Lesotho

Demographic and Health Survey

Key Indicators
2014

Lesotho

Demographic and Health Survey 2014

Key Indicators Report

Ministry of Health
Maseru, Lesotho

The DHS Program
ICF International
Rockville, Maryland, USA

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The 2014 Lesotho Demographic and Health Survey (2014 LDHS) was implemented by the Lesotho Ministry of Health from 22 September to 7 December 2014. The funding for the LDHS was provided by the government of Lesotho, the United States Agency for International Development (USAID), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Centers for Disease Control and Prevention (CDC), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank, and the World Health Organization (WHO). ICF International provided technical assistance through The DHS Program, a USAID-funded project providing support and technical assistance in the implementation of population and health surveys in countries worldwide.

Additional information about the 2014 LDHS may be obtained from the Ministry of Health, P.O. Box 514, Maseru, Lesotho; Telephone: +266-22-314404; Internet: http://www.gov.ls/health/.

Information about The DHS Program may be obtained from ICF International, 530 Gaither Road, Suite 500, Rockville, MD 20850, USA; Telephone: +1-301-407-6500; Fax: +1-301-407-6501; E-mail: info@DHSprogram.com; Internet: www.DHSprogram.com.

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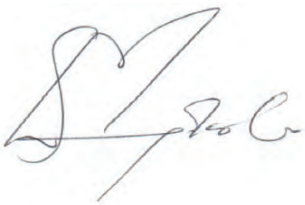
FOREWORD

The 2014 Lesotho Demographic and Health Survey (LDHS) was implemented by the Ministry of Health (MOH). The 2014 LDHS was the third DHS survey to be conducted in Lesotho in collaboration with the worldwide Demographic and Health Surveys Program. This report, which presents key findings from the 2014 LDHS, is intended to provide policymakers and programme managers with a first glimpse of the survey results. A more comprehensive and detailed report is scheduled for later in 2015.

The MOH wishes to acknowledge the efforts of a number of organisations and individuals who contributed substantially to the success of the survey. First, we would like to acknowledge the financial assistance from the government of Lesotho, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Centers for Disease Control and Prevention (CDC), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), the World Health Organization (WHO), and the World Bank. We thank the Bureau of Statistics (BOS) for providing the sample frame, for providing GIS shapefiles corresponding to the LDHS sample points, and for training enumerators on conducting the household listing. We would like to thank ICF International for technical backstopping throughout the survey. The survey also could not have been carried out successfully without the dedication of the staff of the MOH who planned, participated in, and oversaw the entire LDHS.

Finally, we are grateful to the survey respondents who generously gave their time to provide the information that forms the basis of this and future reports.



Mr. L. Manyokole
Principal Secretary
Ministry of Health

INTRODUCTION 1

The 2014 Lesotho Demographic and Health Survey (LDHS) was implemented by the Lesotho Ministry of Health (MOH). Data collection took place from 22 September to 7 December 2014. ICF International provided technical assistance through the DHS Program, which is funded by the United States Agency for International Development (USAID) and offers support and technical assistance for the implementation of population and health surveys in countries worldwide. Other agencies and organisations that facilitated the successful implementation of the survey through technical or financial support were the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Centers for Disease Control and Prevention (CDC), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank, the World Health Organization (WHO), the Christian Health Association of Lesotho (CHAL), the National University of Lesotho, the Bureau of Statistics (BOS) of the Ministry of Development Planning, and the Food and Nutrition Coordinating Office (FNCO) of the Prime Minister's Office.

This key indicators report presents a first look at selected findings of the 2014 LDHS. A comprehensive analysis of the data will be presented in a final report to be published in late 2015.

SURVEY OBJECTIVES

The primary objective of the 2014 LDHS project is to provide up-to-date estimates of basic demographic and health indicators. Specifically, the LDHS collected information on fertility levels, marriage, sexual activity, fertility preferences, awareness and use of family planning methods, breastfeeding practices, nutrition, childhood and maternal mortality, maternal and child health, awareness and behaviour regarding HIV/AIDS and other sexually transmitted infections (STIs), and other health issues such as smoking, knowledge of breast cancer, and male circumcision. In addition, the 2014 LDHS provides estimates of anaemia prevalence among children age 6-59 months and adults and estimates of hypertension and HIV prevalence among adults. The 2014 LDHS is a follow-up to the earlier LDHS surveys (2004 and 2009).

The information collected through the LDHS is intended to assist policymakers and programme managers in evaluating and designing programmes and strategies for improving the health of the country's population.

SURVEY IMPLEMENTATION 2

2.1 SAMPLE DESIGN

The sampling frame used for the 2014 LDHS is an updated frame from the 2006 Lesotho Population and Housing Census (PHC) provided by the Lesotho Bureau of Statistics (BOS). The sampling frame excluded nomadic and institutional populations such as persons in hotels, barracks, and prisons.

The 2014 LDHS followed a two-stage sample design and was intended to allow estimates of key indicators at the national level as well as for urban and rural areas, four ecological zones,[1] and each of Lesotho's 10 districts.[2] The first stage involved selecting sample points (clusters) consisting of enumeration areas (EAs) delineated for the 2006 PHC. A total of 400 clusters were selected, 118 in urban areas and 282 in rural areas.[3]

The second stage involved systemic sampling of households. A household listing operation was undertaken in all of the selected EAs in July 2014, and households to be included in the survey were randomly selected from these lists. About 25 households were selected from each sample point, for a total sample size of 9,942 households. Because of the approximately equal sample sizes in each district, the sample is not self-weighting at the national level, and weighting factors have been added to the data file so that the results will be proportional at the national level.

All women age 15-49 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed. In half of the households, all men age 15-59 who were either permanent residents of the selected households or visitors who stayed in the household the night before the survey were eligible to be interviewed. In the subsample of households selected for the male survey, blood pressure measurements and anaemia testing were performed among eligible women and men who consented to being tested. With the parent's or guardian's consent, children age 6-59 months were also tested for anaemia. In the same subsample, blood samples were collected for laboratory testing of HIV from eligible women and men who consented; height and weight information was collected from eligible women, men, and children age 0-59 months; and mid-upper-arm circumference (MUAC) measurements were collected for children age 6-59 months.

2.2 QUESTIONNAIRES

Three questionnaires were used for the 2014 LDHS: the Household Questionnaire, the Woman's Questionnaire, and the Man's Questionnaire. These questionnaires, based on The DHS Program's standard Demographic and Health Survey questionnaires, were adapted to reflect the population and health issues relevant to Lesotho. Input was solicited from various stakeholders representing government ministries and agencies, nongovernmental organisations, and international donors. After the preparation of the definitive questionnaires in English, the questionnaires were translated into Sesotho.

The Household Questionnaire was used to list all of the members of and visitors to selected households. Basic demographic information was collected on the characteristics of each person listed, including his or her age, sex, marital status, education, and relationship to the head of the household. For children under age 18, parents' survival status was determined. The data on age and sex of household

[1] Lowlands, Foothills, Mountains, and Senqu River Valley.

[2] Butha-Buthe, Leribe, Berea, Maseru, Mafeteng, Mohale's Hoek, Quthing, Qacha's Nek, Mokhotlong, and Thaba-Tseka.

[3] One rural EA was inadvertently dropped from the sample. After the fieldwork was completed, it was determined that that EA had not been visited.

members obtained in the Household Questionnaire were used to identify women and men who were eligible for individual interviews. The Household Questionnaire also collected information on characteristics of the household's dwelling unit, such as source of water, type of toilet facilities, materials used for the floor of the dwelling unit, and ownership of various durable goods.

The Woman's Questionnaire was used to collect information from all eligible women age 15-49. These women were asked questions on the following topics:

- Background characteristics (age, education, media exposure, etc.)
- Birth history and child mortality
- Knowledge and use of family planning methods
- Fertility preferences
- Antenatal, delivery, and postnatal care
- Breastfeeding and infant feeding practices
- Vaccinations and childhood illnesses
- Marriage and sexual activity
- Women's work and husbands' background characteristics
- Knowledge, awareness, and behaviour regarding HIV/AIDS and other sexually transmitted infections (STIs)
- Adult mortality, including maternal mortality
- Knowledge, attitudes, and behaviour related to other health issues (e.g., tuberculosis, diabetes, breast and cervical cancer)

The Man's Questionnaire was administered to all men age 15-59 in the subsample of households selected for the male survey. The Man's Questionnaire collected much of the same information found in the Woman's Questionnaire but was shorter because it did not contain a detailed reproductive history or questions on maternal and child health.

In this survey, instead of using paper questionnaires, interviewers used personal digital assistants (PDAs) to record responses during interviews, and team supervisors managed the data using tablet computers. The PDAs and tablets were equipped with Bluetooth technology to enable remote electronic transfer of files (e.g., transfer of assignment sheets from team supervisors to interviewers and transfer of completed questionnaires from interviewers to supervisors). The computer-assisted personal interviewing (CAPI) data collection system employed in the 2014 LDHS was developed by The DHS Program using the mobile version of CSPro. The CSPro software was developed jointly by the U.S. Census Bureau, The DHS Program, and Serpro S.A.

2.3 Blood Pressure Measurement, Anthropometry, Anaemia testing, and HIV Testing

In the half of the households selected for the male survey, the 2014 LDHS incorporated several "biomarkers": blood pressure measurement, anthropometry, anaemia testing, and HIV testing. In contrast to the data collection procedure for the household and individual interviews, data related to all biomarkers except blood pressure were initially recorded on a paper form (the Biomarker Data Collection Form) and subsequently entered into the team supervisor's tablet computer. The survey protocol, including biomarker collection, was reviewed and approved by the Lesotho Ministry of Health Research and Ethics Committee, the Institutional Review Board of ICF International, and the Centers for Disease Control and Prevention.

Blood pressure. During the individual interview, three blood pressure measurements were taken from consenting women age 15-49 and men age 15-59 using Omron M3W blood pressure monitors. Measurements were taken at intervals of 10 minutes or more. The average of the second and third measurements was used to classify the respondent with respect to hypertension, according to internationally recommended categories (WHO, 1999). The results, as well as information about the symptoms of high

blood pressure and ways in which it can be prevented, were provided to the respondent via the Blood Pressure Findings Report Form and Brochure.

Anthropometry. Height and weight measurements were recorded for children age 0-59 months, women age 15-49, and men age 15-59. In addition, mid-upper-arm circumference (MUAC) was recorded for children age 6-59 months.

Anaemia testing. Blood specimens for anaemia testing were collected from women age 15-49 and men age 15-59 who voluntarily consented to be tested and from all children age 6-59 months for whom consent was obtained from their parents or the adult responsible for the children. Blood samples were drawn from a drop of blood taken from a finger prick (or a heel prick in the case of children age 6-11 months) and collected in a microcuvette. Haemoglobin analysis was carried out on-site using a battery-operated portable HemoCue analyser. Results were provided verbally and in writing. Parents of children with a haemoglobin level under 7 g/dl were instructed to take the child to a health facility for follow-up care. Likewise, non-pregnant women, pregnant women, and men were referred for follow-up care if their haemoglobin levels were below 7 g/dl, 9 g/dl, and 9 g/dl, respectively. All households in which anthropometry and/or anaemia testing was conducted were given a brochure explaining the causes and prevention of anaemia.

HIV testing. Interviewers collected finger-prick blood specimens for laboratory testing of HIV from women age 15-49 and men age 15-59 who consented to be tested. The protocol for blood specimen collection and analysis was based on the anonymous linked protocol developed for The DHS Program. This protocol allows for merging of HIV test results with the sociodemographic data collected in the individual questionnaires after removal of all information that could potentially identify an individual.

Interviewers explained the procedure, the confidentiality of the data, and the fact that the test results would not be made available to the respondent. If a respondent consented to HIV testing, five blood spots from the finger prick were collected on a filter paper card to which a barcode label unique to the respondent was affixed. A duplicate label was attached to the Biomarker Data Collection Form. A third copy of the same barcode was affixed to the Dried Blood Spot Transmittal Sheet to track the blood samples from the field to the laboratory.

Respondents were asked whether they would consent to having the laboratory store their blood sample for future unspecified testing. If respondents did not consent to additional testing using their sample, it was indicated on the Biomarker Data Collection Form that they refused additional tests using their specimen, and the words “no additional testing” were written on the filter paper card. Each respondent, whether providing consent or not, was given an informational brochure on HIV and a list of nearby sites providing HIV counselling and testing (HCT) services.

Blood samples were dried overnight and packaged for storage the following morning. Samples were periodically collected from the field and transported to the National Reference Laboratory (NRL) in Maseru. Once it arrived at the NRL, each blood sample was logged into the CSPro HIV Test Tracking System database, given a laboratory number, and stored at -20˚C until tested.

The HIV testing protocol stipulated that blood could be tested only after questionnaire data collection had been completed, data had been verified and cleaned, and all unique identifiers other than the anonymous barcode number had been removed from the data file. As of this report, HIV testing had not been completed.

The testing algorithm calls for testing all samples on the first assay test, the Vironostika® HIV Ag/Ab (Biomérieux) enzyme-linked immunoassay (ELISA). A negative result is recorded as negative. All positives are subjected to a second ELISA, the Enzygnost® HIV Integral II assay (Siemens). Positive samples on the second test are recorded as positive. If the first and second tests are discordant, the two ELISAs are repeated. If the results remain discordant, a third confirmatory test, the HIV 2.2 western blot (DiaSorin), is administered. The final result is recorded as positive if the western blot confirms it to be

positive and negative if the western blot confirms it to be negative. If the western blot results are indeterminate, the sample is recorded as indeterminate.

After HIV testing has been completed, the HIV test results for the 2014 LDHS will be entered into a spreadsheet with a barcode as the unique identifier. The barcode will be used to link the HIV test results with the data from the individual interviews. Data from the HIV results and linked demographic and health data will be published in the 2014 LDHS final report.

2.4 PRETEST

Ten women and five men participated in a training to pretest the LDHS survey protocol over a three-week period in June 2014. The majority of participants had worked in various LDHS survey activities previously, including the 2009 LDHS. Participants were employed by the MOH, the BOS, or the Lesotho Planned Parenthood Association. Ten days of classroom instruction were provided. Trainers were from The DHS Program. Pretest field practice took place over four days in both rural and urban locations. Following field practice, a debriefing session was held with the pretest field staff, and modifications to the questionnaires were made based on lessons drawn from the exercise.

2.5 TRAINING OF FIELD STAFF

The MOH recruited and trained 100 people for the main fieldwork to serve as supervisors, interviewers, secondary editors, and reserve interviewers. The field staff main training took place over four weeks (6-29 August 2014) at the Khotsong Lodge in Thaba-Bosiu, Lesotho. The training course consisted of instruction regarding interviewing techniques and field procedures, a detailed review of questionnaire content, instruction on how to administer the paper and electronic questionnaires, instruction in weighing and measuring children and adults, mock interviews between participants in the classroom, practice biomarker collection between participants, and practice interviews with real respondents in areas outside the 2014 sample points. In addition, participants completed limited field practice in blood pressure measurement, anthropometry, anaemia testing, and blood collection for HIV testing.[4]

Participants were evaluated through homework, in-class exercises, quizzes, and observations made during field practice. Ultimately, 75 were selected to serve as interviewers and 15 as team supervisors. The latter received additional training in data quality control procedures, fieldwork coordination, and use of special programmes for the tablet computers.

2.6 FIELDWORK

Data collection was carried out by 15 field teams, each consisting of one team supervisor, two or three female interviewers, two or three male interviewers, and one driver. All interviewers on each team also served as biomarker technicians. Electronic data files containing interview results were transferred from each interviewer's PDA to the team supervisor's tablet each day. Six senior staff members from the MOH coordinated and supervised fieldwork activities. Electronic data files were transferred to the central office every few days via the secured Internet File Streaming System (IFSS). Participants in fieldwork monitoring also included two survey technical specialists from The DHS Program.

Data collection took place over a 2.5-month period, from 22 September 2014 through 7 December 2014. The substantial gap between the end of the main training and the start of fieldwork was due to concerns about team safety following political disturbances on 30 August 2014. Immediately prior to the launch, the MOH conducted a two-day refresher training course for interviewers and supervisors at MOH headquarters.

[4] Equipment shortages due to procurement issues necessitated that field practice teams share height boards, HemoCue analysers, and blood pressure monitors.

2.7 DATA PROCESSING

All electronic data files for the 2014 LDHS were transferred via IFSS to the MOH central office in Maseru, where they were stored on a password-protected computer. The data processing operation included secondary editing, which involved resolution of computer-identified inconsistencies and coding of open-ended questions. The data were processed by one person who took part in the main fieldwork training. Data editing was accomplished using CSPro software. Secondary editing and data processing were initiated in October 2014 and completed in February 2015.

KEY FINDINGS 3

3.1 RESPONSE RATES

Table 3.1 shows response rates for the 2014 LDHS. A total of 9,942 households were selected for the sample, of which 9,543 were occupied. Of the occupied households, 9,402 were successfully interviewed, yielding a response rate of 99 percent. This compares favourably to the 2009 LDHS response rate (98 percent).

In the interviewed households, 6,818 eligible women were identified for individual interviews; interviews were completed with 6,621 women, yielding a response rate of 97 percent. In the subsample of households selected for the male survey, 3,133 eligible men were identified and 2,931 were successfully interviewed, yielding a response rate of 94 percent. The lower response rate for men was likely due to their more frequent and longer absences from the household.

