by dimension and ecological zone, 5–12 years

	Health*	Protection*	Education*	Water*	Sanitation*	Housing*	Information*
Senqu River valley	63.0	31.7	21.9	25.3	53.2	97.2	9.4
Mountains	66.1	38.8	24.3	45.9	60.4	97.6	18.9
Foothills	57.5	42.0	17.8	32.0	55.7	99.2	12.3
Lowlands	34.8	33.4	12.2	26.1	43.3	77.9	5.0

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Number of children in the household

With the exception of the information dimension, children in households with more children have higher deprivation rates across all dimensions of well-being (Figure 49). The biggest gap in deprivation rates is observed for health, protection, education and water dimensions. For instance, almost half of all children (48 per cent) who live in households of five or more children are deprived in the dimension protection, compared to 27 per cent of children living in a household of one or two children.

Figure 47: Deprivation headcount ratio (%) by dimension in rural and urban locations, 5–12 years

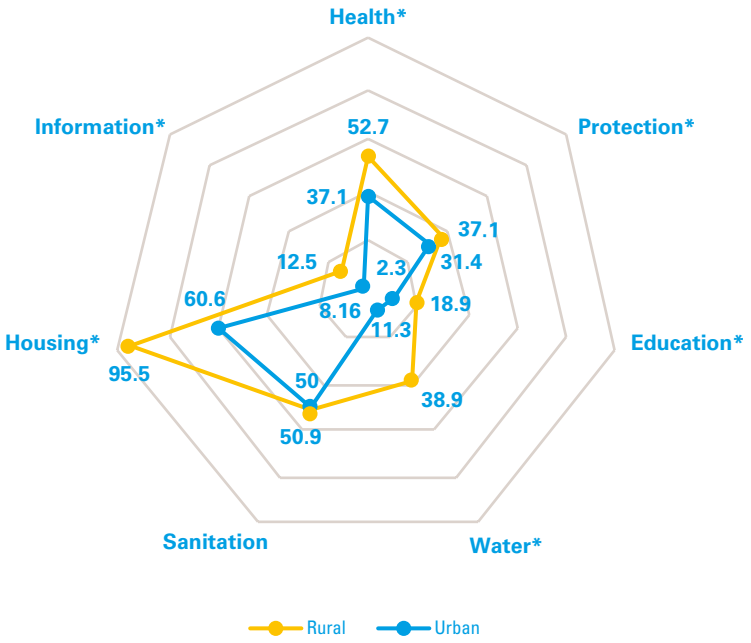
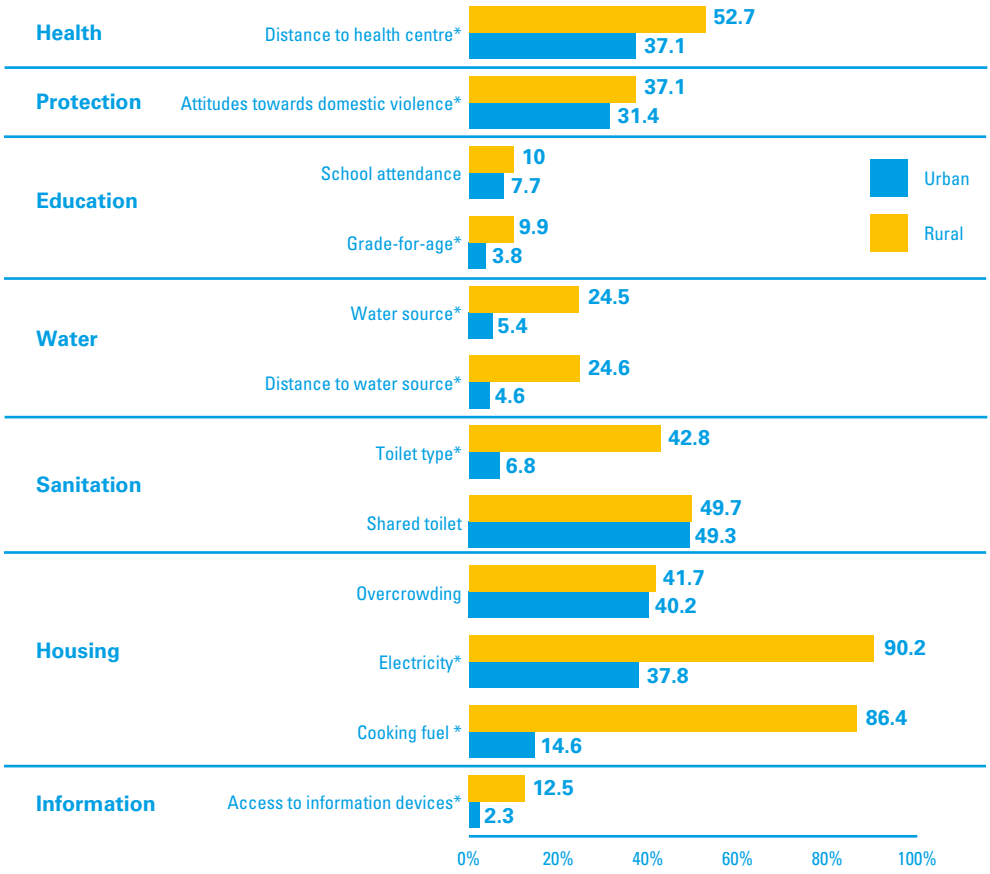


Figure 48: Deprivation headcount ratio (%) by indicator in rural and urban locations, 5–12 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Education level of the household head

Children living with more-educated household heads are less deprived across all dimensions of well-being (Figure 50). Notably, all children whose household head has no education or attained only preschool (100 per cent) are deprived in the dimension of housing. In comparison, the deprivation rate among children whose household head has secondary or higher education is 61 per cent in the same dimension. Higher gaps in the deprivation rates for children according to the education level of the household head are also observed for health, education and information dimensions.

Gender of the child

There is little difference in the deprivation rates for boys and girls in all dimensions of well-being, except for education (Figure 51). Specifically, more boys (22 per cent) aged 5–12 years compared to girls (13 per cent) are deprived in education, in that they lag behind in school, or do not attend it.

Orphanhood

Orphans have higher deprivation rates in all dimensions, except in protection and sanitation. The gap in deprivation between orphans and children whose parents are alive is higher in health (53 per cent versus 48 per cent) and information (16 per cent versus 8 per cent) (Figure 52).

3.3.3.b Multidimensional deprivation analysis

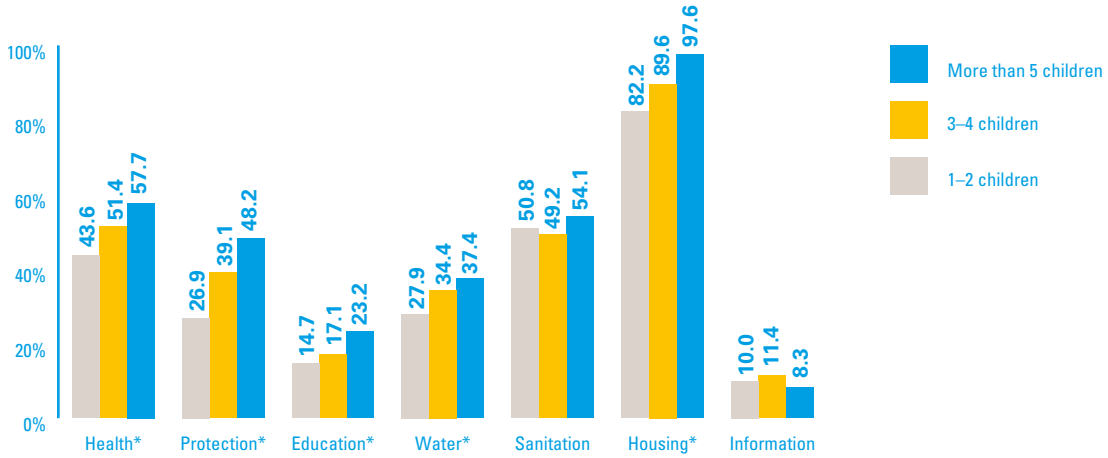
Number of deprivations faced by children aged 5–12 years

Figure 53 shows the distribution of deprivations in the population of children aged 5–12 years at the national level and by the rural–urban location.

The number of deprivations affecting most children in this age group at the national level (Figure 53a) cluster around two, three and four simultaneous deprivations (affecting 25.1 per cent, 26.1 per cent, and 19.6 per cent of children, respectively). Only 4.2 per cent of children aged 5–12 years face no deprivations, while 11.5 per cent of children experience between five and seven deprivations simultaneously.

The number of simultaneous deprivations experienced by children in urban areas is lower, overall, compared to children living in rural locations (Figure 53b). Specifically, the vast majority of urban children are simultaneously deprived in 0–3 dimensions (86.4 per cent) whereas a similar proportion of children (73.6 per cent) in rural areas experience 2–4 deprivations at a time. Notably, 13.1 per cent of urban children aged 5–12 years are not deprived in any of the dimensions measured and no urban children in this age group experience the maximum of seven deprivations simultaneously. The corresponding rates for rural children are 1.8 per cent and 0.3 per cent, respectively.

Figure 49: Deprivation headcount ratio (%) by dimension and number of children in the household, 5–12 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 50: Deprivation headcount ratio (%) by dimension and level of education of the household head, 5–12 years

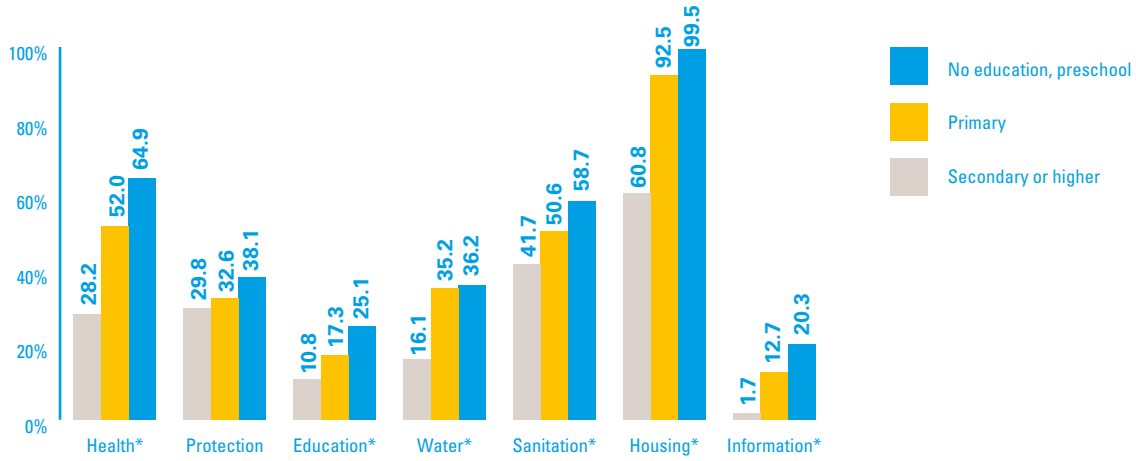


Figure 51: Deprivation headcount ratio (%) by dimension of girls and boys, 5–12 years

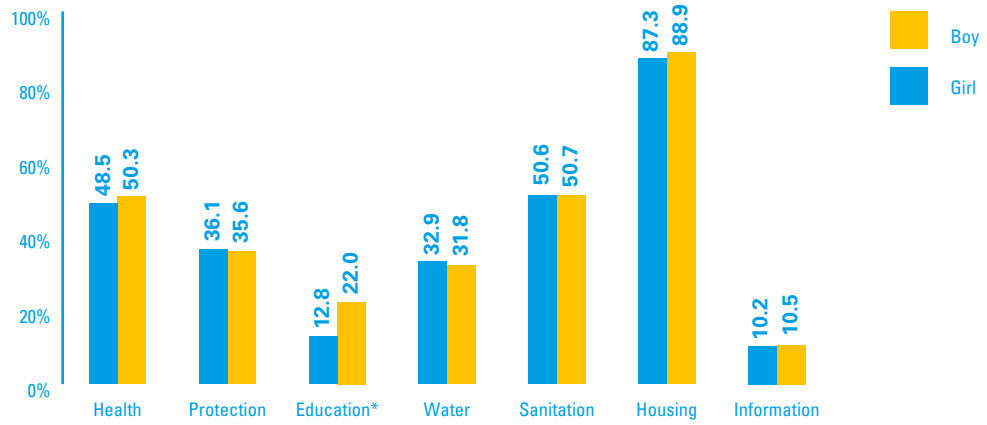
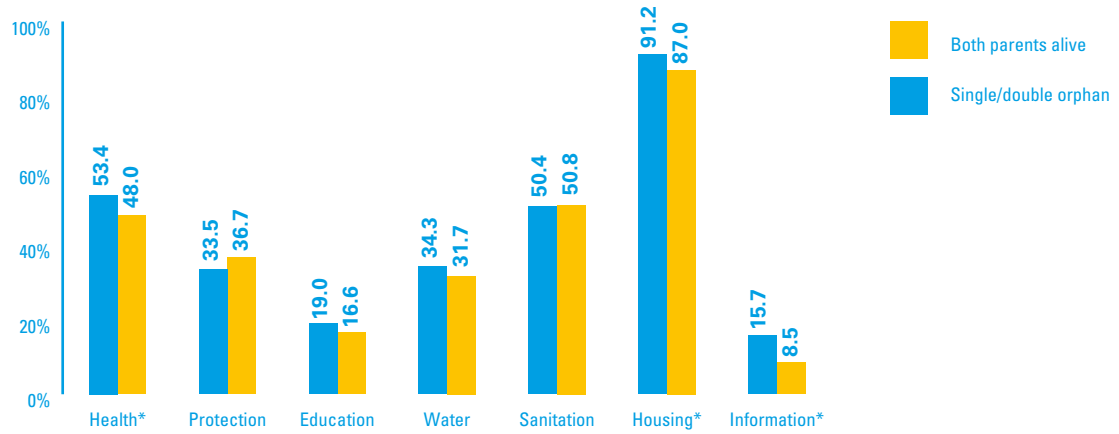
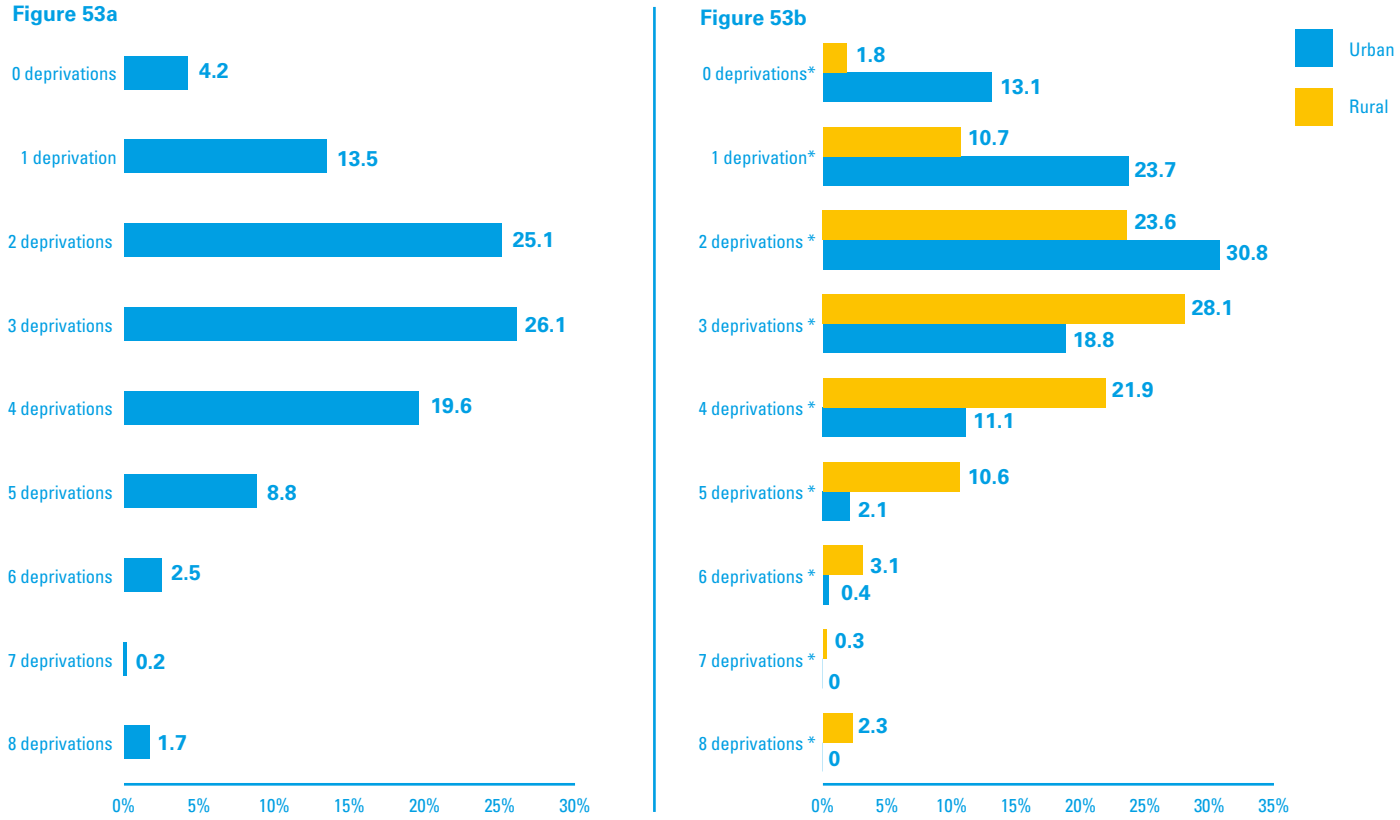


Figure 52: Deprivation headcount ratio (%) by dimension and orphanhood, 5–12 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 53: Distribution of deprivation level at the national level (a) and by rural–urban location (b), 5–12 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Table 13 shows the distribution of deprivations among children aged 5–12 years by district. Of all districts, Maseru and Berea have the highest proportion of children deprived in 0–1 dimensions and the lowest proportion of children deprived in 6–7 dimensions. Comparatively, children living in Thaba-Tseka and Mokhotlong experience the highest number of deprivations in the country. Notably, in all districts, a very low proportion of children aged 5–12 years are simultaneously deprived in all 7 dimensions (between 0 per cent and 0.7 per cent). The distribution of deprivations by district among children aged 5–12 years largely mirrors that of children of younger age groups.

