REPRODUCTIVE HEALTH at a GLANCE

LESOTHO

62935

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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.[1] 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.[2, 3]

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.[4] 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.[3] 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.[5]

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.[4]

Lesotho: MDG 5 Status

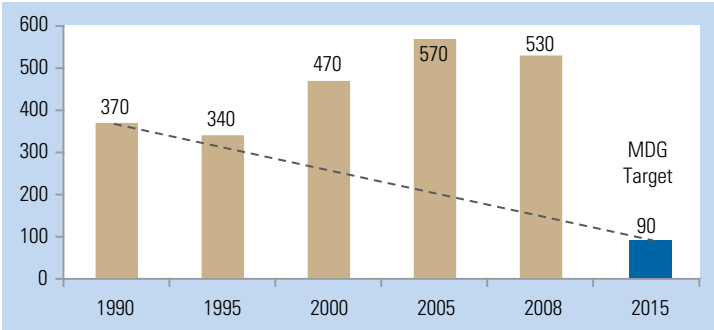
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	530
Births attended by skilled health personnel (percent)	61.5
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	47
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	96
Antenatal care with health personnel (percent)	92
Unmet need for family planning (percent)	23

Source: Compiled from multiple sources.
[a]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).[6]

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



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

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)

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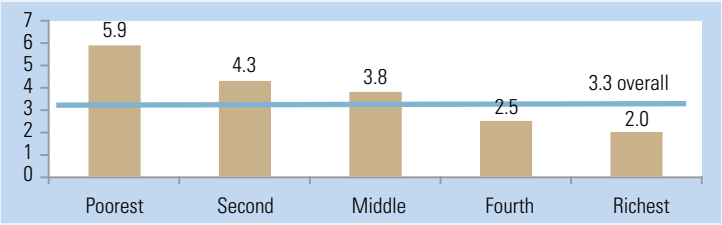
Key Challenges

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.[7] Nevertheless, fertility among poorest Basotho is about three times higher than among the wealthiest (Figure 2).

Figure 2 ▪ Total fertility rate by wealth quintile

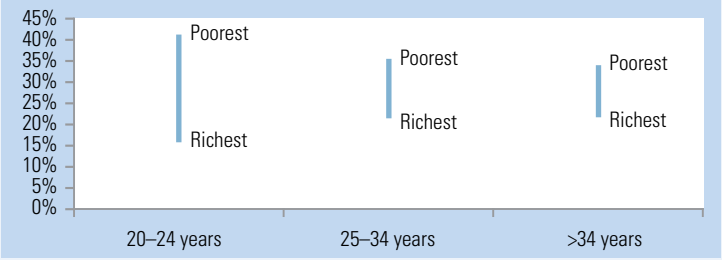


Source: DHS final report, Lesotho 2009.

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.[4]

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

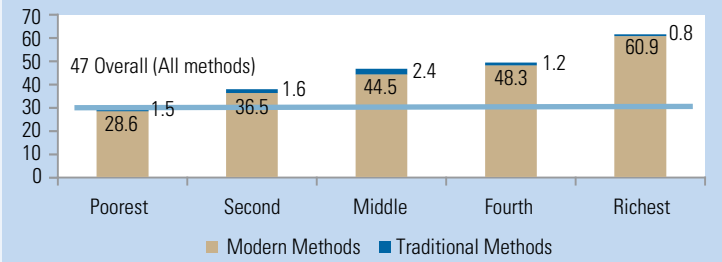


Source: DHS final report, Lesotho 2009 (author's calculation).

Nearly 50 percent of married women use some form of contraception. In Lesotho, use of modern contraception has increased remarkably from 37 percent in 2004 to 47 percent in 2009.[7] However, wide disparities among wealth quintiles remain: only 29 percent of women in the poorest quintile compare to 61 percent of women in the wealthiest quintile (Figure 4). Injectables are the most commonly used modern method among all women (13 percent), followed by the male condom (10 percent) and the pill (8 percent). Use of long-term methods such as the IUD and implants are negligible.

Unmet need for contraception is high at 23 percent[7] indicating that women may not be achieving their desired family size.[8] This is especially the case for the poorest: 37 percent for women in the poorest quintile versus 13 percent of women in the wealthiest quintile report having an unmet need for contraception. Additionally, 61 percent of women who were not using any form of contraception at the time of the survey indicate that they intend to use contraception in the future which may signal a huge potential demand for family planning services. Reasons why women are not using contraception and/or do not intend to use in the future were not reported in the 2009 DHS.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS final report, Lesotho 2009.

