2019 Vulnerability Assessment and Analysis Report

Lesotho Vulnerability Assessment Committee (LVAC)

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I.ACKNOWLEDGEMENTS

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Moreover, LVAC would like to express its sincere gratitude to Mr. Brian Svesve from FEWSNET and Mr. Daison Ngirazi who remotely supported the LVAC during data analysis as well as to Ms. Quraishia Merzouk and Ms. Mary Njenga from FAO Kenya who assisted the team during IPC AFI level 1 refresher training and analysis.

1. Introduction

The Lesotho Vulnerability Assessment Committee (LVAC) was established in 2002. It is a government led multi-disciplinary committee within the Office of the Prime Minister- Disaster Management Authority (DMA). Its membership consists of Government Ministries and Departments, United Nations Organizations, Non-Governmental organizations and the Private Sector. It is mandated to carry out livelihood vulnerability analysis and its aim is to provide timely analysis for emergency interventions as well as medium to long-term programming. The process of vulnerability assessment and analysis is currently centralized, although moving towards decentralization whereby district teams are now responsible for data collection in their respective districts and some district members also participated in data analysis.

LVAC has been conducting annual vulnerability assessments (VA) of food security and livelihoods situation for rural population since 2003 to date. In Lesotho, like in most countries the VAA methodology is based on the Household Economy Approach (HEA) that takes a holistic approach to food security based on livelihood systems including all strategies that households apply to make their living and the external context that may support and/or restrain them.

The current year assessment combined HEA methodology with household survey in order to integrate Nutrition, HIV and gender into Vulnerability Assessment and Analysis and also to understand in depth the impact of different shocks on different sectors.

1.1 Objectives:

The main objective was to analyse food and nutrition security, and vulnerability of the population of Lesotho in 2019/2020 consumption year. Provide policy makers, government and other stakeholders with information for decision making and development programming.

1.1.1 Specific Objectives:

1. To estimate the number of vulnerable population, their location and level of severity in Lesotho for 2019/2020 Consumption year.
2. To identify the underlying and immediate causes of food and nutrition insecurity.
3. To provide recommendations for assistance/interventions.

2. The Inquiry Process – Methodology

2.1 Study Design

The assessment was undertaken using Household Economy Approach (HEA) complimented by a household survey to integrate gender, HIV and Nutrition. Secondary data review (literature), key informant interviews (community leaders and key stakeholders) and household questionnaires were used to collect a combination of quantitative and qualitative information regarding food security, nutrition, HIV and gender outcomes. As an overall guide, the analytical framework that informed the structure of the study and design of applied tools was the Food and Nutrition Security Conceptual Framework agreed between SADC member states for integrated assessment and analysis. This was the point of departure in the choice of information that was collected for the study as well as the type of analysis conducted to answer the assessment objectives.

2.2. Implementation Strategy

2.2.1 Primary data collection

Primary data for this study was gathered through individual household sample survey and focus group discussions with key informants providing a process through which data at household and associated analysis outcomes are linked to underlying livelihood system and strategies employed by different wealth groups, providing more disaggregated statistical analysis particularly for nutrition, HIV and gender outcomes. Data collection tools that were used are appended at the end of this report.

2.2.2 Sampling Frame

The survey had employed a representative sample selected from the Sample Master Frame created by the BoS from the 2016 Lesotho Population and Housing Census. The sample design for the survey is a stratified multi-stage cluster sampling and the districts were considered as domains of the survey upon which stratification was considered by rural and urban settlements. Enumeration Areas (EAs), served as Primary Sampling Units (PSUs), were selected at the first stage with probability proportional to size such that population in the EAs served as the measure of size. However, households within the selected EAs were selected in the second stage using systematic sampling technique.

2.2.3. Sample Size Determination

Sample size determination was based on specific assumptions and calculations, hence a sample of 300 EAs with 3,600 households was designed with an aim to yield estimates at a tolerable margin of error of point estimates set a low of 2.0%, and this means that the estimates from this sample are not expected to be in error by more than 2.0%. Alternatively, the estimates are expected to be correct at least by 95% level of confidence. Also using the results from the previous LVAC sampling

methodology, the proportion of the households with the desired characteristics was estimated (estimated prevalence of GAM) at 3.5% and a fixed number of 12 households were therefore interviewed within each EA.

The tables below show the allocation of the sample of EAs by the administrative units (District, Ecological Zone and Settlement Type).

Table 1: Allocation of Sampled EAs by District

District Code	District Name	No of Selected EAs	Number of Households studied within selected EAs
1	Botha Bothe	17	219
2	Leribe	46	426
3	Berea	43	442
4	Maseru	85	771
5	Mafeteng	28	236
6	Mohale's Hoek	24	261
7	Quthing	15	181
8	Qacha's Nek	10	120
9	Mokhotlong	14	156
10	Thaba-Tseka	18	166
Total	Lesotho	300	2978

Table 2: Allocation of Sample EAs by Ecological Zone

Ecological Zone Code	Ecological Zone Name	No of Selected EAs	Households to be studied within selected EAs
1	Lowlands	194	2328
2	Foothills	26	312
3	Mountains	56	672
4	Valley	24	288
Total	Lesotho	300	3600

Table 3: Allocation of Sampled EAs by Settlement Type

Settlement Type Code	Settlement Type Name	No of Selected EAs	Households to be studied within selected EAs
1	Urban	116	1392
2	Peri-urban	24	288
3	Rural	160	1920
Total	Lesotho	300	3600

2.2.4 Household survey:

The household survey collected information on livelihoods, access to health, HIV, gender, water and sanitation and finally on anthropometric measurements (weight (kg), height (m), MUAC (cm) and presence of oedema for children under the age of five. The anthropometric measurements data allowed the computation of current nutrition outcomes. With regards to livelihoods, it should be noted that information collected at this stage was used to strengthen computation of problem specifications that were used to run an outcome analysis for the current consumption year (2019/2020). In addition, the household tool contained several wealth indicators that were used to compute wealth groups and thereby linking the household survey data to HEA information, correlating HEA outcomes with HIV, Gender and nutrition outcomes. In total 2978 household interviews were done and 915 children under the age of five were reached during the survey.

2.2.5 Focus group Discussions with key informants

Group discussions were carried out with 6 to 10 key informants who were mainly the community leaders and other key stakeholders especially government staff working in the area. The discussions with key informants provided an in-depth information about the livelihood key parameters which was used to calculate problem specification for; crop production, livestock herd sizes, labour market opportunities, market prices/rates for income source and expenditures.

2.2.6 Field processes

A 6-day training workshop was held for enumerators in Berea, Blue Moutain Inn hotel. The topics covered included: HEA framework overview, Food and Nutrition security Conceptual framework and the link of the two frameworks for the study. Training also covered administering of the data collection tools and taking of anthropometric measurements.

2.2.7 Field Work Timing

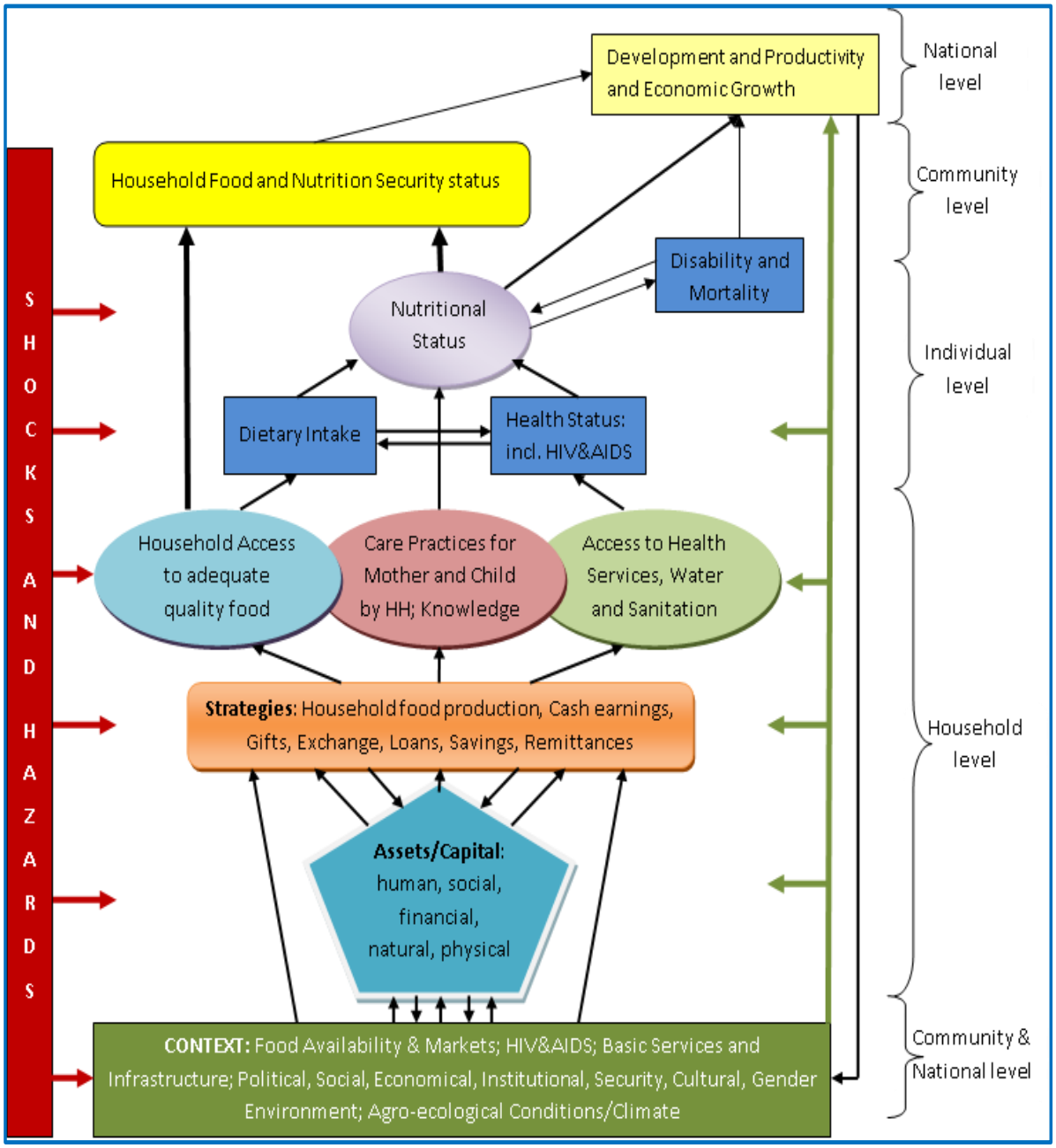
The field work for the study was undertaken in May/June 2019 for 13 days. Trained enumerators were deployed to carry out the assessment with guidance from experienced practitioners from district levels.

2.2.8 Data analysis and report compilation

The data analysis process involved developing analysis of household livelihood strategies and nutrition status for respective wealth groups. Household interview data was analysed using SPSS whilst livelihoods HEA data was analysed using LIAS. Finally, Integrated Food Security Phase Classification (IPC) Acute Analysis was done to estimate the number of rural population estimated to be food insecure in the current consumption year (2019/20) and to classify each district into IPC Phase

based on its level of food insecurity severity. The Consolidated Approach to Reporting Food Security Indicators (CARI) was used to estimate the number of food insecure population within urban settlement. The overall analysis segregated data into rural and urban settlements and also by districts. Secondary data from other sources was also used and some of the data/information was drawn from the 2018 LVAC report and the rapid assessment findings of March 2019.

Figure1: Causal framework for household food and nutrition security, development, productivity and economic



3.0 National Context

Lesotho is a landlocked country surrounded by South Africa. The estimated area is 30,344M² of which three quarters is mountains and the population is estimated at 2 million (BOS Population Projections 2016). It is a lower middle income country ranked 160 of 187 countries on Human development index and 38 of 46 countries on the economic freedom scores in Sub-Saharan Africa Region (UNDP 2016). Inflation rate has increased to 6.6% in June 2019 compared to 3.8% in April 2018.The agricultural sector, which accounts for only 8.6% of GDP, is the main source of income for majority of rural population. In recent years, increasing foreign investments in textile industry and commerce have created more jobs and strengthened the economy. However, widespread poverty, estimated at 53.7%, unemployment (24-28%) and high prevalence rate of HIV (25%) remain the main obstacles to economic growth.

Life expectancy is estimated at 56 years (WHO 2015), national stunting prevalence at 33%, Underweight at 10% and both above the WHO acceptable thresholds while GAM (Wasting)prevalence is 3% and within acceptable levels, mortality rate remained at 85 deaths per 1000 live births, all according to LDHS 2014.

Crop production is predominantly rain-fed. Compared to the previous year, food security situation in the country has declined due to decreased agriculture production, hence the country will have to supplement this with imports from abroad.

Price projections indicate that prices for maize meal are increasing in a stable rate and are above the previous year prices by 12.5% but less than five year average. Purchasing power was negatively impacted due to decline in agricultural labour activities. However, prices for labour and livestock slightly increased. Price for a kg of maize meal is M9.00 which is 12.5% greater than last year and higher compared to M3.00 in the reference year (2009/10). The country depends mostly on purchases of cereal and is therefore vulnerable to any price increase from imports.

3.1 Household demographics

Household Size: The average household size was found to be four (4) in both rural and urban settlement.

Households studied: 2978 household were studied across the country. The highest number were in Maseru (25.9%) followed by Berea (14.8%) and Leribe (14.3%), while the lowest were in Qacha's Nek (4%) and Mokotlong (5.2%). By settlement type 65.2% were in rural areas. Most of the households studied were in the Northern lowlands and Mountains livelihood zones.

Table 4 Number of studied households

Number of Households studied by District

District	No. of Households	Percent
Butha-Buthe	219	7.4
Leribe	426	14.3
Berea	442	14.8
Maseru	771	25.9
Mafeteng	236	7.9
Mohale's Hoek	261	8.8
Quthing	181	6.1
Qacha's Nek	120	4.0
Mokhotlong	156	5.2
Thaba-Tseka	166	5.6
Total	2978	100.0

Sex of Household Heads: In rural area male headed households were at 54.7% while female headed households were at 45.3%.

Marital Status of Household Head: most households were headed by married persons living together at 46.1%, followed by widowed household heads at 32.1%. Proportion of households headed by never married persons was 8.5%, married living apart was 8% and divorced/separated was 4%.

Education Level of Household Head: Most of households heads (52.9%) indicated to have acquired primary education followed by secondary at 16.6% and no education at 12.5%. Other household heads responded to have achieved technical and university levels at 4.2% and 2.4% respectively most of which came from urban areas as compared to rural areas. 2% indicated that they have informal education.

School Enrolment: 8.8% indicated to have children who were not going to school. The Percentage of children who were not going to school were 11.3% in rural areas and 4.3% in Urban areas.

Reasons for Not Attending School: 2.5% indicated that they did not attend school due to expensive school fees, 1.1% were not interested, 0.5% were herdboys while 0.4% were ill.

Household Head Age Category: 74.5% were headed by 18-64 age group followed by 25.4% of the elderly headed while 0.1% of the households were child headed.

Economically Active Households: Of the sampled households 66.1% of them were found to economically active.

Households with Orphans: .13.7% reported to have orphans under the age of eighteen years. Most of the orphans were reported rural settlement.

Households with Disabled Members: 10.3% had a member with disability.

3.2 Seasonal Performance

Agricultural season started later than normal (November/December 2018) as a result of late onset of rainfall and that was accompanied by dry spells and extreme high temperatures during the November 2018 to January 2019 period. Normalised Difference Vegetation Index (NDVI) indicated that the level of vegetation was below average by about 10 to 20 percent which was the indication of low vegetation cover. Other parts of the country received localised hailstorms that caused a damage in crops. According to the department of Water Affairs, Water levels from the main rivers (Mohokare, Makhaleng and Senqu) and Metolong dam remained on average due to good rains received from February to April 2019. Water levels from two main dams are way below long term average, Katse dam 28%, Mohale dam 33% full.

Figure 2 Cumulative rainfall in Leribe district (northern side of the country)

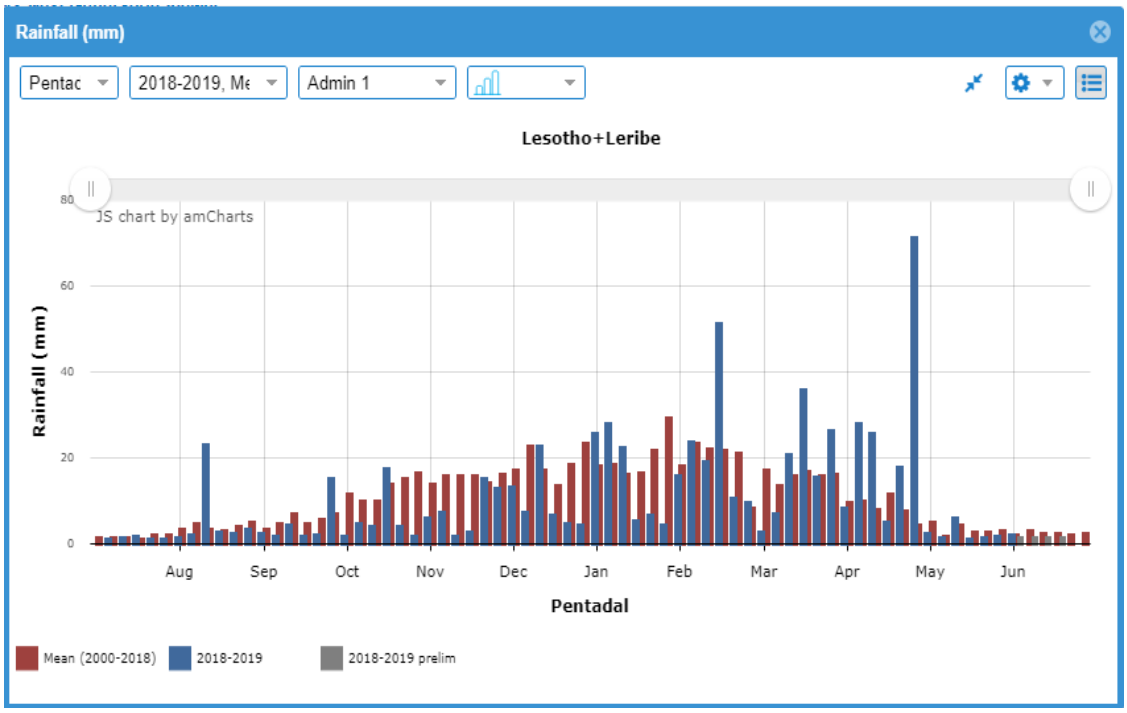
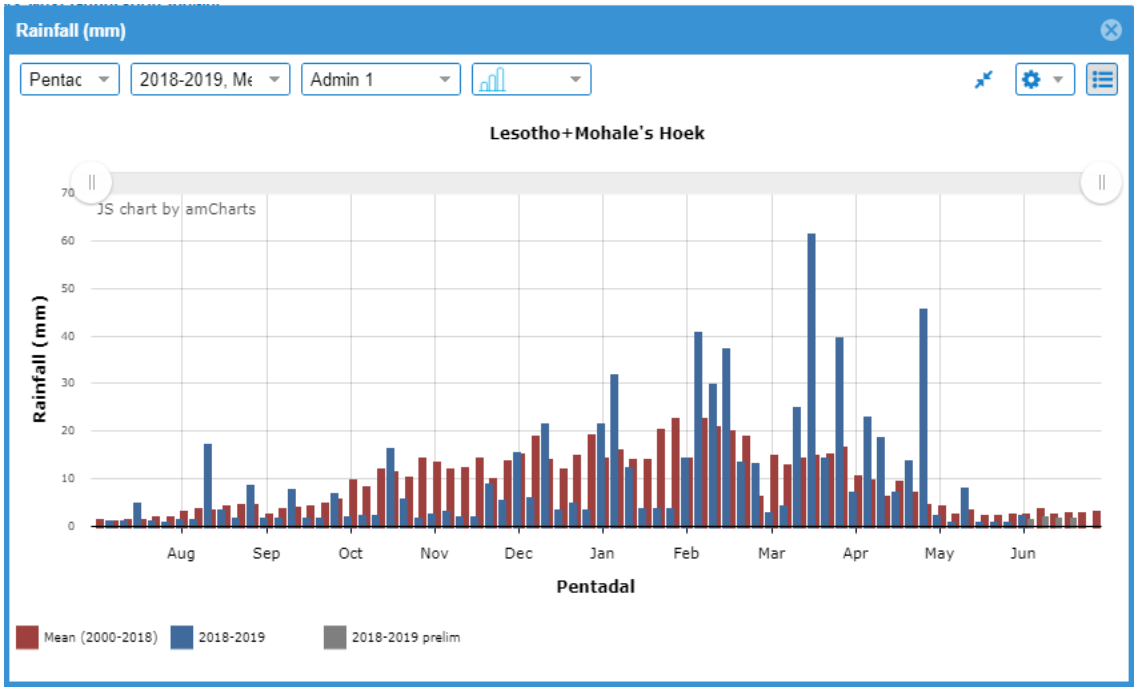


Figure 3 Cumulative rainfall in Mohale's Hoek (southern side of the country)



4. Food Availability

Food availability covers whether adequate food is ready at people's disposal focusing more the supply side determined by the level of food production, stock levels and net trade.

4.1. Crop Production

2018/2019 agricultural season was delayed by the late onset of rains, coupled with extreme hot temperatures. And for the districts which planted on time, especially those ones in the mountain areas, experienced the poor germination of crops due to low soil moisture content while those who planted late especially in the foothills and lowlands, the crops did not reach quality maturity. Other shocks which affected the crops were the prolonged dry spells, hailstorms and crop pests. These driven weather conditions, had contributed drastically to the decline of cereal production intensifying food insecurity situation for 2019/2020. These unfavourable climatic conditions also negatively affected the livestock production due to poor rangelands performance as the available grass did not meet the livestock food requirement.

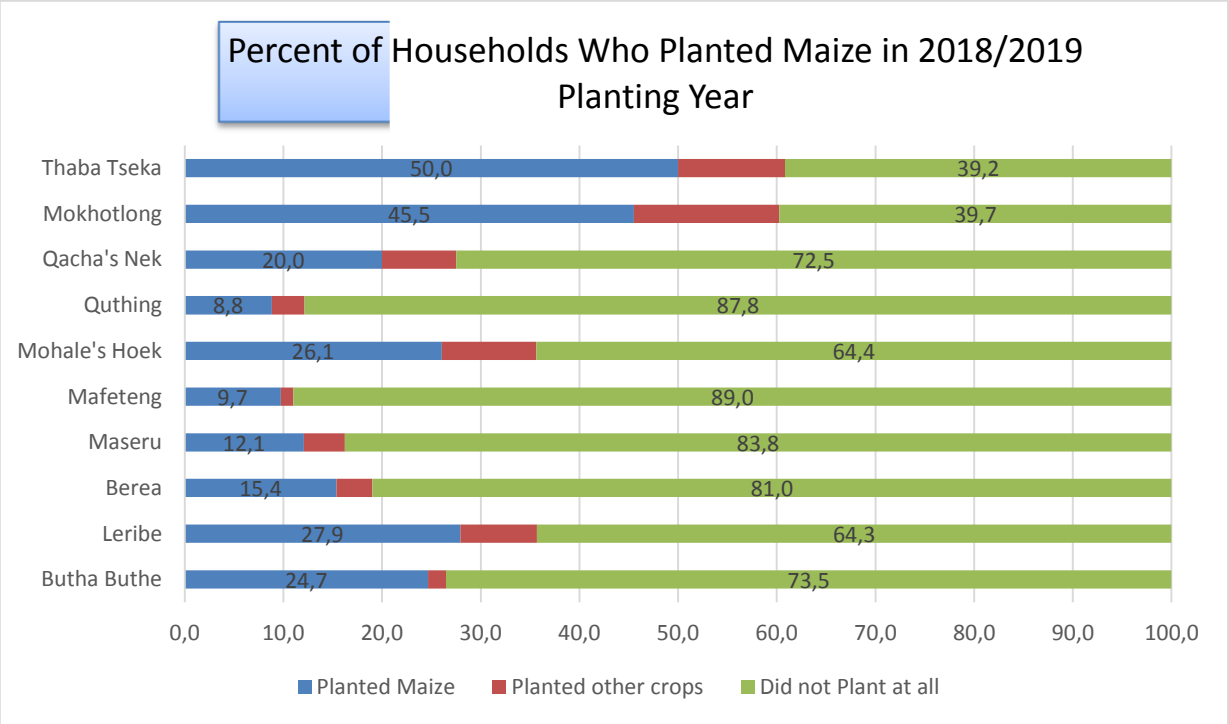
Table 5: Area Planted, Yield and Production of Maize by District for 2018/2019 Agricultural Year

District	Area Planted (ha)	Yield(mt/ha)	Production(mt)
Botha-Bothe	1,267	0.58	737
Leribe	9,661	1.35	13,020
Berea	6,984	1.26	8,788
Maseru	7,810	0.63	4,947
Mafeteng	3,642	0.60	2,172
Mohale's Hoek	2,675	0.19	514
Quthing	1,037	0.07	72
Qacha's Nek	1,407	0.01	11
Mokhotlong	4,742	0.52	2,465
Thaba-Tseka	5,071	0.40	2,008
Lesotho	**44,296**	**0.78**	**34,734**

According to Bureau of Statistics report (2018/2019), the trend of area planted for maize for a period of five years (2014/2015 to 2018/2019) shown on the table above that, the total area planted has been fluctuating throughout past five the years. When looking at the years, 34.2 % decline was experienced from 2014/2015 to 2015/2016. A further drastic increase from 73,506ha was observed from 2015/2016 to 2016/2017. Another decline was observed, from 146,313ha to 44,296ha in 2017/2018 to 2018/2019.