Table 13: Distribution of simultaneous deprivations by district, 5–12 years

Districts	Number of simultaneous deprivations experienced by the child							
	0	1	2	3	4	5	6	7
Thaba-Tseka	0.5	6.1	15.7	22.1	29.5	18.3	7.1	0.7
Mokhotlong	1.9	4.0	14.1	26.7	30.7	16.4	5.4	0.7
Qacha's Nek	1.4	13.5	19.7	27.4	23.0	11.5	3.4	0.2
Quthing	2.3	16.2	28.9	23.4	16.6	9.1	3.1	0.5
Mohale's Hoek	2.3	9.1	22.5	28.7	22.3	10.7	4.3	0.1
Mafeteng	6.2	13.2	23.9	27.1	21.4	6.7	1.3	0.2
Maseru	6.8	17.8	29.6	24.5	14.8	4.5	1.8	0.2
Berea	6.4	16.3	24.0	25.3	20.0	7.6	0.5	0.0
Leribe	4.2	15.7	30.2	29.5	13.6	5.9	0.8	0.0
Butha-Buthe	3.3	15.4	32.2	27.1	14.8	6.7	0.5	0.0

Figure 54: Multidimensional deprivation headcount ratio (%) at the national level, 5–12 years

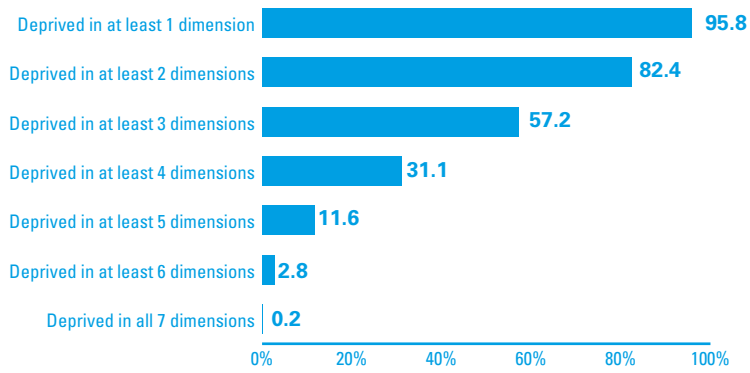
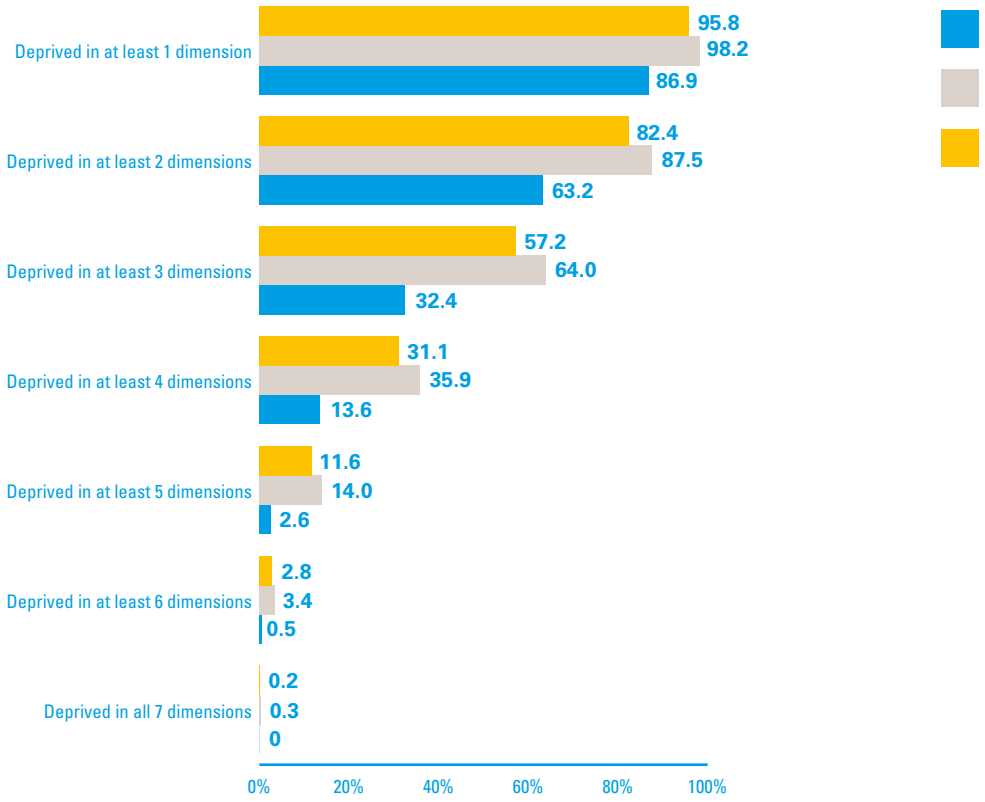


Figure 55: Multidimensional deprivation headcount ratio (%) at the national level and in rural and urban locations, 5–12 years



Multidimensional deprivation indices

Figure 54 presents the *multidimensional deprivation headcount ratio* for children aged 5–12 years, at the national level. Similar to previous age groups, almost all children aged 5–12 years are deprived in at least one dimension. A proportion of 57.2 per cent of children in this age group are multidimensionally poor, meaning they face three or more deprivations simultaneously. Notably, relatively few children are simultaneously deprived in six or seven dimensions (2.8 per cent and 0.2 per cent, respectively).

Figure 55 shows the *multidimensional deprivation headcount* at the national level and by rural–urban location. Almost twice as many children aged 5–12 years living in rural areas are multidimensionally poor (using three simultaneous deprivations as the cut-off point) compared to urban children (64 per cent and 32.4 per cent, respectively). Moreover, at all cut-off points urban children are doing better than rural children.

The *intensity of deprivation* is the average number of dimensions that multidimensionally poor children (deprived in at least three dimensions) experience. This value provides additional information on the depth of deprivation (i.e. how poor the poor children are). Children aged 5–12 years who are multidimensionally poor have, on average, 3.8 out of a total of 7 deprivations, which translates to a rate of 61.1 per cent of the total number of dimensions. The intensity of deprivation of children aged 5–12 years is similar to that of younger age groups.

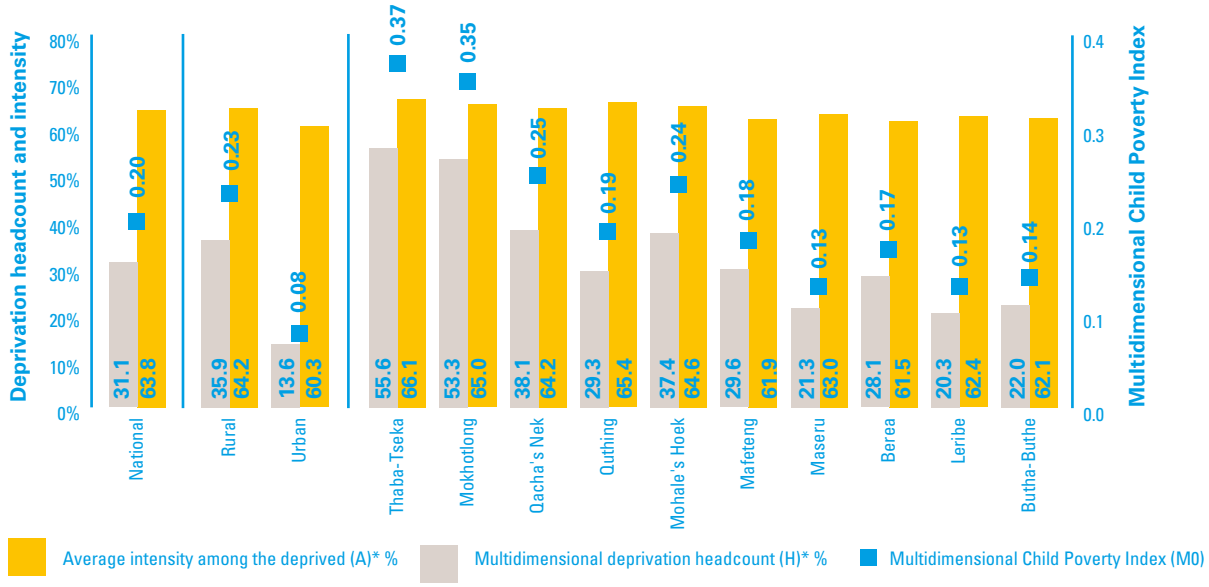
Figure 56 presents the *Multidimensional Child Poverty Index* at the national level and by area of residence (rural–urban and district). It is calculated as the product of the deprivation headcount and the average intensity. A higher indexed value indicates more vulnerability. Data show that urban children aged 5–12 years are doing significantly better in comparison to children living in rural areas (0.16 and 0.35, respectively).

Figure 56 also shows the multidimensional poverty indices (headcount ratio, intensity of deprivation and Child Poverty Index) by district for children aged 5–12 years. Across districts, Maseru has the lowest deprivation headcount, of 0.24, while children living Thaba-Tseka and Mokhotlong have the highest (0.46 each). As per other age groups, the average intensity of deprivation among children aged 5–12 years is rather similar across all districts. It implies that the severity of deprivation among the most deprived children is similar across the country.

How does each dimension contribute to the Multidimensional Child Poverty Index?

Figure 57 shows the decomposition of dimensions for multidimensionally poor children aged 5–12 years in Lesotho. Overall, the dimensions of housing, sanitation and health are large contributors to multidimensional child deprivation at the national level. However, some differences in the decomposition between urban and rural areas can be observed, mainly in relation to water and protection. In the rural context, the water dimension contributes more towards multidimensional child deprivation than in urban areas (13.8 per cent and 5.9 per cent, respectively). On the contrary, the protection dimension contributes more to the multidimensional deprivation of children in urban locations than in rural locations of residence (17.6 per cent and 12.6 per cent, respectively). Notably, the dimension of education contributes equally to the multidimensional deprivation of children in rural and urban contexts (6.2 per cent).

Figure 56: Multidimensional Child Poverty Indices at the national level and by rural–urban area and district for children aged 5–12 years deprived in at least three dimensions



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Deprivation overlap analysis

Figure 58 presents the deprivation overlap of any given dimension in relation to the remaining six other dimensions for children aged 5–12 years. It is important to observe how deprivations overlap as the results presented so far show that being deprived in any given dimension often goes together with being deprived in other dimensions. Indeed, the majority of children aged 5–12 years are being deprived in the given dimension plus three or more additional dimensions. For example, out of 88.1 per cent of children deprived in housing, less than 10 per cent are deprived in housing alone; 79.7 per cent are deprived in at least one other dimension.

Figure 57: Decomposition of the Multidimensional Child Poverty Index, 5–12 years

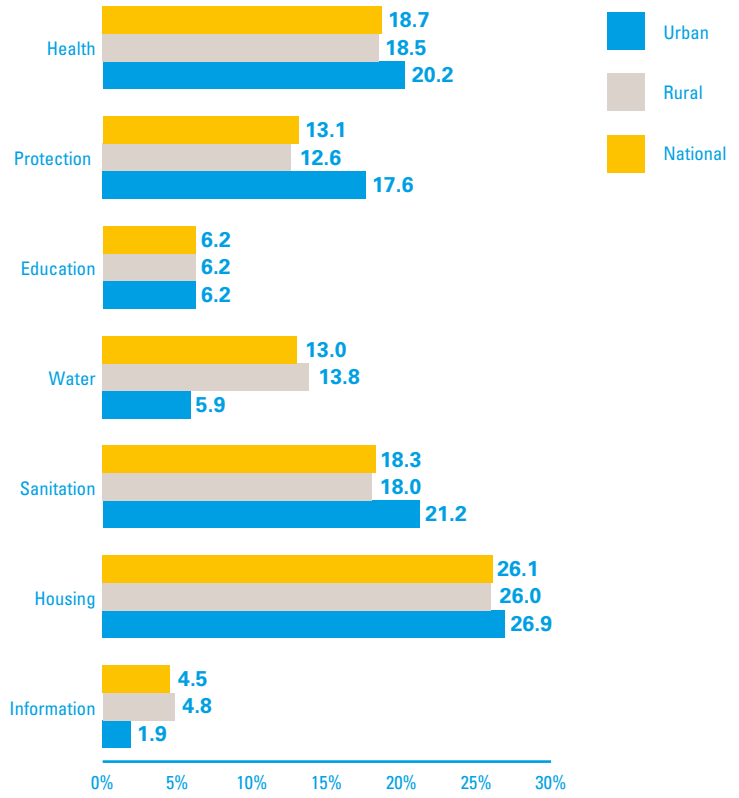
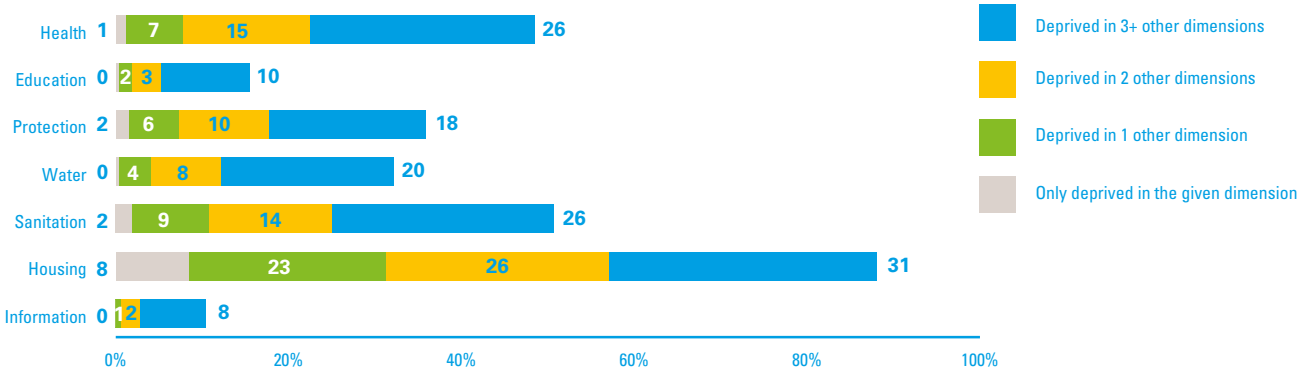


Figure 58: Deprivation overlap for each dimension, 5–12 years



Example of deprivation overlap of three dimensions

Figure 59 shows the deprivation overlap of three dimensions – water, sanitation and housing – at the national level and by rural–urban location, for children aged 5–12 years. This example uses Venn diagrams to plot the deprivation overlap. For brevity, only this example is presented here, but overlap in any other combinations of three conditions are included in Annex 2.

Figure 59 reveals that 18.7 per cent of children aged 5–12 years are simultaneously deprived in all three dimensions. The overlap between sanitation and housing affects 28.5 per cent of children, while the overlap between water and housing affects 12.8 per cent of children in this age group.