The response rates for both women and men were slightly lower in the 2014 LDHS than in the 2009 LDHS (in which response rates were 98 percent for women and 95 percent for men). Strikingly, however, the numbers of eligible women and men identified in households in the 2014 LDHS were substantially lower than in the 2009 LDHS. Whereas there was an average of 0.83 eligible women and 0.72 eligible men per household in the 2009 LDHS, the corresponding averages in 2014 were 0.73 and 0.67 (data not shown).

The reason for the difference in the average number of eligible women and men between the 2009 and 2014 LDHS surveys is unknown. Possibilities range from a demographic shift in the population of Lesotho to data quality issues such as age displacement or omission of household members (or a combination of both). These issues will be explored in the 2014 LDHS final report.

Table 3.1 Results of the household and individual interviews

Number of households, number of interviews, and response rates, according to residence (unweighted), Lesotho 2014

	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	2,934	7,008	9,942
Households occupied	2,843	6,700	9,543
Households interviewed	2,798	6,604	9,402
Household response rate[1]	98.4	98.6	98.5
Interviews with women age 15-49			
Number of eligible women	2,282	4,536	6,818
Number of eligible women interviewed	2,202	4,419	6,621
Eligible women response rate[2]	96.5	97.4	97.1
Interviews with men age 15-59			
Number of eligible men	960	2,173	3,133
Number of eligible men interviewed	903	2,028	2,931
Eligible men response rate[2]	94.1	93.3	93.6

[1] Households interviewed/households occupied
[2] Respondents interviewed/eligible respondents

3.2 CHARACTERISTICS OF RESPONDENTS

Table 3.2 shows the weighted and unweighted numbers and the weighted percent distributions of women and men age 15-49 interviewed in the 2014 LDHS, by background characteristics. More than half of respondents age 15-49 were under age 30, reflecting the young age structure of the population. The vast majority of respondents are Christian; about four in ten are Roman Catholic. One-third of women (33 percent) and more than half of men (56 percent) have never been married. Women are more often married or living together with a partner (i.e., in union) than men (55 percent and 37 percent, respectively), but women and men are equally likely to report that they are divorced or separated (5 percent). Seven percent of women report that they are widowed, as compared with 2 percent of men. A majority of respondents live in rural areas (64 percent of women and 65 percent of men).

With respect to educational status, 1 percent of women and 8 percent of men report that they have never attended school. Eighteen percent of women and 33 percent of men attended, but did not complete, primary school. Twenty-one percent of women and 12 percent of men completed primary school without continuing to secondary education. Fifty-two percent of women and 39 percent of men attended secondary

school. Nine percent of women and 8 percent of men attended a level of education higher than secondary school.

Table 3.2 Background characteristics of respondents

Percent distribution of women and men age 15-49 by selected background characteristics, Lesotho 2014

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	21.7	1,440	1,542	26.0	691	690
20-24	20.0	1,325	1,300	21.1	561	534
25-29	16.5	1,094	1,072	15.4	410	394
30-34	14.5	957	907	12.6	334	345
35-39	11.2	744	728	10.4	276	275
40-44	8.5	562	582	8.3	221	222
45-49	7.5	499	490	6.3	168	166
Religion						
Roman Catholic	38.6	2,558	2,514	40.9	1,088	1,018
Lesotho Evangelical	17.1	1,133	1,133	17.9	476	472
Anglican	7.2	477	453	7.8	207	202
Pentecostal	24.9	1,646	1,682	18.8	499	507
Other Christian	10.1	668	691	6.8	180	196
Other non-Christian	1.4	90	83	1.6	42	36
No religion	0.7	49	65	6.3	168	195
Marital status						
Never married	33.1	2,190	2,201	56.4	1,501	1,464
Married	53.6	3,549	3,556	36.0	959	971
Living together	1.0	63	53	0.9	25	22
Divorced/separated	5.4	358	340	4.9	132	122
Widowed	7.0	461	471	1.7	45	47
Residence						
Urban	36.5	2,419	2,202	34.6	920	821
Rural	63.5	4,202	4,419	65.4	1,741	1,805
Ecological zone						
Lowlands	63.2	4,184	3,290	64.3	1,711	1,348
Foothills	10.4	688	670	9.5	252	258
Mountains	19.5	1,288	1,897	19.7	523	734
Senqu River Valley	7.0	461	764	6.5	174	286
District						
Butha-Buthe	5.8	385	593	5.4	143	222
Leribe	16.1	1,064	785	14.7	390	283
Berea	13.5	892	760	14.3	379	326
Maseru	28.2	1,864	930	30.4	809	427
Mafeteng	8.7	576	624	9.1	242	268
Mohale's Hoek	7.8	519	621	7.6	202	241
Quthing	4.8	315	556	3.9	105	187
Qacha's Nek	3.1	204	558	2.8	74	201
Mokhotlong	5.3	349	605	5.4	144	241
Thaba-Tseka	6.8	452	589	6.5	172	230
Education						
No education	1.0	68	81	8.0	213	237
Primary incomplete	17.8	1,178	1,282	32.9	875	911
Primary complete	20.8	1,375	1,383	11.9	316	317
Secondary	51.6	3,418	3,354	39.2	1,043	972
More than secondary	8.8	581	521	8.0	214	189
Wealth quintile						
Lowest	14.5	960	1,183	14.1	376	468
Second	15.6	1,033	1,138	18.0	479	501
Middle	18.8	1,244	1,307	20.1	536	542
Fourth	24.2	1,605	1,453	23.2	616	550
Highest	26.9	1,778	1,540	24.6	654	565
Total 15-49	100.0	6,621	6,621	100.0	2,660	2,626
50-59	na	na	na	na	271	305
Total 15-59	na	na	na	na	2,931	2,931

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.
na = Not applicable

3.3 FERTILITY

To generate data on fertility, all women who were interviewed were asked to report the total number of sons and daughters to whom they had ever given birth. To ensure that all information was reported, women were asked separately about children still living at home, those living elsewhere, and those who had died. A complete birth history was then obtained, including information on the sex, date of birth, and survival status of each child; age at death for children who had died was also recorded.

Table 3.3 Current fertility

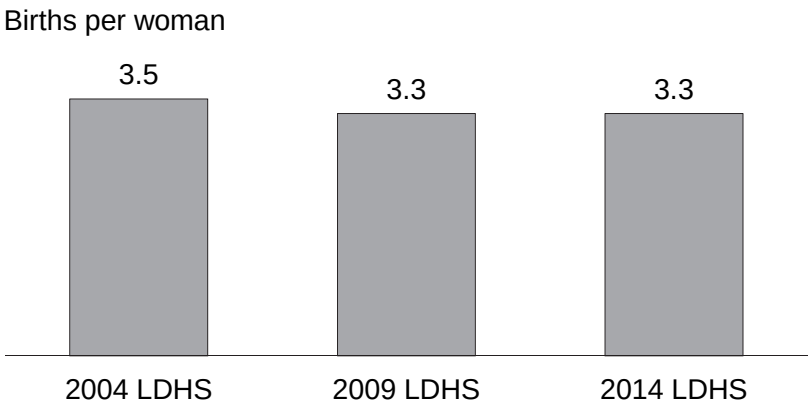
Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the three years preceding the survey, by residence, Lesotho 2014

	Residence		
Age group	Urban	Rural	Total
15-19	58	112	94
20-24	127	211	181
25-29	113	159	140
30-34	90	129	112
35-39	39	92	72
40-44	21	64	49
45-49	3	4	4
TFR (15-49)	2.3	3.9	3.3
GFR	85	137	118
CBR	23.3	24.7	24.3

Note: Age-specific fertility rates are per 1,000 women. Rates for the 45-49 age group may be slightly biased due to truncation. Rates are for the period 1-36 months prior to interview.
TFR: Total fertility rate, expressed per woman
GFR: General fertility rate, expressed per 1,000 women age 15-44
CBR: Crude birth rate, expressed per 1,000 population

Table 3.3 shows age-specific fertility rates among women by five-year age groups for the three-year period preceding the survey. Age-specific and total fertility rates were calculated directly from the birth history data. The sum of age-specific fertility rates (known as the total fertility rate, or TFR) is a summary measure of the level of fertility. It can be interpreted as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the current observed age-specific rates. If fertility were to remain constant at current levels, a woman from Lesotho would bear an average of 3.3 children in her lifetime. As shown in Figure 3.1, the TFR has not changed since the 2009 LDHS, when it was also 3.3 births per woman; however, it is slightly lower than the rate reported in the 2004 LDHS. Fertility is notably higher among rural women than among urban women; on average, rural women will give birth to nearly two more children during their reproductive years than urban women (3.9 and 2.3, respectively).

Figure 3.1 **Trends in total fertility rate, 2004-2014**



3.4 TEENAGE PREGNANCY AND MOTHERHOOD

The issue of adolescent fertility is important on both health and social grounds. Children born to very young mothers are at increased risk of sickness and death. Teenage mothers are more likely to experience adverse pregnancy outcomes and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing.

Table 3.4 shows the percent distribution of women age 15-19 who have given birth or were pregnant with their first child at the time of the survey, according to background characteristics. Overall, 19 percent of women age 15-19 have begun childbearing: 15 percent have had a live birth and 4 percent were pregnant at the time of the interview. The proportion of teenagers who have begun childbearing rises rapidly with age,

from 3 percent at age 15 to 40 percent at age 19. Rural teenagers and those in the lowest wealth quintile tend to start childbearing earlier than other teenagers.

Table 3.4 Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, by background characteristics, Lesotho 2014

Background characteristic	Percentage of women age 15-19 who: Have had a live birth	Are pregnant with first child	Percentage who have begun childbearing	Number of women
Age				
15	1.4	1.6	3.0	295
16	5.7	2.2	8.0	333
17	11.7	4.2	15.9	246
18	24.2	7.2	31.4	285
19	34.0	5.6	39.6	280
Residence				
Urban	10.0	1.7	11.7	449
Rural	17.3	5.1	22.5	991
Ecological zone				
Lowlands	12.2	3.3	15.6	854
Foothills	20.4	8.0	28.3	161
Mountains	18.6	4.1	22.7	321
Senqu River Valley	19.0	4.0	23.0	104
District				
Butha-Buthe	21.5	3.2	24.7	82
Leribe	16.0	3.5	19.5	244
Berea	17.1	5.6	22.7	201
Maseru	11.6	2.6	14.2	329
Mafeteng	8.9	5.8	14.7	148
Mohale's Hoek	18.2	4.2	22.4	108
Quthing	18.7	2.7	21.5	84
Qacha's Nek	9.9	5.8	15.8	54
Mokhotlong	18.4	5.6	24.0	99
Thaba-Tseka	16.5	4.1	20.6	92
Education				
No education	nc	nc	nc	0
Primary incomplete	11.9	5.2	17.1	226
Primary complete	25.7	7.7	33.4	177
Secondary	14.0	3.2	17.3	1,026
More than secondary	*	*	*	11
Wealth quintile				
Lowest	23.8	4.5	28.3	226
Second	14.5	6.7	21.3	248
Middle	19.4	5.7	25.1	315
Fourth	14.7	3.1	17.8	349
Highest	4.8	1.1	5.8	301
Total	15.0	4.1	19.1	1,440

Note: An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
nc = No cases

3.5 FERTILITY PREFERENCES

Information on fertility preferences is used to assess the potential demand for family planning services for the purposes of spacing or limiting future childbearing. To elicit information on fertility preferences, several questions were asked of currently married women (pregnant or not) regarding whether they want to have another child and, if so, how soon.

Table 3.5 shows that 15 percent of women want to have another child soon (within the next two years) and 24 percent want to have another child later (in two or more years). Fifty-six percent of women want no more children.

Fertility preferences are closely related to number of living children. Three of four women with no living children (76 percent) want a child soon, as compared with only 4 percent of women with six or more children. In general, the more children a woman has, the higher the likelihood that she does not want another child.

Table 3.5 Fertility preferences by number of living children

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, Lesotho 2014

	Number of living children[1]							
Desire for children	0	1	2	3	4	5	6+	Total
Have another soon[2]	76.0	18.7	9.7	5.3	1.8	1.3	3.5	14.9
Have another later[3]	10.3	49.8	22.6	8.1	3.4	1.1	1.0	24.1
Have another, undecided when	1.2	1.2	1.1	0.6	0.0	0.0	0.0	0.9
Undecided	1.0	1.0	1.9	0.7	0.9	0.4	0.8	1.2
Want no more	4.8	28.4	62.7	82.1	87.9	91.5	86.2	56.0
Sterilised[4]	0.0	0.1	1.4	2.5	4.1	4.0	7.7	1.7
Declared infecund	6.8	0.8	0.6	0.7	1.8	1.8	0.8	1.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	245	1,102	1,033	585	331	164	152	3,612

[1] The number of living children includes current pregnancy.
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both female and male sterilisation

3.6 FAMILY PLANNING

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Contraceptive methods are classified as modern or traditional methods. Modern methods include female sterilisation, male sterilisation, the intrauterine contraceptive device (IUCD), implants, injectables, the pill, male condoms, and female condoms. Methods such as rhythm, withdrawal, and folk methods are grouped as traditional.

Table 3.6 shows the percent distribution of currently married women and sexually active unmarried women by the contraceptive method they currently use. Overall, 60 percent of currently married women are using a method of family planning, and nearly all use a modern method; less than 1 percent of currently married women are using a traditional method. Among currently married women, the most popular methods are injectables (used by 24 percent), male condoms (used by 17 percent), and the pill (used by 14 percent). The contraceptive prevalence rate (CPR) among married women increases with age, reaching a peak at age 35-39 (71 percent) before declining to 40 percent among women age 45-49. Contraceptive use increases with increasing education and, in general, increasing wealth. Women with living children are more likely than women without living children to use contraceptives.

Among sexually active unmarried women, 73 percent are currently using a contraceptive method; 72 percent are using a modern method. In contrast to married women, the most commonly used method among sexually active unmarried women is the male condom (45 percent).

A comparison of results from the 2004, 2009, and 2014 LDHS surveys reveals that the CPR among married women in Lesotho has steadily increased: from 37 percent in 2004 to 47 percent in 2009 and 60 percent in 2014. Similarly, the CPR among sexually active unmarried women has steadily risen from 48 percent in 2004 to 58 percent in 2009 and 73 percent in 2014.

Table 3.6 Current use of contraception by background characteristics

Percent distribution of currently married women and sexually active unmarried women age 15-49 by contraceptive method currently used, according to background characteristics, Lesotho 2014