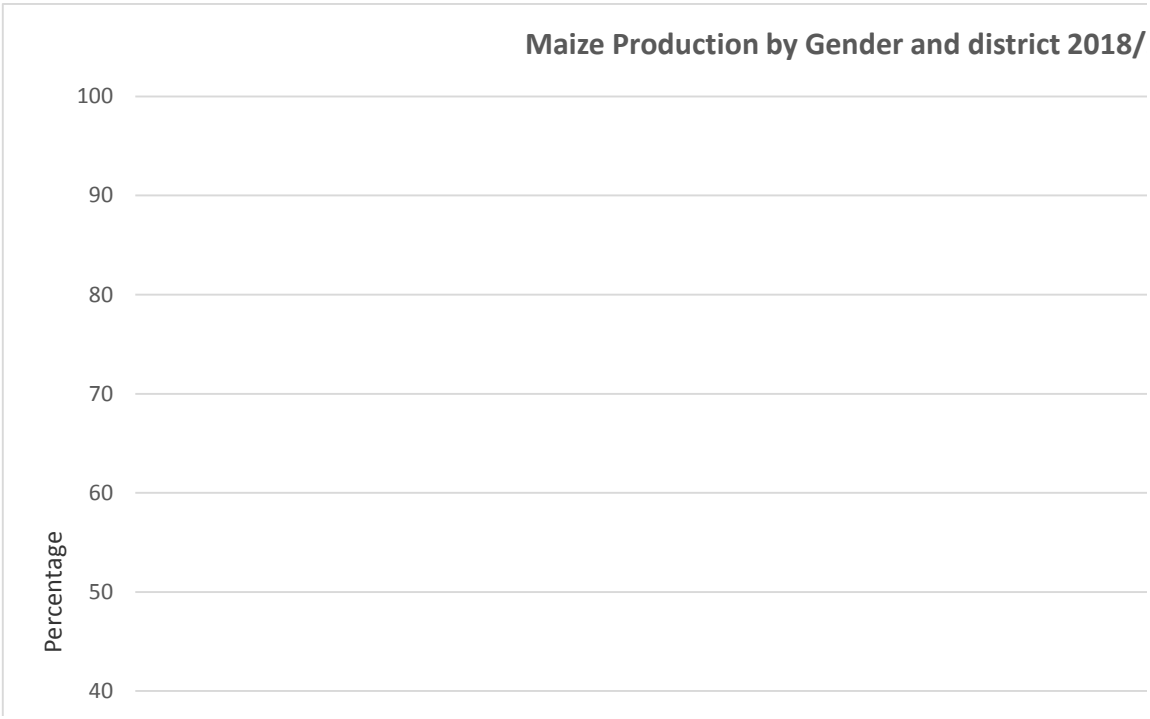
From the data that has been provided by BoS (2018/2019), the area planted for maize seemed to be increasing during the years where there was good onset of rainfall coupled with timely inputs support to the communities from the government subsidy and local development partners like Food and Agriculture Organization (FAO) and Catholic Relief Services (CRS). When the area planted for maize is decreased, the production is also negatively affected like now the country has experienced a drastic maize production decrease of 68.4 percent in 2018/2019.

Figure 4: Maize production in 2018/19 season



Less than 50% of the households from the 9 districts in the country did not plant for winter season due to drought and some other weather related factors like the late onset of rainfall. Only Thaba Tseka district households, 50% of them planted. All in all, over 60% of the households indicated that they did not plant as a result of current drought which badly hit the main planting season, resulting into a negative impact to food security in the country, which might also influence a decrease in the household dietary diversity, increasing the food consumption gaps. Additionally, most of the households, especially the very poor and poor households are expected to experience a lean season earlier than expected.

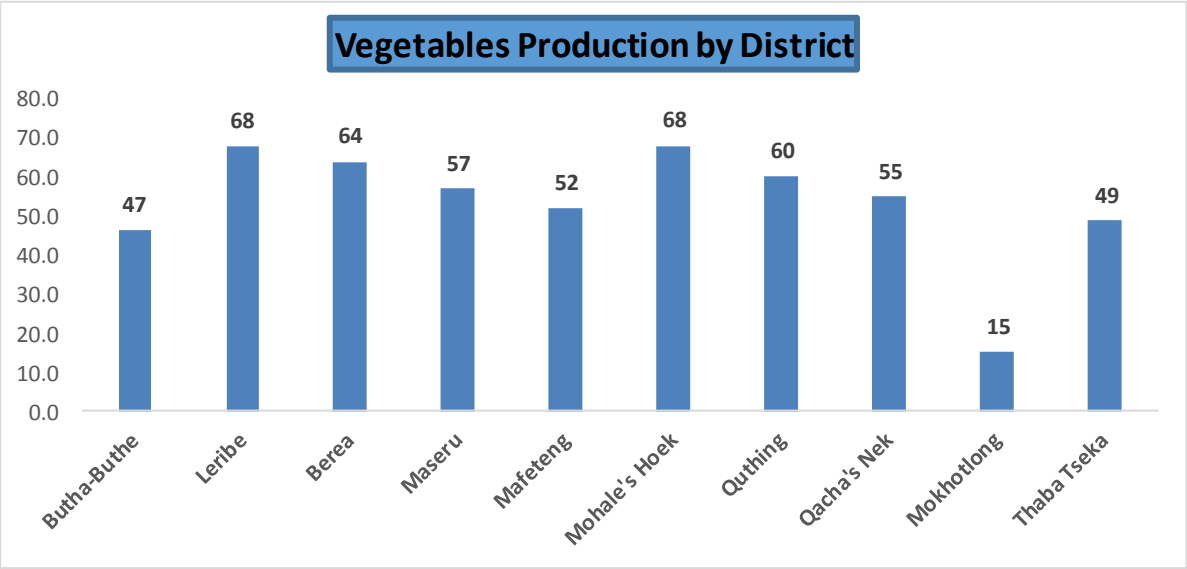
Figure 5: Maize production by district



More males have been engaged in maize production from all the districts than females. This could be due to the fact that mostly males are the one who decides on which crops the households should plant than the females. The most prominent district where males produced maize are Thaba Tseka (59%) followed by Mokhotlong (45%).

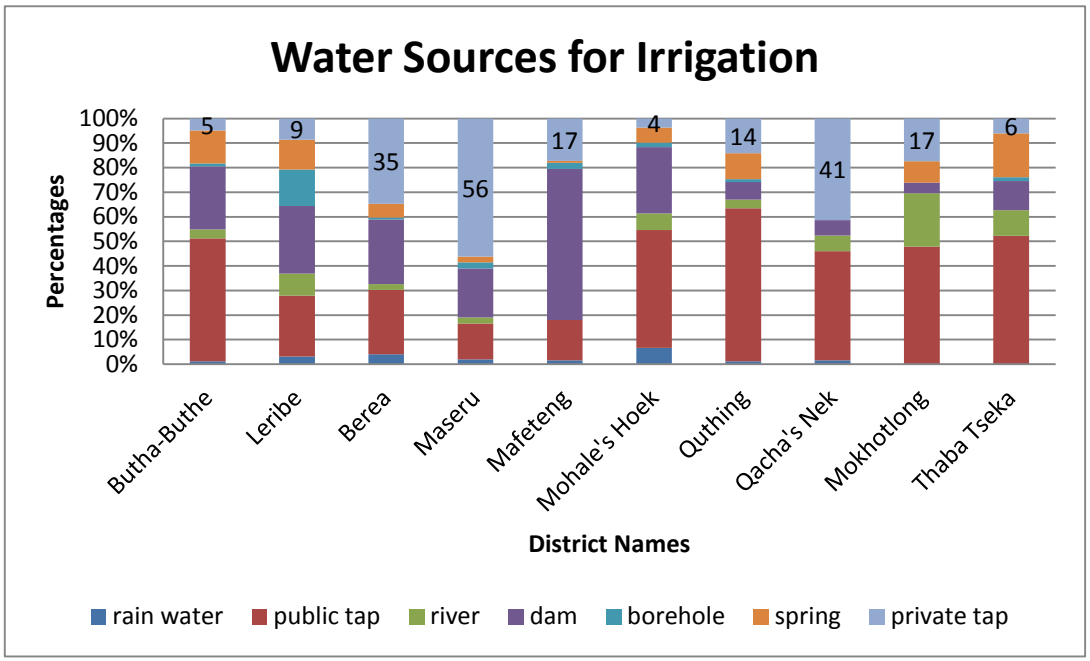
4.2 VEGETABLE PRODUCTION

Figure 5.1 Vegetable production



Over 50% of households in Leribe, Berea, Maseru, Mafeteng, Mohale's Hoek, Quthing and Qacha's Nek had planted vegetables and in other districts only less than 50% were engaged in vegetables production. Four main vegetables which were planted are spinach, mustard, English rape and cabbage in all districts. Compared to the previous year, most households indicated that they planted the same area followed by those that planted less due to the prevailed drought in that planting season (2018/2019). Only Thaba Tseka (38.3%), Leribe (39.3%), and Mokhotlong (50%) planted less area on vegetables while the remaining districts planted the same area. A decreased area planted is likely to impact negatively on food availability. Over 70% of households that planted vegetables pointed out that they irrigated their gardens. Irrigation of vegetables contributed positively to their growth hence availability of different types of vegetables in the households.

Figure 6: sources of water for irrigation

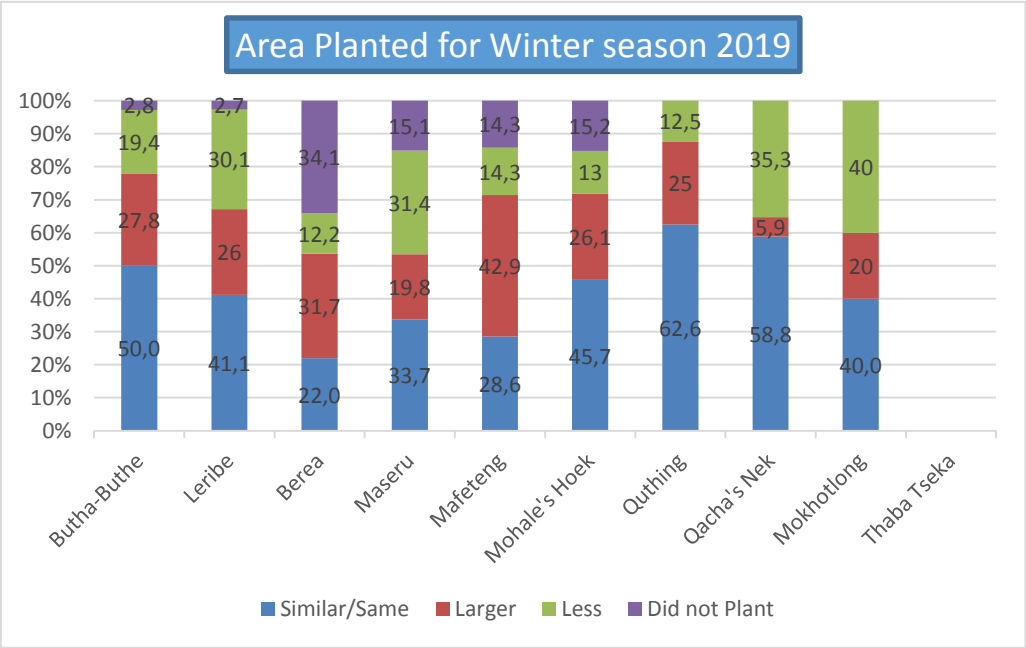


Majority of households used public taps to irrigate their vegetables, followed by dams and private taps especially in the districts like Maseru, Berea and Qacha's Nek. Most households used watering cans to irrigate their vegetables because it is easier to access in affordable costs. Households also mentioned that watering cans save water and do not destroy plants when watering.

4.3 Winter Cropping

The proportion of households that were engaged in winter cropping was higher in Mohale's Hoek (17.6%), followed by Leribe (17.1%) and Botha Bothe (16.4%). It should be noted that overall, less than 20% showed that they engaged in winter cropping.

Figure 7: Area planted for winter season

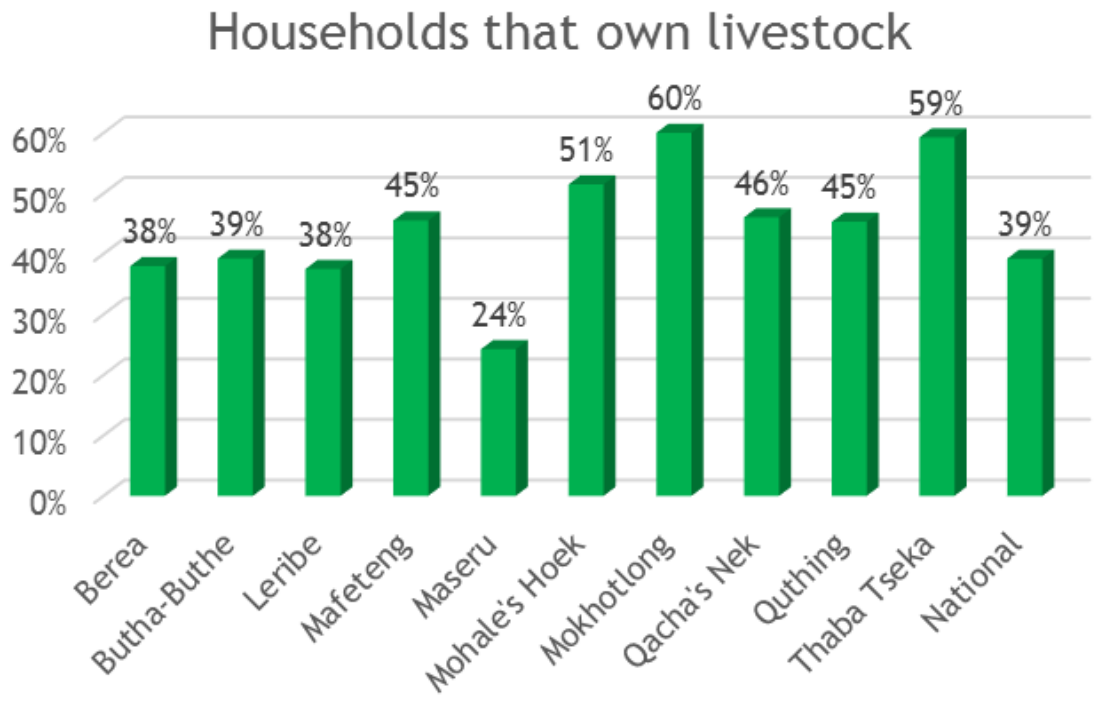


Majority of households that engaged in winter cropping planted the same area compared to the previous season. The main crops that are planted for winter cropping are vegetables followed by peas, wheat and fodder. However, wheat seeds were not easily accessed for the winter cropping due to poor supply. It was found that most households do not engage in fodder production and this shows that there is a need to sensitise the communities to realise the importance of producing fodder. The findings indicated that most households who planted during winter season, planted OPV untreated seeds from the last season harvest. In Maseru district, most households planted hybrid seeds than any other types of seeds and this is because households are able to access seeds from local seed vendors as well as from the government.

4.4 LIVESTOCK PRODUCTION

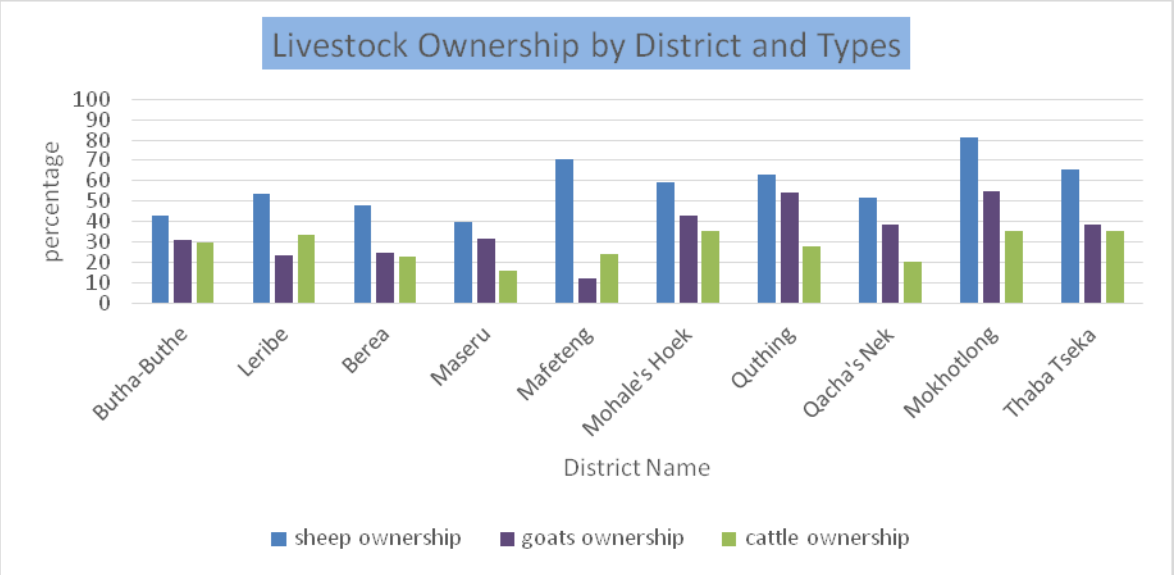
The Vulnerability Assessment and Analysis also captured information on livestock ownership and its dynamics in order to monitor whether there is any improvement or deterioration. The main reason to collect such information is to understand the impact of any hazard on livestock because a significant percentage of households especially in the Mountains and Foothills depend mostly on livestock production as their means of living.

Figure 8 Livestock ownership



Overall, 39% of households owned livestock. Highest number recorded in Mokhotlong (60%), Thaba-Tseka (59%) and Mohale's Hoek (51%) districts. On average 29% of households owned cattle each household with an average of 3 cattle.

Figure 9 livestock ownership



Sheep and goats ownership appeared to be the most dominant in all districts. The prominent districts with high percentage of sheep ownership were Mokhotlong (81.4%), Mafeteng (70.7%) and Thaba Tseka (65.6%).

Table 6: **Price of livestock by districts**

District	livestock average prices by Districts		
	Cattle (M)	**Goats (M)**	**Sheep (M)**
Botha-Bothe	7500	500	900
Leribe	7000	500	900
Berea	7200	500	900
Maseru	7500	500	900
Mafeteng	7800	500	1000
Mohale's Hoek	7200	500	900
Quthing	7700	600	900
Qacha's Nek	7100	600	900
Mokhotlong	5400	500	800
Thaba Tseka	5600	500	800

The average prices for Botha Bothe, Leribe, Berea, Maseru, Mafeteng, Mohale's Hoek, Quthing and Qacha's Nek districts, ranged from M7,000.00 to M7,800.00 while in Mokhotlong and Thaba Tseka ranged from M5,400.00 and M5,600.00 respectively. The average sheep prices for all districts ranged from M800.00 to M1,000.00 and for goats, the average prices ranged M500.00 and M600.00.

5.0 Food access

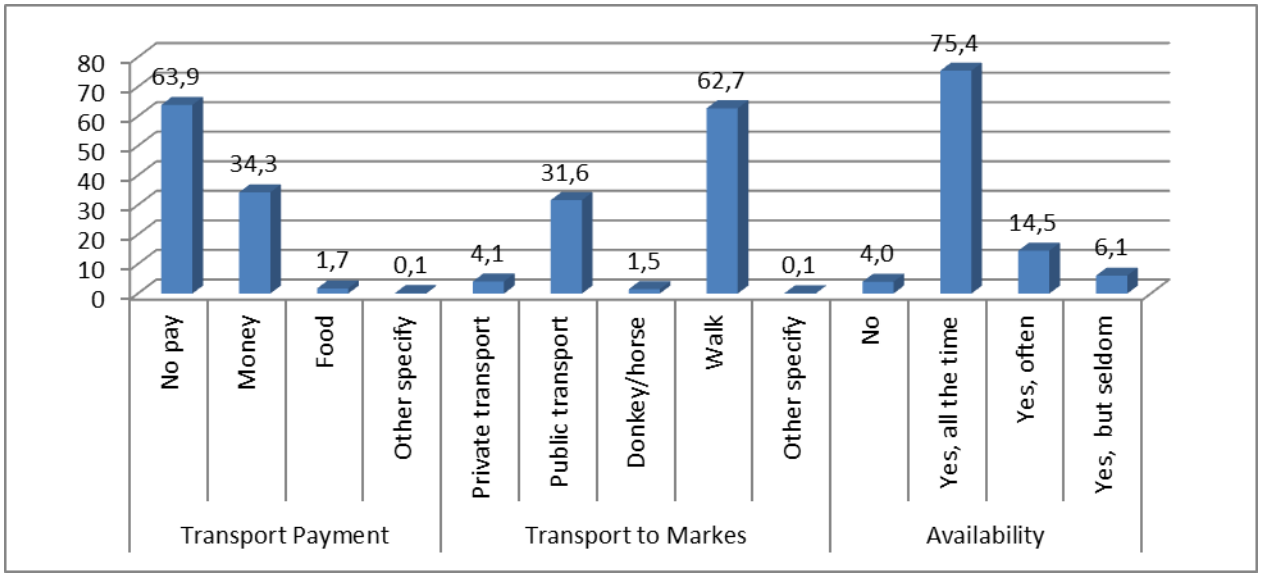
This section presents factors that contributed to food access[1]. Indicators assessed in this section include access to markets, food prices, food expenditure, sources of food, livelihoods and shocks that hindered household ability to obtain food.

5.1 Access to markets: markets played a vital role in food access as most households obtained their food through purchases. Although not in depth, this assessment tried to establish whether households were able to access markets by looking at physical access to markets as well as food prices. Most households (63%) walked to the markets, some (32%) used public transport, while few rural households used horses/donkeys, and in urban areas, few households also used private transport to reach the markets. At least % 34% indicated that they paid money for transport.

The majority of households (75% including HIV affected households were satisfied with availability of food in the markets, indicating that food commodities were always available. Only 14% stated that food commodities were frequently available, especially in rural areas, meaning that there were times when some food commodities were not available in the markets. Based on this analysis, generally many households were able to reach the markets and food commodities were available most of the time, implying that markets functioned well in most areas.