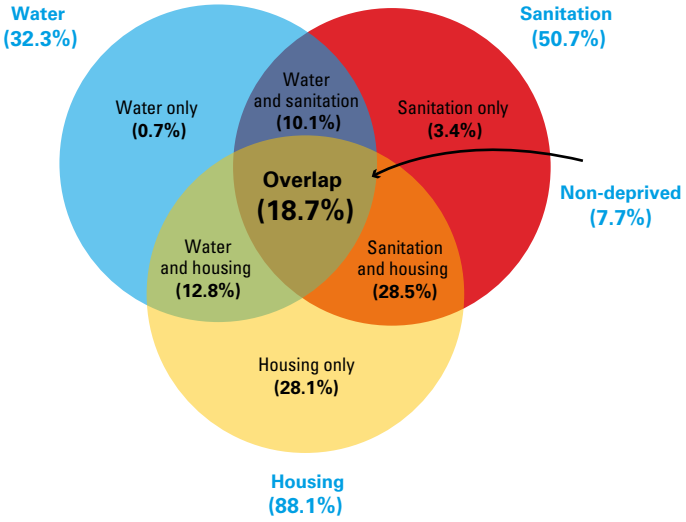
The desegregation of the deprivation overlap of the three dimensions into rural and urban areas shows contrasting results. In the rural context, 22.6 per cent of children aged 5–12 years are simultaneously deprived in water, housing and sanitation, while in urban areas, this rate is only 4 per cent (Figure 59). Furthermore, there is a higher proportion of children that are not deprived in any of the three dimensions in urban areas compared to children in rural areas (25.4 per cent and 3 per cent, respectively). The findings of this example reveal the importance of addressing the vulnerabilities together in specific contexts such as rural areas.

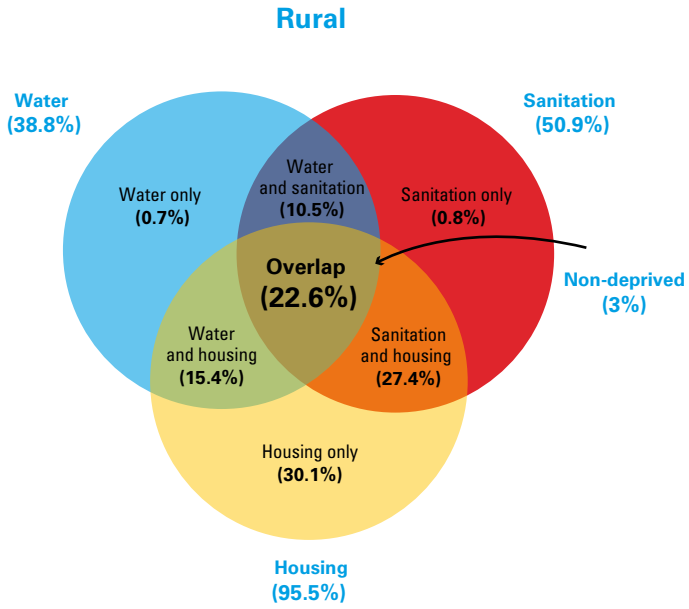
3.3.4 Children aged 13–17 years

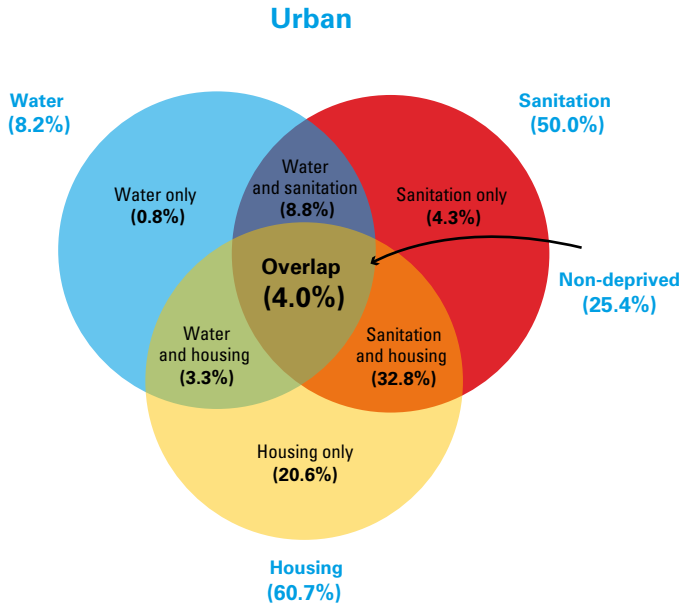
Main trends for children aged 13–17 years

- Of children aged 13–17 years, 67.3 per cent are multidimensionally poor, being deprived in at least three dimensions of well-being.
- The multidimensionally poor children experience, on average, 4.1 out of 7 deprivations.
- Almost all (96.1 per cent) of children in this age group face at least one deprivation.
- The highest rates of deprivation experienced by children aged 13–17 years are in the dimensions of housing, education and sanitation, (84.2 per cent, 61.6 per cent and 48.2 per cent, respectively).
- Almost one fifth (17.5 per cent) of the children in this age group do not attend school. More than half (53.4 per cent) of children in this age group lag by two or more years in education.
- Children living in rural areas have significantly higher deprivation rates than children living in urban areas. Moreover, rural children face more multiple deprivations than urban children.
- Boys are significantly more deprived in education than girls (72.4 per cent of boys compared to 49.9 per cent of girls).
- Children living in Maseru and Berea face a relatively low number of deprivations, whereas children living in Thaba-Tseka and Mokhotlong are more multidimensionally deprived.

Figure 59: Deprivation overlap between the dimensions of water, sanitation and housing at the national level and by rural–urban location, 5–12 years







3.3.4.a Sectoral deprivation analysis

The deprivation analysis of children aged 13–17 years includes seven dimensions of well–being, namely health, protection, education, water, sanitation, housing and information. The deprivation rates for the indicators are presented in Figure 60, and the deprivation rates for the dimensions are presented in Figure 61.

As observed with the younger age groups, the dimension of *housing* yields the highest rate of deprivation for children aged 13–17 years at 84.2 per cent. In contrast to the previous age group, the dimension of *education* comes second, with 61.6 per cent of all children aged 13–17 deprived in schooling, while *sanitation*, with a deprivation rate of 48.2 per cent, comes third. The deprivation rates for each of the dimensions and their indicators are presented below.

The *health* dimension is measured by distance to the nearest health facility, with 44.2 per cent of children deprived in this age group.[16]

19.9 per cent of children live in households where it takes more than 30 minutes to fetch water from the nearest water source.

The *protection* dimension is measured by the attitude towards domestic violence. It shows that 42.5 per cent of children aged 13–17 years live in households in which the domestic violence is tolerated.

As mentioned above, the *education* dimension has the second highest deprivation rate among children aged 13–17 years, standing at 61.6 per cent. The dimension is measured by two indicators: school attendance and grade-for-age. Data show that 17.5 per cent of children in this age group do not attend school, while 53.4 per cent lag behind in education by two or more years. The high deprivation rate for education in this age group reflects the fact that secondary-school education is non-compulsory in Lesotho, and hence not subsidised by the government. This results in high dropout rates among children in locations without secondary-school facilities and among children whose families cannot afford the costs of secondary-school education. Policy actions that target school infrastructure and costs of education may do well to reduce this vulnerability among children of secondary-school age.

The *water* dimension includes information on the source of drinking water and the distance to the water source; it holds an overall deprivation rate of 31.8 per cent among children aged 13–17 years. Data on indicators show that 19.1 per cent of children live in households that have unimproved drinking water sources, and 19.9 per cent of them live in households where it takes more than 30 minutes to fetch water from the nearest water source.

The *sanitation* dimension has a deprivation rate of 48.2 per cent and is measured by indicators that look at the type of toilet facilities and the use of shared toilet facilities. The results show that 31.4 per cent of children aged 13–17 years live in households with unimproved toilet facilities, and 47.2 per cent of them share the toilet facilities with people that are not members of the household.

Of all dimensions, *housing* has the highest deprivation rate, affecting 84.2 per cent of children aged 13–17 years. As is the case for younger age groups, this deprivation is mostly driven by the lack of electricity, which affects 74.7 per cent of children. In addition, 67.4 per cent of children in this age group live in households that use unimproved cooking fuel. Furthermore, one in three children of this age group (33 per cent) live in overcrowded conditions (i.e. there are three or more people per sleeping room).

Consistent with results from younger age groups, the *information* dimension yields the lowest deprivation rate of all dimensions, affecting 9.6 per cent of children aged 13–17 years. This dimension is measured by the access to media and communication devices such as a radio, a television or a mobile phone.

Profiling deprived children aged 13–17 years

In this section, the deprivation rates of children are measured for a number of profiling characteristics.

16 A household is located far away from a health care centre when it takes more than 30 minutes with any means of transportation in urban areas, and more than 60 minutes with a vehicle or 120 minutes by foot in rural areas to reach the facility.

Figure 60: Deprivation headcount ratio (%) for each indicator at the national level, 13–17 years

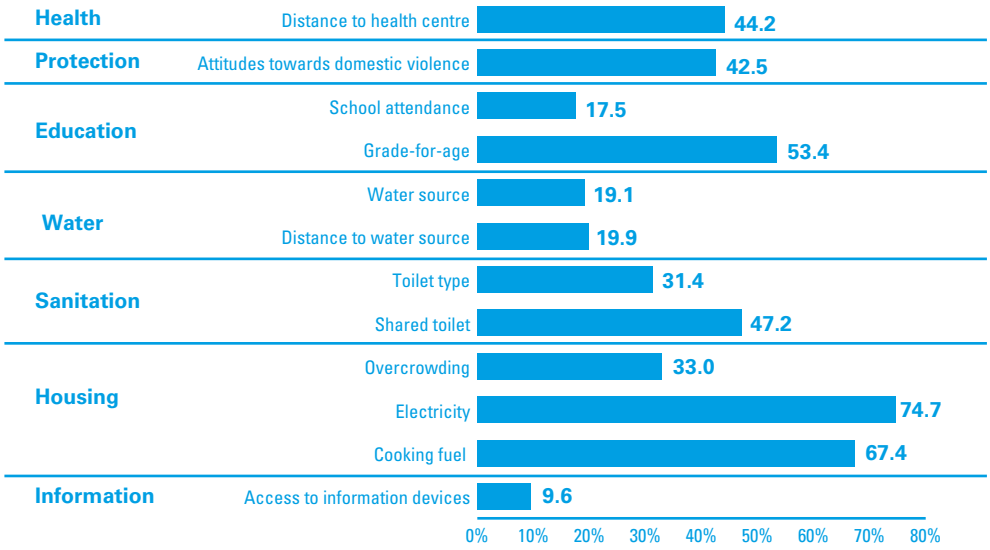
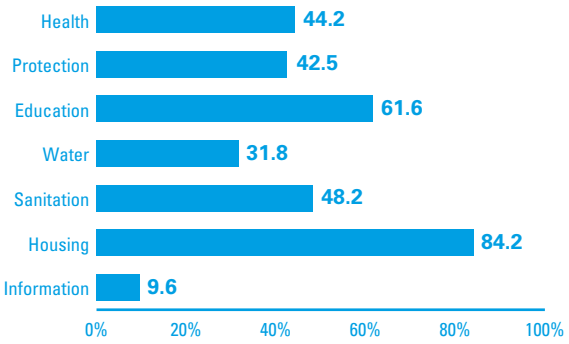


Figure 61: Deprivation headcount ratio (%) for each dimension at the national level, 13–17 years



Geographical location

Similar to previous age groups, rural children are more vulnerable than children living in urban areas. Figure 62 shows higher deprivation rates for rural areas in all dimensions of well-being. Except in sanitation, the observed differences are statistically significant. The most remarkable disparity can be found in the dimension of housing, with a difference of 42.2 percentage points between urban and rural areas; this discrepancy is driven by indicators related to cooking fuel and access to electricity.

Table 14 presents the deprivation rates for each dimension disaggregated by districts for children aged 13–17 years. Thaba-Tseka is doing worst out of all districts with the highest proportion of deprived children in the dimensions of health (63.1 per cent), education (77.9 per cent), water (52.4 per cent), housing (96.1 per cent) and information (23.8 per cent). Mokhotlong has the highest deprivation rate in sanitation (75.8 per cent). An interesting observation is the fact that nearly half of the children living in Maseru are deprived in the dimension of protection. On the other hand, Maseru has relatively low proportions of deprived children in all other dimensions of a child's well-being. The districts of Berea and Leribe are also doing well.

Figure 62: Deprivation headcount ratio (%) by dimension in rural and urban locations, 13–17 years

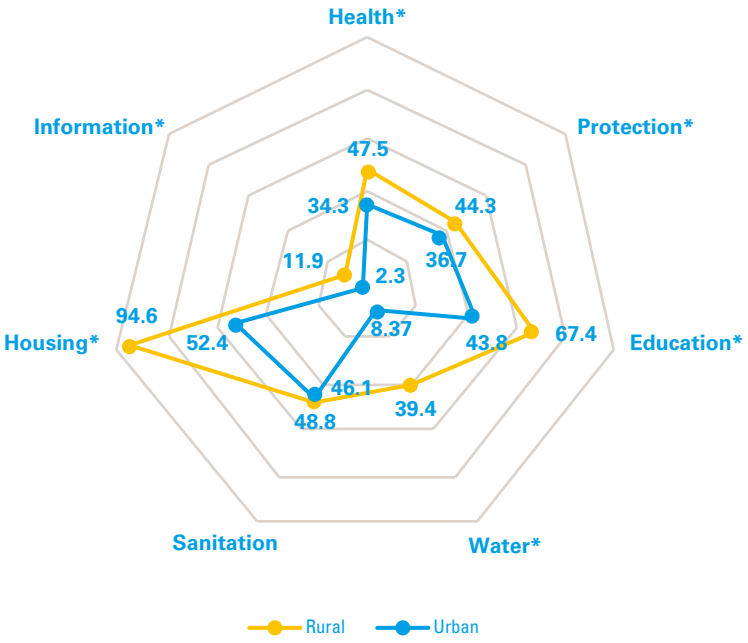
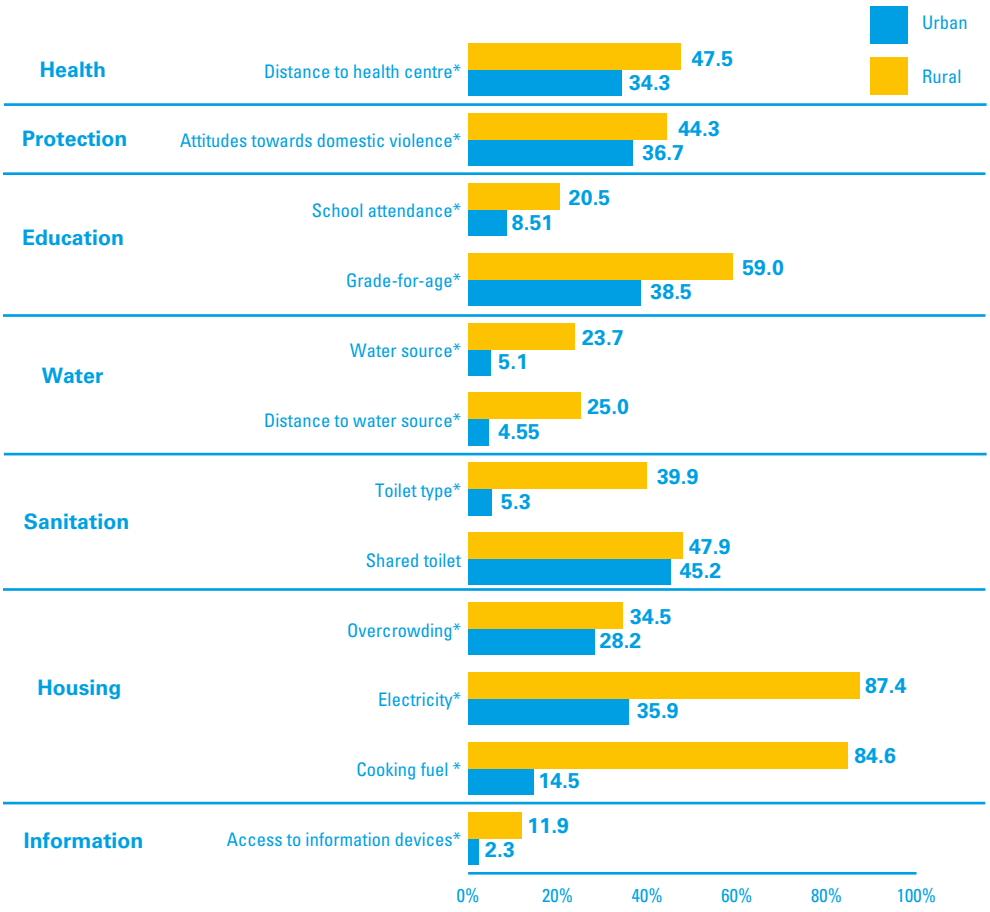


Figure 63: Deprivation headcount ratio (%) by indicator in rural and urban locations, 13–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

With respect to ecological zones (Table 15), lowlands have the lowest deprivation rates of all ecological zones in all dimensions studied. Mountainous zones are worst off.

