

# Lesotho

## Country programme document 2013-2017

The draft country programme document for Lesotho (E/ICEF/2012/P/L.8) was presented to the Executive Board for discussion and comments at its 2012 annual session (5-8 June 2012).

The document was subsequently revised, and this final version was approved at the 2012 second regular session of the Executive Board on 14 September 2012.

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*Basic data<sup>†</sup>**(2010 unless otherwise stated)*

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Child population (millions, under 18 years)	1.0
U5MR (per 1,000 live births)	85 <sup>a</sup>
Underweight (% , moderate and severe, 2009)	13 <sup>b</sup>
(% , urban/rural, poorest/richest)	12/13, 18/9
Maternal mortality ratio (per 100,000 live births, 2008)	530 <sup>c</sup>
Primary school enrolment/attendance (% net, male/female, 2009)	87/91 <sup>d</sup>
Survival rate to last primary grade (% , 2004-2005)	84 <sup>d</sup>
Use of improved drinking water sources (%)	78
Use of improved sanitation facilities (%)	26
Adult HIV prevalence rate (% , 15-49 years of age, 2009)	23.6
Child labour (% , 5-14 year olds, 2000)	23
Birth registration (% , under 5 years, 2009)	45
(% , male/female, urban/rural, poorest/richest)	46/45, 43/46, 42/49
GNI per capita (US\$)	1080
One-year-olds immunized with DPT3 (%)	83
One-year-olds immunized against measles (%)	85

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<sup>†</sup> More comprehensive country data on children and women can be found at [www.childinfo.org/](http://www.childinfo.org/).

<sup>a</sup> The Lesotho Demographic and Health Survey (DHS) 2009 reports a U5MR of 117 per 1,000 live births.

<sup>b</sup> Underweight estimates are based on the WHO Child Growth Standards adopted in 2006.

<sup>c</sup> 1,155 deaths per 100,000 live births is the 2009 estimate reported in the Demographic and Health Survey, 2009. The Maternal Mortality Estimation Inter-agency Group (WHO, UNICEF, UNFPA and the World Bank, together with independent technical experts), adjusted for underreporting and misclassification of maternal deaths. For more information, see [www.childinfo.org/maternal\\_mortality.html](http://www.childinfo.org/maternal_mortality.html).

<sup>d</sup> Survey data.

## Summary of the situation of children and women

1. Lesotho is classified as a low human development country and ranks 160th of 187 countries in the Human Development Index.<sup>1</sup> It faces the triple threat of HIV and AIDS, extreme poverty and high levels of food insecurity. Some 58 per cent of its population of 1.88 million is under 19 years of age.<sup>2</sup>

2. A total 56.6 per cent of Lesotho's population lives below the poverty line.<sup>3</sup> Poverty rates are 50 per cent higher in rural areas than in urban areas. The Gini coefficient (0.52 in 2010) indicates that there is a high level of income inequality.<sup>4</sup>

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<sup>1</sup> *Human Development Report 2011*, UNDP 2011.

<sup>2</sup> The Government of Lesotho is using data from the 2009 Demographic and Health Survey (DHS), released in 2010, as the latest reliable source of information. Accordingly, data from the DHS 2009 is being used for the country's development and to make an investment case for the national strategic plan, the UNDAF and this draft CPD.

<sup>3</sup> Household Budget Survey, 2002-2003, Bureau of Statistics, Ministry of Finance and Development Planning, Lesotho.

<sup>4</sup> *Human Development Report 2011*, UNDP.

3. Lesotho's gross per capita income of \$1,080 (2008, Atlas method) places it on the cusp of middle-income status. The 2008 global economic crisis seriously affected the country through its negative impacts on revenues from the Southern Africa Customs Union, the local textile industry, and employment opportunities for Basotho in South Africa. The consequent decline in revenue threatens public capacity to deliver equitable access to social services. Economic growth is still recovering, expected to reach a modest 4 per cent in 2012.

