Country Context

Lesotho’s progress in moving from a predominantly subsistence-oriented economy to a lower middle income, diversified economy exporting natural resources and manufacturing goods has brought higher, more secure incomes to a significant portion of the population. But, despite important progress on several of its MDG indicators, food security and poverty remain a problem with 43 percent of the population still subsisting on less than US $1.25 per day.

Country’s large share of youth population (more than 39 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate due to the global recession and the country’s high unequal income distribution.

Gender equality and women’s empowerment are important for improving reproductive health. Higher levels of women’s autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes. In Lesotho, the literacy rate among females ages 15 and above is 95 percent. Many more girls are enrolled in secondary schools compared to boys with a 132 percent ratio of female to male secondary enrollment. Further, 72 percent of adult women participate in the labor force and many young women are benefiting from arising opportunities in the urban labor market, mostly in the textile sector. Gender inequalities are reflected in the country’s human development ranking; Lesotho ranks 119 of 157 countries in the Gender-related Development Index.

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.

Lesotho: MDG 5 Status

<table>
<thead>
<tr>
<th>MDG 5A indicators</th>
<th>UN estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio (maternal deaths per 100,000 live births)</td>
<td>530</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (percent)</td>
<td>61.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG 5B indicators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Prevalence Rate (percent)</td>
<td>47</td>
</tr>
<tr>
<td>Adolescent Fertility Rate (births per 1,000 women ages 15–19)</td>
<td>96</td>
</tr>
<tr>
<td>Antenatal care with health personnel (percent)</td>
<td>92</td>
</tr>
<tr>
<td>Unmet need for family planning (percent)</td>
<td>23</td>
</tr>
</tbody>
</table>

Source: Compiled from multiple sources.

*The Lesotho DHS estimates maternal mortality is between 874 and 1435.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Lesotho has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets (Figure 1).

Figure 1 - Maternal mortality ratio 1990–2008 and 2015 target


World Bank Support for Health in Lesotho

The Bank’s current Country Assistance Strategy is for fiscal years 2010 to 2014.

Current Projects:
- P104403 LS-GBOBA W3: Lesotho Health ($6.25)
- P107375 LS-HIV & AIDS TAL (FY10) ($4.6m)

Pipeline Project:
- P114859 LS-Maternal & Newborn Health PBF

Previous Health Project:
- P076658 LS-Health Sec Reform Phase 2 APL (FY06)
- P087843 LS-HIV/AIDS Cap Bldg TAL (FY05)
**Key Challenges**

**High fertility**

Fertility has been declining over time but is still high among the poorest Basotho. Lesotho has one of the lowest total fertility rates (TFR) in sub-Saharan Africa. TFR has dropped substantially from 5.4 births in 1976 to the current rate of 3.3 births per woman. Nevertheless, fertility among poorest Basotho is about three times higher than among the wealthiest (Figure 2).

![Figure 2: Total fertility rate by wealth quintile](image1)

**Adolescent fertility rate is high (96 births per 1,000 women) affecting not only young women and their children's health but their long-term education and employment prospects.** Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.

**Early childbearing is more frequent among the poor.** While 42 percent of the poorest 20–24 years old women have had a child before reaching 18, only 16 percent of their richer counterpart did (figure 3). Further, younger cohorts of poor girls are more likely to have a child early in life now than their older cohorts.

![Figure 3: Percent women who have had a child before age 18 years by age group and wealth quintile](image2)

**Poor Pregnancy Outcomes**

Over 9 in 10 pregnant women receive antenatal care from skilled health personnel. Further, seventy percent of pregnant women have the recommended four or more antenatal visits. Yet the quality of antenatal services need to be improved given that a quarter of pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.

Three-fifth of pregnant women deliver with the assistance of skilled health personnel but wide disparities still exist. While 90 percent of women in the wealthiest quintile delivered with the assistance of skilled health personnel, only 35 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 42 percent of women who gave birth did not get a postnatal check-up within 6 weeks of delivery.

Majority of women who indicated problems in accessing health care cited concerns regarding unavailability of medicines (Table 1).

Human resources for maternal health are limited with only 0.05 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.62 per 1,000 population.