Table 14: Deprivation rates by dimension and district, 13–17 years

District	Health*	Protection*	Education*	Water*	Sanitation*	Housing*	Information*
Thaba-Tseka	63.1	41.2	77.9	52.4	59.8	96.1	23.8
Mokhotlong	50.9	44.2	75.6	39.7	75.8	95.7	14.3
Qacha's Nek	58.1	47.8	61.0	20.4	48.1	90.7	14.1
Quthing	41.8	45.5	66.0	30.1	43.7	95.2	7.6
Mohale's Hoek	54.0	30.1	69.0	32.4	57.8	92.4	12.5
Mafeteng	38.0	48.4	62.6	29.5	47.3	82.9	9.0
Maseru	42.2	49.4	54.9	19.5	47.4	69.0	5.9
Berea	38.5	43.5	54.9	31.5	36.5	78.1	6.3
Leribe	34.8	36.9	57.0	37.9	39.1	83.9	4.6
Butha-Buthe	41.2	35.7	53.2	30.2	40.1	90.9	12.2

Table 15: Deprivation rates by dimension and ecological zones, 13–17 years

District	Health*	Protection*	Education*	Water*	Sanitation*	Housing*	Information*
Senqu River valley	58.2	39.6	66.5	29	51.1	97.2	12.7
Mountains	58.4	44.3	76.6	42.8	59.9	95.6	19.0
Foothills	57.0	51.5	68.7	34.2	54.1	99.2	10.7
Lowlands	32.8	40.3	52.5	26.7	41.1	73.9	4.6

Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Number of children in the household

Children living in households with a higher number of children suffer from higher deprivation rates compared to children living in households with fewer children. The largest distinction can be found in the dimension of protection, with a difference of 28 percentage points between households with one or two children and households with more than five children (Figure 64).

Education level of the household head

The higher the education level of the household head, the lower the proportion of deprived children in all dimensions of well-being. The housing dimension shows a difference of 41 percentage points between household heads with no education or preschool and household heads with secondary or higher education (Figure 65).

Gender of the child

When considering gender disparities, boys are more deprived in all dimensions of well-being than girls, except in protection and sanitation (Figure 66). The highest gap in deprivation

between boys and girls is observed in education (72.4 per cent and 49.9 per cent, respectively). The gap in other dimensions between boys and girls is, however, small.

Orphanhood

Orphans experience higher deprivation rates in all dimensions than children whose parents are alive, except in protection. The highest gap between the deprivation of orphans and non-orphans is observed for education (66.4 per cent and 57.5 per cent, respectively) (Figure 67).

3.3.4.b Multidimensional deprivation analysis

Number of deprivations faced by children aged 13–17 years

Figure 70 presents the distribution of deprivations that children experience simultaneously, at the national level and by the rural–urban location. The distribution of deprivations is slightly skewed to the right (Figure 70a), reflecting that the majority of children aged 13–17 experience several deprivations at a time. Indeed, the data show that 67.3 per cent of all children aged 13–17 experience three or more simultaneous deprivations. Of these children, 23.7 per

Figure 64: Deprivation headcount ratio (%) by dimension and number of children in the household, 13–17 years

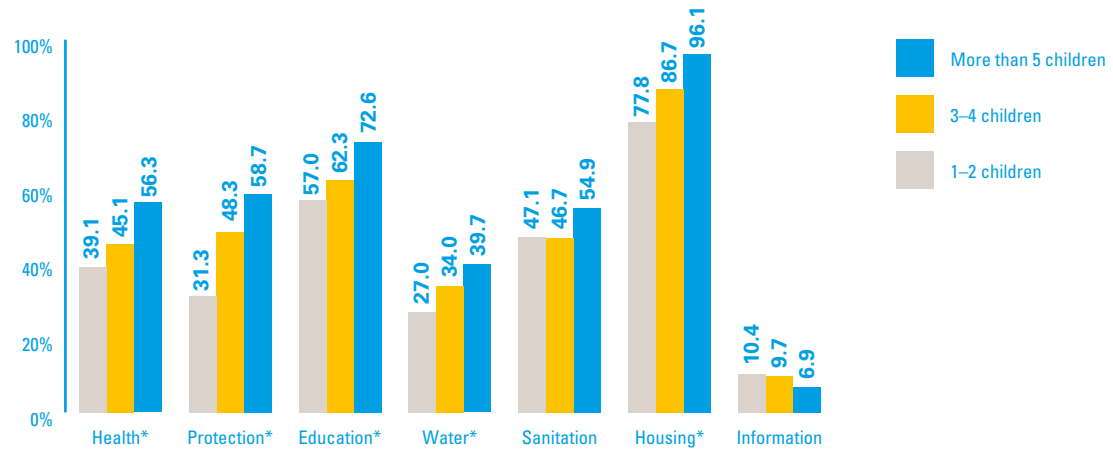
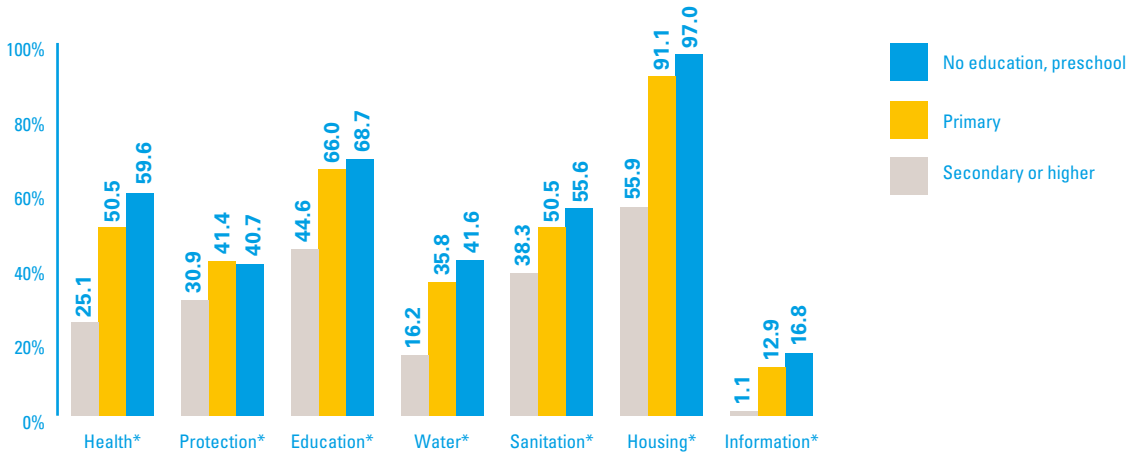


Figure 65: Deprivation headcount ratio (%) by dimension and level of education of the household head, 13–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 66: Deprivation headcount ratio (%) by dimension of boys and girls, 13–17 years

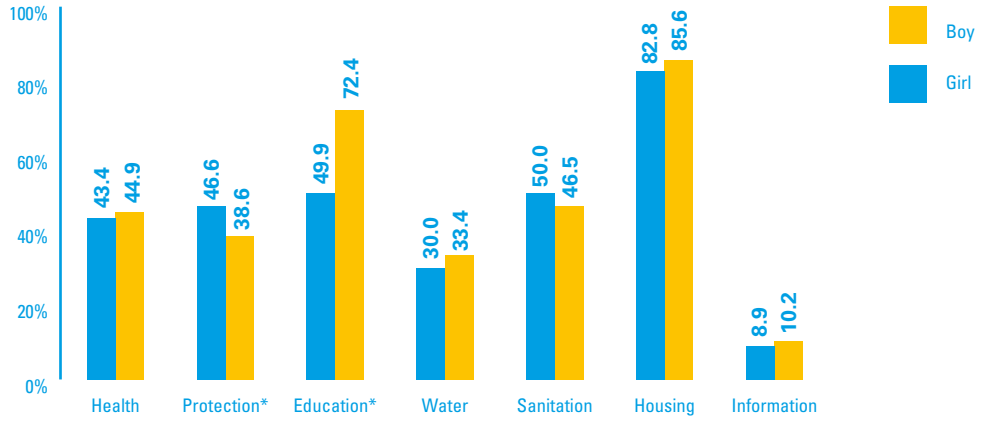


Figure 67: Deprivation headcount ratio (%) by dimension and orphanhood, 13–17 years

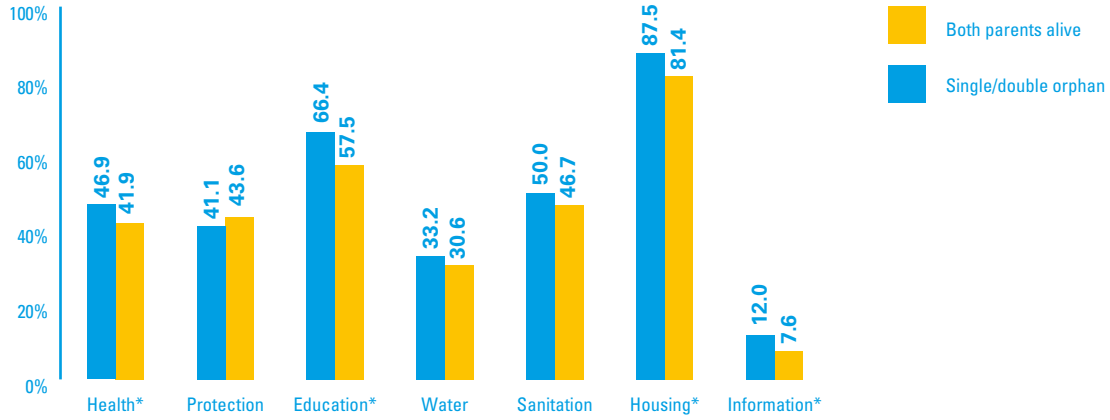
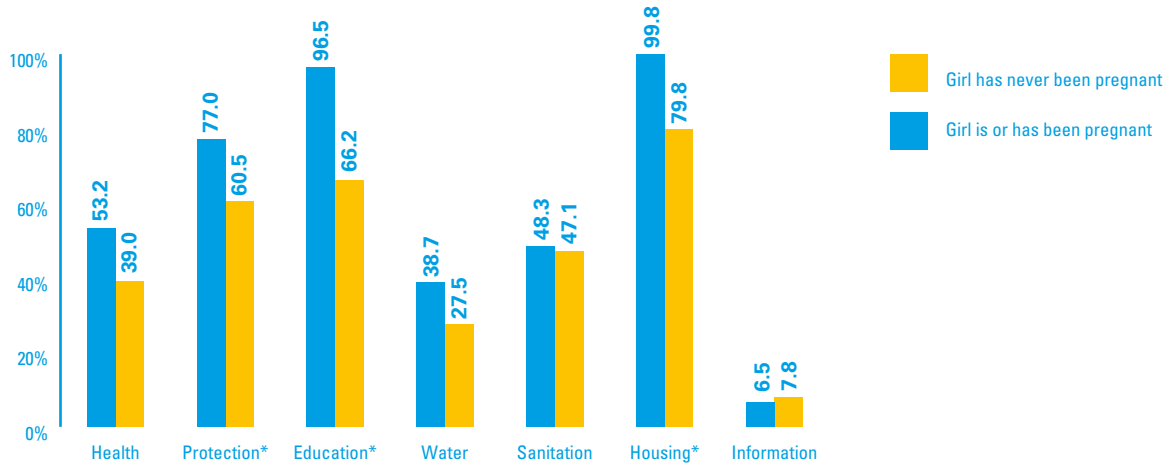


Figure 68: Deprivation headcount ratio (%) by dimension and pregnancy status of girls, 13–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

cent are deprived in exactly three dimensions at a time, while only 0.8 per cent of them are simultaneously deprived in all seven dimensions. Notably, a small proportion of children aged 13–17 years (3.9 per cent) experience no deprivations.

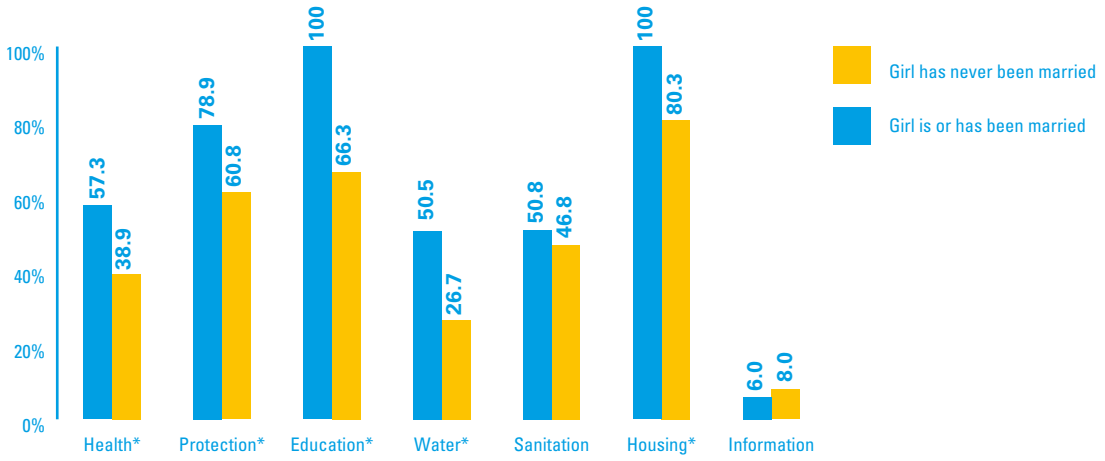
Children in rural areas experience more simultaneous deprivations compared to urban children (Figure 70b). Half of all urban children aged 13–17 years (50.0 per cent) are deprived in one or two dimensions at a time, whereas the same proportion of rural children (50.1 per cent) are simultaneously deprived in three or four dimensions. Furthermore, one in ten urban children (10.8 per cent) experience no deprivations, compared to only 1.6 per cent of rural children.

Table 16 shows the distribution of simultaneous deprivations in each of the 10 districts. Across the country, most children aged 13–17 years are simultaneously deprived in three, four or five dimensions. As per previous age groups, children living in Maseru and Berea face a relatively lower number of deprivations, whereas children living in Thaba-Tseka and Mokhotlong are more multidimensionally deprived.