4. HIV prevalence remains persistently high, at over 23 per cent of the adult population. Women and adolescent girls are disproportionately affected: prevalence among young women aged 20-24 years (24.1 per cent) is six times higher than among adolescent girls aged 15-19 years (4.1 per cent), and four times higher than among young men aged 20-24 years (5.9 per cent). The immediate drivers of the epidemic include multiple and concurrent partnerships, low levels of consistent and correct condom use and low levels of medical male circumcision. This is further exacerbated by gender inequality, cultural norms and practices, and limited social mobilization around HIV prevention. Nationally, advances have been made in the prevention of mother-to-child transmission of HIV (PMTCT) and nearly four fifths of HIV-positive pregnant women receive antiretroviral drugs. Only half of children and adults in need are in treatment and limited progress has been made in primary prevention, particularly among young people.

5. Lesotho is off track for achieving the targets of the Millennium Development Goals 4 (on child mortality) and 5 (on maternal health). The under-five mortality rate (U5MR) increased from 90 per 1,000 live births in 1996 to 117 per 1,000 live births in 2009.<sup>5</sup> The main causes of child mortality are neonatal conditions (48 per cent), AIDS (17 per cent), pneumonia (13 per cent), and diarrhoea (10 per cent). The U5MR is 19 per cent higher in rural areas than in urban areas. In poor households, children have a 30 per cent higher mortality rate compared to children in rich households.

6. Stunting levels have stagnated at 39 per cent since 2004. Stunting is higher among children from poor households and those residing in rural mountain districts, reaching 52 per cent in the Thaba-Tseka district. The immediate causes of stunting are inadequate diet due to food insecurity and poor feeding practices, and recurrent childhood illnesses.

7. The maternal mortality ratio (MMR) increased from 762 per 100,000 live births in 2004 to 1,155 in 2009. About 59 per cent of maternal deaths are HIV/AIDS-related.<sup>6</sup> Other causes include puerperal sepsis and complications of abortion. Though antenatal care attendance is 91.8 per cent, skilled birth attendance and postnatal care remain low, at 62 per cent and 48 per cent, respectively, particularly in the rural mountainous areas and among the poor.

8. The underlying causes of the worsening maternal and child health status are a health system weakened by human resource shortages and a high prevalence of childhood illnesses associated with poor nutrition and sanitation. There is strong political commitment for scaling up successful interventions; the health sector budget constitutes about 11 per cent of the national budget.

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<sup>5</sup> DHS 2009.

<sup>6</sup> *Trends in Maternal Mortality: 1990 to 2008*. Estimates developed by WHO, UNICEF, UNFPA and the World Bank.

9. Lesotho ratified the Convention on the Rights of the Child in 1992 and submitted its initial report in 1998. A combined second, third and fourth report is in preparation. The major recommendation of the Committee on the Rights of the Child was to incorporate the provisions of the Convention in national legislation and this has been addressed through the Children's Protection and Welfare Act 2011 (CPWA) but its operationalization constitutes a major challenge.

10. The threat of HIV and poverty is increasingly exposing children to violation of rights. The 2011 Situation Analysis of Orphans and Other Vulnerable Children estimates that 34 per cent of children (363,526) are orphans, representing a sharp increase from the 1996 Population Census figure (221,403). The study confirms the high prevalence of physical and sexual violence indicated by cases reported to the Child and Gender Protection Unit and the Child Help Line. According to the 2009 DHS, 34 per cent of all children are not living with either of their parents, largely as a result of death or migration; and 45 per cent of births were registered (26 per cent in the 2004 DHS), but birth certificates were issued to only 18 per cent.

11. Lesotho is on track for achieving the gender equality and women's empowerment targets of Goal 3. It ratified the Convention on the Elimination of All Forms of Discrimination against Women in 1995, and submitted a combined (initial, second, third and fourth) report in July 2010. The Sexual Offences Act (2003), the Legal Capacity of Married Persons Act (2006) and other laws establish the legal framework for the protection of women's rights and the prohibition of discrimination based on gender. However, customary law is not fully aligned with the principles of non-discrimination, especially in relation to adoption, marriage, divorce, burial, devolution of property, and death.