Background characteristic	Any method	Any modern method	Modern method: Female sterilisation	Male sterilisation	IUCD	Implants	Injectables	Pill	Male condom	Female condom	Any traditional method	Traditional method: Rhythm	Withdrawal	Not currently using	Total	Number of women
CURRENTLY MARRIED WOMEN																
Age																
15-19	35.3	35.3	0.0	0.0	0.0	1.5	17.4	3.3	12.8	0.3	0.0	0.0	0.0	64.7	100.0	255
20-24	57.8	57.4	0.0	0.0	0.2	1.6	29.6	13.6	12.4	0.0	0.4	0.0	0.4	42.2	100.0	701
25-29	65.4	65.3	0.4	0.0	0.2	1.7	30.1	17.8	15.2	0.0	0.1	0.0	0.1	34.6	100.0	757
30-34	67.1	66.8	1.1	0.0	1.4	1.9	26.4	18.3	17.5	0.1	0.3	0.3	0.0	32.9	100.0	669
35-39	71.0	70.1	3.2	0.5	2.8	1.1	23.2	14.7	24.5	0.1	1.0	0.6	0.4	29.0	100.0	544
40-44	59.5	59.3	4.3	0.0	3.5	0.3	16.0	13.5	21.0	0.8	0.1	0.1	0.0	40.5	100.0	377
45-49	39.9	39.4	5.3	0.0	2.4	0.3	8.4	7.6	15.2	0.2	0.4	0.4	0.0	60.1	100.0	310
Residence																
Urban	65.5	65.2	1.3	0.2	2.0	1.4	21.3	17.2	21.7	0.1	0.3	0.3	0.0	34.5	100.0	1,150
Rural	57.7	57.3	1.8	0.0	1.0	1.3	25.3	12.9	14.7	0.2	0.4	0.1	0.2	42.3	100.0	2,463
Ecological zone																
Lowlands	63.8	63.4	2.0	0.1	1.8	1.4	22.7	15.3	20.0	0.1	0.4	0.3	0.1	36.2	100.0	2,134
Foothills	55.4	55.4	1.3	0.0	1.2	0.5	26.5	13.9	11.6	0.4	0.0	0.0	0.0	44.6	100.0	427
Mountains	53.1	52.6	1.3	0.0	0.3	1.6	25.6	10.8	12.8	0.3	0.4	0.1	0.3	46.9	100.0	797
Senqu River Valley	59.4	59.2	0.8	0.0	0.7	2.0	26.2	16.9	12.6	0.0	0.2	0.0	0.2	40.6	100.0	254
District																
Butha-Buthe	56.5	56.2	0.9	0.0	3.1	0.9	27.2	14.3	9.4	0.4	0.3	0.3	0.0	43.5	100.0	211
Leribe	64.2	63.4	3.7	0.0	2.4	2.0	24.2	12.4	18.6	0.2	0.8	0.5	0.3	35.8	100.0	577
Berea	63.9	63.9	2.4	0.0	1.8	1.5	23.7	12.4	21.8	0.2	0.0	0.0	0.0	36.1	100.0	461
Maseru	62.5	62.3	1.3	0.3	1.3	1.2	22.7	14.0	21.3	0.2	0.3	0.3	0.0	37.5	100.0	968
Mafeteng	58.6	58.2	0.6	0.0	0.3	0.0	20.5	23.4	13.3	0.0	0.4	0.0	0.4	41.4	100.0	312
Mohale's Hoek	53.4	53.4	0.4	0.0	0.7	1.3	23.9	16.7	10.0	0.4	0.0	0.0	0.0	46.6	100.0	297
Quthing	64.0	63.6	0.7	0.0	1.1	0.2	26.1	19.7	15.9	0.0	0.4	0.0	0.4	36.0	100.0	158
Qacha's Nek	56.5	56.1	3.1	0.0	1.2	2.3	26.8	8.3	14.4	0.0	0.4	0.0	0.4	43.5	100.0	114
Mokhotlong	49.2	48.4	1.4	0.0	0.0	2.4	22.6	11.6	10.4	0.0	0.9	0.3	0.6	50.8	100.0	205
Thaba-Tseka	56.7	56.4	1.0	0.0	0.3	1.8	29.0	10.6	13.6	0.0	0.3	0.0	0.3	43.3	100.0	308
Education																
No education	38.1	38.1	0.0	0.0	0.0	2.6	10.6	9.1	15.8	0.0	0.0	0.0	0.0	61.9	100.0	47
Primary incomplete	52.9	52.3	1.3	0.0	0.5	2.3	24.0	10.7	13.3	0.1	0.6	0.0	0.6	47.1	100.0	695
Primary complete	58.1	58.0	1.8	0.0	0.9	0.8	24.3	14.2	15.9	0.1	0.1	0.1	0.0	41.9	100.0	909
Secondary	63.4	63.3	1.5	0.0	1.7	1.3	25.3	14.4	18.8	0.3	0.1	0.1	0.0	36.6	100.0	1,665
More than secondary	68.7	66.8	3.3	0.9	2.5	1.4	18.3	22.4	18.1	0.0	2.0	1.4	0.5	31.3	100.0	297
Wealth quintile																
Lowest	50.3	49.9	0.7	0.0	0.1	1.3	26.3	10.2	11.1	0.1	0.5	0.1	0.4	49.7	100.0	592
Second	56.6	56.3	0.5	0.0	0.1	1.4	29.1	13.0	11.8	0.3	0.3	0.0	0.3	43.4	100.0	602
Middle	62.3	62.3	1.2	0.0	1.1	1.0	25.8	14.1	18.9	0.2	0.1	0.0	0.1	37.7	100.0	676
Fourth	61.4	60.8	3.4	0.0	2.0	1.9	22.9	13.7	16.9	0.2	0.6	0.4	0.2	38.6	100.0	844
Highest	66.2	65.9	1.8	0.3	2.5	1.2	19.0	18.4	22.7	0.1	0.3	0.3	0.0	33.8	100.0	898
Number of living children																
0	17.0	17.0	0.0	0.0	0.0	0.0	2.7	2.5	11.6	0.2	0.0	0.0	0.0	83.0	100.0	355
1-2	65.1	64.6	0.7	0.1	0.9	1.5	27.1	17.0	17.4	0.1	0.4	0.3	0.2	34.9	100.0	2,043
3-4	70.3	70.2	3.1	0.0	3.1	1.7	27.8	14.9	19.4	0.1	0.1	0.1	0.1	29.7	100.0	902
5+	47.5	46.6	5.8	0.0	1.1	1.2	17.3	8.0	12.6	0.7	0.9	0.2	0.7	52.5	100.0	312
Total	60.2	59.8	1.7	0.1	1.3	1.4	24.0	14.2	16.9	0.2	0.4	0.2	0.2	39.8	100.0	3,612
SEXUALLY ACTIVE UNMARRIED WOMEN																
Residence																
Urban	76.0	74.3	0.0	0.0	0.0	1.3	10.8	8.2	53.4	0.6	1.7	0.6	1.1	24.0	100.0	235
Rural	70.5	69.7	0.7	0.0	1.0	6.1	17.6	7.6	35.9	0.8	0.8	0.0	0.8	29.5	100.0	215
Total	73.4	72.1	0.3	0.0	0.5	3.6	14.0	7.9	45.0	0.7	1.3	0.3	1.0	26.6	100.0	450

Note: If more than one method is used, only the most effective method is considered in this tabulation.

3.7 NEED AND DEMAND FOR FAMILY PLANNING

The proportion of women who want to stop childbearing or who want to space their next birth is a crude measure of the extent of the need for family planning, given that not all of these women are exposed to the risk of pregnancy and some may already be using contraception. This section discusses the extent of need and the potential demand for family planning services. Women who want to postpone their next birth

for two or more years or who want to stop childbearing altogether but are not using a contraceptive method are said to have an unmet need for family planning. Pregnant women are considered to have an unmet need for spacing or limiting if their pregnancy was mistimed or unwanted. Similarly, amenorrhoeic women are categorised as having an unmet need if their last birth was mistimed or unwanted. Women who are currently using a family planning method are said to have a met need for family planning. Total demand for family planning services comprises those who fall in the met need and unmet need categories.

Table 3.7 presents data on unmet need, met need, and total demand for family planning among currently married women and sexually active unmarried women. Figure 3.2 presents trends in unmet need, modern contraceptive use, and percentage of total demand satisfied with modern methods among currently married women. These indicators help evaluate the extent to which family planning programmes in Lesotho meet the demand for services. The definition of unmet need for family planning has been revised so that data on levels of unmet need are comparable over time and across surveys. The unmet need estimates in Figure 3.2 for the 2004 and 2009 LDHS surveys have been recalculated using the revised definition of unmet need but differ only slightly from the numbers published in the previous final reports.

Table 3.7 shows that 18 percent of currently married women have an unmet need for family planning services. Sixty percent of married women are currently using a contraceptive method. Therefore, about eight in ten currently married women (79 percent) have a demand for family planning. At present, 77 percent of the potential demand for family planning is being met. Thus, if all married women who said they want to space or limit their children were to use family planning methods, the CPR would increase from 60 percent to 79 percent.

Among unmarried sexually active women, 20 percent have an unmet need for family planning, and 73 percent are currently using a contraceptive method. The total demand for family planning among unmarried sexually active women is 94 percent, and at present 78 percent of the potential demand for family planning is being met. If all of the unmarried sexually active women who said they want to space or limit their births were to use family planning methods, the CPR would increase from 73 percent to 94 percent.

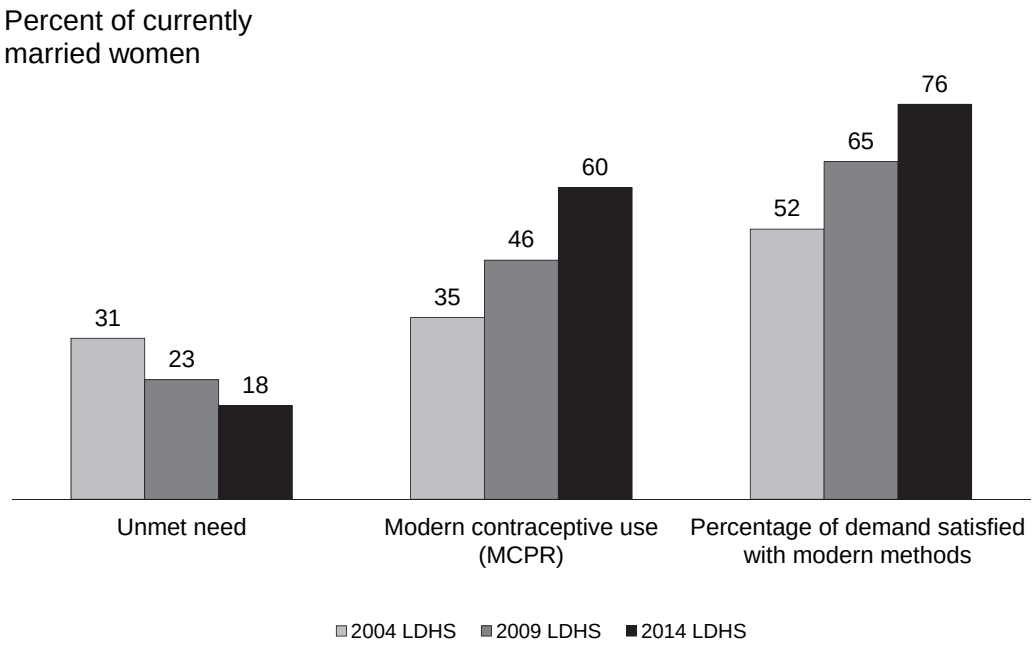
Table 3.7 Need and demand for family planning among currently married women and sexually active unmarried women

Percentage of currently married women and sexually active unmarried women age 15-49 with unmet need for family planning, percentage with met need for family planning, percentage with met need for family planning who are using modern methods, percentage with demand for family planning, percentage of the demand for family planning that is satisfied, and percentage of the demand for family planning that is satisfied with modern methods, by background characteristics, Lesotho 2014

Background characteristic	Unmet need	Met need for family planning (currently using)		Total demand for family planning[3]	Percentage of demand satisfied[1]		Number of women
		All methods	Modern methods[2]		All methods	Modern methods[2]	
CURRENTLY MARRIED WOMEN							
Age							
15-19	28.9	35.3	35.3	64.2	55.0	55.0	255
20-24	21.5	57.8	57.4	79.2	72.9	72.4	701
25-29	17.4	65.4	65.3	82.8	79.0	78.8	757
30-34	16.3	67.1	66.8	83.4	80.4	80.1	669
35-39	15.1	71.0	70.1	86.2	82.5	81.3	544
40-44	19.8	59.5	59.3	79.3	75.0	74.8	377
45-49	14.1	39.9	39.4	54.0	73.9	73.1	310
Residence							
Urban	13.7	65.5	65.2	79.1	82.7	82.4	1,150
Rural	20.7	57.7	57.3	78.3	73.6	73.1	2,463
Ecological zone							
Lowlands	16.1	63.8	63.4	79.9	79.9	79.3	2,134
Foothills	23.8	55.4	55.4	79.2	70.0	70.0	427
Mountains	22.2	53.1	52.6	75.3	70.5	69.9	797
Senqu River Valley	17.2	59.4	59.2	76.6	77.6	77.3	254
District							
Butha-Buthe	20.9	56.5	56.2	77.4	73.0	72.7	211
Leribe	16.7	64.2	63.4	81.0	79.3	78.4	577
Berea	17.2	63.9	63.9	81.1	78.7	78.7	461
Maseru	16.4	62.5	62.3	78.9	79.2	78.9	968
Mafeteng	20.8	58.6	58.2	79.4	73.8	73.3	312
Mohale's Hoek	22.4	53.4	53.4	75.7	70.5	70.5	297
Quthing	16.1	64.0	63.6	80.1	79.9	79.4	158
Qacha's Nek	18.4	56.5	56.1	75.0	75.4	74.9	114
Mokhotlong	25.4	49.2	48.4	74.6	65.9	64.8	205
Thaba-Tseka	18.5	56.7	56.4	75.2	75.4	75.0	308
Education							
No education	31.8	38.1	38.1	69.9	54.5	54.5	47
Primary incomplete	20.0	52.9	52.3	72.9	72.5	71.7	695
Primary complete	23.5	58.1	58.0	81.5	71.2	71.2	909
Secondary	15.7	63.4	63.3	79.1	80.2	80.0	1,665
More than secondary	12.5	68.7	66.8	81.2	84.6	82.2	297
Wealth quintile							
Lowest	24.5	50.3	49.9	74.8	67.3	66.6	592
Second	23.1	56.6	56.3	79.7	71.0	70.6	602
Middle	17.3	62.3	62.3	79.6	78.3	78.2	676
Fourth	17.0	61.4	60.8	78.4	78.3	77.5	844
Highest	13.5	66.2	65.9	79.7	83.0	82.7	898
Total	18.4	60.2	59.8	78.6	76.5	76.1	3,612
SEXUALLY ACTIVE UNMARRIED WOMEN							
Residence							
Urban	19.7	76.0	74.3	95.7	79.4	77.6	235
Rural	20.8	70.5	69.7	91.3	77.2	76.3	215
Total	20.2	73.4	72.1	93.6	78.4	77.0	450

Note: Numbers in this table correspond to the revised definition of unmet need described in Bradley et al., 2012.
[1] Percentage of demand satisfied is met need divided by total demand.
[2] Modern methods include female sterilisation, male sterilisation, IUCD, implants, injectables, pill, male condom, and female condom.
[3] Total demand is the sum of unmet need and met need (with all methods).

Figure 3.2 **Trends in unmet need, modern contraceptive use, and percentage of demand satisfied with modern methods, 2004-2014**



3.8 EARLY CHILDHOOD MORTALITY

Infant and child mortality rates are basic indicators of a country's socioeconomic situation and quality of life (UNDP, 2007). Estimates of childhood mortality are based on information collected in the birth history section of the questionnaire administered to women, which includes questions about women's aggregate childbearing experience (i.e., the number of sons and daughters who live with their mother, the number who live elsewhere, and the number who have died). Table 3.8 presents estimates for three successive five-year periods prior to the 2014 LDHS. The rates are estimated directly from the information in the birth history on a child's birth date, survivorship status, and age at death for children who died. This information is used to directly estimate the following five mortality rates:

Neonatal mortality:	the probability of dying within the first month of life
Postneonatal mortality:	the difference between infant and neonatal mortality
Infant mortality:	the probability of dying before the first birthday
Child mortality:	the probability of dying between the first and the fifth birthday
Under-5 mortality:	the probability of dying between birth and the fifth birthday

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to age 12 months.

As shown in Table 3.8, during the five years immediately preceding the survey, the infant mortality rate was 59 deaths per 1,000 live births. The child mortality rate was 27 deaths per 1,000 children surviving to age 12 months, while the overall under-5 mortality rate was 85 deaths per 1,000 live births. Sixty-nine percent of all deaths among children under age 5 in Lesotho take place before a child's first birthday, with 40 percent occurring during the first month of life. The 2014 LDHS documents a pattern of decreasing under-5 mortality during the 15 years prior to the survey.

Table 3.8 Early childhood mortality rates

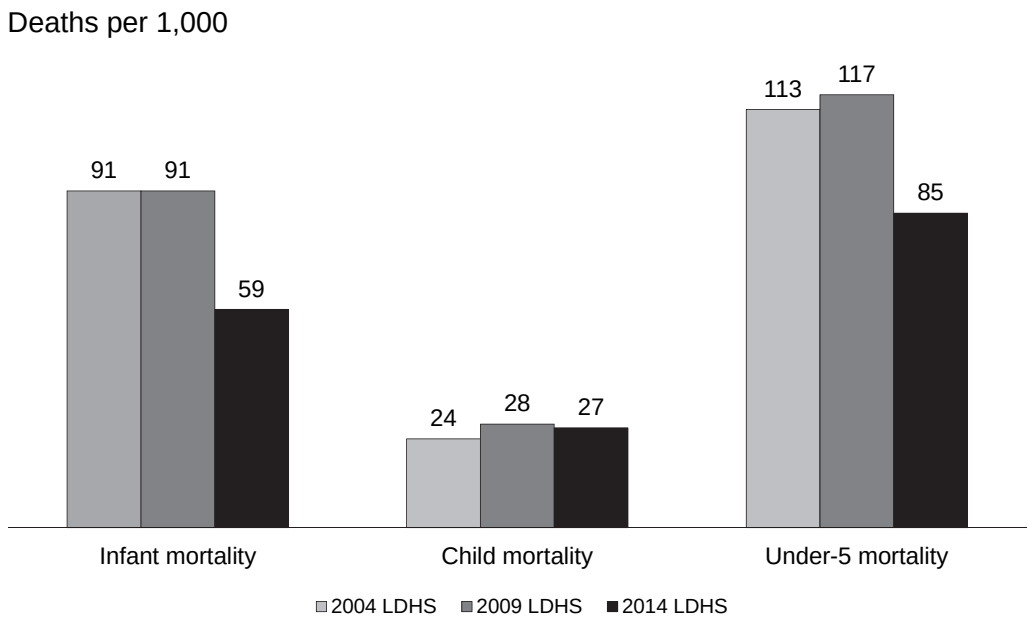
Neonatal, postneonatal, infant, child, and under-5 mortality rates for five-year periods preceding the survey, Lesotho 2014

Years preceding the survey	Neonatal mortality (NN)	Postneonatal mortality (PNN)[1]	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
0-4	34	26	59	27	85
5-9	33	46	79	22	99
10-14	39	43	82	24	104

[1] Computed as the difference between the infant and neonatal mortality rates

Figure 3.3 presents trends in childhood mortality, as assessed through the 2004, 2009, and 2014 LDHS surveys. While there was little change in mortality rates between the 2004 and 2009 surveys, the changes between the 2009 and 2014 surveys are striking, with the under-5 mortality rate decreasing from 117 to 85 deaths per 1,000 live births. Nearly all of this decline was due to a substantial decrease in infant mortality, which dropped from 91 deaths per 1,000 live births to 59 deaths per 1,000 live births.

Figure 3.3 **Trends in childhood mortality, 2004-2014**



3.9 MATERNAL CARE

Proper care during pregnancy and delivery is important for the health of both the mother and the baby and is the fifth Millennium Development Goal (MDG). In the 2014 LDHS, women who had given birth in the five years preceding the survey were asked a number of questions about maternal care. Mothers were asked whether they had obtained antenatal care during the pregnancy for their most recent live birth in the five years preceding the survey and whether they had received tetanus toxoid injections while pregnant. For each live birth over the same period, mothers were also asked what type of assistance they received at the time of delivery. Finally, women who had a live birth in the two years before the survey were asked if they received a postnatal checkup within two days of delivery. Table 3.9 summarises information on the coverage of these maternal health services.