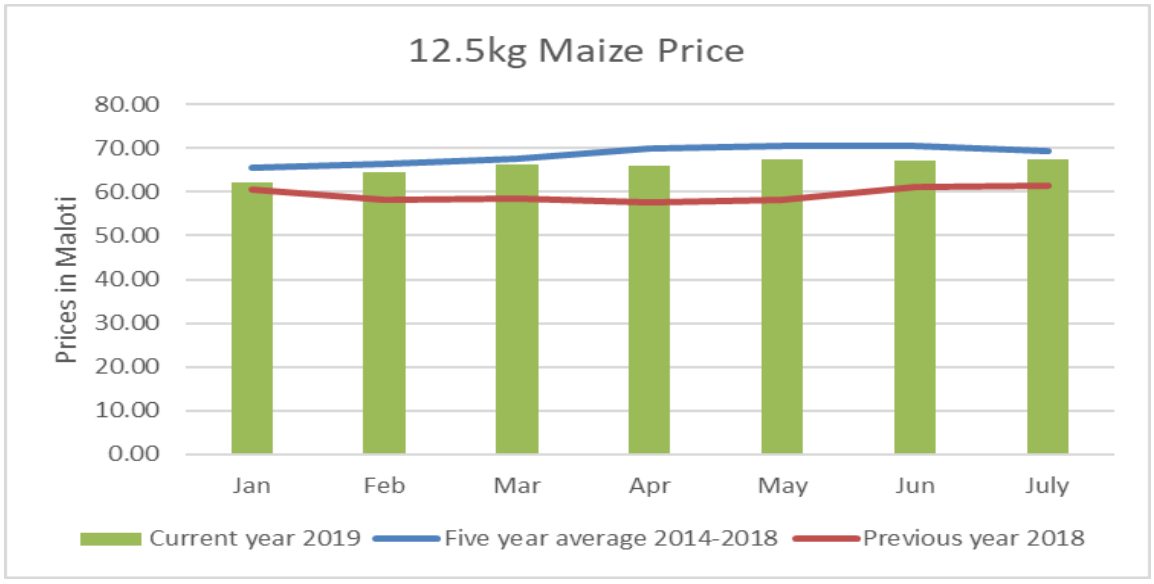
Figure 10: Access to markets

[1] Food access refers to household ability to obtain food through different means in order to ensure food security



***5.2 Food prices*:** prices are the determinants of food purchases, which either enable or restrict households to buy variety of foods from the markets. Low food production in a row is exposing poor households to high prices as they will have to rely more on markets. Secondary data (BOS 2014-2019) was used to present price trend in staple food, using 12.5kg maize meal. Overall, prices presented a stable trend since May 2019. Compared to last year, prices of maize meal were higher by an average of 10%. Even though the prices were higher than last year they were slightly lower than five year average. Low food prices enable households to obtain food through the markets, although this largely depends on household purchasing power

Figure 11: Average price of 12.5 kg maize meal



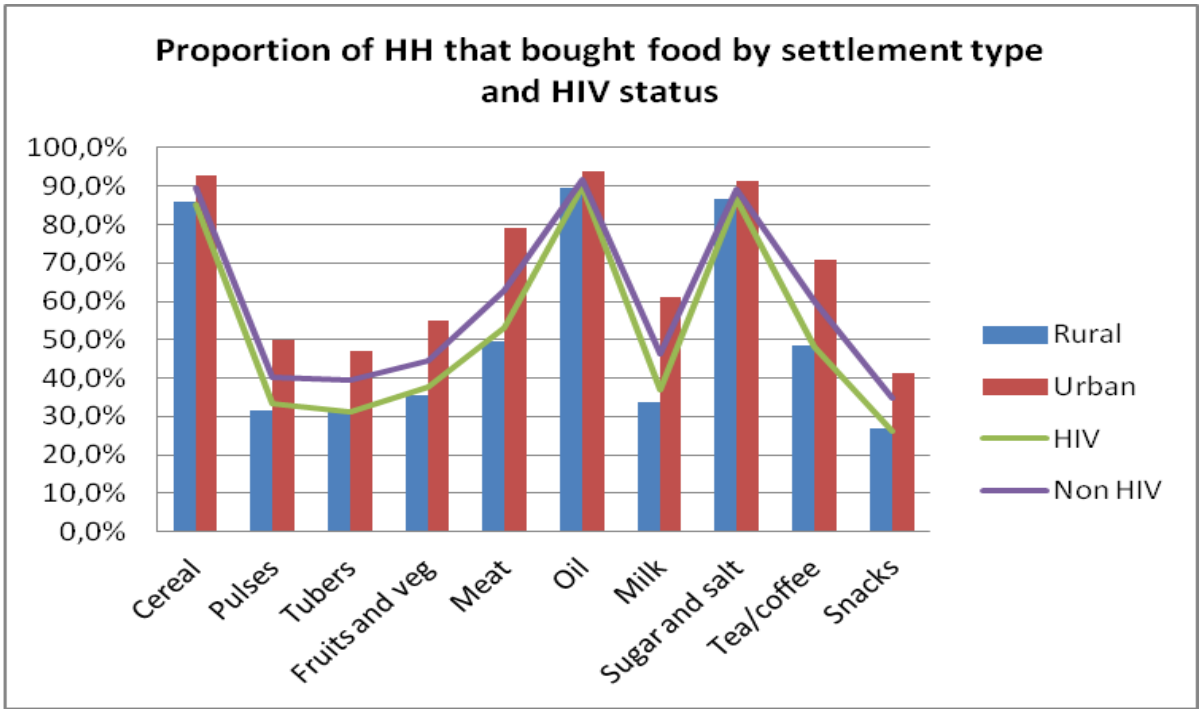
5.3 Prices of basic food commodities: prices of other basic food commodities were also collected. For most commodities, prices in urban areas were slightly lower than prices in rural areas. By districts, prices in the highlands districts were higher than in other districts. Prices in Mohale's Hoek followed almost the same pattern as prices in highlands districts.

Table 7: Prices of basic food commodities

Prices of basic food commodities						
	500g salt	**12,5kg maize meal**	**500g beans**	**750ml cooking oil**	**500g sugar**	**Head cabbage**
District						
Berea	5.84	67,04	11,96	17,50	9.13	18.33
Butha-Buthe	4.98	61,27	11,71	19,69	9.36	14.68
Leribe	5.22	66,91	11,41	16,68	8.98	16.14
Mafeteng	5.78	64,44	11,75	17,94	8.88	25.34
Maseru	5.84	63,77	12,64	18.85	8.86	23.12
Mohale's Hoek	6.08	76,45	12,31	18,32	9.25	24.58
Mokhotlong	6.50	71,32	13,50	19.32	9.23	22.21
Qacha's Nek	6.89	64,57	14,52	21,00	9.82	36.23
Quthing	5.65	65,69	12,21	17,55	8.72	30.17
Thaba Tseka	6.60	71,22	13,11	19.44	9.97	18.60
Settlement type						
Rural	5.95	8.20	23.42	19.05	9.32	22.94
Urban	5.65	8.24	22.67	18.20	8.76	20.12
Total	**5.82**	**8.21**	**23.08**	**18.71**	**9.07**	**21.69**

5.4 Food purchases*:* this section looks at the extent to which households bought different food commodities. Generally the higher proportion of urban households bought different food commidities compared to rural households. In both settlements, the most commonly purchased food commodities were cereal, oil and sugar/salt. Over 80% of total households bought cereal, with 85% in rural areas and 90% in urban areas. This showed an increasing proportion of rural households (85%) buying cereal compared to last year (75%), the urban areas trend remained the same. More than half of urban households bought protein rich foods (meat, milk, pulses) while less than 40% of rural households bought these food commodities. Urban households also bought tubers and fruits/vegetables more than rural households. Based on this analysis, many households bought more of cereal, oil and sugar than other food commodities, indicating that majority were not able to buy a variety of food, which could be due to low purchasing power.

Figure 12: Households that bought commodities by settlement type

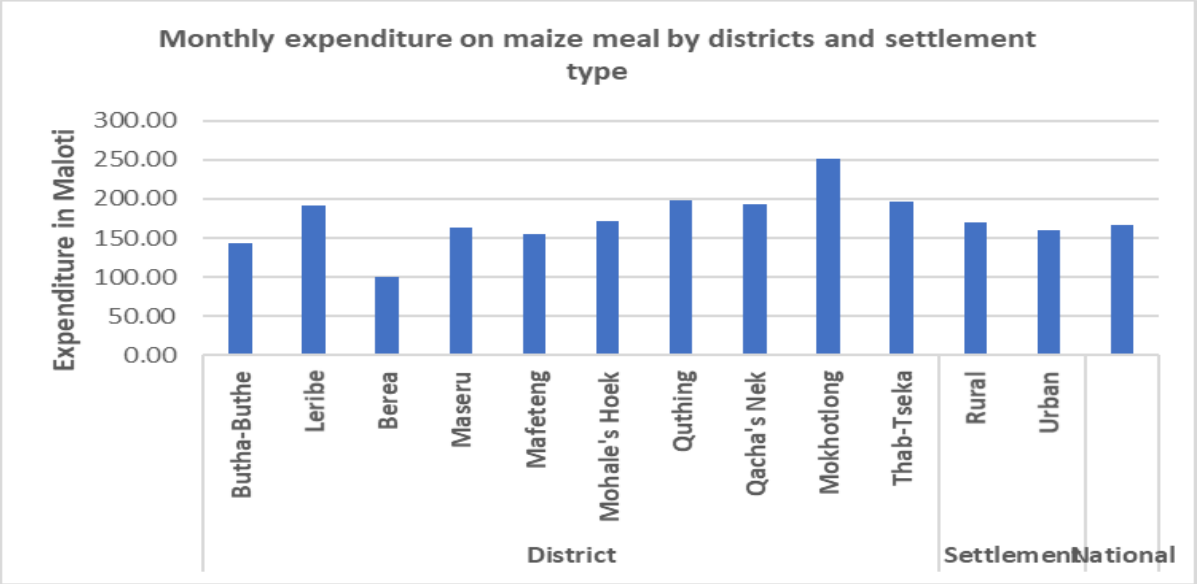


5.5 Expenditure on food[2]: food expenditure was analyzed considering cash, credit and monetary value of non-purchased food. On average urban households spent higher on food (M560) compared to rural households (M453). Most households spent their income on cereal, with an average expenditure of M160.00 on maize meal, which indicated that mostly the quantity bought was 12.5kg-25kg of maize meal per month. This indicates a 32% increase in average maize meal expenditure compared to last year with an average M121. Households in the highlands districts (Thaba-Tseka, Mokhotlong, Qacha's Nek and Quthing) spent more on cereal (M190.00 to M250.00) than other households, while there was no significant difference in cereal expenditure between rural and urban households. Figure 11: Monthly expenditure on cereal

The second food commodity with relatively higher expenditure was meat, with an average of M128.00 per month. Maseru recorded the highest expenditure of M168.00, while Mohale's Hoek recorded the lowest expenditure of M60.00. Urban households spent more on meat (M161.00) than rural households (M100.00). many households also spent their income on buying cooking oil, sugar and pulses. Monthly expenditure on different food commodities has increased in all districts compared to the same time period in the previous year. This is due to the decreased crop production and increased prices.

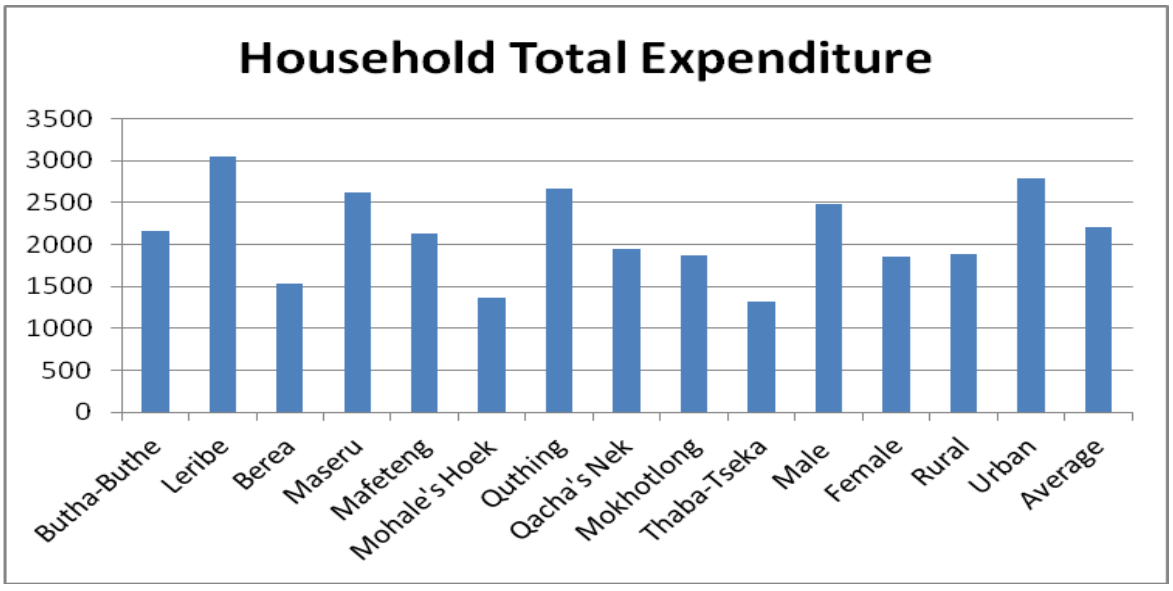
Figure 13: Monthly expenditure on cereal

[2] Food Expenditure refers to monetary value of food through cash, credit and non-purchased food.



5.6 Average total expenditure[3]**:** On average total expenditure on food and non food items was estimated at M2200.00 per month. There were slight variations in expenditure between different households. Average expenditure for urban households was slightly higher (M2787.00) than rural households (M1891.00); male headed households had higher average expenditure (M2488.00) than female headed households (M1858.00).

Figure 14: Household expenditure on food and non-food

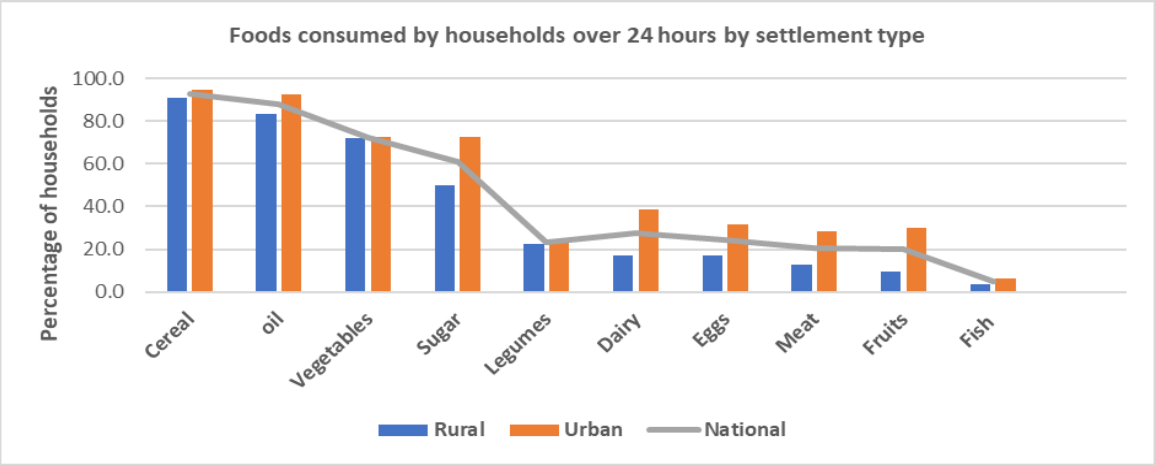


[3] Average total expenditure refers to expenditure on food over a period of a month, expenditure on non-food over a month and non-food over six-month period.

5.7 Food consumed: Proportion of households who consumed different foods was analysed to determine whether households diversified diet over 24 hour period. Foods that were eaten by almost 90% of housheols were staple and cooking oil, followed by vegetables at 72% and sugar at 61%. The rest of the foods were consumed by less than 40% of households.

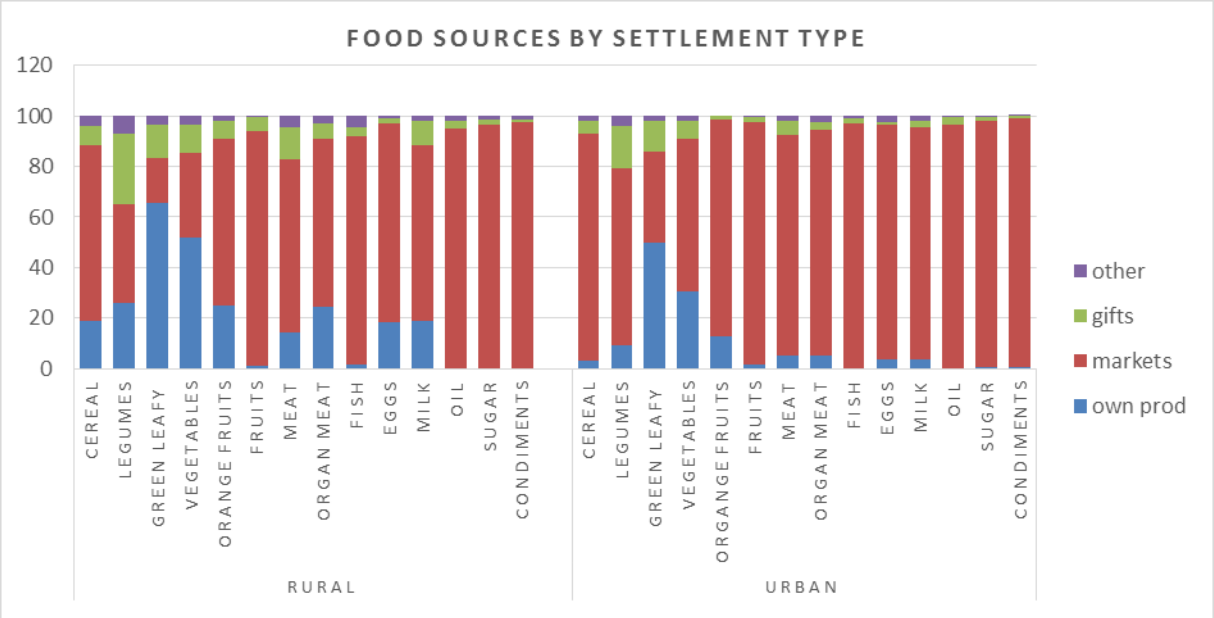
Higher proportion of urban households (6%-38%) ate protein-rich foods (meat, fish, eggs and dairy) than rural households (4%-17%) and 30% of urban households consumed fruits compared to 10% in rural setting.

Figure 15: Foods consumed over 24 hour period



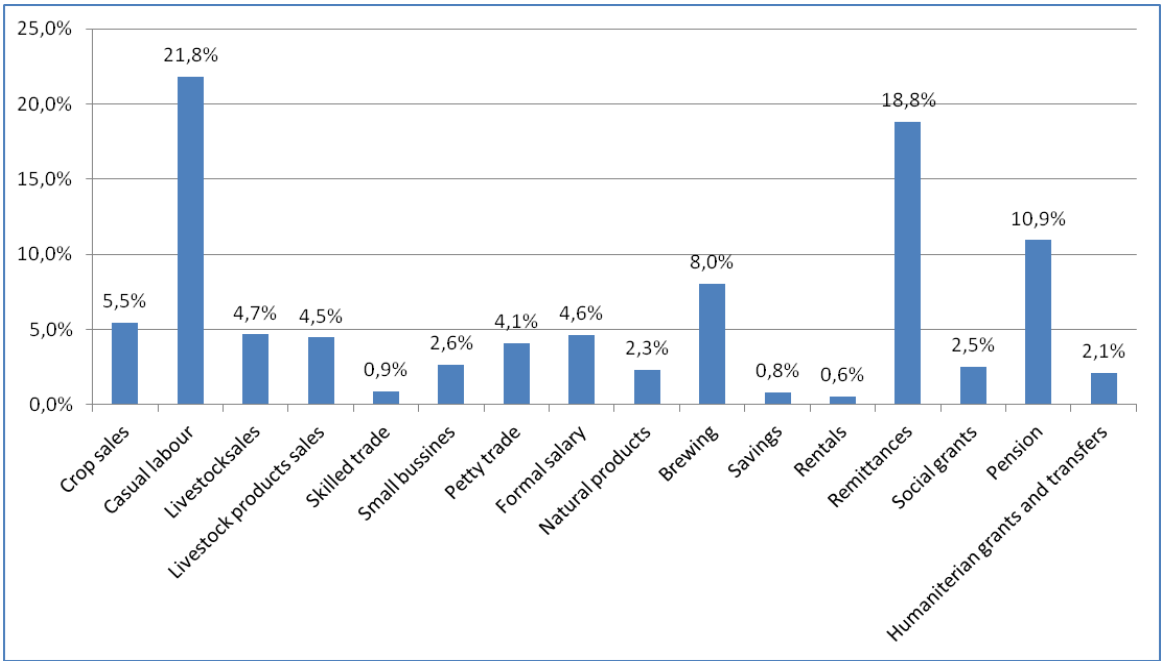
***5.8 Sources of food*:** most households obtained their food through purchases irrespective of whether they were located in rural or urban areas. Own production especially of vegetables was also common in both settings. Gifts from relatives and friends seemed to be significant sources of food in the rural areas;

Figure 16: Food Sources by Settlement type



5.9 Livelihood sources:

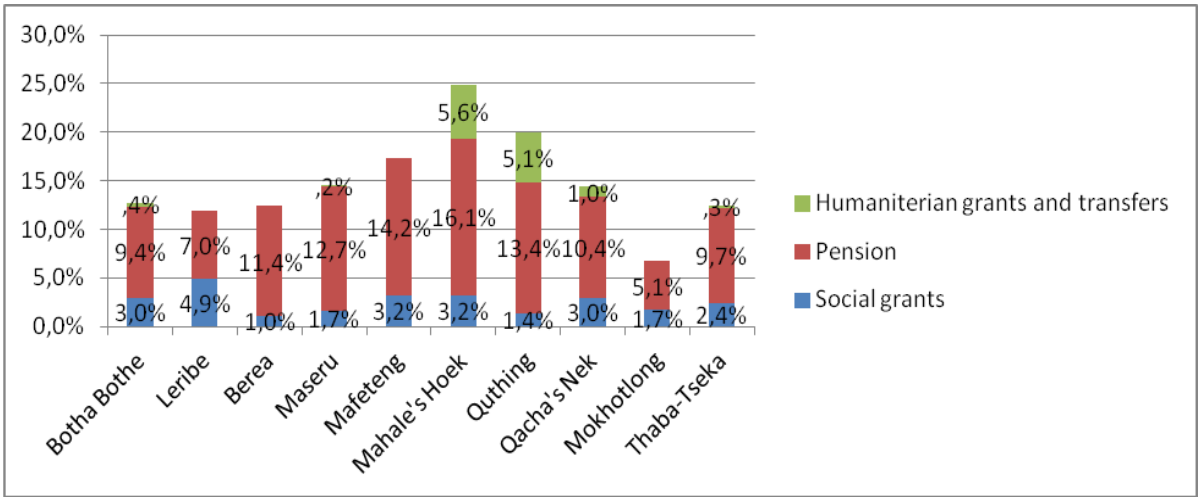
Table 17:Livelihood sources at national level



Livelihood sources were analyzed to determine household means of food and income. Due to contextual factors such as prolonged dry spells many households are expected to rely on these livelihoods for few months in 2019/20 consumption year. One of the most important livelihood sources is agriculture based casual labour which indicated a 20% decline compared to the previous year due to late onset of rains. Remittances/gifts (18.8%) showed a slight decrease of 6% compared to the previous year and pension (10.9%) remained stable. Other livelihood sources were used by less than 10% of households. Casual labour was common across all districts with an average of 21.8%. Most districts recorded between 12% and 26% of households that relied on remittances, Maseru 23%, Mafeteng 26.6%, Mohale`s Hoek 23.9% and Qacha`s Nek 22.3%. It was found that most HIV affected households relied on casual labour (27.5%) and remittances (20.8%). Brewing was common in Mokhotlong (18.5%) and Thaba-Tseka (22%); while about 10% of households in Botha-Bothe and Leribe districts relied on crop sales.

5.10 GRANTS BASED LIVELIHOODS SOURCES

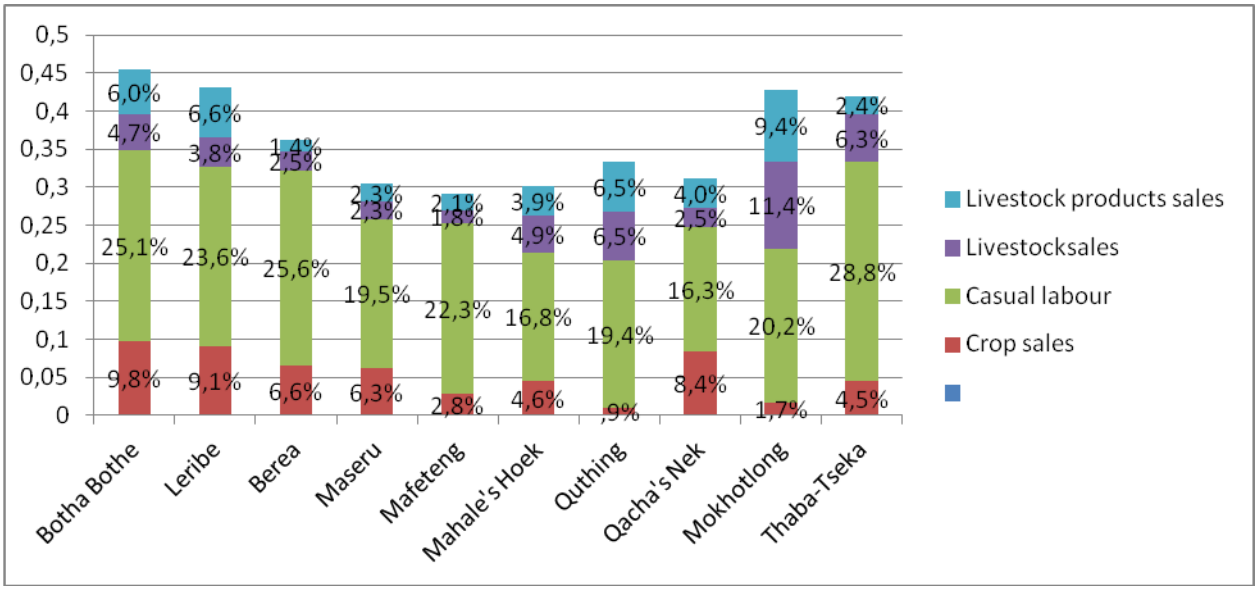
Figure 18: Grants based livelihoods sources



The three most important safety nets were old age pensions followed by social grants and humanitarian grants transfers. Old age Pensions seemed to be playing an important role in providing households with means of living. Mohale`shoek with 16.1%, Mafeteng 14.2%, Berea 11.4% and Quthing 13.4% had higher percentages of households with pensions as one of their main livelihood sources. Humaniterian grants transfers was common in three districts that are located in the southern part of the country; Mohale's Hoek (5.6%), Quthing (5.1%) and Qacha's Nek (1%) with the smallest proportion. The transfers were driggered by the past VA assessment whereby those districts were found to be most vulnerable.