Table 16: Deprivation distribution by district, 13–17 years

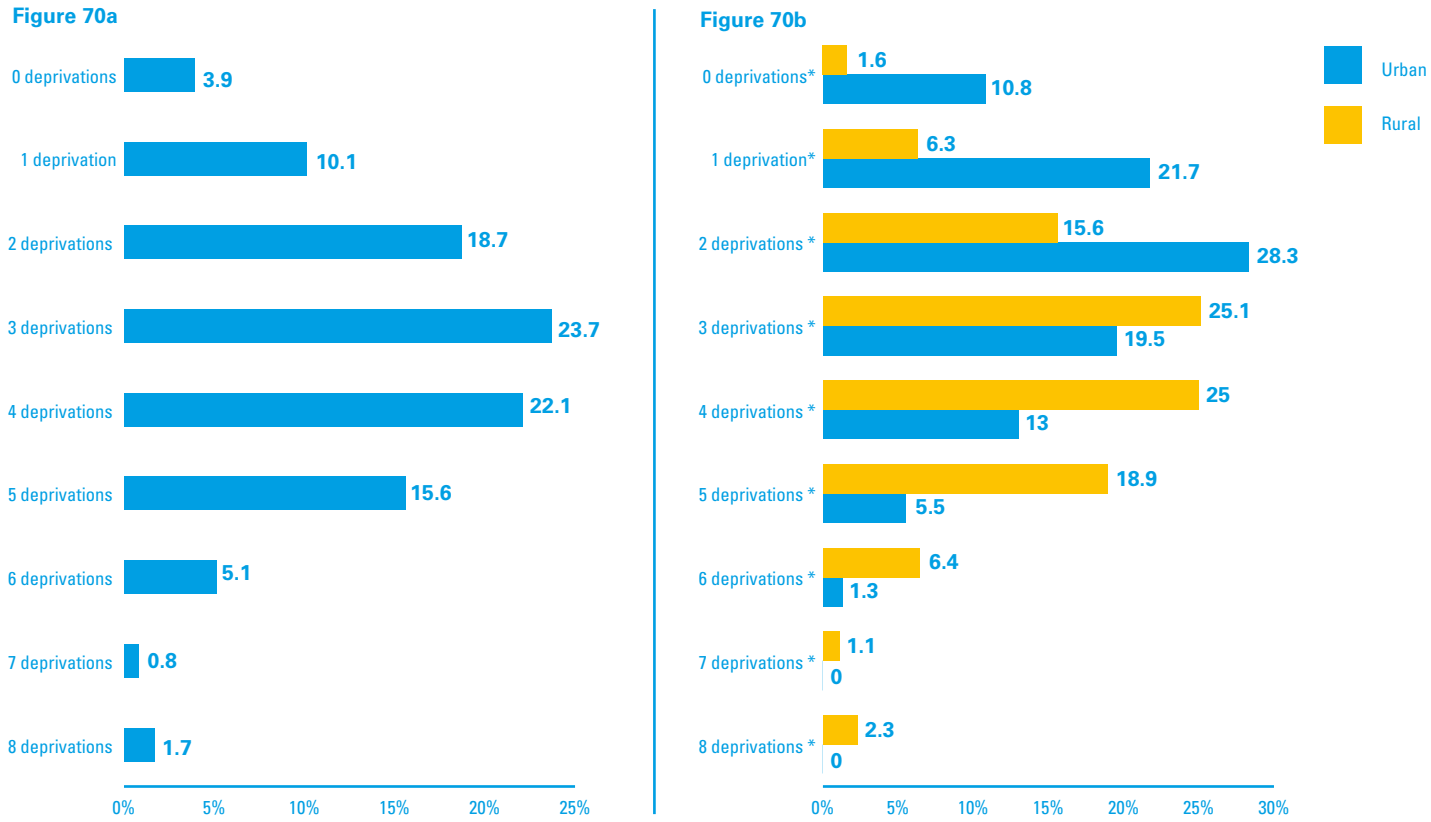
Districts	Number of simultaneous deprivations experienced by the child							
	0	1	2	3	4	5	6	7
Thaba-Tseka	0.5	2.2	10.1	18.7	24.8	29.7	10.7	3.4
Mokhotlong	2.1	2.9	8.5	20.2	26.8	30.4	8.3	0.9
Qacha's Nek	2.9	6.7	16.3	25.5	24.8	18.3	4.4	1.0
Quthing	0.9	9.4	23.0	21.2	24.6	15.4	4.0	1.6
Mohale's Hoek	2.2	6.4	18.6	24.2	20.6	19.6	7.8	0.8
Mafeteng	4.0	9.4	16.8	27.9	23.4	14.4	3.1	0.9
Maseru	6.3	15.1	22.4	18.3	21.5	11.7	4.1	0.6
Berea	6.2	15.3	20.4	23.0	17.4	13.3	4.4	0.0
Leribe	4.1	10.8	21.8	30.0	21.2	8.9	2.9	0.3
Butha-Buthe	3.6	11.4	18.9	30.6	21.6	8.3	5.7	0.0

Figure 69: Deprivation headcount ratio (%) by dimension and marital status of girls, 13–17 years



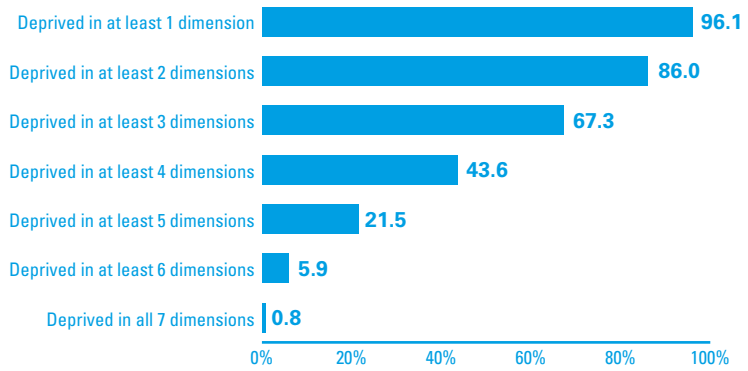
Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 70: Distribution of deprivation level at the national level (a) and by rural–urban location (b), 13–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Figure 71: Multidimensional deprivation headcount ratio (%) at the national level, 13–17 years



Multidimensional deprivation indices

Figure 71 shows the *multidimensional deprivation headcount ratio* for children aged 13–17 years. By establishing the standardized threshold of simultaneous deprivation in at least three dimensions, the proportion of multidimensionally poor children in this age group is 67.3 per cent. As a comparison, the proportion of children that are simultaneously deprived in two or more dimensions is 86 per cent.

Figure 72: Multidimensional deprivation headcount ratio (%) at the national level and in rural and urban locations, 13–17 years

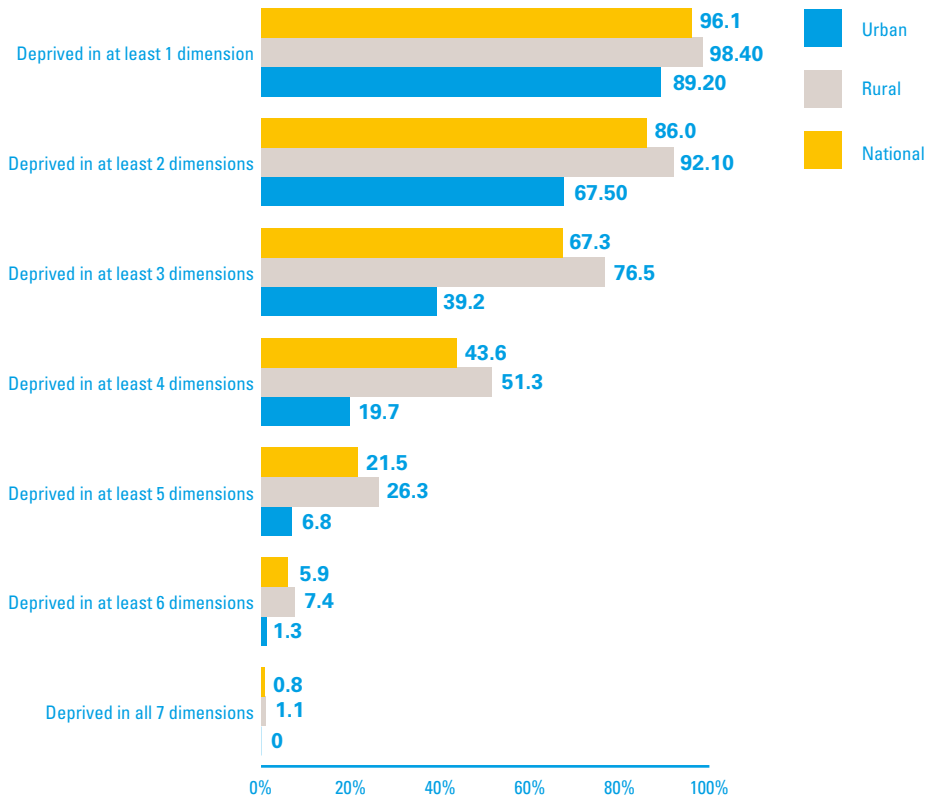


Figure 72 presents the deprivation headcount ratio for children aged 13–17 years at the national level and by rural–urban location. As pointed out above, there is a relatively large difference in deprivation rates when comparing rural and urban children in Lesotho. In the age group of 13–17 years, 76.5 per cent of rural children are multidimensionally poor (deprived in three or more dimensions at a time), whereas the proportion of similarly deprived urban children is 39.2 per cent. The lines with cut-off points for urban and rural children do not intersect, implying that at any level of deprivation, urban children are doing better than their rural counterparts.

The *intensity of deprivation* shows the depth of deprivation. Specifically, it measures the average number of dimensions that multidimensionally poor children experience (i.e. giving an indication of how poor the poor children are). For children aged 13–17 years, data show that those who are multidimensionally poor face, on average, 4.1 out of 7 deprivations. It implies that multidimensionally poor children are deprived in 58.6 per cent of the total number of dimensions.

Figure 73 presents the *Multidimensional Child Poverty Index* for children aged 13–17 years at the national level and by location. The index is calculated as the product of the multidimensional deprivation headcount and the average intensity, with higher values denoting greater vulnerability. The Multidimensional Child Poverty Index shows that children in urban areas (Multidimensional Child Poverty Index = 0.21) are doing significantly better than children in rural areas (Multidimensional Child Poverty Index = 0.45).

With respect to districts in Lesotho, the Multidimensional Child Poverty Index is the highest in Thaba-Tseka and Mokhotlong (0.56 and 0.54, respectively) and lowest in Maseru and Berea (0.33 each). The intensity of deprivation among multidimensional poor children aged 13–17 years is relatively uniform across districts, implying that poor children are equally poor across districts, and the rural–urban divide.

Figure 73: Multidimensional Child Poverty Indices at the national level and by rural–urban area and district for children aged 13–17 years deprived in at least three dimensions

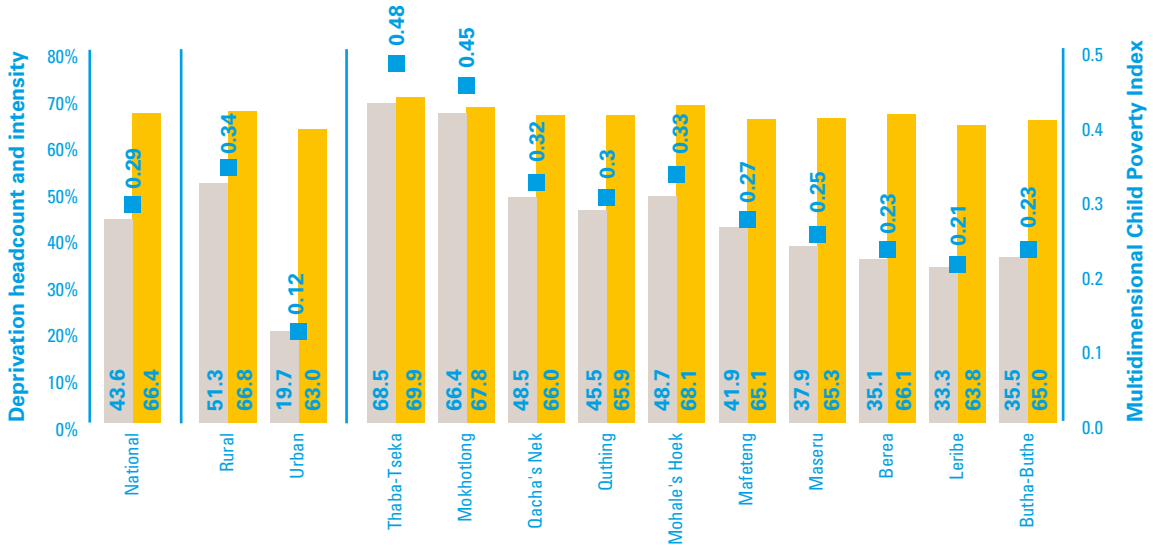
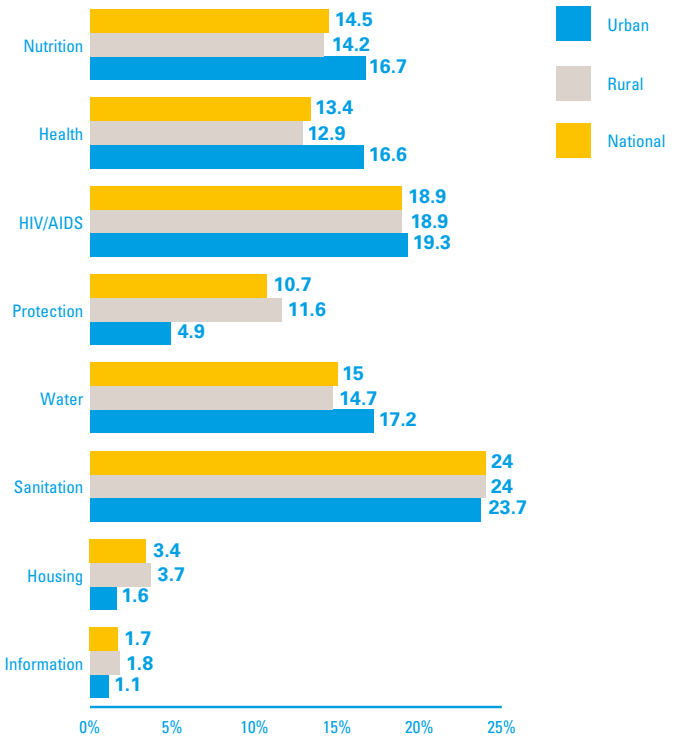


Figure 74: Decomposition of the Multidimensional Child Poverty Index, 13–17 years



How does each dimension contribute to the Multidimensional Child Poverty Index?

Figure 74 decomposes the Multidimensional Child Poverty Index according to its contributing dimensions. For children aged 13–17 years, the dimensions of housing, education and sanitation contribute most to the multidimensional deprivation at the national level and in both rural and urban areas. Some discrepancies between rural and urban contexts can also be noted. For instance, the water dimension is twice as high in contributing to the multidimensional vulnerability of children in rural areas compared to those in urban locations (11.6 per cent and 4.9 per cent, respectively). Additionally, protection and sanitation contribute more to the multidimensional deprivation of children in urban areas than in rural areas.

Deprivation overlap analysis

Figure 75 shows the deprivation overlap of a given dimension in relation to the number of other deprivations of children aged 13–17 years. A large proportion of children deprived in any dimension are also deprived in three or more other dimensions. For instance, 43.2 per cent of children deprived in housing are also simultaneously deprived in three or more other dimensions. In contrast, only 8.5 per cent of children deprived in information are also deprived in three or more other dimensions simultaneously. Notably, only a very small proportion of children aged 13–17 years are deprived solely in any given dimension. This evidence reveals the need for inter-sectoral policy responses to tackle child deprivation.

Example of deprivation overlap of three dimensions

Figure 76 presents the deprivation overlap of the three dimensions that contribute most to multidimensional poverty of children aged 13–17: education, sanitation and housing. At the national level, 29.3 per cent of children in this age group are simultaneously deprived in the three dimensions. There are also significant proportions of children deprived in combinations of two dimensions. For example, 26.4 per cent of children are deprived in the overlap between education and housing, while 14 per cent are deprived in both sanitation and housing.

In rural and urban areas, however, the deprivation overlap rates in the three dimensions are 34.2 per cent and 14.2 per cent, respectively. Notably, 19.4 per cent of urban children are not deprived in any of the three dimensions, compared to 2.8 per cent of rural children. (Overlaps between all other dimensions are tabulated in Annex 2.)

3.4 Monetary child poverty (Wealth Index) and its overlap with multidimensional deprivation

This section includes an analysis of monetary child poverty, which uses a set of household wealth indicators as gauges.[17] The wealth assets are used to classify households into five wealth quintiles. Children living in households belonging to the two lower wealth quintiles are termed 'monetarily poor'. As per the analyses in previous sections, a child is considered multidimensionally poor if she/he is simultaneously deprived in three or more dimensions of well-being.

Figure 77 illustrates the overlap between monetary poverty and multidimensional poverty among children aged 0–17 years in Lesotho. Data indicate the following results:

1. Almost one third (31 per cent) of children aged 0–17 are deprived in at least three dimensions of well-being, but are not monetarily poor based on their wealth status.
2. Just 8 per cent of children aged 0–17 that live in monetarily poor households (based on wealth status) are not multidimensionally poor.
3. A third (34 per cent) of children aged 0–17 are both monetarily and multidimensionally poor.
4. Less than a third (27 per cent) of children aged 0–17 experience no monetary or multidimensional poverty.

However, conclusions related to data presented in Figure 77 must be approached with caution. This is due to the fact that there is not a *complete* overlap between monetary poverty and multidimensional poverty in the context of Lesotho. Several reasons help to explain this statement. Firstly, the wealth status, or money, cannot always capture the well-being of children. As such, more wealth does not always lead to improvements in a child's standard of living. It implies that vulnerabilities can still exist despite the availability of assets or monetary resources. Secondly, children often have different needs to adults, and these needs cannot always be captured by monetary measurements. Thirdly, monetary poverty assumes that household wealth is equally distributed amongst its members. Yet, we know that the

17 See Table 3 for a complete list of assets that define monetary poverty. The list of assets were identified by a working group composed of experts from UNICEF Lesotho country office, Ministry of Education, Ministry of Police, Ministry of Health, Ministry of Social Development, Lesotho Bureau of Statistics, Ministry of Labour and Employment, Economic Policy Research Institute and Social Policy Research Institute.