3.9.1 Antenatal Care

Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and child during pregnancy, at delivery, and during the postnatal period (within 42 days after delivery). The 2014 LDHS results show that 95 percent of women who gave

birth in the five years preceding the survey received antenatal care from a skilled provider at least once for their last birth. Three-quarters of women had four or more ANC visits (74 percent). Urban women were somewhat more likely than rural women to have received ANC from a skilled provider (98 percent and 94 percent, respectively) and to have had four or more ANC visits (80 percent and 72 percent, respectively). As shown in Figure 3.4, the percentage of women receiving antenatal care from a skilled provider has increased slightly from 2004 (90 percent) and 2009 (92 percent).

Women who received antenatal care were asked where they received it. Although the vast majority of women reported having received antenatal care at a public or private facility in Lesotho, 3 percent reported having made at least one visit to a facility outside of the country (data not shown). By district, women in Quthing (13 percent) and Qacha's Nek (10 percent) were more likely than women from any other district to report having had at least one ANC visit at a facility outside of Lesotho (data not shown). Given Lesotho's geographic location, presumably most of these visits took place in South Africa.

3.9.2 Tetanus Toxoid

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of early infant death in many developing countries, often due to failure to observe hygienic procedures during delivery. Table 3.9 shows that 74 percent of women received sufficient doses of tetanus toxoid to protect their last birth against neonatal tetanus. The percentage of women whose last birth was protected from tetanus increases with age and wealth and is higher among those in urban than rural areas. The proportion of women whose last live birth was protected against tetanus was similar to that reported in the 2009 LDHS (76 percent).

3.9.3 Delivery Care

Access to proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may lead to death or serious illness for the mother and/or baby (Van Lerberghe and De Brouwere, 2001; WHO, 2006). Seventy-eight percent of women reported that their last live birth in the five years preceding the survey was delivered by a skilled provider (Table 3.9). Seventy-seven percent of births were delivered in a health facility. The proportion of live births delivered by a skilled provider and the proportion delivered in a health facility are much greater than the proportions reported in either the 2004 or 2009 LDHS (Figure 3.4).

Ninety percent of births to urban mothers were assisted by a skilled provider and 89 percent were delivered in a health facility, as compared with 73 percent and 71 percent, respectively, of births to rural women. Four percent of women reported delivering their last birth in a facility outside of Lesotho (data not shown). As was observed for antenatal care, women in Quthing (13 percent) and Qacha's Nek (16 percent) were more likely than women from other districts to report having delivered their last birth in a facility outside of Lesotho (data not shown).

Mothers' educational status is highly correlated with whether their delivery is assisted by a skilled provider and whether the birth is delivered in a health facility. For example, 59 percent of births to mothers with some primary school education were assisted by a skilled provider and 57 percent were delivered in a health facility, as compared with 97 percent and 96 percent, respectively, of births to mothers with more than a secondary education. A similar relationship was observed with wealth.

3.9.4 Postnatal Care for the Mother

A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programmes recommend that all women receive a check of their health within two days after delivery.

To assess the extent of postnatal care utilisation, respondents were asked, for their last birth in the two years preceding the survey, whether they had received a checkup after delivery and the timing of the first checkup. As shown in Table 3.9, 61 percent of women reported having received a PNC checkup in the first two days after birth.

The proportion of women receiving a postnatal checkup within two days of delivery is higher in urban areas than rural areas and increases with increasing education and wealth.

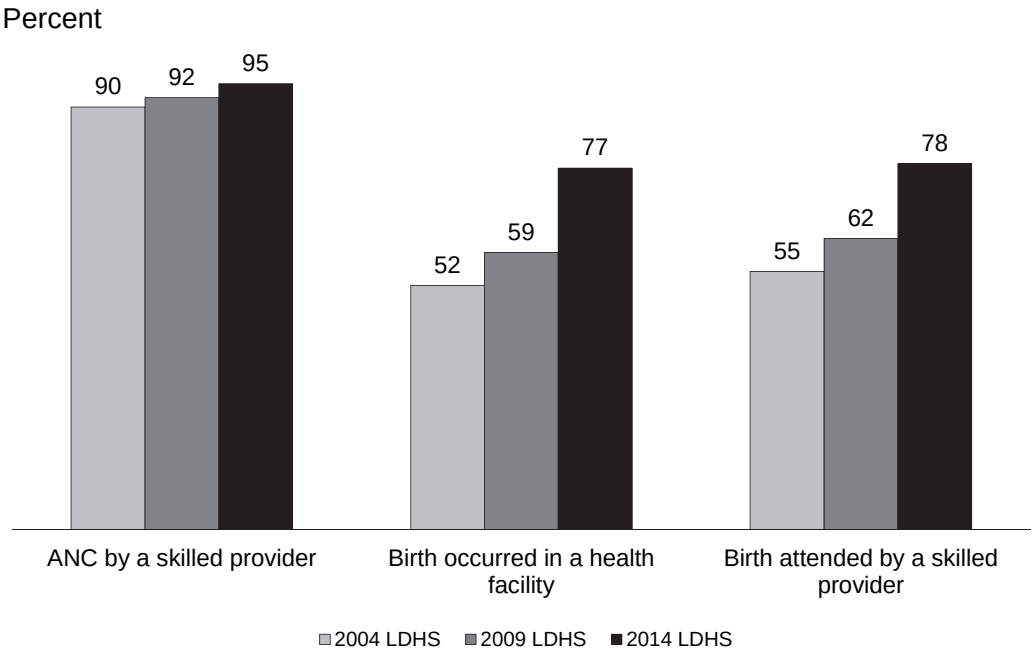
Table 3.9 Maternal care indicators

Among women age 15-49 who had a live birth in the five years preceding the survey, percentage who received antenatal care from a skilled provider for the last live birth, percentage with four or more ANC visits for the last live birth, and percentage whose last live birth was protected against neonatal tetanus; among all live births in the five years before the survey, percentage delivered by a skilled provider and percentage delivered in a health facility; and among women age 15-49 who had a live birth in the two years preceding the survey, percentage who received a postnatal checkup in the first two days after the last live birth, by background characteristics, Lesotho 2014

	Women who had a live birth in the five years preceding the survey				Live births in the five years preceding the survey			Women who had a live birth in the two years preceding the survey	
Background characteristic	Percentage with antenatal care from a skilled provider[1]	Percentage with 4+ ANC visits	Percentage whose last live birth was protected against neonatal tetanus[2]	Number of women	Percentage delivered by a skilled provider[1]	Percentage delivered in a health facility	Number of births	Percentage of women who had a postnatal checkup in the first two days after birth	Number of women
Mother's age at birth									
<20	97.1	70.2	66.9	467	82.5	80.6	616	62.0	283
20-34	95.3	75.4	75.9	1,805	78.1	76.7	2,158	60.8	962
35+	91.5	75.1	76.9	303	68.4	67.8	338	59.8	148
Residence									
Urban	97.5	80.1	79.1	749	89.7	88.9	900	68.2	365
Rural	94.2	72.1	72.4	1,825	73.1	71.4	2,211	58.3	1,028
Ecological zone									
Lowlands	96.2	77.8	76.8	1,459	86.1	85.0	1,733	68.2	757
Foothills	91.1	66.7	68.1	316	60.7	59.4	380	52.8	173
Mountains	95.0	72.4	71.5	598	68.8	66.4	752	51.1	351
Senqu River Valley	94.6	68.0	74.7	202	74.9	73.8	247	55.2	111
District									
Butha-Buthe	92.5	70.7	78.7	167	77.3	72.8	197	62.0	96
Leribe	97.5	72.3	74.4	423	85.0	83.7	494	70.7	216
Berea	95.3	75.9	72.6	322	79.5	78.0	381	62.6	176
Maseru	95.5	78.9	75.4	636	82.0	81.0	786	62.7	339
Mafeteng	93.6	79.8	76.8	213	75.1	75.3	253	65.4	101
Mohale's Hoek	96.6	70.3	74.8	234	74.7	74.0	273	61.0	138
Quthing	92.0	68.1	66.9	136	72.8	71.9	173	52.9	83
Qacha's Nek	97.5	77.0	79.4	70	79.3	78.9	87	65.0	35
Mokhotlong	96.4	70.7	68.9	161	62.8	60.8	203	40.3	92
Thaba-Tseka	91.6	71.3	74.7	212	71.0	68.0	266	51.1	116
Mother's education									
No education	(83.8)	(75.7)	(61.0)	23	(48.6)	(51.8)	28	*	6
Primary incomplete	91.2	67.2	67.5	491	59.4	56.7	639	45.1	266
Primary complete	94.5	71.2	76.9	644	72.0	70.9	806	54.6	341
Secondary	96.8	76.5	75.9	1,222	87.1	86.0	1,415	67.7	696
More than secondary	98.7	90.8	75.3	195	97.2	95.7	224	81.5	83
Wealth quintile									
Lowest	92.3	66.5	69.9	512	60.1	56.9	665	44.8	315
Second	92.5	69.1	72.6	504	67.2	65.9	624	53.0	274
Middle	94.4	71.4	75.6	522	80.8	80.2	621	67.0	298
Fourth	98.2	76.6	75.7	540	89.9	89.1	630	66.5	290
Highest	98.3	88.8	78.0	498	94.0	92.9	572	78.5	216
Total	95.2	74.4	74.4	2,575	77.9	76.5	3,112	60.9	1,393

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Skilled provider includes doctor or nurse/midwife.
[2] Includes mothers with two injections during the pregnancy of their last live birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last live birth), or four or more injections (the last within 10 years of the last live birth), or five or more injections at any time prior to the last live birth

Figure 3.4 **Trends in maternal health care, 2004-2014**



3.10 CHILD HEALTH AND NUTRITION

The 2014 LDHS collected data on a number of key child health indicators, including vaccinations of young children, nutritional status as assessed by anthropometry, infant feeding practices, and treatment practices when a child is ill.

3.10.1 Vaccination of Children

Historically, in DHS surveys, a child is considered to have received all basic vaccinations if he or she has received a BCG vaccination against tuberculosis; three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus; at least three doses of polio vaccine; and one dose of measles vaccine. These vaccinations should be received during the first year of life. The 2014 LDHS collected information on the coverage of these vaccinations among all children born in the five years preceding the survey. Since late 2008, DPT has not been given to infants in Lesotho as a stand-alone vaccine. Instead, it has been combined with other antigens that protect against hepatitis B and *Haemophilus influenzae* type b, and this vaccine (DPT-HepB-Hib) is known as the pentavalent vaccine. As such, the 2014 LDHS reports on pentavalent vaccine coverage as opposed to DPT coverage.

Lesotho has established a schedule for the administration of all basic childhood vaccines. BCG should be given shortly after birth. Polio vaccine should be given at birth and at approximately age 6, 10, and 14 weeks. Pentavalent vaccine should also be given at approximately age 6, 10, and 14 weeks. Measles vaccine should be given at or soon after the child reaches age 9 months. It is also recommended that the vaccinations be recorded on a health booklet or card that is given to the parents or guardians.

In the 2014 LDHS, information on vaccination coverage was obtained in two ways—from health booklets or cards and from mothers' verbal reports. All mothers were asked to show the interviewer the health booklets in which vaccination dates are recorded for all children born since January 2009. If the booklet was available, the interviewer then recorded from the booklet the dates of each vaccination received. In cases in which the booklet indicated the child had not received all basic vaccinations, the mother was then asked whether the child had received other vaccinations that were not recorded on the booklet, and, if so, they too were recorded. If there was no health booklet or card, or if the mother was unable to show the booklet or card to the interviewer, the child's vaccination information was based on the mother's recall. The

mother was asked to recall whether the child had received BCG, polio, pentavalent, and measles vaccines. If she indicated that the child had received the polio or pentavalent vaccines, she was asked about the number of doses that the child received. The results presented here are based on both health booklet information and, for those children without a booklet or card, information provided by the mother.

Table 3.10 pertains to children age 12-23 months, the age by which children should have received all basic vaccinations. Seventy-seven percent of these children have a vaccination booklet or card that was seen by the interviewer, including 4 percent with a card from South Africa (data not shown). Overall, 68 percent of children have received all basic vaccinations. Basic vaccination coverage has increased modestly since the 2009 LDHS estimate (62 percent). Ninety-eight percent of children have received BCG, 98 percent have received the first dose of pentavalent, and 96 percent have received polio 1. Eighty-five percent and 76 percent of children have received the third dose of the required three doses of the pentavalent and polio vaccines, respectively. Coverage of vaccination against measles is 90 percent. Only 1 percent of children in Lesotho have not received any vaccinations; this compares favourably to the 2009 LDHS, in which 3 percent of children were reported to have not received any vaccinations.

Table 3.10 Vaccinations by background characteristics

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card seen, by background characteristics, Lesotho 2014

Background characteristic	BCG	Pentavalent[1]			Polio[2]				Measles	All basic vaccinations[3]	No vaccinations	Percentage with a vaccination card seen	Number of children
		1	2	3	0	1	2	3					
Sex													
Male	98.9	99.4	96.7	86.3	85.4	96.2	88.1	76.9	87.6	68.3	0.4	78.4	339
Female	97.0	97.0	93.2	84.4	85.2	95.8	88.8	74.3	92.8	68.3	1.6	75.8	316
Residence													
Urban	98.6	99.3	96.3	82.4	91.7	96.3	87.2	75.8	92.8	70.1	0.7	72.6	180
Rural	97.8	97.9	94.5	86.5	82.9	95.9	88.9	75.6	89.1	67.6	1.1	78.8	475
Ecological zone													
Lowlands	98.1	98.5	94.9	85.6	87.4	97.0	89.5	79.0	91.9	71.3	0.7	77.0	370
Foothills	97.5	98.9	98.9	89.1	85.6	95.0	85.0	69.2	93.6	65.8	1.1	78.4	66
Mountains	97.4	97.0	93.7	81.9	83.8	95.8	89.3	71.6	83.4	62.5	1.8	75.6	172
Senqu River Valley	100.0	100.0	95.3	91.2	74.4	90.3	81.9	73.3	96.2	69.4	0.0	81.8	46
District													
Butha-Buthe	97.9	97.9	97.9	86.7	86.8	96.8	93.0	70.6	95.7	70.6	2.1	72.0	36
Leribe	98.9	100.0	98.2	90.6	88.2	95.5	90.4	77.1	92.0	69.3	0.0	76.2	109
Berea	98.5	95.3	92.2	87.7	85.3	98.5	91.0	80.1	91.8	74.4	1.5	77.8	89
Maseru	97.3	100.0	92.6	78.0	87.1	97.6	84.1	75.5	90.9	66.1	0.0	76.3	157
Mafeteng	97.6	97.6	97.6	91.8	93.1	97.6	96.1	86.1	91.6	79.5	2.4	82.5	51
Mohale's Hoek	100.0	99.1	98.0	92.3	78.5	88.2	83.3	72.9	92.7	64.9	0.0	81.8	64
Quthing	98.7	97.5	92.2	81.5	81.3	96.9	83.5	65.6	86.8	60.1	0.0	77.0	36
Qacha's Nek	97.3	97.3	96.0	88.9	82.0	93.5	90.9	77.1	90.9	74.1	2.7	76.1	20
Mokhotlong	95.9	94.5	91.9	67.5	67.4	93.1	84.7	60.3	76.4	47.5	4.1	69.0	38
Thaba-Tseka	96.6	98.0	96.0	90.7	90.6	98.0	94.2	79.7	84.8	72.3	2.0	79.2	55
Mother's education													
No education	*	*	*	*	*	*	*	*	*	*	*	*	3
Primary incomplete	96.2	97.6	94.6	83.9	78.3	96.1	86.2	70.3	87.3	61.8	1.3	77.1	141
Primary complete	97.1	98.7	96.2	86.2	87.2	97.8	92.1	79.5	87.2	70.4	1.3	82.3	142
Secondary	99.2	98.5	95.4	86.0	87.2	96.4	89.0	77.0	92.4	70.0	0.5	75.5	332
More than secondary	(98.3)	(98.3)	(89.7)	(84.6)	(95.0)	(89.7)	(83.0)	(75.2)	(94.0)	(75.2)	(1.7)	(73.3)	36
Wealth quintile													
Lowest	97.0	97.2	95.0	83.7	75.7	95.6	86.8	67.9	87.6	59.7	1.8	73.8	155
Second	96.6	96.8	94.3	80.9	86.7	95.3	87.4	72.2	85.3	62.7	1.6	78.5	121
Middle	98.0	98.9	96.1	93.5	88.0	98.0	94.1	85.7	97.1	81.5	0.0	84.5	129
Fourth	99.1	99.1	93.6	88.0	90.8	96.5	87.9	79.0	91.0	70.4	0.9	77.1	140
Highest	99.5	99.5	96.5	79.7	87.2	94.4	86.0	74.4	89.7	68.4	0.5	71.7	109
Total	98.0	98.3	95.0	85.4	85.3	96.0	88.5	75.7	90.1	68.3	1.0	77.1	655

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Pentavalent is DPT-HepB-Hib.
[2] Polio 0 is the polio vaccination given at birth.
[3] BCG, measles, and three doses each of pentavalent and polio vaccine excluding polio vaccine given at birth

Basic vaccination coverage does not differ by the sex of the child and varies only slightly by urban-rural residence. However, large differences are observed at the district level; the percentage of children with full vaccination coverage ranges from a high of 80 percent in Mafeteng to a low of 48 percent in Mokhotlong. Importantly, however, the numbers of cases at the district level are small, meaning that the standard errors surrounding these values are large.