5.11 AGRICULTURAL EXPECTED LIVELIHOODS

Figure 19: agricultural expected livelihoods



Most important livelihood sources were casual labour followed by livestock and livestock products sales and crop sales. Casual labour indicated a 20% decline compared to the previous year since most households rely on agricultural labour opportunities which have deteriorated due to late onset of rains. This has compromised the purchasing power especially for the poor thus affecting food access negatively. However, four districts showed a higher percentage of households who relied on casual labour as compared to other districts. Mainly Thaba-Tseka with 28.8%,Botha-Bothe 25.1%,Leribe 23.6% and 22.3%. Mokhotlong showed a high percentage 11.4% of households who relied **on livestock sales.**

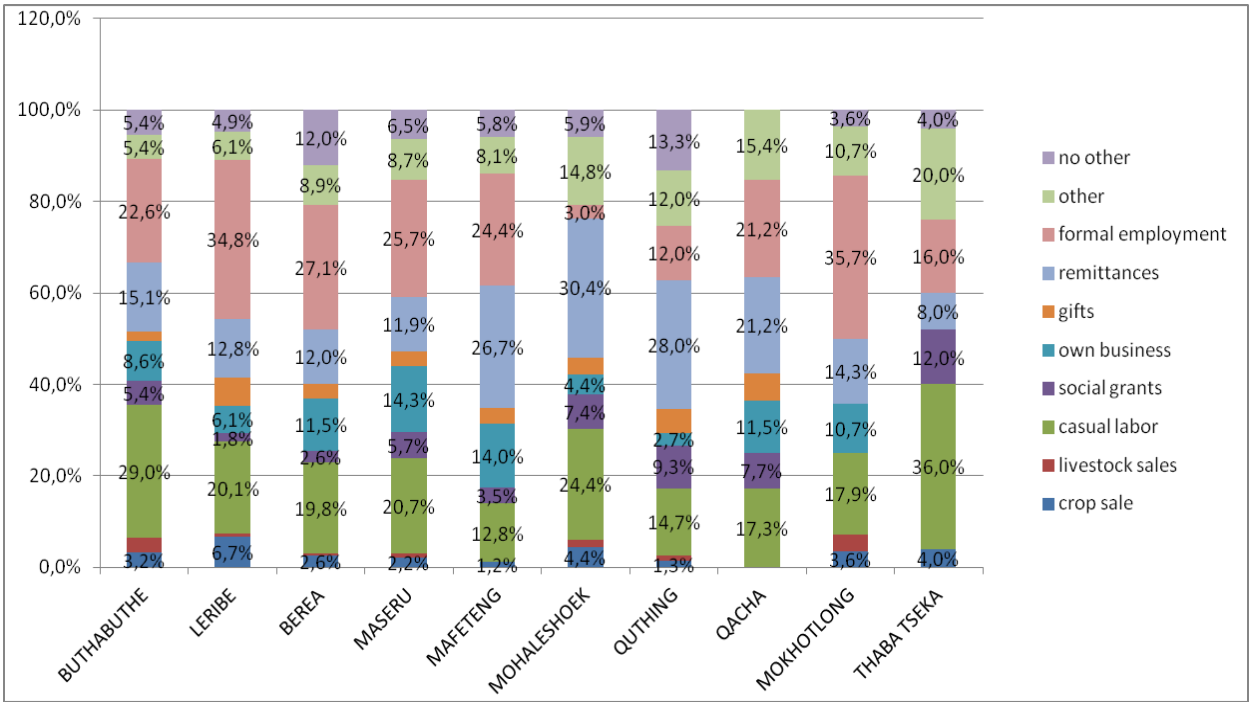
5.12 EXPECTED LIVELIHOODS SOURCES

Expected livelihoods: households were asked to indicate which livelihoods sources they expect to rely on in the next 12 months. The three most important livelihoods were remittances**,** pension and formal salary. The households showed that these sources are predictable and are not easily influenced by other factors like drought. They also indicated that crop sales and agricultural casual labour is no longer stable due to the unpredictable weather performance. Although remittances was mentioned as one of the main sources, it should be noted that some households are not expecting to get it on a monthly basis. The districts of Thaba Tseka (21.9%) and Mokhotlong (18.5%) indicated a high percentage of households that will rely mostly on brewing as their main livelihood source in the coming twelth months.

5.13 INCOME SOURCES

Formal employment (22.2%) followed by casual labour (21.3%) and remittances (18%) were the most sources of income for households across the country. There were other sources as depicted in table xx which also contributed to households income.

Figure 20: INCOME SOURCES BY DISTRICT

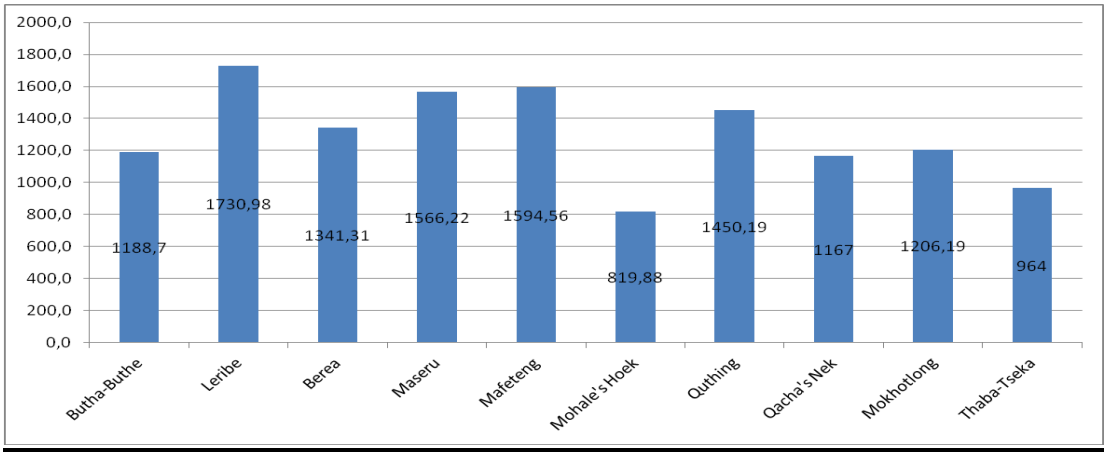


Mokhotlong (35.7%), Leribe (34.8%), Berea (27.1%) and Maseru (25.7%) showed a higher percentage of households that rely mostly on formal employment their income source. Mohale`s Hoek (30.4%), Quthing (28%), Mafeteng (26.7%) and Qacha`s Nek (21.2%) recorded a slight high percentage on remittances compared to other districts.

5.14 Average Income Levels by Districts

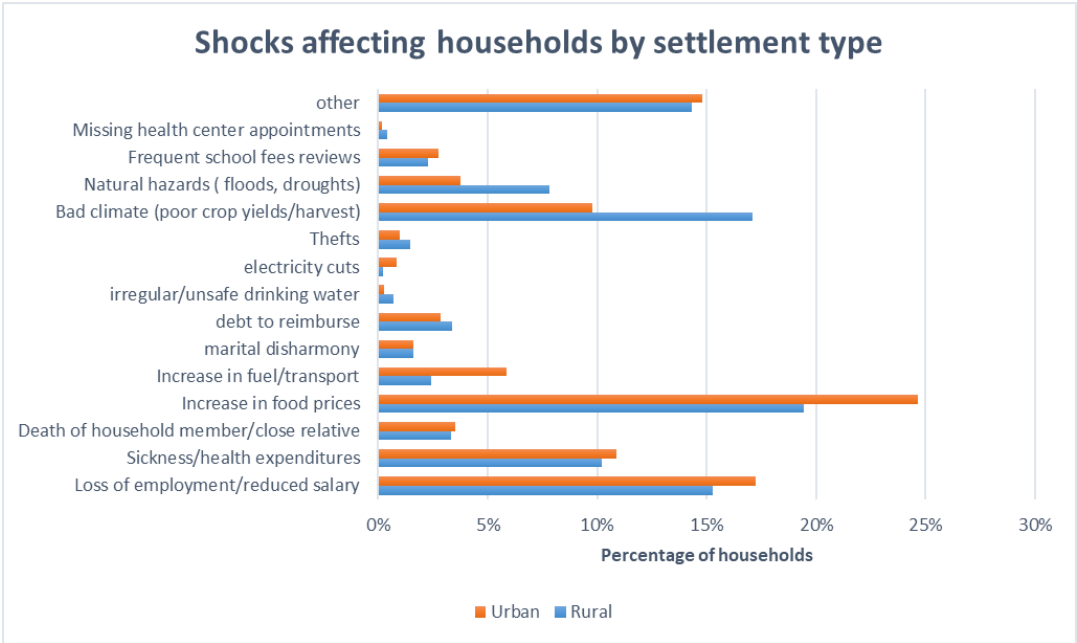
Household residing in urban areas were asked to indicate the income that they received in a month through cash and in-kind contributions. Cash contributions per month ranged from M819.00 in Mohale`s hoek to M1,730.00 in Leribe and the average monthly income was M1,275.00. The monthly average income showed a decrease of 33% compared to the previous year's cash contribution of (M1970.00). This implies that the purchasing power of the households was negatively affected.

Figure 21: average income by district



***5.13 Shocks**:* This section analyses shocks that households experienced in the last six months that influenced food access in the rural and urban areas. Households mentioned factors that hindered them from obtaining food at some point in the recall period. The findings show that high food prices, loss of employment/reduced salary, poor crop yields and sickness/increased expenditure on health were common both rural and urban setting. Higher proportion of urban households (25%) mentioned high prices compared to (18%), and a higher proportion of households (17%) in rural areas mentioned poor harvest compared to urban households (10%).

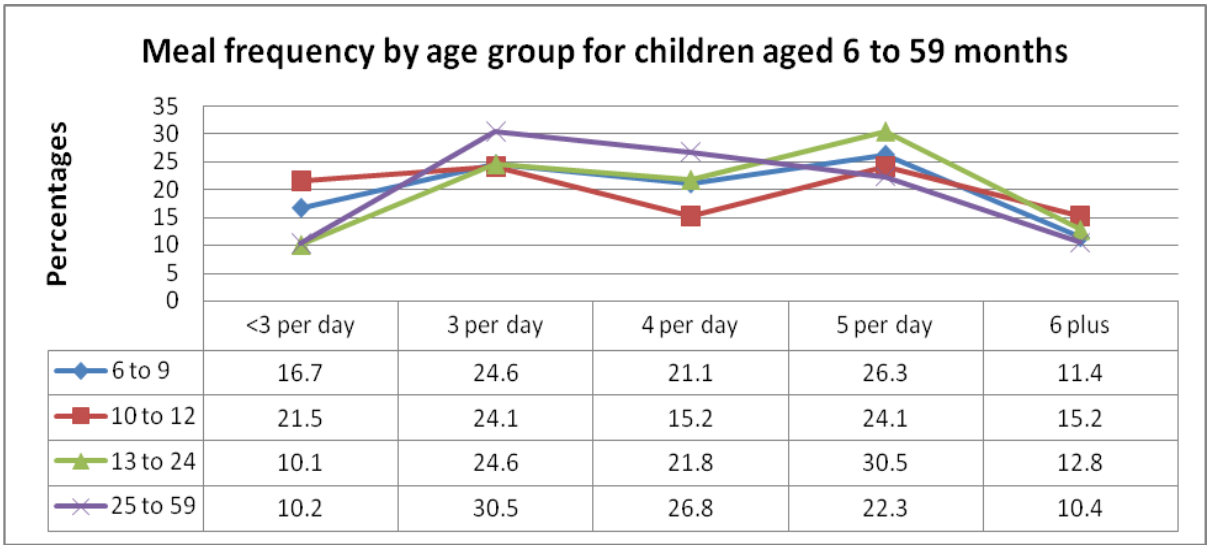
Figure 22: Shocks experienced by household



5.15 MEAL FREQUENCY

An estimated total of 88.3% of children aged 6 to 59 months ate three meals and above during the previous 24 hours .Meal frequency for rural areas was higher (86.3%) than in urban areas (62.8%). An estimated total of 88.3% of children aged 6 to 59 months ate three meals and above during the previous 24 hours .Meal frequency for rural areas was higher (86.3%) than in urban areas (62.8%).

Figure 23: Meal frequency by age group for children aged 6-59 months



	<3 per day	3 per day	4 per day	5 per day	6 plus
6 to 9	16.7	24.6	21.1	26.3	11.4
10 to 12	21.5	24.1	15.2	24.1	15.2
13 to 24	10.1	24.6	21.8	30.5	12.8
25 to 59	10.2	30.5	26.8	22.3	10.4

Approximately 7.4% of people aged five years and above ate three meals a day and 29.7% ate two meals per day. The results as per settlement also indicate that at rural area, 34.7% of people ate two meals per day and 44% ate three meals a day respectively. In the urban area almost 51.8% ate three meals; however 23.4% ate two meals per day.

The highest prevalence of food consumed were grains and tubers at 36.7%followed by dairy products at 15.1% and other fruits and vegetables at 14.3% however legumes and meats were less consumed with 9.5%.

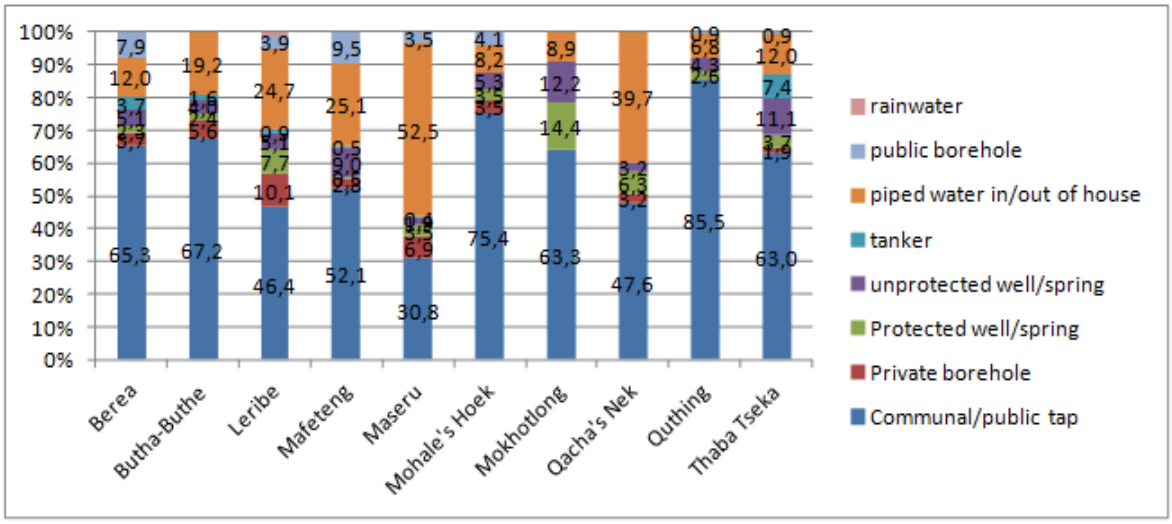
6.0 Utilization

Food Utilization looks into whether households have access to safe drinking water, improved sanitation facilities, care and feeding practices, food preparation, diversity of diet and intra-household distribution of food as well as to what type of shelters do households own.

6.1 ACCESS TO SAFE DRINKING WATER SOURCES:

According to Rapid assessment report April 2019, majority of households 94% have access to safe and clean drinking water. 47% of people mostly in rural areas access water through communal/public taps and 24% through private taps mostly in urban areas. Other improved water sources include piped in water in or out of house, protected well/springs, private or public boreholes and water tanker represent 24%. However, 2% to 12% of households access water through unprotected water sources such as from unprotected springs/well which may pose health hazards to people. The highest proportion of this is from Mokhotlong and Thaba-Tseka. Access to improved water sources needs to be enhanced to prevent the likelihood of waterborne diseases especially because majority of households don't usually treat water before consumption. People who treat their water before human consumption were 10%, 5% treat sometimes and 85% do not treat their water. For those who treat their water, 84% boil it, 6% use other methods, 4% add chlorine, 4% strain through a cloth and 2% use solar disinfection.

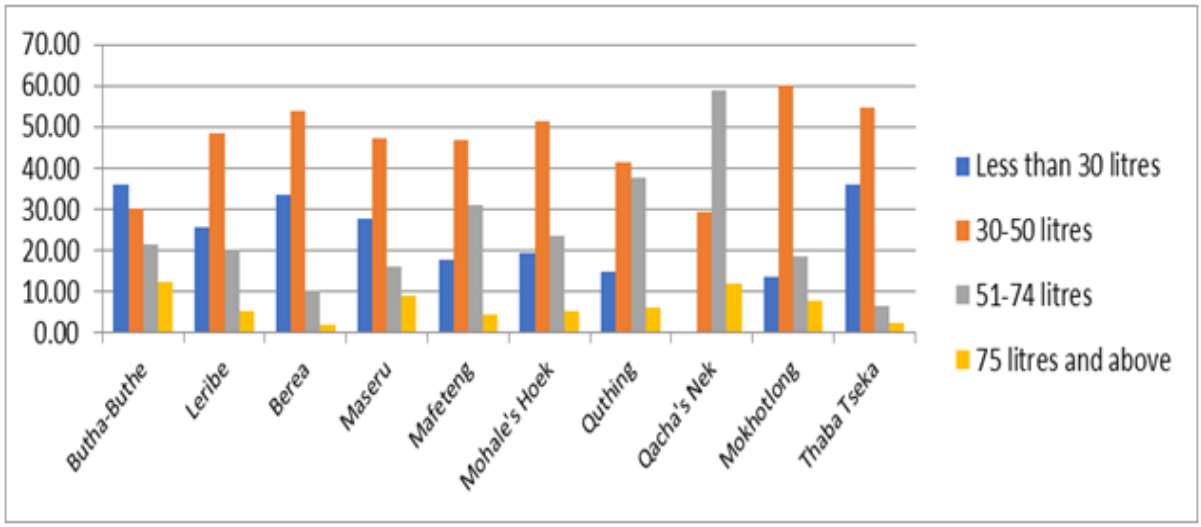
Figure 24: Households distribution of water sources by districts



6.2 WATER DEMAND/USE PER DAY

74% of people have access to 30 litres per day and above of water while 26% have access to less than 30 litres per day which does not meet the household demand. Majority of the people who access less than the threshold (30 litres per day) are in the districts of Butha-Buthe, Berea and Thaba-Tseka that is over 30% of the respondents.

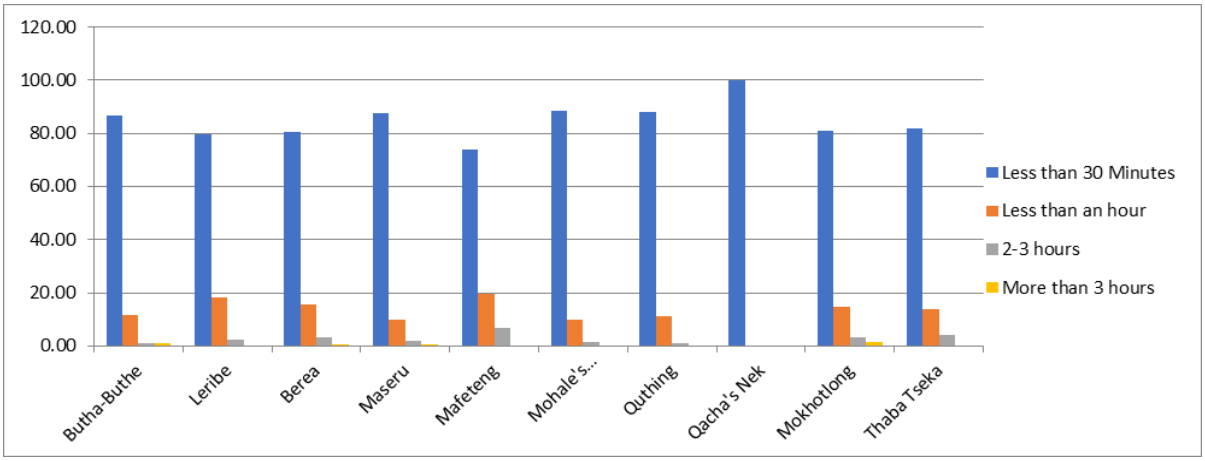
Figure 25: Household water demand distribution



6.3 DISTANCES TO THE NEAREST WATER SOURCES

The findings indicated that 84% of households travel less than half an hour to water source. The travelling time and waiting period of less than 30 minutes is a relatively acceptable for the social protection of the vulnerable groups as some of the water sources are located in remotest places within the village. The shorter the distance and waiting periods makes it possible to timely identify or make note when there is a possibility of a vulnerable group being in danger.

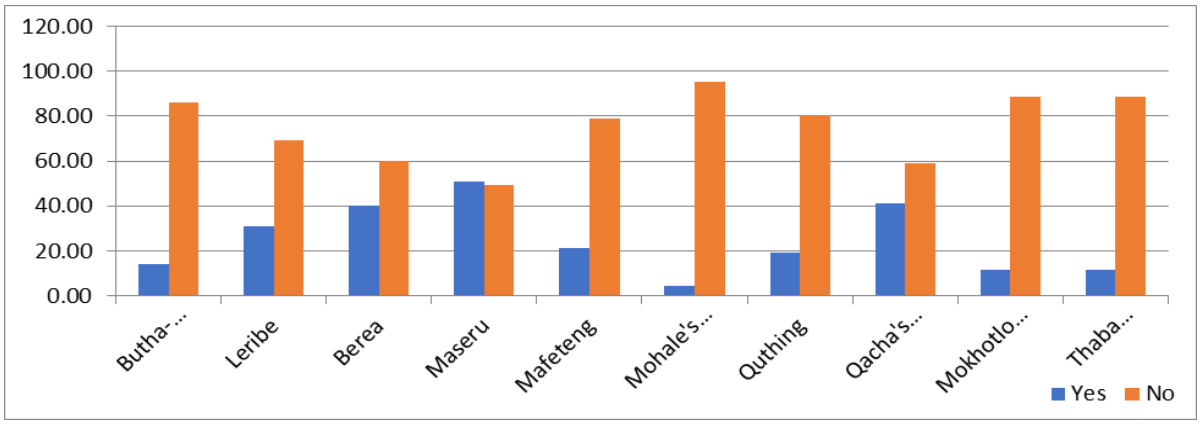
Figure 26: Access to water sources including waiting period



6.4 WATER PAYMENT

About 70% of respondents indicated that they do not pay for water supply services mainly in Butha-Buthe, Quthing, Mohales'Hoek, Mokhotlong, Thaba-Tseka. The payment also includes the maintenance of water schemes in their areas and this will affect the functionality of these systems in the near future if contribution is not consistent and maintained. The other 30% who pay for water services indicated that the price is affordable for 82% of them.