Poor Pregnancy Outcomes

Over 9 in 10 pregnant women receive antenatal care from skilled health personnel.[7] 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.[9]

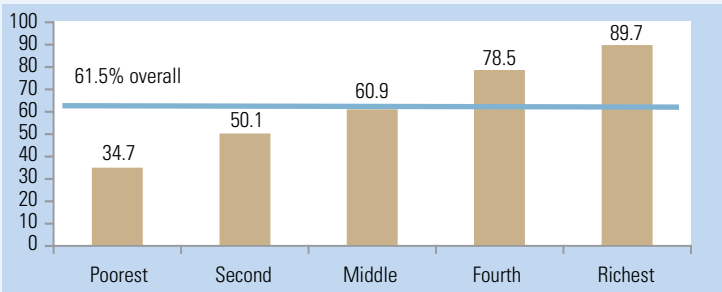
Three-fifth of pregnant women deliver with the assistance of skilled health personnel but wide disparities still exist. While 90 percent of women in the wealthiest quintile delivered with the assistance of skilled health personnel, only 35 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 42 percent of women who gave birth did not get a postnatal check-up within 6 weeks of delivery.[7]

Majority of women who indicated problems in accessing health care cited concerns regarding unavailability of medicines (Table 1).[7]

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.[3]

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



Source: DHS final report, Lesotho 2009.

Table 1 ▪ Reasons for not delivery in a health facility (women age 15–49)

Reason	%
At least one problem accessing health care	72.9
Concern no drugs available	58.5
Getting money for treatment	33.1
Having to take transport	32.1
Distance to health facility	30.7
Not wanting to go alone	11.8
Getting permission to go for treatment	6.5

Source: DHS final report, Lesotho 2009.

Development Partners Support for Reproductive Health in Lesotho

Christian Health Assn. of Lesotho (CHAL):	Provides Maternal, Newborn and Child health care services in the hard to reach areas (owns about 48% of health facilities in Lesotho)
WHO:	Safe motherhood;
UNFPA:	Reproductive health and rights;
UNICEF:	Child Protection and prevention of under five mortality by facilitating procurement of vaccines as well providing Maternal and Child Nutrition technical and financial support
USAID:	Health systems strengthening; skilled birth attendance
CIDA:	Healthcare workforce
AUSAID:	Safe Motherhood
PEPFAR:	Provides technical and financial support to HIV and AIDS prevention initiatives including PMTCT
EGPAF:	Provides maternal and Child health care including PMTCT and Nutrition
MSF:	Strategic objective is to promote integration of HIV and AIDS/ TB and MCH/SRH services;
ICAP:	Provides technical and financial support on PMTCT services and TB
World Vision:	Provides support on maternal and child health nutrition
PIH:	Provides SRH services in the hard to reach areas including Prevention of Mother to Child Transmission
UNAIDS :	Prevention of HIV and AIDS
WPF:	Provides Maternal and child nutrition including vulnerable groups
Irish Aid:	Provides capacity building SRH health providers
LPPA:	Sexual and Reproductive Health Rights, educating & empowering youths , STIs and HIV prevention, provides FP services countrywide
Global Fund:	Provides support for PMTCT through capacity building, procurement of ARVs, supplies and equipment in relation to HIV prevention
MCA:	Improvement on maternal health services by upgrading 138 health centers that will include the ante-natal shelters
GIZ:	Provides support for decentralization of all health services

emergency obstetric and neonatal care (EmONC) remains a challenge.

STIs/HIV/AIDS prevalence is high

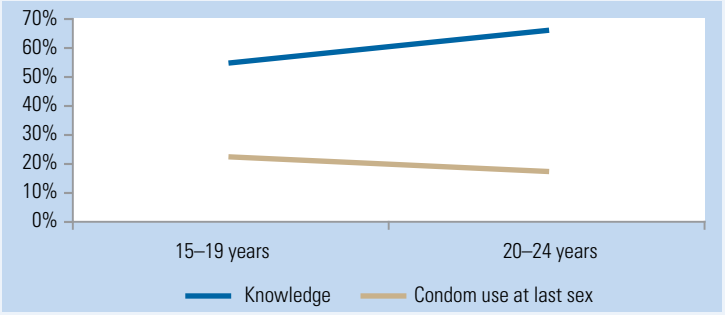
Lesotho has one of the highest HIV prevalence rates in the world (23 percent); the prevalence among females is significantly higher than among males (26 percent and 19 percent, respectively) with women of childbearing age comprising 58 percent of the HIV positive population.[7] According to Annual Joint Review Report for 2010 71 percent of HIV-positive pregnant women receive the antiretroviral drugs that reduce mother-to-child transmission.[2]

Knowledge of mother-to-child prevention methods is high. Knowledge among women (aged 15-49 years) that HIV can be transmitted through breast milk and that the likelihood of passing HIV from mother to child can be reduced by drugs has increased remarkably from 42 percent in 2004 to 71 percent in 2008.[2]

Majority of adults believe that 12–14 years old children should be taught about condom use (68 percent of adult women and 62 percent of adult men).