Figure 75: Deprivation overlap for each dimension, 13–17 years

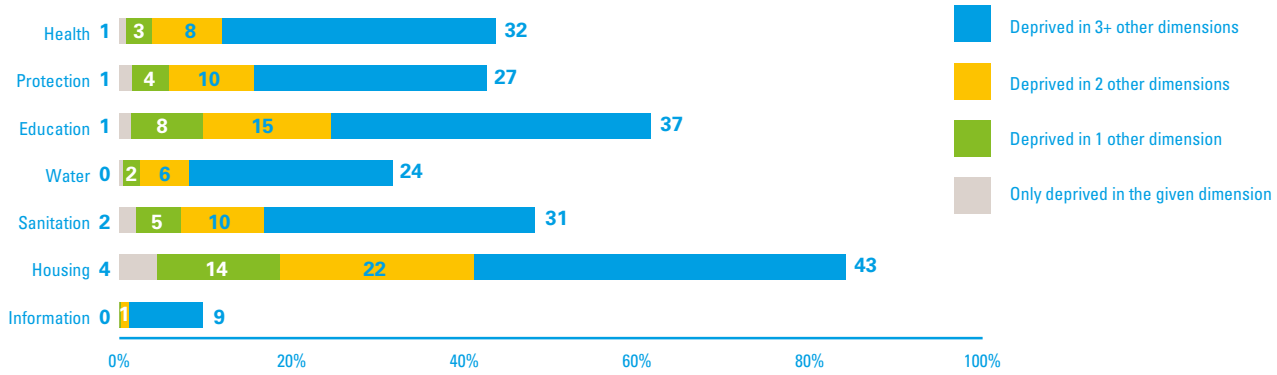
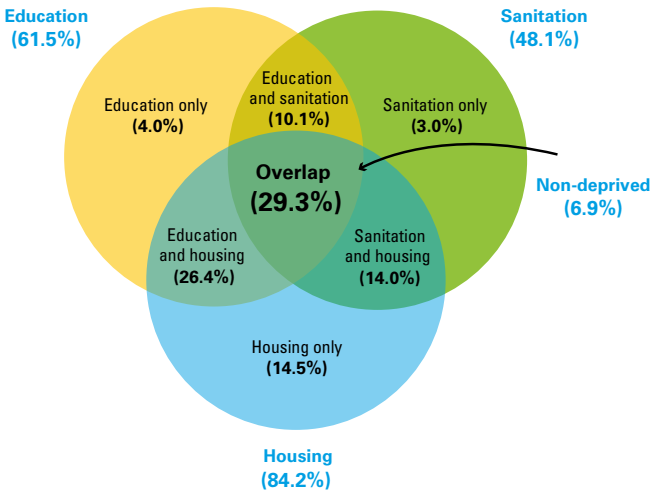
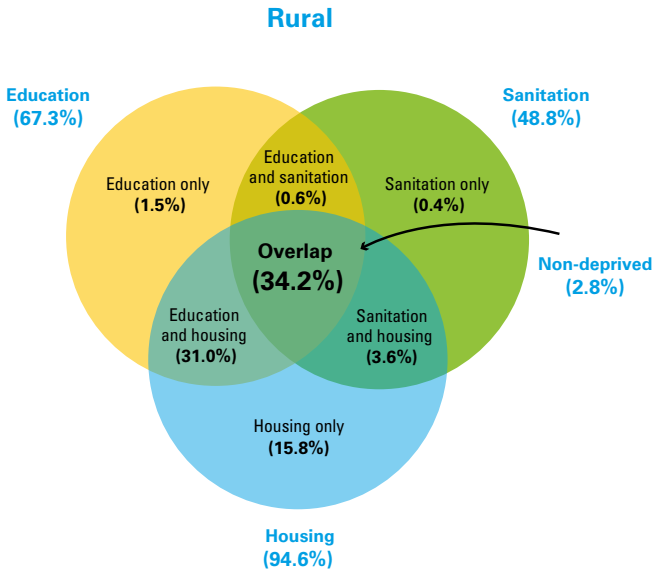
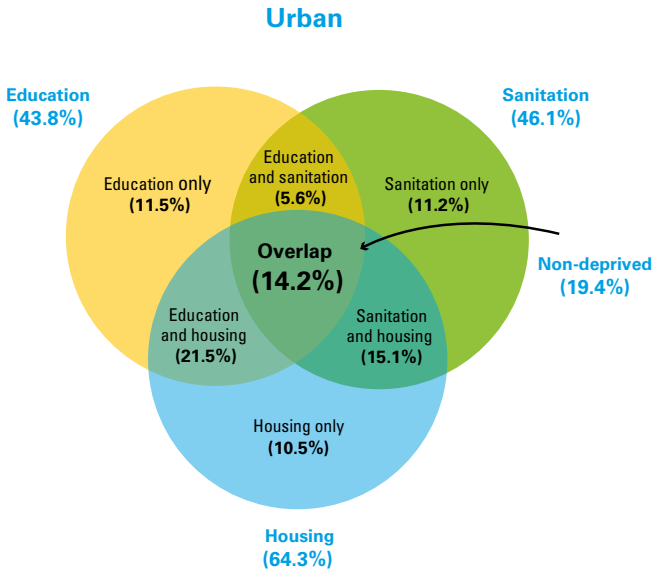


Figure 76: Deprivation overlap between education, sanitation and housing dimensions at the national level and in rural and urban areas, 13–17 years







distribution of resources in the household is not always equal. More often than not, children are not in charge of expenditure in households and they depend on decisions made by adults. Finally, having access to monetary resources does not equate to a child having access to basic services. As shown in Figure 77, a child may live in a wealthy household, but still be deprived in other dimensions of well-being. We caution the reader to bear these in mind when reading through the results presented in this section.

The four categories of children depicted in Figure 77 are disaggregated by rural–urban area and district in Table 17. The overlap between monetary and multidimensional poverty is higher among children in rural areas compared to those in urban contexts. Specifically, 37 per cent and 26 per cent of rural and urban children, respectively, are both monetarily and multidimensionally poor. At the same time, fewer children in rural areas (6 per cent) compared to those in urban contexts (12 per cent) are monetarily poor, but not multidimensionally poor. Moreover, 36 per cent of children in rural areas and 17 per cent in urban areas are multidimensionally poor, but not monetarily poor. The proportion of children in rural areas who are not poor in monetary and multidimensional terms is less than half that of children in urban areas (22 per cent and 45 per cent, respectively).

At the district level, the overlap between monetary and multidimensional poverty provides some interesting results. Of all districts, Thaba-Tseka and Mokhotlong have the highest proportions of children deprived in both monetary and multidimensional terms (63 per cent and 67 per cent, respectively), whereas Maseru and Berea have the lowest (25 per cent and 22 per cent, respectively). An interesting finding is that across all districts, there is a large share of children (between 18 per cent and 45 per cent) who are multidimensionally poor, but not monetarily poor. This supports the argument presented above, that the availability of wealth does not necessarily lead to investments in child well-being. Access to basic services or lack of information could also be reasons accounting for this phenomenon.

Figure 77: Overlap between child poverty based on wealth status of households and multidimensional poverty, children 0–17 years

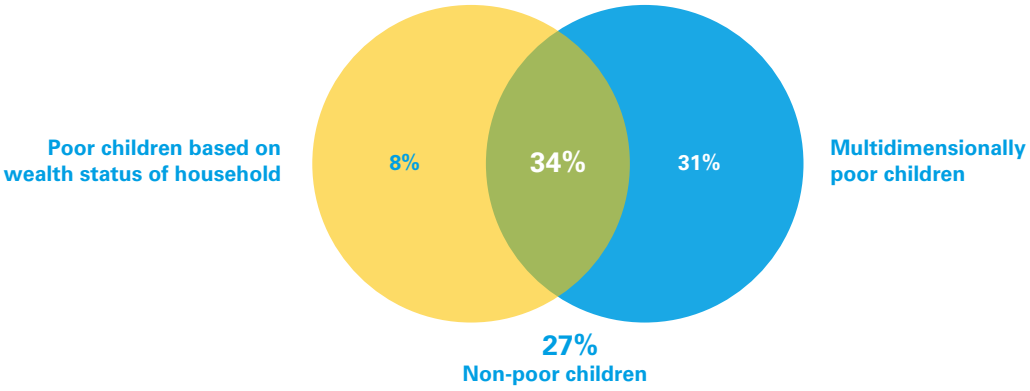
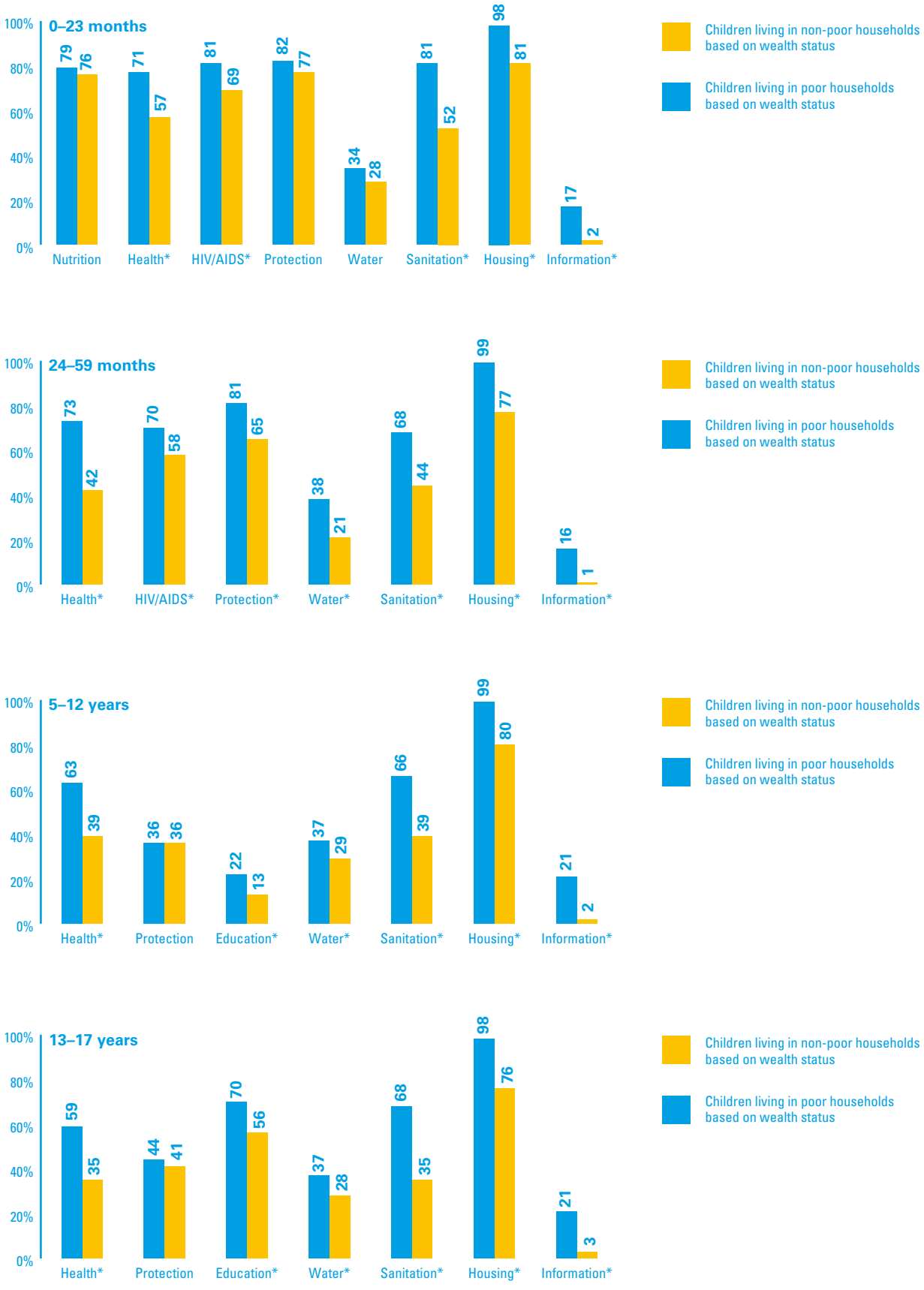


Figure 78: Deprivation headcount ratio (%) for each dimension of well-being by wealth status, children aged 0–17 years



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Table 17: Overlap between monetary and multidimensional poverty for children aged 0–17 years in rural and urban areas and different districts

		Both monetarily and multi-dimensionally poor	Monetarily poor, but not multidimensionally poor	Multidimensionally poor, but not monetarily poor	Neither monetarily nor multidimensionally poor
Area	Rural	37	6	36	22
	Urban	26	12	17	45
District	Thaba-Tseka	63	9	21	8
	Mokhotlong	67	7	18	8
	Qacha's Nek	53	13	19	16
	Quthing	29	8	34	29
	Mohale's Hoek	43	7	30	20
	Mafeteng	20	4	45	31
	Maseru	25	7	31	37
	Berea	22	6	37	34
	Leribe	24	6	37	33
	Butha-Buthe	35	13	26	26

Figure 78 shows the *deprivation headcount ratio* for all dimensions of well-being, by wealth status and by children's age groups. In all dimensions of well-being, a higher proportion of monetarily poor children are deprived in comparison with children who are not monetarily poor. For instance, 98 per cent of children aged 0–23 months who are monetarily poor, are also deprived in the housing dimension, in contrast to 81 per cent of their counterparts who are not poor, but also deprived in housing. One reflection is that despite not being monetarily poor, many children of different age groups still end up being deprived in many of the dimensions of well-being.

The *distribution of deprivations relative to the wealth status* of children aged 0–17 years is shown in Figure 79. It is observed that children living in households that are not monetarily poor tend to have fewer simultaneous deprivations, while children living in monetarily poor households experience more simultaneous deprivations. For instance, 83 per cent of children who are monetarily poor experience three or more simultaneous deprivations, whereas the same rate of deprivation among children who are not monetarily poor is 53 per cent.

Figure 80 shows the *distribution of deprivations by wealth quintiles* among children aged 0–17 years. Data show that children in wealthier quintiles experience fewer simultaneous deprivations. The opposite is true for children in poorer quintiles. Nonetheless, children in wealthier quintiles are still deprived in many dimensions of well-being. For example, 40 per cent of children in the wealthiest quintile are simultaneously deprived in three or more dimensions of well-being.