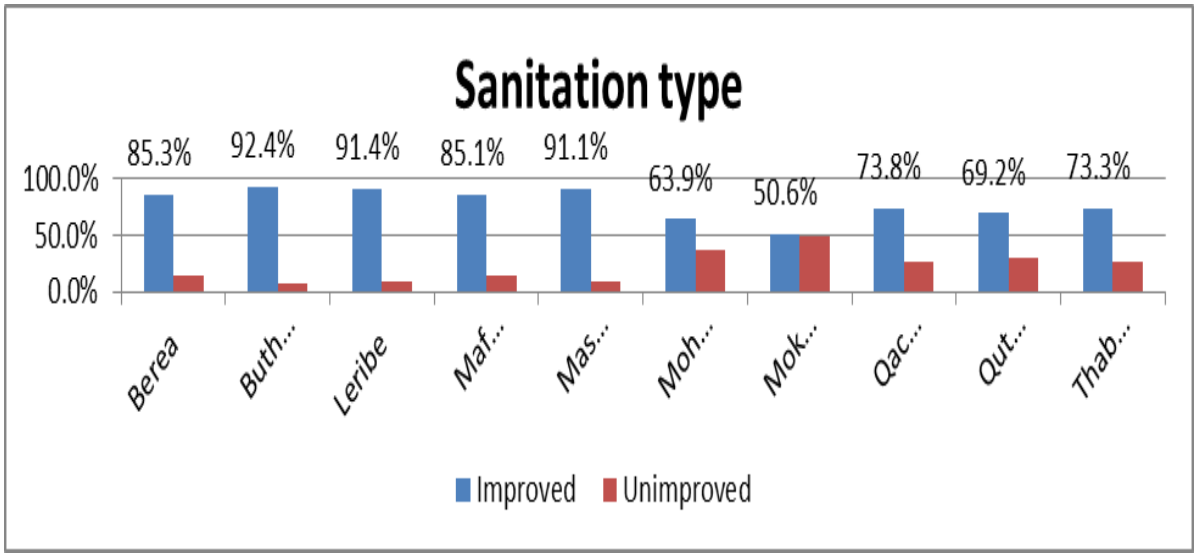
Figure 27: Water payment distribution by districts



6.5 ACCESS TO IMPROVED SANITATION TYPES

As per LVAC 2018 report, most households (83% used improved sanitation sources. These improved sanitation sources included Ventilated improved pit latrines, pit latrines, communal or public toilets and flush/pour toilets. However there were few households which still use unimproved sanitation particularly open defecation/ bush. The highest proportion of unimproved sanitation was noted in Mokhotlong (49.4%), followed by Quthing (30%) and Qacha's Nek and Thaba-Tseka. In addition, about 65% of people do not share their toilet, while 30% share their toilet with other households (LVAC 2019 report). That requires to be taken into consideration for further improvement of sanitation services especially in rural areas.

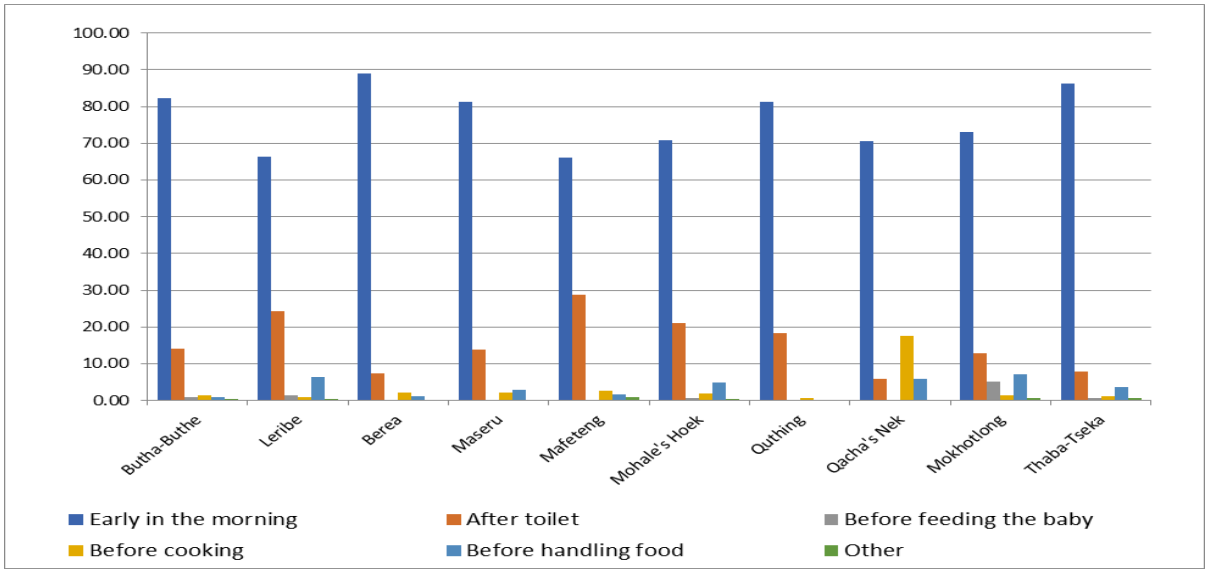
Figure 28: Sanitation facilities classification by type



6.5 HANDWASHING PRACTICES

78% of people wash their hands in the early morning while only 16% after defecation. The other 6% have the knowledge to wash their hands before handling the food. That explicitly shows the poor hygiene practices for people related to hand washing mainly after defecation and before handling the food. The findings show less than 1% of mothers who wash their hands before feeding their children.

Figure 29: Hygiene practises by distribution of districts



6.5.1 Infant and young child feeding practices

The results indicate that children who were breastfeed are at 90.3%. On average, duration of breastfeeding in rural is at 16% rural and 12% urban. Overall, approximately 63.4% were initiated to breastfeeding within the first hour. In urban, 65.3% of children were initiated timely and 62.3% at rural. The findings also indicate that 63.4% were exclusively breastfeed showing an increase of 10.4% from 2017 results.

6.5.2. Complementary feeding

Of all the households that were interviewed, about 52.9% of under-five children benefited from well-timed introduction of complementary foods, which shows a remarkable increase of 19.6% compared from 2017 results.

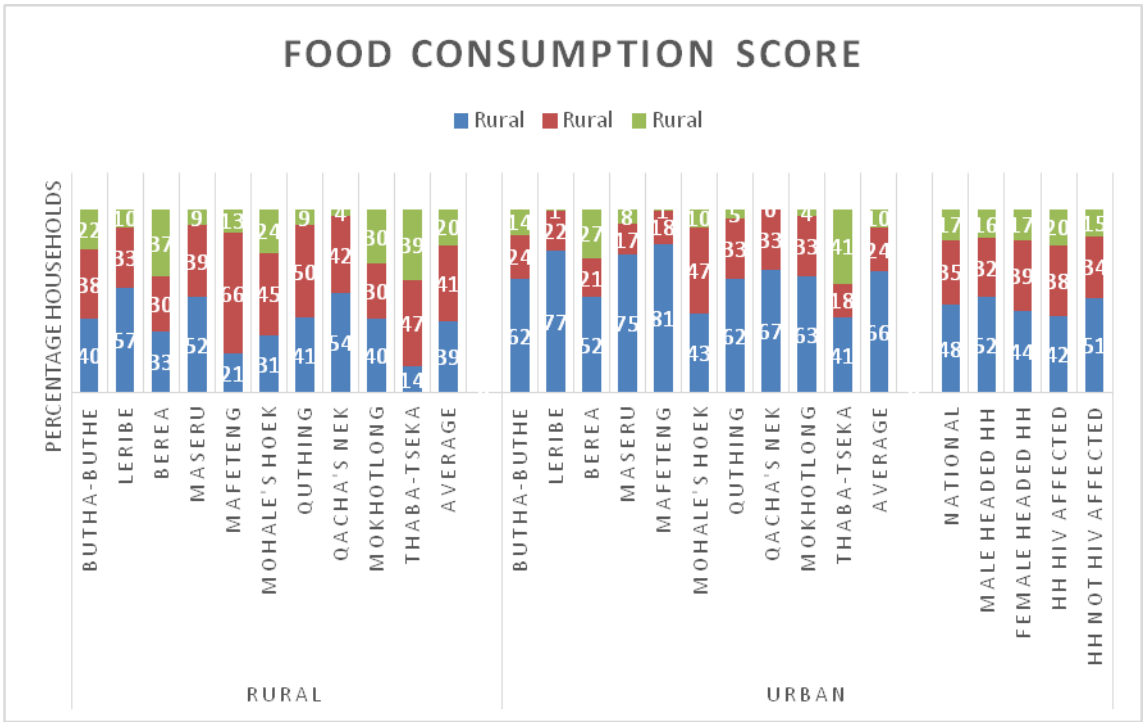
7.0 Food Security Outcomes for 2019/20

7.1 HOUSEHOLD FOOD CONSUMPTION SCORE

An analysis of food consumption score[4] by settlement type and districts indicated that there are more households in the rural areas who had inadequate food consumption (borderline and poor food consumption) with an average of 61% of households in Phase 3 and worse compared to 34% in the urban setting. All rural areas had a significant number of households with the borderline and poor food consumption ranging from 43-73 percent with Leribe the lowest and Mafeteng the highest. There was no significant difference between households headed by males and females in terms of food consumption. In addition, households who had a member with HIV had higher proportion of borderline and poor food consumption compared to households who did not have a member with HIV.

[4] Food Consumption Score-FCS- 'Poor' food consumption is generally regarded as a sign of extreme household food insecurity. It refers to a diet composed mainly of maize daily and vegetables for a maximum of four days per week. 'Borderline' food consumption is classified as a diet made up cereals and vegetables daily plus oil/fats for five days and sugar products for three days per week. 'Acceptable' food consumption is classified as daily intake of cereals, vegetables, oil, and sugar, and at least one-day consumption of food rich in protein

Figure 30: Food consumption score by settlement type and districts



7.2 FOOD CONSUMPTION NUTRITION

Food consumption was further analyzed to assess intake of macro and micro nutrient rich foods in a 7-day period.[5] These included consumptions of vitamin A, protein and iron rich foods. In both urban and rural settlements, iron rich foods were least consumed, followed by foods rich in protein. In rural, proportion of households who never or sometimes consumed iron and protein rich foods was (iron 49% and 46%), (protein 17% and 50%), in urban areas (iron 18% and 73%), (protein 2% and 44%). Vitamin A rich foods were the most consumed. In urban areas 75 percent of households consumed Vitamin A rich foods on daily basis, while 50 percent of their counterparts in rural setting consumed it every day.

5 Consumption of protein, vitamin and iron rich foods was grouped into 0 days which means no consumption, 1-6 days which refers to sometimes and 7 days which refers to daily

Figure 31: Food consumption nutrition in urban areas

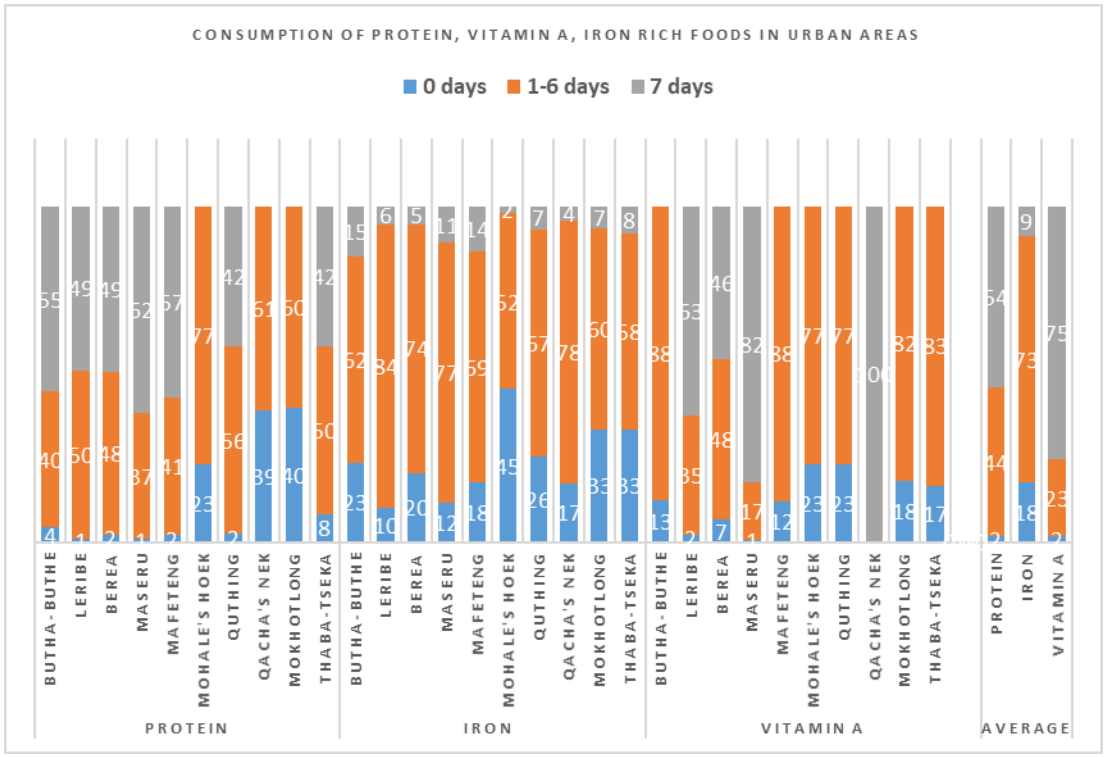
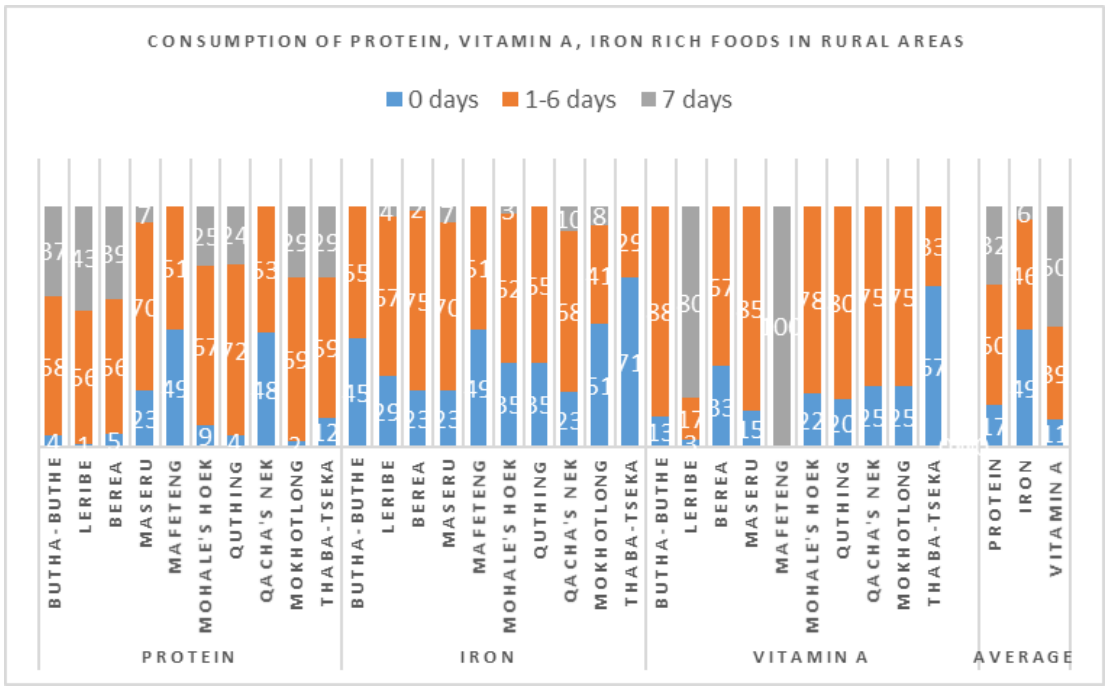


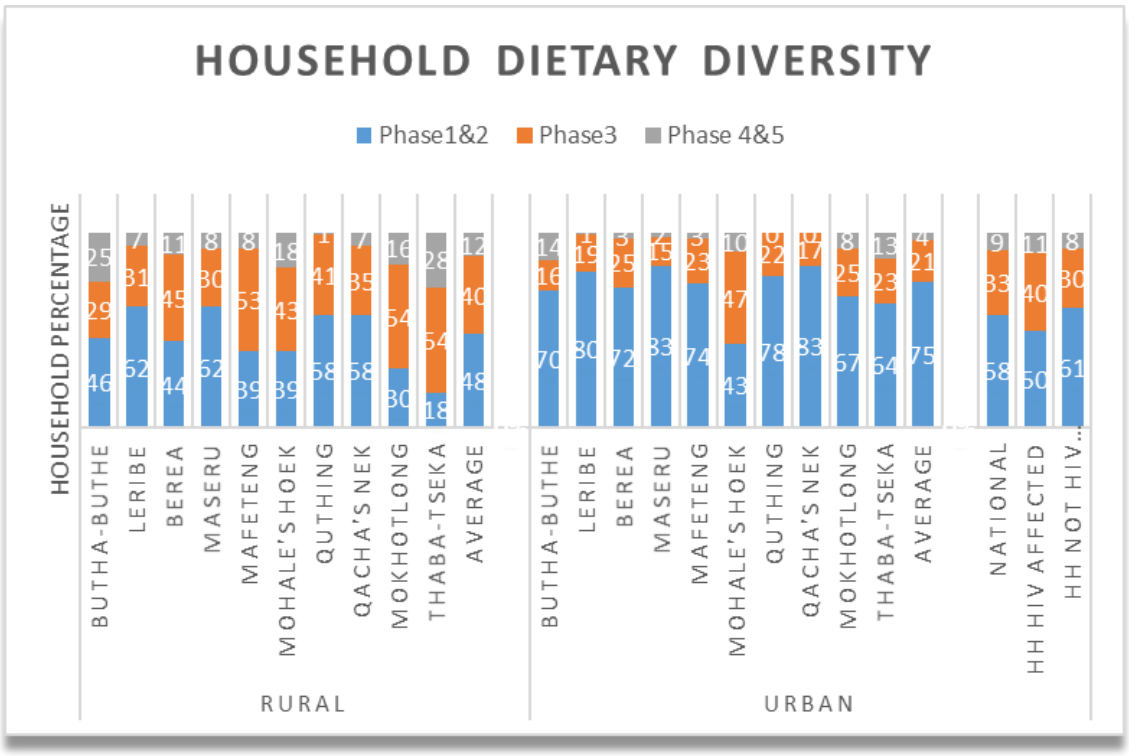
Figure 32: Food consumption nutrition in rural areas



7.3 HOUSEHOLD DIETARY DIVERSITY

An analysis of dietary diversity[6] was done to assess number of food groups the household consumed over the 24-hour period. This is a proxy indicator of intake of nutrients. The findings indicated that generally significant proportion of households did not diversify their meals regardless of settlement type. On average rural households had a higher proportion of households (52%) who had moderate and low dietary diversity compared to urban households with (25%). The rural of Thaba-Tseka and Mokhotlong had the highest proportion of households with moderate and low dietary diversity. There was no significant difference in diet diversity in households with a member with HIV and a household without a such a member.

Figure 33: Household Dietary Diversity in rural areas



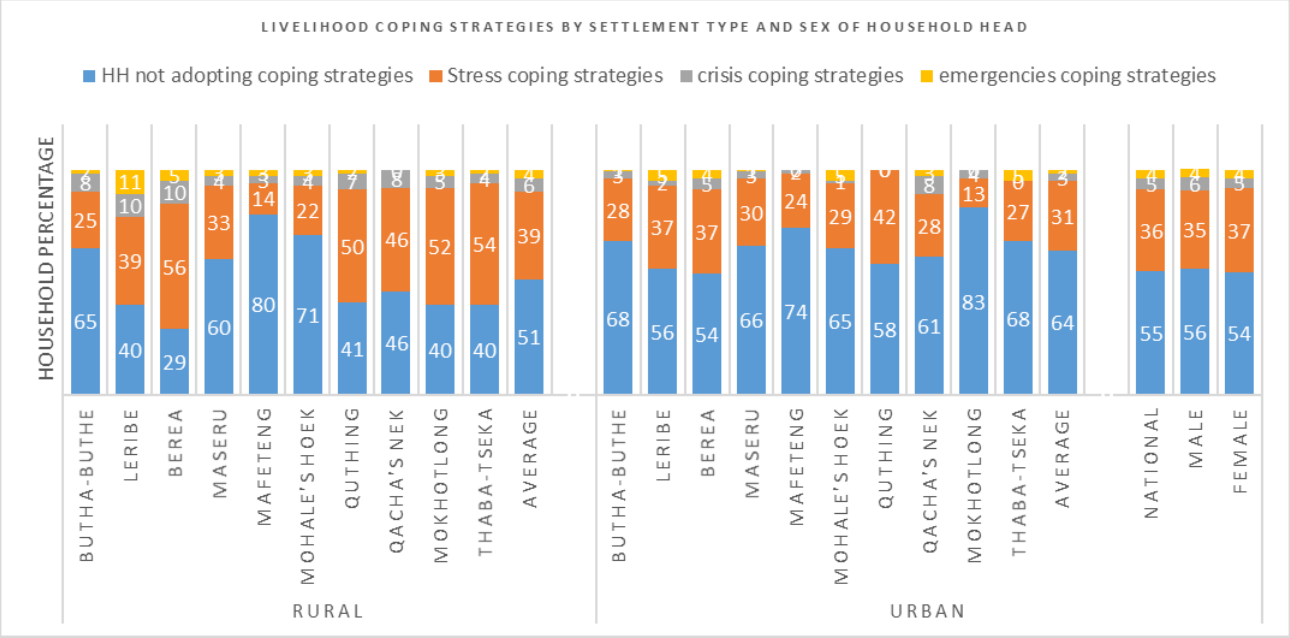
7.4 LIVELIHOOD COPING STRATEGIES

An analysis of livelihood coping strategies was done to understand the hardship that the households were faced with to acquire food and future ability to produce.

6 **Dietary diversity** is a measure of different food groups households consumed. The households are classified as 'Low dietary diversity' when have consumed 1-3 food groups. Households who consume 4-5 food groups are classified into 'Moderate dietary diversity'. Households who consume 6 and above food groups are classified into 'High dietary diversity'. Food groups consumed are classified regardless of type of food groups consumed.

Strategies are classified as [7]stress, crisis and emergency strategies. Households who did not employ any of these coping strategies were regarded to be food secure based on this analysis only. On average proportion of households who did not adopting any coping strategies was higher in urban areas (64%) compared to rural households (51%). Of the households that employed coping strategies among rural and urban household's majority employed stress coping strategies, mainly buying food on credit and borrowing money to buy food. The same proportion of households headed by females and males(54%-56%) did not employ any coping strategies and where the coping strategies were employed were more of stress than crisis and emergency .

Figure 34: Livelihood Coping Strategies by settlement type



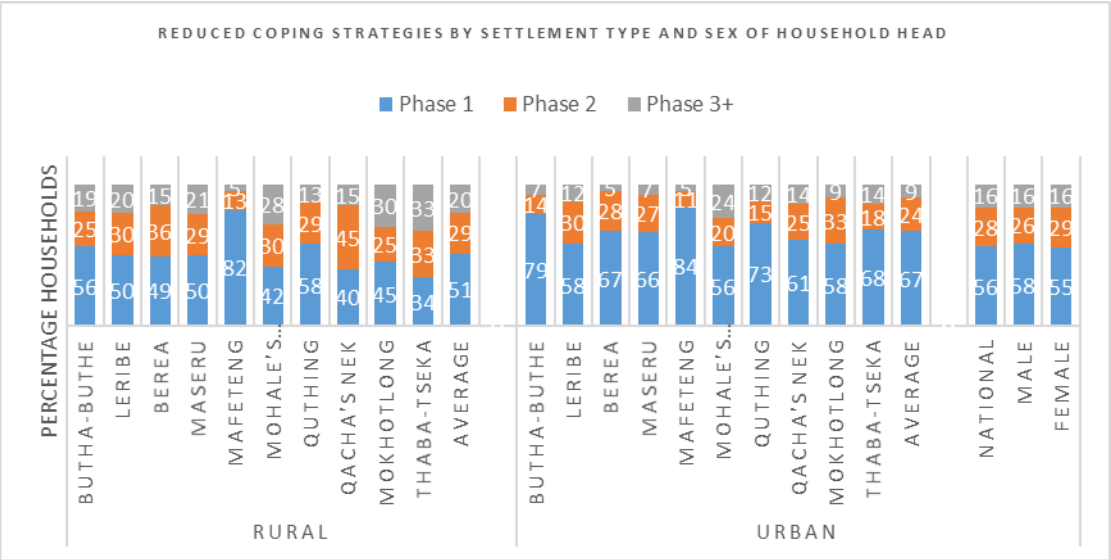
7.5 REDUCED CONSUMPTION-BASED STRATEGIES (RCSI)

Consumption-based coping strategies were assessed to understand the consumption behaviors or strategies that households had to engage when faced with food gap. Analysis of these strategies was used to generate the *reduced coping strategies index* (rCSI)- the higher the index the food insecure the households based

7 Stress strategies, such as borrowing money, selling more animals than usual, purchasing food on credit or borrowing are those that indicate a reduced ability to deal with future shocks due to a current reduction in resources or increase in debts. **Crisis strategies**, such as consuming seeds that were saved for the next season, cutting down on the expenses on fertilizers, animals feeds etc. directly reduce future productivity. **Emergency strategies**, such as selling land or last female animals affect future productivity, but are more difficult to reverse or more dramatic in nature.

on this indicator alone. [8]RCSI is higher among rural households compared to their urban counterparts. Female and male headed households had the same index. Overall, most households bought less preferred food and relied on help from friends or relatives when faced with food gap.