3.10.2 Childhood Acute Respiratory Infection, Fever, and Diarrhoea

Acute respiratory infection (ARI), fever, and dehydration from diarrhoea are important contributing causes of childhood morbidity and mortality in developing countries (WHO, 2003). Prompt medical attention when a child has the symptoms of these illnesses is, therefore, crucial in reducing child deaths. In the 2014 LDHS, for each child under age 5, mothers were asked if the child had experienced an episode of diarrhoea; a cough accompanied by short, rapid breathing or difficulty breathing as a result of a chest-related problem (symptoms of ARI); or a fever in the two weeks preceding the survey. Respondents were also asked if treatment was sought when the child was ill. Overall, 5 percent of children under age 5 showed symptoms of ARI, 15 percent had a fever, and 12 percent experienced diarrhoea in the two weeks preceding the survey (data not shown). It should be noted that the morbidity data collected are subjective because they are based on a mother's perception of illnesses without validation by medical personnel.

Table 3.11 shows that treatment from a health facility or provider was sought for 63 percent of children with ARI symptoms and 61 percent of those with a fever. Treatment was sought from a health facility or health provider for 51 percent of children with diarrhoea. Fifty-three percent of children with diarrhoea received a rehydration solution from an oral rehydration salt (ORS) packet, and 1 percent were given zinc. All children who received zinc also were treated with rehydration solution from an ORS packet (data not shown).

Table 3.11 Treatment for ARI symptoms, fever, and diarrhoea

Among children under age 5 who had symptoms of acute respiratory infection (ARI) or had a fever in the two weeks preceding the survey, percentage for whom advice or treatment was sought from a health facility or provider, and among children under age 5 who had diarrhoea during the two weeks preceding the survey, percentage for whom advice or treatment was sought from a health facility or provider, percentage given a fluid made from oral rehydration salt (ORS) packets, and percentage given zinc, by background characteristics, Lesotho 2014

	Children with symptoms of ARI[1]		Children with fever		Children with diarrhoea			
Background characteristic	Percentage for whom advice or treatment was sought from a health facility/ provider[2]	Number of children	Percentage for whom advice or treatment was sought from a health facility/ provider[2]	Number of children	Percentage for whom advice or treatment was sought from a health facility/ provider[2]	Percentage given fluid from ORS packet	Percentage given zinc	Number of children
Age in months								
<6	*	9	(63.5)	32	*	*	*	20
6-11	*	14	70.6	66	53.7	53.3	0.8	76
12-23	(68.8)	38	66.3	123	56.6	58.9	1.2	144
24-35	(57.3)	29	52.2	85	39.8	48.0	0.0	51
36-47	(76.3)	26	55.5	70	(50.8)	(68.6)	(0.0)	29
48-59	*	18	56.9	61	*	*	*	22
Sex								
Male	60.5	65	58.8	201	51.8	50.6	0.0	174
Female	65.7	69	62.9	235	50.0	56.3	1.4	168
Residence								
Urban	*	31	60.1	116	42.3	52.6	0.0	84
Rural	63.0	103	61.3	319	53.7	53.6	0.9	257
Ecological zone								
Lowlands	64.4	72	60.3	254	45.0	47.1	0.6	200
Foothills	(55.1)	28	59.4	67	(56.4)	(62.2)	(1.4)	46
Mountains	(74.3)	27	64.2	90	62.2	67.3	0.5	76
Senqu River Valley	*	8	(61.1)	25	(54.3)	(43.5)	(0.0)	20
Mother's education								
No education	*	3	*	4	*	*	*	2
Primary incomplete	(45.9)	41	55.6	97	54.3	52.1	0.0	88
Primary complete	(77.8)	30	67.1	110	57.0	54.3	0.4	88
Secondary	(70.1)	52	60.2	202	47.2	53.7	0.8	155
More than secondary	*	9	*	22	*	*	*	9
Wealth quintile								
Lowest	(59.9)	29	61.5	87	58.9	60.9	0.5	80
Second	(66.5)	31	59.2	87	51.9	55.4	0.0	78
Middle	(63.4)	25	57.1	94	43.1	54.1	1.8	70
Fourth	*	29	70.1	105	45.2	47.2	0.0	63
Highest	*	21	(53.2)	63	(54.6)	(44.8)	(1.3)	49
Total	63.1	135	61.0	436	50.9	53.4	0.7	342

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Symptoms of ARI (cough accompanied by short, rapid breathing that is chest-related and/or by difficult breathing that is chest-related) are considered a proxy for pneumonia.
[2] Excludes pharmacy, shop, and traditional practitioner

3.10.3 Nutritional Status of Children

Anthropometric indicators for young children were collected in the 2014 LDHS to provide outcome measures of nutritional status. As recommended by WHO, evaluation of nutritional status in this report is based on a comparison of three indices for the children in this survey with indices reported for a reference population of well-nourished children (WHO Multicentre Growth Reference Study Group, 2006). The three indices (height-for-age, weight-for-height, and weight-for-age) are expressed as standard deviation units from the median for the reference group. Children who fall below minus two standard deviations (-2 SD) from the median of the reference population are regarded as moderately malnourished, while those who fall below minus three standard deviations (-3 SD) from the reference population median are considered severely malnourished. Marked differences, especially with regard to height-for-age and weight-for-age, are often seen between different subgroups of children within a country.

Height and weight measurements were obtained for 1,981 children under age 5 who were present in the LDHS sample households at the time of the survey. Table 3.12 and Figure 3.5 focus on the 95 percent for whom complete and credible anthropometric and age data were collected.

Table 3.12 shows nutritional status for children under age 5 according to the three anthropometric indices, by background characteristics. Height-for-age is a measure of linear growth. A child who is below minus two standard deviations from the reference median for height-for-age is considered short for his or her age, or stunted, a condition reflecting the cumulative effect of chronic malnutrition. Thirty-three percent of Basotho children are stunted (below -2 SD), and 11 percent are severely stunted (below -3 SD). Stunting increases with age, peaking at 43 percent among children age 24-35 months. A higher proportion of male (39 percent) than female (28 percent) children are stunted, and stunting is greater among children in rural areas (35 percent) than urban areas (27 percent). Stunting is inversely correlated with wealth quintile; 46 percent of children in the lowest wealth quintile are stunted, as compared with 13 percent of children in the highest quintile.

Weight-for-height describes current nutritional status. A child who is below minus two standard deviations from the reference median for weight-for-height is considered too thin for his or her height, or wasted, a condition reflecting acute or recent nutritional deficits. Overall, 3 percent of children are wasted. Although the differences are much smaller than those observed for stunting, wasting is greater in rural areas than urban areas and correlates inversely with increasing wealth.

Weight-for-age is a composite index of weight-for-height and height-for-age and thus does not distinguish between acute malnutrition (wasting) and chronic malnutrition (stunting). Children can be underweight for their age because they are stunted, wasted, or both. Weight-for-age is an overall indicator of a population's nutritional health. The results show that 10 percent of all children are underweight, and 2 percent are severely underweight. A higher percentage of male than female children are underweight (13 percent and 8 percent, respectively). The proportion of children who are underweight is greater in rural areas (11 percent) than urban areas (8 percent) and correlates inversely with increasing wealth.

Z-score means are calculated as summary statistics representing the nutritional status of children in a population. These mean scores describe the nutritional status of the entire population without the use of a cutoff. A mean Z-score of less than 0 (i.e., a negative value for stunting, wasting, or underweight) suggests that the distribution of an index has shifted downward and, on average, children in the population are less well nourished than children in the WHO Multicentre Growth Reference Study. As shown in Table 3.12, the mean stunting, wasting, and underweight Z-scores for children under age 5 are -1.5, 0.4, and -0.6, respectively.

Table 3.12 Nutritional status of children

Percentage of children under age 5 classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Lesotho 2014

	Height-for-age[1]			Weight-for-height[1]				Weight-for-age				
Background characteristic	Percentage below -3 SD	Percentage below -2 SD[2]	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	Percentage below -3 SD	Percentage below -2 SD[2]	Percentage above +2 SD	Mean Z-score (SD)	Number of children
Age in months												
<6	2.5	13.7	-0.5	0.9	4.8	24.8	0.9	0.2	4.7	1.3	0.1	168
6-8	3.8	22.0	-1.1	1.4	5.1	15.1	0.5	0.9	13.1	4.7	-0.4	67
9-11	4.2	21.6	-0.9	3.2	6.0	8.3	-0.2	4.0	16.1	3.6	-0.7	85
12-17	7.1	27.6	-1.2	1.4	6.1	5.6	0.2	2.1	13.3	0.8	-0.5	194
18-23	9.5	37.5	-1.5	0.3	4.0	7.5	0.3	1.7	8.4	3.2	-0.5	168
24-35	19.2	43.1	-1.8	0.3	2.6	7.1	0.5	1.1	11.3	0.8	-0.7	410
36-47	11.9	40.3	-1.7	0.3	0.8	4.1	0.4	1.3	8.3	0.3	-0.7	394
48-59	10.5	29.5	-1.5	0.0	0.9	2.7	0.2	2.4	11.3	0.0	-0.8	383
Sex												
Male	13.5	38.8	-1.6	0.6	2.6	7.8	0.4	2.1	12.5	0.7	-0.7	892
Female	8.8	28.1	-1.3	0.6	3.0	7.0	0.4	1.2	8.3	1.3	-0.5	977
Mother's interview status												
Interviewed	10.4	32.5	-1.4	0.7	3.0	8.0	0.3	1.7	10.8	1.3	-0.6	1,312
Not interviewed but in household	12.8	29.5	-1.5	0.0	3.4	5.5	0.3	1.7	9.2	0.0	-0.6	151
Not interviewed, not in household[3]	12.2	36.9	-1.6	0.3	1.8	6.0	0.5	1.4	9.3	0.8	-0.6	406
Residence												
Urban	7.8	27.3	-1.2	0.3	1.3	6.6	0.4	0.7	8.2	1.1	-0.5	453
Rural	12.0	35.1	-1.5	0.7	3.3	7.6	0.4	1.9	11.0	1.0	-0.6	1,416
Ecological zone												
Lowlands	8.6	27.2	-1.3	0.2	1.7	7.0	0.4	0.9	8.1	1.1	-0.4	1,008
Foothills	15.4	40.9	-1.7	2.2	4.5	9.4	0.4	4.4	14.9	2.3	-0.7	221
Mountains	13.6	42.0	-1.7	0.4	4.1	6.8	0.2	1.7	13.1	0.6	-0.8	475
Senqu River Valley	12.6	34.4	-1.6	1.3	3.4	8.8	0.3	2.4	9.8	0.8	-0.7	165
District												
Butha-Buthe	12.3	40.3	-1.5	1.2	1.8	8.8	0.4	1.8	7.5	1.6	-0.6	124
Leribe	10.4	31.3	-1.3	0.0	3.3	7.6	0.4	1.1	8.0	2.0	-0.5	283
Berea	8.3	27.4	-1.3	0.0	3.5	4.3	0.3	1.6	12.7	1.6	-0.5	233
Maseru	10.4	29.9	-1.4	0.5	1.8	7.3	0.4	1.2	8.7	0.4	-0.5	444
Mafeteng	8.6	25.9	-1.3	1.3	2.6	7.7	0.4	1.5	10.8	1.3	-0.5	170
Mohale's Hoek	14.3	38.1	-1.7	1.7	3.3	10.3	0.3	3.0	11.6	0.6	-0.7	165
Quthing	10.4	34.1	-1.5	0.0	1.2	7.5	0.5	0.3	5.5	0.9	-0.5	109
Qacha's Nek	10.1	32.5	-1.6	1.7	4.0	10.4	0.3	3.7	12.0	0.5	-0.7	55
Mokhotlong	18.9	47.7	-1.8	0.3	3.6	7.4	0.2	3.3	15.8	0.0	-0.9	124
Thaba-Tseka	10.4	40.0	-1.6	0.4	4.1	6.3	0.1	1.4	14.2	1.1	-0.8	162
Mother's education[4]												
No education	*	*	*	*	*	*	*	*	*	*	*	16
Primary incomplete	15.3	40.3	-1.7	1.2	5.1	7.6	0.3	2.5	15.1	1.4	-0.8	295
Primary complete	11.7	35.3	-1.6	0.9	3.8	5.1	0.1	2.9	12.9	0.9	-0.8	379
Secondary	8.0	29.1	-1.3	0.4	2.1	7.7	0.4	0.9	8.7	0.8	-0.5	665
More than secondary	6.6	15.1	-0.8	0.0	0.7	18.2	0.9	0.0	1.1	3.9	0.2	104
Wealth quintile												
Lowest	15.5	45.6	-1.8	1.2	4.8	7.5	0.1	3.6	15.5	0.8	-0.9	392
Second	15.8	38.1	-1.6	0.9	4.0	7.3	0.4	2.6	12.8	1.7	-0.7	428
Middle	9.8	34.8	-1.5	0.3	2.2	7.4	0.4	0.2	9.0	1.2	-0.6	392
Fourth	9.1	28.2	-1.4	0.1	1.3	7.3	0.4	1.2	9.1	0.0	-0.5	368
Highest	2.0	13.4	-0.8	0.0	0.9	7.4	0.5	0.0	2.8	1.7	-0.1	288
Total	11.0	33.2	-1.5	0.6	2.8	7.4	0.4	1.6	10.3	1.1	-0.6	1,869

Note: Table is based on children who stayed in the household the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the WHO Child Growth Standards adopted in 2006. The indices in this table are NOT comparable to those based on the previously used 1977 NCHS/CDC/WHO Reference. Table is based on children with valid dates of birth (month and year) and valid measurement of both height and weight. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed. Total include 3 cases in which mother's education level is missing.

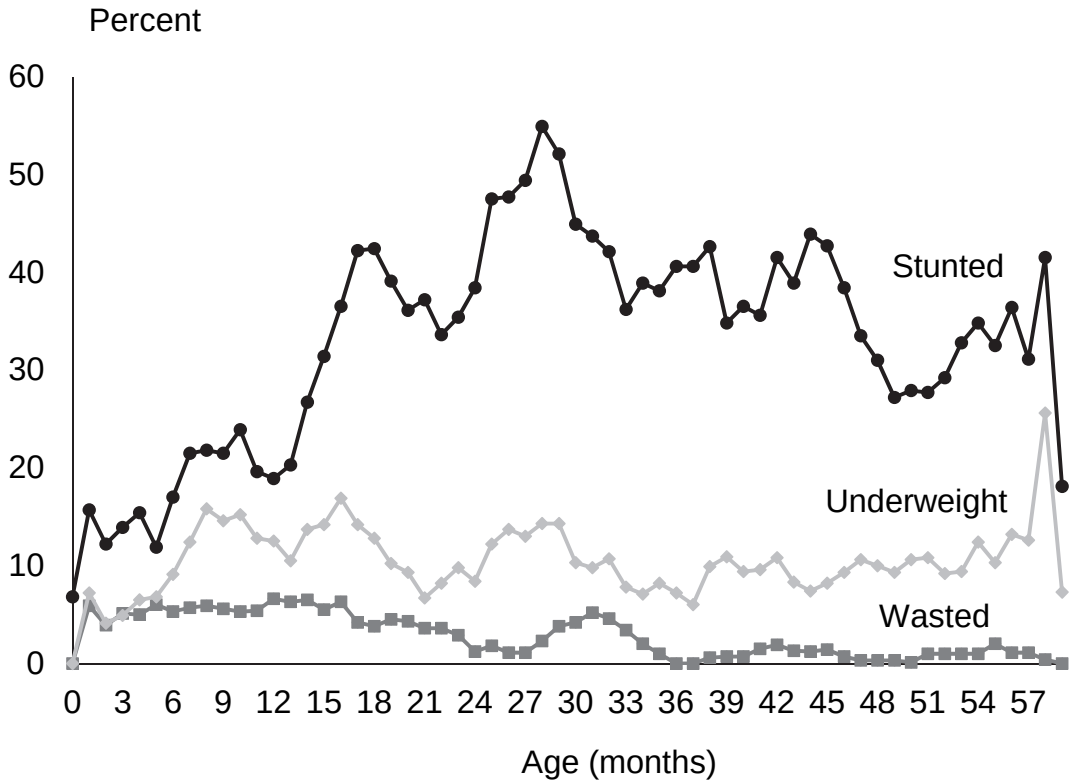
[1] Recumbent length is measured for children under age 2 or in the few cases when the age of the child is unknown and the child is less than 85 cm; standing height is measured for all other children.

[2] Includes children who are below -3 standard deviations (SD) from the WHO Growth Standards population median

[3] Includes children whose mothers are deceased

[4] For women who are not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers are not listed in the Household Questionnaire.

Figure 3.5 **Nutritional status of children by age**



Note: *Stunting* reflects chronic malnutrition; *wasting* reflects acute malnutrition; *underweight* reflects chronic or acute malnutrition or a combination of both. Plotted values are smoothed by a five-month moving average.

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3.10.4 Infant and Young Child Feeding Practices

Breastfeeding is sufficient and beneficial for infant nutrition in the first six months of life. Breastfeeding immediately after birth also helps the uterus contract, hence reducing the mother's postpartum blood loss. Supplementing breast milk before the child is age 6 months is discouraged because it may inhibit breastfeeding and expose the infant to illness. At a later stage of the baby's development, breast milk should be supplemented by other liquids and eventually by solid or mushy food to provide adequate nourishment (Pan American Health Organization, 2002).