The high maternal mortality ratio at 530 maternal deaths per 100,000 live births indicates that access to and quality of

![Figure 5: Birth assisted by health personnel (percentage) by wealth quintile](image3)
Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at www.worldbank.org/population.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.
Key Actions to Improve RH Outcomes

Strengthen gender equality
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility
- Ascertain the factors that contributed to the 10 percentage increase in use of contraceptive during 2004–2009 and apply the lessons learned accordingly. Additionally, ascertain the reasons why some women do not intend to use contraception in the future as this was not reported in the 2009 DHS. There is a huge potential demand for family planning services as three-fifths of women not using contraception plan to do so.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Strengthen performance in services to poor and marginalized populations through incentives schemes.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality
- Promote institutional delivery through provider incentives and generating demand for the service. During antenatal care, educate pregnant women about the importance of delivering with a skilled health personnel and getting timely postnatal check.
- Promote institutional delivery through provider incentives and implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.
- Address the perception that drugs are not available at the health facilities by strengthening the reproductive health commodity logistics management systems.

Reducing STIs/HIV/AIDS
- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care services.
- Focus on adolescents, youth and married women in providing information, education and communication on HIV/AIDS and condom use.

References:

Correspondence Details:
This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE). For more information contact Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: www.worldbank.org/population.
### Lesotho Reproductive Health Action Plan Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>2008</td>
<td>63</td>
</tr>
<tr>
<td>Newborns protected against tetanus (%)</td>
<td>2008</td>
<td>83</td>
</tr>
<tr>
<td>DPT3 immunization coverage (% by age 1)</td>
<td>2010</td>
<td>75</td>
</tr>
<tr>
<td>Pregnant women living with HIV who received antiretroviral drugs (%)</td>
<td>2005</td>
<td>12.1</td>
</tr>
<tr>
<td>Prevalence of HIV, total (% of population ages 15–49)</td>
<td>2007</td>
<td>23.2</td>
</tr>
<tr>
<td>Female adults with HIV (% of population ages 15+ with HIV)</td>
<td>2007</td>
<td>57.7</td>
</tr>
<tr>
<td>Prevalence of HIV, female (% ages 15–24)</td>
<td>2007</td>
<td>14.9</td>
</tr>
</tbody>
</table>

### National Policies and Strategies that have Influenced Reproductive Health

#### 2002:
- **National Social Welfare Policy** emphasizes on coordination of efforts in attempting to curb the rate of teenage pregnancy and offering appropriate support to teenage mothers.

#### 2004:
- **National Population Policy** puts emphasis on reduction of maternal mortality for couples not to have more than two children.

#### 2005:
- **The National Policy on Orphans and Vulnerable Children** gives support to all pregnant mothers to have access to Prevention of Mother to Child Transmission of HIV/AIDS services and to decrease transmission of HIV infection to newborn babies.
- **Road Map for Accelerated Reduction of Maternal and Newborn Deaths** developed.
- **Legal Capacity of Married Persons Act, 2006** removes the minority status of the married women and repeals marital power a husband has over the woman and property.
- **The National Adolescent Health Policy’s objective is to reduce maternal morbidity and mortality due to pregnancy and childbirth, among adolescents.**
- **Blood Transfusion Policy.**
- **Lesotho Nurses & Midwives’ Act was reviewed for increasing scope of practice for nurses.**

#### 2007:
- **Prevention of Mother To Child Transmission of HIV Scale up Plan** developed and implemented and it is now due for review in 2011.
- **Infant and Young Child Feeding Policy** puts emphasis on exclusive breastfeeding of an infant for six months.
- **Code of Marketing of BM substitutes promotes proper infant and young child feeding methods with emphasis on exclusive BF for first six months and proper use of BM substitutes.**
- **User fees at primary health care level were abolished and at hospital level fees were standardized.**
- **A strategy for reproductive health commodity security is finalized; National Reproductive Health Policy which provides for notification of maternal and newborn deaths.**
- **Prevention of Mother To Child Transmission Guidelines provides guidance to health providers on ARV prophylaxis to both the mother and the child.**
- **National Guidelines for HIV and AIDS Care and Treatment.**
- **SRH Strategic Plan.**
- **National Health Policy and National Strategic Plan under Review and provide for SRH issues.**