Figure 35: Reduced Coping Strategies by settlement type



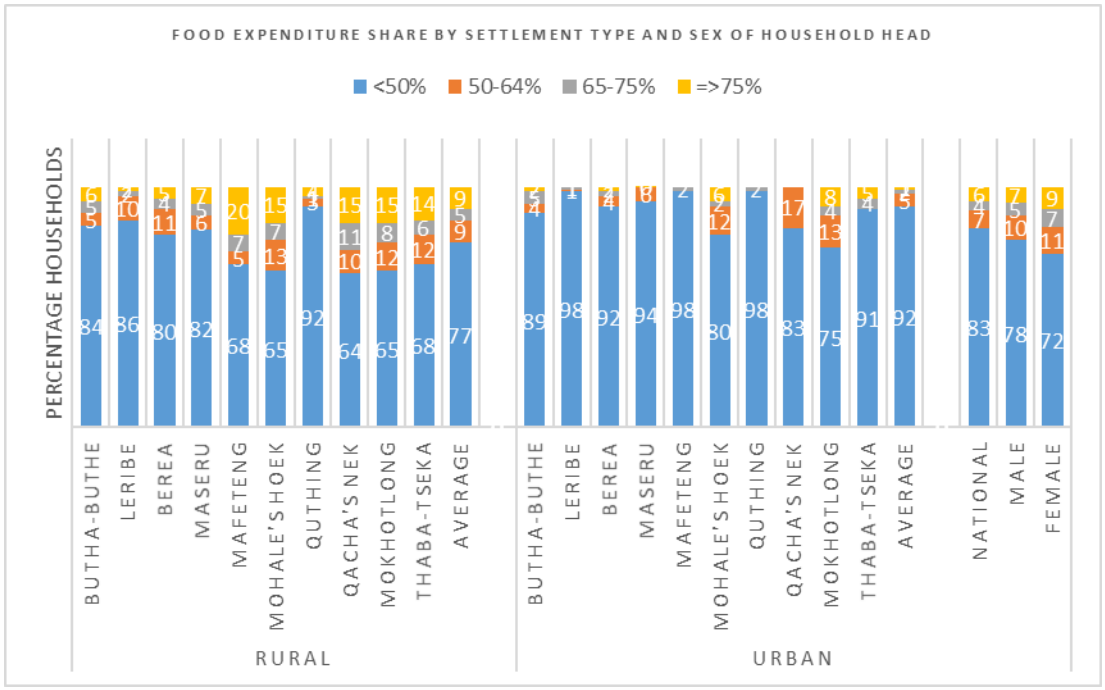
7.6 HOUSEHOLD FOOD EXPENDITURE SHARE

Households were asked to estimate the value of cash spent on food and non-food items over the period of 30 days and value of cash spent on non-food items over a period of six months. Based on these estimates, total share of money spent on food over the total expenditure was calculated. This analysis was done to assess the economic vulnerabilities of households. Households were classified into four categories, those who spent less than half of their expenditure on food (<50) and three categories of those who spent more than half of their expenditure on food (50-60), (65-<74), (<75 and above). The higher amount of money spent on food compared to the total expenditure, the vulnerable the household. Households who spent less than half of their total expenditure on food are food secure based on this indicator.

On average both in rural and urban areas more than 70% of households spent less than 50% of their expenditure on food. More than 70% of female and male headed households spent less than 50% of their income on food. Rural and urban households spent an average of 453 and 560 maloti per month on food respectively.

[8] Households who have reduce coping strategy index of 0-3 were classified in phase 1, households with index of 4-18 were classified in phase 2, households with index of 19 and above were classified in phase 3 and above

Figure 36: Food expenditure Share by settlement type



7.7 HEALTH AND NUTRITION

A total of 915 children aged 6 to 59 months from 2978 studied households were assessed for nutritional status.

7.7.1 GLOBAL ACUTE MALNUTRITION (GAM), STUNTING AND UNDERWEIGHT IN CHILDREN UNDER FIVE YEARS

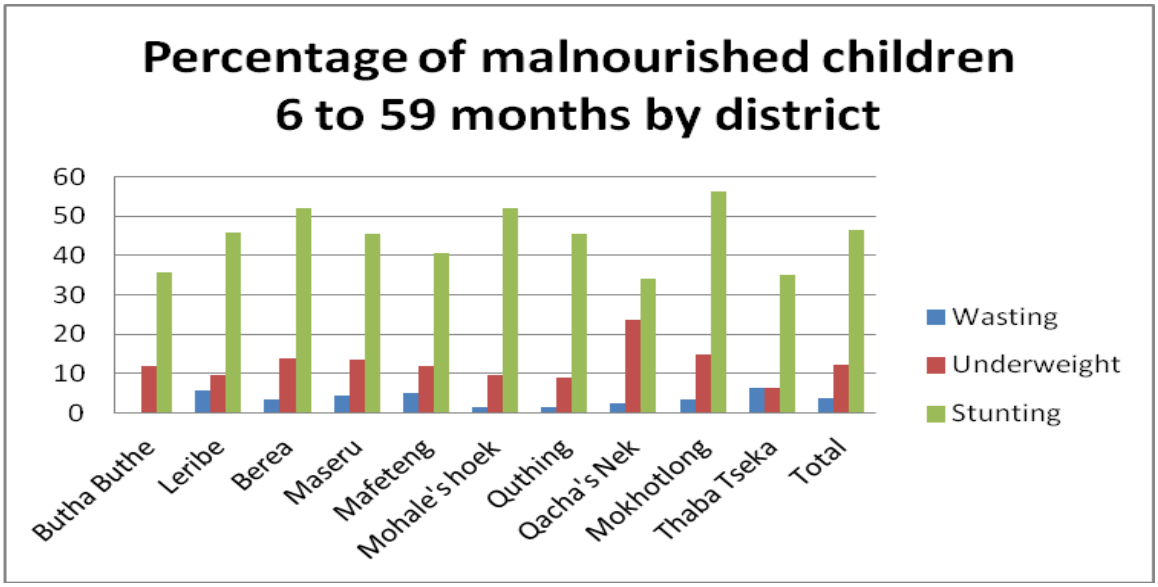
The Vulnerability Assessment 2019 measured height, weight and Mid Upper Arm Circumference (MUAC) for children 6 to 59 months in all sampled households, regardless of whether the respondent was a mother of that particular child. However, relationship with the child was ascertained.

Due to the small sample size of children assessed during the survey the data on nutrition status is used as an indicative of the general picture.

According to LVAC June 2019, 3.6% of children 6 to 59 months are wasted or children too thin for the height, a measure of acute undernutrition and represents the failure to receive adequate nutrition in the period immediately before the assessment. The findings were similar compared to 2018 (3.5%) and a slight improvement compared to 2017 (4.7%), LVAC reports. Acute malnutrition in almost all the district was within the acceptable WHO child growth standard (<5%) except in Thaba Tseka (6.3%), Leribe (5.6%) and Mafeteng (5%) districts. Wasting impairs the functioning of the immune system and can lead to increased severity and duration of and susceptibility to infectious diseases and an increased risk for death.

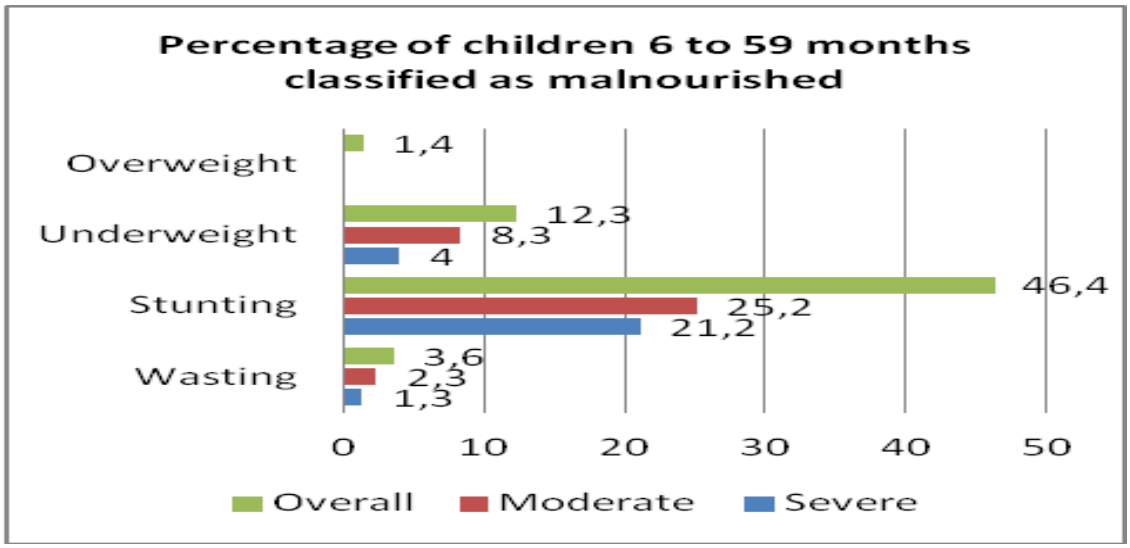
The findings also estimated stunting or children too short for their age, a sign of chronic undernutrition that reflects failure to receive adequate nutrition over a long period at 46.2%, which suggest an increase from the 2014 DHS (33.3%). The prevalence is very high according to the WHO child growth standards (≥40% very high prevalence). Stunting often results in delayed mental development, poor school performance and reduced intellectual capacity. This in turn affects economic productivity at national level. Women of short stature are at greater risk for obstetric complications because of a smaller pelvis. The finding also indicates that stunting in Lesotho ranged from a minimum of 34.2% in Qacha's Nek to 56.2% in Mokhotlong. Figure 34 shows prevalence of malnutrition among children 6 to 59 months by district.

Figure 37: Nutrition status of Children 6 to 59 months by district



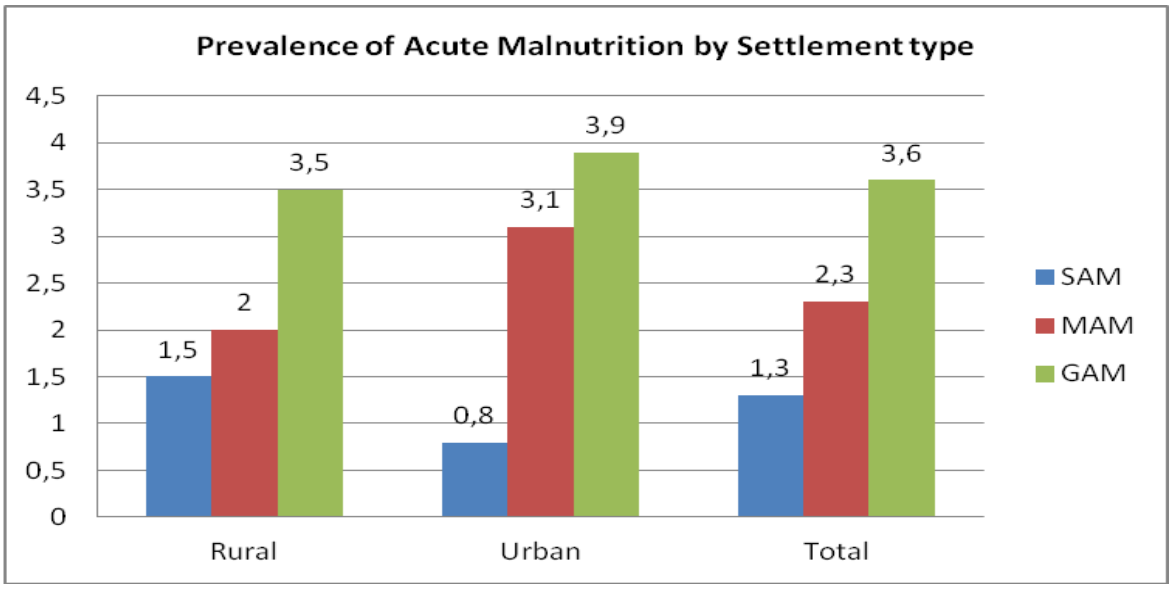
Furthermore, the assessment found the prevalence of underweight to too thin for age, this includes both acute (wasting) and chronic (stunting) undernutrition; and is an indicator of overall undernutrition, to be 12.3% which indicates an increase of 0.4% and 2.6% from 2017 and 2018 respectively. However, underweight prevalence in Lesotho remained higher than the international cut-off values for public health significance (<10% low prevalence). Overweight prevalence among children 6 to 59 months is 1.4%. Figure 36 below represents prevalence of malnutrition among children 6 to 59 months.

Figure 38: Nutrtition Status of Children 6 to 59 months



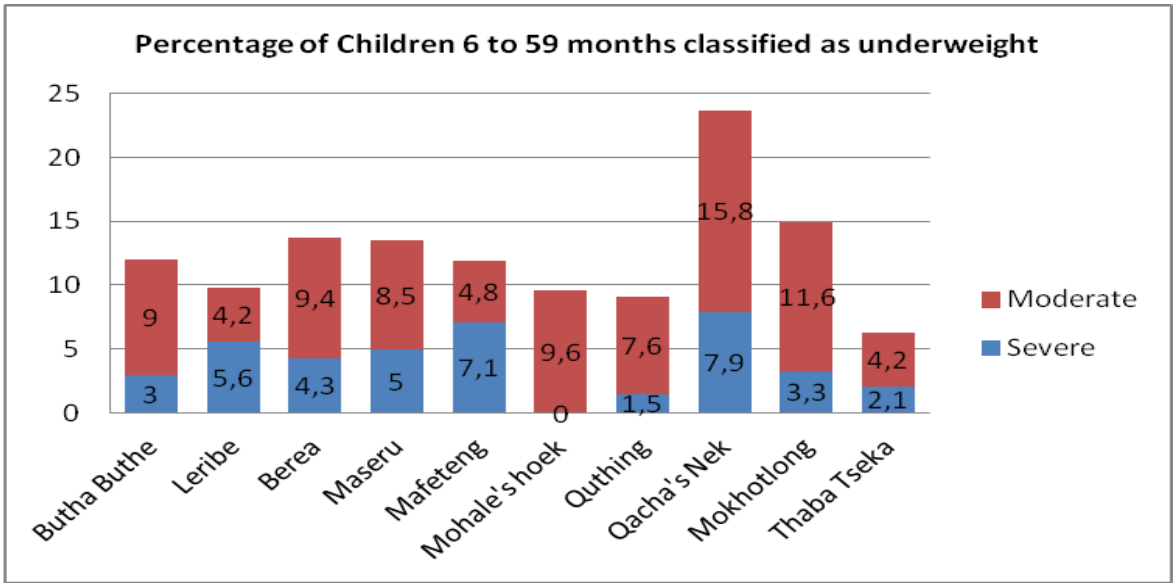
The findings estimated prevalence of wasting in Lesotho ranging from a minimum of 0% in Botha Bothe to 6.3% in Thaba Tseka. Wasting was 3.1% for children residing at urban centres and 2% for those at rural settlement. However, over the years Global Acute Malnutrition (GAM) wasting remained lower than the 5% WHO child growth standards. By age, moderate wasting was higher among children aged 6 to 23 months (3.1%) than among children 24 to 59 months (1.8%), while severe wasting is at 1.1% among 6 to 23 and 1.4% among children 24 to 59 months. There was no significant difference in the prevalence of moderate wasting for boys (2.4%) and girls (2.2%). Figure 37 prevalence of acute malnutrition by settlement type.

Figure 39: Acute Malnutrition of Children 6 to 59 months by Settlement type



Prevalence of underweight for children aged 6 to 59 months varied across the districts with the highest prevalence found in Qacha's Nek (23.7%) followed by Mokhotlong (14.9%) and the lowest found in Thaba Tseka (6.3%) followed by Quthing(9.1% and Mohale's hoek(9.6%). By age groups and settlement type, underweight is 10.4% for children aged 6 to 23 months and 7% for those aged 24 to 59 months while for rural settlement is 7.6% and 10% for urban settlement. There is no significant difference in underweight rate for boys(8.2%) and girls(8.4%). The proportions of boys and girls that were overweight were not significantly different; 1.2% of boys versus 1.6% of girls and was estimated at 1.4% for children aged 6 to 23 months and 12 to 59 months. Figure 37 shows further disaggregation of Severe and Moderate underweight by district.

Figure 40: Uunderweight in children under the age of 5 years by district



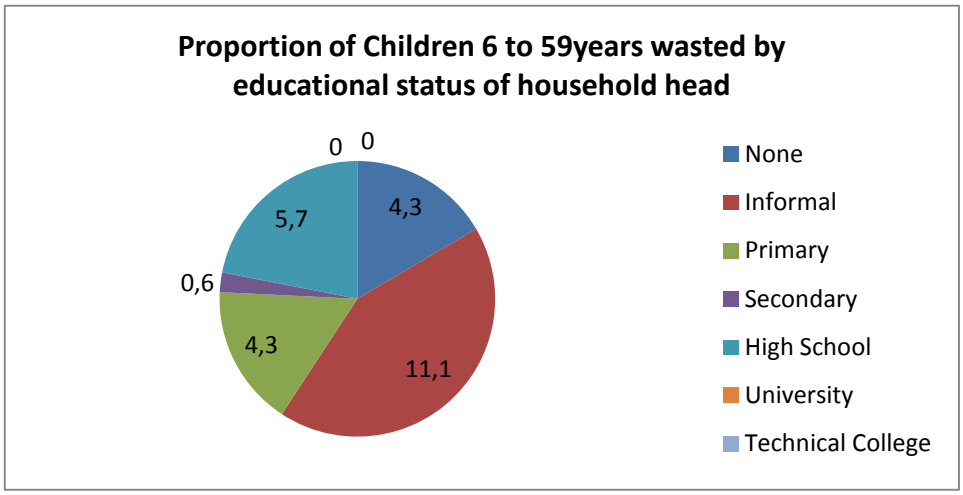
7.7.2 NUTRITIONAL STATUS OF CHILDREN UNDER FIVE YEARS BY HOUSEHOLD HEAD GENDER AND AGE

Out of the 915 households that were found to be having children under five years that were studied, 538 households were headed by males and 387 by females. The findings indicated that the prevalence of underweight among children aged 6 to 59 months whose households were headed by males was 12.1% and by females was 12.7%. Prevalence of underweight among children 6 to 59 months whose household age ranges from 65 years and above (14.1%) was higher than that of those aged 18 to 65 years (12%). By gender of household head, wasting among children was not significantly different (3.8% and 3.4%). Whilst by age of household head, wasting among children whose household heads age were 65 and above was above the acceptable WHO standard by 2.1%.

7.7.3 NUTRITION STATUS OF CHILDREN UNDER FIVE YEARS BY MARITAL STATUS AND EDUCATION OF HOUSEHOLD HEAD

The proportions of children under five years that were wasted were observed to be higher than the WHO child growth standard among children whose parents were cohabiting (16.7%). Prevalence of underweight among 6 to 59 months was lower than 10% for all children whose parents are widow/widower. Overweight was observed among children whose parents were married living together, widow/widower and never married against parents married living apart, divorced/separated and co-habiting. Prevalence of stunting was higher than 40% for children regardless of parents marital status. By household head educational status, stunting remained higher than 20% for all children regardless of parents' educational status. The proportion of wasting is higher than the acceptable international standard 5% cut-off) for children whose household head attained informal education(11.1%) and was observed among children whose household head achieved technical college and university education. The proportion of wasting is higher than the acceptable international standard (5% cut-off) for children whose household head attained informal education (11.1%) and High school (5.7%) and was not found among children whose household head achieved technical college and university education. Whilst children whose households head that reached primary education (9.8%) prevalence of underweight is lower than 10%. Figure 38 shows percentage of children with wasting by household head educational status.

Figure 41: Acute malnutrition in children under the age of 5 years by educational status of household head



7.7.4 NUTRITION STATUS OF CHILDREN UNDER FIVE YEARS BY HOUSEHOLDS WITH HIV POSITIVE PERSON

There was no significant relationship between prevalence of malnutrition and households with members living with HIV found in this study. For instance wasting was at 2.1% for children from households with HIV members and 2.4% for households without HIV member.

7.7.5 BREAST FEEDING AND COMPLEMETARY FEEDING PRACTICES

Early initiation of breastfeeding is important for both the mother and the child. The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also encourages bonding between the mother and her newborn facilitating the production of regular breast milk. However, data on early initiation of breastfeeding and exclusive breastfeeding was not collected as a result findings from the LVAC 2019 Rapid Assessment were used.

The results showed that 90.3% of children were breastfed and approximately 7.8% were no breastfed at all. Main reasons for not breastfeeding were work followed by child not able to suck, lack/insufficient milk and sickness of mother. According to LVAC Rapid Assessment conducted in March 2019, 62.4% were initiated to breastfeeding within the first hour (timely initiation of breastfeeding). While within both urban and rural the children were initiated timely at 64.7% urban and 61.2% at rural. On average 59.9% of children were exclusively breastfeed. In addition, 7.8% of women indicated that they did not breastfed up to 24 months due to lack of time while 14.6% indicated work and 10.4% HIV status.

The LVAC rapid assessment further showed that above 50% of the children were introduced to complementary feeding at age of six months and 93% of all children who were assessed did not meet minimum diet diversity with above 94.% at rural and 92% at urban. A total of 73.5% of children did not meet meal frequency in both settlements with proportions above 70 % each (76.3% urban and 71.9% at rural). Regarding liquids taken by the children in the past 24 hours, 53.2% drank water followed by thin porridge at 27.7% while fresh milk and infant formula were at 6.3% and 2.8% respectively.

MID-UPPER ARM CIRCUMFERENCE (MUAC) FOR CHILREN 6 TO 23 MONTHS

The findings for MUAC indicates that 96.4% of children were normal while 3.6% were malnourished of which 3.2% were moderate and 0.4% were severe.

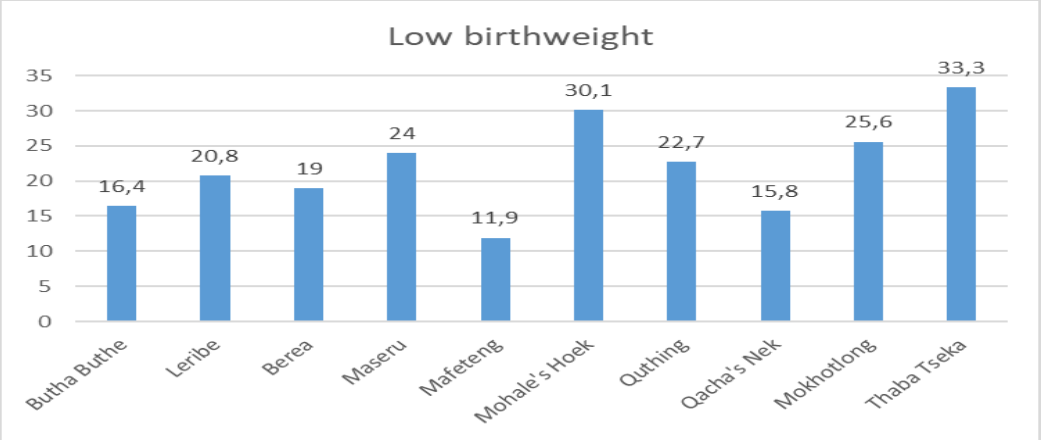
7.7.6 LOW BIRTH WEIGHT

The proportion of infants with a low birth weight is an indicator of a multifaceted public health problem that includes long-term maternal malnutrition, ill health, hard

work and poor health care in pregnancy. In Vulnerability Assessment birth weight was recorded based on either a written record.

Overall, it was estimated that 22.5% of children, out of the 915 live births, which birth weights were available, were less than 2.5kgs (low birth weight) at birth, which indicated an increase from 13.1% and 17.1% in 2017 and 2018 respectively, LVAC reports. Furthermore, 23.4% of babies in rural areas compared to 20.3% in urban areas were low birth weight. By district, the prevalence of low birth weight ranged from a minimum of 11.9% in Mafeteng to a maximum of 33.3% in Thaba-Tseka.

Figure 42: Children Under Five Years born with weight below 2.5kg



7.7.7 VACCINATION, DEWORMING AND VITAMIN A SUPPLEMENTATION ESTIMATED COVERAGE IN CHILDREN UNDER FIVE YEARS

Information on Vitamin A supplementation, deworming, measles rubella and pentavalent vaccinations, deworming were obtained from the child booklet or the respondent. The findings below were based on the households that responded “yes" to the question.