The 2014 LDHS collected data on infant and young child feeding (IYCF) practices for all children born in the two years preceding the survey. Table 3.13 shows breastfeeding practices by child's age.[5] Sixty-seven percent of infants under age 6 months are exclusively breastfed, which is a 13-percentage-point increase from the figure reported in the 2009 LDHS (54 percent) and a 30-percentage-point increase from the figure reported in 2004 (37 percent). Contrary to the recommendation that children under age 6 months be exclusively breastfed, 4 percent of infants consume plain water, 5 percent consume non-milk liquids, 8 percent consume other milk, and 10 percent consume complementary foods in addition to breast milk. Twenty-six percent of infants under age 6 months are fed using a bottle with a nipple, a practice that is discouraged because of the risk of illness to the child.

[5] When comparing the results of the 2014 LDHS with previous LDHS surveys, note that the 2014 table on breastfeeding status by age is restricted to the youngest children and all children under age 2 living with their mothers, instead of the youngest children and all children under age 3 living with their mothers (as in the 2004 and 2009 LDHS surveys).

Seventy-five percent of children age 6-8 months receive timely complementary foods, and two-thirds (67 percent) of children age 18-23 months have been weaned.

Table 3.13 Breastfeeding status by age

Percent distribution of youngest children under age 2 who are living with their mother by breastfeeding status and the percentage currently breastfeeding, and the percentage of all children under age 2 using a bottle with a nipple, according to age in months, Lesotho 2014

	Breastfeeding status										
Age in months	Not breast-feeding	Exclusively breast-feeding	Breast-feeding and consuming plain water only	Breast-feeding and consuming non-milk liquids[1]	Breast-feeding and consuming other milk	Breast-feeding and consuming comple-mentary foods	Total	Percent-age currently breast-feeding	Number of youngest children under age 2 living with their mother	Percent-age using a bottle with a nipple	Number of all children under age 2
0-1	1.3	81.8	3.2	10.3	3.4	0.0	100.0	98.7	80	12.1	85
2-3	6.0	76.0	4.2	2.4	9.7	1.7	100.0	94.0	131	18.8	136
4-5	10.9	44.1	2.8	4.9	10.6	26.8	100.0	89.1	105	45.6	107
6-8	9.5	9.5	2.0	0.5	3.7	74.8	100.0	90.5	155	39.0	157
9-11	18.2	1.3	3.3	1.3	0.0	75.9	100.0	81.8	177	27.9	185
12-17	29.0	0.8	1.6	0.4	0.0	68.2	100.0	71.0	325	19.9	343
18-23	67.0	0.3	0.2	0.0	0.2	32.3	100.0	33.0	277	13.9	311
0-3	4.2	78.2	3.8	5.4	7.4	1.1	100.0	95.8	211	16.3	221
0-5	6.4	66.9	3.5	5.2	8.4	9.6	100.0	93.6	315	25.8	328
6-9	13.6	7.4	2.2	1.1	2.9	72.7	100.0	86.4	199	40.3	204
12-15	28.8	1.0	1.9	0.3	0.0	68.0	100.0	71.2	243	22.0	254
12-23	46.5	0.5	1.0	0.2	0.1	51.7	100.0	53.5	602	17.1	655
20-23	70.5	0.0	0.0	0.0	0.0	29.5	100.0	29.5	186	11.7	216

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, non-milk liquids, other milk, and complementary foods (solids and semisolids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus, children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

[1] Non-milk liquids include juice, juice drinks, clear broth, or other liquids.

The minimum acceptable diet indicator is used to assess the proportion of children age 6-23 months who meet minimum standards with respect to IYCF practices. Specifically, children age 6-23 months who have a minimum acceptable diet meet all three IYCF criteria below:

1. Breastfeeding, or not breastfeeding and receiving two or more feedings of commercial infant formula; fresh, tinned, or powdered animal milk; or yogurt.

2. Fed with foods from four or more of the following groups: a. infant formula, milk other than breast milk, and cheese or yogurt or other milk products; b. foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; c. vitamin A-rich fruits and vegetables (and red palm oil); d. other fruits and vegetables; e. eggs; f. meat, poultry, fish, and shellfish (and organ meats); and g. legumes and nuts.

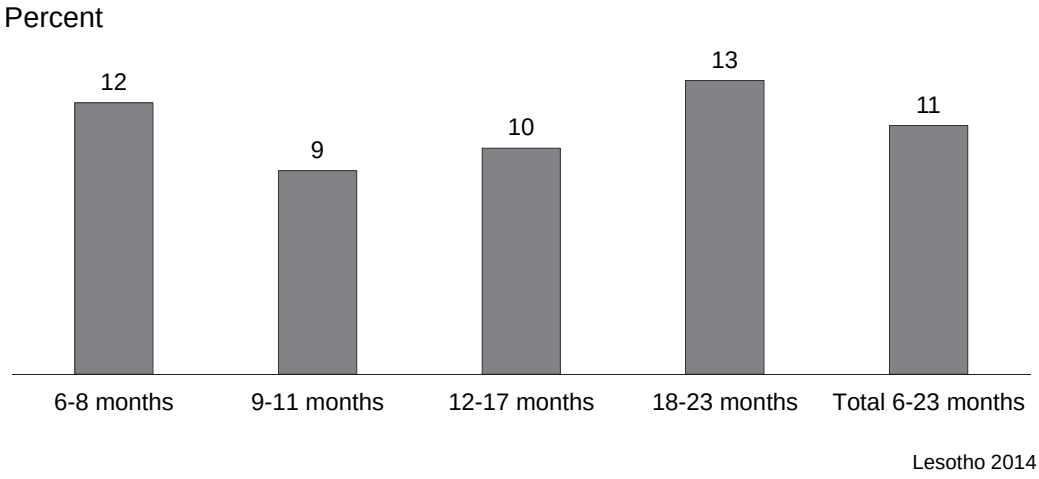
3. Fed the minimum recommended number of times per day according to their age and breastfeeding status:

   a. For breastfed children, minimum meal frequency is receiving solid or semisolid food at least twice a day for infants age 6-8 months and at least three times a day for children age 9-23 months.

   b. For nonbreastfed children age 6-23 months, minimum meal frequency is receiving solid or semisolid food or milk feeds at least four times a day.

Figure 3.6 shows the percentage of children being fed the minimum acceptable diet, by age. In total, only 11 percent of children age 6-23 months have met the criteria for a minimum acceptable diet.

Figure 3.6 **Minimum acceptable diet by age, in months**



3.11 ANAEMIA PREVALENCE IN CHILDREN, WOMEN, AND MEN

Anaemia is a condition that is marked by low levels of haemoglobin in the blood. Iron is a key component of haemoglobin, and iron deficiency is estimated to be responsible for half of all anaemia globally. Other causes of anaemia include hookworm and other helminths, other nutritional deficiencies, chronic infections, and genetic conditions. Anaemia is a serious concern for children because it can impair cognitive development, stunt growth, and increase morbidity from infectious diseases.

The 2014 LDHS included direct measurement of haemoglobin levels using the HemoCue system. This system consists of a battery-operated photometer and a disposable microcuvette coated with a dried reagent that serves as the blood collection device. For the test, a drop of capillary blood taken from a child's fingertip or heel is drawn into the microcuvette. The blood in the microcuvette is analysed using the photometer, which displays the haemoglobin concentration. Haemoglobin levels among women and men were measured using procedures similar to those used for children, except that capillary blood was collected exclusively from a finger prick. Haemoglobin levels were successfully measured for 96 percent of the children eligible for testing, 98 percent of the women eligible for testing, and 96 percent of the men eligible for testing (data not shown).

Table 3.14 presents anaemia prevalence for children age 6-59 months and women age 15-49, by background characteristics. Table 3.15 presents anaemia prevalence for men age 15-49. Haemoglobin levels for children, women, and men were adjusted for altitude and, for women and men only, smoking status. Children and pregnant women with haemoglobin levels below 11.0 g/dl, non-pregnant women with haemoglobin levels below 12.0 g/dl, and men with haemoglobin levels below 13.0 g/dl were defined as anaemic.

Overall, half (51 percent) of children suffered from some degree of anaemia: 25 percent were classified as mildly anaemic, 25 percent were moderately anaemic, and 1 percent were severely anaemic. The prevalence of anaemia decreases with age, ranging from a high of 62 percent among children age 6-11 months to a low of 42 percent among children age 36-59 months. Boys are slightly more likely to be anaemic than girls (53 percent and 49 percent, respectively). Anaemia prevalence varies by district, from a low of 41 percent in Berea to a high of 59 percent in Butha-Buthe and Mokhotlong.

Table 3.14 Anaemia among children and women

Percentage of children age 6-59 months and women age 15-49 classified as having any, mild, moderate, and severe anaemia, by background characteristics, Lesotho 2014

Background characteristic	Any anaemia	Severity of anaemia: Mild anaemia	Moderate anaemia	Severe anaemia	Number
		CHILDREN			
Sex					
Male	52.8	26.2	25.2	1.4	826
Female	48.9	23.4	24.6	0.9	883
Age in months					
6-11	61.7	26.8	33.3	1.6	154
12-23	60.5	26.0	31.5	2.9	369
24-35	54.3	22.3	31.5	0.4	404
36-47	42.4	25.0	16.9	0.6	398
48-59	42.0	25.1	16.2	0.7	384
Residence					
Urban	48.3	22.7	25.3	0.3	410
Rural	51.6	25.4	24.7	1.4	1,299
Ecological zone					
Lowlands	49.1	24.2	24.0	0.9	917
Foothills	47.9	23.2	23.0	1.7	197
Mountains	55.8	25.8	28.1	1.9	447
Senqu River Valley	49.9	27.3	22.6	0.0	149
District					
Butha-Buthe	59.2	27.0	29.6	2.7	112
Leribe	55.7	30.1	22.6	3.0	262
Berea	40.9	21.0	19.9	0.0	200
Maseru	48.5	23.4	25.0	0.2	402
Mafeteng	44.5	23.2	20.5	0.7	158
Mohale's Hoek	56.1	22.5	32.0	1.5	158
Quthing	47.4	28.4	18.6	0.4	98
Qacha's Nek	47.3	21.0	24.9	1.5	52
Mokhotlong	58.5	25.0	32.0	1.5	118
Thaba-Tseka	53.5	25.5	26.9	1.1	149
Wealth quintile					
Lowest	53.9	26.0	26.7	1.2	371
Second	54.8	25.9	27.4	1.4	387
Middle	50.8	25.3	23.9	1.5	364
Fourth	47.1	18.4	27.8	0.9	332
Highest	45.0	28.8	15.7	0.5	255
Total	50.8	24.8	24.8	1.2	1,709
		WOMEN			
Residence					
Urban	32.0	22.6	8.3	1.1	1,144
Rural	24.8	18.8	5.6	0.4	2,159
Ecological zone					
Lowlands	30.8	23.0	7.1	0.7	2,049
Foothills	21.5	15.9	4.8	0.7	335
Mountains	20.8	14.7	5.5	0.5	672
Senqu River Valley	23.8	16.5	6.7	0.6	247
District					
Butha-Buthe	29.4	22.7	6.4	0.3	203
Leribe	25.2	18.5	6.1	0.6	522
Berea	23.0	18.6	4.2	0.2	433
Maseru	34.2	25.0	8.2	1.1	901
Mafeteng	27.9	19.9	7.2	0.8	287
Mohale's Hoek	25.8	18.2	7.2	0.4	278
Quthing	23.6	18.1	5.4	0.0	164
Qacha's Nek	27.5	21.3	5.3	0.8	99
Mokhotlong	24.4	15.2	8.5	0.6	178
Thaba-Tseka	16.9	12.6	3.5	0.8	238
Wealth quintile					
Lowest	22.8	16.4	6.0	0.4	481
Second	23.1	18.3	4.2	0.6	554
Middle	27.5	20.1	7.0	0.4	628
Fourth	30.9	23.7	6.6	0.6	799
Highest	28.9	20.0	8.0	0.9	841
Total	27.3	20.1	6.5	0.6	3,303

Note: Table is based on children and women who stayed in the household the night before the interview. Prevalence of anaemia, based on haemoglobin levels, is adjusted for altitude (for children and women) and smoking (for women) using CDC formulas (CDC, 1998). Women and children with haemoglobin levels below 7.0 g/dl are classified as having severe anaemia, women and children with haemoglobin levels of 7.0-9.9 g/dl are classified as having moderate anaemia, and non-pregnant women with haemoglobin levels of 10.0-11.9 g/dl and children and pregnant women with haemoglobin levels of 10.0-10.9 g/dl are classified as having mild anaemia.

One in four women age 15-49 (27 percent) are anaemic. The majority of these women are mildly anaemic (20 percent of all women); 7 percent are moderately anaemic, and 1 percent are severely anaemic. The proportion of women with any anaemia is higher in urban areas than rural areas (32 percent and 25 percent, respectively). Anaemia levels also vary by district; for example, the prevalence of anaemia among women residing in Maseru (34 percent) is twice as high as the prevalence among women from Thaba-Tseka (17 percent). The prevalence of anaemia in women generally increases with increasing wealth, from a low of 23 percent among women in the lowest and second wealth quintiles to a high of 31 percent among women in the fourth wealth quintile.

Fourteen percent of Basotho men age 15-49 are anaemic (Table 3.15). The prevalence of anaemia in men varies little by urban-rural residence but greatly by district: only 6 percent of men in Quthing are anaemic, as compared with 22 percent in Butha-Buthe. The proportion of men classified as anaemic declines as household wealth increases. In comparison with children (51 percent) and women (27 percent), the anaemia rate among men is moderate (14 percent). From a public health perspective, the anaemia prevalence observed among men and women is serious, and the prevalence among children is critical.

Table 3.15 Anaemia among men

Percentage of men age 15-49 classified as having any, mild, moderate, and severe anaemia, by background characteristics, Lesotho 2014

		Percentage with anaemia			
Background characteristic	Any anaemia	Mild anaemia	Moderate anaemia	Severe anaemia	Number
Residence					
Urban	14.2	6.7	7.2	0.3	862
Rural	13.4	7.3	5.5	0.6	1,658
Ecological zone					
Lowlands	12.7	6.8	5.6	0.3	1,614
Foothills	19.7	8.3	9.4	2.0	239
Mountains	15.5	8.5	6.7	0.3	503
Senqu River Valley	9.3	3.9	4.8	0.6	164
District					
Butha-Buthe	21.9	9.3	9.8	2.8	140
Leribe	11.8	6.3	4.8	0.7	365
Berea	9.5	6.6	2.6	0.3	360
Maseru	14.1	7.6	6.3	0.2	764
Mafeteng	11.6	4.1	7.3	0.2	229
Mohale's Hoek	16.3	6.7	9.6	0.0	194
Quthing	6.1	1.9	4.2	0.0	99
Qacha's Nek	19.9	11.4	7.2	1.3	73
Mokhotlong	20.2	11.5	8.0	0.6	137
Thaba-Tseka	14.1	8.2	5.4	0.5	159
Wealth quintile					
Lowest	18.8	10.8	7.0	1.0	359
Second	15.0	8.8	5.8	0.4	457
Middle	13.1	6.7	6.1	0.3	511
Fourth	13.0	5.3	7.7	0.0	591
Highest	10.8	5.8	4.2	0.8	601
Total 15-49	13.7	7.1	6.1	0.5	2,520
50-59	23.0	11.5	10.2	1.3	266
Total 15-59	14.6	7.5	6.5	0.6	2,786

Note: Table is based on men who stayed in the household the night before the interview. Prevalence is adjusted for altitude and smoking using CDC formulas (CDC, 1998). Men with haemoglobin levels below 9.0 g/dl are classified as having severe anaemia, men with haemoglobin levels of 9.0-11.9 g/dl are classified as having moderate anaemia, and men with haemoglobin levels of 12.0-12.9 g/dl are classified as having mild anaemia.

3.12 HIV/AIDS AWARENESS, KNOWLEDGE, AND BEHAVIOUR

The 2014 LDHS included a series of questions that addressed respondents' knowledge of HIV prevention, their awareness of modes of HIV transmission, and behaviours that can prevent the spread of HIV.

Table 3.16 shows that 92 percent of women and 88 percent of men age 15-49 know that consistent use of condoms is a means of preventing the spread of HIV. Ninety-one percent of women and 87 percent of men know that limiting sexual intercourse to one faithful and uninfected partner can reduce the chances of contracting HIV. The proportions of women and men who know that both using condoms and limiting sexual intercourse to one uninfected partner are means of preventing HIV are 86 percent and 81 percent, respectively.