Figure 81 presents the multidimensional deprivation indices – the multidimensional deprivation headcount, the intensity of deprivation and the adjusted multidimensional deprivation headcount – by wealth status of children aged 0–17 years. The deprivation headcount shows the proportion of multidimensionally poor children (i.e. deprived in at least three dimensions). Data reveal that 82 per cent of monetarily poor children are also multidimensionally deprived, whereas 53.5 per cent of children who are not monetarily poor are multidimensionally poor. The association between monetary poverty and higher rates of

Figure 79: Deprivation distribution by wealth status, children aged 0–17 years

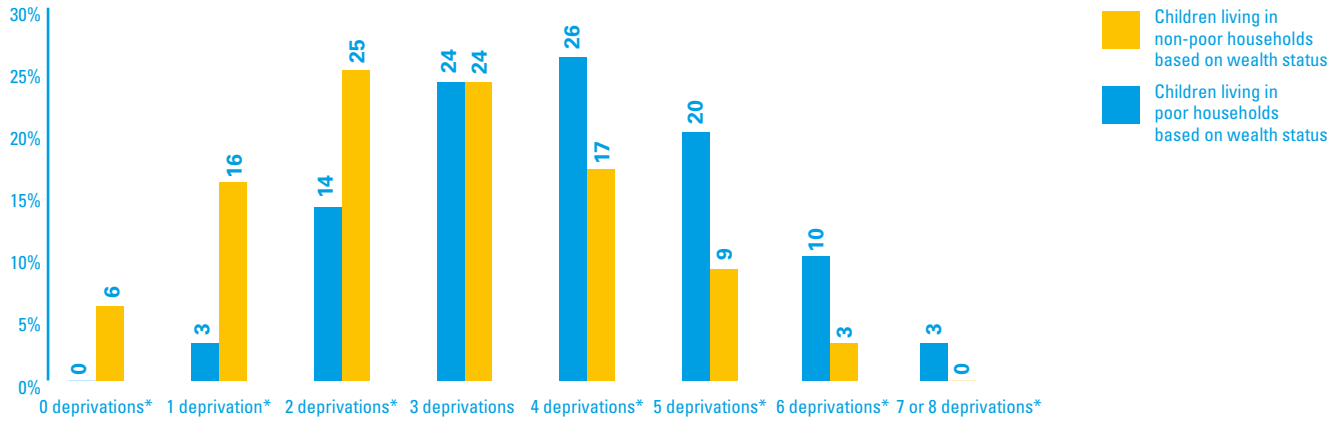


Figure 80: Deprivation distribution by wealth quintile, children aged 0–17 years

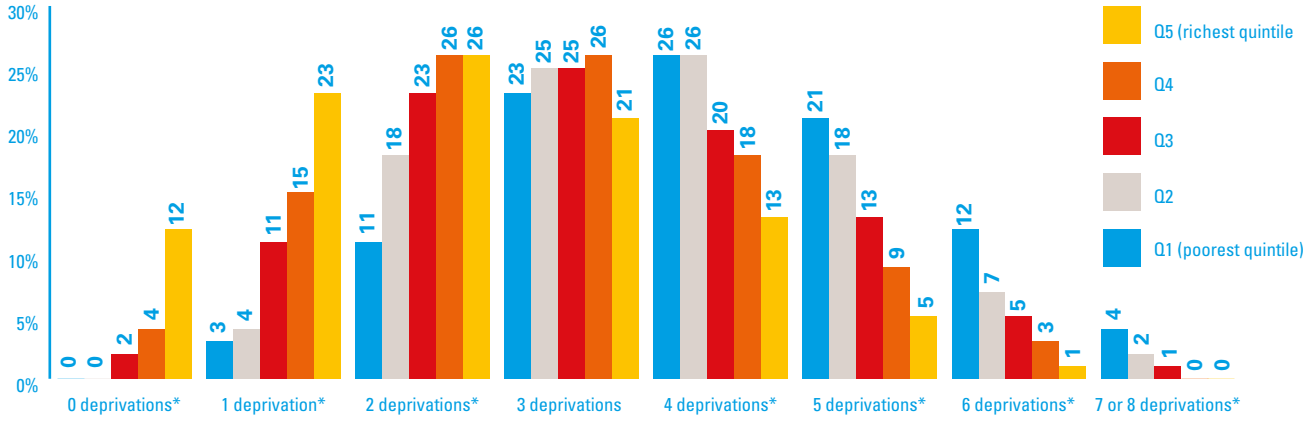
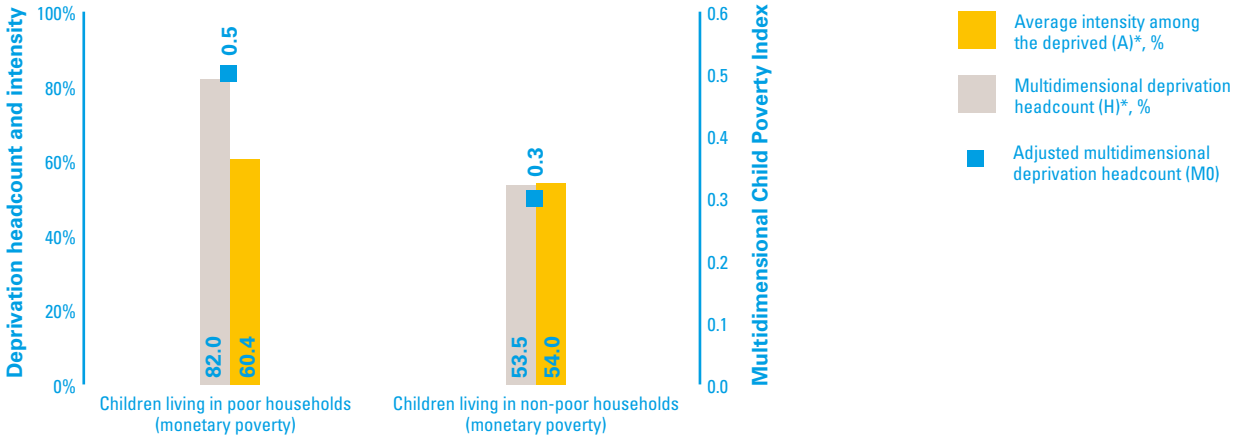


Figure 81: Deprivation indices for multidimensionally poor children (aged 0–17 years and deprived in at least three dimensions of well-being) by wealth status

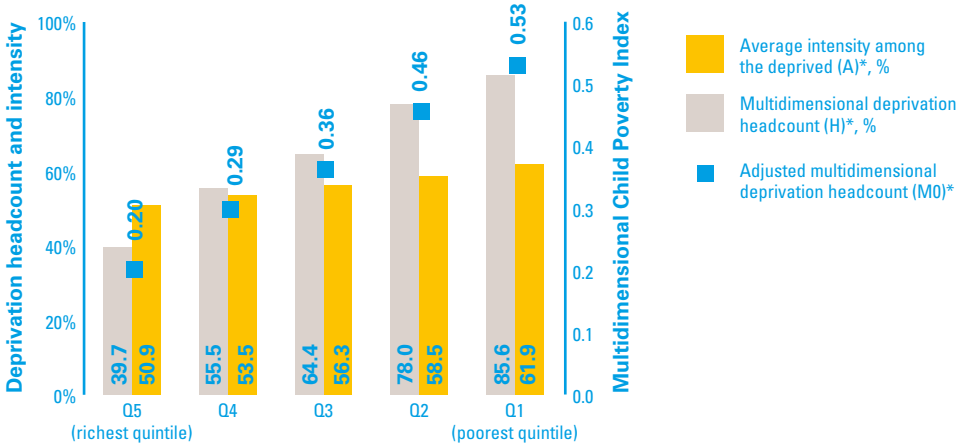


Note: The '' denotes statistical significant correlation between categories at p< 0.05*

multidimensional deprivation is also supported by values of the adjusted multidimensional deprivation headcount. The average intensity of deprivation exposes the depth of multidimensional deprivation. Figure 81 shows little variation in the intensity of deprivation when comparing children living in monetarily poor and non-poor households. This implies that multidimensionally poor children are equally deprived, irrespective of their monetary wealth.

Figure 82 presents the variations in the deprivation indices (headcount ratio, intensity of deprivation and Multidimensional Child Poverty Index) as per the wealth quintiles for children aged 0–17 years. Children in wealthier quintiles are also those who have lower rates of multidimensional deprivation headcount ratio (deprived in at least three dimensions of well-being). Children in poorer wealth quintiles, on the contrary, tend to be more multidimensionally deprived. The average intensity of deprivation does not vary across the wealth quintiles. This implies that multidimensionally poor children of each of the five wealth quintiles are equally deprived.

Figure 82: Deprivation indices for multidimensionally poor children (aged 0–17 years and deprived in at least three dimensions of well-being) by wealth quintile



Note: The '' denotes statistical significant correlation between categories at p< 0.05*

Conclusions and recommendations

This study employs an innovative methodological tool, the Multiple Overlapping Deprivation Analysis (MODA) to estimate multidimensional child poverty in Lesotho. It is a child-centred study aimed at understanding the complexity of child deprivation and supporting policymaking to better target the developmental outcomes of Basotho children. This study is timely as it is in line with SDG 1, Target 1.2, which aims at reducing – at least by half – the proportion of children, men, and women living in poverty in all its dimensions by 2030.

Given that children of different ages have different needs and developmental paths, the study adopts a life-cycle approach and targets four age groups: 0–23 months, 24–59 months, 5–12 years and 13–17 years. Each of these age groups is analysed using carefully selected indicators and dimensions, corresponding to the needs of children at their stages of life. The empirical baseline for this study is provided by the Lesotho Demographic and Health Survey of 2014 (LDHS; MOH and ICF International, 2016). Multidimensional child poverty in Lesotho is determined based on selected indicators and dimensions of well-being available in the LDHS and defined using both national and international definitions of deprivation. This study is a collaborative effort, involving national stakeholders[18] and the UNICEF country office in Lesotho.

In addition to MODA, this study also includes an analysis of monetary poverty, measured by a Wealth Index of household assets, and a comparative overview of multidimensional poverty and monetary poverty. Reflections on findings and policy recommendations are discussed below.

The main finding of this study is the proportion of multidimensionally poor children in Lesotho. Of all children aged 0–17 years, 65.4 per cent are multidimensionally poor, meaning they are simultaneously deprived in three or more dimensions of well-being. In the same age group, less than 5 per cent are not deprived in any of the dimensions of well-being. There is an urgent need for policy actions aimed at alleviating child poverty in Lesotho in its multidimensional form. One of the objectives of this study is to set the baseline figure for child poverty as per the SDG 1, Target 1.2, to allow for a policy response and for future monitoring of child poverty in the country. Considering the current multidimensional poverty rate of 65.4 per cent, the aim is to reduce the proportion of multidimensionally poor children in Lesotho by half, to 32.7 per cent, by 2030 as per the target. This target should be monitored over the next years to track progression.

18 Ministry of Education, Ministry of Police, Ministry of Health, Ministry of Social Development, Lesotho Bureau of Statistics and Ministry of Labour and Employment.

The dimensions of health, sanitation and housing have on overlap of **26.5 per cent** among children aged 5–12 years.

4.1 Addressing child deprivation by dimensions of well-being

The analysis of multidimensional child poverty in Lesotho included the following dimensions of well-being: nutrition, health, HIV/AIDS, protection, education, water, sanitation, housing and information. Based on results presented in the previous section, a number of recommendations are listed below.

- Of all dimensions of well-being, **housing** deprives the largest share of children in Lesotho. Within this dimension, access to electricity drives the deprivation in housing. Almost 8 out of 10 children live in households without electricity. Addressing this vulnerability must be a priority for the Government of Lesotho. Investing in infrastructure and creating renewable energy sources is a long-term solution for solving the energy problem. Subsidies to purchase generators for electricity that target households with children, may serve as a short-term solution. Attention should be given in reaching remote locations and rural areas, as children in these places are more vulnerable. In addition, it is recommended to provide an alternative to solid cooking fuels and to advocate for cooking outside the house to diminish the chance of children inhaling smoke.
- **Nutrition** is one of the main problems for children aged 0–59 months. Policy actions that sensitize families on practices to avoid malnutrition, and food diversity and frequency are advised. Food subsidies that provide proper nutritional intakes for children in their first 1,000 days of life should be trialled, and their implementation monitored and enforced. Actions aimed at encouraging exclusive breastfeeding of children in their first six months of life are essential. Sensitivity campaigns, flexible hours for working mothers, (extra) paid maternal leave and other monetary benefits are tested actions that boost the practice of breastfeeding.
- Actions related to children's **health** are recommended. One in five children aged 0–23 months do not have all the required vaccinations. Policy actions that enforce vaccinations are needed. Distance to the nearest health facility is a problem for many Basotho children, particularly those who live in remote locations and where the access is restricted due to difficult terrain. Facilities that include emergency medical air units, or mobile clinics that provide emergency medical help using remote communication tools may prove viable solutions for alleviating this deprivation.
- To alleviate children's deprivation related to **HIV/AIDS**, it is recommended to include classes on HIV/AIDS in schools to increase the general knowledge amongst adolescents. Similarly, organize sensitization campaigns in local health-care centres and communities to reach the parents.
- The **protection** of children in Lesotho is a reason for concern. More than half of the children aged 0–59 months do not have a birth certificate. Actions that facilitate the procedures of obtaining birth certificates for young children must be considered a priority. Many children in Lesotho also live in households in which domestic violence is tolerated. Sensitivity campaigns that inform parents of the negative repercussions for children when living in an environment prone to domestic violence are recommended.
- The **education** development of children is also struggling in Lesotho. In the age group 13–17 years, 17.5 per cent of children do not attend school and 53.4 per cent lag behind in school by two or more years. This is mainly because secondary education in Lesotho in not compulsory, and hence not subsidized. Introducing free (subsidized) secondary education is highly recommended. Making junior-secondary education compulsory is also recommended.
- The recommendations for **water** include providing facilities and infrastructure to collect and deliver improved water sources to deprived communities.
- A large proportion of children face **sanitation** deprivations in Lesotho. Use of unimproved and shared toilet facilities are widespread. This is because infrastructure for the collection and recycling of toilet waste in both urban and rural areas is largely absent. Investment in sanitation infrastructure is recommended. Furthermore, sensitivity campaigns that urge families to dispose of children's faeces in a safe manner are recommended. Waste collection in urban and rural areas must be improved and enforced.

4.2 A multidimensional approach to poverty

An important conclusion of this study is that children are deprived in multiple dimensions simultaneously. It is therefore imperative to create policy packages that involve different sectors to more efficiently target multidimensionally poor children. Inter-sectoral efforts to address child poverty may also be more effective in terms of budgeting and reducing costs of implementation. Based on results, particular attention should be given to addressing the following combinations of deprivations.

- For children aged 0–23 months, the combination of nutrition, protection and housing shows the highest overlap, with 55.2 per cent of children deprived in all three dimensions.
- Of all children aged 24–59 months, 44 per cent are simultaneously deprived in HIV/AIDS, protection and housing.
- The dimensions of health, sanitation and housing have on overlap of 26.5 per cent among children aged 5–12 years.
- For children aged 13–17 years, the highest deprivation overlap is found in the combination of education, sanitation and housing (29.3 per cent).

4.3 Profiling vulnerable children

When identifying poor children, it is important to profile those characteristics that make children more vulnerable in order to design the most effective policy responses. A number of profiling characteristics and how they relate to child deprivation are presented below.

- Children living in rural areas are consistently more multidimensionally deprived than urban children.
- At the district level, Thaba-Tseka and Mokhotlong are performing the worst with respect to multidimensional child poverty, whereas Maseru and Berea are doing better, albeit in relative terms and by small margins.
- Stunted children aged 0–59 months are more deprived in the health dimension compared to children who are not stunted.
- In general, no differences are observed based on the gender of the child. However, for children aged 5–17 years, girls are doing better than boys in education. More attention should be given to boys, especially ensuring that they finish primary education and continue with secondary education. Often, for boys, the opportunity cost of education in terms of child labour is very high, and the reason behind the high school dropout rate.
- A higher level of education of the mother or the father or the household head of a child is associated with an increase in the well-being of children, especially if secondary education or higher has been attained. Education is thus an important area to invest in and can have long-term benefits for children.
- Early pregnancy and/or early marriage amongst girls aged 15–17 years is correlated with higher multidimensional poverty rates. Those girls should be provided support or assistance.
- Higher multidimensional poverty rates are observed amongst double orphans.
- Lower child poverty rates are observed when the mother participates in household's decisions.
- Households with higher numbers of children face higher deprivation rates.

4.4 The overlap between multidimensional and monetary poverty

There is no complete overlap between multidimensional and monetary poverty. One third of children (34 per cent) are poor in both concepts; 8 per cent of children are only poor in monetary terms; and 31 per cent of children are only multidimensionally poor. Multidimensional poverty is measured by dimensions of well-being, whereas monetary poverty is calculated from household wealth, measured through a list of assets. The findings indicate that having more wealth does not always result in improved standards of well-being for children and vice versa. Thus, tackling the vulnerability in one area would likely have a limited effect in the other. This, however, is just an exploratory analysis, in which monetary poverty is loosely defined based on household assets. More analyses are required to measure and define the overlap between monetary poverty (based on individual or household income) and multidimensional poverty to come to more conclusive recommendations.

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Annexes

Annex 1: List of dimensions, indicators and thresholds for measuring child poverty in Lesotho

The table below lists the agreed dimensions, indicators and thresholds from the Lesotho Demographic and Health Survey 2014 (LDHS; MOH and ICF International, 2016) dataset used to measure multidimensional child poverty in Lesotho with the Multiple Overlapping Deprivation Analysis (MODA) methodology.

Dimension	Indicator	Age group and threshold (i.e. deprived if …)
Nutrition	Exclusive breastfeeding	<6 months: Child is not exclusively breastfed.
	Food frequency and diversity	6–23 months: Child is not meeting the World Health Organization (WHO) standards for meal frequency and food diversity, as defined below. *Minimum meal frequency is defined as:* Twice for breastfed infants aged 6–8 months Three times for breastfed children aged 9–23 months Four times for non-breastfed children aged 6–23 months *Dietary diversity refers to the child receiving at least four of the following food groups:* 1. Grains, roots and tubers 2. Legumes and nuts 3. Dairy products (milk, yogurt, cheese) 4. Flesh foods (meat, fish, poultry and liver/organ meats) 5. Eggs 6. Vitamin-A-rich fruits and vegetables 7. Other fruits and vegetables.