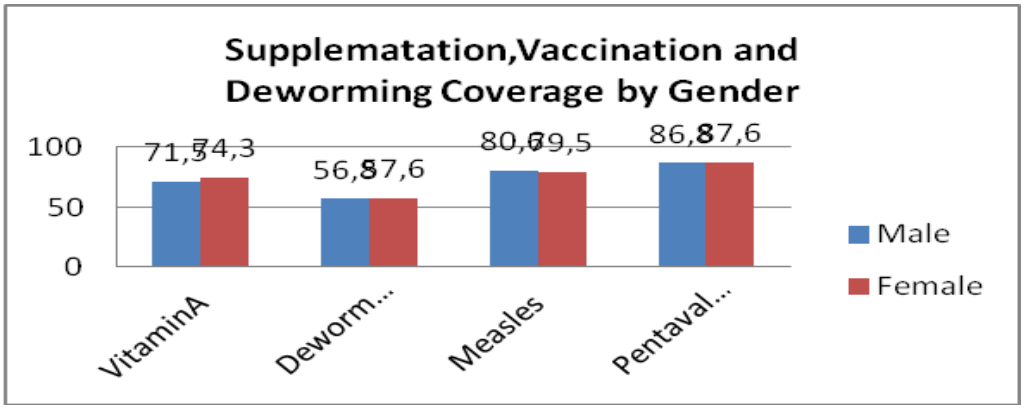
On average, the coverage of vitamin A supplementation amongst sampled households was estimated at 74.5%, with the highest coverage reported in Berea (85.4%) and Quthing (84.8%) versus 2017 and 2018 assessment findings whereby the highest were Qacha’s Nek (92.9%) and Butha Buthe respectively. Overall, vitamin A supplementation coverage was above 60% in all districts in the 2019 assessment results. Estimated coverage for Measles Rubella vaccination was over 80% in 7 districts which is above the overall coverage of 78% while Thaba Tseka (47.9%) was the lowest. Deworming coverage is above 50% in 8 out of 10 districts and only 33% in Mokhotlong and 45.8% in Thaba Tseka. Table 9 presents information on vaccination status, deworming, and Vitamin A by districts.

Table 8 Vaccination, deworming and Vitamin A supplementation estimated coverage in children under five years

District	Vitamin A	Deworming	Measles Rubella	Pentavalent
Butha-Buthe	76.1%	71.6%	82.1%	89.6%
Leribe	60.4%	51.4%	85.4%	84.0%
Berea	85.4%	74.1%	86.2%	83.6%
Maseru	73%	58.5%	75.5%	84.5%
Mafeteng	66.7%	61.9%	71.4%	90.5%
Mohale's Hoek	83.6%	68.5%	87.7%	91.8%
Quthing	84.8%	60.6%	84.8%	89.4%
Qacha's Nek	81.6%	55.3%	81.6%	92.1%
Mokhotlong	66.1%	33.1%	81.8%	99.2%
Thaba-Tseka	62.5%	45.8%	47.9%	66.7%
Average	74.0%	58.1%	78.4%	87.1%

Out of the 915 households with children 6 to 59 months only 668 households responded yes to whether the child received vaccination, deworming and Vitamin A supplementation versus %who responded no and % who responded don't know. Out of 668, 35.5% were boys and 64.5% were girls. Figure 40 shows no significance difference in coverage when disaggregated by gender of children 6 to 59 months.

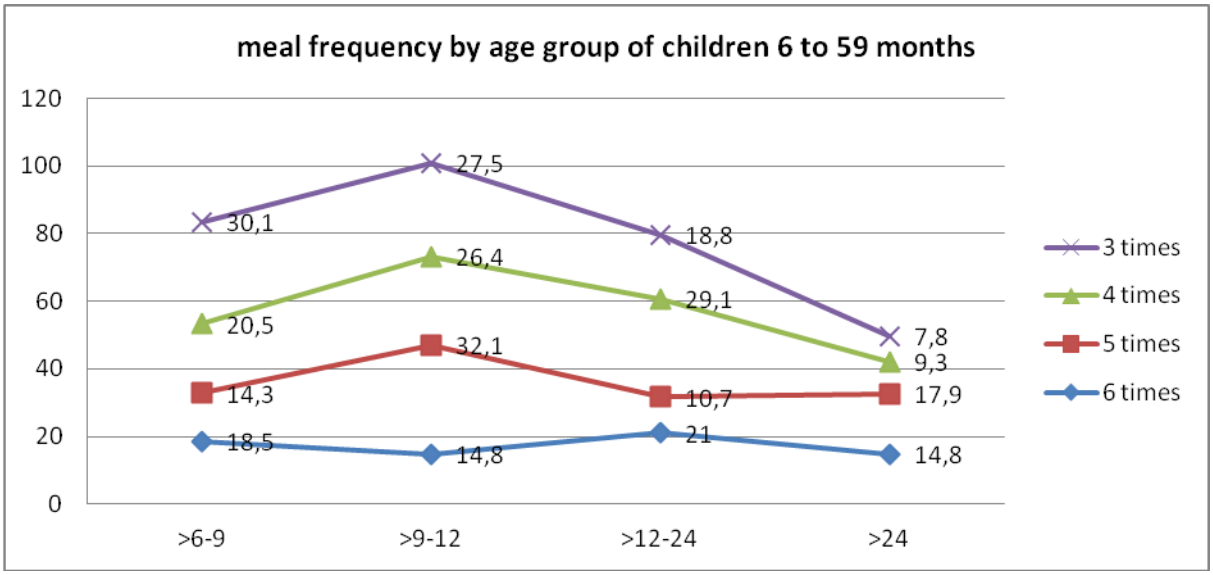
Figure 43: Supplementation, Vaccinatiion and Deworming coverage for children under the age of 5 years by gender



7.7.8 MEAL FREQUENCY

The minimum meal frequency is a proxy for a child's energy requirements. An estimated total of 7.8% of children aged 24 months and above ate at least 3 meals during the previous 24 hours. While 9.3% ate at least 4 meals the previous day, 17.9% ate 5 meals and only 14.8% ate at least 6 meals. Over 80% of children of all ages ate at least 3 meals during the previous day. Almost 30.1% of children aged 9 to 12 months ate at least 4 meals per day, whil less than 60% of children aged 12 to 24 months ate more than 4 meals per day. Less than a third of children in all age groups ate at least 5 meals per day. (See *figure 41* below)

Figure 44: Estimated percentage of children under five years consuming 3, 4, 5 and 6 or more meals per day



7.7.9 CHILD ILLNESSES

The following three common childhood illnesses were assessed; diarrhoea, fever and cough. The percentage of children who were ill with cough ranged from a minimum of 55.9% in Quthing district to a maximum of 86% in Leribe. Fever ranged from a minimum of 6.7% in Mokhotlong to a maximum of 41.2% in Quthing, Overall, 21.3% reported having experienced fever during the 2 weeks before the assessment. No one reported having diarrhoea in the district of Butha Buthe, Mafeteng, Mohale's hoek and Qacha's Nek versus 11.1% Mokhotlong and 7.7% Thaba Tseka, towards the time of the assessment . Around 84.6% of total children who were ill were treated at health centres and 3.0% used homemade remedy. The table below illustrates the proportion of children who had experienced cough, fever or diarrhoea disaggregated by settlement area and sex. In both rural and urban areas, approximately two thirds of children experienced cough, about one third of children experienced fever and less than one tenth experience diarrhoea.

Table 9 Percentage of children under the age of 5 years who were ill with cough, diarrhoea or fever during the 2 weeks before the assessment

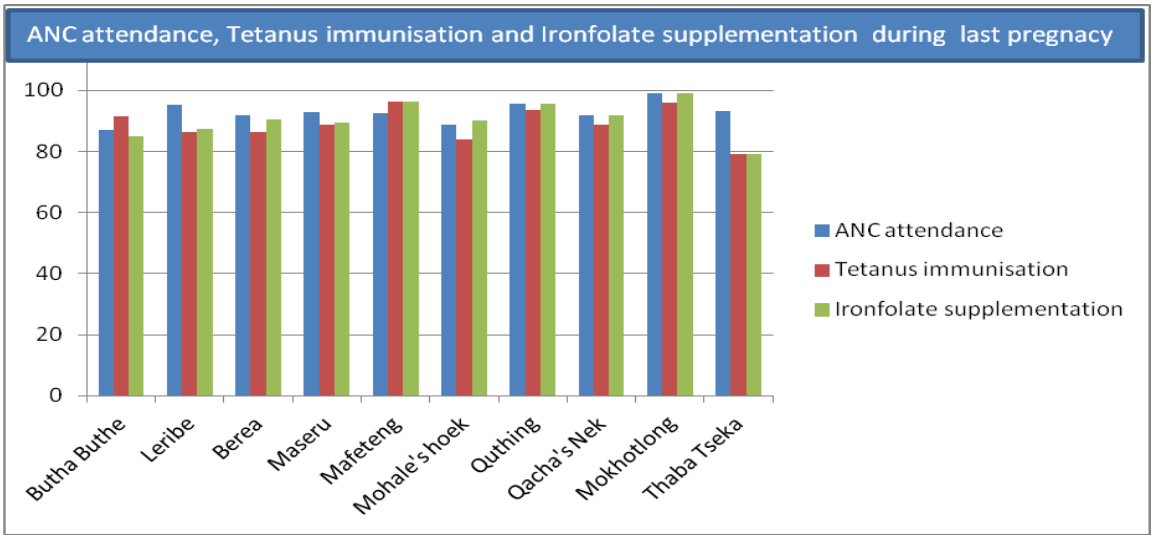
	Cough	Fever	Diarrhoea
Rural	76.4%	19.6%	4.1%
Urban	70.1%	25.6%	4.3%
Male	73.2%	22.3%	4.5%
Female	35.5%	20.5%	3.8%

7.7.10 MATERNAL HEALTH AND NUTRITION

ANTENATAL CARE COVERAGE

A total of 93.7% of 646 women interviewed indicated that they attended antenatal care during pregnancy. The indicate a slight increase of 15% from 2018 LVAC findings. Figure 41 below shows that self reported ANC attendance ranged from a minmum of 87.2% in Butha Buthe to a maximum of 99.0% for Mokhotlong. ANC attendance was not that different comparing rural (93.3%) and urban (94.5%). Over 80% of women in all districts reported having received ironfolate and vaccinated against tetanus, except Thaba Tseka with only 79.3% in both. In rural areas, 90% reported receiving ironfolate supplementation compared to 92% in urban areas.

Figure 45: Percentage of mothers who attended ANC during, received iron folate, and were immunised against tetanus during the last pregnancy



AGE AT FIRST BIRTH AND FIRST LIVE BIRTH

Most women fall pregnant; include miscourages, at least 5 times. On average, women in Lesotho had their first live birth at the age of 20 years. Highly educated women (university, technical college etc) have their first child later than other women. Women with more than secondary education begin childbearing almost 5 years later than women with no education (21 to 24 years versus 18 to 20years).

Households were asked whether there have been a member who has given birth in the past 12 prior to the assessment and if the answer was yes, were asked to give the place where delivery took place. In Butha Buthe, Maseru, Mohale's Hoek, Quthing, Mokhotlong and Thaba Tseka there are deliveries that took place at home. Table 11 below presents households with women who delivered in the past 12 months prior to the assessment. By settlement type, most deliveries took place at health facilities at urban settlement (95%) than rural settlement (82.1%) while 17.9% of deliveries at rural settlement took place at home.

Table 10 Percentage of women who delivered during the 12 months before the assessment by facility and district

Where delivery conducted	Butha Buthe	Leribe	Berea	Maseru	Mafeteng	Mohale's Hoek	Quthing	Qacha's Nek	Mokhotlong	Thaba Tseka
Home	12.5 (2)	100 (8)	100 (1)	16.2 (6)	100 (5)	7.7 (1)	28 (7)	100 (5)	16.7 (1)	10.5 (2)
Health facility	87.5 (14)	0	0	83.8 (31)	0	92.3 (12)	72 (18)	0	83.3 (5)	89.5 (17)

7.7.11 WATER, SANITATION AND HYGIENE PRACTICES

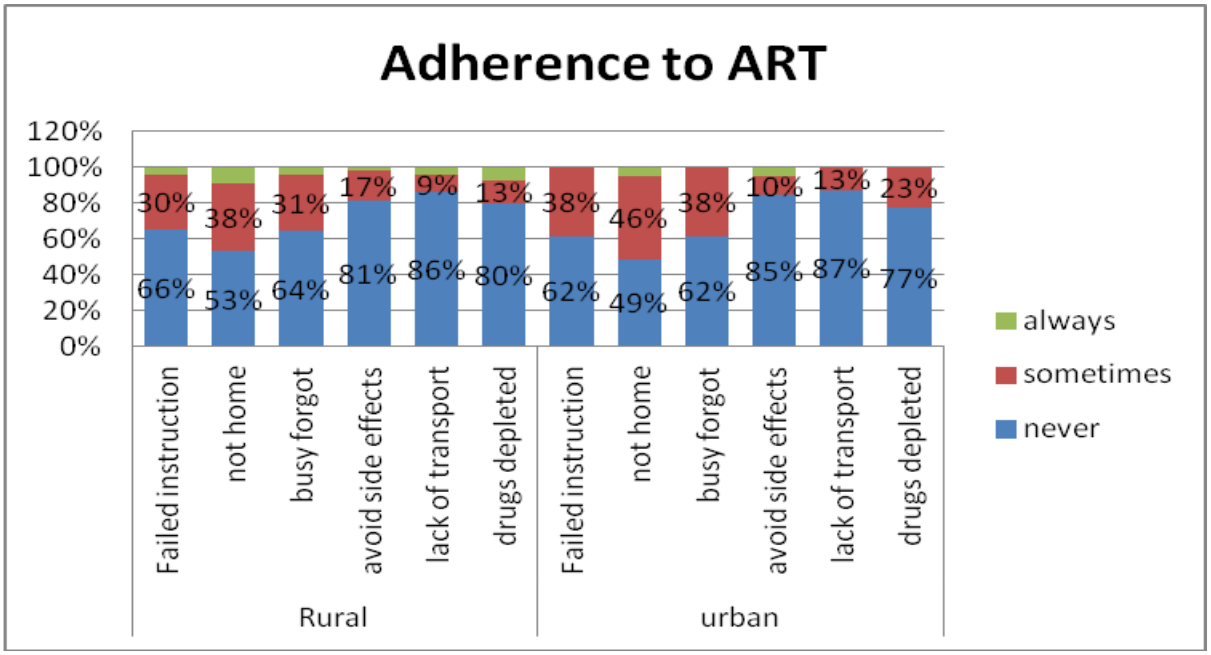
The findings indicated that only 21.4 % of households with children under five years of age washed hands after toilet and 21.8% before preparing food. The smallest percentage was recorded under washing hands after changing the nappy at 6.7%. The results were similar to that of the Rapid Assessment conducted in March 2019. In addition, 80.4% washed hands using soap and water and 1.6% used water and ash. Furthermore those who wash hands 92% using basin.

7.7.12 HIV/AIDS and TB

HIV and AIDS: about 32.2% of households indicated to have a member with HIV and out of those households 50.2% were female headed. Urban settlement prevalence was at 30.2% whereas rural was at 33.2%.

Majority of households indicated that they at 46.6%. Moreover, prevelance is high from those households headed by people with no education and up to secondary level ranging from 31% to 37% for such households. Furthermore, when analysing HIV looking at marital status, households headed by widows or widowers were the most with HIV prevelance. The study also investigated whether there were any household member who died in the previous 12 months and 4.8% indicated that was the case. On top of that 21.1% showed that the person was HIV positive while 48.6% indicated that the person was a bread winner.

Figure 46: Adherence to ART



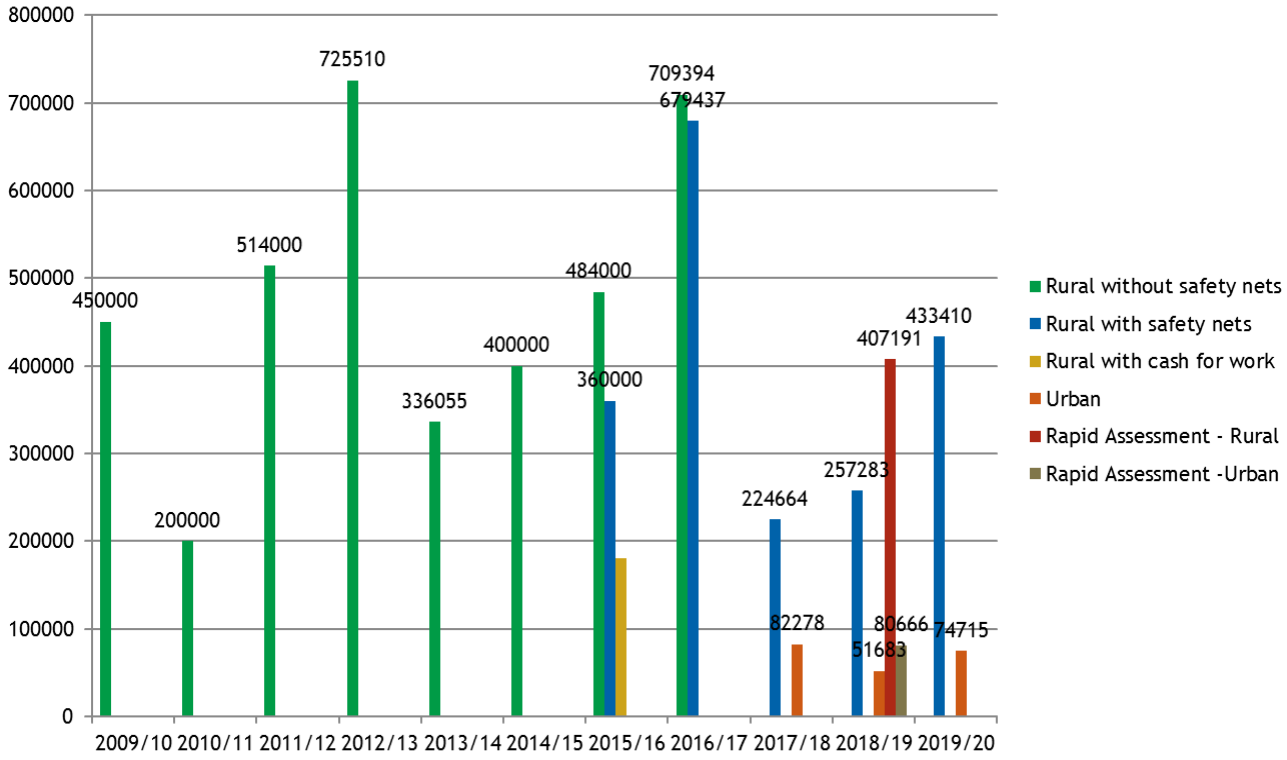
Some of the interviewed households with a member living with HIV admitted that they did not adhere to treatment in the past 30 days due to various reasons as depicted in the above graph. Within the households that were sampled, TB prevalence was at 2.2%.. When assessing the households with TB by type of settlement, rural households had more percentatge with TB at 2.3% compared to urban at 2%. It was found that male headed households had high percentage (2.7) of TB prevelance compared to female headed households (1.6%)

7.8 Food Insecure Population in rural settlement

A total of **433, 410 (30%)** rural population is estimated to be food insecure for the Consumption year 2019/20. The affected populations are from the very poor and poor household groups across all the districts. The projected survival and livelihood protection gaps are mainly resulting from low crop production, reduction in labour opportunities especially from agricultural activities and limited targeting of some safety nets.

Compared to last year (2018), the current year food security situation of the country decreased significantly as a result of low agricultural production and declined on-farm and off-farm labour opportunities. Figure 44 shows trends of food insecure population since 2009/10.

Figure 47: Trends of food insecure population



7.8.1 ESTIMATION OF FOOD INSECURE POPULATION AS PER THE INTEGRATED FOOD SECURITY PHASE CLASSIFICATION

The Integrated Food Security Phase Classification (IPC) Acute Food Insecurity(AFI) analysis was used to estimate and classify food insecure population by Phases per district. It should be noted that the IPC analysis was done in two time periods being the Current situation and Projected situation. Household Economy Approach

analysis spreadsheets (LIAS) were used to calculate the food or cash requirements for the food insecure population for the consumption year 2019/20.The IPC phases and the priority response objectives per each phase are explained as:

Phase 1 Minimal: Households are able to meet essential food and non-food needs without engaging in atypical, unstainable strategies to access food and income. This phase is inditified by light green colour. Priority actions required are to build households resilience and Disaster Risk Reduction skills.

Phase 2 Stressed: Households have minimally adequate food consumption but are unable to afford some essential non food expenditures without engaging in stress coping strategies. The colour attached to this phase is yellow. Actions required for Disaster Risk Reduction and protection of livelihoods.

Phase 3 Crisis: Households either: have food consumption gaps that are reflected by high or above usual acute malnutrition or are marginally able to meet minimum food needs only by depleting essential livelihood assets or through crisis coping strategies. The colour given to Phase 3 is orange and urgent action is required to protect livelihoods and reduce food consumption gaps.

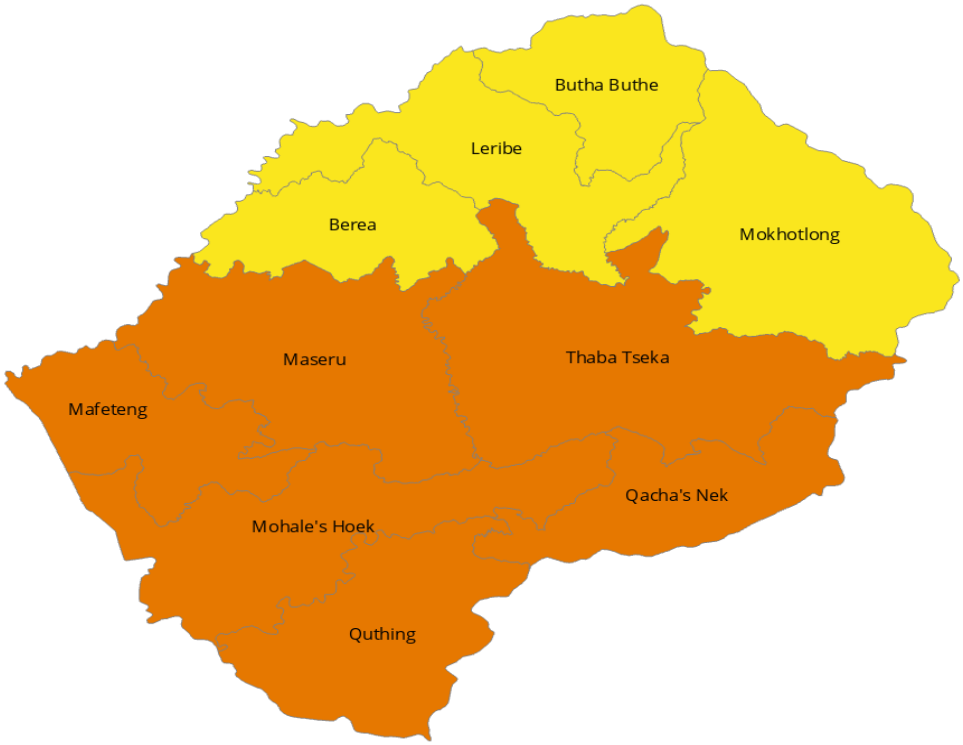
Phase 4 Emergency: Households either; have large food consumption gaps resulting in very high acute malnutrition and excess mortality or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation. The red colour therefore distinguishes this phase from other phases, and urgent action is required to save lives and livelihoods.

Phase 5 Famine: Households have extreme lack of food and/or other basic needs even after full employment of coping strategies. Starvation, death, destitution and extremely critical acute malnutrition levels are evident. (Evidence for all the criteria of food consumption, wasting and Crude Death Rate are used as basis to classify area into famine. The colour for famine phase is brown. The urgent actions are required to prevent widespread mortality and total collapse of livelihoods. **NB:** For an area to be classified into a phase there should be at least 20% of the population in that phase or worse.

7.8.1.1 IPC Phase classification and food insecure population for the current time period (May –September 2019) AFI analysis

The current situation reveals that six districts are classified in Phase 2 ‘Stressed’ while the other four are in phase 3 ‘Crisis’. (See Map 1 below). There is no district that is classified in Phase 4 and 5, although there are some population (5% in each distict) in phase 4 ‘Emergency’ with the exception of Botha Bothe. Across the country 44% of the total rural population is in Phase 1 ‘None/Minimal Acute Food Insecurity’, 32% in Phase 2 ‘Stressed’, 19% in Phase 3 ‘Crisis’ and 5% in Phase 4 ‘Emergency’.