12. Lesotho is on track for achieving Goal 2 targets on education. The Education Act 2010 made primary education free and compulsory. However, serious challenges continue to face the sector: the high percentage of unqualified teachers (around 40 per cent since 2008 and higher in rural and mountainous districts); and low achievement outcomes. The high repetition rate for the first four grades has stagnated at approximately 20 per cent since 2008.<sup>7</sup> The overall net enrolment ratio in primary education has stagnated at 80 per cent since 2008. Some of the underlying causes of poor enrolment are herding for boys in mountainous districts and declining girls' enrolments in lowland districts since 2007.<sup>8</sup> Concerning early childhood development, 68 per cent of children aged 3-5 years, mostly those from poor and rural areas, do not access Integrated Early Childhood Care and Development (IECCD) services. Although the primary school completion rate in 2010 is high (87 per cent), the transition rate to secondary school is lower (75 per cent).

13. Lesotho is vulnerable to natural disasters, particularly floods and drought, as well as food insecurity, disease outbreaks, and socio-political crises.

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<sup>7</sup> *Education Statistics Bulletin 2010*, Ministry of Education Training, Lesotho.

<sup>8</sup> *Continuous Multipurpose Survey 2009*, Bureau of Statistics, Ministry of Finance and Development Planning, Lesotho.

## **Key results and lessons learned from previous cooperation, 2008-2012**

### **Key results achieved**

14. Significant progress was recorded towards making a comprehensive package of high impact maternal, neonatal and child survival interventions accessible to at least 90 per cent of women and children. The proportion of women receiving antenatal care was sustained at over 90 per cent, coverage of skilled attendance at delivery increased, from 55 per cent to 62 per cent, and postnatal care coverage increased, from 23 per cent to 48 per cent, since 2004. Improved coverage of services has contributed to a levelling off in child mortality at 117 deaths per 1,000 live births over the past five years.<sup>9</sup> Sustained high polio and tetanus vaccination coverage has contributed to the eradication of poliomyelitis and the elimination of neonatal tetanus. The Government added pentavalent vaccine to the Expanded Programme on Immunization (EPI) schedule in 2008 following advocacy by UNICEF and the World Health Organization (WHO). UNICEF also supported the procurement of supplies for the routine immunization, nutrition, obstetric and neonatal care programmes and capacity-building activities for community health workers and health professionals to manage better labour, delivery and sick children.

15. The target of making quality PMTCT and paediatric AIDS care services available to 80 per cent of affected and infected mothers and children was met, with 81 per cent of HIV-positive pregnant women receiving antiretrovirals in 2010, up from 31 per cent in 2007. Mother-to-child transmission declined from over 35 per cent in 2003 before the introduction of PMTCT to 13.1 per cent in 2010; and the number of children on antiretrovirals almost doubled — from 4,446 in 2008 to 8,036 in 2010.<sup>10</sup> UNICEF provided technical and financial support for the development of national PMTCT and paediatric HIV care guidelines, and supported training of health care staff and supply of more efficacious antiretrovirals. WHO, the United Nations Population Fund (UNFPA), the Baylor College of Medicine, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) and the Christian Health Association of Lesotho (CHAL) supported the training of health workers and service delivery.

16. Advocacy by UNICEF and other partners, including Irish Aid and the management of the church schools contributed to the passing of the Education Act 2010, arguably the most important result for the sector. The Act provides for: free and compulsory primary education; non-repetition in the first three grades of primary school; recognition of non-formal education centres and IECCD centres as forms of schools; and education services within 5 kilometres of every habitation provided by the Ministry of Education and Training. Out-of-school children were supported through distance and non-formal education and as a result, enrolment rose from 6,771 in 2008 to 10,514 in 2010 exceeding the target of 7,466. Further, UNICEF supported evidence-based advocacy that leveraged \$20 million Fast Track Initiative funding.