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While the majority of young women are aware that using a condom in every intercourse prevents HIV, only 22 percent of them report having used condom at last intercourse (Figure 6). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS final report, Lesotho 2009.

Technical Notes:

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

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- 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 pro vision 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.

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LESOTHO REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2009	3.3	Population, total (million)	2006	1.88
Adolescent fertility rate (births per 1,000 women ages 15–19)	2009	96	Population growth (annual %)	2008	0.9
Contraceptive prevalence (% of married women ages 15–49)	2009	47	Population ages 0–14 (% of total)	2008	39.2
Unmet need for contraceptives (%)	2009	23	Population ages 15–64 (% of total)	2008	56.1
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	4.7
Median age at marriage (years)	2004	19.5	Age dependency ratio (% of working-age population)	2008	78.3
Mean ideal number of children for all women	2009	2.8	Urban population (% of total)	2008	25.5
Antenatal care with health personnel (%)	2009	91.8	Mean size of households	2004	4
Births attended by skilled health personnel (%)	2009	61.5	GNI per capita, Atlas method (current US$)	2008	1060
Proportion of pregnant women with hemoglobin <110 g/L	2008	25.4	GDP per capita (current US$)	2003	791
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	370	GDP growth (annual %)	2008	3.9
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	340	Population living below US$1.25 per day	2003	43.4
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	470	Labor force participation rate, female (% of female population ages 15–64)	2008	71.9
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	570	Literacy rate, adult female (% of females ages 15 and above)	2004	95.1
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	530	Total enrollment, primary (% net)	2007	73
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	90	Ratio of female to male primary enrollment (%)	2007	99
Infant mortality rate (per 1,000 live births)	2008	63	Ratio of female to male secondary enrollment (%)	2007	131.9
Newborns protected against tetanus (%)	2008	83	Gender Development Index (GDI)	2008	119
DPT3 immunization coverage (% by age 1)	2010	75	Health expenditure, total (% of GDP)	2007	6.2
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	12.1	Health expenditure, public (% of GDP)	2007	3.6
Prevalence of HIV, total (% of population ages 15–49)	2007	23.2	Health expenditure per capita (current US$)	2007	51.1
Female adults with HIV (% of population ages 15+ with HIV)	2007	57.7	Physicians (per 1,000 population)	2008	0.05
Prevalence of HIV, female (% ages 15–24)	2007	14.9	Nurses and midwives (per 1,000 population)	2008	0.62

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2009	5.9	4.3	3.8	2.5	2.0	3.3	3.9	3.0
Current use of contraception (Modern method)	DHS	2009	28.6	36.5	44.5	48.3	60.9	45.6	–32.3	0.5
Current use of contraception (Any method)	DHS	2009	30.1	38.1	46.9	49.5	61.7	47.0	–31.6	0.5
Unmet need for family planning (Total)	DHS	2008	36.7	29.4	21.7	20.6	12.9	23.0	23.8	2.8
Births attended by skilled health personnel (percent)	DHS	2008	34.7	50.1	60.9	78.5	89.7	61.5	–55.0	0.4

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 new born babies.

2006: Road Map for Accelerated Reduction of Maternal and Newborn Deaths developed.

2006: 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.

2006: The National Adolescent Health Policy's objective is to reduce maternal morbidity and mortality due to pregnancy and childbirth, among adolescents.

2006: Blood Transfusion Policy.

2006: 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.

2008: Infant and Young Child Feeding Policy puts an emphasis on exclusive breast feeding of an infant for six months.

2008: 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.

2008: User fees at primary health care level were abolished and at hospital level fees were standardized.

2009: A strategy for reproductive health commodity security is finalized;

2009: National Reproductive Health Policy which provides for notification of maternal and newborn deaths.

2010: Prevention of Mother To Child Transmission Guidelines provides guidance to health providers on ARV prophylaxis to both the mother and the child.

2010: National Guidelines for HIV and AIDS Care and Treatment.

2010: SRH Strategic Plan.

2011: National Health Policy and National Strategic Plan under Review and provide for SRH issues.