Figure 48: Map of IPC acute insecurity Classification phase by districts during May to Aug 2018 period



The current food security situation therefore implies that at least one in five households from Botha Bothe, Leribe, Berea and Mokhotlong have minimally adequate food consumption but are unable to afford some esseantial non-food expenditures without engaging in stress coping strategies. However, there is a need for urgent action for the 24% population that is in phase 3 (crisis) or worse. The response objectives that are recommended are to protect livelihoods, reduce food consumption gaps and save lives. Table shows population distribution according to their phase classification of food insecurity per district.

Table 11 Distribution of population according to phases of Food insecurity for current situation

		Population Table: Current Situation (May –September 2019)									
				Phase 1 None/Minimal		Phase 2 Stressed		Phase 3 Crisis		Phase 4 Emergency	
District	District Rural Pop	% Pop requiring urgent measures to protect livelihoods , alleviate food gaps & acute Malnutrition (IPC 3+4).		HH group is able to meet essential food & non-food needs without engaging in atypical, unsustainable strategies to access food and income.		Households have minimally adequate food consumption but are unable to afford some essential non food expenditures without engaging in stress coping strategies		Households either: have food consumption gaps that are reflected by high or above usual acute malnutrition or are marginally able to meet minimum food needs only by depleting essential livelihood assets or through crisis coping strategies.		Households either; have large food consumption gaps resulting in very high acute malnutrition and excess mortality or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation.	
		#	%	#	%	#	%	#	%	#	%
Botha-Bothe	85 619	12 842	15	51 371	60	21 404	25	12 842	15	0	0
Leribe	255 921	38 388	15	127 960	50	89 572	35	25 592	10	12 796	5
Berea	179 283	17 928	10	80 677	45	80 677	45	8 964	5	8 964	5
Maseru	229 285	80 249	35	68 785	30	80 249	35	68 785	30	11 464	5
Mafeteng	153 904	61 561	40	61 562	40	30 781	20	53 866	35	7 695	5
Mohale's Hoek	156 906	39 226	25	78 453	50	39 226	25	31 381	20	7 845	5
Quthing	116 111	34 833	30	52 250	45	29 028	25	29 027	25	5 806	5
Qacha's Nek	54 848	10 969	20	21 939	40	21 999	40	8 227	15	2 742	5
Mokhotlong	97 386	14 607	15	43 823	45	38 954	40	9 738	10	4 869	5
Thaba-Tseka	125 992	37 798	30	50 397	40	37 798	30	31 498	25	6 300	5
Total	1 455 255	348 401	24	637 217	44	469 628	32	279 920	19	68 481	5

7.8.1.2 IPC Phase classification and food insecure population for the projected period (October 2019 to March 2020) AFI analysis

In the Projected Period (October 2019-March 2020), the peak hunger period in the country, all the districts are classified in Phase 3 'Crisis' as shown in Map 2 below. All the districts have at least 20% of the total district rural population in phase 3 or worse. Although there are no districts classified in phase four and five during this period, It should be noted that there are proportions of population in phase four with ranges between 5% and 10%. Interventions to protect livelihoods, reduce food consumption gaps, and save lives are required urgently.

Figure 49: IPC acute food insecurity phase Classification by districts for the period October 2019 to March 2020.

Overall total population in phase 3 or worse is 30%, significantly higher compared to 18% in 2018. Table 12 shows distribution of population per phase for all districts. The current season shows a deteriorating food security, as the number of acutely food insecure households has been increasing steadily since last year. Nearly a quarter of the rural population (349,000 people) are estimated to be experiencing severe acute food insecurity (IPC Phase 3+), with around 69,000 people being in Emergency (Phase 4) and nearly 280,000 people in Crisis (Phase 3). Six districts, namely; Maseru, Mafeteng, Mohale's Hoek, Quthing, Qacha's Nek and Thaba Tseka are classified in Phase 3, and the other four districts, namely: Berea, Botha Bothe,

Leribe, and Mokhotlong in Phase 2 (Stressed). In the previous year, all ten districts were classified in Phase 2 in the current period, and four out of these moved into Phase 3 during the November IPC update. This means two more districts have now slipped into a Crisis situation. Having districts classified in Phase 2 or worse, at the time when households are supposed to have enough food stocks, is an indication that household ability to cover food consumption needs has weakened. The country experienced late onset of rains coupled with high temperatures, and resulted in late planting as well as a significant decrease in area planted compared to the previous season. The mountain livelihood zone that planted on time experienced poor germination due to low moisture content, while those that planted late, crops did not reach maturity. Other shocks that negatively affected crops include hailstorms and pests. Although in the highlands planting was done on time, prolonged dry spells resulted in poor germination and crop conditions. Crop estimates show a declining trend over two consecutive years, with production of maize declining by 70% compared to last year, which already had a 36% decline in the same crop that year. Sorghum production declined by almost 98%, while wheat production increased by 18% compared to last year. A significant drop in crop production in two successive years has resulted in low or no household food stocks, and has also negatively affected livelihoods and income sources, especially for households that depend mainly on agricultural labour activities. Opportunities for other income sources such as self- employment (beer brewing) and non-agricultural casual labour, in particular those that offer payment in-kind, also declined as food stocks decreased. Prolonged dry spells further affected the grazelands adversely and led to poor livestock and livestock products conditions. The majority of households rely on unpredictable livelihoods sources that are prone to small shocks, thus reducing household purchasing power and widening food gaps. Although food production has declined significantly compared to last year, food availability remains a minor limiting factor. This is attributed to the fact that the country has proven to have the ability to import food from South Africa over the years and the markets are fully functional. Prices of staple food remain slightly higher than last year, but are stable and below the five-year average. Food access becomes a major limiting factor for most districts, due to reduced own production and purchasing power to buy food. Purchasing power for the very poor and poor households is also likely to be compromised for the projected period due to anticipated late start of the next agricultural season, as a result of forecasted EL-NINO Phenomenon at regional level.

The scenario for the projected period is likely to change and VAA update exercise is needed in October/November 2019 to update the projection. Moreover close monitoring of prices is as well critical to inform early actions.

Table 12 Distribution of population according to phases of Food insecurity for the projected period

		Population Table: Projected Period (October 2019-March 2020)									
				Phase 1		Phase 2		Phase 3		Phase 4	
District	District Rural Pop	% Pop requiring urgent measures to protect livelihoods alleviate food gaps & acute Malnutrition (IPC 3+4).		HH group is able to meet essential food & non-food needs without engaging in atypical, unsustainable strategies to access food and income.		Households have minimally adequate food consumption but are unable to afford some essential non food expenditures without engaging in stress coping strategies		Households either: have food consumption gaps that are reflected by high or above usual acute malnutrition or are marginally able to meet minimum food needs only by depleting essential livelihood assets or through crisis coping strategies.		Households either; have large food consumption gaps resulting in very high acute malnutrition and excess mortality or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation.	
		#	%	#	%	#	%	#	%	#	%
Botha-Bothe	85 619	17 124	20	38 529	45	29 967	35	17 124	20	0	0
Leribe	255 921	51 184	20	102 368	40	102 368	40	38 388	15	12 796	5
Berea	179 283	35 615	20	62 325	35	80 132	45	26 711	15	8 904	5
Maseru	229 285	91 637	40	45 857	20	91 714	40	80 250	35	11 387	5
Mafeteng	153 904	61 562	40	46 171	30	46 171	30	53 866	35	7 695	5
Mohale's Hoek	156 906	47 072	30	62 762	40	47 072	30	39 227	25	7 845	5
Quthing	116 111	46 445	40	34 833	30	34 833	30	40 639	35	5 806	5
Qacha's Nek	54 848	19 197	35	13 712	25	21 939	40	13 712	25	5 485	5
Mokhotlong	97 386	19 447	20	29 216	30	48 693	50	14 608	15	4 869	5
Thaba-Tseka	125 992	44 097	35	31 498	25	50 397	40	37 798	30	6 300	5
Total	1 455 255	433 410	30	467 271	32	493 990	38	362 323	25	71 087	5

7.8.3 RESOURCES REQUIRED TO FILL BOTH SURVIVAL AND LIVELIHOODS PROTECTION DEFICITS.

Household Economy Approach is used to define the existing gaps in terms of the two thresholds namely Survival and Livelihoods Protection Deficits through Outcome Analysis which are described as follows:

Survival Threshold: represents Total income required to cover 100% of minimum food energy needs (2100 kcal) plus costs associated with food preparation and consumption per person per day. Survival Deficits occur when there is insufficient expenditure to cover the survival requirements.

Livelihoods Protection Threshold: is the total income required to sustain livelihoods. This means total expenditure to ensure survival plus access to essential services (e.g. Routine medical, school expenses etc.), sustain livelihoods in the medium to longer term (e.g. regular purchases of seeds, fertilizer, veterinary drugs etc.). Livelihood Protection deficit occur when total income is not sufficient to cover the cost of Survival expenses plus other livelihoods costs.

The table below presents the summary of resources required to cover both the survival and the livelihoods protection deficits for different districts. Population facing survival deficit already have livelihood protection deficit. Therefore, when calculating the need for population facing only livelihoods protection deficit, the population facing survival deficit is subtracted from this number to avoid double counting. The resources do not include the operational costs required to implement any proposed interventions. The total number of rural population in need of assistance which is **433, 410** (an increase from **257, 283** people in need in 2018) will need an amount of 53 048MT or M477 434 250.00. (compared to 13,340MT or M107, 441,380 in 2018) to cover both survival and livelihoods protection deficits. The detailed breakdown of survival deficit, livelihoods protection deficit and the requirement to close the gap is attached in Annex A.

Table 13 Resource requirements for food insecure population within rural areas

District	Total Rural Population	Population in need	% Population in need	# of Months	MT required	Cash required (x1000)
Botha-Bothe	85 619	17 124	20	6	1788	16 090
Leribe	255 921	51 184	20	6	5344	48 092
Berea	179 283	35 615	20	6	3718	33 464
Maseru	229 285	91 637	40	6	9567	86 102
Mafeteng	152 865	61 562	40	6	6427	57 844
Mohale's Hoek	156 906	47 072	30	6	4914	44 229
Quthing	116 111	46 445	40	6	4849	43 640
Qacha's Nek	54 848	19 197	35	6	2004	18 038
Mokhotlong	97 386	19 477	20	6	2033	18 301
Thaba-Tseka	125 992	44 097	35	6	4604	41 434
Total	**1 455 255**	**433 410**	**30**	**6**	**45 248**	**407 232**

7.8.4 Food Insecure populations by Livelihood zones (Rural)

Table 7 depicts total food insecure population per Livelihood Zone for each district. The table serves as a guidance for implementing interventions. In Botha Bothe, for example, 13% of rural population is food insecure and 12% comes from the Foothills while 1% comes from the Mountains Livelihood Zone as indicated in table 7 below.

Table 14: Beneficiaries by Livelihood Zones

District	Livelihood Zone	Total District Population	No. Affected by LZ	Percentage
Botha Bothe	Foothills	85619	13800	16%
	Mountains		1379	2%
	Northern LowLands		1945	2%
Leribe	Foothills	255921	41879	16%
	Mountains		9305	4%
Berea	Foothills	179283	7986	4%
	Northern LowLands		27629	15%
Maseru	Foothills	229285	14972	7%
	Mountains		5503	2%
	Southern LowLands		71162	31%
Mafeteng	Foothills	153904	7472	5%
	Southern LowLands		54090	35%
Mohale's Hoek	Foothills	156906	6820	4%
	Mountains		7900	5%
	Southern LowLands		30406	19%
	Senqu River Valley		1946	1%
Quthing	Mountains	116111	26360	23%
	Senqu River Valley		20085	17%
Qacha's Nek	Mountains	54848	17583	32%
	Senqu River Valley		1614	3%
Mokhotlong	Mountains	97386	19477	20%
Thaba Tseka	Mountains	125992	40923	32%
	Senqu River Valley		3174	3%
Total		1 455 255	433 410	30%

7.8.5 Summary of Food insecure population by district

7.8.5.1 Botha-Bothe

The results indicated that 20% of population has survival and substantial livelihoods protection deficits and that suggests intervetions to save and protect lives. The

population which is likely to face deficit in the district is estimated at 17 124. Population at risk are the very poor and poor households. A total of 1 788Mt of maize meal or M16 090 (X1000) is required to cover existing gap.

7.8.5.2 Leribe

Leribe district has population that is likely to have both survival and livelihood protection deficits. The total estimated food insecure population is 20%; about 51 184 people which is an increase compared to 33 270 people in 2018. This population is among the very poor and poor households. The existing deficit will require 5344MT of maize meal or M48 092 (x1000) cash equivalent.

7.8.5.3 Berea

An estimated 20% which is 35 615 households in the district will experience both survival and Livelihoods Protection defecits. This population is among the very poor and poor households of the district rural population and the total food requirement is estimated at 3 718MT or M33 464 (x1000) cash equivalent.

Table 15: Resource estimation to cover food gaps within urban settlement. Please note column c for proportion of beneficiaries in 2018/19 compared to column d presenting food insecure population in 2019/20.

a) District	b) Urban Population	c) % Beneficiaries (2018/19)	d) % Beneficiaries (2019/20)	e) MT Required	f) Cash requirement (M X1000)
Butha-Buthe	21 273	8% (2640)	36,8% (7 838)	818	7 364
Leribe	51 731	6% (6100)	5,5% (2 843)	297	2 671
Berea	91 093	9% (6400)	23% (20 983)	2 191	19 715
Maseru	281 572	8% (7040)	6,9% (19 318)	2 017	18 151
Mafeteng	33 139	13% (7793)	6,7% (2 208)	230	2 074
Mohale's Hoek	18 134	12% (7256)	63,9% (11 591)	1 210	10 891
Quthing	4 744	9% (4068)	34,9% (1 656)	173	1 556
Qacha's Nek	16 840	7% (1523)	9,8% (1 656)	173	1 556
Mokhotlong	15 089	16% (5993)	11% (1 656)	173	1 556
Thaba-Tseka	18 330				

		6% (2870)	27.1% (4 968)	519	4 667
Total	**551 946**	**9.2% (51 683)**	**13,5% (74 715)**	**7 800**	**70 202**

Protection, Child Protection, Gender Based Violence and Migration:

The data collected during the assessment on gender-based violence and child protection shows the prevalence of 1.3% of sexual harassment and rape violence from a total of 2875 of respondents who confirmed experience of this type of violence in the household. Berea district seemed to be top on the list of districts with seven (7) heads of households who attested to the prevalence of sexual violence. Respondents indicate by type that there were 21 cases of sexual harassment and 17 cases of rape. Of the 38 households that confirmed occurrence of sexual violence 55.3% is headed by male and 44.7% is headed by female.

On the question of child labour the data collected in the 10 districts indicates that children are involved in construction projects (19.1%), farm work (14.9), mine work (2.1%), transport (2.1%), herding livestock (0.9%), domestic work (0.4%) and other form of labor. Child Labor consist of the engagement of children in work, which deprives them of their childhood, denies them of opportunity to education, dignity and is harmful to their physical and mental development. For purpose of this assessment child labour was important to elicit vulnerability of the families.

Households were asked whether in a couple of months back any member of the family who is below 18 has been married. Out of 2978 households 55 households reported marriage of a child below 18 years. The prevalence of child marriage is at 2.0% as indicated by heads of households interviewed

Gender Based Violence and other protection concerns witnessed including safety threat of harm, harassment, community dispute, and violence against women and children. Women have higher concern regarding safety as compared with men. 22.8 % (446 head of households) reported having difficulties in accessing Water and Sanitation facilities. The reasons reported for not feeling safe while using toilet facilities are violence to and from facility, harassment, conflict about use of water source and others. Almost half of households reporting not feeling safe while accessing water and toilet facilities are women (57% of respondents).

The following were barriers that were indicated as preventing women from accessing some basic facilities like health facilities, water and sanitation facilities:

Long distances, Costs, Lack of female staff, Cultural restrictions, Lack of specialized services, other. This group is followed by both children and elderly (14%) people representing both (14.4%), elderly (10.4%), people with disabilities and other. The districts of Maseru, Mohale's Hoek and Leribe reported a higher number of people not feeling safe while accessing water facilities.

Migration

A small number of households interviewed (5.2% (102 families) reported to have at least a member of the household who have migrated to South Africa. In all districts respondents reported having family member who have migrated. Majority of households who reported having a member of the household who migrated are from Leribe (35.3%) and Berea (13.7%), followed by Mokholong (10.8%) and Qacha's Nek (9.8%). Mafeteng, Mohale's Hoek and Mseru each have 6.9 % of households reporting having a member of household who migrated to South Africa while 5.9% households in Quthing and 2% of households each in Butha-Buthe and Taba Tseka reported having a member of their family who migrated. Among those who migrated to South Africa 6% of the responding households reported lack of water and food as one of the driving factor for migration.

Of the 102 households who reported having a member of their family who migrated to South Africa (44%) further indicated a member of their household who was on antiretroviral treatment (ARV). Only 20% of households reported their family members on AVR having access to the treatment in South Africa while the rest (80%) said they have no access to the treatment.

Furthermore, 2.2 % of those taking ART said failed to take ART. The reasons categories which do not differ significantly (0.5) level or about 1.9 % respondents of those who missed taking their ART the reasons include failed instruction, not being home, busy and forgot, avoid side effects, lack of transport, drug depleted and migration in and out of the country, and HIV medication stolen. For those who responded to this question, only 9 (0.5% who are HIV positive and have migrated to South Africa) out of 45 individuals said that they have access to the medication in South Africa. A very small number of households 2.6% (or 51 families) reported to have received an orphans in their households.

8.Recommendations

1. Nutrition

Overall GAM rates were within acceptable range. However, for districts with wasting above 5% there is a need for in-depth study on nutrition indicators in which sample size would be more representative.

2. Food availability

Food availability is slightly compromised as a result of low agricultural production. However, markets are still functional and fully supplied. The following are therefore recommended:

- Agriculture input subsidy programme should be on time and inputs be closer to farmers.
- Incorporate Climate Smart technologies in subsidies particularly Conservation Agriculture (CA) for resilience building.
- The government should consider construction on irrigation infrastructure to ease access to water for the farmers.
- Government to reconsider sharecropping scheme which was not evident in the 2018/19 agricultural season.

3. Food Access

Own production will last households for less than two months instead of four months in a normal year due to low harvest. Staple price are increasing in a stable rate. However, poor households will not be able to purchase staple throughout the consumption year because of decreased income opportunities especially from agricultural activities. Moreover, international staple price are increasing and are likely to influence local staple price. The following measures should be implemented:

- The government must ensure that all social protection and cash transfer programmes are well targeted.
- Monitoring of food prices so that they could be stabilized should they increase in a high rate.
- Humanitarian Assistance – Conditional assistance in a form of Cash for Work in districts that are in phase 3 or worse.

4. Food Utilization

Majority of households have access to clean and safe water as well as to improved sanitation facilities. However, there is a certain percentage of households that use open defaecation and draw water from unprotected springs. To address this challenge, the following should be taken care of:

- Improve water access in districts where there is a problem with water supply.
- Capture and improve unprotected water sources.
- WASCO and DRW to improve water access and increase coverage throughout the country.

5. Gender based violence, migration and other protection concerns

- There is a need for developing and implementing standard case management and referral mechanisms and standard operating procedures for protection concerns.
- Strengthen child protection and GBV activities to include not only dissemination of Information, Education and Communication (IEC) materials to affected communities but link vulnerable groups to livelihood and education-related activities.
- Need for advocacy and awareness raising to address child labor in the communities.
- There is a need to strengthen the understanding of law enforcement agencies and health services delivery on protection issues especially those face by the affected population. This include meaningful physical access to basic services to elderly, women and men exposed to protection risks such as access to toilets and water sources.
- Effective referral mechanisms must be strengthened and established where they are not available and shall be followed by the relevant authorities and agencies that calls for dignified and equal access relevant to the provisions of services as enshrined in the Constitutions of Lesotho and conformity with the internationally recognized humanitarian standards.
- Special needs of older people and people with disability and chronically ill should be considered while designing the response activities including those involving construction of structures (e.g. toilet, drilling of boreholes, platforms where humanitarian assistance is distributed etc.) to ensure issues of safety and meaningful and equal access to services.

  Provision of legal identity documentation to all vulnerable groups to facilitate their access to legal, welfare, social services including humanitarian assistance.

- Ensure safe housing for victims or survivors of GBV and Trafficking and other form of violence and is gender and age appropriate.
- Continue and expand sensitization initiatives for women and children and community members on vulnerabilities related to accessing water, collecting wood, using public toilets, and playing in the fields for children.
- Raising awareness among people living with HIV and AIDS (PLWHA) and those on ARV who intend to migrate about the importance of reporting to their local health facility as well as their Community adherence groups is vital to ensure that they take enough supply of their medication with them and receive additional medication through their CAG fellows before their stocks run out and avoid defaulting on their treatment.

Annex: The names of VAA participants and their institutions

1. Ms Eunice Masipho Mazibuko	Health- Botha Bothe
2. Mr Phano Ntene	DMA- Botha Bothe
3. Mr Seabata Ramotso	BOS –Botha Bothe
4. Ms Makabelo Mokhesuoe	MAFS- Botha Bothe
5. Mr Mare Keketsi	DMA- Leribe
6. Ms Mamosa Nei	MFRSC - Mokhotlong
7. Ms Nthabiseng Maqekoane	LMS - Leribe
8. Ms Limakatso Koae	FNCO- Leribe
9. Ms Malimpho malefane	FNCO - Mokhotlong
10. Mr Alex Mpharoane	DMA- Berea
11. Ms Maletsatsi Lesia	FNCO- Berea
12. Ms Matsoanelo Mololo	DMA- Berea
13. Ms Mpolai Chele	FMU - Berea
14. Mr Mashampene Shampene	Education - Mokhotlong
15. Ms Matseko Pitso	Small Business - Berea
16. Ms Matsitso Motemekoane	DMA- Qacha's Nek
17. Mr Thabo Pitso	DMA- Maseru
18. Ms Pulane Makitle	DMA- Maseru
19. Ms Lineo Sehloho	WFP – Maseru
20. Ms Malefu Lesee	HEALTH - Leribe
21. Ms Nonkosi Tshabalala	DMA- Maseru
22. Mr Ramabele Lekoatsa	STATISTICS - Leribe
23. Mr Tsepo Motseleli	NSS - Leribe
24. Mr Thabo Kholopo	Gender-Maseru
25. Ms Masitsane Mathulenyane	Education-Maseru

26. Mr Lekhabunyane Khoeli	GENDER - Leribe
27. Ms Mampuo Motsamai	Local Gvt-Maseru
28. Ms Mamonyaku Koloti	DMA- Mafeteng
29. Mr Morakabi Ramohlanka	DMA- Mafeteng
30. Ms Mamorakane Rafeeea	FNCO-Mafeteng
31. Ms Masenate Mofoka	MTEC - Mohale's Hoek
32. Ms Mamoea Rakolobe	DMA-Mohale's Hoek
33. Ms Matlotliso Sekhesa	DMA-Mafeteng
34. Ms Relebohile Ramokoatsi	MTEC - Mohale's Hoek
35. Mr Thabo Letsie	DMA- Mohale's Hoek
36. Ms Mabahlakoana Lekhooana	MAFS – Mohale's Hoek
37. Ms Leetoane Fatle	Health- Mohale's Hoek
38. Ms Machaka Lebitsa	MAFS – Mohale's Hoek
39. Mr Hlomohang Matjopile	DMA-Quthing
40. Ms Maneo Motanya	FNCO- Quthing
41. Ms Kekeletso Seleteng	MAFS- Qacha's Nek
42. Mr Ntsane Matlatsa	MAFS-Qacha's Nek
43. Ms Ntoetsi Sejakhosi	DMA-Mokhotlong
44. Ms Khopotso Rakolobe	DMA- Thaba Tseka
45. Ms Masemela Khomoealefifi	DMA- Thaba Tseka
46. Matsitso Motemekoane	DMA Qacha's Nek
47. Ithabeleng Koneshe	DMA- Qacha's Nek
48. Bolokoe Mohale	Social Dev Thaba Tseka
49. Makarabelo Lebitsa	Education Thaba Tseka
50. Mamolibeli Ngakane	Gender - Maseru
51. Masupu Rasupu	CABINET - Maseru
52. 'Mapuo Motsamai	DA's Office - Maseru
53. Mammopa likotsi	FNCO - Maseru
54. Marethabile Koenene	LRCS - Maseru
55. Likese lerotholi	LRCS - Maseru
56. Mokhothoane Ntlaloe	Small Business - Maseru
57. Sophie Ralejoe	DMA- Maseru
58. Mabulara Motlomelo	LRCS - Maseru
59. Manthona Seliane	DMA-Maseru
60. Mookho Mohapi	DMA-Maseru
61. Puseletso Ramaqele	LRCS - Maseru
62. Thapelo Rankoe	DMA-Maseru
63. 'Mamolapo Lehata	DMA – Leribe
64. Silyvia	Livestock – Maseru