17. UNICEF, in collaboration with the Ministry of Gender, Youth, Sports and Recreation, supported Kick4Life, the Lesotho Planned Parenthood Association, Catholic Relief Services and community-based partners to carry out risk reduction

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<sup>9</sup> DHS 2009.

<sup>10</sup> *Annual Joint Review 2011*, Ministry of Health and Social Welfare, Lesotho.

and avoidance interventions to increase knowledge and enhance skills for HIV prevention. As a result, over 100,000 young people (30 per cent of young people in three districts with the highest prevalence of HIV), were reached through sports, peer networking, community-based drama, and an interactive short message service (SMS) platform. During the 2010 midterm review of the country programme, the partners recognized UNICEF as a credible convenor of stakeholders engaged in HIV prevention among young people.

18. To reach the most vulnerable children, including those affected or infected by HIV and AIDS, the Lesotho Child Grants Programme (CGP) expanded to reach nearly 10,000 vulnerable households caring for more than 27,700 children (12 per cent of total orphans) in five districts. By the end of 2011, more than 120,000 orphans and vulnerable children were receiving a range of support, and almost 25,000 were enabled to attend school. The Government of Lesotho, the European Union, UNICEF, World Vision and Ayala Consulting were lead partners. Further, the CGP established linkages with other social safety nets and piloted the National Information System for Social Assistance, which is being promoted as the future central registry system for all social safety nets. UNICEF advocacy was key in getting the issue of social protection included in the National Strategic Development Plan (NSDP) 2012-2017.

19. The most significant development in relation to ensuring a protective environment for children in Lesotho was the enactment of the Child Protection and Welfare Act (CPWA) in 2011. The completed child poverty study and the situation analysis of orphans and other vulnerable children will contribute to evidence-based advocacy and interventions.

### **Lessons learned**

20. Provision of a take-away package of antiretroviral drugs to pregnant women as part of PMTCT is feasible and acceptable to service providers and clients and increases drug availability for mothers and their infants in areas with low access to health facilities. Since 2007, a Minimum PMTCT Package comprising antiretrovirals to be taken during pregnancy, delivery and postpartum, is being given to HIV-infected pregnant women. A 2009 Feasibility and Acceptability Study showed that 80 per cent of women who received the pack were satisfied and 91 per cent gave their babies the antiretroviral at birth. However, 9 per cent were embarrassed to receive the pack because it indicated their HIV status. This has been addressed by providing HIV-negative pregnant women with a similar pack containing iron-folate and vitamins. Co-packaging will be an important strategy for increasing the availability of essential medicines in areas with limited access to health facilities.

21. The Lesotho CGP is a non-conditional social cash transfer that provides approximately \$50 quarterly to vulnerable families with children. The 2010 Rapid Assessment confirmed significant positive impacts on the lives of vulnerable children. Lessons learned include the need for detailed analysis of institutional arrangements, technical capacity, resource requirements and delivery mechanisms, and incorporation of a preparatory stage (12-18 months) to test and complete the design and establish institutional arrangements before embarking on implementation. Developing a comprehensive capacity-building strategy at all levels, along with building public-private partnerships while promoting participatory monitoring and evaluation systems, remains critical.

## The country programme, 2013-2017

### Summary budget table

<i>Programme</i>	<i>(In thousands of United States dollars)</i>		
	<i>Regular resources</i>	<i>Other resources</i>	<i>Total</i>
HIV and health	2 400	14 000	16 400
Child protection	1 000	12 900	13 900
Basic education	500	9 500	10 000
Social policy, planning, monitoring and evaluation	520	2 200	2 720
Cross-sectoral	840	1 400	2 240
<b>Total</b>	<b>5 260</b>	<b>40 000</b>	<b>45 260</b>

### Preparation process

22. The draft CPD was jointly prepared by the UNICEF Country Office and the Government of Lesotho, under the leadership of the Ministry of Finance and Development Planning, based on the NSDP 2012-2017, the United Nations development Assistance Framework (UNDAF) 2013-2017, the Situation Analysis of Women and Children, the UNICEF internal Strategic Moment of Reflection, and was informed by the findings of the child poverty study, consultations with children, the midterm review of the country programme and UNICEF annual reviews.