Dimension	Indicator	Age group and threshold (i.e. deprived if …)
Health	Vaccinations	0–35 months: Child did not receive all the basic vaccinations recommended by WHO on time. Vaccination and the respective age at which it should be given: BCG at birth (anti-tuberculosis bacilli Calmeet-Guérin vaccine) DPT 1 at 2 months old (diphtheria, pertussis and tetanus vaccine) DPT 2 at 4 months old DPT 3 at 6 months old Polio 1 at 2 months old (poliomyelitis vaccine) Polio 2 at 4 months old Polio 3 at 6 months old Measles at 12–35 months old
	Distance to health facility	0–17 years: Child is living in a household where the time taken to get to the nearest health facility exceeds the standards below. *Urban areas:* – car/truck/bus/taxi >30 minutes – motorcycle/scooter >30 minutes – horse/donkey/mule >30 minutes – walking >30 minutes – combination of walking and bus/taxi >30 minutes *Rural areas:* – car/truck/bus/taxi >60 minutes – motorcycle/scooter >60 minutes – horse/donkey/mule >60 minutes – walking >120 minutes – combination of walking and bus/taxi >120 minutes
	Knowledge on tuberculosis	0–17 years: Child living in a household where the female or male caretaker is not sufficiently informed about tuberculosis.
HIV/AIDS	Mother's HIV testing and HIV counselling during antenatal care	0–23 months: The mother has not been tested for HIV/AIDS as part of her antenatal care and during delivery, or she has been tested but did not receive the results, or the mother was not given all the information about HIV/AIDS during antenatal care visits concerning mother-to-child transmission, things to do, tested for HIV, or offered a test.
	Mother's knowledge on HIV/AIDS	0–4 years: The mother (caretaker) of the child is not sufficiently informed about HIV/AIDS (i.e. has never heard of HIV or AIDS, does not know appropriate methods of prevention or possible means of transmission, including prevention of mother-to-child transmission (PMTCT)).
Protection	Birth registration	0–4 years: Child does not have a birth certificate and/or is not registered.
	Attitudes to domestic violence	0–17 years: Child lives in a household where the mother, father or any other adult in the household agrees that the husband is justified in hitting or beating his wife under each of the following five circumstances: – she burns the food – she argues with him – she goes out without telling him – she neglects the children – she refuses to have sex with him.
Education	School attendance	6–17 years: Child is not attending school.
	Grade-for-age	6–17 years: Child is one or more years behind in schooling.

Dimension	Indicator	Age group and threshold (i.e. deprived if …)
Water	Drinking water source	0–17 years: The household's main source of drinking water is unimproved (according to WHO standards). *Improved water sources:* Piped into dwelling, plot or yard; public tap or standpipe; neighbour's tap; tube well or borehole; protected dug well; protected spring; rainwater; bottled water. *Unimproved water sources:* Unprotected well; unprotected spring; surface water (river, dam, lake, pond, stream, canal, irrigation channel), tanker truck.
	Distance to drinking water source	0–17 years: Child lives in a household where the time needed to go to the water source, get the water and come back is more than 30 minutes (WHO standard).
Sanitation	Toilet type	0–17 years: Child lives in a household that uses an unimproved toilet facility. *Improved toilet facilities:* Flush to piped sewer system; flush to septic tank; flush to pit latrine; ventilated, improved pit latrine; pit latrine with slab; composting toilet. *Unimproved toilet facilities:* Flush to somewhere else; flush to don't know where; pit latrine without a slab; open pit latrine; no facility (bush or field).
	Shared toilet	0–17 years: Child lives in a household that shares a toilet facility with other households.
	Disposal of youngest child's faeces	0–59 months: The disposal of young child's faeces is done in an unsafe way. **Rural areas:** *Safe ways of disposal:* Used a toilet or latrine; put or rinsed into a toilet or latrine. *Unsafe ways of disposal:* Put or rinsed into a drain or ditch; thrown into the garbage; buried; left in the open; not disposed of; other. **Urban areas:** *Safe ways of disposal:* Used a toilet or latrine; put or rinsed into a toilet or latrine; thrown into the garbage. *Unsafe ways of disposal:* Put or rinsed into a drain or ditch; buried; left in the open; not disposed of; other.
Housing	Overcrowding	0–17 years: Child lives in a household that has, on average, more than three people per sleeping room.
	Electricity	0–17 years: Child lives in a household that does not have electricity.
	Cooking fuel	0–17 years: Child lives in a household where unimproved cooking fuel is used. *Improved cooking fuel:* Electricity, liquefied petroleum gas (LPG), biogas, paraffin (kerosene). *Unimproved cooking fuel:* Coal, lignite, wood, straw, shrubs, grass, agricultural crop, animal dung, other.
Information	Access to a radio, a television or a mobile phone	0–17 years: Child lives in a household where there is no radio or television or mobile phone.

Annex 2: Deprivation rates in combinations of three dimensions for children aged 0–23 months, 24–59 months, 5–12 years and 13–17 years

Table A2.1: Deprivation rates (%) in combinations of three dimensions, 0–23 months

Combination of three dimensions	Overlap between dimensions:				Deprivation in only:			Deprived in none of the three dimensions
	All	First two	First and third	Second and third	First dimension	Second dimension	Third dimension	
Sanitation, housing, information	7	52	0	1	6	29	0	5
Water, housing, information	3	27	0	5	1	54	0	10
Water, sanitation, information	3	19	0	4	9	39	1	25
Water, sanitation, housing	21	0	9	37	1	5	22	5
Protection, housing, information	7	64	0	1	8	16	0	4
Protection, sanitation, information	6	47	1	1	26	11	0	9
Protection, sanitation, housing	48	5	23	10	3	1	7	2
Protection, water, information	3	23	4	0	49	4	1	16
Protection, water, housing	25	1	46	4	7	0	13	3
Protection, water, sanitation	19	7	33	3	20	2	9	7
HIV/AIDS, housing, information	6	61	0	1	6	20	0	5
HIV/AIDS, sanitation, information	6	43	1	1	24	14	0	10
HIV/AIDS, sanitation, housing	45	4	22	13	3	2	8	3
HIV/AIDS, water, information	2	21	5	1	46	6	0	18
HIV/AIDS, water, housing	23	1	45	7	6	0	14	5
HIV/AIDS, water, sanitation	16	7	32	5	18	2	10	8
HIV/AIDS, protection, information	6	54	1	1	14	18	0	6
HIV/AIDS, protection, housing	55	5	13	16	2	3	5	2
HIV/AIDS, protection, sanitation	40	20	9	12	6	7	3	3
HIV/AIDS, protection, water	20	39	3	6	11	14	2	5
Health, housing, information	7	55	0	1	4	26	0	7
Health, sanitation, information	6	39	1	1	20	19	0	15
Health, sanitation, housing	42	2	19	16	2	3	11	4
Health, water, information	3	21	4	0	37	6	1	27
Health, water, housing	24	0	37	6	4	1	21	6
Health, water, sanitation	18	7	27	4	14	3	16	12
Health, protection, information	6	47	1	1	11	25	0	9
Health, protection, housing	51	3	11	21	1	5	6	3
Health, protection, sanitation	37	17	8	15	4	10	4	5
Health, protection, water	21	33	3	5	9	20	1	8
Health, HIV/AIDS, information	6	46	1	1	13	22	0	11
Health, HIV/AIDS, housing	49	3	13	19	2	4	8	3
Health, HIV/AIDS, sanitation	35	16	10	14	5	9	6	6
Health, HIV/AIDS, water	19	33	6	5	9	18	2	10
Health, HIV/AIDS, protection	42	9	11	17	3	6	8	3
Nutrition, housing, information	7	62	0	1	8	18	0	3

Combination of three dimensions	Overlap between dimensions:				Deprivation in only:			Deprived in none of the three dimensions
	All	First two	First and third	Second and third	First dimension	Second dimension	Third dimension	
Nutrition, sanitation, information	5	43	1	1	27	14	0	7
Nutrition, sanitation, housing	45	4	24	14	4	2	6	1
Nutrition, water, information	3	21	4	0	50	7	1	15
Nutrition, water, housing	23	1	46	6	8	0	13	3
Nutrition, water, sanitation	17	7	32	5	22	2	11	5
Nutrition, protection, information	6	55	1	1	16	17	0	4
Nutrition, protection, housing	55	5	14	16	3	3	4	0
Nutrition, protection, sanitation	40	21	9	13	8	6	3	1
Nutrition, protection, water	20	40	4	6	13	13	1	3
Nutrition, HIV/AIDS, information	6	52	1	1	19	15	0	6
Nutrition, HIV/AIDS, housing	52	5	16	15	3	1	4	2
Nutrition, HIV/AIDS, sanitation	37	20	11	11	9	5	4	2
Nutrition, HIV/AIDS, water	18	39	6	5	14	11	2	5
Nutrition, HIV/AIDS, protection	46	12	15	14	5	3	5	1
Nutrition, health, information	6	45	1	1	26	14	0	7
Nutrition, health, housing	47	3	22	14	5	1	5	2
Nutrition, health, sanitation	33	17	16	11	11	4	4	3
Nutrition, health, water	19	32	5	5	22	10	1	6
Nutrition, health, protection	41	10	20	13	7	2	6	2
Nutrition, Health, HIV/AIDS	40	10	17	11	10	4	6	2

Table A.2: Deprivation rates (%) in combinations of three dimensions, 24–59 months

Combination of three dimensions	Overlap between dimensions:				Deprivation in only:			Deprived in none of the three dimensions
	All	First two	First and third	Second and third	First dimension	Second dimension	Third dimension	
Sanitation, housing, information	5	44	0	2	5	35	0	9
Water, housing, information	3	24	0	4	1	55	0	13
Water, sanitation, information	3	15	1	3	10	34	1	34
Water, sanitation, housing	18	0	10	32	1	5	27	8
Protection, housing, information	6	58	0	1	7	21	0	6
Protection, sanitation, information	5	37	2	1	29	12	0	15
Protection, sanitation, housing	39	3	26	11	5	2	11	4
Protection, water, information	3	19	3	0	46	6	1	21
Protection, water, housing	22	1	43	6	7	0	16	6
Protection, water, sanitation	14	8	28	4	22	2	9	13
HIV/AIDS, housing, information	6	52	0	2	6	28	0	7
HIV/AIDS, sanitation, information	4	33	2	1	25	16	0	19
HIV/AIDS, sanitation, housing	34	3	24	16	3	2	13	5
HIV/AIDS, water, information	3	17	3	1	41	8	1	27
HIV/AIDS, water, housing	19	0	38	9	6	0	20	7
HIV/AIDS, water, sanitation	13	7	24	5	20	4	12	15
HIV/AIDS, protection, information	5	43	1	1	15	23	0	12
HIV/AIDS, protection, housing	44	3	13	21	3	4	9	4
HIV/AIDS, protection, sanitation	28	19	8	13	8	11	5	7
HIV/AIDS, protection, water	16	32	4	7	12	18	2	10
Health, housing, information	6	46	0	1	3	34	0	11
Health, sanitation, information	5	28	1	1	21	21	0	23
Health, sanitation, housing	32	1	20	18	2	4	17	7
Health, water, information	3	18	3	1	31	8	1	37
Health, water, housing	20	0	32	8	3	0	27	10
Health, water, sanitation	14	6	18	4	16	4	18	19
Health, protection, information	5	37	1	1	11	28	0	16
Health, protection, housing	41	2	11	24	1	5	11	5
Health, protection, sanitation	26	16	6	15	6	14	7	9
Health, protection, water	16	26	4	6	8	24	2	14
Health, HIV/AIDS, information	5	33	1	1	16	25	0	19
Health, HIV/AIDS, housing	36	1	16	21	2	5	14	6
Health, HIV/AIDS, sanitation	23	15	9	14	8	12	8	11
Health, HIV/AIDS, water	15	23	6	5	11	21	3	16
Health, HIV/AIDS, protection	31	7	12	17	5	9	13	7

Table A2.3: Deprivation rates (%) in combinations of three dimensions, 5–12 years

Combination of three dimensions	Overlap between dimensions:				Deprivation in only:			Deprived in none of the three dimensions
	All	First two	First and third	Second and third	First dimension	Second dimension	Third dimension	
Sanitation, housing, information	7	40	0	4	3	37	0	8
Water, housing, information	4	27	0	6	1	50	0	11
Water, sanitation, information	3	16	1	4	12	28	2	33
Water, sanitation, housing	19	0	13	29	1	3	28	8
Education, housing, information	3	12	0	8	1	66	0	11
Education, sanitation, information	2	7	1	5	6	37	3	40
Education, sanitation, housing	9	0	6	38	1	3	35	8
Education, water, information	1	4	1	3	8	24	5	53
Education, water, housing	5	0	9	26	1	1	47	10
Education, water, sanitation	4	2	5	15	5	12	27	31
Protection, housing, information	3	29	0	7	3	49	0	9
Protection, sanitation, information	2	17	1	5	16	27	2	30
Protection, sanitation, housing	18	1	15	29	2	3	26	6
Protection, water, information	2	11	2	3	22	17	4	40
Protection, water, housing	12	0	20	19	3	0	36	8
Protection, water, sanitation	8	5	11	11	12	8	21	24
Protection, education, information	1	5	2	2	27	8	5	50
Protection, education, housing	6	0	27	9	3	1	47	8
Protection, education, sanitation	4	2	15	5	15	4	26	28
Protection, education, water	2	4	10	3	19	6	17	38
Health, housing, information	7	39	0	3	2	39	0	10
Health, sanitation, information	5	22	2	2	19	22	1	27
Health, sanitation, housing	27	1	20	21	2	3	21	7
Health, water, information	3	17	4	1	24	11	2	37
Health, water, housing	20	0	26	12	2	1	30	9
Health, water, sanitation	13	7	14	6	14	7	18	21
Health, education, information	2	7	5	1	34	6	2	43
Health, education, housing	9	0	37	6	2	1	36	9
Health, education, sanitation	6	3	21	3	18	3	20	25
Health, education, water	4	5	16	2	23	5	11	35
Health, protection, information	2	16	5	1	25	17	2	32
Health, protection, housing	17	1	29	15	2	3	27	7
Health, protection, sanitation	10	8	17	9	13	9	15	19
Health, protection, water	8	10	12	5	18	13	8	26
Health, protection, education	4	14	6	2	25	15	4	30

Table A2.4: Deprivation rates (%) in combinations of three dimensions, 13–17 years

Combination of three dimensions	Overlap between dimensions:				Deprivation in only:			Deprived in none of the three dimensions
	All	First two	First and third	Second and third	First dimension	Second dimension	Third dimension	
Sanitation, housing, information	7	37	0	3	5	38	0	11
Water, housing, information	4	27	0	6	1	48	0	14
Water, sanitation, information	3	15	1	4	13	27	2	36
Water, sanitation, housing	17	0	13	26	1	5	28	10
Education, housing, information	7	48	0	2	6	26	0	10
Education, sanitation, information	5	26	2	1	28	16	1	21
Education, sanitation, housing	29	2	26	14	4	3	14	7
Education, water, information	3	18	4	1	36	9	1	27
Education, water, housing	21	1	35	9	5	1	19	9
Education, water, sanitation	13	9	18	5	22	5	12	16
Protection, housing, information	4	34	0	6	5	41	0	11
Protection, sanitation, information	2	19	1	4	20	23	2	29
Protection, sanitation, housing	20	1	18	24	4	3	23	7
Protection, water, information	2	13	2	2	26	15	4	37
Protection, water, housing	14	1	23	16	5	1	30	10
Protection, water, sanitation	8	6	13	10	15	8	18	23
Protection, education, information	3	27	1	4	12	28	2	24
Protection, education, housing	27	3	10	29	3	3	18	7
Protection, education, sanitation	15	14	6	16	7	16	11	14
Protection, education, water	11	19	4	11	9	21	6	19
Health, housing, information	6	34	0	3	3	41	0	13
Health, sanitation, information	4	20	2	2	17	22	1	31
Health, sanitation, housing	23	1	17	20	2	4	24	9
Health, water, information	3	15	4	1	22	13	2	41
Health, water, housing	17	0	23	13	3	1	31	12
Health, water, sanitation	11	6	13	6	13	8	18	25
Health, education, information	5	25	1	2	12	29	1	24
Health, education, housing	29	1	12	27	2	5	17	8
Health, education, sanitation	17	13	7	14	6	17	10	15
Health, education, water	13	18	5	9	8	22	5	20
Health, protection, information	3	17	4	1	20	22	2	32
Health, protection, housing	19	1	22	19	2	4	25	9
Health, protection, sanitation	11	9	13	10	10	12	14	20
Health, protection, water	8	12	10	6	14	16	8	26
Health, protection, education	15	5	15	15	9	8	17	17