Table 3.16 Knowledge of HIV prevention methods

Percentage of women and men age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting HIV by using condoms every time they have sexual intercourse and by having one sex partner who is not infected and has no other partners, by background characteristics, Lesotho 2014

	Women				Men			
	Percentage who say HIV can be prevented by:				Percentage who say HIV can be prevented by:			
Background characteristic	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of women	Using condoms[1]	Limiting sexual intercourse to one uninfected partner[2]	Using condoms and limiting sexual intercourse to one uninfected partner[1,2]	Number of men
Age								
15-24	88.6	88.5	82.3	2,765	88.9	85.6	81.3	1,252
15-19	86.6	86.2	79.8	1,440	87.3	83.7	79.1	691
20-24	90.8	91.1	85.0	1,325	90.9	87.9	84.0	561
25-29	93.4	92.4	87.8	1,094	89.4	88.3	84.5	410
30-39	94.8	93.1	90.0	1,701	85.6	87.7	78.7	610
40-49	94.8	92.7	89.5	1,062	86.5	86.0	78.8	389
Marital status								
Never married	88.8	88.8	82.6	2,190	88.0	85.4	80.7	1,501
Ever had sex	92.2	91.1	86.1	1,295	90.1	88.3	83.6	1,156
Never had sex	83.8	85.3	77.6	895	80.8	75.9	71.1	345
Married/living together	93.5	92.4	88.5	3,612	88.0	87.8	81.4	983
Divorced/separated/widowed	94.1	90.7	86.6	819	86.2	89.3	78.9	176
Residence								
Urban	94.3	93.4	89.1	2,419	93.5	92.4	88.6	920
Rural	90.6	89.6	84.7	4,202	84.9	83.5	76.8	1,741
Ecological zone								
Lowlands	93.6	92.6	88.3	4,184	91.7	90.1	85.6	1,711
Foothills	91.6	90.3	86.0	688	80.3	78.6	70.2	252
Mountains	87.3	86.9	80.7	1,288	79.9	79.4	71.2	523
Senqu River Valley	91.1	89.3	84.6	461	85.1	84.8	78.2	174
District								
Butha-Buthe	89.2	82.4	79.0	385	82.4	77.5	71.6	143
Leribe	95.3	93.9	90.4	1,064	90.9	91.9	87.1	390
Berea	92.3	91.9	87.8	892	85.4	89.0	81.8	379
Maseru	94.3	93.6	89.5	1,864	94.2	90.9	87.4	809
Mafeteng	91.2	89.0	83.1	576	86.2	82.5	75.1	242
Mohale's Hoek	89.0	90.9	83.4	519	84.3	84.1	77.7	202
Quthing	91.4	88.4	85.4	315	86.1	81.5	75.2	105
Qacha's Nek	91.6	87.3	83.1	204	87.7	85.3	80.7	74
Mokhotlong	86.5	88.8	81.5	349	80.8	80.7	69.9	144
Thaba-Tseka	85.6	87.0	80.2	452	74.6	73.5	66.0	172
Education								
No education	84.6	72.8	68.8	68	67.9	76.5	60.5	213
Primary incomplete	85.8	85.5	77.9	1,178	81.1	78.6	71.3	875
Primary complete	93.2	90.6	87.0	1,375	92.9	87.9	84.2	316
Secondary	93.1	92.5	88.2	3,418	94.4	93.1	89.7	1,043
More than secondary	96.1	96.5	92.8	581	96.0	95.2	92.4	214
Wealth quintile								
Lowest	84.6	83.8	77.5	960	75.9	75.4	66.8	376
Second	89.1	87.2	81.2	1,033	84.1	83.5	77.1	479
Middle	94.4	93.1	89.4	1,244	86.6	84.5	77.4	536
Fourth	94.2	93.8	89.6	1,605	91.9	91.6	86.3	616
Highest	94.0	93.2	89.0	1,778	94.7	92.1	89.4	654
Total 15-49	92.0	91.0	86.3	6,621	87.9	86.6	80.9	2,660
50-59	na	na	na	na	82.8	83.5	73.3	271
Total 15-59	na	na	na	na	87.4	86.3	80.2	2,931

na = Not applicable
[1] Using condoms every time they have sexual intercourse
[2] Partner who has no other partners

By marital status, women and men who have never been married and never had sex are least likely to know that using condoms and limiting sexual intercourse to one uninfected partner reduce the risk of HIV transmission (78 percent and 71 percent, respectively). Those residing in urban areas, especially men, are more likely to be knowledgeable about HIV prevention methods than their counterparts residing in rural areas. Better educated respondents and those in the higher wealth quintiles are generally more knowledgeable of HIV prevention methods than other respondents.

Knowledge of HIV prevention methods has increased over the last 10 years. As noted, according to the 2014 LDHS, 86 percent of women know that HIV can be prevented by using a condom and by limiting sexual partners; this compares with 71 percent in 2004 and 81 percent in 2009. Among men, the percentage with knowledge of HIV prevention methods has increased from 60 percent in 2004 and 72 percent in 2009 to 81 percent in 2014.

Table 3.17 shows knowledge of HIV prevention among young people age 15-24. Knowledge of HIV prevention is defined as knowing that both condom use and limiting sexual intercourse to one uninfected partner are HIV prevention methods, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission: that HIV can be transmitted by mosquito bites and by sharing food with a person who has HIV. Knowledge of how HIV is transmitted is crucial to enabling people to avoid HIV infection, and this is especially true for young people, who are often at greater risk because they may have shorter relationships with more partners or engage in other risky behaviours.

Table 3.17 Knowledge about HIV prevention among young people

Percentage of young women and young men age 15-24 with knowledge about HIV prevention, by background characteristics, Lesotho 2014

	Women age 15-24		Men age 15-24	
Background characteristic	Percentage with knowledge about HIV prevention[1]	Number of women	Percentage with knowledge about HIV prevention[1]	Number of men
Age				
15-19	34.8	1,440	29.7	691
15-17	32.8	874	26.9	415
18-19	38.1	566	33.9	277
20-24	40.6	1,325	32.3	561
20-22	39.4	841	30.5	361
23-24	42.7	484	35.8	200
Marital status				
Never married	37.9	1,719	31.5	1,151
Ever had sex	40.5	850	31.9	826
Never had sex	35.3	869	30.4	325
Ever married	37.2	1,046	24.4	101
Residence				
Urban	43.8	922	40.2	384
Rural	34.5	1,843	26.8	868
Education				
No education	*	3	(8.7)	28
Primary incomplete	20.0	370	17.0	404
Primary complete	27.9	396	30.6	122
Secondary	40.3	1,852	37.7	629
More than secondary	74.6	144	(60.4)	68
Wealth quintile				
Lowest	26.4	424	18.7	150
Second	33.5	462	25.6	225
Middle	35.7	562	30.9	274
Fourth	39.7	679	36.2	313
Highest	47.6	638	35.6	290
Total 15-24	37.6	2,765	30.9	1,252

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission or prevention of HIV (that HIV can be transmitted by mosquito bites and by sharing food with a person who has HIV).

Table 3.17 shows that 38 percent of young women and 31 percent of young men have knowledge of HIV prevention. Among both sexes, the proportion with comprehensive knowledge generally increases with age, educational attainment, and wealth. Urban young people are more likely than rural young people to have knowledge of HIV prevention.

Information on sexual behaviour is important in designing and monitoring intervention programmes to control the spread of HIV. The 2014 LDHS included questions on respondents' sexual partners during the 12 months preceding the survey and during their lifetime. Information was also collected on use of condoms at respondents' last sexual intercourse. These questions are sensitive, and it is recognised that some respondents may have been reluctant to provide information on recent sexual behaviour. Results are shown in Table 3.18.1 for women and Table 3.18.2 for men.

Table 3.18.1 Multiple sexual partners in the past 12 months: Women

Among all women age 15-49, the percentage who had sexual intercourse with two or more sexual partners in the past 12 months; among those having two or more sexual partners in the past 12 months, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during their lifetime for women who ever had sexual intercourse, by background characteristics, Lesotho 2014

	All women		Women who had 2+ partners in the past 12 months		Women who ever had sexual intercourse[1]	
Background characteristic	Percentage who had 2+ partners in the past 12 months	Number of women	Percentage who reported using a condom during last sexual intercourse	Number of women	Mean number of sexual partners in lifetime	Number of women
Age						
15-24	5.1	2,765	67.2	142	2.1	1,892
15-19	2.9	1,440	(57.9)	41	1.7	660
20-24	7.6	1,325	71.0	100	2.4	1,232
25-29	8.1	1,094	54.5	89	3.0	1,067
30-39	8.6	1,701	43.8	146	3.0	1,655
40-49	5.6	1,062	46.4	59	2.7	1,048
Marital status						
Never married	5.6	2,190	81.2	122	2.8	1,276
Married/living together	7.1	3,612	39.5	258	2.4	3,577
Divorced/separated/widowed	6.7	819	60.9	55	3.7	808
Residence						
Urban	6.6	2,419	68.7	160	3.0	2,049
Rural	6.6	4,202	45.3	276	2.5	3,612
Ecological zone						
Lowlands	6.9	4,184	61.3	290	2.9	3,569
Foothills	6.7	688	(36.9)	46	2.1	605
Mountains	5.2	1,288	37.5	67	2.2	1,079
Senqu River Valley	6.8	461	45.9	32	2.8	409
District						
Butha-Buthe	3.4	385	*	13	2.0	332
Leribe	7.9	1,064	64.2	84	2.5	914
Berea	6.9	892	67.0	61	3.1	770
Maseru	7.0	1,864	58.4	131	2.9	1,601
Mafeteng	5.0	576	(31.6)	29	2.4	478
Mohale's Hoek	7.7	519	29.5	40	2.4	454
Quthing	7.3	315	(58.5)	23	3.1	269
Qacha's Nek	6.2	204	(49.6)	13	2.5	177
Mokhotlong	4.4	349	(37.1)	16	2.3	282
Thaba-Tseka	5.7	452	(34.6)	26	2.2	386
Education						
No education	5.9	68	*	4	2.4	67
Primary incomplete	7.6	1,178	36.4	90	2.5	1,002
Primary complete	5.5	1,375	45.8	76	2.5	1,275
Secondary	6.1	3,418	60.7	210	2.6	2,783
More than secondary	9.5	581	(69.7)	55	3.6	534
Wealth quintile						
Lowest	5.5	960	26.6	53	2.4	823
Second	6.1	1,033	47.7	63	2.4	888
Middle	6.3	1,244	54.7	78	2.5	1,068
Fourth	6.5	1,605	54.4	104	2.7	1,380
Highest	7.7	1,778	66.5	137	3.1	1,503
Total	6.6	6,621	53.9	435	2.7	5,662

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.
[1] Means are calculated excluding respondents who gave non-numeric responses.

Table 3.18.2 Multiple sexual partners in the past 12 months: Men

Among all men age 15-49, the percentage who had sexual intercourse with two or more sexual partners in the past 12 months; among those having two or more sexual partners in the past 12 months, the percentage reporting that a condom was used at last intercourse; and the mean number of sexual partners during their lifetime for men who ever had sexual intercourse, by background characteristics, Lesotho 2014

	All men		Men who had 2+ partners in the past 12 months		Men who ever had sexual intercourse[1]	
Background characteristic	Percentage who had 2+ partners in the past 12 months	Number of men	Percentage who reported using a condom during last sexual intercourse	Number of men	Mean number of sexual partners in lifetime	Number of men
Age						
15-24	22.7	1,252	78.2	284	6.0	914
15-19	15.3	691	79.7	106	4.0	410
20-24	31.8	561	77.3	178	7.6	504
25-29	38.5	410	72.9	158	12.6	389
30-39	30.7	610	52.7	187	12.4	582
40-49	21.2	389	35.1	82	10.9	364
Marital status						
Never married	23.5	1,501	82.8	353	7.6	1,135
Married/living together	31.1	983	44.9	306	11.4	952
Divorced/separated/widowed	30.0	176	(66.6)	53	13.3	161
Residence						
Urban	32.0	920	70.6	295	12.7	786
Rural	23.9	1,741	61.6	417	7.9	1,462
Ecological zone						
Lowlands	27.8	1,711	69.5	475	10.7	1,441
Foothills	27.5	252	63.3	69	8.5	209
Mountains	23.2	523	51.7	122	6.9	448
Senqu River Valley	26.3	174	60.5	46	8.3	149
District						
Butha-Buthe	14.2	143	(72.2)	20	5.8	106
Leribe	30.2	390	72.8	118	9.2	339
Berea	23.9	379	61.1	91	9.1	313
Maseru	31.8	809	70.8	258	11.8	711
Mafeteng	22.7	242	56.3	55	10.9	198
Mohale's Hoek	23.5	202	66.1	47	7.3	160
Quthing	21.9	105	(60.5)	23	7.6	90
Qacha's Nek	30.0	74	67.2	22	9.5	68
Mokhotlong	29.9	144	40.4	43	8.5	120
Thaba-Tseka	20.0	172	(52.0)	34	6.4	144
Education						
No education	19.9	213	34.0	42	7.3	192
Primary incomplete	23.2	875	58.6	203	7.4	745
Primary complete	28.4	316	63.4	90	9.7	281
Secondary	28.2	1,043	73.4	294	10.8	833
More than secondary	38.7	214	71.2	83	14.6	198
Wealth quintile						
Lowest	21.0	376	50.4	79	6.4	311
Second	23.3	479	62.8	111	7.4	392
Middle	24.0	536	58.6	129	8.7	456
Fourth	28.5	616	71.1	176	9.9	529
Highest	33.2	654	71.3	217	13.3	559
Total 15-49	26.7	2,660	65.3	711	9.6	2,248
50-59	11.5	271	(46.5)	31	9.9	249
Total 15-59	25.3	2,931	64.5	743	9.6	2,496

Note: Figures in parentheses are based on 25-49 unweighted cases.
[1] Means are calculated excluding respondents who gave non-numeric responses.

Overall, 7 percent of women reported that they had two or more partners in the past 12 months. Among women who had two or more partners in the past 12 months, 54 percent reported using a condom during their last sexual intercourse. The mean number of lifetime partners among all women who have ever had sexual intercourse is 2.7.

Twenty-seven percent of men age 15-49 reported that they had two or more partners in the past 12 months, and 65 percent of these men reported using a condom during their last sexual intercourse. The mean

number of lifetime partners among all men who have ever had sexual intercourse is 9.6, more than three times the mean number for women.

3.13 COVERAGE OF HIV TESTING SERVICES

Knowledge of HIV status helps HIV-negative individuals make specific decisions to reduce risk and increase safer sex practices so that they can remain disease free. Among those who are HIV infected, knowledge of their status allows them to take action to protect their sexual partners, to access treatment, and to plan for the future.

To assess awareness and coverage of HIV testing services, LDHS respondents were asked whether they had ever been tested for HIV. If they said that they had, they were asked whether they had received the results of their last test and where they had been tested. If they had never been tested, they were asked whether they knew a place where they could go to be tested.

Tables 3.19.1 and 3.19.2 show that the majority of respondents age 15-49 (97 percent of women and 92 percent of men) knew of a place where they could get an HIV test. Younger respondents (age 15-19) were less likely than those age 20-49 to know a place where they could go to be tested. Never-married respondents who had never had sex were less likely than others to know a place to get an HIV test. Knowledge of a place to get an HIV test generally increases with increasing wealth and, among men but not women, increasing education.

Tables 3.19.1 and 3.19.2 also show coverage of HIV testing services. Among respondents age 15-49, a larger proportion of men (35 percent) than women (15 percent) had never been tested. Most of those who had been tested said that they had received the results of the last test they took. Overall, 84 percent of women and 63 percent of men had ever been tested and had received the results of their last test. Among women, the likelihood of having ever had an HIV test and receiving the results was highest in the 25-29 age group (95 percent); among men, rates increased with age. Among men but not women, urban residents were much more likely than rural residents to have been tested and to have received the results (75 percent and 57 percent, respectively). Among men, testing coverage generally increases with increasing education and wealth. Among women, no association is observed between HIV testing and education or wealth.

Fifty-eight percent of women and 36 percent of men age 15-49 had been tested in the 12-month period preceding the survey and had been told the results of the last test they took.

Relative to the data reported in the two preceding LDHS surveys, the proportion of respondents age 15-49 who have ever been tested for HIV and received results has increased dramatically, from 12 percent in 2004 and 66 percent in 2009 to 84 percent in 2014 among women and from 9 percent in 2004 and 37 percent in 2009 to 63 percent in 2014 among men (Figure 3.7). There has also been a dramatic increase in the proportion of respondents age 15-49 who were tested for HIV in the 12-month period preceding the survey and received their last test results, from 6 percent in 2004 to 58 percent in 2014 among women and from 5 percent in 2004 and 24 percent in 2009 to 36 percent in 2014 among men.[6]

[6] Data on the percentage of women tested for HIV in the past 12 months are unavailable in the 2009 LDHS due to a skip error in the questionnaire.