### Programme components, results and strategies

23. The overall goal of the country programme is to advance the fulfilment of the rights of all children and women in Lesotho to survival, development, participation and protection. It will strengthen national capacity to respond to, prevent, and mitigate the impact of high HIV prevalence on children and women towards achievement of national and international goals. It will pursue an equity-focused approach for reducing child and maternal mortality, strengthening social and child protection systems and expanding basic education.

24. The programme will focus on expanding access to quality PMTCT and paediatric care and treatment as well as on strengthening partnerships to improve coordination and coverage of HIV prevention interventions for young people, with a focus on hard-to-reach locations. A comprehensive package of high-impact health, nutrition and water, sanitation and hygiene education (WASH) interventions will address poor nutrition and high child mortality, with a focus on the worst performing districts.

25. The protective environment for children at risk of, and exposed to, violence, exploitation and abuse will be strengthened through implementation of the CPWA 2011. It will also enhance child and gender sensitive social protection systems for vulnerable children and their families, including those infected and affected by HIV.

26. Support for implementation of the Education Act 2010 will improve primary school enrolment, result in enhanced learning outcomes for vulnerable girls and boys of primary school-going age and over-age children, and contribute to a reduction in repetition rates. Access to quality IECCD services will be enhanced

through policy development and support to service delivery, especially in rural and mountainous areas.

27. Policy advocacy, with a focus on data analysis and evidence-based child friendly policies and resource allocation to address the needs of vulnerable children, especially in remote areas, will be a key programme strategy to reduce disparities. Results-based management and continuous monitoring will measure progress in the realization of rights and ensure that resources are used efficiently and effectively. Gaps in the capacity of duty bearers will be addressed through a human rights-based approach to programming. Special attention will be paid to building the capacity of village assistance committees, district child-protection teams and district health-management teams. Working with local government structures will be vital in the context of ongoing decentralization. Faith-based organizations will contribute in the areas of HIV and AIDS, maternal and child health, and education. Communication for development will be mainstreamed in all programme components, in order to achieve positive social and behavioural change. Gender, disaster risk reduction and environmental sustainability will be mainstreamed in all programme components.

### **Programme components**

28. **HIV and health.** This programme component, in collaboration with key line ministries, United Nations agencies and civil society organizations (CSOs), and in line with the National HIV and AIDS Strategic Plans (2011-2012, 2015-2016) and the Health Sector Policy (2012), will strengthen national capacities to address and respond to new HIV infections among children and young people. The programme will achieve the following key results: (a) by 2015, 95 per cent coverage of quality PMTCT and paediatric HIV care and treatment services attained to eliminate new infections among children and to keep those infected alive; (b) by 2017, 80 per cent of young women and young men (10-24 years) have the knowledge and skills to protect themselves from HIV infection; and (c) by 2017, contributing to national efforts to address deteriorating maternal and child health and nutrition statistics, access to high-impact health, nutrition and WASH interventions increased by at least 10 percentage points in the four focus districts that have the worst child mortality and malnutrition rates.

29. In order to meet targets for elimination of mother-to-child transmission of HIV, this component will sustain and strengthen UNICEF support for PMTCT, the prevention and care components as well as paediatric AIDS, to address the needs of underserved populations through innovative outreach and community-based approaches.

30. With a focus on high-prevalence districts, the programme component will aim to equip young people, particularly adolescent girls, with information, skills and supportive services to protect themselves from HIV. It will contribute to the scale up of quality adolescent health care, including HIV testing, counselling and referral, and support to adolescents living with HIV. UNICEF will promote strengthened coordination and monitoring among stakeholders delivering services for HIV prevention among young people at national and district levels. The media, new technologies, and community-based structures, including youth groups, will be utilized to increase comprehensive knowledge and health-seeking practices for HIV prevention among young people.



31. The component will also strengthen the capacity of relevant actors in evidence-based planning, budgeting and costing to ensure increased resource allocation to districts for the implementation of high impact health, nutrition, and water and sanitation interventions. In line with the Government's decentralization policy and UNICEF's equity focus, it will reinforce the capacity of district-level health management teams and other structures to deliver close-to-client preventive and curative health and nutrition services in underserved communities and remove knowledge, transport and financial barriers to the utilization of services. Integrated delivery of HIV/AIDS, nutrition and health services will be promoted within routine facility- and community-based maternal and child health systems.

32. **Child protection.** Within the framework of the CPWA 2011 and the National Policy on Orphans and Vulnerable Children 2006, among other legal and policy frameworks, this programme component will support line ministries (a) to prevent and respond to violence, exploitation and abuse of children; and (b) to address social and economic vulnerability.

(a) *Ensure that the protective environment is strengthened for children at risk of, and exposed to, violence, exploitation and abuse.* The component will help to strengthen the capacity development of law enforcement agencies in relation to the CPWA. It will also support institutional strengthening of the Department of Social Welfare towards effective delivery of services. Social norms that perpetuate adverse behaviours towards children will be addressed through enhancing the capacity of existing community-based structures or establishing new ones, as well as focusing on communication for social change, in collaboration with civil society partners.

(b) *Strengthen child- and gender-sensitive social protection systems for vulnerable children and their families.* This will be achieved by expanding the CGP to all 10 districts to alleviate households' economic vulnerability. The CGP will be used as an entry point for establishing and sustaining a functional referral system for households in need of other social services, and for strengthening institutional arrangements for a more sustainable government-led social protection system. Through the CGP, the programme component will promote birth registration in collaboration with the newly established National Identity and Civil Registry Department.

33. **Basic education.** This programme component will contribute to the implementation of the Education Act and Education Sector Strategic Plan, through the Ministry of Education and Training, churches and NGO partners. Key results are the following: *by 2017, in response to stagnating enrolment and low education quality enhanced access to quality IECCD services, especially for the most vulnerable children; and enrolment and learning outcomes are enhanced for vulnerable girls and boys of primary school-going age and over-age children.*

34. **IECCD.** This sub-component will focus on policy development and on increasing access and quality, especially for vulnerable children, with a focus on rural and mountainous areas. In primary and non-formal education, the focus will be on institutional capacity development through pre- and in-service teacher training, and curriculum, standards and guidelines development. A revitalized education sector-wide approach will support enhanced advocacy, coordination, planning, and monitoring of performance.

35. **Social policy, planning, monitoring and evaluation.** This programme component will work closely with all programmes and in collaboration with line ministries, civil society organizations and the United Nations. Evidence-based policy and programming will be enhanced through support to the national monitoring and evaluation system for the collection, analysis and dissemination of strategic information and by conducting research in priority areas to fill knowledge gaps. The use of DevInfo by government partners for planning purposes will be promoted. Building on the evidence gathered, the programme will engage in high-level advocacy and dialogue with the Government, towards the adoption of child-friendly social and economic policies, legislative measures and budgetary allocations. It will also leverage resources for children and women.

36. **Cross-sectoral.** This component includes programme expenses that cannot be allocated directly to individual programme components; for example, programme planning and coordination-related costs; and staff and operating expenses related to supply, logistics, administration and finance.

#### **Relationship to national priorities and the UNDAF**

37. Lesotho's National Vision is implemented through the NSDP 2012-2017, which articulates six strategic goals: (a) accelerated growth and employment; (b) infrastructure development; (c) enhancing the skills base; (d) reversing environmental degradation and adapting to climate change; (e) improving health, combating HIV and AIDS and reducing social vulnerability; and (f) building effective institutions and promoting democratic governance. The Lesotho UNDAF) comprises 11 outcomes contributing to the NSDP objectives. UNICEF country programme results will contribute to achievement of the projected UNDAF outcomes in the following areas by 2017: (a) promoting human rights, gender equality and increased access to justice; (b) promoting evidence-based policymaking; (c) supporting equitable access to high impact health and nutrition interventions for vulnerable populations; (d) supporting equitable access to quality and relevant primary education; (e) increasing access to an adequate and effectively managed child-sensitive social protection system; and (f) strengthening the national, multisectoral HIV and AIDS response, including coordination, prevention, treatment and care.