Table 3.19.1 Coverage of prior HIV testing: Women

Percentage of women age 15-49 who know where to get an HIV test, percent distribution of women age 15-49 by testing status and by whether they received the results of the last test, percentage ever tested, and percentage who were tested in the past 12 months and received the results of the last test, according to background characteristics, Lesotho 2014

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of women by testing status and by whether they received the results of the last test: Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of women
Age								
15-24	94.1	71.0	1.5	27.5	100.0	72.5	54.0	2,765
15-19	90.2	56.5	1.5	42.1	100.0	57.9	40.5	1,440
20-24	98.2	86.8	1.5	11.7	100.0	88.3	68.6	1,325
25-29	99.4	95.1	1.4	3.5	100.0	96.5	69.8	1,094
30-39	99.3	93.1	2.2	4.8	100.0	95.2	59.8	1,701
40-49	99.1	89.5	2.6	7.8	100.0	92.2	53.5	1,062
Marital status								
Never married	93.4	64.0	1.2	34.8	100.0	65.2	43.5	2,190
Ever had sex	97.4	77.7	1.3	20.9	100.0	79.1	54.0	1,295
Never had sex	87.7	44.1	1.1	54.8	100.0	45.2	28.4	895
Married/living together	98.9	93.3	2.0	4.7	100.0	95.3	66.5	3,612
Divorced/separated/widowed	99.2	93.2	2.8	4.0	100.0	96.0	58.9	819
Residence								
Urban	98.4	83.1	1.6	15.3	100.0	84.7	57.1	2,419
Rural	96.3	83.9	2.0	14.1	100.0	85.9	58.5	4,202
Ecological zone								
Lowlands	98.1	84.0	1.3	14.7	100.0	85.3	57.1	4,184
Foothills	96.8	82.5	3.4	14.2	100.0	85.8	59.4	688
Mountains	94.8	83.0	2.7	14.3	100.0	85.7	58.9	1,288
Senqu River Valley	95.3	83.9	2.1	13.9	100.0	86.1	61.4	461
District								
Butha-Buthe	93.1	82.5	1.8	15.8	100.0	84.2	62.0	385
Leribe	98.5	84.6	1.0	14.4	100.0	85.6	58.4	1,064
Berea	97.2	82.7	1.5	15.8	100.0	84.2	55.7	892
Maseru	98.4	84.2	1.9	13.8	100.0	86.2	58.0	1,864
Mafeteng	97.9	83.2	2.6	14.2	100.0	85.8	52.5	576
Mohale's Hoek	97.1	84.8	2.6	12.6	100.0	87.4	60.8	519
Quthing	93.2	77.9	1.7	20.4	100.0	79.6	52.7	315
Qacha's Nek	96.8	84.7	2.4	12.9	100.0	87.1	62.6	204
Mokhotlong	94.7	79.6	2.5	17.9	100.0	82.1	54.0	349
Thaba-Tseka	95.6	87.4	1.7	10.9	100.0	89.1	66.3	452
Education								
No education	97.0	73.3	6.2	20.5	100.0	79.5	37.3	68
Primary incomplete	93.1	81.0	3.2	15.7	100.0	84.3	55.5	1,178
Primary complete	97.7	89.6	1.5	8.8	100.0	91.2	61.9	1,375
Secondary	97.8	81.6	1.5	17.0	100.0	83.0	57.8	3,418
More than secondary	99.8	88.0	1.2	10.8	100.0	89.2	57.3	581
Wealth quintile								
Lowest	93.8	82.2	3.0	14.8	100.0	85.2	59.4	960
Second	95.7	84.3	2.8	12.9	100.0	87.1	60.7	1,033
Middle	97.2	85.8	1.2	13.0	100.0	87.0	59.6	1,244
Fourth	98.7	83.7	1.2	15.1	100.0	84.9	59.1	1,605
Highest	98.2	82.4	1.7	15.9	100.0	84.1	53.5	1,778
Total	97.1	83.6	1.8	14.5	100.0	85.5	58.0	6,621

[1] Includes "don't know/missing"

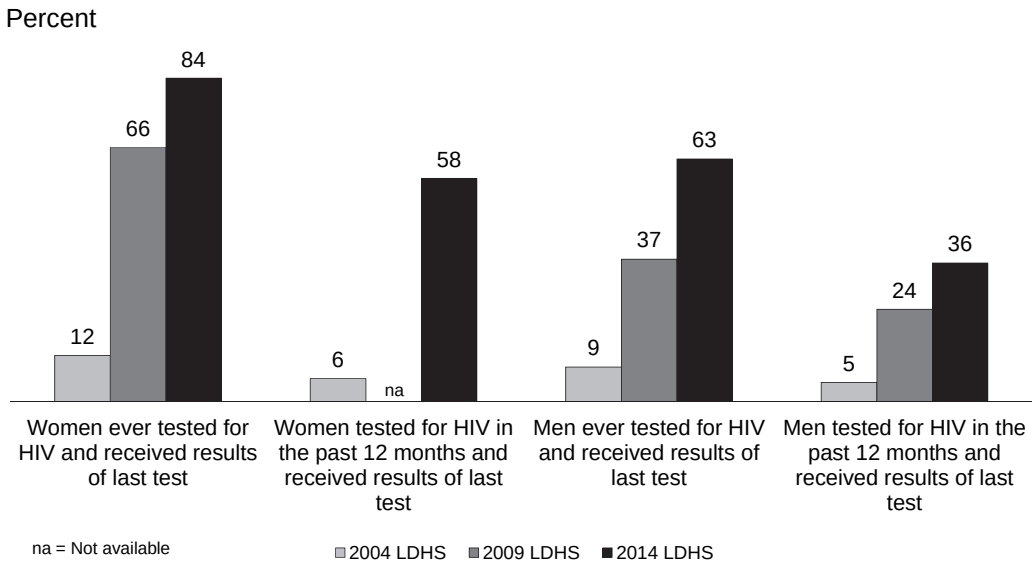
Table 3.19.2 Coverage of prior HIV testing: Men

Percentage of men age 15-49 who know where to get an HIV test, percent distribution of men age 15-49 by testing status and by whether they received the results of the last test, percentage ever tested, and percentage who were tested in the past 12 months and received the results of the last test, according to background characteristics, Lesotho 2014

Background characteristic	Percentage who know where to get an HIV test	Percent distribution of men by testing status and by whether they received the results of the last test: Ever tested and received results	Ever tested, did not receive results	Never tested[1]	Total	Percentage ever tested	Percentage who have been tested for HIV in the past 12 months and received the results of the last test	Number of men
Age								
15-24	87.2	51.2	1.8	47.0	100.0	53.0	28.6	1,252
15-19	84.2	46.1	1.9	52.0	100.0	48.0	24.9	691
20-24	91.0	57.5	1.7	40.8	100.0	59.2	33.1	561
25-29	96.1	71.8	1.9	26.4	100.0	73.6	43.2	410
30-39	95.7	73.8	3.1	23.1	100.0	76.9	43.9	610
40-49	96.1	74.1	3.3	22.6	100.0	77.4	42.6	389
Marital status								
Never married	87.8	54.0	1.6	44.5	100.0	55.5	29.3	1,501
Ever had sex	90.8	57.1	1.7	41.2	100.0	58.8	31.3	1,156
Never had sex	77.9	43.5	1.1	55.4	100.0	44.6	22.5	345
Married/living together	96.6	75.2	2.7	22.1	100.0	77.9	46.2	983
Divorced/separated/widowed	98.9	70.1	6.9	23.0	100.0	77.0	42.9	176
Residence								
Urban	96.6	74.5	2.5	23.0	100.0	77.0	46.7	920
Rural	89.3	56.7	2.2	41.0	100.0	59.0	30.9	1,741
Ecological zone								
Lowlands	94.8	67.7	2.2	30.1	100.0	69.9	39.9	1,711
Foothills	86.5	52.9	2.0	45.1	100.0	54.9	32.0	252
Mountains	85.0	51.5	3.1	45.4	100.0	54.6	27.6	523
Senqu River Valley	90.7	63.8	2.3	34.0	100.0	66.0	34.9	174
District								
Butha-Buthe	91.6	60.2	2.0	37.8	100.0	62.2	37.4	143
Leribe	93.7	68.2	0.0	31.8	100.0	68.2	36.7	390
Berea	91.6	65.7	1.2	33.0	100.0	67.0	37.1	379
Maseru	94.1	68.7	2.9	28.4	100.0	71.6	43.3	809
Mafeteng	94.2	55.4	3.8	40.9	100.0	59.1	30.4	242
Mohale's Hoek	87.3	52.3	3.9	43.9	100.0	56.1	29.6	202
Quthing	88.7	55.9	3.5	40.6	100.0	59.4	25.3	105
Qacha's Nek	94.7	68.8	3.3	27.9	100.0	72.1	36.7	74
Mokhotlong	88.2	54.2	2.5	43.3	100.0	56.7	23.7	144
Thaba-Tseka	83.0	51.2	2.8	46.0	100.0	54.0	34.8	172
Education								
No education	85.1	53.3	5.6	41.0	100.0	59.0	27.0	213
Primary incomplete	84.7	50.4	3.5	46.1	100.0	53.9	26.8	875
Primary complete	95.2	66.5	1.2	32.2	100.0	67.8	38.4	316
Secondary	96.4	70.1	1.0	28.9	100.0	71.1	41.8	1,043
More than secondary	100.0	83.0	2.6	14.5	100.0	85.5	55.8	214
Wealth quintile								
Lowest	83.8	49.2	3.5	47.3	100.0	52.7	22.8	376
Second	89.1	59.5	2.1	38.4	100.0	61.6	33.8	479
Middle	90.6	56.2	2.4	41.4	100.0	58.6	34.7	536
Fourth	93.5	67.9	2.3	29.8	100.0	70.2	38.1	616
Highest	97.9	73.9	1.9	24.2	100.0	75.8	46.0	654
Total 15-49	91.8	62.9	2.3	34.8	100.0	65.2	36.4	2,660
50-59	95.9	71.5	6.4	22.1	100.0	77.9	36.0	271
Total 15-59	92.2	63.7	2.7	33.6	100.0	66.4	36.4	2,931

[1] Includes "don't know/missing"

Figure 3.7 **Trends in coverage of prior HIV testing, women and men age 15-49, 2004-2014**



3.14 MALE CIRCUMCISION

Male circumcision has been associated with a lower risk of HIV transmission from women to men (Williams et al., 2006; WHO and UNAIDS, 2007). In Lesotho, male circumcision that occurs as part of a traditional ceremony within an initiation school is a common practice.

The protective effect of male circumcision on HIV transmission requires complete removal of the foreskin. A recent study among Lesotho Defence Force applicants showed that half of men who reported that they were circumcised retained all or a portion of their foreskin, as assessed through a physical exam (Thomas et al., 2011). The proportion of men having their foreskin completely removed was significantly higher among those who had been medically circumcised than those who had been circumcised in an initiation school. Thus, in some cases, traditional circumcision may not afford the same degree of protection in terms of HIV transmission as medical male circumcision.

In 2012, the Lesotho MOH launched a voluntary male medical circumcision (VMMC) programme. The goal of this programme is to rapidly scale up VMMC in order to reach 80 percent coverage by 2017. This translates into an immediate target of 317,215 men age 15-49 (WHO, 2013).

To examine the practice of circumcision in Lesotho, men interviewed in the 2014 LDHS were asked separately about whether they had undergone traditional circumcision and medical male circumcision. As shown in Table 3.20, 49 percent of men age 15-49 reported that they are traditionally circumcised, 28 percent reported that they are medically circumcised, and 5 percent reported that they are both traditionally and medically circumcised. Overall, 72 percent are either traditionally or medically circumcised.

The proportion of men who report that they are traditionally circumcised increases rapidly with age, from 29 percent among men age 15-19 to 55 percent among men age 20-24, and plateaus at 56-58 percent among men age 25 and older. Traditional circumcision is more common among men living in rural areas than urban areas (61 percent and 27 percent, respectively). The proportion of men who are traditionally circumcised is inversely correlated with education and wealth.

Table 3.20 Male circumcision

Percentage of men age 15-49 who report having been traditionally or medically circumcised, by background characteristics, Lesotho 2014

Background characteristic	Percentage traditionally or medically circumcised	Percentage traditionally circumcised	Percentage medically circumcised	Percentage both traditionally and medically circumcised	Number of men
Age					
15-24	69.7	40.7	34.3	5.3	1,252
15-19	58.9	28.9	33.2	3.2	691
20-24	83.0	55.1	35.7	7.9	561
25-29	76.5	57.8	24.7	5.9	410
30-39	75.0	55.9	22.8	3.6	610
40-49	71.9	56.8	17.1	2.0	389
Residence					
Urban	68.4	27.1	46.4	5.0	920
Rural	74.3	60.8	17.8	4.3	1,741
Ecological zone					
Lowlands	70.4	39.8	35.0	4.4	1,711
Foothills	72.4	63.5	12.0	3.0	252
Mountains	76.7	68.3	14.0	5.6	523
Senqu River Valley	77.3	62.9	19.2	4.8	174
District					
Butha-Buthe	78.2	65.6	17.3	4.7	143
Leribe	74.7	50.5	27.9	3.7	390
Berea	68.9	39.1	34.1	4.3	379
Maseru	68.3	36.0	37.6	5.2	809
Mafeteng	72.9	53.3	22.7	3.0	242
Mohale's Hoek	73.6	64.6	11.4	2.5	202
Quthing	73.7	54.5	27.2	8.0	105
Qacha's Nek	74.8	61.6	20.2	7.1	74
Mokhotlong	77.8	69.1	15.7	7.0	144
Thaba-Tseka	78.8	67.0	14.5	2.7	172
Education					
No education	87.6	86.2	5.6	4.2	213
Primary incomplete	72.6	66.7	10.2	4.3	875
Primary complete	72.9	56.9	19.8	3.8	316
Secondary	68.3	31.9	40.7	4.3	1,043
More than secondary	73.8	12.7	68.8	7.7	214
Wealth quintile					
Lowest	76.8	74.4	6.7	4.4	376
Second	75.3	64.9	15.4	5.0	479
Middle	71.5	56.4	18.4	3.3	536
Fourth	70.2	41.3	33.6	4.7	616
Highest	70.1	24.5	50.6	5.1	654
Total 15-49	72.3	49.1	27.7	4.5	2,660
50-59	70.2	56.4	14.8	1.0	271
Total 15-59	72.1	49.8	26.5	4.2	2,931

The background characteristics of those who report having undergone medical male circumcision differ strikingly from those who report having been traditionally circumcised. Younger men are more likely than older men to report that they are medically circumcised: 34 percent of men age 15-24 report that they are medically circumcised, as compared with 17 percent of men age 40-49. Medical male circumcision is much more common in urban areas than rural areas; 46 percent of men age 15-49 in urban areas report that they are medically circumcised, compared with 18 percent in rural areas. The proportion of men who are medically circumcised rises rapidly with increasing education and wealth. For example, 7 percent of men in the lowest wealth quintile are medically circumcised, as compared with 51 percent in the highest wealth quintile.

Overall, as noted, 72 percent of men age 15-49 reported that they were either traditionally or medically circumcised. In the 2004 and 2009 LDHS surveys, male respondents were asked whether they were circumcised, but no effort was made to distinguish between traditional and medical circumcision. Among men age 15-49 in the 2004 and 2009 surveys, 47 percent and 52 percent, respectively, reported that they were circumcised. Notably, these proportions are similar to the proportion of men in the 2014 LDHS who reported that they had undergone traditional circumcision. Given that VMMC programmes in Lesotho were not initiated until 2012, it seems reasonable to conclude that the majority of men in the 2004 and 2009 LDHS surveys who reported that they were circumcised underwent traditional circumcision.

Millennium Development Goal Indicators

Lesotho 2014

Indicator	Sex: Female	Sex: Male	Total
1. Eradicate extreme poverty and hunger			
1.8 Prevalence of underweight children under age 5	8.3	12.5	10.3
2. Achieve universal primary education			
2.1 Net attendance ratio in primary education[1]	97.5	93.0	95.3
2.3 Literacy rate of 15- to 24-year-olds[2]	98.6	90.6[a]	94.6[b]
3. Promote gender equality and empower women			
3.1 Ratio of girls to boys in primary, secondary, and tertiary education			
3.1a Ratio of girls to boys in primary education[3]	na	na	1.0
3.1b Ratio of girls to boys in secondary education[3]	na	na	1.5
3.1c Ratio of girls to boys in tertiary education[3]	na	na	1.0
4. Reduce child mortality			
4.1 Under-5 mortality rate[4]	82	102	85
4.2 Infant mortality rate[4]	60	78	59
4.3 Proportion of 1-year-old children immunised against measles	92.8	87.6	90.1
5. Improve maternal health			
5.2 Percentage of births attended by skilled health personnel[5]	na	na	77.9
5.3 Contraceptive prevalence rate[6]	60.2	na	na
5.4 Adolescent birth rate[7]	94.3	na	na
5.5 Antenatal care coverage			
5.5a Antenatal care coverage: at least one visit[8]	95.2	na	na
5.5b Antenatal care coverage: four or more visits[9]	74.4	na	na
5.6 Unmet need for family planning	18.4	na	na
6. Combat HIV/AIDS, malaria, and other diseases			
6.2 Condom use at last high-risk sex[10]	81.9	78.7[a]	80.3[b]
6.3 Percentage of the population age 15-24 with comprehensive correct knowledge of HIV/AIDS[11]	37.6	30.9[a]	34.3[b]
6.4 Ratio of school attendance of orphans to school attendance of non-orphans age 10-14	0.95	0.90	0.92
	Urban	**Rural**	**Total**
7. Ensure environmental sustainability			
7.8 Percentage of population using an improved drinking water source[12]	96.3	76.9	82.2
7.9 Percentage of population with access to improved sanitation[13]	49.0	51.6	50.9

na = Not applicable

[1] The ratio is based on reported attendance, not enrolment, in primary education among primary school age children (age 6-12). The rate also includes children of primary school age enrolled in secondary education. This is a proxy for MDG indicator 2.1, net enrolment ratio.

[2] Refers to respondents who attended secondary school or higher or who could read a whole sentence or part of a sentence

[3] Based on reported net attendance, not gross enrolment, among 6- to 12-year-olds for primary, 13- to 17-year-olds for secondary, and 18- to 24-year-olds for tertiary education

[4] Expressed in terms of deaths per 1,000 live births. Mortality by sex refers to a 10-year reference period preceding the survey. Mortality rates for males and females combined refer to the 5-year period preceding the survey.

[5] Among births in the 5 years preceding the survey

[6] Percentage of currently married women age 15-49 using any method of contraception

[7] Equivalent to the age-specific fertility rate for women age 15-19 for the 3-year period preceding the survey, expressed in terms of births per 1,000 women age 15-19

[8] With a skilled provider

[9] With any health care provider

[10] Higher-risk sex refers to sexual intercourse with a non-marital, non-cohabitating partner. Expressed as a percentage of men and women age 15-24 who had higher-risk sex in the past 12 months.

[11] Comprehensive knowledge means knowing that consistent use of a condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission or prevention of HIV.

[12] Percentage of de jure population whose main source of drinking water is a household connection (piped), public tap or standpipe, tube well or borehole, protected dug well or spring, rainwater collection, or bottled water

[13] Percentage of de jure population whose household has a flush toilet, ventilated improved pit latrine, ordinary pit latrine/pit latrine with a slab, or composting toilet and does not share this facility with other households

[a] Restricted to men in the subsample of households selected for the male interview

[b] The total is calculated as the simple arithmetic mean of the percentages in the columns for male and females.

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