38. Priority issues affecting the realization and protection of children's and women's rights identified in the 2012 Situation Analysis of Children and Women include: (a) the persistent high prevalence of HIV, especially among women in the 15-24 age-group; (b) extreme poverty and food insecurity; (c) the increasing MMR; (d) the stagnating U5MR; (e) the unacceptably high levels of stunting; (f) the stagnating enrolment in primary school and poor learning performance; and (g) high levels of violence, abuse and exploitation of children.

#### **Relationship to international priorities**

39. The country programme aims to accelerate progress towards the Millennium Development Goals and the Plan of Action of *A World Fit for Children* and contribute to the achievement of the Global Strategy of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The programme is guided by the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the African Charter on the Rights and Welfare of the Child, the Paris Declaration on Aid Effectiveness, and the Hyogo Framework for

Action. Planned results are formulated in all focus areas of the UNICEF medium-term strategic plan 2006-2013, with priority investments in children and AIDS, and social and child protection.

### **Major partnerships**

40. Government line ministries are the main implementing partners. The Ministry of Education and Training will continue to be the key implementing partner for education. UNICEF will partner with teacher-training institutions for pre-service and in-service teacher training to strengthen the quality of education. Partnerships with non-governmental organizations (NGOs) and United Nations agencies to strengthen quality of pre-school education and non-formal education will continue. The Ministry of Health and Social Welfare, the Baylor College of Medicine and the Sentebale organization will continue to be key partners in programming for adolescents living with HIV. Cooperation with Baylor College, the Clinton Foundation, the Elizabeth Glaser Paediatric AIDS Foundation and Mothers to Mothers are essential for scaling up PMTCT services and paediatric AIDS treatment. The Ministry of Health and Social Welfare, the Ministry of Education and Training, the Ministry of Gender Youth Sports and Recreation, and NGOs, such as Public Services International, and Kick4Life, and United Nations agencies will be key partners for HIV prevention among young people. UNICEF is committed to the principles of aid effectiveness and as such actively contributes to the Development Consultative Partners' Forum and the Health Development Partners' Forum in Lesotho.

41. UNICEF partners with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States Agency for International Development and the European Union to support the Department of Social Welfare to implement the CPWA. The potential for developing partnerships with faith-based organizations around social protection and child protection issues will be explored. Cooperation with UNDP, the International Labour Organization, the World Food Programme and UNAIDS is helping to advance the social protection agenda. Lesotho is a "self-starter" country for the Delivering as One pilot and UNICEF has been an active member of the United Nations country team in advancing the Delivering as One agenda.

### **Monitoring, evaluation and programme management**

42. The UNDAF monitoring and evaluation matrices provide the framework within which UNICEF's integrated monitoring and evaluation plan is implemented. The UNDAF Action Plan specifies key indicators, baselines and targets that will be reviewed annually and at the end of the programme cycle. The MTR review of the country programme will be synchronized with the UNDAF MTR in 2015. Planned data collection exercises include the Continuous Multipurpose Survey, a DHS in 2014, and the Millennium Development Goals progress report in 2016. The United Nations will continue to support the Government in the use of DevInfo.

43. All programme implementation will be coordinated under the Ministry of Finance and Development Planning and subject to oversight from a multisectoral Steering Committee jointly convened by the Ministry and UNICEF.

44. Emergency preparedness and response and disaster-risk reduction will focus on natural hazards (drought and floods), food insecurity, poverty, and the impact of HIV and AIDS. The Early Warning Early Action Plan is updated on an annual basis

and UNICEF will participate in coordinated inter-agency responses under the leadership of the United Nations Resident Coordinator.

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